



REPRODUCTIVE INJUSTICE

RACIAL AND GENDER DISCRIMINATION
IN U.S. HEALTH CARE



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Cover photo credit: Jennifer Whitney, jennwhitney.com.

Cover photo caption: Pilar could not afford surgery in the U.S. to remove a tumor that developed after the birth of her last child. A last minute trip to a doctor in Mexico saved her life, but she was forced to risk her life once again to cross the border and be reunited with her children.

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SisterSong.net

SisterSong Women of Color Reproductive Justice Collective formed in 1997 as a national membership organization to build an effective network of individuals and organizations to improve institutional policies and systems that impact the lives of marginalized women. SisterSong's mission is to strengthen and amplify the collective voices of Indigenous women and women of color to achieve reproductive justice by eradicating reproductive oppression and securing human rights.

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*A Shadow Report for the UN Committee on the Elimination of
Racial Discrimination*



Sylvia (left), from Mission, Texas, has not been able to get contraception or a screening for cervical cancer since the local family planning closed in 2011.

Photo Credit: Jennifer Whitney

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EXECUTIVE SUMMARY

When it ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the United States committed to ensure the right to health care free from all forms of racial discrimination to all within its borders. Yet, as the U.S. prepares to report to the U.N. expert body charged with monitoring U.S. progress on implementation of these commitments, discrimination in health care remains entrenched. This report evaluates the U.S. record on addressing racial and gender discrimination in sexual and reproductive health care. Recognizing that discrimination exists in both law and fact, we focus on the need for policy change as well as proactive measures to address the structural forms of discrimination that inhibit the ability of women of color and immigrant women to exercise their human right to health.

RACIAL DISPARITIES IN MATERNAL MORTALITY

Maternal mortality is a human rights crisis in the United States. Between 1990 and 2013, as the overwhelming majority of countries dramatically reduced the incidence of maternal mortality, the maternal mortality ratio in the U.S. more than doubled from 12 to 28 maternal deaths out of every 100,000 live births. Racial disparities fuel this crisis. For the last four decades, Black women have been dying in childbirth at a rate three to four times their White counterparts. Cities and states with a high African American population also have the highest rates of maternal mortality in the country; in some areas of Mississippi, for example, the rate of maternal death for women of color exceeds that of Sub-Saharan Africa, while the number of White women who die in childbirth is too insignificant to report.

In addition to race, drivers of maternal mortality in the U.S. include social determinants of health such as poverty and lack of health insurance. Women of color are much more likely than White women to live in poverty and to lack health insurance. Because of these barriers to health care access, women of color are far more likely to exhibit risk factors for maternal death, such as diabetes and heart disease. Disparities in quality of care also persist for women of color and poor women and, in some cases, are growing worse—the U.S. Department of Health and Human Services identified maternal mortality as one of the most rapidly deteriorating areas of health quality over the past three years.

In its 2008 Concluding Observations, the Committee on the Elimination of Racial Discrimination (Committee) expressed concern about persistent disparities in sexual and reproductive health, including maternal mortality. It recommended the U.S. increase efforts to expand health insurance coverage, facilitate access to maternal health care and family planning, and improve sexuality education and information. The U.S. government has taken some steps to improve

coverage, primarily through passage of the Affordable Care Act. However, political resistance to this law—especially in states with the highest rates of uninsured, people living in poverty, and maternal mortality—threaten to undermine the goals of the legislation to increase access to health care and reduce health disparities.

In May 2014, the Center for Reproductive Rights and SisterSong Women of Color Reproductive Justice Collective gathered first-hand accounts of Black women living in the South in order to better understand the role of racial and gender discrimination in their reproductive and sexual lives. The narratives, analyzed for the first time in this report, show that the U.S. government has failed to implement the Committee's recommendations. Women living in Georgia and Mississippi—two states with the highest rates of maternal death in the country—shared their experiences with the health care system from the time of their first sexual activity through childbirth. Their stories reveal key inequalities in the health care system for women of color, including:

- lack of information about sexuality and sexual health;
- discrimination in the health care system;
- lack of access to sexual and reproductive health care; and
- poor quality of sexual and reproductive health information and services.

Policy change is necessary, but these stories demand much more. Eliminating disparities in reproductive health care, including maternal mortality, will require proactive steps by the U.S. government to: increase both general and pregnancy related coverage of uninsured women; improve access to contraceptive services and maternal health care; train healthcare providers to avoid racial stereotypes and provide high quality care to all women; ensure comprehensive sexuality education and information; and provide adequate social supports for recent parents, including paid parental leave. In addition, the U.S. should strengthen monitoring and accountability measures for maternal mortality in line with human rights standards.

DISCRIMINATION AGAINST NON-CITIZEN WOMEN IN ACCESS TO HEALTH CARE

U.S. policy excludes large groups of immigrants from eligibility for public health insurance, thereby greatly restricting the ability of immigrants to access health care. The Affordable Care Act incorporated restrictions set in place in 1996 that require non-citizens who are lawfully present in the U.S. to wait five years before they can enroll in Medicaid (although some states, including those with large immigrant populations like Texas, do not allow lawfully residing immigrants to enroll even after completion of the waiting period). Moreover, undocumented immigrants are completely barred from Medicaid, and the Affordable Care Act prohibits this group from purchasing private insurance on the newly developed health insurance exchanges, even with their own money.

These restrictions exacerbate existing barriers to coverage for immigrant women. Immigrants are more likely to work in low-wage jobs that lack employer-based insurance, and immigrant women of reproductive age are approximately 70% more likely than their U.S.-born peers to lack health insurance. These barriers to public and private insurance mean they are often unable to receive the preventive reproductive health care they need, including contraception, prenatal care, screenings for breast and cervical cancer, and tests for HIV/AIDS and other sexually transmitted infections.

Meanwhile, the reproductive health safety net that provides family planning services to low-income women who do not qualify for Medicaid has come under attack at the federal and state level. Funding for the Title X family planning program has been cut to below 2008 levels, even as the population in need of its services has grown. Latinas represent the fastest growing group in need of publicly funded contraception, with a growth of 47% in the decade between 2000 and 2010 compared to a 4% growth in need among White women.

In addition, states are slashing their own family planning budgets and passing ideologically motivated policies to further restrict access to preventive reproductive health care. For example, a combination of funding cuts and other restrictions on family planning has most severely impacted low-income Latinas and immigrants living in the Lower Rio Grande Valley of Texas. As documented in a recent report by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health – ***Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley*** – the loss of family planning services in one of the most medically underserved areas of the country has created a health crisis for immigrant women and their families. Now without any source of affordable health care, they are facing numerous consequences to their health: cervical and breast cancer that could have been detected and treated early, chronic pain from untreated reproductive health conditions, and unintended pregnancies from the inability to access affordable contraception.

This Committee has made it clear that the right to non-discrimination in the exercise of the right to health applies to all regardless of citizenship status. Any differential treatment between non-citizens and citizens must not amount to discrimination on the basis of citizenship status, race, ethnicity, or other grounds. U.S. policy excluding qualified immigrants from eligibility for Medicaid and undocumented immigrants from participation in the ACA's health insurance exchanges fulfills no legitimate aim and is incompatible with government obligations under the Convention. In addition to repealing these exclusions, the government should maximize sexual and reproductive health access by allocating health resources on an equitable basis, prioritizing the needs of the most marginalized populations, including immigrants, low-income, and rural women.



Non-citizens living in extreme poverty in the Rio Grande Valley are not eligible for public health insurance because of their immigration status.

Photo Credit: Jennifer Whitney, jennwhitney.com.

