



REPRODUCING PATRIARCHY

How the Trump Administration has Undermined Women's Access to Reproductive Health Care

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Global Justice Center
Human Rights Through Rule of Law



Leitner Center
for International Law and Justice
AT FORDHAM LAW SCHOOL, NEW YORK CITY



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I. INTRODUCTION

Since taking office, the Trump administration has unleashed a blitz of regressive and discriminatory laws and policies. Of the many issues under attack, few have seen similar ire and attention as sexual and reproductive health and rights (SRHR). Both internationally and domestically, the Trump administration has engaged in a broad, systematic effort to undermine reproductive choice and bodily autonomy.

Internationally, the Trump administration has attempted to undermine international law and institutions that protect SRHR and has cut funding for organizations that promote reproductive rights and services. Within days of taking office, President Trump reinstated and expanded the Global Gag Rule, an onerous policy that limits funding for foreign non-governmental organizations that provide abortion services as a method of family planning and restricts a wide variety of speech about abortion services, research, and advocacy, with well-documented detrimental impacts on sexual and reproductive health, HIV and AIDS services, and maternal mortality.¹ The Trump administration has attempted to erase language on SRHR from governmental and inter-governmental documents, such as in the State Department's annual human rights report, United Nations (UN) negotiated documents, and UN resolutions.² In 2019, the United States (US) cut funding to the Organization of American States (OAS), a quasi-governmental regional body, for allegedly violating restrictions on lobbying for abortion rights by commenting on state practice on reproductive choice.³ Most recently, the unlawfully formed and operated State Department's Commission on Unalienable Rights, created to advise the Secretary of State on human rights and intended to inform US foreign policy, issued a draft report which misrepresents the nature of the international human rights framework and inaccurately frames access to abortion as a "divisive social and political controvers[y]" rather than an established right under international law.⁴

The Trump administration's attacks on reproductive rights are not limited to international and foreign-policy related targets. Domestically, the Trump administration has also taken steps to erode protections for SRHR, including by targeting the Title X Family Planning program with new regulations, *Compliance with Statutory Program Integrity Requirements* (the Final Rule), published on March 4, 2019. The Final Rule imposes a number of new physical, financial, and administrative burdens on clinics receiving Title X funding in an effort to restrict women's access to particular reproductive health information and services. As this report documents, the Final Rule violates fundamental human rights and the US' obligations under international human rights law. Although the US has attempted to minimize or ignore its international human rights obligations, as shown in the recent Commission on Unalienable Rights draft document, this report reviews the substantive obligations of the US and the binding nature of these legal obligations.

¹ The Mexico City Policy: Memorandum for the Secretary of State, the Secretary of Health and Human Services, and the Administrator of the United States Agency for International Development, 82 Fed. Reg. 8495 (Jan. 23, 2017); Global Justice Center & Center for Health and Gender Equity, *Censorship Exported: The Impact of Trump's Global Gag Rule on the Freedom of Speech and Association* (Jan. 2019), https://globaljusticecenter.net/files/Censorship_Exported_Impact_of_Trumps_GGR.pdf.

² Akila Radhakrishnan & Elena Sarver, *Canary in the Coal Mine: Abortion & The Commission on Unalienable Rights*, 4.1 COLUM. HUM. RTS. L. REV. ONLINE 1, 14-16 (2019), http://hrlr.law.columbia.edu/files/2019/12/Radhakrishnan_Sarver_FINAL.pdf.

³ *Id.* at 16; Remarks to the Press, Michael R. Pompeo, Secretary of State (Mar. 26, 2019), <https://www.state.gov/remarks-to-the-press-7/>.

⁴ U.S. Dep't of State Commission on Unalienable Rights, *Draft Report of the Commission on Unalienable Rights*, 24 (July 16, 2020), <https://www.state.gov/wp-content/uploads/2020/07/Draft-Report-of-the-Commission-on-Unalienable-Rights.pdf>.

Part II of this report provides background information on the establishment and administration of the Title X program and specifics of the Final Rule amending how Title X funding should be directed. Part III addresses the impact of the Final Rule restrictions on clinics' participation in the Title X program and on access and quality of medical care for patients. It also considers specific populations likely to be disproportionately impacted by the Final Rule changes, including women, low-income families, people of color, non-English speakers, people living in rural areas, people with disabilities and LGBTQ communities.

Part IV examines whether the new Title X regulations are consistent with the US' international legal obligations. It first considers whether the Final Rule violates treaties the US has signed and ratified, including the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Racial Discrimination (CERD), and the Convention Against Torture (CAT). It then examines whether the Final Rule would defeat the object and the purpose of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Rights of the Child (CRC), three treaties the US has signed but not yet ratified. For the reasons discussed below, the Final Rule violates a number of the rights guaranteed by treaty obligations binding on the US, including the rights to life, equality, privacy, freedom from gender, racial and ethnic discrimination, freedom from cruel, inhuman and degrading treatment and freedom of speech and association, and must therefore be revoked.

II. TITLE X

Title X of the Public Health Service Act (Public Law 91-572),⁵ was enacted in 1970 to fund projects that would provide family planning and related services for low-income women. It evolved from the Johnson administration's War on Poverty, which was designed to promote economic development and avert welfare dependency.⁶ Research at the time showed that disparities in birth rate for low-income women and higher-income women were due to inequitable access to contraceptives.⁷ Research also revealed that unintended pregnancies increased poverty and reliance on public assistance and reduced women's ability to participate in the workforce or complete an education.⁸ To alleviate poverty and improve the health of women and children, the federal government made its first grants to support family planning services in 1965, but the benefits and services varied widely since states largely controlled the funding for these programs.⁹ Title X was enacted in 1970 during the Nixon administration to more systematically address these issues.¹⁰ President Nixon stated that the purpose of the act was to "provide adequate family-planning services . . . to all those who want them but cannot afford them."¹¹ Title

5 UNITED STATES STATUTES AT LARGE, PL 91-572, December 24, 1970, 84 Stat. 1504.

6 Cheryl A. Vamos, et. Al., *Approaching 4 Decades of Legislation in the National Family Planning Program: An Analysis of Title X's History From 1970 to 2008*, National Center for Biotechnology Information, U.S. National Library of Medicine (Nov. 2011) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222394/#bib8>.

7 Rachel Benson Gold, Title X: *Three Decades of Accomplishment*, Guttmacher, https://www.guttmacher.org/sites/default/files/article_files/gro40105.pdf.

8 *Id.*

9 *Id.*

10 *Id.*

11 Richard Nixon, *Statement on Signing the Family Planning Services and Population Research Act of 1970*, PES1, THE AMERICAN PRESIDENCY PROJECT (Dec. 26, 1970), <https://www.presidency.ucsb.edu/documents/statement-signing-the-family-planning-services-and-population-research-act-1970>.

X funds have never been permitted to be used to fund abortions as a method of family planning.¹² Fifty years after its enactment, Title X continues to be the only federal program dedicated solely to the provision of family planning services and related preventative health care.¹³

In addition to providing “natural family-planning methods, infertility services, and services for adolescents; highly effective contraceptive methods; breast and cervical cancer screening,”¹⁴ Title X-funded clinics also offer services such as community education, HIV-prevention education, outreach services, patient education and counseling, physical assessments for both women and men, and STI testing.¹⁵ For many individuals, Title X is their entry into the healthcare system. There are other statutory programs that provide funding for family planning services, including Medicaid and state appropriations, but many women do not qualify for or cannot access Medicaid services owing to the strict eligibility requirements and low provider reimbursement rates.¹⁶ 65% of Title X patients have incomes at or below the federal poverty line, meaning, for single-person households, they earn less than \$12,140 annually.¹⁷ Two-thirds of Title X clients are people of color.¹⁸ Because Title X is dedicated to servicing patients with lower incomes, the clinics charge fees on a sliding scale.¹⁹ A woman with an income below the federal poverty level may receive services free of charge.²⁰ Women with incomes between 100% and 250% of the poverty level are charged according to the sliding fee schedule.²¹ For adolescents, fees are based on their incomes rather than their parents’, and many adolescents receive services free of charge.²²

ADMINISTRATION AND BUDGET OF THE TITLE X PROGRAM

The Office of Population Affairs (OPA), housed in the US Department of Health and Human Services (HHS), administers Title X and reviews and awards grants through regional offices across the U.S.²³ A public or nonprofit private entity that offers a “broad range” of acceptable family-planning methods is eligible to apply for Title X funding.²⁴ Grants are competitively awarded and applicants must abide by reporting requirements and standards that apply to all clinics serving women under the Title X program.²⁵ According to OPA’s 2018 annual report, 99 grants were awarded to 49 state and local health departments and 50 nonprofit family planning agencies.²⁶ These in turn funded 3,954 service sites operated either by grantees or subrecipients in all 50

12 42 U.S.C.A. § 300a-6.

13 Gold, *supra* note 7.

14 42 U.S.C.A. § 300.

15 Vamos et al., *supra* note 6.

16 *Id.*

17 National Family Planning and Reproductive Health Association, Key Facts About Title X, available at <https://www.nationalfamilyplanning.org>.

18 Laurie Sobel, New Title X Regulations: Implications for Women and Family Planning Providers, 4, available at <https://www.kff.org/womens-health-policy/issue-brief/new-title-x-regulations-implications-for-women-and-family-planning-providers/>

19 Vamos, et al., *supra* note 6.

20 Gold, *supra* note 7.

21 *Id.*

22 *Id.*

23 Vamos, et al., *supra* note 6.

24 *Id.*

25 Subpart A—Project Grants for Family Planning Services, ELECTRONIC CODE OF FEDERAL REGULATIONS (Jan. 23, 2020), https://www.ecfr.gov/cgi-bin/text-idx?SID=c1c1bd72e13f7230f1e8328fa52b57899&mc=true&nde=sp42.1.59.a&rgn=div6#se42.1.59_14; Gold, *supra* note 7.

26 OFFICE OF POPULATION AFFAIRS, *Title X Family Planning Annual Report 2018 Summary*, <https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2018-national-summary.pdf>

states, the District of Columbia, and eight U.S. territories.²⁷ In 2018, Title X-funded providers served 3.9 million family planning users (individuals with at least one family planning encounter at a Title X service site), a decrease from the over 5 million served in 2008.²⁸

Congress dispenses funding annually for Title X.²⁹ In fiscal year 2018, the Title X program received approximately \$286.5 million in federal funding,³⁰ a decrease from its highest budget of \$317.4 million in 2010.³¹ This decrease was justified as part of an effort by the federal government to reduce the federal deficit.³² There have been other pressures on the funding of the Title X program in the past decade. Between 2011 and 2018, the Republican-controlled US House of Representatives voted to defund the program six times;³³ however, these efforts failed because the US Senate continued to support Title X.³⁴ Even before the budget cuts, however, the funding for Title X had decreased dramatically.³⁵ For example, in 1980, Title X provided 1 of every 2 dollars spent on publicly-funded family planning services, an amount that decreased to 1 of every 10 dollars in 2006.³⁶ Despite the efforts to cut funding for Title X, studies have shown that for every dollar the government spends on family-planning services, three dollars are saved in Medicaid costs for pregnancy-related and newborn care.³⁷

2019 COMPLIANCE WITH STATUTORY PROGRAM INTEGRITY REQUIREMENTS (THE “FINAL RULE”)

HHS has issued regulations since Title X was first enacted, determining how Title X funding is directed. On March 4, 2019, HHS published the Final Rule, amending how Title X funding should be allocated. According to OPA, the changes to the regulations are meant to ensure that Title X funds are not used for abortion services and to clarify grantees’ obligations under Title X regarding transparency, nondirective services, and recordkeeping.³⁸ Whatever the stated purpose of the Final Rule, the practical effects of the revised regulations will likely be to reduce the number of clinics available to provide family planning services and to reduce the range of family planning services and the quality of medical care offered to low income women.

This section will briefly discuss several of the changes introduced by the 2019 amendments, including: (1) amending the definition of what constitutes acceptable methods of family planning; (2) requiring physical and financial separation between projects’ Title X activities and abortion services; (3) removing the requirement for nondirective abortion counseling and prohibiting referrals for abortion services; (4) encouraging parental involvement in family planning services

27 *Id.*

28 *Id.*; Vamos, *supra* note 6.

29 *Title X Budget & Appropriations*, NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASS’N, https://www.nationalfamilyplanning.org/title-x_budget-appropriations

30 *Funding History*, OFFICE OF POPULATION AFFAIRS, <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html>

31 *Id.*

32 NATIONAL FAMILY PLANNING, *supra* note 17.

33 *Id.*

34 *Id.*

35 Vamos, *supra* note 6.

36 *Id.*

37 Gold, *supra* note 7.

38 *Id.*; Section 1008 of Title X of the Public Health Services Act states that “[none] of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.” 42 U.S.C. § 300a-6.

for minors; (5) imposing a “comprehensive health services” requirement; and (6) increasing the administrative and reporting requirements for and oversight of recipients of Title X funds.

