¡Somos Poderosas!
A HUMAN RIGHTS HEARING IN THE RIO GRANDE VALLEY
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It was a long day, but the activists of the Nuestro Texas campaign were not tired. We were happy to be there, and I was very proud of everyone who shared their stories that day.

The stories we heard showed the many problems we have here in the Valley. We heard women say they were sick but that they could not afford a doctor’s visit. That they are worried about their own future and that of their children. That as women, they hold their families and communities together, but they don’t have basic human rights.

Nuestro Texas is made of poderosas. The majority of us shed tears that day. But we also wiped away these tears to continue forward with strength. The problems we face in our communities have answers, and finding those solutions depends on all of us.

On International Women’s Day, we heard the words of the human rights experts who came to the Valley and listened to us. Their words encouraged and strengthened me because it showed that we are not alone. We are part of a strong, powerful team. That strong and powerful team began right here in the Rio Grande Valley with our poderosas who work every day for change in our communities.

This is the beginning. We are taking up our tools, and we will not give up. We will continue to fight; we will continue to rise up, no matter what we are facing. What Texas looks like today does not matter. What is important is that you and I can change it. We will rise up and say, “Sí se puede.” We have the power.

The other day someone told me, “Do you know what, Lucy? Texas is waking up.” And I said to them, “Do you know what? Texas never fell asleep.” Because Texas was always listening. Texas was always talking. But now we are going to raise our voices so that we are finally heard.

I fight for me. I fight for my mother. And I fight for my son because I do not want him to face the same Texas tomorrow that we are facing today. I tell him to pay attention to what we are going to do. We are all fighting together for a different Texas—a just Texas. What we want is a Texas with human rights for all.

Forward

By Lucy Ceballos Félix, Senior Field Coordinator
NLIRH Texas Latina Advocacy Network
INTRODUCTION & BACKGROUND

On March 9, 2015, in McAllen, Texas, less than ten miles from the southernmost U.S. border with Mexico, hundreds of people from local communities gathered for a public human rights hearing, a first-of-its-kind event in Texas. They brought their children, mothers, friends, and neighbors to support the brave women who were willing to share their stories publicly, many for the first time. The women testifying were from border communities hardest hit by the women’s health crisis in Texas that escalated in late 2011. The seventeen women who testified were Latinas of reproductive age—mostly low-income and uninsured immigrants—each with a story about hardship and resilience.

The event, Nuestra Voz, Nuestra Salud, Nuestro Texas: A Women’s Human Rights Hearing was timed to coincide with International Women’s Day 2015 and with the middle of the 84th Texas legislative session. Latinas of the Valley armed to send a message to Texas elected officials that the reproductive health crisis the legislature triggered four years ago was far from over. Their message was clear: reproductive rights are fundamental human rights that must be guaranteed for all Texans.

A REPRODUCTIVE HEALTH CRISIS IN TEXAS

Latinas and immigrants in Texas, particularly those in border regions, have long faced difficulties in accessing the health care they need. For decades, specialized family planning providers had offered services at frontline clinics located in rural communities across the state, often serving as the only health provider for a population that is largely uninsured, ineligible for government health insurance programs because of immigration status, and low-income. These clinics provided crucial reproductive health services including family planning, well-woman exams, and cancer screenings for free or at low-cost rates. Evidence shows these clinics were both effective and efficient. Publicly funded family planning services in Texas saved close to $750 million in 2010 through the prevention of unintended pregnancies and other potential negative reproductive health outcomes.1

Despite the proven success of these state and federally funded programs, the Texas legislature in 2011 drastically changed the funding and policy landscape with respect to women’s preventive health care. The legislature severely cut state funding for family planning services by two-thirds, then restricted provider participation in the state’s women’s health programs.1 A study by the Texas Policy Evaluation Project showed that between September 2011 and March 2013, 40% of specialized family planning clinics in the state were forced to close, and 31% of the remaining ones reduced their service hours.2 For clients seeking services, the funding cuts resulted in longer wait times for appointments, stricter requirements to show proof-of-residency and income in order to qualify for reduced rate services, higher fees as fixed rate services replaced sliding scale fee structures, and decreased availability of preferred contraceptive methods.3

The impacts of the policy changes on providers and the women they serve has been profound, especially in the Lower Rio Grande Valley with its high uninsured and immigrant population.3 The funding cuts and restrictions on reproductive health providers forced 9 out of 32 specialized family planning clinics that were funded by the Department of State Health Services (DSHS) to close from 2011-2012.4 Dozens of others reduced services and hours, with some only able to stay open one day per week.3

Although funding levels were restored during the legislative session in 2013, and then surpassed in the 2015 session, the damage to the provider network will endure for years to come, especially in the hardest hit areas of the state like the Rio Grande Valley. A handful of clinics in the Valley have since reopened, but many of the women who lost services in the interim still face difficulties accessing timely and affordable care.4 Statewide, the number of clients served at DSHS-funded family planning clinics decreased by 54% from FY2011 to FY2012-2013.5 The policy changes have also cost the state more per patient in terms of dollars spent on family planning services.6

In 2013—just as the statewide rates of unintended pregnancy were skyrocketing due to lack of access to affordable contraception—Texas passed HB2, the most restrictive abortion legislation in the country. Although part of the legislation is currently enjoined, partial implementation of HB2 has resulted in the closure of approximately half of Texas’ abortion clinics that existed prior to the enactment of the law. Whole Woman’s Health, the Lower Rio Grande Valley’s sole remaining abortion clinic, was forced to cease providing abortions for 11 months. If the U.S. Supreme Court does not enjoin the law fully, the clinic’s ability to provide abortions will be severely restricted, preventing it from serving all of the patients in the region who seek abortion services. With the next closest abortion clinic located in San Antonio—a four hour drive on highways with multiple immigration checkpoints—it is anticipated that many of the women in the Lower Rio Grande Valley will lose access to abortion altogether.

NUESTRO TEXAS CAMPAIGN

In 2013, the Center for Reproductive Rights (the Center) and National Latina Institute for Reproductive Health (NLIRH), in partnership with the Texas Latina Advocacy Network (TX LAN) that serves as the voice and advocacy presence of NLIRH in Texas, released a report documenting the human rights violations experienced by women in the Lower Rio Grande Valley as a result of the loss of women’s health services beginning in 2011. This report—Nuestra Voz, Nuestra Salud,
INTRODUCTION & BACKGROUND

Nuestro Texas: The Fight for Women’s Reproductive Health in the Rio Grande Valley—galvanized the community and laid the foundation for the Nuestro Texas human rights campaign.

Now in its third year, Nuestro Texas has become a platform for advocacy and community mobilization with the goal of securing the human right to affordable reproductive health care for all Texans. Organizers used the report to further mobilize activist bases of the TX LAN in El Paso, Houston, Corpus Christi, and San Antonio. In January 2015, the campaign produced a proactive policy blueprint for the 84th Texas Legislative Session called Nuestro Texas: A Reproductive Justice Agenda for Latinas. The TX LAN has used this blueprint to advocate for the reversal of the worst impacts of the 2011 session and to advance a set of policies that affirms the health and human rights of immigrants and Latinas throughout the state.

The campaign has also used global platforms to draw attention to the situation in the Valley and to hold the United States accountable to its human rights obligations. In March 2014, Lucy Félix represented the TX LAN before the United Nations Human Rights Committee during its periodic review of the United States’ human rights record in complying with the International Covenant on Civil and Political Rights. From 2014-2015, the Center and NLIRH collaborated on three reports to U.N. treaty monitoring bodies about how the United States is failing to ensure all women have the ability to exercise their human right to reproductive health care. The collaborative international advocacy resulted in strong recommendations from the Human Rights Committee, the Committee on the Elimination of Racial Discrimination, and the Human Rights Council. Taken together, these recommendations urge the United States to eliminate discrimination in access to public health insurance for immigrants and to ensure timely and affordable access to health care—including reproductive health care—for women and their families regardless of immigration status.
OVERVIEW OF THE HEARING

GOALS

Nuestra Voz, Nuestra Salud, Nuestro Texas: A Women’s Human Rights Hearing was organized to provide women directly impacted by the reproductive health crisis in Texas with a public forum to share their experiences with community members, lawmakers, human rights experts, and allies from across Texas, the United States, and Mexico.

