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**THIRD JUDICIAL DISTRICT COURT,**
**SALT LAKE COUNTY, UTAH**

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff,

*Plaintiff,*

v.

STATE OF UTAH, *et al.*,

*Defendants.*

**SECOND MOTION FOR A PRELIMINARY INJUNCTION AND SUPPORTING MEMORANDUM**

**Oral Argument Requested**

Case No. 220903886

Judge Andrew Stone

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## SUMMARY OF DISPOSITION REQUESTED AND SUPPORTING GROUNDS

Last summer, when the U.S. Supreme Court overruled *Roe v. Wade* and Utah's near-total abortion ban took effect, this Court entered emergency relief pursuant to the protections of the Utah Constitution to preserve the safe and legal access to pre-viability abortion that Utahns have relied on for the past fifty years. *See* Order Granting Prelim. Inj. ("PI Order"); Senate Bill 174, 2020 Leg., Gen. Sess. (Utah 2020) (codified at Utah Code Ann. tit. 76, ch. 7A) (the "Trigger Ban"). The State's appeal of that preliminary injunction is fully briefed and pending before the Utah Supreme Court.

With the Trigger Ban enjoined by this Court and pending review by the Utah Supreme Court, the Utah Legislature sought an alternative means to its desired end: state control over women's reproductive freedom and bodily autonomy. This time, its solution was to ban abortion *clinics*. House Bill 467, 2023 Leg., Gen. Sess. (Utah 2023) ("HB 467") requires all abortions to be performed in a hospital and criminalizes abortions performed in licensed abortion clinics (the "Clinic Ban"). Because hospitals in Utah provide abortion only in a narrow set of circumstances, licensed abortion clinics provide over 95 percent of the abortions in the state, just as safely and at far lower cost than hospitals. The Clinic Ban therefore functionally bans abortion in Utah.

Accordingly, if left unrestrained, the Clinic Ban will effectively nullify this Court's 2022 preliminary injunction. Plaintiff Planned Parenthood Association of Utah ("PPAU") will be forced to stop providing abortion under any circumstance. The vast majority of Utahns will be left without access to legal abortions in their home state. Women will be forced to carry pregnancies to term against their will; to remain pregnant until they can travel out of state to access this critical, time-sensitive medical care, at great cost to themselves and their families even if they are able to obtain an appointment and make this trip; or to attempt to self-manage their abortions outside the medical

system. And Utahns will lose their constitutional rights to determine the composition of their families; to gender equality; to bodily integrity; and to make private health care decisions—each an irreparable constitutional harm.[1]

To be clear, the Clinic Ban amends both the Trigger Ban, Utah Code Ann. § 76-7a-201, and Utah's 18-Week Ban, now codified at Utah Code Ann. § 76-7-302, to require all abortions permitted under either of those laws to be performed in a hospital. But because amendments to the Trigger Ban have no operative effect while the underlying Trigger Ban prohibition remains enjoined by this Court, this motion seeks preliminary injunctive relief against the Clinic Ban only to the extent that it requires abortions before 18 weeks LMP to be performed in a "hospital" as defined by HB 467; prohibits licensed "abortion clinics" from providing abortions before 18 weeks LMP; and eliminates "abortion clinics" as a facility licensure category.

A functional ban on abortions, accomplished by delicensing and intimidating abortion providers, violates multiple provisions of the Utah Constitution just as an express abortion ban does. PPAU therefore urges the Court to enter a preliminary injunction against the Clinic Ban before its May 3, 2023 effective date, to preserve the status quo currently maintained by the preliminary injunction against the Trigger Ban while it addresses the significant constitutional violations concurrently inflicted by the two laws.

## STATEMENT OF FACTS

### I. PPAU AND ITS SERVICES

PPAU is a Utah non-profit organization dedicated to ensuring Utahns' access to affordable, high-quality sexual and reproductive health care. Decl. of David Turok, M.D., M.P.H., FACOG in

[1] PPAU uses "woman" or "women" as a short-hand for people who are or may become pregnant, but people of a range of gender identities, including transgender men and gender-diverse individuals, may become pregnant and seek abortion, and are also harmed by HB 467.

Supp. of Pl.'s Mot. for TRO ("First Turok Decl.") ¶¶ 12–13, submitted in support of the temporary restraining order of the Trigger Ban and attached hereto for ease of reference as Exhibit A; Decl. of David Turok, M.D., M.P.H., FACOG in Supp. of Pl.'s Second Mot. for Prelim. Inj. ("Second Turok Decl.") ¶¶ 12–13, attached hereto as Exhibit B. Through its physicians licensed to practice in Utah, PPAU provides abortion at three health centers. Second Turok Decl. ¶ 14. PPAU is one of only two outpatient abortion providers in Utah. *Id*. ¶ 63.

Each of PPAU's three health centers is licensed as an "abortion clinic" under Utah law. *Id*. ¶ 14; Decl. of Annabel Sheinberg in Supp. of Pl.'s Second Mot. for Prelim. Inj. ("Sheinberg Decl.") ¶ 4, attached hereto as Exhibit C. To maintain these facility licenses, PPAU must submit license renewal applications to the Utah Department of Health and Human Services ("DHHS") annually; comply with the requirements in Utah Code title 76, chapter 7, part 3, Abortion, including the recordkeeping and reporting requirements of section 313; and adhere to the health, safety, sanitary, and recordkeeping requirements established by R432-600 of the Utah Administrative Code. Utah Code Ann. §§ 26-21-6.5(4); 26-21-8(4)(a). At least twice each year, DHHS inspects each of PPAU's three licensed facilities to ensure that the abortion clinic is complying with all applicable statutory and licensing requirements. Utah Code Ann. §§ 26-21-6.5(4)(f), (5). At least one of these two inspections must be a surprise inspection, without advance notice to PPAU. Utah Code Ann. § 26-21-6.5(5).

## II. THE TRIGGER BAN

In 2020, the Utah Legislature enacted the Trigger Ban, which bars abortion at any point in pregnancy with limited exceptions. As detailed in PPAU's first motion for a preliminary injunction, Mot. for Prelim. Inj. ("First PI Mot.) at 3, the Trigger Ban provided that it would take effect only upon certification "that a court of binding authority ha[d] held that a state may prohibit

the abortion of [a fetus] at any time during the gestational period." 2020 Utah Laws ch. 279, § 4(2). This condition was met last year, soon after the U.S. Supreme Court held that *Roe v. Wade*, 410 U.S. 113 (1973), and its progeny were overruled, eliminating nearly fifty years of precedent protecting a federal substantive due process right to abortion until viability. *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022). Shortly thereafter, the Utah Senate announced that the Utah legislative general counsel had issued the certification required for the Trigger Ban to take effect. First PI Mot. at 3–4.

Upon certification of the Trigger Ban in June 2022, PPAU was forced to stop providing abortions that did not meet the Ban's limited exceptions. The next day, PPAU filed this litigation and sought emergency injunctive relief against the Trigger Ban. This Court granted a temporary restraining order on June 27, 2022, allowing PPAU to continue to provide abortion services.

PPAU then moved for a preliminary injunction, alleging that the Trigger Ban violated Utahns' rights under the Utah Constitution. After further briefing and oral argument, this Court preliminarily enjoined the Trigger Ban on July 11, 2022. In its Order, the Court found that PPAU had "made a strong showing that, without a preliminary injunction, the [Trigger Ban would] cause irreparable harm to PPAU, its patients, and its staff," that the balance of harms weighed in PPAU's favor, and that a preliminary injunction would be in the public interest. PI Order ¶¶ 3–5. The Court granted the preliminary injunction on the grounds that PPAU had raised "at least serious issues on the merits that should be the subject of further litigation." PI Order ¶¶ 6–7. Under this injunction, PPAU has continued to provide abortions up to 18 weeks of pregnancy, which is the legal limit pursuant to a separate provision of Utah law not challenged in this litigation.

The State petitioned the Utah Supreme Court for permission to appeal the preliminary injunction and moved to stay the preliminary injunction pending appeal. On October 3, 2022, the

Supreme Court denied the motion to stay but granted the petition for interlocutory appeal. Order, *State v. PPAU*, No. 20220696-SC (Utah Oct. 3, 2022). Briefing in that appeal was completed on February 21, 2023.

## III. UTAH HOUSE BILL 467

Even as the Utah Supreme Court prepared to decide that appeal, however, the Utah Legislature enacted a new abortion ban, scheduled to take effect on May 3, 2023. HB 467 makes it illegal in Utah to provide an abortion anywhere other than a hospital, unless a medical emergency necessitates performing the abortion in another location. HB 467 §§ 17–18, 28–29 (amending Utah Code Ann. §§ 76-7-301(6), -302(3); 76-7a-101(4), -201(2)(b)). HB 467 also eliminates the longstanding licensure category of abortion clinics, prohibiting the Utah Department of Health and Human Services ("DHHS") from issuing any abortion clinic licenses after May 2, 2023 and requiring DHHS to revoke the license of any facility other than a hospital that provides an abortion. *See* HB 467 §§ 1–6, 16, 21, 24, 28 (amending Utah Code Ann. §§ 26-21-2, -6.5(1)–(2); 26-21-7, -11(2); 26-21-8, -25; 76-7-301, -305, -314; 76-7a-101). Collectively, these provisions ban abortion in Utah anywhere other than at a hospital (the "Clinic Ban"). Notably, neither HB 467's sponsors nor Governor Cox claimed to justify the Clinic Ban on health or safety grounds; rather, HB 467's supporters presented it as a "clarifying" bill that would complement and facilitate the Trigger Ban's elimination of abortion in virtually all circumstances with limited exceptions—despite that the Trigger Ban remains enjoined.[2]

[2] *Hearing on H.B. 467 before the H.*, 2023 Leg., Gen Sess., recording starting at 01:22:20 (Utah Feb. 17, 2023) (statement of Rep. Karianne Lisonbee, floor sponsor of HB 467) (explaining that HB 467 "unlicenses abortion clinics that are specifically there to conduct elective abortions" but permits other clinics to provide abortions "for people who fall under exemptions [to the Trigger Ban]" and clarifies those Trigger Ban exceptions), available at https://le.utah.gov/av/floorArchive.Jsp? markerID=122136; *Hearing on H.B. 467 before the S.*, 2023 Leg., Gen. Sess., recording starting at 01:42:04 (Utah March 2, 2023) (statement of Sen. Daniel McCay, floor

Violating the Clinic Ban is punishable as a second-degree felony, with the possibility of imprisonment for up to fifteen years and aggressive criminal fines (up to $10,000 for individuals and up to $20,000 for corporations), and by adverse licensure consequences for both facilities and providers. *See* HB 467 §§ 5, 17, 24–25, 29 (amending Utah Code Ann. § 26-21-11(2)); 76-7-302(3), -314(3), -314.5(1); 76-7a-201(2)(b)); Utah Code Ann. §§ 76-3-203(2), -301(1)(a), -302(1). Additionally, under separate provisions of HB 467, the Utah Division of Professional Licensing ("DOPL") can deny or revoke a medical professional's license if DOPL believes the practitioner has violated the Clinic Ban, regardless of whether the practitioner is ultimately found criminally liable for violating the Ban. HB 467 §§ 7–14 (amending Utah Code Ann. §§ 58-31b-502(1)(q); 58-44a-502(8); 58-67-304, -502(1)(e); 58-68-304, -502(1)(e); 58-70a-501; 58-77-603)) (the "Professional Licensing Penalties").

Given the threat of these severe criminal and professional penalties, PPAU will be unable to perform abortions under any circumstance if the Clinic Ban takes effect, even though this Court's injunction against the Trigger Ban remains in place. Because Utah hospitals do not provide abortion outside of a few narrow circumstances and over 95 percent of abortions in Utah are provided by a licensed abortion clinic, the Clinic Ban functionally bans abortion in Utah.

HB 467 was signed by the Governor on March 15, 2023, and is set to take effect on May 3, 2023. If the Clinic Ban is allowed to take effect, PPAU, its staff, and its patients will suffer the

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sponsor of HB 467) (explaining that HB 467 aims "to ensure our state strikes the best balance of protecting innocent life and protecting the women who experience rare and dangerous complications during pregnancy"), available at https://le.utah.gov/av/floorArchive.jsp?markerID=123524; *Governor's Monthly News Conference, March 2023*, PBS Utah, recording starting at 00:16:20 (Mar. 16, 2023), https://www.pbsutah.org/pbs-utah-productions/series/governors-monthly-conference/ (explaining that the intent of HB 467 is to clarify the Trigger Ban's exceptions and to require that abortions that fall within those exceptions be provided only in hospitals).

same harms they would have suffered under the Trigger Ban, including irreparable violations of their rights under the Utah Constitution. *See* PI Order ¶ 3.

## IV. HB 467'S CLINIC BAN EFFECTIVELY BANS ABORTION IN UTAH

By criminalizing abortion at abortion clinics, the Clinic Ban criminalizes the vast majority of abortions provided in the state. Over 95 percent of the abortions in Utah are provided by PPAU's licensed abortion clinics or by the only other Utah outpatient abortion provider—Wasatch Women's Center, located in Salt Lake City. Second Turok Decl. ¶ 63. This is consistent with nationwide rates. In 2020, up to 97 percent of abortions nationally were performed in outpatient clinics or physicians' offices and as little as 3 percent of abortions were performed in hospitals. *Id*. ¶ 64. If the Clinic Ban takes effect on May 3, 2023, Utah's outpatient abortion providers will be forced to stop providing abortions under any circumstance. *Id*. ¶ 7.

Utah hospitals cannot and will not step in to replace abortion clinics as generally-available abortion providers. As HB 467's legislative sponsors and Governor Cox implicitly recognized in focusing their justifications for the Clinic Ban on abortions that fall within the Trigger Ban's narrow exceptions,[3] abortion is generally only performed by Utah hospitals as a result of one of two circumstances: either a medical condition that seriously threatens a patient's life or health or a diagnosis of a grave fetal anomaly. *Id*. ¶ 65. Utah law prohibits the use of state funds to pay for abortion other than to protect the life of the patient, to prevent significant damage to one of the patient's major bodily functions, or in cases of rape or incest that have been reported to law enforcement. Utah Code Ann. § 76-7-331(2). This prevents public hospitals like the University of Utah Hospital from offering abortions to the general public. Second Turok Decl. ¶ 65. Fewer than

[3] *See supra* note 2 (collecting legislative testimony that HB 467 would require hospitals to perform abortions only under the Trigger Ban's exceptions).

30 pregnancy terminations are performed by University of Utah providers each year.[4] Additionally, Utah law allows medical facilities and providers to refuse to provide abortion on moral or religious grounds. Utah Code Ann. § 76-7-306. Reflecting this, five Utah hospitals recently acquired by a Catholic-affiliated hospital system will not "provide elective abortions . . . in order to align with their new owner's 'ethical and religious directives.'"[5]

Even if a Utah hospital were willing to provide abortion in a wider range of circumstances, the logistics of providing abortion in a hospital setting would make it extremely difficult for a hospital to offer more than five abortion appointments a day. *Id.* ¶ 68. This would be a woefully inadequate substitute for the number of patients currently seen by Utah's outpatient abortion clinics, where, as explained below, people can obtain abortion just as safely and at far lower cost. *Id*. ¶ 60; *see infra* Statement of Facts, Part V. Hospitals currently struggle with staffing shortages for surgical care, contributing to delays in case scheduling. *Id*. ¶ 68. Abortions performed at hospitals are usually performed by induction, requiring an operating room, extensive staffing (including an anesthesiologist), increased costs, increased patient pain, and a much longer investment of time for patients. *Id.* And at hospitals like the University of Utah, the vast majority of abortion patients receive general anesthesia, increasing the total appointment time, post-procedure recovery time, and staffing and facility requirements. *Id.* ¶ 69. All these factors mean that Utah hospitals would only be able to provide at best a small fraction of the abortion care currently offered by licensed abortion clinics, even if hospitals were willing to provide generally-

[4] *University of Utah Statement: U.S. Supreme Court's overturn of Roe v. Wade*, Univ. of Utah (June 24, 2022), https://attheu.utah.edu/facultystaff/university-of-utah-statement-u-s-supreme-courts-overturn-of-roe-v-wade/.

[5] Paighten Harkins, *As 5 Utah hospitals change hands, will it mean less reproductive care?*, Salt Lake Tribune (March 27, 2023), https://www.sltrib.com/news/2023/03/27/utah-shifts-abortions-hospitals/.

available abortion services rather than limiting their services to abortions for medical indications or grave fetal anomalies.

Additionally, the criminal penalties and Professional Licensing Penalties attached to the Clinic Ban will chill medical providers' willingness to provide abortion even where it is permitted by the terms of the Ban. Physicians considering providing abortion in Utah will be keenly aware of the current national political landscape and the threat of zealous prosecutors or private litigants attempting to push the boundaries of the law to punish abortion providers. *Id.* ¶ 85. Hospital physicians who lack experience providing abortion or familiarity with Utah abortion law will be even less comfortable taking on the criminal and professional risks that the Clinic Ban and Professional Licensing Penalties attach to performing abortion. *Id.* ¶ 86. Indeed, this chilling effect is already being felt by physicians in other states with punitive abortion laws, with dire consequences for patients in need of care. *Id.* ¶ 83. And abortion bans in other states are deterring physicians from providing even other forms of obstetrical care—for example, leading one hospital in Idaho to stop providing labor and delivery services entirely.[6] *Id.* ¶ 89.

By banning abortion at abortion clinics, HB 467's Clinic Ban prohibits abortion as effectively as the Trigger Ban already enjoined by this Court.

## V. HB 467'S CLINIC BAN DOES NOT IMPROVE ABORTION SAFETY

Robust medical evidence demonstrates that first- and second-trimester abortion is just as safe when provided in an outpatient clinic as it is when provided in a general hospital. Second Turok Decl. ¶¶ 7, 43. Regardless of where it is performed, abortion is one of the safest procedures in contemporary medical practice and many times safer than labor and delivery, which Utah law

[6] Gloria Oladipo, *Idaho hospital to stop delivering babies as doctors flee over abortion ban*, The Guardian (March 20, 2023), https://www.theguardian.com/us-news/2023/mar/20/idaho-bonner-hospital-baby-delivery-abortion-ban.

allows women to undergo at home.[7] *Id*. ¶¶ 32, 36–7. All methods of abortion provided at PPAU—medication abortion, aspiration abortion, and dilation and evacuation ("D&E")—are simple, straightforward medical treatments that typically take no more than ten minutes to perform, involve no incisions, have an extremely low complication rate, and, nationwide, are almost always provided in outpatient, office-based settings. *Id*. ¶¶ 27, 30. Major complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23 percent of abortions performed in outpatient, office-based settings. *Id*. ¶ 34. Published research conducted in Utah concluded that second-trimester D&Es in dedicated outpatient facilities, such as PPAU's health centers, could be safer and less expensive than hospital-based D&Es or abortion by induction of labor. *Id*. ¶ 44.

Indeed, like other medical procedures, abortion is safest when performed by experienced clinicians. *Id*. ¶ 43. PPAU physicians have incredibly low abortion complication rates and superb safety records. Because PPAU specializes in providing patient-centered, holistic sexual and reproductive health care, PPAU patients benefit from receiving care from highly experienced and specialized providers and staff. *Id*. ¶ 46. In recognition of PPAU's providers' skill and experience, Utah hospitals throughout Utah and the Intermountain West regularly refer complicated or high-risk D&E cases to PPAU physicians. Upon receiving these referrals, PPAU physicians determine the most appropriate setting for the patient's care, which is usually PPAU's Metro Health Center in Salt Lake City. *See id*. ¶ 42.

Meanwhile, the features that differentiate hospitals from abortion clinics include system operations requirements, staffing requirements, and building construction requirements. These features are not relevant or necessary in the context of abortion care and provide no medical

[7] *See* Utah Code Ann. § 58-77-304 (recognizing "the right of parents to deliver their baby where, when, how, and with whom they choose").

benefit. *Id*. ¶ 50. This is particularly so for medication abortion, where the patient simply takes two sets of pills. *Id*. ¶ 51.

Even in the rare event that an abortion complication arises during the procedure, it can nearly always be safely and appropriately managed in an outpatient office setting. For example, most cases of hemorrhage (the technical term for bleeding) are managed in the clinical setting with uterotonic medications, like misoprostol, that cause uterine contractions and reduce bleeding and with uterine massage. *Id*. ¶ 57. Most cases of cervical laceration are managed in the clinic setting either with Monsel's Solution or suture. *Id*. Cases of incomplete abortion are generally managed through repeat aspiration or medication. *Id*. In the exceedingly rare event that a higher level of care is needed to manage complications, patients are safely stabilized and transferred to a hospital, sometimes even more quickly than they would be transferred between departments within the same hospital system. *Id*. ¶¶ 58–9.

Procedures with higher complication rates than abortion are routinely, and without controversy, performed in outpatient, office-based settings throughout Utah. These include vasectomies, colonoscopies, wisdom teeth extractions, and surgical removal of the tonsils. *Id*. ¶ 35. Most relevantly, although a woman is more than 12 times more likely to die from childbirth than from having an abortion, Utah law permits physicians and certified nurse-midwives to deliver babies in locations other than a hospital, including at birthing centers and even in private homes. Utah Code Ann. § 58-77-304 ("Nothing in this chapter abridges, limits, or changes in any way the right of parents to deliver their baby where, when, how, and with whom they choose, regardless of licensure under this chapter."); *id*. § 26-21-29; Second Turok Decl. ¶¶ 36–7.

For all these reasons, national medical experts such as the National Academies of Sciences, Engineering, and Medicine, the American College of Obstetricians and Gynecologists, and the

American Public Health Association agree that abortions can be provided safely in office-based settings and that a hospital setting is not clinically necessary. *Id*. ¶ 48.

## A PRELIMINARY INJUNCTION IS WARRANTED

A preliminary injunction is "preventative in nature" and "serves to 'preserve the status quo pending the outcome of the case.'" *Hunsaker v. Kersh*, 1999 UT 106, ¶ 8, 991 P.2d 67 (citations omitted). The decision whether to grant a preliminary injunction is committed to the sound discretion of the district court. *See id.* ¶ 6.

When this Court preliminarily enjoined the Trigger Ban, Utah rules authorized preliminary injunctive relief where the movant demonstrated (1) that the movant would suffer irreparable harm without the injunction; (2) that the threatened injury to the movant outweighed any injury to the party restrained; (3) that the injunction would not be adverse to the public interest; and (4) either that there was a substantial likelihood that the movant would prevail on the merits of the underlying claim, or that the case presented serious issues on the merits which should be the subject of further litigation. Utah R. Civ. P. 65A(e) (2022). Transparently in response to this Court's order enjoining the Trigger Ban based on its determination that PPAU had "demonstrated that there are *at least* serious issues on the merits that should be the subject of further litigation," PI Order ¶ 6 (emphasis added), however, the Legislature amended Utah's longstanding preliminary injunction standard to require a showing in every case of substantial likelihood of prevailing on the merits. House Joint Resolution 2, 2023 Leg., Gen. Sess. (2023) ("HJR 2"). The other Rule 65A factors remain unchanged.

As set forth below, PPAU satisfies each part of the Rule 65A test for the Clinic Ban, which bans abortion for the vast majority of Utahns just like the Trigger Ban.

## I. PPAU IS SUBSTANTIALLY LIKELY TO PREVAIL ON THE MERITS OF ITS CLAIMS THAT THE CLINIC BAN VIOLATES THE UTAH CONSTITUTION

First, the Clinic Ban distinguishes between similarly-situated health care facilities—hospitals and licensed abortion clinics—without any safety justification for doing so, in violation of the Utah Constitution's Uniform Operation of the Laws Clause.

Second, because the Clinic Ban accomplishes in effect what the Trigger Ban sought to do directly, PPAU is substantially likely to prevail on the merits of many of the same constitutional claims it previously asserted in challenging the Trigger Ban: the right to determine one's own family composition; the right to equal protection under Utah's Equal Rights Provision and Uniform Operation of Laws Clause; the right to bodily integrity; and the right to privacy. In addition to the argument and evidence presented for the first time in support of this motion, PPAU incorporates by reference all briefing and evidence submitted in support of its motion for a preliminary injunction against the Trigger Ban.[8]

### A. The Clinic Ban distinguishes between licensed abortion clinics and hospitals without justification.

PPAU's licensed abortion clinics provide abortion just as safely as Utah hospitals do. The Clinic Ban's distinction between these two types of health care facilities—criminalizing abortion at one but not the other—fails to advance any reasonable government objective and violates the Utah Constitution's Uniform Operation of Laws ("UOL") Clause.

That clause provides that "[a]ll laws of a general nature shall have uniform operation." Utah Const. art. I, § 24. Although sometimes described as a "state-law counterpart to the federal Equal Protection Clause," *State v. Canton*, 2013 UT 44, ¶ 35, 308 P.3d 517, the UOL Clause's

[8] As explained in PPAU's first PI motion, PPAU has standing in this case to litigate claims on behalf of itself, its staff, and its patients. First PI Mot. at 4–6; PI Reply at 3–5.

language is distinct from that used in the U.S. Constitution, *see* U.S. Const. amend. XIV, § 1 (prohibiting a state from "deny[ing] to any person within its jurisdiction the equal protection of the laws"). This "differing language," in addition to different "context[] and jurisprudential considerations found in and surrounding the two provisions[,] have led to differing legal consequences" under the Utah Constitution and its federal counterpart. *State v. Drej*, 2010 UT 35, ¶ 33, 233 P.3d 476 (internal quotation marks omitted); *accord Lee v. Gaufin*, 867 P.2d 572, 577 (Utah 1993). "The most notable of these differing legal consequences is that" the Uniform Operation Clause "demands more than facial uniformity; the law's operation must be uniform" as well. *Drej*, 2010 UT 35, ¶ 33; *accord DIRECTV v. Utah State Tax Comm'n*, 2015 UT 93, ¶ 49, 364 P.3d 1036.

Utah courts apply a "three-step inquiry" to UOL Clause claims, asking "(1) whether the statute creates any classifications; (2) whether the classifications impose any disparate treatment on persons similarly situated; and (3) if there is disparate treatment, whether the legislature had any reasonable objective that warrants the disparity." *Count My Vote, Inc. v. Cox*, 2019 UT 60, ¶ 29, 452 P.3d 1109 (quoting *State v. Robinson*, 2011 UT 30, ¶ 17, 254 P.3d 183); *see also Salt Lake City Corp. v. Utah Inland Port Auth.*, 2022 UT 27, ¶¶ 11–28, 524 P.3d 573 (explaining that this modern formulation is the applicable standard). PPAU is substantially likely to prevail at each step.

*1. The Clinic Ban creates a classification between licensed abortion clinics and "hospitals."*

The Clinic Ban creates a classification between hospitals and abortion clinics by making it a crime to provide abortion in one but not the other.[9] Under the Clinic Ban, "[a]n abortion may be

[9] Collectively, the Clinic Ban appears at HB 467 § 17 (amending Utah Code Ann. § 76-7-302(3)) ("An abortion may be performed only in . . . a hospital, unless it is necessary to perform the abortion in another location due to a medical emergency."); *id.* § 29 (amending Utah Code

performed only in a hospital, unless it is necessary to perform the abortion in another location due to a medical emergency." HB 467 § 17 (amending Utah Code Ann. § 76-7-302(3)). Meanwhile, "a licensed abortion clinic may not perform an abortion in violation of any provision of state law," including this hospital requirement. *Id.* § 2 (amending Utah Code Ann. § 26-21-6.5(1)(b)). The Clinic Ban requires DHHS to revoke the license of any health care facility other than a hospital that provides an abortion. *Id.* § 5 (amending Utah Code Ann. § 26-21-11(2)).

*2. Licensed abortion clinics and "hospitals" are similarly situated.*

This classification between licensed abortion clinics and "hospitals" constitutes disparate treatment of health care facilities that are similarly situated for purposes of abortion safety.

Abortion is just as safe when provided by experienced clinicians in outpatient settings as when provided at hospitals. *See supra* Statement of Facts, Part V. Indeed, the Clinic Ban itself defines "hospital" to include some outpatient health centers, implicitly recognizing that hospitals and outpatient clinics are similarly situated. Under HB 467, the definition of "hospital" includes health care facilities other than general hospitals so long as abortion is provided (1) by physicians who are credentialed at a general hospital to provide abortion using the same procedure; and (2) as safely as it would be at a hospital. HB 467 § 16 (amending Utah Code Ann. § 76-7-301(6)).[10]

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Ann. § 76-7a-201(2)(b)) ("An abortion may be performed only[] . . . in a hospital, unless it is necessary to perform the abortion in another location due to a medical emergency."); *id.* § 16 (amending Utah Code Ann. § 76-7-301(6)) (defining "hospital"); *id.* § 28 (amending Utah Code Ann. § 76-7a-101(4)) (defining "hospital"); *id.* §§ 2, 5 (amending Utah Code Ann. §§ 26-21-6.5(1)(b), -11(2)) (barring licensed abortion clinics from providing abortions in violation of Utah law, including the Clinic Ban); *id.*, §§ 1–4, 6, 21, 24 (amending Utah Code Ann. §§ 26-21-2, -6.5, -7–8, -25; 76-7-305(2)(a), -314(7)) (eliminating the "abortion clinic" licensure category); HB 467, §§ 24–25 (amending Utah Code Ann. §§ 76-7-314; 76-7-314.5) (criminalizing violations of the Utah Criminal Code, Title 76, Chapter 7, Part 3, including HB 467's hospital requirement as codified at Utah Code Ann. § 76-7-302(3)).

