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Report on the United States' Compliance with Its Human Rights Obligations In the Area of Women's Reproductive and Sexual Health

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A. EXECUTIVE SUMMARY

1. A woman's right to make fundamental decisions about her life and her family, her right to access reproductive health services and her ability to decide when and whether to have children are based on a number of fundamental human rights. Among others, these rights include life, health, dignity, equality, self-determination, information, education, privacy and freedom from cruel, inhuman and degrading treatment. This report focuses on three areas of reproductive rights that treaty monitoring bodies have identified as issues of human rights concern: (1) pervasive racial disparities in reproductive and sexual health; (2) obstacles to women's access to safe, legal abortion; and (3) the practice of shackling incarcerated pregnant women. The report uses the framework set out in the General Guidelines for the Preparation of Information under the Universal Periodic Review: Section B provides an overview of the legal and policy framework, Section C details the parameters of the human rights problems, and Section D provides recommendations of concrete steps the U.S. should take to respect, protect and fulfill reproductive rights on a basis of equality.

B. FRAMEWORK FOR PROMOTION AND PROTECTION OF HUMAN RIGHTS

2. Women's access to comprehensive sexual and reproductive healthcare in the United States is neither uniform nor guaranteed. The federal Constitution does not explicitly protect the right to health and, as a result, healthcare is available through a patchwork of private and public coverage that leaves many without adequate access to care.
3. The majority of people in the U.S. rely on employer-based insurance for their healthcare.¹ Many of those without employer-based insurance receive coverage through government programs, if they meet eligibility requirements; others either purchase an individual plan or go without coverage entirely. New healthcare reform legislation promises to extend coverage to more people, but has serious limitations in the areas of sexual and reproductive health. People of color in the U.S. are more likely than the majority white population to lack private health insurance, to rely on government programs for health coverage, and to go without coverage.² Women of color are far more likely than white women to lack affordable healthcare through either private health insurance or a government healthcare program: 30 percent of Latinas, 19 percent of Asian/Pacific Islander women, and 18 percent of African American women lack affordable healthcare, as compared to 10 percent of white women.³
4. Medicaid is the government health coverage program that provides the largest source of funding for medical and health-related services for low-income and indigent people in the U.S., providing coverage for nearly 45 million people.⁴ It is also the primary source of sexual and reproductive healthcare coverage for low-income women. Roughly 12 percent of all women of reproductive age in the U.S.—and 37 percent of women of reproductive age in low-income families—rely on Medicaid for their healthcare coverage.⁵ As compared to white women, Latinas are twice as likely, and African American women nearly three times as likely, to rely on Medicaid coverage for their healthcare.⁶
5. Safe, legal abortion is an integral part of reproductive healthcare and an essential component of reproductive rights. Human rights bodies have recognized that where abortion is legal, women must have meaningful access to the procedure.⁷ In the U.S., the constitutional right to abortion was recognized in the Supreme Court's 1973 *Roe v. Wade* decision.⁸ Since then, however, the Court's rulings have accommodated an increasing number of restrictions that impede women's access to abortion services.⁹ As a result, dozens of state laws now restrict

women's access to abortion in ways that had been previously struck down as unconstitutional. These laws often bear no relationship to medical evidence about the safety of the abortion procedure or about patient care; they are meant to make abortion more difficult to obtain. In addition, the persistent intimidation and harassment of abortion providers without effective law enforcement response has created a shortage of services that further jeopardizes women's ability to access abortion. Federal restrictions on the use of federal and private funds for abortion coverage create additional obstacles.

6. As of December 31, 2008, 114,852 women were incarcerated in federal and state prisons,¹⁰ 85 percent for non-violent crimes.¹¹ The vast majority of incarcerated women are held in state custody; about ten percent are in federal custody.¹²
7. Women of color are imprisoned at alarmingly disproportionate rates. The U.S. government estimates that seven times as many African American women—and three times as many Hispanic women—as white women will be incarcerated at some point in their lifetime. And while African American women constitute only 13 percent of all women in the U.S., they represent nearly 50 percent of incarcerated women.¹³
8. Nationally, an estimated six to ten percent of incarcerated women are pregnant.¹⁴ Prison facilities have generally failed to adequately address the unique health needs of pregnant women, including prenatal and postnatal care and proper nutrition.¹⁵ Pregnant women incarcerated in state facilities are frequently shackled while traveling to and from medical appointments and during childbirth, jeopardizing their health and unjustifiably subjecting them to a cruel, inhuman and degrading practice.

