



FULFILLING UNMET PROMISES

SECURING AND PROTECTING
REPRODUCTIVE RIGHTS AND
EQUALITY IN THE UNITED STATES

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Cover photo caption: Nancy Guerra from the Rio Grande Valley of Texas helps the National Latina Institute for Reproductive Health mobilize Latinas and educate immigrants in her community about their reproductive health.

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*Supplemental Information for the 2013 Review of
U.S. Compliance with the International Covenant
on Civil and Political Rights*

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KEY REPRODUCTIVE RIGHTS ISSUES IN THE UNITED STATES

Where does the U.S. stand on reproductive rights? This question is one the U.S. will be called upon to answer in October 2013 before the U.N. Human Rights Committee, a body of independent human rights experts charged with monitoring government compliance with the International Covenant on Civil and Political Rights (ICCPR). The U.S. ratification of the ICCPR—one of the two core human rights treaties to comprise the International Bill of Rights—made the provisions of the treaty binding on the United States. It also conferred a responsibility on the government to provide periodic updates of its progress in implementing the treaty to the Human Rights Committee. The fourth periodic review process was triggered in December 2011 when the U.S. government submitted its official report to the Committee. It will culminate in an interactive dialogue between the Committee and a U.S. delegation at the U.N. Headquarters in Geneva in October 2013. Following this dialogue, the Committee will issue its Concluding Observations—a series of recommendations that serve as a roadmap for how the U.S. can improve its human rights record.

The Human Rights Committee has asked governments to provide a comprehensive assessment of the policies and practices that limit women's ability to exercise their reproductive rights particularly in access to family planning and abortion.¹ At every stage of the review process, the Center for Reproductive Rights has provided the U.S. government and the Human Rights Committee with information about particularly important reproductive rights issues at the federal and state level. Nevertheless, the U.S. materials contain substantial gaps on these issues. This “shadow report” aims to fill these gaps by describing, through women's personal stories, what is really at stake when the U.S. fails to respect, protect or fulfill reproductive rights.

This submission focuses on three areas of concern for reproductive rights that the U.S. failed to adequately or comprehensively address in its submissions to the Committee: (1) the use of restraints on pregnant women in state detention; (2) discrimination against immigrant women in accessing affordable reproductive healthcare; and (3) restrictive abortion laws. These policies and practices violate fundamental human rights enumerated in the ICCPR and other core human rights treaties, namely the rights to life, health, non-discrimination, equality, privacy, information, education, and freedom from torture and cruel, inhuman, and degrading treatment.² As this report shows, women from rural North Dakota to the Rio Grande Valley of Texas are fighting to exercise reproductive rights that are firmly grounded in the U.S. Constitution and the ICCPR. This report opens the door to accountability.

RIGHTS TO EQUALITY AND NON-DISCRIMINATION

The policies and practices presented in this report violate an interdependent and indivisible set of human rights protected under the ICCPR. Cutting across all of these violations is the government's failure to ensure the rights to non-discrimination and substantive equality for marginalized groups of women in the U.S. The HRC has recognized in General Comment 28 that “[d]iscrimination against women is often intertwined with discrimination on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status. States parties should address the ways in which any instances of discrimination on other grounds affect women in a particular way, and include information on the measures taken to counter these effects.”³ It has also noted that ensuring equality requires not only removing barriers but also taking *proactive measures* “to achieve the effective and equal empowerment of women.”⁴

In periodic reviews of state compliance with the ICCPR, the HRC has urged states to address both de jure and de facto discrimination in private and public matters,⁵ take efforts to eliminate gender stereotypes about women in family and society,⁶ and address practices such as cutting funds to social programs that disproportionately impact women.⁷ The HRC has also urged states to take affirmative measures to ameliorate social conditions such as poverty and unemployment that impact women's right to equality in healthcare.⁸

Both the Committee on the Elimination of Discrimination against Women (CEDAW) and the Committee on Economic, Social and Cultural Rights (CESCR) also recognize that States parties are under an obligation to respect, protect and fulfil the right to non-discrimination of women and implement their right to substantive equality.⁹ The CEDAW Committee has recognized that “[t]he position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed.”¹⁰ The CESCR has reinforced this understanding of equality in its General Comments 16 and 20, noting that “[e]liminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination.”¹¹

Therefore, in addition to violating the rights to life, dignity, privacy and ill treatment, the examples below all provide evidence of the failure of the U.S. to take effective and proactive measures, including through allocation of resources and development of policies, to ensure that marginalized groups of women do not continue to suffer disproportionate, systemic discrimination. In clarifying the obligations of the U.S. government with respect to the issues raised in this report, it is critical for the HRC to identify both positive and negative duties to ensure the rights to equality and non-discrimination.



Tina Reynolds was shackled while giving birth to her son despite the absence of a flight risk. Now Tina works with formerly and incarcerated women to share their stories and challenge such inhuman policies.

USE OF RESTRAINTS ON PREGNANT WOMEN IN DETENTION (ARTICLES 2, 7, 10)

A. 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 traumatizing and can cause otherwise avoidable health risks for the woman and the fetus.¹² 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.¹³ Two large studies published in 2009 found that U.S. prisons lack adequate nutrition and hygiene and other conditions suitable for pregnant women.¹⁴ 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.¹⁵

Because a disproportionate number of incarcerated women are women of color, this population is especially impacted by shackling and other abuses experienced in detention. Black women and Latinas are incarcerated in the criminal justice system at a rate three times and 1.5 times higher, respectively, than white women,¹⁶ largely due to prosecutions for non-violent drug offenses.¹⁷ Failure to address the root causes of over-incarceration of women of color, including endemic gender and race discrimination in the law enforcement process,¹⁸ or the failure to provide alternatives to incarceration for the 64% of women prisoners who committed non-violent crimes,¹⁹ increases the vulnerability of women of color to human rights abuses in detention. Also, 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.²⁰ Women and their children are often detained in prison-like facilities that create inappropriate conditions for women and families.²¹

Some significant improvements 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 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.²² The U.S. focuses on policy improvements at the federal and state level, including the 2008 Federal Bureau of Prisons policy and 2011 Immigration and Customs Enforcement (ICE) National Detention Standards.²³ Both policies prohibit the use of restraints on pregnant women in federal prisons and immigration detention except in very narrow circumstances.²⁴ The U.S. report also notes a growing trend to enact state legislation banning the practice in state-run facilities. As of August 2013, 18 states have passed a prohibition on shackling during at least some part of childbirth, though not necessarily all phases of labor, delivery, transportation and recovery.²⁵

Although policies have been strengthened since the last periodic review, shackling continues in practice due to lack of enforcement, lack of training of corrections officials, and impunity for violations. In immigration detention facilities, pregnant women are most frequently shackled during transport to and from hearings or medical appointments, as in the case of an Arizona woman who was shackled while six months pregnant despite having committed a non-violent crime and posing no risk of escape or danger.²⁶ The 2011 ICE Detention Standards are non-binding and fail to address fundamental issues such as the lack of an impartial external body to receive and review grievances filed by detainees.²⁷ Other pervasive problems with the grievance procedure include inadequate protections against staff reprisals, scarce translation services, and resistance to independent oversight of DHS/ICE facilities.²⁸

The Bureau of Prisons policy is not codified in binding regulations nor does it provide for independent oversight and accountability for perpetrators. It also does not apply to state facilities. Moreover, the strict administrative exhaustion requirement of the 1996 Prison Litigation Reform Act²⁹ often prevents prisoners from filing lawsuits in court, forcing them to rely on weak internal grievance procedures. These procedures often prevent prisoners from pursuing complaints because of the short timeframe for filing, lack of confidentiality of the complaint mechanism, high burden of proof on the prisoner seeking redress, and lack of protection against retaliation by accused staff.³⁰ Administrative barriers, coupled with unreliable investigations of complaints, make prosecutions of offenders extremely rare.³¹ Consequently, non-compliance with anti-shackling policies is pervasive. 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.³²

Shawanna Nelson is one of the few women who have been able to find accountability and a remedy for being shackled while in childbirth. Shawanna was six months pregnant with her second child when she was incarcerated for a nonviolent offense by the Arkansas Department of Corrections in 2003. Her legs were shackled to the sides of a hospital bed for hours while she was in labor. She was unable to move her body to relieve pain due to the physical restraints. She was briefly unshackled during childbirth, but was immediately re-shackled after delivering her son. She subsequently soiled her sheets with human waste, but was unable to abate the humiliating and unsterile condition due to her inability to move. On October 2, 2009, the Eighth Circuit Appellate Court ruled that Nelson's treatment violated her Eighth Amendment right to be free from cruel and unusual punishment.³³ While Shawanna's story and those of others who experienced shackling are turning public opinion against the practice, strong resistance from state departments of corrections has thwarted efforts at reform in several states.

