

January 27, 2009

**A Communication to the U.N. Special Rapporteurs
Regarding the Risks and Vulnerabilities Facing
Reproductive Healthcare Providers in the United States**

Human rights defenders play a critical role in ensuring that human rights enshrined in international treaties and documents translate into meaningful rights at the national level. Tragically, these courageous individuals are frequently targeted for attack by those opposed to changes in the status quo. Women's rights defenders face different and additional risks than other defenders. Ms. Hina Jilani, the former Special Representative on Human Rights Defenders, explained that "[p]romoting and protecting women's rights can be an additional risk factor, as the assertion of some such rights is seen as a threat to patriarchy and as disruptive of cultural, religious and societal mores."¹ Women defenders may be targeted with violations such as sexual violence that are specific to women's gender, sexuality or gender identity. Women's rights defenders may also be targeted because their work focuses on gender-specific rights, such as access to reproductive health services. Women's rights defenders "face stronger resistance to their work, are more vulnerable and, therefore, more threatened."² The heightened risks and vulnerabilities of women's rights defenders require states to take extra measures to respect, protect and fulfill their rights.

This communication documents the failure of the United States government to guarantee the rights of a particular class of women's rights defenders—medical professionals who provide reproductive healthcare services, including the right to abortion. Reproductive rights are comprised of a number of separate human rights that are founded upon principles of dignity and equality. As recognized in the Beijing Platform for Action, "[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."³ This right to reproductive and sexual self-determination includes women's ability to control the number and spacing of their children; the right to reproductive and sexual health services, goods and supplies;⁴ and the rights to information, privacy and confidentiality.⁵ In the United States, as in many countries in the world, women's reproductive rights include a constitutional right to abortion.⁶ Reproductive rights cannot be fulfilled unless medical professionals are able to provide reproductive healthcare services free of violence, intimidation and harassment by public and private actors.

The Declaration on Human Rights Defenders (“the Declaration”),⁷ adopted unanimously by the UN General Assembly in 1999, recognizes the important role of human rights defenders and sets forth the rights pertaining to them. The former Special Representative on Human Rights Defenders, Ms. Hina Jilani, recognized that those who promote women’s right to sexual and reproductive health are women’s human rights defenders because they enable women to exercise their human rights to reproductive health and reproductive autonomy.⁸ She has also identified healthcare providers as human rights defenders where those individuals are targeted for their work promoting access to healthcare.⁹ Threats to reproductive healthcare providers jeopardize women’s right to healthcare that is available, accessible, acceptable, and of good quality.¹⁰ Mr. Paul Hunt, the former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, stated clearly that “human rights law places obligations on [governments] to do all they can to dismantle the barriers to sexual and reproductive health.”¹¹ For example, “[w]here abortions are legal, they must be safe; public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible.”¹² Ms. Yakin Erturk, the Special Rapporteur on Violence Against Women, has stated that denial of proper medical care may violate women’s reproductive rights and place their lives at risk.¹³ In her report on the “Intersections of Violence Against Women and HIV/AIDS,” she stated unequivocally that governments “must allow women to control their sexual and reproductive lives”¹⁴ by ensuring equal access to healthcare for women.¹⁵

The regional human rights systems have echoed the UN’s focus on the role of women’s rights defenders in advancing women’s rights. The European Union Guidelines on Human Rights Defenders calls on member states “to apply a gender perspective when approaching the issue of human rights defenders.”¹⁶ The EU’s review of the implementation of these Guidelines undertaken in 2006 reiterates the need for states to pay special attention to the needs of women’s rights defenders.¹⁷ The Inter-American Commission on Human Rights, working with the U.N. Special Representative on Human Rights Defenders, established a Human Rights Defenders unit within the office of the Executive Secretary. In 2006 the Unit released a report on human rights defenders in the Americas in which it called on states to take special measures to address the security of those advancing women’s rights.¹⁸ In October 2008, the Commission held a thematic hearing on the risks and vulnerabilities facing women’s human rights defenders across the Americas, including those working on sexual and reproductive rights.

This communication shows how reproductive healthcare providers are forced to work under circumstances far more dangerous and difficult than other medical professionals in the United States. From 1973 through the present, when the constitutional right to an abortion was recognized in the U.S. Supreme Court decision *Roe v. Wade*,¹⁹ abortion providers have been targeted for harmful treatment by both state and non-state actors. Because anti-abortion extremists cannot legally prohibit women from exercising their rights, they target healthcare workers such as physicians, nurses, and other employees of healthcare clinics to make it impossible for them to provide abortion services. Part I describes the range and persistency of attacks against reproductive healthcare professionals, including violence and threats to physical security, destruction of private property, and attacks on their private life. Part II reveals how the

U.S. government's response to this violence is at best inadequate, and at worst openly hostile towards providers. Federal and state laws fail to deter many forms of violence and harassment against providers, and there is insufficient enforcement of the protective laws that do exist. Part III discusses how the federal and state governments often pass legislation targeting abortion providers, subjecting them to criminal penalties and other sanctions that are not imposed on providers of comparable medical services. Other laws are designed to impose insurmountable economic burdens on abortion providers or allow private groups to use state mechanisms as tools of harassment.

The cumulative impact of these attacks by state and non-state actors is that fewer and fewer reproductive healthcare professionals are willing or able to provide abortion services. The number of U.S. abortion providers has fallen by at least 37 percent since 1982.²⁰ As a result, 87 percent of U.S. counties and 97 percent of non-metropolitan counties have no abortion provider, and these counties are home to one-third of women of reproductive age.²¹ The failure to respect, protect and fulfill the rights of reproductive healthcare providers ultimately results in women losing access to reproductive rights.

