October 26, 2017

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office of the Assistance Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Ave. S.W.
Room 415F
Washington, D.C. 20201

Re: Center for Reproductive Rights' Comments on the Draft HHS Strategic Plan FY 2018-2022

To Whom It May Concern:

The Center for Reproductive Rights (the Center) write to express our deep concern with the Health and Human Services' (HHS) Draft Strategic Plan FY 2018-2022. We are alarmed by several new additions and changes to the language and content of the Draft Strategic Plan that constitute a harmful departure from past strategic plans, by prioritizing ideology over evidence. Specifically, we have serious concerns regarding the following:

- Explicit anti-abortion and fetal personhood language undermines women's right to choose
- Improper emphasis on the rights of religious and faith-based groups indicates HHS' unwillingness to put patients first.
- Refusal to address the needs of vulnerable and underserved groups undermines progress to eliminate health discrepancies.

Founded in 1992, the Center is a global legal advocacy organization dedicated to reproductive rights, with expertise in both U.S. constitutional and international human rights law. The Center's litigation and advocacy over the past twenty-five years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception, safe abortion services, and comprehensive sexuality information.

Under the Government Performance and Results Act (GPRA) of 1993 (P.L. 103-62) and the GPRA Modernization Act of 2010 (P.L. 111-352), the Department of Health and Human Services (HHS) is required to submit a strategic plan describing the agency's plan to address evolving health and human services issues. Under § 306 of the GPRA Modernization Act of 2010, such a strategic plan must include not only general goals and objectives for the major functions and operations of the agency, but also a description of how specific performance goals contribute to achieving the general goals and objectives in the strategic plan. In previous Strategic Plans, including the Strategic Plan for 2014-2018, this requirement has resulted in concrete, measurable Performance Goals for each Objective. These Performance Goals have provided benchmarks to measure progress both qualitatively and quantitatively.

Past Strategic Plans have included benchmarks to measure progress, such as increasing a percentage of adults who are screened for depression, or decreasing the total morphine milligram equivalents dispensed.[1] The Draft Strategic Plan contains no specific measurable performance goals, only "strategies" expressed in vague, precatory terms, such as "promote," "collaborate," or "engage with." The Draft Strategic Plan as it stands does not meet the requirements under law to create a guide and workplan that is measurable.[2] Coupled with the unnecessary and harmful anti-abortion language as well as open-ended support for religious and moral exemptions, the overall effect is that the Draft Strategic Plan comes across as a political agenda to message support for the Administration's perceived allies, rather than an actual plan to better the health of all Americans. Further, the HHS Draft Strategic Plan diminishes, rather than ensures, government accountability, by failing to establish data-driven, evidence-based measurable goals. It is a waste of government resources to draft and try to execute against this type of "plan."

1. <u>Explicit anti-abortion and fetal personhood language undermine women's right to choose.</u>

The Draft Strategic Plan defines an American lifespan as beginning at "conception" (e.g., Objective 2.4 vows to protect "the inherent dignity of persons from conception to natural death"). The explicit statement that a fertilized egg has the same inherent human dignity as an actual person not only runs counter to well-established constitutional caselaw going back more than forty years, but it also is dangerous, threatening Americans' access to a range of critical health services.

Roe v. Wade established abortion as a fundamental right for women, declaring that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." This central holding of *Roe,* protecting a woman's right to access abortion, has been consistently upheld and reaffirmed by the Supreme Court, including just last year in *Whole Woman's Health v. Hellerstedt.* The language in the Draft Strategic Plan is an attempt to directly undermine this fundamental constitutional right by advancing an unlawful definition of persons and living Americans as beginning at conception, which has no basis in science.

Moreover, equating a fertilized egg and a human being threatens women's access to crucial healthcare services, including birth control, assisted reproductive technology (ART), stem cell research, and *in vitro* fertilization (IVF). Perhaps most crucially, this unconstitutional non-medical definition threatens autonomous decision-making for all pregnant women, including those intending to carry their pregnancies to term. This is an unacceptable and unconstitutional infringement on a woman's autonomy over her own body, and we urge HHS to immediately remove all language that could threaten women's access to a broad array of healthcare services.