C. IMPLEMENTATION AND EFFICIENCY OF HUMAN RIGHTS FRAMEWORK

1. **Persistent Racial Disparities in Reproductive and Sexual Health**
9. Women of color fare worse than white women in every aspect of reproductive health, with disparities particularly pronounced in three areas: maternal mortality, sexually transmissible infections (STIs), and unintended pregnancies. In 2008, the Committee on the Elimination of Racial Discrimination recognized these pervasive racial disparities in women's sexual and reproductive health as a human rights concern and called on the U.S. to improve women's access to reproductive and sexual healthcare, including contraception and sexuality education.¹⁶ Although the causes of racial disparities are complex and systemic, and long-term interventions are likely needed to eradicate them, the U.S. can—and should—modify its policies to improve access to reproductive and sexual healthcare in the short term. Continued failure to address these disparities threatens the human rights of women of color.
10. Today, and for the last fifty years, African American women die in pregnancy or childbirth at three to four times the rate of white women.¹⁷ No single factor fully explains this racial disparity in maternal mortality, but the Centers for Disease Control and Prevention have recognized that access to prenatal care can reduce maternal mortality and other negative pregnancy outcomes.¹⁸ Most pregnancy-related deaths occur after a live birth, and women who do not receive prenatal care are three to four times more likely to die after a live birth than women who attend even one prenatal appointment.¹⁹
11. The U.S. government could improve access to prenatal care by eliminating two discriminatory policies that preclude low-income women, who are overwhelmingly likely to be women of color,²⁰ from enrolling in Medicaid. First, the U.S. government should repeal

the policy that bars immigrants who have resided in the U.S. for less than five years from Medicaid enrollment. Since this policy went into effect, Medicaid enrollment has declined by half among immigrant women, including those who did not fall within the scope of the bar. Second, the U.S. government should rescind the policy that requires Medicaid applicants to produce proof of U.S. citizenship or legal immigrant status. Low-income individuals often lack a passport or a birth certificate, and the cost of procuring those documents can be prohibitive. This policy delays women from getting Medicaid coverage for time-sensitive services like prenatal care and has caused a significant decline in the Medicaid enrollment rate, especially for poor African American citizens.

12. Disparities in access to reproductive and sexual healthcare and to medically accurate sex education are paralleled by persistent racial disparities in every major reportable STI and in rates of unintended pregnancy. Nearly all minority groups contract STIs at much higher rates than the majority white population. Together, African American women and Latinas account for 80% of reported female HIV/AIDS diagnoses, even though they represent only 25% of the U.S. female population.²¹ And while women of color are much more likely to die of cervical cancer than are white women, with the exception of African American women, they are less likely to receive regular Pap smears, a crucial screening mechanism.²²
13. Although the overall rate of unintended pregnancy has declined over the last fifteen years, it has remained consistently high among poor women of color. As at least one human rights body has recognized, the cost of contraception and the lack of medical insurance coverage can be barriers for low-income women seeking to avoid pregnancy.²³ Since 2002, rates of contraception use have declined due to nonuse among low-income women of color.²⁴ Low-income Latinas are nearly twice as likely as low-income white women to have an unintended pregnancy. Almost half of all unintended pregnancies in the U.S. end in abortion; African American women, who are three times as likely as white women to experience an unintended pregnancy, are also three times as likely as white women to obtain abortion services.²⁵
14. Improving access to Medicaid is an important way to increase access to prevention, testing and treatment for STIs and to contraception. In addition, the U.S. government could increase funding for Title X, a federal program that provides funding to clinics that offer those reproductive healthcare services. The program serves 6.6 million low-income women, 40% of whom are women of color. However, the federal government consistently fails to fund Title X at the level necessary to meet the reproductive healthcare needs of its target population. Taking inflation into account, funding for Title X in constant dollars is actually 62% *lower* today than it was in 1980.²⁶ The need for services has increased, and the challenge of meeting a rising demand for services with less government funding has forced more than half of clinics to make cutbacks in staffing and/or services offered.²⁷
15. The U.S. government could also address racial disparities in STIs and unintended pregnancy rates by improving access to comprehensive and scientifically accurate sex education. Beginning in 1981, the federal government poured hundreds of millions of dollars each year into programs teaching that abstinence until marriage is the only acceptable form of sexuality. These programs—whose efficacy at delaying sexual activity has been debunked—exclude any discussion of contraception, except to emphasize failure rates, and many include content with negative stereotypes about women, people of color, and LGBT people. The Obama administration took an important step away from these programs by defunding them

in the fiscal year 2010 budget. However, the new healthcare reform bill contains \$250 million over the next five years in further funding for these programs.

