January 14, 2019

Members of the Human Rights Committee
Office of the United Nations High Commissioner for Human Rights
Palais Wilson
52 rue des Pâquis
CH-1201 Geneva, Switzerland

Suggested List of Issues to Country Report Task Force on the United States for the 125th Session of the Human Rights Committee, 4-29 March 2019

The undersigned reproductive rights and justice and human rights organizations submit this suggested List of Issues to the Human Rights Committee (HRC) in preparation for the meeting of the Country Task Force on the United States during its 125th Session.

This submission identifies seven reproductive rights and justice[1] issues for the HRC to consider as it prepares its List of Issues for the review of the United States:

(1) restrictive abortion laws
(2) racial disparities in maternal health outcomes
(3) permitting denial of reproductive health care based on one's religious or moral beliefs
(4) discrimination against immigrant women in accessing affordable health care
(5) criminalization of pregnancy and pregnancy outcomes
(6) treatment of women in detention
(7) impact of the Mexico City Policy, or Global Gag Rule, on global reproductive health

These policies and practices implicate a range of rights protected by the ICCPR, including the rights to: non-discrimination (Article 2); equality between men and women (Article 3); life (Article 6); freedom from torture and cruel, inhuman and degrading treatment (Article 7); privacy (Article 17); freedom of thought, conscience, religion and belief (Article 18); freedom of expression and opinion (Article 19); and equality before the law (Article 26).

Signed,

Abortion Care Network
Amnesty International
Black Mamas Matter Alliance
Center for Reproductive Rights
The City University of New York Law School, Human Rights and Gender Justice Clinic
In Our Own Voice
National Advocates for Pregnant Women
National Asian Pacific American Women's Forum
National Latina Institute for Reproductive Health
SIA Legal Team
SisterSong, Women of Color Reproductive Justice Collective

Abortion Access (Articles 2, 3, 6, 17)

1. Issue Summary

Abortion access is under attack in the United States, and people seeking or providing this health care face a growing number of obstacles that threaten their rights to life, privacy, bodily integrity, and equal protection. Although the U.S. Supreme Court has repeatedly affirmed the constitutional right to abortion established in *Roe v. Wade*,[2] including most recently in *Whole Woman's Health v. Hellerstedt*,[3] states continue to pass laws that shut down clinics, impose medically unnecessary regulations, and shame women for their decisions.

In 2017, state legislatures enacted 63 laws restricting women's access to reproductive health care.[4] In recent years, states have enacted laws outlawing the standard procedure for abortions performed after approximately 15 weeks of pregnancy.[5] Others have enacted more general pre-viability bans on abortion,[6] including a ban on abortions performed at as early as six weeks of pregnancy.[7] Many recently enacted laws restricting abortion access seek to shame and stigmatize women in the name of "fetal dignity." These include measures requiring the burying or cremation of embryonic or fetal tissue.[8] In addition, many states have enacted and expanded regulations that target abortion providers or make abortion services less accessible. Such restrictions subject providers to medically unjustified regulations and subject women seeking abortion to mandatory delays, multiple clinic visits, and medically inaccurate information.[9] The result is a patchwork of access to abortion care across the United States, with six states having only one abortion provider.[10] Restrictions on abortion access particularly impact marginalized communities, including immigrants, low-income women, and women of color.[11]

Abortion access is also unavailable to millions of low-income and poor women because of cost. Since 1976, the Hyde Amendment has banned federal programs like Medicaid (which provides health insurance to people with low-incomes) from covering abortion care, except in the limited cases of rape, incest, or life endangerment. Since 1976, Congress has expanded the reach of the Hyde Amendment's abortion coverage bans and federal funding bans. Over half of the 7.5 million women potentially affected by the Hyde Amendment are women of color.[12]

2. Human Rights Committee Concluding Observations

The Committee has not previously issued Concluding Observations related to abortion in the United States.

In other recent State party reviews, the Committee has expressed concern about the impact of severe legal restrictions, barriers, and stigma on abortion access, and called on states to amend legislation, lift barriers, remove criminal penalties, and prevent stigmatization of women and girls seeking abortion, in order to ensure effective access to safe, legal abortion services.[13]

3. Human Rights Committee General Comments

General Comment 36: Article 6 (Right to Life) requires States to provide safe, legal, and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or

when carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering; States may not introduce new barriers to abortion and should remove existing barriers that deny effective access by women and girls to safe and legal abortion; States should prevent the stigmatization of women and girls seeking abortion. (Para. 8)

General Comment 28: States parties should eliminate interference with right to privacy in reproductive health (recognized as a violation of Article 3). (Para. 20)

4. Recommendations by Other Human Rights Bodies to the United States

At the conclusion of its 2015 visit to the United States, the **UN Working Group on Discrimination Against Women in Law and Practice** recommended that the U.S. ensure that women be able to exercise their existing constitutional right under *Roe v. Wade* to choose to terminate a pregnancy in the first trimester, repeal the Hyde Amendment, and combat the stigma attached to reproductive and sexual health care.[14]

The **UN Special Rapporteur on Extreme Poverty**, at the conclusion of his 2017 visit to the United States, noted that low-income women face legal and practical obstacles to exercising their constitutional, privacy-derived right to access abortion services. Obstacles include mandatory waiting periods and long driving distances to clinics. This lack of access to abortion services traps many women in cycles of poverty.[15]

Recommended Questions

1. What steps are the United States taking to ensure that women have meaningful access to their constitutional right to abortion, as enumerated by *Roe v. Wade*, 410 U.S. 113 (1973), and recently affirmed by *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016)?
2. What measures are the United States taking to prevent the stigmatization of women seeking abortions?

Suggested Recommendations

1. Enact federal legislation affirming the constitutional right to abortion and women's right to make decisions about their reproductive lives without interference by the states.
2. Repeal the Hyde Amendment and ensure abortion access for all women.
3. State legislatures should refrain from passing laws or promulgating regulations related to abortion provisions that interfere with the right to abortion and women's right to make decisions about their reproductive lives.

Racial Disparities in Maternal Health Outcomes (Articles 2, 3, 6, 24, 26)

1. Issue Summary

In the United States, Black women suffer preventable maternal deaths in violation of their right to life and non-discrimination. With the highest maternal mortality ratio in the developed world, the United States is one of only thirteen countries where maternal mortality is on the rise.[16] This crisis disproportionately impacts Black women, who are nearly four times more likely than white women to suffer a maternal death,[17] and twice as likely to suffer maternal morbidity.[18]

In the United States, racial disparities in health are closely linked to social and economic inequalities, reflecting systemic obstacles to health that harm women of color especially. Factors such as poverty, lack of access to health care, and exposure to racism all undermine health and contribute to the disproportionately high number of maternal deaths among Black women.

