20YEARS CENTER FOR REPRODUCTIVE RIGHTS

May 23, 2012

To: Harold Koh, Legal Advisor
Michael Posner, Assistant Secretary of State for Democracy, Human Rights and Labor

Re: Comments Submitted by the Center for Reproductive Rights on the U.S. Government's Fourth Periodic Report to the Human Rights Committee

On December 30, 2011, the Obama Administration submitted the U.S. government's Fourth Periodic Report to the U.N. Human Rights Committee (HRC), the expert body charged with monitoring state compliance with the International Covenant on Civil and Political Rights (ICCPR). The Administration subsequently invited civil society to provide supplementary information, and correct any inaccuracies in the report, in preparation for the HRC review in 2013.[1] The Center for Reproductive Rights respectfully submits these comments to the United States government in response to this invitation. Our objective is to assist the federal government in providing the HRC with current and comprehensive information about the government's obligations to respect, protect, and fulfill reproductive rights under the ICCPR.

The first Part of these comments explains the government's reporting obligation to provide information about the status of reproductive rights – in policy and practice – under different articles of the ICCPR. The second Part provides an analysis of the treatment of reproductive rights in the Fourth Periodic Report. We identify four such issues deserving special scrutiny in this review process: (1) the use of restraints against pregnant women in detention; (2) federal and state laws allowing healthcare providers to refuse to provide care on the basis of religious objections; (3) discrimination against immigrant women in access to affordable reproductive healthcare; and (4) state laws mandating ideological physician speech in abortion provision.

I. The United States' Obligation to Report on Reproductive Rights under the ICCPR

International human rights instruments and expert monitoring bodies recognize that all women and men have reproductive and sexual rights. Reproductive rights are based on a number of fundamental human rights enumerated in the ICCPR and other core human rights treaties, including the rights to life, non-discrimination, equality, privacy, information, education, health, expression and opinion, freedom from violence, and freedom from torture and cruel treatment.[2]

[1] This invitation was issued by Harold Koh and Michael Posner during a consultation with members of civil society on January 10, 2012 and a subsequent email to participants of the convening on January 18, 2012.

[2] International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, arts. 2(1), 3, 6(1), 7, 17, 18, 19, 26, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976

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In general, when reporting on women's rights to equality and non-discrimination, States are required to submit information that reflects "the actual role of women in society," including "all legislative and other steps taken to eliminate stereotypes that discriminate against women and to put an end to discriminatory actions, both in the public and in the private sectors, which impair the equal enjoyment of rights by women and men."[3] The HRC has expressed concern that claims to tradition, religion and culture have often been used to justify violations to reproductive rights and urges states to provide appropriate information on such threats to women's equality.[4]

More specifically, the HRC has requested States parties to report on the status of reproductive rights with respect to specific articles of the Covenant. When reporting on articles 3 (equality between women and men) and 6 (right to life), States parties should give information on "birth rates and pregnancy and childbirth-related deaths of women," and "any measures taken by the state to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions."[5] State parties are also expected to provide information about reproductive rights violations amounting to torture or cruel, inhuman or degrading treatment under article 7.[6] The HRC also requests specific information about State efforts to address interferences with women's right to privacy in reproductive decision-making under article 17,[7] in recognition of the fact that "[an] area where States may fail to respect women's privacy relates to their reproductive functions."[8]

The Fourth Periodic Report is by far the most comprehensive report ever submitted by the U.S. government to a U.N. treaty body. With submission of this report and subsequent meetings with civil society, the Administration has signaled its intention to engage in a robust review process. The Center for Reproductive Rights commends the Administration for its efforts

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[hereinafter ICCPR]; International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, arts. 2, 5(e)(iv), U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969; 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, arts. 1, 2, 3, 10, 12, 14, 16(e), U.N. Doc. A/34/46 (1979), *entered into force* Sept. 3, 1981 [hereinafter CEDAW]; International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, arts. 2(2), 3, 12, 13, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976; K.L. v. Peru (1153/2003), para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); 13 IHRR 355 (2006). *See also* Int'l Conference on Population & Dev., Cairo, Egypt, Sept. 5-13, 1994, *Programme of Action*, Principle 8 and para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1994). *See accord* Fourth World Conference on Women, Beijing, China, Sept. 4-15, 1995, *Beijing Declaration and the Platform for Action*, paras. 94-97, U.N. Doc. A/CONF.177/20 (1995).

[3] Human Rights Comm., *Guidelines for the Treaty-specific Document to Be Submitted by States Parties under article 40 of the International Covenant on Civil and Political Rights*, para. 37, U.N. Doc. CCPR/C/2009/1 (Nov. 22, 2010) [hereinafter HRC, Guidelines on State Submissions].

[4] Human Rights Comm., *Gen. Comment No. 28, "Equality of rights between men and women,"* para. 5, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (29 March 2000) [hereinafter HRC, Gen. Comment No. 28].

[5] HRC, Gen. Comment No. 28, *supra* note 4, para. 10; HRC, Guidelines on State Submissions, *supra* note 3, para. 48.

[6] HRC, Gen. Comment No. 28, *supra* note 4, para. 11 (examples include access to safe abortion for victims of rape, female genital mutilation, forced abortion or forced sterilization); *see also* K.L. v. Peru, *supra* note 2.

[7] HRC, Gen. Comment No. 28, *supra* note 4, para. 20.

[8] *Id.*, para. 20.

to fulfill its human rights reporting obligations, yet expresses concern that an assessment of many fundamental reproductive rights, and acknowledgement of some of the barriers to their enjoyment, are largely absent from the report. These comments aim to help fill those gaps by summarizing key areas where U.S. policies and practices fall short of respecting, protecting and fulfilling reproductive rights under the ICCPR.

II. Analysis of the Fourth Periodic Report's Coverage of Reproductive Rights

This section identifies four issues of particular concern to the Center for Reproductive Rights. We address the extent to which each issue is covered in the Fourth Periodic Report and provide additional information where necessary. In each case, we discuss the ways that government action or inaction gives rise to specific violations of the ICCPR, including the rights to: non-discrimination (article 2); equality between men and women (article 3); life (article 6); freedom from torture and cruel, inhuman and degrading treatment (article 7); freedom of thought, conscience, religion and belief (article 18); freedom of expression and opinion (article 19); and equality before the law (article 26).

A. Use of Restraints on Pregnant Women in Detention

The widespread U.S. practice of shackling detained women during childbirth has been an area of critical concern for both the HRC and the U.N. Committee against Torture. Both treaty bodies condemned the practice in their 2006 Concluding Observations to the United States as a form of cruel, inhuman and degrading treatment and recommended that the U.S. prohibit the practice.[9] The U.N. General Assembly and three U.N. Special Procedures have added to the treaty bodies' concern on this issue, signifying clear international consensus that the U.S. practice of shackling pregnant women violates the right to be free from cruel, inhuman and degrading treatment.[10]

[9] Human Rights Comm., *Concluding Observations: United States of America*, para. 33, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (Dec. 18, 2006); Comm. against Torture, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006).

[10] Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Second Report to the Human Rights Council*, para. 41, U.N. Doc. A/HRC/7/3 (Jan. 15, 2008) (by Manfred Nowak) [hereinafter SR-Torture's Report to the HR Council (2008)] (recommending that "measures of physical restraint should be avoided during delivery"); Special Rapporteur on violence against women, its causes and consequences, *Report of the mission to the United States of America on the issue of violence against women in state and federal prisons*, paras. 54, 133, U.N. Doc. E/CN.4/1999/68/Add.2 (Jan. 4, 1999) (by Radhika Coomaraswamy) [hereinafter SR-VAW's Report on the U.S. Mission (1999)] (finding that the use of shackles on pregnant women during childbirth "violates international standards and may be said to constitute cruel and unusual practices"); Special Rapporteur on violence against women, its causes and consequences, *Report of the Mission to the United States of America*, Human Rights Council, para. 115, U.N. Doc. A/HRC/17/26/Add.5 (June 1, 2011) (by Rashida Manjoo) [hereinafter SR-VAW's Report on the U.S. Mission (2011)] (calling on the U.S. to "[a]dopt legislation banning the use of restraints on pregnant women, including during labor or delivery, unless there are overwhelming security concerns that cannot be handled by any other method"); *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*, Rule 24, U.N. Doc. A/C.3/65/L.5 (Oct. 6, 2010) (specifying that "Instruments of restraint shall never be used on women during labour, during birth and immediately after birth").