2. Limitations on Women's Access to Abortion

16. Abortion has been legal in the U.S. for almost forty years, but many women face significant challenges in obtaining the procedure. There are three key obstacles that women face. Pervasive attacks on the doctors and healthcare workers who provide abortions have significantly decreased the availability of abortion services, to the detriment of women's ability to exercise their reproductive rights. Medically unnecessary requirements imposed on providers and patients make care more costly to provide and more difficult to obtain. Access is further undermined by discriminatory policies which single out and exclude abortion care from Medicaid coverage and in the newly created health insurance exchanges.
17. Abortion providers ensure women's access to reproductive health services and enable them to exercise their human rights. Their crucial work often exposes abortion providers to threats, violence and harassment, jeopardizing their safety and violating their human rights. The National Abortion Federation compiled reports of 16 death threats, 9 incidents of assault and battery, 144 incidents of trespassing or vandalism, and 1,699 incidents of harassing phone calls or hate mail directed against abortion providers in 2009.²⁸
18. On May 31, 2009, Dr. George Tiller was murdered in his church in Wichita, Kansas. Dr. Tiller was one of the small number of physicians who provide abortions, and one of the even smaller number who provide abortions late in pregnancy. For years, he was subjected to harassment and intimidation and violent attacks including a shooting in 1993. The man who murdered him stated that he did so because Dr. Tiller was an abortion provider.
19. In a 2009 fact-finding report, CRR documented the ongoing intimidation and harassment of abortion providers throughout the U.S.²⁹ One clinic staff member remarked, "anyone could walk in anytime off the street. . . . It wears on you, being cautious all the time, looking to see if someone is following you." To protect physicians and clinic staff, many clinics employ full time security managers and armed guards or install surveillance cameras and metal detectors. Abortion providers are not only targeted at clinics, but also at their homes. One doctor, in Pennsylvania, has been targeted at home for the past ten years; protestors have followed him each time he has moved. Another doctor stopped providing abortions after dead animals were left on her doorstep and her house broken into.³⁰
20. Federal and state laws provide some protection to abortion providers and clinic access, but their efficacy is limited by lax enforcement. The federal Freedom of Access to Clinic Entrances Act of 1994 protects both providers and recipients of reproductive healthcare services from violent, obstructionist, or damaging conduct, including threats, harassment, assault, trespass and vandalism. State and local laws regulating the time, place and manner of protests, such as permit and noise ordinances, may also help individual clinics. In particular, providers have reported that laws creating "buffer zones"—delineated areas around a health facility and/or individuals entering or leaving it in which anti-abortion activity is restricted—can decrease the level, aggression, and effects of anti-abortion activity. But police often misunderstand these laws or refuse to enforce them. For example, when the entrances to a clinic in Pennsylvania were completely obstructed by a hundred protestors in

2007, police responded not by dispersing the protestors and clearing the entrances but rather by locking patients and staff in and out of the clinic for three hours, disrupting patient care.³¹

21. The extreme toll taken by routine intimidation and harassment is a significant factor in the scarcity of abortion providers, which harms patients. Mississippi and North Dakota have only a single clinic each, and many of their patients must travel four or five hours to reach them. Elsewhere, providers are clustered together, often in urban areas. Only a limited number of physicians provide abortions, and some travel hundreds of miles to provide care at multiple clinics. The shortage of providers increases the difficulty women—especially poor and rural women—experience in trying to access abortion. Many abortion clinics do not provide abortions past the first trimester of pregnancy, so women seeking abortions later in pregnancy must travel even farther.³²