Despite these troubling maternal health outcomes, the United States does not adequately prioritize or monitor maternal deaths. The lack of systematically collected maternal mortality and morbidity data precludes comparisons across states and regions and undermines accountability for preventable maternal deaths and injuries.[19]

Maternal health is further undermined by a lack of social supports and basic health care services for those who cannot afford to pay for them. Rather than expanding access to such resources, recent progress is now under attack. In 2017, Congress tried and failed to repeal the Affordable Care Act (known as the ACA, this law changed health insurance rules and imposed requirements that expanded access to health care and addressed certain health inequities for many people in the U.S.). Since then, Congress and the Administration have continued to undermine laws, policies, and programs that support health care access (the ACA, Medicaid, Title X, etc.) through executive and agency action.[20] In addition, many low-income uninsured people whom the ACA was intended to cover have fallen through the cracks because state legislatures have opted out of Medicaid expansion.[21] Moreover, many immigrants are excluded from coverage under the ACA.[22]

As a result, millions of women lack access to basic primary care and critical sexual and reproductive health care services that support healthy pregnancies and births, exacerbating racial and economic disparities.[23]

2. Human Rights Committee Concluding Observations

The Human Rights Committee has not previously issued recommendations related to maternal health in the United States. With respect to other country reviews, the Committee has recommended that states continue efforts, under Article 6, to effectively eliminate preventable maternal mortality and ensure non-discriminatory access to affordable quality health care, including prenatal and emergency obstetric care, especially for women residing in rural areas.[24]

3. Human Rights Committee General Comments

General Comment 36: State parties should ensure the availability of, and effective access to, quality prenatal health care for women and girls, in all circumstances, on a confidential basis (Para. 8); States' duty to protect life requires States to take appropriate measures to address adequate conditions for protecting the right to life and advancing the enjoyment of life, including by developing strategic plans for improving access to medical examinations and treatments designed to reduce maternal and infant mortality. (Para. 26)

4. Recommendations by Other Human Rights Bodies to the United States

In its 2014 review of the United States, the **Committee on the Elimination of Racial Discrimination** expressed concern with high maternal and infant mortality rates among African American communities.[25] The Committee recommended that the United States ensure effective access to affordable and adequate health-care services; eliminate racial disparities in the field of sexual and reproductive health and standardize data collection on maternal and infant deaths; and improve monitoring and accountability mechanisms for preventable maternal mortality, including at the state level.[26]

After its 2015 visit to the United States, the **UN Working Group on discrimination against women in law and practice** recommended that the U.S. address racial disparities in maternal health.[27] Similarly, at the conclusion of its 2016 U.S. visit, the **UN Working Group of Experts on People of African Descent** noted that racial discrimination has a negative impact on Black women's ability to maintain good health and recommended that the United States prioritize policies and programs to reduce maternal mortality for Black women.[28]

At the conclusion of his 2017 visit to the United States, **UN Special Rapporteur on Extreme Poverty** noted concern that the U.S. has the highest maternal mortality rate among wealthy countries, and that Black women are three to four times more likely to die from child birth.[29]

Recommended Questions

1. What steps are the United States taking to ensure the availability of, and effective access to, quality maternal health care for women and girls?
2. What steps are the United States taking to reduce maternal mortality and morbidity, and in particular to address persistent racial disparities in maternal health outcomes?

Suggested Recommendations

1. Guarantee access to and availability of affordable, acceptable, and quality comprehensive health-care services, free from racial bias, including expanded access to midwifery, doulas, and culturally competent, community-based models of care.
2. Improve accountability for preventing maternal deaths and racial disparities and engage communities in data collection related to maternal mortality and morbidity.
3. Recognize and provide adequate resources to address the social determinants of health, including adequate housing, transportation, nutritious food, clean water and healthy environments, fair treatment within the criminal justice system, safety and freedom from violence, and equal economic opportunity.

Permitting Denial of Reproductive Health Care Based on One's Religious or Moral Beliefs (Articles 2, 3, 6, 18, 26)

1. Issue Summary

In recent years, the United States has expanded the concept of religious refusals far beyond its appropriate scope, resulting in violations of women's right to life, health care access, and equality. An array of federal and state laws permit individual and institutional health care providers to opt out of providing critical health services, including abortion (46 states), contraception (12 states), and sterilization (18 states).[30] In some cases, the right to refuse is afforded not only to those directly involved in health care services but also to ancillary health care personnel, such as pharmacists (12 states).[31]

In most cases, these laws extend beyond individual providers to also allow health care institutions (e.g., hospitals and clinics) to refuse to provide reproductive health care based one's religious or moral beliefs. Forty-four states extend so-called conscientious objection protections to health care institutions and corporations.[32] At the federal level, the 1973 Church Amendment (42 U.S.C. § 300a-7) prohibits the federal government from requiring individuals or facilities receiving public funds to provide abortion or sterilization services. Over the past four decades, federal lawmakers have expanded the scope of these laws to allow an increasingly wide range of health care professionals and institutional entities to refuse to provide needed, and even life-saving, health care services.[33]

In 2017, the Trump Administration issued new regulations that allow virtually any employer or university to deny employees, students, and their dependents contraceptive coverage under the Affordable Care Act based on religious or moral objections, without making any alternative arrangements to ensure that employees receive coverage.[34] In addition to stretching the scope of activities covered by so-called "conscience" refusals, the regulations grant religious conscience rights to all employers, including publicly traded corporations, and further permit opt-outs on non-religious moral grounds for closely held corporations and non-profits. These regulations have been temporarily enjoined as a result of two federal lawsuits.[35]

In addition, in January 2018, the Department of Health and Human Services (HHS) announced a new division of HHS's Office of Civil Rights (OCR), which focuses exclusively on religious and moral exemption claims.[36] In so doing, the Administration is positioning providers who oppose their patients' exercise of sexual and reproductive rights as the true victims of civil rights abuses, effectively encouraging health care providers and institutions to discriminate against patients seeking reproductive health care services.[37]

When implemented without balancing, religious and moral refusal laws can be—and have been—exploited to limit access or deny care, particularly in the field of reproductive health care. Refused services include access to safe pregnancy termination, miscarriage management, and contraception, which are all necessary to ensure women's health and wellbeing.[38] The prioritization and exploitation of refusals over patient care, even in emergency situations, harms to women who are deprived of health care.