[10] In full, as amended by section 16 of HB 467, title 76, chapter 7, section 301(6) of the Utah Code provides that "'Hospital' means: (a) a general hospital licensed by the department according to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and (b) a clinic or other medical facility . . . that meets the following criteria: (i) a clinician who performs

PPAU provides abortion via physicians who are credentialed to provide those same methods of abortion at a hospital, and, as explained above, those methods of abortion are as safe at an outpatient clinic like PPAU's licensed abortion clinics as they would be if provided at a hospital. *Supra* Statement of Facts, Part V. Accordingly, HB 467's alternative definition of "hospital" *includes* some licensed abortion clinics by its terms.[11] Indeed, HB 467 actually defines "abortion clinic" to *exclude* facilities that satisfy the definition of "hospital," apparently recognizing that these two categories overlap. HB 467 § 1 (amending Utah Code Ann. § 26-21-2(1)(b)) ("'Abortion clinic' does not mean a clinic that meets the definition of hospital under Section 76-7-301 or Section 76-7a-101.").

Because this expanded definition of "hospital" appears to apply to PPAU's licensed abortion clinics, PPAU asked DHHS how PPAU's licensed abortion clinics could become designated as "hospitals" under HB 467, such that they could remain licensed as abortion clinics and continue providing abortion after May 3, 2023, notwithstanding the Clinic Ban. Sheinberg Decl. ¶ 15. But DHHS informed PPAU that only licensed hospitals and satellite clinics operating under a general hospital's license would be eligible for the Clinic Ban's expanded "hospital" definition, despite that this limitation appears nowhere in the text of HB 467. *Id.* ¶¶ 16–17. Thus, PPAU's licensed abortion clinics do not satisfy the statutory and regulatory requirements for licensure as a general hospital under the Clinic Ban in operation.

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procedures at the clinic is required to be credentialed to perform the same procedures at a general hospital licensed by the department; and (ii) any procedures performed at the clinic are done with the same level of safety for the pregnant woman and unborn child as would be available in a general hospital licensed by the department."

[11] HB 467 adds this same definition of "hospital" to the Trigger Ban's definitions provision and requires abortions performed under one of the Trigger Ban's exceptions to be performed in a "hospital." *See* HB 467 §§ 28–29 (amending Utah Code Ann. §§ 76-7a-101(4), -201(2)(b)). This amendment to the Trigger Ban's exceptions will not take effect, however, while the underlying Trigger Ban prohibition remains enjoined by this Court.

Therefore, notwithstanding that PPAU's licensed abortion clinics are similarly situated to hospitals and even qualify as "hospitals" under the text of HB 467 itself, the Clinic Ban will, in operation, force PPAU to stop providing abortion on May 3, 2023.

*3. The Clinic Ban's disparate treatment of licensed abortion clinics and "hospitals" does not further any reasonable objective.*

Because the Clinic Ban's legislative classification implicates the fundamental constitutional rights to family self-determination, gender equality, bodily integrity, and privacy, heightened scrutiny applies, *Salt Lake City Corporation v. Utah Inland Port Authority*, 2022 UT 27, ¶ 17, and the Ban fails that review. *See infra* Part I.B. But because the Clinic Ban fails even rational basis, PPAU is substantially likely to prevail on its UOL Claim wholly independent of its other constitutional claims, particularly given that Utah's "rationally related" test may be more exacting than its federal counterpart. *See Mountain Fuel Supply Co. v. Salt Lake City Corp.*, 752 P.2d 884, 889 (Utah 1988); *Malan v. Lewis*, 693 P.2d 661, 670–71 (Utah 1984).

Abortion is just as safe, if not safer, in an outpatient clinic as in a hospital, so the Clinic Ban does not further any general government interest in patient safety, particularly given the Clinic Ban's allowance of abortion at *some* outpatient clinics. *Supra* Part I.A.2. And notably, even HB 467's sponsors did not claim that the Clinic Ban was intended to promote a government interest in patient safety and did not identify any evidence that abortions provided in general hospitals are safer than the same method of abortion provided in an outpatient clinic.

For example, during legislative debate, in response to the concern that the Clinic Ban would force abortion patients to obtain care in a restrictive and expensive hospital setting without any safety benefit (even if they could find a hospital willing to provide their procedure), HB 467's House sponsor did not attempt to justify the bill's hospital requirement on safety grounds. Rather,

she responded that the Clinic Ban would still allow *some* clinics to continue providing abortion—just not *PPAU*'s licensed abortion clinics:

> I actually don't think that that is what this bill does . . . the language about hospitals is the existing language. *There is a deletion of Planned Parenthood—or I'm sorry, of abortion clinics*. . . . This [bill] doesn't preclude an individual to visit their doctor in a clinic environment and receive a prescription . . . . We are certainly not pigeonholing patients into one type of service.[12]

One additional legislative purpose of the Clinic Ban, then, appears to have been to prevent PPAU, specifically, from providing abortion, even as it permitted equivalent outpatient clinics satisfying HB 467's expanded definition of "hospital" to continue to provide abortion. Of course, neither animus against PPAU nor a desire to sabotage this litigation are *reasonable* government objectives. *See Salt Lake City Corp. v. Utah Inland Port Auth.*, 2022 UT 27, ¶ 11; *U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 534–35 (1973) (holding that "a bare congressional desire to harm a politically unpopular group cannot constitute a legitimate governmental interest"); *Lee*, 867 P.2d at 580 (making clear that a bare desire to engage in "invidious discrimination" can never be a legitimate state interest); *cf. Brian High Dev., LC v. Brian Head Town*, 2015 UT App 100, ¶ 9, 348 P.3d 1209. Indeed, exempting *some* outpatient clinics, but not PPAU, from the Clinic Ban's legislative classification would offend the "historical understanding" of the UOL Clause as well as its modern formulation. *See Utah Inland Port Auth.*, 2022 UT 27, ¶ 13 (quoting *Canton*, 2013 UT 44, ¶ 34 & nn. 7–8); *Malan*, 693 P.2d at 671–72 (explaining that laws with exceptions that "in

[12] *Hearing on H.B. 467 before the H. Judiciary Comm.*, recording starting at 00:08:40 (Utah Feb. 15, 2023) (statement of Rep. Karianne Lisonbee, floor sponsor of HB 467), available at https://le.utah.gov/av/committeeArchive.jsp?timelineID=225717; *see also Hearing on H.B. 467 before the H.*, *supra* note 2, recording starting at 01:22:20 (statement of Rep. Karianne Lisonbee, floor sponsor of HB 467) (explaining that HB 467 "unlicenses abortion clinics that are specifically there to conduct elective abortions" but that the bill permits other clinics to provide abortions "for people who fall under exemptions [to the Trigger Ban]"); *id*. at 01:28:06 (Rep. Lisonbee stating that under HB 467, "services in clinics will never be eliminated").

effect change the nature of the act" and "result in only a small number of persons being subject to the act" violate the UOL Clause).

Nor is the Clinic Ban rationally related to a government interest in promoting potential life. By its terms, the Clinic Ban changes where—not whether—Utahns may have abortions. Meanwhile, the Clinic Ban's functional effect of banning abortion in Utah, thereby subjecting Utah women to forced pregnancy and all the physical, personal, and financial harms that entails, is a vastly overbroad means of serving any purported interest in promoting childbirth: instead of making it easier to have a child, the State has imposed additional burdens on Utah women and families. A statute's degree of over- and under-inclusiveness is relevant in applying Utah's rationally-related test. *See, e.g.*, *Malan*, 693 P.2d at 672; *Merrill v. Utah Lab. Comm'n*, 2009 UT 26, ¶ 38, 223 P.3d 1089, *on reh'g*, 2009 UT 74, ¶ 38, 223 P.3d 1099. Furthermore, the Clinic Ban will likely deter even some Utahns who want to expand their families from becoming pregnant, due to legitimate concerns over whether they would be able to access abortion at a Utah hospital should a future pregnancy become complicated. Second Turok Decl. ¶ 76. And because the Clinic Ban will interfere with Utah hospitals' ability to recruit and retain OB/GYNs, Utah patients seeking other kinds of obstetric and gynecological care will face an even worse provider shortage, further undermining the State's purported interest in promoting healthy pregnancies and childbirth. *Id*. ¶¶ 73, 88–9.

The Clinic Ban's distinction between licensed abortion clinics and hospitals fails to promote patient safety, and indeed lacks a rational relationship to any government interest other than preventing abortion clinics from providing abortion—and that interest is not a legitimate one. PPAU is therefore substantially likely to prevail on the merits of its claim that the Clinic Ban violates the Uniform Operation of Laws Clause.

### B. As a near-total ban on abortion in Utah, the Clinic Ban violates the Utah Constitution for the same reasons the Trigger Ban does.

In preliminarily enjoining the Trigger Ban last summer, this Court concluded that PPAU had shown "at least serious issues on the merits that should be the subject of further litigation," including as to: (1) a right to determine one's own family composition under article I, sections 2, 25, and 27 of the Utah Constitution; (2) a right to equal protection under Utah's Equal Rights Amendment (article IV, section 1 of the Utah Constitution); (3) a right to the uniform operation of laws under article I, sections 2 and 24 of the Utah Constitution; (4) a right to bodily integrity under article I, sections 1, 7, and 11 of the Utah Constitution; and (5) a right to privacy under article I, sections 1 and 14 of the Utah Constitution. PI Order ¶ 6. Even as the Trigger Ban remains enjoined by this Court, however, the Clinic Ban, if it takes effect on May 3, will *independently* ban the vast majority of abortions in Utah. It therefore violates the Utah Constitution for all the same reasons the Trigger Ban does.

#### *1. Right to Determine One's Family Composition*

By preventing people from deciding whether to end their pregnancies, the Clinic Ban violates Utahns' right to determine the composition of their families. *See In re J.P.*, 648 P.2d 1364, 1372–74 (Utah 1982) (recognizing family rights as "fundamental" and protected under article I, sections 2, 25, and 27 of the Utah Constitution); *Jensen ex rel. Jensen v. Cunningham*, 2011 UT 17, ¶ 73, 250 P.3d 465 (describing the right to parent as "fundamental"); *see also, e.g.*, *In re Castillo*, 632 P.2d 855, 856 (Utah 1981) ("[T]he ideals of individual liberty which . . . [are] essential in a free society . . . protect the sanctity of one's home and family."). As discussed in detail in PPAU's first motion for a preliminary injunction, First PI Mot. at 19–22, customs and traditions from the time of Utah's founding reflect Utah's long-held understanding that people

should be free to determine the composition of their families.[13] By effectively banning abortion in Utah, the Clinic Ban eliminates this fundamental right to determine one's family composition and to decide for oneself and one's family how best to care for one's existing children.

Most Utahns obtaining abortions are already parents, and they generally make their abortion decisions after weighing the impact of a new child on their other children. First Turok Decl. ¶¶ 19, 43. These patients frequently conclude that having another child will make it harder for them to meet their existing children's needs for emotional, physical, and economic support. *Id.* ¶ 19. Substantial research shows that the impact of denying abortions to women who seek them has long-lasting and negative repercussions for those women's families. *See id.* ¶ 43; Decl. of Colleen M. Heflin in Supp. of Pl.'s Mot. for Prelim. Inj. ("Heflin Decl.") ¶ 43, attached hereto as Exhibit D. Other families receive grave fetal diagnoses during pregnancy and determine that the care and attention required by a new child would make it impossible to fulfill the rest of their family's needs. First Turok Decl. ¶ 19. Finally, some Utahns who want to expand their families will be deterred from doing so by the Clinic Ban, out of a fear that, should a desired pregnancy become complicated, they will be unable to obtain the care they need at a Utah hospital. Second Turok Decl. ¶ 76.

These decisions are protected by the Utah Constitution. As Utah courts have recognized, "family autonomy helps to assure the diversity characteristic of a free society." *In re J.P.*, 648 P.2d at 1376; *cf.* Utah Code Ann. § 58-77-304 (recognizing "the right of parents to deliver their baby

[13] *See, e.g.*, Introduction, at ix–xi, *Women in Utah History* (eds. Patricia Lyn Scott & Linda Thatcher 2005), available at https://digitalcommons.usu.edu/cgi/viewcontent.cgi?Article=1108&context=usupress_pubs; *see also* Carrie Hillyard, *The History of Suffrage and Equal Rights Provisions in State Constitutions*, 10 BYU J. Pub. L. 117, 122 (1996); Lisa Madsen Pearson & Carol Cornwall Madsen, *Innovation and Accommodation: The Legal Status of Women in Territorial Utah, 1850–1896*, at 41, 44, 47, in *Women in Utah History* (eds. Patricia Lyn Scott & Linda Thatcher 2005), available at https://digitalcommons.usu.edu/cgi/viewcontent.cgi?article=1108&context=usupress_pubs.

where, when, how, and with whom they choose" and providing that nothing in the professional licensing statutes "abridges, limits, or changes [that right] in any way"). "A statute that infringes upon this 'fundamental' right" to parent "is subject to heightened scrutiny" and is presumptively unconstitutional. *Jensen*, 2011 UT 17, ¶ 72. It is the State's burden to demonstrate that the statute "(1) furthers a compelling state interest and (2) 'the means adopted are narrowly tailored to achieve the basic statutory purpose.'" *Id.* (quoting *Wells v. Children's Aid Soc'y of Utah*, 681 P.2d 199, 206 (Utah 1984)); *see also Utah Safe to Learn—Safe to Worship Coal., Inc. v. State*, 2004 UT 32, ¶ 24, 94 P.3d 217. The Clinic Ban cannot meet this or any other standard.

The legislative sponsors of HB 467 explained that they intended the bill to balance two specific state interests: "protecting innocent life," including "the unborn," while also "protecting women who experience rare and dangerous complications during pregnancy."[14] As explained above, *supra* Part I.A.3, the contours of the Clinic Ban make clear that the law does not substantially further an interest in fetal life, and that it is not narrowly tailored to that goal. Moreover, as PPAU detailed in seeking injunctive relief against the Trigger Ban, First PI Mot. at 22, asserting a government interest in "unborn life" to justify the Clinic Ban infringes on the rights of Utahns who do not share the State's view of when life begins. The State's view enforces outdated gender stereotypes by, among other things, endorsing the conscription of women into "the home and the rearing of the family," *Stanton v. Stanton*, 421 U.S. 7 (1975), despite the increased risks to their physical and mental health, financial stability, and long-term well-being.

[14] *Hearing on H.B. 467 before the H. supra* note 2, recording starting at 01:21:15 (statement of Rep. Karianne Lisonbee, floor sponsor of HB 467); *id*. at 01:35:47 (statement of Rep. Lisonbee) (stating her belief that "life begins at implantation" and that Utah has a tradition of "protecting the unborn" by outlawing abortion); *Hearing on H.B. 467 before the S., supra* note 2, recording starting at 01:45:25 (statement of Sen. Daniel McCay, floor sponsor of HB 467) (noting that he worked to ensure HB 467 "strikes [a] balance [between] protecting innocent li[ves] and protecting [] women who experience rare and dangerous complications during pregnancy").

*See* First Turok Decl. ¶ 5; Second Turok Decl. ¶ 8. And it enshrines into law the State's moral disapproval of women who do not wish to be parents or to have additional children. Even if this interest is legitimate—which it is not—it cannot be compelling because it intrinsically values potential life over the lives of Utah's current citizens. *Cf. Blue Cross & Blue Shield of Utah v. State*, 779 P.2d 634, 640 (Utah 1989) ("The second issue under our analytical model is the legitimacy of the objectives pursued by the legislation.").

Nor can the Clinic Ban be supported by any asserted interest in patient health and safety. First, it is not clear the State asserts any such interest; to the contrary, as discussed above, *supra* Part I.A, legislative history and public statements in connection with the Clinic Ban's enactment reflect a clear focus on clarifying the scope of the Trigger Ban's exceptions and ensuring that abortions *that fall within those narrow exceptions* are provided in hospitals rather than in licensed abortion clinics—not any claim that abortions cannot generally be safely provided in abortion clinics.[15] But at any rate, the Clinic Ban is not narrowly tailored to achieve that purpose, *Jensen*, 2011 UT 17, ¶ 72, and indeed, does nothing to advance it.

First, for patients with *uncomplicated* pregnancies, the methods of abortion provided at PPAU are just as safe when provided by PPAU's experienced clinicians at PPAU's licensed abortion clinics as when provided at a Utah hospital, as discussed at length above. *Supra* Statement of Facts, Part V. Requiring those patients to attempt to obtain an abortion at a Utah hospital, therefore, does nothing to promote their health or safety and instead effectively bars them from

[15] The State's claimed interest in "protecting women who experience rare and dangerous complications during pregnancy" may have motivated some of HB 467's amendments to the Trigger Ban's exceptions—like removing a medically-inappropriate "immediacy" requirement from the definition of "medical emergency," *see* HB 467 § 28 (amending Utah Code Ann. § 76-7a-101(5)—even as other HB 467 amendments narrow the Trigger Ban's exceptions and worsen its constitutional defects, *see* HB 467 § 29 (amending Utah Code Ann. § 76-7a-201(1)(c) (eliminating the rape and incest exception for patients more than 18 weeks pregnant). Because the Trigger Ban remains enjoined, however, these amendments have no operative effect.

receiving an abortion at all. As a result, the vast majority of patients will be forced to seek abortion out-of-state or remain pregnant and ultimately give birth against their will, a process at least 12 times more deadly than abortion. Second Turok Decl. ¶ 37, 72.

Second, even for patients who do "experience rare and dangerous complications during pregnancy," the Clinic Ban interferes with their ability to receive the best possible care: as discussed above, abortion will simply not be available at many Utah hospitals. *Id*. ¶ 7. Currently, hospitals throughout Utah refer complicated and high-risk abortion patients to PPAU physicians, who often treat those patients at PPAU's Metro Health Center. *Id*. ¶¶ 42, 47. The Clinic Ban would remove this option. Patients seeking abortion to avert the risks of a serious pregnancy complication will therefore have to find a hospital—and individual clinicians—willing to provide abortion despite the chilling effect of HB 467's heightened licensing and professional penalties. *Id*. ¶ 77, 82–6. These difficulties and delays in obtaining medically necessary care will increase the risk of their already risky pregnancies. *Id*. ¶ 75. Therefore, rather than being narrowly tailored to a government interest in protecting the health of patients with complicated pregnancies, the Clinic Ban is both grossly overbroad and contrary to this interest.

Because the Clinic Ban is neither supported by a compelling state interest, nor narrowly tailored to further any purported interest, it violates Utahns' fundamental right to decide, without unwarranted governmental interference, how their families should be composed. And as explained above, *supra* Part I.A.3, the Clinic Ban fails even rational basis review.

*2. Right to Gender Equality under the Equal Rights Provision and the Uniform Operation of Laws Clause*

As discussed in depth in PPAU's first motion for a preliminary injunction, First PI Mot. at 24–35, two separate provisions of the Utah Constitution establish Utahns' right to gender equality. First, the Equal Rights Provision forbids laws that result in either disparate treatment or disparate

impact on women as compared to men. Utah Const. art. IV, § 1. Second, the UOL Clause prohibits laws that discriminate "on the basis of a 'suspect class' (e.g., race or gender)," *Canton*, 2013 UT 44, ¶ 36, and requires not only "facial uniformity" in the operation of Utah statutes, but uniformity in "the law's operation" as well, *Drej*, 2010 UT 35, ¶ 33 (internal quotation marks omitted); *accord DIRECTV*, 2015 UT 93, ¶ 49. The Clinic Ban implicates both by restricting health care sought predominantly by women to an unnecessarily restrictive and inaccessible setting, thereby effectively banning that care and preventing women, but not men, from determining the course of their lives, without regard to the increased physical, personal, and financial harms this restriction will inflict. Second Turok Decl. ¶ 61; *cf. Redwood Gym v. Salt Lake Cnty. Comm'n*, 624 P.2d 1138, 1147 (Utah 1981) (finding no sex classification created by economic regulation on "opposite-sex massage[s]" because it did not "place either sex at an inherent legal disadvantage vis-a-vis the other"); *see also N.M. Right to Choose/NARAL v. Johnson*, 126 N.M. 788, ¶¶ 38–43, 975 P.2d 841 (1998) (requiring a compelling justification for using "classifications based on the unique ability of women to become pregnant and bear children . . . to the disadvantage of the persons they classify"); *Canton*, 2013 UT 44, ¶ 36.

Claims under the Equal Rights Provision, and UOL Clause claims involving discrimination on the basis of a suspect class such as gender, are subject to a heightened degree of scrutiny. The analysis first asks whether a law results in either disparate treatment *or* disparate impact on women as compared to men, or whether it disproportionately impairs women's ability to fully enjoy their privileges and civil, political, and religious rights.[16] *See Est. of Scheller v. Pessetto*, 783 P.2d 70,

[16] Because the Utah Constitution includes both an Equal Rights Provision and a Uniform Operation of Laws Clause, it must have been understood that the two provisions provided different protections. The Uniform Operation of Laws Clause already subjects discriminatory classifications to heightened scrutiny. *Canton*, 2013 UT 44, ¶ 36. The Equal Rights Provision, which was added to the Utah Constitution after the Uniform Operation of Laws Clause, would therefore likely have been understood to go beyond these protections. Otherwise, it would have been superfluous.

76–77 (Utah Ct. App. 1989). If the law does either of those things, then strict scrutiny applies, and the State bears the burden of showing that the Act is supported by a "*compelling*" interest while also advancing that interest in "the *least restrictive means* possible." *In re Adoption of J.S.*, 2014 UT 51, ¶ 69 (emphasis in original) (describing strict scrutiny standard applicable to race-based challenges under UOL Clause); *see also, e.g.*, *Johnson*, 126 N.M. 788, ¶ 47 (applying strict scrutiny under New Mexico's Equal Rights Amendment).

Like the Trigger Ban, the Clinic Ban cannot survive this review. The Clinic Ban "operates to the disadvantage of persons so classified." *Johnson*, 126 N.M. 788, ¶ 40 (citation omitted). By functionally banning abortion for the vast majority of Utahns, *supra* pp. 7–9, the Clinic Ban disproportionately limits women's bodily autonomy and liberty, their ability to decide for themselves matters of great consequence to their lives, and their ability to obtain the same education and financial independence available to those who cannot become pregnant. These disproportionate effects flatly undermine women's equal privileges of citizenship.

Moreover, for all the reasons described in Part I.A.3, the Clinic Ban is not supported by a legitimate, much less compelling, state interest, nor does it use the least restrictive means of advancing the State's purported interest in the law. It is irrelevant that the Clinic Ban may be motivated by an interest in regulating pregnancy, a physical characteristic unique to one sex. "Since time immemorial, women's biology and ability to bear children have been used as a basis for discrimination against them." *Doe v. Maher*, 40 Conn. Supp. 394, 444, 515 A.2d 134 (Super. Ct. 1986). Such laws have the disproportionate effect of keeping women from full participation in society. *See Johnson*, 126 N.M. 788, ¶ 40; *Planned Parenthood of Mich. v. Att'y Gen. of the State of Mich.*, No. 22-000044, 2022 WL 7076177, at *16 (Mich. Cl. Ct. Sept. 7, 2022) (recognizing

Similarly, the plain text of the Equal Rights Provision protects the equal enjoyment of not only civil, political, and religious rights, but also privileges.

that near-total abortion ban "deprives *only women* of their ability to thrive as contributing participants in [the] world outside the[ir] home"). While "[i]nherent differences between men and women . . . remain cause for celebration, . . . . [they] may not be used, as they once were, to create or perpetuate the legal, social, and economic inferiority of women." *United States v. Virginia*, 518 U.S. 515, 533–34 (1996) (internal quotation marks & citation omitted). Moreover, as Utah's constitutional convention history confirms, First PI Mot. at 24–31; Reply in Supp. of Pl.'s Mot. for Prelim. Inj. ("PI Reply") at 8–14, the founders rejected arguments that perceived biological differences between the sexes justified inequality between them. Classifications, then, based solely on these differences that work to disadvantage women are not legitimate.

Because the Clinic Ban disproportionately disadvantages women, and because it is not narrowly tailored to further a compelling state interest, it violates Utah's Equal Rights Provision and UOL Clause.

Even if strict scrutiny does not apply here, at a minimum, the Court must review PPAU's claims under the "intermediate scrutiny" standard applicable to a gender-based classification under federal law, the baseline identified by the Utah Supreme Court for this type of claim. *See Pusey v. Pusey*, 728 P.2d 117, 119–20 (Utah 1986); *In re Adoption of J.S.*, 2014 UT 51, ¶¶ 68–74 & n.24 (applying same standard to UOL Clause case); *Est. of Scheller*, 783 P.2d at 77. That intermediate standard requires the State to demonstrate "an *important* governmental interest that is *substantially* advanced by the legislation." *In re Adoption of J.S.*, 2014 UT 51, ¶ 69 (emphasis in original). The Clinic Ban also fails this level of review. "For 'official action that closes a door or denies opportunity to women (or to men),' it is difficult for the government to show that its discriminatory policy 'substantially' advances an important objective." *In re Adoption of J.S.*, 2014 UT 51, ¶ 70 (quoting *Virginia*, 518 U.S. at 532). The Ban denies women (but not men) the ability to make

decisions about their own bodies and forces women (but not men) to unwillingly take on increased medical risks simply as a result of having sex. This serves not to "preserv[e] meaningful opportunities to both sexes," *id.*, but to penalize only women for behavior that both sexes engage in. The Clinic Ban thus violates the Equal Rights Provision and UOL Clause under either standard of review.

*3. Right to Bodily Integrity*

The Clinic Ban violates the fundamental right of pregnant Utahns to bodily integrity. As the Utah Supreme Court has recognized, this right inheres in article I, section 11 of the Utah Constitution, which provides that "[e]very person, for an injury done to him in his person . . . shall have remedy by due course of law." *Malan*, 693 P.2d at 674 n.17 (quoting *Weber v. Aetna Casualty & Surety Co.*, 406 U.S. 164 (1972)). And it is bolstered by numerous other provisions of the state constitution and applicable precedent. *See, e.g.*, Utah Const. art. I, § 1 ("All persons have the inherent and inalienable right to enjoy and defend their lives and liberties[.]"); *id.* § 7 ("No person shall be deprived of life, liberty or property, without due process of law."); *id.* § 14 ("The right of the people to be secure in their persons, houses, papers and effects against unreasonable searches and seizures shall not be violated[.]").

The right to bodily integrity undoubtedly protects one's ability to be free from nonconsensual "harmful or offensive contact." *Wagner v. State*, 2005 UT 54, ¶¶ 51, 57, 122 P.3d 599. But it also protects one's "right of security of bodily comfort which one has provided for oneself." *Buchanan v. Crites*, 106 Utah 428, 150 P.2d 100, 105–06 (1944) (discussing "bodily security" and treating it analogously to "bodily integrity"), *overruled on other grounds*. In the context of search and seizures, for example, Utah courts have held that bodily integrity is threatened by "intruding into the suspect's living room, eavesdropping on phone calls, or

compelling the suspect to go to the police station with the officers." *State v. Alverez*, 2006 UT 61, ¶ 34, 147 P.3d 425. And Utah's body of tort law recognizes that "the law of torts, and battery in particular, was designed to protect people from unacceptable invasions of bodily integrity." *Wagner*, 2005 UT 54, ¶ 57. The right also underpins the common-law doctrine of informed consent in medical decision making. *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) ("This duty to inform stems from the fiduciary nature of the relationship and the patient's right to determine what shall or shall not be done with his body." (citation omitted)).

Forcing someone to remain pregnant against their will, as the Clinic Ban does, is a fundamental violation of the right to control one's bodily integrity. For a host of reasons, the decision to become or remain pregnant is one of the most personal and consequential a person will make in a lifetime. First PI Mot. at 11. By preventing pregnant people in Utah from ending their pregnancies, the Clinic Ban forces them to submit to more than nine months of dramatic physical transformation, implicating the most personal aspects of their lives and identities, without their consent. *See id*. at 8–11. The Clinic Ban thus clearly invades Utahns' bodily integrity, as other states have found when considering whether such a right encompasses a right to decide to have an abortion. *E.g*. *Women of Minn. v. Gomez*, 542 N.W.2d 17, 27 (Minn. 1995) (citing and quoting *Jarvis v. Levine*, 418 N.W.2d 139, 148–50 (Minn. 1988)); *Moe v. Sec'y of Admin. & Fin.*, 382 Mass. 629, 648–49, 417 N.E.2d 387 (1981) (citation omitted); *Planned Parenthood of Mich.*, 2022 WL 7076177, at *7–13 (holding that an abortion ban violates Michigan's right to bodily integrity, because "[i]nherent in the right of bodily integrity is the right to bodily autonomy, to make decisions about how one's body will be used, 'a right of self-determination in matters that touch individual opinion and personal attitude'" (quoting *W. Va. State Bd. of Ed. v. Barnette*, 319 US 624, 630–31 (1943))). Pregnant people in Utah also have a strong liberty interest in being free

from the "nonconsensual" invasion of their bodily integrity, *id.* at *7, and the Clinic Ban infringes on that right.

The Clinic Ban also forces pregnant people to endure increased physical risk from pregnancy and childbirth, including an increased risk of death, and more invasive medical interventions such as delivery by C-section. First Turok Decl. ¶¶ 24–35; Second Turok Decl. ¶¶ 36–40. And the rare patients who may be able to obtain an abortion at a Utah hospital under the Clinic Ban will be exposed to more extensive and invasive medical interventions, such as general anesthesia or abortion by induction, and may face an increased risk of harm from less experienced clinicians than they would find at an outpatient abortion clinic like PPAU's. Second Turok Decl. ¶¶ 68–9. This, too, infringes on the right to bodily integrity. *See Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 616–18, 646–50, 678, 440 P.3d 461 (2019) (per curium).

"Where a statute infringes on a fundamental right, the means adopted must be narrowly tailored to achieve the basic statutory purpose." *Jones v. Jones*, 2013 UT App 174, ¶ 34, 307 P.3d 598 (internal quotation marks & citation omitted), *aff'd*, 2015 UT 84, 359 P.3d 603. As discussed above, the Clinic Ban is not supported by a legitimate, much less compelling, state interest, and it does not sufficiently advance any asserted state interest, no matter the standard of constitutional review. *See supra* Part I.B.1.

