Systemic Racism and Reproductive Injustice in the United States:

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

Submitted on July 15, 2022 by the following
reproductive rights, health, and justice organizations:

Abortion Care Network, Ancient Song Doula Services, Birthmark Doula Collective, Black Mamas Matter Alliance, Center for Reproductive Rights, Changing Woman Initiative, Human Rights & Gender Justice Clinic: CUNY School of Law, If/When/How, Indigenous Women Rising, National Birth Equity Collaborative, Movement for Family Power, Restoring Our Own Through Transformation, SisterSong Women of Color Reproductive Justice Collective

The undersigned coalition[1] of reproductive rights, health, and justice organizations respectfully submits this report to the UN Committee on the Elimination of Racial Discrimination (CERD Committee), in preparation for its tenth review of the United States of America ("U.S.") in August 2022.[2] This report evaluates U.S. progress on the human rights commitments it made when it ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).[3] Among those commitments, the U.S. agreed to ensure the right to health care that is free from all forms of racial discrimination, to all within its borders.[4]

Drawing on the experience and expertise of reproductive rights, health, and justice organizations from across the U.S., this coalition document provides information about a health equity crisis affecting maternal health and abortion access for people of color, in violation of their human rights. It fills 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, and it responds to the Committee's 2014 Concluding Observations to the U.S. regarding the impact of gender and race discrimination on the enjoyment of the right to health.[5] This report is intended to assist the Committee in evaluating U.S. progress on implementation since the last periodic review, and to recommend priorities for the Committee's interactive dialogue with the U.S. government in Geneva in August 2022.[6]

We urge the CERD Committee to condemn violations of reproductive rights during its upcoming periodic review of the United States and to recommend that the U.S. government:

1. Ensure the meaningful participation of women of color in all decision-making processes that impact their reproductive health
2. Remove barriers to accessible, high quality, comprehensive reproductive health care
3. Address and eliminate racial and intersectional discrimination in reproductive health care settings, including birthing facilities and criminal and immigration detention settings
4. Ensure that communities of color can access and provide culturally aligned services that improve maternal health, including midwifery and doula care
5. Halt and remedy retrogression of the right to abortion, and ensure abortion access
6. Address the impact of environmental racism on reproductive health

Respectfully,

Abortion Care Network, Ancient Song Doula Services, Birthmark Doulas, Black Mamas Matter Alliance, Center for Reproductive Rights, Changing Woman Initiative, Human Rights & Gender Justice Clinic, CUNY School of Law, If/When/How, Indigenous Women Rising, National Birth Equity Collaborative, National Latina Institute for Reproductive Justice, Movement for Family Power, Restoring Our Own Through Transformation, SisterSong Women of Color Reproductive Justice Collective.[7]

I. Violations of Sexual and Reproductive Health and Rights contravene U.S. Commitments under ICERD and raise concern among UN human rights experts

When it ratified the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the United States (U.S.) committed to ensure the right to health care, free from racial discrimination to all within its borders (Articles 2, 5).[8] In 2022, racial discrimination in U.S. health care is rampant. For women of color, intersectional discrimination on the basis of race, ethnicity, and gender is fueling a reproductive health equity crisis.[9] Immigrants and women of color in the U.S. do not have adequate access to health care, including essential reproductive health services.[10] The care that is available and accessible is often low quality, compromised by discrimination.[11] And across a broad range of health outcomes, racial disparities reveal systemic inequities, within and beyond the U.S. health care system.[12]

This Committee (the **Committee on the Elimination of Racial Discrimination, or CERD**) has noted the gender-related dimensions of racial discrimination, recognizing that "some forms of racial discrimination have a unique and specific impact on women."[13] The Committee has specifically addressed the preventable maternal deaths of Black women and barriers to health care (which impact reproductive health outcomes) for immigrants and people of color in its concluding observations to the United States.

- In its **2014 Concluding Observations regarding the U.S.**, the **CERD** stated its concern about high maternal mortality rates among Black women.[14] The CERD recommended the U.S. eliminate racial disparities in sexual and reproductive health and "standardize the data collection system on maternal and infant deaths in all states to effectively identify and address the causes of disparities in maternal and infant mortality rates"[15] and "improve monitoring and accountability mechanisms for preventable maternal mortality, including by ensuring state-level maternal mortality review boards have sufficient resources and capacity."[16] It also noted that many U.S. states with large populations of racial and ethnic minorities had opted out of the Medicaid expansion program and thus "failed to fully address racial disparities in access to affordable and quality health care."[17] It recommended the U.S. take concrete measures to ensure that all individuals, "in particular those belonging to racial and ethnic minorities who reside in states that have opted out of the Affordable Care Act […] have access to affordable and adequate health-care services."[18] The CERD recommended the U.S. take concrete measures to ensure that all individuals, in particular "undocumented immigrants and their families who have been residing lawfully in the United States for less than five years, have access to affordable and adequate health-care services."[19]

- In its **2008 Concluding Observations regarding the U.S.,** the **CERD** expressed concern about disparities in health affecting racial, ethnic, and national minorities who "face numerous obstacles to access adequate health care and services"[20] and recommended the U.S. "eliminat[e] obstacles" that prevent or limit access to health care, such as "lack of health insurance, unequal distribution of health care resources, persistent racial discrimination in the provision of health care and poor quality of public health care services."[21] The CERD also expressed concern regarding the U.S.'s racial disparities in sexual and reproductive health, noting high maternal and infant mortality rates, especially among Black women.[22] The CERD recommended the U.S. improve "access to maternal health care, family planning, pre- and post-natal care and emergency obstetric services," by, among other things, "the reduction of eligibility barriers for Medicaid coverage."[23]

Related concerns about sexual and reproductive health and rights violations in the U.S.—including related to maternal health and abortion access—have been raised by the UN Human Rights Committee (CCPR), during the Universal Periodic Review, by the UN Commissioner for Human Rights, and by many UN Special Procedures, including the UN Working Group on Discrimination Against Women in Law and Practice, the UN Working Group of Experts on People of African Descent, the Working Group on Arbitrary Detention, and the Special Rapporteur on Extreme Poverty. **For a summary of statements and recommendations, please see the Appendix.**

II. Eliminating racial discrimination requires the full realization of reproductive rights

The right to make and act on decisions about one's own sexual and reproductive health is fundamental to autonomy, self-determination, and both gender and racial equality.[24] For generations, women of color in the U.S. have been fighting for the rights and resources needed to decide whether, when, and with whom they will have or raise children; to prevent, end, or continue a pregnancy; to give birth under conditions they choose and consent to; to parent children in safe, supportive environments, free from discrimination and harassment by the state or others; and to achieve the highest attainable standard of health possible for themselves and their families.[25]

The human rights violations described in this report—discrimination in maternal health care and birth outcomes, abortion bans, the shackling and forced sterilizations of women in immigrant and criminal detention facilities, and the criminalization of women of color during reproductive health experiences—are all forms of intersectional discrimination that reinforce race and gender inequality in the United States.[26] Women of color will not be free from all forms of racial discrimination until these harms are addressed and eliminated.

From its founding to the present, U.S. laws, policies, and practices have treated Black, brown, and Indigenous people as disposable bodies, to be exploited or restrained. With the sanction of U.S. law, Black women were enslaved, raped, tortured, forced to birth, and had their children sold for profit by their oppressors.[27] Indigenous women were targets of attempted genocide, colonization, and sexual and reproductive violence including rape, murder, sterilization, and the kidnapping and abuse of children in institutions of forced assimilation.[28] Under the Trump Administration, immigrant women of color were held in detention and subjected to unconsented hysterectomies amidst rising anti-immigrant political rhetoric.[29] Gender discrimination and violations of sexual and reproductive health and rights are not incidental to this ongoing history of racial discrimination and domination, they are key enablers of it.

In the eight years since the last periodic review of the U.S., much has changed—and much has not.[30] The U.S. has seen a rise in white nationalism, attacks on democracy, and a national reckoning with racism,[A] ignited by the murder of George Floyd in 2020.[31] In the wake of that killing, the U.N. Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance, E. Tendayi Achiume noted during the Human Rights Council's historic "Urgent Debate," that while the focus of the debate was law enforcement, "the uprising in the United States and in other parts of the world are rejections of *all* systemic racism in *all* areas of life."[32]

Reproductive justice leaders of color battle inequities in all areas of U.S. life and are leading multiple fronts of the U.S. human rights movement.[33] They are demanding an end to the impunity that allows police officers to routinely destroy Black and Indigenous lives, supporting voting rights, advocating for immigrants, and protecting the environment for future generations. . . all while defending their sexual and reproductive autonomy against escalating threats.[34] These leaders recognize the interdependent nature of human rights, yet their own needs and gendered experiences with racial oppression are frequently minimized or deprioritized.[35] Sexual and reproductive health and rights are critical to achieving substantive equality for women, transgender, and non-binary people of color, and they can no longer be sidelined.[36]

III. Maternal Health

Maternal health outcomes are indicators of inequality in the United States.[37] The outcomes and experiences of women of color in the U.S. during pregnancy, birth, and postpartum depict a country complacent with systemic racism, unwilling to repair a broken health care system, and far from meeting its treaty obligations under ICERD.[38]

[A] **Human rights advocacy spotlight: Monica Simpson, SisterSong.** *In 2014, Monica Simpson was sitting among civil society leaders in Geneva, preparing to deliver a statement to the CERD Committee during its periodic review of the United States. Ms. Simpson, a leader of the U.S. reproductive justice movement, wanted CERD to know that Black women in the United States were unnecessarily dying during pregnancy, childbirth, and the postpartum period because one of the wealthiest, most powerful countries in the world didn't value their lives, their motherhood, or their children enough to stop it. Before her turn to speak, she was confronted by the news that a white police officer had killed Michael Brown in Ferguson, Missouri. Ms. Simpson recognized immediately that racial disparities in maternal mortality and police brutality are both systemic problems and symptoms of deeply rooted racial discrimination in a country built on violations of Black, brown, and Indigenous people's bodily autonomy. Ms. Simpson's human rights advocacy includes seeking justice for Breonna Taylor, who was killed by police in Louisville, KY and never got to build the family she dreamed of.*

a. Maternal mortality disproportionately affects Black and Indigenous communities

Higher rates of maternal mortality among women of color in the U.S. are both a form and a symptom of intersectional discrimination.[39] For decades, the U.S. has failed to adequately intervene in pregnancy-related deaths, normalizing gender stereotypes that objectify women as vessels for reproduction, meant to suffer and sacrifice through pregnancy.[40] And by tolerating racial and ethnic disparities in who survives the effort to carry a pregnancy or build a family, the U.S. reinforces white supremacy, making clear whose lives matter most.[41]

In the eight years since CERD last reviewed the U.S., more than 2,500 Black and Indigenous women have lost their lives to maternal mortality.[42] The Centers for Disease Control and Prevention (CDC), the national public health agency of the U.S., estimate that 700-900 women per year die from pregnancy-related causes in the United States.[43] **Regardless of income or education, Black women are more than three times more likely to die than white women are, and American Indian and Alaskan Native women are twice as likely as white women to die[44].** Based on CDC data, the Center for Reproductive Rights estimates that at least 233 Black women and 82 Indigenous women are lost to maternal mortality each year.[45]

During 2020, the first year of data impacted by the COVID-19 pandemic, maternal deaths rose even higher among Black and Hispanic women, but not white women.[46] A lack of political will to ensure Black and Indigenous people's right to life during pregnancy has driven the rise in maternal deaths and has made the U.S. an outlier among wealthy nations, with the worst maternal mortality ratio in the developed world.[47]

When the CERD reviewed the U.S. in 2014, it recommended that the U.S. improve data collection and monitoring of maternal deaths.[48] Progress has been made in this area, and better data collection and analysis reveals that a majority of U.S. maternal deaths are preventable.[49]

b. Racial inequities are deeply embedded across a range of maternal health outcomes

Maternal mortality is a violation of human rights, and the extreme end of a spectrum of harms that people of color in the U.S. face during pregnancy, birth, and postpartum.[50] For every maternal death in the U.S., about 100 women will experience a life-threatening pregnancy complication and survive.[51] Maternal morbidity can include traumatic injuries and illnesses that result in short or long-term disability.[52] Like maternal mortality, maternal morbidity has been rising in the U.S. and disproportionately affects women of color, particularly Black and Hispanic women.[53]

Infant mortality is also linked to maternal health and is higher for infants of color. Pre-term birth, a leading cause of infant mortality, is 1.5 times higher among Black women than white women. Researchers have concluded that racism[B] is the most plausible explanation for the disparity.[54] Black women also have higher rates of miscarriage than white women do between 10 and 20 weeks of pregnancy.[55] Stillbirth, defined as a pregnancy loss after 20 weeks gestation, is experienced by Black mothers at nearly twice the rate of white mothers and rates of stillbirth are higher in U.S. south where many women of color live.[56] Similar racial inequities exist in the rate of infertility in the U.S. where Black women are nearly twice as likely to experience infertility than white women yet they, and Hispanic and American Indian/Alaska Native women are less likely to access fertility care, undermining their access to the fertility care they need to build their family.[57] And although Indigenous women in the U.S. experience many health inequities, including with regard to reproductive health, they are often not even included in discussions of them because of discriminatory data practices. Data analyses often conclude that Native American and Alaska Native people are "statistically insignificant" and U.S. government entities often do not make data available to tribes.[58]

[B] **Human rights advocacy spotlight: Dr. Joia Crear-Perry, MD, FACOG, National Birth Equity Collaborative**. "*Black race is listed as a risk factor for many health conditions. In health and health care we work to mitigate risk factors. But race is a social/political construct and Blackness does not need to be mitigated. It's racism, not race, that is driving poor health outcomes among Black, brown, and Indigenous folks and it's racism that we must end.*"

c. Racism is the cause of racial disparities in maternal health

Stigmatization, stereotypes, and blaming patients is common across "women's health" issues.[59] Until recently, the predominant narrative explaining rising maternal mortality and morbidity in the U.S. was one of unchallenged ableism, sexism, and racism— patients who suffered or died from pregnancy complications were dismissed as simply too old, fat, biologically inferior, or unhealthy to achieve good birth outcomes.[60] Stereotypes about women being irrational, poor decision-makers, and of Black women as aggressive, irresponsible, and undeserving of care are sprinkled throughout U.S. medical records documenting "non-compliant" and uncooperative patients.[61] For too long, women of color who died from pregnancy-related causes were seen as unfit bodies produced by unhealthy cultures and the U.S. government felt little pressure to examine its role in contributing to these outcomes.[62]

To counter this racist and deadly narrative, Black women in the U.S. are building a movement[C] that centers racial justice and has the potential to improve maternal health for all.[63] The reproductive and birth justice movement recognizes that fundamental human rights are violated when women, girls, and people capable of pregnancy are forced to endure preventable suffering, including death, illness, injury, mistreatment, abuse, discrimination, and denials of information and bodily autonomy.[64]

Maternal deaths can be tied to a number of contributing factors, but racism is the factor that explains why Black and Indigenous women are at higher risk than white women are.[65] According to the CDC's website, "[v]ariability in the risk of death by race/ethnicity may be due to several factors including access to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases."[66] All of these factors—access, quality, the opportunity to prevent and manage disease, and to be free from discrimination—are influenced by systemic racism in the United States.[67] Women of color are denied equal access to health care, receive lower quality care when they do access it, and are deprived of material and social conditions that promote health and protect against disease.[68]

d. Structural racism impedes access to quality care

The U.S. is a large country, with 330 million people covering 8 million square miles.[69] It does not ensure that health care is distributed equitably across the land or that it is accessible to all people.[70] There is no universal health care system and public health insurance is limited in what and who it will cover.[71] Health care costs are exceptionally high compared to other countries, and conservative politicians have fought efforts to provide everyone with a basic level of access to care.[72] Immigrants, women of color, rural Indigenous communities, and low-income people have difficulty affording and accessing health care in general, and reproductive health care in particular.[73]

For some immigrants and women of color, adverse maternal health outcomes begin with lack of access to health care pre-pregnancy.[74] Economic, social, and geographic barriers to primary care, preconception care, contraception and family planning services can prevent women of color from entering pregnancy in their best health, at the time that is right for them.[75] States that refused to expand public insurance (Medicaid) under the

[C] **Human rights advocacy spotlight: The Black Mamas Matter Alliance (BMMA).** *BMMA serves as a national entity working to advance Black maternal health, rights, and justice, and uplifts the work of locally based, Black-led and Black women-led maternal health initiatives and organizations. Black women are improving maternal health in their communities every day as health care providers, researchers, educators, and advocates. Too often, their work is overlooked and underfunded. BMMA brings these experts together to share ideas, build power, and hold decision-makers accountable for improving policies and processes that impact Black mamas. Since the alliance was founded in 2016, BMMA has drawn much needed attention to rising rates of maternal mortality and racial disparities in U.S. maternal health, and has insisted that national conversations about maternal health include Black women. BMMA's advocacy touches policy, research, culture, and healthcare and frames the need to address racial inequities in maternal health as a human rights imperative.*

Affordable Care Act (ACA) continue to block access to health care for individuals who fall into the coverage gap that state opposition to the ACA has created.[76] Non-citizens are more likely than U.S. born and naturalized citizens to lack health insurance, especially Black and Latina non-citizens.[77] Under the ACA, lawfully residing immigrants are required to wait five years before becoming eligible for public health insurance through Medicaid and the Children's Health Insurance Program (CHIP), and undocumented immigrants cannot access Medicaid or even purchase private health insurance in the market places created by the ACA.[78]

To obtain health care during pregnancy, women of color must navigate complex and fragmented health care delivery and payment systems, often with minimal assistance or empathy from providers and policymakers.[79] By placing many of the burdens of health care coordination on patients, the health care system exacerbates inequities and barriers to care that women and girls of color already face, including disproportionate poverty, childcare responsibilities, pregnancy discrimination in employment and housing, and unmet transportation needs.[80] And while public insurance (Medicaid) is available to many low-income people during pregnancy, many providers do not accept it and in most states, the coverage ends just 60 days after the pregnancy does[D]—despite a growing proportion of maternal deaths occurring during the first year postpartum.[81]

Moreover, many women of color in the U.S. are segregated into dysfunctional health systems by poverty, location, or insurance status.[82] Nearly half of all U.S. counties lack an obstetric provider and hospitals that provide critical maternity and emergency care to rural areas, Native Americans, and communities of color are closing across the country.[83] The hospitals that primarily serve Black patients provide lower quality care and have worse maternal health outcomes.[84] Indian Health Service hospitals, which are responsible for providing federal health services to American Indians and Alaska Natives—have also been found to provide low quality labor and delivery care, including failure to follow national clinical guidelines and best practices.[85] Physicians and nurses of color are significantly underrepresented in the health care workforce, and many women of color never have an opportunity to be cared for by someone who shares their racial or cultural background.[86]

e. Institutional and interpersonal racism facilitate mistreatment in the U.S. health care system

Discrimination within the health care system often exacerbates structural inequities. In the U.S., gender-based violence is racialized.[87] The devaluation of women of color increases the risk for abuse and neglect in maternity care facilities.[88] Because discrimination is both normalized and denied in the U.S., many instances of mistreatment and violence in maternity care are overlooked or accepted by government actors, health care professionals, and sometimes even patients themselves.[89]

Concerns about abuse and neglect of people of color in medical settings are grounded in history and routinely affirmed in modern practice.[90] For instance, significant technical advancements in the field of Obstetrics and Gynecology are credited to a white physician who forced enslaved Black women to endure the torture of repeated experimental surgeries, without anesthesia.[91] Today, women in hospital labor and delivery units are routinely treated as bodies from which babies will be extracted, rather than the authority and ultimate decision-maker in the physiological process of birth.[92] For women of color, the risks of objectification and violence are heightened.[93]

[D] **Human rights advocacy spotlight: Breana Lipscomb, Center for Reproductive Rights.** *Breana Lipscomb worked with lawmakers and advocates to get public health insurance (Medicaid) coverage extended to 12 months after the end of pregnancy in her home state of Georgia. Previously, pregnancy-related Medicaid coverage ended just 60 days after the pregnancy did, leaving many low-income people without access to health care during the postpartum period. As of May 30, 2022, 11 states provide pregnancy-related health insurance for a full year postpartum. (Georgia, South Carolina, Tennessee, Michigan, Louisiana, Virginia, New Jersey, Illinois, California, Florida, Kentucky, and Oregon).*