b. Discriminatory Legal Restrictions

22. In many states, legislatures and regulatory bodies have singled out abortion providers and patients for onerous and medically unnecessary regulation in order to obstruct the provision of services. Such restrictions harm providers and patients in several ways; among other things, they increase the cost of providing and accessing services to a point that is nearly impossible for some providers and/or patients to bear.
23. One ubiquitous form of medically unjustified over-regulation is a requirement that before a woman can obtain an abortion, she must receive biased and sometimes inaccurate state-mandated information in the form of a lecture and written materials. The information is overtly designed to dissuade women from obtaining an abortion and is often inappropriate for a woman's circumstances. These requirements bear no relationship to the patient-driven and patient-centered information and counseling that already occurs, in accordance with medical ethics, as part of the informed consent process. These laws violate the free speech rights of doctors and patients and the right of patients to receive accurate information that allows them to protect their health. Some states require that a woman wait a certain amount of time, often 24 hours, after receiving the state-mandated lecture and materials before she may obtain an abortion. These laws force women to delay abortions without medical justification and, in some cases, even though the delay is detrimental to a woman's health. In their most burdensome form, these laws require women to travel twice to the clinic to first hear the lecture in person and then obtain the abortion. Clinic and provider schedules, as well as the patient's logistical hurdles, can often result in delays of a week or longer.³³ Women who have few financial resources, are geographically isolated from providers, need to protect against the risk of disclosure or have later pregnancies are most at risk of being harmed by these mandatory delays.

c. Restrictions On The Use Of Public And Private Funds

24. Women who rely on government health insurance programs, like Medicaid, are further impeded in accessing abortion by restrictions on the use of federal funds for abortions, except where a woman's pregnancy results from rape or incest or endangers her life. The Hyde Amendment, which restricts the use of Medicaid funds for abortion, leaves low-income women without coverage for abortions even when necessary to preserve their health.³⁴ It discriminates against women, because abortion is the only medically necessary service that is excluded from Medicaid coverage and is a service that only women need. Although a 1980 Supreme Court decision held that the Hyde Amendment did not violate the federal

Constitution,³⁵ courts in thirteen states have held that comparable restrictions on state funds violate women’s equality and/or privacy rights, interfering with women’s ability to exercise their constitutional right to abortion and to protect their right to health. In those states, and four others, state funding is available for medically necessary abortions.

25. Funding restrictions place an additional obstacle in the path of low-income women who seek abortion. The costs of arranging for an abortion—including transportation, child care and loss of wages—are significant for low-income women, and can be prohibitive even if funding assistance can be secured. Delaying an abortion to raise the necessary funds can result in later procedures, potentially increasing the risk to a woman’s health, loss of income, and costs of the procedure and additional travel and child care. For low-income women, who are already vulnerable to rights violations, the Hyde Amendment makes it logistically and financially harder to obtain an abortion and can result in complete obstruction.³⁶
26. Troublingly, although recently-enacted healthcare reform legislation increases opportunities for health insurance coverage, that law and its accompanying Executive Order have also created new restrictions on insurance for abortions. Healthcare insurance plans on government insurance exchanges that provide coverage for abortion are required to have enrollees opt into coverage—using a separate payment—at enrollment. State governments also have the option of excluding abortion coverage from insurance policies purchased through the exchanges. This runs contrary to the market mechanisms and general practices of insurance, in which coverage extends to a set of health conditions regardless of whether a policyholder needs those services. The distinction stigmatizes and burdens the choice of a plan that provides abortion coverage. And, for the first time, federal law restricts the scope of coverage in the private insurance market, in a way that interferes with women’s rights to choose abortion and protect their health.³⁷

3. Shackling Incarcerated Pregnant Women

27. The use of shackles to restrain pregnant women during the birthing process is a cruel, inhuman and degrading practice that needlessly inflicts excruciating pain and humiliation. The Committee Against Torture has expressed concern regarding the treatment of detained women in U.S. prisons and jails.³⁸ Similarly, the Human Rights Committee expressed concern about the persistence of shackling pregnant prisoners in childbirth and urged the United States to prohibit the practice.³⁹ After visiting prisons in six states in 1998, the Special Rapporteur on Violence Against Women concluded that the use of restraints on pregnant women in the manner employed by prison officials violates international standards and “may be said to constitute cruel and unusual practices.”⁴⁰
28. Yet pregnant women incarcerated in prisons and jails in the U. S. are routinely restrained by their ankles and/or wrists when transported for medical care. Shackles are also used on pregnant women detained because of their immigration status.⁴¹ Incarcerated pregnant women often remain shackled during labor, delivery, and the post-delivery recovery period for hours, or even days, despite the constant presence of armed guards.
29. Only seven states have enacted legislation restricting the use of shackles during labor and delivery.⁴² And while several other states have policies prohibiting the practice, the absence of a statutory prohibition leaves officials free to change their policies. Lawyers, journalists and human rights advocates continue to gather evidence that the use of restraints on

