April 23, 2020

To: U.S. Department of State Commission on Unalienable Rights:

On behalf of the International Women's Health Coalition (IWHC), in consultation with IWHC board member Aryeh Neier,[1] I submit the following comment for consideration by the Commission on Unalienable Rights created under the aegis of the Secretary of State and the United States Department of State.[2]

During the Commission's public hearings, which IWHC attended, certain witnesses discussed the "prioritization" of freedom of religion over other rights.[3] We would like to address this question.

For 35 years, the International Women's Health Coalition has fought to protect and advance the health and human rights of women and girls worldwide. As a feminist organization, IWHC is committed to working toward a just and sustainable world where all people, regardless of gender, enjoy their human rights and health, and have power over their lives. We welcome the opportunity to contribute our expertise to the Commission on women's human rights and, particularly, regarding what is at stake for women, girls, and marginalized persons worldwide if freedom of religion is elevated above all others.

The Commission must uphold the international human rights system

IWHC urges the United States government to uphold its obligations to promote, respect and fulfill "human rights and for fundamental freedoms for all, without distinction as to race, sex, language, or religion." Membership in the United Nations comes with these obligations, as clearly stated in Articles 1 and 55 of the United Nations Charter.

Since the United Nations' founding, governments, legal experts, and civil society advocates have worked together to flesh out this basic obligation and the human rights principles laid out in the 1948 Universal Declaration of Human Rights (UDHR). They have developed these principles into standards that address critical issues and specific persons that needed further explication—from racial discrimination to the rights of women, from children to people with disabilities—in order to define a comprehensive set of government obligations to respect, protect, and fulfill human rights. The Commission should acknowledge the evolution of human rights in its report and urge the United States government to

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continue and reinforce its leadership in the promotion of a strong and comprehensive international human rights framework.

The United States, because of its founding principles and its system of laws, has in fact played a critical leadership role in the development of the international human rights system, one of the most important achievements of the international community post-World War II. The Universal Declaration of Human Rights (UDHR), the cornerstone of that system, was drafted by a committee led by former First Lady Eleanor Roosevelt. She is widely acknowledged as one of the driving forces behind the UDHR's scope - a wide range of civil, political, economic, social and cultural rights - and in securing consensus on that pivotal agreement.

When religious freedom is invoked to discriminate

IWHC is specifically concerned about the use of religious freedom to enable and excuse discriminatory conduct. Given our partnership and work with women's organizations around the world, we have repeatedly observed how freedom of religion or conscience is used to justify discrimination against women, girls, LGBTQI people, and members of other marginalized groups, particularly when these individuals seek health care.

In many countries, including in the United States, policies that prioritize freedom of religion at the expense of other human rights have explicitly allowed health providers to refuse health care to patients on the basis of the providers' personal religious views. This right to refuse care is sometimes extended to entire organizations or hospitals, and to non-medical staff working in those facilities. These policies have devastating consequences for the health of women and girls, as they serve to block their access to sexual and reproductive health services, including abortion and modern contraception. For LGBTQI people, these policies often prevent them from accessing all health care, as providers are allowed to refuse to serve them altogether because they disapprove of LGBTQI people; for trans people, access to gender affirming care, such as hormonal therapy and surgery, is also often specifically targeted.

What do refusals mean in practice? When a provider refuses a patient access to abortion—a procedure which, by its nature, cannot be delayed—the patient may turn to an unqualified, clandestine provider, or try to terminate their pregnancy using unsafe methods, risking injuries or death, as well as, in some countries, criminal prosecution. They may also be forced to continue an unwanted pregnancy, often at great physical, emotional, social and economic cost. A patient who is turned away by a provider might be forced to travel great distances to seek healthcare, with the mental distress and economic hardship that entails.

Refusals place the burden of securing care on the patient, who must navigate a health care system often hostile to them, and possibly face repeated refusals. Policies or laws that allow refusals absolve providers and health care institutions of any duty of care, and in some cases, even actively defend their conduct. Under any of these scenarios, the patient's human rights to life, security of the person, non-discrimination on the basis of sex, and to the highest attainable standard of health are violated.[4]

Furthermore, we have found that policies allowing refusal of care have discriminatory and unjust effects. In the case of abortion, around the world, refusals affect most severely those who already face disadvantages and discrimination – poor women, young women and girls, women living in rural areas, indigenous women, undocumented and migrant women, women of color and women belonging to ethnic and religious minorities. Wealthier women by and large suffer few consequences from policies and laws that allow for refusals of care, as they have the financial and other resources to procure the services they need.