B. International Human Rights Standards

The widespread U.S. practice of shackling detained women during childbirth has been an area of critical concern for the Human Rights Committee as well as other human rights treaty bodies and experts. In its Concluding Observations on the U.S. 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.³⁴

The HRC has made it clear that States parties' obligations under article 7 go beyond prohibition of torture or ill treatment to include taking positive measures, including "legislative, administrative, judicial and other measures... to prevent and punish acts of torture and cruel, inhuman and degrading treatment."³⁵ States also have a heightened duty "towards persons who are particularly vulnerable because of their status as persons deprived of liberty."³⁶ The HRC has identified pregnant women as one such group, noting they "should receive humane treatment and respect for their inherent dignity at all times, and in particular during the birth and while caring for their newborn children..."³⁷

The Committee against Torture has also condemned the practice of shackling as a form of cruel, inhuman and degrading treatment under Article 16. In its 2006 Concluding Observations to the United States, the CAT Committee recommended that the U.S. "adopt all appropriate measures to ensure that women in detention are treated in conformity with international standards."³⁸ This issue remains one of critical concern to the CAT Committee, as indicated by its inclusion in the List of Issues for the upcoming U.S. periodic review.³⁹ In general, the CAT Committee has recognized that women and girls are at heightened risk of ill treatment where they are in the custody or control of others, such as when receiving "medical treatment, particularly involving reproductive decisions."⁴⁰

Three U.N. Special Rapporteurs to the Human Rights Council have added to the treaty bodies' concern on this issue, signifying clear international consensus that the U.S. practice of shackling pregnant women violates the right to be free from ill treatment.⁴¹ In her 2011 report on the United States, the U.N. Special Rapporteur on violence against women called on the U.S. to "[a]dopt legislation banning the use of restraints on pregnant women, including during labor or delivery, unless there are overwhelming security concerns that cannot be handled by any other method."⁴²

Furthermore, there is growing recognition that States ought to consider alternatives to detention of pregnant women in order to avoid placing them in a vulnerable situation. For example, in addition to stating that "[i]nstruments of restraint *shall never be used* on women during labour, during birth and immediately after birth,"⁴³ the U.N. Rules for the Treatment of Women Prisoners favor non-custodial measures for pregnant offenders and impose a duty on States to take special care to ensure the health and safety of pregnant prisoners.⁴⁴ The Special Rapporteur on the situation of migrants has similarly concluded that "as a general rule [concerning migrants in administrative detention], the detention of pregnant women in their final months and nursing mothers should be avoided."⁴⁵

C. Relevant Question in List of Issues

The Human Rights Committee raised the issue of shackling in paragraph 16 of the List of Issues in the context of conditions of detention. The Committee asked, "Please also clarify whether the State party intends to prohibit the shackling of detained pregnant women during transport, labour, delivery and post-delivery, under all circumstances."⁴⁶

D. U.S. Government Response

The Written Reply does not answer the Committee's question, but rather refers the Committee to the discussion of non-binding federal policies with respect to shackling summarized in the U.S. periodic report.⁴⁷

E. Recommended Questions

- ➔ What plans does the U.S. have to enact a **legislative prohibition** on the practice of shackling pregnant women during pregnancy, including but not limited to transport, labor, delivery and recovery?
- ➔ What **positive measures**—including legislative, administrative, and other measures—are the U.S. taking to ensure compliance with existing federal policies and guidelines that discourage the use of restraints on pregnant women, to prevent and punish violations, and to ensure adequate remedies for victims?
- ➔ What efforts is the U.S. making to address the **over-incarceration of women** of color, which makes this population particularly vulnerable to abuses such as shackling during pregnancy?

F. Suggested Recommendations

- ➔ Enact a **federal statute** with binding administrative regulations prohibiting the use of restraints on pregnant women at all stages of pregnancy and at a minimum during transportation, labor, delivery, and post-delivery. The ban on shackling should apply to women held in all federal facilities, including immigration detention facilities, and contain effective enforcement mechanisms and remedies.
- ➔ **Take positive measures** to address (a) the incarceration of pregnant and nursing women by, *inter alia*, promoting sentencing alternatives to detention for non-violent offenders who fall into these categories, and (b) the over-incarceration of women of color by, *inter alia*, addressing discrimination in policing, and improving educational and employment opportunities for this population.
- ➔ Encourage **state legislatures** to enact legislation prohibiting the use of restraints on pregnant women detained in state facilities in accordance with international human rights standards and the Eighth Amendment of the U.S. Constitution.
- ➔ Establish an **independent oversight mechanism** at the congressional level to monitor federal corrections facilities' and immigration detention facilities' compliance with human rights standards and federal policies prohibiting shackling.
- ➔ **Conduct training** for corrections officers and staff at private and public immigration detention facilities on enforcement of standards concerning the treatment of incarcerated women, especially pregnant and nursing women.

DISCRIMINATION AGAINST IMMIGRANT WOMEN IN ACCESS TO AFFORDABLE REPRODUCTIVE HEALTHCARE (ARTICLES 2, 3, 6, 26)

A. Issue Summary

The U.S. is the only western industrialized country that lacks universal health coverage. The market-based system of care in the U.S. results in healthcare spending amounting to twice the amount per capita than the average spent in similarly wealthy countries.⁴⁸ Yet, the U.S. fails to deliver better healthcare goods and services, and key health outcomes like life expectancy are far lower than for similarly situated countries.⁴⁹ Despite having the most expensive system of healthcare in the world, the U.S. underperforms in every area of health performance (quality, access, efficiency, equity, and healthy lives).⁵⁰ Moreover, low-income people and racial and ethnic minorities face the highest barriers to healthcare and are likely to receive poorer quality care where they can get it.⁵¹

In the U.S., lack of health insurance is the most significant barrier to healthcare and the principal driver of healthcare disparities.⁵² The U.S. took very important steps towards expanding health insurance access for many Americans by enacting the Affordable Care Act (ACA)⁵³ in 2010. As implementation of that Act continues, it is anticipated that increasing numbers of people in the U.S. will have health insurance. Large groups of immigrants, however, will not be among them because the ACA bars them from accessing government-supported health insurance as well as affordable private insurance.

Immigrants are disproportionately uninsured, with non-citizens three times as likely as U.S.-born citizens to lack private or public insurance.⁵⁴ This is true in large part because non-citizens are more likely than citizens to work in low-wage jobs that do not offer employer-based insurance, and because they face discriminatory restrictions on eligibility for public insurance.⁵⁵ Gender also drives disparities in coverage; nationally, immigrant women of reproductive age are approximately 70% more likely than their U.S.-born peers to lack health insurance.⁵⁶

The ACA perpetuates harmful federal policies dating from 1996 that exclude certain large groups of immigrants from eligibility for many social benefits.⁵⁷ These policies bar *undocumented* immigrants, and they impose a five-year waiting period on those who are *lawfully present*⁵⁸ in the U.S. before they are eligible for Medicaid, the government's insurance program for low-income Americans. Aside from limited exceptions for coverage of low-income women's prenatal care and delivery costs,⁵⁹ undocumented women and those subject to the five-year bar have no access to government health insurance.

Women in the Rio Grande Valley used to rely on government supported family planning clinics like this one. But budget cuts have caused over one-third of the clinics in the area to close, and many more to scale back services.

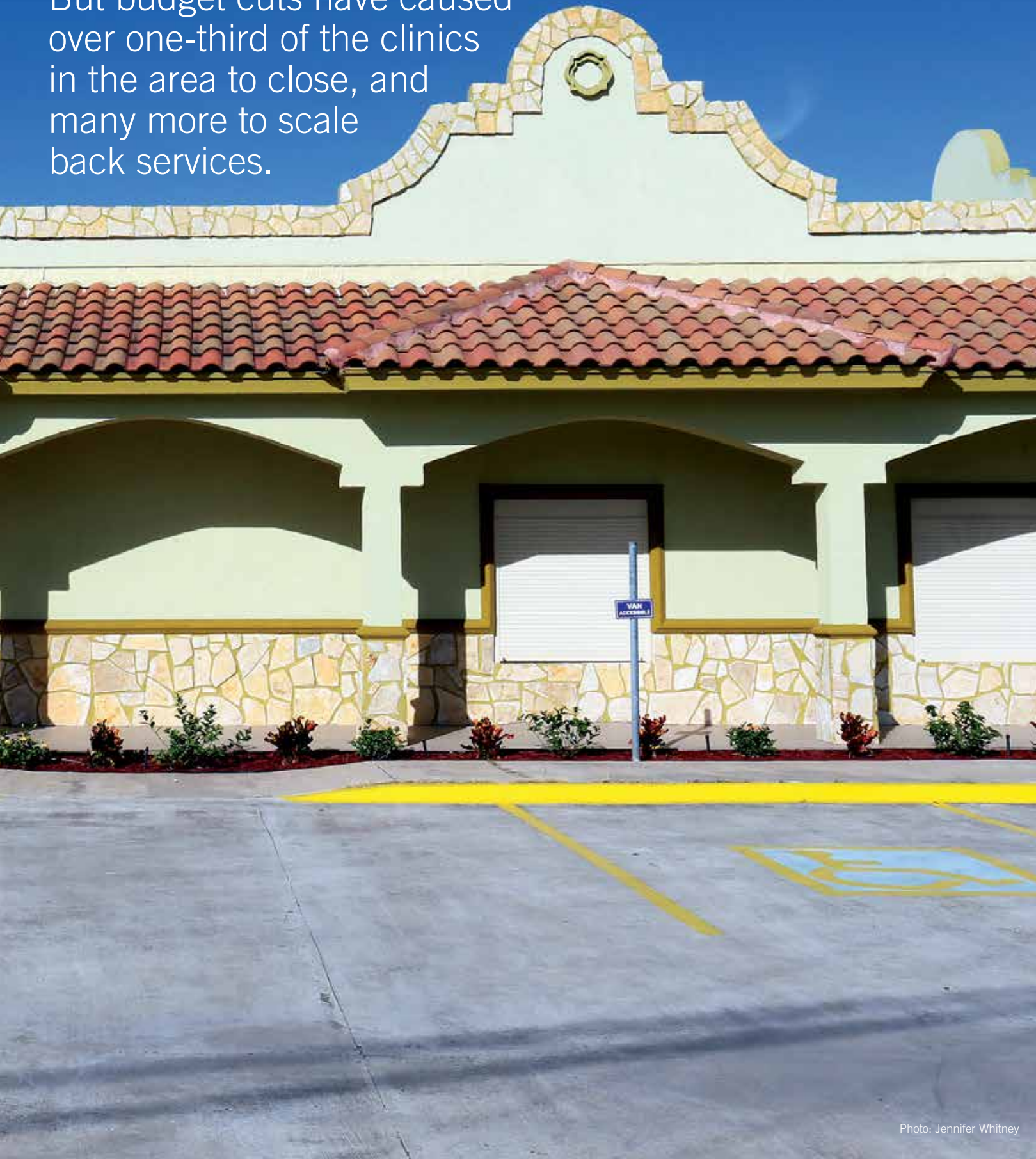


Photo: Jennifer Whitney

Because low-income immigrant women are largely excluded from government-supported insurance and generally cannot afford private insurance, they have virtually no options for accessing and affording reproductive healthcare such as contraception services and counseling, screenings for sexually transmitted infections, and treatment for reproductive system cancers.⁶⁰ These access barriers contribute to wide disparities in sexual and reproductive health outcomes among immigrant women, including higher rates than their native-born peers of unintended pregnancy, teen births, cervical and breast cancer, and sexually transmitted infections.⁶¹