incarcerated pregnant women during labor and delivery remains standard, even in states where the practice is prohibited.⁴³

30. In addition to being punitive and traumatizing, shackling pregnant women can create health risks.⁴⁴ Two leading professional organizations have condemned the use of shackles on pregnant women during labor and delivery because of the negative effects on women's physical and psychological health and wellbeing.⁴⁵ Shackling a woman during transport increases the risk of falling and restraints prevent her from protecting herself by breaking her fall. Shackling women during childbirth hampers physiological management of labor, which slows labor, intensifies pain and causes undue physical stress on both mother and baby. Restraints also impede repositioning or surgical access in the event of an emergency. Finally, leg shackles inhibit a woman's recovery, as many experts recommend walking to rehabilitate muscles.

D. RECOMMENDATIONS FOR ACTION

31. The U.S. government should take concrete steps to address racial disparities in reproductive and sexual health, including the following: (a) Eliminate barriers to Medicaid coverage that disproportionately affect women of color, including the five-year bar for recent immigrants and the citizenship documentation requirements; (b) Increase Title X funding to meet the reproductive and sexual healthcare needs of its target population, including funding for measures that would increase accessibility of care, such as cultural and linguistic interpreters; (c) Integrate and co-locate reproductive and HIV/AIDS healthcare services to reduce the barriers to care and information faced by HIV-positive women; (d) Identify gaps in the data, particularly ethnically disaggregated data, and fund research into disparities in reproductive and sexual health access and outcomes in order to design and implement evidence-based programs to reduce these inequities; and (e) Secure funding for medically accurate, age-appropriate, comprehensive sexuality education at a level sufficient to ensure that children receive such education throughout the country.
32. The federal government should publicly condemn intimidation, harassment and physical attacks directed at healthcare providers who ensure access to fundamental human rights. The government should also take action to prevent such attacks, to protect healthcare professionals against such attacks, and to prosecute those who perpetrate attacks. The Declaration on Human Rights Defenders, adopted by the U.N. General Assembly in 1999 with the full support of the U.S., recognizes the central role played by those who promote the realization of human rights and sets out the special obligation of governments to protect them.⁴⁶ And U.N. expert reports have recognized that healthcare providers are entitled to special protection as human rights defenders where they fulfill their professional duties in a way that promotes human rights, such as the right to health.⁴⁷ The federal government should protect and expand women's access to abortion in several ways, including: (a) The Department of Justice (DOJ) should devote additional resources to provide training for and improve cooperation between federal, state, and local law enforcement agencies in responding to violence and threats of violence directed at abortion providers; (b) The DOJ should devote additional resources to enforcing the Freedom of Access to Clinic Entrances Act and related federal statutes; and (c) Repeal federal restrictions on the use of public funds for abortion, including the Hyde Amendment, and repeal federal restrictions on the use of private funds for abortion coverage contained in the new healthcare reform legislation and accompanying Executive Order.