The concept of the event drew inspiration from various human rights hearings held in the United States and around the world over the past two decades. In 2014, the U.S. Human Rights Network (USHRN)—in partnership with local grassroots groups in New Mexico, Arizona, and New Orleans—held several human rights hearings in preparation for the Universal Periodic Review of the United States by the U.N. Human Rights Council in May 2015. In addition, a series of women’s human rights hearings held at global women’s rights conferences in the mid-1990s laid the foundation for global recognition of women’s rights as human rights, especially the Cairo Hearing on Reproductive Health and Human Rights at the 1994 International Conference on Population and Development. 14 At that pivotal hearing, testimonies from women around the world underscored that reproductive health is a fundamental human right and essential for gender equality. This paved the way for recognition of reproductive health and rights in the seminal ICPD Programme of Action and in subsequent international human rights instruments.15

More than 20 years later, the call for reproductive health, rights, and justice is just as urgent in the state of Texas. The Nuestra Texas women’s human rights hearing was an opportunity to situate the call for reproductive health access, equity, and justice within the broader human rights movements for immigrant justice and women’s rights. The organizers agreed to four specific goals for the hearing:

• to draw global attention to the urgent reproductive health crisis in South Texas and its impact on Latinas living on the border;
• to empower the women most impacted by Texas’s reproductive health policies to share their stories publicly and demand accountability;
• to engage policy-makers in identifying solutions to the health crisis that uphold women’s fundamental human rights; and
• to build a broad, inclusive movement for reproductive justice and human rights led by those most affected by human rights violations.

EVENTS AND ACTIVITIES

The date of the hearing was selected to coincide with International Women’s Day, an annual day to both celebrate women’s achievements and renew the call for gender equality. On Sunday, March 8, the TX LAN led a series of events in partnership with other community leaders to introduce the Lower Rio Grande Valley to the participating human rights experts, state and national activists, and other guests. The goal for the day was to showcase the empowerment, creativity, and resilience of the women of the Valley in the face of many challenges to their basic human rights.

Early in the morning, the TX LAN hosted a community meeting, or junta communitaria, at a colonia near the town of Mission. The junta, which took place in one of the TX LAN leader’s homes, was the first opportunity to introduce the human rights experts to the activists and leaders in the community and to share the TX LAN’s model of organizing and leadership development. Despite that morning’s torrential downpour, the activists created a safe and welcoming environment for learning and organizing, made all the more intimate by the sharing of homemade Mexican pozole.

The experts and activists then caravanned through pouring rain to Whole Woman’s Health in McAllen, the last remaining abortion clinic in the Valley, where they were led on a tour of the facility and had the opportunity to learn about the impact of Texas’ abortion restrictions on the clinic’s ability to serve the women of the region. Meanwhile, outside the clinic, volunteers, activists, and promotoras from the Nuestra Texas campaign gathered alongside the TX LAN for a sidewalk rally in support of the clinic and the critical reproductive health care services it provides.

In the afternoon, the experts and activists joined the TX LAN and over a dozen other community-based organizations for the first International Women’s March in the Rio Grande Valley. These co-sponsoring organizations included the Human Rights Coalition of South Texas, a cross-movement group that was co-founded by the TX LAN in 2013, the ACLU of Texas, Planned Parenthood Texas Votes, Texas Freedom Network, NARAL Pro-Choice Texas, Progress Texas, and Whole Woman’s Health. The march began at a border crossing bridge in Brownsville and ended at a local park, where a festive rally and community health fair awaited the marchers. At the rally were speakers including the partners of the Nuestra Texas campaign, leaders from various community groups, clergy, and local poets and musicians. And on March 9, the day of the hearing, dozens of women arrived early, despite torrential rains and flash flooding, to attend a human rights training co-hosted by the USHRN and NLRHR. They learned about the international human rights framework and how they could integrate the concepts and strategies into their local organizing and leadership development work.
After the training, hundreds of community members filled the room for the hearing. The leaders of the Center and NLIRH began by celebrating the collaboration on the Nuestro Texas campaign and each organization’s deep commitment to political and social change in Texas. A video followed from three Texas legislators sending greetings from the 84th Texas Legislature in the state capitol of Austin.

Throughout the morning and early afternoon, seventeen women shared their personal stories and, in some cases, the stories of their families or friends who gave them permission to speak on their behalf. These testimonies had been prepared in advance with support from the TX LAN, NLIRH, the Center, and students from the University of Texas Law School’s Human Rights Clinic and the International Women’s Human Rights Clinic at CUNY Law School. The full testimonies are included in the Testimony Insert. In addition to women directly affected by human rights violations, three additional people were invited to provide testimony at the hearing.

The Nuestro Texas women’s human rights hearing was a great moment—a glimpse of what can happen when we unleash the creativity and energy of our people!

— Karina Garcia, Education Manager, NLIRH and co-facilitator of the human rights training

The Center recruited the hearing’s human rights experts, prepared background materials for them to understand the context of the health crisis in the Valley, and coordinated all logistics for the hearing. The Center also provided general support for the hearing, including travel of participants and communications needs.

NLIRH recruited women to testify at the hearing and facilitated their participation. Activists and staff from the TX LAN served as the liaisons between community members and the hearing organizers. The TX LAN worked with community members to coordinate the march and rally on International Women’s Day, and NLIRH co-facilitated the human rights training with USHRN.

Along with co-hosting the human rights training, USHRN advised on outreach to experts, publicized the event to the broader human rights community, and supported communications. USHRN also produced a report on the hearing as one of the five human rights hearings organized prior to the Universal Periodic Review of the United States by the Human Rights Council in May 2015.15

PARTNERS AND ROLES

The Nuestro Texas women’s human rights hearing was a partnership between multiple organizations working at the global, national, state, and local levels. The partners leveraged different strategies, including human rights advocacy, community mobilization and education, leadership development, communications, and cross-movement organizing.

Women have long been the drivers of social change and leaders within their communities. Unfortunately, women and children are also disproportionately impacted by social, political, and economic inequalities that deny access to their fundamental human rights. The TX LAN is organizing those most impacted by detrimental policy decisions to build a culture of resilience and to demand access to their human rights. Empowered to move outside of their roles as victims of poor governance, racism, violence, and other systemic barriers, the women have become agents of change in their communities. They call themselves las poderosas—the powerful.

The TX LAN has mobilized a multi-generational activist base to lobby for policy change and hold government actors accountable to their human rights obligations. Having lost funding to support promotora (health education and outreach) programs, women now open the doors to their homes, churches, and community centers to hold educational workshops on reproductive health. In the face of clinic closures and reduced services, women organize transportation to health clinics farther away and pool their money for gas. They host community meetings, health fairs, rallies, and marches to educate each other and to develop a cadre of Latina leaders to fight for their rights and for a more just Texas.

After years of cultivating relationships with the community to build a network of change agents within the community, the TX LAN continues to support these women as they bravely share their stories in public forums and harness their own power to fight for health, dignity, and justice.

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HUMAN RIGHTS EXPERTS

Seven human rights experts from the United States and Mexico were invited to attend the hearing and offer commentary on the testimony. All are domestic or global leaders in the fields of health care and health policy, immigration, and reproductive rights. They include lawyers, academics, advocates, and service providers. The majority are bilingual in English and Spanish (simultaneous translation was provided during the hearing to commentators and audience members who requested it). The experts’ names and affiliations are below, with full biographies at the end of the report.

- Alicia Yamin – Policy Director, Francois-Xavier Bagnoud Center for Health and Human Rights and Director, JD/MPH Program, Harvard School of Public Health (Boston, MA)
- Catherine Albisa – Executive Director, National Economic & Social Rights Initiative (New York, NY).
- Cynthia Soohoo – Director, International Women’s Human Rights Clinic, City University of New York Law School (New York, NY)
- Edward Zuroweste – Chief Medical Officer, Migrant Clinicians Network; Assistant Professor of Medicine, Johns Hopkins School of Medicine (Syracuse, NY)
- Marielena Hincapié – Executive Director, National Immigration Law Center (Los Angeles, CA)
- Regina Tamés Noriega – Executive Director, Grupo de Información en Reproducción Elegida (Mexico City, Mexico)
- Sera Bonds – Founder/CEO, Circle of Health International (Austin, TX)

ACKNOWLEDGMENTS

The Nuestro Texas campaign extends its deep appreciation to the women who bravely testified at the Women’s Human Rights Hearing. Their participation would not have been possible without the tireless and inspiring leadership of the Texas Latina Advocacy Network, especially Lucy Félix, Dinorah Martinez, and Ana Rodriguez DeFrates. Katrina Anderson from the Center and Diana Lugo-Martínez from NLIRH co-coordinated the hearing with invaluable support from their staff, especially Karla Torres and Seth Weintraub at the Center, and Angy Rivera, Dieniz Costa, Elizabeth Estrada, Karina Garcia, Kimberly Inez McGuire, and Natalie Camastra at NLIRH.

