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Members of the Human Rights Committee
Office of the United Nations High Commissioner for Human Rights
Palais Wilson
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Suggested List of Issues to Country Report Task Force on the United States for the 107th Session of the Human Rights Committee, 11-28 March 2013

The Center for Reproductive Rights is an international non-governmental organization headquartered in the United States that uses the law to promote reproductive freedom worldwide. We respectfully submit this suggested list of issues to the Human Rights Committee in preparation for the meeting of the Country Task Force on the United States during its 107th Session.

Reproductive rights are based on a number of fundamental human rights enumerated in the International Covenant on Civil and Political Rights (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.¹ The Human Rights Committee (HRC) requests States Parties to submit information on reproductive rights as a reflection of the status of women's rights to equality, non-discrimination, and other core human rights protected by the ICCPR.²

This submission identifies four reproductive rights issues for the HRC to consider as it prepares its List of Issues for the review of the United States: (1) the state practice of using restraints on pregnant women in detention; (2) the impact of religious refusal laws on women's reproductive healthcare; (3) discrimination against immigrant women in accessing affordable healthcare; and (4) restrictive abortion laws that violate the freedom of expression of both patients and their physicians. These policies and practices implicate a range of rights protected by 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).

¹ 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 [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 International 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).

² Human Rights Committee (HRC), *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).

A. Use of Restraints on Pregnant Women in Detention (Articles 2, 7, 10)

1. Issue Summary

The United States is one of the few countries in the world that continues to use restraints on pregnant women during transport, labor, delivery, and post-delivery. Shackling pregnant incarcerated women is needlessly punitive and traumatizing¹ and can cause otherwise avoidable health risks for the woman and the fetus.² Incarcerated women already constitute a high-risk maternal population because they experience violence, poor physical and mental health, and substance abuse in higher proportion than the average population.³ Two large studies published in 2009 found that U.S. prisons lack adequate nutrition and hygiene and other conditions suitable for pregnant women.⁴ Fewer than half of U.S. jails provide OB/GYN services to assist pregnant women in prison, and 38 states have no policies on pre-natal care for prisoners.⁵

Because a disproportionate number of incarcerated women are women of color, this population is especially impacted by shackling and other abuses in prison. The number of women incarcerated in state facilities grew by 888% from 1986-1999 due to increased prosecution of women for drug-related offenses.⁶ Black women and Latinas are incarcerated in the criminal justice system at a rate 3 times and 1.5 times higher, respectively, than white women,⁷ largely due to prosecutions for drug offenses.⁸ Similarly, the number of immigrant women in civil detention has risen steadily since 2001, now accounting for at least 10% of all immigrants in detention; the vast majority of this population is Latina.⁹

Changes in federal and state policies since the last periodic review signify a growing consensus that restraining women during pregnancy and childbirth is unacceptable from a human rights perspective. The 2008 Federal Bureau of Prisons policy and 2011 Immigration and Customs Enforcement (ICE) National Detention Standards banned the use of restraints on pregnant women in federal prisons and immigration detention except in very narrow circumstances.¹⁰ Eighteen states have enacted legislation banning the practice.¹¹

Despite policy improvements, the policy of shackling during pregnancy and childbirth remains prevalent due to lack of enforcement. Neither the Bureau of Prisons policy nor the ICE Standards is codified in binding regulations or provides for independent oversight and accountability for perpetrators. Moreover, the failure of states to train corrections officers or discipline violators leads to non-compliance. For example, on May 23, 2012, a federal court in Chicago awarded a \$4.1 million settlement to a group of 80 women who alleged they were shackled while they were pregnant or in labor in spite of an Illinois state law banning the practice.¹² This case demonstrates that eradication of the practice will require additional measures beyond policy change.

2. HRC Concluding Observations

In 2006, the HRC expressed concern about the impact of shackling on the rights of women under Articles 7 and 10 and recommended that the U.S. prohibit the practice of restraining pregnant women during childbirth.¹³

3. U.S. Government Report

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.¹⁴ 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 U.S. report inappropriately characterizes shackling of pregnant women as an issue arising solely under ICCPR Article 10 (conditions of detention) and not Article 7 (torture and cruel, inhuman and degrading treatment) and Article 2 (non-discrimination). The report's focus on policy improvements obscures ongoing problems with lack of enforcement mechanisms, continued prevalence of the practice, and inadequate remedies for women harmed.

