

WOMEN'S REPRODUCTIVE RIGHTS IN THE UNITED STATES

A Shadow Report

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Prepared for the Eighty-Seventh Session of the Human Rights Committee

**CENTER
FOR
REPRODUCTIVE
RIGHTS**

**WOMEN'S REPRODUCTIVE RIGHTS IN THE UNITED STATES:
A SHADOW REPORT**

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INTRODUCTION

This report is intended to supplement, or “shadow,” the report of the government of the United States to the Human Rights Committee (“the Committee”). As has been expressed by Committee members, non-governmental organizations (NGOs) can play an invaluable role in providing credible and reliable independent information on laws and practices of reporting countries, as well as on governments’ periodic reports submitted pursuant to the International Covenant on Civil and Political Rights (ICCPR). NGOs can provide information the Committee needs to make recommendations that respond to a reporting country’s most pressing human rights concerns. These recommendations, in turn, provide NGOs with valuable tools with which to press their governments to enact or implement legal and policy changes.

Throughout the world, gender inequality permeates every society and every facet of women’s lives. The United States is no exception. This report focuses on the reproductive rights of women in the United States. It is intended to summarize the issues of greatest concern with respect to reproductive rights. U.S. laws and policies endanger the lives and health of women and girls within the United States through restrictions on their access to reproductive health care. Furthermore, U.S. foreign policy jeopardizes the lives and health of women in low-income countries by imposing restrictive U.S. reproductive and sexual health policies upon countries that receive U.S. development aid.

Because reproductive rights are fundamental to women’s health and equality, states parties’ commitment to ensuring them should receive serious attention. The Committee has long recognized that women’s reproductive health and rights receive broad protection under the ICCPR. In its elaboration of equality of rights between men and women in General Comment 28, the Committee directs states parties to report on laws as well as government or private actions that interfere with women’s equal enjoyment of the right to privacy in the area of reproductive health.¹ The Committee asks states parties to eliminate any interference in the exercise of this right.² Women’s lack of access to health services, particularly reproductive health services, has been identified by the Committee as a violation of Article 3, which guarantees the equality rights of men and women.³

The Committee has reaffirmed the obligation of states parties to undertake affirmative measures to diminish or eliminate conditions that cause or perpetuate discrimination,⁴ which is defined in General Comment 18 as “any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.”⁵ The Committee has frequently expressed concern over violations of the anti-discrimination provisions of the ICCPR⁶ and has discussed discrimination against racial and ethnic minorities in access to health care.⁷ In its General Comment 28, the Committee recognizes that certain women suffer discrimination on grounds other than gender, such as race, national or social origin or “other status,” and it asks states parties to address the discrimination suffered by women on multiple grounds and include this information in the reporting process.⁸

This report represents a collaborative effort of the International and Domestic Legal Programs of the Center for Reproductive Rights. It draws upon the expertise of the International Legal Program in international human rights and shadow reporting, and upon the expertise of the Domestic Legal Program in its defense of women's reproductive rights through its litigation and policy work within the United States. The report also draws, of course, upon statistical and factual resources collected by numerous government agencies and nongovernmental organizations, whose work is credited in the endnotes.

This report was co-ordinated by Kim Shayo Buchanan and edited by Ms. Buchanan, Laura Katzive and Priscilla Smith, all of the Center for Reproductive Rights. Kerry McLean, Laura Paley, Meghan Rhoad and Maya Sen provided invaluable research support.

EXECUTIVE SUMMARY

A. THE RIGHT TO REPRODUCTIVE HEALTH CARE, INCLUDING FAMILY PLANNING AND SAFE AND LEGAL ABORTION (ARTICLES 3, 6, 23, 26); WOMEN'S ECONOMIC AND SOCIAL RIGHTS, INCLUDING HEALTH INSURANCE (ARTICLES 2, 3, 9, 26)

Restricting contraception. U.S. laws and policies restrict the access of low-income women, who are disproportionately Latina or African-American, to contraception, abortion, and other reproductive health care. Many government-imposed barriers impede women's access to safe and effective modern contraceptives: obstacles to insurance coverage for reproductive health care; laws authorizing pharmacists and other health care providers to arbitrarily refuse contraception or other reproductive health care on the basis of moral disapproval; restrictions on access to emergency contraception (the “morning-after pill”); and school-based abstinence-only-until-marriage programs that suppress information about the effectiveness, safety, and proper use of modern contraceptives, and about access to them. Thus 49% of all pregnancies in the United States are unintended; half of those pregnancies result in abortion.

Delaying abortion. The earlier an abortion procedure is performed, the safer it is. Although the health risks of abortion are low, they increase exponentially with gestational length. Nonetheless, state and federal laws impose myriad barriers to women's access to safe, legal and timely abortion. The state of South Dakota recently passed an (admittedly unconstitutional) law that bans abortion altogether. Some laws, such as those that impose burdensome licensing requirements on abortion clinics, prohibit certain forms of abortion, or require the disclosure of confidential information about abortion patients, are designed to stigmatize abortion and make it prohibitively expensive and difficult to obtain. Other constraints imposed by law—parental notification or consent requirements for young women's abortions, restrictions on public funding, mandatory delays, and requirements for multiple unnecessary clinic visits—have the effect of delaying abortions, especially for young or poor women. Thus low-income women receive abortions two to three weeks later in pregnancy than do wealthier women. In states requiring parental notification or consent, young women delay an average of more than two weeks before telling their parents of their pregnancy. And many young women who are close to the age of majority delay their abortions into the second trimester, undergoing riskier procedures in order to outwait the parental notification requirement.

Eroding health protections. U.S. constitutional law currently requires that any restriction on abortion must allow for the procedure when it is necessary to protect the life *or health* of the pregnant woman. Abortion laws may not subject women to legally created health risks, by either (a) banning or delaying abortion when the pregnancy poses a risk to the woman's health, or (b) requiring that a riskier abortion procedure be used. Despite this constitutional requirement, a recurrent theme of recent federal and state anti-abortion

regulation has been the deliberate attempt to undermine constitutional health protections by passing laws that create health risks to women in both of these ways.

B. RACIAL DISPARITIES: UNWANTED PREGNANCY, MATERNAL MORTALITY AND REPRODUCTIVE COERCION (ARTICLES 2, 3, 6, 24)

Poverty and discrimination. African-Americans, Latinas, Native Americans, and other nonwhite ethnic groups in the United States feel the brunt of government-imposed reproductive health restrictions because they are much more likely than whites to be poor, to lack health insurance, or to be subject to government-imposed restrictions on reproductive health coverage. As a result, they fare worse than whites on every measure of reproductive health, including the following indicators:

- **Maternal and infant mortality.** African-American women experience rates of maternal mortality more than four times higher than those of white women. African-American children are 2.5 times more likely than white children to die in the first year of life; Native American infant mortality is 50% higher than for whites.
- **Unintended pregnancy.** 41% of Latinas lack health insurance; unsurprisingly, they are also the group of women least likely to be using birth control. As a result, they experience higher rates of unintended pregnancy and birth than any other ethnic group. Moreover, while births to adolescent women declined sharply in the United States between 1994 and 2002, birth rates remained high and stable among Latina youth. For adult Latinas, the overall pregnancy rate remained stable, but the proportion of those pregnancies that were unintended increased substantially.
- **Abortion.** Because of their higher rates of poverty, unemployment, lack of education, lack of health insurance, and unintended pregnancy, the abortion rate among Latinas is more than double the rate among white women, and the abortion rate among African-American women is more than five times higher than that of whites. Because of extensive economic and legal barriers to health care, white women, who are more likely to be middle-class and privately insured, are more likely than Latinas or black women to have abortions at the safest, earliest stage of pregnancy: at or before 8 weeks' gestation. Latinas and African-American women are more likely than whites to have abortions at later, riskier stages of pregnancy: 13 weeks or later.
- **Sexually transmissible infection (STI).** Rates of STIs and HIV infection are severely elevated for Latinos and Latinas, Native Americans, and especially African-Americans. Black women are more than 25 times more likely than white women to be infected with HIV: the prevalence of HIV among African-American women is over 5%. Latinas are six times likelier than white women to be infected with HIV, and infection rates among Native women are more than two and one half times higher than for white women.
- **Contraception: effective and voluntary?** White women, who are more likely

to have health insurance, are likely to use one of the most effective reversible methods of contraception: the birth control pill. Black women and Latinas, by contrast, are more likely than white women to be sterilized, to use Depo-Provera (a long-acting three-month contraceptive injection) or to use no method at all.

C. ADOLESCENTS' REPRODUCTIVE HEALTH (ARTICLES 6, 12, 16, 17, 18, 23-26)

Barriers to abortion. More than half of U.S. states currently enforce laws that require a young woman seeking an abortion to notify or obtain the written consent of one or both parents prior to the procedure. These laws allow parents to override a young woman's decision to terminate her pregnancy unless she can obtain authorization for the abortion from a judge. While young women who have good relationships with their parents are likely to consult them when facing an unplanned pregnancy, mandatory parental notification or consent laws expose many young women to violence, anger, coercion, and expulsion from the home by disapproving parents. Such laws often lead young women to delay both abortion and prenatal treatment until it is too late.

“Kiss and tell” law. As part of a growing trend, the Attorney General of the state of Kansas issued an opinion mandating that any physician, nurse, counselor or other health care provider who learns that a person under 16 years old has been sexually active must report the young person to child protective services or the police—even if it was consensual sexual activity with an age-matched peer, and even if the activity did not involve sexual intercourse. Such reporting requirements do not deter teenage sexual activity, but do deter young people from seeking appropriate reproductive health care, including contraception and STI treatment. This law was struck down by a federal judge in April 2006, but the Attorney General has appealed.

D. SEXUAL HEALTH EDUCATION; FREEDOM OF EXPRESSION, CONSCIENCE, AND FAMILY PRIVACY (ARTICLES 2, 3, 19, 24, 26)

Abstinence-only-until-marriage programs. The federal government and 47 states spend hundreds of millions of dollars on ineffective, misleading “abstinence-only-until-marriage” programs, often presented by religious groups, at public expense, in public schools, churches, and community centers. These curricula misinform young people about sexual health, exaggerate the dangers of premarital sex, and teach that birth control is dangerous and condoms do not work—on the theory that if young people lack information about contraception, they will abstain from sex.

Every rigorous study of these programs has demonstrated that they are ineffective. They do not reduce rates of adolescent pregnancy or STI, nor do they deter premarital sex. They do, however, have one notable effect: those who have received such programming are significantly more likely to have unprotected sex.

Disparaging condoms. Federal rules governing abstinence promotion require instructors to withhold all information about condoms and modern contraceptives except failure rates. These curricula typically teach that condoms do not work. Some curricula claim, inaccurately, that there is a 15% chance of pregnancy every time a couple uses a condom; many teach, falsely, that sperm and STI pathogens can pass through microscopic holes in an intact condom. Some curricula also discourage young people from carrying condoms for fear of damaging their “reputations.”

Promoting gender stereotypes. These curricula promote egregious gender stereotypes: that the man should be the breadwinner, while the woman’s role is as dependent wife and mother; that men marry for sex and “domestic support,” while women marry for emotional closeness and “financial support.” They teach that the “raging hormones” of men and boys make it normal for them to try to pressure and coerce girls into sex, and that it is girls’ responsibility to be “modest” and to ensure that boys do not get to have premarital sex with them. Girls who “surrender” to sex are said to lack self-respect and to be undeserving of the love and respect supposedly afforded to virgins. These programs have been linked to elevated levels of violence and harassment of gay, lesbian, bisexual and transgender students in U.S. schools. Research has also shown that the shame, stigma, and gender inequality that these programs promote contribute to the spread of STIs, including HIV/AIDS.