Definition of Acceptable Methods of Family Planning

Prior to the 2019 amendments, OPA had required Title X grantees to follow the Centers for Disease Control (CDC) recommendations on what constituted quality family planning and to offer a variety of Food and Drug Administration (FDA)-approved contraceptive methods.³⁹ Title X projects were required to “provide a broad range of acceptable and effective *medically approved* family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).”⁴⁰ The Final Rule eliminates “medically approved” from the regulatory requirement. Under the Final Rule, family planning can include a range of “acceptable and effective choices, which may range from choosing not to have sex to the use of other family planning methods and services to limit or enhance the likelihood of conception (including contraceptive methods and natural family planning or other fertility awareness-based methods) and the management of infertility (including adoption).”⁴¹

This regulatory change now welcomes projects that refuse to offer a range of FDA-approved contraceptive methods.⁴² Prior to the amendment, organizations were able to participate in Title X even if they provided only a single method of family planning, as long as they offered a broad range of family planning services.⁴³ The Final Rule includes language that is more permissive, providing that “projects are not required to provide every acceptable and effective family planning method,” thereby encouraging participation of service providers that provide only one family planning method or that encourage abstinence as the sole method of family planning.

Imposition of New Physical and Financial Separation Requirements

As noted above, Title X funding has never been permitted to fund abortion as a method of family planning.⁴⁴ Title X projects historically have had to keep their abortion activities separate and distinct from their Title X-funded family planning activities. This had been interpreted to mean that Title X programs could not use Title X funds to pay for abortions and had to keep all abortion-related activities financially separate from their Title X activities.⁴⁵

The Final Rule now additionally requires Title X projects to be “physically and financially separate from prohibited activities,” such as abortion services, counseling, and referrals.⁴⁶ This requires projects to now have separate entrances, waiting and exam rooms, separate staff, separate accounting and medical records, separate phone numbers, websites and email addresses, and other requirements for abortion referrals and abortion-related activities.⁴⁷ The requirement

39 Sobel, *supra* note 18.

40 Grantee Guidance: Documenting Compliance with the 2019 Title X Final Rule Compliance with Statutory Program Integrity Requirements (*emphasis added*).

41 Title X Family Planning Program: 2019 Final Rule, CONGRESSIONAL RESEARCH SERV. (May. 20, 2019), <https://fas.org/sgp/crs/misc/IF11142.pdf>.

42 *Analysis of 2019 Final Rule on Title X Family Planning Program*, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASS’N (Mar. 4, 2019), <https://www.nationalfamilyplanning.org/file/2019-Title-X-Final-Rule---Detailed-Analysis---3.4.2019-FINAL.pdf>.

43 *Id.*

44 See *supra* Part II.A.

45 Sobel, *supra* note 18.

46 *Id.*

47 *Id.*

of physical and financial separation covers both the provision of abortion as well as abortion referral and counseling (other than by physicians or “advanced practice providers”).⁴⁸ It is a huge financial burden for reproductive health providers to maintain separate facilities for these purposes and may result in their inability to provide abortion-related services if they also want to keep Title X funding.

Elimination of Nondirective Counseling Requirement and Prohibition of Abortion Referrals (the “gag rule”)

Prior to the 2019 Final Rule, Title X required that Title X projects provide nondirective counseling to pregnant patients. This meant that pregnant patients would receive information about prenatal care, childcare, foster care, adoption, and termination of the pregnancy. The Final Rule now instead mandates that Title X Projects refer all pregnant patients for prenatal care without requiring counseling on patients’ other options.

Moreover, Title X projects are prohibited from providing abortion referrals. This “gag rule” provision mandates that a Title X provider “may not perform, promote, refer for, or support abortion as a method of family planning, nor take any other affirmative action to assist a patient to secure such an abortion.”⁴⁹ If a patient requests an abortion referral, a Title X provider may only provide a list of “comprehensive primary health care provider[s] for medically necessary prenatal health care.”⁵⁰ The list may include healthcare providers who perform abortions, but that is not required, and Title X project personnel may not indicate which providers do perform abortions.⁵¹

HHS maintains that requiring nondirective counseling and abortion referrals violates federal conscience laws.⁵² Elimination of the nondirective counseling requirement may permit health care providers to practice medicine as their conscience dictates, but not as requested by their patients or by what is in a patient’s best interest.⁵³ HHS has claimed that this change will increase participation in the Title X program of health providers who are morally opposed to abortion, but HHS fails to acknowledge the negative impact this change will have on the quality of care and information that women are likely to receive. Even if a patient is ultimately able to access abortion services, delaying that care can drive up costs and reduce the number of available providers.⁵⁴

48 NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASS’N, *supra* note 17. The Final Rule defines an Advanced Practice Provider as a “medical professional who receives at least a graduate level degree in the relevant medical field and maintains a license to diagnose, treat, and counsel patients.” 42 CFR § 59.2.

49 42 C.F.R. § 59.14(a).

50 *Id.*

51 *Id.* The Final Rule allows referrals for abortion “in cases in which emergency care is required” such as when an ectopic pregnancy is discovered. 42 C.F.R. § 59.14(b)(2).

52 Sobel, *supra* note 18. Federal conscience statutes prevent recipients of federal funding from discriminating against health providers who refuse to provide certain health services based on religious or moral grounds. See Conscience Protections for Healthcare Providers, <https://www.hhs.gov/conscience/conscience-protections/index.html>.

53 Sobel, *supra* note 18.

54 Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, PERSPECTIVES SEXUAL & REPRODUCTIVE HEALTH (June 2017), <https://www.guttmacher.org/journals/psrh/2017/04/barriers-abortion-care-and-their-consequences-patients-traveling-services>.

Encouragement of Family Participation

Though all Title X services are confidential and parental notification or parental consent is not required to provide family planning services to minors, the Final Rule requires Title X grantees to encourage family participation in medical decisions to the extent possible.⁵⁵ It also requires Title X providers to maintain records that “document the specific actions taken to encourage such family participation (or the specific reason why such participation was not encouraged)” except where the minor may be the victim of child abuse or incest.⁵⁶ This ignores Title X’s statutory limitation on encouraging family involvement only “to the extent practical.”⁵⁷ This new requirement may be especially harmful to minors who may not want their family to know that they are sexually active for a wide range of moral, cultural, religious, or other reasons.

Comprehensive Primary Health Services Requirement

The Final Rule now requires Title X projects to offer comprehensive primary health services onsite or to have a robust referral linkage with primary health providers who are in “close physical proximity.”⁵⁸ As explained by the American Medical Association (AMA), this requirement “is inappropriate since providing comprehensive primary care services is not a permissible use of Title X funds . . . Moreover, some stand-alone family planning clinics, especially in rural areas, may not be near primary health providers, and may not qualify for funding under this requirement.”⁵⁹ This new requirement is likely to further limit the number of service providers eligible for Title X funding.

Increased Oversight of Title X Grantees and Subrecipients

Prior to the Final Rule, OPA had oversight of Title X grantees, who in turn had oversight authority for their subrecipients. Under the Final Rule, OPA has direct oversight over all grantees and subrecipients, who are subject to new and onerous reporting requirements. These reporting requirements include detailed information about all subrecipients and services provided, how the grantee will “ensure adequate oversight and accountability for quality and effectiveness of outcomes among subrecipients,” and records of minor patients.⁶⁰ These recordkeeping requirements will be burdensome for providers and may disincentivize minors from accessing these services if they are not able to maintain their anonymity.⁶¹

Demonstrating Compliance

For organizations already receiving Title X funding, OPA has published a comprehensive guide on how to demonstrate compliance with the new regulations. Projects receiving Title X funding have to submit a written assurance stating that their project does not provide abortion services and

55 Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, 7751 (Mar. 4, 2019) (to be codified at 42 C.F.R. pt. 59).

56 42 C.F.R § 59.5 (a)(14); *Title X 2019 Guidance: Frequently Asked Questions*, HHS, <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/compliance-with-statutory-program-integrity-requirements/faqs/index.html>

57 NATIONAL FAMILY PLANNING, *supra* note 17.

58 Compliance with Statutory Program Integrity Requirements at 7747.

59 AMA opposes proposed rule on Title X family planning program (July 31, 2018), available at <https://www.ama-assn.org/press-center/press-releases/ama-opposes-proposed-rule-title-x-family-planning-program>.

60 Compliance with Statutory Program Integrity Requirements at 7750.

61 Sobel, *supra* note 18.

does not promote abortion services as a method of family planning.⁶² These organizations must also submit an action plan: (1) describing the steps that they will take to comply with the Final Rule, and (2) providing documentation needed for OPA to verify compliance.”⁶³

III. THE IMPACT OF THE FINAL RULE ON CLINICS’ PARTICIPATION IN TITLE X AND PATIENTS’ ACCESS TO HEALTHCARE

Since implementation of the Final Rule, Title X clinics have had to choose between continuing to accept Title X funding with the new Final Rule restrictions, or withdrawing from the funding program and risking a shutdown or limiting services if they are unable to make up the financial shortfall. Many sites that have chosen to remain in the Title X Program have done so to ensure that the clients who rely on them for services and resources continue to have access to these necessities. Title X sites that have withdrawn from the Title X program have done so to ensure they can comply with professional ethical obligations, preserve their First Amendment rights, and maintain the range and quality of services they provide to their clients.

IMPACT ON CLINICS THAT REMAIN IN THE TITLE X PROGRAM

Title X-funded clinics in small, rural communities or other medically underserved areas are often the only source of reproductive healthcare and education in the areas they serve.⁶⁴ Clinics in these areas understand the importance of their continued existence at maximum capacity, supported by the Title X funds. Without this funding, they would likely have to shut down over time, leaving the members of their communities without any form of family planning facilities, and especially services at an affordable price, near them.⁶⁵ In states with restrictive reproductive health laws, the clinics would not be widely affected by the new gag rule since their state laws have already whittled down the types of care and information such clinics are able to provide.⁶⁶ In Missouri, for example, there is only one clinic in the whole state that currently provides abortion services, making the question of abortion less likely to impact the operations and doctor-patient conversations in other clinics in the state.⁶⁷

62 Grantee Guidance: *Documenting Compliance with the 2019 Title X Final Rule Compliance with Statutory Program Integrity Requirements*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (Aug. 5, 2019), <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/statutes-and-regulations/compliance-with-statutory-program-integrity-requirements/grantee-guidance/index.html>.

63 *Id.*

64 Erin Heger, *We are Headed Toward a Public Health Crisis: Title X Clinics Grapple with Trump’s Gag Rule*, REWIRE (Sept. 2019), <https://rewire.news/article/2019/09/11/we-are-headed-toward-a-public-health-crisis-title-x-clinics-grapple-with-trumps-gag-rule/>.

65 *Id.*; The largest Title X Administrator in the United States, Essential Access Health, stated that they will remain part of the program and comply with the new regulations. Their reasoning echoes the above concerns, stating that their main goal is to provide the best reproductive healthcare they can while still receiving Title X funds. They highlight how critical these sites are to poor and low-income people who rely on these clinics for services even beyond reproductive care, including, cancer, STI and HIV screenings and treatments.

66 Some state laws, including AK, ID, KY, NB, SD and UT have laws that require doctors to inform clients there is a treatment that can reverse abortion, although the American Congress of Obstetricians and Gynecologists found this to be wholly unfounded. After Title X Regulation Changes: Difficult Questions For Policy Makers And Providers. HEALTH AFFAIRS (Sept. 24, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190923.813004/full/>.

67 Heger *supra* note 64.

Without Title X funding, sites have to look to outside sources for funding.⁶⁸ Many sites will not be able to keep their current staff, including medical staff, trainers, and educators, without federal funds.⁶⁹ Additionally, without Title X funding, sites may lose their eligibility for 340B Drug Pricing, which allows clinics to obtain many drugs, including contraceptives, at discount prices.⁷⁰ Faced with such constraints, a number of clinics have chosen to remain in the Title X program and abide by the Final Rule even if doing so limits the range and quality of family planning services they are able to provide.

IMPACT ON CLINICS THAT HAVE WITHDRAWN FROM TITLE X

Many Title X-funded clinics have opted to withdraw from the funding program rather than comply with the restrictions imposed by the Final Rule. Sites that have withdrawn from the Title X program do not want to continue accepting funds if it forces them to violate their ethical obligations and cede their constitutional rights while providing fewer services of lower quality.

The Final Rule's restrictions requiring providers to deny patients information needed to make informed medical decisions violates professional ethics obligations.⁷¹ The AMA *Code of Medical Ethics* details the conduct that medical professionals must uphold. The Final Rule violates the AMA Code's requirements that: (1) physicians must base their referral decisions on the patient's medical needs; (2) patients have a right to expect their physician to cooperate with other healthcare professionals; and (3) physicians must not withhold information without the patient's knowledge or consent except in emergencies.⁷² Doctors have also spoken about how these speech restrictions undermine the fundamental relationship of trust that should exist between a patient and a healthcare provider.⁷³ In addition, the AMA and many clinics have voiced serious concerns about the Final Rule's restrictions on providers' constitutionally protected free speech rights.

The largest of the Title X providers to withdraw in response to the Final Rule is Planned Parenthood, a nonprofit organization that provides reproductive healthcare in the United States and abroad. Planned Parenthood withdrew from the Title X program on August 19, 2019. Trump administration advisors reportedly presented the Final Rule to the President as a means of fulfilling his campaign promise to defund Planned Parenthood,⁷⁴ a longtime policy goal of conservative lawmakers and

68 Further discussed in *infra* III.B.

69 Brittni Frederiksen et al., *Data Note: Impact on New Title X Regulations on Network Participation*, KAISER FAMILY FOUNDATION 5, 6 (Sept. 2019), <https://www.kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation/>

70 *Id.*

71 "The CEO of Maine Family Planning, George Hill, stated that the new regulations "would fundamentally compromise the relationship our patients have with us as trusted providers of this most personal and private health care. It is simply wrong to deny patients accurate information about and access to abortion care." David Crary and Ricardo Alonso-Zaldivar, 'We Will Not Be Bullied': Planned Parenthood withdraws from US family-planning program, DEPARTMENT USA TODAY NEWS (Aug. 20, 2019), <https://www.usatoday.com/story/news/2019/08/19/planned-parenthood-withdraws-us-family-planning-funding/2055302001/>

72 Andis Robeznieks, *Judge says AMA is right: Title X gag rule violates ethics*, AMERICAN MEDICAL ASS'N (Apr. 30, 2019), <https://www.ama-assn.org/delivering-care/patient-support-advocacy/judge-says-ama-right-title-x-gag-rule-violates-medical>.

