New York City, United States, 18 July 2018

Señora Magistrada:
CRISTINA PARDO SCHLESINGER
Corte Constitucional
E.S.D.

REF.: Expediente No**. T-6612909**

Acción de tutela con reserva de identidad de accionante, contra COMPENSAR E.P.S.

We, the International Women's Health Coalition (hereinafter "IWHC"),[1] located in New York City, United States, respectfully request that the Court allow us, in our capacity as a civil society organization, to submit evidence in the present case in accordance with Article 13 of Decree 2591 of 1991, which establishes that "*whoever has a legitimate interest in the result of the case shall be permitted to intervene as amicus or amici curiae".*

We request to intervene in the present case given our experience as an international nongovernmental organization that has been working for over 30 years to advance women's health worldwide. Since our founding in 1984, IWHC has been working closely with organizations from 50 countries from different regions worldwide, to advance the sexual and reproductive health and rights of women and young people, as well as supporting and strengthening leaders and organisations that work at community, national, regional and global levels.[2]

At the international level, IWHC brings pioneering ideas to the forefront of negotiations on women's rights and health at the United Nations and in Washington, DC. IWHC's work has been instrumental in securing government commitments to women's health—from the landmark population and development conference in Cairo in 1994 to the historic adoption by a consensus of 193 Member States of the United Nations of the 2030 Agenda and its Sustainable Development Goals in September 2015. IWHC also conducts research and documentation of the impacts of policies on women's and girls' health and rights and contributes as a

[1] https://iwhc.org/

[2] For much of the information cited in this amicus, please refer to two of our most recent publications: Michelle Truong et al., "Unconscionable: When Providers Deny Abortion Care" (International Women's Health Coalition, 2018), https://iwhc.org/wp-content/uploads/2018/06/IWHC_CO_Report-Web_single_pg.pdf; International Women's Health Coalition, "Unconscionable: When Providers Deny Abortion Care, Policy Brief" (International Women's Health Coalition, 2018), https://iwhc.org/wp-content/uploads/2018/06/CO-Policy-Brief_General-FINAL.pdf.

thought leader to the field, both at the domestic and global levels. Consequently, we have profound knowledge of these issues based on firsthand experience.

IWHC's support to women and youth-led organizations in developing countries gives IWHC a comparative and global perspective on the impact of abortion restrictions in different regions, allowing us to contribute relevant information to the present case. In recognition of IWHC's expertise on these issues, IWHC holds special consultative status with the United Nations Economic and Social Council (ECOSOC). In addition, IWHC is in "official relations" with the World Health Organization (WHO), a status granted to very few organizations worldwide. As defined by WHO, it is a privilege that may be granted to those organizations that "have had and continue to have a sustained and systematic engagement in the interest of the [World Health] Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO's Constitution, and they shall contribute significantly to the advancement of public health".[3]

Given our special interest and over 30 years of experience in the field of women's health, we respectfully request that the Court consider the following arguments in deciding the present case:

I. Restrictions on abortion have proven to be ineffective in reducing its occurrence and, at the same time, very harmful to women's health.

Across the world, restrictions on abortion have proven to be ineffective in reducing its occurrence. Research demonstrates that criminalizing abortion, for example, does not reduce the number of abortions that occur each year. In fact, empirical data indicates that the criminalisation of abortion does little or nothing to reduce the number of procedures performed and has little or no effect on preventing abortions.

Research carried out by the World Health Organisation, in partnership with the Guttmacher Institute concluded, for example, that, across the globe, rates of abortions are similar or lower in countries that allow the procedure, in comparison with those that ban it.[4] In countries where abortion is completely forbidden or authorised only to save the life of pregnant women, incidence of abortion observed is on average 37 for every 1000 women. Whereas the incidence of abortion in countries where abortion is permitted at the request of the woman is 34 for every

[3] http://www.who.int/about/collaborations/non-state-actors/in-official-relations/en/

[4] Gilda Sedgh et al, *Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends*, Volume 388, No. 10041, p258–267, 16 July 2016. Available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961786-8/fulltext>. Guttmacher Institute, *Induced Abortion Worldwide: Global Incidence and Trends*, available at: <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>.