I. Persistent Attacks on Reproductive Healthcare Providers

Providers of reproductive healthcare, particularly those who offer abortion services, face a variety of threats including threats to their physical security, destruction of private property, and attacks on their private life, family, and reputation. These attacks intimidate and deter medical professionals from providing reproductive healthcare services or impede their ability to do so effectively. In both cases, women's access to necessary services is jeopardized.

A. Attacks on Physicians' Physical Security

There is a long history of violence, death threats, and murder of physicians who perform abortions in the United States, undertaken with the express purpose of preventing physicians from providing abortions. Since 1973, three physicians and four clinic workers in the U.S. have been killed by anti-abortion extremists.²² Five other physicians or clinic workers have been seriously injured in such attacks.²³ On August 19, 1993, an anti-abortion extremist attempted to assassinate Dr. George Tiller, a physician who operates a medical practice, Women's Health Care Services (WHCS), in Wichita, Kansas, where he provides safe and legal abortion services to women from across the country.²⁴ He specializes in later term abortion services for women who face substantial health risks or fetal anomalies. Because he is one of only three physicians in the country who provides abortions later in pregnancy, his clinic is a frequent target for harassment and violence by anti-abortion protestors and extremists.²⁵

Prior to the shooting, WHCS had been targeted for two years by anti-abortion forces dedicated to closing the clinic at whatever cost. In 1991, an extremist group called Operation Rescue led a six-week siege on WHCS during its "Summer of Mercy" protest in Wichita, which involved numerous blockades of clinic entrances, death threats to doctors who perform abortions, and daily, often violent, protests at abortion clinics.²⁶

The government did not take adequate measures to protect Dr. Tiller, such as ordering federal marshal protection,²⁷ despite a known, significant association between severe intimidation tactics and violence against abortion clinics.²⁸ Tellingly, Dr. Tiller's would-be assassin had participated in the Summer of Mercy blockades as a member of the Army of God, an underground network that believes violence is acceptable and justifiable to end abortion.²⁹ The correlation between intimidation and severe violence continues today. In 2005, clinics facing one or more forms of intimidation were three times more likely to experience violence compared with clinics that faced no intimidation tactics.³⁰

As a result of the violence, reproductive healthcare clinics have been forced to take extreme security measures that are expensive and burdensome to maintain. Clinics have spent thousands of dollars to install maximum security measures, including security barriers, bulletproof glass, metal detectors, and security cameras.³¹ Maintenance of alarm systems and security personnel amount to tens of thousands of dollars.³² Providers also take precautionary measures at their private homes for fear of being targeted there. For example, Dr. Tiller wears a bullet proof vest and moved to a home in a gated community with a state-of-the-art security system and barrier wall in order to protect himself and his family from shootings by extremists.³³ Although some abortion providers have been placed under federal marshal protection for certain brief periods of time, in general they must provide and pay for their own security. Continued threats to abortion providers' physical security is a key factor contributing to the decline in physicians who provide abortions around the country.³⁴

B. Destruction of Private Property

Today, one in five abortion clinics in the U.S. is targeted with forms of violence considered the most severe, including bombing, arson and invasion.³⁵ Between the years 1977-2007, there were over 41 bombings, 175 arsons, 94 attempted bombings and arsons, and 623 bomb threats directed at abortion providers, resulting in \$8.5m in damages.³⁶ Since May 2007, four clinics in New Mexico, Virginia, and California have been damaged or attacked by arson.³⁷ One clinic in Albuquerque, New Mexico run by Dr. Curtis Boyd was destroyed by fire in December 2007 after arsonists threw a gas can into the exam room and lit it on fire.³⁸

As many as one in four abortion clinics have now experienced some form of vandalism, a substantial increase from the late 1990s.³⁹ For example, in 2007, Dr. Tiller's facility was attacked by vandals who cut a hole in the ceiling of WHCS, inserted a garden hose, and flooded part of the facility with several inches of water. They also attempted to seal the gates of the parking lot.⁴⁰ WHCS was forced to close for more than a month due to mold damage.⁴¹ The closure prevented approximately 230 women from obtaining reproductive health services at the clinic while it closed for renovations, and the flood resulted in at least \$86,000 of damages not including lost income.⁴² This was the second time that WHCS was forced to close; the first was in 1986, when a bomb exploded at the clinic and caused \$100,000 in damage.⁴³

Abortion opponents have also targeted the private property of physicians who provide abortions, yet these crimes have seldom been prosecuted. For example, in 1991, a suspicious fire was set on the property of Dr. Leroy Carhart, a Nebraska physician who provides later term abortion services. Arsonists set seven fires on Dr. Carhart's property, destroying his family home and horse barn.⁴⁴ The fire also killed two family pets and 17 horses.⁴⁵ County officials bulldozed the site immediately, destroying any potential evidence before arson investigators could arrive.⁴⁶ An anonymous letter delivered to the clinic the next day claimed that the fire was justified by Dr. Carhart's performance of abortions.⁴⁷ Yet, no one was ever charged in the case.⁴⁸

C. Attacks against Private Life, Family, and Reputation

Now that a federal law prohibits clinic blockades,⁴⁹ anti-abortion extremists have shifted tactics and begun to wage smear campaigns—some of which advocate violence—against doctors providing abortions. Physicians who provide abortions have been featured in “most-wanted” posters resembling the posters used by the FBI to track down most-wanted criminals.⁵⁰ Some of these posters offered a \$1,000 reward for stopping physicians from performing abortions.⁵¹ Two physicians featured on these posters were later assassinated.⁵² Some anti-abortion extremists, including the extremist who tried to murder Dr. Tiller, defend the murder of abortion providers as “justifiable homicide.”⁵³ These actions are facilitated by websites such as the infamous “Nuremburg Files,” which until it was shut down by a federal judge in 1999 published the names, addresses, and other identifying information of abortion providers, with the names of those who had been killed crossed out in black.⁵⁴