73 Testimony of Jamila Perritt, MD, MPH, FACOG Fellow, Physicians for Reproductive Health before the House Committee on Energy & Commerce, Oversight and Investigations Subcommittee (June 19, 2019), <https://docs.house.gov/meetings/IF/IFo2/20190619/109650/HHRG-116-IFo2-Wstate-PerrittMDMPHFACOGJ-20190619.pdf>; Julie Chor, *Don't Let Politics Come Between Me and My Patients*, N.Y. TIMES (July 25, 2018), <https://www.nytimes.com/2018/07/25/opinion/trump-title-x-abortion.html>.

74 See Jonathan Swan and Caitlin Owens, *Trump weighs cutting Planned Parenthood's Title X funds*, AXIOS (Apr. 30, 2018), <https://www.axios.com/trump-abortion-title-x-funding-planned-parenthood-301465b-a25b-4bbe-8f06-689143b4cede.html>.

anti-abortion activists.⁷⁵ Although Planned Parenthood represented only 13% of the nation's Title X clinics, it served 41% of Title X patients.⁷⁶ In some states, it has served most or even all Title X patients.⁷⁷ In Michigan, for example, Planned Parenthood served approximately 65% of the Title X clients in the state, putting pressure on other clinics to fill the gap created by Planned Parenthood's exit from the Title X program.⁷⁸ With more than half of its clinics located in rural, underserved, or designated "health professional shortage" areas,⁷⁹ it has been an indispensable source of healthcare where few others exist.

Although Planned Parenthood's withdrawal from Title X has garnered the most media attention due to the organization's size and scope, it was not alone in its decision to leave the program. Smaller providers have also left, such as Maine Family Planning, which has 47 health centers around the state⁸⁰ and is the only Title X recipient in the state of Maine.⁸¹ Overall, more than 600 clinics outside of the Planned Parenthood organization, or approximately 23% of Title X sites, have announced their withdrawal from the program and, with significantly less funding available, they will be forced to cut back on their services.⁸² A few clinics have already closed, while others have laid off large numbers of employees or instituted hiring freezes, reduced their hours, cut programs, and raised their fees or introduced fees for previously free services.⁸³

A number of states are withdrawing from the program as well, and some have already committed to filling the funding gap from state budgets. Among the states that announced plans to avoid compliance with the Final Rule are Hawaii, Illinois, Maryland, Massachusetts, New Jersey, New York, Oregon, and Washington.⁸⁴ It is unclear, however, how sustainable this effort will be. Washington, for example, has suggested that it will have to limit who is eligible for Title X-funded care or what services the program will continue to cover.⁸⁵ The Reproductive Health Unit of the Michigan Department of Health and Human Services is attempting to fill the gap created by

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- 75 See Julie Rovner, *The Decades-Long War on Planned Parenthood*, NEWSWEEK (Aug. 3, 2015) <https://www.newsweek.com/decades-long-war-planned-parenthood-359292>; see also Julie Rovner, *Planned Parenthood: A Thorn In Abortion Foes' Sides*, NPR (Apr. 13, 2011), <https://www.npr.org/2011/04/13/135354952/planned-parenthood-makes-abortion-foes-see-red>; see e.g., *85+ Pro-Life Groups to Trump Admin: Stop Funding Abortion Businesses like Planned Parenthood Under Title X*, SUSAN B. ANTHONY LIST (Mar. 1 2018), <https://www.sba-list.org/newsroom/press-releases/85-pro-life-groups-trump-admin-stop-funding-abortion-businesses-like-planned-parenthood-under-title-x>.
- 76 *Publicly Supported Family Planning Services in the United States*. GUTTMACHER INST, (Oct. 2019), <https://www.guttmacher.org/fact-sheet/publicly-supported-FP-services-US>.
- 77 Pam Belluck, *Planned Parenthood Refuses Federal Funds Over Abortion Restrictions*, N.Y. TIMES (Aug. 19, 2019), <https://www.nytimes.com/2019/08/19/health/planned-parenthood-title-x.html>.
- 78 Heger, *supra* note 64.
- 79 Testimony of Jamila Perritt, *supra* note 73.
- 80 *Fighting to Save Title X*, MAINE FAMILY PLANNING, <https://mainefamilyplanning.org/title-x/>.
- 81 *Reproductive Health, Rights, Justice: Submission to the United Nations Universal Periodic Review of United States of America, Third Cycle 36th Session of the UPR Human Rights Council*, CTR. FOR REPRODUCTIVE RIGHTS (May 2020), <https://reproductiverights.org/sites/default/files/2020-01/3rd%20US%20UPR%20-%20repro%20rights%20and%20justice%20stakeholder%20report.pdf>.
- 82 Frederiksen et al., *supra* note 69.
- 83 Nakisa B. Sadeghi & Leana S. Wen, *After Title X Regulation Changes: Difficult Questions For Policymakers And Providers*, HEALTH AFFAIRS (Sept. 24, 2019) <https://www.healthaffairs.org/doi/10.1377/hblog20190923.813004/full/>
- 84 Belluck, *supra* note 77; Jamie Ducharme, *Planned Parenthood Faces an Uncertain Road Without Title X Funding—and Patients May Struggle to Get Care*, TIME (Aug. 19, 2019), <https://time.com/5655500/planned-parenthood-title-x-funding/>.
- 85 Karen Pinchin, *With Planned Parenthood Out of Title X, Clinics Face "A Terrible Choice,"* PBS (Aug. 27, 2019), <https://www.pbs.org/wgbh/frontline/article/with-planned-parenthood-out-of-title-x-clinics-face-a-terrible-choice/>

Planned Parenthood’s withdrawal by developing a wider network of Title X providers. They are seeking local health departments and other federally qualified community health centers that have not participated in the Title X program previously.⁸⁶

The loss of Title X funds has other cascading effects that will harm providers nationwide, even where state governments are trying to provide relief. As noted above, Title X participation makes providers eligible for the 340B program, which provides federally funded clinics with discounted drugs.⁸⁷ In one example of the impact of ineligibility for these discounts, Public Health Solutions in Brooklyn, New York ran out of the HPV vaccine Gardasil, Nexplanon implants, Depo-Provera shots, and whooping cough vaccines.⁸⁸ Not only could they not afford to buy new drugs, but they were also required by law to either return or throw away any medications previously purchased with federal money.⁸⁹ State emergency funds have helped keep the doors open and staff employed in clinics like Public Health Solutions, but without access to the 340B program, these clinics struggle to provide the same quality of care as before.⁹⁰

IMPACT ON ACCESS AND QUALITY OF CARE FOR PATIENTS

Conservative politicians frequently claim that other healthcare providers could easily fill the void left by Planned Parenthood,⁹¹ but the reality suggests otherwise. To cover the gap in contraceptive services, for example, sites remaining in the Title X program will need to take on 70% more contraceptive cases.⁹² It seems inevitable that the remaining Title X clinics will be overwhelmed, especially with a very short time frame to ramp up staff and supplies.⁹³ The resulting longer wait times to schedule an appointment could lead to delays in accessing care (as could the burden of traveling longer distances if the available clinics are located farther from home), and patients may miss out on time-sensitive services like STI and cancer screenings, or may lapse in their contraceptive use.⁹⁴

The number of patients who rely on Title X for these types of care is significant. In 2016, Title X clinics’ screening and vaccination services prevented an estimated 4,600 cases of pelvic inflammatory disease and 740 cases of cervical cancer, as well as significantly limiting the spread of STIs.⁹⁵ Meanwhile, Title X contraceptive services prevented approximately 755,000 unintended pregnancies in 2016.⁹⁶ Missing out on healthcare opportunities could have life-changing impacts not only on patients’ health, but also their careers, their educations, and their families’ well-being.⁹⁷

86 Heger, *supra* note 64.

87 HEALTH RES. & SERVS. ADMIN., 340B DRUG PRICING PROGRAM, (Jan. 2020), <https://www.hrsa.gov/opa/index.html>

88 Pinchin, *supra* note 85.

89 *Id.*

90 *Id.*

91 Sarah Kliff, *Stat check: No, women couldn’t just “go somewhere else” if Planned Parenthood closed*, Vox (Dec. 4, 2015) <https://www.vox.com/2015/9/24/9373721/planned-parenthood-go-somewhere-else>.

92 Rachel Benson Gold & Lauren Cross, *The Title X Gag Rule Is Wreaking Havoc—Just as Trump Intended*, GUTTMACHER INST. (Aug. 29, 2019), <https://www.guttmacher.org/article/2019/08/title-x-gag-rule-wreaking-havoc-just-trump-intended>.

93 Heger, *supra* note 64.

94 Ducharme, *supra* note 84.

95 Benson et al., *supra* note 92.

96 *Id.*

97 Adam Sonfield et al., *The Social and Economic Benefits of Women’s Ability to Determine Whether and When To Have Children*, GUTTMACHER INST. (March 2013), <https://www.guttmacher.org/sites/default/>

Although it is unknown just how big the impact will be, a case study is available in Texas’s decision to exclude Planned Parenthood clinics from eligibility for the state-funded Texas Women’s Health Program in 2013. The other clinics expected to step up were unable to fill the gaps created by Planned Parenthood’s absence. Research published in the *New England Journal of Medicine* found that in counties where Planned Parenthood had closed, there was a 35.5% decrease in the use of long-acting reversible contraceptives, a 31.1% decrease in the use of injectable contraceptives, a 40.2% decrease in patients previously using injectable contraceptives who returned on time for subsequent injections, and a 27.1% increase in Medicaid-covered childbirths by women who had been using injectable contraceptives within the previous 18 months.⁹⁸ The researchers interpreted these results as likely indicators of increased unintended pregnancies.⁹⁹

If many sites continue withdrawing from Title X, there is also concern about the quality of care received at the clinics remaining in or newly joining the Title X program. As noted above, the Final Rule removes the requirement that Title X recipients provide family planning methods that are “medically approved” as well as explicitly stating that providers can now offer only a single method of family planning.¹⁰⁰ Health care providers have expressed concerns that patients will be less likely to hear about long-acting reversible contraceptives, such as intrauterine devices (IUDs) and implants, which have the highest pregnancy prevention success rates.¹⁰¹ Additionally, the Final Rule now makes eligible for Title X funding clinics that do not provide any FDA-approved contraceptive methods (such as birth control pills, IUDs, etc.) and instead focus exclusively on fertility awareness methods.¹⁰² This is not simply a hypothetical situation. Obria, a Christian chain of clinics that calls itself an abstinence-only organization, opposes all forms of medical birth control, and offers unscientific “abortion reversal” services, received a \$5.1 million Title X grant in March 2019, before the rule even went into effect.¹⁰³ Again, when lack of contraception causes unintended pregnancies, it can have medical, financial, and other life-long impacts on women’s lives.¹⁰⁴

IMPACT OF THE FINAL RULE ON PARTICULAR POPULATIONS

The Final Rule changes to the Title X program will have a disproportionate impact on certain populations. As documented in the 2018 *Family Planning Annual Report*, Title X providers overwhelmingly serve individuals who are female and low-income, and also disproportionately serve the uninsured and underinsured, people of color, non-English speakers, LGBTQ individuals,

[files/report_pdf/social-economic-benefits.pdf](#).

98 Kliff, *supra* note 91; Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women’s Health Program*, *NEW ENG. J. MED.* (March 3, 2016) <https://www.nejm.org/doi/full/10.1056/NEJMsa1511902>.

99 *Id.*

100 Compliance with Statutory Program Integrity Requirements at 7740; *Analysis of 2019 Final Rule on Title X Family Planning Program*, *supra* note 42.

101 *Changes to the Title X Program Reject Science and Endanger Comprehensive Care*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Feb. 26, 2018), <https://www.acog.org/About-ACOG/News-Room/Statements/2018/Changes-to-the-Title-X-Program-Reject-Science-and-Endanger-Comprehensive-Care>.

102 *Title X and Trump’s Gag Rule*, POPULATION CONNECTION ACTION FUND, <https://www.populationconnectionaction.org/title-x-and-trumps-domestic-gag-rule/>.

103 Stephanie Mencimer, *The Trump Administration Is Giving Family Planning Funds to a Network of Anti-Abortion Clinics*, MOTHER JONES, (Jan./Feb. 2020), <https://www.motherjones.com/politics/2019/11/the-trump-administration-is-giving-family-planning-funds-to-a-network-of-anti-abortion-clinics-obria/>.

104 See, e.g., Sonfield *supra* note 97.

people in rural areas, people with disabilities, and young people.¹⁰⁵ This part includes data on populations served by Title X and a discussion of existing healthcare disparities that will likely be exacerbated by reduced access to Title X services.