Those who do not qualify for Medicaid or other affordable health insurance due to immigration status are forced to rely on a thin, and fraying, safety net of reproductive healthcare. Funding for the Title X family planning program (see Fourth Periodic Report at paragraph 442) has been steadily eroded since the 1970s despite the program's early and proven success in providing contraceptive goods and services to low-income people.⁶² As more and more immigrants turn to Title X programs for their healthcare, this program faces increased difficulty keeping up with increased demand for its free or low-cost supplies and services.⁶³ Tellingly, although 8.9 million women received publicly supported contraception in 2010, there were 19.1 million women in need of it.⁶⁴ In the past decade, the group with by far the largest increase in need of publicly supported contraception is Latinas.⁶⁵

Meanwhile, some states with especially high immigrant populations have slashed state family planning programs that serve as the frontline source of reproductive healthcare for immigrant women. Texas, a state with one of the highest immigrant populations of any state (including the second highest population of Latinos),⁶⁶ also has the highest uninsured population in the country.⁶⁷ The Center for Reproductive Rights (CRR), in partnership with the National Latina Institute for Reproductive Health (NLIRH), recently documented immigrant women's experiences in trying to access affordable reproductive healthcare in the Rio Grande Valley of Texas on the southernmost border of the United States.⁶⁸ These women live in one of the poorest regions of the country and—until recently—largely relied on government-subsidized family planning clinics for their reproductive health needs. The state of Texas enacted budget cuts in 2011 that decimated the state's family planning program, cutting it by two-thirds. These policies forced 59 clinics serving low-income women to close within one year and severely restricted the availability of affordable contraception, resulting in a dramatic rise in unintended pregnancies.⁶⁹

One of the women interviewed for the CRR/NLIRH fact-finding report is Laura, a 27-year-old recent widow and mother of five children under age eight. She admits that her three-month old youngest child was not a planned pregnancy. In the past, Laura obtained contraception for free because of her poverty level, but “when they took the funding for contraceptives away and I couldn't get them anymore, that's when I got pregnant.” Another study found that the clinic closures and reduced services in the Lower Rio Grande Valley of Texas since 2010 have negatively impacted women's access to reproductive health services and cost the state many millions of dollars in Medicaid spending on unplanned births.⁷⁰ The study calculated that as of 2012, approximately

180,000 women in the Rio Grande Valley were in need of subsidized contraception services, constituting 65% of reproductive age women (15-45).⁷¹

Low-income immigrant women CRR/NLIRH interviewed in Texas are also unable to obtain annual gynecological exams and cancer screenings that used to be available for free at state-funded family planning clinics. Many report living in constant pain from untreated conditions, or dealing with stress and fear that breast or cervical cancer may be progressing without the possibility of early detection and treatment.

Ana is a domestic violence survivor who fled to the U.S. from Mexico to protect herself and her young daughter from her partner's abuse. In the spring of 2012, she found lumps in her armpit—which she astutely identified as a possible sign of breast cancer. She tried in vain to get a breast exam from an affordable clinic. “I tried getting an appointment, but I was told all the slots were taken and to try again next month. Next month, same story.” She tried many more times to get an appointment at different clinics, but eventually gave up. Nine family planning clinics in her area have closed, and the remaining clinics do not have resources or capacity to treat all the women in need. “In the end I just said, ‘well, I don’t feel well right now, but whatever it is it’s temporary, and I’ll just wait till it goes away on its own. But things are all piling up and I’m starting to feel the impact... I’m responsible for my girl, and if I don’t care of myself, I may not be there for her.”

These stories illustrate the devastating impact of the combined effect of *de jure* discrimination against immigrants—both undocumented and lawfully residing—in eligibility for government supported health insurance, and *de facto* discrimination against immigrant women through defunding state and federal family planning programs that are their only source of affordable reproductive healthcare.

B. International Human Rights Standards

Reproductive rights include first and foremost the fundamental human right to life.⁷² The HRC has said the right to life should not be narrowly interpreted, and that fulfillment of this right requires governments to take positive measures to reduce maternal mortality, unintended pregnancies and unsafe abortion.⁷³ On numerous occasions the HRC has linked restrictions on access to reproductive health, especially lack of access to contraception information and family planning services, to women's reliance on unsafe abortion and high rates of maternal mortality that violate the right to life under article 6.⁷⁴ Recently, the HRC called on the Philippines to reverse the ban on government funding and dissemination of contraception in Manila, urging it instead to “ensure that reproductive health services are accessible for all women and adolescents.”⁷⁵ The HRC has further found that the high cost of contraception interferes with women's access to healthcare and therefore jeopardizes article 3's right to equality between men and women.⁷⁶

CEDAW has found that non-discrimination in the exercise of the right to health requires eliminating barriers to healthcare access including high fees.⁷⁷ Equal access to healthcare includes ensuring access to contraception especially

for the most vulnerable groups. For example, in March 2013 the CEDAW Committee urged Hungary to “[p]rovide adequate access to family planning services and affordable contraceptives, including emergency contraception, to all women including women with disabilities, Roma women, women living with HIV/AIDS and migrant and refugee women, i.e. by covering costs of range of modern contraceptives under the public health insurance and eliminating the prescription requirement for emergency contraception.”⁷⁸

As a State party to the ICCPR, the U.S. assumed an obligation under Article 2 of the Covenant to extend rights to “*all* individuals within its territory and subject to its jurisdiction,”⁷⁹ and to do so “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”⁸⁰ The HRC has interpreted “other status” to include immigration status⁸¹ and urged states to eliminate distinctions in access to social services on the basis of immigration status.⁸² Fulfilling this duty may require amending legislation or administrative regulations—such as Medicaid rules that exclude certain classes of immigrants from eligibility—and addressing non-legal barriers that impact access to reproductive healthcare, such as high cost of contraceptive services and supplies, and transportation barriers for women in rural areas.⁸³

The Committee on the Elimination of Racial Discrimination (CERD) has previously addressed differential treatment of non-nationals as a form of discrimination in access to healthcare. In its 2008 review of the U.S., CERD found that because persistent disparities in reproductive health are evidence of gender and racial discrimination in access to healthcare, the U.S. should take steps to eliminate barriers to healthcare that impede access for women of color including immigrants. One specific recommendation was to reduce eligibility barriers to Medicaid.⁸⁴

The CEDAW Committee has urged states to provide universal health coverage, including reproductive healthcare such as comprehensive and affordable contraception, to migrant women and girls in order to reduce barriers to care for this marginalized population.⁸⁵ Finally, the Special Rapporteur on the human rights of migrants has stressed that States have an obligation under human rights law to go beyond a “mere commitment to emergency care” and ensure instead the “the critical importance of providing migrants with essential primary health care,” which reduces costs and health risks to the benefit of everyone.⁸⁶

C. Relevant Question in List of Issues

In its discussion of non-discrimination and equal rights of men and women, the Committee asked the U.S. to “provide information on obstacles to the access of undocumented migrants to health services and higher education institutions, and to federal and state programmes addressing such obstacles.”⁸⁷

D. U.S. Government Response

The Fourth Periodic Report highlights the Administration's efforts to eliminate health disparities through the Affordable Care Act (ACA) (paragraph

Children in the Rio Grande Valley play on a trampoline with gaping holes – a potent symbol of the fraying safety net for poor, immigrant families.