We are grateful to the human rights experts who provided insightful commentary and analysis of the testimony, and who continue to support the Nuestro Texas campaign in their respective spheres of influence: Alicia Yamin, Catherine Albisa, Cynthia Soohoo, Edward Zuroweste, Marielena Hincapé, Regina Tamés Noriega, and Sera Bonds.

Our organizational co-sponsors helped organize the community march and publicize the hearing to the community. Thanks to the ACLU of Texas, CUNY School of Law International Women’s Human Rights Clinic, IBIS Reproductive Health, NARAL Pro-Choice Texas, Planned Parenthood Texas Votes, Human Rights Coalition of South Texas, Texas Freedom Network, Texas Research Institute, University of Texas School of Law Human Rights Clinic, Progress Texas, USHRN, and Whole Woman’s Health.

We also acknowledge the contributions of our community allies who provided additional testimony about the impact of Texas’ reproductive health policies on women and providers in the Valley: Andrea Ferrigno of Whole Woman’s Health McAllen, Liza Fuentes of Ibis Reproductive Health and the Texas Policy Evaluation Project, and Kathryn Hearn of the Access Esperanza Clinic. Special thanks also to the staff of Whole Woman’s Health McAllen for providing a tour of the clinic.

Many volunteers helped with the activities surrounding the hearing and community march. Law students from two human rights clinics researched and wrote various background memos for the human rights experts and helped record women’s testimony prior to the hearing. Thanks to Sarah Verbil and Diana Aragundi from the International Women’s Human Rights Clinic at the City University of New York Law School under the supervision of Professor Cynthia Soohoo, and to Bianca Scott and Silvia Higuera from the University of Texas School of Law Human Rights Clinic under the supervision of Professor Ariel Dulitzky.
**THEMES FROM TESTIMONY**

**INVESTING IN WOMEN’S HEALTH LEADS TO HEALTHIER COMMUNITIES**

Much of the testimony at the hearing focused on the role of women as community leaders and main providers for their families. The women who testified called on policy makers to recognize that an investment in women’s health is essential for families and communities to thrive.

Brenda, a single mother facing breast cancer, asked: “When am I going to be able to treat these lumps [in my breast] that affect me every day? What consequences will I continue having if these lumps continue to go untreated? As a woman who gives life, I need my benefits, my care, my rights, my clinics. Our community needs it, our Valley needs it.” Paula, a promotora in the Valley, explained that women need to be healthy because of the multiple roles they play in their families and communities: “[Reproductive health] services are important so we can focus on bringing up our families, finishing our education, and living full, healthy, prosperous lives.”

Teresa explained:

*We need help because we need to be healthy to raise our children to succeed as women. I would like for these services and this support to be provided not just to one person, but to the thousands of women that would benefit from better health. Many women are dying of cancer because they do not have sufficient means for cancer prevention. Therefore, we need support and help where it can be offered. More than anything, we need support to open the doors to greater access to health care. We need the support of the government; we need more help and for them to give more attention to us as women. We need this help to be healthy and to keep forging ahead.*

**PERSISTENT OBSTACLES TO ACCESSING CLINICS**

More than three years after the 2011 budget cuts led to clinic shutdowns in the Valley, women reported that finding affordable and timely reproductive health care was still very challenging. The inability to get a timely appointment left some with no choice but to delay or forego care.

Teresa told the tragic story of her neighbor and friend who died from cancer that could have been detected and treated if she had received a preventive screening at the time she first sought one:

*She died of [uterine] cancer. She was thirty-three years old. She went to the clinic several times to get treated, but they never had funding and she could not see a doctor. She went to the clinic in pain, and when she finally went to the hospital, the cancer had spread. They did not detect the cancer in time, because the clinic never had doctors or funding. She only lived for two months [after finding out that the cancer had spread], because the cancer was more advanced than she had ever imagined. This is a difficult story, because her young children were left [without a mother]. The children have been taken by the state and are now up for adoption.*

Others testified about additional serious health consequences resulting from delays in accessing care. Julia sought treatment at her local family planning clinic in December 2012 for intense pain and heavy bleeding. “When I asked them for help, they told me they did not have appointments until September 2013. I told them jokingly that by then I would be dead.” Faced with no other options, Julia eventually went to the emergency room, where she was diagnosed with advanced colon cancer. Since then she has struggled to pay for and receive timely radiation, chemotherapy, and other necessary treatments.

Kathryn Heam from Access Esperanza Clinic explained that many women were forced to go with no care at all when that clinic closed in 2011 due to the loss of state reproductive health funds. When the clinic reopened its doors in 2013—after disaffiliating with Planned Parenthood in order to qualify for state funding—the staff was shocked to learn that women had not received any care whatsoever in the intervening time period. “Over and over again we asked the women, ‘Where have you gone these past two years? Who have you seen for your health care?’ And they said, ‘Nowhere. We’ve seen no one.’ … In those first weeks [after the clinic reopened], we saw
so many women who came in who had serious illnesses. “The patients included one with a reproductive system cancer that would have been detected through timely preventive screening.

**LACK OF AFFORDABLE HEALTH CARE**

Many of the women who testified at the hearing spoke about the economic burden of now having to pay much higher fees for the reproductive health care they formerly received at low-cost rates. Most of the women who testified lack health insurance entirely or are underinsured, forcing them to pay out-of-pocket for their health care needs. The cumulative costs of doctors’ visits, contraception, lab fees, and specialty care can place an enormous financial strain on a family’s resources, forcing many women to choose between paying more than they can reasonably afford for their health care or foregoing care altogether.

Some are forced to live with pain for extended periods of time because they cannot afford timely or appropriate care. Leticia experienced severe pain and hemorrhaging for three months, but was unable to go to the doctor because she could not afford the $250 consultation fee. She repeatedly showed up at the doctor’s office asking to be seen. “Seeing me insensible, they tended to me. Unfortunately, that is when they detected a tumor in my womb. I felt the world close in on me. The first thing I thought of was my children. Who will care for them if I am not here?” Margarita’s family lacks health insurance, and she is unable to afford tests for her 13-year-old daughter, who has cysts in her breast. “My daughter realized how much money her biopsy would cost me and said that she would rather not have it because she knew we didn’t have the money to pay for it. She said this to me even though there are times she can’t stand the pain.”

Others testified that they often had to skip doctors’ visits because of lack of funds. Karina testified about the financial burden of receiving care for the cysts in her uterus that have caused her to hemorrhage for up to three months at a time. She makes a minimal income from selling tamales and lacks the resources to pay for doctor visits. “When I have made it to the doctor, it is often a battle and sometimes I have had to miss appointments because I do not have enough money [to pay for my care].” Paula is a promotora who teaches other women about the importance of regular screenings but has not been able to afford one herself for over four years. Her job is part-time and temporary, and she cannot trust she will be employed once the year-long wait for an appointment is over. “I can schedule appointments, and I can wait a year. I have already waited four years. But because of my unstable employment, I don’t know if I will have money to pay for the services then.”

The cuts in family planning funding meant that “fewer (clinics) were able to provide IUD (intrauterine devices), implants, or surgical sterilization to all who wanted it.” Liza Fuentes reported. Without access to the most effective forms of contraception, women had to rely on less reliable forms, such as birth control pills. Paula explained that women’s efforts to save money place them at risk: “One woman told me that she has to share her birth control pills with her sister because they are expensive. This puts them both at risk of getting pregnant.”

Araceli and Alejandra each spoke about how their inability to access affordable contraception led to an unintended pregnancy. Araceli was thrilled when she qualified for the Texas Women’s Health Program (TWHP) and could access birth control as a student on a limited income. But five months later, her TWHP benefits were denied. “I didn’t understand. I felt discouraged and even fearful of reappearing after my second attempt. Not being able to afford my birth control, I became pregnant at nineteen.” She decided to terminate her pregnancy, but “to this day, I still cannot qualify for the TWHP and have not seen a women’s health provider in over two years.” Alejandra became pregnant for the third time, despite using “expensive contraceptive methods, which I could not afford.” She had been trying to avoid another pregnancy because her resources were strained by caring for two children, including one with cerebral palsy.