2. Human Rights Committee Concluding Observations

The Committee did not raise the issue of refusals of reproductive health care in the last review of the U.S. In other State reviews, the Committee has expressed concern about improper use of conscience clauses by medical professionals resulting in denial of access to reproductive health services and called on states to regulate the practice in compliance with their Article 6 obligations, affirming that governments must ensure that medical professionals' refusals to provide abortion care on grounds of conscience do not impede access to legal abortion services.[39]

3. Human Rights Committee General Comments

General Comment 28: States must ensure that "religious or cultural attitudes are not used to justify violations of women's right to equality before the law and equal enjoyment of all Covenant rights." Art. 18 "may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion." (Para. 5)

General Comment 22: laws imposing or restricting the freedom to manifest religion or belief "may not be imposed for discriminatory purposes or applied in a discriminatory manner;" laws designed to protect particular religious or conscientious beliefs may not harm dissenting individuals. (Paras. 8, 10)

General Comment 36: States should remove barriers to safe and legal abortion caused by the exercise of conscientious objection by individual medical providers. (Para. 8)

4. Recommendations by Other Human Rights Bodies to the United States

At the conclusion of its 2015 fact-finding visit to the United States, **UN Working Group on Discrimination Against Women** reiterated that laws on religious or conscience-based refusals to provide reproductive health care in the U.S. should be reconciled with international human rights standards.[40] The Working Group recommended that the United States "disallow[] conscientious objection by health care personnel, providers and insurers to performing procedures to which women are legally entitled and for which there is no easily accessible, affordable and immediate alternative health provider."[41]

Recommended Questions

1. Please explain how the federal and state laws allowing individual health care providers and health care institutions to refuse to provide reproductive health care on the basis of religious or moral views impact women's reproductive rights protected by the ICCPR?
2. What steps are the United States taking to ensure that laws permitting refusal based on religious and moral beliefs do not hinder access to reproductive health care services that women are legally entitled to receive?

Suggested Recommendations

1. Take measures to ensure that laws permitting refusal based on religious and moral beliefs guarantee women's access to reproductive health care, including abortion and contraception, and that measures are put in place to monitor and prevent abuses.

Discrimination Against Immigrant Women in Access to Health Care (Articles 2, 3, 6, 26)

1. Issue Summary

In the United States, immigrant women are regularly denied access to health care in violation of their right to life and non-discrimination. Existing health laws and newly proposed changes to immigration policy reinforce a two-tiered system of health care access that positions immigrant women and their families as undeserving of essential health care.

Non-U.S. citizens are three times as likely as U.S.-born citizens to lack private or public insurance.[42] This is because non-citizens (1) are more likely than citizens to work in low-wage jobs that do not offer employer-based insurance, and (2) face discriminatory restrictions on eligibility for public insurance.[43] For instance, federal policies have excluded immigrants from government health insurance programs since 1996.[44] These policies exclude both undocumented immigrants as well as immigrants who have been deemed "lawfully present" in the United States for less than five years. Immigrant women of reproductive age are disproportionately uninsured and face particularly high barriers to affordable health care.[45] Restricted access to health insurance has greatly impacted the ability of low-income immigrant women to access maternity care and family planning, in addition to other reproductive health care services.[46]

A newly proposed federal regulation would intensify this longstanding pattern of exclusion by broadening the "public charge" test that has been a part of federal immigration law for decades.[47] U.S. immigration officials make a "public charge" determination when a person applies to enter the United States or to adjust to Lawful Permanent Resident status (otherwise known as "green card" holders). If a person is deemed likely to become a "public charge," that person can be refused permission to enter or refused a green card. The proposed rule expands the public charge definition to include an immigrant who simply "receives one or more public benefits" and includes benefits from key programs that address basic needs.[48] This could force immigrant families to choose between future permanent legal status and immediate needs to access healthy food, safe housing, and health care, leading to devastating impacts on immigrant women's health.[49]

Already, the proposed regulation has generated substantial fear within immigrant communities and is affecting immigrants' decisions to seek care.[50] (Additional information about the human rights violations experienced by detained immigrants is provided in previous section).

2. HRC Concluding Observations

In its 2014 Concluding Observations to the United States, the Committee expressed concern about the exclusion of millions of undocumented immigrants and their children from coverage under the Affordable Care Act (ACA) and the limited coverage of undocumented immigrants and immigrants residing lawfully in the United States for less than five years by Medicare and Children's Health Insurance.[51] The Committee recommended that the United States "identify ways to facilitate access to adequate health care, including reproductive health-care services, by undocumented immigrants and immigrants and their families who have been residing lawfully in the United States for less than five years."[52]

3. Human Rights Committee General Comments[53]

General Comment 18: reaffirming States' obligation to take affirmative measures to diminish or eliminate conditions that cause or perpetuate discrimination and expressing concern over violations resulting in difficulties for immigrants in accessing adequate health care. (Para. 15)

General Comment 28: recognizing that certain women suffer additional forms of discrimination on grounds aside from gender, including race or national origin, and asking States to address discrimination suffered by women on multiple grounds and to include this information in the reporting process. (Para. 3)

4. Recommendations by Other Human Rights Bodies to the United States

In its 2014 review of the United States, the **UN Committee on the Elimination of Racial Discrimination (CERD)** expressed concern at the exclusion of undocumented immigrants and their children from coverage under the ACA, as well as limited coverage of undocumented immigrants and immigrants residing lawfully in the U.S. for less than five years by Medicaid and Children's Health Insurance Program.[54] It reiterated concern at the persistence of racial disparities in the field of sexual and reproductive health[55] and recommended that the U.S. take steps to ensure that all individuals, in particular undocumented immigrants and immigrants and their families who have been residing lawfully in the U.S. for less than five years, have effective access to affordable health care services.[56]

After its 2015 visit to the United States, the **UN Working Group on the issue of discrimination against women and girls in law and in practice** found that "immigrant women and girls face severe barriers in accessing sexual and reproductive health services."[57]

At the conclusion of his 2017 U.S. visit, the **UN Special Rapporteur on Extreme Poverty** expressed concern that women immigrants experience higher poverty rates and have less access to social protection benefits, noting in particular the exclusion from benefits under the ACA and other benefits for permanent residents who have lived in the U.S. for less than five years.[58]

Recommended Questions

1. What measures is the United States taking to ensure all immigrant women have access to reproductive health care in the United States?
2. What is the United States doing to eliminate persistent reproductive health disparities among immigrant women and women belonging to racial and ethnic minorities?

Suggested Recommendations

1. Remove the federal five-year waiting period for "lawfully present" immigrant women to qualify for Medicaid and other health insurance programs.
2. Ensure access to comprehensive and quality reproductive health care for all, regardless of nationality, and including those in immigration detention facilities.

Criminalization of Pregnancy and Pregnancy Outcomes (Articles 2, 3, 7, 17, 26)

1. Issue Summary

Across the United States, women have been criminalized for allegedly causing harm, or even merely risking harm, to their own pregnancies, in violation of their rights to equal protection, bodily integrity, and privacy.[59]

This criminalization reaches women across a wide array of pregnancy outcomes, from those who end their own pregnancies outside a clinical setting, to those who give birth to healthy babies but are still prosecuted for actions or circumstances during pregnancy, including the use of criminalized drugs.