4. Recommendations from other Human Rights Bodies

In its 2006 Concluding Observations, the Committee against Torture also expressed concern about shackling during childbirth and gender-based humiliation of women detainees.¹⁵ The Committee raised the issue of shackling in its 2010 List of Issues to the United States, inquiring whether the U.S. government plans to take positive steps to address ill treatment in detention (this review will likely take place in 2013).¹⁶ Manfred Nowak, the former Special Rapporteur on Torture, stated in 2008 that shackling during childbirth should be avoided.¹⁷ The Special Rapporteur on violence against women has condemned the practice and urged the U.S. to prohibit it in labor and delivery.¹⁸

Recommended Questions

- a) Human rights treaty bodies and experts have condemned the practice of shackling pregnant women as a form of cruel, inhuman and degrading treatment. When will the U.S. government recognize this practice as a violation of ICCPR Article 7?
- b) What plans does the U.S. have to enact a legislative prohibition on the practice of shackling that includes enforcement mechanisms and remedies for women whose rights are violated?
- c) What efforts is the U.S. making to address the over-incarceration of women of color, which makes this population particularly vulnerable to abuses like shackling?

Suggested Recommendations

- a) Enact a federal statute prohibiting the use of restraints on pregnant women during transportation, labor, delivery, and post-delivery. The statute should apply to women held in all federal facilities, including immigration detention facilities, and contain effective enforcement mechanisms and remedies.
- b) All states should enact legislation prohibiting the use of restraints on pregnant women in accordance with international standards and the Eighth Amendment of the U.S. Constitution.
- c) Provide training for federal and state corrections officers on international and national standards for the treatment of incarcerated women, especially pregnant women.

¹ In this document, we use the term “incarcerated” to refer to women in state or federal prisons and jails, as well as women in immigration detention facilities.

² Amnesty International, *Not Part of My Sentence: Violations of the Human Rights of Women in Custody* (Mar. 1999), <http://www.amnesty.org/en/library/asset/AMR51/001/1999/en/dom-AMR510011999en.html>; Jenni Vainik, *The Reproductive and Parental Rights of Incarcerated Mothers*, 46 FAM. CT. REV. 670, 678 (2008); Kendra Weatherhead, *Cruel But Not Unusual Punishment: The Failure to Provide Adequate Medical Treatment to Female Prisoners in the United States*, 13 HEALTH MATRIX 429, 450 (2003).

³ See Angela Brown et al., *Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women*, 22 INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY (1999).

⁴ World Health Organization, *Women’s Health in Prison: Correcting Gender Inequity in Prison Health* (2009); Institute on Women and Criminal Justice, *Mothers, Infants and Imprisonment* (2009).

⁵ National Women’s Law Center & Rebecca Project for Human Rights, *Mothers Behind Bars* 16 (2010), available at <http://www.nwlc.org/sites/default/files/pdfs/mothersbehindbars2010.pdf> (finding that 38 states received failing grades (D/F) for their failure to institute adequate policies, or any policies at all, requiring that pregnant women receive adequate prenatal care.).

⁶ American Civil Liberties Union et al., *Caught in the Net: the Impact of Drug Policies on Women and Families*, at 1, available at http://www.aclu.org/files/images/asset_upload_file431_23513.pdf.

⁷ Bureau of Just. Statistics, U.S. Department of Justice, *Prevalence of Imprisonment in the U.S. Population, 1974-2001* 1 (2003), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/piusp01.pdf>. And one in 19 Black women, compared with one in 118 white women, has a chance of going to prison in her lifetime. Id. at 8.

⁸ ACLU, *Caught in the Net*, *supra* note 8, at 1 (noting that “In 1997, 44% of Hispanic women and 39% of African American women incarcerated in state prison were convicted of drug offenses, compared to 23% of white women...”).

⁹ 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.

¹⁰ Bureau of Prisons, U.S. Department of Justice, PROGRAM STATEMENT 5538.05: ESCORTED TRIPS, § 9, p. 10; Immigration & Customs Enforcement, U.S. Department of Homeland Sec., PERFORMANCE-BASED NAT’L DETENTION STANDARDS § 4.4 (2011), <http://www.ice.gov/doclib/detention-standards/2011/pbnds2011.pdf>.