1000 women. The evidence points to an important fact: decriminalising abortion does not lead to a higher incidence of abortions, while criminalising it does not lead to a reduction.

The data in Latin America and the Caribbean also confirms that fact. In this region, over 97% of women of reproductive age live in countries where abortion is restricted or completely banned.[5] Despite restrictive laws, both the absolute number of abortions and rates of abortion in the region have increased in recent decades. Estimates indicate that 6.5 million abortions were performed annually in the period between 2010 and 2014, a considerable increase in relation to the 4.4 million a year that were observed a decade before.[6] During the same period in this region, the percentages of pregnancies that terminated in abortion increased: from 1 in 4 in 1990 to 1994 to 1 in 3 pregnancies in 2010 to 2014.[7] In South America alone, it is estimated that there are 4.6 million abortions performed every year, with 34% all pregnancies ending in abortion.[8]

It should also be noted that the abortion rates registered in South America, where the procedure is widely restricted, are much higher than those observed in Western Europe and North America, where abortion is generally legal on demand or on broad grounds. In South America, 48 per 1000 women of reproductive age have abortions annually, compared to 16 per 1000 women in Western Europe and 17 per 1000 in North America.[9] Therefore, despite the legal restrictions in South America and the liberalisation of the procedure to a great extent North America and Western Europe, there are three times more abortions in South America.[10] In fact, in developed countries, where abortion is mostly extensively permitted, the incidence of procedures performed has plummeted by 41% since 1990 and is lower than the incidence found in developing countries.[11]

The burden of unsafe abortion and its criminalisation is not distributed equally. Over 40% of women of reproductive age live in countries where abortion is totally forbidden, or permitted only to save their lives or to protect their health.[12] Most of those countries (93%) are in developing regions, which are also the regions

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[5] Guttmacher Institute, *Abortion in Latin America and the Caribbean: Incidence and Trends*, available at <https://www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean>.
[6] Idem.
[7] Idem. The percentage of all pregnancies that were terminated rose from 23% to 32%.
[8] Table 3 of Gilda Sedgh et al, *Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends*, Volume 388, No. 10041, p258–267, 16 July 2016. Available at <http://www.thelancet.com/action/showFullTableImage?tableId=tbl3&pii=S0140673616303804>.
[9] Guttmacher Institute, *Induced Abortion Worldwide: Global Incidence and Trends*, available at: <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>
[10] Idem.
[11] Idem.
[12] Singh S et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access*, New York: Guttmacher Institute, 2018, available at <https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf>.

where most abortions are performed in the world.[13] Whereas over 80% of women in developed regions live under laws that allow for abortions with no restriction in terms of reasons, less than 30% of women in developing countries live under equivalent legal regimes.[14] And, while in countries where abortion has been legalised the procedure is overwhelmingly safe, it is precisely in regions with more restrictive laws that abortions are mostly unsafe, jeopardising the health and lives of millions of women every year.

What actually leads to a reduction in the number of abortions is not criminalisation, but rather investments in public health and education. Policies that increase access to contraceptives, as well as information and education, expand the effective use of modern contraceptive methods and reduce unintended pregnancies. Multiple research studies confirm that increasing the availability of contraceptives to women is the most efficient way to reduce the number of abortions and is in no way related to the use of criminal law.[15]

The decriminalization of abortion also ultimately helps in the reduction in the number of procedures. Decriminalisation not only allows for access to safe abortion procedures, but also promotes a context of autonomy and equality, empowering women and encouraging them to seek counselling and care on sexual and reproductive health, family planning and contraception. Therefore, the decriminalisation of abortion is frequently associated with an atmosphere of lessened stigma and more information regarding methods to prevent pregnancy, which in practical terms leads, in the mid to long term, to a lower number of unplanned pregnancies and a decrease in the number of abortions performed.

