

**Mandates of the Working Group on the issue of discrimination against women in law and in practice;  
the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard  
of physical and mental health; and the Special Rapporteur on violence against women, its causes and  
consequences**

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Excellency,

We have the honour to address you in our capacities as Chairperson-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and Special Rapporteur on violence against women, its causes and consequences pursuant to Human Rights Council resolutions 23/7, 24/6, and 23/25.

In this connection, we would like to bring to the attention of your Excellency's Government information we have received concerning the retrogression in the enjoyment of women and girls of their rights to health, including reproductive health, and to physical integrity as a consequence of the implementation of the 2013 Texas House Bill 2. This law, which relates to the regulation of abortion procedures, providers and facilities, does not appear to be in compliance with international human rights law and standards.

According to the information received:

In July 2013, the state of Texas enacted the House Bill 2 (HB2) relating to the regulation of abortion procedures, providers and facilities. This legislation bans nearly all abortions after 20 weeks of pregnancy, unless the life of the mother is endangered or the foetus has severe abnormalities. It requires that abortion-inducing drugs, such as mifepristone, be administered in the presence of a doctor, resulting in repeated separate clinic visits. It mandates that physicians performing the procedure have admitting privileges at a hospital within 30 miles of the clinic where they practice. And it demands that all abortion clinics have the same equipment and building requirements as ambulatory surgery centers, even if all they do is administer oral abortion drugs.

On 29 August 2014, a federal judge overturned two provisions of this law - the ambulatory surgical center requirements and the admitting privileges requirement - which had allegedly forced the closure of half the state's abortion clinics. This

decision allowed nearly a dozen other facilities, which would have had otherwise to close on 1 September 2014, to continue running. The judge allegedly affirmed that some of the provisions of this law represent an unconstitutional undue burden: while federal law grants a woman the constitutional right to terminate her pregnancy before foetal viability, individual states are permitted to impose restrictions on abortion throughout pregnancy but only if they do not unduly burden a woman's right to choose.

On 2 October, the U.S. Court of Appeals for the Fifth Circuit overruled the federal court decision and allowed the immediate enforcement of the HB2 law in Texas, including the requirements relating to the equipment and building requirement and to the admitting privileges of doctors. This resulted in a situation in which no more than eight clinics became operational to offer safe, legal abortion care to all women across the vast state of Texas. These remaining operational clinics were all located in urban centers, leaving most parts of the west and south of the state without any access to safe and legal abortion care.

On 14 October 2014, the U.S. Supreme Court reinstated an injunction blocking some of the provisions of the HB2 law that had forced most of the reproductive health care clinics in the state to close. This ruling allowed clinics previously shuttered to reopen their doors and offer abortion services, while the case is heard by the U.S. Court of Appeals for the Fifth Circuit.

Of the 41 abortion clinics which were open in Texas in May 2013, only 17 remain open today. Most of the remaining clinics are located in Texas' five largest cities which imply that the women whose access to safe abortion has been severely curtailed are mostly poor, rural, and immigrant women unable to travel to urban centers. In the Rio Grande Valley, the two abortion clinics serving an area with 1.3 million people have closed as a result of the HB2. Women in the Rio Grande Valley must now travel nearly 250 miles each way, or 4 hours by car, to access the nearest clinic in San Antonio, Texas. The transportation and lodging costs associated with traveling to obtain an abortion represent a supplementary burden for them added to the existing fee for an abortion procedure. The increased costs and travel distances cause many of the poorest women - primarily migrant women or of Latino-American origins - to delay accessing abortion care and others to forgo abortion. Nearly 40% of the Rio Grande Valley residents live below the federal poverty level and most of these women often cannot afford the fee for an abortion procedure. Since the HB2 law went into effect, the overall rate of safe and legal abortion seems to have decreased by 13%. Some of these women, unable to obtain a legal abortion, will more likely resort to unsafe means to end their pregnancy (for instance purchasing miscarriage-inducing drugs on the black market), which may put their health, and possibly their life, at further risk.