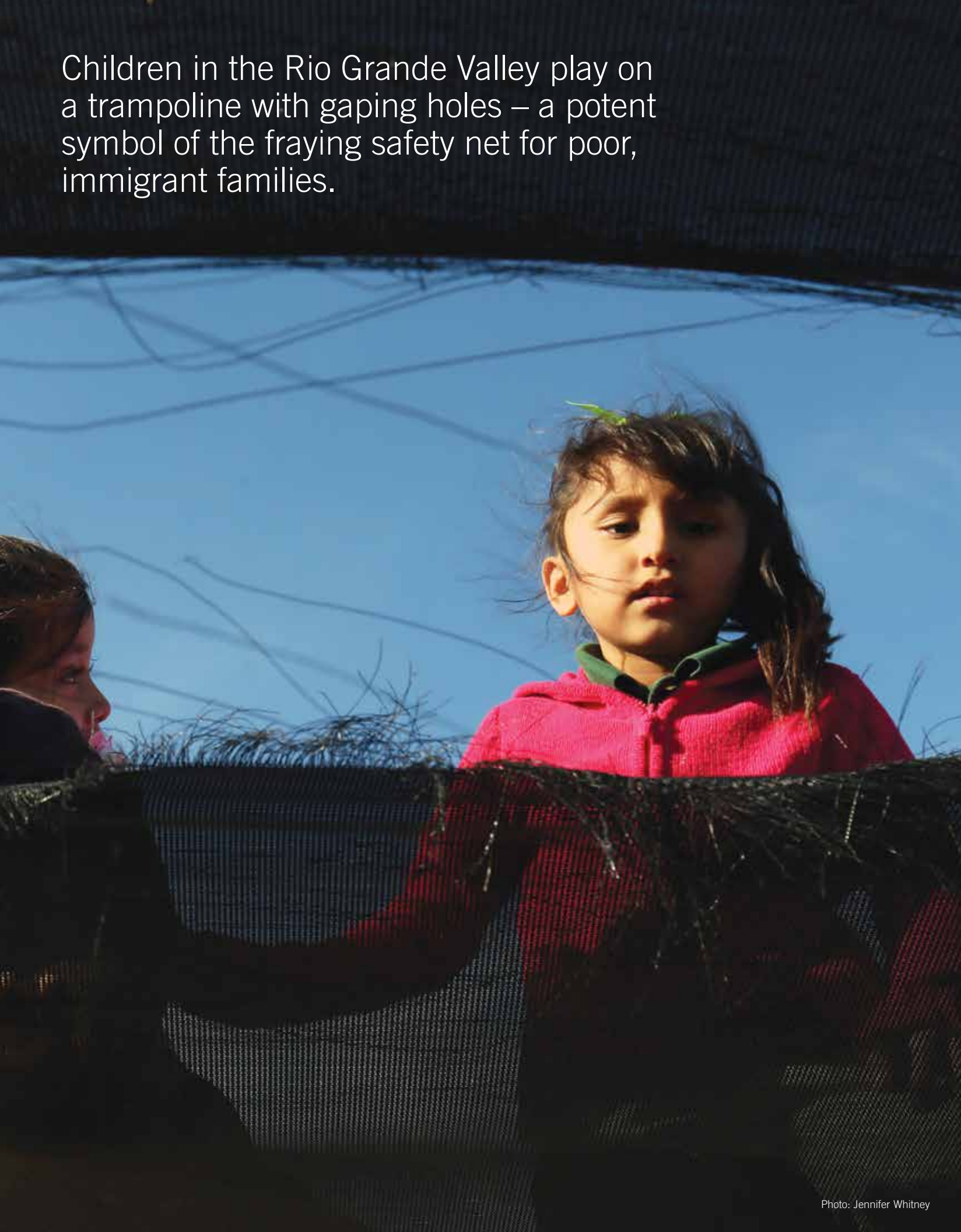


Photo: Jennifer Whitney

434). However, the Report neither assesses the impact of eligibility exclusions for immigrants nor discusses how these exclusions disproportionately impact women.⁸⁸ In response to the Committee’s question on this topic, the Written Reply points to a federal statute – the Emergency Medical Treatment and Labor Act (EMTALA) – that requires all hospitals receiving funding through Medicare to provide emergency treatment to undocumented immigrants regardless of their ability to pay.⁸⁹ This policy, while commendable, has created an untenable situation where emergency rooms are now the *only* source of healthcare for many undocumented people.

The Written Reply mentions the Administration’s “Deferred Action for Childhood Arrivals” (DACA) policy, which grants temporary administrative relief from deportation to young undocumented immigrants who arrived in the U.S. as children. Although this policy is a welcome reprieve from deportation for millions of young immigrants who have lived most of their lives in the United States, the policy does not address the HRC’s concerns about healthcare or education for immigrants. The Written Reply also fails to explain that in August 2012 the Administration proposed two regulations that will exclude approximately 1.7 million young immigrants from benefiting from healthcare reforms under the Affordable Care Act, making them ineligible for affordable health coverage through government insurance programs (Medicaid and the Children’s Health Insurance Program), and barring even their ability to purchase affordable health plans through the new insurance exchanges.⁹⁰ (It is worth noting that other groups of immigrants granted relief from deportation via different programs *are* eligible for such programs.) This exclusion carries gendered consequences: it will affect approximately 880,000 immigrant women under age 30 who will not have access to women’s preventive health services, including contraception access, testing for sexually transmitted infections, and other vital reproductive and sexual healthcare. The policy will also disproportionately impact Latinas, who comprise the vast majority of youth eligible for relief.⁹¹ In combination with the eligibility exclusions for Medicaid described above, these new regulations threaten to increase barriers to affordable reproductive and sexual healthcare for young immigrant women of color.

E. Recommended Questions

- ➔ What is the rationale for excluding certain groups of immigrants from access to affordable health insurance through the Affordable Care Act, Medicaid and the DACA program? Given that nearly half of non-citizens are uninsured, how does the government plan to **expand coverage** to these populations and ensure their equal access to healthcare?
- ➔ How does the U.S. plan to ensure that immigrant women can exercise their reproductive rights **without discrimination** on the basis of gender or immigration status (Articles 2, 3, 6, and 17)?
- ➔ What positive measures, including through allocation of resources and changes in policy, is the U.S. government taking to **eliminate persistent disparities** in reproductive and sexual health, especially given the barriers to accessing preventive care for immigrants under the Affordable Care Act?

F. Suggested Recommendations

- ➔ **Remove the federal five-year waiting period** for “lawfully present” immigrant women to qualify for Medicaid and other health insurance programs, and lift the exclusion of undocumented women from eligibility for Medicaid.
- ➔ **Increase funding for the Title X** family planning program to enable *all* 19.1 million U.S. women in need in publicly supported contraception to exercise their human right to control the number and spacing of their children.
- ➔ **Repeal federal regulations** excluding young immigrants granted relief from deportation under DACA from eligibility for affordable healthcare under the Affordable Care Act and Medicaid programs.

STATE RESTRICTIONS ON ABORTION (ARTICLES 2, 3, 6, 17)

A. Issue Summary

Although the right to abortion is firmly grounded in U.S. constitutional law, abortion remains under attack politically, especially in the states. State legislatures in recent years have considered and enacted numerous and more extreme restrictions in an effort to restrict women’s ability to exercise their right to a safe and legal abortion. Over 170 restrictive abortion laws have been enacted since 2010.⁹² 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.⁹³

Over the past several years, anti-abortion activists and politicians have mounted a campaign to pass unconstitutional bans on abortion. Since 2010, 13 states have enacted bans on abortion at 20 weeks.⁹⁴ These violate settled U.S. constitutional principles: the U.S. Constitution prohibits a state from banning an abortion—or from imposing a substantial obstacle on a woman’s ability to exercise her right to abortion—until the point the fetus is determined to be viable (which varies, but does not generally occur until 24 weeks or later).⁹⁵ Eight of these laws are currently in effect, three have been blocked by courts, and two have been signed and are scheduled to go into effect later this year. In 2013, anti-abortion activists and politicians went even further in introducing unconstitutional measures, resulting in the enactment of bans on abortion within the first trimester in two states: Arkansas at 12 weeks and North Dakota at six weeks. Both laws were challenged by the Center for Reproductive Rights and have been preliminarily enjoined by federal courts.⁹⁶

Bans on abortion harm all women, but research shows they have a disproportionate impact on marginalized women, specifically those who are poor, young, less educated, women of color, and those without access to health insurance or affordable care.⁹⁷ Importantly, these bans are imposed in addition to other restrictions on abortion access that make it very difficult for women, and low-income women in particular, to obtain abortions earlier in pregnancy.

Cost—the most significant barrier to abortion—is a problem exacerbated by both state and federal governments. In 2009, the average cost of a first trimester abortion was \$470, but a second trimester can cost two to three times that amount.⁹⁸ A policy known as the Hyde Amendment restricts federal insurance coverage for abortion under Medicaid except in the very limited circumstances of rape, incest or life endangerment.⁹⁹ While 17 states provide state funds for Medicaid-covered abortions beyond these circumstances, in practice there are numerous barriers (e.g., enrollment delays and low provider reimbursement rates)

In addition to restrictions that directly target women’s ability to exercise their reproductive decisions—such as bans and insurance coverage restrictions—state legislatures are also limiting that ability indirectly by targeting the medical provision of abortion care with special regulations on clinicians and facilities where abortions are performed. These types of laws—called Targeted Regulation of Abortion Providers, or TRAP—exist in 28 states. Proponents of TRAP laws justify them on grounds of promoting women’s health and safety, but the laws actually impose great burdens on the provision of abortion services without benefiting women’s health. These burdens are unjustified based on the methods and associated risks of abortion and are not imposed on the provision of comparable or riskier medical services.¹¹⁰

Over-regulation of abortion has led to clinic closures across the country. The decrease in providers and the many regulations have made safe abortion very difficult to access in large parts of the U.S., especially—but not only—in rural areas.¹¹¹ For example, in the 2013 legislative session, Texas enacted multiple restrictions including a 20-week ban and a new requirement that all abortion facilities—including those only providing first trimester abortions—meet requirements equivalent to those for ambulatory surgical centers.¹¹² The latter requirement will force all but five of the state’s 42 abortion clinics to close, including the remaining two abortion facilities in the Rio Grande Valley. These two clinics serve poor, rural and immigrant women who cannot afford to drive 235 miles north to the next closest facility, in San Antonio.¹¹³ Concerns about access in Texas are echoed in the four states (Mississippi, North Dakota, South Dakota, and Arkansas) with only one abortion facility in operation, all of which also have TRAP laws.¹¹⁴