¹¹ As of December 2012, 18 states have legislatively prohibited shackling of pregnant incarcerated women: Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Louisiana, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia.

¹² Colleen Mastoney, *\$4.1 million settlement for pregnant inmates who say they were shackled*, CHICAGO TRIBUNE, May 23, 2012.

¹³ HRC, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (Dec. 18, 2006).

¹⁴ Fourth Periodic Report of the United States of America to the United Nations Committee on Human Rights Concerning the International Covenant on Civil and Political Rights, paras. 231-33, 676 (Dec. 30, 2011), available at <http://www.state.gov/j/drl/rls/179781.htm>.

¹⁵ Committee against Torture (CAT), *Concluding Observations: United States of America*, para. 33, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006).

¹⁶ The Committee suggested measures 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.” CAT, 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). Note that since the last periodic review of the U.S. in 2006, the U.N. General Assembly adopted the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, which states clearly that “[i]nstruments of restraint shall never be used on women during labour, during birth and immediately after birth”). *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).

¹⁷ 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).

¹⁸ Special Rapporteur on violence against women, its causes and consequences, *Report of the Mission to the United States of America*, para. 115, U.N. Doc. A/HRC/17/26/Add.5 (June 1, 2011) (by Rashida Manjoo); *see also* 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).

B. Religious Refusal Laws Denying Women Reproductive Healthcare (Articles 2, 3, 6, 18 and 26)

1. Issue Summary

An array of federal and state laws permit individual and institutional healthcare providers to refuse to provide reproductive healthcare to women based on professed religious convictions, in violation of accepted norms of medical care. These laws allow healthcare providers to opt out of providing critical health services, including abortion (46 states), contraception (13 states), and sterilization (18 states).¹ In some cases, the right to refuse is afforded not only to those directly involved in healthcare services but also to ancillary healthcare personnel, such as pharmacists (12 states).²

In most cases, these federal and state laws extend beyond individual providers to also allow healthcare *institutions* (e.g., hospitals and clinics) to refuse to provide reproductive healthcare on moral or religious grounds. Under such laws, a hospital corporation's management can impose the religious or moral views of the institution on both the patients who turn to these hospitals for care, as well as employees covered by the institution's insurance plan. Forty-four states extend conscience protections to healthcare institutions and corporations.³ At the federal level, the 1973 Church Amendment (42 U.S.C. § 300a-7) prohibits the federal government from requiring individuals *or facilities* receiving public funds to provide abortion or sterilization services. While healthcare institutions are legally permitted to refuse services based on a notion of "institutional conscience," healthcare professionals whose conscience compels them to provide reproductive health services are, in almost all circumstances, not legally protected if they work for objecting institutions.⁴

Over the four decades since enactment of the Church Amendment, 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.⁵ In 2010, the Affordable Care Act (ACA) was enacted with a provision, Section 1303(b)(4), which prohibits healthcare 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.⁶ During the legislative debate over the ACA, some religious institutions strongly objected to a proposed regulation that would require them to cover a full range of contraceptive methods.⁷ The Obama Administration reached a workable solution that will allow objecting religious 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.⁸ Though the compromise is widely popular with the American public, the opponents of reproductive rights are challenging the rule in court and seeking to carve out ever larger religious refusal exemptions in the ACA and other federal laws.⁹

Religious refusal laws jeopardize women's lives because their broad scope allows individual and institutional healthcare providers to withhold potentially life-saving reproductive healthcare. 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.¹⁰ 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 suffered disseminated intravascular coagulopathy so dire that her eyes filled with blood.¹¹ According to the doctor, she spent 10 days in the intensive care unit and “very nearly died.”¹²

2. HRC Concluding Observations

The HRC did not raise the issue of religious refusals to reproductive health care in the last review of the U.S. With respect to other state reviews, the HRC has expressed concern about improper use of conscience clauses by medical professionals resulting in denial of access to reproductive health services, and called on states to regulate the practice in compliance with its Article 6 right to life obligations.¹³ The HRC made it clear in General Comment 22 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.”¹⁴ It has also emphasized that laws designed to protect particular religious or conscientious beliefs may not harm dissenting individuals,¹⁵ such as those with a conscientious commitment to provide reproductive healthcare.

3. U.S. Government Report

The U.S. report is silent on the impact of religious refusal laws on reproductive rights.