E. DISCRIMINATION AGAINST PREGNANT WOMEN (ARTICLES 3, 6, 9, 17, 26)

Criminal and civil penalties for behavior during pregnancy. Despite the consensus at international law that pregnancy discrimination is sex discrimination, pregnancy is treated under U.S. law as an exception to the constitutional guarantee of gender equality. Thus police, prosecutors and lawmakers throughout the United States have imposed criminal and civil penalties that are targeted overwhelmingly at African-American, Latina, and indigenous women. Such women face punitive penal or civil sanctions for behavior during pregnancy, such as use of alcohol, medication, or illegal drugs, that is alleged to have harmed the fetus. In addition to exposing women to forms of civil and criminal liability that are never imposed on men, such laws deter substance-dependent women who become pregnant from seeking the prenatal care or addiction treatment they need.

F. EXTRATERRITORIAL EFFECTS OF RESTRICTIVE U.S. REPRODUCTIVE POLICIES (ARTICLE 2; SEE ALSO GENERAL COMMENT 31)

Global gag rule. In 2001, the United States imposed a global gag rule, known as the “Mexico City Policy,” that forbids any recipient of U.S. Agency for International Development (USAID) funding to provide abortions or abortion information or referrals. It further prohibits any advocacy that abortion be made, or kept, safe and legal—a constraint which would be unconstitutional if imposed on an organization within the United States.

Export of abstinence promotion programs. USAID funds the export of ineffective, misleading and stereotypical abstinence-only programs through its global AIDS policy, the President’s Emergency Plan for AIDS Relief (PEPFAR). This funding is directed at 15 “focus countries,” most of which are low-income African countries with high rates of HIV infection.

Abstinence promotion requirement. A federal statute requires that 33% of all USAID funds for HIV prevention be used for abstinence-only-until-marriage programs. The State Department’s Office of the Global AIDS Coordinator (OGAC) has ordered the recipients of PEPFAR grants to cut their funding of proven, effective interventions—medical and blood safety, prevention of mother-to-child transmission, and comprehensive HIV-prevention messages—in order to redirect funds toward (ineffective) abstinence promotion. Thus the abstinence funding requirement jeopardizes the health of women, girls, men, and boys in the low-income countries that receive U.S. HIV-prevention funds.

Stigmatizing condom use. PEPFAR describes its mandated approach to HIV prevention as “ABC”: **A**bstinence, **B**e faithful, and **C**ondoms. However, the United States refuses to fund broad-based social marketing or condom distribution campaigns, and deems condom promotion use inappropriate for the general population. Organizations receiving PEPFAR funding must present abstinence as the *only* appropriate prevention strategy for young people, and “be faithful” as the *only* suitable prevention strategy for married adults. PEPFAR deems condoms to be suitable only for “high-risk persons or groups,” defined to include sex workers, substance abusers, persons with HIV/AIDS, and men who have sex with men. This approach, of course, stigmatizes condom users—and people infected with HIV—as social undesirables.

“ABC” in Uganda: increasing HIV incidence. PEPFAR makes the misleading claim that “ABC” is a local initiative that was developed in Uganda and proven successful. This is untrue. Uganda’s pre-2002 model included public education, destigmatization of HIV/AIDS, comprehensive sex education, partner reduction, distribution of condoms, and free flow of information about access to, effectiveness of, and correct use of condoms—and it resulted in a substantial reduction in HIV prevalence in Uganda, from 15% in 1990 to 6% in 2002. Since the prior comprehensive approach was replaced by the PEPFAR “ABC” strategy in 2002, the incidence of HIV in Uganda has nearly doubled, from 70,000 new infections in 2003 to 130,000 new infections in 2005.

In implementing the PEPFAR “ABC” strategy, the Ugandan government, working together with USAID, has suppressed the advertising and distribution of condoms. Ugandan abstinence programs, like their U.S. counterparts, teach that condoms have microscopic holes that allow HIV to pass through. Exported abstinence campaigns

promote gender stereotypes even more blatantly than do the domestic programs: in Uganda, the U.S.-funded abstinence campaign urges girls and women, but not boys and men, to remain virgins until marriage. This approach is fundamentally misguided. In many countries, including Uganda, widespread societal tolerance for male pre- and extra-marital sex make abstinence and fidelity quite ineffective as strategies for protecting women against HIV infection. A woman's own virginity and fidelity do nothing to protect her against her husband's prior or extramarital HIV infection. Between 60 and 80% of infected women in Uganda and other low-income countries have had only one sexual partner: their husbands. The promotion of such gender inequality facilitates the spread of HIV by undermining women's ability to negotiate sex and condom use.

REPORT

A. THE RIGHT TO REPRODUCTIVE HEALTH CARE, INCLUDING FAMILY PLANNING AND SAFE AND LEGAL ABORTION (ARTICLES 3, 6, 23, 26); WOMEN'S ECONOMIC AND SOCIAL RIGHTS, INCLUDING HEALTH INSURANCE (ARTICLES 2, 3, 9, 26)

The Article 6 guarantee of the right to life requires that governments take “positive measures” aimed at preserving life.⁹ Such measures should respond to the needs of both women and men, in keeping with Articles 3 and 26, which guarantee the right to equal enjoyment of the rights in the Covenant and equality before the law.¹⁰ Because reproductive health care is an essential condition for women’s survival, these provisions collectively give rise to a governmental duty to ensure the full range of reproductive health services, including the means of preventing unwanted pregnancy. Furthermore, in its General Comment 19(39), the Human Rights Committee has recognized the right to “procreate and live together,” which by inference includes the right to reproductive health care and to all safe and appropriate forms of contraception.¹¹

Pursuant to these provisions, the Committee has found possible violations of the Covenant where women have difficulty accessing contraceptive methods¹² and has repeatedly admonished states for failing to take adequate measures to prevent unwanted pregnancies.¹³ It has recognized that barriers to contraceptive access—including economic barriers such as the high cost of contraceptives—constitute discrimination against women.¹⁴ The connection between the inaccessibility of legal reproductive health care services and “conscientious objection” by health care providers has also been a subject of concern for the Committee.¹⁵

Despite high income levels in the United States and the fact that contraception and abortion are largely legal, lack of health insurance coverage and pervasive restrictions on health care coverage contribute to the fact that 49% of all pregnancies among U.S. women are unintended.¹⁶ Half of these unintended pregnancies result in abortion.¹⁷ There is anecdotal evidence that abortion restrictions force some women and girls to resort to clandestine illegal abortion by unsafe methods such as off-label use of abortifacient drugs,¹⁸ having their partners beat or kick them in the stomach,¹⁹ or even by shooting themselves in the abdomen.²⁰ Specifically, studies have shown that restrictions on funding for and access to abortion delay low-income women’s access to abortion, forcing them to obtain abortions several weeks later in pregnancy than they otherwise would have.²¹ Funding restrictions also prevent some women from obtaining abortions altogether.²²

1. Health insurance; access to contraception and reproductive health care

In general, U.S. women face substantial and intrusive limits on access to contraception and reproductive health care. For most Americans, access to contraception depends upon private health insurance coverage provided in connection with employment. More than one fifth of U.S. women aged 15-44, 21%, have no health insurance;²³ 41% of Latinas, 36% of indigenous women, and 24% of African-American women are uninsured.²⁴ Low-income women, civil servants, members of the military, and many Native American women depend on government insurance. Many private insurance plans do not cover prescription contraceptives.²⁵ Only 23 states require drug plans to cover contraceptives;²⁶ in states without such mandates, only 47-61% of insurance plans offer contraceptive coverage.²⁷ Thus many women, particularly low-income, minority and indigenous women, must pay for contraception out of pocket, or risk unplanned pregnancy.

U.S. women face many other legal barriers to access to contraception. For example, in recent years, a movement has emerged among certain pharmacists to refuse to fill women's lawful prescriptions for birth control pills and emergency contraception.²⁸ Rather than securing women's ability to access lawful contraception, 17 states and the federal government have passed legislation authorizing health care providers (including pharmacists, physicians and others) to refuse to provide contraception, sterilization or other reproductive health services on the basis of moral disapproval.²⁹ Furthermore, the U.S. Food and Drug Administration (FDA) continues to refuse to allow nonprescription sale of emergency contraception (also known as the "morning after pill"), despite the recommendation of its own internal scientific advisory committee and uncontroverted scientific evidence that the medication is safe, effective, and appropriate for nonprescription sale.³⁰ A recent independent investigation by the Government Accountability Office found the FDA refusal to be "unusual" and unprecedented, suggesting that political interference may have informed the refusal.³¹ Moreover, in a lawsuit challenging the agency's inaction, the judge took the agency to task for its inaction, stating, "This case has all the earmarks of an administrative agency filibuster."³²

Despite all these barriers to contraception, at least 19 states and the federal government authorize a financial penalty, or "family cap," for women who give birth while receiving social assistance: denial of benefits for the newborn child.³³ This results, of course, in deprivation and hunger for children and adults whose families depend on social assistance.³⁴ In 12 of the 19 "family cap" states, public funding for abortion is, by law or in practice, effectively unavailable.³⁵ In these 12 states, the average income for a one-child family receiving social assistance is \$201 per month (ranging from a low of \$124.74 to a high of \$338.57),³⁶ while the median cost of a first-trimester abortion is \$372.³⁷ This creates an impossible dilemma for a pregnant woman receiving social assistance: she cannot afford to obtain an abortion, but if she gives birth, she will not be able to adequately feed or house her existing children.

In six other states, abortion is publicly funded, but the “family cap” denies benefits if a child is born to a woman on social assistance. This creates a compelling economic incentive for a woman receiving social assistance to terminate her pregnancy even if she does not want to do so. A research study in one such state, New Jersey, found that the “family cap” caused an increase in abortion rates among women on welfare.³⁸

2. Barriers to abortion

The Committee has acknowledged that states’ duty to protect and ensure the right to life includes a duty to protect women who terminate their pregnancies.³⁹ It has called upon states to take measures “to ensure that women do not risk life because of restrictive legal provisions on abortion,” i.e. by being forced to seek abortions under clandestine, unsafe conditions.⁴⁰ In its analysis of states’ duties under Article 6, the Committee has also noted with concern the harmful effects of unsafe abortion on women’s health. For example, in 2004, the Committee expressed “deep concern” about restrictive abortion laws in Poland that could force women to risk “their life and health” by seeking unsafe, illegal abortions.⁴¹

Accordingly, the Committee has expressed concern about laws that explicitly restrict the availability of abortion as well as those that have the effect of limiting access to and discouraging the use of safe and legal abortion services. It has recommended liberalization of laws that criminalize abortion⁴² and has acknowledged that criminal sanctions for abortion may inhibit doctors from providing abortions under legally permissible circumstances.⁴³

It is worth noting here that the interpretation of Article 6(1) put forward in the *Second and Third Periodic Report of the United States of America to the UN Committee on Human Rights concerning the International Covenant on Civil and Political Rights* is at odds with that of this Committee. In its report, the United States asserts that laws that ban abortion and expand the definition of legal “persons” to include fetuses are ways to comply with Art. 6(1).⁴⁴ This stance disregards the Committee’s consistent concern about the threat to women’s lives and health posed by restrictive laws that force women to resort to illegal and unsafe abortion.⁴⁵

Since 1973, the U.S. Supreme Court has recognized that women have a constitutional right to choose abortion.⁴⁶ However, on numerous occasions since the early 1980s, the U.S. government has intervened in abortion cases before the Supreme Court to argue that *Roe v. Wade*, the landmark Supreme Court decision that prohibited states from banning abortion, should be overruled.⁴⁷ If the Supreme Court eventually does overrule *Roe*, states would have the power to ban abortion unless a state’s own constitution prevents it from doing so.

