10 May 2021

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on the right of everyone to sexual and reproductive health – challenges and opportunities during COVID-19, which will be presented to the UN General Assembly in October 2021.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: (<https://www.ohchr.org/EN/Issues/health/pages/srrighthealthindex.aspx>).

All submissions received will be published in the aforementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 3000 words per questionnaire. Please submit the completed questionnaire to [srhealth@ohchr.org](mailto:srhealth@ohchr.org). The deadline for submissions is: **10 June 2021.**

Tlaleng Mofokeng

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

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**Contact Details**

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

|  |  |
| --- | --- |
| Type of Stakeholder (please select one) | Member State  Observer State  X Other (please specify)-   * Civil Society Organizations * “United Church of Christ, Board For World Ministries” and “Preterm, Cleveland”   Note, the Current legal name of the UCC in the United States is: “Wider Church Ministries (a Covenanted Ministry of the United Church of Christ)”, though we are known to the UN as the above. |
| Name of State  Name of Survey Respondent | United States of America  Rev. Dr. Chris Davies |
| Email | daviesc@ucc.org |
| Can we attribute responses to this questionnaire to your State publicly\*?  \*On OHCHR website, under the section of SR health | Yes X No  Comments (if any):  All authors and contributors are listed below. |

**QUESTIONNAIRE**

# Background

The right to sexual and reproductive health is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights and a key priority theme for the work of the Special Rapporteur on the right to physical and mental health during her tenure.

The Special Rapporteur, Tlaleng Mofokeng will focus her next thematic report to the General Assembly on “The right to sexual and reproductive health – challenges and opportunities during COVID – 19”.

# Objectives of the report

With her report, the Special Rapporteur intends to shed light on the current status/level of realization of the right to sexual and reproductive health and the availability, accessibility, acceptability and quality of related services, during the COVID-19 pandemic. Building on the work and previous reports of the mandate, she aims to further develop understanding of the structural and systemic issues preventing all persons from freely and fully enjoying the right to sexual and reproductive health.

She will focus on elements historically neglected, including the impact of colonialism and racism in the enjoyment of these right, with an intersectional approach and will also analyze the impact of COVID -19 and related policies, legal developments and practices on access to sexual and reproductive health services. She will also aim to present challenges and opportunities in the operationalization of the right to sexual and reproductive health in the current context of pandemic.

*For the purpose of this questionnaire:*

*The* ***Right to sexual and reproductive health*** *entails the right to make free and responsible decisions and choices, free of violence coercion and discrimination regarding matters concerning one’s body and sexual and reproductive health. It also entails entitlement to unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of CESCR.*

***Sexual reproductive health care*** *refers to services, goods and facilities including:*

* *Pregnancy and post-natal related services*
* *Family planning and contraception, including access to safe abortion*
* *Prevention, diagnosis and treatment of reproductive cancers, sexually transmitted infections, and, HIV/AIDS*
* *Hormonal treatments*
* *Gender affirming treatments*
* *Access to information on all aspects of sexual and reproductive health issues.*

# Key questions

1. Since the beginning of COVID-19 pandemic, States have adopted new policies, laws and other measures in response to the crisis. Please refer to the relevant measures in your country (or countries in focus) and their impact on the right to sexual and reproductive health. Please share information on opportunities and challenges.

For the purposes of this report, the primary author is writing from the point of view of an ordained clergywoman in the United Church of Christ, and board member for Preterm, an Independent Abortion Clinic in Cleveland, Ohio, United States.

The United Church of Christ is a Christian denomination centered in ecumenism with a powerful and progressive history of supporting access to abortion. Our clergy were critical in the pre-legal era of helping women get information and support for their choices. In 1971, (before the passing of Roe v. Wade in the United States) the General Synod (or decision making body) of the denomination [passed a resolution](https://www.uccfiles.com/pdf/GS-Resolutions-Freedom-of-Choice.pdf) claiming that “a responsible position concerning abortion should be based on the consideration of the rights of the individual woman, her potential child, her family and society, as well as the rights of the fetus,” and urged local churches to appeal towards legal abortion and counsel women effectively. This decision was affirmed again and expanded in 1973, then calling churches to resist the erosion of the now-legal status of abortion, among other actions in support.

The United Church of Christ continued to publicly affirm abortion access through resolutions in 1977, 1979, 1981, 1987, 1989, 1991, and still through our collective action, advocacy, and care to this day, as demonstrated through this report.

Through this lens of history and advocacy, the primary author serves on the Board for Preterm, an Independent Abortion Clinic in Cleveland, OH, and the examples and case studies of this dual context will inform the responses to follow.