Other challenges such as lack of transportation and child care add to the economic burden on women seeking health care. The lack of public transportation makes it very challenging for women in rural areas to access health clinics. Those with access to a private vehicle spoke about the price of gas as a deterrent to seeking care. The closure of a rural clinic may mean that women have to travel very long distances to reach the next closest provider. As Carolina explained, the closure of every clinic but one in her area meant that “the appointments were delayed a long time, and some of us had to wait in long lines. Not all of us were able to receive treatment.” She eventually found a clinic located one hour from her home, but she had to miss two full days of work to make separate trips for the appointment and the follow-up visit, which further added to her economic burden.

**ACCESS BARRIERS FOR IMMIGRANTS**

Many of the women who testified are undocumented immigrants who work in low-paying jobs in the informal economy. Because there are few remaining clinics in the Valley with the funds to serve women on a sliding scale, the facilities that do offer this often require their clients to produce proof of income to qualify for reduced rates. The application process is arduous and daunting, especially for those with language barriers and little familiarity with the U.S. health care system.

Brenda explained that she could not produce the necessary documentation to qualify for a sliding scale fee at a clinic. She has tried fruitlessly to obtain a low-cost mammogram to check on several small breast lumps she first discovered in 2012. Her only other option is to pay for services at a private clinic, which she cannot afford. Dealing with the bureaucracy has cost her much time and lost wages. The financial stress has added to her worries about a potentially fatal and undetected illness, and ultimately the security of her child. “The only thing I am gaining is increased pain and the possibility of gradually losing my life and my precious daughter.”

Several women testified that they were unable to find information about where they could access alternate sources of affordable care once their trusted family planning provider had closed and about whether they were still eligible for low-cost programs that had allowed them to access care at a reasonable cost. Alejandra stated that she didn’t have “the financial resources or knowledge about the existence of programs and clinics offering low-cost women’s reproductive health services” that could have helped her. “I also believed that because I was an immigrant, I did not have any rights,” she said.
Some spoke about encountering discrimination from health care providers as a result of their undocumented status. After learning from her doctor that she had advanced cancer and would have three months to live unless she started treatment immediately, Julia was discouraged from applying for insurance offered by the county to cover certain kinds of medical care for the indigent. The hospital social worker told her, “You’re not going to find insurance here. It would be better if you went back to where you came from.”

A consistent theme raised during the testimony was the need for access to health care that does not depend on immigration status. Josefina testified, “Being able to prevent illness should be within every woman’s reach because we want healthy women in our homes, in our communities, and in our Texas. The clinics should be accessible to everyone. Regardless of our immigration status, we have rights.”

Some women testified about their wishes being ignored or dismissed by service providers, especially during childbirth. When Elena arrived at the hospital to give birth, all signs were normal, and she expressly stated her desire for a natural birth to the attending doctor. However, shortly afterwards, the doctor told her boyfriend to leave the room, then broke her baby, but the doctor didn’t even let me try.”

There were also stories of medical neglect. Verónica’s physician failed to react in a timely manner when she raised alarms about new and unusual symptoms she was experiencing during pregnancy. She eventually miscarried. Her doctor knew about a tumor in her uterus but refused to treat her following the miscarriage because Medicaid would not reimburse for the procedure unless it was performed immediately following childbirth. He urged her to visit the emergency room instead. Despite three visits in which she described her “intense pain,” the hospital also refused to treat her. Eventually, she was forced to lie about her insurance status in order to get treatment. She then learned that the tumor had completely consumed her uterus and required emergency surgery. “To avoid being denied care again, I lied to them about my insurance status,” Verónica said.

**BARRIERS TO ABORTION CARE**

Recently enacted abortion restrictions are increasing barriers to safe abortion at the same moment that women in the Valley face challenges in securing affordable contraception. Liza Fuentes explained the results of a recent study by the Texas Policy Evaluation Project on the impact of HB2 in the Valley.

This law has forced women to pay more for an abortion and travel farther away to obtain one, in some cases preventing women from obtaining a safe abortion altogether. When the admitting privileges requirement and restriction on medication abortion went into effect in October 2013, Whole Woman’s Health McAllen—the sole abortion clinic in the Valley—could not continue to offer abortion services. For 11 months, women were forced to travel four hours away to San Antonio to receive abortion care, incurring significant costs to cover transportation, accommodation, and lost wages from work.

Liza Fuentes explained:

> Among the most significant impacts is that some of these women did not have the abortions they sought. Two of the twenty women we interviewed did not obtain their abortions at all after failed attempts to make appointments, even though they wanted one. For them, the lack of information, time, and money pushed them to make the decision to carry their pregnancy to term. Both initially strongly preferred a medical abortion, and they recognized their pregnancies early enough to be eligible, but they could not locate a clinic within their reach.

> “If you can’t see me [for an appointment],” the woman said, “then I can tell you what is underneath my kitchen and bathroom sinks, and you can tell me what I can take to abort.”

The McAllen clinic reopened in September 2014 by order of the U.S. Supreme Court and remains open as of July 2015 pending the resolution of the underlying legal challenge. Andrea Ferrigno, vice president of Whole Woman’s Health, reported that the loss of services in the Valley deprived many of the state’s most vulnerable women from accessing safe abortion care. She received calls from women who were unable to go to San Antonio because they feared passing through the immigration checkpoint on that route. One woman begged her to perform an abortion, explaining that she needed to focus all her resources on her existing children and could not afford another child.

Those who were able to obtain a safe abortion discussed the barriers they had to overcome in order to act on this decision, including legal barriers that fueled abortion stigma. Arcelí told the story of becoming pregnant in college at age 19 after losing access to affordable birth control. She decided to seek an abortion, but her confidence in her decision did not prepare her for the vitriol of anti-abortion protestors outside the clinic. “The amount of shame and dehumanization that I received on my brief walk to the clinic doors was so traumatizing and surreal.” The Texas 24-hour waiting period law required her to return for a second visit and face the protestors again: “I remember my body shaking with anxiety of having to pass through these hateful people once more.” She expressed outrage that Texas law required her not only to have an ultrasound but also to view it, which she found “unnecessary and disrespectful” in light of her decision to terminate the pregnancy. “An ultrasound that felt so uncomfortable and shameful is embedded in my memory and the mandatory view of said ultrasound made me question so much about what I had control over in my decision.” After her abortion, Arcelí learned that one of the anti-abortion protestors who had harassed her as she entered the clinic for her appointment is the director of the McAllen Pregnancy Center, “a local center that works to dissuade folks from having abortions by providing them with false information about their pregnancies and heavy religious rhetoric.”

Valentina—a woman who testified that her legal abortion was one of the best decisions of her life—worries that the most marginalized women will not have that choice due to the cost of the procedure and the travel burden. “As we see more anti-choice laws being passed, it is the poor and undocumented who are affected first and most harshly.” Paula, the promotora who testified, acknowledged that most women do not stop seeking an abortion if they have decided to get one, and instead they turn to self-administered methods that can be unsafe and ineffective, such as herbs, drinks, or physical injury, as well as other methods that are safe, such as abortion pills. “When women find themselves with the need to seek medical attention and they can’t find it, they decide to self-medicate or look for home remedies, which can put their lives in more danger.”
Following the testimony, the commentators met together to discuss what they had heard, then returned to deliver brief remarks based on their individual expertise. This section identifies some of the common themes that emerged in the commentary.

Several commentators found synergies between the organizing efforts in the Valley and other human rights movements, including movements for reproductive rights in Mexico and domestic struggles for immigrant rights and for the right to universal health care. Those who are medical service providers noted the discrimination and other problems that inhibit quality health care for immigrants. They also addressed structural barriers—such as poverty, stigma, and violence—that prevent women from accessing health services at all. Legal advocates focused on the responsibility of government to address both policy and non-legal barriers to care and noted the large chasm between the U.S. system of health care and one based on human rights principles.

**Resilience and Power**

The commentators commended the women who testified for their courage in sharing their stories, as well as their determination to fight for a better future even while struggling with illness, adversity, and daily violations of their human rights.