Recent changes in the composition of the Supreme Court have encouraged anti-abortion activists around the nation to pass stricter restrictions on abortion. In 2006, South Dakota

enacted a criminal law that completely prohibits abortion⁴⁸—a ban that is acknowledged, even by its proponents, to be extreme (it contains no exception for a woman who is pregnant as a result of rape) and clearly unconstitutional.⁴⁹ A recent study shows that, if *Roe* is overturned, 29 states could ban abortion within one year; women in 21 of those states are at the highest risk of losing the right altogether.⁵⁰

Even without an outright reversal of *Roe*, federal and state legislation and Supreme Court decisions have steadily eroded the availability of legal abortion ever since the decision was issued.⁵¹ For example, over the last ten years, federal and state governments have adopted approximately 400 measures restricting abortion, including: the South Dakota total ban on abortion; a federal law criminalizing the most common procedures used in abortions after the first trimester, with no exception for circumstances in which the procedures are necessary to protect women's health;⁵² state laws singling out abortion for burdensome licensing requirements that are different and more stringent than those applicable to other, comparable medical procedures, and that are designed to make abortion prohibitively expensive and increasingly difficult to obtain;⁵³ actions taken by federal and state officials seeking confidential medical records of women and girls who have obtained abortions and other reproductive health care;⁵⁴ state laws requiring women seeking abortions to receive anti-abortion "counseling";⁵⁵ laws imposing mandatory delays and multiple unnecessary clinic visits before abortion;⁵⁶ and laws excluding abortion from federally- and state-funded Medicaid public health insurance coverage for low-income Americans.⁵⁷ For women under the age of 16 or 18, most states also impose parental notification or consent requirements that effectively allow parents to override a young woman's decision to terminate her pregnancy unless she can obtain authorization for the abortion from a judge.⁵⁸

Governmental restrictions and burdens on abortion combine with a related increase in stigmatization of abortion services to limit women's access to abortion for geographic and economic reasons. Eighty-seven percent of all U.S. counties, home to 34% of women of reproductive age, lack any abortion provider.⁵⁹ Nearly one quarter of U.S. women must travel at least 50 miles to obtain an abortion.⁶⁰

Women face substantial economic barriers to abortion, as well. Only 26% of abortion services are covered by private or public health insurance.⁶¹ Thus 74% of women must pay out of pocket for their abortions. In 2000, the cost of a clinic abortion at 10 weeks' gestation ranged between \$150 and \$4,000 (average \$372).⁶² Abortion is excluded from the health services covered by Medicaid, the federal health insurance program for low-income Americans, except in cases of danger to the woman's life, or in case of rape or incest that has been reported to police or health authorities.⁶³ (In 16 states, state-funded Medicaid covers those abortions which are medically necessary.⁶⁴) Moreover, Medicaid authorities reportedly disregard these exceptions, so that women and girls are routinely denied Medicaid funding for abortions after they have been raped.⁶⁵ As discussed in the next section, because of the high cost of uninsured abortion, many low-income

women are forced to delay their abortions until late in their pregnancies, exponentially increasing the costs and risks of the procedure,⁶⁶ or forcing them to carry their unwanted pregnancies to term.

3. Delayed access to abortion

The earlier an abortion procedure is performed, the safer it is. The health risks of abortion, though low, increase exponentially with increased gestational length, from a rate of 0.1 deaths per 100,000 legal abortions performed at or before 8 weeks' gestation, to 8.9 deaths per 100,000 abortions performed after 20 weeks.⁶⁷ Thus laws and policies that obstruct and delay women's access to abortion pose a direct threat to women's health.

Women who say they wish they had obtained abortions earlier than they did report the following reasons for the delay: "lack of awareness of [the] pregnancy, lack of money, difficulty finding a provider, the distance to the nearest provider, the inability to leave work and the need to arrange for child care."⁶⁸ As discussed in sections A(1) and A(2), above, federal and state laws and policies contribute to all these obstacles to abortion. Almost all states⁶⁹ impose one or more criminal laws that restrict abortion—parental consent or notification requirements, a waiting period requiring multiple trips to the clinic, biased counseling, and restriction of Medicaid funds for abortion.⁷⁰ In March 2006, as discussed above, South Dakota banned abortion altogether.⁷¹

Parental notification and consent laws have been shown to delay young women's access to abortion in at least two ways. One study found that 32% of young women who were required by law to obtain parental consent to their abortions waited more than two weeks after learning of the pregnancy to tell their parents about it.⁷² Several studies have found an association between parental involvement laws and delays in young women's access to abortion, either beyond eight weeks of pregnancy,⁷³ or into the second trimester.⁷⁴ Such laws also force young women to travel to other states, if they can, to obtain abortions without parental consent.⁷⁵ Moreover, a recent study found that parental consent or notification laws greatly increase the likelihood of second-trimester abortion for those young women who will reach the age of majority during the second trimester of pregnancy (i.e., who can outwait a parental notification requirement by waiting for a riskier second-trimester abortion).⁷⁶

Young women and low-income women, in particular, may encounter difficulty securing the funds to pay the costs of travel and abortion care, and may experience difficulty escaping parental or employer surveillance for the repeated clinic visits required by laws imposing mandatory delays.

Thirty-three states and the District of Columbia prohibit public funding for abortion unless the woman's life is in danger or she is a victim of rape or incest.⁷⁷ Even this limited exception is illusory, though: in 2001, only 6 of these 33 states reported funding *any* abortions.⁷⁸ Abortion is financially out of reach for low-income women in these

states, where a one-child family on social assistance receives an average of \$234.66 per month (ranging from a low of \$124 per month in Arkansas to a high of \$436 in New Hampshire);⁷⁹ for a woman on welfare, the \$372 average cost of a first-trimester abortion represents her family's entire income for between three weeks and three months. Lack of public funding significantly delays abortion for these women, who must find ways to raise the required funds. Women who are eligible for Medicaid get abortions an average of two to three weeks later in pregnancy than more affluent women do.⁸⁰

Because the financial and health costs of abortion increase as gestation progresses, “many poor women become trapped in a vicious cycle”:⁸¹ the longer it takes a woman to raise the funds, the more costly her abortion gets. As a result, “funding restrictions have forced some women to carry their unintended pregnancies to term ... because they lacked the money to pay for the procedure themselves.”⁸² Studies have shown that Medicaid funding restrictions prevent about one in five Medicaid-eligible women from having abortions they would otherwise have had.⁸³

4. Erosion of health protections

For more than thirty years, the Supreme Court has held that the U.S. Constitution mandates that any law restricting abortion must allow the abortion “where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”⁸⁴ In a 2000 decision, *Stenberg v. Carhart*,⁸⁵ the Supreme Court applied this rule to strike down a state law banning certain pre-viability methods of abortion because the ban did not contain any exception to protect women's health. The Court held that state laws cannot “force women to use riskier methods of abortion.”⁸⁶

Despite the Court's consistent protection of the health of women, a recurrent theme of recent federal and state anti-abortion regulation has been the attempt to erode or eliminate this health protection. Both state and federal legislatures have passed laws that deliberately restrict or prohibit abortion even when the ban or restriction will endanger women's health.

Between 1992 and 2000, anti-abortion state legislators engaged in a deceptive but successful campaign to prohibit the safest methods of abortion used as early as 12 weeks in pregnancy: more than thirty U.S. legislatures banned procedures they labeled “partial birth abortion.” Use of the banned procedures was prohibited even in circumstances in which they were the best procedures to protect the woman's health.⁸⁷ In *Stenberg v. Carhart*, the Supreme Court reaffirmed its longstanding precedent that a health protection is always required, declaring: “a State ***may promote but not endanger*** a woman's health when it regulates the methods of abortion.”⁸⁸ The Court held that laws restricting abortion must not subject women to legally created health risks by either (a) disallowing abortion when the pregnancy poses a risk to the woman's health, or (b) requiring that a riskier abortion procedure be used.⁸⁹

Despite this clear holding, just three years later, the United States Congress enacted, and the President signed into law, legislation nearly identical to the state law that the Supreme Court had struck down in 2000: once again, the statute was written so broadly that it banned the safest procedures used early in the second trimester; once again, it contained no exception for situations in which the banned procedure was the safest one available.⁹⁰ Because it is functionally identical to the legislation the Supreme Court had previously declared unconstitutional, this legislation was struck down by all three appellate courts that heard challenges to it.⁹¹ However, in March 2006, the Supreme Court agreed to review one of the appellate decisions, *Gonzales v. Carhart*.⁹² In the case, the U.S. government is asking the Court to reconsider its own *Stenberg* decision of just six years before.

Similarly, in 2003, the state of New Hampshire passed a law requiring that a young woman's parents be notified 48 hours before any abortion could be performed on her. The law lacked any exception for medical emergencies that threatened a young woman's health. Even if the 48-hour delay would result in substantial and irreparable harm to the minor's health (short of death), the law delayed the abortion for 48 hours after parental notification.⁹³ As a result, the law would have forced minors facing serious health crises, such as pre-eclampsia (uncontrolled high blood pressure), to notify their parents and then wait 48 hours; obtain a judge's permission for the abortion; or wait until their condition became *life*-threatening before they could obtain a health-saving abortion. Fortunately, prior to the 2006 addition of a second new justice, the Supreme Court struck down this law.⁹⁴

Finally, as discussed above, South Dakota recently passed a law banning virtually all abortions.⁹⁵ Under the law, enacted as a direct challenge to *Roe v. Wade*,⁹⁶ anyone who performs an abortion (other than the woman herself) can be imprisoned for up to five years.⁹⁷ The law contains no health protection and no exception for circumstances where the pregnancy is a result of rape or incest.⁹⁸

B. RACIAL DISPARITIES: UNWANTED PREGNANCY, MATERNAL MORTALITY AND REPRODUCTIVE COERCION (ARTICLES 2, 3, 6, 24)

The Committee has frequently expressed concern over violations of the anti-discrimination provisions of the ICCPR⁹⁹ and has discussed discrimination against racial and ethnic minorities in access to health care.¹⁰⁰ With respect to reproductive and sexual rights issues in particular, the Committee has recognized that indigenous women are more vulnerable to violence in reproductive health care services.¹⁰¹ The prevalence of forced sterilization among minority populations has twice prompted the Committee to remind states parties of the importance of informed consent in contraception procedures.¹⁰² In the context of Article 23 and the government obligation to protect the family, the Committee has also warned states that family planning policies should not be discriminatory or compulsory.¹⁰³

In the United States, widespread and deeply rooted discrimination persists against African-Americans, Latinas/os,* Asian-Americans and other ethnic minorities, as well as against indigenous people.

As is described above in Section A(1), Latinas/os, African-Americans, and Natives are disproportionately likely to be uninsured. Furthermore, for many reasons, they are more likely than most Americans to depend on government for their health insurance coverage, and to have their access to health care impeded either by lack of insurance or by government-imposed restrictions on coverage for reproductive health care. As a result, African-Americans, indigenous people, and Latina/os fare worse than whites on virtually every measure of reproductive health.

1. Maternal and infant mortality

African-Americans, Latinas, and Native American women are significantly less likely than white women to receive prenatal care,¹⁰⁴ resulting in elevated rates of miscarriage and maternal mortality. Latina and African-American women suffer rates of pregnancy loss about 50% higher than white women.¹⁰⁵ African-American women also suffer greatly elevated rates of maternal mortality: they are more than four times as likely as white women to die in childbirth (24.9 maternal deaths vs. 6.0 maternal deaths per 100,000 live births).¹⁰⁶ Latinas also experience a significantly elevated risk of maternal mortality: 7.1 maternal deaths per 100,000 live births.¹⁰⁷

Racial disparities in women's reproductive health care affect racial minority children, especially black children: African-Americans are much more likely than whites to give birth to severely premature infants with low or very low birth weight.¹⁰⁸ African-American infants are 2.5 times more likely than whites to die in the first year of life; Native American infant mortality is 50% higher than for whites (African-American: 14.0 infant deaths per 1,000 live births; Native American 8.6; white 5.7).¹⁰⁹ Nonetheless, as is discussed in Section E, below, African-American, Latina, and indigenous women are targeted for criminal prosecution and removal of their children when their pregnancies result in poor outcomes.

