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FOR
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RIGHTS

FORMERLY THE CENTER FOR REPRODUCTIVE LAW AND POLICY

December 19, 2007

Nathalie Prouvez
Secretary
Committee on the Elimination of Racial Discrimination
UNOG-OHCHR
CH 1211 Geneva 10
Switzerland

Re: Supplementary Information about the United States
Scheduled for review during the CERD Committee's 72nd Session

1. This letter supplements the periodic report submitted by the government of the United States, which is scheduled for review during the Committee's 72nd Session. The Center for Reproductive Rights (CRR), an independent, non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the International Convention on the Elimination of All Forms of Racial Discrimination (the Convention). This letter highlights several areas of concern related to the status of the reproductive health and rights of women of color in the United States.

2. Reproductive and sexual rights are firmly grounded in CERD and other international human rights treaties. The broad framework for these rights includes, among others, the right to life, liberty and security; the right to health, reproductive health, and family planning; the right to privacy; the right to be free from discrimination, violence and coercion; and the right to information, education and decision-making. Reproductive and sexual rights are fundamental to women's health because without regular access to safe, high-quality reproductive and sexual health services, women face risks such as death or injury during pregnancy and childbirth, unwanted pregnancy, and sexually transmitted infections. Further, the ability of women to make autonomous, informed decisions about their sexual and reproductive lives is a fundamental condition for enabling women to participate equally in the economic, social and political life of the nation. Despite the fundamental nature of these rights, within the United States racial and ethnic disparities in reproductive and sexual health indicators and access to care are dramatic and pervasive.

3. In its 2001 Concluding Observations, the Committee urged the United States to adopt special measures to address persistent racial disparities in health care, but the U.S. has failed to do so. As a result, women of color in the United States have significantly poorer sexual and reproductive health than the majority white population. For example,

120 WALL STREET
NEW YORK, NEW YORK 10005
TEL 917 637 3600 FAX 917 637 3666
WWW.REPRODUCTIVERIGHTS.ORG

African American women are nearly four times more likely to die in childbirth than white women,[1] and they are 23 times more likely to be infected with HIV/AIDS than their white counterparts.[2] American Indian/Alaskan Native women are over five times more likely than white women to have chlamydia, a sexually transmitted infection particularly harmful to women's health.[3] The unintended pregnancy rate among Latinas is 75 percent higher than among non-Hispanics,[4] and Latinas are three to four times more likely than white women not to use contraception.[5] These disparities reveal significant barriers to reproductive and sexual health care access for women of color in the United States.

4. The government's obligation to address racial disparities in reproductive and sexual health stems from its obligation under CERD's Article 2 to eliminate racial discrimination in all its forms, and to take special measures where necessary to correct persistent disparities. CERD's definition of discrimination includes state actions or inactions that have the "purpose *or effect* of creating or perpetuating discrimination."[6] Therefore, actions that have a disparate impact on racial or ethnic minorities are considered discrimination under CERD. Article 5(e)(iv) mandates that States parties ensure that all people, without distinction as to race, national or ethnic origin or color, have the right to "public health, medical care, social security and social services."[7] The right to non-discrimination in health includes equal access to reproductive and sexual health services for racial and ethnic minorities.[8] Finally, the U.S. is obligated under Article 6 to provide an effective remedy for racial discrimination that violates individuals' ability to enjoy and access their reproductive and sexual rights.

5. Furthermore, General Recommendation 25 directs States parties to address the intersection between race and gender when reporting on their progress in implementing the Convention.[9] The Committee has specifically called on States parties to report on measures taken to eradicate gender-related racial discrimination in the area of reproductive and sexual health.[10] Despite these clear reporting guidelines and the Committee's specific request to the U.S. in 2001 to include disaggregated data on gender, race, and ethnicity in this report,[11] the 2007 U.S. Periodic Report omits information about racial and ethnic disparities in reproductive and sexual health.

6. This letter is intended to aid the Committee by providing crucial information about discrimination in sexual and reproductive health care in the United States. While acknowledging that women of color fare worse than white women in every aspect of reproductive health, this letter highlights three areas where racial disparities are particularly pronounced: maternal mortality, sexually transmitted infections, and unintended pregnancy. It will then show how these disparities have been created and exacerbated by discriminatory government policies, and how the U.S. has failed to take steps to eradicate them.

I. Racial Disparities in Reproductive and Sexual Health (Articles 1, 2 and 5; General Recommendation 25)

A. Maternal Mortality

7. The U.S. has one of the highest rates of maternal mortality among western developed nations and ranks 30th in the world in its maternal mortality rate.[12] Racial disparities in maternal mortality help explain why this rate is so high. African American women are nearly four times more likely to die in childbirth than white women.[13] These disparities have remained unchanged over the past five decades.[14] Despite this evidence of persistent racial disparities, which has been recognized in several U.S. government reports,[15] the 2007 U.S. Periodic Report to CERD makes no mention of the problem of maternal deaths.

8. The government's failure to effectively address this disparity is particularly troubling because maternal mortality rates can be reduced through proper access to prenatal care. The Center for Disease Control has stated that "[a]ppropriate prenatal care … can enhance pregnancy outcome by assessing risk, providing health care advice, and managing chronic and pregnancy-related health conditions."[16] Most pregnancy-related deaths occur after a live birth, and those women who receive no prenatal care are three to four times more likely to die after a live birth than women who receive any prenatal care.[17] The U.S. government even recommended in its National Healthcare Disparities Report "that women begin receiving prenatal care in the first trimester of pregnancy.[18] Barriers to access to prenatal care for minority women, including the lack of private health insurance and the insufficiency of government health care programs are discussed below in Section II.

9. The CERD Committee has specifically expressed concern over racial disparities in maternal and infant mortality as evidence of discrimination based on gender, race, and economic status.[19] The CEDAW Committee[20] also stated that high maternal mortality rates indicate a failure of the government's obligation to ensure women's access to health care.[21] Both the CEDAW Committee and the Special Rapporteur on the Right to Health have framed the issue as a violation of women's right to health and life.[22] As the Human Rights Committee has noted, protecting the right to life "requires that States adopt positive measures."[23] The U.S. government's failure to eliminate the disparate rates of maternal mortality violates women's right to non-discrimination in the exercise of their rights to life and health under Article 5(e). In addition, because the disparity in maternal mortality has persisted for over five decades with no improvement, the government has violated its Article 2(2) obligation to take special measures to address persistent disparities.

B. Sexually transmitted infections, including HIV/AIDS

10. Since the last U.S. Periodic Report, racial disparities in sexually transmitted infections (STIs) have either remained stagnant or grown. The prevalence of HIV/AIDS among women of color has reached epidemic proportions. African American women are infected with HIV/AIDS at a rate 23 times that of white women[24] and constituted 66% of the new HIV infections among women in 2005.[25] Black women between the ages of 25-44 were over 14 times more likely to die of HIV/AIDS than white women (23.1 v. 1.6 deaths per 100,000).[26] Together, African American women and Latinas account for 82% of reported female HIV/AIDS diagnoses, even though they represent only 24% of the U.S. female population.[27] In addition, the face of HIV/AIDS is becoming increasingly a female one.[28] Between 2001 and 2004, the largest number of HIV/AIDS diagnoses was among women of all races aged 15-39.[29]

11. Additionally, African American women have a gonorrhea infection rate 18 times greater than the rate for whites.[30] The prevalence of chlamydia is 8 times higher among African American women than white women and over 5 times as high among American Indian/Alaskan Natives as white women.[31] The rate of primary and secondary syphilis increased among all women between 2005 and 2006, but it jumped 37.5% among American Indian/Alaska Native women and 18.2% among Asian/Pacific Islander women, compared to 5.6% among non-Hispanic white women.[32]

12. Finally, the STI human papillomavirus (HPV), which is more prevalent among racial minorities,[33] is believed to be responsible for 90-95% of cervical cancers.[34] Despite recent trends of declining cervical cancer incidence and mortality among women overall, women of color, especially Latinas and blacks, are significantly more likely than white women to develop cervical cancer and to die from it.[35] Because it is one of the most curable diseases if detected early, high death rates are linked to low screening rates and follow-up care in these populations.[36] For example, Vietnamese-American women, who have the highest incidence rate of cervical cancer of any racial or ethnic population (and three times higher than the next group, Latinas), are among the least likely to be screened for the disease or understand the purpose of pap tests.[37]

13. The high instances of HIV/AIDs and STIs among women of color reflect an access to care issue as well as the government's failure to provide comprehensive and medically accurate sexuality education programs, discussed below in Section II(C). The Committee has previously expressed concern over high rates of HIV/AIDS among racial and ethnic minorities.[38] In recent years, the Committee has also urged States parties to include information about their strategies to address HIV/AIDS among women.[39] Similarly, other treaty bodies have called for a gender analysis in addressing HIV/AIDS.[40] The CEDAW Committee has recognized that certain women may be particularly vulnerable due to their race or immigration status and recommended that states take an intersectional approach in their responses.[41] Racial disparities in

prevalence of STIs, including HIV/AIDS, is a violation of women's right to access health care under Article 5(e)(iv).