Policies that allow for refusals are also discriminatory on their face, since they appear to be targeting two very specific groups: women and girls in need to reproductive health care, and LGBTQI people. In both cases, denying these persons the care they seek affects their dignity and autonomy, and the security of their person. For women and girls, control of their body and reproduction is fundamental to the realization of a host of their other rights – from education to employment to political participation. Control of reproduction is so embedded in our current understanding of the potential and capacities of women, that we have perhaps forgotten the dire impact that repeated pregnancies have on women's personhood. For LGBTQI people, being denied health care altogether or being, as a trans person, denied gender-affirming care because a provider objects to who they are, is a similar affront to their very being.

Refusals of care also condone and reinforce stigma, which already constitutes a significant barrier to care. In 2011, the UN Special Rapporteur on the Right to Health issued a watershed report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health that highlighted the negative impact of legal restrictions, including "conscientious objection." "These laws make safe abortions and post-abortion care unavailable, especially to poor, displaced and young women," the Rapporteur stated. The Special Rapporteur noted that "conscientious objection" reinforces the stigma of abortion as an "objectionable" practice. He emphasized that "the marginalization and vulnerability of women as a result of abortion-related stigma and discrimination perpetuate and intensify violations of the right to health."[5] The Special Rapporteur's report reinforced recommendations issued by the Committee on the Elimination of Discrimination Against Women (CEDAW) as far back as 1999; at the time, the CEDAW Committee had stated in its General Recommendation Number 24 on article 12 on women and health that it is discriminatory for states to refuse to provide certain reproductive health care services that only women need.[6]

Reflections from a global convening on refusals of care

In 2017, IWHC and our partner Mujer y Salud en Uruguay (MYSU) co-organized a global convening of 45 experts from 22 countries in Montevideo, Uruguay, to examine the growing issue of refusals of care based on the religion or conscience of the provider. The experts reviewed a number of country cases from various continents, as well as the state of international law on the subject.

IWHC and MYSU's 2017 report *Unconscionable* documents these examples and the conclusions of the convening. In Uruguay, for example, studies by MYSU showed conscience claims on the rise since the enactment of Uruguay's 2012 law that allowed abortion upon request. In rural areas

of western and northern Uruguay, 60-80 percent of obstetrician-gynecologists refused to provide abortion services, while in the South, 30 percent of obstetrician-gynecologists objected. The prevalence of conscience claims also differed based on the type of facility. In Montevideo, 53 percent of providers working in public primary care facilities refused to provide abortions; at Médica Uruguay, a private facility in Montevideo, 27 percent of providers refused to do so; while at a specialized women's hospital, only 15 percent refused. Despite the legalization of abortion in Uruguay, access remained predicated on one's location and access to private and specialized providers. This caused hardship and worse health outcomes for poor, rural and other women in vulnerable situations.

The same has proven true in the United States. Existing United States policies, including statutory provisions like the Church Amendments, allow recipients of federal funds to refuse to provide medical services on the basis of the providers' religious beliefs[7]. One in six hospital beds in the United States is in a hospital owned by or affiliated with a Catholic health system; these are governed by "Ethical and Religious Directives" issued by the US Conference of Catholic Bishops (USCCB), rather than by medical professionals. The Directives prohibit a range of reproductive health services, including contraception, sterilization, many infertility treatments, and abortion, even when a woman's health or life is jeopardized by a pregnancy. Patients seeking these services are turned away, and forced to spend additional time, effort, and resources to find alternative providers, endangering their health and lives. This is of particular concern for marginalized groups, who already face significant disparities in health care access. For example, a 2018 report revealed that women of color are more likely to access Catholic hospitals, and thus disproportionately rely on religiously restricted reproductive health care. Since women of color in the United States experience significantly worse reproductive health outcomes than white women—with black women facing the greatest disparity, as they are 243 percent more likely to die from pregnancy or childbirth-related causes than white women—policies that allow refusals compound the danger to their health and lives.[8]

The *Unconscionable* Report noted that international human rights standards do not guarantee the right to "conscientious objection" for health care providers. On the contrary, treaty monitoring bodies have called for *limitations* on the exercise of conscience claims when states do allow them. The experts at the convening concluded that the denial of health care based on a provider's personal beliefs is a violation of patients' human rights. They outlined concrete examples of how policies that prioritize providers' conscience over patients' right to nondiscrimination and health care have harmed the women seeking care, and discussed what should be done to ensure patients can access the care they need and want.