4. Recommendations by Other Human Rights Bodies

The Committee on the Elimination of Discrimination against Women (CEDAW) has explicitly stated that religious refusal laws that disproportionately affect women constitute gender discrimination under the Convention.¹⁶ Both CEDAW and the Committee on Economic, Social and Cultural Rights (CESCR) have expressed concern about the practice of conscientious objection interfering with women’s access to healthcare and urged states to regulate the practice through implementing a system of timely and systematic referral in the event of an objection.¹⁷ The Special Rapporteur on the right to health issued a report in 2011 on sexual and reproductive health, in which he called on states to remove laws and practices on conscientious objection that make abortion unavailable, interfere with women’s decision-making, and reinforce stigma.¹⁸ He recommended that states define the scope of objections and regulate their use to ensure that women have meaningful access to reproductive healthcare services.¹⁹

Recommended Questions

- a) Please explain how the federal and state laws allowing individual healthcare providers and healthcare *institutions* to refuse to provide reproductive healthcare on the basis of religious or moral views impact women’s reproductive rights protected by ICCPR Articles 2, 3, 6, and 26?
- b) What steps is the U.S. government taking to ensure that religious refusal laws are not hindering access to reproductive healthcare services women are legally entitled to receive?

- c) What efforts is the U.S. government making to protect the conscience rights of healthcare professionals whose conscience compels them to *provide* reproductive healthcare?

Suggested Recommendations

- a) Take measures to ensure that religious refusal laws guarantee women's access to reproductive healthcare they are legally entitled to receive, including abortion and contraception, and that measures are put in place to monitor and prevent abuses. At a minimum, religious refusal laws should apply to (1) individuals only, not institutions; (2) those directly involved in healthcare provision (e.g., doctors and nurses), not ancillary providers (e.g., pharmacists); and (3) non-emergency situations only.

¹ 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.

² *Id.* Six states have explicit clauses allowing pharmacists to object, while 6 more have broad refusal clauses that may be read to apply to pharmacists.

³ *Id.*

⁴ This is true for all federal laws with the exception of the Church Amendment, Section C.

⁵ 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.

⁶ 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>.

⁷ 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).

⁸ 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>.

⁹ 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. See Robert Pear, *Senate Rejects Step Targeting Coverage of Contraception*, N.Y. TIMES, Mar. 1, 2012, at A1.

¹⁰ Lori Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008).

¹¹ *Id.*

¹² *Id.* at 1777.

¹³ HRC, *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010) and *Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004).

¹⁴ HRC, *Gen. Comment 22 on the Right to Freedom of Thought, Conscience and Religion*, para. 8, U.N. Doc. CCPR/C/21/Rev.1/Add.4 (1993).

¹⁵ *Id.*, para. 10.

¹⁶ Committee on Elimination of Discrimination against Women, *General 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).

¹⁷ *Id.*; Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, para. 11, U.N. Doc. E/C.12/2000/4 (2000).

¹⁸ Report of the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim report*, U.N. Doc. A/66/254 (2011) (by Anand Grover).

¹⁹ *Id.*

C. Discrimination against Immigrant Women in Access to Affordable Reproductive Healthcare (Articles 2, 3, 6, 26)

1. Issue Summary

In the U.S., the lack of insurance is the principal driver of healthcare disparities.¹ Non-citizens are three times as likely as U.S.-born citizens to lack private or public insurance.² This is because non-citizens (1) are more likely than citizens to work in low-wage jobs that do not offer employer-based insurance, and (2) face discriminatory restrictions on eligibility for public insurance.³ Immigrant women of reproductive age disproportionately uninsured and, consequently, face particularly high barriers to affordable healthcare.⁴

Federal policies have excluded immigrants from government health insurance programs since 1996.⁵ These policies exclude undocumented immigrants as well as immigrants who are “lawfully present” in the U.S. but have yet to satisfy a five-year residency requirement. In 2002, the federal government gave states the option to extend prenatal care coverage to undocumented immigrant women in 2002.⁶ However, only 14 out of 50 states have agreed to cover this group.⁷ In 2009, the federal government gave states the option to expand full health insurance coverage to all women who are legally present in the U.S., without requiring a five-year waiting period.⁸ Currently, only 18 states opt to cover this group.⁹ These restrictions have greatly impacted low-income immigrant women’s ability to access maternity care and family planning, in addition to other reproductive healthcare services.¹⁰ The Affordable Care Act (ACA) enacted in March 2010—which provides very important steps towards expanding health insurance access for many Americans—unfortunately also perpetuates harmful eligibility exclusions that will prevent many low-income immigrants from qualifying for public health insurance programs or purchasing private health insurance on the exchange market.¹¹