B. 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. Repeated efforts by the Center for Reproductive Rights to raise the attack on abortion rights at the state level as a topic for consideration in this review have gone unanswered.¹¹⁵

C. International Human Rights Standards

When reporting on article 6, the right to life, the HRC has asked States parties to “give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure they do not have to undertake life-threatening clandestine abortions.”¹¹⁶ In its Concluding Observations, the HRC has frequently expressed its concern over restrictive legislation on abortion and called on States to liberalize their abortion laws. In connection with articles 6 and 26, it has urged States to help women prevent unintended pregnancies and protect them from resorting to clandestine and unsafe abortion.¹¹⁷ It has also expressed concern about the unavailability of abortion in practice, even when the law permits it.¹¹⁸

In the landmark case *K.L. v. Peru*, the HRC found that the State had interfered with a minor’s decision to terminate her pregnancy in violation of her rights to non-discrimination (article 3), privacy (article 17), and freedom from ill treatment (article 7).¹¹⁹ The HRC’s approach in this case is consistent with its expressions of concern about the impact of abortion restrictions on the most marginalized women, including racial and ethnic minorities,¹²⁰ youth,¹²¹ poor and rural women.¹²² Concern for the healthcare of women from marginalized groups has prompted the CEDAW Committee to recommend social security coverage for abortions,¹²³ in addition to comprehensive, youth-friendly, and gender-sensitive reproductive health services.¹²⁴

D. Recommended Questions

- ➔ How does the federal government plan to ensure women’s access to their **constitutional right to abortion** regardless of their socioeconomic status, age, race, migration status, and geographic location?

E. Suggested Recommendations

- ➔ **Enact federal legislation** to protect a woman’s ability to exercise her right to determine whether and when to bear a child or terminate a pregnancy.
- ➔ **Repeal the prohibition on Medicaid coverage for abortion** under the Hyde Amendment, which serves as the most significant barrier to low-income women in exercising their right to a safe and legal abortion.

Endnotes

- ¹ 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).
- ² International Covenant on Civil and Political Rights, arts. 2(1), 3, 6(1), 7, 17, 18, 19, 26, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR]; Convention on the Elimination of All Forms of Racial Discrimination, adopted Dec. 21, 1965, arts. 2, 5(e)(iv), G.A. Res. 2106 (XX), Annex, U.N. GAOR, 20th Sess., Supp. No. 14 at 47, 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 (CEDAW), adopted Dec. 18, 1979, arts. 1, 2, 3, 10, 12, 14, 16(e), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46 at 193, U.N. Doc. A/34/46 (1979) (entered into force Sept. 3, 1981); International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, arts. 2(2), 3, 12, 13, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16 at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (entered into force Jan. 3, 1976); K.L. v. Peru, Human Rights Committee (HRC), Communication No. 1153/2003, para. 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); 13 IHRR 355 (2006). See also *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, Principle 8 and para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995). See *accord Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, paras. 94-97, U.N. Doc. A/CONF.177/20 (1996).
- ³ HRC, *General Comment 28: Equality of Rights between Men and Women (Art. 3)*, 68th Sess., para. 30, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), in COMPILATION OF GEN. COMMENTS & GEN. RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, U.N. Doc. HRI/GEN/1Rev.5 at 1668 (2001) [hereinafter, HRC, *General Comment 28*].
- ⁴ *Id.* para. 3 (emphasis added).
- ⁵ HRC, *Concluding Observations: Jordan*, CCPR/C/JOR/CO/4, para. 7 (HRC, 2010)
- ⁶ HRC, *Concluding Observations: Cape Verde*, CCPR/C/CPV/CO/1, para. 8 (HRC, 2012)
- ⁷ HRC, *Concluding Observations: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999);
- ⁸ HRC, *Concluding Observations: Kyrgyzstan*, Report of the Human Rights Committee, Vol. I, 55th Sess., para. 401, U.N. Doc. A/55/40 (2000).
- ⁹ CEDAW, *General recommendation No. 25 on article 4, paragraph 1, on temporary special measures, reprinted in* COMPILATION OF GEN. COMMENTS & GEN. RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, para. 8, U.N. Doc. HRI/GEN/1/Rev.7 at 282 (2004).
- ¹⁰ *Id.* para. 10
- ¹¹ Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 20, Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, para. 8, U.N. Doc. E/C.12/GC/20 (2009); CESCR, *General Comment 16, Article 3: the equal right of men and women to the enjoyment of all economic, social and cultural rights* (34th Sess., 2005), para. 7, U.N. Doc. E/C.12/2005/3 (2005).
- ¹² AMNESTY INT'L, NOT PART OF MY SENTENCE: VIOLATIONS OF THE HUMAN RIGHTS OF WOMEN IN CUSTODY (Mar. 1999), available at <http://www.amnesty.org/en/library/info/AMR51/019/1999>; 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).
- ¹³ See Angela Brown et al., *Prevalence and Severity of Lifetime Physical and Sexual Victimization among Incarcerated Women*, 22 INT'L J. OF LAW & PSYCHIATRY (1999).
- ¹⁴ WORLD HEALTH ORGANIZATION & UNITED NATIONS OFFICE ON DRUGS AND CRIME, WOMEN'S HEALTH IN PRISON: CORRECTING GENDER INEQUITY IN PRISON HEALTH (2009); Inst. on Women & Criminal Justice, *Mothers, Infants and Imprisonment* (2009).
- ¹⁵ NAT'L WOMEN'S LAW CTR. & 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).
- ¹⁶ BUREAU OF JUST. STATISTICS, U.S. DEPT. OF JUSTICE, SPECIAL REPORT: PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974-2001 1 (2003), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/piusp01.pdf>. 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.
- ¹⁷ The number of women incarcerated in state facilities grew by 888% from 1986-1999 due to increased prosecution of women for drug-related offenses. AM. 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.
- ¹⁸ *Id.*; see also MICHELLE ALEXANDER, THE NEW JIM CROW (2010); The Sentencing Project, *Racial Disparity in Sentencing: A Review of the Literature* (Jan. 2005), available at http://www.sentencingproject.org/doc/publications/rd_sentencing_review.pdf.
- ¹⁹ BUREAU OF JUST. STATISTICS, U.S. DEPT. OF JUSTICE, PRISONERS IN 2010 (2012).
- ²⁰ 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.
- ²¹ As of 2009, women detainees were housed in 150 jails, with only 38 women parents of minor children held in family residence facilities. DR. DORA SCHRIRO, IMMIGRATION & CUSTOMS ENFORCEMENT, DEP'T OF HOMELAND SEC., IMMIGRATION DETENTION OVERVIEW AND RECOMMENDATIONS 11 (Oct. 6, 2009). See also *id.* at 2-3 ("With only a few exceptions, the facilities that ICE uses to detain aliens were built, and operate, as jails and prisons to confine pre-trial and sentenced felons. ICE relies primarily on correctional incarceration standards designed for pre-trial felons and on correctional principles of care, custody, and control. These standards impose more restrictions and carry more costs than are necessary to effectively manage the majority of the detained population.").
- ²² Federal and state policies and practices are detailed in Section II of the U.S. Fourth Periodic Report regarding implementation of ICCPR provisions, as well as in Section III in response to the HRC's specific recommendations in its 2006 Concluding Observations. Gov't of the United States, *Fourth Periodic Report of the United States of America to the United Nations Comm. on Human Rights Concerning the International Covenant on Civil and Political Rights*, paras. 231-33, 676 (Dec. 30, 2011) [hereinafter Fourth Periodic Report of the USA], available at <http://www.state.gov/j/drl/rls/179781.htm>.
- ²³ The Bureau of Prisons policy bars the practice of shackling pregnant women during transportation, labor, and delivery, except in the most extreme circumstances. The 2011 standards released by the Immigration and Customs Enforcement prohibit the use of restraints on pregnant women and women in post-delivery recuperation absent truly extraordinary circumstances that render restraints absolutely necessary, and they prohibit outright the use of restraints on women in active labor or delivery. See *id.*
- ²⁴ BUREAU OF JUST. STATISTICS, U.S. DEPT. OF JUSTICE, PROGRAM STATEMENT 5538.05: ESCORTED TRIPS, p. 10, para. 9; IMMIGRATION & CUSTOMS ENFORCEMENT, U.S. DEPARTMENT OF HOMELAND SEC., PERFORMANCE-BASED NAT'L DETENTION STANDARDS para. 4.4 (2011) [hereinafter 2011 ICE DETENTION STANDARDS], <http://www.ice.gov/doclib/detention-standards/2011/pbnds2011.pdf>.
- ²⁵ These states include: Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Louisiana, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia.
- ²⁶ UNIV. OF ARIZONA, UNSEEN PRISONERS: A REPORT ON WOMEN IN IMMIGRATION DETENTION FACILITIES IN ARIZONA 21 (2009), available at http://www.law.arizona.edu/depts/bacon_program/pdf/Unseen_Prisoners.pdf.
- ²⁷ See 2011 ICE DETENTION STANDARDS, *supra* note ?, at 333-40.
- ²⁸ See HUMAN RIGHTS WATCH, DETAINED AND DISMISSED, *supra* note ?, at 40-42; PHYSICIANS FOR HUMAN RIGHTS, DUAL LOYALTIES: THE CHALLENGES OF PROVIDING PROFESSIONAL HEALTH CARE TO IMMIGRATION DETAINEES (2011), at 10-11. See 2011 ICE DETENTION STANDARDS, *supra* note ?, at 333-340.
- ²⁹ 18 U.S.C. § 3626 (1997).
- ³⁰ See UNIV. OF VIRGINIA, ED., VIOLENCE AGAINST WOMEN IN THE UNITED STATES AND THE STATE'S OBLIGATION TO PROTECT: CIVIL SOCIETY BRIEFING PAPERS ON COMMUNITY, MILITARY AND CUSTODY SUBMITTED TO THE U.N. SPECIAL RAPPORTEUR ON VIOLENCE AGAINST WOMEN, RASHIDA MANJOO IN ADVANCE OF HER MISSION TO THE UNITED STATES OF AMERICA 153-60 (2011), available at <http://www.law.virginia.edu/vaw>.
- ³¹ *Id.* at 159.
- ³² Colleen Mastoney, *\$4.1 million settlement for pregnant inmates who say they were shackled*, CHICAGO TRIB., May 23, 2012.
- ³³ Nelson v. Corr. Med. Serv., 583 F.3d 522 (8th Cir. 2009).
- ³⁴ HRC, *Concluding Observations: United States of America*, para.33, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (Dec. 18, 2006).
- ³⁵ HRC, *General Comment No. 20: Article 7* (44th Sess., 1992), in COMPILATION OF GENERAL COMMENTS AND GENERAL RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, at 30, U.N. Doc. HRI/GEN/1/Rev.1 (1994).
- ³⁶ HRC, *General Comment No. 21: Article 10*,