REVIEWING THE U.S. RECORD ON RACIAL DISCRIMINATION

In August 2014, the UN Committee on the Elimination of Racial Discrimination (Committee) will take stock of U.S. commitments to end racial discrimination. When the U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)¹ in 1993, it agreed to take action to remedy discrimination in all its forms and at all levels of government. The government also agreed to report periodically to the body of independent human rights experts charged with monitoring state compliance under the treaty. The U.S. last reported to the Committee in 2008. In June 2013, the Obama administration submitted a comprehensive report updating the Committee on actions taken to address the Committee's priority concerns and recommendations from the prior review.²

This report fills the gaps in the U.S. government's report on the status of women's rights to substantive equality, non-discrimination, and other core human rights protected by the ICERD. Further, the information contained in this report responds to the Committee's 2008 Concluding Observations to the U.S. regarding the impact of gender and race discrimination on the enjoyment of the right to health. This report is intended to assist the Committee in evaluating U.S. progress on implementation since the last review and to recommend priorities for the Committee's interactive dialogue with the U.S. government in Geneva in August 2014.

WOMEN'S RIGHTS TO EQUALITY AND NON-DISCRIMINATION UNDER ICERD

The Committee takes a substantive and intersectional approach to interpreting the right to non-discrimination as set forth in Article 1. In its General Recommendation 25, the Committee recognizes the importance of analyzing racial discrimination from a gender perspective: in particular, addressing the “circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men.”³ The recognition that certain people may experience multiple and intersecting forms of discrimination underlies the principle of equality under ICERD, which includes both formal equality (*de jure*) before the law, and substantive equality (*de facto*) in the exercise of one's human rights.⁴

With respect to assessing discrimination against women, human rights bodies have urged governments to analyze discriminatory power structures—including historical and socialized roles of women, gender stereotypes, and laws and policies—and how these structures affect the ways that differently situated women experience discrimination. In its General Recommendations, the Committee has requested that states identify the specific “disadvantages, obstacles and difficulties” women face when exercising their human rights under ICERD.⁵

Further, the Committee has called on states to ensure they are taking the necessary steps to proactively address these impacts and to change the context in which discrimination arises. In periodic reviews of state compliance under ICERD, the Committee has urged states to address discrimination by amending laws, policies and practices, and by taking *proactive* steps, such as adopting temporary special measures to ensure that marginalized groups can effectively enjoy their human rights. In the last review of the United States, for example, the Committee recommended that the U.S. not only revise policies that inhibit low-income women's access to health insurance, but also to take steps to increase access to reproductive health services, education, and information.⁶

Other human rights treaty bodies have taken a consistent approach. The Human Rights Committee, which monitors compliance with the International Covenant on Civil and Political Rights, has urged states to address both *de jure* and *de facto* discrimination in private and public matters,⁷ take efforts to eliminate gender stereotypes about women in family and society,⁸ and address practices such as cutting funds to social programs that disproportionately impact women.⁹ The HRC has also urged states to take affirmative measures to ameliorate social conditions such as poverty and unemployment that impact women's right to equality in health care.¹⁰

The Committee on the Elimination of Discrimination against Women has recognized that “[t]he position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed.”¹¹ The Committee on Economic, Social and Cultural Rights has reinforced this understanding of equality in its General Comments 16 and 20, noting that “[e]liminating discrimination in practice requires paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations. States parties must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto *discrimination*.”¹² To do this they must address the underlying stereotypes and socialized roles, structural barriers, and unequal outcomes that result in discrimination that disparately impacts certain groups.¹³

This letter presents evidence of the failure of the U.S. to recognize and address the multiple and intersecting forms of discrimination against women of color in the area of health care. These examples show that the U.S. has violated its commitment under Article 5 of ICERD to take effective and proactive measures, including through allocation of resources and development of policies, to ensure that women of color and immigrant women can enjoy their right to health free from discrimination. In clarifying the obligations of the U.S. government with respect to the issues raised in this letter, it is critical for the Committee to identify both positive and negative duties to ensure the rights to equality and non-discrimination.

A. RACIAL DISPARITIES IN MATERNAL MORTALITY

Maternal mortality is a human rights crisis in the United States. The 2014 *Trends in Maternal Mortality* report issued jointly by WHO, UNICEF, UNFPA, the World Bank, and the UN Population Division shows that the maternal mortality ratio (MMR) in the US *increased* by 136% between 1990 and 2013, from 12 to 28 maternal deaths for every 100,000 live births.¹⁴ This is nearly double the rate of Saudi Arabia and more than triple that of the United Kingdom.¹⁵ The U.S. is one of only 15 countries whose MMR has increased annually since 1990, and at 3.8%, it has the *highest level of annual increase in maternal death* out of all countries surveyed in the joint report. Despite the fact that the U.S. spends an estimated \$98 billion per year on hospitalization during pregnancy and childbirth—twice as much as any other country¹⁶—its MMR has more than doubled in the past 23 years.¹⁷

1. INCREASED DISPARITIES IN MATERNAL MORTALITY

The causes of maternal mortality in the U.S. are multiple and complex,¹⁸ but the problem must be understood in the context of pervasive racial and socioeconomic disparities. Nationwide, Black women are nearly four times as likely to die in childbirth as their White counterparts.¹⁹ Areas with a high African

American population have some of the highest rates of maternal mortality in the country. Washington, D.C., with its 50% Black population, has an MMR of 41.6, compared to the national average of 28. Fulton County, Georgia, which includes the city of Atlanta, has an MMR more than three times the national average—there are 94 maternal deaths per 100,000 live births for African Americans, while the rate for White women is too insignificant to report at all.²⁰ In Chicksaw County, Mississippi, the MMR for women of color (595 per 100,000 live births) is higher than rates in countries of Sub-Saharan Africa, including Kenya (400) and Rwanda (320).²¹

Socioeconomic factors and geography also drive disparities. Women of color comprise more than half of U.S. women living in poverty,²² and the poverty rate for both Black women and Latinas is three times that of Whites.²³ High cost of health care, poor access to providers for women who depend on publicly financed care, a lack of prenatal care, and inadequate maternal and postnatal care all contribute to higher rates of maternal death in low-income women.²⁴ A 2010 report by Amnesty International on maternal mortality in the U.S. showed that states with high poverty rates had MMRs that were 77% higher than states with a higher percentage of people living above the poverty line.²⁵ African Americans living in Southern states are not only more likely to be poor and uninsured, but also less likely to have access to health care and more likely to have chronic health conditions that are risk factors for maternal death, such as diabetes and heart disease.²⁶

The 2012 Report of the Agency for Healthcare Quality and Research found that access to health care is decreasing, especially for people of color and low-income groups.²⁷ Consequently, low-income and uninsured Black women are already at high risk of maternal death by the time they become pregnant. Compared to White women, women of color fare significantly worse in key general health indicators including diabetes, obesity, heart disease, and hypertension.²⁸ These poor health indicators are often exacerbated during pregnancy, especially if they remain untreated, and are a driving force behind preventable maternal deaths.²⁹ The Centers for Disease Control and Prevention (CDC) points to an increase in pregnant women with chronic health conditions as a driving factor for the rise in maternal mortality between 2006 and 2009.³⁰

Poor health care quality also contributes to higher maternal mortality. The U.S. report acknowledges that “in many cases, health care quality in America could be improved.”³¹ Not only are improvements in quality advancing slowly, but “few disparities in quality of care are narrowing.”³² Disparities in quality of care for racial minorities in the U.S. have long been documented. According to the 2013 National Healthcare Disparities Report, African Americans and Latinos received worse care on 40% of measures compared to Whites and poor people received worse care on 60% of measures compared to higher income people.³³ While no disparities for sexual and reproductive health showed marked improvement over time, two—the maternal mortality ratio and the number of reproductive age women receiving a Pap test—were categorized as showing the most rapid rate of *worsening* of all health disparities quality measures.³⁴



Photo Credit: SisterSong.