Smear campaigns are carefully coordinated to pressure abortion clinics to go out of business. Employees of Dr. Tiller's clinic have been subjected to continuous smear campaigns since the 2004 “Year of Rebuke” organized by Operation Rescue.⁵⁵ The “name and shame” campaign involved targeted picketing of each clinic employee. Protestors picketed outside private homes, mailed postcards to their neighbors, greeted employees at restaurants with photos of mangled fetuses, and even sorted through employees' home garbage.⁵⁶ They also drove a moving billboard of bloody post-abortion fetuses around the neighborhoods where clinic employees live and work.⁵⁷ Operation Rescue even mounted an attack against over 200 companies doing business with the clinic or Dr. Tiller personally, demanding that they cease their affiliations or face a boycott.⁵⁸ Recently, anti-abortion extremists in Wichita have begun a public shaming campaign entitled “People Are Watching,” where they wear binoculars and stake out the movements of Dr. Tiller and his employees.

Many of these forms of harassment are protected speech under the U.S. Constitution. However, the established link between forms of intimidation and violence against abortion providers requires heightened diligence on the part of state actors to monitor potential threats, provide proper training to law enforcement and other public officials to offer the same level of protection to abortion providers as other human rights defenders, and promptly investigate instances when public expression crosses the line to threatening behavior.⁵⁹

II. U.S. Government's Failure to Protect Reproductive Healthcare Providers or Provide an Effective Remedy for Violations

Under article 12 of the Declaration, the United States has an obligation to take all necessary measures to protect human rights defenders against any violence, threats, or retaliation directed against them as a result of their activities to defend human rights. The government also has an obligation to conduct a prompt and impartial investigation or inquiry whenever allegations of a violation arise, punish acts or provide redress as appropriate, and enforce judicial decisions on remedies.⁶⁰ However, the U.S. has not only failed to adequately protect reproductive healthcare providers from attacks on their physical security, it has also failed to provide an effective remedy in the event that violations do occur. This has led to a climate of impunity for those who repeatedly target abortion providers, emboldening those who commit such acts to continue to target women's rights defenders.

A. Federal Response: Non-recognition of Violations and Lack of Enforcement

Following a peak of clinic blockades and violence against abortion providers in the early to mid 1990s, in 1994 the federal government passed the Federal Access to Clinic Entrances (FACE) Act⁶¹ to protect reproductive healthcare providers and facility as well as women seeking to access clinics. There have been several successes, including the prosecution of Dr. Tiller's attacker. While it aims to deter some of most egregious forms of violence directed at abortion providers, FACE does not recognize the full range of harassment they experience, including severe intimidation that has been linked to violence.⁶² FACE does not explicitly define areas that the protestors are prohibited from entering, but rather provides for injunctive relief or civil remedies only after a FACE violation has occurred.

Abortion opponents soon learned the loopholes in FACE and began to embrace more sophisticated tactics. First, they concentrated their harassment on a small number of physicians with the aim of forcing them to stop performing abortions. Second, their tactics became increasingly more personal, involving protests at providers' private homes where FACE does not reach. Meanwhile, violence against physicians and clinics continues, albeit in different forms. While blockades have decreased and no one has attempted to murder a physician since 1998, other forms of violence including assault and battery, death threats, bomb threats and stalking are on the rise, reaching their highest levels in 2007 since the 1990s.⁶³

Finally, clinic employees report that FACE enforcement is waning. In 1995, President Clinton ordered the Department of Justice (DOJ) to establish local working groups in each U.S. Attorney's office. The purpose of these working groups was to maximize coordination and communication among federal, state and local law enforcement and to better address security risks at clinics. After the 1998 slaying of an abortion provider named Dr. Barnett Slepian, Attorney General Janet Reno established a national Task Force on Violence Against Health Care Providers to assist the local working groups and coordinate national investigation and prosecution of abortion clinic

violence.⁶⁴ This system was meant to address a problem that arose soon after FACE was passed, where federal and state authorities dodged jurisdiction when they received complaints.⁶⁵ The Task Force established local working groups that proved to be a key mechanism for effective FACE enforcement because they coordinated trainings and responses to clinic violence between federal and local law enforcement agencies.

Under the Bush Administration the local working groups have been inactive and insufficiently funded. Consequently, they have not provided assistance to local law enforcement that is critical for prevention of violence and successful prosecutions. Jen Boulanger, Executive Director of the Allentown Women’s Center in Allentown, Pennsylvania, explains that the loss of federal support has had a great impact on her clinic:

*There is a great need for better coordination of law enforcement efforts on the federal, state and local levels. Under the Clinton Administration, there were great efforts made to prevent violence and disruption outside of clinics. Federal Marshalls were connected with local law enforcement officers. There was a concerted effort to train local law enforcement and clinic administrators on how to handle incidents involving anti-choice extremists and domestic terrorism. When there were clear guidelines and strict enforcement, incidents of violence and disruption were prevented. ... We need a coordinated response from the government so that we are not left to fend for ourselves, and so that we can continue providing women with their human right to reproductive healthcare.*⁶⁶

Another provider in the South explains that under the Bush administration the Department of Justice acted belatedly, if at all, in response to alleged FACE violations.⁶⁷

B. Inadequate State and Local Responses

Recognizing the loopholes in FACE, a few states have passed legislation providing further protection of clinics against the activities of anti-abortion extremists.⁶⁸ For example, six states prohibit threatening or intimidating staff or patients entering a reproductive healthcare facility.⁶⁹ A handful of states prohibit property damage or other forms of harassment such as telephone threats or possessing a weapon during a demonstration at a facility.⁷⁰ Six states⁷¹ and a handful of cities⁷² have taken further steps to protect providers by passing “buffer zone” legislation requiring that protestors stay a certain number of feet away from people accessing the clinic or from clinic entrances. However, the *vast majority* of states and municipalities lack legislation to prohibit activities not covered by FACE that are designed to frighten and intimidate providers, and that often cross the line to violence.

