



**NATIONAL LATINA
INSTITUTE FOR
REPRODUCTIVE HEALTH**
Salud | Dignidad | Justicia



September 22, 2014

Dear Committee Members:

1. The Center for Reproductive Rights, Women Enabled International, and the National Latina Institute for Reproductive Health respectfully submit this letter to assist the Committee against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT Committee) during its 53rd Session in its review of the United States' compliance with the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.

The **Center for Reproductive Rights** is a global human rights organization that uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect and fulfill.

The **National Latina Institute for Reproductive Health** is the only national reproductive justice organization dedicated to advancing health, dignity, and justice for the 26 million Latinas, their families and communities in the United States.

Women Enabled International advocates and educates for the human rights of all women and girls, with an emphasis on women and girls with disabilities, and works tirelessly to include women and girls with disabilities in international resolutions, policies and programs addressing women's human rights and development.

2. This submission focuses on how three groups of women who face multiple forms of discrimination in the U.S. are disproportionately subjected to severe physical or mental suffering that amounts to torture or ill-treatment in the exercise of their reproductive rights: (1) poor, rural and immigrant women in the Rio Grande Valley of Texas who are denied reproductive health care; (2) immigrant women in detention who are denied access to reproductive health care and subjected to shackling; and (3) women and girls with disabilities who are subject to forced or coerced sterilization.

I. Denial of Reproductive Health Care for Immigrant Women

3. Immigrant women of reproductive age are often denied reproductive health care, which threatens their rights to life, health, and freedom from ill-treatment. A combination of state and federal policies have cut off access for immigrant women to essential reproductive health care, including family planning goods and services, reproductive cancer screenings, and abortion

care. This section describes the national impact with a particular focus on violations in the state of Texas, a state with the second highest immigrant population (after California) and some of the most restrictive policies on reproductive rights in the nation.

Pain and Suffering Caused by Denial of Reproductive Health Care

4. Thousands of low-income uninsured immigrant women living in the Rio Grande Valley of South Texas, on the U.S. border with Mexico, are denied the reproductive health care they need at great cost to their health, well-being, and lives. Recent policy changes have exacerbated longer term structural barriers to health care, depriving these women of a range of reproductive health goods and services including screenings for breast and cervical cancer, contraceptive counseling and supplies, tests for sexually transmitted infections, and abortion. Their stories and those of nearly 200 other Latinas are documented in a recent fact-finding report by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley*.¹ Excerpts below illustrate the pain and suffering women are experiencing without a source of affordable health care.

5. *Forced to Take Life-Threatening Risks to Access Care*

Adriana is a 41-year-old undocumented migrant who has lived in the U.S. for over 20 years and raised her children and now her two grandchildren here. Yet, she was forced to swim across the Rio Bravo River into Mexico to be operated on for ovarian cysts, because without health insurance she could not find anywhere to access affordable care in the U.S. “I’m supposed to be getting checkups, but I have no money... *I risked everything crossing that way via river – I risked my life, risked drowning, [being] assaulted or killed.*” Adriana worries that the cysts may return, especially because her mother died young of uterine cancer.²

Amanda is a single mother who recently lost access to her source of affordable contraception. She was forced to go to Mexico to obtain a long-acting contraceptive shot. She was on her way to the pharmacy with her three-year old daughter when a shootout erupted. “People just started running and saying there was going to be a shooting, and so we took off. So I couldn’t get my shot... The crime situation in Mexico is so bad. I’ve been in three shootouts. I shudder from fear every time I go to Reynosa. *As a woman and a U.S. resident, why would I have to go to another country to see a doctor? The cost is too high here, but I risk my life if I go across the border.*” She now takes contraception only when she can afford to buy it on the black market.³

6. *Physical Pain from Delays and Denial of Care*

Rosa, a 32-year-old mother of three, felt a lump in her breast and tried to access an ultrasound but was unable to pay the \$500 fee. A few months later, she felt pain in her uterus and again was turned away because her clinic no longer offered subsidized services. After one year of waiting in stress and physical pain, she was finally able to qualify for subsidized surgery to remove an ovarian cyst that by then had consumed her whole uterus. Since her surgery, she has been unable to afford follow-up care she needs. “Not getting any help from the clinics, from doctors, from hospitals, is really getting to me, getting to my husband because he can’t

work, getting to my children because they see me sick, lying in bed in pain for a year, suffering, trying to save money to buy medication since I could not afford a clinic because they were too expensive.”⁴