SPOTLIGHT: BLACK WOMEN IN THE SOUTH

In May 2014, the Center for Reproductive Rights and SisterSong Women of Color Reproductive Justice Collective spoke to Black women of reproductive age living in the South about their sexual and reproductive histories. The purpose of the project was to gather first-hand accounts of Southern Black women's sexual and reproductive lives from their first sexual activity through early parenthood in order to better understand the role of racial and gender discrimination. In May 2014, SisterSong facilitated two conversations, one in Jackson, Mississippi, and another in Atlanta, Georgia, with a total of 25 women. All participants gave consent for their stories to be shared in this report, but the names of participants have been changed out of respect for their privacy. (Quotes were lightly edited for readability; original transcripts are on file with the Center for Reproductive Rights.)

While these narratives were not collected as part of a randomized survey and therefore should not be generalized, the perspectives of this select group offer insights about discrimination against Black women living in the South, a group with particularly poor reproductive and sexual health indicators. Key themes that surfaced in the conversations include:

- lack of information about sexuality and sexual health;
- discrimination in the health care system;
- lack of access to sexual and reproductive health care; and
- poor quality of sexual and reproductive health services and information.

LACK OF ACCESS TO INFORMATION ON SEXUAL AND REPRODUCTIVE HEALTH

Women reported that sexuality education was virtually nonexistent in Jackson and Atlanta and may have grown worse since they were adolescents. Kendra from Jackson did not learn anything about her body or about sex when she was younger. "I started having my period in the ninth grade . . . I started having sex at 16. . . . Boom, in the twelfth grade I'm already knocked up. . . . I tried to have an abortion. . . . I couldn't even say 'I'm pregnant' in the house because my only sex education was: 'This is a pad, this is a tampon.'"

The absence of comprehensive sexuality education in schools forced women to seek out information wherever they could, but it often proved inaccurate or incomplete. Destiny from Atlanta described her experience trying to learn about contraceptive use when she became sexually active:

[W]hen I was younger the stigma [prevented me from] buying my own condom so, you had to remind the guy to have a condom. You couldn't really talk to your mom about it. So far as family planning went, . . . I'd whisper it to my doctor when my mom wasn't in the room, and then try to just do as much as I could, on the sly, without getting caught. Which means most of the time it was pretty unsafe and dangerous. . . . Georgia teaches abstinence more than sex education. I learned how to say "no" a lot, but we didn't really learn a whole lot, [such as] if you said "yes" [to sex, then] this could happen, or if you said "yes," you should have [protection]. . . . I'd say I had more abstinence training than I had sex education.

Alexandra from Atlanta described how her knowledge about sex was self-taught. “I was educated on the street. That’s not where you want to be educated. You want someone with knowledge to educate you.” Another participant from Jackson said that she learned from her peers.

You couldn't go tell your parents [and say] “Hey, you know, I'm thinking about possibly . . .” No. You weren't going to sit down for a week [because she would be beaten by her parents if she told the truth]. That was just something that you couldn't do; it wasn't feasible. You went to the older kids, and nine times out of ten, the ones who were older than you, they've been down that road, they're probably already maybe one to two children in, so they weren't necessarily the best sources to go to, but . . .

After LaKeisha from Atlanta was unable to get the information she needed about practicing safe sex, she contracted an infection but confused it with a sexually transmitted disease.

I got my first yeast infection and I didn't know what to do. I thought I had a full-blown STD. I didn't even know what it was, and I let it go so far that I could barely sit down [from the pain]. . . . I couldn't tell anybody because I was so terrified. Then I came back [from the drugstore with yeast infection medication] and it went away in three days. I thought, “Alright, now I know what a yeast infection is.”

DISCRIMINATION IN THE HEALTH CARE SYSTEM

Even when young women were able to find a source for information about sexual health, they were stigmatized by parents, school officials, and health care professionals. Young women commonly felt shamed when they raised questions about sexuality, leading them in some cases to delay or avoid seeking information about sexual health services and information.

Kayla described a highly stigmatized environment for young women seeking sexual health information and services in Jackson. Policies restricting access in schools create a chilling effect on school officials' willingness to talk about sexual education.

The [school] clinic is prohibited from giving out condoms and they cannot [provide or talk about] birth control. The school district prohibits them from giving out birth control. I remember I went and talked to the nurse practitioner. The nurse practitioner told me that if kids come in and ask for condoms, she cannot give them condoms. In fact, when kids would ask her for condoms, she went so far as to throw them on the floor and say, “Hey, if you find anything you need in the room before you leave, feel free to pick it up and take it with you. . . .”

Kayla said that her daughter avoids seeking health services and information because of the stigma she encountered when trying to get contraception. “It is extremely hard for her to access family planning services. [The staff at the health clinic] told my daughter to go home and pray. . . . She has refused to go back. . . . She hasn't gotten back on long-term birth control because she won't go to any of these places because they're so horrid.”

Other women confirmed that service providers shame youth seeking contraception or other services that indicate they are engaging in sexual activity, and this can result in adolescents foregoing care. When Tiffany's sexually active daughter, a senior in high school, went to a local clinic seeking contraception, she was told by the health professional:

You've got other things in your life you need to be concerned about other than having sex. What do you need a [long-acting contraceptive] shot for? That makes absolutely no sense. You are too young for all of that, but since you requested it, we have to give it to you. But you may want to be focusing on your books; you don't need to be focusing on boys.

Adolescents who are questioning sexuality are especially challenged to find accurate, non-stigmatized information. After Courtney's 18-year-old daughter realized she was a lesbian, she made an appointment at her local Jackson health clinic.

She went in for her Pap [test], and she went in to get some information [about] the likelihood of getting [an STI] from another woman. . . . She asked her doctor and the nurses, they had this conversation: “What is the probability of me actually contracting something from another woman?” They were asking her about her sexual history [with men]. She was like, “Nope. Haven't been with a boy in years; I like women.” They were like, “What?” First it was, “Oh, so you're a lesbian,” [then] “You're not even old enough to really understand what that means yet. How do you really know that you like women?”

Negative stereotypes about Black women also affected women's experiences with the health care system when they sought reproductive health care. Kayla reported:

My daughter, my fifth daughter, was born with deformities. She had conjoined fingers, and she had an extra finger on one hand, and she only has two toes on her left foot. When they saw her [they made assumptions]. . . . Of course, I'm Black, I'm young, it's my fifth child, I'm under 25. The assumption by the hospital staff was I must have done drugs. The reason I know that is because as soon I woke up and got out of recovery, they questioned me about drug use five times. Then they came and did two blood draws . . . It made no sense for them to do it, and then they refused to let me have my baby for five hours. Finally, because they probably thought she was a fetal alcohol syndrome baby, and they thought I had done drugs, finally, they let me have my child. But [before this] they questioned my mom about whether or not I had done drugs; they questioned my boyfriend about whether or not I had done drugs.

Having encountered these stereotypes while giving birth, several women requested—and were denied—the presence of a traditional birth attendant to serve as a patient advocate during a subsequent childbirth. One woman from Jackson talked about the importance of having an advocate to ensure that stereotypes about Black women would not affect the quality of care she received, and that most importantly, her reproductive decisions would be respected: “Having someone who can tell you what questions to ask, what conversations to have with your care provider in the prenatal period is vital. That's one of the reasons why I am a staunch advocate for having a doula . . . if you're having a hospital birth, you need to have an advocate that is not related to you somehow.”



