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Members of the Committee on the Elimination of Racial Discrimination
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Suggested List of Themes to the Country Rapporteur and Task Force on the United States for the 106th Session of the Committee on the Elimination of Racial Discrimination, April 11-29, 2022

Impact of intersectional discrimination and systemic racism on sexual and reproductive health and rights in the United States

The undersigned reproductive rights and justice organizations submit this suggested List of Themes (submission) to the Committee on the Elimination of Racial Discrimination (CERD) in preparation for its review of the United States during its 106th session.

This submission respectfully encourages the CERD to include questions in the United States' review that address the *impact of intersectional discrimination and systemic racism on sexual and reproductive health and rights for racial and ethnic minorities and for immigrant communities in the United States*.

Specifically, we respectfully urge the CERD to include the following in the List of Themes for the United States' review:

What measures is the United States taking to address the impact of intersectional discrimination¹ and systemic racism on the sexual and reproductive health and rights of racial and ethnic minorities in the United States? Specifically:

- **What steps is the United States taking to ensure that all people, regardless of their race, ethnicity, or immigration status, have meaningful access to sexual and reproductive health care, including abortion, in the United States?**
- **What measures is the United States taking to reduce the high maternal mortality and morbidity rates among Black and Indigenous people and to address persistent racial and ethnic discrimination in maternal health care and maternal health outcomes?**
- **What measures is the United States taking to ensure all immigrant communities in the United States have access to adequate sexual and reproductive health care, including while in detention, and that they are free from immigration detention-related rights violations?**
- **What measures is the United States taking to mitigate the reproductive and maternal health harms to Black women and birthing people caused by climate change?**
- **What measures is the United States taking to prevent and remedy the harms of criminalization of pregnancy outcomes faced by Black, Indigenous, and other people of color and immigrants?**

¹ Here we reference Professor Kimberlé Williams Crenshaw's intersectionality framework wherein an individual's intersecting social categorizations, such as their race and gender, create combined or overlapping systems of discrimination or disadvantage.

Accordingly, this submission identifies and briefly discusses five reproductive health, rights, and justice issues for the CERD to consider as it prepares its List of Themes for the review of the United States:

1. Disproportionate Impact of Abortion Bans and Restrictions on Black, Indigenous, and other People of Color
2. Disparate Impact of U.S. Maternal Health Crisis on Black and Indigenous Women and Birthing People
3. Immigrant Communities' Lack of Access to Reproductive Health Care and Rights Violations Against Immigrant Communities in Detention
4. Disproportionate Impact of Climate Change on the Reproductive and Maternal Health of Black Women and Birthing People
5. Overrepresentation of Black, Indigenous, and other People of Color in Criminalization of Pregnancy and Pregnancy Outcomes

During its last Universal Periodic Review, the United States received several recommendations to improve equitable access to comprehensive sexual and reproductive health care and services (*see infra*, Section IV). The United States supported these recommendations in full. Additionally, the United States has received numerous recommendations from the CERD and other treaty monitoring bodies, as well as from United Nations Special Procedures mandate holders, expressing concern with the persistence of racial disparities and the impact of systemic discrimination on sexual and reproductive health and rights (*see infra*, Sections II and V).

The policies and practices discussed in this submission implicate a range of rights protected under the UN Convention on the Elimination of Racial Discrimination (UN CERD), including the rights to be free from racial discrimination (Article 2) and to enjoy the right to public health and medical care without distinction as to race, color, or national or ethnic origin (Article 5).