The Fourth Periodic Report is the first report the U.S. government has submitted to the HRC that addresses the issue of shackling pregnant women during childbirth.[11] Federal and state policies and practices are detailed in Section II regarding implementation of ICCPR provisions (paragraphs 231-33), as well as in Section III in response to the HRC's specific recommendations in its 2006 Concluding Observations (paragraph 676). The report's attention to this issue signals a growing understanding at all levels of government that the use of restraints on pregnant women is indeed a human rights concern. Noting the adoption of new federal policies and state prohibitions on the practice since the last periodic review, the report states that the various efforts to address the problem since 2006 "suggest[] a significant trend toward developing explicit policies banning or restricting the use of restraints on pregnant inmates and detainees at both the federal and state level."[12]

Indeed, the U.S. has made notable progress in raising federal and state policies to the level of international standards. The Fourth Periodic Report identified ten states that have passed legislation restricting the use of restraints on pregnant women in state facilities, but the Center for Reproductive Rights has identified 16 states with such legislation as of March 2012.[13] The 2008 Federal Bureau of Prisons policy and 2011 Immigration and Customs Enforcement (ICE) National Detention Standards now ban the use of restraints on pregnant women except in very narrow circumstances.[14] The Center applauds these significant developments and, in particular, the engagement of the Department of Justice and Department of Homeland Security with members of civil society in the process of developing standards that strengthen protections for vulnerable populations in detention.

1. Fourth Periodic Report Contains Gaps in Information Regarding Shackling

While the Fourth Periodic Report rightfully notes improvements in the policy sphere, it unfortunately omits critical information about the continued prevalence of shackling in practice. Enforcement of anti-shackling policies at the federal and state levels remains an area of critical concern. Neither the Bureau of Prisons policy nor the ICE Detention Standards are enforceable—they are internal policies subject only to self-policing, not binding regulations that provide for independent oversight and accountability for perpetrators. Similarly, the American Correctional

[11] Fourth Periodic Report of the United States of America to the United Nations Comm. on Human Rights Concerning the International Covenant on Civil and Political Rights, paras. 231-33, 676 (Dec. 30, 2011) [hereinafter Fourth Periodic Report of the USA], *available at* http://www.state.gov/j/drl/rls/179781.htm.

[12] Fourth Periodic Report of the USA, *supra* note 11, para. 233.

[13] *See id.*, para. 232. In 2011-2012, six more states passed anti-shackling legislation: Hawaii, Idaho, Nevada, Rhode Island, Florida and Arizona.

[14] BUREAU OF PRISONS, U.S. DEP'T OF JUSTICE, PROGRAM STATEMENT 5538.05: ESCORTED TRIPS, § 9, p. 10; IMMIGRATION & CUSTOMS ENFORCEMENT, U.S. DEP'T OF HOMELAND SEC., PERFORMANCE-BASED NAT'L DETENTION STANDARDS § 4.4 (2011) [hereinafter ICE 2011 Detention Standards], *available at* http://www.ice.gov/doclib/detention-standards/2011/pbnds2011.pdf (stating that "[r]estraints are never permitted on women who are in active labor or delivery" and that "[a] pregnant woman or women in post-delivery recuperation shall not be restrained absent truly extraordinary circumstances that render restraints absolutely necessary as documented by a supervisor or directed by the onsite medical authority"); *see also* Fourth Periodic Report of the USA, *supra* note 11, paras. 231, 676.

Association's new policy[15] restricting the use of restraints lacks any enforcement mechanism save withholding of accreditation to non-compliant state correctional facilities.

The government's report also fails to provide a contextual analysis about the over-incarceration of women of color. The number of incarcerated women has grown dramatically in recent years, increasing by over 150 percent from 1990–2009.[16] Black women and Hispanic women are incarcerated at a rate three times and 1.5 times higher, respectively, than white women.[17] One in 19 Black women, compared with one in 118 white women, has a chance of going to prison in her lifetime.[18]

Failure to address the root causes of over-incarceration of women of color—including endemic gender and race discrimination in the law enforcement process[19] and the failure to provide alternatives to incarceration for the 64 percent of women prisoners who committed non-violent crimes[20]—increases the vulnerability of women of color to human rights abuses in detention. As the CAT Committee has stated, the prevention and punishment of ill treatment of detained women, especially those belonging to racial and ethnic minorities, requires *positive* steps such as the "specific training for those working within the criminal justice system and raising awareness about the mechanisms and procedures provided for in national legislation on racism and discrimination."[21]

The over-incarceration of immigrant women similarly places this population at heightened risk of abuse in detention. The number of women in immigration detention has been increasing steadily since 2001 and as of 2009 accounts for ten percent of the detained population.[22] Women and their children are often detained in prison-like facilities that create inappropriate conditions for women and families.[23] In general, the over-incarceration of *non-*

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[15] *See* Fourth Periodic Report of the USA, *supra* note 11, paras. 232-33.

[16] Bureau of Just. Statistics, U.S. Dep't of Just., *Correctional Population in the United States, 2010* 8 (Dec. 13, 2011), *available at* http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2237.

[17] Bureau of Just. Statistics, U.S. Dep't of Just., *Prevalence of Imprisonment in the U.S. Population, 1974-2001* 1 (2003), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/piusp01.pdf.

[18] *Id*. at 8.

[19] *See, e.g.*, MICHELLE ALEXANDER, THE NEW JIM CROW (2010); Am. Civil Liberties Union et al., *Caught in the Net: The Impact of Drug Policies on Women and Families* (Mar. 15, 2005), *available at* http://www.aclu.org/drug-law-reform/caught-net-impact-drug-policies-women-and-families; The Sentencing Project, *Racial Disparity in Sentencing: A Review of the Literature* (Jan. 2005), *available at* http://www.sentencingproject.org/doc/publications/rd_sentencing_review.pdf.

[20] Bureau of Justice Stat., U.S. Dep't of Justice, *Prisoners in 2010* at 7 (2012).

[21] Comm. Against Torture, *List of Issues prior to the Submission of the Fifth Periodic Report of United States of America*, para. 41, U.N. Doc. CAT/C/USA/Q/5 (2010) [hereinafter CAT, List of Issues for the 5th Periodic Report of the USA].

[22] HUMAN RIGHTS WATCH, DETAINED AND DISMISSED: WOMEN'S STRUGGLES TO OBTAIN HEALTH CARE IN UNITED STATES IMMIGRATION DETENTION 11 (2009), *available at* http://www.hrw.org/sites/default/files/reports/wrd0309web_1.pdf.

[23] As of 2009, women detainees were housed in 150 jails, with only 38 women parents of minor children held in family residence facilities. DR. DORA SCHRIRO, IMMIGRATION & CUSTOMS ENFORCEMENT, DEP'T OF HOMELAND SEC., IMMIGRATION DETENTION OVERVIEW AND RECOMMENDATIONS 11 (Oct. 6, 2009). *See also id.* at 2-3 ("With

criminal immigrants is facilitated by the Administration's expansion of local-federal partnership programs to enforce immigration laws.[24] ICE has also been slow to up-scale pilot programs that offer alternatives to detention for non-violent criminals despite their low cost and proven success.[25] Nevertheless, there are signs of progress. In July 2011, the Director of ICE issued a memorandum urging the agency's employees to focus resources on pursuing non-citizens who posed a risk to public safety and national security rather than those with close ties to the United States.[26] ICE has also requested less money for detention and more resources for alternatives in its 2012 budget.[27] The Administration should ensure these changes are not merely cosmetic but rather genuine pathways to reforming the current detention model for immigrants, especially women and their children.

Finally, the Fourth Periodic Report provides virtually no attention to the lack of remedies for women in detention who are victims of human rights violations. The HRC has requested detailed information about "the practical availability, effect and implementation of remedies" under article 7 as part of the government's reporting obligation.[28] Human rights groups have documented numerous hurdles faced by those in both the criminal justice and immigration detention systems when seeking remedies. Grievance procedures in immigration detention facilities are inadequate and ineffective.[29] In the criminal justice system, the strict administrative

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only a few exceptions, the facilities that ICE uses to detain aliens were built, and operate, as jails and prisons to confine pre-trial and sentenced felons. ICE relies primarily on correctional incarceration standards designed for pre-trial felons and on correctional principles of care, custody, and control. These standards impose more restrictions and carry more costs than are necessary to effectively manage the majority of the detained population.").

[24] The federal-local partnership programs, including most notably Secure Communities, have come under heavy criticism for, among other reasons, targeting non-criminal immigrants in practice, if not design, and opening a wide door to racial profiling. For a summary of the main complaints levied against Secure Communities, *see* Michele Waslin, Immigration Pol'y Ctr., *The Secure Communities Program: Unanswered Questions and Continuing Concerns* (*updated* Nov. 2011), *available at* http://www.immigrationpolicy.org.

[25] *See* Special Rapporteur on the human rights of migrants, *Report to the Human Rights Council, Addendum: Mission to the United States of Am.*, para. 121, U.N. Doc. A/HRC/7/12/Add.2 (2008) (by Jorge Bustamonte).