7. *Stress and Anxiety from Delays and Denial of Care*

Ida has human papillomavirus (HPV), a risk factor for cervical cancer, and has had surgeries to remove cervical cysts in the past. Now, she cannot afford to get a Pap test that doctors told her she needed every six months to check on her condition. “It’s \$60 for a checkup. I thought, either I pay \$60 or I buy food for my children... *Being unable to see a doctor has me worries sick. I’m so afraid of the virus coming back.* Last time it wasn’t cancerous, but I’m afraid that if it does come back it will be worse, because I’m not having regular checkups.”⁵

Fatima is an undocumented mother of two young girls who lost access to subsidized contraceptives when her local clinic was forced to close due to state restrictions. “I’d get them for free right there. *But at one point they ran out of funding, and that was the end of it... So sometimes I did [use birth control] and sometimes I didn’t. That’s when I got pregnant.*” Fatima continues to struggle to provide for her growing family, still cannot afford a consistent supply of contraception, and lives in fear of what her limited access to contraceptives will mean for her future and the well-being of her children.⁶

8. The lack of affordable services to screen for and diagnose reproductive health illnesses, including cervical, breast and uterine cancer, forces low-income immigrant women with identifiable symptoms of cancer to delay obtaining care—often until their condition becomes too serious or expensive to treat. Others take extreme risks to access affordable care in Mexico, where border violence in Tamaulipas State has sharply escalated in recent years. Crossing the border can involve physical danger, fear for one’s safety, and prolonged or permanent family separation. Those unable to get the care they need in the U.S. or Mexico reported experiencing physical pain from untreated conditions, stress from not knowing whether they have a life-threatening illness that is progressing undiagnosed, and crippling anxiety over the financial burden their illness or unintended pregnancy created for their families.

Laws and Policies Leading to the Denial of Reproductive Health Care

9. Beginning in 2010, many states, particularly those in the South and those with high immigrant populations, have passed laws targeting women’s access to reproductive health care. One of the most severe attacks occurred in Texas, when in 2011 the state legislature cut the state’s budget for preventive reproductive health services by two-thirds.⁷ The severe funding cuts disproportionately harmed women living in the Rio Grande Valley, where the closure of reproductive health clinics resulted in a 72% drop in services by the end of 2012.⁸
10. Poor women in states such as Texas stand to gain little from federal health reform. Texas, like 20 other states, has refused to expand Medicaid—the nation’s public health insurance program for low-income people—to cover a larger number of individuals who cannot afford private insurance. The **Affordable Care Act** (ACA),⁹ passed in 2010, required states to expand Medicaid in order to reach the goal of increasing health coverage to the nation’s 55 million

uninsured, and it provided substantial federal incentives to states to do so.¹⁰ The Supreme Court upheld the ACA in a major legal challenge in 2011, but struck down the provision requiring states to participate in Medicaid expansion.¹¹ As of September 2014, 21 states have opted not to expand Medicaid at this time. The state of Texas, by refusing to expand Medicaid, leaves the women of the Rio Grande Valley and its estimated 500,000 uninsured residents without affordable health care options available to similarly low-income individuals in other states.¹²

11. Critically, even if states do choose to expand Medicaid, many immigrants most in need of affordable care are ineligible for the benefits of the Affordable Care Act. The law excludes many categories of non-citizens who are most in need of affordable access to care given their low socio-economic standing.¹³ Exclusions apply to the following groups:

- *Qualified immigrants*: The ACA requires non-citizens who are “lawfully present” and “qualified” in the U.S. to wait five years before they are eligible to enroll in federal Medicaid, regardless of their income eligibility.¹⁴ This restriction applies to lawful permanent residents, individuals with work authorization, refugees, and asylees. Other lawfully present immigrants who fall outside the definition of “qualified immigrants” are ineligible for non-emergency Medicaid altogether, unless they qualify for a federal option provided to states to provide health coverage to lawfully present pregnant women and children under 21 and live in a state that has adopted this option.¹⁵
- *Undocumented immigrants*: The ACA completely excludes undocumented immigrants from eligibility for Medicaid¹⁶ and bars them from purchasing private insurance on the newly developed health insurance exchanges, even at full cost.
- *Deferred Action for Childhood Arrivals (DACA)*: Under the U.S. Department of Health and Human Services’ changes to existing federal rules (issued as federal regulations and guidance in August 2012),¹⁷ those who have qualified for DACA are excluded from affordable health insurance options available to other immigrants with deferred action status (temporary relief from deportation). These changes exclude DACA recipients who are minors or pregnant from eligibility for Medicaid and the Children’s Health Insurance Program in about half of all states and exclude all DACA recipients from expanded coverage under the ACA.