C. Lack of Access to Contraception, Unintended Pregnancies, and High Abortion Rates

14. The rate of unintended pregnancy is another key indicator of women's access to health care, including the accessibility of contraceptives, as well as their access to medically accurate sexuality education. While the overall rate of unintended pregnancy has declined since 1994, disaggregated data by race and ethnicity and income reveals that it remains very high for poor women of color.[42] Latinas have a 75% higher unintended pregnancy rate than non-Hispanics,[43] and low-income Latinas are nearly twice as likely to have an unintended pregnancy as low-income white women.[44] In 2006, teen pregnancies rose for the first time since 1991, and the racial group with the largest increase was black women aged 15-19.[45]

15. An unintended pregnancy can have drastic consequences for a woman's life. A woman carrying an unwanted pregnancy to term is less likely to seek prenatal care because she may not realize or accept that she is pregnant.[46] Both the pregnant woman and infant face an increased risk of negative health outcomes from the lack of pregnancy care.[47] An unintended birth also has significant social and economic consequences for the mother, often limiting her woman's educational and professional opportunities and creating economic strain in caring for a new child.[48] Importantly, the highest risk group for unintended pregnancy—women of color who are also poor, young, and single—is the same population for whom the consequences of unwanted births are the most severe.[49]

16. Half of unplanned pregnancies occur among women who are not using a contraceptive method at the time they became pregnant.[50] The CEDAW Committee has identified cost of contraceptives as a barrier for low-income women seeking to avoid unplanned pregnancies.[51] In the U.S., more low-income women have unintended pregnancies than higher-income women; between 1994-2001, the unintended pregnancy rate rose 29% among women living below the poverty level even while it declined 20% among women with higher economic status.[52] Moreover, a higher percentage of women of color are economically disadvantaged than white women, making poverty a significant barrier to contraceptive use among women of color. Overall, blacks, Hispanics, and women of other races and ethnicities are less likely to use contraception than their white counterparts.[53] Latinas, for example, are three to four times more likely than white women to use no method of contraception.[54] In addition, while overall rates of contraception use increased in the 1990s, since 2002 rates have started to decline due to rising nonuse among low-income women of color.[55]

17. Almost half of unintended pregnancies in the United States end in abortion.[56] Research reveals that abortion rates increase during times when contraception is less accessible to low-income women.[57] Because low-income women have higher unintended

pregnancy rates, and are also less likely to be able to support a child, they are more likely to terminate their pregnancies than higher income women.[58] While abortion rates are declining overall, economically disadvantaged women are the only group for whom abortion rates increased significantly between 1994 and 2000.[59] Abortion rates among black women are particularly high in large part because they are disproportionately low-income and unmarried—two key risk factors for unintended pregnancy.[60] Since 1973, the year that the Supreme Court legalized abortion in *Roe v. Wade,*[61] the rate of legal abortions has declined by nearly half for white women (from 32.6 to 16.5 abortions per 100 live births), while the rate for black women has steadily increased (from 42 to 49.1 per 100 live births).[62] The CDC reports that since 1991, the abortion rate for black women has remained three times higher than that for white women.[63]

18. Women of color are less likely to obtain an abortion at an earlier stage of pregnancy, when the risks to a woman's health are minimal. Often, low-income women, a disproportionate number of whom are racial and ethnic minorities, delay seeking an abortion because of cost—both for the initial health care visit to confirm a pregnancy and the cost of the procedure itself.[64] Because the cost of an abortion increases with a more advanced gestational age, poor women are often trapped in the cycle of delaying the procedure to raise money, then having to pay even more for a procedure later in the pregnancy.[65] As a result, low-income women obtain an abortion on average three weeks later in their pregnancy than other women,[66] even though 67 percent of these women report they would have preferred to get an abortion earlier.[67] The delay not only burdens women economically but, more importantly, increases the risk of complication from an abortion performed at a later gestational age.[68] Moreover, some low-income women are unable to obtain an abortion at all, as evidenced by the fact that low-income women are five times more likely to have an unintended birth than women in the highest income category.[69] As mentioned earlier, this burden disproportionately falls on women of color; the group most likely to obtain an abortion later in pregnancy is women who are young, poor, black and unmarried.[70] In particular, black women are less likely than white women to obtain an abortion at less than eight weeks gestation.[71]

19. The CEDAW Committee has stated that access to contraception is an essential aspect of women's reproductive and sexual health.[72] Specifically, it has highlighted the importance of access to contraception for the prevention of unwanted pregnancy[73] and criticized States parties for imposing barriers to contraceptive access, including lack of insurance coverage.[74] The CEDAW Committee has also urged states to improve access to contraception and family planning, especially as a means of preventing unsafe abortion.[75] The government's failure to make contraception widely available, accessible, and affordable has led to higher rates of unintended pregnancy among women of color. These women seek abortions to terminate their unwanted pregnancies, but because they are disproportionately low-income, they are forced to do so at later and more dangerous stages of pregnancy. As such, the government has not honored its obligation to provide equal access to family planning as a fundamental component to women's health under Article 5(e)(iv).

II. Government Policies with Discriminatory Effects on Reproductive and Sexual Health Care

20. Article 2(2) requires that where government policies discriminate in purpose or effect, a state "*shall*, when the circumstances so warrant, *take … special and concrete measures* to ensure … the full and equal enjoyment of human rights and fundamental freedoms."[76] In particular, states must take special measures where "persistent disparities" exist.[77] The Committee has previously recognized the importance of taking "all necessary measures" to improve the health of minority women with poorer health indicators than the majority population.[78] It also informed the U.S. in its last Periodic Review that special measures are necessary in order to correct the persistent disparities in the enjoyment of the right to health care in the United States.[79] The U.S. government has not only failed to correct these disparities through special measures, but has exacerbated them through its policies.

21. The key barrier to comprehensive reproductive and sexual health care is the lack of affordable health care. Most Americans must rely for their health care on private health insurance obtained through their employers. Forty-seven million people (15.8% of the population) are left without affordable health care, however, because they are not working, are self-employed, their employers do not provide insurance, or they are not enrolled in any government program.[80] Government health care programs provide some coverage, but significant gaps remain.[81] Many women of reproductive age do not have affordable reproductive and sexual health care. Even if a woman does qualify for government health insurance, she faces numerous restrictions on reproductive and sexual health services that do not apply to those with private insurance.

22. The U.S. government imposes numerous barriers to eligibility for public health insurance. Of the nearly 45 million uninsured people in the United States, 56% are not eligible for Medicaid or other government health programs even though they have incomes below 300% of the federal poverty level (FPL).[82] Almost all of the 25.5 million childless adults (92%) who are uninsured are not eligible for public programs but cannot afford private insurance.[83] A disproportionate number of women with incomes below the FPL and lacking either private health insurance or government-funded coverage are women of color.[84]

23. In the United States, women of color are significantly poorer than white women; 27% of African American women, 26% of Hispanics, 21% of American Indian/Alaskan Natives, and 13% of Asian Pacific Islanders (API) live in poverty compared to 9% of white women.[85] Low-income women have poorer health. Lower socioeconomic status harms women's health because it makes health insurance and health care unaffordable. Poverty also makes low-income women disproportionately reliant on public health

insurance programs and therefore more likely to be harmed by policies restricting access to key reproductive and sexual health services.