In the vast majority of cases, these prosecutions take place without legal authority – the right to end a pregnancy is protected by the Constitution and no state has a law explicitly criminalizing pregnancy loss. Nevertheless, prosecutors use a variety of laws, from criminal child endangerment laws, to feticide laws, to antiquated laws criminalizing abortion, to punish women who have ended or lost a pregnancy, or for other actions or omissions during a pregnancy.[60] Such misuse of laws violates women's human rights, but often persists unchecked because the women most likely to be targeted -- women of color, women living in poverty, and women with untreated substance use disorders -- are far less likely to have access to adequate legal representation or be able to bear the collateral burdens of fighting their prosecutions.[61]

This criminalization is calculated to enshrine in the law that fetuses should be treated as though they have rights in conflict with the person who carries and sustains them. This creates a second-class status for pregnant and postpartum women, who lose their rights to privacy and bodily integrity upon becoming pregnant and are singled out for surveillance and punishment. Further, the consequences to the public health[62] that ensue from threatening women with arrest for seeking reproductive health care are devastating.[63]

2. Human Rights Committee Concluding Observations

In 2014, the HRC expressed concern about the racial disparities in the criminal justice system, and the impact on people of color under Articles 2, 9, 14, and 26.[64]

3. Human Rights Committee General Comments

General Comment 36 (Right to Life): providing that "restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy." Furthermore states "should not . . . . apply criminal sanctions against women and girls undergoing abortion." States should also protect the lives of women and girls by "and prevent[ing] the stigmatization of women and girls seeking abortion" and "ensur[ing] the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, in all circumstances, and on a confidential basis." (Para 8)

4. Recommendations by other Human Rights Bodies and Experts to the United States

Reporting on its visit to the United States in 2016, the **UN Working Group on Arbitrary Detention** expressed concern about civil detentions of pregnant women who used or were suspected to have used criminalized drugs, noting that "[t]his form of deprivation of liberty is gendered and discriminatory in its reach and application." [65]

Following a 2018 visit to the United States, the **UN Special Rapporteur on Extreme Poverty** expressed concern that people in poverty, and in particular pregnant women, are disproportionately criminalized and subjected to interrogations that strip them of privacy rights.[66]

Recommended Questions

1. When will the U.S. view all laws that criminalize pregnancy and/or punish pregnancy outcomes as gendered crimes that target women and violate ICCPR Articles 3, 17, and 26?
2. What plans does the U.S. have for enacting legislation to specifically prohibit the prosecution of women for actions/inactions in relation to pregnancy?
3. What efforts is the U.S. making to ensure all women, including pregnant women, have access to affordable and confidential health care, considering the fears some may have in seeking health care if as a result they can be reported to law enforcement?

Suggested Recommendations

1. Eliminate laws that permit criminalization of women for experiencing a miscarriage or stillbirth.
2. Eliminate the practice of prosecuting women for crimes related to their pregnancies.
3. Prioritize comprehensive reproductive health care and evidence-based approaches to health concerns during pregnancy.

Women in Detention Facilities (Articles 2, 6, 7, 10, 24, 26)

1. Issue Summary

In 2006 and 2014, the Human Rights Committee recommended that the United States ensure adequate reproductive health care for detained women and end shackling during childbirth. However, denial of reproductive health care and shackling persist. Further, since 2017, immigration detention of pregnant women has increased, accompanied by denial of prenatal and emergency care. Detained pregnant women also face considerable barriers to abortion, including a federal policy preventing detained immigrant minors from obtaining abortions.

An estimated 12,000 pregnant women are detained in jails and prisons,[67] and 1,400 women give birth in custody every year.[68] In December 2017, Immigration and Customs Enforcement (ICE) officially ended a policy not to detain pregnant women absent extraordinary circumstances.[69] Between December 14, 2017 and April 7, 2018, 590 pregnant women were in immigration detention.[70]

Shackling of pregnant women continues, both in jurisdictions with and without legal prohibitions.[71] Twenty-six states prohibit shackling women in labor, and some states and the federal government have broader legal restrictions banning the use of restraints for pregnant women.[72] No law prohibits shackling in 24 states.[73] In 2017, a lawsuit against Milwaukee County jail alleged that at least 40 women gave birth in shackles.[74] In February 2018, Bronx police officers handcuffed a woman in labor to a hospital bed and shackled her ankles maintaining that police procedures superseded the state anti-shackling law.[75]

Similarly, immigration policies prohibiting shackling[76] are not enforced. In 2015, a pregnant asylum seeker, shackled at the wrists, ankles, and stomach, miscarried after she fell on her stomach.[77] Since 2017, pregnant women have been shackled around hands, legs and belly during transport and shortly after giving birth.[78]

There is a lack of data and no national standards regarding treatment of pregnant women in jails and prisons. Pregnant women report denial of medical care or long delays, including having guards ignore requests for medical care when going into labor.[79] They are subject to squat and cough strip searches, denied adequate nutrition[80] and have been placed in solitary confinement.[81] Women are denied family support and forced to have a correctional officer present during delivery, and then immediately separated from their infant[82] and denied the ability to breast-feed.[83] Detained pregnant immigrants in need of prenatal and emergency care face delays and denials of access that in several cases may have resulted in miscarriages.[84] Common detention practices, such as harsh physical conditions, work detail, and use of shackles pose unique and acute dangers for pregnant women.

Generally, health care services for detained pregnant women do not include abortions. Women have sued jails over denial of a medical furlough or transport to clinics to obtain an abortion.[85] Recently, immigration officials refused to allow detained immigrant minors access to abortion services even if they arrange for and pay for the procedure themselves. A class action lawsuit has challenged this policy.[86]

2. Human Rights Committee Concluding Observations

In 2014, the Committee expressed concern about mandatory detention of immigrants and recommended that the U.S. review "policies of mandatory detention . . . to allow for individualized decisions"[87] and "monitor the conditions of detention in prisons . . . with a view to ensuring that [detained] persons are treated in accordance with . . . articles 7 and 10 . . . and the Standard Minimum Rules for the Treatment of Prisoners."[88]

In 2006, the Committee expressed concern "about the shackling of detained women during childbirth and recommended that the U.S. "prohibit the shackling of detained women during childbirth.[89]

3. Human Rights Committee General Comments

General Comment 28: stating that "[p]regnant women who are deprived of their liberty 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." (Para. 20)

General Comment 36: providing that states "should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion." (Para. 15)