Alicia Yamin objected to using the term “human rights expert” to apply to the panel of commentators, saying, “The truth is that you are the real experts because you know what it means to lead a dignified life and to be deprived of leading a dignified life.” Marielena Hincapié linked the organizing work in the Valley to national efforts working for political change on behalf of all immigrants:

*I am inspired by the community that you have developed and how you continue creating political power, because eventually that’s the only thing that will make change. The political power that you are planting here, and that you are watering every day, I know it is going to bloom, and we will be able to achieve changes because of the work of each one of you.*

Hincapié quoted Lucia’s testimony when she said: “the woman is the backbone of the family, yet women continue being ignored, marginalized, and forgotten by our government.” Cynthia Soohoo also addressed this paradox: “We know that women should be able to take care of themselves and make their own decisions about their reproductive health and their reproductive futures. This is because women are so important to their families. You need to be able to take care of yourselves so you can take care of your families. We’ve heard this over and over today.”

**Inequality and Discrimination**

Commentators highlighted the theme of inequality that recurred throughout the testimony. Alicia Yamin began her comments by focusing on how the U.S. health care system entrenches rather than remedies social inequality:

*The health care system in any society is a social institution that can facilitate equality—material equality and real democracy. But it can also be exclusive, reflecting the discrimination patterns of the society at large. In this case, the health system not only reflects but worsens the discrimination you have faced in your lives in the United States. In many cases, poverty, marginalization, and oppression are experienced when interacting with the health care system, especially for women who have reproductive health needs.*

The commentators underscored the fundamental importance of reproductive rights to gender equality. Their analysis examined the ways that policies discriminate on the basis of gender by targeting reproductive health care services that women need, such as family planning and abortion. Cynthia Soohoo focused specifically on how gender discrimination appeared in various forms throughout the testimony:

*From structural barriers that especially impact women—such as poverty—to legal and policy barriers restricting access to contraception and abortion.*

Human rights standards make clear that all States have an obligation to ensure that health care is provided in a non-discriminatory way. When health care services discriminate and fail to provide the services that women need, that’s discrimination—and that’s unacceptable under international law.

She went on to explain that Texas violates the right to be free from gender-based discrimination when it passes policies targeting health services:

*I am appalled that the (Texas) legislature is passing laws that are not designed to protect women’s health, but rather designed to shut down abortion clinics. When you look at these laws, that’s really the only purpose: to close down clinics so that people can’t get the health care they need and also to put barriers in the way of people’s access to abortion services. Here in the United States, access to abortion is supposed to be a constitutional right. I don’t understand how the state can pass laws that actually make it more difficult to get these services.*

In addition, the commentary addressed how these policies do not affect all women equally. A human rights analysis of
“A Crisis That Affects Us All”
— A Post-Hearing Reflection by Catherine Albisa —

The testimony at the women’s human rights hearing on March 9 in McAllen, Texas, was offered by the impressive women who together make up las poderosas and their Nuestro Texas Campaign. They echoed the stories of people from coast to coast who have been incomprehensibly denied health care in a country that spends enough health care dollars to provide for everyone. Health care resources, however, do not follow need but rather profit in our system. This means health care is treated as a commodity rather than a right and a public good.

In the “Healthcare is a Human Right Campaign” in Vermont, it was White working class people who shared their stories about having to choose between providing for their families and getting life-saving care. In the Moral Mondays Movement throughout the South, people from all walks of life are fighting for universal care. The region is suffering from such lack of access that in Alabama alone the refusal to expand Medicaid left 300,000 people out of the health care system, more than a third from the Black community. And in Texas, it is the brave, mostly immigrant Latinas who represent the face of those failed by our abusive system.

The challenges across the country may look different, but they are inextricably connected. The life-threatening health care violations and struggles on the Texas border are not simply the product of a few pieces of bad and hostile legislation. While it is true that the Texas legislature has cut budgets and passed inhumane legislation that destroyed what limited access uninsured immigrant women had to reproductive health care, the reality is that such legislation could only have been put forward within the empty spaces of abusive health care and immigration systems. The current health care crisis on the border would simply be impossible in the context of a universal health care system that recognized the basic right to access health care for every person within our country. And even absent a universal health care system, an immigration system that recognized the needs of communities on both sides of the border would have blunted the force of this hateful legislation.

The failures at a systemic level that allow for the hate and discrimination reflected in Texas policy to seep into the lives of marginalized communities are the result of a fragmented and privatized health care system. Fragmentation results in a range of programs providing different levels of access depending on income, geography, immigration status, and other factors, and it inherently creates a risk of people and families falling between the cracks. Privatization then ensures that resources disproportionately flow to those who can pay rather than equitable use of those resources for all those who are ill and injured. This leads to absurd scenarios where just one private company like Pfizer spends $175,000 million a year in advertising for Viagra while 54% of U.S. chronically ill patients do not get recommended care, fill prescriptions, or see a physician when sick because of the high cost of care. And our poorest communities, like many border communities, are experiencing a severe drought of needed resources, while only a few hours away wealthier Texans can access high quality care.

The crisis on the border is inherently an American crisis that affects us all. Human rights and public goods go hand in glove and are essential to any healthy democracy. Listening to women—who don’t even know whether the cancer they probably have will kill them—agonize over what will happen to their children is the extreme manifestation of a degraded human rights landscape that we must commit to change.
“I am committed to elevating the public dialogue on issues that affect the Latino community. I see access to a full range of reproductive health care for all Texans, no matter your zip code, no matter your immigration status, and no matter your age, to be of paramount concern . . . Enough with the shame, enough with the judgment. Please know that I am standing in solidarity with you, the brave Latinas of today’s hearing who are fighting today and every day for a better Texas. I am with you as you share your collective strength and publicly share your experiences about violations of your human rights.”

— State Senator Silvia Garcia

the right to be free from discrimination is based on intersectionally, taking into account the ways in which multiple identities intersect and make certain people more vulnerable to discrimination. The commentators explored how the women of the Valley experience multiple forms of discrimination—based on their gender, ethnicity, socio-economic class, immigration status, and rural residence—that uniquely affect their ability to access services. For example, Marielena Hincapié stated, “What I take home in my heart, listening to these stories, is that civil and human rights are being violated, especially when one combines gender, immigration status, and economic status. As a woman, as an immigrant, as a low-income person, you feel these human rights violations the most . . . Medical care is a human right regardless of the immigration status of the person.”

The commentators applied a substantive equality approach when analyzing the testimony. This approach recognizes the need for governments to identify the underlying causes of discrimination that lead to inequalities, including both discrimination in law (de jure) as well as in effect (de facto). It also requires that governments measure progress on addressing inequalities by looking at the outcomes of results for all persons—including the most marginalized—and ensuring equality of results. As several experts recognized, this may require enacting practices and policies aimed at benefiting certain groups that have been historically marginalized, including women and immigrants. Regina Tamés urged policy makers to address “the bureaucratic obstacles and lack of training for health personnel that perpetuate biases against those who have the right to use health services.” Such structural barriers include degrading or humiliating treatment by providers, denial of information, and service delays.

VIOLATIONS OF THE RIGHT TO HEALTH

Several commentators addressed the wide gulf between a health care system based on the human right to health and the one described by the women in their testimony. Catherine Alibus explained that the challenges that women in the Valley face in obtaining care derives from the fundamental problem of a lack of recognition for the right to health in the United States: We have a fragmented system that is not working for constituents. It is not working here on the border, and it is not working anywhere in this country . . . How do we get to a system that has all the elements that fulfill human rights? How do we get to a universal system that includes everyone and all the services, that is equitable, where rights are not bought but are financed publicly so everyone has access, a system that is accountable to the community when it fails; a system that is democratic and that can improve with the participation of all in the community? This is a human rights system. Our system in this moment is fragmented, privatized, unstable, and exclusive of our communities. This is not a system based on human rights and the right to health.

Despite its lack of recognition in the United States, the right to health is a fundamental human right protected by numerous international instruments that the United States has drafted, signed, and ratified. Alicya Yamin explained that governments have minimum core obligations with respect to the right to health. These include ensuring non-discrimination in access to health care; equitable distribution of health facilities, goods, and services; and reproductive, maternal, and child health care. In her view, Texas has failed to meet its minimum core obligations to ensure reproductive health care.