Women and Low-Income Families

Because the Final Rule changes largely involve contraceptive access and pregnancy options, the direct effect of the rule will be felt primarily by women. Moreover, women are the primary users of Title X clinics. In 2018, Title X patients were 87% female.¹⁰⁶ Women also continue to experience higher rates of poverty than men (12.9% compared to 10.6%).¹⁰⁷ Title X is required by federal regulations to prioritize care for individuals from low-income families.¹⁰⁸ As noted previously, patients with family incomes at or below poverty level receive care free of charge.¹⁰⁹ In 2018, 65% of Title X patients were eligible for free care based on their income and 89% were eligible for either free or subsidized care.¹¹⁰ Because Title X lacks strict eligibility criteria for its services (unlike Medicaid, which in many states covers only a subset of low-income people, such as pregnant or elderly individuals),¹¹¹ it has historically played a critical role in providing care to women who are not eligible for Medicaid but also unable to afford other types of health insurance.¹¹² In 2018, 40% of Title X patients were uninsured, and 58% had some form of public insurance.¹¹³

People of Color

In 2018, 33% of Title X patients identified as Hispanic or Latinx,¹¹⁴ 22% identified as Black, 4% as Asian, 1% identified as American Indian or Alaska Native, 1% as Native Hawaiian or other Pacific Islander, 4% identified as multiracial, and 16% were of unknown or unreported race. Compared to the general population of the US in 2018, Black and Latinx individuals are overrepresented in Title X patients.¹¹⁵ People of color already face barriers to healthcare and experience disparities in healthcare outcomes, including in the sphere of reproductive healthcare.¹¹⁶ Black women face higher rates of unintended pregnancy, higher rates of HIV and other STIs, and higher maternal and infant mortality than white women.¹¹⁷ Black women are also three to four times more likely to experience pregnancy-related death than white women. Latinx women have higher rates

105 See *generally* CHRISTINA FOWLER ET AL., OFF. OF POPULATION AFFS., TITLE X FAMILY PLANNING ANNUAL REPORT 2018 NATIONAL SUMMARY (Aug. 2019), <https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2018-national-summary.pdf>.

106 *Id.* at 9.

107 JESSICA SEMEGA ET AL., U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2018 (Sept. 10, 2018), <https://www.census.gov/library/publications/2019/demo/p60-266.html>.

108 FOWLER, *supra* note 105, at 21.

109 *Id.*

110 *Id.*

111 CTR. ON POLICY & BUDGET PRIORITIES, POLICY BASICS: INTRODUCTION TO MEDICAID (Aug. 16, 2016), <https://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid>.

112 RACHEL BENSON GOLD, GUTTMACHER INST., TITLE X: THREE DECADES OF ACCOMPLISHMENT (Feb. 2001), https://www.guttmacher.org/sites/default/files/article_files/gro40105.pdf.

113 FOWLER, *supra* note 105, at 21.

114 *Id.*

115 In 2018, the U.S. population was 13.4% black and 18.3% Hispanic or Latino. See U.S. CENSUS BUREAU, QUICK FACTS (July 1, 2018), <https://www.census.gov/quickfacts/fact/table/US/PST045218>.

116 Brief for National Health Law Program, et al. as Amici Curiae Supporting Plaintiff-Appellee, Mayor of Baltimore v. Azar, 2019 WL 3714650 (C.A.4) (No. 19-1614), at 10-11;

117 *Id.* at 11-12. National Partnership for Women and Families, Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities (April 2018), available at <https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html>.

of unintended pregnancy, STIs, and cervical cancer than non-Hispanic whites.¹¹⁸ These health disparities will be exacerbated by reduced access to medical services caused by implementation of the Final Rule.

Non-English Speakers

Title X grantees are required to ensure meaningful access to care for individuals who do not speak English. In 2018, 13% of Title X patients were classified as limited English proficient (LEP).¹¹⁹ Without access to providers who have to meet this standard, non-English speakers are likely to experience a worse quality of care.

People Living in Rural Areas

In addition to having high poverty rates, rural areas often have shortages of doctors and hospitals, and patients in rural areas already have to travel long distances to access care.¹²⁰ Numerous closings of rural hospitals and rural obstetric units in recent years have contributed to the challenges of accessing care in these areas.¹²¹ Rural areas have high rates of HIV, STIs, cervical cancer, and infant mortality.¹²² Rural women are less likely to begin prenatal care in their first trimester of pregnancy and have higher rates of complications during pregnancy.¹²³ More than half of Planned Parenthood's clinics serve rural or medically deprived areas. The withdrawal of Planned Parenthood from the Title X program therefore will only exacerbate the challenge of accessing care in rural areas.

People with Disabilities

People with disabilities are more likely to be low-income (and therefore more reliant on low cost or free healthcare services), more likely to be women, and more likely to be Black or Hispanic than white — all factors that make it likely that they are overrepresented among Title X patients.¹²⁴ They often struggle to access care due to lack of transportation, lack of knowledge about disabilities among medical providers, and lack of accessibility (including inaccessible exam rooms and providers who cannot communicate with deaf patients).¹²⁵ People with disabilities are more likely to be victims of sexual abuse and assault, are at risk for HIV and other STIs, and they are less likely to have received screenings for breast and cervical cancers.¹²⁶ The Final Rule's

118 Brief for National Health Law Program, et al. as Amici Curiae Supporting the Plaintiff-Appellee, *supra* note 116 at 12.

119 Fowler *supra* note 105 at 22.

120 Brief for National Health Law Program, et al. as Amici Curiae Supporting the Plaintiff-Appellee, *supra* note 116 at 14.

121 Jessica Siegel, *Rural Hospital Closures Rise to Ninety-Eight*, NAT'L RURAL HEALTH ASS'N (Feb. 20, 2019), <https://www.ruralhealthweb.org/blogs/ruralhealthvoices/february-2019/rural-hospital-closures-rise-to-ninety-seven>; HEALTH RESOURCES AND SERVICES ADMIN., *Rural Counties Lose Birthing Units*, (May 4, 2017) <https://www.hrsa.gov/eneews/past-issues/2017/march-16/rural-ob.html>.

122 Brief for National Health Law Program, et al. as Amici Curiae Supporting the Plaintiff-Appellee, *supra* note 116 at 14-15; Lulu Yu, et al., *Rural-Urban and Racial/Ethnic Disparities in Invasive Cervical Cancer Incidence in the United States, 2010-2014*, Preventing Chronic Disease (2019), available at https://www.cdc.gov/pcd/issues/2019/18_0447.html.

123 *Health Disparities in Rural Women*, AM. COLL. OBSTETRICIANS AND GYNECOLOGISTS (Feb. 2014), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women>.

124 Brief for National Health Law Program, et al. as Amici Curiae Supporting the Plaintiff-Appellee, *supra* note 116 at 17.

125 *Id.* at 18.

126 *Id.* at 19.

effect of limiting low-cost or free health services can only further restrict access to care for people with disabilities.

LGBTQ Individuals and Communities

Planned Parenthood and other Title X clinics are known to be important providers for LGBTQ individuals and often serve as a critical “entry point” for communities that otherwise may have limited contact with the healthcare system.¹²⁷ The LGBTQ population faces higher rates of poverty, unemployment, and being uninsured than the broader population,¹²⁸ and therefore is necessarily more reliant on low-cost or free healthcare services. Planned Parenthood is also known for offering a safe and inclusive environment for LGBTQ patients.¹²⁹ For transgender patients, who often avoid seeking medical care due to experiences of discrimination, Planned Parenthood is a comparatively trusted source of nonjudgmental care that provides services specific to transgender patients’ needs, such as hormone therapy.¹³⁰ LGBTQ patients, already frequently denied healthcare services due to provider bias, are further under threat due to a Trump administration rule that would give providers and insurers broad discretion to invoke religious objections in denying care.¹³¹ The Title X rule change serves to exacerbate this climate of unequal access by further narrowing LGBTQ patients’ options.

Young People

In 2018, 17% of Title X patients were under 20 and 46% were between 20 and 29.¹³² As noted previously, minors seeking confidential healthcare services are charged on the basis of their own income, and not that of their family,¹³³ making Title X providers an attractive option for young people seeking confidential care. Adolescents are at particularly high risk for acquiring STIs, and homeless youth and minors in the child welfare system are especially vulnerable to sexual and reproductive health issues like STIs, unintended pregnancies, and sexual assault.¹³⁴ Young people are also especially likely to face barriers to healthcare access such as lack of transportation and lack of information about how to access care.¹³⁵

127 Brief for Nat’l Ctr. Lesbian Rights et al. as Amici Curiae Supporting Plaintiffs-Appellees, *California v. Azar, Essential Access Health, Inc. v. Azar*, 927 F.3d 1068 (9th Cir. 2019) (Nos. 19-15974, 19-15979), at 9.

128 See *LGBT Proportion of Population: United States*, WILLIAMS INST. ON SEXUAL ORIENTATION AND GENDER IDENTITY LAW AND PUBLIC POLICY, UCLA SCH. L. (Jan. 2019), <https://williamsinstitute.law.ucla.edu/visualization/lgbtstats/?topic=LGBT#density>.

129 Alex Berg, *Cuts to Planned Parenthood a Scary Prospect for Some LGBTQ Patients*, NBC NEWS (July 21, 2017) <https://www.nbcnews.com/feature/nbc-out/cuts-plannedparenthood-scary-prospect-some-lgbtq-patients-n785291>

130 *Id.*

131 HUMAN RIGHTS WATCH, “*You Don’t Want Second Best*”: *Anti-LGBT Discrimination in US Health Care* (July 23, 2018), <https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care>; Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People From Accessing Health Care*, CTR. AM. PROGRESS (Jan. 18, 2018), <https://www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>.

132 *Id.* at 9

133 *Id.* at 21.

134 Brief for National Health Law Program, et al. as Amici Curiae Supporting the Plaintiff-Appellee, *supra* note 116, at 22; Brief for National Center for Youth Law as Amicus Curiae Supporting the Plaintiff-Appellee, 2019 WL 3714650 (C.A.4) (No. 19-1614), at 6.

135 Brief for National Center for Youth Law as Amicus Curiae Supporting the Plaintiff-Appellee, *supra* note 134, at 12, 14-15, 17.

For minors participating in Title X after the imposition of the Final Rule, providers must, with very limited exceptions, attempt to involve family members in minor patients' family planning decisions.¹³⁶ This violation of minors' privacy exposes them to potential abuse. Providers are also required to screen for abuse when a teen is pregnant or has an STI, even if there is no reason to suspect abuse.¹³⁷ For young people, knowing that their personal information may become public or that they will face intensive questioning, this could have a chilling effect on their willingness to seek reproductive healthcare.

IV. DOMESTIC LITIGATION CHALLENGING TITLE X RESTRICTIONS AS UNLAWFUL

In response to the publication of the Final Rule, 23 states, many Title X providers, nonprofit organizations, individual clinicians, and other impacted parties filed lawsuits challenging the new Title X funding regulations. These cases were consolidated in federal courts in Washington, Oregon, California, Maryland, and Maine.¹³⁸ Plaintiffs in the five consolidated cases assert that the Final Rule is unlawful under the Administrative Procedure Act (APA), which requires a reviewing court to “set aside agency action . . . found to be . . . (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations . . . (D) without observance of procedure required by law.”¹³⁹ Plaintiffs allege the Final Rule is unlawful under all four of these provisions of the APA, maintaining that the Final Rule runs counter to the evidence before the agency;¹⁴⁰ violates both the First and Fifth Amendments to the US Constitution;¹⁴¹ is inconsistent with a number of statutes, including the Appropriations Act,¹⁴² the Affordable Care Act,¹⁴³ Title X itself,¹⁴⁴ and the Religious Freedom Restoration Act;¹⁴⁵ and that the agency did not abide public notice and comment requirements for provisions of the Final Rule.¹⁴⁶

The consolidated cases are at various stages of litigation but, based on decisions issued in these cases to date, it is unclear whether the Final Rule will be successfully challenged as violative of US Constitutional law and statutory law. Notwithstanding the outcome of the domestic legal

¹³⁶ Compliance with Statutory Program Integrity Requirements 42 C.F.R. § 59.5(a)(14), § 59.2; *Analysis of 2019 Final Rule on Title X Family Planning Program*, *supra* note 42.

¹³⁷ Compliance with Statutory Program Integrity Requirements 42 C.F.R. § 59.17; *Id.*

¹³⁸ *Family Planning Ass'n of Maine*, 404 F. Supp. 3d 286 (D.Me. 2019); *Mayor of Baltimore v. Azar*, 392 F. Supp. 3d 602 (D. Md. 2019); *California v. Azar*, 385 F.Supp.3d 960 (N.D. Cal. 2019); *Oregon v. Azar*, 389 F.Supp.3d 898 (D. Or. 2019); *Washington v. Azar*, 376 F.Supp.3d 1119 (E.D. Wash. 2019).

¹³⁹ 5 U.S.C. §706(2)(A)-(D).

¹⁴⁰ Complaint, *Oregon v. Azar*, *Id.* at 96.

¹⁴¹ *Family Planning Ass'n of Maine v. United States Dep't of Health & Human Servs.*, 404 F. Supp. 3d 286, 297 (D. Me. 2019); *Baltimore v. Azar*, 392 F. Supp. 3d.; Complaint, *Oregon v. Azar*, at 101.

¹⁴² *Family Planning Ass'n of Maine*, 404 F. Supp. 3d at 297; *Mayor of Baltimore v. Azar*, 392 F. Supp. 3d 602 (D. Md. 2019); Complaint, *California v. Azar*, *supra* note 138, at ¶207; Complaint, *Oregon v. Azar*, *supra* note 138, at 92; Complaint, *Washington v. Azar*, *supra* note 138, at 78.