*4. Right to Privacy*

Utah's right to privacy, Utah Const. article I, section 14, "extend[s] to protect against intrusion into or exposure of not only things which might result in actual harm or damage, but also to things which might result in shame or humiliation, or merely violate one's pride in keeping [one's] private affairs to [one]self." *Redding v. Brady*, 606 P.2d 1193, 1195 (Utah 1980). It "includes those aspects of an individual's activities and manner of living that would generally be

regarded as being of such personal and private nature as to belong to" the individual "and to be of no proper concern to others." *Id.*; *see also Allen v. Trueman, Judge of the 2d Jud. Dist.*, 100 Utah 36, 110 P.2d 355, 360 (1941). In these ways, the right to privacy under the Utah Constitution fairly encompasses both a right to decisional privacy—the privacy of one's affairs—and to informational privacy—security from unwarranted disclosures of one's personal information. HB 467's Clinic Ban violates at least the first of these two components.

An individual's pregnancy and decision to form family relationships is one such "activit[y] and manner of living that would generally be regarded as being of such personal and private nature as to belong to [one]self and to be of no proper concern to others." *Redding*, 606 P.2d at 1195. Even though Utah banned abortion at the time of its founding, women still sought abortions,[17] particularly before "quickening," and abortifacients were widely available both through the mail and at pharmacies.[18] First PI Mot. at 41–42. Today, generations of women have now grown to have a reasonable expectation that their private decision making includes an ability to decide to end a pregnancy. Medical advances have likewise changed how individuals experience and understand abortion, allowing for greater patient privacy surrounding the abortion decision. *See* First Turok Decl. ¶ 17. For example, more than two decades ago, the U.S. Food and Drug

[17] *See, e.g.*, B.O.L. Potter, M.D., Letter, *That Abortion Case*, Salt Lake City Tribune, Nov. 6, 1884, at 4, available at https://newspapers.lib.utah.edu/search?facet_type=%22page%22&gallery=1&rows=200&parent_i=13120260#g3.

[18] *See* Advertisement, *Mesmin's French Female Pills*, Daily Enquirer, Apr. 10, 1893, at 2, available at https://newspapers.lib.utah.edu/search?facet_type=%22page%22&gallery=1&rows=200&parent_i=1466218#g1; Advertisement, *Dr. Mott's Pennyroyal Pills*, The Ogden Daily Standard, May 2, 1893, at 2, available at https://newspapers.lib.utah.edu/search?facet_type=%22page%22&gallery=1&rows=200&parent_i=7514821#g1; Advertisement, *Dr. Martel's Female Pills*, Deseret Evening News, Sept. 12, 1910, at 9, available at https://newspapers.lib.utah.edu/search?facet_type=%22page%22&gallery=1&rows=200&parent_i=2356506#g8. For a fulsome accounting of the history of abortifacient advertising in Utah newspapers, *see* Amanda Hendrix-Komoto, *The Other Crime: Abortion and Contraception in Nineteenth- and Twentieth-Century Utah*, 53 Dialogue 33, 41–42 (2020).

Administration approved the labeling of a medication specifically for abortion, and the use of that medication has allowed patients to pass pregnancies at home or in other private settings. *See id.*; Second Turok Decl. ¶ 23.

This precedent and history establish that the right to privacy under the Utah Constitution encompasses a right to choose to end a pregnancy through abortion. Interpreting their constitutional privacy protections, numerous other states have reached the same conclusion. *See, e.g.*, *Planned Parenthood S. Atl. v. State*, 438 S.C. 188, 882 S.E.2d 770 (2023); *Armstrong v. State*, 1999 MT 261, ¶ 47, 296 Mont. 361, 989 P.2d 364; *Am. Acad. of Pediatrics v. Lundgren*, 16 Cal. 4th 307, 327, 940 P.2d 797 (1997); *Hope v. Perales*, 83 N.Y.2d 563, 575, 634 N.E.2d 183 (1994); *Maher*, 40 Conn. Supp. 394, 426; *see also Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 964, 968–69 (Alaska 1997); *In re TW*, 551 So. 2d 1186, 1192–93 (Fla. 1989); *Right to Choose v. Byrne*, 91 N.J. 287, 303–04, 450 A.2d 925 (1982). The Clinic Ban infringes on Utahns' right to privacy by subjecting a highly personal medical decision to government scrutiny and control, and by requiring patients to obtain abortions in a hospital rather than in a more personal outpatient clinic setting, risking the confidentiality of their care. *See* Second Turok Decl. ¶¶ 69, 71.

Because the Clinic Ban infringes on the fundamental right to privacy, heightened scrutiny applies. As discussed above, the Clinic Ban is not supported by a legitimate, much less compelling, state interest, and it does not sufficiently advance any asserted state interest, no matter the standard of constitutional review. *See supra* Part I.B.1; *Jones*, 2013 UT App 174, ¶ 34 (internal quotation marks & citation omitted), *aff'd*, 2015 UT 84. Accordingly, PPAU is substantially likely to prevail on its claim that the Clinic Ban violates the right to privacy.

## II. PPAU, ITS PATIENTS, AND ITS STAFF WILL SUFFER IRREPARABLE HARM WITHOUT AN INJUNCTION

PPAU incorporates by reference all briefing and evidence submitted in support of its motion for a preliminary injunction against the Trigger Ban, which surveyed in great detail the harms that a near-total abortion ban will cause PPAU, its staff, and pregnant Utahns and their families. *See* First PI Mot. at 6–16; PI Reply at 6–7. In granting a preliminary injunction against the Trigger Ban, this Court found that this briefing and evidence constituted a "strong showing that, without a preliminary injunction," the Trigger Ban would "cause irreparable harm to PPAU, its patients, and its staff." PI Order ¶ 3. The same holds true for the Clinic Ban.

In short, the Clinic Ban will force many Utahns seeking an abortion to carry pregnancies to term against their will, with all of the physical, emotional, and financial costs that entails. First Turok Decl. ¶ 5; *see also id.* ¶¶ 21–43; *see also* Heflin Decl. ¶¶ 41–42. Some Utahns will inevitably turn to self-managed abortion by buying pills or other items online and outside the U.S. healthcare system, which may in some cases be unsafe, ineffective, and/or subject the person to criminal investigation or prosecution. First Turok Decl. ¶ 22. And even Utahns who are ultimately able to obtain an abortion—either because they have been able to scrape together the resources to travel out of state or because they are able to obtain an abortion at a Utah hospital—will suffer irreparable harm. *Id.* ¶¶ 44–54; *see also* Heflin Decl. ¶¶ 34–40. Specifically, patients who obtain abortions in Utah hospitals will be forced to bear dramatically increased costs, loss of confidentiality, greater medical risk, scheduling delays and the associated increases in cost and medical risk, and a much greater investment of total appointment time compared to the status quo. Second Turok Decl. ¶ 69.

PPAU and its staff will also suffer harms that cannot be compensated after judgment, including being forced to cease offering medical care they have trained for years and even decades specifically to provide or else risk felony criminal prosecution and loss of their professional

licenses, with dire consequences for their vocations and livelihoods. *See* First Turok Decl. ¶ 3; Second Turok Decl. ¶ 87 ("On a personal note, I have devoted my entire career to providing all people, regardless of their financial resources, the full range of top quality reproductive health care, including abortions, but HB 467 would bar me from providing my patients the full spectrum of reproductive health care."). The Clinic Ban and Professional Licensing Penalties will harm PPAU's ability to recruit and retain physicians to provide even other types of sexual and reproductive health care, a consequence that will likely affect patient care at Utah hospitals as well. Second Turok Decl. ¶ 88.

In addition to these irreparable physical, personal, professional, and economic harms, the Clinic Ban will deny PPAU's patients access to medical care that is both time-sensitive and constitutionally protected. First PI Mot. at 17–45; PI Reply at 7–25; *supra* Part I.B. The loss of a constitutional right is alone sufficient to justify injunctive relief. *See Corp. of President of Church of Jesus Christ of Latter-Day Saints v. Wallace*, 573 P.2d 1285, 1287 (Utah 1978) (affirming temporary restraining order to protect religious rights); *see also Fish v. Kobach*, 840 F.3d 710, 752 (10th Cir. 2016) (emphasizing when a constitutional right "is involved, most courts hold that no further showing of irreparable injury is necessary" (quoting *Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001))).[19] The presumption of irreparable injury from a constitutional violation applies with special force in the context of abortion: "[T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences." *Bellotti v. Baird*, 443 U.S. 622, 643 (1979); *see also Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B 1981) (infringement of constitutional right to have an abortion

[19] Where persuasive, Utah courts may look to federal case law, as well as precedent from other states, as to the scope of irreparable harm. *See, e.g., Zagg, Inc. v. Harmer*, 2015 UT App 52, ¶ 8, 345 P.3d 1273.

"mandates" a finding of irreparable injury because an infringement "cannot be undone by monetary relief").

To prevent these certain and imminent harms, the Court should enter a second preliminary injunction blocking enforcement of the Clinic Ban and the new Professional Licensing Penalties added by HB 467.

## III. THE THREATENED INJURY TO PPAU, ITS PATIENTS, AND ITS STAFF OUTWEIGHS ANY INJURY TO THE STATE, AND AN INJUNCTION WOULD NOT BE ADVERSE TO THE PUBLIC INTEREST

Just as this Court found in entering a preliminary injunction against the Trigger Ban, PI Order ¶¶ 4–5, PPAU satisfies the last two Rule 65A factors, too.

PPAU and its patients face far greater harm if the Clinic Ban is allowed to go into effect than Defendants will face if the Court enters an injunction to preserve the status quo.

The public has a substantial interest in an injunction blocking a law that, like the Trigger Ban, would fundamentally upset the longstanding status quo on which Utah women and their families have relied upon for at least five decades. *Cf. Utah Med. Prod., Inc. v. Searcy*, 958 P.2d 228, 233 (Utah 1998) (upholding trial court determination that injunction was contrary to public interest where it would have "remove[d] a valuable medical device . . . from certain markets").

The State's interest, if any, is marginal by comparison. The State "does not have an interest in enforcing a law that is likely constitutionally infirm." *Chamber of Com. of U.S. v. Edmondson*, 594 F.3d 742, 771 (10th Cir. 2010). Utah already bans nearly all abortions after 18 weeks of pregnancy, including in cases of rape or incest. *See* Utah Code Ann. § 76-7-302(2) (as amended by HB 467). An injunction against the Clinic Ban would not prevent Utah from enforcing this ban on abortions after 18 weeks' gestation.

The balance of equities and public interest thus weigh decisively in PPAU's favor.

## IV. AN INJUNCTION SHOULD BE ISSUED WITHOUT POSTING OF SECURITY

Under Rule 65A(c), the Court "has wide discretion in the matter of requiring security" as a condition for a temporary restraining order or preliminary injunction. *See Wallace*, 573 P.2d at 1287. "[I]f there is an absence of proof showing a likelihood of harm" to Defendants from an injunction, "certainly no bond is necessary." *Id.*; *accord Kenny v. Rich*, 2008 UT App 209, ¶ 40, 186 P.3d 989. The Court should use that discretion to waive the security requirement here, where the relief sought will result in no monetary loss for Defendants and is necessary to protect the constitutional rights of PPAU and its patients. *See, e.g.*, *Wallace*, 573 P.2d at 1287 (affirming trial court's waiver of security requirement in constitutional rights case).

## CONCLUSION

For the foregoing reasons, PPAU respectfully requests that this Court enter a preliminary injunction that enjoins and restrains Defendants and their officers, employees, servants, agents, appointees, and successors from administering and enforcing HB 467's Clinic Ban and Professional Licensing Penalties with respect to any abortion provided during the pendency of either this injunction or the injunction against the Trigger Ban, including in any future enforcement actions for conduct in reliance on either injunction, and that such an injunction issue without posting of security.

Respectfully submitted,

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**Pro hac vice application forthcoming*

*Attorneys for Plaintiff Planned Parenthood Association of Utah*

Dated: April 3, 2023

## CERTIFICATE OF SERVICE

I hereby certify that on the 3rd of April, 2023, I caused the foregoing to be electronically filed and served on the following via GreenFiling:

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**Notice to responding party**

You have a limited amount of time to respond to this motion. In most cases, you must file a written response with the court and provide a copy to the other party:

- within 14 days of this motion being filed, if the motion will be decided by a judge, or
- at least 14 days before the hearing, if the motion will be decided by a commissioner.

In some situations a statute or court order may specify a different deadline.

If you do not respond to this motion or attend the hearing, the person who filed the motion may get what they requested.

See the court's Motions page for more information about the motions process, deadlines and forms:
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**Aviso para la parte que responde**

Su tiempo para responder a esta moción es limitado. En la mayoría de casos deberá presentar una respuesta escrita con el tribunal y darle una copia de la misma a la otra parte:

- dentro de 14 días del día que se presenta la moción, si la misma será resuelta por un juez, o
- por lo menos 14 días antes de la audiencia, si la misma será resuelta por un comisionado.

En algunos casos debido a un estatuto o a una orden de un juez la fecha límite podrá ser distinta.

Si usted no responde a esta moción ni se presenta a la audiencia, la persona que presentó la moción podría recibir lo que pidió.

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# Exhibit A

Declaration of David Turok, M.D., M.P.H., FACOG
in Support of Plaintiff's Motion for a Temporary Restraining Order

**THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH**

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

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

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

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

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

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

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

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

## I. My Background

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

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

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

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

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

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

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

## II. PPAU and Its Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## III. The Impact of the Criminal Abortion Ban

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

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

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

### *A. Forced pregnancy and parenting*

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

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

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

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

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

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

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

[7] *Id.* at 964–67.

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

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

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

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

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

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

[11] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[21] *Id.*

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

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

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

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

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

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

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

[25] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[37] *Id.* at 409, 412–13.

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

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

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

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

### *C. Other harms the Criminal Abortion Ban inflicts on patients*

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

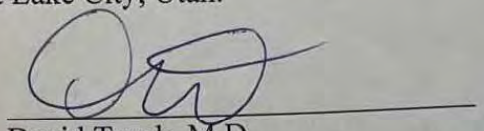
55. For all of these reasons, if the Criminal Abortion Ban is permitted to remain in effect, it will be devastating to the Utah patients who depend on PPAU for care.

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

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

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

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



David Turok, M.D.

# Exhibit A

# Curriculum Vitae

Last Updated: 03/04/2022

## PERSONAL DATA

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

## EDUCATION

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

## BOARD CERTIFICATIONS

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

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

## UNIVERSITY OF UTAH ACADEMIC HISTORY

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

| | |
|---|---|
| 01/01/2019 | Associate Professor with tenure |

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

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

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

| | |
|---|---|
| 03/01/2018 | Adjunct Associate Professor |

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

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

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

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

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

## PROFESSIONAL EXPERIENCE

**Full-Time Positions**

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

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

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

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

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

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

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

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

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

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

**Editorial Experience**

2014 Guest Editor for *Clinics in Obstetrics and Gynecology*

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

2011 - Present Editorial Board for *Contraception*

**Reviewer Experience**

Cochrane Collaboration

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

Reviewer for *African Journal of Reproductive Health*

Reviewer for *American Journal of Men's Health*

Reviewer for *American Journal of Obstetrics and Gynecology*

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

Reviewer for *BMC Pregnancy and Childbirth*

Reviewer for *Contraception*

Reviewer for *Journal of Women's Health*

Reviewer for *Obstetrics and Gynecology*

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

Reviewer for *Women's Health Issues*

## SCHOLASTIC HONORS

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

## ADMINISTRATIVE EXPERIENCE

### Administrative Duties

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

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

**Professional Organization & Scientific Activities**

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

**Grant Review Committee/Study Section**

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

**Symposium/Meeting Chair/Coordinator**

| | |
|---|---|
| 2011 | Chair, Conference Committee Annual Meeting of the Association of Reproductive Health Professionals |
| 2009 - Present | University of Utah Family Planning Symposium |
| 2003 - 2010 | Organizer, Family Practice Obstetrics Morbidity and Mortality Conference |

## PROFESSIONAL COMMUNITY ACTIVITIES

| | |
|---|---|
| 2017 - Present | Board Member, Physicians for Reproductive health |
| 1997 - 1998 | Organizer & Participant, Reach Out and Read, Organizer & Participant, Reach Out and Read, Blackstone Valley Community Health Center, Central Falls, RI |
| 1996 - 1998 | Physician, Traveler's Aid Medical Van, Provided primary care services to uninsured clients in conjunction with city homeless shelters. Extensive experience with people in addictions recovery. Providence, RI |
| 1992 | Volunteer Instructor, Alianza Para la Salud, Designed and executed a survey of child health. Developed an educational nutrition program based on local food sources for mothers in rural San Juan Province. Dominican Republic |

## UNIVERSITY COMMUNITY ACTIVITIES

**University Level**

| | |
|---|---|
| 2015 - Present | Member, Institutional Review Board |
| 2007 - 2019 | Director, University of Utah, Family Planning Research Group, Multi-disciplinary group of investigators including members of various departments |

## CURRENT MEMBERSHIPS IN PROFESSIONAL SOCIETIES

American College of Obstetricians and Gynecologists

National Abortion Federation

Society of Family Planning

Utah Medical Association

## FUNDING

**Active Grants**

| | |
|---|---|
| 09/01/21 - 09/30/24 | CCTN Clinical evaluation of Daily Application of Nestorone (NES) and Testosteorone (T) Combination Gel for Male Contraception<br>Principal Investigator(s): David K. Turok<br>University of Washington, NICHD<br>Role: Principal Investigator |
| 08/01/20 - 07/30/27 | Contraceptive Clinical Trials Network (CCTN) Core Function Activities. Task Order Number HHSN27500001 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development.<br>Principal Investigator(s): David K. Turok |

Role: Principal Investigator

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

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

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

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

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

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

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

Role: Principal Investigator

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

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

**Past Grants**

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

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

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

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

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

Role: Co-Investigator

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

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

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

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

07/26/16 - 11/01/18 Cervical Attachment Study.
Principal Investigator(s): David K. Turok
Bioceptive Inc
Role: Principal Investigator

07/05/16 - 06/30/19 Tolerability Of Levocept. Project Number 50503354. Proposal ID 10042919
Principal Investigator(s): David K. Turok
Direct Costs: $57,477 Total Costs: $78,456
Contramed LLC
Role: Principal Investigator

06/15/16 - 06/15/17 Male Partners In Contraception. Project Number 51005426. Proposal ID 10042697
Principal Investigator(s): David K. Turok
Direct Costs: $70,984 Total Costs: $70,984
Society of Family Planning
Role: Principal Investigator

05/26/16 - 05/31/17 HER SL - Merck. Project Number 50303118. Proposal ID 10040845
Principal Investigator(s): David K. Turok
Direct Costs: $18,934 Total Costs: $25,125
Merck & Company, Inc.
Role: Principal Investigator

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

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

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

Role: Principal Investigator

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

Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

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

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

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

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

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

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

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

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

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

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

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

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

Role: Principal Investigator

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

Teva Women's Health Research
Role: Principal Investigator

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

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

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

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

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

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

Role: Principal Investigator

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

Role: Principal Investigator

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

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

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

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

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

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

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

Role: Principal Investigator

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

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

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

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

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

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

## TEACHING RESPONSIBILITIES/ASSIGNMENTS

**Course Lectures**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Clinical Teaching**

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

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

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

**Didactic Lectures**

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

**Internal Teaching Experience**

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

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

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

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

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

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

CE Courses Taught

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

## PEER-REVIEWED JOURNAL ARTICLES

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

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

16. Royer PA, Olson LM, Jackson B, Weber LS, Gawron L, Sanders JN, **Turok DK** (2020). "In Africa, There Was No Family Planning. Every Year You Just Give Birth": Family Planning Knowledge, Attitudes, and Practices Among Somali and Congolese Refugee Women After Resettlement to the United States. *Qual Health Res*, *30*(3), 391-408.
17. Everett BG, Myers K, Sanders JN, **Turok DK** (2019). Male Abortion Beneficiaries: Exploring the Long-Term Educational and Economic Associations of Abortion Among Men Who Report Teen Pregnancy. *J Adolesc Health*, *65*(4), 520-526.
18. Thompson I, Sanders JN, Schwarz EB, Boraas C, **Turok DK** (2019). Copper intrauterine device placement 6-14 days after unprotected sex. *Contraception*, *100*(3), 219-221.
19. Campbell AD, **Turok DK**, White K (2019). Fertility Intentions and Perspectives on Contraceptive Involvement Among Low-Income Men Aged 25 to 55. *Perspect Sex Reprod Health*, *51*(3), 125-133.
20. Sanders JN, Moran LA, Mullholand M, Torres E, **Turok DK** (2019). Video counseling about emergency contraception: an observational study. *Contraception*, *100*(1), 54-64.
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## NON PEER-REVIEWED JOURNAL ARTICLES

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2. Jacobson JC, Simonsen SE, Ward KM, Havlicak AL, **Turok DK** (2011). A Survey of Sexual Activity and Contraceptive use among University of Utah Undergraduate Students Aged 18-20.

## REVIEW ARTICLES

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3. Gawron LM, **Turok DK** (2015). Pills on the World Wide Web: reducing barriers through technology. [Review]. *Am J Obstet Gynecol*, *213*, (4), 500.e1-4.
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## BOOK CHAPTERS

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5. **Turok DK**, Schultz TR (2008). Chapter 8, Section I: Complications of Pregnancy, Endocrine Conditions. In Ratcliffe S (Ed.), *In Family Practive Obstetrics* (3rd Edition, pp. 243-54). Philadelphia: Mosby.
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7. **Turok DK**, Van Horn JT (2004). Obstetrics and Gynecology. In Haas LJ (Ed.), *Primary Care Psychology* (pp. 87-94). Oxford University Press.
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## ADDITIONAL PUBLICATIONS

### Editorials

1. **Turok DK**. (2017). For emergency contraception, political gaps are not scientific gaps. *BJOG*.
2. **Turok DK** (2017). The quest for patient-centered family planning. *Am J Obstet Gynecol*, *216*(2), 98-100.
3. **Turok DK** (2014). Contraceptive update: evidenced based optimism. *Clin Obstet Gynecol*, *57*(4), 633-4.
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**Letters**

1. Fay K., Kaiser J., **Turok D**. (2020). The no-test abortion is a patient-centered abortion. [Letter to the editor]. *Contraception*, *102*(2), 142.
2. Gawron LM, Gero A, Kushner KL, **Turok DK**, Sanders JN (2020). Unprotected intercourse in the 2 weeks prior to quick-start initiation of an etonogestrel contraceptive implant with and without use of oral emergency contraception. [Letter to the editor]. *Am J Obstet Gynecol*, *222*(4S), S891-S892.
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6. **Turok DK**, Clark EA, Esplin MS (2013). Framework for preventing preterm birth must include contraception. [Letter to the editor]. *Am J Obstet Gynecol*, *208*(6), 508.

**Newspapers**

1. **Turok DK** (2020). Trust people with the freedom to choose abortion. . *Salt Lake Tribune Op Ed*.
2. **Turok DK**, Jones K (2012). Compassion, Contraception, and Abortion. *Salt Lake Tribune; Available at: http://www.sltrib.com/sltrib/opinion/53609137-82/abortion-women-contraception-effective.html.csp* .

**Multimedia**

1. **Turok DK**, Wysocki S, Grimes DA, Deal MA (2011). Contraceptive Update: CDC Medical Eligibility Criteria for Women With Chronic Conditions [Video], Medscape Women's Health Education.

## PENDING PUBLICATIONS

**Review Articles**

1. **Turok DK**, Wysocki S, Grimes DA, Deal MA. (In Press). Contraceptive Update: CDC Medical Eligibility Criteria for Women With Chronic Conditions. [Review].
2. **Turok DK** (In Press). The Intrauterine device (IUD) for emergency contraception fact sheet.. [Review].

## RECENTLY PUBLISHED ABSTRACTS (LAST 3 YEARS)

1. **Turok DK**, Gero A, Simmons R, Kaiser J, Stoddard GJ, Sexsmith CD, Gawron LM, Sanders JN. (2020). The Levonorgestrel vs. Copper Intrauterine Device for Emergency Contraception: a Non-inferiority Randomized Controlled Trial. Society of Family Planning Annual Meeting. Top 4 oral abstract. Online virtual meeting. October 9-11, 2020 [Abstract].
2. Sanders JN, Geist C, Diener Z, Myers K, Simmons R, **Turok DK** (2019). Contraceptive methods used in the four weeks leading up to new contraceptive visit: HER Salt Lake Contraceptive Initiative. Los Angeles, CA. [Abstract]. *Soceity of Family Planning Annual Meeting*.
3. Everett BG, Sanders JN, Higgins J, Simmons R, Geist C, Myers K, **Turok DK** (2019). Changes in Gender of Sexual Partners and Contraception Discontinuation and Switching. Los Angeles, CA. [Abstract]. *Society of Family Planning Annual MNeeting*.
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5. R Simmons, J Sanders, K Myers, D Turok (2019). Does Access to No-Cost Contraception Change Method Selection Among Individuals who Report Trouble Paying for Health-Related Care? *Family Planning Division, University of Utah, Salt Lake City, UT, USA* [Abstract]. *Contraception Journal*, *100*(4), 329.
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8. Z Diener, K Myers, R Simmons, G Aguilera, B Everett, C Geist, D Turok (2019). Contraceptive Strategies Used in the 4 Weeks Before and After New Contraceptive Visits in HER Salt Lake's Title X Clinics. *Family Planning Division, University of Utah, Sal t Lake City, UT, USA.* [Abstract]. *Contraception Journal*, *100*(4), 337.

## POSTER PRESENTATIONS

2019 Wright, KQ, Higgins, JA, Sanders, JN, Everett, BG , **Turok, DK**. To what extent are people's sexual experiences with their contraceptive methods associated with contraceptive satisfaction and continuation? Results from the HER Salt Lake Initiative. Poster presentation at Society of Family Planning Annual Meeting, Los Angeles, CA

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

2019 Higgins JA, Wright KQ, Everett BG, **Turok DK**, Sanders JN. Sexual Outcomes Associated with Contraceptive Use At One, Three, and Six Months in the HER Salt Lake Initiative. Oral presentation at Society of Family Planning Annual Meeting, Los Angeles, CA.

2019 Gero A, Simmons R, Sanders J, **Turok DK**, Myers K. Does Access to No-Cost Contraception Change Method Selection Among Individuals Who Report Trouble Paying for Health-Related Care? Poster presentation at Society of Family Planning Annual Meeting, Los Angeles, CA

2018 Kozlowski Z, Gawron LM, Sanders JN, Panushka K, Myers K, **Turok DK**. *'I'm Poor So I'll Take What I Can Get": Contraceptive Preferences and Needs Among Women With Housing Insecurity or Homelessness*. Poster session presented at North American Forum on Family Planning.

2018 **Turok DK,** Nelson A. Phase 2 Efficacy, Safety, and Tolerability Results of the VeraCept Low-Dose Copper Intrauterine Contraceptive: 24-Month Data. Poster Presentation at North American Forum on Family Planning. New Orleans, LA.

2018 C Geist, J Sanders, K Myers, R Simmons, B Everett, L Gawron, **Turok DK**. Changing Lives, Dynamic Plans? 12-Month Shifts in Pregnancy Intentions, Poster Presentation at North American Forum on Family Planning. New Orleans, LA.

2018 JE Kaiser, R Simmons, K Myers, J Sanders, L Gawron, **DK Turok**. Predictors of Contraceptive Method Switching and Discontinuation Six Months Post-abortion. Poster presentation at North American Forum on Family Planning. New Orleans, LA.

2018 J Higgins, J Sanders, K Wright, D Adkins, **D Turok**. Beyond safety and efficacy: how sexuality-related priorities impact contraceptive method selection. Top 4 oral presentations at North American Forum on Family Planning. New Orleans, LA.

2018 B Everett, J Sanders, K Myers, **D Turok.** Long-Term Socioeconomic Outcomes of Women who Avoided Teen Parenthood Through Abortion. North American Forum on Family Planning. New Orleans, LA.

2018 **Turok DK**, Nelson A. *A novel low-dose copper intrauterine contraceptive: Phase 2 clinical trial data with 18-month data*. Poster session presented at European Society of Contraception, Budapest, Hungary.

2017 Everett B, Sanders JN, Myers K, Geist C, **Turok DK**. *1 in 3: Utah Family Planning Clinics Challenge Heteronormative Assumptions.* Poster session presented at North American Forum on Family Planning.

2017 Benson A, Bullock H, Sanders JN, **Turok DK**.. *Comparing reduced-cost versus no-cost contraception on postabortal contraceptive method mix: a prospective cohort study*. Poster session presented at North American Forum on Family Planning.

2016 Bellows B, Tak C, Sanders J, **Turok D**, Schwarz EB. Cost-effectiveness of emergency contraception options over 1 year. North American Forum on Family Planning. Denver, CO.

2016 Moran L, Sanders J, Torres E. Wolsey K, **Turok D**. Video counselling for emergency contraception: impact on patient choice. North American Forum on Family Planning. Denver, CO.

2016 Royer P, Weber L, Jenkins A, Sanders J, Gawron L, **Turok D.** Family planning knowledge and contraceptive use among resettled African refugee women. North American Forum on Family Planning. Denver, CO.

2016 Royer P, Jenkins A, Weber L, Jackson B, Sanders J, **Turok D**. Group versus individual contraceptive counseling for resettled African refugee women: a pilot randomized controlled trial. North American Forum on Family Planning. Denver, CO.

2016 Maddukuri V, Sanders J, Huish RP, **Turok D**. A retrospective review of recurrent preterm birth and use of highly effective reversible contraceptives. North American Forum on Family Planning. Denver, CO.

2016 Jessica Sanders, **Turok DK**, Lori Gawron, Amy Law, Lonnie Wen, Richard Lynen Continuation of highly effective reversible contraception at two years in a University

Healthcare Setting: A retrospective review. Academy of managed care pharmacy. San
2016 Francisco, CA.