Challenges:

During the pandemic, some US States, including Ohio, deemed abortion to be a non-essential medical service that must be suspended during the pandemic, and the clinics were unable to continue to provide services because of legal action and other relevant actions. There is no question that patients were impacted in those US states as a result of this legal battle.

On March 17th, 2020, Amy Acton, MD, MPH, the Director of the Ohio Department of Health at the time, suspended all non-essential or elective surgeries.

The Joint Statement by the American College of Obstetricians and Gynecologists

(ACOG), the American Board of Obstetrics & Gynecology, et al., on Abortion Access During the COVID-19 Outbreak, issued March 18, 2020, which states that to “the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure” because it “is an essential component of comprehensive health care” and “a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible.”

On March 21st, 2020, Preterm received a Cease & Desist Letter from the Deputy Attorney General ordering abortion providers to stop performing “non-essential” surgeries.

On March 21st, Preterm’s Board of Directors passed a policy affirming alignment of abortion with the definition of “essential surgeries,” empowering the physicians to make the decision, encouraging patients to delay where possible (during this critical period, which was initially only expected to be two weeks), and/or consider medication abortion wherever possible, and to preserve Personal Protective Equipment and have as few staff as possible in the room.

On March 30th, based on the lack of clarity from the government of Ohio about what could legally be performed as well as how enforcement would occur, Preterm sought a Temporary Restraining Order and Preliminary Injunction against the State of Ohio based on the unconstitutional nature of the restriction under the Fourteenth Amendment of the United States Constitution guaranteeing the right to reproductive freedom. This was granted, and upheld, until the Ohio ban on elective surgeries was lifted on May 1, 2021.

In late March to late April of 2020, all who were eligible for medication abortions were required to choose this procedure. If they wanted a surgical abortion, and were beyond the first trimester at this point, and were not eligible for a medication abortion, Preterm was instructed by the court in Ohio to delay the procedure unless there was a clear underlying reason to have them come in.

Also relevant, at the time, a federal lawsuit suspended some of the requirements of in-person dispensing of medication abortion. However, not all US states could take advantage of it due to the state laws in Ohio and others which require in-person visits for medication abortion.

There are some US states which made abortion more accessible via telehealth, however, at the time, 19 US states had laws prohibiting remote access to medical abortion. In December 2020, Ohio passed Senate Bill 260, the issue of a telemedicine ban, which a judge has blocked, and litigation is ongoing.

Preterm experienced serious trouble with staffing (whether because they were sick, or immunocompromised, or caring for people who are.) They experienced challenges in staff who were not able to access childcare. They decided to incentivize and pay bonuses for staff who were able to come in. They had to find staffing to check temperatures at the door.

Because of restrictions and adaptations to the COVID-19 virus, there was a need to limit people in the building, and it impacted the clinic in the following ways:

No support people or significant others with patients,

Limiting the patient schedule,

Re-arranging the waiting rooms,

Re-arranging counseling rooms,

Upgrading HVAC systems and added air purifiers in all rooms,

And the clinic cut sexual health appointments (not abortion related) unless people were symptomatic, as many patients had access to telehealth with their PCPs.

Opportunities:

Preterm was able to implicate a change in Medication Abortion Follow-ups, in such a way that patients (who are required by Ohio law to come in twice) do *not* need to come to the clinic a third time for a follow up.

Innovations became necessary as a result of staffing, and use of technology. At some points, the optional post-abortion counseling was a digital intervention offered through telemedicine for the patients that chose to utilize this service.

Preterm was able to access the Paycheck Protection Program, a COVID-19 response measure to support small businesses. Abortion clinics, while historically excluded from federal support as a result, were able to receive this money.

1. Please also specify legal or other measures introduced during the pandemic aiming at recognizing, or restricting, banning or criminalizing: a) **access to legal abortion**; b) consensual sex between adults; c) same sex sexual relations, d) consensual sex between adolescents of similar ages, e) sex work, f) same sex marriage, g) information on the right to sexual and reproductive health; h) HIV transmission and i) **autonomy and free decision making on one’s body and sexual and reproductive health.**

Relevant in Ohio:

Ohio Senate Bill 260:

**prohibits telemedicine for medication abortion,** requiring patients to take the first dose of the two-pill medication abortion regimen in the physical presence of the prescribing physician. The bill carries criminal and professional licensing penalties for physicians who fail to comply.

The bill was signed into the law by the Governor Mike DeWine of Ohio on January 9th, 2021, and was blocked from action by a judge. It is in litigation at the time of writing.