A. Lack of Affordable Health Care

24. In the United States, people of color disproportionately lack private health insurance.[86] This is because private health insurance is generally provided through employers,[87] and many people of color work in low-wage jobs that do not offer employer-based health insurance.[88] White women (70%) are more likely to have employer provided health coverage than black women (59%) or Latinas (39%).[89]

25. The result of this scheme is that women of color are far more likely than white women to have no affordable health care, that is, they lack private health insurance and are not enrolled in government health care programs; 30% of Latinas, 19% of API women, and 18% of African-American women are without affordable health care compared to only 10% of white women.[90] Foreign-born women are more than twice as likely to lack health care as white women.[91] In total, women of color constitute 51% of those without health care, despite representing only 32% of population.[92]

26. Because health care is expensive in the United States,[93] to be low-income and without health insurance usually means forgoing health care altogether. Uninsured women are much less likely to have had a doctor's visit in the past year or to have a regular health care provider.[94] Women of color are more likely to delay or avoid care because they disproportionately lack health insurance.[95] Thus, women of color are less likely to receive preventative health services such as screenings and checkups, which are essential for maintaining good health and preventing serious health problems.[96]

27. The Committee has called on States parties to prioritize the provision of health care to racial and ethnic minorities.[97] It has also made the connection between poverty and poor health and has stressed the importance of improving the overall standard of living for minority groups who have poor health indicators due to their lower socio-economic status.[98] Therefore, disparate coverage under private health insurance, combined with the large percentage of women of color not receiving public insurance, demonstrates the government's failure to fulfill the right to equal access to health care under Article 5(e)(iv).

B. Restrictions on Government Health Care Programs

28. The government provides some health care to its poorest populations through a complex patchwork of federal and state programs. However, recent eligibility restrictions and inadequate funding have disproportionately affected the ability of immigrants and people of color to access health care through government programs. In addition, government programs impose numerous restrictions on access to reproductive

health services that undermine their effectiveness. Rather than narrowing reproductive health disparities for women of color, these restrictions have exacerbated the inequalities.

1. Medicaid: Eligibility Barriers to Health Insurance Coverage

29. Medicaid, one of the two largest government health care programs, offers federal and state funding to cover an array of services, including family planning services and supplies, preventive screenings for STIs and reproductive system cancers, and pregnancy-related care.[99] Medicaid is the primary source of coverage for reproductive and sexual health care for low-income women of color.[100] To qualify for Medicaid, women must meet the program's eligibility criteria, which limits coverage to certain vulnerable categories of people such as children and pregnant women and requires that individuals meet income eligibility criteria.[101] Latinas are twice as likely (12%) and African American women are nearly three times as likely (18%) to be on Medicaid as white women (6%).[102]

30. Welfare reform has eroded access to reproductive health care for the women of color who rely on Medicaid. Most notably, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) barred Medicaid enrollment for resident immigrants who have resided in the U.S. for less than five years. By 2005, Medicaid enrollment among recent immigrant women of reproductive age declined from 26% to 17%.[103] However, enrollment also dropped by the same percentage among long-standing immigrant women who should not have been affected by the policy change.[104] In total, Medicaid coverage has declined by half among all immigrant women during the years that this policy has been in effect,[105] deterring immigrant women's access to vital preventative and primary reproductive health services.

31. Meanwhile, a documentation requirement imposed in the 2005 Deficit Reduction Act (DRA) has impeded the ability of citizen women to get health care through Medicaid. Intending to combat a perception of Medicaid fraud among undocumented immigrants,[106] Congress passed this law to require proof of U.S. citizenship or legal immigrant status as a precondition to Medicaid coverage.[107] Prior to the DRA, citizens could verbally confirm their citizenship status and the status of their children to apply for or re-determine program eligibility. These new documentation requirements pose a barrier to health coverage because low-income individuals often lack a passport or birth certificate, and acquisition costs can deter low-income people from procuring them.[108] The policy has caused a significant drop in the Medicaid enrollment rate, especially for poor African-American citizens.[109] It has also decreased enrollment for long-standing resident immigrants, who are deterred from enrolling because they believe they must produce proof of citizenship instead of only proof of legal status to qualify.[110] The citizenship documentation requirement delays women from getting Medicaid coverage when they need time-sensitive services such as pre-natal care.[111] In addition, family planning services are particularly impacted by the policy; states have reported that enrollment is declining in state Medicaid family planning expansion programs, which were designed to

offer family planning services to low-income individuals who may not meet Medicaid eligibility standards.[112]

32. The CERD Committee has expressed concern over racial disparities in health care, and has urged a State party to "take all necessary measures to ensure [that members of the racial minority group] enjoy the full right to health and health care," which includes "prioritiz[ing] and target[ing] social services for persons belonging to the most vulnerable groups."[113] Furthermore, General Recommendation No. 30 calls on States parties to "respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventative, curative, and palliative services."[114] The government's policy barriers to Medicaid coverage, and its failure to address the growing numbers of low-income women of color excluded from private or public insurance coverage, leaves this vulnerable population without access to key reproductive and sexual health services. In particular, women are denied: (1) timely prenatal care that prevents maternal mortality; (2) testing and treatment for STIs, including HIV/AIDS, and cervical cancer; and (3) a full range of contraception that prevents unwanted pregnancies and abortions. Without such access, women of color are unable to exercise their right to health care under Article 5(e)(iv).

2. Title X: Inadequate Funding for Family Planning

33. Many women who do not have private insurance and are not eligible for Medicaid rely on the Title X program for reproductive health care, including family planning.[115] The Title X program provides funding to clinics across the country who provide reproductive services, including family planning but excluding pregnancy-related care and abortion, without charge or on a sliding scale based on income. In addition, STI testing and treatment are core services provided by Title X-funded clinics.[116] The Title X program serves 6.6 million low-income women, 40% of whom are women of color.[117]

34. For many years, however, Congress has failed to fund the Title X program at the level necessary to meet the reproductive health needs of its target population. Funding for Title X clinics is now 61% lower in inflation-adjusted dollars than in 1980.[118] Meanwhile, the need for services has steadily increased, especially among immigrant populations who are now ineligible for Medicaid.[119] The challenge of meeting a rising demand for services with less money has left two-thirds of Title X-supported clinics unable to offer a full range of contraceptives or otherwise meet the family planning needs of low-income women.[120]

35. Several treaty bodies have criticized States parties' for failing to provide access to sexual and reproductive health services necessary for the prevention of unintended pregnancy,[121] as well as for the prevention and treatment of HIV/AIDS.[122] The U.S. has failed to ensure equal access to contraception, leading to disparate rates of unintended pregnancies and STIs among women of color. This violates the government's obligation

to guarantee equal access to reproductive and sexual health care, as required by Article 5(e)(iv).