2. <u>Improper emphasis on the rights of religious and faith-based groups indicates HHS' unwillingness to put patients first.</u>

HHS' overarching mission and function is "to enhance and protect the health and well-being of all Americans." In accordance with this mission, past Strategic Plans have focused on ways to expand

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[1] HHS Strategic Plan 2014-2018, Strategic Goal 1 Objective E; *Id.* at Strategic Goal 1 Objective B.

[2] GPRA Modernization Act of 2010, 5 U.S.C. § 306 (2012) ("Such plan shall contain . . . (2) general goals and objectives, including outcome-oriented goals, for the major functions and operations of the agency; (3) a description of how any goals and objectives contribute to the Federal Government priority goals required by section 1120(a) of title 31; (4) a description of how the goals and objectives are to be achieved, including—(A) a description of the operational processes, skills and technology, and the human, capital, information, and other resources required to achieve those goals and objectives; and (B) a description of how the agency is working with other agencies to achieve its goals and objectives as well as relevant Federal Government priority goals . . . (8) a description of the program evaluations used in establishing or revising general goals and objectives, with a schedule for future program evaluations to be conducted.").

patients' access to quality care, using a patient-centric approach to track progress towards better health outcomes for all Americans. On the contrary, this Draft Strategic Plan subordinates the goal of expanding health care access by emphasizing throughout that HHS will "affirmatively accommodate" burdens imposed on the exercise of religious beliefs and moral convictions by persons and entities partnering with HHS (e.g. Objective 1.3).

HHS' implied concession that a patient's right to access healthcare can and should be limited by religious and moral providers' beliefs is dangerous. HHS should be committed to putting measurable goals toward improving individual patient care at the center of any strategic plan, and should work to ensure medical standards of care and individual patient circumstances determine patient care, not politicians or providers' and insurance companies' religious beliefs. Furthermore, HHS' approach in the Draft Strategic Plan is not in line with those of many other developed democratic countries that have had to consider the question of conscience rights when they infringe on patient access. Even in countries that allow certain healthcare providers to exercise religious or moral refusals, such as the UK, France, Italy, and Spain, courts and other authorities limit the right to only direct providers (only physicians, pharmacists, etc., not employers or insurance providers), and mandate safeguards to protect patients, such as informed consent and mandatory referral rules.[3] Strikingly, the Draft Strategic Plan completely lacks any analysis of the possible impact on patients as a result of healthcare providers refusing to provide healthcare based on their professed religious or moral beliefs, or of how HHS plans to ensure patients' access to care in the presence of such objections. Instead, the affirmative accommodations for religious and moral beliefs outlined in the Draft Strategic Plan are open-ended and provide no protection for patients whatsoever.

Furthermore, HHS has stated in multiple places in the Draft Strategic Plan that HHS will "promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or conducted activities." The problem is that permitting faith-based organizations that have religious objections to providing the full range of health services to all eligible individuals to participate in HHS-funded or conducted activities means putting organizations that refuse to provide key services on the same footing as organizations that are willing to provide them. This is not equality—it is religious favoritism at the expense of patients and other beneficiaries.

In addition, to implement HHS' stated goals here in a measurable way, HHS may aim to increase the raw number of faith-based organizations receiving HHS grants and contracts. This priority could result in persons and organizations receiving funding based primarily or solely on the fact that they are faith-based,

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[3] See, e.g., *Comite de Bioetica de España*, Opinion of the Spanish Bioethics Committee on Conscientious Objection in Medical Care, p. 10 (2011) (Spanish Bioethics Committee guidelines clarifying that religious refusals only applies to individuals because "[o]nly individuals have conscience, not legal entities or other collective bodies.") http://assets.comitedebioetica.es/files/documentacion/en/Conscientious%20objection%20in%20medical%20care_CBE_2011.pdf; *Pichon and Sajous v. France*, No. 49853/99, Eur. Ct. H.R. (2001) (inadmissible) (European Court of Human Rights decision holding that pharmacy owners' claim that they could refuse to sell contraceptives based on their religious beliefs is inadmissible under the European Convention on Human Rights because pharmacy owners cannot prioritize their beliefs over their professional obligations); Ley Orgánica 2/2010, de 3 de Marzo, de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo, BOE 2010, 3514, art. 19, *translation available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Organic%20law%202-2010%20on%20SRH%20and%20voluntary%20pregnancy%20termination%20-%20English%20Translation.pdf (Spanish law stating that health care providers may object on conscientious grounds, "provided their choice does not undermine access or the quality of care."); Code de la Sante Publique (Fr.), arts. L2212-8 (French law mandating that doctors in France who object to providing an abortion have a legal duty to refer the woman to another provider who is willing to perform the procedure.); General Medical Council (UK), Good Medical Practice, ¶ 52 (2013), http://www.gmc-uk.org/Good_medical_practice___English_1215.pdf_51527435.pdf (UK General Medical Counsel guidelines specifying that objecting doctors must inform patients of their right to see another doctor and make sure the patients have enough information to exercise that right).