III. Government Regulations and Restrictions on the Constitutional Right to an Abortion

Article 11 of the Declaration sets forth the duty of the state to respect the right of human rights defenders to the lawful exercise of their profession.⁷³ However, the federal and state governments are making it increasingly difficult for abortion providers to exercise this human right, in turn compromising their ability to provide comprehensive

reproductive healthcare to their patients. In her report on women's rights defenders, Hina Jilani recognized the subversive nature of this type of law:

Laws which are directed at or allow criminalization of human rights activity continue to be enforced and are being used, in some of the countries, to prosecute human rights defenders. ... Such laws serve no useful purpose nor are they relevant to any legitimate concerns of the State.⁷⁴

In the United States, a panoply of state and federal laws create a complicated legal minefield for abortion providers. Physicians and other medical professionals who perform abortions are subject to far greater risk of legal liability than those who provide comparable medical services. They work with fear of criminal sanctions, civil liability, or loss of their medical license if they unintentionally fail to comply with one of the many regulations governing every aspect of their medical practice. In addition to fear of legal liability, these regulations impose insurmountable economic barriers that force many reproductive health clinics to cease providing abortion services. Being forced to navigate a legal minefield in order to provide abortions, combined with the economic burden imposed by the regulations, deters many physicians from offering the service at all. This results in a provider shortage and, ultimately, diminished abortion access for women.

C. Criminal Penalties and other Severe Sanctions for Exercising the Right to Provide Medical Care

Laws that single out abortion providers regulate everything from the methods physicians use to perform abortions, to the physical plant requirements of their facilities, to staffing levels and qualifications. Failure to comply with these requirements can result in substantial criminal sanctions, civil penalties, or loss of medical licensure. In contrast, all other doctors, including those in the field of gynecology and obstetrics who do not perform abortions, are subject only to professional ethics codes and medical malpractice laws. For example, as a physician who provides abortion services in the state of Kansas, Dr. Tiller must comply with four laws that *do not apply* to other kinds of physicians. These laws include:

- A state ban on certain methods of abortion that carries a penalty of **imprisonment for non-compliance**. Kan. Stat. Ann. § 65-6721.
- A federal ban on certain methods of abortion that carries a penalty of **2 years imprisonment**. 18 U.S.C.A. § 1531 (2003).
- A Kansas law requiring that another financially and legally independent doctor verifies the first physician's independent judgment that a post-viability abortion is necessary. Failure to comply could result in **one year imprisonment, the loss of a medical license or fines**. Kan. Stat. Ann. § 65-6703(a).
- A biased counseling law that requires Dr. Tiller to provide patients medically unnecessary or inappropriate materials to patients 24 hours prior to receiving

an abortion. A violation could lead to **loss of a medical license or fines**.
Kan. Stat. Ann. §§ 65-6701; 65-6708-15.

In addition, 44 states and the District of Columbia impose regulations on abortion providers that do not apply to other medical professionals.⁷⁵ Known as **Targeted Restrictions on Abortion Providers (TRAP)**, these laws regulate where abortions can be performed and who can perform them. Generally, compliance is difficult and often impossible due to the complicated, detailed nature of the requirements and the great expense involved. Failure to comply with TRAP laws can carry criminal penalties, civil liability, or loss of licensure for physicians employed by the clinic. (The economic burden of TRAP laws on clinics is discussed in Part IV(D).)

Finally, the state of Louisiana has a particularly insidious law stating that physicians may be held strictly liable to a woman on whom an abortion is performed for any harm resulting to the pregnant woman *or the fetus*. This special statute replaces medical malpractice laws for physicians who perform abortions, thus making an abortion provider legally liable even if he or she complied with the appropriate standard of care.⁷⁶ Because an abortion causes harm to the fetus *by definition*, a doctor performing this procedure is left open to civil liability with every procedure he or she performs.

D. Insurmountable Economic Burdens on Reproductive Healthcare Providers

TRAP laws impose burdensome requirements on the facilities where healthcare professionals provide abortions that are far more stringent than regulations applied to facilities where comparable medical procedures are performed. TRAP laws are not medically necessary and have neither the purpose nor effect of improving the quality of abortion care. For example, a TRAP law in South Carolina requires that abortion facilities keep their outdoor shrubbery insect-free.⁷⁷ Moreover, the cost and burden of compliance with these regulations can be so high that some clinics may not be able to continue providing abortion services. A current TRAP law in Missouri would require such significant renovations to abortion facilities that three out of four of Missouri's clinics would be forced to shut down, cease providing abortions entirely, or undergo prohibitively expensive renovations.⁷⁸

E. Manipulation of Legal Mechanisms to Harass Reproductive Healthcare Providers

Navigating the legal minefield is difficult in itself for physicians, but public officials with political motivations can substantially heighten the risk. Zealous prosecutors have abused the power of their state office to investigate and prosecute physicians providing abortion services. For example, former Kansas Attorney General Phill Kline, who described himself as “unabashedly pro-life,”⁷⁹ initiated an aggressive multi-year inquisition of Dr. Tiller for the purpose of investigating whether he violated Kansas abortion law. Kline issued subpoenas for the private medical records of 90 of Dr. Tiller's patients and eventually charged him with 30 misdemeanor crimes based on their contents.⁸⁰ Kline's successor as Attorney General, Paul Morrison, convinced the Kansas

Supreme Court to drop the misdemeanor charges against Dr. Tiller because according to his office, the basis of the charges was “absolutely inaccurate and false”⁸¹ and “based on a political agenda.”⁸²