In countries such as Romania[16] and Portugal[17], where the procedure has been decriminalized, reductions in the number of abortions were observed over time, associated with an increase in the use of contraceptive methods. In Romania,

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[13] Of the 56 million abortions performed every year, 88% (49 million) occur in developing regions. Guttmacher Institute, *Induced Abortion Worldwide: Global Incidence and Trends*, available at: <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>.

[14] Singh S et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access*, New York: Guttmacher Institute, 2018, available at <https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf>.

[15] World Health Organisation, *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendation*s, Available: <http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf>; Gilda Sedgh et al, *Abortion incidence between 1990 and 2014: global, regional, and sub-regional levels and trends*, Volume 388, No. 10041, p258–267, 16 July 2016. Available at <http://www.thelancet.com/action/showFullTableImage?tableId=tbl3&pii=S0140673616303804>; Guttmacher Institute, *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017*, available at <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>.

[16] Horga et al., "The remarkable story of Romanian women's struggle to manage their fertility," *BMJ Sexual & Reproductive Health* 39, no. 1 (2013): 2-4.

[17] República Portuguesa, "Relatório dos registos das interrupções da gravidez, Dados de 2016" (Direção-Geral de Saúde, 2016), http://www.saudereprodutiva.dgs.pt/ficheiros-de-upload-diversos/relatorio-de-ivg-2016-pdf.aspx.

for example, a restrictive abortion law was overturned in 1989, and the abortion rate dropped by 94% in the ten years afterward.[18] In addition, the average number of abortions per woman in Romania dropped from 3.4 in 1993 to 0.8 in 2004.[19] The same trend was observed in Portugal, where, in 2016 15,416 abortions were registered, 14.4% less than the 18,014 registered in 2008.[20]

Access to contraception, however, is not sufficient to ensure women's health. It is never possible to eliminate the need for abortion, because contraceptive methods may fail, women who use contraception may have other health issues requiring an abortion, and rape continues to occur in places where contraception is available.[21] Access to safe abortion methods is thus essential to prevent women from undergoing deadly procedures that endanger their health and lives.

Criminalizing abortion not only has no impact on its occurrence, but it also results in poorer maternal health and higher rates of maternal morbidity. What criminalizing the termination of pregnancy does do, in practical terms, is to force millions of women every year to try to self-induce abortions or to resort to dangerous procedures performed by people without the necessary training or in unhygienic conditions.[22]

According to the World Health Organisation, even though there exist simple, safe and effective procedures to end a pregnancy,[23] close to 25 million unsafe abortions occur every year,[24] significantly contributing to maternal mortality and morbidity throughout the world.[25] Annually, nearly 7 million

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[18]The abortion rate declined from 163.6 induced abortions per 1,000 women in 1990 to 10.1 induced abortions per 1,000 women in 2010. Horga et al., "The remarkable story of Romanian women's struggle to manage their fertility."

[19]Ministry of Health of Romania, World Bank, UNFPA, USAID, UNICEF, "Reproductive health survey: Romania, 2004," (UNICEF, 2005), https://www.unicef.org/romania/Reproductive_Health_Survey_Romania_2004.pdf.

[20] Official data from the Portuguese government, available at <http://www.saudereprodutiva.dgs.pt/ficheiros-de-upload-diversos/relatorio-de-ivg-2016-pdf.aspx>. See page 22.

[21]World Health Organization, "Abortion rates drop in more developed regions but fail to improve in developing regions," (World Health Organization, 2016), http://www.who.int/reproductivehealth/news/abortion-rates/en/.

[22]World Health Organization, "Preventing unsafe abortion" (World Health Organization, 2018), http://www.who.int/mediacentre/factsheets/fs388/en/; Bela Ganatra et al., "Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model," *The Lancet* 390, no. 10110 (2017): 2372-2381.