Signed,

Abortion Care Network
Black Mamas Matter Alliance
Center for Reproductive Rights
The City University of New York Law School, Human Rights and Gender Justice Clinic
If/When/How: Lawyering for Reproductive Justice
National Asian Pacific American Women's Forum
National Birth Equity Collaborative
SisterSong Women of Color Reproductive Justice Collective

I. The Impact of Intersectional Discrimination and Systemic Racism in the United States on the Sexual and Reproductive Health and Rights of Black, Indigenous, and other People of Color and on Immigrant Communities

Racism is a public health crisis in the United States, and Black, Indigenous, and other People of Color (BIPOC) and immigrant communities face intersectional discrimination that threatens their sexual and reproductive health and rights. For generations, communities of color and immigrant communities have been denied equal access to high quality medical care, education, employment, housing, food, transportation, infrastructure investments, and other resources that help prevent illness and promote health. Cumulative, systemic inequities compounded by voter disenfranchisement and other violations deprive these communities of access to social determinants of health, making them more vulnerable to human rights violations, especially during stressful events, such as pregnancy, public health crises, and the rapid onset of climate change. The COVID-19 pandemic has only exacerbated these inequities and injustices.

In October 2021, the Biden-Harris Administration adopted the first ever National Strategy on Gender Equity and Equality,¹ which takes an explicit intersectional approach and includes priorities related to access to health care, including sexual and reproductive health and rights, and the maternal health crisis. The strategy sets forth important commitments by the Administration that the CERD Committee can help focus, particularly as they relate to the impact of intersectional discrimination and systemic racism on sexual and reproductive health and rights in the United States.

The themes discussed in this submission provide examples of how systems and policies in the United States reinforce systemic racism and undermine the rights of BIPOC and immigrant communities to health, sexual and reproductive health, bodily and reproductive autonomy, and equality and non-discrimination, severely impacting their reproductive and family lives. To respect, protect, and fulfill the rights of all BIPOC and immigrant women in the United States, we strongly *encourage the CERD to include in its List of Themes an inquiry into how the United States addresses intersectional discrimination and systemic racism and their impact on the reproductive and family life of BIPOC and immigrant communities, including limited access to abortion, negative maternal health outcomes, limited access to reproductive health care and rights violations while in detention, harmful exposure to climate change, and their disproportionate criminalization during pregnancy.*

a. Disproportionate Impact of Abortion Bans and Restrictions on Black, Indigenous, and Other People of Color

Abortion bans and restrictions are escalating in the United States, disproportionately impacting Black, Indigenous, and other people of color (BIPOC) experiencing intersectional discrimination.² The proliferation of increasingly extreme laws and regulations banning or restricting abortion access is retrogressive and reflects a callous disregard for their real-life impact. Abortion bans and medically unnecessary restrictions deprive, delay, demean, stigmatize, and misinform people seeking abortion care while increasing health risks for patients. These bans and restrictions also extend a violent legacy of state control over the reproductive lives of BIPOC, in violation of their rights to autonomy, privacy, life, health, equality, and non-discrimination.³

State legislatures throughout the country enacted historic numbers of highly restrictive abortion laws and outright bans on abortion services in 2021.⁴ Due to systemic racism, the state legislatures creating these barriers to abortion care are disproportionately white, male, and do not reflect the diversity of the

people they represent.⁵ The state of Texas enacted Senate Bill 8 (“S.B. 8”), the latest in a constant stream of abortion restrictions enacted by its legislature and exemplary of the country’s profound retrogression on the right to access abortion care.⁶ S.B. 8 bans abortion as early as six weeks of pregnancy and effectively makes abortion care unavailable beginning at this early stage of pregnancy to anyone who cannot afford to travel out of state.⁷ It also includes an unprecedented provision that authorizes private individuals — including anti-abortion activists with no connection to the patient — to file lawsuits seeking “enforcement” of the ban and allows for civil penalties and bounty provisions against people who assist others in accessing abortion care.⁸ S.B. 8 took effect on September 1, 2021 and, except for 24 hours during which a federal District Court enjoined its enforcement,⁹ has remained in effect. The U.S. Supreme Court has continuously refused to block S.B. 8 and has allowed only a narrow portion of the case challenging the law to proceed.¹⁰