Of particular concern was the fact that many policies seemed to be placing the onus of securing care on the woman, girl, or the LGBTQI person, with the providers and hospitals suffering none of the consequences of their refusal. In that respect, refusals of care differ from true "conscientious objection."

In the context of military service, human rights bodies have recognized the right to conscientious objection. Yet, there are least two differences between conscientious objection in that context that make it inappropriate to draw an analogy to refusals to provide or take part in a medical procedure.

First, so far as the military is concerned, conscientious objection applies to conscripts, not to those who have voluntarily entered the military profession. Those who choose to become military professionals are expected to carry out all the lawful tasks of the military; they may not pick and choose which tasks they will carry out or which battle they will fight. Second, conscripts who are accorded status as conscientious objectors must perform alternate service. This typically involves public service performing dangerous or unpleasant work for a period equivalent to the time they would otherwise spend in the military. It includes such work as serving as ambulance drivers in battlefield areas while not carrying a weapon. Thus, the person who refuses to serve in war is also the one to bear the consequences of their objection to military service. By contrast, providers who deny women or LGBTQI people health care suffer none of the consequences.

The experts assembled in Montevideo called for a reversal of that burden, and for providers and hospitals to bear an affirmative duty to ensure that care is provided in the case of a refusal. Passive referrals, where the patient is simply sent on to the next provider, are insufficient, and have been shown to fail to guarantee care. At the same time, experts noted that policies that mandate active referrals, where health care providers have the obligation to refer a patient to a provider willing to meet their health needs, have also proven to be insufficient due to a lack of compliance and enforcement.[9]

The example of Sweden, where anyone who wishes to practice in a specialty of medicine must agree *a priori* to perform all of the medical acts normally expected of that discipline, was discussed as an interesting systemic approach to preserving the rights of patients without limiting the religious freedom of any particular individual.[10] This approach was recently upheld by the European Court of Human Rights, which refused to hear a case brought by two midwives who argued that Sweden's policy discriminated against them on the basis of religion and violated their rights to freedom of conscience. The court noted that "Sweden provides nationwide abortion services and therefore has a positive obligation to organize its health system in a way as to ensure that the effective exercise of freedom of conscience of health professionals in the professional context does not prevent the provision of such services."[11]

The Montevideo experts also noted that medicine, as a profession that enjoys a lucrative and prestigious monopoly with significant authority, must accept professional obligations that go beyond what ordinary persons – for example, bakers of wedding cakes – can be compelled to. It would seem a reasonable requirement for persons training in obstetrics and gynecology to be prepared to provide the full panoply of services commonly expected of those disciplines – just as an emergency room physician would be expected to provide blood transfusions, even though certain religions find them objectionable. Experts also debated whether anyone can claim a right to practice obstetrics, and why providers who do not want to provide abortion or modern contraception, don't simply choose another of the many specialties in medicine.

Testing limitations on religious freedoms

The International Covenant on Civil and Political Rights (ICCPR), in its Article 18, recognizes that freedom to manifest one's religion or beliefs may only be limited in rare cases, which include the protection of the fundamental rights and freedoms of others.[12] There is, therefore, no unlimited

freedom of religion when that freedom violates the rights of others. How does one, then, reconcile these "competing claims"?