[23] Idem.

[24] World Health Organisation, *Preventing Unsafe Abortion*, available at <http://www.who.int/mediacentre/factsheets/fs388/en/>; Bela Ganatra et al, *Global, regional, and sub-regional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model*, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/abstract>.

[25] World Health Organisation, *Health worker roles in providing safe abortion care and post-abortion contraception*, available at <http://apps.who.int/iris/bitstream/10665/181041/1/9789241549264_eng.pdf?ua=1&ua=1>.

women,[26] mostly in developing countries, are treated for complications resulting from unsafe abortion procedures, and up to 47,000 women die each year as a result.[27]

The burden and the dangers of an unsafe abortion are not evenly distributed among the different regions of the world. To the contrary: 97% of unsafe abortions (i.e. 24.3 million precarious and dangerous procedures) are performed in developing countries,[28] where access to legal and safe procedures is limited to a few legal grounds, as is the case in Colombia, or banned altogether.[29] According to the World Health Organisation, in those countries where legal abortion is thus restricted, safe abortion becomes a privilege of the rich,[30] and the barriers and risks fall mainly on those rural, poor, adolescent, single women or those with less access to education,[31] resulting in avoidable deaths and complications.

II. Harmful restrictions on access to health care services are not limited to law and policies, but also include refusals by health providers, as observed in this case

Women face multiple restrictions on access to health care services, including abortion. Such restrictions are not limited to laws and policies but also include refusals by health care providers and institutions to provide care on the basis of religious or conscience claims, often mislabeled as "conscientious objection." The use of personal beliefs to deny medically sound, evidence-based, needed and wanted health care, such as abortion, is a growing phenomenon with deadly implications for women and girls, especially those who are most vulnerable. This is precisely one of the issues addressed in the present case.

Refusals by health care professionals to provide abortion services increasingly threaten women's access to such services in countries that have joined the global trend toward more liberal abortion laws.[32] For example, in Italy up to

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[26]Singh et al., "Abortion Worldwide: A Decade of Uneven Progress" (Guttmacher Institute, 2009), https://www.guttmacher.org/sites/default/files/pdfs/pubs/AWWfullreport.pdf.
[27]World Health Organization, "Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008" (World Health Organization, 2011), http://apps.who.int/iris/bitstream/10665/44529/1/9789241501118_eng.pdf.
[28] World Health Organisation, *Worldwide, an estimated 25 million unsafe abortions occur each year*, available at <http://www.who.int/mediacentre/news/releases/2017/unsafe-abortions-worldwide/en/> ; Bela Ganatra et al, *Global, regional, and sub-regional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model*, available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/abstract>.
[29] World Health Organisation, Safe abortion: technical and policy guidance for health systems, available at <http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf>.
[30] Idem.
[31] Idem.
[32]Katherine Mayall and Johanna B. Fine, "Abortion Worldwide: 20 Years of Reform" (Center for Reproductive Rights, 2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/20Years_Reform_Report.pdf.

70 percent and in Uruguay, up to 80 percent of health care professionals refuse to provide lawful abortion services to women who need them, with grave consequences for women's health, wellbeing and lives. Women prevented from accessing essential health care are forced to seek services elsewhere, to face delays in care, or to forgo care altogether. Finding another provider can be prohibitively expensive or time-consuming and, in certain contexts, may be entirely impossible. A woman who cannot access safe procedures may be forced to undergo a clandestine, unsafe abortion with severe consequences for her health and life, or to continue an unwanted or risky pregnancy.