instead of using other scientific, evidence-based measures to determine which organizations are the best qualified to carry out a program. Using such non-evidence-based qualifications to purposefully increase certain groups' participation and funding over others is highly inappropriate and risks crossing the constitutional line to establish government endorsement of particular religious views.

The Draft Strategic Plan's repeated commitment to accommodate religious and moral objections and increase faith-based groups' funding and participation is fraught with the risk of harming patient access and running afoul of the Establishment Clause. We urge HHS to redact all language implying non-evidence-based approaches to rewarding funding and partnership opportunities. We also urge HHS to redact the broad language promoting open-ended deference to providers with religious and moral objections, and commit to truly putting patient health first.

3. Refusal to address the needs of vulnerable and underserved groups undermines progress to eliminate health discrepancies.

The current HHS Strategic Plan for FY2014-2018 establishes specific measurable goals to improve the health outcomes of all Americans by specifically recognizing the health disparities that persist among populations, including racial and ethnic minorities, individuals with disabilities, refugees, and lesbian, gay, bisexual, and transgender (LGBT) individuals.[4] To give just one example of stark health disparities that exist in the United States, black women are three to four times more likely to die from pregnancy complications than white women are, and they are twice as likely to suffer maternal morbidity.[5] Indeed, international human rights experts have expressed specific concern over high maternal and infant mortality rates among African American communities.[6] The 2014-2018 Plan recognizes and highlights the need for active efforts to reduce existing disparities among specific populations and to ensure that the most vulnerable populations within the United States receive access to health care. Furthermore, the 2014-2018 Plan details a data-driven agenda to support research that will increase our understanding of population subgroups such as racial and ethnic minorities, the re-entry population, and LGBT populations. In contrast, while the Draft Strategic Plan promotes "culturally-competent care" and recognizes that health disparities exist generally, it removes all language identifying these communities and sub-populations specifically by name. At best, this makes the objectives and goals with the Draft Strategic Plan less measurable and meaningful; at worst, these omissions indicate that the agency will deprioritize work on closing gaps in health care services and outcomes across these groups. We strongly urge HHS to include, as it has in the past, specific objectives and goals relating to the persistent health disparities that continue to exist for ethnic and racial minorities, individuals with disabilities, refugees, LGBT individuals, and re-entry populations.

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[4] *See, e.g.*, HHS Strategic Plan 2014-2018, Strategic Goal 1 Objective E; HHS Action Plan to Reduce Racial and Ethnic Health Disparities (2011).

[5] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Reproductive Health: Pregnancy Mortality Surveillance System*, (last updated June 29, 2017), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html; Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis*, 2008-2010, 210 AM. J. OBSTET. GYNECOL. 435, 437 (2014).

[6] COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION, *Concluding Observations—United States of America*, ¶ 15, UN Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014); HUMAN RIGHTS COUNCIL, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice, on its Mission to the United States*, ¶¶ 72, 89, UN Doc. A/HRC/32/44/Add.2 (June 7, 2016); HUMAN RIGHTS COUNCIL, *Report of the Working Group of Experts on People of African Descent, on its Mission to the United States*, ¶ 117, UN Doc. A/HRC/33/61/Add.2 (Aug. 18, 2016).

Additional line-by-line objections to the text of the Draft Strategic Plan are detailed in the chart below. We appreciate the opportunity to comment on the HHS Draft Strategic Plan FY 2018-2022. If you require additional information about the issues raised in this letter, please contact Susan Inman, Senior Federal Policy Counsel, at sdinman@reprorights.org.