Due to these restrictions, an estimated **9.5 million non-citizens will be excluded from the coverage benefits of the ACA** solely due to their immigration status.¹⁸

12. Meanwhile, federal cuts to preventive reproductive health programs have eroded access to contraceptive services for millions of women without adequate health insurance, including immigrants excluded from the ACA. Federal funding for Title X—the country’s largest family planning program—was reduced by 12.3% (\$39.2m) in the fiscal years between 2010 and 2013.¹⁹ Consequently, the number of women receiving publicly subsidized contraceptive services decreased by 9% from 2000 to 2012, despite a 22% increase in the demand for such services.²⁰ The unmet demand for affordable contraception is nearly eight times greater among Latinas than whites²¹ and is disproportionately high in states with large immigrant populations, like Texas.²²

Legal Restrictions Limiting Access to Safe and Legal Abortion

13. The U.S. Constitution protects a woman's right to choose to terminate her pregnancy prior to viability.²³ Nevertheless, today a woman's ability to access an abortion increasingly depends on the state in which she happens to live. Since 2010, state legislatures have enacted over 170 restrictive abortion laws designed to make it harder or impossible for women to access abortion services in their communities.²⁴ Where not blocked by court orders, this new wave of restrictions is shutting down clinics, closing off essential services, and harming women.
14. The state of Texas is implementing the most extreme package of abortion restrictions in the country. In 2013, Texas enacted a sweeping package of anti-choice legislation under House Bill 2 (HB2).²⁵ Today, of the 41 abortion clinics open in May 2013, only 20 remain open.²⁶ The most harmful provision of the law is currently enjoined by a federal court as of August 30, 2014, but if the challenge to the law fails on appeal, the legislation will close all but seven abortion clinics in Texas.²⁷ Because most of the remaining clinics are located in Texas' five largest cities, the women who have lost access to safe abortion are mostly poor, rural, and immigrant women unable to travel to urban centers.²⁸
15. In the Rio Grande Valley, the two abortion clinics serving this population of 1.3 million people have closed as a result of HB2. Women in the Rio Grande Valley must now travel nearly 250 miles each way, or 4 hours by car, to access the nearest clinic in San Antonio, Texas. Although an abortion clinic in the Rio Grande Valley has reopened following the August 30, 2014 decision by a federal district judge to strike down two of the law's most harmful provisions,²⁹ that clinic may be forced to close again if the appeal seeking to preserve those provisions of the law is successful. Many women have an immigration status that does not permit them to travel to San Antonio due to numerous internal immigration checkpoints on Texas highways. Moreover, nearly 40% of Valley residents live below the federal poverty level³⁰ and cannot afford the fee for an abortion procedure, let alone the transportation and lodging costs associated with traveling to obtain one.
16. The increased costs and travel distances cause many of the poorest women, primarily immigrants and Latinas, to delay accessing abortion care and others to forgo abortion altogether. Since the law went into effect in November 2013, the overall rate of safe and legal abortion has decreased by 13%.³¹ Some women unable to obtain a legal abortion will take desperate measures to end their pregnancies, including crossing the border into Mexico or finding other ways to purchase miscarriage-inducing drugs on the black market. A 2012 study in Texas found that 7% of women reported attempts to self-abort before seeking medical care, which was *before* the recent closure of approximately one-third of Texas abortion clinics.³² The same study showed that in border cities like McAllen, Texas, self-induction has increased by a factor of 12 since 2008.³³ Since the clinic closures, providers have noted the growth in black-market purchases of miscarriage-inducing drugs.³⁴

International Law on Denial of Reproductive Health Care as Ill-Treatment

17. The CAT Committee has affirmed that state policies restricting reproductive rights may rise to the level of ill-treatment. Such circumstances include absolute abortion bans,³⁵ prohibitions on

emergency contraception for rape survivors,³⁶ denial of post-abortion care,³⁷ and denial of abortion posed by overly broad conscientious objection laws.³⁸ Most recently, the CAT Committee has urged states to “ensure the provision of sexual and reproductive health services to women and adolescents, in order to prevent unwanted pregnancies” as part of their obligation to prevent torture, cruel, inhuman or degrading treatment.³⁹