To make matters worse, in August 2012, the federal government proposed a new healthcare regulation (77 Fed. Reg. 52614, Aug. 30, 2012) that will exclude approximately 1.7 million young immigrants from benefiting from healthcare reforms under the Affordable Care Act. These young people are eligible to apply for relief from deportation under the Deferred Action for Childhood Arrivals (DACA) program if they meet certain requirements. Without the proposed rule, those granted such relief would have been eligible for health insurance under the ACA. If the rule goes into effect, it will carve out an exception to bar young immigrants from insurance coverage under the ACA. This rule will exclude approximately 880,000 immigrant women under age 30 from coverage for women’s preventive health services—including contraception and screenings for reproductive health system cancers and sexually transmitted infections—as well as comprehensive pregnancy-related care. Because over 80% of the youth eligible for DACA relief are from Latin America,¹² the rule will decrease access to reproductive healthcare for immigrant Latinas. This will exacerbate reproductive health disparities among a group that experiences significantly higher rates of unintended pregnancy,¹³ cervical cancer incidence and mortality,¹⁴ and HIV/AIDS than white women.¹⁵

2. HRC Concluding Observations

In periodic reviews of other states parties, the HRC has interpreted “other status” as a basis for discrimination under Article 2 to include immigration status and urged states to eliminate differential treatment of non-citizens in the exercise of their rights under the Covenant.¹⁶ Differential treatment includes eliminating distinctions in access to social services on the basis of immigration status¹⁷ and ensuring through legislation and other measures that non-citizens have access to key social benefits.¹⁸

3. U.S. Government Report

The Fourth Periodic Report highlights the Administration’s efforts to promote equity in healthcare access and outcomes through the ACA (paragraph 434), but it does not mention the impact of eligibility exclusions for immigrant women, nor the fact that measures to reduce health disparities have not been fully funded by Congress.

4. Recommendations by Other Human Rights Bodies

In its 2008 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.¹⁹ 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.²⁰

Recommended Questions

- a) What is the rationale for the proposed rule (77 Fed. Reg. 52614) to exclude those eligible for deportation relief under the Deferred Action for Childhood Arrivals program from the Affordable Care Act? How will the proposed rule affect immigrant women’s reproductive rights under Articles 2, 3 and 6?
- b) What measures are state and federal governments taking to ensure all immigrant women have access to reproductive healthcare in the United States?
- c) What is the federal government doing to eliminate persistent reproductive health disparities among immigrant women and women belonging to racial and ethnic minorities?

Suggested Recommendations

- a) Revoke proposed rule 77 Fed. Reg. 52614, which would exclude young immigrants from healthcare coverage under the Affordable Care Act.
- b) Remove the federal five-year waiting period for “lawfully present” immigrant women to qualify for Medicaid and other health insurance programs.
- c) Fully fund provisions of the Affordable Care Act designed to eliminate health disparities, particularly community health clinics that provide reproductive healthcare to women regardless of their immigration status.

¹ Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson (Institute of Medicine), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 83 (2002).

² Forty-seven percent of non-citizens are uninsured compared to 16% of U.S.-born citizens and 24% of naturalized citizens. Kaiser Commission on Medicaid & the Uninsured, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under Health Reform 2* (Feb. 2012), available at <http://www.kff.org/uninsured/upload/8279.pdf>.

³ *Id.*; Kaiser Commission 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>.

⁴ 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>.

⁵ 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).

⁶ 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 provide coverage to the “unborn child” being carried by a pregnant woman. This definition is problematic for many reasons, not least because it only provides care related to the fetus, not comprehensive health coverage. 67 Fed. Reg. 61955, 61974 (Oct. 2, 2002), revising 42 C.F.R. § 457.10.

⁷ Kaiser Commission, *Key Facts*, *supra* note 42, at 3 (Feb. 2012).

⁸ For more information about the change in policy and particular benefits to lawfully present immigrant women, see Center for Children and 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>.