¹⁴³ *Family Planning Ass'n of Maine v. United States Dep't of Health & Human Servs.*, 404 F. Supp. 3d at 297; *Baltimore v. Azar*, 392 F. Supp. 3d; Complaint, *Id.*, at ¶207; *Id.*, at 79-82.

¹⁴⁴ *Family Planning Ass'n of Maine*, 404 F. Supp. 3d at 297; *Baltimore v. Azar*, 392 F. Supp. 3d 602; *Id.*, at ¶212.

¹⁴⁵ *Mayor of Baltimore v. Azar*, 392 F. Supp. 3d 602 (D. Md. 2019).

¹⁴⁶ *Family Planning Ass'n of Maine v. United States Dep't of Health & Human Servs.*, 404 F. Supp. 3d 286, 297 (D. Me. 2019); *Baltimore v. Azar*, 392 F. Supp. 3d 602; Complaint, *California v. Azar*, *supra* note 138 at ¶212; Complaint, *Oregon v. Azar*, at ¶95; Complaint, *Washington v. Azar*, at ¶83.

challenges, the US is also bound by international human rights law, and this report will now consider whether the Final Rule is consistent with the US' international human rights obligations.

V. THE FINAL RULE VIOLATES THE UNITED STATES' INTERNATIONAL HUMAN RIGHTS LEGAL OBLIGATIONS

The Final Rule implicates numerous rights protected by international treaties and treaty bodies. This part first considers whether the provisions of the Final Rule are consistent with rights protected by the ICCPR, CERD, and CAT, treaties the US has signed and ratified. It will then consider whether the US has acted in ways that would defeat the object and the purpose of CEDAW, the ICESCR, and the CRC, three treaties the US has signed but not yet ratified.

THE FINAL RULE VIOLATES THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR)

The US signed the ICCPR in 1977 and ratified it in 1992.¹⁴⁷ As a party to the ICCPR, the US has agreed to promote the rights listed in the covenant and to take “necessary steps” to protect them.¹⁴⁸ The US must comply with and implement the provisions of the ICCPR, subject to reservations, understandings, and declarations entered when it ratified the treaty.¹⁴⁹ With the implementation of the Final Rule, the US is violating numerous provisions of the ICCPR, including those protecting the rights to life; equality and freedom from discrimination; privacy; freedom from cruel, inhuman and degrading treatment; and freedom of speech and association.

Right to Life

The ICCPR guarantees every person the “right to life,”¹⁵⁰ ensuring that “individuals are free from acts and omissions that are intended or may be expected to cause their unnatural or premature death, as well as to enjoy a life with dignity.”¹⁵¹ With regard to reproductive health, States parties have an obligation to “ensure access for women and men, and, especially, girls and boys, to quality and evidence-based information and education about sexual and reproductive health and to a wide range of affordable contraceptive methods.”¹⁵² States parties must also provide access to “quality prenatal and post-abortion health care for women and girls in all circumstances, and on a confidential basis.”¹⁵³

The ICCPR also requires States to “protect the lives of women and girls against the mental and physical health risks associated with unsafe abortions.”¹⁵⁴ States may adopt measures to regulate voluntary termination of pregnancy, but those measures “must not result in violation of the right

147 <https://indicators.ohchr.org/>

148 ICCPR, Article 2.

149 The U.S. permits distinctions based on “race. . . sex . . . or other status” when such distinctions are “at minimum, rationally related to a legitimate governmental objective.” ICCPR U.S. Understanding, Article 1.

150 ICCPR, Article 6 (1).

151 Human Rights Comm., General Comment 36, Article 3.

152 ICCPR Article 6 (1).

153 Human Rights Comm., General Comment 36, Article 8.

154 *Id.*

to life of a pregnant woman or girl, or her other rights under the Covenant.”¹⁵⁵ Nor can those measures “subject them to physical or mental pain or suffering . . . discriminate against them or arbitrarily interfere with their privacy.”¹⁵⁶ Moreover, States may “not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion, including barriers caused as a result of the exercise of conscientious objection by individual medical providers.”¹⁵⁷

The Final Rule violates these legal obligations in a number of ways. First, it limits rather than ensures access to reproductive healthcare. Many states and providers have been forced to withdraw from the Title X funding program in response to the implementation of the Final Rule, resulting in closures of facilities and limited services, longer wait times and higher fees at the facilities remaining in the program. Second, the Final Rule removes the requirement for “evidence-based” information and no longer requires Title X recipients to offer a range of FDA-approved contraceptive methods. This allows the participation of recipients that only provide one family planning method or encourage abstinence as the sole method of family planning rather than the required “wide range of affordable contraceptive methods.” Third, the Final Rule violates the ICCPR’s privacy protections and confidentiality requirements for minors, as it encourages parental involvement in family planning services. Fourth, the Final Rule allows medical providers’ conscientious objections to dictate medical care in violation of the ICCPR. Allowing healthcare providers to choose not to provide abortion services or counseling delays services and degrades the quality of care for women in need. Finally, the Final Rule creates a number of new barriers to accessing reproductive healthcare, including: requiring Title X recipients to have complete physical and financial separation between abortion-related counseling and services and non-abortion services, and increasing administrative and reporting requirements for recipients of Title X funds.

Right to Equality and Freedom from Discrimination

The ICCPR sets forth both a general right to be free from discrimination of any kind¹⁵⁸ and a right to be free from discrimination with respect to the rights protected by the Covenant.¹⁵⁹ The Final Rule violates the protections of the ICCPR, as it discriminates against women and on the basis of race.

Article 2 requires that States parties ensure individuals the rights recognized within the ICCPR with no distinction to “race . . . sex . . . or other status.”¹⁶⁰ Article 3 requires States to ensure “the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.”¹⁶¹ These provisions are violated “whenever any person is denied the full and equal enjoyment of any right” set forth in the Covenant.¹⁶² Article 26 provides that “all persons are equal before the law and are entitled without any discrimination to the equal protection of the law” and prohibits discrimination on any ground.¹⁶³ Article 26 is broader than Article 2 in

155 *Id.*

156 *Id.*

157 *Id.*

158 ICCPR Article 26.

159 ICCPR Articles 2, 3.

160 ICCPR Article 2.

161 ICCPR Article 3.

162 Human Rights Comm., General Comment 28, Article 2.

163 Human Rights Comm., General Comment 18, Article 26 ¶ 1.

that the protections of equality and non-discrimination of Article 26 are not limited to those rights that are provided for in the ICCPR and may be invoked regarding rights not set forth in the treaty.¹⁶⁴

Title X's Final Rule violates the ICCPR by discriminating based on sex and race. First, Title X's Final Rule adversely discriminates against women. Among other restrictions, the Final Rule creates unreasonable barriers for pregnant women to access healthcare through the requirements it imposes for physical separation of facilities, impeding timely access to healthcare services, and interfering with the full range of communications between healthcare providers and their patients by restricting the information providers may give to pregnant patients. The new regulations discriminate against women because the restrictions apply only to pregnant individuals.

Second, the Final Rule disproportionately affects patients of color. The Final Rule reduces access to Title X providers, which will worsen existing health disparities for women of color, who compared to white women face higher rates of unintended pregnancies, HIV, STIs, cervical cancer, and maternal mortality.¹⁶⁵ As noted previously, in 2018, two-thirds of Title X patients were people of color, including 22% who identified as Black and 34% who identified as Latinx.¹⁶⁶ Thus, the Final Rule will have a disproportionately harmful effect on women of color in violation of the ICCPR.

Right to Privacy

Article 17 protects the right to "privacy," pursuant to which no State shall arbitrarily or unlawfully interfere with an individual's privacy, family, home, or correspondence, nor to unlawful attacks on their honor and reputation.¹⁶⁷ Privacy rights protect an individual's right to have an abortion when abortion is legal under existing legislation.¹⁶⁸ In *Whelan v. Ireland*, the Human Rights Committee (HRC) held the refusal to provide abortion in accordance with state law "constituted intrusive interference" in an individual's decision to cope with pregnancy, and thus their right to privacy.¹⁶⁹ General Comment 36 similarly notes that "restrictions on the ability of women or girls to seek abortion must not . . . discriminate against them or arbitrarily interfere with their privacy."¹⁷⁰

The Final Rule's restriction on providing information regarding abortion services discriminates against women and arbitrarily interferes with their privacy. The Final Rule bars Title X recipients from providing abortion referrals to their patients, even when requested. The new physical and financial separation requirements for abortion and non-abortion services likewise create new burdens for women seeking legal abortions. These restrictions to accessing legal abortion services constitute arbitrary interference with the right to privacy under the ICCPR. The Final Rule also violates the ICCPR's privacy protections in encouraging parental involvement in minors' family planning services. Accordingly, the Final Rule unnecessarily causes physical and mental

164 *Id.* at ¶ 2. Article 26 protections extend beyond the ICCPR and also guarantees equality for the rights in the ICESCR. Human Rights Comm., General Comment 18, Article 26 ¶ 12.

165 Brief of Amici Curiae National Health Law Program, et al., in Support of Plaintiff-Appellee, Mayor of Baltimore v. Azar, 10-12.

166 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶10 (May 8, 2008).

167 ICCPR Art. 17.

168 *K.L v. Peru*, UN Human Rights Comm., Communication No. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003 (2005).

169 UN Human Rights Comm., Communication No. 2425/2014, UN Doc. CCPR/C/119/D/2425/2014 (2017) ¶ 7.9.

170 Human Rights Comm., General Comment 36, Article 8.

anguish to women attempting to access legal abortion services and the privacy of adolescents attempting to access reproductive care in violation of Article 17 of the ICCPR.

Right to be Free from Cruel, Inhuman or Degrading Treatment

Article 7 states that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”¹⁷¹ This protects both the physical and mental integrity of individuals.¹⁷² The HRC has confirmed that the high level of anguish a person suffers from the denial of abortion or being forced to continue a pregnancy constitutes cruel and inhumane punishment.¹⁷³ Such suffering may be exacerbated by the inability to receive sufficient care from trusted health professionals and by the resulting psychological and physical burdens imposed on a person.¹⁷⁴

The Final Rule’s barriers to quality reproductive healthcare and timely abortion-related services may create physical and mental pain for women accessing Title X-funded clinics. These women may be forced to access lower quality, more expensive, or distant services or to carry unwanted pregnancies to term. Further, the HRC reiterated that States parties to the ICCPR may not use “moral and political considerations” to justify prohibiting abortion as a matter of law.¹⁷⁵ Thus, HHS may not invoke federal conscience laws to justify its violation of the ICCPR’s right to be free from cruel, inhuman or degrading treatment.

Rights to Freedom of Speech and Freedom of Association

The fundamental rights of freedom of speech and freedom of association are protected by Articles 19 and 22 of the ICCPR. The right to freedom of expression includes the “freedom to seek, receive and impart information and ideas of all kinds.”¹⁷⁶ “[A]ll forms of opinion are protected, including opinions of a political, scientific, historic, moral or religious nature.”¹⁷⁷ Article 22 protects one’s right to freely associate with others,¹⁷⁸ including the right to form an association as well as the ability to “secure and use resources . . . essential to the existence and effective operations of any association.”¹⁷⁹ The HRC has established a strict three-part test to determine whether freedom of speech or association restrictions are permissible under the ICCPR. As discussed below, the Final Rule restrictions infringe upon the speech rights of medical providers, the rights of patients to receive relevant information, and the rights of the clinics and providers to freely associate.

The Final Rule restricts the rights of medical providers to freely and completely share medical information with their patients. The Rule requires providers to refer pregnant clients to a healthcare provider for prenatal healthcare, without requiring counseling on the patient’s other options. Although Title X funds have never been allowed to be used for abortion services, this new rule does not allow medical providers to fully address a patient’s questions and concerns

¹⁷¹ ICCPR Article 7.

¹⁷² Human Rights Comm., General Comment 20, Article 2.

¹⁷³ UN Human Rights Comm., Communication No. 1153/2003, art. 6.3, UN Doc. CCPR/C/85/D/1153/2003 (2005); UN Human Rights Comm., Communication No. 2425/2014, UN Doc. CCPR/C/119/D/2425/2014 (2017), ¶ 7.7; UN Human Rights Comm., Communication No. 2324/2013, UN Doc. CCPR/C/116/D/2324/2013 (2016), ¶ 7.6.

¹⁷⁴ UN Human Rights Comm., Communication No. 2324/2013, UN Doc. CCPR/C/116/D/2324/2013 (2016), ¶ 7.6.

¹⁷⁵ UN Human Rights Comm., Communication No. 2425/2014, UN Doc. CCPR/C/119/D/2425/2014 (2017), ¶ 7.7.

¹⁷⁶ ICCPR Article 19(2).

¹⁷⁷ Human Rights Committee, General Comment 34, Article 19 ¶ 9.

¹⁷⁸ ICCPR Article 22(1).

¹⁷⁹ ICCPR Article 22; 2013 Report of the Special Rapporteur on the Rights to Freedom of Peaceful Assembly and of Association, ¶¶ 16-17.

and bars them from providing abortion referrals. While a Title X provider *may* give the patient a list of healthcare providers that *may* include clinics that provide abortions, the provider is prohibited from disclosing which ones provide abortion services.