States also grant private citizens the power to trigger the minefield of legal liability for abortion providers. For instance, two anti-abortion extremist groups in Kansas used an 1887 state law to convene a “citizen grand jury” to investigate whether Dr. Tiller violated the state’s abortion laws, even though the state was conducting its own investigation of Dr. Tiller at the time.⁸³ Fortunately, the Kansas Supreme Court recently held that the citizen grand jury must take certain precautions to protect patient privacy when issuing subpoenas of medical records.⁸⁴ Despite these limits, the state has allowed the citizen grand jury to be turned into a mechanism for the harassment of physicians and an anti-abortion “political weapon.”⁸⁵

Increasingly, anti-abortion protesters are turning to the courts to try to harass providers and prevent local governments from protecting clinics. In Allentown, PA, clinic protestors have filed lawsuits against city government, city officials, police officers and police departments alleging violations of their free speech rights when these agents attempted to protect clinic employees from violent protestor activity. Jen Boulanger explains:

*In Allentown, there have been 2 lawsuits against the city so far, and one more pending. In the most recent lawsuit the protestors have sued me and the clinic as well. They use these lawsuits to “fish” for confidential information about the clinic for purposes of intimidation. They subpoena patient records, lease agreements, names of clinic staff and volunteers, email communications and correspondence, and surveillance videos that we have to fight to protect in court.*⁸⁶

The City of Allentown settled the lawsuit without consulting the Allentown Women’s Center. This action resulted in further harm to the clinic and its employees. According to Ms. Boulanger, “*within weeks following the settlement, [the protestors] began to reveal confidential and private information about clinic workers, including myself and the doctor. Our employees are frightened and some have quit because of it.*”⁸⁷

IV. Recommendations

The perseverance of healthcare professionals in providing women their constitutional right to an abortion—served in the face of great risks to their safety, reputation, and profession—deserves both great admiration and greater protection by the U.S. government. We urge the Special Rapporteurs to issue a joint statement that acknowledges the numerous threats to U.S. reproductive healthcare providers and recommends that the U.S. government ensure their rights through the following actions:

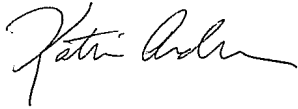
- Provide strong federal protection for reproductive freedom: The first step towards protecting healthcare professionals who provide abortions is to recognize their

role in providing women's fundamental right to reproductive freedom. Congress should pass federal legislation designed to protect women's reproductive rights regarding decisions about whether and when to become pregnant and whether to continue or terminate a pregnancy. This legislation should override federal and state laws that seek to rollback the constitutional right to an abortion established in *Roe v. Wade*. It should also repeal bans on abortion, other restrictions on access, and TRAP laws, which have no health-related purpose and impose severe penalties on providers for exercising their legal right to provide healthcare to women.

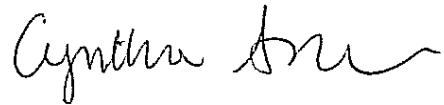
- Publicly recognize the role of reproductive healthcare providers as WHRDs: The U.S. government should recognize the special role of WHRDs, including reproductive healthcare providers who provide abortions, in ensuring reproductive rights as human rights. In addition, the government should implement national laws and guidelines that reflect international obligations to protect WHRDs.
- Stop impunity for those who attack, threaten and harass healthcare professionals: Develop and implement a national strategy to investigate, prosecute and punish those who commit human rights violations against reproductive healthcare providers. Renew the mandate and funding for the DOJ's Task Force on Violence Against Health Care Providers to encourage collaboration between law enforcement at all levels of government and to ensure sufficient resources for violence prevention. Urgently adopt measures to strengthen security for providers who are known to be most at risk.
- Improve institutional mechanisms for implementing human rights: Establish a national human rights commission or equivalent body with a mandate to implement measures and recommendations issued by the United Nations and the Inter-American Commission on Human Rights. The institution should have sufficient funding and other resources to carry out its mandate. It should incorporate a gender perspective into the design and implementation of its activities, including providing mechanisms for the meaningful participation of women's rights defenders.
- Repeal state laws that ban or restrict abortion or otherwise target reproductive health professionals: Encourage individual states to pass state-level laws to express strong support for reproductive rights as human rights and to protect the right of reproductive healthcare professionals to practice their profession without fear of sanctions. In addition, urge states to (1) repeal existing bans on abortion, TRAP laws, and other restrictions on abortion access that subject reproductive healthcare providers to extreme sanctions and economic burdens, and (2) prevent manipulation of state institutions and legal mechanisms to harass reproductive healthcare providers.

Thank you for your attention to this matter. Please do not hesitate to contact our office with any further questions or with requests for assistance.

Sincerely,



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Endnotes

¹ *Report Submitted by Ms. Hina Jilani, the Special Representative of the Secretary-General on Human Rights Defenders: Promotion and Protection of Human Rights Defenders*, 58th Sess., Provisional Agenda Item 17(b), ¶ 94, U.N. Doc. E/CN.4/2002/106 (2002) [hereinafter 2002 Report of the Special Representative].

² *Id.* ¶ 115.

³ *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, ¶ 96, U.N. Doc. A/CONF.177/20 (1995) [hereinafter *Beijing Declaration and Platform for Action*]; see also *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, ¶ 7.3 U.N. Doc. A/CONF.171/13/Rev.1 (1995) (recognizing that reproductive rights includes couples and individuals' "right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents") [hereinafter *ICPD Programme of Action*].

⁴ Committee on Economic, Social, and Cultural Rights (CESCR), *General Comment No. 14: the Right to the Highest Attainable Standard of Health (Art. 12)*, ¶ 8, U.N. Doc. E/C.12/2000/4 (July 4, 2000); Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 12, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; *ICPD Programme of Action*, Principle 8.