[26] John Morton, U.S. Immigration & Customs Enforcement, *Exercising Prosecutorial Discretion Consistent with the Civil Immigration Enforcement Priorities of the Agency for the Apprehension, Detention, and Removal of Aliens* (June 17, 2011), *available at* http://www.ice.gov/doclib/secure-communities/pdf/prosecutorial-discretion-memo.pdf.

[27] Alfonso Serrano, *ICE Slow to Embrace Alternatives to Immigrant Detention*, NEW AM. MEDIA (Apr. 10, 2012), http://newamericamedia.org/2012/04/ice-slow-to-embrace-alternatives-to-immigrant-detention.php.

[28] HRC, Guidelines for State Submissions, *supra* note 3, para. 26 (stating the requirements for reporting under article 7). Specifically, States parties are required to provide answers to the question: "What kind of remedies, including the right to obtain compensation, is provided by national law for the victims of torture and ill treatment, as well as the procedure which complainants must follow. Information should be provided on specific cases in which compensation has been obtained during the reporting period, including details on the nature of the complaint and compensation granted." *Id*., para. 49.

[29] Some of the most pervasive problems in the grievance system include the fact that detainees must file a complaint internally rather than to an impartial external body, protections against staff reprisals are inadequate, translation services are scarce, and independent oversight of DHS/ICE facilities has been resisted. *See* HUMAN RIGHTS WATCH, DETAINED AND DISMISSED, *supra* note 22, at 40-42; PHYSICIANS FOR HUMAN RIGHTS, DUAL LOYALTIES: THE CHALLENGES OF PROVIDING PROFESSIONAL HEALTH CARE TO IMMIGRATION DETAINEES (2011), at 10-11. While the new 2011 ICE Detention Standards attempt to address some of these problems, the new procedures largely preserve the status quo and fail to address fundamental issues such as the lack of an external body to review grievances. *See* ICE 2011 Detention Standards, *supra* note 14, at 333-340.

exhaustion requirement of the 1996 Prison Litigation Reform Act[30] often prevents prisoners from filing lawsuits in court, forcing them to rely on weak internal grievance procedures. These procedures often prevent prisoners from pursuing complaints because of the short timeframe for filing, lack of confidentiality of the complaint mechanism, high burden of proof on the prisoner seeking redress, and lack of protection against retaliation by accused staff.[31] These administrative barriers, coupled with unreliable investigations of complaints, make prosecutions of offenders extremely rare.[32] As a result, a woman's right to a remedy under article 7 is often out of reach.

2. Shackling Pregnant Women During Childbirth Rises to the Level of Cruel, Inhuman and Degrading Treatment (article 7)

Although the Fourth Periodic Report gives a more comprehensive overview of federal and state policies addressing shackling than in prior reports, the report positions shackling as an issue arising under article 10 (conditions of detention). Human rights bodies and experts have clearly stated that shackling during childbirth gives rise to violations of the right to be free from cruel, inhuman or degrading treatment protected by ICCPR article 7 and CAT article 16.[33] As the Committee against Torture explained in General Comment No. 2, naming practices as torture or ill treatment is important for several reasons:

> Naming and defining [the crimes of torture and ill treatment] will promote the Convention's aim, *inter alia*, by alerting everyone, including perpetrators, victims, and the public, to the special gravity of the crime of torture. Codifying this crime will also (a) emphasize the need for appropriate punishment that takes into account the gravity of the offence, (b) strengthen the deterrent effect of the prohibition itself, (c) enhance the ability of responsible officials to track the specific crime of torture and (d) enable and empower the public to monitor and, when required, to challenge State action as well as State inaction that violates the Convention.[34]

One possible explanation for the failure to properly name shackling as a violation of article 7 is the reservation the U.S. government attached to article 7 at the time it ratified the

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[30] 18 U.S.C. § 3626 (1997).

[31] *See* UNIV. OF VIRGINIA, ED., VIOLENCE AGAINST WOMEN IN THE UNITED STATES AND THE STATE'S OBLIGATION TO PROTECT: CIVIL SOCIETY BRIEFING PAPERS ON COMMUNITY, MILITARY AND CUSTODY SUBMITTED TO THE U.N. SPECIAL RAPPORTEUR ON VIOLENCE AGAINST WOMEN, RASHIDA MANJOO IN ADVANCE OF HER MISSION TO THE UNITED STATES OF AMERICA 153-160 (2011), *available at* http://www.law.virginia.edu/vaw.

[32] *Id.* at 159.

[33] HRC, *Concluding Observations: USA*, *supra* note 9, para. 33 (analyzing the shackling of detained women during childbirth as a violation of articles 7 and 10); CAT, *Concluding Observations: USA*, *supra* note 9, para. 33 (analyzing shackling of women in childbirth as an article 16 violation); CAT, *List of Issues for the Fifth Periodic Report of the USA*, *supra* note 21, para. 33 (requesting information from the U.S. about "information on the impact and effectiveness of [state] measures in reducing cases of *ill-treatment* of detained women") (emphasis added); SR-VAW's Report on the U.S. Mission (1999), *supra* note 10, paras. 54, 133; SR-VAW's Report on the U.S. Mission (2011), *supra* note 10, para. 115; SR-Torture's Report to the HR Council (2008), *supra* note 10, para. 41.

[34] Comm. Against Torture, *Gen. Comment No. 2: Implementation of Article 2 by States Parties*, para. 11, U.N. Doc. CAT/C/GC/2 (Jan. 24, 2008).

ICCPR. Reservation No. 3 states: "… the United States considers itself bound by article 7 to the extent that 'cruel, inhuman or degrading treatment or punishment' means the cruel and unusual treatment or punishment prohibited by the Fifth, Eighth, and/or Fourteenth Amendments to the Constitution of the United States."[35] However, that reservation cannot justify this failure, especially in light of a federal circuit court decision declaring the practice inconsistent with the Eighth Amendment's protection against cruel and unusual punishment.[36]

B. Religious Refusal Laws Denying Women Reproductive Healthcare

An array of federal and state laws permit individual and institutional healthcare providers to refuse to provide medically necessary – and even life-saving – healthcare to women[37] based on professed religious convictions,[38] in violation of accepted norms of medical care.[39] These laws cover a broad range of critical health services, including abortion, contraception, and sterilization. The abortion-related religious refusal laws, which are nearly ubiquitous throughout the states, have been used not only to refuse to provide elective abortions, but also to refuse to provide medically indicated ectopic-pregnancy management and miscarriage management, in some cases leading to grievous injury.[40]

The refusal laws are particularly pernicious because they are not limited to individual healthcare providers (i.e., doctors and nurses), but instead extend to healthcare institutions (i.e., hospitals and clinics), including those that accept public funding.[41] Under the laws, a hospital corporation's management can impose the company's so-called conscience on employees who may disagree and upon unwitting patients. For example, at the federal level, the Church Amendment, enacted in 1973, prohibits the government from requiring individuals *or facilities* receiving public funds to provide abortion or sterilization services – even when the institution's

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[35] U.S. Reservations, Declarations, and Understandings, International Covenant on Civil and Political Rights, 138 CONG. REC. S4781-01 (daily ed., April 2, 1992).

[36] Nelson v. Corr. Med. Serv., 583 F.3d 522, 534 (8th Cir. 2009) (finding that shackling during labor and post-partum recovery, absent clear evidence of a security or flight risk, violates clearly established constitutional protections against cruel and unusual punishment).

[37] Although some of the religious-refusal laws permit refusals in the context of services used by men (such as sterilization), the laws overwhelmingly affect women's reproductive rights.

[38] Some laws also permit refusals based on non-religious, moral grounds. However, most of the laws in question focus on refusals based on religious qualms, and therefore the term "religious refusal laws" is used here.

[39] Nat'l Health Law Program, *Health Care Refusals: Undermining Quality Care for Women* (2010), *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.

[40] *See, e.g.*, Lori Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008); MergerWatch, *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States* (2002), *available at* http://www.mergerwatch.org/mergerwatch-publications.