4. Recommendations by Other Human Rights Bodies to the United States

In 2014, the **Committee Against Torture** (CAT) recommended that the United States "[p]rohibit the use of solitary confinement for . . . pregnant women, women with infants and breastfeeding mothers, in prison."[90] It expressed concern that despite legal restrictions "incarcerated women are still shackled or otherwise restrained throughout pregnancy and during labour, delivery and post-partum recovery," and recommended that the United States "[r]evise the practice of shackling incarcerated pregnant women" bearing in mind that prisons should "respond to the needs of pregnant women, nursing mothers and women with children."[91]
It also expressed concern about "substandard conditions of immigration detention facilities" and recommended that the United States "develop and expand community-based alternatives to immigration detention."[92]

The **UN Special Rapporteur on Violence Against Women** (SRVAW) and **UN Working Group on Discrimination Against Women** (WGDAW) raised concerns about United States shackling of pregnant women following visits in 1998, 2011[93] and 2015.[94] In 2011, the SRVAW noted that despite restrictions, shackling regularly occurred and that existing policies were not adequately enforced.[95]

In 2016, the **WGDAW** expressed concern about lack of appropriate health care services for women in U.S. immigration detention.[96]

In 2011, the **SRVAW** expressed concern about women's health care in U.S. justice facilities, noting the system is "insufficiently responsive to gender-specific needs, including the reproductive health needs of women, and is under-staffed and under-resourced."[97]

Recommended Questions

1. What steps are the United States taking to ensure that pregnant women are not unnecessarily detained and are given adequate and appropriate reproductive health care including prenatal and emergency care and access to abortion?
2. What steps are the United States taking to ensure that immigration, law enforcement and correctional officials are properly trained about the rights of pregnant women and are held accountable for rights violations?

Suggested Recommendations

1. Ensure that pregnant individuals are only detained or incarcerated if there are no possible and appropriate alternatives and have access to gender appropriate health care, including prenatal, emergency and abortion care, and that policies and procedures regarding housing, work detail, nutrition, transportation, recreation, visitation, and security searches reflect the needs and rights of pregnant people.
2. Ensure that solitary confinement and use of shackles and other forms of restraints are banned throughout pregnancy and during labor, delivery and post-partum recovery.
3. Ensure that immigration, law enforcement and correctional officials are properly trained about the rights of pregnant women and are held accountable for rights violations.
4. Ensure that statistics are maintained tracking the number of pregnant women in law enforcement, correctional and immigration custody and develop national standards concerning the treatment of pregnant women in detention.

Impact of Global Gag Rule on Global Reproductive Health (Articles 3, 6, 19, 26)

1. Issue Summary

The United States' reinstatement and dramatic expansion of the Mexico City Policy, also known as the "Protecting Life in Global Health Assistance" (PLGHA) policy,[98] or the Global Gag Rule (GGR), violates the rights of women and girls around the world.

Under this new, expansive iteration of the GGR, nongovernmental organizations (NGOs) incorporated outside of the United States that wish to receive, or that currently receive, U.S. global assistance funds cannot use those funds, or any funds acquired from any other source, to "perform or actively promote abortion as a method of family planning."[99] Furthermore, U.S. NGOs that receive U.S. government funds are required to enforce the policy and cannot provide financial support to foreign NGOs that "perform or actively promote abortions as a method of family planning."[100] As the largest global donor for family planning funds, the United States is decimating decades of collaborative progress between civil society organizations (CSOs), national governments, and intergovernmental organizations to not only improve the health of women and girls, but also provide them with a clear path to social and economic empowerment.[101]

The GGR denies women and girls the right to control their own fertility, makes it more difficult for pregnant women to receive proper prenatal and postnatal maternal care, and leaves communities at risk.[102] CSOs, integrated health care providers, and small, remote clinics must choose between cutting vital abortion services and finding new sources of funding that are not tied up in the GGR; in many cases, funds cannot be recovered, and they must shut their doors entirely.[103] Many regions have limited or no access to medication, condoms, and contraception. The ultimate result is that women lack access to sexual and reproductive health care, including access to safe and legal abortion and diagnosis and treatment of HIV/AIDS and other STDs.

The GGR specifically targets and denies women equal rights by denying them access to essential health services. It censors the dissemination of vital information related to abortion, which in turn prevents women from making informed choices and prevents advocates from holding their governments accountable. The GGR, by denying women access to safe and legal health care, increases the likelihood that women will seek out unsafe methods of terminating a pregnancy, thereby increasing their chances of injury, infection, ill-treatment and death and depriving them of their intrinsic value and right to life.

2. Human Rights Committee Concluding Observations

The Committee did not issue recommendations specifically related to the GGR during its previous reviews of the United States. The policy was not in place during the Committee's first review, under the Clinton Administration. During the Committee's combined second and third

review, the original, less-expansive version of the GGR policy was actively in place after being reinstated by George W. Bush from 2001– 2009.

3. Human Rights Committee General Comments

General Comment 31: States must "respect and ensure the rights laid down in the Covenant to anyone within the power or effective control of that State Party, even if not situated within the territory of the State Party." (Para 10)

General Comment 34: States are prohibited from coercing the holding or not holding of any opinion (Para. 10); and must protect the right to access information. (Para. 18, 19)

General Comment 36: States are prohibited from regulating pregnancy and abortion "in a manner that runs contrary to [the States'] duty to ensure that women and girls do not have to undertake unsafe abortions…"; States "should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion." (Para. 8).

4. Recommendations from Other Human Rights Bodies to the United States

None related to the Global Gag Rule.

Recommended Questions

1. What steps has the U.S. government taken to systematically research and map the impact of the Mexico City Policy, also known as the PLGHA policy or the Global Gag Rule, on women and girls' reproductive rights protected by ICCPR Articles 3, 6, 19, and 26.
2. What steps has the U.S. government taken to ensure that the Mexico City Policy, also known as the Global Gag Rule or the PLGHA policy, is not hindering access to reproductive health care services women and girls are legally entitled to receive?

Suggested Recommendations

1. Revoke the Mexico City Policy, also known as the Global Gag Rule or the PLGHA policy.
2. Enact a federal statute reversing and prohibiting any future enactment of the Mexico City Policy, also known as the Global Gag Rule or the PLGHA policy.