International law recognizes that governments have varying levels of resources and may not be able to fully implement the right on an immediate basis. Nevertheless, States are expected to move as quickly as possible towards that goal. The duty of progressive realization27 of the right to health requires states to take steps that are “delicate, concrete and targeted,” to the “maximum of [the State’s] available resources.”28 The correlative duty of non-retrogression prohibits governments from implementing measures that reverse progress on realizing the right to health.29 Texas violated the duty of non-retrogression when it cut its budget for women’s reproductive health care services in 2011. Yamin elaborated: The concept under international law of non-retrogression (means) if there are budget cuts, the government—in this case the state government—has the obligation to justify that cut. And that cut should be according to the most proportionate measures, having a minimum impact on people’s rights. The state will have to show that it has considered and evaluated all possible options, and that the cuts will not hurt the most marginalized and poorest people in the state. And in this case, the Texas state government has not done this. Therefore, you have the right to demand from the government an explanation that justifies the decision to cut services, and they have to do this publicly, in a transparent way.

Elements of the Right to Health

While all of the experts addressed inferences with the right to health, they each focused on a different aspect of that right. Alicya Yamin offered an introduction to the components of the right to health.

Under international human rights law, the right to health has four interrelated elements.30 The first element is availability. Availability of goods, clinical services, and human resources. These, as we have been able to see throughout all these stories, do not exist in the Valley:

The second element is that of access to services and goods and facilities.31 And access has several dimensions: (1) physical access, and we have heard about the problems with transportation, about access of information, about closed clinics; (2) economic access, meaning it has to be affordable, and we have also heard several problems in that area; (3) non-discrimination based on disability, race, ethnicity, language, immigration status—we have also heard some stories about violations of that element of the human right to health; (4) information access, and this is of paramount importance because we have heard several stories in which women lacked information not only about their rights but also about their physical health.

Under international human rights law, the right to health has four interrelated elements:

1. Availability
2. Access
3. Non-discrimination
4. Information access

The first element is availability. Availability of goods, clinical services, and human resources. These, as we have been able to see throughout all these stories, do not exist in the Valley:
In March 2015, I traveled to the Rio Grande Valley of Texas for the first time. The reality there left me shocked, but, at the same time, it was familiar. The dirt roads with no pavement, the houses built bit by bit depending on how much money was available (but all with television antennas), the many boys and girls running around, the lack of public electricity—all made me feel like I was in Mexico. The landscape was not different from one you could find in any community a few kilometers away from the big cities. Maybe listening to the frequent mix of English and Spanish was what made me realize that I was not in Mexican territory. The common denominator of poverty was also palpable and, when I started listening to the women, I was convinced that the discrimination against them transcended borders.

These Latina women, my fellow citizens from the other side of the border, confront legal obstacles that impede them from accessing reproductive health services on a daily basis. Their immigration status makes more difficult their already complicated situation of being Latinas. They are not asking for anything extraordinary, just simply to be able to access preventive services such as Pap smears or mammograms, access to contraceptive methods to avoid unwanted pregnancies, services to terminate their pregnancies, access to pregnancy, pre-natal, and post-natal care, among other things. And these obstacles were made even more difficult in 2011 when policy reforms in Texas restricted access to health services through severe public funding cuts and limitations placed on service providers.

During this visit, I had the opportunity to hear testimonies from these brave women who, although their voices cracked, were not afraid to use them against the injustices that they have suffered. The stories not only moved me, they made me angry. I heard someone talk about how she lost her newborn baby because of late and negligent birth attention; or of one who could not share her story because she died after childbirth. Some shared that, because of lack of access to contraceptive methods, they became pregnant when they were not planning to and now they have large families. Others told of mistreatment by medical staff because they were Latinas who could not speak English. Some women told of occasions when they returned to Mexico to have exams like Pap smears or to purchase contraceptives. Not all of these women had the option to cross the border, though, because of their immigration status. Let us not forget the constant fear that many of them live with of being deported. Other women shared that some still seek out home remedies to interrupt their pregnancies because of lack of access to safe abortion services.

While in Brownsville, I did an exercise of closing my eyes and listening to the powerful stories of these women. I could not stop asking myself why these stories of discrimination, humiliation, and contempt were the same in Mexico and the United States. Without a doubt, each border has its peculiar aspects, its problems, and its challenges, but the stories are equally terrible. With the same seriousness with which we demand that the Mexican government respect the human rights of migrants in our country, we should demand this for our fellow citizens in the United States who, for various reasons, but mainly because of the failures of the Mexican state, have crossed the border looking for a better life and who now confront the same obstacles in the United States.
condition, and the information has to be delivered in accessible formats in ways that people understand.

The third element of the right to health is acceptability, meaning medical and clinical acceptability, but also acceptability from an ethical point of view; in other words, no obstetric violence. For example, that nobody touches you; that nobody breaks your waters when you are pregnant, that [providers] speak in your own language.

And the fourth element is quality—quality of life where you have the right to a timely diagnosis, implying that you have the right to preventive services, and quality meaning that you have the right to have information to make decisions about your own body.

Edward Zuroweste focused on the availability aspect of the right to health. As a physician in the field of migrant health care, he works within a system with highly unequal distribution of health resources. This results in a skewed concentration of providers in urban areas, which deprives women in rural areas of the health care they need.

We’re not serving who we can serve. All of you talked about having long lines and not being able to be seen for two or three months. That’s because we have a nationwide deficit of primary care physicians—I’m talking about nurse practitioners, physician assistants, nurse midwives, nurses, dentists, social workers, psychologists, and doctors . . . If you have a nationwide lack [of providers], guess where those people are going to go? They’re not going to go to the most rural places where people are struggling financially. Recruiting those providers is very difficult for people in the Valley.

The absence of primary care physicians, especially those trained to provide culturally and linguistically competent care, prevent many of the women who are most in need of preventive care from obtaining it. He noted that although the provider shortage is particularly acute in Texas, “it’s a nationwide problem, it’s not just here in the Valley.” The solution, therefore, must be national in scope with a focus on the most underserved areas and populations.

Several experts addressed barriers in access to health care. Sera Bonds identified the barriers of information and a healthy environment.28 Sera Bonds discussed the cluster of rights that comprise reproductive rights under international law including the right to life,29 the right to autonomy, and the right to self-determination.30 Restrictions on access to reproductive rights may interfere with access, and these include “being delayed at checkpoints, waiting three to six months for an appointment, and being encouraged to lie [about age or insurance status] in order to access services.”

Underlying Determinants of the Right to Health

The International Covenant on Economic, Social and Cultural Rights defines the human right to health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”31 As such, it extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.32 Sera Bonds discussed the social determinants of health that remain unmet for women in the Valley and therefore impede their access to care. While noting that “we need to have the providers, we need to keep the clinics open,” the testimonies consistently mentioned “all of these additional layers about being able to access the clinic.” These included the lack of child care and the lack of transportation that prevent rural women from accessing clinics, which are increasingly concentrated in urban areas. Bonds also highlighted the barriers that significantly impact immigrant women, including the lack of translation services and culturally competent care. These are important in the reproductive health context, where conversations touch on sensitive topics such as contraception and abortion. Shame and stigma also interfere with access, and these include “being delayed at checkpoints, waiting three to six months for an appointment, and being encouraged to lie [about age or insurance status] in order to access services.”

Violations of the Right to Life

Cynthia Soohoo explained the link between lack of access to safe abortion and violations of the right to life. International human rights law recognizes that [access to contraception and access to safe abortion] are crucial services for women’s right to health and right to life. I was particularly appalled when I heard the story about the closures of [abortion] clinics and that some women, because they can’t travel, are thinking about self-inducing abortion. Unsafe abortion is one of the key causes of maternal mortality around the world. Internationally, we recognize that lack of safe abortion is a violation of women’s human rights.

The cluster of rights that comprise reproductive rights under international law include first and foremost the fundamental human right to life.33 The U.N. Human Rights Committee has said the right to life should not be narrowly interpreted, and as such requires governments to take policy and other measures to reduce maternal mortality, unintended pregnancies, and unsafe abortion.34 Restrictions on access to reproductive health—such as limited availability of contraception or barriers to abortion access—can lead to reliance on unsafe abortion and jeopardize the right to life.35
“The Poderosas:
Real-Life Superheroes”
— A Post-Hearing Reflection by Sera Bonds —

Circle of Health International (COHI) is an international humanitarian organization founded in 2004 with the mission to work with women and their communities in times of crisis and disaster to ensure access to quality reproductive, maternal, and newborn care. COHI has responded to ten humanitarian emergencies and served over three million women, both domestically and internationally. COHI, to date, has worked alongside midwives and public health professionals in post-tsunami Sri Lanka, post-hurricane Louisiana, Tibet, Tanzania, Israel, Palestine, Jordan, Syria, tornado-affected Oklahoma, Sudan, Haiti, and Afghanistan. Currently, we are caring for moms and babies in Haiti, the Philippines, Nicaragua, the Middle East, and along the U.S./Texas border. COHI works with women and providers who are fighting against dangerous and life threatening conditions and barriers to access around the world.