One of the most common forms of mistreatment that women of color report is being ignored or not believed when communicating life-threatening symptoms.[94] Such neglect can be fatal.[95] When Black women express concerns and needs during birth and providers fail to listen, potentially lifesaving health care may be denied or delayed.[96] Research shows that U.S. physicians diagnose and treat women and Black patients differently than they treat men and white patients, and that they hold false beliefs about Black women's capacity to endure pain.[97] Women of color also report being humiliated, verbally abused, coerced, threatened, restricted to a hospital bed during labor, forced to birth without a companion, treated as teaching aids for medical students, racially profiled for drug testing and referral to child welfare authorities, forced into procedures, denied information and the opportunity to give or refuse consent, denied care and pain medication, and having police or hospital security called on them[E] for acts of self-advocacy.[98]

Pregnant women who are incarcerated or in immigration detention facilities have even fewer options and lack avenues for recourse when they are mistreated and denied appropriate maternal health care.[99] While these systems resist the transparency needed to facilitate accountability for human rights violations, media reports and the testimony of currently and formerly incarcerated or detained people have exposed abuses.[100] Women in these settings continue to be shackled—even where applicable laws and policies prohibit it—and pregnant women experiencing labor or obstetric emergencies have been denied necessary health care.[101]

The human rights framework— and pregnant people themselves— assert that access and survival are not enough. Dignity, self-determination, bodily autonomy, informed decision-making, privacy, consent, and respect are important too. As the U.S. reckons with the way police wield and abuse authority over Black bodies, that reckoning must also extend to health care institutions where Black women and other pregnant people of color birth, and too often, die preventable deaths.[102]

f. Racism undermines the availability and acceptability of maternal health care for women of color

Women of color in the U.S. have always played important roles caring for one another during pregnancy, birth, and postpartum.[103] As skilled birth attendants, they provide respectful, culturally aligned maternal health care in their own communities and offer physical, emotional, and social support surrounding reproductive life experiences.[104] Over the last few generations, birth workers of color have been pushed out of these roles as U.S. health care became more professionalized and elite decision-makers sought to bring pregnancy and birth under the control of white male physicians and hospital institutions.[105] For some people, birthing with a surgeon in a hospital will be the safest or most comfortable choice.[106] But nearly eliminating community-based alternatives didn't make birth safer for everyone.[107]

The effort to eliminate community-based birth removed many women of color from the reproductive health field and has contributed to over-medicalization of the birth process, unnecessary interventions, centering physicians rather than pregnant people as the authorities and ultimate decision-makers during pregnancy-related health care encounters, criminalization of traditional midwives, loss of cultural knowledge, less access to maternity care providers, and more.[108] Today, obstetricians and midwives licensed to practice are overwhelmingly white and hospital-based, limiting the meaningful options that women of color have for where, how, and with whom they will experience pregnancy and birth.[109] Nevertheless, there are women of color who sustained birth work

[E] **Human rights advocacy spotlight: Jessica Roach, Restoring Our Own Through Transformation.** *Jessica Roach, a doula, former nurse, and founder of ROOTT, an organization that supports pregnant Black women in the state of Ohio, almost lost her daughter to preventable maternal mortality. Recognizing the severity of her daughter's pregnancy complication and the dismissiveness of the health care providers, Jessica advocated for her. The hospital responded by calling armed security guards.*

traditions through these challenges and a new generation of community leaders is working to restore midwifery care in the U.S. and provide doula support in communities of color.[110]

g. Restoring midwifery in communities of color

Midwifery care has the potential to address many barriers to safe and respectful maternal health care that disproportionately impact low-income, rural, and Black and Indigenous communities.[111] Restoring legal, sustainable midwifery practices for communities of color is a critical step towards protecting human rights in maternal health.[112] Midwives provide skilled, compassionate care[F] for people during pregnancy, birth, and postpartum.[113] The midwifery model of care approaches birth as a natural process, rather than a pathology, and upholds the birthing person's right to make informed, autonomous decisions.[114] It is patient centered, holistic, and valued by the World Health Organization (WHO) as key to ensuring excellent maternal health outcomes.[115] According to the WHO and others, midwives, when educated, licensed and fully integrated in and supported by interdisciplinary teams, and in an enabling environment, can provide a wide range of clinical interventions and contribute to broader health goals, such as advancing primary health care, addressing sexual and reproductive rights, promoting self-care interventions and empowering women.[116]

The WHO recognizes the benefits of midwifery care in both high and low resource countries.[117] Research in the U.S. indicates that midwifery care has many benefits for birthing people and their babies.[118] Midwives spend more time with their patients than obstetricians do. People cared for by midwives are less likely to have low birthweight babies, C-sections, episiotomies, epidurals, and drug induced labor (interventions that can lead to complications and increase costs).[119] They are more likely to breastfeed and describe their birth experience as joyful and positive than patients cared for by obstetricians.[120] And low-income people with public health insurance (Medicaid) had healthier babies when they received prenatal care from birth center midwives.[121] In states where midwives are integrated into the health care system, there are lower rates of C-section, prematurity, and infant mortality. However, many states have laws that inhibit access to and integration of midwifery care, which increases risks to the person giving birth and undermines potential benefits.[122]

Unlike many other wealthy nations where midwives provide maternal health care for most people giving birth, the U.S. has marginalized midwifery care by imposing medically unnecessary legal and financial barriers and has created a patchwork of laws that vary from state to state.[123] Restrictive licensure requirements and regulations, public and private insurance coverage policies, and birth facility regulations can make it difficult or impossible for midwives to practice in their communities.[124] For many, these restrictions make birthing in the nearest hospital (which may be far) with a surgeon the default and only option.[125] And while some wealthy women in states with midwifery-friendly laws can pay out-of-pocket for midwifery care, poor people cannot.[126]

Legal restrictions on midwifery are rooted in racism and competition.[127] The initial campaigns to limit who could practice midwifery and what midwifery could entail relied on racist propaganda targeting Black, Indigenous, and immigrant midwives.[128] According to legal scholar Michelle Goodwin, "[s]killed Black midwives represented both real competition for white men who sought to enter the practice of child delivery, and a threat to how obstetricians viewed themselves."[129] To eliminate competition from midwives, "[s]uccessful racist and misogynistic smear campaigns, cleverly designed for political persuasion and to achieve legal reform, described Black midwives as unhygienic, barbarous, ineffective, non-scientific, dangerous, and unprofessional."[130] Seeking financial gains,

[F] **Human rights advocacy spotlight: Nicolle Gonzales, CNM, Changing Woman Initiative.** *Nicolle Gonzales is a Dine midwife. She provides maternal health care to Indigenous women and families in their homes and in her birth center, helping to renew cultural birth knowledge and the sovereignty of Indigenous midwifery. Although Nicolle is Indigenous to the area she practices in and is a Certified Nurse Midwife, the midwifery certification most favored by U.S. law, she still has to navigate colonial borders and legal restrictions on where she can assist pregnant people. The Navajo Nation, which Nicolle belongs to, overlaps with five U.S. states and Nicolle is licensed in one.*

recognition, and a monopoly, "[g]ynecologists pushed women out of the field of reproductive health by lobbying state legislatures to ban midwifery […]. Doing so not only undercut women's reproductive health, but also drove qualified Black women out of medical services."[131]

Communities of color in the U.S. have since been denied the right to continue much needed, culturally affirming maternal health care traditions[G] because of laws and policies that restrict the ability of many midwives to legally practice their skills.[132] In many states, Black and Indigenous midwives with a demonstrated record of providing essential, respectful, life-saving health care now face punishment and poverty if they continue to care for their own communities.[133] Women of color who wish to learn and practice midwifery continue to be disproportionately impacted by the barriers erected to shut them out.[134] And as the COVID-19 pandemic strains already burdened health and hospital systems, millions of people continue to need safe places to birth and access pregnancy-related care.[135] *(For more information about policy barriers to midwifery care in the state of Florida, please see the shadow human rights report submitted by the University of Miami School of Law Human Rights Clinic and the Florida Health Justice Project).*

h. Expanding doula support in communities of color

Doulas are birth workers who provide non-clinical emotional, physical, and informational support to people who are pregnant, birthing, and postpartum.[136] Doulas are not health care providers, but they are recommended by the WHO and have positive impacts on health outcomes, including reduced pain and fewer interventions.[137] In the U.S., doulas of color are playing a particularly powerful role[H] in transforming expectations about how women of color should be treated during pregnancy and birth.[138]

Across the country, doulas committed to racial and gender justice are creating local models of service delivery that build the capacity of their own communities to provide dignified care to one another.[139] These community-based doula groups train women of color from within neighborhoods that are affected by racial disparities and mistreatment in maternal health, increasing the diversity of the doula field and ensuring that marginalized women have free or low-cost access to doula care.[140] In the process, they raise awareness about respectful maternal health care throughout the community, while empowering women of color with the knowledge that at least one person present at their birth will champion their dignity and autonomy.[141] In most cases, community-based doula groups are providing these critical services without adequate support or government funding, and they are sometimes excluded from births by providers or hospitals who view doulas as a threat to their authority.[142]

[G] **Human rights advocacy spotlight: Shafia Monroe, Birthing Change.** *Shafia Monroe became a midwife in the 1970s. Since then, she has provided individualized, high-quality care to hundreds of Black families in the U.S., while teaching midwives and doulas around the world as the founder of the International Center for Traditional Childbearing and founding member of the Oregon Doula Association. Despite her expertise, legal changes in the state where she now lives (Oregon) have made it illegal for her to call herself a midwife or collect payment for midwifery care.*

[H] **Human rights advocacy spotlight: Chanel Porchia-Albert, Ancient Song Doula Services**. *Chanel Porchia-Albert founded Ancient Song Doula Services ("Ancient Song") in Brooklyn, NY where the rates of maternal mortality for Black women are, on average, more than 9 times higher compared to white women. Ancient Song provides doula care to families of color that would not otherwise be able to afford it. Ancient Song also trains women, transgender, and non-binary people of color to become doulas capable of offering physical, emotional, and informational support to individuals across a range of reproductive life experiences. Chanel's curriculum includes information about biology and massage, but also reproductive and birth justice, policy advocacy, and human rights. As a doula herself, Chanel witnessed women of color violated during births, including treatment without consent and verbal abuse. Now, she works with both pregnant people and health care providers to change the policies, expectations, and power dynamics that enabled those abuses.*

Attempts to expand access to doula services has had mixed results. In several states, law makers who have not prioritized participation of the people most affected by their decisions have rushed forward with legislation seeking to regulate doulas.[143] In some cases, these are well intentioned efforts to facilitate reimbursement of doula care by public insurance programs.[144] But they also risk repetition of the harm that occurred when women of color were nearly regulated out of U.S. midwifery.[145] In many instances, the regulations being proposed and enacted will favor white doula businesses and disproportionately exclude women of color, further limiting access to culturally affirming doula support for Black, brown, and Indigenous people.[146] Ironically, many of the government led efforts to expand access to doula care in low-income communities of color do not provide the doulas of color with a living wage.[147] Across the country, doulas of color know what they and their communities need, yet they are being marginalized from policy making processes that will determine whether and how they can continue to help improve maternal health.[148]

i. Racism compromises social determinants of health for women of color

Due to structural and systemic racism, immigrants and women of color in the U.S. do not have equitable access to healthy living conditions.[149] Generation after generation, communities of color have been denied equal access to high quality medical care, education, employment, housing, food, transportation, infrastructure investments, clean environments, and other resources that help prevent illness and promote health.[150] Immigrants and families of color in the U.S. also have a thinner safety net than families in many other wealthy countries, with no guarantee of paid parental or sick leave, or affordable childcare.[151] These inequities in access to the social determinants of health—the conditions in which we live, work, grow, and age— make immigrant women and women of color more vulnerable during stressful events, such as pregnancy, pandemics, and disasters.[152]

In essence, exposure to racial discrimination is stressful, and racial discrimination simultaneously ensures that women of color have fewer resources to cope with that stress.[153] For Black women, the toxic stress caused by repeated exposure to racial discrimination has a demonstrated weathering effect on their bodies, negatively impacting their health and birth outcomes.[154]

While racial discrimination must be addressed at all levels and in all areas of U.S. life, the impact of environmental racism on maternal health is an area of rapidly growing concern.[155] Women of color in the United States are disproportionately exposed to toxic environments that harm their reproductive health.[156] In many cases, exposure is not inevitable, but is the result of government policies that deprioritize the safety and well-being of marginalized communities.[157]

For instance, in Flint, Michigan, government officials changed the source of the public's water supply in 2014, in an effort to save costs.[158] Subsequent studies found that the proportion of lead exposed children in Flint doubled after the water change, while fertility declined.[159] Women living in Flint during the water crisis experienced a dramatic increase in miscarriages and recorded stillbirths.[160] Many of the women in Flint who lost wanted pregnancies and/or are mothering lead-exposed children are low-income women of color.[161]

Air pollution and heat exposure related to climate change also adversely impact neonatal and maternal health, and women of color disproportionately.[162] Across the country, poor and minority communities bear the burdens of pollution, due to both the lack of infrastructure investment in their communities and the placement of hazardous sites in their neighborhoods.[163] The exploitation and contamination of natural resources is often intertwined with the theft of Indigenous land and the displacement of communities of color.[164] With extreme weather events and

climate disasters becoming more frequent, more women of color are facing hurricanes,[l] floods, wildfires and other events while pregnant, in labor, or postpartum.[165]

j. International human rights standards

Treaty monitoring bodies have developed strong human rights standards on women's right to maternal health care, framing this right within the rights to life, health, equality and non-discrimination, and freedom from ill-treatment.[166] States must guarantee all women available, accessible, acceptable, and good quality maternal health services.[167] The right to maternal health care encompasses an individual's right to the full range of services in connection with pregnancy and the postnatal period and the ability to access these services free from discrimination, coercion, and violence.[168] The CEDAW Committee has, for over 20 years, recommended that States should "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[169] In General Comment No. 22, the CESCR Committee reiterated States' obligation "to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realization of the right to sexual and reproductive health."[170] The CESCR Committee described the right to sexual and reproductive health as covering a range of freedoms and entitlements, including "the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health."[171]

Treaty monitoring bodies have recognized that intersectional discrimination can hinder women's access to maternal health services and have recommended that States put a particular focus on the maternal health needs of women from marginalized groups, including adolescents, poor women, minority women, rural women, migrant women, and women with disabilities.[172] The CESCR Committee has recognized that individuals belonging to particular groups, including indigenous or ethnic minorities, may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health, requiring special measures to guarantee substantive equality.[173] Although the U.S. has not ratified CEDAW and ICESCR, as a signatory, it is obligated to not defeat their object and purpose.[174]

Treaty monitoring bodies have also found that social and other determinants of health must be addressed in order for women to be able to seek and access the maternal health services they need.[175] In General Comment No. 36 the Human Rights Committee affirmed that preventable maternal deaths are a violation of the right to life and recommended that States should develop strategic plans and campaigns for improving access to treatments designed to reduce maternal mortality, as part of advancing the enjoyment of the right to life.[176]

k. **U.S. government response**

In its report to CERD, the U.S. government identifies several efforts the Biden-Harris Administration has taken or maintained to improve maternal health, which include (1) making it easier for, but not requiring, states to extend Medicaid coverage for pregnant people up to 12 months postpartum; (2) HRSA's research on underserved populations and funding of the Title V Maternal and Child Health Services Block Grant Program; (3) work that CDC and partners are doing to strengthen Maternal Mortality Review Committees (MMRCs) at the state level; (4)

[l] **Human rights advocacy spotlight: Birthmark Doula Collective.** *Birthmark Doula Collective is a multi-racial, worker-owned cooperative that provides support, education, and a variety of services and programs for pregnant and parenting families during the perinatal year and beyond. This includes doula services, childbirth education, perinatal health advocacy, lactation services, and support circles. Pregnant and parenting people of color living along the gulf coast have been hit hard by climate change and repeated storms. Since 2018, Birthmark Doula Collective has been addressing climate-related threats to maternal and infant health by providing information and supplies related to perinatal emergency preparedness. Birthmark has distributed over 800 emergency infant feeding kits to help families safely feed their infants during emergencies. They have also trained close to 500 emergency preparedness and response stakeholders and perinatal health professionals on safe infant and young child feeding in emergencies. During hurricanes Laura, Delta, Zeta, and Ida, Birthmark activated an emergency parent-infant hotline which supported 105 pregnant and parenting families with young children.*

Maternal, Infant, and Early Childhood Home Visiting Programs; and (5) an HHS Action Plan launched with an NGO partner to work with rural providers, implement quality improvement in hospitals, and collect data in collaboration with state MMRCs and other task forces.[177]

Because rising maternal mortality and disempowering maternal health care for people of color have been ignored for so long, the increased attention that the U.S. government has paid to these issues in the last few years is in some ways striking.[178] It also highlights the importance of political representation and the slow rate of progress the U.S. has made on that front.[179] Vice President of the United States Kamala Harris is the first woman of color to hold that position and she has been a strong supporter of racial justice in maternal health since her time serving as one of the few women of color in the U.S. Congress.[180] As a Senator, Vice President Harris co-sponsored the MOMNIBUS, a package of bills created by Black law makers (who formed a Black Maternal Health Caucus) to fill gaps in U.S. law and address the racial inequities in maternal health.[181] Only one of the 12 proposed and critically important bills in the MOMNIBUS has passed into law.[182]

What remains missing from many of the U.S. government's efforts and initiatives is an explicit commitment to addressing the racism that drives human rights violations in maternal health. Further, by failing to prioritize the needs and participation of Black and Indigenous women in the new programs, initiatives, and decision-making processes it champions, the U.S. government risks simply reinforcing a health care system that has already failed women of color. New investments in old gate keepers will not change the status quo for women of color at the community level.

To ensure that the Biden-Harris Administration's commitments to improve sexual and reproductive health care benefit those experiencing the worst maternal health violations, more must be done to tailor such efforts to Black and Indigenous communities and ensure their participation in policy change. This approach aligns with U.S. obligations under ICERD and will ultimately improve maternal health conditions for all.