Photo Credit: SisterSong.

LACK OF ACCESS TO REPRODUCTIVE HEALTH CARE

Contraception

Women reported minimal access to contraceptive services and information in their communities. In Jackson, for example, the family planning clinics close at 5 PM on weekdays and are not open on the weekends. Only one clinic that serves adult women is open late, but its services are restricted to testing for sexually transmitted infections. According to Kendra from the Jackson area, “Family planning information in my community is almost nonexistent. We have a family planning clinic in the medical mall, with very limited information, and if you want brochures you have to ask for the brochures; they don’t have them out like they used to.” Women who work during the day and are unable to take time off for a doctor’s visit must go to extraordinary lengths to procure contraception.

Others were not aware of their right to access contraception. Kimberly, a pregnant woman from Atlanta, was unfamiliar with the term “family planning.” She has never found a health care environment in which she felt comfortable discussing contraceptive options.

I’m kind of surprised to hear you use the phrase ‘family planning.’ I’ve never had anyone talk to me in terms of, “this health care is about you, [is there] any type of family planning you’d like to do? . . . Do you want to have babies?” [Health care providers] just assumed you were sexual and that you probably were unmarried and judgment was passed. No one ever said, “Do you want babies?” It was more like, “Don’t have any [babies]” and basically, “Stop having sex.” Then, if you don’t [take precautions], the repercussion is a baby, and you don’t want that if you’re not married. . . I’ve never had a doctor that made me feel comfortable asking anything and everything.

Some were forced to confront negative stereotypes about Black women’s sexuality and reproduction when seeking contraception. Aaliyah from Jackson said her doctor had assumed she would not or could not effectively use contraception: “After I had the baby, and I went back for my checkup . . . [the doctor] told me, ‘I’ll see you in six weeks.’ I said, ‘Why?’ He said I’d be pregnant again.”

Prenatal Care

The women covered by Medicaid reported inadequate or poor quality prenatal care at local public hospitals. Aaliyah from Jackson said that her doctor did not explain anything to her during her few prenatal visits about the status of her pregnancy, and he neglected routine care. She recalled:

[H]e told me, “You didn’t have a sonogram since you first found out you were pregnant.” I said, “Yeah, I thought you knew that.” He said, “No. Let’s go check the baby.” Then [I] came to find out that my baby had no fluids around him, so [the doctor] had to send me over to be induced . . . He said, “Don’t worry about nothing. The baby will be okay. You only have one week left.”

But the baby was born with complications:

[When the baby was born], he wasn't breathing. You know how you [usually] hear the baby crying? He wasn't crying. I asked, "Momma, what's wrong?" She said, "He's blue." She asked the doctor, "Why is he blue?" The doctor said, "Oh, he's okay. He's just choking." Come to find out, they put my baby on C-PAP [breathing mask], then he went through all these tubes [intubation]. He went through three weeks of this.

Labor and Delivery

Lack of trust in the provider-patient relationship led several women to question the medical necessity for their caesarean deliveries. Many reported that doctors failed to adequately consult them about their reproductive health options or help them make informed decisions.

Nicole from Jackson was told by her doctor that a caesarean was necessary to preserve the baby's health, but she later learned this was not true.

Two weeks, three weeks before it was time for me to have the baby, I go to this doctor, never been to him before. He tells me, "Your baby is breech. He has no room to grow. He has not moved since we've been here, and we've been here two hours. We've got to take your baby because he might be dead." I started crying. The nurse came in; she helped me. She said, "This is just his manner; this is how he talks. There's nothing wrong with your baby. This is how he talks." Anyway, we still had the baby early.

Some felt their doctors pushed certain procedures based not on the patient's best interest but rather based on stereotypes about Black women's sexuality and reproduction. Kendra from Jackson explained: "We really don't have a lot of good experiences when it comes to having childbirth, especially because we're poor . . . Why are all these women having caesareans? Was it really necessary for me? . . . You have more Black women having caesareans. Now I'm questioning."

Lack of Adequate Postnatal Care and Socioeconomic Supports for Parenthood

Women reported a general lack of postnatal care, particularly if they were uninsured or enrolled in Medicaid. LaKeisha from Atlanta experienced a difficult childbirth via emergency caesarean, but she received inadequate medical attention following the surgery, even when she exhibited signs of an infection. In addition, the lack of post-surgery counseling deprived her of information she needed regarding her physical and mental recovery following her traumatic birth experience.

My follow-up [care] was not good. I ended up with [an] infection. There were no calls from the doctor's office to say, "How are you doing?" I sat with an infection for two weeks. I thought it was just the pain. . . . I remember feeling horrible [after my caesarean]. I really think this whole post C-section, not just post-delivery in general, but post C-section issue is completely under-exposed for how traumatic it is. . . . I really feel like reproductive issues with women should be paired with counseling because I think that counselors have a better way of helping you to understand how to deal with

it and receive the core information you need so that you can actually do the follow up that's necessary because I didn't do much follow up. [Later] I got my own counseling to deal with it. . . . I think [it was] only up until last year that I really psychologically recovered from that experience.

Several participants said that minimal postnatal care combined with fast work re-entry following childbirth had caused an enormous amount of stress. Returning to work one to three weeks following birth was common among participants in both Atlanta and Jackson. As a Jackson resident said about her postnatal check-ups: "You go for your two week [check-up], you go for your six week [check-up], and then you go back to work." Kimberly from Atlanta said her postnatal experience felt like "living a life that's attached to an experience that wasn't one that you wanted," as opposed to what she wanted: "a postnatal process of trying to heal and become whole so that the reproductive process can even be considered as an option again if and when you feel like it."

Brittany from Atlanta felt that she needed more postnatal care than the six-month period offered by Medicaid, but she was unable to afford it.

Six months, exactly six months. Then every day I think. . . "At least she's [her daughter] okay," but I wish that I could have had longer because you feel like, okay, I'll just get over this in six months. I wish there was more time or maybe more access. They were very helpful with helping me to get Medicaid because when you are pregnant you can get Medicaid at any time. When you're not pregnant it's like, "Wait in line, go over there." It would be nicer if we got postnatal care and more help along the way.

Financial stress—paying medical bills and childcare—were at the forefront of women's concerns post-childbirth. Jamila had her first child while in graduate school and could not afford to pay for child care, so she juggled childcare responsibilities with her full-time student schedule. "The rate to use the childcare facility at Georgia State for grad students [to watch a child of] his age was like 180 [dollars] a week . . . it would come out to [the same amount] we were paying in rent. I couldn't justify paying that."

LaKeisha—the participant from Atlanta who lacked appropriate follow-up care and contracted an infection—described the stress she felt while trying to physically recover while having to return to work sooner than anticipated for economic reasons:

I had to go back to work. My husband had gotten laid off on Father's Day, his first Father's Day, and so I had to go back a month and a half earlier [than expected] . . . and I'm telling you it was traumatic. I collapsed going to bed. . . and [I'd] just cry because I didn't want to leave my baby. It was really difficult, the job . . . I think they pretended to be cooperative, but six months later they let me go. . . They talk about [how] you [will be] popping back a little bit quicker [following a vaginal delivery], but with the C-section I always felt cold, couldn't lift heavy things for a while, then I wasn't healing right.