18. In two recent cases against Poland, the European Court of Human Rights found violations of the right to be free from ill treatment due to the denial of reproductive health services. One case involved the denial of prenatal genetic testing to a pregnant woman by doctors who assumed she would seek a legal abortion on grounds of fetal anomaly.⁴⁰ In the other, the state had caused significant delays in granting a lawful abortion to a pregnant minor girl who had been raped.⁴¹
19. Recently, other human rights treaty bodies have expressed concern about discriminatory U.S. policies that exclude immigrants from health insurance coverage, thereby serving as a *de facto* bar to immigrants’ access to preventive, curative and palliative health care, including sexual and reproductive health care. In March 2014, the Human Rights Committee expressed concern over the Affordable Care Act’s exclusions of qualified immigrants and undocumented immigrants from eligibility for Medicaid and participation in the health care exchanges, respectively, and urged the U.S. to “identify ways to facilitate access to adequate health care, including reproductive health-care services,” for these groups.⁴² In August 2014, the Committee on the Elimination of Racial Discrimination echoed these concerns over U.S. policies that “result[] in difficulties for immigrants in accessing adequate health care” and racial disparities in sexual and reproductive health.⁴³ It recommended the U.S. “take concrete measures to ensure that all individuals ... have effective access to affordable and adequate health-care services.”⁴⁴

20. Suggested Recommendations for the U.S. Government

- Eliminate discriminatory policies that restrict immigrant women’s access to health insurance on the basis of their citizenship status, including the prohibition on undocumented immigrants’ participation in the health insurance exchanges established by the Affordable Care Act and the five-year waiting period on qualified immigrants’ eligibility for Medicaid. As a preliminary measure, the Obama Administration should rescind the exclusion on access to affordable health coverage and care for those granted deferred action under Deferred Action for Childhood Arrivals. It should strongly urge Congress to pass the HEAL Immigrant Women and Families Act.
- Address the unmet demand for affordable contraception among immigrants who are ineligible for Medicaid by substantially increasing the budget for the Title X family planning program and expanding full contraceptive access through community health centers.
- Enact the Women’s Health Protection Act in order to prohibit states such as Texas from passing legislation designed to erode a woman’s constitutional right to abortion.

II. Reproductive Rights Violations of Immigrant Women in Detention

21. The CAT Committee's List of Issues to the United States⁴⁵ requests the following information pursuant to Article 16:
- **Question 33:** In light of the Committee's previous concluding observations, please elaborate on the measures adopted by the State party to ensure that women in detention are treated in conformity with international standards, as well as on the implementation of these measures (para. 33). Furthermore, please provide information on the impact and effectiveness of these measures in reducing cases of ill-treatment of detained women.
 - **Question 39:** Please inform the Committee of steps taken to address the reports of inconsistent and inadequate medical care for immigrant women held by United States Immigration and Customs Enforcement detention system and for HIV-positive immigration detainees.
22. Under the Fifth Amendment of the U.S. Constitution, immigrants have a right to receive medical care and to be free from inhumane or unsafe conditions.⁴⁶ Civil detainees, including those in detention due to immigration law violations, also have a right to a higher standard of care than those accused or convicted of a crime.⁴⁷ Despite these constitutional guarantees, women in immigration detention are subjected to cruel and inhumane practices such as shackling during pregnancy, and have been routinely denied access to medically necessary reproductive health care.⁴⁸

Growth in Civil Detention of Women Immigrants

23. From 2002 to 2010, the number of immigrants in U.S. Immigration and Naturalization Services (INS) detention increased by 80%, from 202,000 people to 363,000.⁴⁹ This growth has occurred despite the fact that immigrant detainees are overwhelmingly non-violent and do not pose a flight risk or public safety concern, and despite evidence showing the success and cost-effectiveness of detention alternatives.⁵⁰ Immigrant women now account for at least 10% of all immigrants in civil detention.⁵¹ A 2009 report by U.S. Immigration and Customs Enforcement (ICE) revealed that women and their children were often detained in prison-like facilities that create inappropriate conditions for women and families; for example, women detainees were housed in 150 jails across the country, with only 38 mothers of minor children held in family residence facilities.⁵² A 2011 report found that the U.S. government had made little progress in moving away from housing immigrants in detention centers that resemble correctional facilities, noting that "... ICE uses the same facilities it was using in 2009, and under the same management."⁵³
24. The categories of non-citizens subject to mandatory detention has also increased significantly through a series of laws enacted since 1988.⁵⁴ A 2010 policy issued by ICE called the "Morton Memo" instructs field office directors not to expend resources on detention of pregnant women, but it explicitly exempts those subject to mandatory detention from this policy.⁵⁵ Consequently, mandatory detention has limited the use of prosecutorial discretion in the cases of pregnant women detained by ICE, sometimes with tragic consequences. Soledad, a woman

held under mandatory detention at the Eloy detention center in Arizona in December 2011, miscarried despite days of complaining of abdominal pains to ICE staff. She was seeking asylum in the U.S. on grounds of domestic violence.⁵⁶