[1] SisterSong Women of Color Reproductive Justice Collective, a Southern U.S. based national membership organization, defines Reproductive Justice as: "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities." *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice/ (last visited Jan.11, 2019).
[2] Roe v. Wade, 410 U.S. 113 (1973).
[3] Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016).
[4] Elizabeth Nash et al., *Policy Trends in the States, 2017*, GUTTMACHER INST. (Jan. 2, 2018), https://www.guttmacher.org/article/2018/01/policy-trends-states-2017.
[5] Alabama, Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Texas, and West Virginia have all passed laws prohibiting the most common second trimester abortion procedure, dilation & evacuation (D&E). *See Bans on Specific Abortion Methods Used After the First Trimester*, GUTTMACHER INST. (July 1, 2018), https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester.
[6] Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin all ban abortion pre-viability at 20 weeks or earlier with limited exceptions. *See An Overview of Abortion Laws*, GUTTMACHER INST. (July 1, 2018), https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.
[7] Iowa and North Dakota. *See* Kristine Phillips, *Iowa Governor Signs 'Heartbeat' Bill Banning Abortion After Six Weeks*, WASH. POST (May 4, 2018), https://www.washingtonpost.com/news/to-your-health/wp/2018/05/02/iowa-lawmakers-just-passed-one-of-the-most-restrictive-abortion-bills-in-the-u-s/?utm_term=.ab664da112ed; *Federal Judge in ND Blocks the Nation's Earliest and Most Extreme Abortion Ban*, CENTER FOR REPRODUCTIVE RIGHTS (July 22, 2013), https://www.reproductiverights.org/press-room/federal-judge-in-nd-blocks-the-nations-earliest-and-most-extreme-abortion-ban.
[8] Regulations requiring burial or cremation of fetal tissue were enacted in Indiana, Louisiana, Texas, Arkansas, and Georgia. Many of these laws are the subject of litigation. *See Targeted Regulation of Abortion Providers (TRAP Laws)*, GUTTMACHER INST. (Feb. 2018), *https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws; 2016 State of the States: A Pivotal Time for Reproductive Rights*, CTR. FOR REPRODUCTIVE RIGHTS (Jan. 2017), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_StateofStates_11.16_Web_Final.pdf.
[9] For an overview of barriers to access and their impact, *see Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INST. (Feb. 2018), https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws; *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (July 1, 2018), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion; Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSP. ON SEXUAL AND REPRODUCTIVE HEALTH 95 (2017).
[10] At minimum six states are down to one clinic — North Dakota, South Dakota, Wyoming, Kentucky, Mississippi and West Virginia; at times, Arkansas and Missouri have had just one clinic, as well. Sabrina Tavernise, *The Future of Abortion Under a New Supreme Court? Look to Arkansas*, N.Y. TIMES (Sept. 7, 2018), https://www.nytimes.com/2018/09/07/us/abortion-supreme-court-arkansas.html.
[11] *See* Liza Fuentes, *Latina immigrant women's access to abortion: Insights from interviews with Latina Grasstops Leaders*, NAT'L LATINA INST. FOR REPRODUCTIVE HEALTH (Sept. 2010), https://nciwr.files.wordpress.com/2011/01/nlirh-reserach-brief-sept2010-final1.pdf; *Key Indicators of Sexual and Reproductive Health Differ for Immigrant and U.S.-Born Women of the Same Race and Ethnicity*, GUTTMACHER INST. (Feb. 20, 2018), https://www.guttmacher.org/news-release/2018/key-indicators-sexual-and-reproductive-health-differ-immigrant-and-us-born-women; ALYSSA LLAMAS ET AL., JACOBS INST. OF WOMEN'S HEALTH, GEO. WASH. U., PUBLIC HEALTH IMPACTS OF STATE-LEVEL ABORTION RESTRICTIONS OVERVIEW OF RESEARCH & POLICY IN THE UNITED STATES 1(Apr. 2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf; Rachel K. Jones et al., *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, vol. 107, no. 12 Am. J. Pub. Health 1904, 1904-9 (Dec. 2017), https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042.
[12] Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, 20 GUTTMACHER POLICY REVIEW 1, 2 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2000116.pdf.

[13] *See* Human Rights Committee (HRC), *Concluding Observations: Lao*, para. 21-22, U.N. Doc. CCPR/C/LAO/CO/1 (Nov. 23, 2018); *Sudan*, para. 27-28, U.N. Doc. CCPR/C/SDN/CO/5 (Nov. 19, 2018); *Gambia*, para. 17-18, U.N. Doc. CCPR/C/GMB/CO/2 (Aug. 30, 2018); *Liberia*, para. 26-27, U.N. Doc. CCPR/C/LBR/CO/1 (Aug. 27, 2018); *Algeria*, para. 25-26, U.N. Doc. CCPR/C/DZA/CO/4 (Aug. 17, 2018); *El Salvador*, para. 15-16, U.N. Doc. CCPR/C/SLV/CO/7 (May 9, 2018); *Lebanon*, para. 25-26, U.N. Doc. CCPR/C/LBN/CO/3 (May 9, 2018); *Guatemala*, para. 14-15, U.N. Doc. CCPR/C/GTM/CO/4 (May 7, 2018). *See also* HRC, *Concluding Observations: Italy*, para. 16-17, U.N. Doc. CCPR/C/ITA/CO/6 (May 1, 2017); *Poland*, para. 23-24, CCPR/C/POL/CO/7 (Nov. 23, 2016); *Ireland*, para. 9, U.N. Doc. CCPR/C/IRL/CO/4 (Aug. 18, 2014). *See also* Siobhán Whelan v. Ireland, Human Rights Committee, Commc'n No. 2425/2014, para. 9, U.N. Doc. CCPR/C/119/D/2425/2014 (2017); Amanda Jane Mellet v. Ireland, Human Rights Committee, Commc'n No. 2324/2013, para. 9, U.N. Doc. CCPR/C/116/D/2324/2013 (2016).

[14] U.N. Working Group on Discrimination Against Women in Law and Practice, *Report of the Mission to the United States of America*, para. 90(vii; x; xvi), U.N. Doc. A/HRC/32/44/Add.2 (June 7, 2016).

[15] Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (by Philip Alston).

[16] The United States has a maternal mortality ratio (MMR) of 14, placing the U.S. behind 45 other countries. WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2015 70-77 (2015), http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1.

[17] Reproductive Health: Pregnancy Mortality Surveillance System, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (last updated June 29, 2017); Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTET. GYNECOL. 435, 437 (2014).

[18] *Reproductive Health: Pregnancy Mortality Surveillance System*, CDC, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (last updated June 29, 2017); Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTET. GYNECOL. 435, 437 (2014).

[19] *MMR Map*, REVIEW TO ACTION http://www.reviewtoaction.org/content/mmr-map (last visited Jan. 11, 2019).

[20] See e.g., Promoting Healthcare Choice and Competition Across the United States, Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017) (encouraging federal officials to make it easier for small businesses and people to purchase insurance not bound by certain regulatory standards, including the required essential healthcare benefits of the ACA); Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 28912 (Aug. 20, 2018) (to be codified at 29 C.F.R. 2510) (exempting certain employers that form association health plans from some of the ACA consumer-protection requirements such as coverage of the 10 required essential health benefits that include contraception coverage); Pub. Law. No. 115-23 (2017), https://www.congress.gov/115/plaws/publ23/PLAW-115publ23.pdf (allowing states to exclude recipients of Title X grants from participating for reasons other than its ability to provide Title X services); DEPT. OF HEALTH& HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES, FACT SHEET: STATE EMPOWERMENT AND RELIEF WAIVER CONCEPTS (Nov. 29, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf (granting waivers to states imposing work requirements on Medicaid recipients); Amy Goldstein, *Administration slashes grants to help Americans get Affordable Care Act coverage*, WASH. POST (July 10, 2018), https://www.washingtonpost.com/national/health-science/administration-slashes-grants-to-help-americans-get-affordable-care-act-coverage/2018/07/10/012a0526-8481-11e8-8553-a3ce89036c78_story.html?utm_term=.7cf89e68485f.