Ohio Senate Bill 27:

**requires burial or cremation of fetal and embryonic tissue from surgical abortions.** The requirements single out abortion clinics—they do not apply to fetal tissue from miscarriages or medication abortions. Patients are required to fill out a form indicating their choice of disposition method (or that they prefer not to choose). Abortion clinics are required to pay the disposition costs.

The bill was signed into law by Governor Mike DeWine of Ohio on December 30th, 2020. It was supposed to go into effect on April 5th, 2021, however, a judge blocked its enactment. The judge's [order](https://case.us5.list-manage.com/track/click?u=bd507ee87f4ad570a97a48243&id=bf0c1f61be&e=c80e48877b) states that the state of Ohio cannot enforce the law until 30 days after it has adopted rules and forms for implementing the law, pursuant to a formal rule making process (which itself takes several weeks). As of now, the formal rule making process has not started.

From the point of view of the General Synod of the United Church of Christ, it is worth noting that the above bill is an infringement upon the rights of religious freedom, as outlined in the First Amendment to the US Constitution. It is extremely concerning for the United Church of Christ that the US State of Ohio is mandating certain rituals as necessary, and the United Church of Christ will be following this closely as a denomination, having contributed to similar cases in the past.

ORDINANCE NO. 2021-053

ORDINANCE OUTLAWING ABORTION, DECLARING LEBANON A SANCTUARY FOR THE UNBORN, MAKING VARIOUS PROVISIONS AND FINDINGS, PROVIDING FOR SEVERABILITY, ESTABLISHING AN EFFECTIVE DATE AND DECLARING AN EMERGENCY

The city of Lebanon, Ohio, amended their city code to ensure there is no access to abortion in the city, including: performing the procedure. Additionally, aiding or abetting; including but not limited to: driving someone to an appointment, receiving instructions on the phone or through the internet, paying for someone’s abortion, supporting someone going through an abortion, recommending it to pregnant people.

Distributing medicine for an abortion is clearly prohibited in the town.

This was passed on May 25th, 2021, despite there being no abortions being performed in the town.

3. Regarding sexual and reproductive health care, what services, goods and information is being provided in your country (or countries in focus), during the pandemic?

We want to note: Crisis Pregnancy Centers (CPC) are mock-clinics often supported by religious centers which are eligible to receive federal funding to provide counseling against abortion, and inaccurate health information. According to [a study at Ohio State University](https://www.sciencedirect.com/science/article/abs/pii/S001078242100158X), nearly one in seven women have attended a CPC at least once, with a disproportionate number of women who have attended them identifying as Black and non-Hispanic, and coming from a lower socioeconomic class. Despite receiving federal funding for healthcare, CPC’s are not healthcare facilities and are not licensed as such. They should not be used in place of medical care.

Additionally, it is worth naming that the United Church of Christ is providing information to our congregations and communities about reproductive healthcare, and how to advocate for access to abortion, in alignment with the General Synod Resolutions as mentioned above. This recently includes a column in our monthly newsletter on abortion access called “[Women’s Bodies Are Not Battlefields](https://www.ucc.org/womens-bodies-are-not-battlefields/)” and an action alert urging passage of the “[Women’s Health Protection Act](https://p2a.co/dMClN3m?inf_contact_key=bfa45db00fffe8be28ff04ba77c39801842e902fbefb79ab9abae13bfcb46658).”

* 1. Any changes compared to pre-COVID 19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?

There was a shortage of PPE for Preterm. The Director of Nursing needed to visit a food service provider to find gloves, after having called multiple medical facilities early pandemic to find access. There was a shortage of drugs (e.g. Fetanyl) as a result of supply chain issues.

* 1. Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID – 19.

People who relied on public transit—staff and patients—were not able to get to their appointments or shifts. Childcare for patients and staff was a challenge.

The less access to resources, the bigger the impact. People of poor and working-class backgrounds, in this area, primarily People of Color, were deeply impacted.

The wait times for abortion was astronomically increased. Accessibility was impacted and our patients traveled from outside our normal range to find something in a legal time frame.

Additionally, through communication with other clinics in nearby US states, Preterm is aware that patients traveled out of state to access abortion believing that it was not accessible in Ohio.

* 1. Please also share information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected.

Because childcare services were suspended, staff needing childcare had undue burdens on getting to work, and people who needed to access the clinic services had to make alternate arrangements.

* 1. Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.

We had a lot of immediate community support through handmade cloth masks, a rise in personal small donations, and advocacy.

As mentioned above, the clinic was able to technologically innovate, where legal to do so, in the use of telehealth for patients.

1. In connection to questions 1 to 3, please also share other relevant information on legal, policy or other changes affecting the right to sexual and reproductive health and related health care in your country or countries in focus, unrelated to COVID-19.