IV. Abortion Access

On June 24, 2022, the Supreme Court of the United States (SCOTUS) issued a decision in *Dobbs v. Jackson Women's Health Organization* that will harm millions of people, and women of color most of all.[183] The ruling overturns *Roe v. Wade*, eliminating an individual's constitutional right to decide to end their own pregnancy.[184] Because the U.S. has a federal system of government, the ruling allows anti-abortion politicians to ban or further restrict abortion in individual states and emboldens their push for a nationwide ban.[185] This is the first time in U.S. history that the Court has eliminated a fundamental constitutional right to personal liberty.[186] As racial justice scholars warned the Court, immigrants and people of color have been disproportionately bearing the brunt of attacks on abortion access for years, and will face even greater risks to their lives, health, and autonomy as a result of this radical retrogression.[187] At a time when many countries are liberalizing their abortion laws, this decision violates U.S. human rights obligations to "remove existing barriers" to safe, legal abortion and "not introduce new barriers."[188]

At its core, the right to abortion is the right to make personal health care decisions that impact one's life, health, and future.[189] For women of color in the U.S., codifying that right, defending it, and making it accessible in practice has been an ongoing struggle.[190] For nearly five decades, *Roe v. Wade* was repeatedly affirmed as the law of the land, and politicians could not enforce bans on abortion before a fetus was viable.[191] *Roe v. Wade* provided a floor of legal protection for pregnancy-related decision-making, but it was never sufficient to guarantee abortion access to everyone who needed it.[192] Immigrants and women of color continued to face numerous barriers to abortion access and the harms those barriers cause are well documented.[193] The Supreme Court's recent decision to destroy federal protection for abortion access in the U.S., and state legislatures' rush to enact increasingly draconian abortion bans— despite evidence of the harm —reflects a callous disregard for the lives of people who can become pregnant, and women of color in particular.[194]

a. Attacks on abortion access have been escalating for years

Anti-abortion law makers in the U.S. have chipped away at abortion access for years.[195] Although a majority of Americans support abortion access,[196] abortion opponents have taken advantage of inequities in U.S. political representation to push restrictions through disproportionately conservative state legislatures.[197] Due to systemic racism, the political bodies creating these barriers to abortion care are disproportionately white, male, and do not reflect the diversity of the people they represent.[198] The recent, racialized escalation of efforts to suppress voting rights will only make this dynamic worse.[199]

In most cases, state legislative attacks on abortion access hit immigrant and low-income women of color hardest.[200] In some cases, the disparate impact is explicitly anticipated.[201] In all cases, the disproportionate harm that abortion restrictions cause is tied to systemic racism and the many ways that immigrants and people of color have been denied access to the rights and resources that many white women are able to leverage to prevent unwanted pregnancies and overcome abortion barriers.[202]

For instance, at the federal level, a legislative provision called the Hyde Amendment has banned federal funding for abortion in most circumstances since 1976.[203] As a result, low-income people with public health insurance—who are disproportionately women of color—are unable to use their insurance for this health care procedure.[204] Related bans withhold abortion coverage from people in other federal health insurance programs, including Native Americans who receive care through Indian Health Services.[205]

At the state level, conservative politicians have eroded reproductive rights in many central and southern states, making abortion access largely dependent on one's location and ability to navigate expensive, time consuming, politically imposed barriers.[206] By passing restrictions that conflicted with almost fifty years of federal legal protection for reproductive rights, anti-abortion state law makers sought to advance cases that would eventually provide the U.S. Supreme Court with an opportunity to overturn its legal precedents.[207] The Trump Administration and federal law makers facilitated this strategy by appointing judges and justices with a record of ruling against abortion rights.[208] By the end of its four-year term, the Trump Administration had replaced three of the nine members of the U.S. Supreme Court, all with lifetime appointments.[209]

From 2018 to 2021, in a race to provide the newly aligned conservative majority on the U.S. Supreme Court with the opportunity to overturn *Roe v. Wade*, state legislatures throughout the country enacted historic numbers of highly restrictive abortion laws and outright bans on abortion services.[210] In Texas, politicians tested the boundaries early, enacting Senate Bill 8 ("S.B. 8"), an abortion ban designed to evade judicial review.[211] S.B. 8 bans abortion as early as six weeks of pregnancy, before many people even realize they are pregnant. It effectively makes abortion care unavailable to anyone unable to travel[J] out of state.[212] "Ripping a page from the darkest annals of American history, the Texas law includes a bounty provision that allows local residents to sue individuals who aid, abet, or assist individuals seeking to terminate a pregnancy. As with its shameful predecessors, the Fugitive Slave Acts, the bounty provision incentivizes private individuals to spy upon, surveille, and interfere with individuals asserting fundamental human and constitutional rights such as bodily autonomy, privacy, and freedom."[213] S.B. 8 took effect on September 1, 2021 and the U.S. Supreme Court continuously refused to block it, causing tremendous harm to pregnant people of color.[214]

[J] **Human rights advocacy spotlight: National Latina Institute for Reproductive Justice (NLIRJ).** *In Texas, immigration check-points can block the roads between people and their health care providers and U.S. immigration policies can discourage immigrants from seeking essential reproductive health care. As Rosa Valderama, Senior Public Affairs and Communications Associate for NLIRJ explains, "[s]howing up for a medical appointment or even going to a hospital or an emergency room without valid identification can be an obstacle and create so much fear that some of our undocumented folks just decide to forego care altogether." And "[w]hen we're talking about abortion care, those obstacles become higher." https://prismreports.org/2022/06/03/undocumented-people-already-living-post-roe/*

On May 2nd, 2022 a draft opinion in *Dobbs v. JWHO* indicating that *Roe v. Wade* would be overturned was leaked from the Supreme Court of the United States.[215] Several states began planning special legislative sessions with the intent of passing retrogressive abortion measures over the summer, and anti-abortion state lawmakers began trying to prohibit people from escaping state bans by accessing abortion across state lines or receiving abortion medication by mail.[216] By early June, two states (Oklahoma and Idaho) enacted S.B. 8 copycat bills, while two others (Florida and Arizona) enacted bans after 15 weeks of pregnancy.[217] Three states (Kansas, Kentucky, and Montana) put initiatives on their 2022 ballot that would amend their state constitution to restrict abortion.[218] Advocates in three states (Michigan, Oklahoma, and Vermont) are working on ballot initiatives that would give voters the chance to protect abortion access.[219] Many states had previously enacted so-called "trigger laws" meant to swiftly outlaw abortion once *Roe v. Wade* was weakened or overturned.[220] **By the time the final decision in *Dobbs v. JWHO* was released on June 24, 2022, half the states in the country were poised to ban abortion.[221] Over 31 million women of reproductive age currently live in those states, many of which include large populations of women of color.[222]** Battles over specific laws are sure to continue, but already, large swaths of the country are without abortion access.[223]

b. People of color have already suffered harm from abortion restrictions and will face even greater harm as reproductive rights are reversed

In the U.S., abortion care has been heavily stigmatized and segregated from other types of health care.[224] Independent abortion clinics provide the majority of abortions, often in hostile regulatory environments, and in the face of constant threats and harassment.[225] As legislative attacks on abortion escalate, clinics are forced to close and patients are forced to travel longer distances to reach care.[226] The costs and risks associated with being forced to travel farther and farther distances to access abortion are multi-faceted, and include financial, emotional, and physical burdens, as well as immigration risks.[227] Now that some states are banning abortion entirely, even more people will have to navigate these obstacles.[228]

i. Immigrants and people of color navigate abortion restrictions with fewer resources

Abortion restrictions disproportionately impact pregnant people who are already facing systemic discrimination, including immigrants, people of color, low-income people, young people, and people with disabilities.[229] About three-fourths of all abortions in the U.S. are sought by patients who are poor or have low incomes.[230] Poverty is deeply intertwined with other forms of discrimination, and people of color, immigrants, LGBTQI+ people, people with disabilities, and women and children suffer disproportionately from economic inequalities.[231] Before the *Dobbs v. JWHO* decision was issued, women living in poverty were already more likely to live farther away from abortion providers than women living above the poverty limit.[232] For some, the distance is several hours— and growing.[233] Many low-income individuals who seek abortion care do not own cars, and public transportation options may be limited, inefficient, inaccessible, or unavailable to them.[234] With no limit on the restrictions that states can now impose, low-income people seeking abortion may now have to travel across multiple states to reach a clinic.[235]

When abortion care is several hours away, some patients sleep in their cars, while others spend precious resources on motel or hotel rooms.[236] For people who have difficulty traveling due to a disability or illness, who are struggling financially, who have caregiving responsibilities or abusive partners that they cannot leave for long periods of time, traveling to access abortion may be impossible.[237] Additionally, more than half of all women who have abortions already have children and many will need to secure and pay for childcare while they attend and travel to and from appointments.[238] Many lose wages from work and some risk the loss of their jobs.[239] These cumulative barriers

raise the cost of obtaining an abortion and can push people farther into pregnancy as they scrape together the resources needed[K] to proceed with their decision.[240]

Immigration status often presents additional barriers.[241] The majority of immigrants obtaining abortions in the U.S. have poverty or near poverty-level incomes and almost half are uninsured.[242] Immigrants who are undocumented or traveling with undocumented loved ones must weigh the risks of encountering immigration enforcement check points on the roads that lead to their nearest clinic.[243] In southern states where abortion restrictions have proliferated, federal immigration checkpoints can be located up to 100 miles north of the U.S./Mexico border.[244] Abortion access for pregnant people in criminal and immigration detention settings is especially limited, and the Trump Administration took extreme measures attempting to block pregnant people (including unaccompanied minors) in immigrant detention from accessing abortion.[245]

Now, many of the states that had once sought to erect as many barriers to abortion access as possible will simply ban it.[246] Even in states where abortion remains legal, there are a limited number of abortion providers willing to provide care in the hostile conditions U.S. politicians have enabled.[247] These human rights defenders are struggling to absorb the influx of out-of-state patients while also meeting the health care needs of people in their own communities.[248] As more people are forced to travel, all abortion patients will be affected by the government manufactured scarcity of services and longer wait times will push many patients farther into pregnancy.[249]

ii. Stigmatization of abortion access stigmatizes women of color

Law makers—and now the Supreme Court— have misrepresented the impact of abortion restrictions, describing them as reasonable limitations on a controversial issue that should be decided at the state level.[250] But the experiences of women of color in the U.S. demonstrate why people's fundamental rights should not be up for debate. Restrictive abortion laws are harmful restraints on bodily autonomy and personal decision-making, particularly in the context of systemic discrimination against immigrants and people of color.[251]

Government sanctioned stigmatization of reproductive health not only interferes with patients' access to evidence-based, dignified care, it also contributes to an environment in which patients and their health care providers are routinely exposed to privacy violations and harassment at work, on their way to health appointments, in their communities, and in online spaces where they seek or share information.[252] The recent surge in white nationalist organizing involves many white supremacist members of the anti-abortion movement who surround reproductive health clinics and direct racialized harassment at Black patients and providers. [253] Anti-abortion extremists were also among those who attacked U.S. democracy and the capitol building on January 6, 2021.[254] Laws that restrict abortion access send the message that abortion is distinct from "normal" health care, and that people who seek to end a pregnancy deserve to suffer in the process.[255] Even when patients are ultimately able to overcome these restrictions and obtain an abortion, lawmakers have ensured that they will face some harm while navigating a process designed to punish and condemn their decision.[256]

[K] **Human rights advocacy spotlight: Indigenous Women Rising**. *When government systems fail to protect human rights, communities do what they can to protect themselves and their communities. Abortion is no different. Local abortion funds, many led by women of color, have recognized the unmet needs and are trying to fill the gaps. They raise money to assist others with the cost of the procedure and are increasingly helping people cover other costs as well, including travel, lodging, meals, and childcare. But the need has exploded, depleting the funds and their organizers. As abortion access becomes more and more limited, women of color leading funds face heartbreaking decisions about where to direct their finite energy and resources. Indigenous Women Rising, an organization that raises funds for Indigenous/Native Americans seeking abortion care had to pause funding in April and June of 2022.*

c. Without federal Constitutional protection for abortion, pregnant people of color are facing a reproductive health equity crisis

While legislative efforts to restrict abortion in the U.S. are not new, the recent decimation of federal Constitutional protection represents a devastating rollback of reproductive rights, which is becoming increasingly dangerous for pregnant people, their health care providers, and the rule of law.[257] Judges, justices, and anti-abortion lawmakers are aware of these harms, which have been documented extensively in court briefs and personal testimony shared by women of color[L] in and outside legislatures, in the media, and in the streets. [258] Based on the way that women of color have already been harmed by abortion restrictions in the U.S., we can anticipate that these conditions will only worsen.[259]

i. Gender equality

Reliance on the right to abortion has been essential to advancing gender equality in the United States. Access to abortion has enabled generations of women more control over their lives and futures, better enabling them to pursue personal, educational, and employment opportunities and life goals.[260] The ability to decide if and when to carry a pregnancy has been essential to countering the long history of discrimination that has limited women's legal, social, and economic progress.[261] For women of color who experience intersectional discrimination on the basis of both race and gender, the fight for legal, social, and economic equality is far from finished, and bodily autonomy is central to that struggle.[262] Taking away an individual's right to make their own decisions about pregnancy would turn back the clock on incremental—but essential—progress and limit the ability of women, transgender men, and non-binary people of color to participate fully and equally in society.[263]

ii. Maternal health

All pregnancies come with risks. A full-term pregnancy lasts an average of nine months and comes with a risk of death 14 times higher than that of an abortion.[264] During pregnancy, a person's body changes drastically and endures additional stress.[265] Even uncomplicated pregnancies can involve painful and uncomfortable changes that impact routine daily activities including sleeping, eating, walking, working, and caring for children.[266] Pregnancy can exacerbate underlying health conditions, create new ones, and increase a person's risk of severe illness or death from COVID-19.[267] Pregnant people can develop gestational diabetes and preeclampsia, and people who give birth can experience major abdominal surgery (c-section), hysterectomy, vaginal tearing, hemorrhage, blood clots, infections, and heart problems.[268] Postpartum people can also experience severe pain, pelvic floor damage, exhaustion, and mental health conditions.[269] This is an incomplete list of the many risks and physical changes that pregnant people face and which the Justices and anti-abortion law makers have chosen to dismiss.[270]

Eliminating health care options for pregnant people results in more pregnancy-related deaths. The newly issued World Health Organization Abortion Care Guidelines confirm this, noting that between 4.7% and 13.2% of all maternal deaths are attributed to unsafe abortions.[271] The proportion of unsafe abortions is significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws. U.S. states with the most restrictive abortion laws have higher maternal mortality rates than states with fewer restrictions.[272] States that imposed gestational restrictions on abortion access increased the maternal mortality rate by 38%.[273] The maternal

[L] **Human rights advocacy spotlight: Dr. Jamila Perritt, MD, MPH, Physicians for Reproductive Health.** *On December 1, 2022, speaking to a crowd gathered on the front steps of the Supreme Court of the United States during oral arguments in the Dobbs v. JWHO case, Dr. Perritt stated, "[f]or every story we hear of a pregnant person who was able to leave their state to access abortion, there are many others who don't have the time, money, or resources to do so. As a doctor and an abortion provider, I trust my patients to make the right decisions for their families and bodies. These are private decisions. These are health care decisions. Abortion is health care. Abortion is safe. Abortion is essential. Abortion is an act of love."*

mortality rate—already unacceptably high among women of color— increased in states where a significant number of Planned Parenthood clinics closed, reducing access to contraception and abortion.[274] While there are ways to safely self-manage an abortion, not everyone will be able to access the information, medicines, and support they need to do so.[275] Forcing women of color to carry pregnancies when they have decided not to has life-altering consequences— and in a rising number of cases, will ultimately violate the right to life.[276]

The largest study of women's experiences with abortion and unwanted pregnancy in the U.S. – "The Turnaway Study"—found that women who wanted an abortion and were denied one were more likely to experience death, serious pregnancy complications, poor health, and chronic pain.[277] They were also more likely to experience household poverty, stay tethered to an abusive partner, and the children they already had showed worse child development compared to the children of women who received an abortion.[278] Immigrants and women of color already facing social, economic, and health inequities cannot afford the many ways that denial of abortion access amplifies their marginalization.[279]

People decide to end pregnancies for many different reasons.[280] No one should be forced to continue carrying a pregnancy when they don't want to, and no one should have to end a wanted pregnancy because systemic, intersectional discrimination prevents them from accessing rights and resources they need to maintain a healthy pregnancy and parent children.[281] Significantly, U.S. states that want to force people to carry pregnancies and birth have spent their political energy and resources curtailing bodily autonomy rather than building communities where families can thrive.[282] Indeed, the states with the most restrictions on abortion also have the fewest supportive policies for women and children.[283]

iii. The ripple effects of legal backlash against reproductive rights

The Constitutional right to abortion in the U.S. was based on legal theories about liberty and privacy developed over nearly fifty years of jurisprudence involving personal decisions about family, relationships, and bodily autonomy.[284] In overturning a fundamental right to abortion, the Supreme Court of the United States puts many other Constitutional rights at risk, including the right to use contraception, the right to marriage equality for same sex and inter-racial couples, and the right to engage in private sexual conduct.[285]

Furthermore, people in the U.S. will still need and have abortions.[286] Now, in addition to navigating increased risks to their health and autonomy, immigrants and women of color will have to navigate heightened surveillance and criminalization in the criminal justice system, the child welfare system, and the health care system— systems defined by racial disproportionality and bias.[287]

Women of color in the U.S. are already subjected to government control and punishment related to their pregnancy or an outcome of their pregnancy.[288] Despite the Constitutional legal protections for reproductive autonomy and decision-making that existed until very recently, state and local law enforcement officers and agencies in the U.S. misused laws to criminalize and arrest pregnant people for pregnancy loss, for having or seeking an abortion, and for conduct during or related to pregnancy that law enforcement officials object to.[289] Because women of color are incarcerated at disproportionately high rates, they are also disproportionately impacted by the sexual and reproductive health and rights abuses that proliferate in these settings.[290] Government child welfare agencies play a similar role, using the civil legal system to forcibly and disproportionately remove children from parents of color in cases where they suspect substance use during pregnancy, and cases where poverty is a larger concern than neglect.[291] Racist stereotypes and the over policing and surveillance of communities of color make women of color particularly vulnerable to pregnancy-related punishments in these family regulation systems.[292] The policing of women of color's decisions during pregnancy and birth, as well as the outcomes they experienced, was an entrenched injustice even with some laws in place that should have discouraged it.[293]

In many cases, it is health care workers who facilitate the punishment of women of color during pregnancy, birth, and the postpartum period.[294] With federal Constitutional protection for decision-making during pregnancy stripped away, women of color will now have even more reason to hesitate before seeking care for pregnancy complications, miscarriages, obstetric emergencies, substance use disorder, and mental health conditions, and are at even greater risk of unconsented interventions, obstetric violence, and having their decisions overridden during childbirth.[295] *(For a detailed exploration of criminalization in the context of reproductive health, please see the human rights shadow report submitted by the Human Rights & Gender Justice Clinic, CUNY School of Law, and others).*

d. International human rights standards

Denying pregnant people bodily autonomy is a grave violation of human rights and dignity, and it must be condemned as such. Treaty monitoring bodies have long recognized the connection between restrictive abortion laws, high rates of unsafe abortion, and maternal mortality[296] and found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from gender discrimination or gender stereotyping, and freedom from ill-treatment.[297]

In General Comment No. 36 on the right to life, the Human Rights Committee has reaffirmed that abortion access is critical to preventing foreseeable threats to the right to life.[298] The Committee noted that abortion regulations must not violate women and girls' right to life, subject them to physical or mental pain, discriminate against them, or arbitrarily interfere with their privacy.[299] At a minimum, the right to life requires states to provide safe, legal, and effective access to abortion where the life and health of the woman or girl is at risk, or when carrying a pregnancy to term would cause her substantial pain or suffering.[300] State parties to the ICCPR "may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to resort to unsafe abortions, and they should revise their laws accordingly."[301] In addition, States may not introduce new barriers to abortion and should remove existing barriers that deny effective access to safe and legal abortion.[302] States must also "prevent the stigmatization of women and girls who seek abortion." [303]

Moreover, the CEDAW Committee has found that criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are forms of gender discrimination and gender-based violence.[304] Treaty monitoring bodies recognize that abortion must be decriminalized, legalized at a minimum on certain grounds, and services must be available, accessible, affordable, acceptable, and of good quality.[305] Treaty monitoring bodies recommend that States should liberalize their abortion laws to improve access and remove legal, financial, and practical barriers that deny effective access by women and girls to safe and legal abortion, including medically unnecessary barriers to abortion and third-party authorization requirements.[306] UN mandate holders emphasized these human rights protections for abortion access in a statement condemning the Supreme Court's decision in Dobbs v. JWHO.[307]

e. World Health Organization recommendation

In outlining states' core obligations in General Comment 22, to ensure the satisfaction of minimum essential levels of the right to sexual and reproductive health, the CESCR Committee notes that states "should be guided by . . . the most current international guidelines established by United Nations agencies, in particular WHO.[308] In its most recent Abortion Care Guideline, the World Health Organization (WHO) makes several law and policy related recommendations, including the full decriminalization of abortion[309] and advises against laws and other regulations that restrict abortion by grounds.[310] The WHO recommends that abortion be available on the request of the woman, girl or other pregnant person.[311] It further recommends against gestational age limits,[312] mandatory waiting periods for abortion[313] and third-party authorization.[314] The WHO includes abortion medication on its essential medicines list and notes that these medicines can expand abortion access within the healthcare system and can be safely self-administered as well.[315] The WHO provides strong public health evidence to support its law

and policy recommendations and consistently refers to discrimination, including based on race and ethnicity, as playing a part in hindering access to abortion services.[316]

f. **U.S. government response**

The abortion access crisis is not mentioned anywhere in the U.S. Government's report.[317] While the Supreme Court decision in *Dobbs v. JWHO* was issued after the government's report was submitted, escalating attacks on abortion access have caused harm to immigrants and people of color every day since the last CERD review.[318]

During his four-year term, former President Donald Trump took several steps to dismantle abortion access, including efforts to prevent people with public insurance from getting any type of healthcare through Planned Parenthood, and blocking abortion access for unaccompanied immigrant minors seeking asylum.[319] Under President Trump, the U.S. government also reinstated and expanded the "Global Gag Rule" and pursued similar policies domestically.[320] In 2016, the U.S Government released a final rule undermining the Title X family planning program, which provides reproductive health care services to over four million low-income, under and uninsured individuals across the country.[321] The rule required strict physical and financial separation of Title X services from abortion services and prohibited Title X funding recipients from referring patients for abortion care.[322] This rule was revoked in March 2022 under the Biden-Harris Administration and a new rule restores funding.[323]

(For information about the 1973 Helms Amendment and the ongoing impact that prohibiting the use of foreign assistance to pay for abortion has on women of color across the world, please see the human rights shadow report submitted by the Gender Justice Clinic, Human Rights Watch, and others).[324]

The Biden-Harris Administration has been more supportive of sexual and reproductive health and rights but has not been able to significantly interrupt the retrogression.[325] In October 2021, the Biden-Harris Administration issued the first-ever U.S. government National Strategy on Gender Equity and Equality, a groundbreaking strategy developed by the White House Gender Policy Council that serves as a roadmap for a government-wide effort to advance gender equity and equality in domestic and foreign policy.[326] The strategy identifies 10 interconnected priorities to advance gender equity and equality, and explicitly makes protecting and expanding access to sexual and reproductive health care, including access to abortion care, a strategic priority.[327]

In December 2021, the U.S. Food and Drug Administration (FDA) permanently lifted some of the medically unnecessary and harmful restrictions on mifepristone, a medication used for early abortion and miscarriage care, by removing the in-person dispensing requirement and allowing certified pharmacies to prescribe mifepristone.[328] Once finalized, this would expand the scope of where the medication can be dispensed and increase access to medication abortion for many.[329] In May 2021, President Biden released his budget proposal, marking the first time in decades that a president has submitted a budget without the Hyde Amendment, a policy that has prohibited coverage of abortion care for people insured through federal health insurance programs, including Medicaid, since 1976.[330]

The House of Representatives in Congress has introduced and passed the Women's Health Protection Act, federal legislation that would protect the right to access abortion in every state.[331] Following its introduction, the Biden-Harris Administration issued a Statement of Administration Policy supporting the legislation.[332] On May 11, the Senate took its second vote, and for the second time fell short of the 60 votes needed.[333] On July 8, 2022, President Biden signed an Executive Order that directs the Secretary of Health and Human Services to identify actions to protect access to reproductive health services, directs the Attorney General, the Secretary of Homeland Security, the Chair of the Federal Trade Commission, and the Secretary of Health and Human Services to consider actions to protect privacy, safety, and security related to provision of reproductive health services, and improves federal coordination around these efforts .[334]

V. Recommendations

We respectfully urge the CERD to **express concern** over the impact of systemic racism and intersectional discrimination on the sexual and reproductive health and rights of racial and ethnic minorities in the United States, including discrimination in maternal health care and maternal health outcomes and retrogression of abortion rights and curtailed access to abortion.

