



Center for Reproductive Rights

Remarks to the Institute of Medicine - Committee on Preventive Services for Women

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My name is Aram Schvey, and I serve as Policy Counsel at the Center for Reproductive Rights. The Center is a global human rights organization that uses constitutional and international human rights law to promote women's equality by establishing and protecting their access to reproductive health care and their control over reproductive health decisions as fundamental rights that all governments around the world must respect, protect, and fulfill. We work in the U.S., Latin America, Sub-Saharan Africa, Eastern Europe, and Asia on a wide range of reproductive health and rights issues, including the right to access contraception, and the obligation of governments to fund contraception. Our recent work includes a study on European standards for government funding of contraception, documentation of the human rights violations stemming from the Manila municipal government policy to bar contraception in government clinics, and successful litigation against the U.S. Food and Drug Administration regarding over-the-counter sales of emergency contraception. Because the Center dedicates itself equally to addressing domestic and international reproductive rights violations, it is uniquely positioned to address the subject of my remarks – the human rights basis for why contraception and family planning services constitute preventive services that should be included in the insurance plans.

Contraception and family planning services, including emergency contraception, should be included among the preventive services offered by insurance plans for two human rights-based reasons: first, human rights law requires that contraception and family planning services be widely available, including through insurance; and second, human rights law specifically requires that vulnerable minorities have access to contraception and family planning services.

According to the Guttmacher Institute, the average American woman would like to have only two children; to accomplish this, she will have to rely on contraceptives for about 30 years.¹ Not surprisingly, virtually all sexually active women – over 99 percent – have used a contraceptive method at

¹ Guttmacher Institute, *Facts on Contraceptive Use in the United States* (June 2010).

some point. But unfortunately, the rate of contraceptive use remains inconsistent. More than ten percent of fertile, sexually active women, who do not wish to become pregnant, do not use contraception. The rate among teens is nearly twice that – a full 19 percent of women between 15 and 19, who do not wish to get pregnant, do not use contraception.² Consequently, unintended pregnancies, and in particular unintended teen pregnancies, remain extremely common, comprising fully half of the six million annual pregnancies in the United States.³ These three million annual unintended pregnancies pose serious dangers both for the pregnant women and, in the case of the approximately fifty percent of unintended pregnancies that are taken to term, for the baby.⁴ Evidence shows that mothers of unintended children are at a greater risk of morbidity and are more likely to experience dysfunctional labor, gestational diabetes, and hypertension.⁵ They are also at a greater risk of physical abuse,⁶ less likely to stay in school, more likely to live in poverty, and more likely to rely on public assistance; and the children who result from these unintended pregnancies are more likely to be exposed to harmful substances like alcohol or tobacco *in utero*, more likely to have a low birth weight, more likely to die in their first year, and more likely to be abused.⁷

The government’s failure to ensure that all women have access to contraception – and America’s corresponding fifty percent unintended pregnancy rate – represent not only profound public-health failures, but also a significant human rights concern, implicating the rights to nondiscrimination and to health. These rights are recognized by the international community and are set forth in the major international human rights treaties to which the U.S. is a party or signatory.

For example, the United States has ratified the International Covenant on Civil and Political Rights. That treaty requires that states “guarantee to all persons equal and effective protection against

² *Id.*

³ Center for Reproductive Rights, *Contraceptive Access in the United States* (March 5, 2009).

⁴ See, e.g., Lawrence B. Finer and Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEX. AND REPR. HEALTH 92 (2006) (noting that of the 3.1 million unintended pregnancies in 2001, 44% resulted in births, 42% in abortions, and 14% in fetal losses).

⁵ See, e.g., *Unintended Pregnancies: 2004-2006 N.C. Pregnancy Risk Assessment Monitoring System* (March 2009), available at <http://www.schs.state.nc.us/SCHS/pdf/UnintendedPregnancies.pdf>.

⁶ *Id.*

⁷ Department of Health and Human Services, *Healthy People 2010* (2010), at 9-5; Finer and Henshaw, at 90.

discrimination on any ground,” including sex.⁸ Such sex discrimination includes discrimination relating to family planning. The Committee on Economic, Social and Cultural Rights – the treaty body that monitors compliance with the International Covenant on Economic, Social and Cultural Rights – a treaty the United States has signed – has explained that “[t]o eliminate discrimination against women,” States should “provide access to a full range of high quality and affordable health care, including sexual and reproductive services.”⁹ According to the Committee, such health care goods and services, including contraception, must be, “whether privately or publically provided, affordable for all, including socially disadvantaged groups.”¹⁰

The link between women’s right to equality and their access to contraception and family planning services is also spelled out in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – a treaty that the United States has also signed, and about which a Senate subcommittee is holding hearings later this week. The Convention requires that states “eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, *including those related to family planning*.”¹¹ And the CEDAW Committee, which monitors treaty compliance, has called on states to “[e]nsure the removal of all barriers to women's access to health services...including in the area of sexual and reproductive health.”¹² The Committee has repeatedly expressed concern to states over women’s lack of access to, and low use of, contraceptives,¹³ and has urged governments to improve access to prevention methods through increased insurance coverage¹⁴ and greater attention to their costs.¹⁵ These prevention

⁸ International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976, art. 26.