⁵ CEDAW, arts. 10(h), 16.1(e); *Beijing Declaration and Platform for Action*, ¶¶ 106(f), 107(e), 223; *ICPD Programme of Action*, Principle 8, ¶¶ 7.2, 7.45.

⁶ See *Roe v. Wade*, 410 U.S. 113 (1973).

⁷ Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, *adopted* Mar. 8, 1999, G.A. Res. 53/144, U.N. Doc. A/RES/53/144 (1999) [hereinafter Declaration on Human Rights Defenders].

⁸ 2002 Report of the Special Representative, *supra* note 1, ¶ 92 (explaining that "women's professional integrity and standing in society can be threatened and discredited in ways that are specific to them, such as the all too familiar pretextual calling into question of their probity when - for example - women assert their right to sexual and reproductive health, or to equality with men, including to a life free from discrimination and violence."); *Report of the Special Representative of the Secretary-General on Human Rights Defenders, Hina Jilani: Mission to Nigeria*, 62nd Sess., Provisional Agenda Item 17(b), ¶ 86, U.N. Doc. E/CN.4/2006/95/Add.2 (2006) (expressing concern that in Nigeria "[o]rganizations working on reproductive rights and health issues have been subjects of slander campaigns and attacks against them.").

⁹ See *Report Submitted by the Special Representative on Human Rights Defenders, Hina Jilani*, 4th Sess., Provisional Agenda Item 2, 2007, ¶¶ 70-72, U.N. Doc. A/HRC/4/37 (2007) (explaining that since the establishment of her mandate, the Special Representative has sent 36 communications to countries in all regions concerning the right to health and has raised issues ranging from threats to health providers treating civilians in the Occupied Territories to those assisting people living with HIV/AIDS in China); *Report Submitted by the Special Representative of the Secretary-General on the Situation of Human Rights Defenders, Hina Jilani*, 7th Sess., Agenda Item 3, ¶¶ 283-88, 1080-83, U.N. Doc. A/HRC/7/28/Add.1 (2008) (summarizing urgent appeals the Special Representative made to governments in 2008 regarding physicians who work with especially vulnerable populations, including people living with HIV/AIDS and access to healthcare for victims of sexual abuse); see also HUMAN RIGHTS FIRST, PROTECTING HUMAN RIGHTS DEFENDERS: A ANALYSIS OF THE NEWLY ADOPTED DECLARATION ON HUMAN RIGHTS DEFENDERS, Parts I and II(D), at http://www.humanrightsfirst.org/defenders/hrd_un_declare/hrd_declare_1.htm (last visited June 20, 2008) (noting that the Declaration recognizes physicians should also be considered human rights defenders because they play a crucial role in safeguarding the human rights of others).

¹⁰ *Report of the Special Rapporteur, Paul Hunt, on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 60th Sess., Provisional Agenda Item 10, ¶ 41, U.N. Doc. E/CN.4/2004/49 (2004) (describing the four components of the right to health, which necessarily includes the right to reproductive health).

¹¹ *Id.* ¶ 15.

¹² *Id.* ¶ 30.

¹³ *Report of Yakin Erturk, the Special Rapporteur on Violence Against Women, Its Causes and Consequences, on Intersections of Violence Against Women and HIV/AIDS*, 61st Sess., Provisional Agenda Item 12(a), ¶ 70, U.N. Doc. E/CN.4/2005/72 (2005).

¹⁴ *Id.* ¶ 83.

¹⁵ *Id.* ¶ 84(C).

¹⁶ Council of the European Union, *Ensuring Protection: European Guidelines on Human Rights Defenders* 3 (2004), available at <http://ue.eu.int/uedocs/cmsUpload/GuidelinesDefenders.pdf>.

¹⁷ Council of the European Union, *Draft Council conclusions on the first review of the implementation of the EU Guidelines on Human Rights Defenders*, Annex II at 7, 9, 14 (2006), available at http://www.ishr.ch/hrdo/documents/EvaluationEUGuidelines_EN.pdf.

¹⁸ Inter-American Commission on Human Rights, *Report on the Situation of Human Rights Defenders in the Americas*, OEA/Ser.L/V/II.124, Doc. 5, rev. 1, at 83 (2006).

¹⁹ 410 U.S. 113 (1973).

²⁰ Lawrence Finer & Stanley Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 6, 10 (2003) (showing there were 1,819 abortion providers in 2000, down 11% from 1996, and that the number of providers fell 14% between 1992 and 1996).

²¹ *Id.* at 10-11.

²² NAT'L ABORTION RIGHTS ACTION LEAGUE (NARAL) PRO-CHOICE AM. FOUND., CLINIC VIOLENCE AND INTIMIDATION 1-3 (2007), <http://www.prochoiceamerica.org/assets/files/Abortion-Access-to-Abortion-Violence.pdf>.

²³ Nat'l Abortion Fed'n (NAF), *History of Violence: Murders and Shootings*, http://www.prochoice.org/about_abortion/violence/murders.asp (last visited June 20, 2008).

²⁴ Seth Faison, *Abortion Doctor Wounded Outside Kansas Clinic*, N.Y. TIMES, Aug. 20, 1993.

²⁵ Stephanie Simon, *A Late Decision, a Lasting Anguish*, L.A. TIMES, May 31, 2005, at A1.

²⁶ Eric Harrison, *Local Groups take up Wichita Abortion Fight*, L.A. TIMES, Aug. 27, 1991, at A18.

²⁷ The federal government ordered temporary federal marshal protection for Dr. Tiller after he was shot, but not prior to the attempt. Interview with Dr. George Tiller in Wichita, Kan. (Apr. 9, 2008).