We further urge the CERD to **recommend** that the United States government:

1. Ensure that the individuals and communities most affected by sexual and reproductive health and rights violations—particularly Black, Indigenous, and other people of color—are centered and supported to meaningfully participate in federal, state, and local programs, policy change, and decision-making processes that affect their health and lives;

2. Ensure rights and remove barriers to health care, including maternal health care and abortion care, for immigrants and women of color, and ensure that all people can access comprehensive reproductive health care with dignity, free from discrimination and criminalization, regardless of where they live;

3. Address and eliminate racism and intersectional discrimination in health care settings, including mistreatment and obstetric violence in maternity care settings and sexual and reproductive health and rights violations in criminal and immigration detention settings;

4. Reform legal and policy frameworks to ensure that communities of color can provide and access culturally aligned midwifery and doula care and take measures recommended by Black and Indigenous communities to improve maternal health and eliminate maternal mortality, morbidity, and mistreatment;

5. Remedy retrogression in the right to abortion and enact positive measures to ensure that all people, including people of color, ethnic minorities, and immigrants, have meaningful access to abortion;

6. Take proactive steps to protect the natural environment, eliminate environmental racism, and mitigate the impact of environmental damage on pregnant people of color and their families.

APPENDIX

Human rights experts have repeatedly expressed concern over sexual and reproductive health and rights violations in the United States, often noting that they disproportionately impact women of color.

The **UN Human Rights Committee (CCPR)** expressed concerns about the U.S. during review cycles under the International Covenant on Civil and Political Rights (ICCPR).[335]

- In its **2019 List of issues** prior to the fifth periodic report of the U.S., the Human Rights Committee (CCPR) requested information about reproductive rights concerns, including racial disparities in maternal health outcomes, laws restricting access to abortion, barriers to contraception, the criminalization of pregnant women who use drugs, the shackling of detained women during birth, lack of abortion services in immigration detention, and the "global gag rule."[336]

- In its **2014 Concluding Observations regarding the U.S.**, the **Human Rights Committee (CCPR)** expressed concern about "the exclusion of millions of undocumented immigrants and their children from coverage under the Affordable Care Act (ACA) and the limited coverage of undocumented immigrants and immigrants residing lawfully in the United States for less than five years by Medicare and Children's Health Insurance."[337] The Committee recommended the U.S. "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."[338]

At the conclusion of its **2020 Universal Periodic Review**, the U.S. received numerous recommendations to ensure access to sexual and reproductive health and rights, including maternal health.[339] These included that the United States:

- make essential health services accessible to all women and girls, paying special attention to those who face multiple and intersecting forms of discrimination;[340]
- guarantee essential health services for all, including sexual and reproductive health services;[341]
- ensure access by all women to sexual and reproductive health information and services;[342] and
- advance universal maternal health care.[343]

In a May 2021 Communication, the **UN High Commissioner for Human Rights** followed up with the U.S. on several areas raised during its UPR.[344] The High Commissioner reiterated recommendations to ensure access to affordable health care, reduce the maternal mortality among Black women, and ensure all women have effective access to reproductive health services and information, including safe and legal abortion.[345]

In the time since the CERD last reviewed the U.S., **UN experts** have consistently expressed concern with racial disparities in maternal health and the impact that abortion bans and restrictions in the U.S. have on marginalized communities, including women of color.[346]

- On June 24, 2022 **UN High Commissioner for Human Rights**, Michelle Batchelet, issued a statement in response to the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization (JWHO)*, which eliminated federal Constitutional protection for abortion. The High Commissioner noted that, "[a]ccess to safe, legal and effective abortion is firmly rooted in international human rights law and is at the core of women and girls' autonomy and ability to make their own choices about their bodies and lives, free of discrimination, violence and coercion. This decision strips such autonomy from millions of women in the U.S., in particular those with low incomes and those belonging to racial and ethnic minorities, to the detriment of their fundamental rights."[347]

- Also reacting to the U.S. Supreme Court decision in *Dobbs v. JWHO* on June 24, 2022, **9 UN Special Procedures** issued a joint statement describing it as a dangerous rollback of human rights and noting, "[t]he Court has completely disregarded the United States' binding legal obligations under international law, including those stemming from its ratification of the International Covenant on Civil and Political Rights, ever more regrettably at a time when many countries have, in what is a positive trend, liberalized their abortion laws to respect and uphold women's human rights to life, health, equality and non-discrimination, privacy and freedom from violence and torture, cruel, inhuman and degrading treatment."[348]

- Following the September 2021 enactment and implementation of a radical ban on abortion after 6 weeks in Texas (S.B. 8), a **group of UN Special Procedures** condemned the law as a violation of international human rights and called on the U.S. to halt its implementation, prevent retrogression in access to abortion, and enact positive measures to ensure access to abortion.[349] The statement noted the law's devastating impact on marginalized women, noting that "women with low incomes, women living in rural areas, and women from racial and ethnic minorities as well as immigrant women will be disproportionately" harmed by the law.[350]

- In May 2020, a group of **UN Special Procedures** led by the Working Group on discrimination against women and girls sent a Communication to the United States expressing concern that some state officials had manipulated the COVID-19 crisis to restrict access to abortion and noted that access barriers exacerbate systemic inequalities and disproportionately harm marginalized communities, including people with low-income, people of color, and immigrants.[351]

- In 2018, a **group of UN Special Procedures** led by the Working Group on arbitrary detention expressed their "grave concerns at the risks to the life, health, liberty, safety, wellbeing and other human rights of pregnant immigrant women," especially those living in detention in the United States.[352] The Communication noted that many pregnant detainees reported receiving inadequate health care jeopardizing their rights to health, including their sexual and reproductive health.[353]

- In 2017, the **UN Working Group on Arbitrary Detention** expressed concern about civil detentions of pregnant women in the U.S. who used or were suspected to have used criminalized drugs, noting that "[t]his form of deprivation of liberty is gendered and discriminatory in its reach and application." [354]

- At the conclusion of his 2017 visit to the U.S., the **UN Special Rapporteur on Extreme Poverty** expressed concern that the U.S. has the highest maternal mortality rate among wealthy countries and that Black women are three to four times more likely to die from childbirth than white women.[355] The Rapporteur also noted that immigrant women experience higher poverty rates and have less access to social protection benefits,[356] noting in particular the exclusion from the ACA of permanent residents who have lived in the U.S. for less than five years.[357] He also noted that people living in poverty, and in particular pregnant women, are disproportionately criminalized and subjected to interrogations that strip them of privacy rights.[358]

- At the conclusion of its 2016 visit to the U.S., the **UN Working Group of Experts on People of African Descent** noted that racial discrimination has a negative impact on Black women's ability to maintain good health and recommended the U.S. prioritize policies and programs to reduce maternal mortality for Black women.[359]

- At the conclusion of its 2015 visit to the United States, the **UN Working Group on Discrimination Against Women in Law and Practice** expressed concern at rising U.S. maternal mortality noting it "hides distressing ethnic and socioeconomic disparities."[360] It recommended the U.S. address the root causes of maternal mortality, "in particular among African-American women."[361] The Working group also noted the over-incarceration and shackling of pregnant women, as well as the lack of appropriate health care services for

women in immigration detention.[362] It noted the "heightened vulnerability" of Native American, Black, Latina, Asian American women, and migrant women,[363] and that "immigrant women and girls face severe barriers in accessing sexual and reproductive health services."[364] It recommended the U.S. ensure that women are able to exercise their constitutional right to terminate a pregnancy in the first trimester and that Congress repeal the Hyde Amendment and enact both the Women's Health Protection Act and the Health Equity and Access under the Law for Immigrant Families (HEAL) Act.[365]

Artwork by Leslie Rosario-Olivo featuring human rights advocates Nicole Martin (top left), Angela Aina (top center), Nicolle Gonzales (top right), Dr. Joia Crear-Perry (bottom left), Chanel Porchia-Albert and her baby (bottom center), and Monica Simpson (bottom right).

[1] Abortion Care Network, Ancient Song Doula Services , Birthmark Doulas , Black Mamas Matter Alliance, Center for Reproductive Rights, Changing Woman Initiative , CUNY Law, If/When/How: Lawyering for Reproductive Justice , Indigenous Women Rising , National Birth Equity Collaborative, National Latina Institute for Reproductive Justice, Movement for Family Power , ROOTT, Sister Song: Women of Color Reproductive Justice Collective.

[2] *Committee on the Elimination of Racial Discrimination*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R: TREATY BODIES, https://www.ohchr.org/en/treaty-bodies/cerd (last visited June 10, 2022); *Thematic Discussion: Racial Discrimination and the Right to Health, Day of General Discussion 2022*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R (Aug. 23, 2022), https://www.ohchr.org/en/events/events/2022/thematic-discussion-racial-discrimination-and-right-health-day-general.

[3] International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Dec. 21, 1965, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969) [hereinafter ICERD].

[4] *See id.* at art. 2*,* 5.

[5] U.N. Comm. on the Elimination of Racial Discrimination (CERD), *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America*, U.N. Doc. CERD/C/USA/Co/7-9 (2014) [hereinafter CERD U.S. Concluding Observations]. Available at: https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhspzOl9YwTXeABruAM8pBAK1Q%2FDZ6XAqlyobgts1zwlHPkQhsSqMrVxuS6brQbHYpDYGXBUCX1bgRtTg3HaweAr5PBs9soaesD5KdByekI9OS.

[6] *Thematic Discussion: Racial discrimination and the right to health, Day of General Discussion 2022*, U.N. HUMAN RTS. OFF. OF THE HIGH COMM'R (Aug. 23, 2022), https://www.ohchr.org/en/events/events/2022/thematic-discussion-racial-discrimination-and-right-health-day-general.

[7] *Supra* note 1.

[8] *Supra* note 4.

[9] "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.' 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." CTR. FOR REPROD. RTS. ET AL, REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE 11 (2014), https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_17560_E.pdf [hereinafter REPRODUCTIVE INJUSTICE].

[10] *See id*.

[11] *See id*.

[12] *See id*.

[13] U.N. Comm. on the Elimination of Racial Discrimination, *General Recommendation No. 25 on Gender-Related Dimensions of Racial Discrimination*, ¶ 3, U.N. Doc. INT/CERD/GEC/7497/E (2000). Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCERD%2fGEC%2f7497&Lang=en.

[14] U.N. Comm. on the Elimination of Racial Discrimination, *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America*, ¶ 15, U.N. Doc. CERD/C/USA/CO/7-9 (2014). Available at: https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhspzOl9YwTXeABruAM8pBAK1Q%2FDZ6XAqlyobgts1zwlHPkQhsSqMrVxuS6brQbHYpDYGXBUCX1bgRtTg3HaweAr5PBs9soaesD5KdByekI9OS.

[15] *Id*. at ¶ 15(b).

[16] *Id*. at ¶ 15(c).

[17] *Id*.

[18] *Id*. at ¶ 15(a).

[19] *Id*. at ¶ 15(a).

[20] U.N. Comm. on the Elimination of Racial Discrimination, *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, ¶ 32, U.N. Doc. CERD/C/USA/CO/6 (2008). Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G08/419/82/PDF/G0841982.pdf?OpenElement.
[21] *Id*.
[22] *Id*. at ¶ 33.
[23] *Id*. at ¶ 33(i).
[24] *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice (last visited June 14, 2022).
[25] *Id*.
[26] *See* REPRODUCTIVE INJUSTICE, *supra* note 9.
[27] Cynthia Prather et al., *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2 HEALTH EQUITY 249 (2018). Available at: https://www.liebertpub.com/doi/full/10.1089/heq.2017.0045. *See e.g.,* Diedre Cooper Owens & Sharla M. Fett, *Maternal and Infant Health: Historical Legacies of Slavery*, 109 AM. J. OF PUB. HEALTH 1342 (2019).
[28] *See* sources cited *supra* note 27.
[29] Izabela Tringali & Martha Kinsella, *Forced Sterilization Accusations at ICE Facility Fit with Trump's Poor Treatment of Immigrants*, BRENNAN CTR. FOR JUST. RSCH. & REPS. (Sept. 18, 2020), https://www.brennancenter.org/our-work/analysis-opinion/forced-sterilization-accusations-ice-facility-fit-trumps-poor-treatment.
[30] *See* CERD U.S. Concluding Observations, *supra* note 5.
[31] John Blake, *There Was No Racial Reckoning*, CNN: US (May 25, 2021, 9:51 AM), https://www.cnn.com/2021/04/18/us/george-floyd-racial-reckoning-blake/index.html.
[32] *U.N. Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance, Working Group of Experts on People of African Descent, Special Rapporteur on the Rights of Freedom of Assembly and Association, and the Coordination Committee of the U.N. Human Rights Special Procedures, Urgent Debate of the Human Rights Council on "The Current Racially Inspired Human Rights Violations, Systemic Racism, Police Brutality and the Violence Against Peaceful Protest,"* U.N. HUM. RTS. OFF. OF THE HIGH COMM'R: MEDIA CTR. (June 17, 2020), https://www.ohchr.org/en/statements/2020/06/urgent-debate-human-rights-council-current-racially-inspiredhuman-rights.
[33] *Supra* note 1.
[34] *See generally supra* note 1; *see* Latona Giwa, *I'm Due to Give Birth Today But All I Can Think About is George Floyd*, HUFFPOST: PERSONAL (May 31, 2020, 11:56 AM), https://www.huffpost.com/entry/black-mother-george-floyd-racism-america_n_5ed383b6c5b65a461cf6e00f?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAENR01LcVYnc3egh_d16PVhq47S9zXUDD6368bCxqOCRW9NQ_Dj46ZegdUDVsfMti8jBSS9Ja4S26x-9cD6GD4EnQpmH4IshVcsreMnC-lAQfvR_l4wt0KsYrwPAVindJh-qRAUaJ8i7cKt9claJQ9YUWHUQD4_4v_6VcJTHuWtc.
[35] *See supra* note 1.
[36] *Id*.
[37] *See generally* BLACK MAMAS MATTER ALL. & CTR. FOR REPROD. RTS., ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE (2018), https://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages.pdf.
[38] *See* ICERD, s*upra* note 3.
[39] *See id*.
[40] *See id*.
[41] *See id*.
[42] *See* CERD U.S. Concluding Observations, *supra* note 5.
[43] *Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL AND PREVENTION: VITAL SIGNS (May 7, 2019), https://www.cdc.gov/vitalsigns/maternal-deaths/index.html.
[44] *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CTR. FOR DISEASE CONTROL AND PREVENTION: CDC NEWSROOM (Sept. 6, 2019), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html.

[45] According to the CDC, there are 700-900 pregnancy-related deaths every year. The CDC also shares maternal mortality ratios for some race/ethnicity groups. The pregnancy-related maternal mortality ratio is calculated as the number of pregnancy-related deaths for every 100,000 live births. The CDC's National Center for Health Statistics also publish data on live births in the U.S. by race/ethnicity. In 2017, there were 3,855,500 total live births in the U.S. and 700-900 deaths. In 2017, there were 560,715 live births among Black women and the maternal mortality ratio for Black women between 2014 and 2017 was 41.7. 560,715/100,000=5.6. 5.6 x 41.7=233.52. For Native American and Alaskan Native women there were 29,957 total live births and a maternal mortality ratio of 28.3. 29,957/100,00=2.9. 2.9 x 28.3=82.07. For Hispanic women there were 898,764 total live births and a maternal mortality ratio of 11.6. 898,764/100,000=8.9. 8.9 x 11.6=103.24. For Asian women there were 249,250 total live births and for Pacific Islander women there were 9,426 total live births. The combined reported maternal mortality ratio is 13.8. 249,250/100,000=2.4 and 9,426/100,000=0.9. 2.4 x 13.8=33. 0.9 x 13.8=12. 33+12=45. *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL AND PREVENTION: REPROD. HEALTH: MATERNAL MORTALITY (June 22, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (illustrating maternal mortality ratios that are calculated with data from 2014-2017, because 2017 is the latest year of data available); NAT'L CTR. FOR HEALTH STAT, CTRS. FOR DISEASE CONTROL AND PREVENTION, BIRTHS: FINAL DATA FOR 2020 (2022), https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf (outlining data on U.S. births).

[46] Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, CTR. FOR DISEASE CONTROL AND PREVENTION: NAT'L CTR. FOR HEALTH STATS. (Feb. 23, 2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm.

[47] *See* U.S. COMM'N ON C.R., RACIAL DISPARITIES IN MATERNAL HEALTH: U.S. COMMISSION ON CIVIL RIGHTS 2021 STATUTORY ENFORCEMENT REPORT (2021), https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf.

[48] *See* CERD U.S. Concluding Observations, s*upra* note 5.

[49] Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047. Available at: https://www.congress.gov/115/plaws/publ344/PLAW-115publ344.pdf. *See also Maternal Mortality Review Information Application (MMRIA, or "Maria")*, CTR. FOR DISEASE CONTROL AND PREVENTION: REPROD. HEALTH (Apr. 13, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMRIA.html; *see generally infra* note 57 for more information on racial discrimination as a contributing factor to maternal mortality.

[50] U.N. Hum. Rts. Comm., *General Comment No. 36 (2018) on Article 6: Right to Life*, ¶ 8, U.N. Doc. CCPR/C/GC/36 (2019) [hereinafter *General Comment No. 36 Right to Life*]. Available at: https://www.refworld.org/docid/5e5e75e04.html.

[51] Sandeep Bathala, Bette Begleiter, Dr. Michael C. Lu, & Dr. Monica Simpson, *What Explains the United States'Dismal Maternal Mortality Rates?*, WILSON CTR. (Nov. 19, 2015), https://www.wilsoncenter.org/event/what-explains-the-united-states-dismal-maternal-mortality-rates.

[52] *See* Samantha Argita et al., *Racial Disparities in Maternal and Infant Health: An Overview*, KAISER FAM. FOUND. (Nov. 10, 2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/.

[53] *Id*.

[54] Paula Braveman et. al, *Explaining the Black-White Disparity in Preterm Birth: A Consensus Statement from a Multi-Disciplinary Scientific Work Group Convened by the March of Dimes*, Frontiers REPROD. HEALTH (Sept. 02, 2021), https://www.frontiersin.org/articles/10.3389/frph.2021.684207/full.