Unenforceable Standards for Medical Care in Detention

25. In 2011, ICE adopted revised Performance-Based National Detention Standards (2011 PBNDS), for federally-contracted detention centers related to detainees' safety, security, and well-being.⁵⁷ The 2011 PBNDS made long overdue improvements in medical care, including reproductive health care such as routine gynecological exams, breast and cervical cancer screenings, STI tests, and access to contraception.⁵⁸ The standards recommend pregnancy care including nondirective options counseling, prenatal care, obstetric care, and access to abortion.⁵⁹ On their face the standards are a major improvement over prior detention standards governing access to medical care and reproductive health care in particular. However, because they lack the enforcement power of binding regulations, implementation to date has been piecemeal and slow. Currently only half of all immigration detention facilities are complying with the revised 2011 PBNDS standards, and half follow outdated standards from 2008 and 2000.⁶⁰ The few detention centers fully controlled by ICE complied quickly, but the vast majority—"dedicated" facilities run by private contractors that house both immigrants and non-immigrant detainees—have delayed because they are not contractually required to implement the revised standards.

Violations of Reproductive Rights in Detention

26. The risk of ill-treatment increases in the detention context, including in the form of denial of appropriate care as well as physical and mental harm caused by the use of physical restraints. Indeed, ICE policy dictates that "absent extraordinary circumstances" pregnant or nursing immigrants should not be detained.⁶¹ Nevertheless, reports reveal that since 2012, 559 pregnant women have been detained in just six of ICE's 250 detention facilities.⁶² A recent investigation uncovered that in 2013, the ICE facility in El Paso, TX, alone held 40 pregnant women, including one woman who was seven months pregnant.⁶³ The updated standards require a showing that pregnant women be provided with routine or specialized prenatal care and nutritional supplements. However, women's access to pregnancy care differs drastically depending on the facility in which they are held.⁶⁴

27. The 2011 PBNDS directs ICE detention facilities to refrain from using restraints on women in active labor, delivery or during transport to an outside facility.⁶⁵ Reports of shackling pregnant women in immigration detention have decreased in recent years, but incidents continue due to the numerous barriers to enforcing the 2011 PBNDS and the absence of laws banning shackling of pregnant women in 32 states.⁶⁶

28. Federal law prohibits funding to cover abortions for immigrant women in detention, even when a woman's health is at risk. Under a provision called the Aderholt Amendment, an amendment to the Department of Homeland Security Appropriations Act, federal funds may not be used to pay for a detained woman's abortion except in cases of rape, incest, and life endangerment (the latter is defined narrowly to exclude a health exception).⁶⁷ Given the low economic status and

health insurance coverage of many immigrant detainees, and the high cost of an abortion, the funding prohibition effectively bars their access to abortion. Moreover, while ICE must continue to escort women who arrange and pay for an abortion outside of the detention facility, the law includes language allowing ICE employees to refuse to “perform, or facilitate in any way the performance of, any abortion” based on their “philosophical beliefs.”⁶⁸ This provision makes it possible for ICE employees to refuse to transport women choosing to exercise their constitutional right to abortion.

International Human Rights Standards on Reproductive Health Care for Immigrant Women in Detention

29. The CAT Committee has condemned the use of restraints on pregnant women in detention in the United States as a form of cruel, inhuman and degrading treatment.⁶⁹ On other occasions, it has urged states to adopt measures to ensure that women in detention are treated in conformity with international standards, for example, to ensure access to health care within detention facilities with special attention to women’s health needs.⁷⁰
30. The CAT Committee has also urged states to find alternative settings to detention for mothers with their children.⁷¹ The U.N. Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders, which supplement the UN Standard Minimum Rules, state that “non-custodial sentences for pregnant women ... shall be preferred where possible and appropriate.”⁷² Where pregnant and nursing women must be detained, they ought to receive “adequate and timely food, a healthy environment and regular exercise opportunities.”⁷³ The Rules further provide that preventive health care should be afforded to *all* women in detention, including screenings for reproductive system cancers, HIV and other sexually transmitted infections.⁷⁴
31. With respect to detention of non-citizens, the CAT Committee has consistently expressed concern about the use of administrative detention and has urged states to minimize the circumstances and length of time for detention of non-citizens not convicted of a crime.⁷⁵ It has also urged states to promote alternative measures to detention at least for asylum seekers.⁷⁶ Further, in General Comment 2, the CAT Committee noted that immigration status can intersect with gender discrimination to increase the risk of ill-treatment or torture for women in detention,⁷⁷ especially in the context of “deprivation of liberty [and] medical treatment, particularly involving reproductive decisions.”⁷⁸