Research into the experiences of women confronted with the denial of abortion indicates that they face an increased risk of physical and psychological harm, socioeconomic disadvantage, and even shortened lifespans.[33] In August 2017, IWHC, in conjunction with Mujer y Salud en Uruguay, organized the *Convening on Conscientious Objection: Strategies to Counter the Effects*, in which 45 participants from 22 countries discussed the consequences of denial of sexual and reproductive health care and shared data from their home countries. Convening participants who work at the community level recounted experiences of women who have suffered the negative effects of conscience claims. In Spain, for example, one woman learned late in her pregnancy that her fetus had a lethal anomaly. The woman was repeatedly denied abortion care in her area, and the local public health authority directed her to travel to Madrid "in order to respect the professionals' right to objection on moral grounds." By the time the woman arrived to Madrid, she was bleeding profusely and had to endure an emergency caesarean section to remove the fetus, which died shortly thereafter. In addition, the woman had no choice but to undergo an emergency operation to remove her uterus, stem the bleeding, and save her life. She is now unable to have children. As this example illustrates, women are harmed both physically and psychologically when they face the denial of abortion services on the basis of conscience claims.

Poor and otherwise disadvantaged women are most negatively impacted by the denial of sexual and reproductive health services. A provider's refusal to perform abortion services exacerbates the effects of the barriers that such women already face, including discrimination, social stigma, poverty, lack of access to

[33]Rana E. Barar, "Best Practice for Abortion Policies: Listen to Women's Stories," ResearchGate (blog), September 8, 2015, https://www.researchgate.net/blog/post/best-practicefor-abortion-policies-listen-to-womens-stories; M. Antonia Biggs, Ushma D. Upadhyay, and Charles E. McCulloch, "Women's Mental Health and Wellbeing 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study," *JAMA Psychiatry* 74, no. 2 (2016): 169–78; Diana Greene Foster, "Introduction to the Turnaway Study," *Advancing New Standards in Reproductive Health* (2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway-intro_2-20-2018.pdf.

information and transportation, and limited autonomy to make decisions about their own bodies.[34]

The denial of abortion care also reinforces the power imbalance between provider and patient, in which health professionals, often more privileged than their patients, maintain a monopoly on the delivery of safe abortion services. Some patients thus find it difficult to challenge a physician's decision to refuse care, or even to ask questions about the physician's refusal. The most marginalized patients will have the most difficulty overcoming this power imbalance to seek the services they want, need, and are entitled to. The result may be mental anguish, trauma, economic hardship, and feelings of isolation and shame in patients who have been denied care.[35]

On a more general level, accommodating health care professionals who refuse to provide services increases the workloads of their colleagues, distorts resource allocation, and causes inefficiency within the health care system at large.[36] Claims of personal conscience to deny the provision of services are contrary to the ethical and professional obligations of health care providers, who must put the health and wellbeing of their patients first.[37]

International human rights bodies do not recognize a right to "conscientious objection" for health care providers. Nevertheless, some countries do allow providers to make such claims. In those cases, human rights treaty monitoring bodies have called for limitations on their use, in order to ensure that health providers' personal beliefs do not hinder access to services, and thus infringe on the rights of patients.

Human rights treaty bodies have called out states' insufficient regulation of the use of "conscientious objection" and have directed them to take steps to guarantee access to health services. For example, the United Nations Committee on Economic, Social and Cultural Rights General Comment 22 on the right to sexual and reproductive health says:

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[34]Debora Diniz, Alberto Madeiro, and Cristiao Rosas, "Conscientious Objection, Barriers, and Abortion in the Case of Rape: A Study Among Physicians in Brazil," *Reproductive Health Matters* 22, no. 43 (2014): 141-48.

[35] Barar, "Best Practice for Abortion Policies: Listen to Women's Stories"; Foster, "Introduction to the Turnaway Study"; Jane Harries et al., "An Exploratory Study of What Happens to Women Who Are Denied Abortions in Cape Town, South Africa," *Reproductive Health* 12, no. 21 (2015): 1-6.

[36]For example, preliminary estimates by the United States government indicate that the nation's health care system will incur more than $300 million in added cost generated by the establishment of mechanisms to conform to a new rule that expands the right to refuse to provide patients with reproductive and other health care. Ricardo Alonso-Zaldivar, "$300M Health Care System Cost to Protect Religious Rights," *The Associated Press*, February 5, 2018, sec. health, https://www.apnews.com/1a1e49053509473b9c97578a0ee98636.