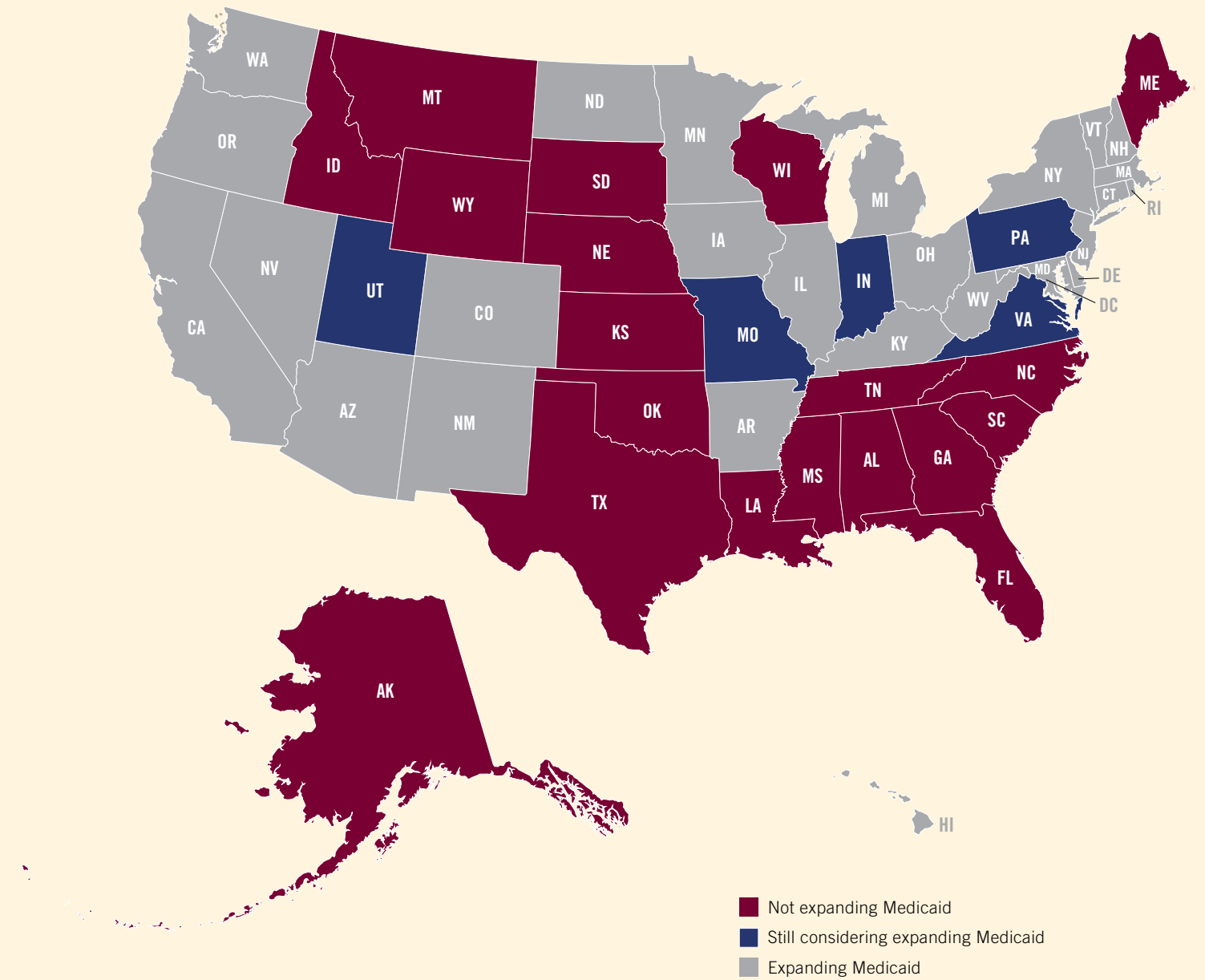
POOR QUALITY OF REPRODUCTIVE HEALTH SERVICES AND INFORMATION

Many women shared an experience of neglect and poor quality of labor and delivery care, especially at public hospitals. When Tiffany went into labor with her third child, she was forced to wait in the hallway of the public hospital in Jackson because there were no available beds. “Not only was [the delivery ward] in the basement, women were lined up on the wall, in the hallway, in labor, I mean full out labor in the hallway. . . I’m 17, in the middle of having a baby, I’m hurting. I was hurting so bad I didn’t know what to do with myself. I went from 4 cm to 8 [cm] in less an hour and a half.” Despite her sister’s pleas for the nurses’ attention, Tiffany was ignored until the baby started to crown. Even then, the nurses told her, “Hold her. Don’t push.” Tiffany said, “By the time we actually got into the labor and delivery room, half of her head was out. She had crowned and was coming out. . . . Got into the labor and delivery [room], five minutes [later] I had a baby.” Tiffany contrasted this experience to the birth of her fourth child in Minnesota. “I had my last little girl in Minnesota; lovely experience. Wonderful doctors, wonderful OB and state medical. Up there, the choices are way more vast, you get way more information, you get a lot more services, a good hospital.”

Others felt they were treated poorly because providers assumed all Black women were uninsured or on Medicaid, and therefore less deserving of high quality health care. Aaliyah from Jackson believes that she received poor quality maternal health care because she was on Medicaid and unable to choose a doctor. Compared to friends who had doctors through private insurance, “I didn’t have that information. They didn’t do this for me.” Kayla from Jackson reported that she “doubted UMC [University of Mississippi Medical Center], honestly,” because it “has a horrible record for how they treat people of color because it is our public hospital.”

Jamila in Atlanta attributed her neglect and poor treatment in the hospital to the fact that she was uninsured.

I was having like really bad pains and so I went to the emergency room and that was its own beast . . . it was like a very, very, very long and trying journey. I was sitting in pains for many, many hours before being seen in the hallway of the hospital. When I finally was able to be seen and they told me that I was pregnant, and my partner had to go to work because we had already been in the hospital for 10 hours at that point. They sent me all around the hospital . . . I would say all this was a really, really negative experience. First, because I was uninsured . . . I felt like there was a lot of projection onto me because I was uninsured. At that point I was only working part-time because I was in grad school and my partner wasn’t there with me for the bulk of the time because he had to go to work. So there was an assumption that here was a young, single, low-income [woman], and there were a lot of assumptions about me.



STATES CHOOSING NOT TO EXPAND MEDICAID

19 states, including most states in the South, where disparities in maternal mortality are especially acute, have opted out of Medicaid expansion under the Affordable Care Act.

2. U.S. GOVERNMENT RESPONSE

LACK OF REPORTING ON MATERNAL MORTALITY AND OTHER REPRODUCTIVE HEALTH INDICATORS

In paragraph 32 of the 2008 Concluding Observations to the U.S., the Committee calls on the U.S. to collect and provide data on health disparities disaggregated by race and gender in its next periodic report. The 2013 U.S. report frankly acknowledges that “more can be done to increase women’s access to health care, reduce unintended pregnancies, and support maternal and child health.”³⁵ However, it fails to provide data specific to these disparities in sexual and reproductive health care, elaborate on how it has failed to achieve these goals, or offer a plan of action. These omissions demonstrate the government’s failure to recognize racial disparities in maternal mortality as a human rights problem.