[21] Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAMILY FOUNDATION (Oct. 19, 2016), http://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/; *see also* Hannah Katch et al., *Medicaid Works for Women – But Proposed Cuts Would Have Harsh, Disproportionate Impact*, CTR. ON BUDGET AND POLICY PRIORITIES (May 11, 2017), https://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact.

[22] Samantha Artiga et al., *Health Coverage and Care for Immigrants*, KAISER FAMILY FOUNDATION (July 11, 2017), http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/.

[23] *See* Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, GUTTMACHER INST. (Mar. 9, 2017), https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.

[24] *See* HRC, *Concluding Observations: Lao*, para. 22, U.N. Doc. CCPR/C/LAO/CO/1 (2018); *Gambia*, para. 18, U.N. Doc. CCPR/C/GMB/CO/2 (2018); *Romania*, para. 26, U.N. Doc. CCPR/C/ROU/CO/5 (2017); *Mali*, para. 14,

U.N. Doc. CCPR/CO/77/MLI (2003); *Peru*, para. 14, U.N. Doc. CCPR/C/PER/CO/5 (2013); *Mongolia*, para. 8, U.N. Doc. CCPR/C/79/Add.120 (2000).
[25] Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations—United States of America*, para. 15, UN Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014).
[26] *Id.*
[27] Human Rights Council, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice, on its Mission to the United States*, para. 72, 89, UN Doc. A/HRC/32/44/Add.2 (June 7, 2016).
[28] Human Rights Council, *Report of the Working Group of Experts on People of African Descent, on its Mission to the United States*, para. 117, UN Doc. A/HRC/33/61/Add.2 (Aug. 18, 2016).
[29] Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 57, U.N. Doc. A/HRC/38/33/Add.1 (May, 4, 2018) (by Philip Alston).
[30] *State Laws and Policies: Refusing to Provide Health Services*, GUTTMACHER INST. (Dec. 1, 2018), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.
[31] *Id.* For example, six states have explicit clauses allowing pharmacists to object, while 6 more have broad refusal clauses that may be read to apply to pharmacist.
[32] *Id.*
[33] The Coats Amendment, 42 U.S.C. § 238n, allows doctors, medical students, and health training programs to refuse to provide or participate in abortion training, abortion services, or referrals. This protection differs from traditional conscience laws because a refusal does not need to be based on moral or religious grounds. In 1997, Congress extended conscience protection beyond healthcare providers, allowing managed care plans operating under the federal Medicaid and Medicare programs to opt-out of providing, reimbursing for, or covering a counseling or referral service to which the plan objects on moral or religious grounds. 42 U.S.C. § 1395w-22(j)(3)(B)(Medicare); 42 U.S.C. § 1396u-2(b)(3)(B)(Medicaid). The Weldon Amendment protects a broad range of healthcare entities from discrimination for refusal to provide, pay for, cover, or refer for abortions. See Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat. 786.
[34] *Fact Sheet: Final Rules on Religious and Moral Exemptions and Accommodation for Coverage of Certain Preventative Services under the Affordable Care Act*, Nov. 7, 2018, U.S. DEPT. of HEALTH & HUMAN SERV., https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html, (last visited Dec. 17, 2018).
[35] *See* Commonwealth of Pennsylvania, v. Trump, et al., 281 F.Supp.3d 553 at 30-31 (E.D. Pa. 2017) (issuing a nation-wide preliminary injunction); California v. Azar, No. 18-15144, 2018 WL 6566752, at *2, *17 (9th Cir. Dec. 13, 2018) (upholding the preliminary injunction against the interim final rules, but limiting its scope to the five states — California, Delaware, Maryland, New York, and Virginia— that brought the lawsuit in the California district court).
[36] *HHS Announces New Conscience and Religious Freedom Division*, U.S. DEP'T OF HEALTH & HUMAN SERVICES (Jan. 18, 2018), https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html.
[37] Dalia Sopher, *HHS Division to Enforce 'Conscience and Religious Freedom' When do a clinician's rights deny those of the patient?*, 118 AM. J. OF NURSING 12 (2018); Robert Pear et al., *Trump Gives Health Workers New Religious Liberty Protections*, N.Y. TIMES (Jan. 18, 2018), https://www.nytimes.com/2018/01/18/us/health-care-office-abortion-contraception.html (quoting Senator Patty Murray of Washington, the senior Democrat on the Senate health committee, saying the administration was using the new division as "a tool to restrict access to health care for people who are transgender and women").
[38] Amy Littlefield, *Catholic Rules Forced This Doctor to Watch Her Patient Sicken—Now, She's Speaking Out*, REWIRE NEWS (Sept. 7, 2017 at 11:18 a.m.), https://rewire.news/article/2017/09/07/catholic-rules-forced-doctor-watch-patient-sicken-now-shes-speaking/ (discussing the growing number of hospitals nationwide that follow the ethical and religious directives and cite them to restrict abortion, contraceptive, and sterilization access; deny transition-related surgery to transgender patients, emergency contraception to rape victims, and abortion care to patients in the potentially life-threatening process of miscarrying); Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, vol. 98 AM. J. PUB. HEALTH 1774-8 (Oct. 2008) (finding OB-GYNs working in Catholic-owned hospitals are sometimes forced to delay care for miscarrying patients due to restrictions on intervening until health risks constitute "a threat to a women's life," leading some physicians to feel patient safety was compromised); Christina Caron, *Michigan Pharmacist Refused to Dispense Miscarriage Medication, Citing Religious Beliefs*, N.Y. TIMES (Oct. 18, 2018), https://www.nytimes.com/2018/10/18/us/catholic-pharmacist-miscarriage.html; *Fact Sheet: Pharmacy Refusals 101*, NAT'L WOMEN'S LAW CTR. (Dec. 28, 2017),

https://nwlc.org/resources/pharmacy-refusals-101/ (finding refusals to dispense contraception and emergency contraception are increasing and have surfaced in at least twenty-six states).

[39] HRC, *Concluding Observations: Poland*, para. 23-24, U.N. Doc. CCPR/C/POL/CO/7 (Nov. 23, 2016); *Italy*, para. 16-17, U.N. Doc. CCPR/C/ITA/CO/6 (May 1, 2017); *Colombia*, para. 20-21, U.N. Doc. CCPR/C/COL/CO/7 (Nov. 17, 2016); *Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010); *Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004).