²⁸ MICHELLE WOOD ET AL., FEMINIST MAJORITY FOUND., 2005 NATIONAL CLINIC VIOLENCE SURVEY 9 (2006), http://feminist.org/research/cvsurveys/clinic_survey2005.pdf [hereinafter FMF Clinic Violence Survey].

²⁹ James Risen, *Anti-Abortion Zealot's Gun May Have Wounded Allies*, L.A. TIMES, Apr. 18, 1994, at A1; NAF, *Anti-Abortion Extremists, The Army Of God and Justifiable Homicide*, http://www.prochoice.org/about_abortion/violence/army_god.html (last visited June 19, 2008).

³⁰ FMF Clinic Violence Survey, *supra* note 28, at 9.

³¹ NARAL PRO-CHOICE AM. FOUND., CLINIC VIOLENCE AND INTIMIDATION, *supra* note 22, at 9; Lisa J. Adams, *Abortion Clinics Increase Security After Latest Outbreak of Violence*, ASSOC. PRESS, Jan. 4, 1995.

³² For example, Dr. Tiller spends over \$70,000 annually on security personnel and maintenance for the clinic's alarm system. Interview with Dr. Tiller, *supra* note 27; see also Lorraine Adams, *Abortion Doctor Thanked Clinton at Coffee*, WASH. POST., Apr. 1, 1997, at A4.

³³ Interview with Dr. Tiller, *supra* note 27.

³⁴ Finer & Henshaw, *supra* note 20, at 14.

³⁵ NARAL PRO-CHOICE AM. FOUND., CLINIC VIOLENCE AND INTIMIDATION, *supra* note 22, at 5.

³⁶ *Id.* at 3.

³⁷ Dan Frosch, *Albuquerque Has Renewal of Attacks on Abortion*, N.Y. TIMES, Dec. 28, 2007; NAF, *Member Security Alert*, Feb. 20, 2008 (on file with Ctr. for Reproductive Rts.).

³⁸ Maggie Shepard, *Albuquerque Abortion Clinic Fire Was Arson, Feds Say*, ALBUQUERQUE TRIB., Dec. 8, 2007.

³⁹ FMF Clinic Violence Survey, *supra* note 28, at 8.

⁴⁰ *Tiller's Abortion Clinic Vandalized* (KAKE 10 ABC television broadcast July 4, 2007), <http://www.kake.com/news/headlines/8324012.html> (last visited June 19, 2008).

⁴¹ Stephanie Simon, *Pressure Rises for Abortion Provider*, L.A. TIMES, Sept. 17, 2007.

⁴² Interview with Dr. Tiller, *supra* note 27.

⁴³ No one was ever prosecuted for the crime, and the case is now closed because the statute of limitations has run. NAF, *History of Violence: Arson and Bombings*, http://www.prochoice.org/about_abortion/violence/arsons.asp (last visited June 19, 2008).

⁴⁴ Sandy Banisky, *Abortion ‘Circuit Rider’ Accepts Risks; ‘Stubborn’ Doctor Defies Many Threats*, ST. LOUIS POST DISPATCH, Sept. 7, 1993, at B5.

⁴⁵ *Id.*; Pam Belluck, *After Abortion Victory, Doctor’s Troubles Persist*, N.Y. TIMES, Nov. 7, 2000, at A18.

⁴⁶ Diane Carman, *Top Court, Arapahoe Draw Line*, DENVER POST, June 29, 2000, at B1.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *See infra* Part II(A).

⁵⁰ Mary Jordan & Don Phillips, *Abortion Foe Arrested in Shooting; Wounded Doctor Returns to Clinic*, WASH. POST, Aug. 21, 1993, at A1.

⁵¹ *Id.*

⁵² PEG JOHNSTON, SOUTHERN TIER WOMEN’S SERVICE, OPTING OUT OF THE WAR (NAT’L COALITION OF ABORTION PROVIDERS, PROVIDER SPEAKERS SERIES) 3 (1998-2002), <http://www.ncap.com/images/PDFS/providerspeakjohnston.pdf>.

⁵³ Risen, *supra* note 29 (noting that Rachel Shannon commented to a policeman as she was being arrested, “Did I get him? If ever there was a justifiable homicide, this was it.”); NAF, *Anti-Abortion Extremists*, *supra* note 29; Gustav Niebuhr, *To Church’s Dismay, Priest Talks of ‘Justifiable Homicide’ of Abortion Doctors*, N.Y. TIMES, Aug. 24, 1994.

⁵⁴ Johnston, *supra* note 52, at 3; NARAL, CLINIC VIOLENCE AND INTIMIDATION *supra* note 22, at 7-8.

⁵⁵ Kimberley Sevcik, *One Man’s God Squad*, ROLLING STONE, July 28, 2004.

⁵⁶ *Id.*; Stephanie Simon, *Protestors Who Push the Limits*, L.A. TIMES, Feb. 17, 2004, at A1.

⁵⁷ NARAL, CLINIC VIOLENCE AND INTIMIDATION, *supra* note 22, at 8; Mary Sanchez, Editorial, *Abortion Debate Needs Reason*, KANSAS CITY STAR, Jan. 27, 2004, at B5.

⁵⁸ NARAL, CLINIC VIOLENCE AND INTIMIDATION, *supra* note 22, at 8-9; Sevcik, *supra* note 55.

⁵⁹ *See* Declaration on Human Rights Defenders, art. 9(5) (imposing a duty on the state to “conduct a prompt and impartial investigation or ensure that an inquiry takes place whenever there is reasonable ground to believe that a violation of human rights and fundamental freedoms has occurred in any territory under its jurisdiction); *id.* art 15 (imposing a duty on the state “to ensure that all those responsible for training ... law enforcement officers ... and public officials include appropriate elements of human rights teaching in their training programme.”).