In the nearly five months S.B. 8 has been in effect, it has caused tremendous harm to pregnant people in Texas who seek an abortion¹¹ and has disproportionately harmed communities who experience intersectional discrimination and political, economic, and social marginalization.¹² The poverty rate for Black and Latina women in Texas is high — 21% of Black women and 23% of Latina women live in poverty.¹³ Black, Indigenous, and Latina women in Texas, who already face substantial barriers to accessing reproductive health care because of systemic racism,¹⁴ struggle to overcome the tremendous financial and logistical hurdles of seeking care out of state and may be forced to carry an unwanted pregnancy to term. Black women and birthing people will disproportionately suffer the gravest consequences of forced pregnancy under S.B. 8 in light of the maternal mortality crisis in Texas and the significantly higher rates of maternal mortality and morbidity Black women and birthing people experience compared to white women in the state.¹⁵ As of December 2021, five states have introduced S.B. 8 copycat bills with others primed to follow suit.¹⁶ The COVID-19 pandemic exacerbated abortion access retrogression when anti-abortion governors and officials attempted to capitalize on the crisis to reduce access to abortion care.¹⁷ The COVID-19 pandemic has also heightened and compounded systemic economic disparities and injustices in Texas and nationally, including through rising unemployment rates, attendant financial insecurity, school closures, and limited childcare options for working parents.

Concurrent with these regressive efforts, the Supreme Court is considering a case in which the state of Mississippi has asked it to overturn nearly 50 years of precedent protecting the constitutional right to choose to terminate a pregnancy before viability.¹⁸ If the Court agrees with Mississippi, BIPOC and people working to make ends meet will be particularly devastated given that they already face significant barriers to accessing health care due to systemic racism, implicit biases, and other forms of discrimination. To address this potentiality, the House of Representatives in Congress has introduced and passed the Women’s Health Protection Act to codify the right to abortion.¹⁹ The bill is awaiting action by the Senate. Following its introduction, the Biden-Harris Administration issued a Statement of Administration Policy supporting the legislation.²⁰

b. Disparate Impact of U.S. Maternal Health Crisis on Black and Indigenous Women and Birthing People

Maternal mortality is an indicator of a State’s commitment to health and equity, and on this measure, the United States has failed. The United States has the highest maternal mortality ratio among high-resource countries²¹ and the government’s own data indicates that the majority of these deaths are preventable.²² For decades, Black women in the United States of all socioeconomic backgrounds have been dying from pregnancy complications at more than three times the rate of white women.²³ And

American Indian/Alaska Native women in the United States, are two and a half times more likely than white women to die from preventable pregnancy complications.²⁴ While most Black women do survive childbirth, they are twice as likely as white women to experience severe pregnancy complications.²⁵

Many birthing people in the United States do not have a meaningful choice in where they give birth, how they birth, or who assists them with birth. The systematic marginalization of midwives and doulas—many of whom were women of color, Indigenous, and/or immigrants who served marginalized communities—by the medical establishment over the past century²⁶ has contributed to the imposition of legal restrictions that continue to constrain the ability of midwives and doulas to practice today.²⁷ In hospital settings, where most Black women in the United States give birth, racism and sexism facilitate mistreatment and abuse. Black women report being ignored, disrespected, coerced, threatened, and denied information and the opportunity to give or refuse consent to medical interventions.²⁸ Evidence shows that repeated exposure to racism, including interpersonal racism in medical settings, has a physiological “weathering” effect that harms Black women and birthing people’s health and contributes to adverse birth outcomes.²⁹ Indigenous women and birthing people are also more likely to report at least one form of mistreatment by healthcare providers compared to white women, including being yelled at or ignored by providers or being refused requests for help.³⁰

During the COVID-19 pandemic, pregnant and birthing women and people in the United States have faced new and escalating threats to their health and human rights. The same structural, institutional, and interpersonal racism that drives disparate maternal health outcomes is at the root of inequitable COVID-19 outcomes. In communities with the highest burden of maternal mortality and morbidity, similarly high rates of infections are observed. Early in the pandemic, Black people were three times more likely than white people to become infected, twice as likely to die from it, and were overrepresented among pregnant people with COVID-19.³¹ Disproportionately high rates of infection were also seen among Navajo Nation and other American Indian/Alaska Native communities.³² Disparities in COVID-19 infections, hospitalization, and death rates for Black and American Indian/Alaska Native communities persist today.³³ Likewise, the pandemic continues to pose heightened risks for Black and Indigenous pregnant people, including direct harm from the coronavirus,³⁴ the increased stress pregnant women and people are experiencing,³⁵ barriers to primary, preconception and prenatal care,³⁶ strained health care systems,³⁷ and the implementation of low-quality and discriminatory maternity care practices.³⁸