[40] Human Rights Council, 33d Sess., *Rep. of the Working Group on the Issue of Discrimination Against Women in Law and in Practice on Its Mission to the United States of America*, para. 71, 95(i), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

[41] *Id.*, at para. 90(l).

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

[43] *Id.*; Kaiser Commission on Medicaid & the Uninsured, *Summary: Five Basic Facts on Immigrants and Their Health Care*, KAISER FAMILY FOUNDATION at 7 (Mar. 2008), http://www.kff.org/medicaid/upload/7761.pdf.

[44] 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).

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

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

[47] Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pt. 103, 212-4; 245; 258).

[48] The government would consider programs including Medicaid (with limited exceptions, including coverage of an emergency medical condition, and certain disability services related to education); the Supplemental Nutrition Assistance Program (SNAP) (formerly "food stamps"); Medicare Part D Low Income Subsidy (assistance in purchasing medicine); Federal Public Housing, including Section 8 housing vouchers, and Section 8 Project-based Rental Assistance. Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114, at 51158-60 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pt. 103, 212-4; 245; 258).

[49] *See* RANDY CAPPS ET AL., MIGRATION POLICY INST., GAUGING THE IMPACT OF DHS' PROPOSED PUBLIC-CHARGE RULE ON U.S. IMMIGRATION (2018), https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration (finding there would be a disproportionate effect on women, children, and the elderly).

[50] *See* Joan Alker et al., *Nation's Progress on Children's Health Coverage Reverses Course*, GEORGETOWN UNIV. HEALTH POLICY INST. CTR. FOR CHILDREN AND FAMILIES (Nov. 2018), https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf (finding the rate of uninsured children rose for the first time in nearly a decade, due partly to policies deterring immigrant parents from enrolling their eligible children, which will likely worsen if the proposed "public charge" rule is put into effect); Suzanne Gamboa, *Immigrants drop subsidized food, health programs — fearing aid will be used against them*, NBC NEWS (Sept. 8, 2018), https://www.nbcnews.com/news/latino/immigrants-drop-subsidized-food-health-programs-fearing-aid-will-be-n906246 (noting doctors and non-profit leaders seeing dropping rates of immigrants participating in public benefit programs, including Medicaid and CHIP, due to fears of the proposed rule, alongside other stepped-up immigration enforcement policies and regulations). *See also* Samantha Artiga et al., *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KAISER FAMILY FOUNDATION (Oct. 11, 2018), https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicaide-key-findings/ (finding that as a result of the proposed rule and overall chilling effect, approximately between 2.1 million and 4.9 million Medicaid/CHIP enrollees living in a family with at least one noncitizen would disenroll).

[51] HRC, *Concluding Observations: United States*, para. 15, U.N. Doc. CCPR/C/USA/CO/4 (Apr. 23, 2014).

[52] *Id.*

[53] *See also* Nell Toussaint v. Canada, Human Rights Committee, Commc'n No. 2348/2014, para. 11.7, 12, 13, U.N. Doc. CCPR/C/123/D/2348/2014 (2018) (holding that denial of health care to a Canadian immigrant violates Canada's obligations under ICCPR Article 6 and Article 26).

[54] CERD, *Concluding Observations: United States of America*, para. 15, UN Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014).

[55] *Id.*
[56] *Id.* at para. 15(a).
[57] Human Rights Council, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice, on its Mission to the United States*, para. 68, UN Doc. A/HRC/32/44/Add.2 (June 7, 2016).
[58] Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 59, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (by Philip Alston).
[59] AMNESTY INT'L, USA: CRIMINALIZING PREGNANCY: POLICING PREGNANT WOMEN WHO USE DRUGS IN THE USA (2017), https://www.amnesty.org/download/Documents/AMR5162032017ENGLISH.pdf.
[60] *Id.* at p.7. These prosecutions have led to jurisprudence in two states permitting women to be charged with child endangerment crimes against fetuses they are carrying if they use a criminalized drug during pregnancy. Prosecutions occur in spite of the fact that there is no scientific basis for the contention that in utero exposure to a criminalized drug is tantamount to abuse or neglect, and often in the absence of any actual effect on the fetus. *See e.g.* Whitner v. State, 328 SC 1, 6, 492 SE2d 777, 779 (1997); S.C. Code Ann §20-7-50; Ala. Code 1975 § 26-15-3.2; Hicks v. State, 153 So 3d 53, 59 (Ala. 2014). *See also* D. Frank, et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613 (2001); Bobbe Ann Gray and Cindra Holland, I*mplications of Psychoactive 'Bath Salts' Use During Pregnancy*, 18 NURSING FOR WOMEN'S HEALTH 223 (2014) (finding "[i]nformation regarding the short- and long-term effects of [psychoactive bath salts] and related drug use by pregnant women is virtually nonexistent").
[61] Khiara Bridges, *Introduction: The Poverty of Privacy Rights*, STAN. U. PRESS (June 2017), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2984982; Nina Martin, *Take A Valium, Lose Your Kid, Go To Jail*, PROPUBLICA (Sept. 23, 2015), https://www.propublica.org/article/when-the-womb-is-a-crime-scene.
[62] Ferguson v. City of Charleston, 532 U.S. 67, 84 n.23 (2001) (noting the *amicus* submissions of numerous leading medical and public health organizations concluding that searching pregnant women for evidence of drug use and facilitating their arrest will harm prenatal health by discouraging women from seeking prenatal care); Stephen Kandall, *Substance and shadow: women and addiction in the United States*, HARV. U. PRESS (1996); National Perinatal Association, Position Statement, *Substance Abuse Among Pregnant Women* (revised 2012) ("NPA supports comprehensive drug treatment programs for pregnant women that are family-centered and work to keep mothers and children together whenever possible. . . NPA opposes punitive measures that deter women from seeking appropriate care during the course of their pregnancies").
[63] Nora Sandstad, *Pregnant Women and the Fourteenth Amendment, A Feminist Examination of the Trend to Eliminate Women's Rights During Pregnancy,* 26 LAW & INEQ. 171 (2008) (noting "[i]f the fetus is a person, there are no limits on the state's power to police and punish pregnant women").
[64] HRC, *Concluding Observations: United States*, para.6, U.N. Doc. CCPR/C/USA/CO/4 (Apr. 23, 2014).
[65] Working Group on Arbitrary Detention, *Rep. of the Working Group on Arbitrary Detention on its visit to the United States of America*, para. 74, U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017).
[66] Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May, 4, 2018) (by Philip Alston).
[67] ACLU BRIEFING PAPER: THE SHACKLING OF PREGNANT WOMEN & GIRLS IN U.S. PRISONS, JAILS & YOUTH DETENTION CENTERS, ACLU (2012), https://www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf.
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