Major medical groups have opposed the types of restrictions contained in Texas HB2. Both the American Medical Association (AMA) and the American Congress of Obstetricians and Gynecologists (ACOG) apparently oppose hospital

admitting privileges as a requirement for physicians providing abortion services. Medical experts confirm that legal abortion care in the United States is extremely safe, with less than 1 percent of patients requiring treatment at a hospital. ACOG also allegedly opposes the imposition of medically unnecessary facility requirements on abortion providers.

While we do not wish to prejudge the accuracy of these allegations, we express serious concern that the HB2 and its implementation appear to have, and to continue to, gravely undermine women and girls' rights to health, including their right to reproductive health, as well as their right to physical integrity, in contravention with international human rights law and standards, including those accepted by the United States under the treaties it has ratified, in particular the International Covenant on Economic, Social and Cultural Rights, accessed to by the United States on 5 October 1977. We are further concerned that if these clinics are, and remain, closed for any amount of time, they may never be able to reopen, and it will be very difficult to rebuild this system.

In connection with the above alleged facts and concerns, please refer to the **Reference to international law Annex** attached to this letter which cites international human rights instruments and standards relevant to these allegations.

As it is our responsibility, under the mandates provided to us by the Human Rights Council, to seek to clarify all cases brought to our attention, we would therefore be grateful for your observations on the following matters:

1. Please provide any additional information and any comments you may have on the above-mentioned allegations.
2. According to our understanding, if a law is appealed before it goes into effect, courts will hold its enforcement in abeyance until the appeal is decided. However this does not seem to have been the case. Kindly provide clarification on the process of implementation of Texas HB2.
3. The current Supreme Court Injunction being only a procedural decision, pending the Fifth Circuit decision, what steps have been envisaged to ensure that the rights of women and girls to sexual and reproductive health, including access to adequate medical services, and to physical integrity are adequately protected and comply with international human rights law.

We would appreciate a response within 60 days. Your Excellency's Government's response will be made available in a report to be presented to the Human Rights Council for its consideration.

While awaiting a reply, we urge that all necessary interim measures be taken to guarantee pregnant women and girls' rights to health, including reproductive health, and to physical integrity. We also take this opportunity to encourage your Excellency's Government to ratify the Convention on the Elimination of All Forms of Discrimination

against Women (CEDAW) as well as the International Covenant on Economic, Social and Cultural Rights.

Please accept, Excellency, the assurances of our highest consideration.

Emna Aouij

Chairperson-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice

Dainius Puras

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Rashida Manjoo

Special Rapporteur on violence against women, its causes and consequences

## **Annex**

### **Reference to international human rights law and standards**

In relation to the above mentioned allegations, we would like to underscore the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The right to health, including the right to sexual and reproductive health, is enshrined, inter alia, in article 25 of the Universal Declaration of Human Rights (UDHR) and article 12 of the International Covenant on Economic, Social and Cultural Rights, signed by the United States on 5 October 1977. Upon signing the Covenant, your Excellency's Government agreed to bind itself in good faith to ensure that nothing is done that would defeat the object and purpose of the international instrument, pending a decision on ratification. This comprises an obligation on the part of all States Parties to ensure that measures are taken to ensure that access to health services is available to everyone, especially the most vulnerable or marginalized sections of the population, without discrimination

The Committee on Economic, Social and Cultural Rights in its General Comment No. 14 made clear that the right to health contains both freedoms and entitlements and holds that "the freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation" (para. 8).

Furthermore, the Committee in this General Comment maintained that the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child, as specified in article 12.2(a) of the ICESCR, may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information. The Committee additionally highlighted the situation of women and the right to health, by pointing to the need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their lifespan. Such a strategy should include, inter alia, policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. The Committee further affirmed that "The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."

Women's right to health is also stipulated in the Convention on the Elimination of All Forms of Discrimination against Women, signed by the United States on 17 July 1980. According to article 12 of the Convention, States should take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Article 16 (1) of the Convention further holds that States should take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular should ensure, on a basis of equality of men and women, the same rights to decide freely and responsibly on

the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

In its General Recommendation 24, the Committee on the Elimination of All Forms of Discrimination against Women held that “measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women”, and “the obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals” (para. 14).