[41] In addition, religious-refusal laws sometimes cover an extremely broad swath of individuals. For example, Mississippi law immunizes from civil, criminal, and administrative liability any healthcare provider (including a medical assistant, counselor, social worker, hospital employee, and any other "professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure") who declines to participate in any "health care service" that violates his or her conscience. The statute broadly defines "health care service" to include, *inter alia*, surgery, patient referrals, drug dispensing, research, counseling, and testing. MISS. CODE ANN. §§ 41-107-3, 41-107-5 (2011).

policy would deny life-saving abortions to patients.[42] Over the four decades since enactment of that law, federal lawmakers have expanded the scope of refusal laws to allow an increasingly wide range of healthcare professionals and institutional entities to refuse to provide needed, and even life-saving, healthcare services.[43] Most recently, the Affordable Care Act was enacted with a provision, Section 1303(b)(4), which prohibits health-care plans in the new state health insurance exchanges from discriminating against facilities or providers for unwillingness to provide, pay for, cover, or refer for abortions.[44]

The Administration has taken a balanced approach to upholding reproductive rights while taking into account the views of religious institutions. In early 2012, the Department of Health and Human Services issued a final rule requiring health insurance companies participating in the new state health insurance exchanges to cover a full range of contraceptive methods without a co-payment.[45] This decision represents a huge stride towards reducing unintended pregnancies in the U.S. and promoting healthier, planned childbirth, while granting an exemption to houses of worship that choose not to extend contraceptive coverage to their employees on religious grounds.[46] Facing opposition from some religious leaders that the rule does not go far enough in exempting *all* religiously affiliated institutions, such as schools and hospitals, President Obama revised the policy to allow objecting employers to opt out of paying for, and communicating about, contraception coverage. Instead, insurance companies will be required to offer the coverage directly to employees.[47] The workable and balanced approach gained the favor of both

[42] 42 U.S.C. § 300a-7. The Church Amendment was enacted as part of the Health Programs Extension Act of 1973, Pub. L. No. 93-94. it applies to individuals or entities that receive federal funds under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act. The Church Amendment also prohibits entities receiving federal funds from discriminating against doctors or other medical personnel who perform or refuse to perform abortion or sterilization procedures on moral or religious grounds. This prohibition applies to entities receiving federal funds under the above named statutes or under a biomedical or behavioral research program administered by the Department of Health and Human Services. Jody Feder, Cong. Research Serv., RS21428, *The History and Effect of Abortion Conscience Clause Laws* 2 (2005).

[43] The Coats Amendment, 42 U.S.C. § 238n, allows doctors, medical students, and health training programs to refuse to provide or participate in abortion training, abortion services, or referrals. The law explicitly provides that training programs are considered accredited by the government even if they fail to comply with abortion training requirements. This protection differs from traditional conscience laws because a refusal does not need to be based on moral or religious grounds. In the Balanced Budget Act of 1997, Congress extended conscience protection beyond healthcare providers, allowing managed care plans operating under the federal Medicaid and Medicare programs to opt-out of providing, reimbursing for, or covering a counseling or referral service to which the plan objects on moral or religious grounds. 42 U.S.C. § 1395w-22(j)(3)(B)(Medicare); 42 U.S.C. § 1396u-2(b)(3)(B)(Medicaid). The Weldon Amendment protects a broad range of healthcare entities from discrimination for refusal to provide, pay for, cover, or refer for abortions. *See* Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat. 786.

[44] *See* U.S. Dept. of Health & Human Servs., *Overview of Federal Statutory Health Care Provider Conscience Protections, at* http://www.hhs.gov/ocr/civilrights/faq/providerconsciencefaq.html.

[45] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 31, 8725 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147).

[46] For more information and analysis of the contraception rule, see Ctr. for Reprod. Rights, *The Contraception Controversy: A Comprehensive Reply* (Apr. 2012), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Contraception_Controversy_041012.PDF.

[47] Press release, The White House, Women's Preventive Services and Religious Institutions (Feb. 10, 2012), *available at* http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions.

religious institutions and reproductive rights advocates and is widely supported by the American public. Nevertheless, the debate remains live as opponents of reproductive rights seek to carve out ever larger exemptions for religious institutions in the ACA and other federal laws. For example, soon after the revised policy was announced the Senate narrowly defeated a proposed amendment to the ACA that would have allowed *any* insurer or employer not to cover *any* medical service required by the ACA based on the religious or moral objections of the insurer, employer, or any individual employee.[48]

Nearly all states recognize a healthcare institution or corporation's "conscience." A recent study by the Guttmacher Institute found that 46 of the 50 states have laws exempting unwilling individual providers from offering abortion services (even life-saving abortions), and that the laws in 44 of those 46 states extend conscience protections to healthcare institutions and corporations.[49] Worse still, this state and federal patchwork of refusal clauses is almost wholly unregulated. There are few, if any, statutory or regulatory procedures in place to ensure that individuals or institutions that intend to refuse to provide certain medically indicated healthcare services notify patients, arrange a referral, and, in the case of an emergency, provide the medical service in question.[50]

The Fourth Periodic Report is silent on the far-reaching impact of religious refusal laws on women's reproductive rights. These federal and state religious refusal laws discriminate against women, jeopardize their lives, and violate the most basic ethical standards of informed consent, in violation of ICCPR articles 2, 3, 6 and 26. In addition, the vast majority of the laws (with the exception of the Church Amendment, Section C) only serve to protect medical providers who claim a conscientious basis to *refuse* services; they provide no protection for medical providers who claim a conscientious commitment to *provide* services, in violation of article 18's protection of freedom of thought, conscience and belief.

1. Religious Refusal Laws Discriminate Against Women (Articles 2, 3, and 26)

The federal and state religious refusal laws target health services that are either used exclusively by women (such as abortion) or predominantly used by women (such as contraception and sterilization). The CEDAW Committee has explicitly stated that religious refusal laws that disproportionately affect women are discriminatory:

> It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For example, if health service providers refuse to perform such services based on conscientious

[48] *See* Robert Pear, *Senate Rejects Step Targeting Coverage of Contraception*, N.Y. TIMES, Mar. 1, 2012, at A1.

[49] *See* Guttmacher Inst., *State Policies in Brief: Refusing to Provide Health Services* (Apr. 1, 2012), *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

[50] Jill Morrison & Micole Allekotte, *Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious, or Ethical Reasons*, 9 AVE MARIA L. REV. 141, 174-75 (2010), *available at* http://www.nwlc.org/sites/default/files/pdfs/amlr_v9i1_morrison_final.pdf.

objection, measures should be introduced to ensure that women are referred to alternative health providers.[51]

The HRC similarly framed religious refusal laws as presumptive violations of the ICCPR's sex-discrimination provisions (articles 2, 3 and 26) in the context of the Committee's 2006 review of the United States.[52] At that time, the Committee asked the United States about what impact "state[] and federal legislation authorizing healthcare providers to refuse contraception, sterilization or other reproductive health services on the basis of moral disapproval" has on the rights of women under articles 2, 3, and 26.[53] The United States maintained that the religious refusal laws did not adversely affect the rights of women.[54] As explained below, not only do religious refusal laws affect the rights of women, they jeopardize women's lives.

The fact that religious refusal laws might seem to comport with article 18's protection of freedom of thought, conscience, and religion is of no consequence, because, as the HRC explained, "article 18 may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion."[55]

2. Religious Refusal Laws Jeopardize Women's Lives (Article 6)

Federal and state religious refusal laws jeopardize women's lives because they permit individual and institutional healthcare providers to withhold potentially life-saving care. A peer-reviewed article in the *American Journal of Public Health* documented numerous instances in which Catholic-affiliated hospitals invoked religious concerns about protecting the fetus to withhold medical care from women suffering potentially fatal miscarriages.[56] For example, one instance involved a woman whose pregnancy was located in her vagina, rather than her uterus, and therefore could not possibly progress to viability. Rather than evacuating the pregnancy, the hospital authorities demanded that she be moved to a tertiary medical center so as to "save" the irretrievably lost pregnancy. The woman became septic, suffered a 106-degree fever, and

[51] Comm. on Elimination of Discrimination against Women, *Gen. Recommendation No. 24: Women and Health*, U.N. Doc. A/54/38 at 5 (1999), *reprinted in Compilation of Gen. Comments and Gen. Recommendations Adopted by Human Rights Treaty Bodies*, para. 11, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

[52] Human Rights Comm., *List of Issues to Be Taken Up in Connection with the Consideration of the Second and Third Periodic Reports of the United States of America* (2006) [hereinafter HRC List of Issues (2006)], para. 18, *available at* http://www2.ohchr.org/english/bodies/hrc/docs/AdvanceDocs/USA-writtenreplies.pdf.

[53] It also inquired about the impact of religious-refusal laws on women's right to life under article 6; that issue is examined *infra*.

[54] Written Reply of the U.S. Government to the *List of Issues to Be Taken Up in Connection with the Consideration of the Second and Third Periodic Reports of the United States of America* 51-52 (2006), *available at* http://www2.ohchr.org/english/bodies/hrc/docs/AdvanceDocs/USA-writtenreplies.pdf.

[55] HRC, Gen. Comment 28, *supra* note 4, para. 21.