(44th Sess., 1992), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 33, para. 3, U.N. Doc. HRI/GEN/1/Rev.1 (1994).

³⁷ HRC, *General Comment 28*, *supra* note ?, para.15.

³⁸ Committee against Torture (CAT), *Concluding Observations: United States of America*, para.33, U.N. Doc. CAT/C/USA/CO/2 (July 25, 2006).

³⁹ The Committee suggested measures such as “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).

⁴⁰ CAT, *General Comment No. 2: Implementation of article 2 by States parties*, (39th Sess., 2007), para. 22, U.N. Doc. CAT/C/GC/2 (2008).

⁴¹ *Second Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment to the Human Rights Council*, para.41, U.N. Doc. A/HRC/7/3 (Jan. 15, 2008) (by Manfred Nowak) (recommending that “measures of physical restraint should be avoided during delivery”); *Report of the Special Rapporteur on violence against women, its causes and consequences, on 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) (finding that the use of shackles on pregnant women during childbirth “violates international standards and may be said to constitute cruel and unusual practices”); *Report of the Special Rapporteur on violence against women, its causes and consequences on the Mission to the United States of America to the Human Rights Council* (by Rashida Manjoo), para.115, U.N. Doc. A/HRC/17/26/Add.5 (June 1, 2011) [hereinafter SR-VAW’s Report of the Mission to the USA (2011)].

⁴² SR-VAW’s Report of the Mission to the USA (2011), *supra* note ?, para.115.

⁴³ *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) (emphasis added).

⁴⁴ *Id.*, para.9 and Rules 5, 15, 22, 25, 39, 42, 48, 64. These rules were passed by the Third Committee of the General Assembly in order to supplement the 50-year old Standard Minimum Rules for the Treatment of Prisoners, which were recognized as not adequately addressing

the needs of women prisoners. See HUMAN RIGHTS: A COMPILATION OF INT’L INSTRUMENTS, VOL. I, PART I: UNIV. INSTRUMENTS, at § J, No. 34, Sales No. E.02.XIV.4 (Vol. I, Part I) (2002), sect. J, No. 34. The HRC has stated that States parties have an obligation to report on the extent to which they are applying relevant U.N. standards on the treatment of prisoners. HRC, *General Comment No. 21: Article 10* (44th Sess., 1992), in *COMPILATION OF GEN. COMMENTS & GEN. RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES*, at 33, para. 5, U.N. Doc. HRI/GEN/1/Rev.1 (1994).

⁴⁵ *Report of the Special Rapporteur on the human rights of migrants to the Human Rights Council* (by François Crépeau), para.36, U.N. Doc. A/HRC/20/24 (2 Apr. 2012); See also *Report of the Special Rapporteur on the human rights of migrants to the Human Rights Council, Mission to the United States of America* (by Jorge Bustamante), para.120-21, U.N. Doc. A/HRC/7/12/Add.2 (March 5, 2008) (recommending alternatives to immigration detention for women who are pregnant, nursing, or suffering the effects of persecution or abuse).

⁴⁶ HRC, *List of issues in relation to the fourth periodic report of the United States of America (CCPR/C/USA/4 and Corr. 1)*, adopted by the Committee at its 107th session (11–28 March 2013), para. 16, U.N. Doc. CCPR/C/USA/Q/4 (2013) [hereinafter HRC, *List of Issues*].

⁴⁷ Gov’t of the United States, *United States Responses to Questions from the United Nations Human Rights Committee Concerning the Fourth Periodic Report of the United States on the International Covenant on Civil and Political Rights (ICCPR)*, para. 85, U.N. Doc. CCPR/C/USA/Q/4/Add.1 (2013) [hereinafter U.S. Written Replies].

⁴⁸ Kaiser Family Fdn., *Snapshots: Health Care Spending in the United States & Selected OECD Countries* (Apr. 12, 2011), at <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/>.

⁴⁹ Gerard F. Anderson & David A. Squires, *Measuring the U.S. Health Care System: A Cross-National Comparison*, The Commonwealth Fund, June 2010, <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Jun/Measuring-the-US-Health-Care.aspx>.

⁵⁰ Karen Davis et al., *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update*, The Commonwealth Fund, June 2010, [\[Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx\]\(http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx\).](http://www.commonwealthfund.org/Content/</p>
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⁵¹ The 2012 Report of the Agency for Healthcare Quality and Research found that access to healthcare is decreasing, especially for people of color and low-income groups, while disparities remain unchanged. Dept of Health & Hum. Servs., Agency for Healthcare Quality and Research, 2012 National Healthcare Disparities Report (2013), available at <http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/index.html>.

⁵² BRIAN D. SMEDLEY ET AL., INST. OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 83-84 (2002). There are 48 million uninsured living in the U.S., but people of color are far more likely to lack health insurance than white Americans. Kaiser Family Fdn. (KFF), *Health Insurance Coverage of Nonelderly 0-64*, at <http://kff.org/other/state-indicator/nonelderly-0-64/>; KFF, *Uninsured Rates for the Nonelderly by Race/Ethnicity*, at <http://kff.org/uninsured/state-indicator/rate-by-raceethnicity/>.

⁵³ See 42 U.S.C. § 18081 (2011).

⁵⁴ Forty-six percent of non-citizens are uninsured compared to 15% of U.S.-born citizens and 23% of naturalized citizens. KAISER COMM’N ON MEDICAID & THE UNINSURED, *KEY FACTS ON HEALTH COVERAGE FOR LOW-INCOME IMMIGRANTS TODAY AND UNDER HEALTH REFORM 2* (Feb. 2012) [hereinafter KAISER COMM’N, *KEY FACTS*], available at <http://www.kff.org/uninsured/upload/8279.pdf>.

⁵⁵ *Id.*; KAISER COMM’N ON MEDICAID & THE UNINSURED, *SUMMARY: FIVE BASIC FACTS ON IMMIGRANTS AND THEIR HEALTH CARE* 6 (Mar. 2008), available at <http://www.kff.org/medicaid/upload/7761.pdf>.

⁵⁶ KAISER COMM’N, *KEY FACTS*, *supra* note ?.

⁵⁷ 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).

⁵⁸ “Lawfully present” immigrants are those on the road to citizenship or who have otherwise been granted permission to remain in the United States on a temporary or permanent basis, such as lawful permanent residents, individuals with work authorization, refugees, and asylees.

⁵⁹ The federal government covers emergency care including labor and delivery and

post-delivery care for up to 60 days under Emergency Medicaid for all those who are otherwise eligible for Medicaid but for their immigration status. In addition, a 2009 federal rule grants states the option under the Children’s Health Insurance Program (CHIP) to provide prenatal care to lawfully present pregnant women without requiring the five-year waiting period (see Fourth Periodic Report of the USA, para.437. However, as of January 2013, only 20 out of 50 states have opted into this program. Some states fill in the gaps in coverage of undocumented immigrants by using state-only funds to provide Medicaid services. As of March 2011, 15 states use state funds to cover lawfully-present immigrants who would be subject to the federal waiting period. Eight states offer health coverage to immigrants regardless of their immigration status, but these states usually restrict such coverage to special groups like children or pregnant women, or cover limited services. Kaiser Comm’n on Medicaid & the Uninsured, *Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act* (Mar. 2013), available at <http://www.kff.org/uninsured/upload/8279.pdf>.

⁶⁰ Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, 10 GUTTMACHER POL’Y REVIEW 7, 8 (2007).

⁶¹ ELLEN 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>; Am. Cong. 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_Underserved_Women/Health_Care_for_Undocumented_Immigrants.

⁶² As of 2011, Title X serves over five million people annually in more than 4500 clinics nationwide, helping to prevent 973,000 unintended pregnancies and saving the government billions of dollars a year. Unfortunately, the program is now funded at a rate 62% lower in constant dollars than 30 years ago. Claire Coleman & Kirtly Parker Jones, *Title X: A Proud Past, an Uncertain*

Future, 84 CONTRACEPTION 209-211 (2011); RACHEL GOLD ET AL., NEXT STEPS FOR AMERICA'S FAMILY PLANNING PROGRAM: LEVERAGING THE POTENTIAL OF MEDICAID AND TITLE X IN AN EVOLVING HEALTH CARE SYSTEM 4 (2009), available at <http://www.guttmacher.org/pubs/NextSteps.pdf>.