Eggebroten J, Sanders J, **Turok DK**, Saltzman H. Patient uptake and outcomes: an
2016 immediate postpartum IUD and implant program. ACOG annual meeting. Washington, DC.

**Turok D**, Espey E, Sanders JN, Eggebroten J, Bullock H, Gawron L. The effect of postplacental versus interval postpartum IUD insertion on Lactogenesis: The Breastfeeding Levonorgestrel IUD Study (BLIS): A randomized controlled trial. Oral abstract at the North
2016 American Forum on Family Planning. Denver, CO.

Gawron L, Sanders J, Sward K, **Turok D**. Uptake of long-acting reversible contraception among women with chronic medical diseases in a tertiary referral center. North American Forum on Family Planning. Denver, CO.

Sanders J, **Turok D**, Gawron L, Law A, Wen L, Lynen R. Three-year continuation of long-
2016 acting reversible contraceptive methods in a mixed-payer health care setting: a retrospective review. North American Forum on Family Planning. Denver, CO.

Sanders J, **Turok DK**, Gawron L, Steele K, Storck K, Bullock H. Tracking IUD bleeding
2016 experiences (TRIBE): A prospective evaluation of bleeding profiles among new IUD users. North American Forum on Family Planning. Denver, CO.

Espey E, **Turok DK**, Sanders J, Singh RH, Thaxton L, Leeman L. Breastfeeding
2016 continuation in postplacental versus interval postpartum IUD insertion: The Breastfeeding Levonorgestrel IUD Study (BLIS): A randomized controlled trial. North American Forum on Family Planning. Denver, CO.

Jacobson E, Roth L, Sanders J, **Turok D**, Bullock H. Changes in IUD uptake with the
2016 availability of a low-cost levonorgestrel IUD – a retrospective review of Title X clinics. North American Forum on Family Planning. Denver, CO.

Gawron L, Suo Y, Carter M, Redd A, **Turok D**, Gundlapalli A. Uptake of long-acting
2016 reversible contraception among homeless versus housed women veterans. North American Forum on Family Planning. Denver, CO.

Ward K, **Turok D**, Thomson I, Sanders J, Knapp L. Single collection of unrinary
2016 reproductive hormones to identify the fertile window: a feasibility study. North American Forum on Family Planning. Denver, CO.

Royer P, Jenkins A, Weber L, Jackson B, Sanders J, **Turok D**. Group versus individual
2016 contraceptive counseling for resettled African refugee women: a pilot randomized controlled trial. North American Forum on Family Planning. Denver, CO.

Herrera C, Sanders JN, Torres LN, **Turok DK**, Clark EA. An assessment of patient
2015 counseling following preterm birth in a tertiary care center. SGI. San Francisco.

Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "It's difficult here, because you
2015 need someone to look after the children" A qualitative analysis of African refugee women's post-resettlement perceptions regarding family size and fertility. FIGO. Vancouver, British Columbia.

Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "We do not know what is
2015 happening inside a woman's body": A qualitative investigation of African refugee women's post-resettlement reproductive health conceptualizations. FIGO. Vancouver.

Schreiber CA, **Turok DK**, Chen BA, Blumenthal PD,Cwiak C, Creinin MD.
2015 Plasma levonorgestrel levels over 36 months in non-obese and obese women using LilettaTM, a new 52 mg levonorgestrel-releasing intrauterine system. FIGO. Vancouver.

**Turok DK**, Eisenberg DL,Teal SB, Westhoff CL, Keder LM, Creinin MD.
2015 Evaluation of pelvic infection in women using LilettaTM, a new 52 mg levonorgestrel-releasing intrauterine system, for up to 2 years. FIGO. Vancouver, British Columbia.

Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "In Africa there was no family
2015 planning, every year you just give birth": A qualitative analysis of contraceptive knowledge,

attitudes and practices among African refugee women after resettlement. FIGO. Vancouver, British Columbia.

2015 **Turok DK,** Cappiello B, Sanders JN, Thompson I, Storck K, Gawron L. A novel atraumatic alternative to the cervical tenaculum: A randomized controlled trial comparing the Bioceptive® suction cervical retractor vs. single tooth tenaculum during IUD insertion. North American Forum on Family Planning. Chicago.

2015 Gawron L, Lorange E, Flynn A, Sanders JN, **Turok DK**, Keefer L. Contraceptive misperceptions and misinformation among women with inflammatory bowel diseases: a qualitative study. North American Forum on Family Planning. Chicago.

2015 **Turok DK**, Cappiello B, Sanders JN, Royer PA, Thompson I, Gawron L. Ex-vivo forces associated with IUD insertion and perforation: Biomechanical evaluation of hysterectomy specimens. North American Forum on Family Planning. Chicago.

2015 Ralph L, Greene Foster D, **Turok DK**, Roberts S. Evaluating the psychometric properties of two decisional conflict scales among women seeking abortion in Utah. North American Forum on Family Planning. Chicago.

2015 Sanders JN, Higgins J, **Turok DK**, Gawron L. The intimate link: sexual functioning and well-being among new IUD and contraceptive implant users. North American Forum on Family Planning. Chicago.

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

2014 Sok C, Sanders JN, **Turok DK**, Royer PA, Torres L. Sexual behavior and satisfaction of postpartum women. North American Forum on Family Planning. Miami, FL

2014 Sanders JN, **Turok DK**, Royer PA, Maddukuri V, Eggebroten J. Why women who previously tried to get an IUD walked away without one. North American Forum on Family Planning. Miami, FL

2014 Dermish A, **Turok DK**, Murphy P, Jacobson J, Jones KP. An intervention to manage difficult IUD insertions. North American Forum on Family Planning. Miami, FL

2014 Conway H, Sanders JN, Jacobson J, Torres LN, **Turok DK.** The Longest Wait: Utah's move to a 72-hour waiting period for abortion services. North American Forum on Family Planning. Miami, FL

2014 Howell L, Sanders JN, Royer PA, Schwarz EB, **Turok DK.** Oops, we did it again! Unprotected intercourse in the two weeks prior to requesting emergency contraception. North American Forum on Family Planning. Miami, FL

2014 Jacobson J, Moran LA, Howell L, Torres LN, Royer PA, **Turok DK** Patient reported length of intrauterine device (IUD) use and reason for discontinuation at the time of removal. North American Forum on Family Planning. Miami, FL

2014 Howell L, Sanders JN, **Turok DK**, Royer PA, Jacobson J. PSA: A marker of unprotected intercourse in a population seeking emergency contraception. North American Forum on Family Planning. Miami, FL

2014 Torres LN, **Turok DK**, Clark E, Sanders JN, Godfrey E. A Randomized-Control Trial of Focused Contraceptive Counseling and Case Management Versus Usual Care in Women Postpartum From a Preterm Birth. North American Forum on Family Planning. Miami,

2014 Peipert J, Zhao O, Stoddard A, McNicholas C, Schreiber C, **Turok DK,** Teal S, Madden T. Impact of Infection and Intrauterine Device Use on Fertility. North American Forum on Family Planning. Miami, FL

2014 **Turok DK**, Sanders JN, Royer PA, Thompson I, Eggebroten J. Copper or LNG IUD for emergency contraception (COLIEC): Device choice and early pregnancies. North American Forum on Family Planning. Miami, FL October 12-13, 2014.

2013 Clark EAS, Winter S, **Turok DK**, Randall H, Torres L. Prevention of Recurrent Preterm Birth: Role of the Neonatal Follow-up Program Association of Maternal and Child Health Programs. Washington, DC.

2013 **Turok DK**, Edelman AB, Lotke PS, Lathrop EH, Espey E, Jacobson JC, Bardsley T, Ward K, Schulz K. Misoprostol vs. Placebo Prior to IUD Insertion in Nulliparous Women: A Prospective Meta-Analysis. North American Forum on Family Planning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ORAL PRESENTATIONS

### Keynote/Plenary Lectures

International

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

Local/Regional

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

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

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

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

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

**Meeting Presentations**

International

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

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

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

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

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

National

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local/Regional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Invited/Visiting Professor Presentations**

International

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

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

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

National

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local/Regional

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

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

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

**Grand Rounds Presentations**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Exhibit B

Declaration of David Turok, M.D., M.P.H., FACOG
in Support of Plaintiff's Second Motion for a Preliminary Injunction

**THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH**

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| PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff,<br>*Plaintiff*,<br><br>v.<br><br>STATE OF UTAH, *et al.*,<br>*Defendants.* | **DECLARATION OF DAVID TUROK, M.D., M.P.H., FACOG, IN SUPPORT OF PLAINTIFF'S SECOND MOTION FOR A PRELIMINARY INJUNCTION**<br><br>Case No. 220903886<br><br>Judge Andrew Stone |

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

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

2. I have been asked to provide my opinion on Utah House Bill 467, 2023 Leg., Gen. Sess. (Utah 2023) ("HB 467"), which amends the Trigger Ban, Utah Code Ann. § 76-7a-201, and other parts of Utah law. In relevant part, HB 467 requires abortions to be performed in hospitals, not abortion clinics (the "Clinic Ban") and imposes new professional licensing penalties for violations of Utah abortion law (the "Professional Licensing Penalties"). I have been asked whether there is any medical justification for the law and whether it would affect access to and the quality of reproductive health care.

3. I previously submitted a declaration in this case in support of emergency relief against the Trigger Ban, which took effect in June 2022 after the U.S. Supreme Court overruled

*Roe v. Wade*. *See* Decl. of David Turok in Supp. of Pl.'s Mot. for TRO. As I will explain in further detail below, all of my opinions about the Trigger Ban apply with equal force to HB 467. This declaration incorporates my prior declaration by reference.

4. I understand HB 467's Clinic Ban requires abortion to take place in hospitals, not abortion clinics, and allows the State to revoke the license of any abortion clinic that provides an abortion. Additionally, HB 467's Professional Licensure Penalties threaten to revoke the licenses of physicians and other medical providers who violate Utah's abortion laws, even if no criminal court has found them guilty. From my understanding, HB 467 will take effect on May 3, 2023 unless it is enjoined through this lawsuit.[1]

5. Through my two decades of experience as a board-certified obstetrician-gynecologist ("OB/GYN") licensed to practice medicine in Utah, I am familiar with the standards of care for abortion procedures, developments in the medicine of abortion, and patient care and patient experience in the context of abortion care. I am also informed by my deep familiarity and on-going review of the relevant research and literature and through my decades of supervising and teaching, including as a tenured Associate Professor in the Department of Obstetrics and Gynecology at the University of Utah School of Medicine, where I am Director of the Division of Family Planning, Director of the Fellowship in Family Planning, and Director of the ASCENT Center for Sexual and Reproductive Health.

[1] It is also my understanding HB 467 amends the Trigger Ban by further narrowing exceptions to its ban on abortions, making it even more challenging for pregnant people to receive abortion in the case of fetal anomalies and pregnancies resulting from rape or incest. It is also my understanding that because the Trigger Ban is enjoined, amendments to its exceptions have no immediate effect. Therefore, I will not address these amendments to the Trigger Ban in this declaration.

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

## OVERVIEW OF OPINIONS

7. PPAU and one other abortion clinic currently provide more than 95 percent of Utah abortions. If allowed to take effect, HB 467's Clinic Ban will force us both to stop performing abortions on May 3, 2023. Utah hospitals do not provide abortion care except in narrow, exceptional circumstances. The Clinic Ban will, therefore, functionally ban abortion in Utah.

8. As a functional ban on abortion, HB 467 will have a devastating impact on Utahns and their families, just as the Trigger Ban would. If HB 467 takes effect, pregnant people seeking abortions will face intense challenges getting the care they need and most will be forced to seek abortions outside the State of Utah. Those who are not able to do so will be compelled to carry pregnancies to term against their wishes or seek ways to end their pregnancies without medical supervision, some of which may be unsafe or lead to criminal investigation or prosecution. I am gravely concerned about the effect HB 467 will have on Utahns' emotional, physical, and financial wellbeing and the wellbeing of their families, including their existing children.

9. HB 467 will also harm PPAU and its staff, including myself, by preventing PPAU from fulfilling its mission of ensuring access for Utahns to affordable, quality sexual and reproductive health care, which necessarily includes abortion. In addition to barring PPAU from providing abortion to patients who seek it, HB 467 will also hamper our ability to recruit and retain medical staff to provide other forms of sexual and reproductive health care.

10. HB 467's Professional Licensing Penalties depart dramatically from existing licensure penalties. The fear of severe criminal and professional penalties with potentially ruinous consequences for physicians' professional futures and families' livelihoods will deter Utah physicians from providing *lawful* abortions. This will prevent patients from receiving necessary and life-saving care.

11. If HB 467's Clinic Ban and Professional Licensing Penalties are enjoined like the Trigger Ban, PPAU will continue to provide abortions up to 18 weeks of pregnancy.

## I. PPAU AND ITS SERVICES

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

13. Founded in 1970, PPAU's mission is to empower Utahns of all ages to make informed choices about their sexual health and to ensure access for Utahns to affordable, quality sexual and reproductive health care and education. PPAU provides care to approximately 37,000 Utah residents each year.

14. PPAU performs abortions at three health centers licensed under Utah law as "abortion clinics." Medication abortion is provided at all three of these health centers and aspiration abortion and dilation and evacuation ("D&E") are provided at one of these health centers.

15. Following the court order in July 2022 preliminarily enjoining the Trigger Ban, PPAU resumed providing abortions up to 18 weeks from the first day of the patient's last menstrual period ("LMP"), confirmed by ultrasound and as permitted by Utah's 18-Week Ban.

16. Abortions at PPAU are performed by board-certified physicians licensed to practice in Utah. All of PPAU's physicians, myself included, also practice in hospitals. In fact, when abortions are performed at a hospital where PPAU physicians work, in the vast majority of the

cases, it is the PPAU physicians who perform the abortion, especially for the most complicated cases. Four of PPAU's five physicians have completed fellowships in complex family planning, which provides post-graduate OB/GYN physicians with additional training in abortion and contraception, making them leaders in clinical care, research, and medical education, or have the equivalent training and experience.

17. In addition to its three licensed abortion clinics, PPAU operates five other health centers that do not provide abortion. Altogether, PPAU's health centers provide a full range of family-planning services, including well-person preventative care visits; breast exams; Pap tests; sexually transmitted infection ("STI") testing; a wide range of U.S. Food and Drug Administration ("FDA")-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments to screen for high-risk issues; referral services for pregnant women; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; and vasectomies.

## II. ABORTION IS COMMON, SAFE, AND CRITICAL HEALTH CARE

### A. All three methods of providing abortion at PPAU are safe, outpatient procedures.

18. All methods of abortion provided at PPAU—medication abortion, aspiration abortion, and D&E—are simple, straightforward medical treatments that typically take no more than 10 minutes, have an extremely low complication rate, are almost always provided in outpatient, office-based settings, and, unlike some other office-based procedures such as vasectomies, involve no incisions.

19. Although aspiration abortion and D&E are both sometimes referred to as "surgical" abortion, they are not what is commonly understood to be surgery. Both aspiration abortion and D&E are done through the natural opening of the vagina and cervix and therefore involve no

incisions. Both can be, and almost always are, performed in outpatient clinics like PPAU by clinicians adhering to widely-accepted medical standards of care.

**i. Medication Abortion**

20. Medication abortion uses medication to cause uterine contractions to empty the uterus. It requires no anesthesia or sedation. PPAU provides the most common form of medication abortion through 11 weeks, or 77 days, LMP.

21. In a typical medication abortion, the patient takes a combination of two prescription drugs—mifepristone (also known as RU-486 or by its trade name, Mifeprex) and misoprostol (also known as a prostaglandin analogue or by its trade name, Cytotec)—a day or two apart. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol causes the cervix to open and the uterus to contract and empty. These same medications are offered as a treatment option to patients who have a miscarriage with retained tissue. Indeed, the process of medication abortion very closely approximates the process of miscarriage, except that a medication abortion is initiated through medications. Under this regimen, the patient completes the abortion process outside any clinical setting in a location of their choice, usually at home.

22. Mifepristone and misoprostol are safe—substantially safer than aspirin, Tylenol, and Viagra. A 2018 report by the National Healthcare Cost and Utilization Project found the rate of hospital stays involving adverse drug reactions caused by antibiotics and similar medications was 151.5 per 10,000 hospital stays.[2] In contrast, there has not been a single reported case of severe allergic reaction or fatal overdose as a result of a medication abortion.

[2] Audrey J. Weiss et al., Agency for Healthcare Research and Quality, *Adverse Drug Events in U.S. Hospitals, 2010 Versus 2014*, at 4 (2018), available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb234-Adverse-Drug-Events.pdf.

23. The FDA approved mifepristone, by its brand name Mifeprex, in 2000. Decades of experience with medication abortion since then have resoundingly confirmed its safety and efficacy. Indeed, earlier this year, the FDA modified its dispensing requirements for mifepristone to reflect the ever-growing body of evidence demonstrating the safety and effectiveness of medication abortion.[3]

**ii. Aspiration Abortion**

24. Aspiration abortion (also known as suction curettage or dilation & curettage) entails using suction to empty the uterus. It is a straightforward procedure performed in the first and early second trimester. PPAU provides aspiration abortion up to approximately 13 weeks LMP. A small plastic tube, called a cannula, is passed through the cervical canal. The cannula is attached to a syringe or electrical pump that creates gentle suction to empty the uterus.

25. Prior to starting the suction procedure, the provider dilates the cervix as needed to allow the cannula to enter the uterus. An analgesic such as ibuprofen, an anti-anxiety medication such as Ativan or Valium, a local anesthetic such as Lidocaine, and/or minimal sedation may be used during or prior to the procedure.

26. The entire procedure, including administration of local anesthesia, dilating the cervix, and aspirating the uterine contents takes 3 to 5 minutes. It involves no incision, cutting, or suturing. The same procedure is used to manage an incomplete miscarriage.

[3] *See Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last reviewed Mar 23, 2023).

**iii. D&E Abortion**

27. Dilation and evacuation, or D&E, uses a combination of gentle suction and additional instruments, including specialized forceps, to evacuate the pregnancy contents from the uterus. D&E is performed after approximately 13 weeks LMP, depending on the provider's individual practice and the patient's individual medical characteristics.

28. Prior to the D&E procedure, the provider dilates the patient's cervix to ease and advance cervical dilation, which assures clinical safety. This may be done through medications such as misoprostol, which softens the cervix, and/or the placement of osmotic dilators in the cervix, which gradually swells as it absorbs moisture, causing the cervix to dilate. The provider may also use mechanical dilators or a combination of these techniques. The provider then empties the uterus using instruments or a combination of suction and instruments. Mild to moderate sedation may be used.

29. In the early part of the second trimester, physicians may perform the cervical preparation and evacuation on the same day. Later in the second trimester, the physician may start the dilation process one day before the evacuation. It is PPAU's current practice to begin the dilation process for patients from 15 to 18 weeks LMP through the placement of osmotic dilators the day before evacuation.

30. The entire evacuation procedure typically takes up to 10 minutes. Like aspiration abortion, D&E does not involve any incision, cutting, or suturing.

**iv. Abortion by Induction**

31. Labor induction abortion is the alternative to D&E in the second trimester. Induction abortion involves the use of the same medications as are used for medication abortion, mifepristone and misoprostol, to cause the uterus to contract and the patient to undergo labor.

Induction abortion typically lasts between eight and thirty-six hours and entails contractions and the process of labor and delivery, which can be painful and require strong medications, sedatives, or anesthesia. Induction abortion also has a higher complication rate than D&E. Unlike other forms of abortion, induction abortion is usually performed in hospitals.[4] Induction abortion is most commonly used in the hospital to terminate a pregnancy when there is a grave or lethal fetal anomaly or a severe maternal medical complication of pregnancy.

**B. Abortion is one of the safest procedures in medicine.**

32. HB 467 does not improve patient health and safety. Abortion is one of the safest procedures in contemporary medical practice and is safely and routinely provided in outpatient settings in countries around the world.

33. Leading medical authorities agree that abortion is one of the safest procedures in medical practice,[5] "stand[ing] in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services."[6]

34. In fact, major complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23 percent of abortions performed in outpatient, office-based settings.[7]

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[4] PPAU does not provide abortion by induction.

[5] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, at 77 (2018), available at http://nap.edu/24950 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[6] *Id.*

[7] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 177 (2015); *see also* Ushma D. Upadhyay et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16 BMC Med. 1, 1 (2018).

35. Abortion compares favorably, with a markedly lower complication rate, to other procedures routinely performed in outpatient, office-based settings, including:

- vasectomies, a form of male birth control that involves transecting and cauterizing the vas deferens, the tubes that carry sperm, resulting in complications two percent of the time while major complications requiring hospitalization occur in 0.2–0.8 percent of cases;[8]
- colonoscopies, an exam used to look for changes in the large intestine (colon) and rectum, such as swollen, irritated tissues, polyps or cancer, with a complication rate of 1.6 percent;[9]
- wisdom teeth extraction, a surgical procedure to remove one or more of the four permanent teeth located at the back corners of the mouth, with a complication rate of 6.9 percent;[10] and
- tonsillectomies, surgical removal of the tonsils, with a complication rate of 7.9 percent.[11]

36. Abortion is significantly safer than the alternative of carrying a pregnancy to term and giving birth.[12] The United States has the highest maternal mortality rate among high-income

[8] Christopher E. Adams & Moshe Wald, *Risks and Complications of Vasectomy*, 36 Urologic Clinics N. Am. 331 (2009).

[9] Isuru Ranasinghe et al., *Differences in Colonoscopy Quality Among Facilities: Development of a Post-Colonoscopy Risk-Standardized Rate of Unplanned Hospital Visits*, 150 Gastroenterology 103, 103 (2016).

[10] Francois Blondeau & Nach G. Daniel, *Extraction of Impacted Mandibular Third Molars: Postoperative Complications and their Risk Factors*, 73 J. Canadian Dental Ass'n 325 (2007).

[11] Jack L. Paradise et al., *Tonsillectomy and Adenotonsillectomy for Recurrent Throat Infection in Moderately Affected Children*, 110 Pediatrics 7 (2002).

[12] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215 (2012).

countries (more than four times the rate of others in that group). Most concerningly, it is getting worse. In 2021, the maternal mortality rate increased 40 percent from the previous year.[13] That year alone, 1,205 pregnant women died of pregnancy-related causes in the United States.[14] The Centers for Disease Control and Prevention (CDC) measure maternal mortality rates as the number of maternal deaths per 100,000 live births.[15] In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births.[16]

37. In contrast, the CDC reported 0.43 deaths per 100,000 legal abortions from 2013 to 2019.[17] While the U.S. maternal mortality rate has significantly increased, there is no evidence that has occurred for abortion care, making legal abortion at least 12 times safer than live birth.[18]

38. Maternal mortality is not the only risk presented by pregnancy and birth. Every year, an estimated 60,000 women experience severe maternal morbidity,[19] or "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health."[20]

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[13] Donna L. Hoyert, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stats., *Maternal Mortality Rates in the United States, 2021*, at 1 (2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf.

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] Katherine Kortsmit et al., *Abortion Surveillance—United States, 2020*, 71 Morbidity & Mortality Weekly Rep. 1, 6 (2022), available at https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-H.pdf.

[18] Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 5, at 75.

[19] *Rates in Severe Morbidity Indicators per 10,000 Delivery Hospitalizations, 1993–2014*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/rates- severe-morbidity-indicator.htm (last visited March 30, 2023).

[20] *Severe Maternal Morbidity in the United States*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#rates (last visited March 30, 2023).

39. In 2021, 32.1 percent of births in the United States occurred by cesarean delivery, which, despite being largely normalized in American culture, is a major abdominal surgery with substantial morbidity and associated risks.[21] Nine percent of women who undergo a cesarean delivery are readmitted to the hospital due to complications.[22]

40. Women who carry their pregnancies to term also face a multitude of pregnancy-related complications prior to birth, including high blood pressure, gestational diabetes, infection, preeclampsia, and depression and anxiety.[23] Pregnancy-related complications are unsurprisingly more common among women who ultimately give birth than those who have an abortion since pregnancies ending in abortion are substantially shorter than those ending in childbirth and thus entail less time for pregnancy-related problems to occur or progress.[24]

**C. Abortions are safely performed in outpatient, office-based settings like PPAU.**

41. There is no medical reason to require abortion to take place in hospitals and not abortion clinics. In Utah, as is done throughout the country, legal abortions are safely and routinely performed in doctors' offices and outpatient health center settings.

42. As a highly experienced OB/GYN who works at both PPAU and the University of Utah Hospital, I have performed and observed abortion care in both hospital and outpatient settings. There is no medical reason to require medication abortion, aspiration abortion, or D&E to be performed in a hospital. In my experience, abortion care is only provided at Utah hospitals

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[21] Joyce A. Martin et al., *Births: Final Data for 2016*, 67 Nat'l Vital Stats. Reps. 1, 7 (2018), available at https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

[22] P. R. Herbert et al., *Serious Maternal Morbidity After Childbirth: Prolonged Hospital Stays and Readmissions*, 94 Obstet. & Gynecol. 942, 944 (1999).

[23] *What are some common complications of pregnancy?*, Nat'l Insts. of Health, https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/complications (last reviewed April 2021).

[24] Raymond & Grimes, *supra* note 12, at 216–17.

in cases of life-threatening maternal health conditions, where the expertise of physicians with other subspecialty experience is critical in providing optimal care; grave or lethal fetal anomalies; or, very rarely, rape or incest, and sometimes in situations where insurance covers care exclusively at a particular hospital. The majority of the abortion referrals we receive at the University of Utah Hospital ultimately end up being cared for at PPAU's Metro Health Center in Salt Lake City, even if the abortion falls into one of the narrow reasons that an abortion could be provided at the hospital. This is because having an abortion at PPAU is more affordable, easier to navigate, requires considerably less time for patients, and, since all of PPAU's physicians also work at the University of Utah Hospital, is provided by the same skilled physicians who likely would have provided their care at the University of Utah Hospital.

43. No scientific evidence indicates abortions performed in a hospital are safer than those performed in an appropriate outpatient, office-based setting.[25] To the contrary, as is true for nearly every medical procedure, fewer complications are seen in settings that perform higher volumes of the same procedure, making abortion clinics like PPAU safer than hospitals for most abortion patients.[26]

44. Research that I published in 2008 supports the conclusion that abortion is safest when performed by clinicians who have lots of experience providing abortions. Specifically, we found that second-trimester terminations of pregnancy by D&E in well-selected patients in a dedicated outpatient facility, such as PPAU's health centers, can be safer and less expensive than

[25] Sarah C. M. Roberts et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319 JAMA 2497 (2018).

[26] Steve Sternberg & Geoff Dougherty, *Risks are High at Low-Volume Hospitals*, U.S. News & World Report (May 18, 2015, 12:01 A.M.), https://www.usnews.com/news/articles/2015/05/18/risks-are-high-at-low-volume-hospitals.

hospital-based D&E or induction of labor.[27] This research led to the development of the clinical fellowship program that I currently direct at the University of Utah, which in turn has contributed to the extraordinarily low rate of complications for abortions in Utah.

45. Outside of the abortion context, lower rates of complications and better outcomes are observed for facilities and providers performing greater numbers of the same procedures.[28] As a result, there is a shift towards regionalization of procedures at high-volume facilities.[29] The reverse is also true: patients face greater risks from common procedures simply because the hospital providers do not get enough practice.

46. PPAU physicians have low abortion complication rates and superb safety records. Because PPAU specializes in providing patient-centered, holistic sexual and reproductive health care, PPAU patients benefit from receiving care from highly experienced and specialized providers and staff.

47. PPAU's reputation for excellent patient care is so widely known in the Utah medical community that PPAU's physicians regularly receive referrals from hospitals to perform complicated or high-risk D&E cases. In fact, PPAU receives referrals every week from doctors in hospital settings throughout Utah and the Intermountain West.

48. According to the National Academies of Sciences, Engineering, and Medicine, "most abortions can be provided safely in office-based settings," and a hospital setting is not clinically necessary.[30] Similarly, major medical associations, including the American College of

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[27] David K.Turok et al, *Second trimester termination of pregnancy: a review by site and procedure type*, 77 Contraception 155, 155 (2008).

[28] Sternberg & Dougherty, *supra* note 26.

[29] *Id.*

[30] *See* Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 5, at 10, 77.

Obstetricians and Gynecologists and the American Public Health Association, reject the notion that abortions should be performed in hospitals.[31]

49. Abortion is rarely performed in hospital settings. Both the University of Utah Hospital and Intermountain Healthcare, Utah's largest hospital system, only provide abortion as a result of maternal medical conditions, grave or lethal fetal anomalies, or rape or incest, and follow internal rules against providing abortion in all other circumstances. Induction abortion, the method of abortion most appropriately performed in a hospital setting, is only performed at the University of Utah Hospital once every few weeks.

50. The hallmark features that differentiate hospitals from abortion clinics include system operations requirements,[32] staffing requirements,[33] and building construction requirements.[34] Not only are these features not relevant or necessary in the context of abortion care, they provide no medical benefit.

51. Early medication abortion, for example, typically involves the ingestion of two prescription drugs—mifepristone and misoprostol—a day or two apart to cause uterine contractions to empty the uterus. There is no reason to require a patient to come to a hospital simply to take medication. From my 25 years working at the University of Utah Hospital, I can think of just two instances of early medication abortion being provided there.

52. Even if early medication abortion were provided in a hospital and the patient ingested the first medication at the hospital, the patient would be allowed to leave and take the second medication between 24 and 48 hours later. Because (exceedingly rare) medication abortion

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[31] ACOG, *Guidelines for Women's Health Care: A Resource Manual* (4th ed. 2014).
[32] Utah Admin. Code r. 432-100-8 through 11, 15–16, 38.
[33] *Id.* 432-100-6 through 7, 12–13.
[34] *Id.* 432-4-1 through 24.

complications typically do not occur until after a patient ingests the second medication, complications would not manifest while the patient is in a hospital setting in any event. Thus, whether a patient receives a medication abortion at a hospital does not impact the safety of medication abortion.