Signed,

The Center for Reproductive Rights
(attachment)

Center for Reproductive Rights' Section-by-Section Objections to the HHS Draft Strategic Plan FY 2018-2022

Section and Objective	Quotation	Objection	Recommendation
Strategic Goal 1, Introduction	"While we may refer to the people we serve as beneficiaries, enrollees, patients, or consumers, our ultimate goal is to improve healthcare outcomes for all people, **including the unborn**, across healthcare settings"	Language referring to "the unborn" threatens a woman's fundamental constitutional right to essential reproductive health care. This non-scientific anti-abortion terminology also interferes with a women's ability to access assisted reproductive technologies (ART) and prioritizes fetal personhood over constitutional and human rights.	We strongly oppose this language and recommend that HHS strike the words "including the unborn," from this section.
Objective 1.1	"Test new payment models on alternative approaches to end-of-life care that incentivize patient and family-centered preferences, **while respecting religious beliefs and moral convictions**"	This phrase implies that religious beliefs and moral convictions of healthcare providers, institutions, and insurance companies may override patients' autonomy on end-of-life care.	We strongly oppose this language and recommend that HHS strike the words "while respecting religious beliefs and moral convictions" from this section.
Objective 1.3	"Improving access to health care involves multiple strategies – from improving healthcare coverage options, to improving consumer understanding of options, to designing options responsive to consumer demands, **while removing barriers for faith-based and other providers**"	This language improperly implies that some limitations to access may be justified based on faith objections, and then inappropriately expands the category of objecting entities to broadly include "other" providers. This undermines the initial stated purpose of the objective ("improving access") and inserts ideological principles that cannot be measured, in violation of the underlying statute.	We strongly oppose this language and recommend that HHS strike the words "while removing barriers for faith-based and other providers" from this section.
Objective 1.3	"Support consumer choice and transparency by promoting the availability of a range of individual health insurance plans and other health care payment options, **including faith-based options**,	Such language signals that healthcare providers and health insurance companies may be allowed to unacceptably deny essential benefits to patients.	We strongly oppose this language and recommend that HHS strike the words "including faith-based options" from this section.

	with different benefit and cost-sharing structures"		
Objective 1.3	"Design healthcare options that are responsive to consumer demands, while **removing barriers for faith-based and other community-based providers**"	This sentence also broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need regardless of their health care or insurance provider's religious beliefs or moral convictions. This language improperly implies that available options may be dictated or limited by faith-based providers and then adds "other community-based providers" without clarifying who these entities might be and what barriers they currently face to providing healthcare options. This undermines the purpose of the objective (to expand, rather than limit, options), and inserts ideological rhetoric that cannot be measured, in violation of the underlying statute.	We strongly oppose this language and recommend that HHS strike the words "faith-based and other" providers from this section.
Objective 1.3	"Vigorously enforce laws, regulations, and other authorities, especially Executive Order 13798 of May 4, 2017, Promoting Free Speech and Religious Liberty, to reduce burdens on the exercise of religious and moral convictions, **promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or conducted activities,**	This sentence unacceptably implies that HHS may give priority in funding opportunities to faith-based organizations over other entities. To implement HHS' stated goal here in a measurable way, HHS would increase the number of faith-based organizations receiving HHS grants and contracts, based on the fact that they are faith-	We strongly oppose this language and recommend that HHS strike "Vigorously enforce laws, regulations, and other authorities, especially Executive Order 13798 of May 4, 2017, Promoting Free Speech and Religious Liberty, to reduce burdens on the exercise of religious and moral convictions,