The Final Rule also infringes a patient’s right to receive relevant medical information as protected by Article 19. Patients rely on medical providers at the Title X-funded sites to inform them of any and all medical information relevant to their specific situation. The Final Rule prohibits the medical providers from speaking about abortion or abortion referrals, infringing on the patient’s right to receive medical information that may be relevant for their health and medical care.

Lastly, although Title X funding has never been permitted to fund abortion services, the Final Rule imposes an additional requirement that the sites must be “physically and financially separate from prohibited activities,” such as abortion services, counseling, and referrals.¹⁸⁰ This requirement violates their right to freely associate because the Title X sites are not able to utilize resources necessary to run their operations effectively, for example by sharing a space with an outside site or provider that allows abortion referrals. This Final Rule provision imposes a financial burden on Title X sites, restricting their ability to use resources essential to the existence and effective operation of their clinic.

These provisions inhibit providers’ and patients’ rights to freedom of expression and association, and only in very limited circumstances are such obstructions allowed under the ICCPR. The HRC has established a strict three-part test to determine whether freedom of speech or association restrictions are permissible under the treaty. The test requires that the restrictions: (1) are provided for by law; (2) serve a legitimate aim; and (3) are necessary and proportionate.¹⁸¹ The Final Rule regulations fail to satisfy all three parts of the test.

Governmental restrictions are “provided by law” if they are accessible to the public, formulated with precise language that does not allow for “unfettered discretion” in their implementation, and are applied consistently to ensure fairness and transparency.¹⁸² The new regulations for Title X are vague in multiple ways. First, the Final Rule permits but no longer requires nondirective counseling; however, a Title X provider may not discuss abortion-related services or directly refer a patient to an outside provider for an abortion, even upon a patient’s request. This language (permitting nondirective counseling while prohibiting Title X providers from performing, promoting, referring, or supporting any abortion-related services) is imprecise and gives HHS unfettered discretion in applying this provision.¹⁸³ Second, the Final Rule lacks a clear test for whether providers are meeting the separation requirements. In addition, the Rule discusses the ability of Title X providers to provide “comprehensive primary health services” and “robust” referral services with other healthcare providers that are in “close physical proximity” to the Title X sites but does not define any of these terms. It also requires grantees to provide funds to “diverse” subrecipients but does not define “diverse” or give any further direction or guidance. As written, the Final Rule leaves room for arbitrary enforcement of the law, which can be considered

180 Sobel, *supra* note 18.

181 Human Rights Comm., General Comment 34, Article 19 ¶ 21, 22.

182 *Id.* at ¶ 25; 2012 Report of the Special Rapporteur on the Situation of Human Rights Defenders, ¶¶ 64, 66-67.

183 See *Analysis of 2019 Final Rule on Title X Family Planning Program*, *supra* note 42; Compare with Global Justice Center, *US Abortion Restrictions on Foreign Aid and Their Impact on Free Speech and Free Association: The Helms Amendment, Siljander Amendment, and the Global Gag Rule Violate International Law* (March 2018), at 4.

“unfettered discretion.” As such, the Final Rule violates the first part of the exception test for freedom of speech and association.

Under the second part of the test, a legitimate aim is defined as “protections of national security, public order, public health, morals or the rights and reputations of others.”¹⁸⁴ Restrictions “cannot withhold public information of legitimate public interest that does not harm public safety.”¹⁸⁵ The third part of the test requires necessity and proportionality, meaning that there must be no other alternative that does not violate fundamental freedoms and it cannot be overbroad.¹⁸⁶ “[A] state must not only demonstrate that its interference with a person’s right meets a ‘pressing social need’ but also that it is proportionate. . . to the legitimate aim pursued.”¹⁸⁷ The HRC has interpreted this last prong to mean that a law must be “directly related to the specific need on which they are predicated.”¹⁸⁸

HHS has stated that the Final Rule aims to promote optimal health for every Title X patient.¹⁸⁹ Although protection of public health is a legitimate aim, the Final Rule’s restrictions are not proportionate to this aim. As discussed above, the Final Rule creates undue barriers to accessing reproductive healthcare for the millions of individuals who use Title X services and disproportionately impacts people of color and of low socioeconomic status, among other vulnerable groups.¹⁹⁰ The harms caused by the Final Rule—including to women who will not be able to access abortion referrals or related services from Title-X funded providers, to physicians who may not provide their patients with accurate and complete information regarding contraceptive care and abortion referrals, and to the clinics themselves that are forced to financially and physically separate—is entirely disproportionate to any potentially legitimate aim. HHS has attempted to justify the Final Rule as allowing participation by clinics that, “for reasons of conscience,” limit the services they offer.¹⁹¹ While there may be a moral debate surrounding abortion, moral arguments do not constitute legitimate aims for purposes of this test.¹⁹² The Final Rule restrictions do not satisfy the three-part test and, as such, violate ICCPR’s protections of freedom of speech and freedom of association.

In sum, the Final Rule violates the rights to life; equality and freedom from discrimination; privacy; freedom from cruel, inhuman or degrading treatment; and freedom of speech and association under the ICCPR.

184 ICCPR Article 19(3).

185 Human Rights Comm., General Comment No. 34, ¶¶ 28, 30.

186 Global Justice Center, US Abortion Restrictions on Foreign Aid and Their Impact on Free Speech and Free Association: The Helms Amendment, Siljander Amendment, and the Global Gag Rule Violate International Law (March 2018), at 5.

187 Electronic Frontier Foundation. Necessary & Proportionate. May 2014. <https://www.ohchr.org/Documents/Issues/Privacy/ElectronicFrontierFoundation.pdf>

188 Human Rights Comm., General Comment No. 34, ¶¶ 22, 35.

189 Press Release, U.S. Dep’t of Health & Human Servs., Fact Sheet: Final Title X Rule Detailing Family Planning Grant Program (February 22, 2019). <https://www.hhs.gov/about/news/2019/02/22/fact-sheet-final-title-x-rule-detailing-family-planning-grant-program.html>

190 Fowler, *supra* note 105.

191 HHS states that the nondirective counseling requirement was removed to support conscience protections for Title X providers.

192 Interim Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, General Assembly, U.N. Doc. A/66/254 (Aug. 3, 2011) at 18, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement>.

THE FINAL RULE VIOLATES THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION (CERD)

The United States signed CERD in 1966 and ratified the treaty in 1994.¹⁹³ CERD defines racial discrimination in Article 1 as “any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.”¹⁹⁴ In General Recommendation XIV, the CERD Committee confirmed that in seeking to determine whether an action violates CERD, “it will look to see whether that action has an unjustifiable disparate impact upon a group distinguished by race, colour, descent, or national or ethnic origin.”¹⁹⁵ Thus, under CERD, State action that has a disparate impact on particular racial groups constitutes racial discrimination.¹⁹⁶ States parties must “nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination.”¹⁹⁷

The CERD Committee has repeatedly stated that the US’s practice of defining discrimination by intent, rather than effect, is inconsistent with its obligations under CERD. In 2001, the CERD Committee called on the US to review all laws and policies at the federal, state, and local levels to “ensure the effective protection against any form of racial discrimination and any unjustifiable disparate impact.”¹⁹⁸ In 2008, it repeated this concern, noting that “the definition of racial discrimination used in the federal and state legislation and in court practice is not always in line with . . . [CERD], which requires States parties to prohibit and eliminate racial discrimination in all its forms, including practices and legislation that may not be discriminatory in purpose, but in effect.”¹⁹⁹ The Committee recommended that the US amend its domestic legislation and judicial interpretation to be consistent with the CERD definition of discrimination. The Committee reiterated these concerns again in 2014.²⁰⁰

The Committee has also set forth what constitutes disparate impact under CERD. It has found that “indirect” or “de facto” discrimination may result if an “apparently neutral provision, criterion or practice would put persons of a particular racial, ethnic or national origin at a disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.”²⁰¹

193 Status of Ratification, Office of the High Commissioner for Human Rights (2014), <https://indicators.ohchr.org>. Upon ratification, the United States made the following reservations: The United States will not accept any obligation “to regulate private conduct that falls within the umbrella of articles 2(1), 2(1)(c), 2(1)(d), 3, and 5, except where mandated by the Constitution and laws of the United States.” International Convention on the Elimination of All Forms of Racial Discrimination, UN Treaty Collection (24 Feb. 2020), https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-2&chapter=4&clang=en

194 International Convention on the Elimination of All Forms of Racial Discrimination, Art. 1(1), 4 Jan. 1965 (emphasis added). This definition is reinforced by General Comment XIV, which states: “A distinction is contrary to the Convention if it has either the purpose or the effect of impairing particular rights and freedoms.

195 CERD General Recommendation XIV (1993) ¶2.

196 CERD General Recommendation 32 (2009) ¶7.

197 CERD General Recommendation XIV (1993) ¶1; CERD Art. 2, ¶1(c). This applies to “any law or practice.” CERD General Recommendation XIV (1993) ¶1.

198 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶14 (August 13, 2001).

199 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶10 (May 8, 2008).

200 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶5 (Sept. 25, 2014).

201 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶10 (May 8, 2008).

The Final Rule Constitutes Impermissible Racial Discrimination under CERD

CERD states that “each State Party shall take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists.”²⁰² The US, therefore, has an obligation under CERD to repeal the Final Rule because of the Rule’s discriminatory impact on people of color.

As discussed in part III.D, people of color, particularly Black and Latina women, are disproportionately represented among the population served by Title X.²⁰³ Therefore, although the Final Rule is facially neutral, it will have an outsize impact on Black and Latina patients. As previously described, these impacts will include reduced access to reproductive health care due to clinic closures.²⁰⁴ Women of color, already at a disproportionate risk for unintended pregnancies and certain STIs and cancers, will be further harmed by delays in getting appointments for such time-sensitive care.²⁰⁵ Additionally, there are significant concerns regarding the types of services offered and the quality of care available at the Title X-funded clinics that remain in the program. Specifically, the Final Rule removes the requirement that services offered at Title X clinics be “medically approved,” opening the door to projects offering a lower standard of care to which people of color will be disproportionately subjected.²⁰⁶ Equally troubling, the Final Rule removes the requirement that project providers give nondirective counseling to pregnant patients on all options, including prenatal care and delivery, infant care, foster care, adoption, and termination of the pregnancy.²⁰⁷ Instead the Final Rule requires providers to refer all patients for prenatal care regardless of patient preference and prohibits providers from giving abortion referrals. As a result, doctors will be permitted to practice medicine in a way that may not include the range of services requested or expected by their patients.²⁰⁸ These changes will negatively affect the quality of care that women are likely to receive at these clinics going forward and, since the majority of Title X recipients are people of color, the Final Rule will have a disparate impact on women of color.

The US did not adequately take into account how the gag rule and separation requirements would disproportionately impact communities of color that have been statistically shown to be more reliant on Title X healthcare sites. As a result, the US has failed to comply with its obligations under CERD.

The United States Must Guarantee Equality Before the Law and in the Enjoyment of Rights under CERD

Article 5 of CERD mandates that States parties “guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law,” particularly in the enjoyment of an enumerated list of essential political, civil, economic, social, and cultural rights. In General Recommendation XX, the CERD Committee recognizes that the rights enumerated within Article 5 have been expanded upon by other Conventions.²⁰⁹ CERD acknowledges that this

202 International Convention on the Elimination of All Forms of Racial Discrimination, Art. 2(1)(c), 4 Jan. 1965.

203 See *supra* Part V(C)(b).

204 See *supra* Part V(C).

205 See *supra* Part V(B) .

206 42 CFR 59(a)(1)

207 *Analysis of 2019 Final Rule on Title X Family Planning Program*, *supra* note 42.

208 *Id.*

209 CERD General recommendation XX (1996) ¶1.

poses varying obligations on States, depending on which additional treaties they have ratified, but it also “requir[es] a guarantee that the exercise of human rights shall be free from racial discrimination.”²¹⁰

As discussed above, as a party to the ICCPR, the US is obligated to respect the right to freedom of opinion and expression protected by Article 19.²¹¹ In CERD, Article 5(d)(viii) protects the right to nondiscrimination in the freedom of opinion and expression.²¹² This right to freedom of expression has consistently been interpreted as including a right to access information.²¹³ The right to access information must therefore be protected in a nondiscriminatory manner under CERD. Because the Final Rule prevents participating medical providers from sharing essential medical information with their patients, and because the affected Title X patients are disproportionately women of color, the Final Rule violates the Title X patients’ right to access information without distinction as to race.

Article 5(e)(iv) of CERD protects against discrimination in the enjoyment of economic, social, and cultural rights, in particular “the right to public health, medical care, social security and social services.” Although the US has not ratified the ICESCR, as a party to CERD, the US may not engage in discrimination in these areas. As stated above, changes to the Title X program will disproportionately affect patients of color because of their overrepresentation in the population served by Title X. Additionally, reduced access to Title X providers will serve to worsen existing health disparities for women of color, who compared to white women face higher rates of unintended pregnancy, HIV and other STIs, cervical cancer, maternal mortality, infant mortality, and other sexual and reproductive health problems in violation of CERD.²¹⁴

Additionally, in General Comment XX, the Committee stated that “whenever a State imposes a restriction upon one of the rights listed in article 5 of the Convention . . . it must ensure that neither in purpose nor effect is the restriction incompatible with [the non-discrimination protections in] Article 1 of the Convention.”²¹⁵ The implementation of the Final Rule will restrict the enjoyment of the right to health in an impermissibly discriminatory manner because people of color disproportionately accessing the Title X-funded clinics will not be able to enjoy the right to health “on an equal footing” when many clinics close and those remaining are unable to provide the best possible care.²¹⁶

The United States is Violating its Obligation to Take Special Measures under CERD

As a party to CERD, the US not only has an obligation to eliminate discriminatory laws and regulations, but also must take special measures to achieve equality in healthcare. Article 2(2) explicitly states that “States Parties shall, when the circumstances so warrant, take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and

210 *Id.*

211 *Id.*; International Convention on Civil and Political Rights, Art. 19, Mar. 23, 1976.