2. Unintended pregnancy

As mentioned above, the rate of unwanted pregnancy among U.S. women is high: about 49% of all pregnancies are unintended.¹¹⁰ Every year, about 5.1% of U.S. women become pregnant unintentionally; about half of these pregnancies end in abortion.¹¹¹ Because government-imposed obstacles to contraception have a disparate impact on low-income women and women of color (discussed in Section A(1), above), Latinas and black women are less likely than their white counterparts to use birth control, and less likely than whites to use the most effective contraceptive methods.¹¹² Fifteen percent of Latinas who are "at risk" of unintended pregnancy (i.e., of childbearing age, sexually active, and not wanting to become pregnant) use no method of birth control, as do 12% of at-risk

*In publishing public health statistics and other official government data, the federal government defines the three largest ethnic groups in the US as "white (non-Hispanic)," "black (non-Hispanic)," and "Hispanic (all races)."

black women; by contrast, only 9% of at-risk white women go without contraception.¹¹³ White women, who are more likely to have health insurance,¹¹⁴ are much more likely than Latinas or black women to use oral contraceptives¹¹⁵—one of the most effective, easily reversible forms of birth control. Latinas and African-American women, who are more likely to be uninsured, are more likely than white women to use Depo-Provera, a long-acting three-month contraceptive injection, or no method at all.¹¹⁶

Because of governmental obstruction and lack of support for sex education, contraception, and reproductive health care, a woman's ability to avoid unwanted pregnancy depends on her income. Every year, more than 11% of women living below the poverty line have unintended pregnancies.¹¹⁷ Among women whose income is at least double the poverty level, less than 3% experience unwanted pregnancy.¹¹⁸ Moreover, the income disparity in unwanted pregnancy is increasing: between 1994 and 2001, unintended pregnancies among poor and near-poor women increased by between 29% and 26%, respectively, even as unintended pregnancies fell by 20% among middle- and upper-income women.¹¹⁹ Because of their higher rates of unintended pregnancy and lesser access to abortion, poor women have unintended births at five times the rate of more affluent women.¹²⁰

At every income level, African-American women and Latinas have higher rates of unintended pregnancies than white women. Among poor women (those whose incomes fall below the poverty level), Latinas have more than 160 unintended pregnancies per 1,000 women of childbearing age. Poor African-American women have more than 130, and white women experience fewer than 90.¹²¹ Meanwhile, among non-poor women (those whose incomes exceed the poverty line), black women have more than 80 unintended pregnancies per 1,000 women of childbearing age, Latinas have nearly 50, and white women have just over 30.¹²² Moreover, among Latinas, the proportion of pregnancies that are unintended has increased substantially between 1994 and 2001.

Although they have been dropping since the early 1990s, rates of adolescent pregnancy, abortion, and births remain much higher in the United States than in other developed countries.¹²³ Racial disparities in U.S. adolescent birth rates are striking. For example, the birth rate for young white women (ages 15-19) is 26.8 per 1,000 women; for young Native women, approximately double the rate for whites (52.5 per 1,000); among young African-American women, two-and-one-half times the white rate (62.7); and among young Latinas more than triple the white rate (82.6).¹²⁴

3. Abortion

Since many unintended pregnancies result in abortion,¹²⁵ the abortion rate per 1,000 Latinas is more than double the rate among white women, and the abortion rate per 1,000 African-American women is about five times as high as for whites.¹²⁶ Low-income women and women dependent on government insurance face severe economic barriers to abortion. Thus white women, who are more likely to be middle-class and privately

insured, are more likely than Latinas or black women to have abortions at the safest, earliest stage of pregnancy: at or before 8 weeks' gestation.¹²⁷ Latinas and African-American women are more likely than whites to have abortions at riskier, late stages of pregnancy: 13 weeks or later.¹²⁸ Almost half of women who had abortions beyond 15 weeks' gestation say they were delayed because they could not afford, find, or access abortion services earlier.¹²⁹

4. Sexually transmissible infection

African-American women, in particular, suffer extremely poor reproductive health outcomes with respect to HIV/AIDS and other STIs. Their infection rates are exponentially higher than those of whites: black women are more than 7.5 times more likely than white women to be diagnosed with chlamydia; 19 times more likely to be infected with gonorrhea; and 5.6 times more likely to be infected with syphilis.¹³⁰ Possibly because of lack of prenatal care, African-American infants are 16 times more likely than whites to be diagnosed with syphilis at birth.¹³¹ For HIV, the disparity is staggering: black women are more than 25 times more likely to be infected: 50.2 of every 100,000 black women are infected, compared to 2.0 of every 100,000 white women.¹³²

Other minorities also suffer elevated rates of STIs and HIV infection: Latinas/os are twice as likely as whites to be diagnosed with syphilis or gonorrhea, and Latina/o babies are 10 times as likely as whites to be diagnosed with syphilis at birth.¹³³ Native Americans' gonorrhea infection rates are more than 3.5 times those of whites.¹³⁴ Latinas' HIV infection rates are more than six times higher than for white women (12.4 per 100,000), and Native women's HIV infection rate is almost two and a half times higher (4.8).¹³⁵

5. Reproductive coercion

The United States has also had a long and disturbing history of reproductive coercion of Latina, African-American and indigenous women. They have been disproportionately deprived of the basic right of informed consent in reproductive health care. Well into the last decades of the 20th century, women of color were targeted for sterilization, which often was imposed on them coercively, secretly, or without their consent.¹³⁶ High rates of sterilization among women of color appear to reflect this targeting: "by 1982, 42 percent of Native American women, 35 percent of Puerto Rican women, and 24 percent of African-American women had been sterilized, compared with only 15 percent of white women."¹³⁷ During the 1990s, increasing numbers of black, Latina and Native women were targeted for long-acting contraceptives, such as Depo-Provera and Norplant, which women cannot voluntarily stop using.¹³⁸ These long-acting contraceptives have also been imposed as conditions of probation or in resolution of child-protection proceedings, regardless of women's autonomy and the risks to their reproductive health.¹³⁹ In California, welfare eligibility is contingent on use of certain methods of contraception—sterilization or long-acting contraceptives, but not reversible methods such as oral contraceptives or condoms—as use of these methods is an exception to the punitive

“family cap” welfare sanctions described above.¹⁴⁰ These factors have contributed to a pattern of contraceptive use that denies many low-income women complete control over their own fertility. Today, poor and low-income women are more than twice as likely as wealthier women to use the three-month injectable contraceptive;¹⁴¹ sterilization is the leading method of birth control among Latinas and black women, while the birth control pill, a fully reversible method, continues to be the leading method for white women and for women with a university education.¹⁴²

C. ADOLESCENTS’ REPRODUCTIVE HEALTH (ARTICLES 6, 12, 16, 17, 18, 23-26)

In General Comment 28, the Committee refers to states parties’ obligation to protect children (Article 24) and recognizes girls’ greater vulnerability to discrimination. It calls upon states to ensure that girls and boys be treated equally in health care, education, and provision of food. It also specifically requires states parties to eliminate cultural or religious practices that prevent girls from exercising their rights under the Civil and Political Rights Covenant.¹⁴³ The Committee has invoked the anti-discrimination provisions of the Covenant in recognizing the particular needs of adolescent girls faced with unwanted pregnancies.¹⁴⁴ Moreover, in General Comment 17, the Committee outlines children’s right to special measures of protection based on their status as minors¹⁴⁵ and reaffirms that children have the right to benefit from all of the guarantees of the Covenant.¹⁴⁶

The Article 17 guarantee that “no one shall be subjected to arbitrary or unlawful interference with his privacy” has particular relevance for minors’ access to health care. While the Committee has not specifically addressed threats to minors’ medical privacy, it has expressed concern over adolescent access to reproductive health care¹⁴⁷ and, on a number of occasions, emphasized the importance of ensuring the confidentiality of medical records.¹⁴⁸ The Committee has also drawn attention to laws that require medical personnel to report abortions and has insisted that states take measures to preserve the confidentiality of medical information.¹⁴⁹ Thus laws requiring disclosure of minors’ medical information to third parties, which impede access to health services and thereby endanger their lives, would violate the ICCPR.

The federal government and various state governments have passed laws that impede minors’ access to reproductive health care and that interfere with the confidentiality of medical services they may receive. More than half of U.S. states are currently enforcing laws that require a young woman seeking an abortion to notify or obtain the written consent of one or both of her parents prior to the procedure.¹⁵⁰ Proposed federal legislation that is likely to pass in 2006¹⁵¹ would make it a crime to help some young women travel out of state to obtain an abortion, unless they had first complied with the home state’s law requiring parental notification or consent. Furthermore, this legislation would require that physicians in many states comply with a federal parental notification and delay requirement, in addition to complying with state parental involvement laws, before performing an abortion on a young woman who resides in another state.

While young women who enjoy good relationships with their parents are likely to consult their parents when faced with an unplanned pregnancy, laws that require parental notification or consent put other young women's health at risk. Young women who find themselves pregnant but who fear that their parents might respond angrily or abusively to the unplanned pregnancy are required to begin a court proceeding to prove that they are mature or that the abortion is in their best interests. These notification and consent laws thus expose young women to violence and interference with their health care from disapproving parents, and often lead young women to delay both abortion and prenatal treatment until it is too late.¹⁵²

Federal and state governments have also sought disclosure of the confidential medical records of young and mature women who have had abortions, on the purported ground of investigation of sexual abuse and in response to women's challenges to a federal abortion ban.¹⁵³ The Attorney General of Kansas has issued an opinion requiring that if a physician, nurse, counselor, or other health care provider learns that a person under 16 years old has been sexually active, the provider must report him or her to child protective services or the police—even if it was consensual sexual activity with an age-matched peer, and even if it did not involve sexual intercourse.¹⁵⁴ Research has shown that such mandatory reporting of sexual activity does not deter teenage sexual activity, but does deter young women from seeking the reproductive health care they need, including contraception and STI testing and treatment.¹⁵⁵ The Attorney General's opinion was enjoined by a federal judge in April 2006,¹⁵⁶ but the Attorney General has appealed.¹⁵⁷

D. SEXUAL HEALTH EDUCATION; FREEDOM OF EXPRESSION, CONSCIENCE, AND FAMILY PRIVACY (ARTICLES 2, 3, 19, 24, 26)

Education is necessary for the exercise of all other rights, including the right to make informed decisions about reproductive health and one's reproductive capacity. Articles 2, 3, and 26 guarantee equal enjoyment of rights and equality under the law, which imply that men and women should have equal access to education, including sexuality education. Article 19 provides for freedom of expression and opinions, including the right to receive information.¹⁵⁸ Education prepares girls to participate on an equal footing with their male counterparts in the public and private spheres. In the reproductive context, education allows young women to protect themselves against unwanted pregnancies and STIs.

The Committee has encouraged measures to remedy discrimination in such areas as education.¹⁵⁹ It has recommended "education and information campaigns" as means to prevent and eliminate persisting discriminatory attitudes and prejudices against women.¹⁶⁰ The Committee has specifically called on states to incorporate "accurate and objective" sex education in schools as a complement to providing access to contraceptive methods.¹⁶¹ It has also reminded states of the importance of ensuring "that traditional, historical, religious or cultural attitudes are not used to justify violations of women's right to equality before the law and to equal enjoyment of all Covenant rights."¹⁶² Finally, it

has expressed concern where insufficient steps have been taken to counter the belief that a woman's "primary role is as wife and mother."¹⁶³

Nonetheless, the federal government and 47 states spend hundreds of millions of dollars on ineffective, misleading "abstinence-only-until-marriage" programs, often presented by religious groups, at public expense, in public schools, churches, and community centers.¹⁶⁴ These curricula provide no information about access to or proper use of condoms or other modern forms of contraception. Rather, they misinform young people about sexual health, exaggerate the dangers of premarital sex, and suppress information about the effectiveness of condoms and other modern contraceptive methods in preventing unwanted pregnancy. They teach that birth control is dangerous,¹⁶⁵ condoms are ineffective in preventing pregnancy,¹⁶⁶ and that HIV, human papillomavirus (HPV) and other STI pathogens can pass through a condom.¹⁶⁷ They also teach young people not to carry condoms for fear of damaging their "reputations."¹⁶⁸ Moreover, as discussed in section D(2), below, they promote egregious stereotypes about the nature and appropriate roles of men and women.