[56] Lori Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008).

suffered disseminated intravascular coagulopathy so dire that her eyes filled with blood.[57] According to the doctor, she spent 10 days in the intensive care unit and "very nearly died."[58]

Not surprisingly, the HRC has consistently framed religious refusal laws as presumptive violations of the right to life guaranteed by article 6. In 2006, when the Committee inquired about religious refusal laws in the United States, it did so with reference both to sex discrimination (as noted above) and the right to life.[59] Similarly, during its 2004 review of Poland, the HRC's Concluding Observations expressed the Committee's concerns about "the lack of information on the use of the conscientious objection clause by medical practitioners who refuse to carry out legal abortions" as a potential violation of article 6.[60] In its subsequent review of Poland in 2010, the HRC went a step further, and called upon that government to "introduce regulations to prohibit the improper use and performance of the 'conscience clause' by the medical profession" so as not to violate article 6.[61]

3. Religious Refusal Laws Violate the Religious and Conscience Rights of Medical Providers and Patients (Article 18)

Federal and state religious refusal laws are often justified by reference to the importance of protecting individuals' consciences. But these laws (with the notable exception of the Church Amendment, Section C) *only* protect the religious or conscientious beliefs of medical providers who do *not* wish to provide services (and of patients who do not wish to receive them). They do nothing to protect medical providers who are religiously or conscientiously driven to provide a full range of reproductive health services but who are employed by institutions that oppose them. Nor do they protect patients whose religious or conscientious beliefs permit them to receive the full range of medically appropriate reproductive health services. The HRC has emphasized that laws designed to protect particular religious or conscientious beliefs may not harm dissenting individuals:

> If a set of beliefs is treated as official ideology in…statutes…etc., or in actual practice, this shall not result in any impairment of the freedoms under article 18 or any other rights recognized under the [ICCPR] nor in any discrimination against persons who do not accept the official ideology or who oppose it.[62]

This concern about dissenting physicians is hardly speculative: "One in five physicians (nineteen percent) who reported providing care to patients in a religiously affiliated hospital had experienced a conflict with the institution's religiously based patient care policies."[63] Finally,

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[57] *Id.*

[58] *Id.* at 1777.

[59] HRC List of Issues (2006), *supra* note 52, at 51-53.

[60] Human Rights Comm., *Concluding Observations* (Poland), para. 8, U.N. Doc. CCPR/CO/82/POL (2004).

[61] Human Rights Comm., *Concluding Observations* (Poland), para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).

[62] Human Rights Comm., *Gen. Comment 22 on the Right to Freedom of Thought, Conscience and Religion*, para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.4 (1993) [hereinafter HRC, Gen. Comment 22].

[63] Steph Sterling & Jessica L. Waters, *Beyond Religious Refusals: The Case for Protecting Health Care Workers' Provision of Abortion Care*, 34 HARV. J. L. & GENDER 463, 470 (2011).

one-sided religious refusal laws allow an institutional or individual healthcare provider's religious or conscientious beliefs to trump those of the patient, also violating article 18. The HRC has made clear that laws imposing or restricting the freedom to manifest religion or belief "may not be imposed for discriminatory purposes or applied in a discriminatory manner."[64]

C. Discrimination against Immigrant Women in Access to Affordable Reproductive Healthcare

People of color in the United States have significantly poorer health outcomes than the majority white population. Persistent disparities in sexual and reproductive health – in maternal and infant mortality, unintended pregnancy, and sexually transmitted infections, to name a few key indicators[65] – explain why health outcomes in the U.S. lag far behind other countries with comparable health systems. Black and Latina women are disproportionately affected by HIV infection compared to white women, with 1 in 32 Black women and 1 in 106 Hispanic/Latina women diagnosed with HIV at some point in her life, compared to 1 in 526 white women.[66] Vietnamese-American women, who are five times more likely to have cervical cancer than white women, are also among the least likely to be screened for the disease or understand the purpose of pap tests.[67]

As of 2010, there were 21.4 million non-citizen immigrants in the United States, and according to the Pew Hispanic Center an estimated 11.2 million of these – or 3.7 percent of the U.S. adult population – were undocumented.[68] Non-citizens are three times as likely as U.S.-born citizens to be uninsured due to lower rates of coverage by both private and public insurance.[69] This is due to the fact that this population has a higher percentage of workers in low-wage jobs that do not offer employer-based insurance, and it faces numerous restrictions to eligibility for public insurance.[70] Because women of reproductive age are more likely to be uninsured than other segments of the population, immigrant women face particularly high barriers to affordable

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[64] HRC, Gen. Comment 22, *supra* note 62, para. 8.

[65] *See* Ctr. for Reprod. Rights, *Supplementary Information about the United States Scheduled for Review during the CERD Comm.'s 72nd Session* (Dec. 19, 2007), *available at* http://reproductiverights.org/sites/default/files/documents/CERD%20Shadow%20Letter%20Final_07_08.pdf.

[66] Ctrs. for Disease Control, *HIV among Women* (August 2011), *available at* http://www.cdc.gov/hiv/topics/women/pdf/women.pdf.

[67] Asian & Pacific Islander Am. Health Forum, *Vietnamese in the United States* (Aug. 2006), *available at* http://www.apiahf.org/sites/default/files/APIAHF_Healthbrief08h_2006.pdf.

[68] Jeffrey S. Passel & D'Vera Cohn, Pew Hispanic Ctr., *Unauthorized Immigrant Population: Nat'l and State Trends, 2010* 1 (Feb. 1, 2011), *available at* http://www.pewhispanic.org/files/reports/133.pdf.

[69] Forty-seven percent of non-citizens are uninsured compared to 16% of U.S.-born citizens and 24% of naturalized citizens. (The "non-citizen" population comprises those who are legal permanent residents as well as those "lawfully present" in the U.S. who are on the pathway to citizenship or are otherwise granted residency, such as refugees, asylees, and student visa holders). Kaiser Comm'n on Medicaid & the Uninsured, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under Health Reform* 2 (Feb. 2012) [hereinafter Kaiser Comm'n, Key Facts], *available at* http://www.kff.org/uninsured/upload/8279.pdf.

[70] *Id.*, at 1.

healthcare.[71] A large body of research confirms that the lower insurance coverage rate of non-citizens leads to poorer access to healthcare and explains why non-citizens receive less healthcare than citizens.[72]

Since 1996, federal policy has barred many immigrants from access to healthcare and other essential public benefits.[73] In particular, the law bars immigrants who are lawfully present in the U.S. from eligibility for Medicaid until they have resided in the country for five years and satisfied other eligibility requirements.[74] In 2002, the Department of Health and Human Services revised the definition of "child" in the Children's Health Insurance Program (CHIP) to allow states the option to cover an "unborn child."[75] This allowed states to extend Medicaid coverage to pregnant women regardless of immigration status, as long as the medical attention was directly related to pregnancy care. However, as of January 2012, only 14 states opted to accept matching funds to cover this group.[76]

In 2009 Congress reauthorized CHIP and amended the program to "make it easier for certain groups to access healthcare under the program, including … uninsured low-income pregnant women."[77] The new policy allows states to cover children and pregnant women residing legally in the U.S. who meet Medicaid or CHIP income eligibility requirements, regardless of the length of time they have held legal status.[78] As with the "unborn child" exception, few states – 18 as of January 2012 – have opted to cover lawfully present pregnant women who would otherwise be barred due to the five-year ban.[79] In the majority of states, however, many lawfully present immigrants – including pregnant women – remain without health insurance, and consequently without healthcare access.

1. The Affordable Care Act Discriminates Against Lawfully Present Immigrants

The Fourth Periodic Report highlights the Administration's efforts to promote equity in healthcare access and outcomes, primarily through the Affordable Care Act (ACA) enacted in

[71] Guttmacher Institute, *A Real-Time Look at the Impact of the Recession on Publicly Funded Family Planning Centers* 3 (2009), *available at* http://www.guttmacher.org/pubs/RecessionFPC.pdf.

[72] Kaiser Comm'n on Medicaid & the Uninsured, *Summary: Five Basic Facts on Immigrants and Their Health Care* 7 (Mar. 2008), *available at* http://www.kff.org/medicaid/upload/7761.pdf.

[73] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) barred undocumented immigrants, as well as immigrants with legal residence who had resided in the U.S. for under five years, from eligibility for "means tested" public benefits, including Medicaid. 8 U.S.C. §§ 1611 et seq. (1996).

[74] 8 U.S.C. § 1613.

[75] 67 Fed. Reg. 61955, 61974 (Oct. 2, 2002), revising 42 C.F.R. § 457.10.

[76] Kaiser Comm'n, Key Facts, *supra* note 69, at 3.

[77] Fourth Periodic Report of the U.S.A., *supra* note 11, para. 437.

[78] For more information about the change in policy and particular benefits to lawfully present immigrant women, see CTR. FOR CHILDREN & FAMILIES, THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009: OVERVIEW AND SUMMARY (March 2009), *available at* http://ccf.georgetown.edu/index/chip-law.

[79] Kaiser Comm'n, Key Facts, *supra* note 69, at 3.

March 2010.[80] This landmark reform legislation aims to make health insurance more affordable by extending health insurance coverage to 32 of the 50 million currently uninsured Americans.[81] The legislation will do this by allowing individuals to purchase affordable health insurance through new health insurance exchanges and expanding Medicaid to cover individuals with incomes up to 133 percent of the federal poverty level. Tax credits will be available to those with incomes up to 400 percent of the poverty level to offset costs of purchasing insurance. These provisions will help many low-income individuals secure health insurance.