212 International Convention on the Elimination of All Forms of Racial Discrimination, Art. 5(d)(viii).

213 Human Rights Committee General Comment No. 34 (2011);

214 Brief of Amici Curiae National Health Law Program, et al., *supra* note 166

215 CERD General Recommendation 20 (1996) ¶2.

216 International Convention on the Elimination of All Forms of Racial Discrimination, Art. 1(1).

fundamental freedoms.”²¹⁷ The US has failed to honor this obligation, both because it has failed to take adequate special measures to address the racial disparities in American healthcare and because the promulgation of the Final Rule will deepen these disparities.

The CERD Committee has repeatedly raised concerns about racism and structural discrimination against people of African descent, noting that the legacy of slavery continues to be reflected in generational poverty and a number of other indicators of inequality.²¹⁸ In General Recommendation 34, the CERD Committee recommends amending legislation to eliminate racial discrimination against people of African descent, implementing national programs “with a view to improving the situation of people of African descent and protecting them against discrimination by State agencies and public officials,” and fully implementing measures already in place to ensure nondiscrimination.²¹⁹ General Recommendation 34 also calls for an intersectional approach to race and gender, stating that “some forms of racial discrimination have a unique and specific impact on women” and calling for all measures adopted by States parties to take into account “the situation of women of African descent, who are often victims of multiple discrimination.”²²⁰ The CERD Committee has also specifically addressed the right to health for people of African descent. States parties should “remove all obstacles that prevent the enjoyment of economic, social and cultural rights by people of African descent,” and “ensure equal access to health care and social security services for people of African descent.”²²¹

The CERD Committee has made a number of findings and recommendations to the US regarding the shortcomings of its policies and the need to undertake special measures to remedy the discriminatory healthcare disparities in the US. In a 2001 report, the CERD Committee noted “persistent disparities in the enjoyment of, in particular, the right to adequate housing, equal opportunities for education and employment, and access to public and private health care,” and urged the US to take “all appropriate measures, including special measures,” to address these concerns.²²² In its 2008 consideration of the US’s submission, the CERD Committee highlighted concerns about minorities (in particular Black and Latinx persons) facing “inadequate access to health care facilities”²²³ and urged the US to “eliminat[e] the obstacles that currently prevent or limit their access to adequate health care, such as lack of health insurance, unequal distribution of health-care resources, persistent racial discrimination in the provision of health care and poor

217 CERD, Art. 2(2). In order to ensure that all individuals are guaranteed the full and equal enjoyment of their human rights, CERD authorizes the use of special measures in Article 1(4). CERD, Article 1(4) (“Special measures taken for the sole purpose of securing adequate advancement of certain racial or ethnic groups or individuals requiring such protection as may be necessary in order to ensure such groups or individuals equal enjoyment or exercise of human rights and fundamental freedoms shall not be deemed racial discrimination, provided, however, that such measures do not, as a consequence, lead to the maintenance of separate rights for different racial groups and that they shall not be continued after the objectives for which they were taken have been achieved”).

218 CERD General Recommendation 34 ¶6 (2011).

219 *Id.* at ¶11.

220 *Id.* at ¶22-23. The Committee’s interest in the gender-specific dimensions of racial discrimination is also highlighted in General Recommendation XXV, which notes that “circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men” (General Recommendation XXV (2000) ¶1), affirms that the Committee will work to take into gender into account in its own efforts (¶3-5), and urges States Parties to bring a gendered analysis and data disaggregated by gender to their reporting (¶6).

221 CERD General Recommendation 34 ¶55 (2011).

222 Report of the Committee on the Elimination of Racial Discrimination, Fifty-eighth session ¶398 (6-23 March 2001), Fifty-ninth session (30 July-17 August 2001) (A/56/18).

223 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶16 (May 8, 2008).

quality of public health-care services.”²²⁴ The CERD Committee has also spoken directly to the problem of sexual and reproductive health disparities for minorities and for Black Americans in particular, most notably maternal and infant mortality rates, unintended pregnancy and abortion rates, and HIV rates.²²⁵

The CERD Committee has been clear that the US must adopt special measures to address the discriminatory healthcare disparities that exist for communities of color in the US, and in particular with respect to sexual and reproductive healthcare for women of color. The ongoing failure to enact special measures to address the disparity in access to reproductive healthcare is a clear violation of the US’s obligations under CERD and must be remedied. The US has itself acknowledged these disparities in its own reports to CERD. In its 2000 report, the US acknowledged that subtle forms of racial discrimination persist despite the progress the country has made, and noted that minorities “tend to have less adequate access to health insurance and healthcare” and identified in particular HIV rates among the Black population.²²⁶ It also admitted that racial discrimination in healthcare has disproportionate effects on women and children.²²⁷ In its 2008 report, the US reiterated its awareness of racial health disparities and stated that eliminating these disparities, including in the area of women’s health, was a particularly important goal of then-HHS Secretary Michael O. Leavitt and of a HHS plan entitled “Healthy People 2020” and that HHS had held a “National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health.”²²⁸ In its 2013 submission, the US stated that HHS recently released its Action Plan to Reduce Racial and Ethnic Health Disparities, as well as a Health Disparities and Inequalities Report.²²⁹

Although the US had begun to address racial disparities in health, these preliminary measures have not been sufficient to close the gap, and now, with the Final Rule in place, that gap will likely only grow. The US has not only failed to take adequate special measures to abide by its obligations under CERD, it has now consciously violated the provisions of the treaty by promulgating the Final Rule. The Final Rule directly contravenes the Committee’s 2008 recommendations to the US to “improv[e] access to maternal health care, family planning, pre- and post-natal care and emergency obstetric services” and “facilitat[e] access to adequate contraceptive and family planning methods.”²³⁰ It also disregards concerns repeatedly raised by the Committee about the racial disparities in sexual and reproductive health in the US,²³¹ since the Final Rule is likely to exacerbate those disparities.

Finally, the CERD Committee’s General Recommendation 34 also calls for States parties to “involve people of African descent in designing and implementing health-based programmes and projects.”²³² This is an obligation the US has itself acknowledged in its communications with

224 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶32 (May 8, 2008).

225 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶33 (May 8, 2008).

226 Third periodic reports of States parties due in 1999, Addendum United States of America ¶ 71(l) (Sept. 21, 2000).

227 Third periodic reports of States parties due in 1999, Addendum United States of America ¶ 71(k) (Sept. 21, 2000).

228 Sixth periodic reports of States parties due in 2005, Addendum United States of America ¶258-262 (Oct. 24, 2007).

229 Seventh to ninth periodic reports of States parties due in 2011, United States of America ¶136-141 (Oct. 3, 2013)

230 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶33 (May 8, 2008).

231 Concluding observations of the Committee on the Elimination of Racial Discrimination ¶15 (Sept. 25, 2014).

232 CERD General Recommendation 34 ¶56.

the CERD Committee.²³³ By circumventing and ignoring parts of the notice and comment process, however, HHS left voices from affected communities out of the development of the policy.

THE FINAL RULE IS INCONSISTENT WITH THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CAT)

The US signed CAT in 1988 and ratified it in 1994.²³⁴ As a party to CAT, the US must guarantee the right to be free from “torture or . . . cruel, inhuman or degrading treatment or punishment.”²³⁵ CAT defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person . . . for any reason based on discrimination of any kind, when such pain or suffering is inflicted . . . with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”²³⁶

CAT’s Application to Reproductive Healthcare Access

In the Committee against Torture’s General Comment 2, published in 2008, the Committee emphasized that the principle of “non-discrimination is . . . fundamental to the interpretation and application of the Convention” and that the Convention’s definition of torture includes pain and suffering inflicted “for any reason based on discrimination of any kind.”²³⁷ It noted that marginalized groups may be particularly at risk, and that gender is a “key factor.”²³⁸ It requested States to identify the contexts in which women and girls are at risk, including “deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence.”²³⁹

The Committee against Torture has made clear that depriving women access to reproductive healthcare may constitute a violation of the treaty, based on both the physical and mental health impacts of such deprivation.²⁴⁰ Initially, the Committee addressed bans on abortion in countries including El Salvador and Nicaragua, finding that such bans increase the risk of maternal mortality, incite violence against the women seeking abortion care, and can result in serious traumatic stress and psychological problems.²⁴¹ It has also criticized countries that have significant restrictions on the ability to access abortion care, stating that such restrictions endangered the physical and mental health of women and constituted cruel and inhuman treatment.²⁴² The Committee has

233 Third periodic reports of States parties due in 1999, Addendum United States of America ¶ 71(l) (Sept. 21, 2000).

234 *Status of Ratification*, United Nations Human Rights Office of the High Commissioner, <https://indicators.ohchr.org>.

235 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Jun. 26, 1987, (hereinafter “CAT”), preamble, Dec. 10, 1984, 1465 U.N.T.S. 85.

236 CAT Article 1.

237 Committee against Torture, General Comment 2, para. 20.

238 Committee against Torture, General Comment 2, para. 22.

239 Committee against Torture, General Comment 2, para. 22.

240 See generally, *Reproductive Rights Violations as Torture or Ill-Treatment*, Ctr. Reproductive Rights (Jun. 5 2014) https://reproductiverights.org/sites/default/files/documents/Reproductive_Rights_Violations_As_Torture.pdf.

241 Committee against Torture, Concluding Observations: Nicaragua, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (Jun. 10, 2009).

242 Committee against Torture, Concluding Observations: Peru, para. 23, U.N. Doc. CAT/C/PER/CO/4 (Jul. 25, 2006); Committee against Torture, Concluding Observations: Peru, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (Jan. 21, 2013). See also Committee against Torture, Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (Dec. 14, 2011).

also called on countries to ensure access to emergency contraception in cases of rape,²⁴³ and it has recommended that States take measures to prevent women putting their health at risk by providing “the required medical treatment, by strengthening family planning programmes and by offering better access to information and reproductive health services[.]”²⁴⁴

The Committee has also criticized States’ justifications for restricting access to reproductive healthcare on the basis of protecting the “conscience” of medical providers or other decision makers. In Bolivia, where the requirement to get judicial approval for an abortion frequently results in “conscientious objection” by judges blocking a woman’s access, the Committee has called for the elimination of this “unnecessary obstacle.”²⁴⁵ In Poland, where doctors’ and clinics’ refusal to provide abortion care on conscience grounds has led women to obtain “clandestine, often unsafe abortions,” the Committee recommended steps to ensure that women are not blocked from “accessing services to which they are legally entitled” and instituting a “legal and/or policy framework that enables women to access abortion where the medical procedure is permitted under the law.”²⁴⁶ Through its decisions, the Committee has reinforced that both the legal right to reproductive healthcare and practical access to such care are required by the CAT.

The Committee’s findings are not limited to abortion care but apply to access to reproductive healthcare more broadly. For example, the Committee expressed concerns to the Philippines about “the inadequate access to sexual and reproductive health services, including misinformation about modern methods of contraception” caused by a ban on the provision of contraceptives or information about contraceptives in Manila.²⁴⁷ The Committee found that the implementation of this ban “has resulted in a significant number of maternal deaths, fostered domestic violence and caused damage to women’s mental and physical health.”²⁴⁸ Its recommendation in this case was to “ensure rights-based counseling and information on reproductive health services to all women[.]”²⁴⁹

Potential Violations of CAT in the Final Rule

Although the Title X restrictions may not be as broad as those condemned by the Committee against Torture thus far, the Final Rule puts people at risk of severe physical and mental pain and suffering and does so in a discriminatory way because the burden lands overwhelmingly on women. The impacts of reduced access to reproductive health care include, as described above, missing out on time-sensitive services like pregnancy tests, cancer screenings, and STI screening; increased risk of unintended pregnancy; and delayed access to abortion care (due to barriers to getting information about providers) that can result in missing cut-off dates and being

243 Committee against Torture, Concluding Observations: Peru, para. 23, U.N. Doc. CAT/C/PER/CO/4 (Jul. 25, 2006); Committee against Torture, Concluding Observations: Peru, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (Jan. 21, 2013). See also Committee against Torture, Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (Dec. 14, 2011).

244 Committee against Torture, Concluding Observations: Peru, para. 23, U.N. Doc. CAT/C/PER/CO/4 (Jul. 25, 2006).

245 Committee Against Torture, Concluding Observations: Bolivia, para. 23 U.N. Doc. CAT/C/BOL/CO/2 (Jun. 14, 2013).

246 Committee Against Torture, Concluding Observations: Poland, para. 23 U.N. Doc. CAT/C/POL/CO/5-6 (2013).

247 Committee against Torture, Concluding Observations: Philippines, para. 39-40, U.N. Doc. CAT/C/PHL/CO/3 (May. 11, 2016); *Manila City's Contraception Ban*, Ctr. Reproductive Rights (Oct. 29, 2009) <https://reproductiverights.org/press-room/manila-citys-contraception-ban>.

248 *Id.*

249 *Id.*

required to continue a pregnancy against one's will. All of these impacts have the potential to harm women in ways similar to those described in the Committee's recommendations to other countries that restrict access to reproductive care. Applying CAT to the Title X Final Rule should therefore result in a finding that it violates the Convention.