3. The Hyde Amendment: Ban on Funding for Medically Necessary Abortions

36. In addition to racial disparities in health caused by the lack of affordable health care, women of color, who are more likely to rely on federal programs for reproductive health coverage, are disproportionately affected by federal restrictions on abortion. Federal public funding for abortions is prohibited except in extremely limited circumstances. Legal restrictions include most notably the Hyde Amendment, a federal policy that bans public funding for abortions except in cases of life endangerment, rape, and incest.[123] Abortions that are medically necessary for the woman's health are excluded under Medicaid, even though the Medicaid program funds all other "medically necessary" services.[124]

37. Although states have the power to extend state Medicaid funding for abortion beyond what is covered by federal Medicaid, the majority of states (32) fail to provide such coverage.[125] As a result, the majority of women who rely on publicly funded health care programs have no access to abortions unless they are able to cover the entire cost of the procedure out-of-pocket. Between 18-35% of Medicaid-eligible women who want an abortion are forced to continue their pregnancies due to the unavailability of public funding.[126]

38. The Hyde Amendment applies not just to Medicaid, but to all programs administered by the Department of Health and Human Services, including the Indian Health Service (IHS). IHS is the primary source of reproductive health care for most Alaskan Native/American Indian women—a population that is less likely than other Americans to have private health insurance or to be able to afford out-of-pocket costs for an abortion.[127] Women incarcerated in federal prisons are also subject to the federal ban on funding for abortions.[128] This policy significantly harms women of color because they comprise over 70% of women in federal prisons.[129]

39. The CEDAW Committee has repeatedly urged states to repeal restrictive abortion laws and strengthen measures that reduce unwanted pregnancies, such as family planning services and access to information on sexual health.[130] The Human Rights Committee has also acknowledged the disproportionate impact of restrictive abortion laws on poor, rural women and said that "in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed."[131] In addition, the CEDAW Committee has recommended that a State party provide public funding for abortion in order to increase access.[132]

40. The Hyde Amendment and other bans on federal funding for medically necessary abortions disproportionately harm low-income women of color because they are more

likely than white women to rely on federally-funded programs for their reproductive health care. These discriminatory health care policies violate the government's Article 5(e)(iv) obligation to provide equal access to health care.

C. Abstinence-Only-Until-Marriage Programs

41. Over the past twenty-five years, the federal government has been promoting abstinence-only-until-marriage programs, which do not provide full or scientifically accurate information about contraceptive effectiveness. These programs disproportionately affect low-income women of color who are at greater risk for STIs and unintended pregnancy and are more likely to rely on such programs for information and education about sexuality and sexual health.

42. The federal government has dedicated over $176 million in matching funds to states since 1997 to be used for abstinence-only-until-marriage programs.[133] In addition, most new funding for abstinence programs (currently at $113 million, a 465% increase over the past five years) has bypassed the states and gone directly to local programs through the Community Based Abstinence Education program.[134] Federal guidelines prohibit abstinence-only programs from advocating for contraceptive use and only permit the discussion of contraceptive methods in the context of failure rates.[135] Many of these programs exaggerate contraceptive failure rates and provide false or misleading information about the effectiveness of contraception in preventing STI infection, including HIV.[136] Research shows abstinence-only programs do not deter premarital sex or diminish the rate of STI infection,[137] and some programs deter condom use among sexually active teens.[138] In addition, by failing to teach adolescents about the risks of unprotected sex, including STI infection, adolescents who become infected lack information about testing and treatment.[139]

43. Low-income young women of color are disproportionately hurt by these programs. A study conducted from 1995 to 2000, the years marking an exponential growth in abstinence-only instruction, revealed that by 2000 the number of young black and Hispanic women receiving abstinence-only instruction in lieu of other forms of sexuality education had significantly increased and was higher than young white women.[140] In addition, young women living below 200% of the poverty level were more likely to receive abstinence-only instruction (or no sex education at all) compared to their higher-income peers.[141] Fewer than half of sexually-experienced young black women had received instruction about contraception prior to their first sexual encounter, compared to two-thirds of their white peers.[142] Thus, the population facing the highest risk of STI infection and unintended pregnancy is also the least likely to receive information necessary to protect themselves against those outcomes.

44. Despite the proven ineffectiveness of abstinence-only-until-marriage programs, government funding for them has increased dramatically in recent years, from $10 million in 1997 to $176 million in 2007.[143] In contrast, no federal program exists to

support comprehensive sexuality education, which has been proven effective in increasing condom use among sexually active youth.[144]

45. Human rights treaty bodies have called for HIV/AIDS information and services designed especially for women and girls.[145] They have also urged States parties to develop comprehensive sexuality education programs, which include promoting condom use as an effective HIV/AIDS prevention measure.[146] The racial and gender disparities in sexually transmitted infections, particularly in HIV/AIDS, demonstrate the government's failure to uphold its Article 5(e)(iv) obligation to prevent discrimination in health care, and its duty Article 5(e)(v) to provide equal access to information about sexual and reproductive health to women and girls of color. By funding and promoting abstinence-only programs, the government is not only failing to provide equal access to health services and information but is exacerbating racial disparities in access.

III. Right to an Effective Remedy (Article 6)

46. Under Article 6, the state must provide "effective protection and remedies" for any form of discrimination. Such relief is limited, however, under U.S. Supreme Court jurisprudence. The Court has interpreted the U.S. Constitution not to impose an affirmative obligation to ensure equal access to reproductive health care.[147] Moreover, government action that has racially differentiated effects is not unconstitutional under the Constitution's guarantee of equal protection unless the action can be traced to a racially discriminatory purpose.[148] Thus, the jurisprudence does not take into account how racism, sexism, or poverty constrain women's reproductive options or the government's obligation to address racial disparities in access to health care.[149] Moreover, although Congress and the President have the authority to do so, the federal government has not established effective programs that would reduce barriers to reproductive health care and eliminate racial disparities.

IV. Issues for the Committee to Consider

Upon consideration of the information provided in this letter, the Center for Reproductive Rights urges the Committee to address the following questions to the United States government:

1. What steps are being taken to reduce the high maternal mortality rate among women of color, particularly African American women, as compared to white women? (Article (5)(e)(iv), General Recommendation 25)

2. What steps are being taken to address the growing racial and gender disparities in STI infection, especially HIV/AIDS? (Articles 5(e)(iv); 5(e)(v), General

Recommendation 25)

3. What steps are being taken to improve access to family planning services for low-income women of color, including providing a full range of contraception and unrestricted access to abortion? (Article 5(e)(iv), General Recommendation 25)

4. How does the government explain its policy to promote and fund abstinence-only-until marriage programs, which limits women of color's access to information about STI and pregnancy prevention? (Article 5(e)(iv) and 5(e)(v), General Recommendation 25)

5. What steps are being taken to address the problem of lack of health care for the uninsured, particularly for the growing numbers of low-income women of color who lack employer-based coverage but do not qualify for government health care programs? How is the government addressing the disparities in reproductive and sexual health indicators that result from lack of affordable health care? (Article 5(e)(iv), General Recommendation 25)

6. What steps are being taken to ensure that immigrants receive basic reproductive and sexual health care regardless of their citizenship status? (Article 5(e)(iv), General Recommendation 30)

We hope the information contained in this letter has been useful to you as you prepare for the review of the U.S. Periodic Report. If you have any questions, or would like further information about racial disparities in reproductive and sexual health, please do not hesitate to contact us.