Though providing very important steps towards ensuring access to healthcare for many Americans and people of color, the ACA also perpetuates harmful eligibility exclusions that will prevent many low-income immigrants from obtaining health insurance.[82] Under the Act, undocumented immigrants will remain ineligible for Medicaid and will not be permitted to apply for tax credits to offset the high cost of private insurance. They will also be prohibited from purchasing insurance on the health insurance exchanges with their own money. Some lower income lawfully present immigrants will be eligible for tax credits to offset the costs of purchasing health insurance during the five years they must wait before becoming eligible for Medicaid. But the vast majority of immigrants lawfully present in the U.S. will remain barred from Medicaid eligibility for five years and will not be able to afford private insurance. Estimates show that almost all uninsured non-citizens meet income eligibility for Medicaid or tax credits for exchange coverage but many will be unable to access these benefits due to the ACA's restrictions.[83]

Safety net programs designed to serve those without other sources of healthcare are insufficient to address the problem. For example, funding for the Title X family planning program (cited in the Fourth Periodic Report at paragraph 442) has steadily eroded despite the program's early and proven success in providing family planning supplies and services to low-income people.[84] As more and more immigrants turn to Title X programs for their healthcare, the program faces increased difficulty keeping up with increased demand for its free or low-cost contraceptive care.[85] The combined effect of excluding immigrants from the ACA and under-

[80] *See* Fourth Periodic Report of the U.S.A., *supra* note 11, para. 434.

[81] Kaiser Comm'n, Key Facts, *supra* note 69; Cong. Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* 3 (Mar. 2012), *available at* http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[82] 42 U.S.C. § 18081 (2011) ("Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions").

[83] Kaiser Comm'n, Key Facts, *supra* note 69, at 4.

[84] Title X serves over five million people annually – 92% of whom are women – in more than 4500 clinics nationwide, helping to prevent 973,000 unintended pregnancies and saving the government billions of dollars a year. RACHEL GOLD ET AL., NEXT STEPS FOR AMERICA'S FAMILY PLANNING PROGRAM: LEVERAGING THE POTENTIAL OF MEDICAID AND TITLE X IN AN EVOLVING HEALTH CARE SYSTEM 4 (2009), available at http://www.guttmacher.org/pubs/NextSteps.pdf. Unfortunately, the program is now funded at a rate 62% lower in constant dollars than 30 years ago. Claire Coleman & Kirtly Parker Jones, *Title X: A Proud Past, an Uncertain Future*, 84 CONTRACEPTION 209-211 (2011).

[85] Title X clinics have seen an 18% increase in the number of users of services between 1999 and 2010. The number of users identifying as Hispanic or Latino increased by 93%, and the number of users with limited English proficiency increased 25%. Guttmacher Inst., *A real-time look at the impact of the recession on publicly funded*

funding safety net programs will leave many immigrants with extremely limited options for affordable healthcare.

2. Eligibility Barriers Based on Immigration Status Violate Rights to Non-Discrimination and Equality (Articles 2, 3, 26)

The HRC has specifically requested information in State reports on how nationality impacts one's ability to enjoy rights without discrimination,[86] both in law and in practice.[87] Article 2 of the ICCPR obligates governments to extend the rights contained in the Covenant not only to its citizens, but to "*all* individuals within its territory and subject to its jurisdiction," and to do so "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[88] The HRC has interpreted "other status" to include immigration status and urged states to eliminate differential treatment of non-citizens in the exercise of their rights under the Covenant.[89] This includes eliminating distinctions in access to social services on the basis of immigration status[90] and ensuring through legislation and other measures that non-citizens have access to benefits.[91]

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family planning centers, supra note 71, at 4; RTI International, *Family Planning Annual Report*, at 8 (Sept. 2011), *available at* http://www.hhs.gov/opa/pdfs/fpar-2010-national-summary.pdf.

[86] HRC, Guidelines on State Submissions, *supra* note 3, para. 36.

[87] Human Rights Comm., *Gen. Comment No. 15: The position of aliens under the Covenant* (1986), *in Compilation of Gen. Comments and Gen. Recommendations Adopted by Human Rights Treaty Bodies*, para. 4, U.N. Doc. HRI/GEN/1/Rev.6 at 140 (2003).

[88] ICCPR, article 2(1) (emphasis added).

[89] *See* Human Rights Comm., *Concluding Observations on the Syrian Arab Republic*, para.19, U.N. Doc. CCPR/CO/84/SYR (2005) (urging the State party to protect and promote the rights of its non-citizen Kurdish minority); Human Rights Comm., *Concluding Observations on Azerbaijan*, para. 20, U.N. Doc. CCPR/CO/73/AZE (2001) (expressing concern that the Constitution only provided the right to legal representation to citizens).

[90] Human Rights Comm., *Concluding Observations on Korea*, para.12, U.N. Doc. CCPR/C/KOR/CO/3 (2006) (recommending "[t]he State party should ensure to migrant workers enjoyment of the rights contained in the covenant without discrimination," and "[i]n this regard, particular attention should be paid to ensuring equal access to social services and educational facilities"); Human Rights Comm., *Concluding Observations on Latvia*, para.18, U.N. Doc. CCPR/CO/79/LVA (expressing concern "over the perpetuation of a situation of exclusion, resulting in lack of effective enjoyment of many Covenant rights by the non-citizen segment of the population, including . . . social benefits" and recommending the State party to "limit the number of . . . restrictions on non-citizens in order to facilitate the participation of non-citizens in public life in Latvia."); Human Rights Comm., *Concluding Observations on Thailand*, para.23, U.N. Doc. CCPR/CO/84/THA (2005) (noting serious concern with "the lack of full protection of the rights of registered and unregistered migrant workers . . . , particularly with regard to . . . access to social services and education" and recommending that "[m]igrant workers should be afforded full and effective access to social services, educational facilities, and personal documents in accordance with principles of non-discrimination").

[91] *See* Human Rights Comm., *Concluding Observations on Korea*, *supra* note 90, para. 12 (recommending that Korea ensure "equal access to social services" because the HRC received information that immigrants faced numerous non-legal barriers in accessing healthcare, despite a 2003 law granting them the legal right to access the national healthcare system on an equal basis of citizens).

The definition of discrimination under the ICCPR includes laws, policies and practices that discriminate *in effect* as well as on their face.[92] In its last review of the U.S., the U.N. Committee on the Elimination of Racial Discrimination (CERD) found that persistent disparities in reproductive health constitute both gender and racial discrimination in access to healthcare prohibited under the Race Convention.[93] CERD recommended that the U.S. government take steps to eliminate obstacles that women of color face when trying to access healthcare, including the lack of health insurance and affordable healthcare. One recommendation to eliminate disparities in reproductive health was to reduce eligibility barriers for Medicaid.[94] Although the ACA reduces eligibility barriers for low-income people as a whole, the exclusion of many immigrants from the ACA will do nothing to address health disparities for a large proportion of women of color who lack U.S. citizenship or permanent residence. The ACA's eligibility exclusions violate immigrant women's rights to non-discrimination and equality as protected by ICCPR articles 2, 3 and 26.

3. Eligibility Barriers Based on Immigration Status Violate Right to Life (Article 6)

The eligibility exclusions will disproportionately impact immigrant women by limiting their access to reproductive health goods and services.[95] On numerous occasions the HRC has linked restrictions on access to reproductive health, especially lack of access to contraception information and family planning services, to women's reliance on unsafe abortion and high rates of maternal mortality that violate the right to life under article 6.[96] The HRC has also found that barriers to women's healthcare, such as the high cost of contraception, interfere with article 3's right to equal enjoyment of human rights.[97] The ACA's exclusion of many immigrant women from eligibility for government health insurance *and* the option to purchase private insurance leaves immigrant women without adequate options for affordable health care. Consequently, the ACA denies immigrant women access to essential reproductive health services like pregnancy-related care, screenings for reproductive health cancers and contraception in violation of article 6.

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[92] Human Rights Comm., *Gen. Comment No. 18: Non-discrimination* (1989), *in* COMPILATION OF GENERAL COMMENTS AND GENERAL RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, para. 7, U.N. Doc. HRI/GEN/1/Rev.1 at 26 (1994).

[93] Comm. on the Elimination of Racial Discrimination (CERD), *Concluding Observations: United States of Am.*, paras. 32-33, U.N. Doc. CERD/C/USA/CO/6 (2008).

[94] CERD Concluding Observations: U.S.A., *supra* note 93, para. 33.

[95] For more information about the impact of the ACA's eligibility exclusions on immigrant women's access to care, see Nat'l Coalition for Immigrant Women's Rights, *Policy Materials: Health Care Access and Reform, at* http://nciwr.wordpress.com/position-statements/#HCAR.