[37] 2nd General Assembly of the World Medical Association, "WMA Declaration of Geneva" (World Medical Association, September 1948), https://www.wma.net/policies-post/wma-declaration-of-geneva/.

Where health-care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations.[38]

International human rights treaty monitoring bodies also affirm that organizations or institutions (such as hospitals) must not be allowed make claims of "conscientious objection."

The existence of legal provisions allowing for "conscientious objection" encourages providers to refuse care, even when there is attempted regulations for such provisions. Evidence demonstrates that State regulations on conscience claims are difficult and costly to enforce, and they rarely guarantee access to sexual and reproductive health services. Indeed, many health care providers who object to performing abortion procedures also refuse to refer patients to other providers or to provide emergency care, alleging that such actions constitute complicity in the provision of abortion.

The effects of allowing the refusal of health care on grounds of conscience extend beyond abortion access. Conscience claims are increasingly used to deny other sexual and reproductive health services, such as contraception, sterilization, infertility treatment, and even the provision of general health services for lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons.[39] In some cases, it is not only direct providers who refuse care. Indirect providers, such as administrators and managers, and entire health care institutions invoke conscience claims to deny care to their patients.[40] Thus, permitting health care professionals to refuse to provide certain services on the basis of religion or conscience harms a broad range of patients and prevents access to a spectrum of lawful sexual and reproductive health care.

In sum, although the legal right to abortion has been widely recognized, the substantive right of access to abortion services often remains unattainable given the barrier of health care professionals' refusal to provide services on the basis of

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[38] Committee on Economic, Social and Cultural Rights, "General Comment No. 22 on the Right to Sexual and Reproductive Health" (United Nations Economic and Social Council, 2016), 22, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en.

[39] Douglas NeJaime and Reva Siegel, "Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism," *The Conscience Wars: Rethinking the Balance Between Religion, Identity, and Equality* (Cambridge: Cambridge University Press, 2018), https://ssm.com/abstract=2714017.

[40] Judith Bueno de Mesquita and Louise Finer, "Conscientious Objection: Protecting Sexual and Reproductive Health and Rights" (University of Essex, 2008), http://repository.essex.ac.uk/9715/1/conscientious-objection-protecting-sexual-reproductive-health-rights.pdf.

religion or conscience, which affects poor and vulnerable women and girls most acutely. In Colombia, the constitutional right to abortion guarantees, as a minimum, legal access to abortion in cases of rape or incest, endangerment of the woman's life or health, and fatal impairment of the fetus. The use of conscience claims prevents Colombian women, particularly those who are poorest and most vulnerable, from obtaining abortion procedures to which they are legally entitled, and it forces them to undergo unsafe, clandestine procedures that harm them physically and psychologically.

In light of the aforementioned information, we respectfully request recognition as amicus curiae in the present case, in accordance with Article 13 of Decree 2591 of 1991. Given that we have proven our legitimate interest in the case, the Court should consider the information presented in this document and its attachments in making its decision.

Attached, please find:

1. Certificate of Incorporation by the state of New York, county of Albany;
2. Amendment of Certificate of Incorporation, changing name from "National Women's Health Coalition, Inc." to "International Women's Health Coalition, Inc.";
3. Letter from the Internal Revenue Service, granting IWHC status as a 501(c)(3) corporation;
4. Amended and restated bylaws of IWHC, adopted as of September 10, 2014, granting the President of IWHC the powers to represent the organization;
5. Board minutes, certifying Françoise Girard as President of IWHC ;
6. Report and policy brief: "Unconscionable: When Providers Deny Abortion Care" and "Unconscionable: When Providers Deny Abortion Care, Policy Brief" (International Women's Health Coalition, 2018).

Respectfully,

Françoise Girard
President

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