Sincerely,

Nancy Northup
President, Center for Reproductive Rights

[1] Nat'l Ctr. for Health Stat., *Maternal Mortality and Related Concepts*, 3 VITAL HEALTH STAT. No.33, 8 (Feb. 2007).
[2] Ctrs. for Disease Control, *HIV/AIDS among African Americans* 2 (June 2007), *available at* http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm (last viewed Dec. 14, 2007).
[3] Dep't of Health & Human Servs., *Sexually Transmitted Disease Surveillance 2006* 8-9 (Nov. 2007), *available at* http://www.cdc.gov/std/stats/toc2006.htm (last viewed Dec. 14, 2007) [hereinafter *STD Surveillance Report 2006*].
[4] Heather D. Boonstra et al., *Abortion in Women's Lives* 28 (Guttmacher Inst., May 2008). As used in this report, the term "Hispanics" includes only non-white Hispanics unless otherwise indicated. It is used interchangeably with "Latinas."
[5] Nat'l Ctr. for Health Stat., *Fertility, Family Planning and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth*, 23 VITAL & HEALTH STAT., No. 25, 101 (2005).
[6] International Convention on the Elimination of All Forms of Racial Discrimination, art. 1, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969 (emphasis added) [hereinafter ICERD]; CERD, *General Recommendation No. 14: Definition of Racial Discrimination*, para. 1, U.N. Doc. A/48/18 (1994).
[7] ICERD, art. 5(e)(iv).
[8] CERD, *Concluding Observations: China*, para. 250, U.N. Doc. A/56/18 (2001) (recommending that the next State party report contain "information on measures taken to prevent gender-related racial discrimination, including in the area of … reproductive health."); CERD Concluding Observations: India, 70th Sess., para. 24, U.N. Doc. CERD/C/IND/CO/19 (2007) (recommending "that the State party ensure equal access to … reproductive health services…"); *see also* ECOSOC, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt*, para. 25, UN Doc. E/CN.4/2003/58 (2003) ("[t]he right to health is a broad concept that can be broken down into more specific entitlements such as the rights to … [m]aternal, child and reproductive health.").
[9] CERD, *General Recommendation XXV: Gender Related Dimensions of Racial Discrimination,* U.N. Doc. A/55/18, annex V at 152 (2000) [hereinafter CERD, *General Recommendation 25*].
[10] *See, e.g.,* CERD, *Concluding Observations: China*, para. 250, U.N. Doc. A/56/18 (2001); CERD, *Concluding Observations: India*, para. 24, U.N. Doc. CERD/C/IND/CO/19 (May 5, 2007); CERD, *Concluding Observations: Uganda*, para. 18, U.N. Doc. CERD/C/62/CO/11 (June 2, 2003).
[11] CERD, *Concluding Observations: United States of America*, para. 403, U.N. Doc. A/56/18 (2001) (recommending that "the next State party report contain socio-economic data, disaggregated by race, ethnic origin and gender…").
[12] World Health Organization (WHO), *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UFPA* (2004), *available at* http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html (last viewed Dec. 14, 2007).
[13] In 2003, although the maternal mortality rate for all women was 12.1 per 100,000 live births, the rate for African-American women was 30.5 deaths versus 8.7 deaths for white women. Nat'l Ctr. for Health Stat., *Maternal Mortality and Related Concepts*, *supra* note 1, at 8.
[14] *Id.*at 8-9 (showing that since 1950 black women have died in pregnancy or childbirth at a rate 3-5 times that of white women); *accord* Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247-51, 247 (2007) (stating that "[f]or the past 5 decades, Black women have consistently experienced an almost 4 times greater risk of death from pregnancy complications than have White women").
[15] *See, e.g.,* Nat'l Ctr. for Health Stat., *Maternal Mortality and Related Concepts, supra* note 1; NAT'L CTR. FOR HEALTH STAT., HEALTH, UNITED STATES, 2006 160-61 (2007), *available at* http://www.ahrq.gov/qual/nhdr06/nhdr06.htm (last viewed Dec. 14, 2007) [hereinafter, NAT'L HEALTHCARE DISPARITIES REP.].
[16] Ctrs. for Disease Control, *Births: Final Data for 2004*, 55 NAT'L VITAL STAT. REP. No. 1, 16 (Sept. 29, 2006).

[17] Ctrs. for Disease Control, *Pregnancy-Related Mortality Surveillance—United States, 1991-1999* (FEB. 20, 2003), *available at* http://www.cdc.gov/od/oc/media/pressrel/fs030220.htm (last viewed Dec. 14, 2007).
[18] NAT'L HEALTHCARE DISPARITIES REP. *supra* note 15, at 160.
[19] CERD, *Concluding Observations: India*, *supra* note 10, para. 24 (stating it was "concerned about reports that members of scheduled castes and scheduled and other tribes are disproportionately affected by … infant, child and maternal mortality…" and recommending "that the State party ensure equal access to … reproductive health services"); CERD, *Concluding Observations: Israel,* para. 24, U.N. Doc. CERD/C/ISR/CO/13 (June 14, 2007) (expressing concern "by the discrepancies still remaining between the infant mortality rates and life expectancy rates of Jewish and non-Jewish populations, and by the fact that minority women and girl children are often the most disadvantaged" and reminding the State party of its obligation under General Recommendation No.25 to "pay particular attention to the situation of Arab women in this regard").
[20] The Committee on the Elimination of Discrimination against Women (CEDAW), which monitors compliance with the Convention on the Elimination of All forms of Discrimination Against Women, has repeatedly addressed States parties' obligation to prevent maternal mortality. As such, the general comments of the CEDAW Committee and its concluding observations on this topic may be particularly instructive to the CERD Committee.
[21] CEDAW, *General Recommendation No. 24: Women and Health*, para. 18, U.N. Doc. HRI/GEN/1/Rev.5 (May 2, 2001) (explaining that high maternal mortality and morbidity rates worldwide "provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care"); *accord* Committee on Economic, Social, and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, para. 14, U.N. Doc. HRI/GEN/1/Rev.5 (Nov. 8, 2000) (stating that the right to health requires States parties to implement measures to "improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services, and access to information, as well as to resources necessary to act on that information.").
[22] *See, e.g.,* CEDAW, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); CEDAW, *Concluding Observations: Columbia*, para. 393, U.N. Doc. A/54/38 (Apr. 2, 1999); Statement by Mr. Paul Hunt upon submission to the General Assembly on Oct. 19, 2006 regarding the *Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health*, U.N. Doc. A/61/338 (Sept. 13, 2006) (declaring that "[a]voidable maternal mortality violates women's rights to life, health, equality and non-discrimination.")
[23] Human Rts. Committee (HRC), General Comment 6, *Article 6 (Right to life)*, para. 5, U.N. Doc. HRI/GEN/1/Rev.7 (May 12, 2004).
[24] Ctrs. for Disease Control, *HIV/AIDS among African Americans*, *supra* note 2, at 2.
[25] Ctrs. for Disease Control, *HIV/AIDS among Women* 3 (June 2007), *available at* http://www.cdc.gov/hiv/topics/women/resources/factsheets/women.htm (last viewed Dec. 14, 2007).
[26] NAT'L HEALTHCARE DISPARITIES REP., *supra* note 15, at 221 (2006).
[27] Ctrs. for Disease Control, *HIV/AIDS among Women*, *supra* note 25, at 2; *see also* Dept. Health & Human Servs., *African-Americans and HIV/AIDS in the United States* (June 2006), *available at* http://hab.hrsa.gov/history/AfricanAmericans (last viewed Dec. 14, 2007).
[28] Young women (13-19) are 57% of all HIV cases in contrast to 25% of cases among 20-24 year olds. University of California San Francisco, Center for AIDS Prevention Studies & AIDS Research Institute, *What are young women's HIV prevention needs?* (2002), *available at* http://www.caps.ucsf.edu/pubs/FS/youngwomen.php (last viewed Dec. 14, 2007).
[29] Ctrs. for Disease Control, *HIV/AIDS among Women*, *supra* note 25, at 3.
[30] *STD Surveillance Report 2006*, *supra* note 3, at 18.
[31] *Id.* at 8-9.
[32] *Id.* at 34.
[33] Elizabeth I.O. Garner, *Cervical Cancer: Disparities in Screening, Testing, and Survival*, 12 CANCER EPIDEMIOLOGY BIOMARKERS & PREVENTION 242S-247S, at 3 (March 2003).
[34] Harold Freeman & B.K. Wingrove, *Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities* 13 (Nat'l Cancer Inst., 2005).
[35] U.S. Cancer Stat. Working Group, *United States Cancer Statistics: 2003 Incidence and Mortality* (2007); WOMEN'S HEALTH DATA BOOK: A PROFILE OF WOMEN'S HEALTH IN THE UNITED STATES, 76-77, 81 (D. Misra ed., 2001) *available at* http://www.kff.org/womenshealth/6004-index.cfm (last viewed Dec. 14, 2007); NAT'L INST. OF HEALTH, WOMEN OF COLOR HEALTH DATA BOOK: ADOLESCENTS TO SENIORS 119 (2006), *available at* http://orwh.od.nih.gov/pubs/WomenofColor2006.pdf (last viewed Dec. 14, 2007) [hereinafter NIH, WOMEN OF COLOR HEALTH DATA BOOK].