Human rights courts and treaty bodies have developed a test to establish whether a measure limiting a non-absolute right, such as freedom of religion, is justifiable. Any limitations must be established by law; serve a legitimate aim or public purpose; be necessary to achieve the public purpose, be proportionate to the legitimate aim or public purpose, i.e. the least onerous possible to achieve that aim, and, crucially, be non-discriminatory. Only when all these criteria are met, can a limitation of religious freedom be considered allowable under international law.[13]

The question for human rights bodies is, what constitutes an impermissible violation of the right to freedom of conscience and religion when it comes to providing health care? Can policies compel institutions to ensure a patient has access to care when individuals within those institutions refuse? Can a refusing physician be compelled to ensure that the patient is referred to a physician who will provide care? Can a state, health institution or system refuse to employ someone who refuses fulfill the stated responsibilities and requirements of the position?

Treaty monitoring bodies – including for those treaties the United States is a party to – have espoused the view that limitations of religious freedom along these lines are in fact permissible. The Human Rights Committee, the body that monitors state compliance with the ICCPR, has issued numerous comments to national governments encouraging them to take action to ensure that providers do not hinder women's access to abortion services because of their own religious views. In 2017, for example, the Committee, while reviewing Italy's compliance, expressed "concern about the reported difficulty in accessing abortion owing to the high number of physicians who refuse to perform abortion for reasons of conscience" and urged the state to take "measures necessary to guarantee unimpeded and timely access to legal abortion services in its territory, including by establishing an effective referral system for women seeking such services."[14] The Committee on Economic, Social, and Cultural Rights issued a 2016 general comment recommending that all countries establish norms to guarantee access to sexual and reproductive health care services.[15] The Committee Against Torture has issued numerous opinions raising concerns about policies allowing providers to refuse reproductive health care, and urging states to ensure access to care.[16] Human rights treaty bodies have also affirmed that blanket claims to "conscientious objection" must never be exercised by institutions.[17]

Regional human rights mechanisms have taken similar positions. In the Americas, the Inter-American Court on Human Rights uses the standards established by the Colombian Constitutional Court's 2008 decision, which limited the use of conscience claims in abortion services after a thirteen-year-old girl was refused an abortion by a healthcare facility, resulting in a forced pregnancy as a result of rape.[18] In Africa, where the main legal instrument for the protection of women's rights – the Maputo Protocol – explicitly recognizes abortion as a human right under certain circumstances, the African Commission on Human and Peoples' Rights issued a 2014 General Comment calling on states' parties to "particularly ensure that health services and health care providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third parties or for reasons of conscientious objection."[19]

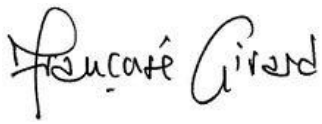
Most recently, the UN Special Rapporteur on Freedom of Religion reinforced these standards in his 2020 annual report. His recommendations expressly call upon governments to "ensure that legal protections for individuals to manifest their religion or belief, such as in healthcare settings, do not have the effect of denying women, girls or sexual orientation or gender identity minorities the right to non-discrimination or other rights; in all cases, States should ensure the right to physical and mental integrity as well as their right to health, including reproductive health, for women, adolescents and LGBTQI people and effective access to reproductive health services and comprehensive sexuality education, in line with international standards."[20]

Refusals of care, we should note, also run counter to medical ethics, which oblige health providers to respect the autonomy of the patient, to "do no harm" to the patient, to be of benefit and to take positive steps to help the patient, and to act fairly and without discrimination. The World Health Organization (WHO)'s safe abortion guidance relies on medical ethics to conclude that, if a referral is not possible, the objecting provider is obligated to provide safe abortion and prevent risks to the woman's health. Any person who presents with complications due to abortion must also receive treatment with urgency and respect, as would any other emergency case. To refuse to do so would run counter to a provider's professional objectives and ethical duties, and risk the health and well-being of the patient.[21]

The international human rights system has elaborated on these critical protections because they are fundamental to the ability of women, girls, and members of marginalized groups to enjoy their human rights. Policies that elevate religious freedom at the expense of other human rights, will continue to cause suffering, hardship, injury, and even death when women are turned away by providers, experience delays in accessing needed services, or otherwise denied critical care.

As such, the International Women's Health Coalition strongly urges the Commission to promote and uphold the international system of human rights in its totality; to reaffirm the United States government's commitment to the international human rights framework as defined by the UDHR and subsequent human rights treaties; to endorse it as a body of law that recognizes and responds to our growing awareness of threats to marginalized groups, including women, girls, and LGBTQI people; and to reiterate that the rights recognized in both the ICCPR and ICESCR are indivisible, interdependent, and enjoyed by all people, regardless of what identity they have, what their reproductive functions are, or who they love. Such a report would uphold the greatest standard of United States leadership in pursuit of human rights and would help safeguard the rights of women and girls around the world.