Data collection on maternal mortality is particularly weak. Government data sources referenced in the U.S. report, such as the Centers for Disease Control’s (CDC) 2013 Health Disparities and Inequality Report, do not include information on maternal mortality. Although the CDC collects and publishes data annually through its Pregnancy Mortality Surveillance System,³⁶ this report relies on non-standardized data voluntarily submitted by states. The lack of standardized data collection across states, the lack of data disaggregated by race and gender, and the unwillingness of states and hospitals to release public information on maternal deaths thwarts progress in understanding the drivers of maternal mortality that pave the way for effective interventions. In addition, approximately 29 U.S. states and Washington, D.C. lack maternal mortality review boards to document and review maternal deaths.³⁷ The 21 states with such mechanisms vary widely in their scope and efficacy; none takes a rights-based approach to ensuring accountability.³⁸

Data on other key women’s health indicators are also missing from the U.S. report despite the Committee’s request for greater attention to these disparities. In 2008, women of color accounted for over 80% of all unintended pregnancies resulting in birth, and African Americans and Latinas were two to three times more likely to have an unintended pregnancy than White women.³⁹ Consequently, abortion rates among low-income women of color account for more than half (55%) of all abortions in the U.S.⁴⁰ Women of color also have poor non-pregnancy related health outcomes, with Latinas nearly 1.5 times more likely to have cervical cancer than White women,⁴¹ and Black women twice as likely to die from cervical cancer compared to White women.⁴² Although African Americans make up only 12% of the U.S. population, they accounted for 44% of new HIV infections in 2010.⁴³ In 2012, Black women were over six times more likely to contract chlamydia and 14 times more likely to have gonorrhea than White women.⁴⁴ Latinas were more than twice as likely to have chlamydia as their White counterparts.⁴⁵

INSUFFICIENT REPORTING ON BARRIERS TO COVERAGE AND ACCESS

The U.S. report acknowledges that, in addition to race and ethnicity, social determinants of health—including income level, health insurance coverage, access to health care services, and access to information—affect both access to and quality of health care.⁴⁶ But the report lacks a comprehensive analysis of the relationship between race, poverty, and health care access that leads to health disparities in the U.S.

The information about health insurance coverage in the U.S. report is incomplete. As the Committee recognized in 2008, lack of health insurance is the most significant barrier to health care and the principal driver of health care disparities in the U.S.⁴⁷ In 2010, the federal government took a very important step towards expanding coverage and access by enacting health care reform legislation known as the Affordable Care Act (ACA).⁴⁸ The ACA aimed to extend health insurance coverage to at least 26 million of the nation’s 55 million uninsured by 2023.⁴⁹ This goal would be reached primarily by expanding Medicaid (the nation’s public health insurance program for low-income people) to cover more low-income people who cannot afford private health insurance and by creating affordable private health insurance options through regulated marketplace insurance exchanges. The U.S. Supreme Court upheld a major legal challenge to the ACA in 2011, but the Court struck down the provision requiring states to participate in Medicaid expansion.⁵⁰

Consequently, many of the low-income uninsured the law was intended to cover have fallen through the cracks. State legislatures with ideological objections to the federal law have opted out of Medicaid expansion, foregoing federal funding that covers 100% of costs for the first three years and 90% thereafter. As of June 2014, 19 states—home to 35% of the country’s population—have opted out of the Medicaid expansion program, and five more are openly debating it.⁵¹ The states that have failed to expand Medicaid are many of the poorest states in the country.⁵² This group includes Southern states (Alabama, Georgia, Louisiana, Mississippi, Texas, South Carolina, and North Carolina) with disproportionately high rates of people of color living in poverty.⁵³ In all of these states, the rate of uninsured women also exceeds the national average.⁵⁴

LACK OF ACCOUNTABILITY MECHANISMS AND ACCESS TO REMEDIES

The U.S. report also fails to mention the lack of effective mechanisms to enforce its ICERD obligations to eliminate *all* forms of discrimination and to provide individuals with access to remedies for discrimination resulting in a disparate impact on certain racial, ethnic, or other minority groups. This was not always the case. At the time of U.S. ratification of ICERD in 1994, Title VI of the 1964 Civil Rights Act provided enforcement mechanisms and remedies for policies and actions undertaken with discriminatory intent or resulting in discriminatory impact. Accordingly, the Reservations, Understandings and Declarations that

the U.S. attached to ratification included a non-self-executing provision,⁵⁵ reflecting the views of the Executive Branch and the Senate that domestic law provided sufficient remedies for violations of the treaty under Title VI.⁵⁶ However, in *Alexander v. Sandoval* (2001), the Supreme Court severely restricted the ability of individuals to bring lawsuits alleging disparate impact discrimination under Title VI.⁵⁷ In the wake of *Sandoval*, the federal government has refused to bring actions to enforce administrative regulations designed to remedy disparate impact discrimination in many areas, including health, and Congress has failed to amend Title VI to provide access to remedies consistent with ICERD.

3. INTERNATIONAL HUMAN RIGHTS STANDARDS

The Committee has stressed the importance of eliminating discrimination in both access to health care and the underlying determinants of health. In its 2008 Concluding Observations to the U.S., the Committee recommended the U.S. not only address intentional racial discrimination in the health care system, but also eliminate obstacles such as lack of health insurance coverage and unequal distribution of health resources.⁵⁸ It also called for special attention to the gender-related aspects of health discrimination by requesting data on health disparities disaggregated by both race and gender in its next periodic report.⁵⁹

In the specific area of sexual and reproductive health disparities, the Committee expressed concern about persistent racial disparities and called on the U.S. to take proactive measures. Recommendations addressed discrimination in both access to care and the underlying determinants of health, such as access to sexuality education:

The Committee regrets that despite the efforts of the State party, wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans, the high incidence of unintended pregnancies and greater abortion rates affecting African American women, and the growing disparities in HIV infection rates for minority women. (Article 5 (e) (iv)). The Committee recommends that the State party continue its efforts to address persistent racial disparities in sexual and reproductive health, in particular by:

- (i) improving access to maternal health care, family planning, pre- and post- natal care and emergency obstetric services, *inter alia* through the reduction of eligibility barriers for Medicaid coverage;
- (ii) facilitating access to adequate contraceptive and family planning methods; and
- (iii) providing adequate sexual education aimed at the prevention of unintended pregnancies and sexually-transmitted infections.⁶⁰

Since the last periodic review of the U.S., much progress has been made at the global level in establishing the legal framework to hold states accountable for preventable maternal mortality. From 2009-2012, the Human Rights Council (HRC) adopted successive resolutions recognizing preventable maternal mortality and morbidity as a human rights issue, and one exacerbated by poverty, gender inequality, multiple forms of discrimination, and a general lack of access to health facilities and infrastructure.⁶¹ The HRC called on states to take a human rights based approach to address preventable maternal mortality and morbidity based on the principles of accountability, transparency, and non-discrimination.⁶² In 2012, the HRC endorsed the United Nations Technical Guidance on reducing preventable maternal morbidity and mortality, and called on states to ensure a just and effective health system through improved data collection, monitoring of health delivery systems, and accountability processes for maternal deaths.⁶³

4. RECOMMENDED QUESTIONS TO THE U.S. GOVERNMENT

What efforts has the U.S. taken since the last periodic review to reduce racial disparities in sexual and reproductive health? What specific and proactive measures does the U.S. plan to take in light of recent studies showing that disparities in maternal mortality have dramatically increased? Please identify, in particular:

- ➔ actions to reduce access barriers to sexual and reproductive health care, particularly for poor women of color living in states that have rejected Medicaid expansion;
- ➔ efforts to improve quality of sexual and reproductive health care for women of color by *inter alia* addressing racial discrimination in the health care system and allocating health resources in an equitable manner;
- ➔ collection, analysis, and reporting of data on racial disparities in maternal mortality and other key reproductive health indicators for women of color; and
- ➔ accountability measures, including effective remedies for victims of *de facto* discrimination in health care.