[55] Sudeshna Mukherjee et al., *Risk of Miscarriage Among Black Women and White Women in a US Prospective Cohort Study*, 177 AM. J. OF EPIDEMIOLOGY 1271 (2013). Available at: https://academic.oup.com/aje/article/177/11/1271/97504.

[56] *Black Mothers are More Likely to Experience Stillbirth Compared to Hispanic and White Mothers*, CTRS. FOR DISEASE CONTROL AND PREVENTION: STILLBIRTH (Sept. 17, 2020), https://www.cdc.gov/ncbddd/stillbirth/features/kf-black-mothers-stillbirth.html.

[57] ANJANI CHANDRA ET AL., CTRS. FOR DISEASE CONTROL AND PREVENTION: NAT'L CTR. FOR HEALTH STATS., INFERTILITY AND IMPAIRED FECUNDITY IN THE UNITED STATES, 1982-2010: DATA FROM THE NATIONAL SURVEY OF FAMILY GROWTH (2013). Available at: https://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf. ANJANI CHANDRA ET AL., CTRS. FOR DISEASE CONTROL AND PREVENTION: NAT'L CTR. FOR HEALTH STATS., INFERTILITY SERVICE USE IN THE UNITED STATES: DATA FROM THE NATIONAL SURVEY OF FAMILY

GROWTH, 1982-2010 (2014). Available at: https://www.cdc.gov/nchs/data/nhsr/nhsr073.pdf. Ada C. Dieke et al., *Disparities in Assisted Reproductive Technology Utilization by Race and Ethnicity, United States, 2014: A Commentary*, 26 J. OF WOMEN'S HEALTH 605 (2017). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548290/.

[58] Lizzie Wade, *COVID-19 Data on Native Americans is 'A National Disgrace." This Scientist is Fighting to be Counted*, SCIENCE (Sep. 24, 2020), https://www.science.org/content/article/covid-19-data-native-americans-national-disgrace-scientist-fighting-be-counted; INDIAN HEALTH SERV., DISPARITIES (2019), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf.

[59] *See supra* note 57; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[60] *See supra* note 59.

[61] *See supra* note 59.

[62] *See supra* note 59

[63] *See generally supra* note 1.

[64] *See* Braveman, *supra* note 54.

[65] *See* Nat'l Birth Equity Collaborative & Ctr. for Reprod. Rts., *Statement to the Office of the U.N. High Commissioner for Human Rights (OHCHR) in Response to the "Promotion and Protection of the Human Rights and Fundamental Freedoms of Africans and of People of African Descent Against Excessive Use of Force and Other Human Rights Violations by Law Enforcement Officers,"* U.N. HUM. RTS. OFF. OF THE HIGH COMM'R (Dec. 4, 2020), https://www.ohchr.org/sites/default/files/Documents/Issues/Racism/RES_43_1/NGOsAndOthers/center-reproductive-rights-national-birth-equity.pdf [hereinafter NBEC & CRR Joint Submission].

[66] *See Pregnancy Mortality Surveillance System*, *supra* note 45.

[67] *See generally* Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KAISER FAM. FOUND. RACIAL EQUITY AND HEALTH POL'Y (May 11, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

[68] A. Baciu et. al, *The Root Cause of Health Inequity*, NAT'L ACADEMIES OF SCIS, ENG'G AND MED., (Jan. 11, 2017), https://www.ncbi.nlm.nih.gov/books/NBK425845/; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[69] *See Quick Facts: United States*, U.S. CENSUS BUREAU (Apr. 1, 2020), U.S. Census Bureau QuickFacts: United States.

[70] *See* sources cited *infra* note 97.

[71] Bruce Vladeck, *Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future*, 93 AM. J. OF PUB. HEALTH 16 (2003). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447684/.

[72]Rachel Garfield & Kendal Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/; Madeline Guth & MaryBeth Musumeci, *An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?*, KAISER FAM. FOUND. (May 3, 2022), https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/.

[73] *See* Gretchen Borchelt, *The Impact Poverty Has on Women's Health*, AM. BAR ASSOC. HUM. RTS. MAG. (August 1, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/poverty-on-womens-health/; Kerry J. Cromer et al., *Barriers to Healthcare Access Facing American Indian and Alaska Natives in Rural America*, 36 J. CMTY. HEALTH NURSING 165 (2019).

[74] *See* NBEC & CRR Joint Submission, *supra* note 65.

[75] *See* Kay Johnson et. al, *A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*, CDC: MORBIDITY & MORTALITY WKLY. REP. (Apr. 21, 2006), https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm; *see also* Jamila Taylor et al., *Eliminating Racial*

Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint, CTR. FOR AM. PROGRESS (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/.
[76] *See* sources cited *infra* note 101.
[77] Liza Fuentes, *New Analyses on US Immigrant Health Care Access Underscore the Need to Eliminate Discriminatory Policies*, GUTTMACHER INSTITUTE (May 2022), https://www.guttmacher.org/report/new-analyses-us-immigrant-health-care-access-underscore-need-eliminate-discriminatory?utm_source=Guttmacher+Email+Alerts&utm_campaign=8e01fa41c9-immigrant%2Fhealanaylsis&utm_medium=email&utm_term=0_9ac83dc920-8e01fa41c9-244292589.
[78] *Health Coverage of Immigrants*, KAISER FAM. FOUND. RACIAL EQUITY AND HEALTH POL'Y (Apr. 6, 2022), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#:~:text=In%20general%2C%20lawfully%20present%20immigrants%20must%20have%20a,after%20obtaining%20qualified%20status%20before%20they%20may%20enroll.
[79] Theresa Chalhoub & Kelly Rimar, *The Health Care System and Racial Disparities in Maternal Mortality*, CTR. FOR AM. PROGRESS (May 10, 2018), https://www.americanprogress.org/article/health-care-system-racial-disparities-maternal-mortality/.
[80] *See id*.
[81] *See* sources cited *infra* note 101, 95.
[82] *See* NBEC & CRR Joint Submission, *supra* note 65.
[83] Corinne Lewis et al., *The Rural Maternity Care Crisis*, COMMONWEALTH FUND (August 15, 2019), https://www.commonwealthfund.org/blog/2019/rural-maternity-care-crisis; Dalton Walker, *Phoenix Indian Hospital Abruptly Shuts Down Birthing Center*, ABC NEWS (Oct. 28, 2020, 1:13 PM); https://abcnews.go.com/Lifestyle/wireStory/phoenix-indian-hospital-abruptly-shuts-birthing-center-73883946; Jan M. Eberth et al., *The Problem of the Color Line: Spatial Access to Hospital Services for Minoritized Racial and Ethnic Groups*, 41 HEALTH AFFS. 237 (2022); Katy B. Kozhimannil, *Role of Racial and Geographical Bias in Rural Maternity Care*, AM. J. OF MANAGED CARE (Sept. 5, 2017), https://www.ajmc.com/view/role-of-racial-and-geographical-bias-in-rural-maternity-care; Jean Lee, *A Rural Hospital Closed Its Obstetrics Unit, Hitting Most Vulnerable the Hardest*, NBC NEWS (Nov. 21, 2021, 4:30 AM), https://www.nbcnews.com/news/us-news/rural-hospital-closed-its-obstetrics-unit-hitting-most-vulnerable-hardest-n1284254.
[84] NAT'L P'SHIP FOR WOMEN & FAMILIES, BLACK WOMEN'S MATERNAL HEALTH: A MULTIFACETED APPROACH TO ADDRESSING PERSISTENT AND DIRE HEALTH DISPARITIES (2018), https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternal-health.html.
[85] CHRISTI A. GRIMM, U.S. DEP'T OF HEALTH AND HUM. SERVS., OFF. OF INSPECTOR GEN., INSTANCES OF IHS LABOR AND DELIVERY CARE NOT FOLLOWING NATIONAL CLINICAL GUIDELINES OR BEST PRACTICES (2020); *see also About IHS*, INDIAN HEALTH SERVS., https://www.ihs.gov/aboutihs/ (last visited July 15, 2022).
[86] *See* Olivia Lewis, *Nurses of Color are Underrepresented – with Serious Consequences*, DIRECTRELIEF (Feb. 24, 2022), https://www.directrelief.org/2022/02/nurses-of-color-are-underrepresented-with-serious-consequences-this-organization-is-working-to-change-that/; *see also* Dhruv Khullar, *Even as the U.S. grows more diverse, the medical profession is slow to follow*, THE WASH. POST: HEALTH AND SCIENCE, (Sept. 23, 2018), https://www.washingtonpost.com/national/health-science/even-as-the-us-grows-more-diverse-the-medical-profession-is-slow-to-follow/2018/09/21/6e048d66-aba4-11e8-a8d7-0f63ab8b1370_story.html.
[87] *Supra* note 57; *See generally* David R. Williams & Toni Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FIN. REV. 75 (2000). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.
[88] Jamila Taylor et al., *Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint*, CTR. FOR AM. PROGRESS (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/.
[89] *See id*.
[90] *Supra* note 57.
[91] *Id*.
[92] *Supra* note 116.

[93] *Id*.
[94] *See id*.; *see Our Story*, 4KIRA4MOMS, https://4kira4moms.com/who-are-we/#1651528416821-914dd51c-2890 (last visited June 17, 2022); *see also* Paula Eiselt & Tonya Lewis, *Sundance Film Festival: Aftershock*, AFTERSHOCKDOCUMENTARY, https://www.aftershockdocumentary.com/ (last visited June 17, 2022).
[95] *Id*.
[96] *Id*.
[97] *See generally* sources cited *supra* note 57; *see also* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NATL ACAD. SCIS. 4298 (2016). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/.
[98] Supra note 57; *See also* Elizabeth Raterman, *The Disproportionate Impacts of Obstetric Violence on Minority Women*, Washington College of Law: Health Law & Policy Brief, (Apr. 21, 2019), http://www.healthlawpolicy.org/the-disproportionate-impacts-of-obstetric-violence-on-minority-women/; *see also* Columbia Mailman School of Public Health, *Working Paper Disrespect and Abuse of Women of Color During Pregnancy and Childbirth: Findings from Qualitative Exploratory Research in New York, City*, COLUM. U.: MAILMAN SCH. OF PUB. HEALTH, https://www.publichealth.columbia.edu/sites/default/files/disrespect_of_woc_during_childbirth_in_nyc_working_paper.pdf (last visited June 17, 2022).
[99] *See* Natalie Avery Barnaby, *Pregnant and Detained: Constitutional Rights and Remedies for Pregnant Detainees*, 111 J. OF CRIM. L. AND CRIMINOLOGY 531 (2021). Available at: https://www.jstor.org/stable/48614946. *See also* Roxanne Daniel, *Prisons Neglect Pregnant Women in Their Healthcare Policies*, PRISON POL'Y INITIATIVE (Dec. 5, 2019), https://www.prisonpolicy.org/blog/2019/12/05/pregnancy/.
[100] *See* Rebecca Figueroa & Carla Canning, *I Had a High -Risk Pregnancy in Jail – Then I Gave Birth in Chains*, MARSHALL PROJECT (Apr. 1, 2022), https://www.themarshallproject.org/2022/04/01/high-risk-pregnancy-jail-birth-chains; Anna Marie Wilder, *Moms Behind Bars*, JOHN JAY COLL.: CTR. ON MEDIA CRIME AND JUST. (May 7, 2021), https://thecrimereport.org/2021/05/07/moms-behind-bars/; Madeline Gatto, *Pregnant Women are Being Abused and Neglected in Immigration Detention Centers*, MS. MAG. (Jul. 13, 2018), https://msmagazine.com/2018/07/13/pregnant-women-abused-neglected-immigration-detention-centers/; AIMEE REGISTE ET AL., INVOLUNTARY STERILIZATIONS CONTINUE: RESPONSE TO IRWIN COUNTY DETENTION CENTER ALLEGATIONS (AMENABLE) (2021), https://blackmamasmatter.org/wp-content/uploads/2022/07/InvoluntarySterilizationContinues_09092021.pdf.
[101] *See id*; *ACLU Briefing Paper: The Shackling of Pregnant Women & Girls in U.S. Prisons, Jails & Youth Detention Centers*, ACLU REPROD. FREEDOM PROJECT & NAT'L PRISON PROJECT, https://www.aclu.org/sites/default/files/field_document/anti-shackling_briefing_paper_stand_alone.pdf (last visited June 17, 2022); Nora Ellmann, *Immigration Detention Is Dangerous for Women's Health and Rights*, CTR. FOR AM. PROGRESS (Oct. 21, 2019), https://www.americanprogress.org/article/immigration-detention-dangerous-womens-health-rights/.
[102] *See* NBEC & CRR Joint Submission, *supra* note 65.
[103] *See generally The Historical Significance of Doulas and Midwives*, SMITHSONIAN: NAT'L MUSEUM OF AFRICAN AM. HIST. & CULTURE (Jan. 31, 2022), https://nmaahc.si.edu/explore/stories/historical-significance-doulas-and-midwives; *see also* Christine Abbyad & Trina Reed Roberson, *African American Women's Preparation for Childbirth From the Perspective of African American Health-Care Providers*, 20 J. PERINAT EDUC. 45 (2011). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3209742/.
[104] *See* sources cited *supra* note 103.
[105] *See* sources cited *supra* note 103.
[106] *See* sources cited *supra* note 103.
[107] *See* sources cited *supra* note 103.
[108] *See* sources cited *supra* note 103.
[109] Nora Ellmann, *Community-Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*, CTR. FOR AM. PROGRESS (Apr. 14, 2020), https://www.americanprogress.org/article/community-based-doulas-midwives/.
[110] *Id*.

[111] *Id*; Cole Bradley, *CHOICES' New Birth Center is Making History and Reviving Black Midwifery in Memphis,* HIGH GROUND NEWS (March 5, 2020), https://www.highgroundnews.com/features/CHOICESBlackMidwives.aspx.
[112] *Supra* note 137.
[113] *Id*.
[114] *Id*.
[115] *Id*.
[116] WORLD HEALTH ORGANIZATION ET AL., THE STATE OF THE WORLD'S MIDWIFERY 2021 (2021), https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302.pdf; *see also Nursing and Midwifery: Key Facts*, WORLD HEALTH ORG.: NURSING & MIDWIFERY (March 18, 2022), https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery.
[117] *Id*.
[118] *See* for more information, context, and links to original sources *infra* note 137; Sandi Doughton, *The Case for Midwives: Washington State Leads the Nation in Midwifery Care*, SEATTLE TIMES (March 15, 2020), https://www.seattletimes.com/pacific-nw-magazine/the-case-for-midwives-washington-leads-the-nation-in-midwifery-care-giving-women-another-childbirth-option/.
[119] Nan Strauss, *Maximizing Midwifery to Achieve High-Value Maternity Care in New York*, CHOICES IN CHILDBIRTH + EVERY MOTHER COUNTS (Jan. 2018), https://everymothercounts.org/wp-content/uploads/2018/10/MaxiMiNY_Final_5_3_18.pdf; *see generally infra* note 131, 137.
[120] *See* Strauss *supra* note 119.
[121] *See id*.
[122] *See infra* note 137.
[123] *See* sources cited *supra* note 116.
[124] *See* Aliza Bancoff, *WHO Recommends Doulas Attend All Births Globally*, INT'L DOULA INST. (Mar. 23, 2016), https://internationaldoulainstitute.com/2016/03/world-health-organization-who-recommends-doulas/.
[125] *See id*.
[126] *See id*.
[127] Michele Goodwin, *The Racist History of Abortion and Midwifery Bans,* ACLU (July 1, 2020), https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/.
[128] *Id*.
[129] *Id*.
[130] *Id*.
[131] *Id*.
[132] Aliza Bancoff, *WHO Recommends Doulas Attend All Births Globally*, INT'L DOULA INST. (Mar. 23, 2016), https://internationaldoulainstitute.com/2016/03/world-health-organization-who-recommends-doulas/; Goodwin, *supra* note 131.
[133] *Id*.
[134] WORLD HEALTH ORGANIZATION ET AL., THE STATE OF THE WORLD'S MIDWIFERY 2021 (2021), https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302.pdf; *see also Nursing and Midwifery: Key Facts*, WORLD HEALTH ORG.: NURSING & MIDWIFERY (March 18, 2022), https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery.
[135] Anna North, *America is Failing Black Moms During the Pandemic*, VOX (August 10, 2020), https://www.vox.com/2020/8/10/21336312/covid-19-pregnancy-birth-black-maternal-mortality.
[136] *See* Goodwin, *supra* note 131.
[137] Aliza Bancoff, *WHO Recommends Doulas Attend All Births Globally*, INT'L DOULA INST. (Mar. 23, 2016), https://internationaldoulainstitute.com/2016/03/world-health-organization-who-recommends-doulas/.
[138] *Id*.
[139] *Id*.
[140] *Id*.
[141] *Id*.
[142] *Id*.

[143] *About the Doula Medicaid Project,* DOULA MEDICAID PROJECT, https://healthlaw.org/doulamedicaidproject/ (last visited June 17, 2022); *see generally* Christina Gebel & Sara Hodin, *Expanding Access to Doula Care: State of the Union*, HARV. CHAN SCH. CTR. OF EXCELLENCE IN MATERNAL & CHILD HEALTH: MATERNAL HEALTH TASK FORCE (Jan. 8, 2020), https://healthlaw.org/doulamedicaidproject/.

[144] *About the Doula Medicaid Project,* DOULA MEDICAID PROJECT, https://healthlaw.org/doulamedicaidproject/ (last visited June 17, 2022); *see generally* Christina Gebel & Sara Hodin, *Expanding Access to Doula Care: State of the Union*, HARV. CHAN SCH. CTR. OF EXCELLENCE IN MATERNAL & CHILD HEALTH: MATERNAL HEALTH TASK FORCE (Jan. 8, 2020), https://healthlaw.org/doulamedicaidproject/.

[145] *See* WORLD HEALTH ORGANIZATION ET AL., THE STATE OF THE WORLD'S MIDWIFERY 2021 (2021), https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302.pdf; *see also Nursing and Midwifery: Key Facts*, WORLD HEALTH ORG.: NURSING & MIDWIFERY (March 18, 2022), https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery.

[146] *See id*; Vina Smith-Ramakrishnan*, Solving the Black Maternal Health Crisis Will Require Advancing Access to Community-Based Doula*, THE CENTURY FOUND.: COMMENTARY BLACK MATERNAL HEALTH (April 7, 2022), https://tcf.org/content/commentary/solving-the-black-maternal-health-crisis-will-require-advancing-access-to-community-based-doula-care/?session=1.

[147] *See* sources cited *supra* note 146.

[148] *Id*.

[149] *See* sources cited s*upra* note 97.

[150] *See id*.

[151] *See* Julia M. Goodman et al., *Racial/ Ethnic Inequities in Paid Parental Leave Access*, 5 HEALTH EQUITY 738 (2021). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8665807/. *See also* Ronald Newman & Louise Melling, *Why The Fight for Paid Sick Leave is a Civil Rights Issue*, ACLU (August 13, 2020), https://www.aclu.org/news/racial-justice/why-the-fight-for-paid-sick-leave-is-a-civil-rights-issue; Taryn Morrissey, *Addressing the Need for Affordable, High-Quality Early Childhood Care and Education for All in the United States*, WASH. CTR. FOR EQUITABLE GROWTH (Feb. 18, 2020), https://equitablegrowth.org/addressing-the-need-for-affordable-high-quality-early-childhood-care-and-education-for-all-in-the-united-states/.

[152] *See* sources cited *supra* note 151.

[153] Brea L. Perry et al., *Racial and Gender Discrimination in the Stress Process: Implications for African American Women's Health and Well-Being*, 56 SOCIOL. PERSPECT. 25 (2013). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3783344/.

[154] *Id.*

[155] *See A National Black Climate Mandate*, RED BLACK & GREEN NEW DEAL, https://redblackgreennewdeal.org/ (last visited June 17, 2022).

[156] Erin Switalski, *The Toxic Assault on Black Women's Health*, WOMEN'S VOICES FOR THE EARTH (Aug. 3, 2016), https://www.womensvoices.org/2016/08/03/toxic-assault-on-black-womens-health/; NAT'L P'SHIP FOR WOMEN AND FAMILIES ET AL., CLEAN WATER AND REPRODUCTIVE JUSTICE: LACK OF ACCESS HARMS WOMEN OF COLOR, REPRODUCTIVE RIGHTS REPORT (2020), https://www.nationalpartnership.org/our-work/health/repro/reports/clean-water-and-reproductive-health.html.