32. Suggested Recommendations for the U.S. Government

- Promote humane alternatives to immigration detention, especially for women and children, developed in consultation with immigrant stakeholder communities.
- Enact legally binding regulations modeled on the 2011 PBNDS to apply to all immigration detention facilities contracted through the Department of Homeland Security, and terminate contracts with non-compliant detention facilities.
- Create an independent monitoring body to oversee ICE detention facility compliance with the 2011 PBNDS.
- Repeal the Aderholt Amendment to ensure access to abortion for immigrant women in detention whose health may be at risk from continuation of the pregnancy.

III. Forced Sterilization of Women with Disabilities

Denial of Informed Consent to Sterilization in Law and Practice

33. Violence, exploitation, and abuse of people with disabilities arises from discrimination based on gender as well as disability, and it may occur in varied situations within and outside the home.⁷⁹ The ability of women with disabilities to exercise their reproductive rights depends on freedom from violence and coercion when making reproductive decisions, such as decisions around contraception use, sterilization, and abortion.⁸⁰
34. Women with disabilities often face coercion from health care providers regarding their reproductive decision-making and may be subjected to medical procedures without their consent. Women with disabilities are more likely to have hysterectomies at a younger age and for a non-medically necessary reason, including by request of a parent or guardian.⁸¹ These issues rose to public attention in 2007 when the parents of a nine-year-old girl with developmental disabilities gave their consent to have her undergo a surgical procedure to stunt her growth and remove her reproductive organs prior to reaching puberty.⁸² Since 2012, there have been 12 confirmed cases and over 100 suspected cases of families subjecting their disabled children to similar treatment.⁸³ Women with disabilities also frequently encounter pressure from doctors, guardians, social service workers, parents, and society to abort a pregnancy because of a misperception of the possibility of passing on disabilities to their children—even if the disability is not genetic.⁸⁴
35. Stereotypes regarding the danger of procreation by women with disabilities are enshrined in state law. Eleven states retain statutory language authorizing a court to order the involuntary sterilization or forced contraceptive use of a person with a disability.⁸⁵ Courts in the U.S. also have addressed these issues, not always consistent with the requirements of the Americans with Disabilities Act (ADA) Title II, which prohibits state and local governments from discriminating on the basis of disability in government services, programs, or activities.⁸⁶ Courts are divided on the legal capacity of women with disabilities to decide about their reproductive lives, particularly regarding the forced sterilization of young women and girls with disabilities, and there is no clear judicial standard that ensures reproductive decision-making resides with women.⁸⁷

International Human Rights Standards on Forced and Coerced Female Sterilization

36. The infliction of severe pain or suffering accompanied by an impermissible purpose, including gender discrimination, is an act that can amount to torture.⁸⁸ Because women with disabilities face multiple forms of discrimination due to gender, disability and other factors, they are at increased risk of forced or coerced sterilization.⁸⁹ In General Comment 2, the CAT Committee explained that States have a heightened duty to protect those who may be at greater risk of torture and ill-treatment as a result of discrimination.⁹⁰ The CAT Committee has explicitly addressed in its Concluding Observations the coerced and forced sterilization of groups subjected to multiple forms of discrimination, including Romani women,⁹¹ poor and indigenous women,⁹² rural women,⁹³ and women with disabilities.⁹⁴

37. Other human rights treaty bodies have made similar findings. The Human Rights Committee has classified forced sterilization as a form of violence against women and called for states to provide information on efforts to prevent this practice as part of their reporting on the right to be free from torture and CIDT.⁹⁵ The Committee on the Rights of Persons with Disabilities has said that forced sterilization violates the right to bodily integrity, family and fertility, health, or legal capacity.⁹⁶ The CEDAW Committee has recognized that forced sterilization is a form of gender-based violence,⁹⁷ and the Committee on the Rights of the Child classified forced sterilization of children with disabilities, particularly girls, as a form of violence.⁹⁸
38. Numerous reports from UN bodies and medical associations indicate that the only valid form of informed consent to sterilization is that which stems from the patients themselves. The International Federation of Gynecology and Obstetrics (FIGO), a global organization of professionals in these fields seeking to promote the well-being of women and improve practice standards, recently released guidelines on female contraceptive sterilization that stress that surgical sterilization must be preceded by “the patient’s informed and freely given consent.”⁹⁹ For women and girls with disabilities, however, so-called “informed consent” for sterilization or abortion often comes from parents, guardians, or medical professionals rather than the woman herself. This practice is the result of the widespread and worldwide practice of depriving women with disabilities of legal capacity and thus the right to make important life decisions, or because individuals assume that women with disabilities lack capacity to make choices about their reproductive health.¹⁰⁰