	and remove barriers to the full and active engagement of faith-based organizations in the work of HHS through targeted outreach, education, and capacity building”	based, instead of using other scientific, evidence-based measures to determine which organizations are the most qualified to carry out the activities. Using such non-evidence-based qualifications to purposefully increase certain groups’ participation and funding over others is highly inappropriate and risks crossing the constitutional line to establish government endorsement of particular religious views. This sentence also broadly supports and encourages organizations that claim religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need.	promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or conducted activities, and remove barriers to the full and active engagement of faith-based organizations in the work of HHS through targeted outreach, education, and capacity building” from this section.
Objective 1.3	“Implement Executive Order 13798 of May 4, 2017, Promoting Free Speech and Religious Liberty, and **identify and remove barriers to, or burdens imposed on, the exercise of religious beliefs and/or moral convictions by persons or organizations partnering with, or served by HHS, and affirmatively accommodate such beliefs and convictions, to ensure full and active engagement of persons of faith or moral conviction and of faith-based organizations in the work of HHS**”	This sentence unacceptably implies that HHS may give priority in partnership and contracting opportunities to faith-based organizations over other entities. To implement HHS’ stated goal here in a measurable way, HHS would increase the number of faith-based organizations receiving HHS contracts and partnerships, based on the fact that they are faith-based, instead of using other scientific, evidence-based measures to determine which organizations are the most qualified to carry out the work. Using	We strongly oppose this language and recommend that HHS strike “Implement Executive Order 13798 of May 4, 2017, Promoting Free Speech and Religious Liberty, and identify and remove barriers to, or burdens imposed on, the exercise of religious beliefs and/or moral convictions by persons or organizations partnering with, or served by HHS, and affirmatively accommodate such beliefs and convictions, to ensure full and

		such non-evidence-based qualifications to favor certain religious and moral views and purposefully increase those groups' participation and funding over others is highly inappropriate and risks crossing the constitutional line to establish government endorsement of particular religious views. This sentence also broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need.	active engagement of persons of faith or moral conviction and of faith-based organizations in the work of HHS" from this section.
Objective 1.3	"**Promote equal and nondiscriminatory participation by persons of faith or moral conviction and by faith-based organizations in HHS-funded, HHS-regulated, and/or HHS-conducted activities**, including through targeted outreach, education, and capacity building"	This sentence unacceptably implies that HHS may give priority in funding opportunities to faith-based organizations over other entities. To implement HHS' stated goal here in a measurable way, HHS could aim to increase the raw number of faith-based organizations receiving HHS grants and contracts. This stated priority and goal could result in persons and organizations receiving funding primarily or solely based on the fact that they are faith-based, instead of using other scientific, evidence-based measures to determine which organizations are the best fit to carry out a program. Using such non-	We strongly oppose this language and recommend that HHS strike "Promote equal and nondiscriminatory participation by persons of faith or moral conviction and by faith-based organizations in HHS-funded, HHS-regulated, and/or HHS-conducted activities, including through targeted outreach, education, and capacity building" from this section.

		evidence-based qualifications to purposefully increase certain groups' participation and funding over others is highly inappropriate and risks crossing the constitutional line to establish government endorsement of particular religious views. This sentence also broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need.	
Objective 1.4	"HHS is investing in a number of strategies to strengthen and expand the healthcare workforce – from reducing provider shortages, to providing professional development opportunities for the healthcare challenges of today and tomorrow**, to removing barriers for health care providers with religious beliefs or moral convictions**, to collecting and analyzing data for continuous improvements"	This sentence broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need. Further, the only existing "barriers" to participation by health care providers with religious beliefs or moral convictions are prohibitions on discrimination, consistent with legal requirements. A stated goal of removing those protections would be unconstitutional.	We strongly oppose this language and recommend that HHS strike the words "to removing barriers for health care providers with religious beliefs or moral convictions" from this section.

Objective 1.4	"Remove any barriers to, and promote, full participation in the health care workforce by **persons and/or organizations with religious beliefs or moral convictions**"	This sentence broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need. Further, the only "barriers" to participation by health care providers with religious beliefs or moral convictions are prohibitions on discrimination, consistent with legal requirements. A stated goal of removing those protections would be unconstitutional.	We strongly oppose this language and recommend that HHS strike the words "by persons and/or organizations with religious beliefs or moral convictions" from this section.
Objective 2.1	"HHS seeks to achieve this objective, in part, **by removing barriers to, and promoting, participation in HHS conducted, regulated, and funded programs by persons and organizations with religious beliefs or moral convictions** and other community organizations"	This sentence unacceptably implies that HHS may give priority in funding opportunities to faith-based organizations over other entities. To implement HHS' stated goal here in a measurable way, HHS might aim to increase the raw number of faith-based organizations receiving HHS grants and contracts. This stated priority and goal could result in persons and organizations receiving funding primarily or solely based on the fact that they are faith-based, instead of using other scientific, evidence-based measures to determine which organizations are most qualified to carry out a program. Using such non-evidence-based qualifications to purposefully increase certain groups' participation and funding over others is	We strongly oppose this language and recommend that HHS strike the words "persons and organizations with religious beliefs or moral convictions and other" from this section.

