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Distinguished Special Rapporteur on violence against women:

In response to your call for submissions on mistreatment and violence against women during reproductive health care with a focus on childbirth, the Black Mamas Matter Alliance and the Center for Reproductive Rights present this joint submission highlighting examples of such violations as they occur in the United States (U.S.). This joint submission also draws attention to some of the innovative interventions that communities directly affected by mistreatment and violence in facility-based birth settings are developing to mitigate and prevent human rights violations.

The Black Mamas Matter Alliance (“BMMA”) is a national cross-sectoral, multidisciplinary network of Black women leaders and organizations working to improve equity and outcomes in U.S. maternal health. BMMA centers the needs, experiences, and knowledge of Black Mamas to advocate, drive research, build power, and shift culture in support of Black maternal health, rights, and justice. BMMA uses the phrase “Black Mamas” to represent a diversity of lived experiences, which includes birthing people of diverse genders (*cis black women, trans folks, and gender non-conforming individuals*) and all people of African descent (*e.g. Afro-Latinx, African-American, Afro-Caribbean, Black, and African-immigrants*). The Center for Reproductive Rights (“The Center”) is a global organization that uses law and policy to advance reproductive rights as fundamental human rights that governments around the world are obligated to respect, protect, and fulfill.

Mistreatment of pregnant and birthing people in the United States

The U.S. healthcare system is expensive, technologically advanced, and complex. But despite these resources, the U.S. has failed to ensure that basic human rights standards related to safe pregnancy, birth, and respectful maternal health care are consistently and equitably applied within health care facilities. At the same time, the U.S. has also failed to create broader enabling conditions that promote the health and dignity of women and their families before, during, and after pregnancy. As a result, some pregnant and birthing women in the U.S. experience mistreatment and violence when accessing health care, in violation of their rights to life, health, equality, non-discrimination, and freedom from torture, cruel, inhuman, and degrading treatment, among others.

In the U.S., gender-based violence is often racialized and women who experience multiple and overlapping forms of oppression are especially vulnerable to violations of their human rights. The devaluation of Black womanhood and Black motherhood in the U.S. places Black women seeking pregnancy related health care at unique risk for abuse and neglect in facility-based birth settings. Because entrenched discrimination on the basis of gender, race, class, and other factors is both normalized and

denied in the U.S., many instances of mistreatment and violence in birth facilities are overlooked or accepted by government actors, health care professionals, and even patients themselves. Nevertheless, a growing movement of U.S. advocates recognize that fundamental human rights are violated when women and girls are forced to endure preventable suffering, including death, illness, injury, mistreatment, abuse, discrimination, and denials of information and bodily autonomy. Since these violations—and the gender stereotyping that perpetuates them—also harm gender minorities who experience pregnancy and birth, this submission will refer to “pregnant and birthing people” in addition to “women and girls.”

Examples of disrespect, abuse, and mistreatment during facility-based births

Disrespect and abuse of pregnant and birthing women and girls is an under-acknowledged problem in the U.S., and more data and research is needed to better understand the nature and prevalence of this discrimination.¹ In the meantime, existing research, media reports, and the experiences of civil society members demonstrate that mistreatment during childbirth does indeed occur in the U.S. and that Black women and other women of color are particularly vulnerable to this type of abuse.

The Black Mamas Matter Alliance encompasses an extensive network of civil society organizations that are working in communities across the U.S. to improve birth outcomes and experiences for Black and other marginalized women. In this capacity, members of the alliance have witnessed, researched, and/or received information about a range of practices that constitute mistreatment and violence toward people seeking reproductive health care, especially during facility-based birth.

Specifically, women and pregnant people in the U.S. have expressed concerns that their birth experiences and the maternal health care they received were compromised by discrimination based on real or perceived personal characteristics. Women and girls report feeling stereotyped, dismissed, treated rudely, or treated with less urgency or dignity because of their race, ethnicity, marital status, education, income, source of insurance (public vs. private), age, gender expression, sexual orientation, immigration status, language abilities, weight, disability, mental and/or physical health history, housing status, and history of carceral or child welfare involvement.² Reports of disrespect also include verbal abuse from providers and other hospital staff, such as insulting, humiliating, and condescending remarks. In some cases, physical abuse or unnecessarily rough physical contact has been observed.

In the U.S., a woman’s access to high quality, respectful maternity care varies significantly depending on her geographic location, race/ethnicity, income, immigration status, and other factors. Many providers do not accept public insurance (Medicaid), nearly half of all U.S. counties lack an obstetric provider, rural hospitals are closing across the country, and hospitals that serve a high proportion of Black patients have been shown to provide lower quality care.³ These structural barriers to equitable maternity care facilitate mistreatment. For example, privacy is systematically eroded for women seeking access to maternal health care via public insurance programs or in crowded public hospitals.⁴ As the Special Rapporteur on poverty noted in his report following an official visit to the U.S. in 2017, “[p]oor pregnant women who seek Medicaid prenatal care are subjected to interrogations of a highly sensitive and personal nature, effectively surrendering their privacy rights.”⁵

Additionally, to obtain prenatal and birth related health care, women must navigate a complex and fragmented health care delivery and payment system, often with minimal assistance or empathy from providers and policymakers. By placing many of the burdens of health care coordination on patients, the health care system exacerbates inequities and barriers to care that women and girls already face, including

disproportionate poverty, childcare responsibilities, pregnancy discrimination in employment and housing, and unmet transportation needs. When women are unable to overcome barriers to comprehensive prenatal care, they are often treated as “irresponsible” patients when they eventually arrive at facilities to give birth.