33. The federal government should take concrete steps to end the practice of shackling pregnant incarcerated women, including the following: (a) The White House should publicly condemn the practice of shackling pregnant incarcerated women during childbirth as a violation of women's human rights; (b) The Bureau of Prisons should ensure that jails, privately operated facilities, and/or community corrections centers with which it contracts comply with the Bureau of Prisons policy prohibiting shackling incarcerated pregnant women during childbirth; (c) As the Bureau of Prisons did in 2008, Immigrations and Customs Enforcement should prohibit the practice of shackling pregnant women held in immigration detention during childbirth; (d) The Attorney General of the United States and DOJ Justice should investigate all complaints that pregnant incarcerated women are shackled in violation of their constitutional and civil rights, and should use all available mechanisms to ensure that states eliminate the practice.
34. The U.S. government should ratify, without reservations, the Convention on the Elimination of All Forms of Discrimination Against Women.
35. President Obama took an important step toward ensuring women's sexual and reproductive health by rescinding the Global Gag Rule, which prevented foreign recipients of U.S. Agency for International Development funds from advocating for access to abortion. The federal government should mitigate the harms caused by the Global Gag Rule in several ways, including the following: (a) Continue to disseminate information that the Global Gag Rule has been rescinded; (b) Support efforts to strengthen information exchange, capacity building, and technical capacity necessary to implement the repeal of the Global Gag Rule; (c) Increase funding to strengthen local capacity to provide reproductive health services and information to women, and to advocate for reproductive rights, including the right to safe abortion; (d) Pass the Global Democracy Promotion Act or similar legislation to prohibit the imposition of restrictions on foreign organizations that it would be unconstitutional to impose on U.S. organizations; (e) Ensure that U.S. funding of foreign human rights institutions is consistent with the State Department commitments to promote and protect women's reproductive rights; and (f) Establish clear guidelines and oversight mechanisms to ensure that institutions receiving U.S. funding are not undermining or challenging these rights.

¹ U.S. CENSUS BUREAU, INCOME, POVERTY, & HEALTH INSURANCE COVERAGE IN THE U. S.: 2008 23 (2009).

² Kaiser Family Foundation, *Issue Brief: The Role of Health Coverage for Communities of Color* 2 (Nov. 2009); see also Kaiser Family Foundation, *Race, Ethnicity & Health Care Fact Sheet* 2 (April 2008) (showing rates of uninsurance among non-elderly Asian Americans, Native Hawaiians and Pacific Islanders).

³ NAT'L INST. OF HEALTH, WOMEN OF COLOR HEALTH DATA BOOK: ADOLESCENTS TO SENIORS 127 (2006). This report uses the term "white women" to refer to women who identify and are identified in the research cited in this report as non-Hispanic white women.

⁴ Kaiser Family Found., *Medicaid Enrollment in the 50 States: December 2008* 1 (2010).

⁵ Kaiser Family Found. & Guttmacher Inst., *Women's Issue Brief: Medicaid's Role in Family Planning* (Oct. 2007).

⁶ Kaiser Family Found. *Key Facts: Race Ethnicity & Medical Care* 2 (Mar. 2004).

⁷ See, e.g., CENTER FOR REPROD. RIGHTS, BRINGING RIGHTS TO BEAR: ABORTION & HUMAN RIGHTS 5 & n.52 (2008) (citing multiple Concluding Observations from the Committee on the Elimination of All Forms of Discrimination Against Women where the Committee has urged states to provide safe abortion services or ensure access where abortion is permitted by law).

⁸ *Roe v. Wade*, 410 U.S. 113 (1973).

⁹ See *Planned Parenthood of Se. Pa v. Casey*, 505 U.S. 833 (1992) (replacing the highest level of judicial review, applied to restrictions of constitutional rights, with the determination that states may regulate abortion provision so long as the regulations do not place an "undue burden" in the path of women seeking abortions).

¹⁰ BUREAU OF JUSTICE STAT., U.S. DEP’T OF JUSTICE, PRISONERS IN 2008 (2009).

¹¹ BUREAU OF JUSTICE STAT., U.S. DEP’T OF JUSTICE, WOMEN OFFENDERS (1999).

¹² As of December 25, 2009, there were 13,625 women in federal custody. See Quick Facts About the Bureau of Prisons, <http://www.bop.gov/news/quick.jsp#1> (last visited Jan. 19, 2010).

¹³ U.S. Dep’t of Justice, Nat’l Inst. Corrections, Gender-Responsive Strategies: Research Practice and Guiding Principles for Women Offenders 2-3 (2003).

¹⁴ Jennifer G. Clarke et al., *Reproductive Healthcare and Family Planning Needs Among Incarcerated Women*, 96 AM. J. OF PUB. HEALTH 834, 834 (2006).

¹⁵ See generally Dana Sussman, *Bound by Injustice: Challenging the Use of Shackles on Incarcerated Pregnant Women*, 15 CARDozo J.L. & GENDER 477, 487 (2009).