All rigorous studies of these programs have shown that they are ineffective: they do not reduce rates of adolescent pregnancy or STI, nor do they deter participants from having premarital sex.¹⁶⁹ The programs do, however, have one notable effect: those who have been exposed to the programs are significantly less likely to use birth control or condoms when they do engage in sexual activity.¹⁷⁰

1. Disparaging condoms, discouraging contraception

Federal rules and legislation prohibit the recipients of abstinence-only funds from providing any information about condoms or any other form of contraception—except for health risks and failure rates. In practice, the curricula funded under the federal abstinence program exaggerate the failure rates of many forms of contraception and teach students that condoms are ineffective.

Federal funding of abstinence-only programs is established under the 1996 *Welfare Reform Act*.¹⁷¹ This statute establishes an eight-part federal definition of "abstinence education." Abstinence education must have, as its "exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity." It teaches that sexual abstinence until marriage is "the expected standard of human sexual activity," and that it is "the only certain way to avoid out-of-wedlock pregnancy, sexually transmissible diseases, and other associated health problems."¹⁷² It further requires that abstinence programs teach that premarital and nonmarital sexual activity are "likely" to lead to "harmful psychological and physical effects."¹⁷³

Federal funding requirements encourage the teaching of "failure rates associated with contraceptives."¹⁷⁴ "Curriculum must not promote or endorse, distribute or demonstrate the use of contraception or instruct students in contraceptive usage,"¹⁷⁵ and must "not

promote or encourage the use of any contraceptives in order to make sex ‘safer.’”¹⁷⁶ Recipients of federal abstinence funding are not permitted to provide any sexual health education outside the abstinence program, even on their own time, with their own funds. They are required to sign a pledge that they “will not provide to an adolescent and/or adolescents any other education regarding sexual conduct,” unless required to do so by federal law.¹⁷⁷

Federally funded abstinence curricula typically exaggerate the risks and failure rates of condom use—while failing to mention the very high user-failure rate of abstinence as a method of preventing STI and unplanned pregnancy.¹⁷⁸ “Although the curricula purport to provide scientifically accurate information about contraceptive failure rates, many exaggerate these failure rates, providing affirmatively false or misleading information that misstates the effectiveness of various contraceptive methods in preventing disease transmission or pregnancy.”¹⁷⁹

Thus, for example, one curriculum used in middle schools instructs that “imperfections in the contraceptive not visible to the eye, could allow sperm, STI, or HIV to pass through.”¹⁸⁰ Other curricula claim, falsely, that condoms fail to prevent pregnancy 31% of the time,¹⁸¹ or that there is a 15% chance of pregnancy every time a couple uses a condom.¹⁸² One curriculum teaches, inaccurately, that “condoms do not appear to provide any protection from HPV[,] which causes 99% of all cervical cancer.”¹⁸³ The same curriculum falsely asserts that there is “no clinical proof” that condoms are effective in preventing chlamydia, trichomoniasis, chancroid, syphilis, genital herpes or HPV.¹⁸⁴ Another federally funded curriculum concludes, “‘Safe sex’ is really a myth,”¹⁸⁵ teaching students, “[t]here is no safe sex from putting a condom on.”¹⁸⁶

Still another federally funded curriculum used in public schools acknowledges in its parent guide that suppression of contraceptive information is a deliberate strategy to scare students into abstinence by increasing the risks of sex. It explains that it does not address contraception because “contraceptives apparently encourage sexual activity by offering some limited protection against the consequence of pregnancy.”¹⁸⁷

2. Promoting gender stereotypes

In addition to discouraging contraception and teaching that condoms do not work, government-funded curricula promote the most egregious of gender stereotypes. They reinforce notions that the man should be the breadwinner, while the woman’s role is as dependent wife and mother;¹⁸⁸ that men marry to get sex and “domestic support,” while women marry to get emotional closeness and “financial support”;¹⁸⁹ that girls are focused on relationships and do not prioritize success at school or work, while boys prioritize workplace success and are uninterested in relationships;¹⁹⁰ and that because of men’s brain size and intellectual capacities, they are better suited to professions such as “math, engineering and architecture,” whereas girls’ “emotional” nature suits them to marriage and motherhood.¹⁹¹

Moreover, these curricula promote dangerous sexual stereotypes that put girls at risk of sexual assault while blaming the victim.¹⁹² They teach that the “raging hormones” of men and boys make it normal for them to try to pressure and coerce girls into sex;¹⁹³ that girls do not have a “natural” sex drive, but that any interest girls may have in sex results from unfortunate social conditioning;¹⁹⁴ that it is girls’ primary responsibility to be “modest”¹⁹⁵ and to ensure that boys do not get to have premarital sex with them;¹⁹⁶ and that girls who “surrender” to sex lack self-respect and are undeserving of the love and respect supposedly afforded to virgins.¹⁹⁷

Recent studies demonstrate that young women who embrace such conventional notions of femininity are more vulnerable to sexual coercion and exploitation,¹⁹⁸ and are less likely to use condoms or contraception.¹⁹⁹ The harm of promoting these gender stereotypes is not limited to young heterosexual women and men: a 2005 study showed that abstinence-only programs are associated with elevated levels of violence and harassment of gay, lesbian, bisexual, and transgender students in U.S. schools.²⁰⁰

As UNAIDS, Human Rights Watch and the Sexuality Information and Education Council of the United States (SIECUS) have pointed out, the shame, stigma and gender inequality that these programs promote contribute to the spread of STIs, including HIV/AIDS.²⁰¹ It is unsurprising, then, that in practice, young people who have undergone such abstinence-only programs are less likely to use condoms, are more likely to engage in risky activities such as anal and oral sex in order to preserve their “virginity,” and experience elevated rates of sexually transmissible infections.²⁰² Moreover, abstinence-only education has been shown to reduce the likelihood that those who contract STIs will seek treatment for them.²⁰³ Thus abstinence-only programs pose a serious health risk not only to students exposed to those programs, but to their future sexual partners.

E. DISCRIMINATION AGAINST PREGNANT WOMEN (ARTICLES 3, 6, 9, 17, 26)

States are obligated under Articles 3 and 26 of the Covenant to prevent discrimination against women, and to ensure their equal enjoyment of Covenant rights. This nondiscrimination obligation applies equally to pregnant women.²⁰⁴ In addition, the Committee has expressed serious concern at the threat to life posed by imprisonment of expectant mothers.²⁰⁵

Nonetheless, contrary to broad international agreement that pregnant women are included in general prohibitions on sex discrimination,²⁰⁶ under U.S. law, pregnancy has been treated as an exception to the constitutional guarantee of gender equality.²⁰⁷ Thus police, prosecutors, and lawmakers throughout the United States have imposed coercive restrictions on pregnant women’s liberty and health care, and have enforced those restrictions through punitive criminal and civil sanctions that are targeted mainly at African-American, Latina and indigenous women.²⁰⁸ For example, many women have been prosecuted and imprisoned for behavior during pregnancy, such as use of alcohol,

medication, or illegal drugs, that is alleged to have harmed the fetus.²⁰⁹ In addition, many state legislatures have sought to enact legislation that imposes civil or criminal liability on women who use substances while pregnant.²¹⁰

Such discriminatory legislation and practices subject women to forms of civil or criminal liability that are never imposed on men. These laws force the drug-addicted woman who becomes pregnant into an impossible predicament: if she seeks prenatal care or even addiction treatment, she exposes herself to criminal charges or the risk that her children may be removed from her home; if she avoids prenatal care, she risks her own life and health and those of her fetus. Thus these laws fail to serve the purported state objective of promoting fetal health: rather, they deter the drug-dependent woman from seeking the prenatal care and treatment she needs.

F. EXTRATERRITORIAL EFFECTS OF RESTRICTIVE U.S. REPRODUCTIVE POLICIES (ARTICLE 2; SEE ALSO GENERAL COMMENT 31)

The Committee has recognized circumstances in which a state may be held accountable for its violations of the rights of individuals who live outside that state's territory.²¹¹ In General Comment 31, the Committee stated that a state party "must respect and ensure the rights laid down in the Covenant to anyone within the Power or effective control of the State Party, even if not situated within the territory of the State Party."²¹²

The Committee has applied this analysis not only in instances where the state exercises political or military control over a particular foreign territory,²¹³ but also where the state lacks territorial domination but has control over the enjoyment of the particular right that was violated.²¹⁴ In explicating the Human Rights Committee's contextual approach to jurisdiction, Professor Martin Scheinin writes that a country can be held accountable where it has effective control over the facts and events that constitute a violation of a human right,²¹⁵ i.e., where its actions violate the human rights of persons outside its territory.

The United States has sought to impose its restrictive reproductive health policies in low-income countries, with devastating consequences for women's reproductive rights and health.

1. The "global gag rule"

As discussed in Section D, above, Article 19 obliges the United States to safeguard the "freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers." Nonetheless, the United States has imposed a global gag rule, known as the "Mexico City Policy,"²¹⁶ that prohibits any recipient of United States Agency for International Development (USAID) funding from providing abortions, referrals for abortion, or any information about abortion whatsoever. USAID funding recipients are also forbidden to advocate that abortion be made—or kept—safe and legal.

By contrast, anti-abortion groups that receive U.S. funds are not subject to the gag rule. They can speak freely and may advocate strict criminal penalties for abortion or intrusive restrictions on abortion access. In light of U.S. constitutional protections for expression, the global gag rule would be unconstitutional if applied to U.S. NGOs.²¹⁷ Nonetheless, the U.S. government restricts the expression of NGOs in aid-recipient countries.²¹⁸

The global gag rule silences advocates for women's health, preventing pro-choice NGOs from imparting relevant health information and silencing their ideas and concerns in political debates about abortion. The global gag rule also hinders the scope of American NGOs' work in public education, legal advocacy, litigation, legislative reform, and human rights work by impeding their co-operation with USAID-funded partners abroad. The gag on law reform dilutes these groups' political effectiveness and blocks essential channels for advocacy in the United States and overseas, as well as in international fora such as the United Nations.

Finally, the implementation of the global gag rule has been linked to increased transmission of sexually transmissible infections, including AIDS, and to the deaths of women undergoing illegal abortions.²¹⁹

2. Export of abstinence-only programs to Uganda and other low-income countries

As noted above, Articles 2, 3, 19, 24 and 26 collectively give rise to a duty to ensure access to sexual health education and a state obligation to respect individuals' freedom of expression. Despite these guarantees, USAID mandates the export of ineffective, misleading and stereotypical abstinence-only programs²²⁰ to low-income countries, requiring those countries to abandon scientifically proven comprehensive HIV- and AIDS-prevention strategies that have proved successful in reducing HIV infection.²²¹

Although abstinence promotion has been repeatedly demonstrated to be ineffective within the United States,²²² the federal *Leadership Act* requires that 33% of all HIV prevention funds be directed to abstinence-only-until-marriage programs.²²³ United States AIDS policy for foreign countries is set out in detail in a State Department policy document, *The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global AIDS Strategy* (PEPFAR Strategy),²²⁴ and in a mandatory "Guidance" for AIDS-prevention funding recipients issued by the by the State Department's Office of the Global AIDS Coordinator (the "OGAC Guidance").²²⁵

In its PEPFAR Strategy, the United States government acknowledges that "[p]revention efforts are ... hampered by the stigma surrounding HIV/AIDS and gender inequality that increases the vulnerability of women and girls."²²⁶ Nonetheless, PEPFAR funds the implementation of abstinence-only programs that, like their domestic counterparts, discourage and stigmatize condom use, promote gender stereotypes, and exacerbate the stigma of HIV/AIDS.