5. SUGGESTED RECOMMENDATIONS

Take proactive steps to eliminate de facto and de jure racial and gender discrimination in reproductive and sexual health care, including:

- ➔ increase coverage for low-income women living in states that have opted out of Medicaid expansion;
- ➔ increase access to a full range of affordable contraceptive services that help women plan healthy pregnancies;
- ➔ promote comprehensive sexuality education in schools and communities, particularly in medically underserved areas;
- ➔ address racial and gender stereotypes that promote stigma, inhibit the ability of women of color to seek and receive sexual and reproductive health services and information, and reduce women's control over their reproductive decision-making;
- ➔ increase quality of and access to maternal health services for women relying on the public health system, including pre- and postnatal care; and
- ➔ pass paid parental leave legislation to ensure optimal health and well-being for women and children.

Improve monitoring and accountability mechanisms for preventable maternal mortality through the following measures:

- ➔ standardize data collection on maternal mortality across all states in line with international standards;
- ➔ in periodic reports to international human rights bodies, include data disaggregated by gender, race, ethnicity, and age on sexual and reproductive health disparities including maternal mortality, reproductive system cancers, sexually transmitted infections including HIV/AIDS, and unintended and teen pregnancy;
- ➔ provide federal support for states to establish maternal mortality review boards with authority to investigate maternal deaths, offer remedies to victims, and issue binding recommendations to address systemic problems in care;
- ➔ implement maternal mortality protocols in public hospitals in order to ensure consistent, high quality maternal health care; and
- ➔ enact a legislative fix to *Sandoval* to ensure access to remedies for those experiencing *de facto* discrimination in the exercise of their right to health.



Paula, a volunteer promotora de salud in Texas' Rio Grande Valley, trains low-income women to conduct breast exams. But she fears that educating women only makes them worry, since she has nowhere to send them for care if they detect a lump.

Photo Credit: Jennifer Whitney, jennwhitney.com.

B. DISCRIMINATION AGAINST NON-CITIZEN WOMEN IN ACCESS TO HEALTH CARE

1. BARRIERS TO HEALTH CARE COVERAGE AND ACCESS FOR NON-CITIZEN WOMEN

In the U.S., citizenship status significantly affects one's ability to access health care. Immigrants are disproportionately uninsured, with non-citizens three times as likely as U.S.-born citizens to lack private or public insurance.⁶⁴ This is true in large part because non-citizens are more likely than citizens to work in low-wage jobs that do not offer employer-based insurance, and because they face discriminatory restrictions on eligibility for public insurance.⁶⁵ The disparity is even greater when viewed through the lens of gender; nationally, immigrant women of reproductive age are approximately 70% more likely than their U.S.-born peers to lack health insurance.⁶⁶

Federal and state policy exacerbates coverage barriers for immigrants. Many categories of non-citizens are explicitly barred from health insurance benefits offered by the Affordable Care Act (ACA) based on their immigration status, regardless of whether they meet income eligibility requirements for Medicaid or tax credits to offset the cost of private insurance. Eligibility barriers apply to the following groups:

- **Qualified immigrants:** Under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), non-citizens who are lawfully present in the U.S.⁶⁷ must wait five years before they are eligible to enroll in Medicaid.⁶⁸ Further, states may impose additional conditions on eligibility; for example, the state of Texas has not agreed to extend Medicaid coverage to lawfully present immigrants who arrived post-1996 even after they have fulfilled the mandatory federal five-year waiting period.
- **Undocumented immigrants:** PRWORA also completely bars undocumented immigrants from Medicaid. Aside from limited exceptions for prenatal care available in some states and coverage for labor and delivery, undocumented immigrants are excluded from coverage under public health insurance.⁶⁹ In addition, the Affordable Care Act prohibits this group from purchasing private insurance on the newly developed health insurance exchanges, even using their own money.

Immigrant women are especially affected by restrictions on insurance coverage because they tend to rely on the health system more than men, in part because of their reproductive health needs.⁷⁰ Low-income uninsured immigrant women of reproductive age—including many lawfully residing in the United States—are often unable to get the preventive care they need, including prenatal care, screenings for breast and cervical cancer, tests for HIV/AIDS and other sexually transmitted infections, and contraceptive counseling and supplies.⁷¹

Because 46% of the foreign-born population of the U.S. is Latino,⁷² Latinos are disproportionately impacted by policies limiting access to insurance and health care for non-citizens. Latinos have by far the highest uninsured rate of any racial or ethnic group in the U.S., with 41% of Latinos uninsured compared to 26% of Blacks, 17% of Asian/Pacific Islanders and 16% of non-Hispanic Whites.⁷³ As mentioned above, many states with high immigrant populations, such as Texas, have declined to participate in Medicaid expansion, thereby excluding from coverage the low-income uninsured who cannot afford private insurance, even with federal tax credits.

These barriers to coverage force low-income immigrant women to rely on family planning clinics for access to low-cost family planning and other reproductive health services. These clinics are subsidized by both federal and state funds and provide services including breast and cervical cancer screenings, contraception, and testing and treatment for sexually transmitted infections including HIV/AIDS. But in the past several years, this reproductive health safety net has come under attack at the federal and state level. Funding at the federal level through the Title X⁷⁴ family planning program has been cut even as the population in need of its services has grown. Meanwhile, states have severely cut their own family planning budgets and passed unnecessary restrictions on the use of state funds for reproductive health services.



Lorena, is the primary caretaker of her 18-year-old son with severe disabilities. She pays out-of-pocket for his medical expenses, leaving little for her own care. She is concerned about a lump she found recently in her breast but cannot afford a doctor's visit to get it checked.

Photo Credit: Jennifer Whitney, jennwhitney.com.

SPOTLIGHT: RIO GRANDE VALLEY OF TEXAS

In November 2013, the Center for Reproductive Rights and the National Latina Institute for Reproductive Health released a report documenting the impact of systemic barriers and draconian reproductive health policy on a particularly marginalized group of women—Latinas and immigrants living in the Lower Rio Grande Valley (“the Valley”) of Texas.⁷⁵ ***Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley*** documents women’s struggles to exercise their right to reproductive health care in the lower Rio Grande Valley, one of the poorest and least medically served areas of the U.S. The report shows how the Texas legislature pushed an impending health crisis to the tipping point when, in 2011, it slashed the state budget for family planning by two-thirds and prohibited the state’s largest service provider from receiving any of the remaining funding.

This attack on family planning—a proxy for lawmakers’ opposition to abortion—hit the poorest regions of the state the hardest. In the Valley, the closure of clinics and cuts in services resulted in a 72% drop in women receiving services. Facing the economic consequences of a surge of unintended pregnancies and illnesses, Texas lawmakers reinstated family planning funds in 2013. However, these funds were not allocated equitably to reach the most vulnerable populations of the state.

Our documentation showed that the policy changes in Texas exacerbated longer-term systemic barriers to health care such as poverty, lack of insurance, and lack of transportation to clinics for women residing in rural areas. Immigration status presented another key obstacle to care, not only because many low-income women are not eligible for Medicaid due to their immigration status, but also because aggressive immigration enforcement policies deter women from seeking any government services that require them to leave their communities or disclose their status.

The funding crisis and provider shortage have made critical reproductive health services unavailable for large numbers of poor, low-income, rural, Latina women in the Valley. Consequently, women are living in constant pain from untreated conditions that could have been detected and treated early. Others are dealing with stress and fear that serious health conditions such as breast or cervical cancer may be progressing without their knowledge. And many women without contraceptive access are experiencing unintended pregnancies, impacting their health and severely straining their ability to provide for their families. Rather than responding to the needs of women living in underserved areas like the Valley, the state and federal governments have exacerbated the problem through unequal allocation of resources and through policies inhibiting immigrant women’s access to health insurance.