¹⁶ *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States*, 72d Sess., para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008). The Human Rights Council and the Committee on the Status of Women have recognized that maternal mortality is an issue of human rights concern. See Preventable maternal mortality and morbidity and human rights, Hum. Rts. C. Res. U.N. Doc. A/HRC/11/L.16/Rev.1 (rev’d draft res. June 16, 2009); Eliminating preventable maternal mortality and morbidity through the empowerment of women, Comm. Status of Women Res., U.N. Doc. E/CN.6/2010/L.6 (advance unedited draft res. March 9, 2010).

¹⁷ In 2006, the age-adjusted maternal mortality ratio was 32.7 maternal deaths per 100,000 live births for African American women, and 9.5 deaths for white women. Nat’l Ctr. for Health Stat., *Deaths: Final Data for 2006*, 57 NAT’L VITAL STAT. REP’T 13 (2009); Margaret Harper et al., *Why African American Women are at Greater Risk for Pregnancy-Related Death*, 17 ANN. EPIDEMIOLOGY 180 (2007); Nat’l Ctr. for Health Stat., *Maternal Mortality and Related Concepts*, 3 VITAL HEALTH STAT. 33 (Feb. 2007) (showing that since 1950, African American women have died in pregnancy or childbirth at a rate 3-5 times that of white women); Myra J. 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 (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.”).

¹⁸ Nat’l Ctr. for Health Stat., *Births: Final Data for 2004*, 55 NAT’L VITAL STAT. REP’T. 16 (Sept. 2006).

¹⁹ Nat’l Ctr. for Health Stat., *Pregnancy-Related Mortality Surveillance—United States, 1991-1999*, 52 MMWR Surveillance Summary 1 (Feb. 2003).

²⁰ Women of color in the U.S. are significantly poorer than white women: 27% of African American women, 26% of Hispanic women, 21% of American Indian/ Alaskan Native women and 13% of Asian Pacific Islanders live in poverty, compared to 9% of white women. U.S. CENSUS BUREAU, INCOME, POVERTY, & HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 18 (Aug. 2007).

²¹ African American women are diagnosed with HIV, gonorrhea, chlamydia, and syphilis at rates from 8 to 26 times those of their white counterparts. Native American women are infected with HIV at a rate 4 times as high as their white counterparts, and with chlamydia at a rate 5 times as high. The rate of primary and secondary syphilis increased among all women in 2005, but 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. CTRS. FOR DISEASE CONTROL, HIV/AIDS SURVEILLANCE REPORT, 2007 14, 17 (2009); CTRS. FOR DISEASE CONTROL, SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 2008 68-70 (Nov. 2009).

²² CTRS. FOR DISEASE CONTROL, MINORITY WOMEN’S HEALTH: CERVICAL CANCER (2009); Akers, Newmann & Smith, *Factors Underlying Disparities in Cervical Cancer Incidence, Screening, and Treatment in the United States*, 31 CURRENT PROB. CANCER 157, 160-61 (2007).

²³ See CTR. FOR REPROD. RIGHTS, *supra* note 6, at 4 & nn.14-15 (collecting Concluding Observations from the Committee on the Elimination of All Forms of Discrimination Against Women).

²⁴ 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. 101 (2005); see also Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 5 (2002).

²⁵ Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL’Y REV. 2, 3 (2008).

²⁶ Guttmacher Inst., *Title X Funding Chart*, Feb. 25, 2010 (memorandum on file with author).

²⁷ GUTTMACHER INST., A REAL-TIME LOOK AT THE IMPACT OF THE RECESSION ON PUBLICLY FUNDED FAMILY PLANNING CENTERS (2009).

²⁸ NATIONAL ABORTION FEDERATION, NAF VIOLENCE AND DISRUPTION STATISTICS (2009).

²⁹ CTR. FOR REPROD. RIGHTS, DEFENDING HUMAN RIGHTS: ABORTION PROVIDERS FACING THREATS, RESTRICTIONS, AND HARASSMENT (2009).

³⁰ *Id.* at 74, 87-88.

³¹ *Id.* at 85.

³² *Id.* at 65, 91, 72, 56.

³³ *Id.* at 47.

³⁴ Similar restrictions obstruct access to abortion for women who rely on other federal health coverage programs, including women who use Indian Health Service, federal employees and their dependents, military personnel and their dependents, Peace Corps volunteers and women in federal prisons.