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[36] Dep't. of Health & Human Servs., *Minority Women's Health: Cervical Cancer*, *available at* http://www.womenshealth.gov/minority/hispanicamerican/cc.cfm (last visited Dec. 13, 2007) (estimating that improved rates of pap testing would prevent 80% of deaths from cervical cancer).
[37] Nat'l Asian Women's Health Org., *A Profile: Cervical Cancer and Asian American Women* (2000), at 1-2, *available at* http://www.nawho.org/pubs/NAWHOCC.pdf (last visited Dec. 14, 2007).
[38] CERD, *Concluding Observations: South Africa*, para. 20, U.N. Doc. CERD/C/ZAF/CO/3 (Oct. 19, 2006); CERD, *Concluding Observations: Estonia*, para. 17, U.N. Doc. CERD/C/EST/CO/7 (Oct. 19, 2006).
[39] CERD: *Concluding Observations: Uganda*, para. 18, U.N. Doc. CERD/C/62/CO/11 (June 2, 2003) (urging the government to "continue to develop strategies [to address HIV/AIDS among "particularly marginalized ethnic groups"] and … that, in this context, due consideration be given to the specific situation of women."); CERD: *Concluding Observations: Botswana*, para. 306, U.N. Doc. A/57/18, Supp.18. (Aug. 23, 2002) (same).
[40] CEDAW, *General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS),* U.N. Doc. HRI/GEN/1/Rev.5, at 212 (Apr. 26, 2001); CEDAW, *General Recommendation No. 24, Women and Health*, supra note 21, para. 18; Committee on Economic, Social, and Cultural Rights (CESCR), *Concluding Observations: Guinea*, para. 22, U.N. Doc. E/C.12.1.Add.5 (May 28, 1996); Committee on the Rights of the Child (CRC), *Concluding Observations: Lesotho*, paras. 45-46, U.N. Doc. CRC/C/15. Add.147 (Feb. 21, 2001).
[41] CEDAW, *Concluding Recommendations: Switzerland*, para. 122, U.N. Doc. A/58/38 (2003); *see also* CEDAW, *General Recommendation 24, supra* note 40 (addressing the lack of access to reproductive and sexual health services, as well as the impact of unequal gender power relations as factors increasing the vulnerability of women and girls to HIV/AIDS)
[42] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 90-96, 94 (2006); Boonstra, et al., *Abortion in Women's Lives, supra* note 4, at 28.
[43] Boonstra et al., *Abortion in Women's Lives*, *supra* note 4, at 28.
[44] Finer & Henshaw, *supra* note 42, at 94.
[45] Ctrs. for Disease Control, 56 NAT'L VITAL STAT. REP. No. 7, at 2 (Dec. 5, 2007) (revealing that the pregnancy rate among adolescents fell 34% between 1991 and 2005 before it reversed in 2006, rising by 3% among females aged 15-19).
[46] Adam Sonfield, *Preventing Unintended Pregnancy: the Need and the Means*, 6 GUTTMACHER REP. ON PUB. POL'Y NO. 5, 7 (Dec. 2003), *available at* http://www.guttmacher.org/pubs/tgr/06/5/gr060507.html (last viewed Dec. 14, 2007).
[47] *Id.*; Finer & Henshaw, *supra* note 42, at 90.
[48] Sonfield, *Preventing Unintended Pregnancy, supra* note 47, at 7.
[49] Boonstra et al., *Abortion in Women's Lives*, *supra* note 4, at 26.
[50] *Id.* at 8.
[51] *See e.g.,* CEDAW, *Concluding Observations: Armenia*, para. 50, U.N. Doc. A/52/38/Rev.1, Part II (Aug. 12, 1997); CEDAW, *Concluding Observations: Hungary*, para. 254, U.N. Doc. A/51/38, (May 9, 1996); CEDAW, *Concluding Observations: Iceland*, para. 84, U.N. Doc. A/51/38 (May 9, 1996).
[52] Boonstra et al., *Abortion in Women's Lives*, *supra* note 4, at 26.
[53] Nat'l Ctr. for Health Stat., *Fertility, Family Planning and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth*, 23 VITAL & HEALTH STAT. No. 25, at 101 (2005); *see also* Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH, No.6, 5 (Sept./Oct. 2002).
[54] Nat'l Ctr. for Health Stat., *Fertility, Family Planning and Reproductive Health of U.S. Women, supra* note 54, at 101.
[55] Boonstra, *Abortion in Women's Lives*, *supra* note 4, at 25-26.
[56] Finer & Henshaw, *supra* note 42, at 90.
[57] Rachel K. Jones et al., *supra* note 54, at 231.
[58] *Id.* at 234 (noting that high abortion rates are caused in part by high pregnancy rates, and as income increased, pregnancy rates declined).
[59] *Id.*
[60] Boonstra et al., *Abortion in Women's Lives*, *supra* note 4, at 28.
[61] 410 U.S. 113 (1973).
[62] NAT'L HEALTHCARE DISPARITIES REP., *supra* note 15, at 154.

[63] Ctrs. for Disease Control, *Abortion Surveillance—United States, 2003*, 55 MORBIDITY & MORTALITY WEEKLY REP. SS-11 6-7 (2006).
[64] Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL'Y REV. No. 1, 14-15 (Winter 2007).
[65] *Id.* at 15-16.
[66] *Id.* at 14.
[67] *Id.*
[68] *Id.* at 16.
[69] Finer & Henshaw, *Disparities in Unintended Pregnancy*, *supra* note 42, at 94.
[70] Boonstra et al., *Abortion in Women's Lives*, *supra* note 4, at 5.
[71] Ctrs. for Disease Control, *Abortion Surveillance*, *supra* note 64, at 30.
[72] CEDAW, *Concluding Observations: Philippines*, para. 301, U.N. Doc. A/52/38/Rev.1, Supp. 38 (1997).
[73] CEDAW, *Concluding Observations: Chile,* para. 229, U.N. Doc. A/54/38/Rev.1, Supp. 38 (1999) ("request[ing] the Government to strengthen its actions and efforts aimed at the prevention of unwanted pregnancies, including by making all kinds of contraceptives more widely available and without any restriction");
[74] *See e.g.*, CEDAW, *Concluding Observations: Georgia*, para. 112, U.N. Doc. A/54/38 (July 1, 1999); CEDAW, *Concluding Observations: Luxembourg*, para. 221U.N. Doc. A/52/38/Rev.1, Part II (Aug. 12, 1997).
[75] CEDAW, *Concluding Observations: Greece*, para. 208, U.N. Doc. A/54/38/Rev.1, Supp. 38 (1999); CEDAW, *Concluding Observations: Belize*, para. 57, U.N. Doc. A/54/38/Rev.1, Supp. 38 (2001); CEDAW, *Concluding Observations: Burkina Faso*, para. 275, U.N. Doc. A/55/38 (Jan. 31, 2000). CEDAW, *Concluding Observations: Slovenia*, para. 119, U.N. Doc. A/52/38/Rev.1 (Aug. 12, 1997).
[76] ICERD, art. 2(2) (emphasis added).
[77] CERD, *Concluding Observations: United States of America*, para. 399, U.N. Doc. A/56/18 (Aug. 14, 2001).
[78] *See, e.g.,* CERD, *Concluding Observations: Slovakia*, para. 14, U.N. Doc. CERD/C/304/Add. 110 (May 1, 2001).
[79] CERD, *Concluding Observations: United States of America*, *supra* note 11, para. 398.
[80] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* 18 (Aug. 2007), *available at* http://www.census.gov/prod/2007pubs/p60-233.pdf (last viewed Dec. 14, 2007).
[81] *Id.* at 20.
[82] Kaiser Family Found., *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* 3 (Feb. 2007), *available at* http://www.kff.org/uninsured/7613.cfm (last viewed Dec. 14, 2007).
[83] *Id.* at 10.
[84] NIH, WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 35, at 108 (explaining that in 2003, of women living below the federal poverty level (incomes of $9,393 for an individual and $18,810 for a family of four), 49% of Hispanic women, 43% of Asian women, 41% of African American women, 40% of American Indian or Alaska Native women, 35% of Native Hawaiian or Other Pacific Islander women, and 27% of white women were uninsured).
[85] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, supra* note 81, at 11 (showing that the overall poverty rate for non-Hispanic Whites (8.2%) was lower than that for Blacks (24.3%), Latinos (20.6%), and Asians (10.3%)).
[86] Kaiser Family Found., *Key Facts: Race Ethnicity and Medical Care* 1,13-14 (Jan. 2007), *available at* http://www.Kaiser Family Found..org/minorityhealth/6069.cfm (last viewed Dec. 14, 2007) (showing that all major racial and ethnic groups except Asian/Pacific Islanders are more likely than whites to lack private (i.e. individual or employer-based) insurance.)
[87] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, supra* note 81, at 18 (noting the percentage of people covered by employment-based health insurance decreased to 59.7% in 2006, from 60.2% in 2005).
[88] Kaiser Family Found., *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey* 2 (Mar. 2004), *available at* http://www.Kaiser Family Found..org/womenshealth/7018.cfm (last viewed Sept. 11, 2007) (showing that 44% of Latinas and 52% of African American women have employer-based health insurance compared to 66% of white women).
[89] NIH, WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 35, at 107.
[90] *Id.*
[91] Kaiser Family Found., *Women's Health Insurance Coverage* (Feb. 2007), *available at* http://www.Kaiser Family Found..org/womenshealth/upload/6000_05.pdf (last viewed Sept. 11, 2007).