⁶⁰ *Id.* arts. 9, 12, 14, 15.

⁶¹ 18 U.S.C. § 248 (1994). FACE makes it unlawful for a person to use force, threat of force, or physical obstruction to intentionally injure or intimidate a person because s/he is or has been obtaining or providing reproductive health services, or to intentionally damage or destroy the property of a facility because it provides reproductive health services. Punishment for a violation of the statute ranges from monetary fines for non-violent physical obstructions to criminal imprisonment for actions resulting in bodily injury.

⁶² *See* Dep’t of Justice, National Task Force on Violence Against Health Care Providers, <http://usdoj.gov/crt/crim/faceweb.htm> (last visited June 19, 2008) (explaining that conduct found illegal under FACE is limited to: physical attacks on clinic employees and escorts, attempted arson of facilities, blockages of clinic entrances, and threats of bodily harm communicated to providers or patients); *see also infra* Part I(A).

⁶³ NAF, INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. AND CANADA 1 (2008), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/violence_statistics.pdf.

⁶⁴ *See* Dep’t of Justice, *supra* note 62.

⁶⁵ Robert Pear, *Abortion Clinic Workers Say Law Is Being Ignored*, N.Y. TIMES, Sept. 23, 1994.

⁶⁶ Interview with Jen Boulanger (Allentown, Pennsylvania, USA) (Oct. 8, 2008).

⁶⁷ Interview with an abortion provider in the South (identity and specific location concealed for protection) (Mar. 10, 2008).

⁶⁸ NAF, FREEDOM OF ACCESS TO CLINIC ENTRANCES (FACE) ACT 4 (2006), http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/face_act.pdf.

⁶⁹ GUTTMACHER INST., STATE POLICIES IN BRIEF: PROTECTING ACCESS TO CLINICS 1 (2008), http://www.guttmacher.org/statecenter/spibs/spib_PAC.pdf.

⁷⁰ *Id.*

⁷¹ *Id.*; *see, e.g.*, COL. REV. STAT. § 18-9-122 (2008) (imposing a 100 foot buffer zone around the facility’s entrances); MASS. GEN. LAWS. ch. 266, § 120E 1/2 (2008) (restricting anyone who is not an employee,

patient, law enforcement officer, or passerby from coming within 35 feet of the entrance to a reproductive healthcare facility, or otherwise obstructing access to the entrances).

⁷² See, e.g., Municipal Code of City of Oakland, CA, Ch. 8.52 (2008) (creating a fixed buffer zone of 15 feet); New York City, N.Y., Code § 8-803 (2007) (making it a misdemeanor crime to physically obstruct or block a person from entering a reproductive health clinic, to follow or harass such a person in public, or to physically damage a clinic such that it disrupts its operation)

⁷³ Declaration on Human Rights Defenders, art. 11.

⁷⁴ 2002 Report of the Special Representative, *supra* note 1, ¶ 117.

⁷⁵ NARAL, Who Decides?, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/fast-facts/issues-trap.html (last visited June 20, 2008).

⁷⁶ LA. REV. STAT. ANN. § 9:2800.12 (2008).

⁷⁷ S.C. CODE ANN. REGS. 61-12 § 606 (2008).

⁷⁸ The law is currently enjoined by a federal court. *Planned Parenthood of KS v. Drummond*, No. 07-4164-CV-C-ODS, 2007 WL 2811407 (W.D. Mo. Sept. 24, 2007). However, in a separate case filed under state law by one clinic, a judge recently upheld the law's constitutionality. *Daily Women's Health Pol'y Rep., Mo. Judge Rejects PPKM Argument against State Law to Reclassify Abortion Clinics as Ambulatory Surgical Centers* (2008), at <http://www.nationalpartnership.org> (last visited June 20, 2008).

⁷⁹ Emily Friedman, *Could One Man Influence Abortion Law?*, ABC NEWS.COM, Oct. 22, 2007, <http://abcnews.go.com/TheLaw/Story?id=3752146&page=1> (quoting Kline's spokesman, Brian Burgess).

⁸⁰ Laura Bauer & Jim Sullinger, *Kline's Abortion Charges Derailed; a Judge Dismisses 30 Counts Filed by the Attorney General against a Wichita Doctor*, KAN. CITY STAR, Dec. 23, 2006, at A1.

⁸¹ Friedman, *supra* note 79 (quoting Morrison's spokeswoman, Ashley Anstaett).

⁸² Emily Bazelon, *Record Shopping*, SLATE, Apr. 8, 2008, <http://www.slate.com/id/2187961/>. The state of Kansas later filed 19 misdemeanor charges against Dr. Tiller on the grounds that he had failed to obtain a referral from a Kansas physician with whom he was not financially or legally affiliated in violation of KAN. STAT. ANN. § 65-6703(a) (2007). Dr. Tiller has moved to dismiss all the charges, which are still pending. No investigation, however, has ever found any wrongdoing as to his medical judgment or the basis on which he has complied with Kansas law governing the medical circumstances under which a late term abortion may be performed.

⁸³ The grand jury issued subpoenas seeking all records of women who consulted a physician at WHCS when her fetus was 22 weeks gestation or more from July 1, 2003 through Jan. 18, 2008, even if the women did not have an abortion.

⁸⁴ *Tiller v. Corrigan*, 182 P.3d 719 (Kan. 2008).

⁸⁵ Monica Davey, *Grand Juries Become Latest Abortion Battlefield*, N.Y. TIMES, June 17, 2008, at A1 (quoting a Republican state senator, "[the citizen grand jury] is being used in a political way to further a political cause, and that was never the purpose of the grand jury system in Kansas.>").

⁸⁶ Interview with Jen Boulanger, *supra* note 66.

⁸⁷ *Id.*