To address this maternal health crisis the Biden-Harris Administration has pushed for the inclusion of historic maternal health investments in the Black perinatal workforce, community-based organizations, postpartum Medicaid coverage, and other areas in the Build Back Better Act. This Act, alongside the Momnibus 2021, a package of bills that addresses the maternal health crisis, are pending in Congress. In December 2021, the Administration hosted the first-ever Maternal Health Day of Action urging public and private sectors to help improve maternal health outcomes. The Administration's support of this issue is critically important; however, there are vast gains that must be made to close the racial and ethnic disparity gap in the United States’ maternal mortality and morbidity rates.

c. Immigrant Communities’ Lack of Access to Reproductive Health Care and Rights Violations Against Immigrant Communities in Detention

Immigrant women of reproductive age are disproportionately uninsured and face particularly high barriers to affordable health care.³⁹ Restricted access to health insurance has greatly impacted the

ability of low-income immigrant women to access maternity care, family planning, and other reproductive health care services.⁴⁰

Federal policies have excluded immigrants from government health insurance programs since 1996.⁴¹ These policies exclude both undocumented immigrants as well as immigrants who have been deemed “lawfully present” in the United States for less than five years.⁴² In August 2019, the Trump Administration issued a federal regulation that intensified the longstanding pattern of exclusion by broadening the “public charge” definition that has been a part of federal immigration law for decades.⁴³ For nearly two years, until March 15, 2021 when the Biden-Harris Administration reversed the expanded public charge definition, if U.S. immigration officials deemed a person likely to become a “public charge,” that person could be refused admission to the United States or, if they were already in the country, could be denied their ability to adjust to Permanent Resident Status. The expanded definition forced immigrant families to choose between future permanent legal status and healthy food, safe housing, and health care, leading to devastating impacts on their health.⁴⁴ The onset of the COVID-19 pandemic worsened immigrant families’ already tenuous financial situations as Latina immigrants had the highest jobless rates of all racial and ethnic groups in the United States in April 2020, representing 22% of Americans who lost their employment.⁴⁵ Even with reversal of this regulation, misinformation about the public charge rule and fears about its application are likely to persist in immigrant communities, chilling their access to public benefits. Additionally, since its reversal, more than a dozen states unsuccessfully asked the U.S. Supreme Court to defend the expanded definition of “public charge.”⁴⁶ These harmful and disruptive factors have resulted in a two-tiered system of health care access that denies essential health care to immigrant women and their families.

The conditions immigrant women face while in detention likewise fail to meet their basic reproductive health needs. Immigrant minors have had their access to abortion blocked⁴⁷ and detained immigrant women have been denied essential prenatal care.⁴⁸ During the COVID-19 pandemic, Immigration Customs Enforcement (ICE) detention centers have further put immigrant women’s health at risk, including by hiding information from staff and detainee immigrants about who has tested positive for COVID-19, overcrowding detention centers, and transferring detained immigrants between facilities despite positive COVID-19 test results.⁴⁹

In September 2020, immigrant rights organizations filed a complaint with the Department of Health Services, Immigration and Customs Enforcement, and the Warden of the Irwin County Detention Center (Irwin) on behalf of detained immigrants at Irwin and a licensed nurse, Dawn Wooten, employed at Irwin.⁵⁰ The complaint documented accounts of medical neglect at Irwin and non-consensual hysterectomies being performed on immigrant women.⁵¹ While Irwin detention center has since been closed, concerns remain about conditions at other detention facilities.⁵² Harrowing experiences like these are only the latest examples of a long history of state-sponsored programs to forcibly sterilize Black, Indigenous, and other women of color and immigrant women in the United States.⁵³

d. Disproportionate Impact of Climate Change on the Reproductive and Maternal Health of Black Women and Birthing People