In May 2021, the U.S. Supreme Court decided to hear a case involving a Mississippi law banning abortion beginning at 15 weeks of pregnancy (Dobbs v. Jackson Women's Health Organization), with a decision in the case expected in June 2022. It would be difficult to overstate the significance of this action. The Court is almost certainly signaling that it is ready to overturn or significantly revisit Roe v. Wade, the U.S. Supreme Court case that established a constitutional right to terminate a pregnancy.

The United Church of Christ is attentive to this upcoming challenge and sent an [action alert](https://p2a.co/dMClN3m?inf_contact_key=bfa45db00fffe8be28ff04ba77c39801842e902fbefb79ab9abae13bfcb46658) on May 27, 2021 to the entire Justice and Peace Action Network (20,000+ Advocates) summarizing what the Supreme Court announcement means and urging Congressional action to support access to abortion. The alert asked for Congressional passage of the “The Women’s Health Protection Act” (introduced on June 8, 2021.) The bill enacts protections on the federal level to safeguard access to high-quality care and to secure constitutional rights by protecting patients and providers from political or religious interference. It would bar state and federal legislation that imposes medically unnecessary regulations on access to abortion services including medication, mandatory waiting periods, or out and out abortion bans. Reliance on the Supreme Court for abortion protection means that in many states and localities people have not been able to access abortions because their local governments have enacted laws to make it difficult or impossible to get an abortion. Federal action and protections would provide more equitable abortion access.

The United Church of Christ also joined with National Partnership for Women & Families to urge President Biden to end the Hyde Amendment in the federal budget, which says federal monies cannot be used for abortions. This penalizes mainly low-income people who need abortion access because it prohibits Medicaid coverage of abortion. In addition to Administrative outreach, the UCC has done Congressional outreach for passage of The Equal Access to Abortion Coverage in Health Insurance (EACH) Act would end the Hyde coverage bans.

The nomination of Judge Barrett to the Supreme Court also presents a challenge to abortion rights, as she repeatedly in past articles and public information has stated opposition to abortion rights and Roe v. Wade, the landmark abortion rights Supreme Court case. The United Church of Christ joined in numerous letters with partners opposing her nomination as well as drafting a statement in opposition to the nomination naming those concerns among others (like dismantling the Affordable Care Act.)

In February 2020, just before the start of the pandemic, a U.S. appeals court upheld and allowed to go into effect a rule that prohibits family planning agencies receiving federal family planning funding from referring for, or counseling about, abortion services. Planned Parenthood had already withdrawn from the Title X program nationwide because of the rule, which was adopted by the Trump Administration in 2019, resulting in a loss of quality family planning services in many regions across the country.

This did not stop Ohio from pushing through new laws or doubling down on other restrictive laws, such as the fetal tissue remains bill as mentioned above, as well as the restriction on abortion for known cases of Down Syndrome, upheld after appeal on April 13th, 2021, and prohibits physicians in Ohio from performing an abortion if they are aware of a known case of Down Syndrome.

Telemedicine was expanded by the Ohio government during the pandemic; yet there was an Ohio law forbidding the use of telemedicine for abortion specifically and medication abortion. It passed in December in 2020, and while not immediately connected to COVID-19, it came during a time when the trend was toward expanding access to telemedicine for medication abortion at the federal level.

1. Please indicate if your country, institution or organization has decreased financial support or aid to other State, donor or institution or programme in the area of sexual and reproductive health, including through international cooperation, compared to pre-Covid time.

The Biden Administration repealed the global Gag Rule. The United States AID funds nowflow to organizations that can advocate for abortion or support abortion services. Additionally, the global Gag Rule has historically been a political game piece with swift changes depending on which political party is in power in the United States.

1. Please indicate if your country, institution or organization has been affected by a decreased in financial support or aid, including through international cooperation, compared to pre-COVID time, and how this has affected sexual and reproductive health care.

Preterm did receive additional foundation -related funding from *Anonymous* as a result of the pandemic, used to bolster staff and paid personnel costs.

Preterm did not receive international support or cooperation.

However, we believe it is worth highlighting the project [*Thank God for Abortion*](https://www.instagram.com/thankgodforabortion/) *–* an international solidarity art project which lifts the love of the divine and the abundant access to abortion as values. It centers Women of Color, educates, and preaches radical acceptance for abortion.

Contributors:

Rev. Dr. Chris Davies, United Church of Christ National Staff & Preterm Board Member

Chrisse France, Preterm Executive Director

Laura Ackerman, RN, Preterm Director of Nursing

Jessie Hill, JD, Preterm Board President and Human Rights Litigator

Katie Adams, Policy Advocate for Domestic Issues, United Church of Christ National Staff