³⁵ *Harris v. McRae*, 448 U.S. 297 (1980).

³⁶ CTR. FOR REPROD. RIGHTS, REPORT ON THE IMPACT OF THE HYDE AMENDMENT ON POOR WOMEN SEEKING ABORTIONS (forthcoming 2010).

³⁷ Ctr. for Reprod. Rights, No Abortion Ban, <http://reproductiverights.org/en/feature/no-abortion-ban-learn-more>.

³⁸ *Conclusions and Recommendations of the Committee Against Torture: United States of America*, 36th Sess., para. 33, U.N. Doc. CAT/C/USA/CO/2 (2006).

³⁹ *Concluding Observations of the Human Rights Committee: United States of America*, 87th Sess., para. 33, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (2006).

⁴⁰ *Report of the Mission to the United States of America on the Issue of Violence against Women in State and Federal Prisons*, 55th Sess., paras. 53–54, 55–63, U.N. Doc. E/CN.4/1999/68/Add.2 (Jan. 4, 1999).

⁴¹ The policy of Immigration and Customs Enforcement allows security staff to use restraints on pregnant women with the consultation of a medical provider. IMMIGR. & CUSTOMS ENFORCEMENT, U.S. DEP’T OF HOMELAND SECURITY, ICE/DRO DETENTION STANDARD, USE OF FORCE AND RESTRAINTS 6 (2008). See generally HUM. RTS. WATCH, DETAINED AND DISMISSED: WOMEN’S STRUGGLES TO OBTAIN HEALTHCARE IN UNITED STATES IMMIGRATION DETENTION (2009).

⁴² California, Illinois, Vermont, New Mexico, Texas, New York and Washington have passed legislation limiting the use of restraints on incarcerated pregnant women. See Rebecca Project for Human Rights, *Shackling of Pregnant Women in Custody*; see also Act effective June 10, 2010, ch. 181, 2010 Wash. Sess. Laws.

⁴³ See, e.g., Richard Winton, *Jail Care For Women Is Criticized: Sheriff's Department Monitor Says Some Prisoners Wait Months to Receive Requested Medical Care*, L.A. TIMES, July 12, 2008, at B3; Adam Liptak, *Prisons Often Shackle Pregnant Inmates in Labor*, N.Y. TIMES, Mar. 2, 2006 at A16; Letter from WORTH, Women On The Rise Telling HerStory to N.Y. State Legislature, in Support of Anti-Shackling Legislation (May 20, 2009).

⁴⁴ See Jenni Vainik, *The Reproductive and Parental Rights of Incarcerated Mothers*, 46 FAM. CT. REV. 670, 678 (2008) (detailing health risks); Kendra Weatherhead, *Cruel But Not Unusual Punishment: The Failure to Provide Adequate Medical Treatment to Female Prisoners in the United States*, 13 HEALTH MATRIX 429, 450 (2003) (same).

⁴⁵ Letter from Ralph Hale, Executive Vice President, American College of Obstetricians and Gynecologists, to Malika Saada Saar, Executive Director, The Rebecca Project for Human Rights (June 12, 2007); AM. PUB. HEALTH ASS’N, TASK FORCE ON CORRECTIONAL HEALTHCARE STANDARDS, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS 108 (2003).

⁴⁶ Declaration on Human Rights Defenders, G.A. Res. 53/144, U.N. Doc. A/RES/53/144 (1999).

⁴⁷ See Report submitted by the Special Representative of the Secretary-General on human rights defenders, Hina Jilani, 4th Sess. paras. 70-72, U.N. Doc. A/HRC/4/37 (2007) (reporting that since the establishment of her mandate, the Special Representative has sent 36 communications to countries in all regions concerning the right to health and has raised issues regarding threats to healthcare providers); Report submitted by Ms. Hina Jilani, the special Representative of the Secretary-General on the Situation of Human Rights Defenders, pursuant to the Commission on Human Rights resolution 2000/61, 59th Sess., Provisional agenda item no. 17(b) para. 50, U.N. Doc. E/CN.4/2003/104 (2003) (explaining that “human rights defenders in such capacities as medical personnel … make essential contributions to the achievement of [the Millennium Development] goals.”).