THE FINAL RULE IS INCONSISTENT WITH THE OBJECT AND PURPOSE OF CEDAW, THE ICESCR, AND THE CRC

The Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations (Vienna Convention) outlines the rules, procedures, and guidelines for how treaties are defined, interpreted and how they operate.²⁵⁰ Pursuant to the Vienna Convention, a State “is obliged to refrain from acts which would defeat the object and purpose of a treaty” when it has signed but not yet ratified a treaty.²⁵¹ “[O]bject and purpose is understood to mean the ‘essential goals’ of a treaty... a signatory state need not comply with every part of a treaty, but it must comply with the most important parts.”²⁵² As a signatory to CEDAW, the ICESCR, and the CRC, the US cannot take any action that defeats the object and purpose of these three treaties.²⁵³ This section will provide an analysis of the object and purpose of these treaties and discuss how the new Title X regulations fail to adhere to them.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

In General Recommendation No. 28, the Committee on the Elimination of Discrimination against Women stated that the “objective of [CEDAW] is the elimination of all forms of discrimination against women on the basis of sex. It guarantees women the equal recognition, enjoyment, and exercise of all human rights and fundamental freedoms in the political, economic, social, cultural, civil, domestic or any other field.”²⁵⁴ CEDAW defines discrimination as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women . . . on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”²⁵⁵ CEDAW specifically requires States to eliminate discrimination against women in accessing healthcare.²⁵⁶ In terms of reproductive healthcare, the Committee has said

250 Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations, Preamble (1986).

251 VCLTIO, Article 18

252 David S. Jonas & Thomas N. Saunders, The Object and Purpose of A Treaty: Three Interpretive Methods, 43 Vand. J. Transnat'l L. 565, 596 (2010).

253 The United States signed CEDAW in 1980 and ICESCR in 1977, but to date neither treaty has been ratified. *Status of Ratification: United States*, OHCHR, <https://indicators.ohchr.org/>.

254 General Recommendation 28 (2010) ¶4.

255 Convention on the Elimination of All Forms of Discrimination against Women, Art. 1, 18 Dec., 1979.

256 Article 12 states that “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.” CEDAW, Art. 12(1). Article 14 states that “States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right ... To have access to adequate health care facilities, including information, counselling and services in family planning.” CEDAW, Art. 14(2)(b). The CEDAW Committee has also stated that rural women should be able to access, among other things, “contraception, including emergency contraception, and to safe abortion and high quality post-abortion care, regardless of whether abortion is legal.” General Recommendation 34 (2016) ¶39.

that “it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.”²⁵⁷

Under CEDAW, States have three central obligations in their efforts to eliminate discrimination against women: (1) to ensure that “there is no direct or indirect discrimination against women *in their laws* and that women are protected against discrimination;” (2) to improve the “de facto position of women through concrete and effective policies and programmes;” and (3) to address “prevailing gender relations and the persistence of gender-based stereotypes.”²⁵⁸ To actively contradict any of these three obligations is to act contrary to the object and purpose of CEDAW. In promulgating the new Final Rule regulations, the US has acted contrary to its obligations not to discriminate against women through law and to improve the de facto position of women.

The Final Rule creates distinctions on the basis of sex that will prevent women from enjoying the right to health on the same basis as men. Among other distinctions, the Final Rule regulations expressly require Title X providers to withhold medical information necessary for women (but not men) to make informed decisions regarding their healthcare options, including contraception and pregnancy. Particular vulnerable groups, such as rural women, will be especially harmed by the Final Rule because there are fewer healthcare facilities in rural areas, and the clinic closures and limited services that will result from implementation of the Final Rule will further limit reproductive healthcare services available to women living in these areas, worsening their de facto position. Thus, in promulgating the Final Rule, the US is not abiding by its obligation to act in accordance with the object and purpose of CEDAW.

International Covenant on Economic, Social, and Cultural Rights (ICESCR)

The ICESCR aims to ensure the protection of various economic, social, and cultural rights, including the right to the highest attainable standards of physical and mental health.²⁵⁹ With respect to the right to health,²⁶⁰ General Comment 14 states, “health is a fundamental human right indispensable for the exercise of other human rights.”²⁶¹ The right to health is not a right to be *healthy*, but rather a freedom and certain entitlements to “control one’s health and body, including sexual and reproductive freedom.”²⁶² In General Comment 3, the Committee on Economic, Social and Cultural Rights states that the overall “objective . . . the *raison d’être*, of

257 General Recommendation 24 (1999) ¶11.

258 General Recommendation 25 (2004) ¶7.

259 World Health Organization, Health and Human Rights Fact Sheet ICESCR, pg. 2 https://www.who.int/hhr/Economic_social_cultural.pdf; Fact Sheet no. 16 (Rev.1), The Committee of Economic, Social and Cultural Rights, §3 International Covenant of Economic, Social and Cultural Rights.

260 CESCR, Article 12(1).

261 Office for the High Commissioner for Human Rights, CESCR General Comment 14 ¶1. The Office of the High Commissioner for Human Rights discusses this right to health that is enshrined in multiple international documents, such as UDHR, CERD, CEDAW, and CRC, but emphasizes that ICESCR contains the most comprehensive article on the right to health.

262 OHCHR, CESCR General Comment 14 ¶8. The general comments surrounding ICESCR and specifically Article 12 help shed light upon what these freedoms include. Article 12 “recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” CESCR, Article 12(1). General Comment 14 discusses what exactly is included in this right and states that Article 12(1) (a) requires measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and postnatal care, and access to information, as well as to resources necessary to act on that information. OHCHR, CESCR General Comment 14 ¶14. “Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.” *Id.* at footnote 12.

the Covenant. . . . is to establish clear obligations for States parties in the respect of the full realization of the rights in question. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal.”²⁶³

The Committee on Economic, Social and Cultural Rights has put forth the minimum core obligations of the Covenant.²⁶⁴ These include a list of minimum essential levels to which States must be working for each of the rights enunciated in the Covenant.²⁶⁵ Relevant provisions to consider when evaluating the Final Rule include: “to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;” “to ensure equitable distribution of all health facilities, goods and services;”²⁶⁶ “to ensure reproductive, maternal (prenatal and well as postnatal) and child health care,” and “to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.”²⁶⁷ The Committee states that these core obligations must be met regardless of a State party’s resources.²⁶⁸

The Final Rule regulations conflict with the US’s obligations to move toward realization of the right to health and in a non-discriminatory way. First, amending what constitutes acceptable methods of family planning to omit the requirement for *medically approved* family planning methods encourages participation of service providers who provide only limited contraceptive services, thereby reducing access to clinics that offer a full range of family planning methods and education about family planning options. In addition, as discussed previously, the requirement of physical and financial separation between projects’ Title X activities and abortion services has led to many clinics withdrawing from the Title X program, with some shutting down due to insufficient funding or offering more limited services and increasing costs for services, all resulting in lesser access to reproductive health care for women.

Moreover, the Final Rule’s mandate that Title X sites refer all pregnant patients for prenatal care, while not requiring counseling or referral for other options, does not ensure equitable distribution of all health facilities, goods and services.²⁶⁹ Patients at Title X-funded clinics will not be able to receive information and services that others who can afford to go to a private clinic or physician are able to access. Additionally, the Final Rule encourages parental involvement in family planning services for minors, which may limit their access to sexual and reproductive health rights and services.²⁷⁰ All of these changes disproportionately impact vulnerable populations, such as people of color and those of low economic means, leaving these populations without equal access to reproductive healthcare.

For the above reasons, the US is violating its obligation to abide by the object and purpose of the ICESCR in implementing the Final Rule regulations.

263 OHCHR, CESCR General Comment 3 ¶9.

264 OHCHR, CESCR General Comment 3 ¶10.

265 OHCHR, CESCR General Comment 14 ¶43.

266 *Id.*

267 *Id.* at ¶44.

268 *Id.*

269 Office for the High Commissioner for Human Rights, CESCR General Comment 14 ¶43.

270 Office for the High Commissioner for Human Rights, CESCR General Comment 14 ¶43.

The Convention on the Rights of the Child (CRC)

The United States signed the CRC in 1995 but is the only country in the world that has not ratified the treaty. The CRC recognizes that children’s unique vulnerability entitles them to special protections²⁷¹ and applies to all individuals under either the age of eighteen or the age of majority in their country.²⁷² The CRC includes many rights found in other treaties, such as nondiscrimination and basic civil, political, economic, social, and cultural rights, but also includes provisions that are unique to children, such as the right to have their “best interests” considered in decisions affecting their well-being.²⁷³

The Committee on the Rights of the Child has identified four particular provisions of the treaty as “general principles”: Articles 2, 3.1, 6 and 12.²⁷⁴ Article 2 protects against discrimination on the basis of the child’s or parent’s “race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.” Article 3.1 states, “[i]n all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.” Article 6 protects the child’s right to life and provides that States parties must “ensure to the maximum extent possible the survival and development of the child.” Finally, Article 12 states that a child has the right to express his or her views freely in “all matters affecting the child.”

As noted above, Title X patients are disproportionately people of color, 17% of Title X patients are under age 20, and the Final Rule includes provisions specifically addressing minors’ healthcare.²⁷⁵ The Final Rule violates the CRC’s direction to protect against discrimination on the basis of race and ethnicity, since the Final Rule will have a disproportionate impact on minor patients of color and their access to healthcare and quality of care, and will exacerbate existing racial disparities in health outcomes.²⁷⁶

The Final Rule is also inconsistent with the obligation to prioritize the best interests of the child. The Final Rule limits minors’ access to health care services and imposes obligations regarding parental involvement that interfere with minors’ privacy and ability to make their own health care decisions.²⁷⁷ These intrusions into minors’ privacy also put minors at risk of abuse and potentially deters minors from seeking healthcare at all.²⁷⁸ Nor do these provisions of the Final Rule treat children’s best interests as primary considerations. Rather, the Final Rule limits the right of children to express their views freely on matters affecting them.²⁷⁹ The Committee on the Rights of the Child has stated that children need “access to confidential medical counselling and advice without parental consent, irrespective of the child’s age, where this is needed for the child’s safety or well-being” and lists the need for “reproductive health education or services” as an example of such a situation.²⁸⁰

271 Convention on the Rights of the Child, Preamble.

272 Convention on the Rights of the Child, Art. 1(Nov. 20, 1989).

273 See *generally*, Convention on the Rights of the Child.

274 Committee on the Rights of the Child, General Comment No. 5, ¶ 12 (2003).

275 See *supra* Part V(C)(7).

276 See *supra* Part VII(A)(2); Part VII(B).

277 See *supra* Part V(C)(7).

278 *Id.*

279 Committee on the Rights of the Child, General Comment No. 12 (2009).

280 Committee on the Rights of the Child, General Comment No. 12, ¶ 101 (2009).

Finally, the Final Rule is inconsistent with the right to life and the obligation to promote a child's survival and development. For all the reasons discussed above in considering the US's ICCPR obligations, the Final Rule violates Title X patients' right to life by creating barriers to abortion care and other reproductive healthcare services.²⁸¹ Additionally, by denying young people the access to and quality of care, information, privacy, and autonomy that they need, the government is not meeting its obligation to ensure their development.²⁸²

Accordingly, the Final Rule fails to abide by the general principles or object and purpose of the CRC.

VI. CONCLUSION

Title X was enacted in order to fund family-planning services and reproductive health care for low-income women in the US. The Final Rule regulations, published on March 4, 2019, amend how Title X funding should be directed in ways that will reduce access to such healthcare and the quality of care women receive at Title X clinics. Particular vulnerable populations who have historically accessed the Title X clinics at disproportionately high rates, including women of color, non-English speakers, women living in rural areas, people with disabilities, LGBTQ individuals, and young people will be especially harmed by the Final Rule regulatory changes. While the Final Rule appears to violate US statutory laws and constitutional protections, domestic cases challenging the Final Rule are pending and the outcome of these challenges is unclear.

Irrespective of the outcome of the domestic legal challenges, the US must comply with its international legal obligations. As set forth in this report, the Final Rule violates numerous rights protected by international human rights treaty law binding on the US, including the rights to life, privacy, to be free from cruel, inhuman or degrading treatment, freedoms of speech and association, and equality and nondiscrimination in these rights and the right to health pursuant to the ICCPR, CERD, and CAT. Moreover, under CERD, laws and regulations that appear facially neutral but have a disproportionately harmful impact on certain racial groups are discriminatory and must be nullified. CERD also requires States to take measures to eliminate racial disparities and achieve actual equality with respect to protected rights, including equal access to healthcare. As documented in this report, the Final Rule discriminates against women in the provision of healthcare, reduces access to reproductive health information and services, and negatively impacts the quality of care offered at Title X clinics, which disproportionately serve people of color and women.

In order to comply with its obligations under CERD, CAT, and the ICCPR, the US must revoke the Final Rule regulations and implement measures intended to eliminate gender and racial disparities in access to and quality of reproductive health care. Further, the US should take steps to ratify additional core human rights treaties including CEDAW, the ICESCR, and the CRC, and meaningfully incorporate and implement the obligations within such treaties.

²⁸¹ See *supra* Part VII(A)(1).

²⁸² See *generally*, Committee on the Rights of the Child, General Comment No. 4 (2003).



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2018 protest against President Trump's "Gag Rule" in Chicago, Illinois [PHOTO: Charles Edward Miller]

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