		highly inappropriate and risks crossing the constitutional line to establish government endorsement of particular religious views. This sentence also broadly supports and encourages organizations that use religious and moral beliefs to refuse to provide certain healthcare, without acknowledgement that these exemptions negatively impact patients and without discussion of how HHS will ensure patients get the care and information they need. Further, the only "barriers" to participation by health care providers with religious beliefs or moral convictions are prohibitions on discrimination, consistent with legal requirements. A stated goal of removing those protections would be unconstitutional.	
Objective 2.4	"Enhance international preparedness through medical countermeasures and community mitigation measures**, respecting the inherent dignity of persons from conception to natural death**"	This sentence implies that personhood begins at conception. This is explicit unconstitutional anti-abortion language that undermines a woman's right to choose and elevates those seeking to overturn *Roe v. Wade*. The availability of safe, accessible abortion is essential to gender equality and women's health, and this language runs counter to decades of well-established caselaw recognizing the reproductive healthcare as a fundamental right. Furthermore, the words "natural death" imply that individuals should not have full autonomy	We strongly oppose this language and recommend HHS strike the words "from conception to natural death" from this section.

		on end-of-life care. This ideological rhetoric is unscientific and inappropriate for the HHS strategic plan. Additionally, this language lacks clear, evidence-based goals or measurable benchmarks consistent with scientific principles, and thus is unenforceable and unachievable.	
Strategic Goal 3	"A core component of the HHS mission is our dedication to serve all Americans **from conception to natural death**"	This sentence implies that personhood begins at conception. This is explicit unconstitutional anti-abortion language that undermines a woman's right to choose and elevates those seeking to overturn *Roe v. Wade*. The availability of safe, accessible abortion is essential to gender equality and women's health, and this language runs counter to decades of well-established caselaw recognizing the right to abortion as a fundamental right. Furthermore, the words "natural death" imply that individuals should not have full autonomy on end-of-life care. This ideological rhetoric is unscientific and inappropriate for the HHS strategic plan.	We strongly oppose this language and recommend HHS strike the words "from conception to natural death" from this section.
Strategic Goal 4	"The research pursued under this strategic goal is to be conducted consistent with the understanding that human subjects protection applies to **all human beings from conception to natural death**"	This sentence implies that personhood begins at conception. This is explicit unconstitutional anti-abortion language that undermines a woman's right to choose and elevates those seeking to overturn *Roe v. Wade*. The availability of safe, accessible abortion is essential to gender equality and women's health, and this language runs counter to decades of	We strongly oppose this language and recommend HHS strike the words "from conception to natural death" from this section.

		well-established caselaw recognizing the right to abortion as a fundamental right. Furthermore, the words “natural death” imply that individuals should not have full autonomy on end-of-life care. This ideological rhetoric is unscientific and inappropriate for the HHS strategic plan.	
Objective 4.3	“Support a broad and diverse portfolio of biomedical research by supporting a range of scientific disciplines, including basic and translational research, to augment scientific opportunities and innovation for public health needs, consistent with human subject protections, **which protect all persons from conception on,** and bioethics”	This sentence implies that personhood begins at conception. This is explicit unconstitutional anti-abortion language that undermines a woman’s right to choose and elevates those seeking to overturn *Roe v. Wade*. The availability of safe, accessible abortion is essential to gender equality and women’s health, and this language runs counter to decades of well-established caselaw recognizing the right to abortion as a fundamental right. This ideological rhetoric is unscientific and inappropriate for the HHS strategic plan. Additionally, this language lacks clear, evidence-based goals or measurable benchmarks consistent with scientific principles, and thus is unenforceable and unachievable.	We strongly oppose this language and recommend HHS strike the words “from conception on” from this section.