Sincerely,



Françoise Girard

President

[1] President Emeritus of the Open Society Foundations, co-founder and former executive director of Human Rights Watch, and former executive director of the American Civil Liberties Union https://iwhc.org/boards/aryeh-neier/.
[2] See U.S. Dep't of State, Department of State Commission on Unalienable Rights, 84 Fed. Reg. 25109, 25109 (May 30, 2019).
[3] During the Commission's third meeting (held on 12/11/19), Commissioner David Pan responded to remarks by Michael Abramowitz of Freedom House regarding concerns over the Commission's apparent desire to create a "hierarchy of rights," asking Mr. Abramowitz if he would "support that same prioritization that we want to do." The Commission also reproduced a discussion regarding the "prioritization" of rights in the published "minutes" of the third meeting. See https://www.state.gov/u-s-department-of-state-commission-on-unalienable-rights-minutes-3/.
4 "International Covenant on Civil and Political Rights," adopted and opened for signature December 16, 1966, https://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf; "International Covenant on Economic, Social and Cultural Rights," adopted and opened for signature December 16, 1966, https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf
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[6] The Committee on the Elimination of Discrimination against Women, "General Recommendation No. 24: Article 12 of the Convention (Women and Health)," 1999, http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf.
[7] 42 U.S.C. § 300a-7(c) (Church Amendment to the Health Programs Extension Act of 1973 §401). https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapVIII-sec300a-7.pdf

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[9] L.A. Keogh et al. "Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers," BMC Med Ethics 20, no. 11 (2019). https://doi.org/10.1186/s12910-019-0346-1; M. Truong and S. Wood, "Unconscionable: when providers deny abortion care," International Women's Health Coalition (2017). https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/
[10] Federation of Catholic Families in Europe (FAFCE) v. Sweden, No. 99/2013 (European Committee of Social Rights March 17, 2015). https://www.coe.int/en/web/european-social-charter/processed-complaints/-/asset_publisher/5GEFkJmH2bYG/content/no-99-2013-federation-of-catholic-family-associations-in-europe-fafce-v-sweden?inheritRedirect=false; Christian Fiala et al., "Yes We Can! Successful Examples of Disallowing 'Conscientious Objection' in Reproductive Health Care," The European Journal of Contraception & Reproductive Health Care 21, no. 3 (2016): 201–6.
[11] Grimmark v. Sweden, No. 43726/17 (European Committee of Human Rights February 11, 2020) http://hudoc.echr.coe.int/eng?i=001-201915
[12] "International Covenant on Civil and Political Rights," adopted and opened for signature December 16, 1966, https://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf
[13] Grimmark v. Sweden, No. 43726/17 (European Committee of Human Rights February 11, 2020) http://hudoc.echr.coe.int/eng?i=001-201915; "Limitations permitted by human rights law," UNODC Education for Justice Initiative (2018). https://www.unodc.org/e4j/en/terrorism/module-7/key-issues/limitations-permitted-by-human-rights-law.html
[14] Human Rights Committee, "Concluding Observations on the Sixth Periodic Report of Italy" (International Covenant on Civil and Political Rights, May 1, 2017), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/ITA/CO/6&Lang=En.
[15] Committee on Economic, Social and Cultural Rights, "General Comment No. 22 on the Right to Sexual and Reproductive Health" (United Nations Economic and Social Council, 2016), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en.
[16] Committee against Torture, "Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Poland" (Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, December 23, 2013), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/C/POL/CO/5-

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[19] The African Commission on Human and Peoples' Rights, "General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa," 2014, http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_ comment2_rights_of_women_in_africa_eng.pdf.

[20] Report of the Special Rapporteur on freedom of religion or belief, A/HRC/43/48, February, 2020, para 77(a)(vi).

[21] Department of Reproductive Health and Research, "Safe Abortion: Technical and Policy Guidance for Health Systems" (World Health Organization, 2012), http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/