[157] *Id*.

[158] Daniel S. Grossman & David J.G. Slusky, *The Effect of an Increase in Lead in the Water System on Fertility and Birth Outcomes: The Case of Flint, Michigan*, Kansas University Paper (August 7, 2017), https://policy.ku.edu/sites/policy.ku.edu/files/PTWhitePaper.pdf.

[159] *Id*.

[160] *Id*.

[161] *Id*.

[162] Shivani Shukla, *Impact of Disproportionate Air Pollution and Heat Exposure on Pregnancy*, CHI. POL'Y REV. (June 8, 2022), https://chicagopolicyreview.org/2022/06/08/impact-of-disproportionate-air-pollution-and-heat-exposure-on-pregnancy/; Bruce Bekkar et al., *Association of Air Pollution and Heat Exposure With Preterm Birth, Low Birth Weight, and Stillbirth in the US: A Systematic Review*, 3 JAMA NETWORK OPEN. 1 (2020). Available at:

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767260?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=061820.

[163]Lauren Kaljur & Macee Beheler, *Tribes Grapple with Contaminated Water, Federal Bureaucracy*, THE OREGONIAN (Aug. 15, 2017), http://www.oregonlive.com/pacific-northwest-news/index.ssf/2017/08/tribes_grapple_with_contaminat.html; *EPA Report Shows Disproportionate Impacts of Climate Change on Socially Vulnerable Populations in the United States*, U.S. ENV'T PROT. AGENCY (Sept. 2, 2021), https://www.epa.gov/newsreleases/epa-report-shows-disproportionate-impacts-climate-change-socially-vulnerable.

[164] *See supra* note 163; Carter Squires et al., *Uncommon Ground: The impact of Natural Resource Corruption on Indigenous Peoples,* BROOKINGS INST. (Aug. 7, 2020), https://www.brookings.edu/blog/up-front/2020/08/07/uncommon-ground-the-impact-of-natural-resource-corruption-on-indigenous-peoples/; INTER-AM. COMM'N H.R., ORG. OF AM. STATES, INDIGENOUS PEOPLES, AFRO-DESCENDENT COMMUNITIES, AND NATURAL RESOURCES: HUMAN RIGHTS PROTECTION IN THE CONTEXT OF EXTRACTION, EXPLOITATION, AND DEVELOPMENT ACTIVITIES (2015), http://www.oas.org/en/iachr/reports/pdfs/extractiveindustries2016.pdf.

[165] Danielle Renwick, *The U.S. Is Facing a Maternal Health Crisis. Is Climate Change Making It Worse?*, Nexus Media News (Mar. 16, 2022), https://nexusmedianews.com/climate-change-hurts-maternal-health/.

[166] CTR. FOR REPROD. RTS., BREAKING GROUND: TREATY MONITORING BODIES ON REPRODUCTIVE RIGHTS (2019), https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf.

[167] U.N. Comm. on Econ., Soc. and Cultural Rts., *Gen. Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant),* ¶ 12, U.N. Doc. E/C.12/2000/4 (2000); Comm. on the Elimination of All Forms of Discrimination Against Women, *Gen. Recommendation No. 24: Article 12 of the Convention (Women and Health),* ¶¶ 26-27, U.N. Doc. A/54/38/Rev.1, chap. I (1999); Comm. on Econ., Soc. and Cultural Rts., *General Comment No. 22: On the right to sexual and reproductive health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights*), ¶ 45, U.N. Doc. E/C.12/GC/22 (2016).

[168] Convention on the Elimination of All Forms of Discrimination Against Women, art. 12, *opened for signature* Dec. 18, 1979, 1249 U.N.T.S. 13.

[169] Comm. on the Elimination of All Forms of Discrimination Against Women, *Gen. Recommendation No. 24: Article 12 of the Convention (Women and Health),* ¶ 31(e), U.N. Doc. A/54/38/Rev.1, chap. I (1999).

[170] Comm. on Econ., Soc. and Cultural Rts., *General Comment No. 22: On the Right to Sexual and Reproductive Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights*), ¶ 45, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter CESCR Committee, *Gen. Comment No. 22*]; *see also* Comm. on Econ., Soc. and Cultural Rts., *Gen. Comment No. 14: The Right to the Highest Attainable Standard of Health Act*, ¶ 8, U.N. Doc. E/C.12/200/4 (2000).

[171] Comm. on Econ., Soc. and Cultural Rts., *General Comment No. 22: On the Right to Sexual and Reproductive Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights*), ¶ 5, U.N. Doc. E/C.12/GC/22 (2016).

[172] Committee on Economic, Social and Cultural Rights, *Gen. Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant),* ¶ 20, U.N. Doc. E/C.12/2000/4 (2000). Comm. on Econ., Soc. and Cultural Rts., *Gen. Comment No. 20, Non-discrimination in Economic, Social and Cultural Rights (Art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 20, U.N. Doc. E/C.12/GC.20 (2009); Comm. on the Elimination of Discrimination Against Women, *General Recommendation No. 9: Statistical Data Concerning the Situation of Women,* (8th Sess., 1989), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. A/44/38 (1989); Comm. on the Rts. of the Child, *General Comment No. 5: General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*, (34th Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, ¶ 45, U.N. Doc. CRC/GC/2003/5 (2003); Comm. on the Rts. of the Child, *Gen. Comment No. 20 (2016) on the Implementation of the Rights of the Child During Adolescence*, ¶ 37(c), U.N. Doc. CRC/C/GC/20 (2016); Comm. on the Elimination of Discrimination Against Women, *Concluding Observations on the Combined Seventh and Eight Periodic Reports of Romania*, ¶¶ 40-41, U.N. Doc. CEDAW/C/ROU/CO/7-8 (2017); Comm. on the Elimination of Discrimination Against Women, *Concluding Observations on the Combined Initial to*

Fourth Periodic Reports of Lesotho, ¶¶ 32-33, U.N. Doc. CEDAW/C/LSO/ CO/1-4/Add.1 (2013); s*ee also* Dubravka Simonovic, *Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences on a Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence*, ¶¶ 43-44, 81(t) U.N. Doc. A/74/137 (2019) (The Special Rapporteur on violence against women has also recognized the "aggravating negative impact" of intersectional discrimination in maternal health care, noting, among other examples, the discriminatory practice of segregating women within maternal health facilities based on race or ethnicity, and stating that "appropriate legal and policy responses are needed in this regard"); *see also* SR health, Reducing maternal mortality: the contribution of the right to health, ¶ 17(c) (2006), available at https://documents-dds-ny.un.org/doc/UNDOC/GEN/N06/519/97/PDF/N0651997.pdf?OpenElement (this entails services that are "sensitive to gender and to the rights and cultures of minorities and indigenous peoples" and "may require addressing discriminatory laws, polices, practices and gender inequalities that prevent women and adolescents from seeking good quality services.").

[173] Comm. on Econ., Soc. and Cultural Rts., *General Comment No. 22: On the Right to Sexual and Reproductive Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 5, 10, 30, U.N. Doc. E/C.12/GC/22 (2016) ("groups such as, but not limited to, poor women, persons with disabilities, migrants, indigenous or other ethnic minorities, adolescents, lesbian, gay, bisexual, transgender and intersex persons, and people living with HIV/AIDS").

[174] Vienna Convention on the Law of Treaties, art. 18, *opened for signature* May 23, 1969, 1155 U.N.T.S. 331 (entered into force Jan. 27, 1980); s*ee also* Michael H. Posner, Assistant Sec'y of State, Bureau of Democracy, Hum. Rts. & Labor, Address to the American Society of International Law: The Four Freedoms Turn 70 (Mar. 24, 2011) ("While the United States is not a party to the [ICESCR], as a signatory, we are committed to not defeating the object and purpose of the treaty").

[175] Committee on Economic, Social and Cultural Rights, *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶¶ 7-8, U.N. Doc. E/C.12/GC/22 (2016); Human Rights Committee, *Gen. Comment No. 36: Right to Life, supra* note 50 at ¶ 26; Committee on Economic, Social and Cultural Rights, *Gen. Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 pf the Covenant)*, ¶¶ 4, 10-12, U.N. Doc. E/C.12/2000/4 (2000); Committee on the Rights of the Child, *Gen. Comment No. 20 (2016) on the Implementation of the Rights of the Child During Adolescence,* ¶ 57, U.N. Doc. CRC/C/GC/20 (2016). Committee on the Rights of the Child, *Gen. Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, ¶ 5, 13, 17, U.N. Doc. CRC/C/GC/15 (2013).

[176] Hum. Rts. Comm., *Gen. Comment No. 36: Right to Life, supra* note 50, ¶ 26.; *see also* SR health, Reducing maternal mortality: the contribution of the right to health, ¶¶ 31-36 (2006).

[177] ICERD, Combined tenth to twelfth periodic reports submitted by the United States of America under article 9 of the Convention, due in 2017, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f10-12&Lang=en. *See generally* The White House, *Fact Sheet: Biden-Harris Administration Announces Additional Actions in Response to Vice President Harris's Call to Action on Maternal Health*, THE WHITE HOUSE: BRIEFING ROOM, (Apr. 13, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/13/fact-sheet-biden-harris-administration-announces-additional-actions-in-response-to-vice-president-harriss-call-to-action-on-maternal-health/; Kaiser Family Foundation, *Medicaid Postpartum Coverage Extension Tracker*, KAISER FAMILY FOUNDATION, (June 17, 2022), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/; Health Resources & Services Administration (HRSA), *Title V Maternal and Child Health (MCH) Block Grant*, HRSA Maternal & Child Health, (Page last Reviewed Mar. 2022), https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-block-grant; CDC, *Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)*, CDC Reproductive Health, (Page last reviewed Apr. 29, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html; HRSA, *Maternal ,Infant, and Early Childhood Home Visiting (MIECHV) Program*, HRSA Maternal Health, (Date last reviewed Dec. 2021),

https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program; *See also* U.S. Department of Health and Human Services (HHS), *ICYMI: HHS Actions to Improve Maternal Health Outcomes*, HHS News, (Dec. 10, 2021), https://www.hhs.gov/about/news/2021/12/10/icymi-hhs-actions-to-improve-maternal-health-outcomes.html.

[178] *Id*.

[179] *Id*.

[180] The White House, *Remarks by Vice President Harris at the Maternal Day of Action Summit*, The White House Briefing Room, (Dec. 7, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/07/remarks-by-vice-president-harris-at-the-maternal-day-of-action-summit/.

[181] Lauren Underwood, *Representatives Underwood and Adams, Senator Harris, Members of the Black Maternal Health Caucus Unveil Historic Legislative Package to Address America's Black Maternal Health Crisis*, Press Release, (March 9, 2020), https://underwood.house.gov/media/press-releases/underwood-adams-harris-members-black-maternal-health-caucus-unveil-historic.

[182] *Id*.

[183] *Dobbs v. Jackson Women's Health Org.,* 142 S. Ct. 2228 (2022).

[184] *See id*.

[185] *See id.*

[186] *See id.*

[187] *See* Brief of Reproductive Justice Scholars as Amici Curiae Supporting Respondents, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022) (No. 19-1392).

[188] U.N. Hum. Rts. Comm., General Comment No. 36: Article 6 Right to Life, ¶ 8, U.N. Doc. CCPR/C/GC/36 (2019); *see also International Human Rights and Abortion: Spotlight on Dobbs v. Jackson Women's Health*, Ctr. for Reprod. Rts. (Nov. 24, 2021), https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-international-human-rights/.

[189] CRR, *Constitutional Protection for the Right to Abortion: From Roe to Casey to Whole Woman's Health*, CRR Memorandum, (Page Last Reviewed Jun. 22, 2022), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/factsheets/Constitutional-Protection-for-the-Right-to-Abortion-Fact-Sheet2.pdf.

[190] Jamille Fields Allsbrook, Nora Ellmann, *A Proactive Abortion Agenda: Federal and State Policies To Protect and Expand Access*, CTR. FOR AM. PROGRESS (Mar. 17, 2021), https://www.americanprogress.org/article/proactive-abortion-agenda/.

[191] *Roe v. Wade*, 410 U.S. 113 (1973).

[192] *Id*.

[193] *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021); MSNBC, *Battle over Texas abortion law leaves Black people behind*, MSNBC: INTO AMERICA (Oct. 15, 2021), https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661.

[194] *Dobbs*, 142 S. Ct. 2228.

[195] Loretta J. Ross, SisterSong, *The Color of Choice: White Supremacy and Reproductive Justice*, UC BERKELEY LAW, (Page Last Viewed June 22, 2022), https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=2K2QA27B.

[196] Hannah Harting, *About Six-in-Ten Americans Say Abortion Should be Legal in All or Most* Cases, PEW RSCH. CTR. (Jun. 13, 2022), https://www.pewresearch.org/fact-tank/2022/06/13/about-six-in-ten-americans-say-abortion-should-be-legal-in-all-or-most-cases-2/.

[197] Julie Rovner, Abortion Opponents Take Political Risks by Dropping Exceptions for Rape, Incest, and the Mother's Life, KAISER HEALTH NEWS, (Jun. 1, 2022), https://khn.org/news/article/abortion-opponents-exceptions-rape-incest-life-political-risks/.

[198] Renuka Rayasam et al., *Why State Legislatures are Still Very White – and Very Male*, POLITICO, (Feb. 2, 2021), https://www.politico.com/interactives/2021/state-legislature-demographics/.

[199] Brennan Center for Justice, *The Impact of Voter Suppression on Communities of Color*, BRENNAN CENTER FOR JUSTICE RESEARCH & REPORTS, (Jan. 10, 2022), https://www.brennancenter.org/our-work/research-reports/impact-voter-suppression-communities-color.
[200] *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021); MSNBC, *Battle over Texas abortion law leaves Black people behind*, MSNBC: INTO AMERICA (Oct. 15, 2021), https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661.
[201] Grace Panetta, *The states where abortion access will be on the ballot in 2022*, INSIDER, (Jun 24, 2022), https://www.businessinsider.com/which-states-have-abortion-ballot-measures-in-2022-2022-5. *A National Black Climate Mandate*, RED BLACK & GREEN NEW DEAL, https://redblackgreennewdeal.org/ (last visited June 17, 2022).
[202] *Id*.
[203] Guttmacher Inst., *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion*, GUTTMACHER INST.: FEDERAL POLICY SNAPSHOTS (May 2021), https://www.guttmacher.org/fact-sheet/hyde-amendment?msclkid=3dab97ddcf0011ec90f87bc6e33fc46f.
[204] *Id*; Former Supreme Court Justice Thurgood Marshall, the first person of color on the Court, observed that, "the Hyde Amendment is designed to deprive poor and minority women of the constitutional right to choose abortion." Ebony News, *The Hyde Amendment: 38 Years of Government Sanctioned Discrimination*, EBONY NEWS & POLITICS (Oct. 2, 2014), https://www.ebony.com/news/the-hyde-amendment-38-years-of-government-sanctioneddiscrimination-403/.
[205] *Id*.
[206] *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021); MSNBC, *Battle over Texas abortion law leaves Black people behind*, MSNBC: INTO AMERICA (Oct. 15, 2021), https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661.
[207] Center for Reproductive Rights (CRR), *What If Roe Fell?*, CRR (2019), https://reproductiverights.org/sites/default/files/2019-11/USP-2019-WIRF-Report-Web.pdf.
[208] After promising during his presidential campaign to appoint only "pro-life" judges, President Trump nominated, and the Republican-led Senate confirmed, a total of three Supreme Court justices, more than 220 lower court judges, and 54 federal appellate judges over the course of just a single presidential term. In so doing, President Trump fundamentally reshaped the federal judiciary into one that is largely be hostile to expanding human rights protections and upholding existing Constitutional protections. Scott S. Greenberger, *Trump-Appointed Judges Fuel Abortion Debate in the States*, PEW RSCH. CTR., (Jan. 25, 2021), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/01/25/trump-appointed-judges-fuel-abortion-debate-in-the-states.
[209] Dan Keating et al., *Abortion access is more difficult for women in poverty*, WASH. POST, (July 10, 2019), https://www.washingtonpost.com/national/2019/07/10/abortion-access-is-more-difficult-women-poverty/?utm_term=.f5a1cc0c1d91. *See also* Center for Reproductive Rights, *Judge Kavanaugh and Reproductive Rights: A Fact Sheet*, CRR, (2018), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/factsheets/Judge-Kavanaugh-and-Reproductive-Rights-Fact-Sheet.pdf (describing Justice Kavanaugh's judicial record on the right to abortion).
[210] Center for Reproductive Rights (CRR), *Center Report: More State Abortion Restrictions Passed in 2021 Than in Any Year Since Roe v. Wade*, CRR 2021 LEGISLATIVE WRAP UP, https://reproductiverights.org/2021-state-legislative-wrap-up/ (last visited June 26, 2022); Elizabeth Nash & Lauren Cross, *2021 Is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, GUTTMACHER INST. (April 2021), https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-antiabortion-state-legislative-session-decades.
[211] V.T.C.A., Health & Safety Code § 171.204.
[212] *Id*.
[213] *Testimony Before the House Judiciary Committee, Revoking Your Rights: The Ongoing Crisis in Abortion Care Access,* (May 18, 2022), (statement of Professor Michele Bratcher Goodwin Chancellor's Professor University of California, Irvine Senior Lecturer Harvard Medical School, Center For Medical Ethics), https://docs.house.gov/meetings/JU/JU00/20220518/114770/HHRG-117-JU00-Wstate-GoodwinM-20220518.pdf; See Fugitive Slave Act of 1793, 2nd Cong. (1793); Fugitive Slave Act of 1850, 31st Cong. (1850).

[214] *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021); MSNBC, *Battle over Texas abortion law leaves Black people behind*, MSNBC: INTO AMERICA (Oct. 15, 2021), https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661.
[215] Josh Gerstein & Alexander Ward, *Supreme Court Has Voted to Overturn Abortion Rights, Draft Opinion Shows*, POLITICO (May 2, 2022), https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473.
[216] *See* The Associated Press, *Is abortion illegal in the U.S. now? Depends where you live*, THE ASSOCIATED PRESS (June 25, 2022), https://apnews.com/article/supreme-court-abortion-ruling-states-a767801145ad01617100e57410a0a21d.
[217] Elizabeth Nash & Peter Ephross, *State Policy Trends at Midyear 2022: With Roe About to Be Overturned, Some States Double Down on Abortion Restrictions*, GUTTMACHER INST. (June 2022), https://www.guttmacher.org/article/2022/06/state-policy-trends-midyear-2022-roe-about-be-overturned-some-states-double-down.
[218] Grace Panetta, *The states where abortion access will be on the ballot in 2022*, INSIDER, (Jun 24, 2022), https://www.businessinsider.com/which-states-have-abortion-ballot-measures-in-2022-2022-5.
[219] *Id*.
[220] Center for Reproductive Rights (CRR), *What If Roe Fell: 2019*, CRR (2019), https://reproductiverights.org/sites/default/files/2019-11/USP-2019-WIRF-Report-Web.pdf.
[221] *Id.*; *see also* Center for Reproductive Rights & Ibis Reproductive Health, *Evaluating Priorities: Measuring Women's and Children's Health and Well-being against Abortion Restrictions in the States, Volume II* 3, (2017), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA-Ibis-Evaluating-Priorities-v2.pdf; (finding "more than 37 million women in 33 states are at risk of living in a state where abortion could become illegal if Roe were reversed. Twenty-two states, nearly all of which are situated in the central and southern most part of the country, could immediately ban abortion outright, while women in an additional 11 states (plus the District of Columbia) would also face losing their right to abortion"); Center for Reproductive Rights (CRR), *Report: Women in 33 States At-Risk of Losing Right to Abortion if Landmark Roe v. Wade Decision Overturned*, Yubanet.com, (Jan. 23, 2017), https://yubanet.com/usa/report-women-in-33-states-at-risk-of-losing-right-to-abortion-if-landmark-roe-v-wade-decision-overturned/.
[222] *Id*.
[223]*Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INSTITUTE (July 12, 2022), https://states.guttmacher.org/policies/. *Supreme Coutr and Roe v. Wade*, N.Y. TIMES, https://www.nytimes.com/news-event/roe-v-wade-supreme-court-abortion?name=styln-abortion-us&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=LegacyCollection&variant=show (last visited July 15, 2022).
[224] Nick Arellano*, Abortion is health care – we need to dismantle the stigma that surrounds it*, PLANNED PARENTHOOD (Apr. 20, 2022), https://www.plannedparenthoodaction.org/planned-parenthood-votes-nevada/blog/abortion-is-health-care-we-need-to-dismantle-the-stigma-that-surrounds-it.
[225] *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021); MSNBC, *Battle over Texas abortion law leaves Black people behind*, MSNBC: INTO AMERICA (Oct. 15, 2021), https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661.
[226] *See* Abortion Care Network, *Communities Need Clinics,* ABORTION CARE NETWORK 1, 4-8 (2019), https://www.abortioncarenetwork.org/communitiesneedclinics (noting that availability of abortion care has become more limited across the U.S. in recent years, one study identified twenty-seven "abortion deserts," cities from which people would have to travel over 100 miles (160 km) to reach the nearest abortion facility); Alice Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20 J. MED. INTERNET RES. e186 (2018), https://www.jmir.org/2018/5/e186/.
[227] Jenna Jerman, Lori F. Frohwirth, Megan L. Kavanaugh & Nakeisha Blades, *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, PERSPECT. SEX REPROD. HEALTH 49(2): 95–102., PMID: 28394463, (Jun. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5953191/.