53. Additionally, unlike invasive surgical procedures, aspiration abortion, which uses gentle suction to empty the uterus, and D&E, which uses a combination of gentle suction and instruments to empty the uterus, do not involve incisions of any kind.

54. In Utah, procedures with risks similar to the risks associated with abortion—including endometrial biopsy, colposcopy, hysteroscopy (scoping of the cervix and uterus), Loop Electrosurgical Excision Procedure ("LEEP") (removing pre-cancerous cells from the cervix), and dilation and curettage for miscarriage management, which, from a clinical perspective, is the same procedure as aspiration abortion—are routinely performed in outpatient clinics and physicians' offices rather than in hospitals.

55. And procedures with higher complication rates than abortion are routinely, and without controversy, performed in outpatient, office-based settings throughout Utah. These include colonoscopies, wisdom teeth extractions, tonsillectomies, and vasectomies.

56. Similarly, despite the fact that the mortality rate from childbirth is greater than 12 times that of abortion,[35] physicians and certified nurse-midwives are authorized in Utah to deliver babies in locations other than a hospital, including birthing centers and private homes.

57. Even in the rare event abortion complications arise during a procedure, management can nearly always be safely and appropriately administered in an outpatient, office

[35] Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 5, at 75 tbl. 2-4 (2018); *see also* Raymond & Grimes, *supra* note 12, at 217 (reporting a mortality rate 14 times higher for childbirth than for abortion).

setting.[36] For example, most cases of hemorrhage (the technical term for bleeding) are managed in the clinic setting with uterotonic medications, like misoprostol, that cause uterine contractions and reduce bleeding and with uterine massage.[37] Most cases of cervical laceration are managed in the clinic setting either with Monsel's Solution or suture.[38] Cases of incomplete abortion are generally managed through repeat aspiration or medication, and, at any rate, arise after completion of the procedure and, even under the Clinic Ban, would occur only after the patient leaves the hospital.

58. As discussed above, major abortion complications occur in fewer than one-quarter of one percent (0.23 percent) of abortions.[39] In the exceedingly rare event that a higher level of care is needed to manage complications, patients are safely stabilized and transferred to a hospital.

59. PPAU physicians are intimately familiar with hospital transfer protocols and can quickly navigate the hospital system to ensure a patient is seamlessly transferred from PPAU to the emergency room or operating room, whichever is most appropriate. I can recall one case when a patient was transferred from PPAU's Metro Health Center to the University of Utah Hospital operating room ("OR") in a matter of minutes. It is not an exaggeration to say this patient was in the OR receiving care more quickly than would have been possible had the patient been transferred after experiencing a major complication from an abortion provided in that same hospital building. Still, it bears emphasizing that hospital transfers are an extremely rare occurrence. Each year, of the thousands of abortions PPAU provides, only between one and five have resulted in a hospital transfer (including patients transferred both by ambulance and private car for observation).

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[36] Roberts et al., *supra* note 25; Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 5.

[37] Jennifer Kearns & Jody Steinhauer, *Management of postabortion hemorrhage*, 87 Contraception 331, 333 (2013).

[38] *Id.*

[39] Upadhyay et al., *Incidence of Emergency Department Visits*, *supra* note 7, at 175.

## III. IMPACT OF THE CLINIC BAN AND PROFESSIONAL LICENSING PENALTIES

60. Rather than make abortion safer, the true effect of HB 467's Clinic Ban will be to functionally eliminate abortion access in Utah. This is because the Clinic Ban restricts abortion clinics, which currently perform more than 95 percent of abortions in Utah, from performing abortions in any circumstance, requiring them to occur in hospitals.[40] Abortion is generally only performed by Utah hospitals as a result of one of three circumstances: either a medical condition that seriously threatens a patient's life or health, a diagnosis of a grave fetal anomaly, or a pregnancy resulting from rape or incest. Utah hospitals lack the capacity to provide more than a few abortion procedures every day, a woefully inadequate substitute for the number of patients currently seen by Utah's outpatient abortion clinics, where people can obtain abortions just as safely and at far lower cost. Further, HB 467's heightened Professional Licensure Penalties will have a chilling effect on physicians, deterring them from performing abortions, including in a hospital. As a result, patients will face insurmountable barriers to access, causing great harm to them and their existing families.

61. I am gravely concerned about the effect an abortion ban will have on the emotional, physical, and financial wellbeing of Utahns and the wellbeing of their families, including their existing children, as I explained at length in my first declaration.

[40] Jennifer Gerson, *Only 1 percent of abortions in Utah took place in a hospital. Soon, that's the only place they'll be allowed.*, The 19th News (March 21, 2023, 7:58 A.M.), https://19thnews.org/2023/03/abortions-utah-percentage-hospitals-clinic-ban/; *see also* Rachel K. Jones, *Abortion incidence and service availability in the United States, 2020*, 54 Persps. on Sexual & Reprod. Health 128, 134 (2022).

### A. HB 467's Clinic Ban will functionally ban abortion in Utah because hospital limitations will prevent the vast majority of patients from receiving care.

62. From my understanding, HB 467's Clinic Ban will ban abortions provided outside hospitals and will require the Utah Department of Health and Human Services to revoke the license of any non-hospital health care facility that provides abortion after May 2, 2023. I further understand that HB 467 will sunset the existing licenses of all abortion clinics, including those currently held by PPAU, on January 1, 2024, or the last valid date of a license, whichever is later, and will prohibit Utah from issuing new abortion clinic licenses after May 2, 2023. Taken together, these provisions of HB 467 will bar licensed abortion clinics from providing abortion starting on May 3, 2023 and will thereafter eliminate abortion clinics in the State of Utah. But for the Clinic Ban taking effect on May 3, 2023, PPAU would continue to perform abortions at its licensed health centers.

63. PPAU and Wasatch Women's Center, located in Salt Lake City and the only other generally-available abortion provider in Utah, currently provide more than 95 percent of Utah abortions.[41] According to a recent news report relying on data from the Guttmacher Institute, a nonpartisan research and policy organization that collects abortion statistics nationwide, as much as 99 percent of abortions performed in Utah in 2020 were provided in outpatient clinics.[42]

64. This is consistent with how abortion is provided nationwide. In published research, the Guttmacher Institute reports that, in 2020, 97 percent of abortions nationally were performed in outpatient clinics or physicians' offices, and only 3 percent of abortions were performed in hospitals.[43]

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[41] *See* Gerson, *supra* note 40; *see also* Jones, *supra* note 40, at 134.
[42] Gerson, *supra* note 40.
[43] Jones, *supra* note 40, at 134 tbl. 3.

65. In my two decades of experience as an OB/GYN in Utah, abortions are only provided at Utah hospitals in cases of life-threatening maternal health conditions, grave or lethal fetal anomalies, or, very rarely, rape or incest. This is partly because Utah law prohibits the use of state funds to pay for abortions other than in cases of rape or incest that have been reported to law enforcement, to protect the life of the patient, or to prevent significant damage to one of the patient's major bodily functions.[44] This prevents public hospitals like the University of Utah Hospital from offering abortion appointments to the general public. Fewer than 30 pregnancy terminations are performed by University of Utah providers each year.[45]

66. Additionally, Utah law allows medical facilities and providers to refuse to provide abortion on moral or religious grounds.

67. I am not aware of any detailed or coordinated plan by a Utah hospital to expand its capacity to provide abortions to more patients in the event HB 467 takes effect. Doing so would be extremely difficult for a variety of reasons including hospitals' religious affiliations, pressure from donors and a hospital's board, political pressure, well organized and hostile public opposition to abortion, and complicated and interconnected funding streams.[46] Utah hospitals that may be interested in providing abortions to a greater number of patients may be prevented from

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[44] Utah Code Ann. § 76-7-331(2).

[45] *University of Utah Statement: U.S. Supreme Court's overturn of Roe v. Wade*, Univ. of Utah (June 24, 2022), https://attheu.utah.edu/facultystaff/university-of-utah-statement -u-s-supreme-courts-overturn-of-roe-v-wade/.

[46] As two examples of Salt Lake-based hospitals with religious affiliations, St. Mark's Hospital in Millcreek is religiously affiliated and Intermountain Healthcare reports it "follow[s] all of the Catholic directives and [Ethical and Religious Directives]." Erin Alberty, *Intermountain to merge with Colorado-based hospital system*, The Salt Lake Tribune (Sept. 16, 2021, 1:56 P.M.), https://www.sltrib.com/news/2021/09/16/ intermountain-merge-with/ (quoting Lydia Jumonville, CEO of SCL).

doing so by the Utah law prohibiting use of state funds to pay for abortion outside of the limited circumstances identified above.

68. Even if a Utah hospital agreed to expand its capabilities to provide abortions beyond narrow, exceptional circumstances, that hospital would be incapable of providing care to a significant portion of the patients who will no longer be able to receive care at a Utah abortion clinic as a result of the Clinic Ban. Abortions performed in hospitals are usually performed by induction, requiring use of an operating room, extensive staffing, including an anesthesiologist, increased costs, increased patient pain, longer recovery periods, and a much longer investment of time for patients. These logistics, plus staffing shortage struggles and scheduling bottlenecks due to competing demands on available ORs, would make it extremely difficult for a hospital to offer more than five abortion appointments a day.

69. The few patients who could get an abortion at a hospital would be harmed by costs two to ten times higher than at PPAU, lengthy wait times, added stress, complicated paperwork and other logistical requirements, loss of confidentiality, and increased medical risk from providers who likely provide abortion care infrequently. Particularly when general anesthesia is used, as is done for the vast majority of abortion patients at hospitals like the University of Utah, the total appointment time, post-procedure recovery time, staffing and facility requirements, costs, and procedure risks increase. D&E patients in a hospital must sit in the waiting room or pre-operative area potentially for hours, despite the fact the procedure typically takes no more than 10 minutes.

70. Though hugely variable, abortions in hospitals cost thousands of dollars. Because Utah law prohibits both private insurance and public insurance, including Medicaid, from being used toward paying for abortion care outside of a select few circumstances, many patients will be

responsible for paying the entire cost of an abortion.[47] Given that only one in three Americans can comfortably cover a $400 emergency expense, the financial burden of an abortion at a hospital will be insurmountable for many would-be patients.[48] In 2021, 45 percent of PPAU abortion patients reported earning less than 130% of the federal poverty level. At PPAU, patients can obtain an abortion, as at other outpatient abortion clinics, for a fraction of the cost charged by hospitals. Specifically, at PPAU, abortion costs $450 at 12 weeks LMP and under; $575 at 13 weeks LMP; $750 at 14 weeks LMP; $1,200 at 15 weeks LMP; $1,500 at 16 weeks LMP; and $1,900 at 17 weeks LMP. At a hospital, abortion costs jump from $700 for a medication abortion, to over $6,700 for a first-trimester aspiration abortion with moderate sedation, to over $7,000 for a D&E. Some hospital abortions can cost as much as $20,000.[49]

71. On this basis alone, even if a patient could find a hospital willing to provide her abortion, hospital treatment would not be feasible for most of my patients. Arranging for transportation, childcare, and taking time off work to come to PPAU is challenging enough for most of my patients. Studies demonstrate increased barriers to access increase the likelihood a patient will not receive care.[50] A majority of patients seeking abortion in Utah are already parents.

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[47] Utah Code Ann. §§ 31A-22-726 (prohibiting insurance coverage for abortion through either private insurance or insurance through a public exchange under the Affordable Care Act, except in cases of reported rape or incest; fatal fetal anomalies; or grave threats to the patient's life or health); 26-18-417(1)(a)(ii).

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

[49] *Hearing on H.B. 467 before the S. Health and Hum. Servs. Comm.*, 2023 Leg., Gen. Sess., recording at 2:27:38 (Utah Feb. 22, 2023) (statement of witness Dr. Alexandra Eller, a Utah maternal fetal medicine physician), available at https://le.utah.gov/av/committeeArchive.jsp?timelineID=227755.

[50] *See e.g.*, Benjamin P. Brown et al., *Association of Highly Restrictive State Abortion Policies With Abortion Rates, 2000-2014*, 3 JAMA Network Open 1, 1 (2020) ("A highly restrictive policy climate, when compared with a less restrictive one, was associated with a … 17% decrease [in] the median abortion rate….").

Many have multiple jobs or jobs with inflexible or unpredictable schedules with no paid sick leave. Some are compromised by physical and/or mental health conditions, have an abusive partner, or struggle with a substance abuse disorder.

72. In practice, the Clinic Ban will drive most people seeking abortion out of state or force them to remain pregnant and ultimately give birth against their will. Patients unable to immediately receive abortion care at a Utah hospital as a result of hospital policies and capacity will be forced to delay receiving abortion care in Utah while they wait for an appointment at a Utah hospital (if they found a hospital willing to provide their procedure) or, more likely, travel out of state to obtain an abortion elsewhere. In either scenario, the abortion will almost certainly be performed later in pregnancy than if the patient had access to care at PPAU.

73. At this time, the nearest Planned Parenthood health center providing abortion outside of Utah is located in Glenwood Springs, Colorado (a distance of 337 miles from Metro Health Center, one way). For patients who need an abortion after the first trimester (i.e., after approximately 14 weeks of pregnancy), the closest Planned Parenthood health center is located in Durango, Colorado (394 miles from Metro Health Center, one way). This health center only provides abortion to 17 weeks of pregnancy. Beyond that point, patients would need to travel to Las Vegas, Nevada (423 miles from Metro Health Center, one way) or Boulder, Colorado (495 miles from Metro Health Center, one way) to visit a Planned Parenthood health center. As this landscape demonstrates, it is growing increasingly more challenging for Utahns to access abortion out of state. Additionally, patients seeking care from out of state providers may experience scheduling delays in part due to the influx of patients seeking abortion care following the enactment of HB 467.

74. Delay of any kind is particularly concerning because, while abortion is safe, its risks increase with gestational age, as does the invasiveness of the procedure and the need for deeper levels of sedation. For pregnancies terminated by medication, the amount of bleeding and risk of needing a blood transfusion increases as the gestational age increases. The financial and logistical hurdles presented by out-of-state travel will, I expect, cause delay, increasing the patient's risk of complications and prolonging the period the person must carry a pregnancy they have already decided to end. People unable to travel out of state will be compelled to carry pregnancies to term against their wishes. Some may seek ways to end their pregnancies without medical supervision, risking possible criminal prosecution or their health and safety.

75. Delay is especially problematic for people seeking abortion due to a life-threatening medical condition or a diagnosis of fetal abnormality. Patients who need to terminate a pregnancy for health reasons are likely to see their medical conditions worsen during this time period. For example, patients forced to delay with premature rupture of membranes or heavy bleeding are at a higher risk for infection or other complications. Medication abortion is the safest option for many people with medical conditions aggravated by pregnancy, but people who are delayed past 11 weeks LMP lose medication abortion as an option. And any delay is especially upsetting to patients terminating pregnancies due to lethal or severe fetal anomalies.

76. Additionally, I expect some Utahns who want to expand their families will be deterred from doing so in Utah because of HB 467, out of concern for being able to access a hospital for an abortion in the event of pregnancy complications. In turn, many OB/GYN departments, including at the University of Utah Hospital, are fearful HB 467 will cause a decline in overall patients.

### B. HB 467's Professional Licensing Penalties will cause physicians to avoid performing abortions.

77. I understand that HB 467's Professional Licensing Penalties authorize the Utah Department of Professional Licensing ("DOPL") to revoke the licenses of physicians and other medical providers if DOPL determines that the licensee has violated one of Utah's abortion laws, even if no criminal court finds them guilty of that crime. HB 467 §§ 7–14. This is in addition to the prison term of one to fifteen years, criminal fines, and traditional licensure penalties imposed by the Trigger Ban. The threat of losing their license—and with it their livelihood—will likely create a chilling effect on physicians, leading them to avoid performing abortions, including abortions in hospitals allowed under HB 467.

78. The fact is, every Utah physician has a lot to lose. Becoming an OB/GYN involves completing extensive and costly education and clinical training requirements.

79. The education and training required to become an OB/GYN is set by the American Board of Obstetrics and Gynecology and includes graduation from an approved medical school; completion of an OB/GYN residency program accredited by the American Council for Graduate Medical Education; rotations divided between obstetrics, gynecology, gynecologic oncology, reproductive endocrinology, and ultrasonography; and optional fellowship(s). All told, it takes between 12 and 16 years of education and training to become an OB/GYN.

80. According to the Utah Medical Education Council's 2020 report on the physician workforce in Utah, the state has the lowest share of active physicians over the age of 60 (26.5%)

in the country.[51] The median age of Utah physicians is 48.[52] In my experience, a majority of my OB/GYN colleagues are young people with young families.

81. The financial responsibilities of OB/GYN professionals generally include extensive medical school debt. The cost of medical training and, relatedly, the debt burden faced by physicians is higher today than ever before. In 2019, 73 percent of the graduating class graduated with debt, with a median debt of $200,000.[53] Only a tenth of physicians graduating in the past 20 years report no debt at graduation.[54] In comparison, more than half of physicians who graduated 50 years ago were debt-free.[55]

82. Utah law permits both medical institutions and individual medical providers to refuse to provide abortion. If providing abortion exposes physicians to the risk of losing their licenses or facing criminal prosecution when their medical judgment is second-guessed by people ideologically opposed to abortion, some physicians are likely to weigh the risk to their careers against the benefit to their patients and opt out of performing abortion even in circumstances where it is permitted by law.

83. A similar chilling effect is already felt by physicians in other states with restrictive and punitive abortion laws, with dire consequences for patients in need of care. In Texas, one physician notes "laws limiting the procedure have created confusion and uncertainty over what

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[51] Jared Staheli and Clark Ruttinger, Utah Med. Educ. Council, *Utah's Physician Workforce, 2020*, at 17 (2020), available at https://umec.utah.gov/wp-content/ uploads/2020-Physician-Workforce-Report-final.pdf.

[52] *Id.* at 1.

[53] *Id.* at 24.

[54] *Id.*

[55] *Id*.

treatments are legal for miscarriage and keep him from even advising pregnant patients on the option of abortion."[56]

84. According to Dr. Rebekah Gee, a gynecologist who headed the Louisiana Department of Health from 2016 to 2020, fears of prosecution are muddling physicians' ability to exercise their medical judgment. "I went to Harvard and Cornell and spent eight years refining my clinical judgment, and now a lawyer with no medical knowledge is deciding a patient's fate."[57]

85. HB 467 cannot be viewed in a vacuum. Physicians considering providing abortion in Utah will be keenly aware of the current national political landscape and the threat of zealous prosecutors or private litigants attempting to push the boundaries of the law to criminalize and punish abortion providers and isolate people seeking abortion care. In Indiana, a doctor is facing potential licensure penalties for providing an abortion to a ten-year-old survivor of rape, despite apparently following all applicable state laws.[58] In this way, HB 467's Professional Licensing Penalties fit the national narrative that physicians providing abortion will incur consequences—both criminal and professional. This will make Utah physicians even more likely to avoid performing abortions, including those that are legal under HB 467.

86. Serving to further heighten physicians' anxiety around performing abortions, including legal abortions, most physicians in Utah hospitals do not routinely perform abortions.

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[56] Christopher Rowland, *A challenge for antiabortion states: Doctors reluctant to work there*, The Washington Post (Aug. 6, 2022, 12:05 P.M.), https://www.washingtonpost.com/business/2022/08/06/abortion-maternity-health-obgyn/.

[57] Emily Baumgaertner, *Doctors in abortion-ban states fear prosecution for treating patients with life-threatening pregnancies*, Los Angeles Times (July 29, 2022, 2:00 A.M.), https://www.latimes.com/world-nation/story/2022-07-29/fearful-of-prosecution-doctors-debate-how-to-treat-pregnant-patients.

[58] Tom Davies, *Indiana AG seeks punishment for doctor who provided abortion to 10-year-old rape survivor*, PBS (Nov. 30, 2022, 4:22 P.M.), https://www.pbs.org/newshour/health/indiana-ag-seeks-punishment-for-doctor-who-provided-abortion-to-10-year-old-rape-survivor.

Physicians who lack experience providing abortions and who, in turn, lack familiarity with the scope of HB 467's exceptions, will be even less comfortable taking on the criminal and professional risks that HB 467 attaches to performing abortions. In this way, HB 467 will deter physicians from providing abortions even where it is permitted by HB 467's terms.

**C. HB 467 will harm PPAU and its staff.**

87. HB 467's Clinic Ban will force PPAU to stop performing all abortions in Utah on May 3, 2023. This will harm PPAU and its staff in all the ways I detailed in my first declaration, including by undermining PPAU's mission to empower Utahns of all ages to make informed choices about their sexual health and to ensure access for Utahns to affordable, quality sexual and reproductive health care and education. On a personal note, I have devoted my entire career to providing all people, regardless of their financial resources, the full range of top quality reproductive health care, including abortions, but HB 467 would bar me from providing my patients the full spectrum of reproductive health care. HB 467 will also undermine PPAU's reputation among Utahns as a provider of patient-centered, evidence-based care.

88. Additionally, by drastically limiting when and where abortions can be provided in Utah, HB 467 will discourage medical students and physicians from remaining in Utah or coming from out-of-state to Utah to train and/or build their practice. This also impedes PPAU's ability to hire and retain clinicians to provide other forms of sexual and reproductive health care. For the first time, the Department of Obstetrics and Gynecology at the University of Utah is facing a recruitment challenge for our highly sought after training programs as more applicants express concern about receiving incomplete training due to abortion restrictions.

89. This trend has already been seen in states where abortion is under attack and suggests that hospitals too will suffer the same consequences. Idaho's Bonner General Health, the only hospital in a city of more than 9,000 people, recently announced it will close its labor and

delivery wing, explaining that the hostile "political climate" surrounding abortion was making it too difficult to keep its labor and delivery department staffed.[59] According to the hospital, "the Idaho Legislature continues to introduce and pass bills that criminalize physicians for medical care nationally recognized as the standard of care. Consequences for Idaho Physicians providing the standard of care may include civil litigation and criminal prosecution, leading to jail time or fines."[60] As a result, "[h]ighly respected, talented physicians are leaving. Recruiting replacements will be extraordinarily difficult."[61] I am deeply concerned that if HB 467 takes effect, hospitals in Utah will face the same consequences.

* * *

90. For all of these reasons, if HB 467 is permitted to take effect on May 3, 2023, it will be devastating to PPAU, myself and the rest of PPAU's staff, and the Utah patients who depend on PPAU for care.

[59] Erin Binnal, Bonner Gen. Health, *Press Release 3/17/2023: Discontinuation of Labor & Delivery Services at Bonner General Hospital* (2023), available at https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3.17.2023.pdf.

[60] *Id.*

[61] *Id.*

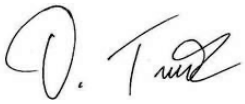
I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on the 31st day of March, 2023, in Salt Lake City, Utah.

David Turok, M.D., M.P.H., FACOG

# EXHIBIT A

# Curriculum Vitae



Last Updated: 02/22/2023

## PERSONAL DATA

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

## EDUCATION

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

## BOARD CERTIFICATIONS

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

07/10/1998 - 7/9/2012: American Board of Family Medicine, Diplomate (Not renewed due to completing a second residency and change in practice)

## UNIVERSITY OF UTAH ACADEMIC HISTORY

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

01/01/2019: Associate Professor with tenure

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

12/18/2017 - 12/31/2018: Associate Professor

07/01/2012 - 12/17/2017: Associate Professor (Clinical)

09/01/2003 - 06/30/2012 Assistant Professor (Clinical)

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

03/01/2018 Adjunct Associate Professor
07/01/2016 - 02/28/2018 Adjunct Assistant Professor
07/01/2002 - 06/30/2016 Adjunct Assistant Professor

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

07/01/2000 - 06/30/2002 Clinical Assistant Professor
06/01/1998 - 06/30/2000 Clinical Instructor

## PROFESSIONAL EXPERIENCE

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

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

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

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

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

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

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

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

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

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

**Editorial Experience**

2014 Guest Editor for *Clinics in Obstetrics and Gynecology*

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

2011 - Present Editorial Board Member for *Contraception*

**Reviewer Experience**

Cochrane Collaboration

Reviewer for *Human Reproduction.* 2015 Top 10% of Reviewers.
Reviewer for *African Journal of Reproductive Health*

Reviewer for *American Journal of Men's Health*

Reviewer for *American Journal of Obstetrics and Gynecology*

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

Reviewer for *BMC Pregnancy and Childbirth*

Reviewer for *Contraception*

Reviewer for *Journal of Women's Health*

Reviewer for *Obstetrics and Gynecology*

Reviewer for *WHO South-East Journal of Public Health*
Reviewer for the *Rhode Island Medical Journal*
Reviewer for *Women's Health Issues*

## SCHOLASTIC HONORS

2020 Society of Family Planning Annual Meeting, Outstanding Researcher Award

2015 District VIII Mentor of the Year Award, American College of Obstetricians and Gynecologists

2015 Faculty Mentor Award, Medical Students for Choice

2015 Top Four Oral Abstracts, North American Forum on Family Planning 2015

2012 Top Scientific Poster – 2nd place, North American Forum on Family Planning 2012

2007 - Present Fellow of the American College of Obstetricians and Gynecologists

2007 - 2008 Community Health Physician of the Year, Awarded by Family Practice Residents, University of Utah School of Medicine

2007 Dr. Jacquelyn Erbin Award, for commitment to reproductive choice, justice, and freedom, Planned Parenthood Action Council

2004 - 2005 Outstanding Clinical Faculty Award, Awarded by Chief Residents, Department of Obstetrics and Gynecology, University of Utah School of Medicine

2004 - 2005 Community Health Physician of the Year, Awarded by Family Practice Residents, University of Utah School of Medicine

2002 Outstanding Resident Research Award, Department of Obstetrics and Gynecology, University of Utah School of Medicine

1999 - 2000 Exemplary Teaching Award, Family Practice Residency Program, University of Utah School of Medicine

## ADMINISTRATIVE EXPERIENCE

### Administrative Duties

2018 - Present Department of Obstetrics & Gynecology, Executive Committee member

2015 - 2022 University of Utah Institutional Review Board Member.

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

2014 Clinics in Obstetrics and Gynecology. Guest Editor.

2014 Contraceptive Technology Update – Editorial Advisory Board

2011 - Present Contraception Journal –Editorial Board.

2010–2022 Fellowship in Complex Family Planning. University of Utah, Director.

2023- Present Fellowship in Complex Family Planning. University of Utah, Associate Director.

2010 - 2014 Association of Reproductive Health Professionals. Washington, DC. Education Committee. Co-Chair. Reproductive 2011 Conference Committee Chair.

2010 - 2013 Medical Students For Choice, National Board Member

2007 - 2018 Director of Family Planning Research Group. University of Utah multi-disciplinary group of investigators including members of various departments.

2005 - 2009 Family Practice Obstetrics Fellowship Co-Director. University of Utah School of Medicine.

2003 - 2010 Family Practice Obstetrics Morbidity and Mortality Conference Coordinator.

### Professional Organization & Scientific Activities

2011 Chair, Association of Reproductive Health Professionals, Conference Committee, Reproductive Health Conference, Las Vegas, NV
Topics presented: Contraception Journal - Outstanding Articles, Tools of the Trade - Demonstration of Online Interactive Birth Control Tools, Hard to Get it in: Tactics for Difficult IUD Insertions

2010 - Present Reviewer, Cochrane Collaboration

2010 - 2014 Co-Chair, Association of Reproductive Health Professionals, Education Committee, Reproductive Health Conference

2010 - 2013 Board Member, Medical Students for Choice

2003 Medical Advisory Board, Association of Reproductive Health Professionals, New Developments in Contraception: Assisted in the creation of a national CME curriculum to introduce health care providers to new methods of contraception focusing on the levonorgestrel intrauterine system.

### Grant Review Committee/Study Section

2022 ZRG1 EMNR-A (11)B- Small Business Innovation Research/Small Business Technology Transfer (R41/R42/R44)

2021 ZHD1 DSR-R (90) 1-T32

2021 - Present Clinical Management in Community-Based Settings (CMPC) - Standing member

2019 NICHD Review Panel for Contraception Research Centers Program U54 Review Meeting

2018 Next Generation Multipurpose Prevention Technologies (NGM) (R61/R33 Clinical Trial Optional)

2017 - 2021 Nursing and Related Clinical Sciences (NRCS) Special Emphasis Panel- Standing member

**Symposium/Meeting Chair/Coordinator**

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

2009 - Present University of Utah Family Planning Symposium

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

## PROFESSIONAL COMMUNITY ACTIVITIES

2017 - 2022 Board Member, Physicians for Reproductive Health

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

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

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

## UNIVERSITY COMMUNITY ACTIVITIES

**University Level**

2015 - Present Member, Institutional Review Board

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

## CURRENT MEMBERSHIPS IN PROFESSIONAL SOCIETIES

American College of Obstetricians and Gynecologists

National Abortion Federation

Society of Family Planning

Utah Medical Association

## FUNDING

**Active Grants**

07/07/21 – 06/30/26 Maternal Health Training
1T34HP42133
Principal Investigator: Thomas Whittaker
DHHS

06/30/2021-06/30/2023 Atorvastatin as an adjunct to Medication Abortion
Principal Investigator: David K. Turok
Grand Challenges Canada

04/15/21 - 07/31/23 CCTN Clinical evaluation of Daily Application of Nestorone (NES) and Testosteorone (T) Combination Gel for Male Contraception
Principal Investigator: David K. Turok
University of Washington, NICHD
Role: Principal Investigator

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

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

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

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

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

Direct Costs: $1,326,332 Total Costs: $1,432,438
NIH National Center For Advancing Translational Sciences
Role: Co-Principal Investigator

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

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

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

Role: Principal Investigator

09/25/15 - 09/30/22 Evaluation of LARCS.
Principal Investigator(s): David K. Turok; Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Principal Investigator
Direct Costs: $225,493 Total Costs: $325,208

**Past Grants**

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

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

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

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

09/14/17 - 03/31/21 Sexual Acceptability's Role in Women's Contraceptive Preferences and Behavior. 5 RO1 HD095661

Principal Investigator(s): Jenny Higgins
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Co-Investigator

07/01/17 - 06/30/18 Family Planning Elevated: Pay For Success. Sorenson Impact Center, University of Utah.