The environmental impacts of climate change in the United States impact all pregnant women and people but disproportionately impact Black women and birthing people who are already subject to structural and anti-Black racism. Low-income communities of color are more likely to live near polluting industries and to be exposed to significantly higher levels of pollution.⁵⁴ Pregnant people experience physiological changes that increase their vulnerability to environmental exposures such as wildfire

smoke, flooding, hurricanes, air pollution, and fracking.⁵⁵ These exposures lead to poor maternal health and birth outcomes.⁵⁶ Black women and birthing people are more likely to be exposed to high temperatures or air pollution, both exacerbated by climate change, and are more likely to have premature and underweight newborns.⁵⁷ The disproportionate harm that climate change wreaks on Black women and birthing people's health contributes to their overrepresentation in the U.S.' maternal mortality crisis (*see supra*, section I(b)).

Pregnancy can be a stressful experience, even in supportive conditions. Climate change, structural and environmental racism, and other discriminatory stressors can lead to poor maternal and fetal outcomes.⁵⁸ To address the negative association between environmental harms brought on by climate change and threats to the health of pregnant women and people, the Biden-Harris Administration has included climate change in its Build Back Better Act. To date, the plan, unfortunately, has not garnered necessary support to pass Congress.

e. Overrepresentation of Black, Indigenous, and other People of Color in Criminalization of Pregnancy and Pregnancy Outcomes

Government laws, policies, and practices that seek to control Black people's bodies and reproductive lives infringe on their human rights to decide whether and when to have children and to raise the children they do have in safe, supportive environments.⁵⁹ Pregnant people in states across the country have been subjected to criminal prosecution or other punitive legal systems because of their pregnancy or an outcome of their pregnancy.⁶⁰ This punishment disproportionately affects BIPOC and immigrant women, especially those living in poverty. Despite Constitutional legal protections for reproductive autonomy and decision-making, state and local law enforcement officers and agencies misuse laws to criminalize and arrest pregnant people for pregnancy loss,⁶¹ for having or seeking an abortion,⁶² and for any conduct believed to have posed a risk to a fetus.⁶³ Government child welfare agencies play a similar role, using the civil legal system to punish women for creating a perceived risk to a fetus by forcibly separating them from their newborn and any existing children. As medical and public health experts have cautioned,⁶⁴ the threat of criminal or civil punishment harms the health of pregnant people by eroding trust in the medical system and deterring them from care when they most need it. This only compounds the existing health risks faced by Black and Indigenous birthing people.

Because Black women are incarcerated at disproportionately high rates,⁶⁵ they are also disproportionately impacted by the sexual and reproductive health and rights abuses that proliferate in these settings.⁶⁶ Black incarcerated women experience denial of medical care and critical reproductive health services,⁶⁷ are sometimes shackled while pregnant and giving birth,⁶⁸ and have been subjected to coerced and non-consented sterilization both inside and outside the criminal justice system.⁶⁹ Destructive stereotypes and the over policing and surveillance of Black communities in the United States make Black women particularly vulnerable to pregnancy-related punishments in these systems.

II. Relevant CERD Concluding Observations to the United States

In its **2014 Concluding Observations regarding the United States**, the CERD stated its concern at the persistence of racial disparities in sexual and reproductive health, noting the high maternal mortality rates among Black women.⁷⁰ It stated its concern that many U.S. states with high 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."⁷¹ It recommended the United States 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.”⁷² Additionally, the CERD recommended the United States 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”⁷³ and “improve monitoring and accountability mechanisms for preventable maternal mortality, including by ensuring state-level maternal mortality review boards have sufficient resources and capacity.”⁷⁴

In its same **2014 Concluding Observations**, the CERD expressed concern that undocumented immigrants and their children were excluded from coverage under the Affordable Care Act and that they and immigrants lawfully residing in the United States for less than five years had limited coverage under Medicaid and the Children’s Health Insurance Program.⁷⁵ These exclusions and limitations in coverage, the CERD noted, resulted in “difficulties for immigrants in accessing adequate health care.”⁷⁶ The CERD recommended the United States 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.”⁷⁷