39. Recommendations

- Remove statutory language in the 11 states that authorize a court to order the involuntary sterilization or forced contraceptive use of a person with a disability.
- Encourage medical associations to adopt the 2011 International Federation of Gynecology and Obstetrics ethical guidelines on obtaining prior informed consent to sterilization.¹⁰¹

¹ CENTER FOR REPRODUCTIVE RIGHTS & NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health Care in the Rio Grande Valley* (2013), <http://www.nuestrotexas.org> [hereinafter *Nuestro Texas*].

² *Id.* at pg. 48.

³ *Id.* at pg. 47.

⁴ *Id.* at pg. 37.

⁵ *Id.* at pg. 25.

⁶ *Id.* at pg. 40.

⁷ Crystal Conde, *Physicians Worry About Women's Access to Care*, 108 TEX MED. 18025 (2012), <http://www.texmed.org/Template.aspx?id=24707#sthash>; Kari White ET. AL., *Cutting Family Planning in Texas*, 367 NEW. ENG. J. MED. 1179 (2012).

⁸ UNIV. OF TEXAS POPULATION RESEARCH CTR., *County: Family Planning Services*, TXPEP Family Planning Data Finder, available at <http://www.prc.utexas.edu/txpep/#county> (last accessed Sept. 11, 2014).

⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 42 U.S.C. 18001 (2010).

¹⁰ Medicaid expansion was created to fill the gap in health coverage for adults. The ACA as enacted required states to expand Medicaid to cover all low-income adults with income up to 138% of the federal poverty line (about \$16,000 per person). States participating in Medicaid expansion will have 100% of the costs reimbursed by the federal government for the first three years, and 90% thereafter. Texas' failure to expand Medicaid translates to a loss of over \$100 billion in federal aid over a ten-year period. Stan Dorn ET. AL., *What is the Result of States Not Expanding Medicaid?*, ROBERT WOOD JOHNSON FOUNDATION & URBAN INSTITUTE (Aug. 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946.

¹¹ *Nat'l Fed'n of Indep. Bus. V. Sebelius*, 132 S.Ct. 2566 (2012). *Nuestro Texas*, *supra* note 1, pg. 54.

¹² Sarah Varney, *Texas' Struggling Rio Grande Valley Presses for Medicaid Expansion*, KAISER HEALTH NEWS, May 21, 2013, <http://www.kaiserhealthnews.org/stories/2013/may/21/texas-border-counties-medicaid.aspx> (reporting that the rate of uninsured residents in the Rio Grande Valley, population 1.3 million, is about 38%).

¹³ Forty-six percent of non-citizens are uninsured compared to 15% of U.S.-born citizens and 23% of naturalized citizens. HENRY J. KAISER FAMILY FOUNDATION, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under Health Reform*, 2 (2012).

¹⁴ The ACA incorporated provisions first established in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which severely limited immigrants' eligibility for public benefits including Medicaid and the Children's Health Insurance Program (CHIP). Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (1996).

¹⁵ NATIONAL IMMIGRATION LAW CENTER, *Overview of Immigrant Eligibility for Federal Programs*, available at http://www.nilc.org/table_ovrw_fedprogs.html (last updated Oct. 2011).

¹⁶ Four states offer state-funded health coverage to immigrants regardless of their immigration status, but these states restrict such coverage to special groups like children or pregnant women, or cover limited services. KFF, *Key Facts on Health Coverage for Low Income Immigrants Today and Under the Affordable Care Act*, 6 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf> [hereinafter *Low Income Immigrants Today and Under the Affordable Care Act*]. NAT'L IMMIGRANT LAW CTR., *Medical Assistance Programs for Immigrants in Various States*, available at <http://www.nilc.org/healthcoveragemaps.html> (last updated Feb. 2014).

¹⁷ See 45 CFR § 152.2(8) (77 Fed. Reg. 52614, Aug. 30, 2012) and 45 CFR § 152.2(8) (78 Fed. Reg. 4613, Jan. 22, 2013) (a pair of interim rules excluding those granted deferred action under DACA from the definition of "lawfully present," and therefore making them ineligible for participation in the health care exchanges established by the ACA, Medicaid, or CHIP).