[92] NIH, WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 35, at 107; Kaiser Family Found., *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care*, *supra* note 89, at 2.
[93] Health care expenditures per capita have increased substantially in recent years. In 1996, 26% of the poor spent more than 10% of their income on health, but that percentage increased to 33% by 2003. In addition, women spend, on average, more on health care annually than men ($3,715 vs. $2,836). Kaiser Family Found., *Health Care Costs: A Primer*, *Key Information on Health Care Costs And Their Impacts* 1, 6 (Aug. 2007), *available at* http://www.Kaiser Family Found..org/insurance/upload/7670.pdf (last viewed Dec. 14, 2007).
[94] WOMEN'S HEALTH DATA BOOK, *supra* note 35, at 176-77 (showing that one-half of uninsured women have no regular doctor compared to 14% of continuously insured women, and one-half report problems accessing necessary care compared to 10% of insured women).
[95] NIH, WOMEN OF COLOR HEALTH DATA BOOK, *supra* note 35, at 110 (reporting that 67% of uninsured women delayed or went without care in the preceding year due to cost, and that in 2004, 21% of white women, 30% of African American women, and 32% of Latinas reported that they did not seek care despite known health problems).
[96] WOMEN'S HEALTH DATA BOOK, *supra* note 35, at 176-77; Kaiser Family Found., *Key Facts*, *supra* note 87, at 21.
[97] CERD, Concluding Observations: Denmark, para. 17, U.N. Doc. CERD/C/304/Add.2 (Mar. 28, 1996).
[98] CERD, Concluding Observations: Bolivia, para. 15, U.N. Doc. CERD/C/63/CO/2 (Dec. 10, 2003); CERD Concluding Observations: Lithuania, para. 22, U.N. Doc. CERD/C/LTU/CO/3 (Apr. 11, 2006) (expressing concern over the "critical health situation of some Roma communities, which is largely a consequence of their poor living conditions.").
[99] Rachel Benson Gold, *Immigrants and Medicaid after Welfare Reform*, 6 GUTTMACHER REP. ON PUB. POL'Y 6-9, 7 (May 2003), *available at* http://www.guttmacher.org/pubs/tgr/06/2/gr060206.html (last viewed Dec. 14, 2007).
[100] *Id.* (stating that Medicaid covers more than one-third of reproductive-age women living below the poverty level); *see also* Kaiser Family Found., *Key Facts*, *supra* note 87, at 14.
[101] *See generally* Ctrs. for Medicaid and Medicare Servs., *Medicaid at a Glance: 2005, A Medicaid Information Source* (2005), *available at* http://www.cms.hhs.gov/MedicaidEligibility/Downloads/MedicaidataGlance05.pdf (last viewed Dec. 14, 2007).
[102] Kaiser Family Found., *Racial and Ethnic Disparities*, *supra* note 89, at 2.
[103] Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, 10 GUTTMACHER POLICY REVIEW 7-11, 8 (Winter 2007), *available at* http://www.guttmacher.org/pubs/gpr/10/1/gpr100107.html (last viewed Dec. 14, 2007).
[104] *Id.*
[105] Gold, *Immigrants and Medicaid after Welfare Reform*, *supra* note 100, at 7.
[106] Sonfield, *The Impact of Anti-Immigrant Policy, supra* note 104, at 9.
[107] U.S. citizens applying for or renewing their Medicaid coverage must submit proof of citizenship in the form of a passport or birth certificate. Under previous rules, citizens could verbally confirm citizenship status, while legal residents were required to provide written proof of legal status. The new rules do not apply to immigrants, who must submit documentation of their legal status when applying for Medicaid. Leighton Ku, Why Immigrants Lack Adequate Access to Health Care and Health Insurance 4 (Sept. 2006), *available at* http://www.migrationinformation.org/Feature/display.cfm?id=417 (last viewed Dec. 14, 2007).
[108] Kaiser Family Found., *Medicaid's Role in Family Planning* 8-9 (Oct. 2007), *available at* http://www.guttmacher.org/pubs/IB_medicaidFP.pdf (last viewed Dec. 14, 2007).
[109] Donna Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show* 3-6 (Ctr. on Budget & Pol'y Priorities, July 2007), *available at* http://www.cbpp.org/7-10-07health.htm (last viewed Decd. 14, 2007).
[110] Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, 10 GUTTMACHER POL'Y REV. (Winter 2007) (noting the enrollment rate among legal residents fell from 26% to 17% between 1994 and 2005); *see also* Ku, Why Immigrants Lack Adequate Access to Health Care and Health Insurance, *supra* note 108.
[111] States are permitted to use state-only funds to cover prenatal care and other services to all immigrants, but as of May 2004, only 21 states offered this expanded coverage to recent immigrants and 13 offered it to undocumented immigrants. Sonfield, *The Impact of Anti-Immigrant Policy, supra* note 111, at 8.
[112] Kaiser Family Found., *Medicaid's Role in Family Planning*, *supra* note 109, at 8.
[113] CERD, *Concluding Observations: Slovokia*, para. 14, U.N. Doc. CERD/C/304/Add.110 (May 1, 2001).
[114] CERD, *General Recommendation No. 30: Discrimination against Non-citizens*, para. 36, U.N. Doc. CERD/C/64/Misc.11/rev.3 (Oct. 1, 2004).

[115] In most states, women with dependent children will qualify for Medicaid if they earn less than 67% of the federal poverty level for working parents, while women would be able to obtain services at a Title X funded clinic if they have an income up to 250% of the federal poverty level. Jennifer J. Frost et al., *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*, 33 GUTTMACHER INST. OCCASIONAL REP. NO. 9, at 10 (Nov. 2006), *available at* http://www.guttmacher.org/pubs/2006/11/16/or33.pdf (last viewed Dec. 14, 2007).

[116] Alan Guttmacher Inst., *Title X and the U.S. Family Planning Effort* 11 (Feb. 1997) (showing how these services have expanded; in 1980 only 10% of visits to a Title X supported clinic involved testing or treatment for STIs, but the rate had jumped to 40% by 1990), *available at* http://www.guttmacher.org/pubs/ib16.html (last viewed Dec. 14, 2007).

[117] *Id.* at 3.

[118] Rachel Benson Gold, *Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort*, 10 GUTTMACHER POL'Y REV. 13-18, 15 (Spring 2007), *available at* http://www.guttmacher.org/pubs/gpr/10/2/gpr100213.html (last viewed Dec. 14, 2007).