The PEPFAR Strategy describes the United States' preferred approach to HIV prevention as "ABC": "Abstinence," "Be faithful," and "Condoms." However, the 33% spending requirement requires that HIV-prevention funds be dedicated to abstinence only, and not to comprehensive strategies involving condom education or promotion. Moreover, the OGAC Guidance requires that any condom education or distribution must be accompanied by urgings to be abstinent and reserve sex for marriage.²²⁷

Although the "ABC" approach promoted in the PEPFAR Strategy and the OGAC Guidance purports to include condoms, it in fact promotes "abstinence" as the *only* appropriate prevention strategy for unmarried young people. "Be faithful" is presented as the *only* prevention strategy suitable for married persons. Condoms are deemed suitable only for "populations who engage in risky behavior,"²²⁸ defined as "prostitutes, sexually active discordant couples, substance abusers, and others."²²⁹ Under the OGAC Guidance, PEPFAR refuses to fund social marketing campaigns for condom use in the general population. It funds "condom information and provision" only in programs "that target at-risk populations with specific outreach."²³⁰

The OGAC Guidance forbids the "marketing of condoms to broad audiences of young people."²³¹ It prohibits the distribution of condoms in school programs,²³² and forbids providing any information about condoms to students who are under 15 years old.²³³ Grantees are instructed to "take great care not to give a conflicting message with regard to abstinence" by "present[ing] abstinence and condom use as equally viable, alternative choices."²³⁴ For young people, abstinence is the only acceptable choice.

The OGAC Guidance recognizes that "certain young people" will have sex, "either by choice or by coercion."²³⁵ It recommends that, if individual students "are identified as engaging in or at high risk for engaging in risky sexual behaviors,"²³⁶ they must be segregated from the other students and referred to a non-school program that provides condom information and distributes condoms in an "ABC" program that is "targeted to specific high-risk individuals or groups."²³⁷

By narrowly targeting condom use as suitable only for disfavored social groups—"sex workers and their clients, sexually active discordant couples or couples with unknown HIV status, substance abusers, mobile male populations, men who have sex with men, people living with HIV/AIDS, and those who have sex with an HIV-positive partner or one whose status is unknown"²³⁸—the approach mandated by PEPFAR stigmatizes condom users, and people living with HIV, as social undesirables. This is the very stigma which successful, proven HIV-prevention strategies—including the successful strategy used by Ugandan AIDS educators during the 1990s—strive to overcome.²³⁹

The 33% abstinence promotion requirement directly harms the health of women, girls, men, and boys in the countries that receive U.S. HIV-prevention funding because local HIV-prevention organizations find that it "challenges their efforts to respond to local

prevention needs.”²⁴⁰ The “country teams” receiving PEPFAR funding point out that the requirement forces them to redirect funds from other important and effective programs—prevention of mother-to-child transmission, care of persons with AIDS, medical and blood safety, prevention programs for persons infected with HIV, and comprehensive HIV-prevention messages—in order to meet the 33% target for abstinence spending.²⁴¹ In one PEPFAR focus country, which “lacks a health care system for providing PMTCT [preventing mother-to-child transmission] services,”²⁴² the country team “has had significant trouble reaching its target for preventing [PMTCT] infections.”²⁴³ Nonetheless, “at the start of fiscal year 2006, OGAC directed the country team to reduce planned funding for PMTCT and dedicate more funding to AB activities” in order to meet its abstinence spending target.²⁴⁴

Uganda, for example, is one of 15 “focus countries” of the U.S. government’s PEPFAR program.²⁴⁵ (Twelve of the 15 “focus countries” are low-income African countries with high prevalence of HIV infection.²⁴⁶) According to the U.S. State Department’s Office of the Global AIDS Coordinator, more than 3.6 million Ugandans were subjected to USAID-funded abstinence promotion programs during fiscal year 2005.²⁴⁷ The serious and far-reaching effects of USAID funding of abstinence-only programs in Uganda were thoroughly documented in a recent Human Rights Watch report, “*The Less they Know, the Better*”: *Abstinence-Only HIV/AIDS Programs in Uganda*.²⁴⁸

PEPFAR characterizes “ABC” as a local initiative that was developed in Uganda and proven successful,²⁴⁹ but it is in fact a U.S. initiative.²⁵⁰ Prior to 2002, the Ugandan HIV-prevention strategy included public education, destigmatization of HIV/AIDS, comprehensive sex education, partner reduction, distribution of condoms, and free flow of information about access to, effectiveness of, and correct use of condoms.²⁵¹ This comprehensive strategy resulted in a substantial reduction in HIV prevalence in Uganda, from 15% in 1990 to 6% in 2002.²⁵²

Since 2002, USAID has funded Uganda’s switch from its prior, successful comprehensive model to the ineffective abstinence promotion strategy preferred by the United States.²⁵³ Like their U.S. counterparts, the PEPFAR-funded abstinence promotion programs adopted by the Ugandan government disparage and discourage condom use, teaching, falsely, that condoms contain microscopic holes that allow HIV to pass through.²⁵⁴ Since embracing the PEPFAR Strategy in 2002, the Ugandan government, working with USAID, has suppressed distribution and social marketing of condoms,²⁵⁵ and even created a national condom shortage by impounding shipments of condoms from abroad.²⁵⁶ In the first two years of implementation of the PEPFAR abstinence-promotion strategy, the incidence of HIV in Uganda nearly doubled: according to Uganda AIDS Commission Director General Dr. Kihumuro Apuuli, the yearly number of new HIV infections increased from 70,000 in 2003 to 130,000 in 2005.²⁵⁷

The exported versions of U.S. abstinence promotion campaigns promote gender stereotypes even more blatantly than those used in the United States: they urge girls

and women, but not boys and men, to remain virgins until marriage.²⁵⁸ This policy puts women at particular risk. Abstinence and fidelity do not protect Ugandan women from HIV infection.²⁵⁹ A woman's own virginity and fidelity do nothing to protect against a husband's prior or extramarital HIV infection. In sub-Saharan Africa as in India, Thailand and other low-income countries, 60-80% of HIV-positive women have had only one partner: their husbands.²⁶⁰ For many women in these countries, marriage is not protective against HIV infection: rather, it is an HIV risk factor.²⁶¹

Ironically, one U.S. government official, quoted in a 2006 report by the United States Government Accountability Office, defends the targeting of girls and women, saying, "abstinence is an important message for young girls ... because of their lack of negotiating power in relationships."²⁶² Yet, by promoting norms that require virginity and fidelity of women, but not men, U.S.-funded abstinence promotion undermines women's ability to negotiate sex and condom use, and thereby facilitates the spread of HIV.

ENDNOTES

1. Human Rights Committee, *General Comment 28, Equality of rights between men and women (Article 3)*, 68th Sess., 1834th mtg., ¶ 20, U.N. Doc. CCPR/C/21/Rev/1/Add/10 (2000) [hereinafter *HRC General Comment 28*].
2. *Id.*
3. See, e.g., *Concluding Observations of the Human Rights Committee: Ecuador*, 63rd Sess., 1692nd mtg., ¶ 11, U.N. Doc. CCPR/C/uo/Add.92 (1998) [hereinafter *HRC Concluding Observations: Ecuador*]; *Concluding Observations of the Human Rights Committee: Poland*, 66th Sess., 1779th mtg., ¶ 11, U.N. Doc. CCPR/C/79/Add.110 (1999) [hereinafter *HRC Concluding Observations: Poland 1999*].
4. *HRC General Comment 28*, *supra* note 1, ¶ 31; Human Rights Committee, *General Comment 18: Non-Discrimination*, 37th Sess., 1989, ¶ 10, in COMPILATION OF GENERAL COMMENTS AND GENERAL RECOMMENDATIONS BY HUMAN RIGHTS TREATY BODIES, at 134, U.N. Doc. HRI/G EN /1/Re v.5 (2001) [hereinafter *HRC General Comment 18*].
5. *HRC General Comment 18*, *supra* note 4, ¶ 7.
6. See e.g., *Concluding Observations of the Human Rights Committee: Sweden*, 55th Sess., 1470th mtg., ¶ 14, U.N. Doc. CCPR/C/79/Add.58 (1995) [hereinafter *HRC Concluding Observations: Sweden*]; *Concluding Observations of the Human Rights Committee: United States of America*, 53rd Sess., 1413th mtg., ¶ 270, U.N. Doc. CCPR/C/79/Add 50, A /50/40 (1995) [hereinafter *HRC Concluding Observations: United States of America*]; *Concluding Observations of the Human Rights Committee: Denmark*, 70th Sess., 1888th mtg., ¶ 14, U.N. Doc. CCPR/CO/70/DNK (2000) [hereinafter *HRC Concluding Observations: Denmark*]; *Concluding Observations of the Human Rights Committee: United Kingdom of Great Britain and Northern Ireland—Crown Dependencies*, 73rd Sess., 1976-1977th mtgs., ¶ 18, U.N. Doc. CCPR/C/79/Add.119 (2000) [hereinafter *HRC Concluding Observations: United Kingdom*]. This list is not exhaustive. A full discussion of the committees' work regarding discrimination based on race or ethnicity is beyond the scope of this report.
7. See e.g., *Concluding Observations of the Human Rights Committee: Brazil*, 57th Sess., 1526th mtg., ¶ 337, U.N. Doc. CCPR/C/79/Add.66; A/51/40 (1996).
8. *HRC General Comment 28*, *supra* note 1, ¶ 30.
9. Human Rights Committee, *General Comment 6: The Right to Life (Art. 6)*, 16th Sess., 1982, ¶ 5.
10. International Covenant on Civil and Political Rights, G.A. Res. 2200A(XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), art. 3, art. 36, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).
11. UNITED NATIONS CENTER FOR HUMAN RIGHTS, MANUAL ON HUMAN RIGHTS REPORTING 120, U.N. Doc. HR/PUB/91/1 (1991) at 113.
12. *Concluding Observations of the Human Rights Committee: Colombia*, 52nd Sess., 1583rd mtg., ¶ 37, U.N. Doc. CCPR/C/79/Add.76 (1997) [hereinafter *HRC Concluding Observations: Colombia*].
13. *Concluding Observations of the Human Rights Committee: Azerbaijan*, 73rd Sess., 1983rd mtg., ¶ 16, U.N. Doc. CCPR/CO/73/AZE (2001); *Concluding Observations of the Human Rights Committee: Viet Nam*, 75th Sess., 2031st mtg., ¶ 15, U.N. Doc. CCPR/CO/75/VNM (2002); *Concluding Observations of the Human Rights Committee: Hungary*, 74th Sess., 2005th mtg., ¶ 11, U.N. Doc. CCPR/CO/74/HUN (2002); *Concluding Observations of the Human Rights Committee: Republic of Moldova*, 75th Sess., 2038th mtg., ¶ 18, U.N. Doc. CCPR/CO/75/MDA(2002); *Concluding Observations of the Human Rights Committee: Mali*, 77th Sess., 2095-2096th mtgs, ¶ 14, U.N. Doc. CCPR/CO/77/MLI (2003), *Concluding Observations of the Human Rights Committee: El Salvador*, 78th Sess., 2125th mtg., ¶ 14, U.N. Doc. CCPR/CO/78/SLV (2003).
14. See e.g., *HRC Concluding Observations: Poland 1999*, *supra* note 3, ¶11(b).
15. The Committee has addressed this issue specifically in terms of abortion. *Concluding Observations of the Human Rights Committee: Poland*, 82nd Sess., 2251st mtg., ¶ 8, U.N. Doc. CCPR/CO/82/POL (2004) [hereinafter *HRC Concluding Observations: Poland 2004*].
16. Alan Guttmacher Inst., *Induced Abortion in the United States, Facts in Brief* (2005), http://www.agi-usa.org/pubs/fb_induced_abortion.html; Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 Persps. on Sexual & Reprod. Health 90-