⁶³ Title X clinics have seen an 18% increase in the number of users of services between 1999 and 2010. The number of users identifying as Hispanic or Latino increased by 93%, and the number of users with limited English proficiency increased 25%. Guttmacher Inst., *A real-time look at the impact of the recession on publicly funded family planning centers* 4 (Dec. 2009), available at <http://www.guttmacher.org/pubs/RecessionFPC.pdf>; RTI Int'l, *Family Planning Annual Report* 8 (Sept. 2011), available at <http://www.hhs.gov/opa/pdfs/fpar-2010-national-summary.pdf>.

⁶⁴ Jennifer J. Frost et al., *Contraceptive Needs and Services—2010* 1 (Guttmacher Inst., July 2013).

⁶⁵ *Id.* at 8.

⁶⁶ KFF, *Demographic Profile of Hispanics in Texas, 2010*, <http://www.pewhispanic.org/states/state/tx/> (last visited Aug. 21, 2013).

⁶⁷ The uninsured comprise 27% of the state's population, or 6.7 million people. TEXAS HEALTH AND HUMAN SERVS. COMM'N, STATE OF TEXAS, 1115(A) RESEARCH & DEMONSTRATION WAIVER 7 (2011), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-womens-health-waiver-pa.pdf>; KFF, *Health Insurance Coverage of Nonelderly 0-64*, <http://kff.org/other/state-indicator/nonelderly-0-64/> (last visited Aug. 22, 2013); KFF, *Uninsured Rates for the Nonelderly by Race/Ethnicity*, <http://kff.org/uninsured/state-indicator/rate-by-raceethnicity/> (last visited Aug. 22, 2013); Latinos, especially those who are foreign-born, are disproportionately uninsured. Sixty percent of the Texas uninsured are Latinos, even though they comprise 40% of the population. KFF, *Population Distribution by Race/Ethnicity*, <http://kff.org/other/state-indicator/distribution-by-raceethnicity/?state=TX>; KFF, *Distribution of the Nonelderly Uninsured by Race/Ethnicity*, <http://kff.org/uninsured/state-indicator/distribution-by-raceethnicity-2/?state=TX>. Foreign-born Latinos in Texas are more than twice as likely (62%) to be uninsured as U.S.-born Hispanics (26%). HISPANIC TRENDS PROJECT, PEW RESEARCH CTR. *Demographic Profile of Hispanics in Texas, 2010*, <http://www.pewhispanic.org/states/state/tx/>.

⁶⁸ This report will be released in November 2013.

⁶⁹ Kari White, et al., *Cutting Family Planning in Texas*, 367 N. ENGL. J. MED. 1179 (Sept. 27,

2012). The research shows that when the state's family planning program was fully funded in 2010, it averted 3.6 times the number of pregnancies in the Rio Grande Valley as the program averted in 2012 after the funding cuts were sustained. Univ. of Texas Population Evaluation Project, TXPEP Family Planning Data Finder application, <http://www.prc.utexas.edu/txpep> (under the "Local Impact" section of the county pages for Cameron, Hidalgo, Starr, and Willacy).

⁷⁰ *Id.* (county pages for Cameron, Hidalgo, Starr, and Willacy) and <http://www.prc.utexas.edu/txpep/#state>.

⁷¹ *Id.* (under the "Demographic Characteristics" section of the county pages for Cameron, Hidalgo, Starr, and Willacy). See also Univ. of Texas Policy Evaluation Project *How Abortion Restrictions would Impact Five Areas of Texas*, (June 2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/ImpactBrief-ProposedHB2-SB1AbortionBill.pdf.

⁷² Univ. Declaration of Human Rights, adopted Dec. 10, 1948, art. 3, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948); ICCPR, art. 6(1).

⁷³ HRC, *General Comment No. 6: Article 6 (Right to life)*, (16th Sess., 1982), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 176, paras. 1, 5, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter HRC, *Gen. Comment No. 6*]; HRC, *Gen. Comment 28*, para. 10. See also *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44 – Addendum – Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, para. 66, U.N. Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999) (noting "[g]overnment failure to take positive measures to ensure access to appropriate health-care services that enable women to safely deliver their infants as well as to safely abort unwanted pregnancies may constitute a violation of a woman's right to life...").

⁷⁴ See, e.g., HRC, *Concluding Observations: Angola*, U.N. Doc. CCPR/C/AGO/CO/1, para.13 (2013); *Dominican Republic*, U.N. Doc. CCPR/C/DOM/CO/5, para.15 (2012); *Paraguay*, U.N. Doc. CCPR/C/PRY/CO/3, para.13 (2013); *Cameroon*, para.13, U.N. Doc. CCPR/C/CMR/CO/4 (2010); *Guatemala*, U.N. Doc. CCPR/C/GTM/CO/3 (2012), para.20; *Peru*, U.N. Doc. CCPR/C/PER/CO/5, para.14 (2013); *Poland*,

para.12, U.N. Doc. CCPR/C/POL/CO/6 (2010); *Mongolia*, para.20, U.N. Doc. CCPR/C/MNG/CO/5 (2011); *Jamaica*, para.14, U.N. Doc. CCPR/C/JAM/CO/3 (2011). See also HRC, *General Comment No. 6: The Right to Life*, para. 1 (noting the right to life should not be interpreted narrowly and includes reproductive health services).

⁷⁵ HRC, *Concluding Observations: Philippines*, U.N. Doc. CCPR/C/PHL/CO/4 (2012), para.13. See also HRC, *Concluding Observations: Peru*, U.N. Doc. CCPR/C/PER/CO/5, para.14 (2013) (urging the government to ensure access to free emergency contraception in order to reduce the risk of maternal death from unsafe abortion).

⁷⁶ HRC, *Concluding Observations: Poland*, para.9, U.N. Doc. CCPR/CO/82/POL (2004); *Argentina*, para.14, U.N. Doc. CCPR/CO/70/ARG (2000), para.14; *Georgia*, para.12, U.N. Doc. CCPR/C/79/Add.75 (1997); *Poland*, para.11, U.N. Doc. CPR/C/79/Add.110 (1999).

⁷⁷ CEDAW, *General Recommendation 24, Women and Health* (20th Sess., 1999), U.N. Doc. A/54/38 at 5 (1999), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para.21, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

⁷⁸ CEDAW, *Concluding Observations: Hungary*, para.31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013)

⁷⁹ ICCPR, art. 2(1) (emphasis added); HRC, *General Comment No. 15: The position of aliens under the Covenant* (1986), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para.1, U.N. Doc. HRI/GEN/1/Rev.6 at 140 (2003) (stating that "[i]n general, the rights set forth in the Covenant apply to everyone, irrespective of reciprocity, and irrespective of his or her nationality or statelessness").

⁸⁰ ICCPR, article 2(1).

⁸¹ See HRC, *Concluding Observations: Syrian Arab Republic*, para.19, U.N. Doc. CCPR/CO/84/SYR (2005); *Azerbaijan*, para. 20, U.N. Doc. CCPR/CO/73/AZE (2001).

⁸² HRC, *Concluding Observations: Korea*, para.12, U.N. Doc. CCPR/C/KOR/CO/3 (2006); *Latvia*, para.18, U.N. Doc. CCPR/CO/79/LVA (2003); *Thailand*, para.23, U.N. Doc. CCPR/CO/84/THA (2005).

⁸³ HRC, *General Comment No. 15: The position of aliens under the Covenant* (1986), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para.4, U.N. Doc. HRI/GEN/1/

Rev.6 at 140 (2003). See also HRC, *Concluding Observations: Canada*, para.20, U.N. Doc. CCPR/C/79/Add.105 (1999) (expressing concern over cuts to social welfare programs that have disproportionately harmed women, especially single mothers, and recommending making an assessment of the impact of such cuts and taking action to redress any discriminatory effects); *Guatemala*, CCPR/C/GTM/CO/3 (HRC, 2012), para.8 (calling on the state to adopt and implement gender equality legislation and to "develop additional policies to promote genuine gender equality" which especially address the needs of indigenous women and Afro-descendent women who face multiple forms of discrimination); *Korea*, para.12, U.N. Doc. CCPR/C/KOR/CO/3 (2006) (recommending that Korea ensure "equal access to social services" after 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).

⁸⁴ Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations: United States of America*, para.32-33, U.N. Doc. CERD/C/USA/CO/6 (2008).

⁸⁵ CEDAW, *General Comment No. 26 on Migrant Women Workers*, U.N. Doc. CEDAW/C/2009/WP.1/R, para.17 (Dec. 5, 2008) (noting "[w]omen migrant workers often suffer from inequalities that threaten their health. They may be unable to access health services, including reproductive health services, because insurance or national health schemes are not available to them, or they may have to pay unaffordable fees. As women have health needs different from those of men, this aspect requires special attention."); see also CEDAW, *Concluding Observations: Cypress*, CEDAW/C/CYP/CO/6-7, para.30 (2013); *Lichtenstein*, CEDAW/C/LIE/CO/4, para.39 (2011).

⁸⁶ *Annual Report of the Special Rapporteur on the human rights of migrants to the Human Rights Council* (by Jorge Bustamonte), para.28, U.N. Doc. A/HRC/14/30 (Apr. 16, 2010).

⁸⁷ HRC, *List of Issues*, para.7.