The testimony that I heard in March in the Rio Grande Valley moved me deeply. The stories I heard were similar to the ones I’ve heard from women in Syria, Nepal, Haiti, and other settings where we work. The women being impacted by the irresponsible legislation in Texas are real—they are mothers, daughters, sisters, neighbors; they are not numbers, and they are not abstract. They are flesh and blood, and deserving of the same access, quality of care, and support that every other human deserves.

In response to the 2014 border crisis, COHI and the Hope Family Health Center, based in McAllen, Texas, partnered to operate a clinic to serve refugee women and children from Central America. The clinic itself is operating out of the Sacred Heart Church on the town square and the receiving center there for refugees is run by Catholic Charities of the Rio Grande Valley. The clinic operates out of a very small room in the back of the receiving center. For one year it has been completely volunteer-staffed seven days a week and twelve hours a day.

We are currently seeing between 100-140 refugees a day at the clinic, and the needs of the women and their children continue. The health care and psycho-social needs of these women don’t end when they leave the COHI clinic, they journey with them to their final destinations in the United States. We are aiming to care for them through the development of a national database to link pro-bono providers who can care for them when they arrive at their destinations. We hear stories of domestic abuse, violence, and poverty. These are the reasons they leave their homes and journey into a terrifying unknown where the violence follows them as they become increasingly vulnerable to exploitation.

I look forward to working closely with the poderosas that I met while participating in this human rights hearing. They are, simply put, real life superheroes doing incredible work in a very hard place. COHI’s model is to partner with women like Lucy and the other poderosas, women who are working within their communities to make the change they want to see. These women, too, are real women. Not numbers, and not abstract. And they should not be underestimated. They are working tirelessly to ensure that the lives of their sisters, mothers, daughters, and sons are healthier than their own. That their neighbors have better access to the care that they deserve. They are making the change that they want to see in the world, and I look forward to working alongside them to do what we can to move our shared work forward.

We at COHI are humbled by the stories we hear from the women and activists in the Valley. Working in this community is some of our proudest work at COHI. Each day we can hear in their voices how much a small kindness matters to these women who have borne so much. This is what keeps us working so hard to keep the doors open. They will come, so we need to be here to care for them. It’s the least we can do.
B E Y O N D  T H E  H E A R I N G

NO NOS VAMOS A DAR POR VENCIDAS
(WE WILL NOT GIVE UP)

Many of the women ended their testimonies with promises to keep fighting for reproductive health care, while sharing their vision for a Texas government that respects, protects, and fulfills their human rights. Alejandra spoke about how her own rights education prompted her to mobilize others to work towards a different vision for Texas:

With the Texas Latina Advocacy Network, I have learned about my rights as a woman and to care for my health. Now, I am educating more women to demand their rights so that what happened to me does not happen to them. Today, I am holding meetings in my community to seek out clinics or programs that can provide us with low-cost reproductive health services. But I do not want my story to end here... I hope that there will be [more] programs for women in my community so that they can exercise their human right to reproductive health care. I want with all my heart for Texas to truly be a state of human rights!

Others issued appeals to their elected officials to recognize their right to affordable and comprehensive reproductive health care. “I think the solution is to return the missing funds to my county and to open the clinics that have closed so that the same thing does not happen to me again,” said Carolina.

“The right to public health services is one of our universal rights... that all human beings have,” Margarita added a more specific request: “I want there to be more clinics that offer low-cost services and payment plans. We don’t ask for anything to be given to us. We only want the opportunity to be able to pay in installments instead of losing time trying to find the money to pay upfront.” Valentina spoke about the need to preserve access to contraception as well as to safe abortion care in the Valley:

Now, in a post-HB2 Rio Grande Valley, even more women don’t have access to family planning and reproductive health care, including low-cost contraceptives and gynecological exams. It seems counter-intuitive to believe that reducing access to such things actually benefits women, but that is what our legislators have tried to convince us is the truth. The truth is reducing access to abortion doesn’t end abortion; it only makes it less safe. As we see more anti-choice laws being passed, it is the poor and undocumented who are affected the most harshly... Abortion access is a human right.

BUILDING SOLIDARITY

Those who attended the hearing and listened to the testimony—human rights experts, advocates, elected officials, and community supporters—made specific commitments to stand with the poderosas in their continued fight for reproductive justice and human rights.

For example, the commentators who work in health service provision vowed to redouble their efforts to focus on the particular challenges of reaching women in underserved areas like South Texas. Sera Bonds pledged to work with the promoters of the Nuestro Texas campaign to coordinate efforts with her organization in reaching the most vulnerable women in the Valley, including immigrants and recently arrived refugees. Edward Zuroweste said he would focus his efforts on educating service providers in the Migrants Clinicians Network about the family planning needs of migrant women, while also advocating for increased federal funding for migrant community health centers.

At several points during the hearing, clear linkages were made between the situation in the Valley and other areas of the world where women lack access to reproductive rights. In her welcome remarks, Nancy Northup, president and chief executive officer of the Center for Reproductive Rights, said:

“We see parallels between what is happening here in the Valley with the Philippines, where access to contraception is virtually unavailable. And with Ireland, where women are forced to travel out of the country to get a safe, legal abortion. Although the U.S. has stronger legal protections than in many countries where we work, a woman’s ability to exercise her basic rights is still out of reach for millions of women in America—especially those who are poor, rural, immigrant, or women of color.

The events were brimming with hope and courage. But what struck me most about the day was the collaboration that made them possible. The [Nuestro Texas] partnership is a case study in what effective collaboration looks like, and what it can do for a movement. I left Texas inspired by the women who shared their stories, and feeling hopeful that the reproductive rights movement will triumph over the relentless assault on women’s autonomy and opportunity.”

~ Christine Clark, Program Officer, U.S. Reproductive Health and Rights, William and Flora Hewlett Foundation

The women who testified not only identified similar types of violations between the Valley and other regions, but also their common struggle for gender equality and human rights. Lucia called for strengthening such links and expanding the movement beyond borders:

“The government has denied [women] access to the basic human right to health. It is time to break these unacceptable chains of gender inequality. We have had enough. Women need to have access to reproductive health... We see that there are women who deserve their basic human rights and assistance to accessible health care, and I would like to communicate and find a way to celebrate our [Nuestro Texas campaign] achievements. I would like this vision to be shared as a global vision.

To that end, several of the human rights experts committed to raising the stories of the women who testified in global human rights forums. Alicia Yamin pledged to discuss the situation in the Valley with global decision makers charged with drafting
“I’ve been a long-time supporter of Nuestro Texas campaign and Texas LAN, because the work not only serves to inform women about their reproductive health but also claim their basic human rights. Make no mistake, access to reproductive health care is a human right. I commend the bravery of the women who share their stories, and I thank you for helping me put a face on the thousands of women in my district who experience similar struggles. You have my commitment that I will continue to fight for state policies that promote the health and human rights of Texas Latinas. Thank you for working to make Texas a better state, and thank you for your bravery.”

— State Representative Terry Canales, District 40 (Hidalgo County)
Biographies of the Expert Commentators

ALICIA ELY YAMIN
Policy Director, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health

Alicia Ely Yamin, JD, MPH, is a lecturer on Global Health and Policy Director of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, and a Senior Associate Researcher at the Centre on Law and Social Transformation at the University of Bergen, Norway. Yamin’s 20+ year career at the intersection of health, human rights and development has bridged academia and activism. From 2007 to 2011, Yamin held the prestigious Joseph H. Flom Fellow on Global Health and Human Rights at Harvard Law School. Prior to that, she served as Director of Research and Investigations at Physicians for Human Rights, where she oversaw all of the organization’s field investigations, and on the faculty of the Mailman School of Public Health at Columbia University. Yamin was appointed as the only non-Colombian independent expert by the Colombian Constitutional Court in 2011 on the implementation of Judgment T 760/08, a major judgment that is locally anchored, but universal and global in its vision. She co-founded NESRI along with Sharda Sekaran and Liz Sullivan in order to build legitimacy for human rights in general, and economic and social rights in particular, in the United States. She is committed to a community-centered and participatory human rights approach that is locally anchored, but universal and global in its vision.