Principal Investigator(s): David K. Turok
Direct Costs: $99,034 Total Costs: $99,034
Planned Parenthood Association of Utah
Role: Principal Investigator

06/02/17 - 06/30/18 Bullock-FS-Same Day Counseling. Project Number 51005634. Proposal ID 10045851

Principal Investigator(s): David K. Turok
Direct Costs: $67,743 Total Costs: $67,743
Society of Family Planning
Role: Principal Investigator

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

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

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

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

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

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

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

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

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

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

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

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

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

Role: Principal Investigator

07/27/15 - 04/30/21 Rapid EC- RCT Assessing Pregnancy with Intrauterine Devices for Emergency Contraception. Award Number 1R01HD083340-01A1.
Principal Investigator(s): David K. Turok
Direct Costs: $1,247,577 Total Costs: $1,247,577
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

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

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

03/01/15 - 06/30/15 GCC VS ICC In Refugee Women. Project Number 51005207. Proposal ID 10038216
Principal Investigator(s): David K. Turok
Direct Costs: $30,000 Total Costs: $30,000
Society Of Family Planning
Role: Principal Investigator

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

01/01/15 - 06/30/16 Copper IUD Quick Start. Project Number 51005178. Proposal ID 10037777
Principal Investigator(s): David K. Turok
Direct Costs: $69,926 Total Costs: $69,926
Society Of Family Planning
Role: Principal Investigator

12/02/14 - 12/31/16 Profiles CU IUD New Users. Project Number 50302754. Proposal ID 10035916
Principal Investigator(s): David K. Turok
Direct Costs: $164,172 Total Costs: $217,856
NIH
Role: Principal Investigator

10/01/14 - 09/30/15 Documenting Contraception. Project Number 54503017. Proposal ID 10037834
Principal Investigator(s): David K. Turok
Direct Costs: $10,725 Total Costs: $11,797
University Of Wisconsin-Madison
Role: Principal Investigator

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

Role: Principal Investigator

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

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

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

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

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

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

Society of Family Planning
Role: Principal Investigator

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

Role: Principal Investigator

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

Role: Principal Investigator

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

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

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

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

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

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

Role: Co-Principal Investigator

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

Role: Principal Investigator

04/01/10 - 04/01/15 A Phase 3, Randomized, Multi-Center, Open-Label Study of a Levonorgestrel-Releasing Intrauterine System (20mcg/day) and Mirena for Long-Term, Reversible Contraception up to Five Years.

Principal Investigator(s): David K. Turok
Medicines 360
Role: Principal Investigator

09/01/09 - 08/31/10 Family Planning Fellow Interview 2009-2010. Project Number 51002337. Proposal ID 10015791

Principal Investigator(s): David K. Turok
Direct Costs: $1,880 Total Costs: $1,880
Anonymous
Role: Principal Investigator

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

07/01/08 - 06/30/09 Program to Develop Future Leaders in Family Planning

Principal Investigator(s): David K. Turok
The Lalor Foundation, Inc.
Role: Principal Investigator

02/01/08 - 01/31/10 Increasing Family Planning Research Capacity. Project Number 51002078. Proposal ID 10007080.

Principal Investigator(s): David K. Turok
Direct Costs: $86,658 Total Costs: $86,658
Anonymous
Role: Principal Investigator

07/01/03 - 09/30/05 Kenneth J. Ryan Residency Training Program in Abortion and Family Planning.

Principal Investigator(s): David K. Turok
University of Utah Department of OB/GYN Development Fund
Role: Principal Investigator

## TEACHING RESPONSIBILITIES/ASSIGNMENTS

### Course Lectures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2014 Developer, OBST: Metabolism and Reproduction - Contraception Small Group Activities, University of Utah, Obstetrics/Gynecology, Contraception Small Group Activities

2014 Instructor, MD ID: OB Lab Rotations, Office of the Dean/Medicine, : MS2016 M+R - OB Lab Rotations

2014 Facilitator, OBST: Metabolism and Reproduction - OB Lab Rotations, University of Utah, Obstetrics/Gynecology, OB Lab Rotations

2013 PI, MDCRC 6950: Independent Study, 1 student, University of Utah, School of Medicine

2011 Instructor, Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion, : MS2013 OB/GYN Clerkship - Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion

2011 Instructor, Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion, : MS2013 OB/GYN Clerkship - Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion

2010 Instructor, MD ID: Clinical Reasoning- Contraception, Office of the Dean/Medicine, : Medical Science - Clinical Reasoning- Contraception

2010 Instructor, MD ID: Case Based Learning Exercise, Office of the Dean/Medicine, : Medical Science - Case Based Learning Exercise

2010 Instructor, OBST 7020: Optional: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Optional: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare

2010 Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop

2009 Instructor, OBST 7020: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare

2009 Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop

2008 Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop

2007 Lecturer, University of Utah, MSPH Program, Abortion and Contraception in Public Health

2007 Instructor, FP MD 6320: Perinatal and Women's Health Epidemiology, University of Utah, Family and Preventive Medicine

2006 Instructor, OBST 7020-6: Small Groups: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS - Small Groups: Contraception Workshop

**Clinical Teaching**

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

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

2003 - Present Active in clinical instruction of 3rd year medical students on their Obstetrics and Gynecology clinical rotation, Ob/Gyn residents on their Obstetrics and Gynecology rotations, and Complex Family Planning Fellows for all clinical activities.

**Didactic Lectures**

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

**Internal Teaching Experience**

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

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

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

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

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

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

## PEER-REVIEWED JOURNAL ARTICLES

1. Simmons RG, Baayd J, Waters M, Diener Z, **Turok DK**, Sanders JN (2023). Assessing contraceptive use as a continuum: outcomes of a qualitative assessment of the contraceptive journey. *Reprod Health*,15;20(1):33.
2. Kaplan J, **Turok DK**, Gero A, Kaiser JE, Simmons RG, Fay KE (2023). Switching and discontinuation of participant-masked randomization to a copper or levonorgestrel intrauterine device when presenting for emergency contraception. *Contraception*,118:109893.
3. Kaiser JE, Kurtz T, Glasser A, Brintz BJ, Gawron LM, **Turok DK**, Sanders JN (2022). Mifepriston for miscarriage treatment in Utah: A survey of clinician knowledge and assessment of an educational video on future use. *AEM Educ Train,*6(6):e10834.
   Shochet T, **Turok D**, Frye LJ, Sexsmith CD, Gawron LM, Kaiser JE, Winikoff B (2022). Single dose letrozole and misoprostol for termination of pregnancy through 63 days' gestation: A pilot study. *Contraception*, 109924.
4. Simmons RG, Baayd J, Elliott S, Cohen SR, **Turok DK** (2022)**.** Improving access to highly effective emergency contraception: an assessment of barriers and facilitators to integrating the levonorgestrel IUD as emergency contraception using two applications of the Consolidated Framework for Implementation Research. *Implement Sci Commun*, 3(1):129.
5. Creinin MD, Schreiber CA, **Turok DK**, Cwiak C, Chen BA, Olariu AI (2022). Levonorgestrel 52 mg intrauterine system efficacy and safety through 8 years of use. *Am J Obstet Gynecol,* 227(6):871:e1-871.e7.
6. Kaiser JE, **Turok DK**, Gero A, Gawron LM, Simmons RG, Sanders JN (2022). One-year pregnancy and continuation rates after placement of levonorgestrel or copper intrauterine devices for emergency contraception: a randomized controlled trial. *Am J Obstet Gynecol,* S0002-9378(22)02189-5.
7. Gawron LM, He T, Lewis L, Fudin H, Callegari LS, **Turok DK**, Stevens V (2022). Oral Emergency Contraception Provision in the Veterans Health Administration: a Retrospective Cohort Study. *J Gen Intern Med,* 37(Suppl 3):685-689.
8. Gero A, Simmons RG, Sanders JN, **Turok DK** (2022). Does access to no-cost contraception change method selection among individuals who report difficulty paying for health-related care? *BMC Womens Health*;22(1):327.
9. Hubacher D, Schreiber CA, **Turok DK**, Jensen JT, Creinin MD, Nanda K, White KO, Dayananda I, Teal SB, Chen PL, Chen BA, Goldberg AB, Kerns JL, Dart C, Nelson AL, Thomas MA, Archer DF,
10. Brown JE, Castaño PM, Burke AE, Kaneshiro B, Blithe DL (2022). Continuation rates of two different-sized copper intrauterine devices among nulliparous women: Interim 12-month results of a single-blind, randomised, multicentre trial. *EClinicalMedicine*, 51:101554.
    Simmons RG, Baayd J, Gero A, Quade C, Mullholand M, Torres E, **Turok DK**, Sanders JN (2022). Implementation and Monitoring of the Family Planning Elevated Contraceptive Access Program, Utah, 2018–2019. *Am J Public Health,* 112(S5):S528-S531.
11. Creinin MD, Schreiber CA, **Turok DK**, Cwiak C, Chen BA, Olariu AI (2022). Levonorgestrel 52 mg intrauterine system efficacy and safety through 8 years of use. *Am J Obstet Gynecol,* :S0002-9378(22)00366-0.
12. White K, Martínez Órdenes M, **Turok DK**, Gipson JD, Borrero S (2022). Vasectomy Knowledge and Interest Among U.S. Men Who Do Not Intend to Have More Children.
    *Am J Mens Health,* 16(3):15579883221098574.
13. Storck KE, Gawron LM, Sanders JN, Wiaderny N, **Turok DK** (2022). "I just had to pay the money and be supportive": A qualitative exploration of the male-partner role in contraceptive decision-making in Salt Lake City, Utah family planning clinics.
    *Contraception,* 113:78-83.
14. Burger T, Li J, Zhao Q, Schreiber CA, Teal S, **Turok DK**, Natavio M, Peipert JF (2022). Association of Obesity With Longer Time to Pregnancy. *Obstet Gynecol*, 139(4):554-560.
15.

16. Higgins JA, Kramer R, Senderowicz L, Everett B, **Turok DK**, Sanders JN (2022). Sex, poverty, and public health: Connections between sexual wellbeing and economic resources among US reproductive health clients. *Perspect Sex Reprod Health,* 54(1):25-28.

17. Thorman A, Engle A, Brintz B, Simmons RG, Sanders JN, Gawron LM, **Turok DK**, Kaiser JE (2022). Quantitative and qualitative impact of One Key Question on primary care providers' contraceptive counseling at routine preventive health visits. *Contraception*, 109:73-79.

18. Sanders JN, Kean J, Zhang C, Presson AP, Everett BG, **Turok DK**, Higgins JA (2022). Measuring the Sexual Acceptability of Contraception: Psychometric Examination and Development of a Valid and Reliable Prospective Instrument. *J Sex Med*. 2022 Mar;19(3):507-520.

19. Kaiser JE, Galindo E, Sanders JN, Simmons RG, Gawron LM, Herrick JS, Brintz B, **Turok DK** (2021). Determining the impact of the Zika pandemic on primary care providers' contraceptive counseling of non-pregnant patients in the US: a mixed methods study. *BMC Health Serv Res*, *21* (1), 1215.

20. Kramer RD, Higgins JA, Everett B, **Turok DK**, Sanders JN (2021). A prospective analysis of the relationship between sexual acceptability and contraceptive satisfaction over time. *Am J Obstet Gynecol*. 2022 Mar;226(3):396.e1-396.e11.

21. Walhof KA, Gawron LM, **Turok DK**, Sanders JN (2021). Long-Term Failure Rates of Interval Filshie Clips As a Method of Permanent Contraception. *Womens Health Rep (New Rochelle)*, *2*(1), 279-284.

22. BakenRa A, Gero A, Sanders J, Simmons R, Fay K, **Turok DK** (2022)**.** Pregnancy Risk by Frequency and Timing of Unprotected Intercourse Before Intrauterine Device Placement for Emergency Contraception. *Obstet Gynecol,* 138(1):79-84.\

23. Fay KE, Clement AC, Gero A, Kaiser JE, Sanders JN, BakenRa AA, **Turok DK** (2021)**.** Rates of pregnancy among levonorgestrel and copper intrauterine emergency contraception initiators: Implications for backup contraception recommendations.
*Contraception*, 104(5):561-566.

24. Higgins JA, Kramer RD, Everett B, Wright KQ, **Turok DK**, Sanders JN (2021). Association Between Patients' Perceptions of the Sexual Acceptability of Contraceptive Methods and Continued Use Over Time. *JAMA Intern Med,* 181(6):874-876.

25. Duncan J, Fay K, Sanders J, Cappiello B, Saviers-Steiger J, **Turok** DK (2021). Ex-vivo forces associated with intrauterine device placement and perforation: a biomechanical evaluation of hysterectomy specimens. BMC Womens Health, 21(1):141.

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## BOOK CHAPTERS

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## ADDITIONAL PUBLICATIONS

### Editorials

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**Letters**

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**Newspapers**

1. **Turok DK** (2020). Trust people with the freedom to choose abortion. . *Salt Lake Tribune Op Ed*.
2. **Turok DK**, Jones K (2012). Compassion, Contraception, and Abortion. *Salt Lake Tribune; Available at: http://www.sltrib.com/sltrib/opinion/53609137-82/abortion-women-contraception-effective.html.csp* .

**Multimedia**

1. **Turok DK**, Wysocki S, Grimes DA, Deal MA (2011). Contraceptive Update: CDC Medical Eligibility Criteria for Women With Chronic Conditions [Video], Medscape Women's Health Education.

## RECENTLY PUBLISHED ABSTRACTS (LAST 3 YEARS)

1. **Turok DK**, Gero A, Simmons R, Kaiser J, Stoddard GJ, Sexsmith CD, Gawron LM, Sanders JN. (2020). The Levonorgestrel vs. Copper Intrauterine Device for Emergency Contraception: a Non-inferiority Randomized Controlled Trial. Society of Family Planning Annual Meeting. Top 4 oral abstract. Online virtual meeting. October 9-11, 2020 [Abstract].
2. Sanders JN, Geist C, Diener Z, Myers K, Simmons R, **Turok DK** (2019). Contraceptive methods used in the four weeks leading up to new contraceptive visit: HER Salt Lake Contraceptive Initiative. Los Angeles, CA. [Abstract]. *Soceity of Family Planning Annual Meeting*.
3. Everett BG, Sanders JN, Higgins J, Simmons R, Geist C, Myers K, **Turok DK** (2019). Changes in Gender of Sexual Partners and Contraception Discontinuation and Switching. Los Angeles, CA. [Abstract]. *Society of Family Planning Annual MNeeting*.
4. K Wright, B Everett, D Turok, J Sanders (2019). Sexual Outcomes Associated with Contraceptive Use at One, Three, and Six Months in the HER Salt Lake Contraceptive Initiative. *University of Wisconsin-Madison, Madison, WI, USA.* [Abstract]. *Contraception Journal*, *100*(4), 309.
5. R Simmons, J Sanders, K Myers, D Turok (2019). Does Access to No-Cost Contraception Change Method Selection Among Individuals who Report Trouble Paying for Health-Related Care? *Family Planning Division, University of Utah, Salt Lake City, UT, USA* [Abstract]. *Contraception Journal*, *100*(4), 329.
6. R Simmons, J Sanders, C Geist, J Higgins, D Turok (2019). Changes in Gender of Sexual Partners and Contraception Discontinuation and Switching. *University of Utah, Salt Lake City, UT, USA.* [Abstract]. *Contraception Journal*, *100*(4), 331.
7. K Wright, B Everett, D Turok (2019). To what Extent is Overall Contraceptive Satisfaction Correlated with Method-Related Sexual Effects? Results from the HER Salt Lake Initiative. *University of Wisconsin-Madison, Madison, WI, USA.* [Abstract]. *Contraception Journal*, *100*(4), 337.
8. Z Diener, K Myers, R Simmons, G Aguilera, B Everett, C Geist, D Turok (2019). Contraceptive Strategies Used in the 4 Weeks Before and After New Contraceptive Visits in HER Salt Lake's Title X Clinics. *Family Planning Division, University of Utah, Sal t Lake City, UT, USA.* [Abstract]. *Contraception Journal*, *100*(4), 337.

## POSTER PRESENTATIONS

2022 Gawron LM. Kaiser J. Gero A. Sanders JN. Johnstone EB. **Turok DK.** Pharmacodynamic evaluation of the etonogestrel contraceptive implant initiated midcycle with and without ulipristal acetate: A pilot randomized controlled trial. Society of Family Planning Annual Meeting, Baltimore, MD

2022 Gawron LM, Gero A, Sanders JN, Clement A, Pangasa M, **Turok DK**. Utilization of LARC methods at time of emergency contraception visit: A prospective observational study. Society of Family Planning Annual Meeting, Baltimore, MD

2022 Clement AC, Gawron LM, Sanders JN, Carter G, **Turok DK**. Rural-urban differences in post-abortion contraception use and past contraceptive access: a cohort study of abortion patients in Utah. Society of Family Planning Annual Meeting, Baltimore, MD

2022 Gero A, Simmons R, Elliott S, Sanders J, **Turok DK**. Impact of the domestic gag rule on service trends at Utah Title X clinics, 2017 – 2021. Society of Family Planning Annual Meeting, Baltimore, MD

2022

Simmons R, Carter G, Gero A, **Turok DK**, Sanders J. And then what happened? Assessing contraceptive use outcomes over 3 years among participants in the HER Salt Lake contraceptive
2021 initiative. Society of Family Planning Annual Meeting, Baltimore, MD

Torres E, Carter G, Gero A, Simmons R, Clement A, Sanders J, **Turok DK**. A prospective assessment of pregnancy risk by Quick Start contraceptive initiation across all methods. Society of Family Planning
2020 Annual Meeting, online

Kaplan J, Gero A, Simmons R, Kaiser J, Fay K, **Turok DK**. Feasibility of randomization to the copper
2019 of levonorgestrel IUD. Society of Family Planning Annual Meeting, online

Wright KQ, Higgins JA, Sanders JN, Everett B, **Turok DK**. To what extent are people's sexual experiences with their contraceptive methods associated with contraceptive satisfaction and continuation? Results from the HER Salt Lake Initiative. Poster presentation at Society of Family Planning Annual Meeting, Los Angeles, CA

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

2019 Higgins JA, Wright KQ, Everett BG, **Turok DK**, Sanders JN. Sexual Outcomes Associated with Contraceptive Use At One, Three, and Six Months in the HER Salt Lake Initiative. Oral presentation at Society of Family Planning Annual Meeting, Los Angeles, CA.

2019 Gero A, Simmons R, Sanders J, **Turok DK**, Myers K. Does Access to No-Cost Contraception Change Method Selection Among Individuals Who Report Trouble Paying for Health-Related Care? Poster presentation at Society of Family Planning Annual Meeting, Los Angeles, CA

2018 Kozlowski Z, Gawron LM, Sanders JN, Panushka K, Myers K, **Turok DK**. *'I'm Poor So I'll Take What I Can Get": Contraceptive Preferences and Needs Among Women With Housing Insecurity or Homelessness*. Poster session presented at North American Forum on Family Planning.

2018 **Turok DK,** Nelson A. Phase 2 Efficacy, Safety, and Tolerability Results of the VeraCept Low-Dose Copper Intrauterine Contraceptive: 24-Month Data. Poster Presentation at North American Forum on Family Planning. New Orleans, LA.

2018 C Geist, J Sanders, K Myers, R Simmons, B Everett, L Gawron, **Turok DK**. Changing Lives, Dynamic Plans? 12-Month Shifts in Pregnancy Intentions, Poster Presentation at North American Forum on Family Planning. New Orleans, LA.

2018 JE Kaiser, R Simmons, K Myers, J Sanders, L Gawron, **DK Turok**. Predictors of Contraceptive Method Switching and Discontinuation Six Months Post-abortion. Poster presentation at North American Forum on Family Planning. New Orleans, LA.

2018 J Higgins, J Sanders, K Wright, D Adkins, **D Turok**. Beyond safety and efficacy: how sexuality-related priorities impact contraceptive method selection. Top 4 oral presentations at North American Forum on Family Planning. New Orleans, LA.

2018 B Everett, J Sanders, K Myers, **D Turok.** Long-Term Socioeconomic Outcomes of Women who Avoided Teen Parenthood Through Abortion. North American Forum on Family Planning. New Orleans, LA.

2018 **Turok DK**, Nelson A. *A novel low-dose copper intrauterine contraceptive: Phase 2 clinical trial data with 18-month data*. Poster session presented at European Society of Contraception, Budapest, Hungary.

2017 Everett B, Sanders JN, Myers K, Geist C, **Turok DK**. *1 in 3: Utah Family Planning Clinics Challenge Heteronormative Assumptions.* Poster session presented at North American Forum on Family Planning.

2017 Benson A, Bullock H, Sanders JN, **Turok DK**.. *Comparing reduced-cost versus no-cost contraception on postabortal contraceptive method mix: a prospective cohort study*. Poster session presented at North American Forum on Family Planning.

2016 Bellows B, Tak C, Sanders J, **Turok D**, Schwarz EB. Cost-effectiveness of emergency contraception options over 1 year. North American Forum on Family Planning. Denver, CO.

2016 Moran L, Sanders J, Torres E. Wolsey K, **Turok D**. Video counselling for emergency contraception: impact on patient choice. North American Forum on Family Planning. Denver, CO.

2016 Royer P, Weber L, Jenkins A, Sanders J, Gawron L, **Turok D.** Family planning knowledge and contraceptive use among resettled African refugee women. North American Forum on Family Planning. Denver, CO.

2016 Royer P, Jenkins A, Weber L, Jackson B, Sanders J, **Turok D**. Group versus individual contraceptive counseling for resettled African refugee women: a pilot randomized controlled trial. North American Forum on Family Planning. Denver, CO.

2016 Maddukuri V, Sanders J, Huish RP, **Turok D**. A retrospective review of recurrent preterm birth and use of highly effective reversible contraceptives. North American Forum on Family Planning. Denver, CO.

2016 Jessica Sanders, **Turok DK**, Lori Gawron, Amy Law, Lonnie Wen, Richard Lynen Continuation of highly effective reversible contraception at two years in a University Healthcare Setting: A retrospective review. Academy of managed care pharmacy. San Francisco, CA.

2016 Eggebroten J, Sanders J, **Turok DK**, Saltzman H. Patient uptake and outcomes: an immediate postpartum IUD and implant program. ACOG annual meeting. Washington, DC.

2016 **Turok D**, Espey E, Sanders JN, Eggebroten J, Bullock H, Gawron L. The effect of postplacental versus interval postpartum IUD insertion on Lactogenesis: The Breastfeeding Levonorgestrel IUD Study (BLIS): A randomized controlled trial. Oral abstract at the North American Forum on Family Planning. Denver, CO.

2016 Gawron L, Sanders J, Sward K, **Turok D**. Uptake of long-acting reversible contraception among women with chronic medical diseases in a tertiary referral center. North American Forum on Family Planning. Denver, CO.

2016 Sanders J, **Turok D**, Gawron L, Law A, Wen L, Lynen R. Three-year continuation of long-acting reversible contraceptive methods in a mixed-payer health care setting: a retrospective review. North American Forum on Family Planning. Denver, CO.

2016 Sanders J, **Turok DK**, Gawron L, Steele K, Storck K, Bullock H. Tracking IUD bleeding experiences (TRIBE): A prospective evaluation of bleeding profiles among new IUD users. North American Forum on Family Planning. Denver, CO.

2016 Espey E, **Turok DK**, Sanders J, Singh RH, Thaxton L, Leeman L. Breastfeeding continuation in postplacental versus interval postpartum IUD insertion: The Breastfeeding Levonorgestrel IUD Study (BLIS): A randomized controlled trial. North American Forum on Family Planning. Denver, CO.

2016 Jacobson E, Roth L, Sanders J, **Turok D**, Bullock H. Changes in IUD uptake with the availability of a low-cost levonorgestrel IUD – a retrospective review of Title X clinics. North American Forum on Family Planning. Denver, CO.

2016 Gawron L, Suo Y, Carter M, Redd A, **Turok D**, Gundlapalli A. Uptake of long-acting reversible contraception among homeless versus housed women veterans. North American Forum on Family Planning. Denver, CO.

2016 Ward K, **Turok D**, Thomson I, Sanders J, Knapp L. Single collection of unrinary reproductive hormones to identify the fertile window: a feasibility study. North American Forum on Family Planning. Denver, CO.

2016 Royer P, Jenkins A, Weber L, Jackson B, Sanders J, **Turok D**. Group versus individual contraceptive counseling for resettled African refugee women: a pilot randomized controlled trial. North American Forum on Family Planning. Denver, CO.

2015 Herrera C, Sanders JN, Torres LN, **Turok DK**, Clark EA. An assessment of patient counseling following preterm birth in a tertiary care center. SGI. San Francisco.

2015 Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "It's difficult here, because you need someone to look after the children" A qualitative analysis of African refugee women's post-resettlement perceptions regarding family size and fertility. FIGO. Vancouver, British Columbia.

2015 Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "We do not know what is happening inside a woman's body": A qualitative investigation of African refugee women's post-resettlement reproductive health conceptualizations. FIGO. Vancouver.

2015 Schreiber CA, **Turok DK**, Chen BA, Blumenthal PD,Cwiak C, Creinin MD.
Plasma levonorgestrel levels over 36 months in non-obese and obese women using LilettaTM, a new 52 mg levonorgestrel-releasing intrauterine system. FIGO. Vancouver.

2015 **Turok DK**, Eisenberg DL,Teal SB, Westhoff CL, Keder LM, Creinin MD.
Evaluation of pelvic infection in women using LilettaTM, a new 52 mg levonorgestrel-releasing intrauterine system, for up to 2 years. FIGO. Vancouver, British Columbia.

2015 Royer PA, Jackson B, Olson L, Grainger E, **Turok DK.** "In Africa there was no family planning, every year you just give birth": A qualitative analysis of contraceptive knowledge, attitudes and practices among African refugee women after resettlement. FIGO. Vancouver, British Columbia.

2015 **Turok DK,** Cappiello B, Sanders JN, Thompson I, Storck K, Gawron L. A novel atraumatic alternative to the cervical tenaculum: A randomized controlled trial comparing the Bioceptive® suction cervical retractor vs. single tooth tenaculum during IUD insertion. North American Forum on Family Planning. Chicago.

2015 Gawron L, Lorange E, Flynn A, Sanders JN, **Turok DK**, Keefer L. Contraceptive misperceptions and misinformation among women with inflammatory bowel diseases: a qualitative study. North American Forum on Family Planning. Chicago.

2015 **Turok DK**, Cappiello B, Sanders JN, Royer PA, Thompson I, Gawron L. Ex-vivo forces associated with IUD insertion and perforation: Biomechanical evaluation of hysterectomy specimens. North American Forum on Family Planning. Chicago.

2015 Ralph L, Greene Foster D, **Turok DK**, Roberts S. Evaluating the psychometric properties of two decisional conflict scales among women seeking abortion in Utah. North American Forum on Family Planning. Chicago.

2015 Sanders JN, Higgins J, **Turok DK**, Gawron L. The intimate link: sexual functioning and well-being among new IUD and contraceptive implant users. North American Forum on Family Planning. Chicago.

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

2014 Sok C, Sanders JN, **Turok DK**, Royer PA, Torres L. Sexual behavior and satisfaction of postpartum women. North American Forum on Family Planning. Miami, FL

2014 Sanders JN, **Turok DK**, Royer PA, Maddukuri V, Eggebroten J. Why women who previously tried to get an IUD walked away without one. North American Forum on Family Planning. Miami, FL

2014 Dermish A, **Turok DK**, Murphy P, Jacobson J, Jones KP. An intervention to manage difficult IUD insertions. North American Forum on Family Planning. Miami, FL

2014 Conway H, Sanders JN, Jacobson J, Torres LN, **Turok DK.** The Longest Wait: Utah's move to a 72-hour waiting period for abortion services. North American Forum on Family Planning. Miami, FL

2014 Howell L, Sanders JN, Royer PA, Schwarz EB, **Turok DK.** Oops, we did it again! Unprotected intercourse in the two weeks prior to requesting emergency contraception. North American Forum on Family Planning. Miami, FL

2014 Jacobson J, Moran LA, Howell L, Torres LN, Royer PA, **Turok DK** Patient reported length of intrauterine device (IUD) use and reason for discontinuation at the time of removal. North American Forum on Family Planning. Miami, FL

2014 Howell L, Sanders JN, **Turok DK**, Royer PA, Jacobson J. PSA: A marker of unprotected intercourse in a population seeking emergency contraception. North American Forum on Family Planning. Miami, FL

2014 Torres LN, **Turok DK**, Clark E, Sanders JN, Godfrey E. A Randomized-Control Trial of Focused Contraceptive Counseling and Case Management Versus Usual Care in Women Postpartum From a Preterm Birth. North American Forum on Family Planning. Miami,

2014 Peipert J, Zhao O, Stoddard A, McNicholas C, Schreiber C, **Turok DK,** Teal S, Madden T. Impact of Infection and Intrauterine Device Use on Fertility.
North American Forum on Family Planning. Miami, FL

2014 **Turok DK**, Sanders JN, Royer PA, Thompson I, Eggebroten J. Copper or LNG IUD for emergency contraception (COLIEC): Device choice and early pregnancies.
North American Forum on Family Planning. Miami, FL October 12-13, 2014.

2013 Clark EAS, Winter S, **Turok DK**, Randall H, Torres L. Prevention of Recurrent Preterm Birth: Role of the Neonatal Follow-up Program Association of Maternal and Child Health Programs. Washington, DC.