⁸⁸ As noted above, the Affordable Care Act expands health insurance access for many Americans, but it excludes many low-income immigrants from qualifying for public health insurance programs or purchasing private health insurance on the exchange market. See 42 U.S.C. § 18081 (2011).

⁸⁹ Specifically, EMTALA requires any hospital

participating in Medicare that offers emergency services to provide a medical screening examination upon request or treatment for an emergency medical condition regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions or an appropriate transfer. 42 U.S.C. § 1395dd. See also U.S. Written Replies, paras. 20-23.

⁹⁰ 77 Fed. Reg. 52614 (Aug. 30, 2012); 78 Fed. Reg. 4594 (Jan. 22, 2013); 77 Fed. Reg. 52614 (Aug. 30, 2012). Although these policies are still in the rule-making process, the Obama Administration began to enforce them as binding regulations as soon as they were proposed.

⁹¹ Over 88% of the youth eligible for DACA relief are from Latin America. Immigration Pol'y Ctr., *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.

⁹² CTR. FOR REPRODUCTIVE RTS. [CRR], 2009 LEGISLATIVE WRAP UP (2010); CRR, 2010 STATE LEGISLATIVE WRAP UP (2011); CRR, 2011: A LOOK BACK (2012); CRR, 2012: A LOOK BACK (2013), all available at <http://www.reproductiverights.org>.

⁹³ CRR, 2013 MID-YEAR LEGISLATIVE WRAP-UP 2 (2013), available at <http://www.reproductiverights.org>. Note that three additional bills passed following publication in the states of North Carolina (N.C. S 353), Ohio (OH H 59), and Texas (TX H 2b).

⁹⁴ Alabama, Arkansas, Georgia, Indiana, Idaho, Kansas, Louisiana, Nebraska, North Carolina, North Dakota, Oklahoma, and Texas have enacted bans on abortion at 20 weeks from the woman's last menstrual period. Arizona enacted a 20-week ban measured from the date of fertilization, effectively making it an 18-week ban.

⁹⁵ *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 845-846, 112 S.Ct. 2791, 2804 (1992). Most abortions in the U.S. occur very early in pregnancy; for example, in 2006, 88% of abortions in the U.S. were performed in the first 12 weeks of pregnancy. Guttmacher Inst., *Facts on Induced Abortion in the United States* (July 2013), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

⁹⁶ *MKB Management, Inc. v. Burdick*, No. 1:13-cv-071 (Dist. Ct. N.D. filed July 22, 2013)

(order granting plaintiffs' motion for preliminary injunction); *Edwards v. Beck*, No. 4:13CV00224 SWW (E.D. Ark. filed May 23, 2013). The Center for Reproductive Rights is co-counsel in the Arkansas case with ACLU and the ACLU of Arkansas.

⁹⁷ Of all abortions in the U.S., 64% are by women of color (other than non-Hispanic white women). Forty-two percent of women obtaining abortions have incomes below 100% of the federal poverty level (\$10,830 for a single woman with no children), and 27% have incomes between 100-199% of the federal poverty level. Rachel K. Jones et al., *Characteristics of U.S. Abortion Patients, 2008* (Guttmacher Inst. May 2010), <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>; see also Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 110-18 (2005).

⁹⁸ Rachel K. Jones, *At what cost?: Payment for abortion care by U.S. women*, 23 WOMEN'S HEALTH ISSUES 173, 173-78 (2013), available at <http://www.guttmacher.org/pubs/journals/jwhi.2013.03.001.pdf>.

⁹⁹ See Dep't of Labor, Health and Hum. Serv., & Educ. and Related Agencies Appropriations Act, 1998, Pub. L. No. 105-78, §§ 509-10, 111 Stat. 1467 (1997).

¹⁰⁰ Jones, *supra* note ?.

¹⁰¹ Exec. Order No. 13535, 75 Fed. Reg. 15599 (March 29, 2010), available at <http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst>.

¹⁰² In total, 27 states have laws restricting insurance coverage of abortion in some form, including bans on coverage of abortion in insurance plans for public employees. Guttmacher Inst., *State Policies in Brief: Restricting Insurance Coverage of Abortion* (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.

¹⁰³ Jones, *supra* note ?.

¹⁰⁴ See CRR, WHOSE CHOICE?: HOW THE HYDE AMENDMENT HARMS POOR WOMEN (2010) [hereinafter CRR, WHOSE CHOICE?], available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf.

¹⁰⁵ *Id.* at 28-29.

¹⁰⁶ *Id.* at 27-28.

¹⁰⁷ One recent study found that even though the majority of women have insurance, the majority also pay for the procedure out-of-pocket. Over

40% said that it was somewhat or very difficult to pay for an abortion, but this percentage was higher (54%) for those lacking insurance. Jones, *supra* note ?.

¹⁰⁸ See CRR, WHOSE CHOICE, *supra* note 105, at 26.

¹⁰⁹ M. Antonia Biggs et al., *Understanding why women seek abortions in the U.S.*, 13(29) BMC WOMEN'S HEALTH (2013); Finer, *supra* note ?.

¹¹⁰ Fewer than 0.3% of abortion patients in the U.S. experience a complication that requires hospitalization, and abortion may be safely preformed in non-hospital settings, such as clinics or doctors' offices. Nearly all abortions in the U.S. take place in such settings. Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 GUTTMACHER POL'Y REV. 7 (2013), <http://www.guttmacher.org/pubs/gpr/16/2/gpr160207.html>

¹¹¹ Univ. of Texas Policy Evaluation Project, *How Abortion Restrictions would Impact Five Areas of Texas*, *supra* note ?.

¹¹² Ambulatory surgical centers (ASCs) are healthcare centers licensed by states to provide some types of outpatient surgical services. Twenty-six states have laws requiring facilities where abortions are performed to meet standards intended for ASCs. These requirements—which include personnel requirements, onerous administrative policies, and extensive renovations to physical facilities—are not imposed by those states on facilities performing procedures comparable in method and/or risk to abortion. They typically cannot be met by clinics or private physicians' offices without great, and often prohibitively great, cost. See Guttmacher Inst., *State Policies in Brief: Targeted Regulation of Abortion Providers* (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf. As one example, such requirements mandate physical plant features not needed to protect patient health or safety, such as hallways wide enough to accommodate stretchers, which are not used in abortion practice.

¹¹³ See Manny Fernandez, *Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight*, N.Y. TIMES, July 18, 2013.

¹¹⁴ See Guttmacher Inst., *Targeted Regulation of Abortion Providers*, *supra* note 113. Similar TRAP laws in Mississippi and North Dakota have been preliminarily enjoined by a court following lawsuits filed in both states by the Center for Reproductive Rights. *MKB Management, Inc. v. Burdick*, No. 1:13-cv-071 (D. N.D. filed July 22, 2013) (Jul. 31, 2013) (enjoining a North Dakota law requiring

a physician performing an abortion to have admitting privileges at a hospital within 30 miles). *Jackson Women's Health Org. et al. v. Currier*, No. 3:12cv436-DPJ-FKB (S.D.M.S. filed Apr. 15, 2013) (enjoining a similar Mississippi law).

¹¹⁵ In December 2012, the Center submitted Comments on the U.S. Government's Fourth Periodic Report to the U.S. State Department, following an invitation by the Legal Advisor to the State Department to civil society to provide supplemental information (see Annex to this report). We did not receive a reply to our submission, nor to subsequent attempts to engage the Administration on the inclusion of reproductive rights in the U.S. government's submissions to the HRC.

¹¹⁶ HRC, General Comment 28, para.10.

¹¹⁷ See, e.g., HRC, *Concluding Observations on Argentina*, para.13 U.N. Doc. CCPR/C/ARG/CO/4 (2010); *Ireland*, para.13, U.N. Doc. CCPR/C/IRL/CO/3 (2008); *Mexico*, para.10, U.N. Doc. CCPR/C/MEX/CO/5 (2010); *Monaco*, para.10, U.N. Doc. CCPR/C/MCO/CO/2 (2008); *Nicaragua*, para.13, U.N. Doc. CCPR/C/NIC/CO/3 (2008); *Panama*, para.9, U.N. Doc. CCPR/C/PAN/CO/3 (2008); *Philippines*, para.13 CCPR/C/PHL/CO/4 (2012).

¹¹⁸ HRC, *Concluding Observations: Cameroon*, para.13, U.N. Doc. CCPR/C/CMR/CO/4 (2010).

¹¹⁹ HRC, *K.L. v. Peru*, Communication No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (22 Nov. 2005).

¹²⁰ HRC, *Concluding Observations: Moldova*, paras. 4, 27, U.N. Doc. 17 CCPR/C/MDA/CO/2

¹²¹ HRC, *Concluding Observations, Ecuador*, para.11, U.N. Doc. CCPR/C/79/Add.92 (1998); *Nicaragua*, para.19, U.N. Doc. CCPR/C/NIC/CO/3 (2008); *Philippines*, para.13, CCPR/C/PHL/CO/4 (2012).

¹²² HRC, *Concluding Observations, Argentina*, para.14, U.N. Doc. CCPR/CO/7/ARG (2000).

¹²³ CEDAW, *Concluding Observations, Burkina Faso*, para.276, U.N. Doc. A/55/38 (2000)

¹²⁴ CEDAW, *Concluding Observations, India*, para.41 U.N. Doc. CEDAW/C/IND/CO/3 (2007); *Jamaica*, para.36, U.N. Doc. CEDAW/C/JAM/CO/5 (2006); *Vanuatu*, para.35, U.N. Doc. CEDAW/C/VUT/CO/3 (2007)

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