[96] *See, e.g.*, Human Rights Comm., *Concluding Observations: Cameroon*, para 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); Human Rights Comm., *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010); Human Rights Comm., *Concluding Observations: Mongolia*, para. 20, U.N. Doc. CCPR/C/MNG/CO/5/2011. *See also* Human Right Comm., *Gen. Comment No. 6: The Right to Life* (1982), *in Compilation of Gen. Comments and Gen. Recommendations Adopted by Human Rights Treaty Bodies*, paras. 1, 5, U.N. Doc. HRI\GEN\1\Rev.1 at 6 (1994) (noting the right to life should not be interpreted narrowly and includes reproductive health services).

[97] Human Rights Comm., *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); Human Rights Comm., *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000), para. 14; Human Rights Comm., *Concluding Observations: Georgia*, para. 12, U.N. Doc. CCPR/C/79/Add.75 (1997); Human Rights Comm., *Concluding Observations: Poland*, para. 11, U.N. Doc. CPR/C/79/Add.110 (1999).

D. State Restrictions on Abortion and Freedom of Expression

A striking omission from the Fourth Periodic Report is information regarding the profound impact of state laws and policies interfering with women's exercise of their reproductive rights. Human rights bodies have recognized that where abortion is legal, women must have meaningful access to the procedure.[98] Since 1973, when the Supreme Court recognized that women have a constitutional right to terminate their pregnancies,[99] opponents of abortion have adopted a strategy of gradually eroding abortion access through state laws that make abortion increasingly difficult and expensive to obtain or provide. State legislatures in recent years have considered and enacted more numerous and more extreme restrictions. For example, from 2009-2011 states enacted at least 133 new restrictive abortion laws.[100]

State governments share responsibility equally with the federal government to respect, protect and fulfill the rights of citizens under the ICCPR.[101] In submitting its periodic reports, the federal government is therefore required to seek information from state governments about the impact of restrictive abortion laws on women's rights to non-discrimination, equality, privacy, health, life, information and education.[102] Discussed below is just one example of ways in which state government-imposed restrictions on provision of abortion violate provisions of the ICCPR; this subsection focuses on the impact of a new type of restrictive abortion law which has appeared since the Committee's 2006 review of the United States, and which has a profound impact on freedom of expression protected under the Covenant.

1. Mandatory Ultrasound Laws Improperly Coerce Physician Speech and Patient Listening

Recently, several states have passed coercive ultrasound laws that violate the right to freedom of expression of physicians providing abortions and patients seeking them. From 2010 to 2011, three states— Texas, North Carolina and Oklahoma— passed laws that require a

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[98] *See, e.g.*, Human Rights Comm., *Concluding Observations: Cameroon*, para. 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); Human Rights Comm., *Concluding Observations: Colombia*, para. 19, U.N. Doc. CCPR/C/COL/CO/6 (2010); Comm. on Elimination of Discrimination against Women, *Concluding Observations: Peru*, para. 25, U.N. Doc. CEDAW/C/PER/CO/6 (2007); Comm. on Elimination of Racial Discrimination, *Concluding Observations: Bolivia*, para. 44, U.N. Doc. CEDAW/C/BOL/CO/4 (2008).

[99] Roe v. Wade, 410 U.S. 113 (1973).

[100] Ctr. for Reprod. Rts., *2009 Legislative Wrap Up* (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/2009%20Year%20End%20Summary%20FINAL.pdf; Ctr. for Reprod. Rts., *2010 State Legislative Wrap Up* (2011), *available at* http://reproductiverights.org/en/feature/2010-state-legislative-wrap-up; Ctr. for Reprod. Rts, *2011: A Look Back* (2012), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/endofyear_2011_FINAL.pdf.

[101] ICCPR, article 50 (noting "[t]he provisions of the present Covenant shall extend to all parts of federal States without any limitations or exceptions").

[102] The HRC has raised questions about the impact of U.S. restrictions on access to and information about reproductive rights on women's rights under articles 3, 6, 24 and 26 of the ICCPR. *See* HRC, List of Issues 2006, *supra* note 52, para. 18.

physician to perform an ultrasound on all women seeking abortions, then place the image in the woman's line of sight and describe the ultrasound image in ways specified by the state legislators, regardless of the woman's wishes.[103] These mandatory ultrasound laws force healthcare providers— under risk of criminal penalties or losing their license to practice medicine—to serve as ideological messengers of the state. The motivations behind these laws are clear: to personify the fetus, shame women seeking abortions, and erect barriers to abortion,[104] with the ultimate goal of dissuading women from exercising their constitutional right to abortion.

The Center for Reproductive Rights has challenged these three state laws in part on grounds they violate constitutional protections of the right to speech.[105] In all three states, judges blocked the state from enforcing the laws, recognizing the threats they pose to constitutional rights.[106] In Texas, however, that state began enforcing its law in early 2012 after a three-judge panel of the Fifth Circuit Court of Appeals overturned the lower court's preliminary injunction blocking enforcement of the law's provisions.[107] Although the district court judge strongly objected that the appeals court decision "eviscerated the First Amendment"[108] protections of healthcare providers and will result in "mak[ing] puppets out of doctors,"[109] the appellate ruling

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[103] N.C. GEN. STAT. §§ 90-21.80 et seq. (2011) ("Women's Right to Know Act"); Act of May 5, 2011, 82d Leg., R.S., Ch. 73, 2011 TEX. SESS. LAW SERV.; H.B. 2780, 2010 OKLA. SESS. LAWS Ch. 36. Similar laws have been proposed in the U.S. Congress. *See, e.g.*, Ultrasound Informed Consent Act, H.R. 3805, 112th Cong. (2012); Heartbeat Informed Consent Act, H.R. 3130, 112th Cong. (2011).

[104] In Texas, the law also mandates that the woman wait at least 24 hours after the ultrasound is performed before she can obtain an abortion (unless she fits into a very narrow exception based on her residence, in which case she must wait two hours). TEX. HEALTH & SAFETY CODE § 171.012(a)(4). Every woman is required to hear the explanation of the ultrasound image, unless she is pregnant due to sexual assault or incest, is a minor, or her fetus has an "irreversible medical condition or abnormality." TEX. HEALTH & SAFETY CODE § 171.012(a)(5). In North Carolina, the law mandates a four-hour wait between the ultrasound and the abortion and no women are exempted from all the law's ultrasound requirements. N.C. GEN. STAT. §§ 90-21.80 et seq. (2011). In Oklahoma, a one-hour wait is mandated and the law contains no exceptions. H.B. 2780, 2010 OKLA. SESS. LAWS Ch. 36.

[105] The Oklahoma law was challenged in state court on the grounds it violates the Oklahoma state constitution. Complaint, Nova Health Systems v. Edmonson, No. CV-2010-533 (D. Okla. Apr. 27, 2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Petition.pdf. The Texas and North Carolina laws were challenged in federal district courts on the grounds they violated federal constitutional rights, including the right to speech provision in the United States Constitution. Complaint, Stuart v. Huff, No. 1:11-cv-00804 (M.D. N.C. Sept. 29, 2011), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Complaint%20-%20filed%20copy.pdf; Amended Class Action Complaint, No. 1:11-cv-00486-SS (W.D. Tex. July 21, 2011), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/TMP%20Amended%20Class%20Action%20Complaint.pdf.

[106] NOVA Health Systems v. Edmonson, No. CV-2010-533 (D. Okla. May 3, 2010) (order granting a temporary injunction); NOVA Health Systems v. Pruitt, No. CV-2010-533, (D. Okla. Mar. 28, 2012) (order granting summary judgment to plaintiffs and permanently enjoining enforcement based on finding that the Ultrasound Act is an unconstitutional special law); Stuart v. Huff, 2011 WL 6330668, at *5 (M.D.N.C. Dec. 19, 2011) (order granting preliminary injunction of ultrasound provisions in North Carolina's "Women's Right to Know Act"); Tex. Med. Providers Performing Abortion Servs. v. Lakey, No. A-11-CA-486-SS (W.D. Tex. Aug 30, 2011) (order granting preliminary injunction of ultrasound requirements in Texas H.B. 15).

[107] Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570 (5th Cir. 2012).

[108] Tex. Med. Providers Performing Abortion Servs. v. Lakey, 2012 WL 373132, at *2 (W.D.Tex. Feb. 6, 2012).