- 96 (2006).
17. Finer and Henshaw, *id.*
 18. See, e.g., Nancy Dillon, *New York's \$1 Abort Pill—A Dose of Danger*, N.Y. Daily News, Oct. 8, 2005 (illegal, off-label use of black-market misoprostol to induce home abortions without medical assistance, largely by low-income Latin American women); Rick Brundrett, *Woman's Abortion is Unique S.C. Case*, The State, May 1 2005 (migrant farm worker criminally charged for using misoprostol to induce abortion).
 19. See, e.g., *Texas Teenager Sentenced to Life in Prison for Helping Pregnant Girlfriend Terminate Pregnancy*, Kaiser Women's Health Policy Report, June 9, 2005, http://kaisernetwork.org/daily_reports/rep_repro_recent_reports.cfm?dr_cat=2&show=yes&dr_DateTime=06-09-05#30616 (boyfriend stomped pregnant girl in the stomach, killing fetal twins); Edward L. Cardenas et al., *Macomb Teens End Pregnancy with Beating; Boyfriend Hits Girl with Bat as Part of a Deal and Boy's Mom Helps Bury Fetus*, Police Say, Detroit Free Press, Nov. 17, 2004, at 1A.
 20. See, e.g., *Suffolk woman escapes inducing abortion charge*, WTKR News, May 8, 2006, <http://www.wtkr.com/global/story.asp?s=4874863&ClientType=Printable>; Linda McNatt, *Woman Charged with Shooting Self to Induce Abortion*, Virginian-Pilot, Feb. 28, 2006, at <http://home.hamptonroads.com/stories/story.cfm?story=100336&ran=212974> (woman shot herself in the abdomen, killing fetus and injuring herself).
 21. See *infra* notes 67-82 and accompanying text.
 22. See, e.g., P Cook et al., *The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes*, 18 J. of Health & Econ. 241-258; S.K. Henshaw & K. Kost, *Abortion Patients in 1994-95: Characteristics & Contraceptive Use*, Family Planning Persps. 12 (1996); J. Trussel et al., *The Impact of Restricting Medicaid Funding for Abortion*, Family Planning Persps., 120-23 & 127-30 (1980).
 23. Alan Guttmacher Inst., *Medicaid: A Critical Source of Support for Family Planning in the United States*, (2004), <http://www.kff.org/womenshealth/7064.cfm>; U.S. Census Bureau, *Current Population Survey, 2002 to 2004 Annual Social and Economic Supplements*.
 24. National Network of Abortion Funds, *Abortion Funding: A Matter of Justice* (2005).
 25. See Alan Guttmacher Inst., *State Policies in Brief: Insurance Coverage of Contraceptives*, (2005), http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.
 26. Ctr. for Reprod. Rights, *Contraceptive Equity Laws in the States: A Look at Contraceptive Equity Laws Around the Country* (2005), http://www.reproductiverights.org/st_equity.html.
 27. Alan Guttmacher Inst., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 Persps. on Sexual & Reprod. Health (March/April 2004), <http://www.agi-usa.org/pubs/journals/3607204.pdf>.
 28. See Nat'l Women's Law Ctr., *Don't Take No For An Answer* (2005), http://www.nwlc.org/pdf/8-2005_DontTakeNo1.pdf; Planned Parenthood, *Refusal Clauses: A Threat to Reproductive Rights* (2004), <http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/fact-041247-refusal-reproductive.pdf>; NARAL Prochoice America, *Refusal Clauses: Dangerous to Women's Health*, <http://www.prochoiceamerica.org/facts/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=16140>.
 29. Alan Guttmacher Inst., *State Policies in Brief: Refusing to Provide Health Services* (2005), http://www.agi-usa.org/statecenter/spibs/spib_RPHS.pdf.
 30. *Complaint, Tummino v. Crawford*, No. 05-CV-366 (S.D.N.Y. Jan. 21, 2005).
 31. See Gov't Accountability Office, *Report to Congressional Requesters, Food & Drug Administration Decision Process to Deny Initial Application for Over The Counter Marketing of the Emergency Contraceptive Drug Plan B was Unusual*, GAO 06-109 (2005), <http://www.gao.gov/new.items/d06109.pdf>.
 32. *Transcript of Civil Cause for Motion Hearing, Tummino v. von Eschenbach*, 2006 WL 963876, at 11 (E.D.N.Y. Dec. 22, 2005).
 33. See Dep't of Health & Human Servs., Office of the Assistant Secretary for Planning & Evaluation, *Setting the Baseline: A Report on State Welfare Waivers*, Table III: Family Cap Policies by State (1997), http://aspe.hhs.gov/hsp/isp/waiver2/TABLE3.htm#N_1_. These programs vary state from state but uniformly seek to eliminate any incremental increases for a child born to a mother on welfare. See, e.g., *Ariz. Rev. Stat. Ann. § 46-292(g)* (2005) (denying benefits to children born into families that are ineligible to receive benefit pursuant to

- a penalty for failure to comply with the benefit eligibility requirements); N.J. Stat. Ann. § 44:10-61(a) (same) (West 2006).
34. JT Cook et al., *Welfare Reform and the Health of Young Children: A Sentinel Survey in Six United States Cities*, 156 Archives of Pediatric & Adolesc. Med. 678-684 (July 2002).
 35. Heather D. Boonstra et al., ABORTION IN WOMEN'S LIVES 34, 37 (2006), <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>.
 36. Arizona, Arkansas, Delaware, Florida, Indiana, Mississippi, Nebraska, North Carolina, South Carolina, Tennessee, Virginia, and Wisconsin. *See id.* at 34 & 37; Dep't of Health & Human Servs., Office of the Assistant Secretary for Planning & Evaluation, Setting the Baseline: A Report on State Welfare Waivers, Table III: Family Cap Policies by State (1997), http://aspe.hhs.gov/hsp/isp/waiver2/TABLE3.htm#N_1_; Admin. for Children & Families, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PROGRAM: SIXTH ANNUAL REPORT TO CONGRESS, Table 10:43 (2004), <http://www.acf.hhs.gov/programs/ofa/annualreport6/chapter10/1043.htm>.
 37. Alan Guttmacher Inst., Induced Abortion, *supra* note at 16.
 38. Michael J. Camasso et al., Final Report on the Impact of New Jersey's Family Development Program: Results from a Pre-Post Analysis of AFDC Case Heads from 1990-1996 (Oct. 1998), <http://www.state.nj.us/humanservices/Press98/rutfdp.html>. Note that New Jersey is one of the 16 states that provide state Medicaid funding of medically necessary abortion for low-income women. *See infra* note 64.
 39. *Concluding Observations of the Human Rights Committee: Chile*, 65th Sess., 1733-1734th mtg., ¶ 15, U.N. Doc. CCPR/C/79/Add.104 (1999) [hereinafter *HRC Concluding Observations: Chile*].
 40. *Concluding Observations of the Human Rights Committee: Peru*, 58th Sess., 1555th mtg., ¶ 22, U.N. Doc. CCPR/C/79/Add.72 (1996) [hereinafter *HRC Concluding Observations: Peru 1996*].
 41. *HRC Concluding Observations: Poland 2004*, *supra* note 15, ¶ 8.
 42. *Concluding Observations of the Human Rights Committee: Chile*, *supra* note 39, ¶ 15.
 43. *Concluding Observations of the Human Rights Committee: Argentina*, 77th Sess., 1893rd mtg., ¶ 14, U.N. Doc. CCPR/CO/70/ARG (2000); *see also K.L. v. Peru*, Communication No. 1553/2003, U.N. Human Rights Committee, 85th Sess., Annex, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).
 44. Second and Third Periodic Report of the United States of America to the UN Committee on Human Rights Concerning the International Covenant on Civil and Political Rights, ¶¶ 98, 102, 103, U.N. Doc CCPR/C/USA/3 (2005).
 45. *See, e.g. Concluding Observations of the Human Rights Committee: Kenya*, 83rd Sess., 2255-2256th mtg., ¶ 14, U.N. Doc. CCPR/CO/83/KEN (2005); *Concluding Observations of the Human Rights Committee: Bolivia*, 59th Sess., 1582nd mtg., ¶ 22, U.N. Doc. CCPR/C/79/Add.74 (1997); *HRC Concluding Observations: Colombia*, *supra* note 12, ¶ 24; *Concluding Observations of the Human Rights Committee: Peru*, 77th Sess., 1892nd mtg., ¶ 20, U.N. Doc. CCPR/CO/70/PER (2000) [hereinafter *HRC Concluding Observations: Peru 2000*]; *HRC Concluding Observations: Poland 1999*, *supra* note 3, ¶ 11; *Concluding Observations of the Human Rights Committee: Senegal*, 61st Sess., 1640th mtg., ¶ 12, U.N. Doc. CCPR/C/79/Add.82 (1997); *Concluding Observations of the Human Rights Committee: Chile*, *supra* note 39, ¶ 15.
 46. *Roe v. Wade*, 410 U.S. 113 (1973).
 47. *Planned Parenthood of E. Pa. v. Casey*, 505 U.S. 833 (1992); *Rust v. Sullivan*, 500 U.S. 173 (1991); *Hodgson v. Minnesota*, 497 U.S. 417 (1990); *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989); *Diamond v. Charles*, 476 U.S. 54 (1986); *Thornburgh v. Am. Coll. of Obstetricians*, 476 U.S. 747 (1986); *see also* Brief of the Solicitor General, *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416 (1983).
 48. S.D. Codified Laws § 22-17.
 49. South Dakota Task Force to Study Abortion, REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION: SUBMITTED TO THE GOVERNOR AND LEGISLATURE OF SOUTH DAKOTA 66-68 (Dec. 2005), <http://www.dakotavoices.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf>.
 50. Ctr. for Reproductive Rights, *What If Roe Fell? The State-by-State Consequences of Overturning Roe v. Wade* (2004), http://www.reproductiverights.org/pdf/bo_whatifroefell.pdf
 51. *See, e.g., Planned Parenthood*, 505 US at 833.
 52. Partial-Birth Abortion Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. § 1531).