2013 **Turok DK**, Edelman AB, Lotke PS, Lathrop EH, Espey E, Jacobson JC, Bardsley T, Ward K, Schulz K. Misoprostol vs. Placebo Prior to IUD Insertion in Nulliparous Women: A Prospective Meta-Analysis. North American Forum on Family Planning.

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

2013 Foster DG, Grossman D, **Turok DK**, Peipert J, Prine L, Schreiber C, Jackson, Barar, Schwarz EB. Interest in and experience with IUC self-removal. North American Forum on Family Planning. Seattle, Washington.

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

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

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

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

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

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

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

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

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

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

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

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

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

2010 J. Jacobson, K. Maurer, **Turok DK,** P. Murphy. Patient travel time and distance for second-trimester dilation and evacuation in the Intermountain West. Reproductive Health 2011. Las Vegas, NV.

2010 J. Jacobson, P. Murphy, **Turok DK**. Sexually transmitted infection prevalence in women choosing the copper-T 380A IUD for emergency contraception. Reproductive Health 2011. Las Vegas, NV.

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

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

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

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

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

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

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

## ORAL PRESENTATIONS

**Keynote/Plenary Lectures**

International

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

Local/Regional

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

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

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

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

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

**Meeting Presentations**

International

2022 **Turok DK,** Respecting the Full Range of Reproductive Health Options in Conservative States Post-Roe. International Stillbirth Association, Salt Lake City, UT

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

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

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

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

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

National

2022 **Turok DK,** Breakthrough Contraceptive Technology Contraceptive Technology Conference (online)
**Turok DK,** What's New with IUDs. Contraceptive Technology Conference (online)

2021 **Turok DK,** Randomized Clinical Trial Assessing Pregnancy with IUDs for Emergency Contraception:
2021 RAPID EC. EC Jamobree (online).
**Turok DK,** IUDs & Implants: Scientific Barrier Busting. Contraceptive Technology Conference
2020 (online)
**Turok DK,** IUDs for Emergency Contraception. Contraceptive Technology Conference (online)

2020 **Turok DK**, Challenging Situations in First Trimester Abortion and miscarriage management. Contraceptive Technology Conference (online)

2020 **Turok DK**, Increasing Options for Vasectomy Counseling and Services at Planned Parenthood of Utah

2018

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local/Regional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Invited/Visiting Professor Presentations**

International

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

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

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

National

2021 **Turok DK,** The Quick Decade from Research Idea to Practice Change. Department of Obstetrics & Gynecology, University of Washington, Seattle, Washington.

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

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

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

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

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

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

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

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

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

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

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

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

Local/Regional

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

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

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

**Grand Rounds Presentations**

2022 **Turok DK**. Abortion Update Post-Dobbs. Department of Internal Medicine, University of Utah

2022 **Turok DK**. IUDs for Emergency Contraception: What's New. Department of Obstetrics & Gynecology Grand Rounds, University of Kansas School of Medicine – Wichita

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

2022 **Turok DK**. IUDs for Emergency Contraception: What's New. Department of Obstetrics & Gynecology Grand Rounds, University of Pennsylvania

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Exhibit C

Declaration of Annabel Sheinberg
in Support of Plaintiff's Second Motion for a Preliminary Injunction

**THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH**

| | |
|---|---|
| PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff,<br>*Plaintiff*,<br><br>v.<br><br>STATE OF UTAH, *et al.*,<br>*Defendants.* | **DECLARATION OF ANNABEL SHEINBERG IN SUPPORT OF PLAINTIFF'S SECOND MOTION FOR A PRELIMINARY INJUNCTION**<br><br>Case No. 220903886<br><br>Judge Andrew Stone |

I, Annabel Sheinberg, being of lawful age, do hereby swear and state as follows:

1. I am the Vice President of External Affairs at Planned Parenthood Association of Utah ("PPAU"), a non-profit organization that has provided health care services in Utah for more than fifty years. My duties include providing oversight for PPAU's Education, Marketing, Public Policy, and Development teams; serving as a member of PPAU's senior leadership team; and working with PPAU's volunteer leadership on relevant committees.

2. I understand that Utah House Bill 467, 2023 Leg., Gen. Sess. (Utah 2023) ("HB 467"), requires abortion to be performed in hospitals, not abortion clinics. HB 467 also requires the Utah Department of Health and Human Services ("DHHS") to revoke the license of any non-hospital health care facility that provides abortion after May 3, 2023. I further understand HB 467 will sunset the existing licenses of all abortion clinics on January 1, 2024, or the last valid date of a license, whichever is later, and will prohibit Utah from issuing new abortion clinic licenses after May 2, 2023.

3. As I explain below, because PPAU's health centers do not qualify as "hospitals" under HB 467 as interpreted by DHHS, PPAU cannot continue providing abortion once HB 467 takes effect on May 3, 2023.

## I. PPAU AND ITS SERVICES

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

2. Founded in 1970, PPAU's mission is to empower Utahns of all ages to make informed choices about their sexual health and to ensure access for Utahns to affordable, quality sexual and reproductive health care and education. PPAU provides care to approximately 37,000 Utah residents each year.

3. PPAU operates eight health centers, three of which provide abortion. PPAU also provides a full range of family-planning services, including well-person preventative care visits; breast exams; Pap tests; sexually transmitted infection ("STI") testing; a wide range of U.S. Food and Drug Administration ("FDA")-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments for pregnant women to screen for high-risk issues; referral services for pregnant women; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; and vasectomies.

4. Through board-certified physicians licensed to practice medicine in Utah, PPAU performs abortion at its Metro Health Center and Salt Lake Clinic in Salt Lake City, and at its Logan Health Center in Logan. Logan Health Center and Salt Lake Clinic provide medication abortion up to 11 weeks of pregnancy, as measured from the first day of the patient's last menstrual period ("LMP"). Metro Health Center provides medication abortion up to 11 weeks LMP; aspiration abortion up to approximately 13 weeks LMP; and dilation and evacuation ("D&E")

from approximately 13 weeks LMP up to 18 weeks LMP. All three of these health centers are licensed by the State as "abortion clinics," as explained further below.

5. Upon the Trigger Ban's certification last summer, PPAU was briefly forced to stop providing abortion other than in circumstances qualifying for one of the Trigger Ban's exceptions. Following the July 2022 court order blocking the Trigger Ban, however, PPAU resumed providing abortions up to 18 weeks LMP, confirmed by ultrasound and as permitted by Utah's 18-Week Ban.

6. So long as the Trigger Ban remains enjoined, PPAU would continue providing abortions up to 18 weeks LMP but for HB 467 taking effect on May 3, 2023.

## II. HB 467'S HOSPITAL REQUIREMENT AND DEFINITION OF "HOSPITAL"

7. HB 467 only permits facilities licensed as "hospitals," not abortion clinics, to perform abortions as of May 3, 2023. Under HB 467's expanded definition of "hospital," PPAU's licensed abortion clinics should qualify as "hospitals" and therefore should be able to continue performing abortions. But DHHS has adopted an interpretation of HB 467 that prevents PPAU from qualifying as a "hospital" notwithstanding the language of HB 467.

8. Specifically, HB 467 amends both Utah Code Ann. § 76-7a-201 (the "Trigger Ban") and Utah Code Ann. § 76-7-302 (the "18-Week Ban") to provide that "an abortion may be performed only in a hospital," unless it is necessary to perform the abortion in another location due to a medical emergency. HB 467 §§ 17, 29. Additionally, HB 467 defines "hospital" as:

> (a) a general hospital licensed by the department according to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and
> (b) a clinic or other medical facility … that meets the following criteria:
> (i) a clinician who performs procedures at the clinic is required to be credentialed to perform the same procedures at a general hospital licensed by the department; and

> (ii) any procedures performed at the clinic are done with the same level of safety for the pregnant woman and unborn child as would be available in a general hospital licensed by the department.

*Id.* § 16 (amending Utah Code Ann. § 76-7-301(6)); *see also id*. § 28 (amending Utah Code Ann. § 76-7a-101(4)).

9. Currently, a Utah health care facility that provides abortion only in the first trimester must be licensed as a "Type I abortion clinic," while a facility that provides abortion in both the first and second trimester must be licensed as a "Type II abortion clinic." Utah Code Ann. §§ 26-21-2(23)–(24). An "abortion clinic" is defined as either a Type I abortion clinic or a Type II abortion clinic. *Id.* § 26-21-2(1).

10. Now, however, HB 467 specifically states a facility that meets the definition of "hospital" is *not* an "abortion clinic." HB 467 § 1 (amending Utah Code Ann. § 26-21-2(1)(b)) ("'Abortion clinic' does not mean a clinic that meets the definition of hospital under Section 76-7-301 [the 18-Week Ban] or Section 76-7a-101 [the Trigger Ban].").

11. Presumably, this means that facilities could continue to provide abortion and possibly even continue to be licensed by DHHS as a "Type I abortion clinic" or a "Type II abortion clinic," provided they satisfy HB 467's definition of "hospital."

12. PPAU's three licensed abortion clinics *do* satisfy HB 467's definition of "hospital." PPAU provides abortion via physicians who are credentialed to provide those same procedures at Utah hospitals licensed by DHHS, such as the University of Utah Hospital. And, as Dr. David Turok explains in his most recent declaration, PPAU provides those methods of abortion "with the same level of safety for the pregnant woman and unborn child as would be available in a general hospital licensed by [DHHS]." *Id.* § 16 (amending Utah Code Ann. § 76-7-301(6)).

13. Indeed, while HB 467 was under consideration during the 2023 legislative session, some legislators indicated to me that they believed this alternative definition of "hospital" would permit PPAU to continue providing abortion.

## III. DHHS'S INTERPRETATION OF "HOSPITAL" AS DEFINED BY HB 467

14. I understand that DHHS was created by statute in July 2022 and was formed through consolidating Utah's two primary social service agencies, the Utah Department of Health and the Utah Department of Human Services.[1] As I understand it, DHHS is now the agency responsible for issuing facility licenses, including "abortion clinic" licenses. *Id.* § 2 (amending Utah Code Ann. § 26-21-6.5). I understand DHHS is also, notably, the agency responsible for "licens[ing] a clinic that meets the definition of hospital" under HB 467. *Id.* § 2 (amending Utah Code Ann. § 26-21-6.5(4)(a)). And if an "abortion clinic" violates any Utah rule or regulation including the Trigger Ban or 18-Week Ban, DHHS is responsible for taking licensing actions against that abortion clinic. *Id.* § 5 (amending Utah Code Ann. § 26-21-11).

15. Because HB 467's expanded definition of "hospital" appears to apply to PPAU's licensed abortion clinics, on March 20, 2023, I met with the director of the DHHS Division of Licensing and Background Checks and asked what PPAU's licensed abortion clinics would need to do to be designated as "hospitals" under HB 467, such that they could remain licensed and continue providing abortion after May 2, 2023, despite HB 467.

16. At that meeting, the DHHS licensing division director informed me that only licensed general hospitals and satellite facilities operating under a general hospital's license would be eligible for HB 467's expanded "hospital" definition.

[1] *About DHHS*, Utah.gov, https://dhhs.utah.gov/about/ (last accessed March 30, 2023).

17. The next day, by email, I asked the DHHS licensing division director to confirm this understanding. *See* Ex. A. She responded on March 27, 2023, confirming that PPAU's health centers would either have to be licensed as general hospitals or have to operate as satellite facilities under a general hospital license in order to continue providing abortion after May 2, 2023. The director stated that the DHHS Office of Licensing would follow existing licensing procedures and provided a packet of materials with information about the requirements for licensure as a general hospital under title R432-100 of the Utah Administrative Code. Title R432-100 governs specific requirements for general acute hospitals and pertains to everything from system operations[2] and staffing[3] to building construction.[4] Notably, one DHHS form that the licensing division director shared defines a "hospital" as "[a]n institution primarily engaged in providing inpatient diagnostic, therapeutic or rehabilitation services." *See* Ex. B.

18. PPAU's licensed abortion clinics are outpatient health centers, not inpatient health care facilities. It is highly unlikely that DHHS would license PPAU's existing health care facilities as general hospitals under the requirements of title R432-100. As such, PPAU will almost certainly not be able to satisfy HB 467's definition of "hospital" as interpreted by DHHS, notwithstanding the plain language of HB 467 itself. And even if PPAU could eventually satisfy DHHS's definition of "hospital" by obtaining the necessary licensure at some point in the future, our patients would suffer an interruption of services in the interim—both abortion and other types of sexual and reproductive health care.

[2] Utah Admin. Code r. 432-100-8–11; -15–16; -38
[3] Utah Admin. Code r. 432-100-6–7; -12–13
[4] Utah Admin. Code r. 432-4-1–24.

## IV. PPAU'S CURRENT ABORTION CLINIC LICENSES

19. PPAU's Metro Health Center holds an Abortion Clinic Type II license and PPAU's Salt Lake Clinic and Logan Health Center both hold an Abortion Clinic Type I license. To maintain these facility licenses, PPAU must submit license renewal applications to DHHS annually; comply with the requirements in Utah Code title 76, chapter 7, part 3, Abortion, including the recordkeeping and reporting requirements of section 313; and adhere to the health, safety, sanitary, and recordkeeping requirements established by title R432-600 of the Utah Administrative Code. Utah Code Ann. §§ 26-21-6.5(4), -8(4)(a). At least twice each year, DHHS inspects each of PPAU's three licensed facilities to ensure that the abortion clinic is complying with all applicable statutory and licensing requirements. Utah Code Ann. §§ 26-21-6.5(4)(f), (5). At least one of these two inspections must be a surprise inspection, without advance notice to PPAU. Utah Code Ann. § 26-21-6.5(5).

20. At the meeting on March 20, 2023, I also asked the DHSS licensing division director how HB 467 would affect the renewal of existing abortion clinic licenses. The director confirmed that, as of May 3, 2023, DHHS will not issue any new abortion clinic licenses or renewals of existing abortion clinic licenses, and that the schedule for renewals of current abortion clinic licenses, including those set to expire shortly after May 3, will not be accelerated.

21. With regards to the renewal of existing abortion clinic licenses, the director stated that the Office of Licensing will follow standard licensing renewal procedures as outlined in title R432-2 as well as its policy of issuing renewal licenses approximately two weeks prior to the license's expiration upon timely receipt of a renewal application.

22. Metro Health Center's Abortion Clinic Type II license is set to expire on May 31, 2023. Because this is more than two weeks after May 3, 2023, it is clear from my conversation

with the licensing division director that PPAU's license would be ineligible for renewal if HB 467 took effect on May 3. Logan Health Center's and Salt Lake City Center's Abortion Clinic Type I licenses are set to expire on January 31, 2024 and July 31, 2023, respectively. These licenses will expire with no avenue for renewal on those dates.

* * *

23. Given DHHS's interpretation of HB 467, if HB 467 is permitted to take effect on May 3, 2023, PPAU's licensed abortion clinics will be forced to stop providing abortion under any circumstances.

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

Signed on the 31st day of March, 2023, in Salt Lake City, Utah.

Annabel Sheinberg

# EXHIBIT A

## Sheinberg, Annabel

**From:** Sheinberg, Annabel
**Sent:** Monday, March 27, 2023 5:23 PM
**To:** Carmen Richins (DHHS)
**Subject:** Re: Following up from our call yesterday

Thank you so much Carmen.
Your timely response is much appreciated.
Take care,
Annabel

---

**From:** Carmen Richins (DHHS) <carmenrichins@utah.gov>
**Sent:** Monday, March 27, 2023 4:30 PM
**To:** Sheinberg, Annabel <annabel.sheinberg@PPAU.ORG>
**Subject:** Re: Following up from our call yesterday

Annabel

Please see my response to your paragraphs below in dark blue.

> Regarding relicensing our current clinics:
>
> There will be no abortion clinic licenses issued after May 2nd (either new licenses or renewals of existing licenses) and the schedule for renewals of current licenses will not be accelerated. PPAU has one Abortion Clinic II license that expires in late May 2023. If we submit a renewal in April it will not be processed ahead of May 2nd and so the renewal will be denied. Any renewal applications submitted after May 2nd, 2023, will be denied as well.
>
> The Office of Licensing will follow the existing licensing renewal procedures as outlined in R432-2. Once a completed renewal application is submitted, the renewal license is issued approximately 2 weeks prior to the expiration of the old license, so long as the completed renewal application is received timely. However, the dates of the original licensing cycle will not be changed.
> HB 467 states - 26-21-6.5(2) "The state may not issue a license for an abortion clinic after May 2, 2023." Therefore any abortion clinic renewal or new provider applications received after May 2, 2023, will not be processed, nor will a license be issued after May 2, 2023.
>
> Regarding relocating our health center in Logan.
>
> If PPAU were to relocate the - Logan Clinic - which has an Abortion Clinic I license that was renewed in January, PPAU would have to complete all required forms - including one 30 days in advance, and a construction license. DHHS will confirm to be sure that the new location would be treated as an existing licensed clinic and not a new license if the location change occurs before the existing license expires. One additional question I thought of after the meeting – does this apply if we are looking to provide services other than abortion? And are things different if we move after May 2nd?

The Office of Licensing will follow the existing licensing procedures as outlined in R432-2. If an abortion clinic submits a completed and accurate change in location application to the office 30 days prior to the move and the move occurs on or before May 2, 2023, then the license will be issued with the same expiration date as the current license. If an abortion clinic submits a change in a location without the 30 day notice or any other change application to the office after May 2, 2023, the office will not issue a license, new or changed. Any other type of service that requires a license from our office would be handled according to R432-2.

Regarding the new type of clinic envisioned by HB 467 that is connected to a hospital.

PPAU would have to be licensed as a general acute hospital under Utah Regulations Title R432-100 to provide abortion care after May 2, even though it satisfies the definition of "hospital" added by HB 467. Could you please provide the introductory information and the application for a hospital license? If a hospital were to operate a clinic that could provide abortion care it would have to be in a facility that is owned by the hospital and functions under the hospital's license. Some surgical centers would qualify if they are owned by a hospital.

The Office of Licensing will follow the existing licensing procedures as outlined in R432-2. Please see the attached packet with the hospital licensure requirements. Licensed hospitals can provide different types of services, including abortions and abortion care. They can provide these services on-site or at a satellite facility under their license.

Question about operating existing PPAU clinics with expiring abortion clinic licenses:

Lastly I have one additional question I did not ask yesterday. In order for PPAU to continue to provide health care other than abortions - including outpatient procedures such as colposcopies and vasectomies - at our locations currently licensed as Abortion Clinic 1 and Abortion Clinic II what would be the licensure requirements. This would apply for three out of our eight locations (the other five locations do not provide either abortion or other outpatient procedures).

The Office of Licensing will follow the existing licensing procedures as outlined in R432-2. Speaking generally, if a clinic location is performing outpatient procedures, does not have more than one procedure room, or is not Medicare certified, then licensure is not required with the Office of Licensing, as required by Title 26, Chapter 21.

Thank you for reaching out with your questions and for taking the time to meet with us.

**Carmen Richins BSBM, CPM, HFA**
Director, Division of Licensing and Background Checks
C: [redacted]
carmenrichins@utah.gov

On Tue, Mar 21, 2023 at 3:40 PM Sheinberg, Annabel <annabel.sheinberg@ppau.org> wrote:

Dear Carmen,

Thank you and your team for meeting with PPAU yesterday. I'm writing to confirm what we discussed and to ask one additional question. If any of the below does not align with your understanding, please let me know as soon as possible.

Regarding relicensing our current clinics:

There will be no abortion clinic licenses issued after May 2nd (either new licenses or renewals of existing licenses) and the schedule for renewals of current licenses will not be accelerated. PPAU has one Abortion Clinic II license that expires in late May 2023. If we submit a renewal in April it will not be processed ahead of May 2nd and so the renewal will be denied. Any renewal applications submitted after May 2nd, 2023, will be denied as well.

Regarding relocating our health center in Logan.

If PPAU were to relocate the - Logan Clinic - which has an Abortion Clinic I license that was renewed in January, PPAU would have to complete all required forms - including one 30 days in advance, and a construction license. DHHS will confirm to be sure that the new location would be treated as an existing licensed clinic and not a new license if the location change occurs before the existing license expires. One additional question I thought of after the meeting – does this apply if we are looking to provide services other than abortion? And are things different if we move after May 2nd?

Regarding the new type of clinic envisioned by HB 467 that is connected to a hospital.

PPAU would have to be licensed as a general acute hospital under Utah Regulations Title R432-100 to provide abortion care after May 2, even though it satisfies the definition of "hospital" added by HB 467. Could you please provide the introductory information and the application for a hospital license? If a hospital were to operate a clinic that could provide abortion care it would have to be in a facility that is owned by the hospital and functions under the hospital's license. Some surgical centers would qualify if they are owned by a hospital.

Question about operating existing PPAU clinics with expiring abortion clinic licenses:

Lastly I have one additional question I did not ask yesterday. In order for PPAU to continue to provide health care other than abortions - including outpatient procedures such as colposcopies and vasectomies - at our locations currently

licensed as Abortion Clinic 1 and Abortion Clinic II what would be the licensure requirements. This would apply for three out of our eight locations (the other five locations do not provide either abortion or other outpatient procedures).

Many thanks for your time and attention Carmen.

Respectfully,

Annabel

Planned Parenthood Association of Utah

Annabel Sheinberg MM, VP External Affairs
annabel.sheinberg@ppau.org
Direct: [redacted]
Cell: [redacted]

********** IMPORTANT MESSAGE **********
This message, including any attachments, may contain confidential information intended for a specific individual and purpose, and is protected by law. If you are not the intended recipient, delete this message, including from trash, and notify me by telephone or email.

If you are not the intended recipient, any distributions or copying of this message, or the taking of any action based on its content is strictly prohibited.

# EXHIBIT B

UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

PO BOX 144103
SALT LAKE CITY, UT 84114-4103
(801) 273-2994
(800) 662-4157 to free
(801) 274-0658 Fax

# INITIAL REQUIREMENTS FOR HOSPITAL

## DESCRIPTION

**Hospital** - An institution primarily engaged in providing inpatient diagnostic, therapeutic or rehabilitation services. These may nc ude: Long Term Care, Psych atr c, Orthoped c, Rehab tat on, Cr t ca Access, and/or Chem ca Dependency/Substance Abuse.

## LICENSING REQUIREMENTS

Your facility must be in compliance with the program requirements as defined in the Utah Administrative Code R432-100.

A copy of the Hea th Fac ty L cens ng Ru es s ava ab e on our webs te at http://health.utah.gov/hflcra.

## LICENSING DOCUMENTATION

### Zoning

Before submitting your application for a license, please contact the appropriate city/county planning and zoning authority to determine if you are able to establish a business at the desired location.

To obtain your license, the following items must be returned to the Bureau of Health Facility Licensing and Certification

### Notice of Intent

### Application

All information that is submitted on the application is official and can not be amended by the Bureau staff. If a change occurs, a new application must be submitted.

### Fees

P ease see the "Fee Schedu e" for a current st ng of a app cab e fees.

### Business License

Please provide a copy of the agency's business license from the local municipality. If the local municipality will not issue a business license until the state has issued the license, please provide us with a copy of the business license application and a receipt showing the licensing application fees have been paid.

### Policy and Procedure Manual

P ease see the "Po cy and Procedure Manua " Sect on of th s document for more nformat on.

### Construction

Your facility must be in compliance with the program requirements as defined in UAC R432-004 and R432-009. A copy of the Health Facility Licensing Rules is available on our website at http://health.utah.gov/hflcra.

Per UAC R432-004-014, pr or to subm tt ng documents for p ans rev ew, the fac ty censee or des gnee sha schedu e a conference with Department representatives, the licensee's architect, and the licensee or his designee to outline the required plans review process. Please call Andrew Baxter at 801-273-2994 or toll free 1-800-662-4157 to schedule a meeting.

**Please note in addition to the hospital license, the Bureau is also responsible to provide a certificate for mammography.**

## FEDERAL MEDICARE REQUIREMENTS

Your facility must be in compliance with the program requirements as defined in the Code of Federal Regulations. To assist you in determining that you are in compliance with the Federal Medicare conditions of participation, we have enclosed the following copies on the enclosed CD. The State Operations Manual is periodically updated; these updates can be found at http://www.cms.gov/manuals/iom/list.asp :

1. T t e 42 of the Code of Federa Regu at on, Part 482, Cond t ons of Part c pat on for Hosp ta s
2. State Operat ons Manua , Chapter 2, §2020 -2054.1: The Cert f cat on Process - Hosp ta s.
3. State Operat ons Manua , Append x A - Interpretat ve Gu de nes and Survey Procedures - Hosp ta s
4. A new requirement is the Organ, Tissue and Eye Procurement Condition of Participation. As a hospital provider, you will be required to enter into a contract with the Intermountain Organ Recovery System, 230 South 500 East, Suite 290, SLC, UT 84102. Mr. Tracy C. Schmidt, Executive Director can be contacted at the above address and by phone at (801) 521-1755.
5. Appendix V - Interpretative Guidelines and Investigative Procedures for Responsibilities of Medicare Participating Hospitals in Emergency Care and a "Medicare Hospital Checklist". Appendix V presents the procedures and guidelines dealing with Emergency Medical Treatment and Active Labor Act (EMTALA), also know as "anti-dumping" regulations. The EMTALA regulations are designed to ensure that Medicare hospitals provide a medical screening, stabilization and treatment for all patients with a medical emergency, regardless of the patients' ability to pay, and provide appropriate transfer of patients when necessary.

## MEDICARE/MEDICAID DOCUMENTATION REQUIREMENTS

In order to process your Medicare certification request, documents 1 through 3 must be returned the Bureau of Health Facility L cens ng and Cert f cat on.

### 1. Health Insurance Benefits Agreement (CMS 1561) two signed copies:

On the second line of this form, after the term "Social Security Act", enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the facility to enter into this agreement.

### 2. Authorization for Accreditation Organization to Release the Most Recent Accreditation Survey for a Hospital or CAH - Exhibit 287

### 3. Assurance of Compliance (HHS 690) and Civil Rights Compliance and Checklist

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color, or national origin in any program receiving federal financing assistance. Although your facility may already have been given assurance of compliance with civil rights requirements in connection with other Federal programs, you will need to complete the online Civil Rights clearance to remove any chance that your participation would be delayed on that account.

The Civil Rights clearance is completed online at https://ocrportal.hhs.gov/ocr/pgportal/. When you submit the packet online the packet will go directly into the OCR intake que and you will receive an e-mail from OCR stating you have completed the civil rights submission. You will need to submit a copy of the e-mail to the Bureau. The Bureau will submit the e-mail with your certification packet to CMS to complete the Civil Rights requirement.

### 5. Provider Based Designation Request

Under Section 413.65(b) (3), a provider may choose to obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements. Providers who wish to obtain such a determination of provider-based status for their facilities should do so through the self-attestation process.

Attached are:

42 CFR §413.65 - Requ rements for a Determ nat on that a Fac ty or an Organ zat on Has Provider-Based Status.
Inter m Prov der-Based Status Attestat on Statement.

While the attestation process is voluntary, we want to strongly encourage providers to complete the attestation statement.

## 6. Medicare Health Care Provider Enrollment Application - (CMS-855)

The Medicare Health Care Provider/Supplier Enrollment Application is processed directly through Medicare Administrative Contractor (MAC). If you have any questions or would like to select a different MAC, you can access information regarding the enrollment process through the CMS's website at *http://www.cms.gov*.

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the **National Plan and Provider Enumeration System (NPPES)** to assign these unique National Provider Identifiers (NPI). It is recommended that you apply for and receive an NPI before submitting your CMS-855 application. An application for an NPI may be submitted online or obtained at https://nppes.cms.hhs.gov or by calling 1-800-465-3203. For further information about the NPI, please see the website or call the customer service number listed above.

## GENERAL MEDICARE INFORMATION:

The appropriate official should sign the forms at this time to be assured the earliest possible effective date of participation.

Prior to an initial certification survey, you must have received approval of the CMS-855 application, submitted all required documentation, are fully operational and have had ten clients who have had or are receiving skilled services; seven of which must be on service at the time of the survey. This is the case whether the initial certification survey is conducted by our office or by a CMS approved accred tat on organ zat on. P ease ca Mr. Ke y Cr dd e, Manager, at (801) 273-2994 or to free 1-800-662-4157, f you have questions concerning the initial certification survey.

After your initial certification survey has been completed and we have reviewed all documentation pertaining to your request for certification, the packet will be forwarded to the Centers for Medicare and Medicaid Services, Denver Region VIII Office. They will review the documents, determine the effective date, and send you official notification that the certification has been approved. One copy of the Health Insurance Benefits Agreement will be returned to you along with the notification that your facility has been approved. ***Until you receive such notification, Medicare certification is not official.***

## POLICY AND PROCEDURE MANUAL

The manual shall address the standards and requirements set forth in the Utah Administrative Code for the proposed health facility/ agency cense requested and T t e 42 Code of Federa Regu at ons. The cens ng sect ons of your po cy and procedure manua sha be reviewed at the time of your state licensing surveys. The deeming organization will review the federal regulation sections of your policy and procedure manual for completeness.

## MEDICAID REQUIREMENTS

The State Medicaid Agency accepts the Medicare certification as evidence that a supplier meets the requirements to receive Medicaid funding. If you desire to participate as a Medicaid provider, you will need to complete the Medicaid Enrollment Application after you have completed the Medicare certification process. For information regarding the Medicaid enrollment process, please contact Mediciad Provider Enrollment, at (801) 538-6155 or toll free at 1-800-662-9651.

## OTHER PROGRAM REQUIREMENTS

## CLIA REQUIREMENTS

In addition to the certification requirements enclosed with this letter, we also need to inform you of a Federal program established by the Congress to improve the quality and reliability of laboratory testing and to notify you of legal requirements that fall under the law. The Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) requires all clinical laboratories to meet quality standards and to be certified by the U.S. Department of Health and Human Services. The law also requires that laboratories finance the administration and enforcement of this law for this purpose. Therefore it will be necessary for you to contact Ms. Rebecca Chr st ansen, Bureau of Laboratory Improvement, te ephone number (801) 965-2531 and request the CMS Form 116 n order for your laboratory to become registered in accordance with CLIA-88 requirements.