Esmeralda

Esmeralda is a recent widow and mother of five children under age 11, the youngest of whom is three months old. She is unable to work because of her child care responsibilities, so a doctor's visit—which involves the cost of the appointment, gas money or bus fare for herself and her children, or arranging and paying for childcare—is simply too much. She admits that her youngest child was not a planned pregnancy. In the past she got her birth control pills from a Planned Parenthood health center, but things changed “when they took the funding for contraceptives away and I couldn't get them [for free] anymore. . . . [It costs] \$50 a month, but I can barely make ends meet. [T]hat's when I got pregnant.”



Esmeralda at home with her fifth child. Photo Credit: Jennifer Whitney, jennwhitney.com.

Brenda

Brenda is a single mother and domestic violence survivor who came to the U.S. to escape violence and seek a better life for her daughter. She lacks health insurance. She found several lumps in her breast in the spring of 2012 but has not been able to find an affordable place to get a proper breast exam. “[It costs] about \$50, I think, just to see a doctor. If you need a mammogram or something, that's extra.” She had difficulty finding a clinic that could schedule an appointment, even if she was able to borrow money for the fee. “I was told all the slots were taken and to try again next month. Next month, same story. . . . They told me to go to [the local community health center], but it's overcrowded, they ask for a lot of papers, and they don't take donations, like they used to here. They charge fees.”

2. U.S. GOVERNMENT RESPONSE

The U.S. report fails to address the differential treatment of non-citizens and citizens in access to health care. Although the government alludes to the expanded coverage afforded to Latinos under the ACA, an estimated 6.5 million income-eligible Latinos will be excluded solely due to their immigration status.⁷⁶ This includes immigrants lawfully residing in the U.S.

The U.S. report acknowledges that “more can be done to increase women's access to health care, reduce unintended pregnancies, and support maternal and child health.”⁷⁷ The report cites to Title X, “the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services.”⁷⁸ Indeed, the Title X program provides funding for the reproductive health safety net of frontline family planning clinics that serve predominantly low-income—and increasingly immigrant—women. Funding for Title X has fallen to below 2008 funding levels, which were then inadequate to serve all low-income women in need of publicly funded contraception. Latinas represent the fastest growing group in need, with a growth of 47% in the decade between 2000 and 2010, compared to a 4% growth in need among White women.⁷⁹ In Texas, the number of women receiving publicly supported contraception decreased by 20% in that same period; by 2010, only 14% of Texas women needing subsidized contraception were able to receive it.⁸⁰

3. INTERNATIONAL HUMAN RIGHTS STANDARDS

Article 5 of the ICERD establishes a right to equal enjoyment of the “right to public health, medical care, social security and social services” without distinction as to race, color, or national or ethnic origin. In its Concluding Observations, the Committee has interpreted this provision to apply to all residing within a country's territory, “irrespective of their migration status,”⁸¹ including permanent and temporary non-citizens.⁸² In General Comment 30 on “Discrimination against Non-Citizens,” the Committee explained that the rights enshrined in Article 5 are to be enjoyed equally by citizens and non-citizens, aside from limited exceptions, such as the right to vote, that are reserved for citizens. Accordingly, “[d]ifferential treatment based on citizenship or immigration status will constitute discrimination if the criteria for such differentiation, judged in the light of the objectives and purposes of the Convention, are not applied pursuant to a legitimate aim, and are not proportional to the achievement of this aim.”⁸³

In its 2008 Concluding Observations to the U.S., the Committee alluded to the discriminatory exclusion of low-income immigrants from public insurance coverage when it urged the U.S. to “improv[e] access to maternal health care, family planning, pre- and post- natal care and emergency obstetric services, inter alia through the reduction of eligibility barriers for Medicaid coverage.”⁸⁴

In March 2014, the Human Rights Committee issued its Concluding Observations to the U.S. expressing concern about federal policies discriminating against immigrants in access to insurance coverage.

[T]he Committee expresses concern about the exclusion of millions of undocumented immigrants and their children from coverage under the Affordable Care Act and the limited coverage of undocumented immigrants and immigrants residing lawfully in the United States for less than five years by Medicare [sic] and Children Health Insurance [sic], all resulting in difficulties for immigrants in accessing adequate health care.

The Committee recommends that the State party . . . identify ways to facilitate access to adequate health care, including reproductive health care services, by undocumented immigrants and immigrants and their families who have been residing lawfully in the United States for less than five years.⁸⁵

4. RECOMMENDED QUESTIONS TO THE U.S. GOVERNMENT

What is the legal justification for the restrictions barring immigrants from public health insurance coverage, in particular (1) the policy excluding undocumented immigrants from eligibility for Medicaid, tax credits for private insurance, or participation in the health care exchanges, and (2) the five-year waiting period imposed on qualified immigrants for Medicaid eligibility?

Given the serious impacts of these policies on the lives and health of immigrants, particularly in the area of reproductive health care, please explain how such differential treatment is legitimate and proportional to the legal justification, rather than unlawful discrimination against non-citizens?

5. SUGGESTED RECOMMENDATIONS

Eliminate discriminatory policies that restrict immigrant women's access to health insurance on the basis of their citizenship status, including legislative repeal of the five-year waiting period on qualified immigrants to enroll in Medicaid, and the ban on participation by undocumented immigrants in the insurance exchanges created by the Affordable Care Act.

Ensure equitable allocation of reproductive health resources by prioritizing the most marginalized populations, in particular low-income and immigrant women, through the following measures:

- ➔ fully funding the expansion of community health centers to increase access to preventive care for low-income and immigrant populations, incorporating best practices for family planning provision within primary care settings;
- ➔ increasing federal Title X family planning funding to strengthen the reproductive health safety net for low-income populations ineligible for Medicaid or private health insurance;
- ➔ expanding low-cost outreach programs to serve rural and immigrant populations with limited access to health care, including mobile reproductive health clinics; and
- ➔ increasing funding for comprehensive sexual and reproductive health education that is culturally and linguistically appropriate in schools, community centers, and other settings.

Endnotes

- ¹ International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), *adopted* Dec. 21, 1965, G.A. Res. 2106 (XX), Annex, U.N. GAOR, 20th Sess., Supp. No. 14 at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, (*entered into force* Jan. 4, 1969).
- ² The submission of the United States of America to the Committee on the Elimination of Racial Discrimination (CERD) contains the seventh, eighth, and ninth periodic reports in one document. Gov't of the United States, *Seventh to Ninth Periodic Report of the United States of America to the United Nations Committee on the Elimination of Racial Discrimination Concerning the International Covenant on the Elimination of Racial Discrimination*, U.N. Doc. CERD/C/USA/7-9 [hereinafter U.S. Report to CERD].
- ³ CERD, *General Recommendation No. 25, On Gender-Related Dimensions of Racial Discrimination*, (56th Sess., 2000), para. 1, U.N. Doc. A/55/18, Annex V at 152 (2000), reprinted in COMPILATION OF GEN. COMMENTS AND GEN. RECOMMENDATIONS ADOPTED BY HUMAN RIGHTS TREATY BODIES, U.N. Doc. HRI/GEN/1/Rev.6 at 214 (2003) [hereinafter CERD, General Recommendation No. 25].
- ⁴ CERD, *General Recommendation No. 32, The Meaning and Scope of Special Measures in the International Convention on the Elimination of All Forms of Racial Discrimination*, (57th Sess., 2009), paras. 6-7, U.N. Doc. CERD/C/GC/32 (2009), http://www2.ohchr.org/english/bodies/cerd/docs/GC32_English.pdf.
- ⁵ CERD, General Recommendation No. 25, *supra* note 3, at 3.
- ⁶ CERD, *Concluding Observations: United States of America*, para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008), <http://www1.umn.edu/humanrts/CERDConcludingComments2008.pdf>.
- ⁷ Human Rights Committee (HRC), *Concluding Observations: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
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