⁹ Committee on Economic, Social and Cultural Rights, General Comment 14 (The Right to the Highest Attainable Standard of Health) (2000), at para. 21.

¹⁰ *Id.*, at para. 12(b).

¹¹ Convention on the Elimination of all Forms of Discrimination Against Women, art. 12(1).

¹² Committee on the Elimination of All Forms of Discrimination Against Women, General Recommendation 24 (1999), at para. 31(b).

¹³ *See, e.g.*, CEDAW Committee, *Concluding Observations* to: Greece, ¶ 207, U.N. Doc. A/54/38 (1999); Hungary, ¶ 254, U.N. Doc. A/51/38 (1996); Ireland, ¶ 186, U.N. Doc. A/54/38 (1999); Lithuania, ¶ 158, U.N. Doc. A/55/38 (2000); Mongolia, ¶ 273, U.N. Doc. A/56/38 (2001).

¹⁴ *See* CEDAW Committee, *Concluding Observations* to: Luxembourg, ¶ 221, U.N. Doc. A/52/38/Rev.1, Part II (1997).

methods, the Committee has stated, should include “a wide range of contraceptive methods, including emergency contraception.”¹⁶

While the population-wide statistics on contraceptive access and unintended pregnancies paint a troubling picture, the statistics with respect to contraceptive access and use among minorities are nothing short of alarming. Over the past fifteen years, the rate of contraception use among low-income women of color has declined. Today, African-American women are three times more likely than white women to have unintended pregnancies, and low-income Latinas are about twice as likely as low-income white women to have them. In light of many African-American women’s limited access to health care relative to white women, discrimination in healthcare facilities, and other factors, African-American women are four times more likely to die of pregnancy-related complications than white women – a disparity that has not improved over the past 20 years.¹⁷

This intolerable racial disparity represents a profound violation of human rights. The United States has ratified the Convention on the Elimination of All Forms of Racial Discrimination; the treaty, which is binding on the United States, requires states parties to “eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of...the right to public health [and] medical care.”¹⁸ Compliance with the treaty is monitored by the Committee on the Elimination of Racial Discrimination. In 2008, the Committee reviewed the United States’ compliance, and specifically cited the high rate of unintended pregnancies among minorities as a possible treaty violation: “The Committee regrets that...wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to...the high incidence of unintended pregnancies and greater abortion rates affecting African American women...”¹⁹ In order to address this human rights treaty violation, the

¹⁵ See, e.g., CEDAW Committee, *Concluding Observations* to: Belarus, ¶ 374, U.N. Doc. A/55/38 (2000); Croatia, ¶ 117, U.N. Doc. A/53/38 (1998); Estonia, ¶ 112, U.N. Doc. A/57/38 (2002); Greece, ¶ 207, U.N. Doc. A/54/38 (1999); Hungary, ¶ 260, U.N. Doc. A/51/38 (1996); Israel, ¶ 181, U.N. Doc. A/52/38 Rev.1, Part II (1997); Mongolia, ¶ 274, U.N. Doc. A/56/38 (2001); Slovakia, ¶ 92, U.N. Doc. A/53/38/Rev.1 (1998).

¹⁶ CEDAW Committee, *Concluding Comments* to: Mexico, ¶ 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).

¹⁷ Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA – Summary* (March 2010), at 3.

¹⁸ Convention on the Elimination of All Forms of Racial Discrimination, art. 5(e)(iv).

¹⁹ Concluding Observations of the Committee on the Elimination of Racial Discrimination, Review of United States, U.N. Doc. CERD/C/USA/CO/6, May 8, 2008, at para. 33.

Committee recommended that the United States “address persistent racial disparities in sexual and reproductive health...by...[f]acilitating access to adequate contraceptive and family planning methods” and by “[p]roviding adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.”²⁰

Less than two weeks ago, the United States underwent its Universal Periodic Review, a process by which the U.N. Human Rights Council, of which the United States is a member, reviews the human rights record of every nation. Again, the question of high rates of unintended pregnancies among minorities was raised during the review, when the U.S. delegation was asked the following question: “African American women and Latinas have a significantly higher risk of maternal mortality, sexually transmitted infections and unintended pregnancy. What steps does the U.S. government plan to take to address the disparities in reproductive and sexual health?”²¹ The U.S. representative responded by stating that the healthcare reform law would address these disparities. Whether or not the new healthcare legislation does, in fact, address these glaring racial disparities in reproductive health will largely depend on whether contraception and family planning services, including emergency contraception, are included as “preventive services” for women. We at the Center for Reproductive Rights urge you to do so.

²⁰ *Id.* at para. 33.

²¹ Advance Questions to the United States of America, Add. 2, Universal Periodic Review of the United States, Nov. 5, 2010.