## DEPARTMENT OF ENVIRONMENTAL QUALITY

You w need to contact the D v s on of Rad at on Contro , 168 North 1950 West, PO Box 144850, SLC, UT 84114-4850, te ephone number (801) 536-4264 to ensure that your mammography, radiology and nuclear medicine equipment meets both State and Federal requirements.

## CLIA REQUIREMENTS

The Bureau of Health Facility Licensing and Certification offers complimentary walk-through inspections to help assure you will be in comp ance w th Federa L fe Safety Gu de nes.

For quest on about L fe Safety Gu de nes, or to schedu e a wa k-through, p ease ca Mr. Dav d Eagar at (801) 273-2994.

# Exhibit D

Declaration of Colleen M. Heflin
in Support of Plaintiff's Motion for a Preliminary Injunction

**THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH**

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

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

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

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

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

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

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

## I. Summary of Opinions

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

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

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

## II. My Professional Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## III. OPINIONS

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

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

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

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

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

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

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

[15] *Id.*

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

[17] *Id.*

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

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

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

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

[20] *Id*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[32] *Id.*

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

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

**B. The Intersection of Poverty and Abortion**

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

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

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

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

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

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

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

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

[39] *Id.*

[40] *See id.* at 11.

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

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

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

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

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

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

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

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

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

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

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

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

### *(1) Procedure Costs*

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

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

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

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

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

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

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

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

[50] *Id.* at 216.

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

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

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

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[52] *Id.* at 43.

[53] Id. at 47.

[54] *Id.* at 48–49 & tbl. 13.

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

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

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

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

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

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

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

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

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

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

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

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

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

***(2) Travel-Related Costs***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[80] *See id*. at 2.

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

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

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

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

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

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

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

## VI. CONCLUSION

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

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

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

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

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

[87] *Id.*

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

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

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

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

Colleen M. Heflin, Ph.D.

# Exhibit A

**COLLEEN M. HEFLIN**

Maxwell School of Citizenship and Public Affairs
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### RESEARCH AND TEACHING INTERESTS

Social policy, food and nutrition policy, social demography

## EDUCATION

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

### POSITIONS

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

### PEER-REVIEWED PUBLICATIONS

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

Heflin, Colleen and Xiaohan Sun. (forthcoming) "Food Insecurity and the Opioid Crisis."

*The ANNALS of the American Academy of Political and Social Science.*

Heflin, Colleen, Leslie Hodges, Irma Arteaga, and Chinedum O. Ojinnaka 2022. "Churn in the older adult SNAP population." *Applied Economics Perspectives and Policy.* http://doi.org/10.1002/aepp.13288.

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Heflin, Colleen and Mary Pattillo-McCoy. 2002. "Kin Effects on Black-White Account and Home Ownership." *Sociological Inquiry 72*(2): 220-39.

Kristine Siefert, Philip Bowman, Colleen Heflin, Sheldon Danziger and David Williams. 2000. "Social and Environmental Predictors of Maternal Depression in Current and Recent Welfare Recipients." *American Journal of Orthopsychiatry*, *70*(4): 510-522.

Siefert, Kristine, Colleen Heflin, Mary Corcoran, and David R. Williams. 2000. "Food Insufficiency and the Physical and Mental Health of Low-Income Women." *Women and Health*, *32*(1/2): 159-177.

Danziger, Sandra, Mary Corcoran, Sheldon Danziger, and Colleen Heflin. 2000. "Work, Income, and Material Hardship after Welfare Reform." *Journal of Consumer Affairs, 34*(1): 6-30.

Corcoran, Mary, Colleen Heflin and Kristine Siefert. 1999. "Food Insufficiency and Material Hardship in Post-TANF Welfare Families." *Ohio State Law Review, 60:* 1395-1422.

**Book Chapters and Conference Proceedings**

Heflin, Colleen. "U.S. Food and Nutrition Policy Across the Life Course." 2021. in Janet Wilmoth and Andrew London (editors). *Life Courses Implications of Public Policy.* Routledge Press.

Heflin, Colleen, and Peter Mueser. 2019. "UI and SNAP Receipt in the Sun: The Great Recession and Its Aftermath in Florida." In David Stevens and Michael Wiseman (editors). *Helping Together: Unemployment Insurance, Supplemental Nutrition Assistance, and the Great Recession.* Upjohn Press: Kalamazoo, MI.

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Heflin, Colleen, Leslie Hodges and Andrew London. 2017. "TAPped Out: A Study of the Department of Defense's Transition Assistance Program (TAP)." In Louis Hicks, Eugenia L. Weiss, and Jose E. Coll (editors). *The Civilian Lives of U.S. Veterans: Issues and Identities*, Volume 1. ABC-Clio: New York, NY.

Heflin, Colleen. 2015. "The Importance of Context to the Social Processes around Material Hardship." In Stephen Nathan Haymes, Maria Vidal de Haymes, and Reuben Jonathan Miller (editors). *Routledge Handbook of Poverty in the United States*. Routledge Press: New York, NY.

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

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

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

**Working Papers**

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

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

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

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

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

**Policy Briefs**

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

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

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

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

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

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

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

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

**RESEARCH GRANTS RECEIVED**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principal Investigator. "Localizing Estimates of Hunger: Creating County-level Estimates of Food Insecurity." Research Council Fellowship, University of Missouri. 2010 ($7,000).

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." Regional Small Grant Program, University of Kentucky Center for Poverty Research. 2008-2009 ($20,000)

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." 2008 RIDGE Program sponsored by the Southern Rural Development Center in partnership with the Economic Research Service, U.S. Department Agriculture. 2008-2009 ($35,000).

Principal Investigator, "The Impact of Improving Access to Benefits for Low-Income Families on Caseload Characteristics and Dynamics." Research Board Fellowship, University of Missouri. 2008-2009 ($33,498).

Principal Investigator, "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Summer Research Fellowship Competition, University of Missouri. 2008-2009 ($7,000).

Principal Investigator, "State-Level Variation in Material Hardship Among Households with Children." West Coast Poverty Center. 2007–2008 ($15,000).

Principal Investigator, "Does the Size of the Check Matter? New Results on the Effects of Welfare Receipt on Early Childhood Cognitive Scores." Spencer Foundation. 2006-2007 ($39,840).

Principal Investigator, "Social Capital and Race Inequality." Research Support Grant, University of Kentucky. 2005–2006 ($19,204).

Principal Investigator, "Does Variation in Transfer Program Participation and Generosity at the State Level Explain Variation in Mental Health?" University of Kentucky Center for Poverty Research. 2005 ($19,124).

Summer Faculty Research Fellowship, University of Kentucky. 2005 ($6,000).

Principal Investigator, "Determinants of Different Forms of Material Hardship in the Women's Employment Survey." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2004–2005 ($34,913).

Principal Investigator, "Does Food Stamp Receipt Mediate the Relationship Between Food Insecurity and Mental Health?" The National Poverty Center. 2003-–2004 ($19,783). With James Ziliak, Co-Investigator.

Principal Investigator, "Household Food Insecurity and the Physical and Mental Health of Low-Income Men and Women." NSAF Small Research Grants Program, Association for Public Policy and Analysis and Management (funded by Annie E. Casey Foundation). 2003-2004 ($20,000).

Principal Investigator, "An Individual-Level Analysis of Food Stamp Dynamics." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2002-–2003 ($31,922).

Co-Principal Investigator, "Do Women's Wages Depreciate While on Welfare?" U.S. Census Bureau/Joint Center for Research on Poverty. 2002–2003 ($29,966). With Mary Noonan, Principal Investigator.

Co-Principal Investigator, "Barriers to Work Among Housing Assistance Recipients on Welfare." United States Department of Housing and Urban Development. 1999–2001 ($49,870). With Mary Corcoran, Principal Investigator.

Collaborator. "Causes and Consequences of Food Insufficiency and Material Hardships as Welfare Recipients Move from Welfare to Work." Economic Research Service, U.S. Department of Agriculture. 1999–2000 ($200,354). With Kristine Siefert and Mary Corcoran, Principal Investigators.

Collaborator. "Food Insecurity and Welfare Reform." Institute for Research on Poverty, University of Wisconsin-Madison. 1999–2000 ($49,704). With Mary Corcoran and Kristine Siefert, Principal Investigators.

#### CONTRACTS

Consultant. "Feeding America SNAP Program Evaluation Multi-Site Case Study." Feeding America. June 2013–November 2014.

Consultant. "Evaluation of Missouri PREP Program." Missouri Department of Health and Senior Services. June 2011–May 2015.

### INVITED PRESENTATIONS

"How will you measure the success of your intervention?" Invited Speaker for SNAP and Nutrition Support Monthly Cohort Meeting. Share Our Strength Advisory Committee. August 18, 2021.

"Building a Culture of Evidence: Opportunities and Challenges." Invited Speaker for Data and Evidence Community of Practice Learning Series on Data Visualization and Program Evaluation for American Public Health Service Association. June 29, 2021. (online)

"Examining the Hunger Crisis Among Veterans and Military Families." Invited Congressional Testimony before the Rules Committee, United States House of Representatives. May 27, 2021. (online)

"Exploring Material Hardship and Administrative Burden." Invited Speaker for TANF Workforce Development Workgroup for American Public Human Service Association. February 27, 2021. (online)

"How Does the System Hurt or Help?: Exploring Material Hardship and Administrative Burden" Invited Speaker at University of Minnesota Future Services Institute's Redesign for Whole Families Summit. October 13th, 2020.

"Reflections on household food insecurity research from a US Perspective" Keynote Speaker at 2nd UK Conference on Food and Poverty: Evidence for Change. London, England. June 23rd, 2020.

"The Value and Limits of Linking Administrative Data" Invited speaker at the National Academy of Sciences Committee on National Statistics Panel on Improving USDA's Consumer Data for Food and Nutrition Policy Research. September 21, 2018. Washington, DC.

"Household Instability and Material Hardship." Invited speaker at the 2016 MU Extension Summit, University of Missouri. October 26, 2016. Columbia, MO.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in Center for Research on Inequalities and the Life Course Seminar, Yale University. April 27, 2016. New Haven, CT.

"Community and Systematic Approaches to Hunger: Social Protections." Invited speaker at the Hunger Summit hosted by Universities Fighting World Hunger (partnership of the United Nations World Food Program and Auburn University). February 26, 2016. Columbia, MO.

"Reflecting on 20 years of Measuring Household Food Security," Invited speaker at the US Department of Agriculture - Economic Research Service, October 21, 2015. Washington, DC.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in the West Virginia University Public Health Dialogues. October 2, 2015. Morgantown, WV.

"In Tandem: Pairing Public and Private Nonprofit Assistance to Make Ends Meet." Invited speaker at The School of Public Affairs at American University and Feeding America, July, 2015. Washington, DC.

"Hot Topics for Program Evaluation." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"Using Program Evaluation to Drive Decision-Making." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"The War on Poverty: 50 Years Later and the Battle Continues" Invited speaker at a congressional briefing hosted by the Population Association of America and the

Association of Population Centers in conjunction with Congressman Mike Honda. June 9, 2014. Washington, D.C.

"Household Instability and Material Hardship." Invited speaker at Poverty, Policy and People: 25 Years of Research and Training at the University of Michigan. April 10, 2014. Ann Arbor, MI.

"Material hardship and the case for measurement." Invited speaker at the Presidential Plenary: Poverty Measurement and Implications for Policy. Southern Sociological Society. April 3, 2014. Charleston, NC.

"Individual and Family Coping Responses to Hunger." Invited speaker at the Workshop on Research Gaps and Opportunities in Child Hunger and Food Insecurity at the Committee on National Statistics. National Academy of Sciences, Food and Nutrition Board, Institute of Medicine. April, 2013.

"Short-Term Dynamics of Food Insecurity and Obesity." Invited speaker at Institute of Medicine Workshop on Understanding the Relationship Between Food Insecurity and Obesity. November 16-19, 2010. Washington, D.C.

### OTHER PRESENTATIONS AND CONFERENCES

Chinedum Ojinnaka, Irma Arteaga, Leslie Hodges, Lauryn Quick and Colleen Heflin. "SNAP Participation and Medication Adherence Among Older Medicaid-Insured Individuals Living with Hypertension" Academy Health 2022 Annual Research Meeting. June 5, 2022. Washington, DC.

Colleen Heflin, Leslie Hodges, Chinedum Ojinnaka, Irma Arteaga and Lauryn Quick. "Churn in the older adult SNAP Population." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Colleen Heflin, Jun Li and Dongmei Zuo. "Increasing Access to the SNAP for Older Adults Through the Standard Medical Deduction." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Michah Rothbart, Colleen Heflin, Taryn Morrissey, and Xioahan Sun. "Does Offering Public PreK Change Social Program Participation?" Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Taryn Morrissey, Colleen Heflin and William Clay Fannin. "Room to Grow: Examining Participation and Stability in the Child Care Subsidies Using State Administrative Data." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Colleen Heflin and Xioahan Sun. "Food Insecurity and the Opioid Crises." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Clay Fannin, Colleen Heflin, and Leonard Lopoo. "Local Control, Discretion, and Administrative Burden: SNAP Interview Waivers and Caseloads during the COVID-19 Pandemic." Annual Research Conference of the Association for Public Policy Analysis and Management. March 28, 2022. (online)

Colleen Heflin, Jun Li, and Dongmei Zuo. “Changing patterns of eligibility and take up in SNAP and the role of out-of-pocket medical expenses.” *Understanding Food-Related Hardships Among Older Americans FNS Reporting Conference.* May 28, 2021. (online)

Colleen Heflin and Hannah Patnaik. “Material Hardships and the Living Arrangements of Older Americans” Population Association of America. April 6, 2021. (online)

Colleen M. Heflin, Michah W. Rothbart and Mattie Mackenzie-Liu. “Below the Tip of the Iceberg: Examining Early Childhood Participation in SNAP and TANF from Birth to Age Six.” Fall Research Conference of the Association for Public Policy Analysis and Management. November 10, 2020.

Leonard Lopoo, Heflin, Colleen, and Joe Boskovski. “Testing Behavioral Interventions Designed to Improve On-Time SNAP Recertification” Fall Research Conference of the Association for Public Policy Analysis and Management. November 11, 2020.

Michah Rothbart and Colleen Heflin. “Achievement Gaps” from Day 1? Evidence on School Readiness by Economic Disadvantage and Race.” Fall Research Conference of the Association for Public Policy Analysis and Management. November 12, 2020.

Colleen Heflin and Dongmei Zuo. "Cognitive Impairment and SNAP Participation among Eligible Older Americans" Fall Research Conference of the Association for Public Policy Analysis and Management. November 12, 2020

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, “When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion”. Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Bullinger, L.R., Heflin, C.M., & Raissian, K.M. “SNAP and Child Maltreatment” Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, “When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion” Increasing Family Income through Child Support: Lessons from Recent Research. Institute for Research on Poverty, University of Wisconsin-Madison and Assistant Secretary for Planning and Evaluation, US. Dept. of Health and Human Services. September 18, 2019. Washington, DC.

Heflin, Colleen. “Food and Nutrition Policy across the Life Course.” American Sociological Association.” August 13, 2019. New York, NY.

Sharon Kukla-Acevedo and Colleen Heflin. “Adolescent Food Insecurity and the Transition to Adulthood.” Research on Food Security Using the Panel Study of Income Dynamics, September 20, 2018. Washington, DC.

Colleen Heflin, Rajeev Darolia, and Sharon Kukla-Acevedo. “Exposure to Food Insecurity during Adolescence and the Educational Consequences.” Fall Research Conference of the

Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Claire Altman, Chaeyung Jun and Colleen Heflin. "Hardships of Undocumented Immigrants in the United States: Evidence from the 1996-2008 SIPP." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Colleen Heflin, Sharon Kukla-Acevedo, and Rajeev Darolia. "Risky Adolescent Behaviors and the Role of Food Insecurity." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008." 2017 American Sociological Association Annual Meeting. August 12-15, 2017. Montreal, Quebec, Canada.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008" (poster presentation). 2017 Population Association of America Annual Meeting. April 27-29, 2017. Chicago, IL.

Arteaga, Irma, Heflin, Colleen, Leslie Hodges and Peter Mueser. "Does the Timing Matter for SNAP Benefits and Pregnancy-Related Emergency Room Visits?" Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Heflin, Colleen. "Social Program Participation and Material Hardship." Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Arteaga, Irma, Colleen Heflin and Sarah Parsons. "The Coverage Gap." Annual meeting of the Population Association of America. March 31, 2016. Washington, DC.

Mueser, Peter, Colleen Heflin and Leslie Hodges. "The Mediating Effects of SNAP on Health Outcomes for Low-Income Households." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnick and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Development Outcomes." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnik and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Developmental Outcomes" (poster presentation). Annual meeting of the Population Association of America. April 30-May 2, 2015. San Diego, CA.

Olson, Kate and Colleen Heflin. "The Changing Face of the United States and the Provision of Social Services." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Hodges, Leslie Beasley, Colleen Heflin and Andrew London. "TAPped out: An Evaluation of the Department of Defense's Transition Assistance Program." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "The Child and Adult Care Food Program and Food Insecurity." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Kukla-Acavado, Sharon and Colleen Heflin. "Participation in the Unemployment Insurance Program and Childhood Achievement." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Heflin, Colleen, Irma Arteaga and Sara Gable. "Families with Hungry Children and the Transition from Preschool to Kindergarten." Research Program on Childhood Hunger, Food and Nutrition Service. March 13, 2014. Washington, D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." National RIDGE Small Grants Conference, December 17, 2013. Washington, D.C.

Potochnick, Stephanie, Irma Arteaga and Colleen Heflin. "An Examination of Household Food Insecurity among Low-Income Immigrant Children." Annual meeting of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Ashley Price. "Emergency Food Assistance and the Great Recession." Annual Conference of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." Southern Rural Development Center RIDGE Small Grants Conference. August 22, 2013. Denver, CO.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the National Association of Welfare Researchers and Statisticians. August 21, 2013. Chicago, IL.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, Joan Hermsen and Ashley Vancil. "A Food Systems Approach to Addressing Obesity Among Food Pantry Clients in Missouri" (poster presentation). Annual meeting of the

Society for Nutrition Education and Behavior. August 11, 2013. Portland, OR. *The abstract was published in the *Supplement to Journal of Nutrition Education and Behavior* 45:4S (July/August), p. S89.

Heflin, Colleen. "Child Poverty" Annual meeting of the American Sociological Association. August 10, 2013. New York, NY.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." IZA/OECD/World Bank Conference on Safety Nets and Benefit Dependence: Evidence and Policy Implications. May 21-22, 2013. Paris, France.

Heflin, Colleen, Jacob Cronin and Ashley Price. "Best Practices for Implementing and Evaluating Evidenced-Based Teen Pregnancy Prevention Programs with Diverse Populations." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Kukla-Acevedo, Sharon and Colleen Heflin. "Unemployment Insurance Participation and Early Childhood Development." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Arteaga, Irma, Colleen Heflin and Sara Gable. "Hungry Children and the Transition from WIC." Annual Conference of the Association of Policy Analysis & Management. November 4-6, 2012, Baltimore, MD.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, and Joan Hermsen. "Food Systems Approach to Addressing Obesity among Food Client Households in Missouri" (poster presentation). 45th Annual Conference of the Society for Nutrition Education and Behavior. July 14-17. Washington, DC.

Arteaga, Irma, Colleen Heflin, and Sara Gable. "Hungry Children and the Transition from WIC". Annual meeting of the Population Association of America. May 4, 2012. San Francisco, CA.

Wilmoth, Janet M., Andrew S. London, and Colleen Heflin. "Economic Well-Being among Older Adult Households: Variation by Veteran and Disability Status." Annual meeting of the Gerontological Society of America. December 2011. Boston, MA.

Heflin, Colleen, and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association for Public Policy and Management. November 4-5, 2011. Washington, DC.

London, Andrew S., Colleen Heflin and Janet M. Wilmoth. "Work-Related Disability, Veteran Status, and Poverty: Implications for Family Well-Being." Annual meeting of the American Sociological Association. August 2011. Las Vegas, NV.

Heflin, Colleen, and Ngina Chiteji. "My Brother's Keeper? The Association between Having Siblings in Poor Health and Wealth Accumulation." Western Economic Association Annual Meetings. June 30, 2011. San Diego, CA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty, and Material Hardship." Annual meeting of the Association for Public Policy and Management. November 4-5, 2010. Boston, MA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty and Material Hardship." SIPP Analytics Research Conference. October 14-15, 2009. Washington, DC.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Reducing Poverty Conference hosted by The Institute for Advanced Policy Solutions. November 19-20, 2009. Atlanta, GA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of Modernization on Florida's Food Stamp Caseload." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." RIDGE Conference at the US Department of Agriculture, Economic Research Service. October 15-16, 2009. Washington, DC.

Heflin, Colleen, Andrew London and Ellen Scott. "Mitigating Material Hardship: The Strategies Low-income Mothers Employ to Reduce the Consequences of Poverty." Annual meeting of the American Sociological Association. August 8-11, 2009. San Francisco, CA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." Southern Rural Development Center Mid-Year Grantees Conference. August 5-6, 2009. Atlanta, GA.

Keiser, Lael and Colleen Heflin. "Explaining the Consequences of TANF Policy Choices Across and Within U.S. States" State Politics and Policy Conference (Hosted by the University of North Carolina-Chapel Hill and Duke University). May 22-23, 2009. Chapel Hill, NC.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." University of Kentucky Center for Poverty Research Small Grants Conference. Mat 19, 2009. Lexington, KY.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." Annual meeting of the Population Association of America. April 30, 2009. Detroit, MI.

Heflin, Colleen. "Macroeconomic Performance and Material Hardship across Time, Space and Race." West Coast Poverty Center Speaker Series. March 9, 2009. Seattle, WA.

Heflin, Colleen and Ngina Chiteji. "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Annual meeting of the Association of Public Policy and Management, November 6, 2008. Los Angeles, CA.

Heflin, Colleen. "State-Level Variation in Material Hardship Among Households with Children." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. "Welfare and Children's Cognitive Test Scores." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. “Does the Size of the Welfare Check Matter? New Results on the Effects of Welfare on Children’s Cognitive Test Scores.” Annual meeting of the Association of Public Policy and Management. November 4, 2006. Madison, WI.

Heflin, Colleen and John Iceland. “Poverty, Material Hardship and Mental Health.” Annual meeting of the Association of Public Policy and Management. November 3, 2006. Madison, WI.

Heflin, Colleen and Jim Ziliak. “Food Insufficiency, Food Stamp Participation and Mental Health.” Institute for Research on Poverty Summer Workshop. June 22, 2006. Madison, WI.

Heflin, Colleen and John Iceland. “Poverty, Material Hardship and Mental Health.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen and Seok-Woo Kwon. “Social Capital and Racial Wage Inequality.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship.” February 1, 2006. McGill University.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Annual meeting of the Association of Public Policy and Management. November 3, 2005. Washington, DC.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. October 2005.

Heflin, Colleen. “Determinants of Different Forms of Material Hardship in the Women’s Employment Survey.” Institute for Research On Poverty’s Small Grant Conference. May 20, 2005. Madison, WI.

Siefert, Kristine, Colleen Heflin and David R. Williams, David R. “Household Food Insufficiency in African American and White Women." Annual meeting of the Society for Social Work and Research. January 18, 2004. New Orleans, LA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams, David R., "Food Insufficiency and Physical and Mental Health in a Longitudinal Survey of African American and White Women." Annual meeting of the American Public Health Association. November 17, 2003. San Francisco, CA.

Heflin, Colleen. “Who Exits the Food Stamp Program after Welfare Reform?” Annual meeting of the Association of Public Policy and Management. November 7, 2003, Washington, DC.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. “What About Arabs? White and Black American’s Attitudes Toward Arab Americans in Detroit in 1992?” Annual meeting of the American Sociological Association. August 17, 2003. Atlanta, GA.

Noonan, Mary and Colleen Heflin. “Do Women’s Wages Depreciate While on Welfare?” Annual meeting of the American Sociological Association. August 19, 2003. Atlanta, GA.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. "What About Arabs? White and Black American's Attitudes Toward Arab Americans in Detroit in 1992?" (poster presentation) Annual meeting of the Population Association of America. May 2, 2003. Minneapolis, MN.

Siefert, Kristine, Colleen Heflin, and David R. Williams. "Household Food Insufficiency and Depression in African American and White Low-Income Women." Annual meeting of the American Journal of Public Health Association. November 9, 2002. Philadelphia, PA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insecurity and Hunger: Implications of Recent Research for Maternal and Child Health Programs." 15th Annual U.S. Department of Health and Human Services Regions V and VII Maternal and Child Health Leadership Conference. April 22, 2002. Chicago, IL.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and the Physical and Mental Health of Current and Former Welfare Recipients." Annual meeting of the Association of Public Policy and Management. Washington, DC.

Heflin, Colleen and Mary Corcoran. "Barriers to Work among Housing Assistance Recipients." Annual meeting of the National Association of Welfare Researchers and Statisticians. Baltimore, MD.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Poverty Dynamics after Welfare Reform." Annual meeting of the Association of Public Policy and Management.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and Women's Health: Findings from a Longitudinal Survey of Welfare Recipients." Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. 2000.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Income Dynamics after Welfare Reform ". Annual meeting of the *National Association of Welfare Researchers and Statisticians*, Scottsdale, AZ.

Heflin, Colleen and Mary Pattillo-McCoy. "Kin Effects on Black-White Account and Home Ownership." Annual meeting of the American Sociological Association. August 2000. Washington, D.C.

Danziger, Sheldon, Colleen Heflin and Mary Corcoran. "Does Work Pay for Single Mothers?" Annual meeting of the Population Association of America. 2000. Los Angeles, CA.

Siefert, Kristine, Colleen Heflin, and Mary Corcoran. "Food Insecurity and the Physical and Mental Health of Low Income Single Mothers." Annual meeting of the American Public Health Association Annual Meeting, 1999. Chicago, IL.

Pattillo McCoy, Mary and Colleen M. Heflin. "Poverty in the Family: Exploring the Kin Networks of the Black and White Middle Class." Annual meeting of the American Sociological Association. 1999. Chicago, IL.

Corcoran, Mary E. and Colleen Heflin. "Changes in Women's Wages, 1979-1989 by Race and Ethnicity." Annual meeting of the Population Association of America. 1999. New York, NY.

Goldberg, Heidi, Colleen Heflin and Kristin Seefeldt. “Welfare-to-Work Programs and Barriers to Employment.” Annual meeting of the National Association of Welfare Research and Statistics. 1999. Chicago, IL.

Corcoran, Mary and Colleen Heflin. “Race, Ethnic and Skill-Based Inequalities in Women's Employment and Wages." Presented at the Institute for Women's Policy Research Conference. 1998. Washington, D.C.

Hall, Richard L. and Colleen Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Midwest Conference of Political Science Association. 1998. Chicago, IL.

Hall, Richard L. and Colleen M. Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Presented at the Midwest Conference of Political Science Association. 1994. Chicago, IL.

### Teaching experience

Public Program Evaluation
Poverty and Social Policy (graduate and doctoral level)
Poverty Policy (undergraduate level)
Applied Regression (graduate level)

## COMMUNITY Service

Member, Data Advisory Team for the Boone Indicators Dashboard Project, a collaboration of the City of Columbia, County of Boone, and Heart of Missouri United Way, 2016–2017.

Member, Indicator Review Committee, Missouri Kids Count, Fall 2015.

## PROFESSIONAL SERVICE

Program Committee, Annual Meeting of the Association for Public Policy and Management, 2013 and 2015.

Invited speaker at Minnesota Department of Labor Conference, “Sustaining Employment in the New Millennium,” February 2000.

## UNIVERSITY SERVICE

Syracuse University (Fall 2017 to present)

*University Service*

Promotion and Tenure Committee, 2018 to 2019
Maxwell Faculty Committee, 2018 to 2019
Equipment Task Force Committee, 2018 to present
SU representative to NYFSRDC, 2017 to present
Policy Studies Program Advisory Committee, 2017 to present

*Departmental Service*

MPA Curriculum Committee, 2017- present (Chair, 2018 to present)
Executive Committee, 2018 to present
Health Care Policy & Management Search Chair, 2019
Economics of Aging Search Committee, 2018
APPAM Policy Camp Committee, 2018

University of Missouri Service (Fall 2007 to Spring 2017)

*University Service*

Tenure Committee, 2016 to 2017
Lecture Committee, 2012 to 2017
Population, Education and Health Seminar Organizer, 2013 to 2014
Population, Education and Health Center Founder and Co-Director, 2014 to 2017

*Departmental Service*

Truman School Ph.D. Program Coordinator, 2014 to 2017
Truman School Seminar Series Co-Organizer, 2014 to 2015
Truman School Doctoral Committee Member, Fall 2007 to 2009; 2013 to 2014
Truman School Personnel Committee, 2012 to 2017
Institute for Public Policy Advisory Committee, Spring 2008 to 2010
Truman School Policy Committee, Fall 2008 to 2009; 2013 to 2017
Chair, Policy Faculty Search 2012
Food Policy Faculty Search 2013

University of Kentucky Service (Fall 2002 to Summer 2007)

*University Service*

University of Kentucky Center for Poverty Research Advisory Board, 2002-2007

*Departmental Service*

Martin School of Public Policy MPA Admissions Committee, Fall 2002 – Summer 2007
Martin School of Public Policy MPA Curriculum Committee, Fall 2002 – Summer 2007
Martin School Director's Search Committee, Fall 2002 and Fall 2003
Martin School Faculty Search Committee, Spring 2003
Martin School Internal Brownbag Seminar Organizer, 2005-2006
Revising the Capstone Committee, Fall 2005 to Spring 2006

**MEMBERSHIP AND AFFILIATIONS**

American Sociological Association, Member
Association for Public Policy and Management, Member
Population Association of America, Member