In its concluding observations on the United States in July 2014 (CERD/C/USA/CO/7-9), the Committee on the Elimination of Racial Discrimination reiterated its previous concern at the persistence of racial disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among African American communities (CERD/C/USA/CO/6, para.33) recommended the State Party to eliminate racial disparities in the field of sexual and reproductive health and standardize the data collection system on maternal and infant deaths in all states to effectively identify and address the causes of disparities in maternal and infant mortality rates.

We would also like to recall the Beijing Declaration and Platform for Action which explicitly recognizes and reaffirms that the right of all women to control all aspects of their health, in particular their own fertility is basic to their empowerment. It also stresses that the prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health.

In its 2014 Agreed Conclusions, the CSW expressed concern about the significant gaps in funding that remain and the magnitude of the unmet need for all sexual and reproductive healthcare services, including emergency obstetric services and skilled attendance at delivery, safe and effective contraception, services for the complications of unsafe abortion, and safe abortion where such services are permitted by national law. It urged Governments to ensure the promotion and protection of the human rights of all women and their sexual and reproductive health, and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, including through the development and enforcement of policies and legal frameworks and the strengthening of health systems that make universally accessible and available quality comprehensive sexual and reproductive health-care services, commodities, information and education, including, inter alia, safe and effective methods of modern contraception, emergency contraception, prevention programmes for adolescent pregnancy, maternal health care such as skilled birth attendance and emergency obstetric care which will

reduce obstetric fistula and other complications of pregnancy and delivery, safe abortion where such services are permitted by national law.

The Special Rapporteur on violence against women, its causes and consequences highlighted in her report (E/CN.4/1999/68/Add.4) that acts deliberately restraining women from using contraception or from having an abortion constitute violence against women by subjecting women to excessive pregnancies and childbearing against their will, resulting in increased and preventable risks of maternal mortality and morbidity (para. 57). She further added that in countries where abortion is illegal or where safe abortions are unavailable women suffer serious health consequences, even death. Women with unwanted pregnancies are forced to resort to life-threatening procedures when an abortion performed under appropriate conditions would otherwise be safe (para.59). Government failure to take positive measures to ensure access to appropriate health-care services that enable women to safely deliver their infants as well as to safely abort unwanted pregnancies may constitute a violation of a woman's right to life, in addition to the violation of her reproductive rights. Furthermore, government failure to provide conditions that enable women to control their fertility and childbearing, as well as to bring voluntary pregnancies to term, constitutes a violation of a woman's right to security of the person (para.66).

In this context, we would also like to recall the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254), which reiterates that the criminalization of sexual and reproductive health services for women generates and perpetuates stigma; restricts their ability to make full use of available sexual and reproductive health-care goods, services and information; denies their full participation in society; hinders their access to healthcare services; and disempowers women. Furthermore, criminalization of abortion results in negative physical and mental health outcomes for women and may increase the likelihood of women seeking clandestine abortions.

In his report (A/HRC/22/53), the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment also "call[ed] upon all States to ensure that women have access to emergency medical care, including post-abortion care, without fear of criminal penalties or reprisals. States whose domestic law authorizes abortions under various circumstances should ensure that services are effectively available without adverse consequences to the woman or the health professional." (para. 90). He furthermore stated that international and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender (para. 46). For many rape survivors, access to a safe abortion procedure is made virtually impossible by a maze of administrative hurdles, and by official negligence and obstruction. In the landmark decision of *K.N.L.H. v. Peru*, the Human Rights Committee deemed the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment (para. 49). The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment. On numerous occasions United

Nations bodies have expressed concern about the denial of or conditional access to post-abortion care often for the impermissible purposes of punishment or to elicit confession. The Human Rights Committee explicitly stated that breaches of article 7 of the International Covenant on Civil and Political Rights include forced abortion, as well as denial of access to safe abortions to women who have become pregnant as a result of rape and raised concerns about obstacles to abortion where it is legal (para. 50).