[119] Rachel Benson Gold, *Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort,* 10 GUTTMACHER POL'Y REV. No. 2, at 18 (Spring 2007) (discussing how Title X clinics are struggling to meet the health needs of the rising numbers of immigrants ineligible for Medicaid); Cynthia Dailard, *Challenges Facing Family Planning Clinics and Title X,* GUTTMACHER REP. ON PUB. POL'Y (Spring 2001), *available at* http://www.guttmacher.org/pubs/tgr/04/2/gr040208.pdf (last viewed Dec. 14, 2007); Adam Sonfield et al., *Cost Pressures on Title X Family Planning Grantees, FY 2001–2004* 4 (Guttmacher Inst., 2006) (explaining that Title X funded clinics reported an average cost increase of 58 percent from 2001–2004 for language assistance services to serve non-native English speakers), *available at* http://www.guttmacher.org/pubs/2006/08/01/CPTX.pdf (last viewed Dec. 14, 2007).

[120] FROST, *supra* note 116, at 11-12 (reporting that "a substantial number" of low-income women lack the family planning services they need, and that particularly vulnerable populations such as homeless, disabled and incarcerated women may go without services at all due to insufficient funds for outreach).

[121] *See* notes 73-76, *infra.*

[122] CEDAW, *General Recommendation No. 24, supra* note 21; CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)* U.N. Doc. HRI/GEN/1/Rev.5 (2001) (providing guidelines to States parties to ensure access to health facilities, goods and services for particularly vulnerable groups such as persons living with HIV/AIDS); CRC, *Concluding Observations: Belize*, para. 25, U.N. Doc CRC/C/15/Add.99 (May 10, 1999) (discussing the need for a "youth-friendly" approach in delivery of reproductive health services in the context of HIV/AIDS).

[123] P.L. No. 105-78 § 509 (1997).

[124] 42 U.S.C. § 1396(a) (2000).

[125] Alan Guttmacher Inst., *State Policies in Brief: An Overview of Abortion Laws* (June 2007).

[126] Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001,* 35 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 16-24, 23 (2003).

[127] Heather D. Boonstra, *The Heart of the Matter, supra* note 65, at 14-15.

[128] *Id.* at 15.

[129] Lawrence A. Greenfeld & Tracy L. Snell, *Women Offenders* 1-14, 7 (U.S. Dept. of Justice, Oct. 2000), *available at* http://www.ojp.gov/bjs/pub/pdf/wo.pdf (last viewed Dec. 14, 2007).

[130] *See, e.g.,* CEDAW, *Concluding Observations: Suriname*, paras. 29-30, U.N. Doc. CEDAW/C/SUR/CO/3 (Feb. 20, 2007); CEDAW, *Concluding Observations: Chile*, paras. 19-20, U.N. Doc. CEDAW/C/CHI/CO/4 (Aug. 25, 2006); CEDAW, *Concluding Observations: Philippines*, paras. 27-28, U.N. Doc. CEDAW/C/PHI/CO/6 (Aug. 25, 2006).

[131] HRC, *Concluding Observations: Argentina*, para. 14, U.N. Doc. CCPR/CO/70/ARG (Nov. 3, 2000).

[132] CEDAW, *Concluding Observations: Burkina Faso*, para. 276, U.N. Doc. A/55/38 (2000) (recommending that "the State party review its legislation on abortion and provide for coverage by social security").

[133] Heather D. Boonstra, *The Case for a New Approach to Sex Education Mounts: Will Policymakers Heed the Message?,*10 GUTTMACHER POL'Y REV. 3 (Spring 2007), *available at* http://www.guttmacher.org/pubs/gpr/10/2/gpr100202.html (last viewed Nov. 2, 2007).

[134] *Id.* 2-3 (noting that the CBAE program has more rigid rules about what constitutes an abstinence program than the guidelines under Title V, the federal-state matching program).

[135] *Id.* at 2.

[136] H.R. Rep., Committee on Government Reform, *The Content of Federally Funded Abstinence-Only Education Programs* 8 (Dec. 2004) [hereinafter "Waxman Report"], *available at* http://www.democrats.reform.house.gov/Documents/20041201102153-50247.pdf (last viewed Dec. 14, 2007).

[137] Mathematica Policy Research, Inc., *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report* 59 (April 2007), *available at* http://www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf (last viewed Oct. 19, 2007) [hereinafter MPR study] (finding that the surveyed abstinence programs had "no overall impact on teen sexual activity [and] no differences in rates of unprotected sex" among those who completed the programs); Am. Psychological Ass'n (APA), *Resolution in Favor of Empirically Supported Sex Education and HIV Prevention Programs for Adolescents* (Feb. 18-20, 2005); Society for Adolescent Medicine, *Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine*, 38 J. ADOLESCENT HEALTH 83-87, 84 (2006); Boonstra, *The Case for a New Approach to Sex Education Mounts, supra* note 134, at 5.

[138] Waxman Report, *supra* note 137, at 4 (showing that students who took a "virginity pledge" as part of an abstinence-only curricula did not have lower rates of STIs than non-pledgers but were less likely to use contraception when they had sex).

[139] Boonstra, *The Case for a New Approach to Sex Education Mounts, supra* note 134, at 5 (stating that "[t]o the extent that they ignore contraception and the benefits of safer-sex practices generally, abstinence-only programs do nothing to help prepare young people for when they will become sexually active."); Waxman Report, *supra* note 138, at 4; John Santelli et al., *Abstinence and abstinence-only education: A review of U.S. Policies and programs*, 38 J. ADOLESCENT HEALTH 72-81, 76 (2006) (summarizing data showing that although virginity pledge-breakers had fewer sexual partners, they were less likely to report seeing a doctor for an STI concern and were less likely to get tested for STIs).

[140] Laura Duberstein Lindberg et al., *Changes in Formal Sex Education: 1995-2002* 38 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH No. 4, 182-88, 185-86 (Dec. 2006), *available at* http://www.guttmacher.org/pubs/journals/3818206.html (last viewed Dec. 14, 2007).

[141] *Id.*

[142] *Id.* at 186.

[143] *Id.* at 182; Boonstra, *The Case for a New Approach to Sex Education Mounts, supra* note 134, at 2.

[144] Alan Guttmacher Inst., *Abstinence-Only Programs Do Not Work, New Study Shows* (Press Release, Apr. 18, 2007) (discussing how even though numerous studies have shown that comprehensive sex education delays sex and increases contraceptive use, there is no federal funding for such programs).

[145] CEDAW, *General Recommendation No. 15, supra* note 40, at 212; CEDAW, *General Recommendation No. 24, supra* note 21, at 244; CRC, *Concluding Observations: South Africa*, para. 31, U.N. Doc. CRC/C/15/Add.122 (Feb. 22, 2000).

[146] CEDAW, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, para. 31, U.N. Doc. A/54/38 (July 1, 1999); CEDAW, *Concluding Observations: Belize*, para 59, U.N. Doc. A/54/38/Rev.1 (July 1, 1999).

[147] *See, e.g.,* Griswold v. Connecticut, 381 U.S. 479 (1965); Roe v. Wade, 410 U.S. 113 (1973); Harris v. McRae, 448 U.S. 297 (1980), Planned Parenthood of Southeastern Pa v. Casey, 505 U.S. 883 (1992), Stenberg v. Carhart, 530 U.S. 914 (2000), Gonzales v. Carhart, 550 U.S. ___ (2007), 127 S.Ct. 1610.

[148] *See* Washington v. Davis, 426 U.S. 229 (1976) (finding that the Equal Protection Clause of the Fourteenth Amendment only prohibits intentional discrimination); Alexander v. Sandoval, 532 U.S. 275 (2001) (finding no private right of action exists to enforce the disparate impact regulations promulgated under § 602 of Title VI of the Civil Rights Act of 1964 (42 USC § 2000(d)(1)).

[149] *See* Harris v. McRae, 448 U.S. at 316-17 (holding that poor women may not challenge the restriction on federal funding for abortion because "[t]he financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental intrusion on access to abortions, but rather of her indigency.").