⁹ Kaiser Commission, *Key Facts*, *supra* note 42, at 3.

¹⁰ See Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, 10 GUTTMACHER POLICY REVIEW 7, 8 (2007).

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

¹² Immigration Policy Center, *Who and Where the DREAMers Are: A Demographic Profile of Immigrants Who Might Benefit from the Obama Administration’s Deferred Action Initiative*, 9 (2012), available at http://www.immigrationpolicy.org/sites/default/files/docs/who_and_where_the_dreamers_are_0.pdf.

¹³ The percentage of all pregnancies that are unintended is 53 for Latinas compared to 40 for white women. Lawrence B. Finer, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 CONTRACEPTION 478-85 (Nov. 2011), available at <http://www.guttmacher.org/pubs/journals/j.contraception.2011.07.13.pdf>.

¹⁴ E. Schleicher, Women’s & Children’s Health Policy Center, Johns Hopkins Bloomberg School of Public Health, *Immigrant Women and Cervical Cancer Prevention in the United States 1-4* (2007), available at <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/ImmigrantWomenCerCancerPrevUS.pdf>. While cervical cancer has been on the decline for U.S.-born women, research indicates that the disease—which can be prevented through routine gynecological care and is highly treatable when caught early—has been on the rise for immigrant women. American Congress of Obstetricians & Gynecologists, *Health Care for Undocumented Women 2* (2009), available at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underrepresented_Women/Health_Care_for_Undocumented_Immigrants.

¹⁵ One in 106 Latina women are diagnosed with HIV at some point in their lives, compared to 1 in 526 white women. Ctrs. for Disease Control, *HIV among Women* (August 2011), available at <http://www.cdc.gov/hiv/topics/women/pdf/women.pdf>.

¹⁶ See HRC, *Concluding Observations: Syrian Arab Republic*, para.19, U.N. Doc. CCPR/CO/84/SYR (2005); *Concluding Observations: Azerbaijan*, para. 20, U.N. Doc. CCPR/CO/73/AZE (2001).

¹⁷ HRC, *Concluding Observations: Korea*, para.12, U.N. Doc. CCPR/C/KOR/CO/3 (2006); *Concluding Observations: Latvia*, para.18, U.N. Doc. CCPR/CO/79/LVA (2003); *Concluding Observations: Thailand*, para.23, U.N. Doc. CCPR/CO/84/THA (2005).

¹⁸ *See id.*, 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).

¹⁹ Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations: United States of America*, paras. 32-33, U.N. Doc. CERD/C/USA/CO/6 (2008).

²⁰ *Id.*, para. 33.

D. State Restrictions on Abortion and Freedom of Expression (Articles 2, 6, 17, 19)

1. Issue Summary

Although women in the U.S. have a constitutional right to terminate their pregnancies,¹ state legislatures in recent years have considered and enacted numerous and more extreme restrictions in an effort to restrict women's ability to exercise that right. For example, from 2009-2012 states enacted over 180 new restrictive abortion laws.² These laws greatly limit women's ability to access reproductive healthcare and to exercise their reproductive rights.

One new type of restrictive abortion law to emerge in the U.S. since the HRC's 2006 review of the United States is coercive ultrasound laws. Since 2010, the states of Texas, North Carolina and Oklahoma passed laws³ that require a physician to perform an ultrasound on all women seeking abortions regardless of her wishes. The physician is required by law to place the image in the woman's line of sight and describe the ultrasound image in ways specified by the state legislators. These laws compel physicians to deliver messages to their patients that are intended to personify the fetus, shame the woman seeking an abortion, and convince her not to terminate her pregnancy. Consequently, 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. Such laws violate principles of medical ethics including informed consent, respect for patient autonomy, and acting in the patient's best interest. They also implicate the freedom to seek, receive and impart information protected by Article 19.

The Center for Reproductive Rights has challenged these three state laws in part on grounds that they violate constitutional protections of the right to speech. In all three states, judges blocked the state from enforcing the laws, recognizing the threats they pose to constitutional rights.⁴ 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.⁵ Despite the shaky legal ground on which these laws stand, at least seven similar bills were proposed in other states in 2012.

2. U.S. Government Report

Information regarding the profound impact of state laws and policies interfering with a woman's exercise of her reproductive rights—especially her constitutional right to abortion—is strikingly absent from the U.S. government's report.