[109] *Id*. *3.

forced the lower court judge to deny a permanent injunction, and the ultrasound requirements now apply to all abortions performed in that state. Although only one state is currently enforcing this type of law, a wave of similar legislation has been introduced in the 2012 legislative season.[110]

2. Coercive Ultrasound Laws Violate the Right to Seek, Receive and Impart Information (Article 19(2))

The right to seek, receive and impart information and ideas of all kinds is foundational to the freedom of opinion and expression protected by article 19.[111] International standards impose clear obligations on states to ensure the ability of women to obtain accurate and *appropriate* information about their reproductive and sexual health.[112] Coercive ultrasound laws interfere with the right of physicians to impart, and the right of patients to seek and receive, health-related information. Freedom of expression within the context of the physician-patient relationship is crucial for women to make informed decisions about their bodies and therefore to exercise their fundamental rights to autonomy, privacy, dignity and health.[113]

Informed consent is the principal ethical doctrine that regulates the exchange of information between physician and patient. Informed consent is required for all medical procedures in the United States, including abortion, and informed consent procedures are routine in abortion care.[114] The informed consent process is necessarily non-directive – the physician's role is to provide the patient with information that will allow her to make an autonomous choice to receive or not to receive care.[115] This includes material factual information about the nature of the proposed procedure, the patient's indications for the procedure, the procedure's medical risks

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[110] As of April 2012, a coercive ultrasound bill (requiring the physician to display and/or explain the ultrasound image to women seeking an abortion) has been introduced in seven state legislatures: Alabama, Kentucky, Louisiana, Michigan, Mississippi, Pennsylvania, and Rhode Island.

[111] ICCPR, article 19(2); *see also* Human Rights Comm., *Gen. Comment No. 34, Article 19: Freedoms of opinion and expression*, para. 11, U.N. Doc. CCPR/C/GC/34 (2011) [hereinafter HRC, Gen. Comment 34].

[112] Human rights instruments and treaty bodies underscore the importance of information and education as a precondition to realizing reproductive rights in a number of contexts. *See generally*, ICPD Programme of Action, *supra* note 2, Chapter 7; CEDAW, article 10(h); *See also* Comm. on Econ., Soc. & Cultural Rights (CESCR), *Gen. Comment No. 14: the Right to the Highest Attainable Standard of Health* (Art. 12), para. 12, U.N. Doc. E/C.12/2000/4 (2000); Comm. on Elimination of Discrimination against Women, *Gen. Recommendation No. 24: Women and Health*, U.N. Doc. A/54/38 at 5 (1999), *reprinted in* Compilation of Gen. Comments and Gen. Recommendations Adopted by Human Rights Treaty Bodies, paras. 22, 31(e), U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003). For a summary of treaty monitoring body jurisprudence on this topic, see Ctr. for Reprod. Rts., *The Right to Information on Sexual and Reproductive Health*, *in* BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORK OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS (2008), *available at* http://reproductiverights.org/sites/default/files/documents/BRB_SexEd.pdf.

[113] CEDAW, Gen. Recommendation 24, *supra* note 51; Am. Coll. of Obstetricians & Gynecologists, 439 *Comm. on Ethics Opinion: Informed Consent* 3 (August 2009) [hereinafter ACOG, *Informed Consent*], *available at* http://www.acog.org/Resources_And_Publications/Comm._Opinions/Comm._on_Ethics/Informed_Consent.

[114] *See* NAT'L ABORTION FED'N, 2012 CLINICAL POLICY GUIDELINES 3 (2012), *available at* http://www.guidelines.gov.

[115] *Id.*; *see also* Am. Med. Ass'n, *Policy No. E-8.08: Informed Consent*, *available at* http://www.ama-assn.org.

and benefits, and available alternatives.[116] Unless requested by the patient, it is inappropriate for a physician to interject into the informed consent discussion the physician's own value-based views or the value-based views of the government or any other third party.[117]

The speech mandates in the Texas, Oklahoma and North Carolina ultrasound laws require physicians to violate central tenets of medical ethics: to act upon the patient only with her consent; to respect the patient's autonomy and right to make medical decisions based on her own values; and to act in the patient's best interests.[118] Laws mandating ideological physician speech harm the physician-patient relationship by putting the patient in the position of protecting herself against unwanted actions (showing the ultrasound image, describing the images, etc.) the physician is doing to her. Thus, such laws violate article 19(2).

3. Coercive Ultrasound Laws Place Impermissible Restrictions on Freedom of Expression (Article 19(3))

The ICCPR recognizes limited circumstances in which states may impose restrictions on the right to freedom of expression. Under article 19(3), restrictions on expression are only accepted where they are (1) provided by law; (2) necessary for a legitimate purpose as set forth in article 19(3); and (3) proportional to the stated aim.[119] Mandatory ultrasound laws such as those in Texas, Oklahoma and North Carolina fail to satisfy any of these criteria and are therefore impermissible restrictions of article 19.

First, the restrictions fail to meet the legality prong. Proponents of these coercive laws seek to justify them on grounds of "protecting" women seeking abortions (by ensuring informed consent to a medical procedure) or based on moral claims (furthering the state's interest in protecting fetal life). While preservation of public health or morals are legitimate grounds for restrictions under article 19(3)(b), governments bear a heavy burden to justify their legal basis.[120] In particular, "limitations must be understood in the light of universality of human rights and the principle of non-discrimination."[121] Laws compelling speech and listening designed to deliver the state's ideological message about abortion to women are grounded in gender discrimination, as they are premised on the assumption that women lack sufficient information to make personal reproductive health decisions without the state dictating the messages they receive, and that women need to be protected from their own choices. Moreover, requiring physicians to deliver

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[116] *See* Am. Med. Ass'n, *Informed Consent*, *available at* http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page.

[117] ACOG, *Informed Consent*, *supra* note 113, at 3 ("[g]iven (the capacity for self-determination) in persons, it is ordinarily an ethically unacceptable violation of who and what persons are to manipulate or coerce their actions…").

[118] International standards on medical ethics require that healthcare providers "owe his/her patients complete loyalty" and put the patient's health above other considerations. The problem of "dual loyalties" arises where the law requires doctors to prioritize other considerations over their patient's best interests. *See* World Med. Ass'n (WMA), *Int'l Code of Medical Ethics* (London, England, Oct. 1949) (as amended in 1968, 1983, and 2006), *available at* http://www.wma.net/en/30publications/10policies/c8/.

[119] ICCPR, article 19(3); *see also* HRC, Gen. Comment 34, *supra* note 111, paras. 21-36.

[120] HRC, Gen. Comment 34, *supra* note 111, para. 27.

[121] *Id.*, para. 32.

certain messages to patients, regardless of the patient's individual circumstances, interferes with other human rights including the patient's right to privacy under article 17. Such restrictions cannot be "provided by law" because they violate the principle of non-discrimination and the universality of human rights.

Second, the laws are not necessary. States have passed these ultrasound requirements absent evidence of any need for them. Disguised as "informed consent" requirements, these provisions distort core principles of medical ethics, as discussed above. The federal district court judge in the Texas case drew attention to the false pretenses behind the State's argument that stronger informed consent provisions were necessary: "[i]nformed consent requirements exist to protect the rights of patients, and to honor their autonomy, not to provide states with an excuse to impose heavy-handed, paternalistic, and impractical restrictions on the practice of medicine."[122]

Finally, laws compelling ideological anti-abortion speech and listening are not proportional to their legislative purpose. The HRC has defined this requirement to mean that "[r]estrictions must not be overbroad" and in fact must be "the least intrusive instrument" available to achieve the purpose.[123] States have numerous legal options to use when seeking to promote a particular viewpoint on abortion, including producing and disseminating information that women seeking reproductive health services may choose to accept. These options are much less restrictive than requiring physicians to be the state's ideological messenger.[124] As the district court judge in the North Carolina case wrote, that state's law "goes well beyond requiring disclosure of those items traditionally a part of the informed consent process," because "the state compels the provider to physically speak and show the state's non-medical message to patients unwilling to hear or see."[125]

III. Conclusion

The process of reviewing the U.S. government's record on implementing civil and political rights requires the assistance of many actors, including local and state governments as well as civil society. These comments supplement the Fourth Periodic Report's information in two ways. First, they provide updated information and analysis regarding topics the HRC has identified as priorities in previous reviews, including the practice of shackling pregnant women and overly broad religious refusal laws. Second, they address threats to women's reproductive rights in the U.S. newly emerged since the last HRC review, including state ultrasound laws mandating physician speech and the entrenchment of discrimination against immigrant women in healthcare reform legislation.

We look forward to further engagement with the U.S. government on these and other areas implicating reproductive rights. In the meantime, please do not hesitate to contact us with any questions or concerns about the information provided here.

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[122] Tex. Med. Providers Performing Abortion Servs. v. Lakey, 2012 WL 373132, at *2, n.5.

[123] HRC, Gen. Comment 34, *supra* note 111, para. 34.

[124] *Id.*, para. 10 ("[a]ny form of effort to coerce the holding or not holding of any opinion is prohibited").

[125] Stuart v. Huff, 2011 WL 6330668, at *5 (M.D.N.C. Dec. 19, 2011).

Best regards,

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