In its **2008 Concluding Observations regarding the United States**, the CERD expressed concern about persistent disparities in health affecting racial, ethnic and national minorities who “face numerous obstacles to access adequate health care and services”⁷⁸ and recommended the United States “eliminat[e] obstacles” that prevent or limit their access to adequate 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.”⁷⁹ The CERD also expressed concern regarding the U.S.’s racial disparities in sexual and reproductive health, taking notice of the high maternal and infant mortality rates, especially among Black women.⁸⁰ The CERD recommended the United States 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.”⁸¹

III. Relevant CERD General Recommendations

General Recommendation 25: Recognizing the importance of integrating a gender analysis when analyzing racial discrimination that considers the different life experiences of women and men.⁸²

General Recommendation 30: Recognizing that “differential treatment based on citizenship or immigration status will constitute discrimination if the criteria for such differentiation, judged in the light of the objectives and purposes of the Convention, are not applied pursuant to a legitimate aim, and are not proportional to the achievement of this aim”⁸³ and recommending States “[r]emove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the area[] of... health.”⁸⁴

IV. Universal Periodic Review Recommendations to the United States

At the conclusion of its 2020 Universal Periodic Review, the United States received numerous recommendations to ensure access to sexual and reproductive health and rights, including maternal health.⁸⁵ 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;⁸⁶
- guarantee essential health services for all, including sexual and reproductive health services;⁸⁷
- ensure access by all women to sexual and reproductive health information and services;⁸⁸ and
- advance universal maternal health care.⁸⁹

In a May 2021 Communication, the UN High Commissioner for Human Rights followed up with the United States on several areas raised during its UPR. In her communication, the High Commissioner reiterated recommendations to ensure access to affordable health care, reduce the maternal mortality rate among Black women, and ensure that all women have effective access to reproductive health services and information, including safe and legal abortion.⁹⁰

V. Relevant Recommendations to the United States by Other Human Rights Bodies and Mechanisms

Following the enactment and implementation of Texas' S.B. 8 in September 2021, a **group of UN Special Procedures** led by the Working Group on discrimination against women and girls condemned the law as a violation of international human rights and called on the United States to halt its implementation, prevent retrogression in access to abortion, and enact positive measures to ensure access to abortion.⁹¹ The statement noted the law's particularly 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.⁹²

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 cause particular harm to marginalized communities, including people with low-income, people of color, and immigrants.⁹³

In 2018, a **group of UN Special Procedures** led by the Working Group on arbitrary detention expressed their "grave concerns at the risks of the life, health, liberty, safety, wellbeing and other human rights of pregnant immigrant women," especially those living in detention. The Communication noted that many pregnant detainees reported receiving inadequate health care jeopardizing their rights to health, including their sexual and reproductive health.⁹⁴

In 2017, the **UN Working Group on Arbitrary Detention** expressed concern about civil detentions of pregnant women in the United States 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."⁹⁵

At the conclusion of his 2017 visit to the United States, the **UN Special Rapporteur on Extreme Poverty** expressed concern that the United States 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.⁹⁶ The Rapporteur also noted that immigrant women experience higher poverty rates and have less access to social protection benefits,⁹⁷ noting in particular the exclusion from the Affordable Care Act of permanent residents who have lived in the United States for less than five years.⁹⁸ He also noted that people in poverty, and in particular pregnant women, are disproportionately criminalized and subjected to interrogations that strip them of privacy rights.⁹⁹

At the conclusion of its 2016 visit to the United States, 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 United States prioritize policies and programs to reduce maternal mortality for Black women.¹⁰⁰

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 the United States’ increased maternal mortality noting it “hides distressing ethnic and socioeconomic disparities” including that Black women “are nearly four times more likely to die in childbirth” than white women.¹⁰¹ It recommended the United States address the root causes of its increased maternal mortality, “in particular among African-American women.”¹⁰² 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.¹⁰³ In so doing, it noted in particular the “heightened vulnerability” of Native American, Black, Latina, Asian American women, and migrant women.¹⁰⁴ Additionally, the Working Group noted with concern that “immigrant women and girls face severe barriers in accessing sexual and reproductive health services.”¹⁰⁵ It recommended the United States ensure that women be 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.¹⁰⁶