3. HRC Concluding Observations

In its recent General Comment 34, the HRC enumerated the limited circumstances under which states may impose restrictions on the right to freedom of expression.⁶ Coercive ultrasound laws fail to conform to the principle of *legality* because they constitute gender discrimination and violate women's right to privacy. These laws are also not *necessary*, as states have passed these ultrasound requirements absent evidence of any need for them. Finally, they are *disproportionate* to their legislative purpose, as states could select less intrusive measures to disseminate their viewpoint on abortion rather than compelling physician speech.⁷ Coercive ultrasound laws

therefore interfere with the right of physicians to impart, and the right of patients to seek and receive, health-related information protected by Article 19(2).⁸ They also run counter to the HRC's position that where abortion is legal, women must have access to the procedure.⁹

4. Recommendations from Other Human Rights Bodies

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.¹⁰ The CEDAW Committee has found that 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.¹¹

Recommended Questions

- a) What role does the federal government play in ensuring that women have meaningful access to their constitutional right to abortion, as enumerated by *Roe v. Wade*, 410 U.S. 113 (1973)?
- b) In the view of the U.S. government, what impact do state laws compelling doctors to perform and women to receive ultrasounds prior to abortion have on the freedom to seek, receive and impart information and ideas as protected by ICCPR Article 19?

Suggested Recommendations

- a) Enact federal legislation affirming the constitutional right to abortion and women's right to make decisions about their reproductive lives without interference by the state.
- b) State legislatures should refrain from passing laws or promulgating regulations related to abortion provision that interfere with the right to seek, receive and impart information under Article 19(2).

¹ *Roe v. Wade*, 410 U.S. 113 (1973).

² Center for Reproductive Rights (CRR), *2009 Legislative Wrap Up* (2010); CRR, *2010 State Legislative Wrap Up* (2011), CRR, *2011: A Look Back* (2012); CRR, State Report on 2012 Legislative Season [forthcoming December 2012], available at <http://www.reproductiverights.org>. For a summary of the type and number of state restrictions on abortion, see Guttmacher Institute, *State Policies in Brief: An Overview of Abortion Laws* (current as of Dec. 1, 2012), available at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

³ 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). 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). In North Carolina, the law mandates a four-hour wait between the ultrasound and the abortion and in Oklahoma a one-hour wait is mandated. In all three states, women who have a medical emergency do not have to wait, but no other women (e.g., minors or victims of rape or incest) are exempted from the requirements in North Carolina and Oklahoma.

⁴ *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*, 834 F. Supp. 2d 424, [] (M.D.N.C. 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).

⁵The district court judge strongly objected that the appeals court decision “eviscerated the First Amendment” protections of healthcare providers and will result in “mak[ing] puppets out of doctors,” *Med. Providers Performing Abortion Servs. v. Lakey*, 2012 WL 373132, at *2, 3 (W.D.Tex. Feb. 6, 2012). However, the appellate ruling forced the lower court judge to deny a permanent injunction, and the ultrasound requirements now apply to all abortions performed in that state. *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).

⁶ Human Rights Comm., *Gen. Comment No. 34, Article 19: Freedoms of opinion and expression*, paras. 21-36, U.N. Doc. CCPR/C/GC/34 (2011).

⁷ *Id.*, para. 10 (“[a]ny form of effort to coerce the holding or not holding of any opinion is prohibited”).

⁸ ICCPR, article 19(2); see also HRC, *Gen. Comment No. 34, supra* note 65, para. 11.

⁹ See, e.g., HRC, *Concluding Observations: Cameroon*, para. 13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); *Concluding Observations: Colombia*, para. 19, U.N. Doc. CCPR/C/COL/CO/6 (2010);

¹⁰ 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 1, Chapter 7; CEDAW, *supra* note 1, art. 10(h); see also Committee on Economic, Social and Cultural Rights (CESCR), *General 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); Committee on Elimination of Discrimination against Women (CEDAW), *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 CRR, *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.

¹¹ CEDAW, *Gen. Recommendation 24, supra* note 69; American College of Obstetricians and Gynecologists, 439 *Comm. on Ethics Opinion: Informed Consent 3* (August 2009), available at http://www.acog.org/Resources_And_Publications/Comm._Opinions/Comm._on_Ethics/Informed_Consent.