CYNTHIA SOOHOO
Director, International Women’s Human Rights Clinic, City University of New York Law School

Cynthia Soohoo is the Director of the International Women’s Human Rights Clinic at CUNY Law School where she directs the Clinic’s work on reproductive rights, human trafficking and children in the adult criminal justice system. Prior to coming to CUNY, she was the Director of the U.S. Legal Program at the Center for Reproductive Rights, Home Project, Human Rights Institute, Columbia Law School, and a supervising attorney for the law school’s Human Rights Clinic. She has worked on U.S. human rights issues before U.N. human rights bodies, the Inter-American Commission for Human Rights, and in domestic courts. Ms. Soohoo practiced law at the firm Covington & Burling for six years and was co-counsel in the landmark Alien Tort Statute case, Doe v. Kahanzic. Prof. Soohoo was a founding board member and is the current board chair for the U.S. Human Rights Network. She has also served as co-chair of the American Constitutional Society’s Working Group on International Law and the Constitution and on the national board for Law Students for Reproductive Justice. Prof. Soohoo is a graduate of the University of Pennsylvania Law School, where she was an editor of the Law Review and a member of the Order of the Coif.

EDWARD ZUROWESTE
Chief Medical Officer, Migrant Clinicians Network; Assistant Professor of Medicine, Johns Hopkins School of Medicine

Edward Zuroweste has over 30 years of experience as a Board-Certified Family Physician focused on the care of underserved populations in the U.S., namely migrant and seasonal farmworkers. For 20 years, Dr. Zuroweste maintained a full-time clinical practice in family practice and obstetrics in Chambersburg, Pennsylvania, first in private practice and later as the Medical Director of a Migrant Health Center. Dr. Zuroweste was a founding member, and current Chief Medical Officer of the Migrant Clinicians Network. He is the Tuberculosis Medical Consultant for the Pennsylvania Department of Health and serves as the attending physician for six PA State Health Department TB Clinics. He is an Adjunct Assistant Professor of Medicine at Johns Hopkins School of Medicine where he directs an international health elective for medical students in Honduras twice a year. He most recently (Oct/Nov 2014) was hired as a medical consultant by the WHO and participated as part of the WHO Ebola Response Team in both Guinea and Sierra Leone where he trained over 200 Cuban physicians and nurses to prepare them to work in Ebola treatment centers in those countries.

MARIELENA HINCAPIÉ
Executive Director, National Immigrant Law Center

Marielena Hincapié is the executive director of the National Immigration Law Center, the main organization dedicated to defending and advancing the rights of low-income immigrants in the U.S. She began her tenure at NILC in 2000 as a staff attorney leading the organization’s labor and employment program, then served as NILC’s director of programs from 2007 to 2011, and has been its co-chair of the American Constitutional Society’s Working Group on International Law and the Constitution and on the national board for Law Students for Reproductive Justice. Prof. Soohoo is a graduate of the University of Pennsylvania Law School, where she was an editor of the Law Review and a member of the Order of the Coif.

CATHY ALBISA
Executive Director, National Economic & Social Rights Initiative

Cathy Albisa is a constitutional and human rights lawyer with a background in the right to health. Ms. Albisa also has significant experience working in partnership with community organizers in the use of human rights standards to strengthen advocacy in the United States. She co-founded NESRI along with Sharda Sekaran and Liz Sullivan in order to build legitimacy for human rights in general, and economic and social rights in particular, in the United States. She is committed to a community-centered and participatory human rights approach that is locally anchored, but universal and global in its vision. Ms. Albisa clerked for the Honorable Mitchell Cohen in the District of New Jersey. She received a BA from the University of Miami and is a graduate of Columbia Law School.

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Alicia Ely Yamin, JD, MPH, is a lecturer on Global Health and Policy Director of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, and a Senior Associate Researcher at the Centre on Law and Social Transformation at the University of Bergen, Norway. Yamin’s 20+ year career at the intersection of health, human rights and development has bridged academia and activism. From 2007 to 2011, Yamin held the prestigious Joseph H. Flom Fellow on Global Health and Human Rights at Harvard Law School. Prior to that, she served as Director of Research and Investigations at Physicians for Human Rights, where she oversaw all of the organization’s field investigations, and on the faculty of the Mailman School of Public Health at Columbia University. Yamin was appointed as the only non-Colombian independent expert by the Colombian Constitutional Court in 2011 on the implementation of Judgment T 760/08, a major judgment that is locally anchored, but universal and global in its vision. She co-founded NESRI along with Sharda Sekaran and Liz Sullivan in order to build legitimacy for human rights in general, and economic and social rights in particular, in the United States. She is committed to a community-centered and participatory human rights approach that is locally anchored, but universal and global in its vision. Ms. Albisa clerked for the Honorable Mitchell Cohen in the District of New Jersey. She received a BA from the University of Miami and is a graduate of Columbia Law School.
SERÁ BONDS
Founder/CEO, Circle of Health International

Será Bonds, MPH, is a social justice, grassroots activist committed to working towards balancing the scales of access, equity, and availability in women’s reproductive health care. She has training in midwifery, a Bachelor of Arts degree in Women’s Studies, and a Master’s Degree in Public Health. Her community organizing background ranges from reproductive rights to violence against women to welfare and poverty issues to anti-war campaigns. She has worked on women’s health rights issues with teenage and minority mothers in rural areas of the Western U.S., with midwives in Northern India, Guatemala, Tibet, Palestine, tsunami-affected Sri Lanka, Sudan, Tanzania, Jordan, Haiti, Afghanistan, Syria, and Israel; with commercial sex workers on issues of HIV/AIDS in Vietnam; with female evacuees from hurricanes Rita and Katrina in Louisiana; with the social service and health care provider community in Central Texas and abroad to stop human trafficking; and along the U.S.-Texas border to provider care for refugees arriving from Latin and Central America.

REGINA TÁMÉS NORIEGA
Executive Director, Grupo de Información en Reproducción Elegida

Regina Támes, a Mexican Lawyer with Masters in Law (LL.M.) degree in International Law with a specialization in human rights and gender policy from the University of Washington College of Law, became GIRE’s Executive Director in April 2011. Before assuming this role, she worked at Planned Parenthood Federation of America as a Program Officer in charge of political advocacy projects on sexual and reproductive rights in Central America. She also worked for six years as Coordinator of Institutional Strengthening at the Mexican Office of the United Nations High Commissioner for Human Rights, where she provided technical assistance on human rights and a gender perspective for public policy. Regina has held positions at the Center for Reproductive Rights and the Inter-American Commission for Human Rights. She has taught undergraduate and masters-level law courses on human rights at the Universidad Iberoamericana as well as post-graduate courses in gender and law at the National Autonomous University of Mexico (UNAM). She is the current coordinator of the Red ALAS network (a network of Latin American academics focused on gender, sexuality and law) and is part of its Executive Committee. Regina is also part of the Civil Society Advisory Region for the Regional UN Women’s Office.


23 ICESCR, supra note 21, at para 12.

24 CESCR, General Comment No. 14, supra note 21, at para. 4.

25 CESCR, General Comment No. 14, supra note 21, at para. 4.


30 By executive action on June 15, 2012, President Obama issued the Deferred Action for Young Arrivals (DACA) program. The Executive Action gives the Department of Homeland Security (DHS) power to grant discretionary, temporary relief from deportation to young undocumented immigrants who came to the U.S. as children. Although DACA does not provide eligible immigrants a path to lawful permanent residence status (LPR) or U.S. citizenship, it does give them lawful status and allows them to apply for a work permit. See National Immigration Law Center, Deferred Action for Childhood Arrivals (DACA) (Nov. 26, 2014), available at nillac.org/ dreamdeferred.html. President Obama expanded DACA, and granted temporary relief from deportation to parents of children who are either LPR or U.S. citizens, by executive action on November 20, 2014. Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) has yet to be implemented following a legal challenge and order issued by a federal district court in Texas that put the program on hold. See National Immigration Law Center, President Obama’s Immigration Announcement (Mar. 3, 2015), available at nillac.org/execsummary.html; State of Texas, et al v. United States of America, et al., No. B-15-254 (So. Dist. TX, 2014), available at https://www.justsecurity.org/ wp-content/uploads/2015/02/255994877-Memorandum-Optinn-And-Order-Texas-v-United-Status-4.pdf.
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TEXAS

Pantone 200 C
Pantone 292 C
Pantone 102 C
Pantone 376 C
Pantone 232 C

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