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¹⁹ NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, *Title X: Budget and Appropriations*, available at http://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Sept. 8, 2014).

²⁰ Jennifer J. Frost et al., *Contraceptive Needs and Services, 2012 Update*, GUTTMACHER INST. (Aug. 2014).

²¹ *Id.*, at pg. 7-8. Of the women served by Title X clinics in the U.S. in 2012, 28% (1,349,528) identified themselves as Hispanic or Latino. Research Triangle Institute, *Family Planning Annual Report: 2012 National Summary*, 12 (2014), available at <http://www.hhs.gov/opa/pdfs/fpar-national-summary-2012.pdf>.

²² The states with the highest number of people with unmet contraceptive needs are California (8.46 million), Texas (5.8), and New York (4.2 million), which coincide with the states that have the highest population of immigrants: California (10.3 million), New York (4.4 million), and Texas (4.3 million). Jennifer Frost ET. AL., *Contraceptive Needs and Services, 2012 Update*, GUTTMACHER INST., 11-12 (2014),

<http://www.guttmacher.org/pubs/win/contraceptive-needs-2012.pdf>; Migration Policy Institute, *Immigration Population by State, 1990-2012*, <http://www.migrationpolicy.org/programs/data-hub/charts/immigrant-population-state-1990-present?width=1000&height=850&iframe=true> (last visited Sept. 19, 2014).

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²⁴ The 2013 legislative session was the second worst on record for reproductive rights, with over 30 harmful anti-abortion bills becoming law in 18 states. CENTER FOR REPRODUCTIVE RIGHTS, *Fulfilling Unmet Promises: Securing and Protecting Reproductive Rights and Equality in the United States*, 21 (2013).

²⁵ The law requires abortion providers to have admitting privileges at a nearby hospital, only allows abortions in ambulatory surgical centers (ASCs), dictates how and when doctors can prescribe medication abortion, and promulgates an absolute ban on post-20 week abortions. Act of July 12, 2013, 83rd Leg., 2nd C.S., Ch. 1, 2013 Tex. Gen. Laws 4795 (codified at Tex. Health & Safety Code Ann. §§ 171.0031, 245.010(a) (West Supp. 2014), text available at <http://legiscan.com/TX/bill/HB2/2013/X2>.

²⁶ THE TEXAS POLICY EVALUATION PROJECT, UNIV. OF TEX. AT AUSTIN, *Assessing the Impact of State Reproductive Health Legislation: Access to Abortion Care in the Wake of HB2*, (Jul. 1, 2014), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/AbortionAccessafterHB2.pdf. [hereinafter TEXAS PEP].

²⁷ Erik Eckholm, *Texas Abortion Clinic to Reopen After Ruling*, N.Y. TIMES (Sept. 3, 2014), <http://www.nytimes.com/2014/09/04/us/texas-abortion-clinic-to-reopen-after-court-ruling.html>.

²⁸ Already the number of Texas women of reproductive age living more than 200 miles from an abortion provider has increased from 10,000 in May 2013 to 290,000 in April 2014; when the law is fully implemented the number is expected to rise to 752,000. TEXAS PEP, *supra* note 26.

²⁹ *Whole Woman's Health v. Lakey*, No. 1:14-CV-284-LY, (W.D. Tex.) (filed Aug. 29, 2014) (striking down a provision requiring all abortion clinics in the state to meet the same building requirements as an ambulatory surgical center, and finding that a provision requiring all doctors performing abortions to have admitting privileges at a local hospital was unconstitutional as applied to the clinics in the state's hardest hit communities: the Rio Grande Valley and West Texas).

³⁰ U.S. CENSUS BUREAU, *State & County QuickFacts*, Starr County, Hidalgo County, available at <http://quickfacts.census.gov/qfd/states/48000.html> (last visited Sept. 2, 2014).

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<http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/>; Lindsey Beyerstein, "Miscarriage Management": *The Next Front in the Abortion Wars*, NEW REPUBLIC (Jan. 29, 2014), <http://www.newrepublic.com/article/116399/abortion-texas-survives-miscarriage-management>; Mary Tuma, *All but Illegal*, THE AUSTIN CHRONICLE (July 25, 2014), <http://www.austinchronicle.com/news/2014-07-25/all-but-illegal/>.

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⁴⁰ *R.R. v. Poland*, No. 27617/04 Eur. Ct. H. R. (2011).

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2000); *Dahlan v. Dep't of Homeland Sec.*, 215 Fed. App'x 97, 100 (3d Cir. 2007).

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