[228] Becky Sullivan, *Here's where abortions are now banned or strictly limited, and where they may be soon*, NPR NEWS, (Jun. 24, 2022), https://www.npr.org/sections/health-shots/2022/06/24/1107126432/abortion-bans-supreme-court-roe-v-wade.

[229] *See* Alyssa Llamas et al., Jacobs Inst. of Women's Health, Geo. Wash. U., *Public Health Impacts of State-level Abortion Restrictions Overview of Research & Policy in the United States* 1, (Apr. 2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf; Erin Durkin, *'Women will die': How New Abortion Bans Will Harm the Most Vulnerable*, THE GUARDIAN (May 19, 2019), https://www.theguardian.com/us-news/2019/may/19/abortion-ban-alabama-women-of-color-poor; Liza Fuentes, *Latina immigrant women's access to abortion: Insights from interviews with Latina Grasstops Leaders,* NAT'L LATINA INST. FOR REPROD. HEALTH 1-4, (Sept. 2010), https://nciwr.files.wordpress.com/2011/01/nlirh-reserach-brief-sept2010-final1.pdf; National Council on Disability, *The Current State of Health Care for People with Disabilities* 51-52, 54-56, (2009), https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf; Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, GUTTMACHER INST. (Jan. 5, 2017), https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact.

[230] One study shows that 49 percent of patients were below the federal poverty level, and an additional 25 percent were under 200 percent of the federal poverty level. Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST. (May 2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014 (Table 1).

[231] M.V. Lee Badgett, Soon Kyu Choi, Bianca D.M. Wilson, *LGBTQ Poverty in the United States*, UCLA SCHOOL OF LAW WILLIAMS INSTITUTE, (Oct. 2019), https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/.

[232] Dan Keating et al., *Abortion access is more difficult for women in poverty*, WASH. POST, (July 10, 2019), https://www.washingtonpost.com/national/2019/07/10/abortion-access-is-more-difficult-women-poverty/?utm_term=.f5a1cc0c1d91 .

[233] *See id*.

[234] *Id*.

[235] *Id*.

[236] *Id*.

[237] *See id*.

[238] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST. 7, (May 2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014; Rachel K. Jones, Ushma D. Upadhyay & Tracy A. Weitz, *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES e173, e176, (Mar. 4, 2013), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf.

[239] *Id*.

[240] *See id*.

[241] Sheila Desai et al., *Characteristics of Immigrants Obtaining Abortions and Comparison with U.S.-Born Individuals*, 11 J. OF WOMEN'S HEALTH 1505, (2019), https://www.ncbi.nlm.nih.gov/pubmed/31237492.

[242] *Id*.

[243] Center for Reproductive Rights (CRR), SisterSong & National Latina Institute for Reproductive Health, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health care*, A SHADOW REPORT FOR THE U.N. COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (CERD), (2014), https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_17560_E.pdf.

[244] Elizabeth Nash, *State Abortion Policy Landscape: From Hostile to Supportive*, GUTTMACHER INST., https://www.guttmacher.org/article/2019/08/state-abortion-policy-landscape-hostile-supportive (Dec. 30, 2020) (detailing abortion proliferation rates since 2000); *Know Your Rights: 100 Mile Border Zone*, AM. CIV. LIBERTIES UNION, https://www.aclu.org/know-your-rights/border-zone (last visited June 13, 2022).

[245] The Trump administration instituted a policy in which the HHS Office of Refugee Resettlement (ORR), which maintains custody over minors who come into the country without parents, had instituted a policy of blocking pregnant young people in its government-funded shelters from accessing abortion care and trying to coerce them to carry pregnancies to term against their will. As a result of litigation on behalf of the young women, dubbed "The Janes," the policy was updated in 2020 to clarify that ORR and ORR-funded shelters cannot block or interfere with unaccompanied immigrant minors' access to confidential reproductive health care, including abortion. *See Garza v. Hargan*, 304 F.Supp.3d 145, 150 (D.D.C. 2018) (describing that in March 2017, the Office of Refugee Resettlement's director issued a directive prohibiting federally funded shelters from taking "any action that facilitates" abortions without the ORR director's approval); Renuka Rayasam, *Trump official halts abortions among undocumented, pregnant teens*, POLITICO (Oct. 16, 2017), https://www.politico.com/story/2017/10/16/undocumented-pregnant-girl-trump-abortion-texas-243844 ("In some cases, a senior HHS official has personally visited or called pregnant teens to try to talk them out of ending their pregnancies."); Ed Pilkington, *Trump Officials Considered Contentious Methods to "Reverse" Undocumented Teen Abortions*, THE GUARDIAN, (Jan. 31, 2018, 3:42 PM), https://www.theguardian.com/us-news/2018/jan/31/scott-lloyd-considered-controversial-method-reverse-abortion/ (noting that a young woman in a federally funded shelter, who took medication abortion was forcibly sent to the emergency room before completing her abortion). According to a Government Accountability Office report, the number of ICE detentions of pregnant women increased from 1,160 in 2017 to 2,098 in 2018, including hundreds of people that were held for weeks or longer. U.S. Gov't Accountability Office, GAO-20-36, Immigration Enforcement: Arrests, Detentions, and Removals, and Issues Related to Selected Populations 38, 123 (2019), https://www.gao.gov/assets/710/703032.pdf.

[246] Becky Sullivan, *Here's where abortions are now banned or strictly limited, and where they may be soon*, NPR NEWS, (Jun. 24, 2022), https://www.npr.org/sections/health-shots/2022/06/24/1107126432/abortion-bans-supreme-court-roe-v-wade.

[247] *Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INSTITUTE (July 12, 2022), https://states.guttmacher.org/policies/. *Supreme Coutr and Roe v. Wade*, N.Y. TIMES, https://www.nytimes.com/news-event/roe-v-wade-supreme-court-abortion?name=styln-abortion-us&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=LegacyCollection&variant=show (last visited July 15, 2022).

[248] *Id*.

[249] *Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INSTITUTE (July 12, 2022), https://states.guttmacher.org/policies/. *Supreme Coutr and Roe v. Wade*, N.Y. TIMES, https://www.nytimes.com/news-event/roe-v-wade-supreme-court-abortion?name=styln-abortion-us&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=LegacyCollection&variant=show (last visited July 15, 2022). *See generally* Guttmacher Institute, *Waiting Periods for Abortion*, GUTTMACHER INSTITUTE, (Jan. 2020), https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion.

[250] Planned Parenthood, *Roe v. Wade Overturned: Supreme Court gives States the Right to Outlaw Abortion*, PLANNED PARENTHOOD, (Page Last Viewed Jun. 28, 2022), https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade.

[251] *See* Abortion Care Network, *Communities Need Clinics,* ABORTION CARE NETWORK 1, 4-8 (2019), https://www.abortioncarenetwork.org/communitiesneedclinics; Alice Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20 J. MED. INTERNET RES. e186 (2018), https://www.jmir.org/2018/5/e186/.

[252] National Birth Equity Collaborative (NBEC) & Center for Reproductive Rights (CRR), *Response to Inputs in preparation of the report of the United Nations High Commissioner for Human Rights pursuant to Human Rights Council resolution 43/1 on the "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers,"*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Dec. 4, 2020), https://reproductiverights.org/wp-content/uploads/2020/12/NBEC-and-CRR-submission-to-OHCHR-re-police-violence-report_2020_FINAL-1.pdf.

[253] Jessica Winter, *The Link Between the Capitol Riot and Anti-Abortion Extremism*, THE NEW YORKER, https://www.newyorker.com/news/daily-comment/the-link-between-the-capitol-riot-and-anti-abortion-extremism.
[254] *Id*.
[255] *See* National Health Law Program (NHeLP), *Abortion is Health Care*, NATIONAL HEALTH LAW PROGRAM, (Page Last Viewed Jun. 28, 2022), https://healthlaw.org/abortion-is-health-care/.
[256] *See* CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST-CENTURY AMERICA 23 (2017) (describing abortion regulation as the civil law equivalent of what legal sociologist Malcolm Feely identified in the criminal context as "process as punishment," i.e. the "real costs" incurred before the ruling — lost wages from missed work, attorney's fees, and wasted time, etc.).
[257] Jessica Arons, With Roe Overturned, What Comes Next for Abortion Rights?, ACLU, (Jun. 24, 2022), https://www.aclu.org/news/reproductive-freedom/what-comes-next-abortion-rights-supreme-court.
[258] Institute for Women's Policy Research (IWPR), *As States Eye Texas-Style Abortion Bans, Economic Costs to Bottom Line and Women are High*, INSTITUTE FOR WOMEN'S POLICY RESEARCH (IWPR), https://iwpr.org/iwpr-issues/reproductive-health/costs-of-restrictions-state-fact-sheets/ (last visited June 28, 2022); Brief for Economists, as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.*, No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022), https://reproductiverights.org/wp-content/uploads/2021/09/Economists-Amicus-Brief.pdf.
[259] Politico Magazine, *20 Ways the Supreme Court Just Changed America*, POLITICO, (Jun. 25, 2022), https://www.politico.com/news/magazine/2022/06/25/post-roe-america-roundup-00042377.
[260] U.N., *USA: UN experts denounce Supreme Court decision to strike down Roe v. Wade, urge action to mitigate consequences*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Jun. 24, 2022), https://www.ohchr.org/en/press-releases/2022/06/usa-un-experts-denounce-supreme-court-decision-strike-down-roe-v-wade-urge.
[261] *See* Center for Reproductive Rights (CRR), *Abortion and Gender Equality: Spotlight on Dobbs v. Jackson Women's Health*, CRR, (Nov. 9, 2021), https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-gender-equality/.
[262] Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STANFORD L. REV. 1241 (1991), https://www.jstor.org/stable/1229039?origin=crossref.
[263] National LGBTQ Task Force, *Queering Reproductive Health, Rights & Justice*, NATIONAL LGBTQ TASK FORCE, https://www.thetaskforce.org/reproductive-justice/ (last visited June 28, 2022).
[264] Elizabeth G. Raymond, David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012).

[265] Mary E. Coussons-Read, *Effects of prenatal stress on pregnancy and human development: mechanisms and pathways*, 62 OBSTET. MED. 52 (June 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5052760/.
[266] *See generally* PregnancyBirth&Baby, *Feelings, relationships and pregnancy*, PREGNANCYBIRTH&BABY (September 2020), https://www.pregnancybirthbaby.org.au/feelings-relationships-and-pregnancy.
[267] Center for Disease Control and Prevention (CDC), *Pregnant and Recently Pregnant People: At Increased Risk for Severe Illness from COVID-19*, CDC (Mar. 3, 2022), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnant-people.html.
[268] Katherine Ellison, Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications Are Growing in U.S.*, NPR SPECIAL SERIES: LOST MOTHERS: MATERNAL MORTALITY IN THE U.S. (December 22, 2017), https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s.
[269] Carolyn W. Swenson, Julia A. DePorre, Jessica K. Haefner, Mitchell B. Berger & Dee E. Fenner, *Postpartum Depression Screening and Pelvic Floor Symptoms Among Women Referred to a Specialty Postpartum Perineal Clinic*, 218 AM. J. OBSTET. GYNECOL. 335.E1 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834372/ ; Pamela Berens, *Overview of the postpartum period: Disorders and complications*, UPTODATE (May 17. 2022), https://www.uptodate.com/contents/overview-of-the-postpartum-period-disorders-and-complications.

[270] Irin Carmon, *I, Too, Have a Human Form: In Justice Alito's Draft Opinion, The Pregnant Body Is Erased*, INTELLIGENCER: LIFE AFTER ROE (May 19, 2022), https://nymag.com/intelligencer/2022/05/roe-v-wade-draft-opinion-pregnant-body-erased.html.
[271] World Health Organization (WHO) & Human Reproduction Programme (HRP), *Abortion Care Guideline*, WHO & HRP: RESEARCH FOR IMPACT, https://srhr.org/abortioncare/ (last visited July 15, 2022).
[272] Dovile Vilda, Maeve E. Wallace, Clare Daniel, Melissa Goldin Evans, Charles Stoecker & Katherine P. Theall, *State Abortion Policies and Maternal Death in the United States , 2015-2018*, 111 AM. J. OF PUB. HEALTH 1696, (September 2021), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306396.
[273] Summer Sherbune Hawkins, Marco Ghianai, Sam Harper, Christopher F. Baum & Jay S, Kaufman, *Impact of State-Level Changes on Maternal Mortality: A Population-Based, Quasi- Experimental Study*, 58 AM. J. OF PREVENTIVE MEDICINE 165 (2020), https://www.sciencedirect.com/science/article/abs/pii/S0749379719304192.
[274] *Id*.
[275] Megan K. Donovan, *Self- Managed Medication Abortion: Expanding the Available Options for U.S. Abortion Care*, GUTTMACHER INSTITUTE (October 17, 2018), https://www.guttmacher.org/gpr/2018/10/self-managed-medication-abortion-expanding-available-options-us-abortion-care.
[276] Jessica Arons, *With Roe Overturned, What Comes Next for Abortion Rights?*, ACLU (Jun. 24, 2022), https://www.aclu.org/news/reproductive-freedom/what-comes-next-abortion-rights-supreme-court.
[277] University of California San Francisco (UCSF), *The Turnaway Study*, UCSF: ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (ANSIRH), https://www.ansirh.org/research/ongoing/turnaway-study (last visited July 7, 2022).
[278] University of California San Francisco (UCSF), *The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study*, UCSF ANSIRH (Apr. 16, 2020), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf.
[279] See Gretchen Borchelt, *The Impact Poverty Has on Women's Health*, AMERICAN BAR ASSOCIATION HUMANS RIGHTS MAGAZINE VOL 43, NO. 3: THE STATE OF HEALTHCARE IN THE UNITED STATES (August 1, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/poverty-on-womens-health/.
[280] Dawn Stacey, *Why Do People Have Abortions?*, VERYWELLHEALTH (Dec. 19, 2021), https://www.verywellhealth.com/reasons-for-abortion-906589.
[281] U.N., United States: *UN Experts Denounce Further Attacks* against Right to safe Abortion and Supreme Court Complicity, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER (Sept. 14, 2021), https://www.ohchr.org/en/statements/2021/09/united-states-un-experts-denounce-further-attacks-against-right-safe-abortion.
[282] *See also* Jamila Taylor, Cristina Novoa, Katie Hamm & Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint*, CTR. FOR AM. PROGRESS (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/.
[283] Center for Reproductive Rights (CRR) & Ibis Reproductive Health, *Evaluating Abortion Restrictions and Supportive Police: Across the United States*, EVALUATING PRIORITIES, https://evaluatingpriorities.org/ (last visited July 6, 2022).
[284] Center for Reproductive Rights (CRR), *Roe and Intersectional Liberty Doctrine*, CRR (2018), https://reproductiverights.org/wp-content/uploads/2020/12/Liberty-Roe-Timeline-spread-for-print.pdf; Brief for Constitutional Law Scholars Lee C. Bollinger, Erwin Chemerinsky, Sherry F. Colb, Michael C. Dorf, Daniel Farber, Joanna L. Grossman, Leah Litman, Martha Minow, Jane S. Schacter, Suzanna Sherry, Geoffrey R. Stone, David A. Strauss, And Laurence H. Tribe as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.,* No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022), https://reproductiverights.org/wp-content/uploads/2021/09/Constitutional-Law-Scholars-Amicus-Brief.pdf.
[285] *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228, (2022).

[286] Julia Mazziotta, *Abortions Are Still Legal in the U.S. – But Here's What Could Happen If Roe is Overturned*, PEOPLE.COM (Mar. 3. 2022), https://people.com/health/abortions-are-still-legal-in-the-u-s-but-heres-what-would-happen-if-roe-is-overturned/.
[287] Lennert Griese, Eva-Maria Berens, Peter Nowak, Jurgen M. Pelikan, Doris Schaeffer, *Challenges in Navigating the Health Care System: Development of an Instrument Measuring Navigation Health Literacy*, 17 INT. J. ENVIRON. RES. PUBLIC HEALTH 1 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7460304/.
[288] Loretta J. Ross, SisterSong, *The Color of Choice: White Supremacy and Reproductive Justice*, UC BERKELEY LAW, https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/loadfile.php?entity_key=2K2QA27B (last visited June 22, 2022).
[289] Christine Vestal, *More States Shield Against Rogue Abortion Prosecutions*, PEW RSCH. CTR., (May 4, 2022), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/05/04/more-states-shield-against-rogue-abortion-prosecutions; Madiba Dennie, Jackie Fielding, *Miscarriage of Justice: The Danger of Laws Criminalizing Pregnancy Outcomes*, BRENNAN CTR. FOR JUST. RESEARCH & REPORTS, (Nov. 9, 2021), https://www.brennancenter.org/our-work/analysis-opinion/miscarriage-justice-danger-laws-criminalizing-pregnancy-outcomes.
[290] Crystal M. Hayes, Carolyn Sufrin, Jamila B. Perritt, *Reproductive Justice Disrupted: Mass Incarceration as a Driver of Reproductive Oppression*, 110 AM. J. PUB. HEALTH S21 (Jan. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6987912/.
[291] Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUSTICE 1 (Dec. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/.
[292] Ava Cilia, *The Family Regulation System: Why Those Committed to Racial Justice Must Interrogate It*, HARVARD CIV. RTS. – CIV. LIBERTIES L. R. (Feb 17, 2021), https://harvardcrcl.org/the-family-regulation-system-why-those-committed-to-racial-justice-must-interrogate-it/.
[293] Renee Mehra, Amy Alspaugh, Linda S. Franck, Monica R. McLemore, Trace S. Kershaw, Jeanette R. Ickovics, Danya E. Keene, Alyasah A. Sewell, *"Police shootings, now that seems to be the main issue" – Black pregnant women's anticipation of police brutality towards their children*, 22 BMC PUB. HEALTH 1 (2022), https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-12557-7.
[294] Samantha Argita, Olivia Pham, Kendal Ogera, Usha Ranji, *Racial Disparities in Maternal and Infant Health: An Overview*, KAISER FAMILY FOUNDATION (KFF) (Nov. 10, 2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/.
[295] Victoria Knight, Rachana Pradhan, Julie Rovner, *Five Things to Know Now That the Supreme Court Has Overturned Roe v. Wade*, KAISER HEALTH NEWS (KHN) (Jun. 24, 2022), https://khn.org/news/article/five-things-to-know-now-that-the-supreme-court-has-overturned-roe-v-wade/; Jamila Taylor, Cristina Novoa, Katie Hamm, Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint*, CTR. FOR AM. PROGRESS (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/.
[296] CESCR Committee*, Gen. Comment No. 22*, *supra* note 170, paras. 10, 28; Human Rights Committee, *Gen. Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights, on the right to life,* ¶ 8, U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018). *See also*, Human Rights Committee, *Concluding Observations: Nigeria,* ¶ 22, U.N. Doc. CCPR/C/NGA/CO/2 (2019); Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Paraguay*, ¶¶ 30, 31, U.N. Doc. CEDAW/C/ PRY/CO/6 (2011); Committee on the Eliminationa of Discrimination Against Women, *Concluding Observations: Sierra Leone,* ¶ 32(d), U.N. Doc. CEDAW/C/SLE/CO/6 (2014)*;* Committee on Economic, Social and Cultural Rights, *Concluding Observations: Argentina,* ¶¶. 55, 56, U.N. Doc. E/C.12/ARG/CO/4 (2018).
[297] *Mellet v. Ireland*, Human Rights Committee, Commc'n No. 2324/2013, ¶¶ 7.6, 7.7, 7.8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016), https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhstcNDCvDan1pXU7dsZDBaDWq2ShUS3gWuQt0jIYwCgT%2f5gI8Mq%2bntSwqPXzhc3wErblBJCSplHroDZxs6KmGL8We%2bkIq6J%2bxGt%2f5XJG7LmzVYiHocor0PGAURHw8Desi8Pddwl4BfwLheQoCB4FlRqU%3d; *Whelan v. Ireland*, Human Rights Committee, Commc'n No. 2425/2014*,* ¶¶ 7.7-7.9, 7.12, U.N. Doc. CCPR/C/119/D/2425/2014 (2017),

https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/IRL/CCPR_C_119_D_2425_2014_25970_E.pdf; *K.L. v. Peru,* Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/ C/85/D/1153/2003 (2005), https://reproductiverights.org/wp-content/uploads/2020/12/KL-HRC-final-decision.pdf; *L.C. v. Peru*, Committee on the Elimination of Discrimination Against Women, Commc'n No. 22/2009, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011), https://reproductiverights.org/wp-content/uploads/2020/12/CEDAW-C-50-D-22-2009-English-clean-copy.pdf; Committee on Economic, Social and Cultural Rights, *Gen. Comment No. 22 (2016) on the Right to Sexual snd Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 10, U.N. Doc. E/C.12/GC/22 (2016), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg; *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011), https://reproductiverights.org/wp-content/uploads/2020/12/Alyne-v.-Brazil-Decision.pdf; Committee Against Torture, *Consideration of Reports Submitted by State Parties Under Article 19 of the Convention: Concluding Observations of the Committee Against Torture El Salvador*, ¶ 23, U.N. Doc. CAT/C/SLV/CO/2 (2009), https://digitallibrary.un.org/record/675453?ln=en; Committee Against Torture, *Consideration of Reports Submitted by State Parties Under Article 19 of the Convention: Concluding Observations of the Committee Against Torture Nicaragua,* ¶ 16, U.N. Doc. CAT/C/NIC/CO/1 (2009), https://digitallibrary.un.org/record/657569.