53. See generally Ctr. for Reprod. Rights, Targeted Regulation of Abortion Providers: Avoiding the “TRAP” (Aug. 2003), http://www.reproductiverights.org/pdf/pub_bp_avoidingthetrap.pdf; Ctr. for Reprod. Rights, 2005 Mid-Year Legislative Summary 4-5 (2005), http://www.reproductiverights.org/pdf/mid_year_report_05.pdf.
54. Brief of Respondent at 2, *Alpha Med. Clinic v. Anderson*, No. 04-93383-S (D. Kan. 2005); Amended Joint Brief of Petitioners, *Alpha Med. Clinic v. Anderson*, No. 04-93383-S (D. Kan. 2005); *Northwestern Mem’l Hosp. v. Ashcroft*, 362 F.3d 923, 930 (7th Cir. 2004); *Planned Parenthood Fed’n of Am., Inc. v. Ashcroft*, No. C03-4872 PJH, 2004 WL 432222 (N.D. Cal. Mar. 5, 2004); *Nat’l Abortion Fed’n v. Ashcroft*, No. 03 Civ. 8695 (RCC), WL 555701 (S.D.N.Y. Mar. 18, 2004); *Northwestern Mem’l Hosp. v. Ashcroft*, No. 04 C 55, 2004 WL 292079 (N.D. Ill. Feb. 4, 2004); see also Suzanne Hoholik, *Women’s Center Sues to Block State From Getting Records*, Columbus Dispatch, Aug. 23, 2005, at 2D (Ohio Health Department seeking records of abortion patients in pursuit of undisclosed complaint); David Klepper, *Area Clinic Alerts Patients that Kline Seeks Records*, Kansas City Star, Mar. 17, 2005, at 1; Peter Slevin, *A Kansan With Conviction; Attorney General Sees Abortion Records Fight as Matter of Principle*, Wash. Post, Mar. 20, 2005, at A03.
55. Thirty states have some form of mandatory counseling requirement. See Ctr. for Reprod. Rights, *Mandatory Delays and Biased Information Requirements* (2005), http://www.reproductiverights.org/st_law_delay.html.
56. Currently, at least 22 states have 24-hour delays. *Id.*
57. The Hyde Amendment excludes abortion from the health care services provided by Medicaid, the federal government’s health insurance plan for low-income people. See 42 U.S.C. §1396 (2003).
58. Consolidated Appropriations Act, 2005, P.L. 104-447 (H.R.4818), Sec. 507(d)(1).
59. Alan Guttmacher Inst., *Induced Abortion*, *supra* note 16.
60. Boonstra, *supra* note 35, at 31; Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States*, 2001, 35 Persps. on Sexual & Reprod. Health 16-24 (2003).
61. *Id.* <http://www.guttmacher.org/pubs/journals/3501603.html>
62. Alan Guttmacher Inst., *Induced Abortion*, *supra* note 16.
63. Pub. L. No. 96-123, §109, 93 Stat. 923 (1979) (codified at 42 U.S.C. §1396 (2003)).
64. Ctr. for Reprod. Rights, *Medicaid Funding for Medically Necessary Abortions* (2003), http://www.reproductiverights.org/st_law_medicaid.html.
65. Adam Sonfield & Rachel Benson Gold, *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980-2001*, (2005), <http://www.guttmacher.org/pubs/fpfunding/tables.pdf>; Stephanie Poggi, *Abortion Funding for Poor Women: The Myth of the Rape Exception* (2005), <http://www.americanprogress.org/site/pp.asp?c=b iJRJ8OVF&b=615981>.
66. See Henshaw & Finer, *supra* note 60, at 23; Alan Guttmacher Inst., *Induced Abortion*, *supra* note 16.
67. Boonstra, *supra* note 35, at 16.
68. *Id.* at 17.
69. The only states that impose none of these restrictions are Connecticut, Hawaii, New York, Oregon, Vermont, and Washington. See *id.* at 34-35.
70. Alabama, Arkansas, Georgia, Indiana, Michigan, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Virginia, and Wisconsin. *Id.* at 34-35.
71. S.D. Codified Laws § 22-17.
72. M. Griffin-Carlson & P.Schwanenflugel, *Adolescent Abortion and Parental Notification: Evidence of the Importance of Family Functioning*, 39 J. of Child Psychology & Psychiatry & Allied Disciplines 4 (1998).
73. C. Ellertson, *Mandatory Parental Involvement in Minors’ Abortions: Effects of the Laws in Minnesota, Missouri and Indiana*, 87 Am. J. Pub. Health 1367 (1997).
74. See Theodore Joyce et al., *Changes in Abortions and Births and the Texas Parental Notification Law*, 10 New Eng. J. Med. 1031-38 & 36 (2006); Marianne Bitler & Madeline Zavodny, *The Effect of Abortion Restrictions on the Timing of Abortions*, 20 J. Health & Econ. 1011-32 (2001).
75. Ellertson, *supra* note 73.
76. Joyce, *supra* note 74, at 1036.
77. Boonstra, *supra* note 35, at 34.
78. *Id.* at 37.
79. Admin. for Children & Families, TEMPORARY

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PROGRAM: SIXTH ANNUAL REPORT TO CONGRESS,
Table 10:43 (2004), <http://www.acf.hhs.gov/programs/ofa/annualreport6/chapter10/1043.htm>.
80. Boonstra, *supra* note 35, at 31.
 81. *Id.* at 31-32.
 82. *Id.* at 31-32.
 83. P. Cook et al., *The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes* 18, *J. of Health & Econ.* 241-258 (1999); Mark I. Evans et al., *The Fiscal Impact of the Medicaid Abortion Funding Ban in Michigan*. 82 *Obstetrics & Gynecology* 555-60, & 56 (1993); Ctrs. for Disease Control, *Effects of Restricting Federal Funds for Abortion—Texas*, 29 *MMWR* 1980, 253-55 (1980); J. Trussell, et al., *The Impact of Restricting Medicaid Funding for Abortion*, 12 *Family Planning Persps.* 120-26 (1980).
 84. *Stenberg v. Carhart*, 530 U.S. 914, 931 (2000) (citation omitted). *See also* *Roe v. Wade*, 410 U.S. 113, 163 (1973) (after viability, the state may prohibit abortion, “except when it is necessary to preserve the life or health of the mother”); *Planned Parenthood of Ctr. Mo. v. Danforth*, 428 U.S. 52, 79 (1976); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986); *Planned Parenthood of E. Pa. v. Casey*, 505 U.S. 833, 846, 872 (1992) (state may restrict abortion only “if the law contains exceptions for pregnancies which endanger the woman’s life or health,” that is, “provided the life or health of the mother is not at stake”); *Ayotte v. Planned Parenthood of N. N. H.*, 126 S.Ct. 961, 967 (2006).
 85. *Stenberg*, 530 U.S. at 914.
 86. *Id.* at 931.
 87. *Carhart v. Gonzales*, 413 F.3d 791, 793 (8th Cir. 2005).
 88. *Stenberg*, 530 U.S. at 931 (emphasis added).
 89. *Id.* at 931.
 90. *Partial-Birth Abortion Act of 2003*, 18 U.S.C. § 1531. Contrary to the medical evidence accepted by the court in *Stenberg*, Congress declared, in the preamble to the legislation, that the “partial-birth abortion” procedure was “never medically necessary,” and that it “poses serious risks to the health of the mother.” All three courts reviewing these Congressional “findings” have held them to be unreasonable in light of the evidence before Congress as well as the evidence in the trial Courts. *See Carhart*, 413 F.3d at 791; *Nat’l Abortion Fed’n v. Gonzales*, 437 F.3d 278 (2d Cir. 2006); *Planned Parenthood Fed’n of Am., Inc. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006).
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 92. *Carhart*, 413 F.3d 791, *cert. granted*, 126 S.Ct. 1314 (Feb. 21, 2006 (No. 05-380)).
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 100. *See e.g., HRC Concluding Observations: Brazil*, *supra* note 7, ¶ 337.
 101. *See e.g., HRC Concluding Observations: Peru 2000*, *supra* note 45, ¶ 21. The committee has treated both race and gender discrimination more generally in its concluding observations. A review of the Committee’s overall body of work relating to race and sex discrimination is beyond the scope of this report.
 102. *Concluding HRC Concluding Observations: Peru 2000*, *supra* note 45, ¶ 21; *Concluding Observations of the Human Rights Committee: Slovakia*, 78th Sess., 2121st mtg., ¶12, U.N. Doc. CCPR/CO/78/SVK (2003).
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213. *See, e.g., Concluding Observations of the Human Rights Committee: Israel*, 78th Sess., 2128-2130th mtgs., ¶ 11, U.N. Doc. CCPR/CO/78/ISR (2003).
214. *See, e.g., Concluding Observations of the Human Rights Committee: Iran*, 1260th mtg., ¶ 9, U.N. Doc. CCPR/C/79/Add.25(1993)(holding Iran accountable for a fatwa issued in that country calling for the death of foreign writer Salman Rushdie, implicating arts. 6, 9, 14, and 19 of the Covenant); *Ibrahim Gueye et al. v. France*, HRC 6 April 1989, Communication No. 196/1985, ¶¶ 9.3-9.5, UN Doc. CCPR/C/35/D/196/1985 (finding that France violated art. 26 of the Covenant with its pension policy for retired Senegalese members of the French army residing in Senegal, who “are not generally subject to French jurisdiction, except that they rely on French legislation in relation to the amount of their pension rights”).
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216. *See* Memorandum from President George W. Bush to the Adm’r of the U.S. Agency for Int’l Dev. (Jan. 22, 2001), <http://www.whitehouse.gov/news/releases/200101235.html>; *see also* Daily Briefing, U.S. Dep’t of State (Jan. 23, 2001), <http://www.state.gov/r/pa/prs/index.cfm?docid=12>.
217. *See Rust v. Sullivan*, 500 U.S. 173 (1991).
218. Ctr. for Reprod. Rights, *The Bush Global Gag Rule: A Violation of International Human Rights*, Briefing Paper (2000), http://www.reproductiverights.org/pdf/pub_bp_bushggr_violation.pdf.
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220. *See* discussion *supra* Section D.
221. Human Rights Watch, *supra* note 201.
222. *See supra* notes 169-170 and accompanying text.
223. United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act, 22 U.S.C.A. §§ 7672(b)(3), 7673(a) (2003).
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226. U.S. Dep’t of State, *supra* note 224, at 23.
227. Office of the Global AIDS Coordinator, *supra* note 225, at 4.
228. U.S. Dep’t of State, *supra* note 224, at 27; *see also* Office of the Global AIDS Coordinator, *supra* note 224, at 8.
229. U.S. Dep’t of State, *id.* note 222, at 27.
230. Office of the Global AIDS Coordinator, *supra* note 225, at 8.
231. *Id.*, at 6.
232. *Id.*, at 6.
233. *Id.*, at 6.
234. *Id.*, at 5.
235. *Id.*, at 6.
236. *Id.*, at 6.
237. *Id.*, at 6.
238. *Id.*, at 4; *see also* U.S. Dep’t of State, *supra* note 224, at 27.
239. Joint United Nations Programme on HIV/AIDS, *supra* note 201, at 13, 135; Human Rights Watch, *supra* note 201, at 70.
240. U.S. Gov’t Accountability Office, *Report to Congressional Committees: Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President’s Emergency Plan for AIDS Relief* 36 (2006), <http://www.gao.gov/new.items/d06395.pdf>.
241. *Id.*, at 36-40.
242. *Id.*, at 39.
243. *Id.*, at 39.

244. *Id.*, at 39.
245. See PEPFAR website, <http://www.pepfarpi.com/eplan.htm> (last visited May 31, 2006).
246. *Id.* The other fourteen “focus countries” of the PEPFAR Strategy are: Botswana, Côte d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Vietnam and Zambia.
247. PEPFAR, Country Profile: Uganda, <http://www.state.gov/documents/organization/61631.pdf> (last visited May 31, 2006).
248. Human Rights Watch, *supra* note 201.
249. U.S. Dep’t of State, *supra* note 224, at 9, 23-24, 28.
250. Human Rights Watch, *supra* note 201, at 68-72.
251. *Id.*
252. *Id.* at 1.
253. *Id.*
254. *Id.* at 63.
255. *Id.* at 63-65.
256. *Id.* at 64-65.
257. Emma Masumbuko & Joseph Miti, *Uganda: 130,000 Got AIDS in 2005*, Monitor, May 19, 2006, <http://allafrica.com/stories/200605180712.html>. (note that despite the misleading headline, Dr. Apuuli’s statement, as quoted, referred to new HIV infections, and not to new AIDS diagnoses). See also Uganda AIDS Commission website, <http://www.aidsuganda.org/aids/index.htm>.
258. Emily Wax, *Virginity Becomes a Commodity in Uganda’s War Against AIDS*, Washington Post, Oct. 7, 2005, at A1.
259. Global Coal. on Women and AIDS, *The Female AIDS Epidemic: 2005* (2005), <http://womenandaids.unaids.org/womenandaidsnovfin.doc>.
260. United Nations Population Fund, *State of World Population 2005: Reproductive Health: A Measure of Equity—The Feminization of HIV/AIDS 4*, http://www.unfpa.org/swp/2005/english/ch4/chap4_page1.htm; see also Human Rights Watch, *supra* note 201, at 4.
261. See United Nations Population Fund, *supra* note 259; Steven W. Sinding, *Does ‘CNN’ (Condoms, Needles and Negotiation) Work Better than ‘ABC’ (Abstinence, Being Faithful and Condom Use) in Attacking the AIDS Epidemic?*, International Family Planning Perspectives 38-40 (2005), <http://www.agi-usa.org/pubs/journals/3103805.html>.
262. U.S. Gov’t Accountability Office, *supra* note 239, at 35.
263. For many women in low-income countries, marriage is not protective against HIV infection; rather, it is a risk factor. See United Nations Population Fund, *supra* note 259.; Steven W. Sinding, *supra* note 260, at 38-40.

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