In its 2014 Concluding Observations, the **UN Human Rights Committee** 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.”¹⁰⁷ The Committee recommended the United States “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.”¹⁰⁸

VI. Recommended Questions for List of Themes

Given the recommendations previously made by the CERD and the information provided in this submission, we respectfully urge the CERD to include the following in the List of Themes for the United States’ review:

What measures is the United States taking to address the impact of intersectional discrimination and systemic racism on the sexual and reproductive health and rights of racial and ethnic minorities in the United States? Specifically:

- What steps is the United States taking to ensure that all people, regardless of their race, ethnicity, or immigration status, have meaningful access to sexual and reproductive health care, including abortion, in the United States?
- What measures is the United States taking to reduce the high maternal mortality and morbidity rates among Black and Indigenous people and to address persistent racial and ethnic discrimination in maternal health care and maternal health outcomes?
- What measures is the United States taking to ensure all immigrant communities in the United States have access to adequate sexual and reproductive health care, including

while in detention, and that they are free from immigration detention-related rights violations?

- What measures is the United States taking to mitigate the reproductive and maternal health harms to Black women and birthing people caused by climate change?
- What measures is the United States taking to prevent and remedy the harms of criminalization of pregnancy outcomes faced by Black, Indigenous, and other people of color and immigrants?

¹ The White House, *Fact Sheet: National Strategy on Gender Equity and Equality* (Oct. 22, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/22/fact-sheet-national-strategy-on-gender-equity-and-equality/>.

² Center for Reproductive Rights, *What if Roe Fell?* (last accessed Dec. 20, 2021), <https://maps.reproductiverights.org/what-if-roe-fell>.

³ Lisa Ko, *Unwanted Sterilization and Eugenics Programs*, PBS (Jan. 29, 2016), <https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/> (hereinafter *Unwanted Sterilization and Eugenics Programs*); Deirdre Owens & Sharla Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, *AJPH* (Oct. 2019), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305243>.

⁴ 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>.

⁵ 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/>.

⁶ V.T.C.A., Health & Safety Code § 171.204.

⁷ *Id.*

⁸ *Id.*

⁹ *United States of America v. The State of Texas*, No. 1:21-CV-796-RP (Western District of Texas Oct. 6, 2021), <https://s3.documentcloud.org/documents/21079947/pitman-order.pdf>.

¹⁰ *United States v. Texas*, No. 21-588 (21A85), 2021 WL 5855550 (S.Ct. Dec. 10, 2021).

¹¹ Katherine Dautrich et al., *Texas Abortion Ban is an Early Glimpse of What Post-Roe America Would Look Like for Women*, *CNN* (Oct. 22, 2021), <https://www.cnn.com/2021/10/22/us/texas-abortion-ban-invs/index.html>.

¹² Trymaine Lee, *Battle Over Texas Abortion Law Leaves Black People Behind*, *MSNBC* (Oct. 15, 2021), <https://www.msnbc.com/podcast/battle-over-texas-abortion-law-leaves-black-people-behind-n1281661>.

¹³ Institute for Women’s Policy Research, *Status of Women in the States* (Feb. 2018), <https://www.liveunitedlubbock.org/sites/liveunitedlubbock.org/files/ECO-Status-Women.pdf>.

¹⁴ Candice Norwood, *Policing and Surveillance: How Texas Abortion Law Could Add to Systemic Racism*, *THE 19TH* (Sept. 14, 2021), <https://19thnews.org/2021/09/texas-abortion-law-people-of-color/>.

¹⁵ Joy Berlin, *A Disturbing Trend – Medicine Examines Causes for Spike in Texas’ Maternal Mortality Rate*, *TEXASMEDICINE* (Dec. 2016), <https://www.texmed.org/Template.aspx?id=43816>.

¹⁶ Alabama, Arkansas, Florida, Missouri, Ohio.

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