[298] U.N. Human Rights Committee*, Gen. Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, ¶ 8, U.N. Doc. CCPR/C/G36 (2018),

[299] *Id*.

[300] *Id*.

[301] U.N. Human Rights Committee*, Gen. Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, ¶ 8, U.N. Doc. CCPR/C/G36 (2018).

[302] *Id*.

[303] *Id*.

[304] Committee on the Elimination of Discrimination Against Women, *Gen. Recommendation No. 35 on Gender-Based Violence Against Women, Updating Gen. Recommendation No. 19,* ¶ 18, U.N. Doc. CEDAW/C/GC/35 (2017); Committee on the Elimination of Discrimination Against Women, *CEDAW Gen. Recommendation No. 24: Article 12 of the Convention (Women and Health),* ¶¶ 11, 14, U.N. Doc. A/54/38/Rev.1, chap. I (1999).

[305] U.N. Committee on Economic, Social, and Cultural Rights, *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶¶ 11-21, U.N. Doc. E/C.12/GC/22 (2016), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg. U.N. Human Rights Committee*, Gen. Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, ¶ 8, U.N. Doc. CCPR/C/G36 (2018), https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf.

[306] U.N. Human Rights Committee*, Gen. Comment No. 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, ¶ 8, U.N. Doc. CCPR/C/G36 (2018), https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/1_Global/CCPR_C_GC_36_8785_E.pdf. *See also* U.N. Human Rights Committee, *CCPR Gen. Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, ¶¶ 10-11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), https://www.refworld.org/docid/45139c9b4.html; Committee on Economic, Social and Cultural Rights, Gen. Comment No. 22 (2016) On the Right to Sexual and Reproductive Health (Article 12 of the International Covenant On Economic, Social and Cultural Rights), ¶¶ 28, 34, 40, 41, 45, 49(a), 49(e), 57, U.N. Doc. E/C.12/GC/22 (2016), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg; U.N. Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, ¶ 14, U.N. Doc. A/54/38/Rev.1, chap. I (1999), https://www.refworld.org/docid/453882a73.html ; U.N. Committee on the Elimination of Discrimination Against Women (CEDAW), General Recommendation No. 35 on Gender-Based

Violence Against Women, Updating General Recommendation No. 19, ¶ 29(c)(i), U.N. Doc. CEDAW/C/GC.35 (2017), https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_35_8267_E.pdf; UN Committee on the Elimination of Racial Discrimination (CERD), *General Recommendation No. 34 Adopted by the Committee: Racial Discrimination Against People of African Descent*, ¶ 39(c), U.N. Doc. CERD/C/GC/34 (2011), https://www.refworld.org/docid/4ef19d592.html; U.N. Committee on the Rights of the Child (CRC), *General Comment No. 20 (2016) on the Implementation Of The Rights Of The Child During Adolescence*, ¶ 60, U.N. Doc. CRC/C/GC/20 (2016), https://www.refworld.org/docid/589dad3d4.html; U.N. Committee on the Rights of the Child (CRC), *General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24*), ¶¶ 31, 70, U.N. Doc. CRC/C/GC/15 (2013), https://www.refworld.org/docid/51ef9e134.html; U.N. Human Rights Committee, *Concluding Observations on the Second Periodic Report of Angola*, ¶¶ 21-22, U.N. Doc. CCPR/C/AGO/CO/2 (2019), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/134/36/PDF/G1913436.pdf?OpenElement; Committee on Economic, Social and Cultural Rights, *Concluding Observations on the Fourth Periodic Report of Cameroon*, ¶ 59, U.N. Doc. E/C.12/CMR/CO/4 (2019), https://digitallibrary.un.org/record/3864983?ln=en; Committee on the Elimination of Discrimination Against Women, *Concluding Observations on the Ninth Periodic Report of Colombia*, ¶¶37-38, U.N. U.N. Doc. CEDAW/C/COL/CO/9 (2019), https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/071/96/PDF/N1907196.pdf?OpenElement; Committee on the Rights of the Child, *Concluding Observations on the Combined Fourth to Sixth Reports of Bahrain*, ¶ 38, U.N. Doc. CRC/C/BHR/CO/4-6 (2019), https://tbinternet.ohchr.org/Treaties/CRC/Shared%20Documents/BHR/CRC_C_BHR_CO_4-6_33813_E.pdf.

[307] U.N. Working Group on Discrimination Against Women and Girls, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Special Rapporteur on Violence Against Women, Its Causes and Consequences, *Joint Web Statement by UN Human Rights Experts on Supreme Court Decision to Strike Down Roe v. Wade*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER (June 24, 2022), https://www.ohchr.org/en/statements/2022/06/joint-web-statement-un-human-rights-experts-supreme-court-decision-strike-down.

[308] U.N. Committee on Economic, Social, and Cultural Rights, *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 49, U.N. Doc. E/C.12/GC/22 (2016), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg.

[309] In Section 2.2.1, the WHO's Abortion Care Guideline provides the first-ever definition of "decriminalization" in the context of abortion by a United Nations agency or human rights mechanism: "Decriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors." It notes that "decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care." WORLD HEALTH ORGANIZATION, ABORTION CARE GUIDELINE, 24-45 (World Health Organization, 2022), https://www.who.int/publications/i/item/9789240039483. *See also* CENTER FOR REPRODUCTIVE RIGHTS (CRR), WHO'S NEW ABORTION GUIDELINE: HIGHLIGHTS OF ITS LAW AND POLICY RECOMMENDATIONS, (2022), https://reproductiverights.org/wp-content/uploads/2022/03/CRR-Fact-sheet-on-WHO-Guidelines.pdf.

[310] *Id*.

[311] *Id.* at Section 2.2.2 (pp. 26–27).

[312] *Id.* at Section 2.2.3 (pp. 28–29).

[313] *Id.* at Section 3.3.1 (pp. 41–42).

[314] *Id.* at Section 3.3.2 (pp. 42–44).

[315] CENTER FOR REPRODUCTIVE RIGHTS (CRR), WHO'S NEW ABORTION GUIDELINE: HIGHLIGHTS OF ITS LAW AND POLICY RECOMMENDATIONS, (2022), https://reproductiverights.org/wp-content/uploads/2022/03/CRR-Fact-sheet-on-WHO-Guidelines.pdf.

[316] See Id. at p. 42, 43.

[317] Committee on the Elimination of Racial Discrimination, *Combined Tenth to Twelfth Periodic Reports Submitted by the United States of America Under Article 9 of the Convention, due in 2017*, U.N. Doc. CERD/C/USA/10-12 (2021), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f10-12&Lang=en.

[318] U.N. Committee on the Elimination of Racial Discrimination, *International Convention on the Elimination of All Forms of Racial Discrimination: Concluding observations on the combined seventh to ninth periodic reports of the United States of America*, U.N. Doc. CERD/C/USA/CO/7-9 (2014), https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhspzOl9YwTXeABruAM8pBAK1Q%2FDZ6XAqlyobgts1zwlHPkQhsSqMrVxuS6brQbHYpDYGXBUCX1bgRtTg3HaweAr5PBs9soaesD5KdByekI9OS.

[319] Jennifer Haberkorn, *Trump's HHS works with conservative group on Planned Parenthood policy*, POLITICO (Feb. 12, 2018), https://www.politico.com/story/2018/02/12/trump-hhs-planned-parenthood-policy-338084; Adam Sonfield, *By Funding Texas' Harmful Antiabortion Crusade, the Trump Administration Is Setting a Dangerous Precedent*, GUTTMACHER INSTITUTE (Mar. 10, 2020), https://www.guttmacher.org/article/2020/03/funding-texas-harmful-antiabortion-crusade-trump-administration-setting-dangerous; Brigitte Amiri, Meagan Burrows, *Victory: After Three Years of Battling in Court, the Trump Administration Abandons its Policy of Banning Abortion for Unaccompanied Immigrant Minors,* ACLU (Sept. 30, 2020), https://www.aclu.org/news/immigrants-rights/victory-after-three-years-of-battling-in-court-the-trump-administration-abandons-its-policy-of-banning-abortion-for-unaccompanied-immigrant-minors.

[320] *See* International Women's Health Coalition (IWHC), *Crisis in Care: Year Two Impact of Trump's Global Gag Rule*, IWHC (2019), https://31u5ac2nrwj6247cya153vw9-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/IWHC_GGR_Report_2019-WEB_single_pg-2.pdf.

[321] *See* HHS Press Office, *HHS Issues Final Regulation Aimed at Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, HHS (Oct. 4, 2021), https://www.hhs.gov/about/news/2021/10/04/hhs-issues-final-regulation-aimed-at-ensuring-access-to-equitable-affordable-client-centered-quality-family-planning-services.html.

[322] *See* U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary of Health (OASH), Office of Population Affairs, *Title X Statutes, Regulations, and Legislative Mandates*, OASH: OFFICE OF POPULATION AFFAIRS, https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates (last visited July 7, 2022). *See also* HHS Press Office, *HHS Issues Final Regulation Aimed at Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, HHS (Oct. 4, 2021), https://www.hhs.gov/about/news/2021/10/04/hhs-issues-final-regulation-aimed-at-ensuring-access-to-equitable-affordable-client-centered-quality-family-planning-services.html.

[323] *See* The White House, *FACT SHEET: The Biden – Harris Administration Advances Equity and Opportunity for Black Americans and Communities Across the Country*, THE WHITE HOUSE, (Jun. 19, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/06/19/fact-sheet-the-biden-harris-administration-advances-equity-and-opportunity-for-black-americans-and-communities-across-the-country/.

[324] *See also* Kellie Moss, Jennifer Kates, *The Helms Amendment and Abortion Laws in Countries Receiving U.S. Global Health Assistance*, KAISER FAMILY FOUNDATION (KFF), (Jan. 18, 2022), https://www.kff.org/global-health-policy/issue-brief/the-helms-amendment-and-abortion-laws-in-countries-receiving-u-s-global-health-assistance/.

[325] *See* Center for Reproductive Rights (CRR), *The First 100 Days of the Biden-Harris Administration: Reproductive Rights, Health and Justice*, CRR, (Apr. 29, 2021), https://reproductiverights.org/the-first-100-days-of-the-biden-harris-administration-reproductive-rights-health-and-justice/.

[326] *See* The White House, *National Strategy on Gender Equity and Equality*, THE WHITE HOUSE, (2021), https://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf.

[327] *See* Center for Reproductive Rights (CRR), *White House's National Strategy on Gender Equity and Equality to Help Guide Domestic and Foreign Policy*, CRR, https://reproductiverights.org/white-houses-national-strategy-gender-equity-equality/ (last visited July 11, 2022).

[328] *See* Pam Belluck, *F.D.A. Will Permanently Allow Abortion Pills by Mail*, THE NEW YORK TIMES, (Dec. 16, 2021), https://www.nytimes.com/2021/12/16/health/abortion-pills-fda.html.

[329] *See* Rita Rubin, *Expanding Access to Medication Abortions*, MEDICAL NEWS & PERSPECTIVES, JAMA (Dec. 22, 2021), https://jamanetwork.com/journals/jama/article-abstract/2787610. *See also* Rachel K. Jones, Elizabeth Nash, Lauren Cross, Jesse Philbin, Marielle Kirstein, *Medication Abortion Now Accounts for More than Half of All US*

Abortions, GUTTMACHER INSTITUTE (Feb. 24, 2022), https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions.

[330] *See generally* Sarah Mccammon, *Biden's Budget Proposal Reverses A Decades-Long Ban on Abortion Funding*, NPR POLITICS (May 31, 2021), https://www.npr.org/2021/05/31/1001881788/bidens-budget-proposal-reverses-a-decades-long-ban-on-abortion-funding; Reuters, *Biden budget drops Hyde Amendment to allow public funding of abortion*, REUTERS (May 28, 2021), https://www.reuters.com/world/us/biden-budget-drops-hyde-amendment-allow-public-funding-abortion-2021-05-28/.

[331] The Women's Health Protection Act (H.R. 3755, 117th Cong. (2021); H.R. 8296 117th Cong. (2022)) is federal legislation that would protect the right to access abortion in every state. WHPA protects the right to access abortion free from medically unnecessary restrictions and bans on abortion—including mandatory waiting periods, biased counseling, two-trip requirements, and mandatory ultrasounds. It would create a statutory right for health care providers to provide abortion care, and a corresponding right for their patients to receive that care. The bill has passed the House of Representatives, but has not yet passed the Senate. On May 11, the Senate took its second vote, and fell short of the 60 votes necessary to overcome the filibuster. The Biden Administration issued a Statement of Administration Policy supporting passage of the Women's Health Protection Act. The Equal Access to Abortion Coverage in Health Insurance (EACH) Act is proposed legislation that would provide and ensure insurance coverage for abortion access.

[332] Executive Office of the President, *Statement of Administration Policy – H.R. 3755 – Women's Health Protection Act of 2021*, (Sept. 20, 2021), https://www.whitehouse.gov/wp-content/uploads/2021/09/SAP-HR-3755.pdf.

[333] Center for Reproductive Rights (CRR), *U.S. Senate Fails to Pass Abortion Rights Legislation,* CRR, (May 11. 2022), https://reproductiverights.org/us-senate-fails-to-pass-abortion-rights-bill/.

[334] The White House, *Executive Order on Protecting Access to Reproductive Healthcare Services*, THE WHITE HOUSE (Jul. 8, 2022), https://www.whitehouse.gov/briefing-room/presidential-actions/2022/07/08/executive-order-on-protecting-access-to-reproductive-healthcare-services/. *See also* The White House, *Remarks by President Biden on Protecting Access to Reproductive Health Care Services*, THE WHITE HOUSE (Jul. 8, 2022), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/07/08/remarks-by-president-biden-on-protecting-access-to-reproductive-health-care-services/.

[335] U.N., *International Covenant on Civil and Political Rights (CCPR)*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Dec. 16, 1966), https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights; *See* U.N. Committee on the Elimination of Racial Discrimination, *Concluding Observations On The Combined Seventh To Ninth Periodic Reports Of the United States of America,* U.N. Doc. CERD/C/USA/CO/7-9 (2014), https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/CERD_C_USA_CO_7-9_18102_E.pdf.

[336] U.N. Human Rights Committee, *International Covenant on Civil and Political Rights: List of issues prior to submission of the fifth periodic report of the United States of America*, ¶ 12, U.N. Doc. CCPR/C/USA/QPR/5 (2019), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fUSA%2fQPR%2f5&Lang=en.

[337] U.N. Human Rights Committee, *International Covenant on Civil and Political Rights: Concluding Observations on the Fourth Periodic Report of the United States of America*, ¶ 15, U.N. Doc. CCPR/C/USA/CO/4 (2014), https://www.refworld.org/docid/5374afcd4.html.

[338] *Id*.

[339] U.N. Human Rights Council, *Report of the Working Group on the Universal Periodic Review, United Sates*, U.N. Doc. A/HRC/46/15 (2020), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/348/52/PDF/G2034852.pdf?OpenElement.

[340] *Id*. at ¶ 26.305.

[341] *Id*. at ¶ 26.308.

[342] *Id*. at ¶. 26.310.

[343] *Id*. at ¶ 26.316.

[344] Michelle Bachelet, *UN High Commissioner for Human Rights Communication to the United States*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER (May 17, 2021), https://lib.ohchr.org/HRBodies/UPR/Documents/Session36/US/HCLetter-USA.pdf.
[345] *Id*.
[346] *See generally*, U.N. Committee on the Elimination of Racial Discrimination, *International Convention on the Elimination of All Forms of Racial Discrimination, Concluding observations on the combined seventh to ninth periodic reports of the United States of America*, ¶ 15, U.N. Doc. CERD/C/USA/CO/7-9 (2014), https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhspzOl9YwTXeABruAM8pBAK1Q%2FDZ6XAqlyobgts1zwlHPkQhsSqMrVxuS6brQbHYpDYGXBUCX1bgRtTg3HaweAr5PBs9soaesD5KdByekI9OS.
[347] U.N., *Bachelet on US ruling on Dobbs v Jackson Women's Health Organization*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Jun. 24, 2022), https://www.ohchr.org/en/statements/2022/06/bachelet-us-ruling-dobbs-v-jackson-womens-health-organization.
[348] U.N., *USA: UN experts denounce Supreme Court decision to strike down Roe v. Wade, urge action to mitigate consequences*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Jun. 24, 2022), https://www.ohchr.org/en/press-releases/2022/06/usa-un-experts-denounce-supreme-court-decision-strike-down-roe-v-wade-urge.
[349] U.N., United States: *UN Experts Denounce Further Attacks* against Right to safe Abortion and Supreme Court Complicity, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (Sept. 14, 2021), https://www.ohchr.org/en/statements/2021/09/united-states-un-experts-denounce-further-attacks-against-right-safe-abortion.
[350] *Id*.
[351] U.N. Working Group on Discrimination against Women and Girls, *United States: Authorities Manipulating COVID-19 Crisis to Restrict Access to Abortion, Say UN Experts*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER, (May 27, 2020), https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=25907&LangID=E.
[352] U.N. Human Rights Council, *Communication of Special Procedures to the U.S. on Immigration Detention of Pregnant Women*, Ref. OL USA 8/2018, (May 16, 2018), https://www.ohchr.org/Documents/Issues/Women/WG/Communications/OL-USA-8-2018.pdf.
[353] *Id*.
[354] U.N. Working Group on Arbitrary Detention, *Rep. of the Working Group on Arbitrary Detention on its visit to the United States of America*, ¶ 74, U.N. Doc. A/HRC/36/37/Add.2, (July 17, 2017), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/193/37/PDF/G1719337.pdf?OpenElement.
[355] U.N. Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, ¶ 57, U.N. Doc. A/HRC/38/33/Add.1, (May 4, 2018), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/125/30/PDF/G1812530.pdf?OpenElement.
[356] *Id*. at ¶ 59.
[357] *Id*.
[358] *Id*. at ¶ 56.
[359] U.N. 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, (2016).
[360] U.N. 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, UN Doc. A/HRC/32/44/Add.2, (2016).
[361] *Id*. at ¶ 95(e).
[362] *Id*. at ¶ 80-81.
[363] *Id*. at ¶ 87.
[364] *Id*. at ¶ 68.
[365] *Id*. at ¶¶ 90(g), (j), (k), (m).