One of the most commonly cited concerns among women and girls who have given birth in the U.S. is that medical providers did not listen to them or provide them with sufficient information. While being dismissed or ignored may appear to be a less severe example of violence against women, for Black women giving birth in the U.S., this neglect can be fatal. The U.S. is the only wealthy country in the world where maternal mortality is rising, and Black women are 3-4 times more likely to suffer maternal death, and twice as likely to suffer maternal morbidity as white women are.⁶ These racial disparities in maternal health outcomes persist across income and education levels, and a growing body of evidence indicates that exposure to racism inside and outside the health care system plays a significant role.⁷ The crisis of preventable maternal mortality in the U.S. has been recognized as a human rights concern in reviews of the U.S. by the Committee on the Elimination of Racial Discrimination in 2008 and 2014 and during the Universal Periodic Review of the U.S. in 2015, as well as in reports concluding official visits to the U.S. from the UN working group on discrimination against women in law and in practice in 2015, the UN working group of experts on people of African descent in 2016, and the Special Rapporteur on extreme poverty in 2017.⁸

When Black women express concerns and needs during birth and providers fail to listen, potentially life-saving health care may be denied or delayed. Indeed, when Serena Williams, (the American tennis star), publicly recounted her struggle to convince health care providers that she was experiencing blood clots after the birth of her daughter in 2018, Black women across the U.S. recognized parallels in their own birth experiences and felt their own fears validated—if such a wealthy, healthy, and well-known Black woman could not get her medical team to take her concerns and self-knowledge seriously, how safe are Black women who give birth in facilities without those privileges?⁹

The lack of options available to birthing people in the U.S. health care system undermines human rights

Relationships between birthing women and their health care providers may also be undermined by legacies of violence and enduring power hierarchies that limit choice and fuel mistrust. Since the nation’s founding, Black women and girls in the U.S. have been dehumanized and subjected to violence, including enslavement, segregated health care, and medical experimentation that entailed sexual and reproductive abuses.¹⁰ Black women’s bodies and decisions have been repeatedly pathologized. Thus, the distrust of medical systems that some women feel is rooted in history, lived experiences, and ongoing demonstrations of bias and discrimination on the part of health care providers.¹¹ Research shows that contemporary U.S. physicians diagnose and treat women and Black patients differently than they treat men and white patients, and that they hold false beliefs about Black women’s capacity to endure pain.¹² Black physicians are significantly underrepresented in the health care workforce, and many Black women never have an opportunity to be cared for by someone who shares their racial or cultural background. In this context, it can be difficult for birthing Black women to connect with providers who effectively communicate respect.

It is also important to note that, in the U.S., many women do not have a meaningful choice in where they give birth, how they will birth, or who they will birth with. In the early 1900s, the medical establishment

mounted a campaign to bring childbirth into hospital facilities, demonizing midwives and home births in the process. The campaign targeted traditional birth attendants—many of whom were women of color, indigenous, and/or immigrants—portraying them as dirty and dangerous.¹³ These efforts contributed to the imposition of legal restrictions that continue to constrain the ability of midwives to practice today. The result is a patchwork of laws that vary from state to state, where some midwives are prohibited from practicing, where women in some locations are prohibited from birthing at home, and where insurance companies' decisions about what they will and won't cover are often determinative of the type of care a woman receives.¹⁴ Consequently, birthing in a hospital with a physician is the only option accessible to most women in the United States.

Finally, pregnant women imprisoned in the criminal justice system or in immigration detention facilities have even fewer options than most, and lack avenues for recourse when they are mistreated and denied appropriate maternal health care.¹⁵ While both of these systems resist the transparency needed to facilitate accountability for human rights violations, media reports and the testimony of currently and formerly imprisoned people have exposed ongoing abuses in the context of pregnancy and birth.¹⁶ Women in these settings continue to be shackled—even where applicable laws and policies prohibit it—and pregnant women experiencing labor or obstetric emergencies have been denied necessary health care.¹⁷

Coercion, threats, and denials of informed consent

Although informed consent for medical care is a legal requirement in the U.S., in practice it is often treated as an exercise in paperwork rather than an opportunity to meaningfully engage women in shared decision-making. True informed consent is frequently undermined by lack of communication, coercion, failure to provide information in a language the patient can understand, and in some cases by misuse or permission of the law.

For example, many women who present to health care facilities in the U.S. are asked to sign pages of fine print documents before they receive any treatment. These documents are designed to protect the hospitals and providers from legal liability and may do little to inform the woman about her rights and options. What happens after that may depend in large part on the individual health care provider's willingness to explain and discuss specific tests, procedures, and options, and the woman's ability to self-advocate for detailed information about her condition and options.

At teaching hospitals, birthing women and girls may be especially vulnerable to objectification as trainees come in and out of patient spaces, openly discussing patient's bodies among one another and sometimes touching patients without prior introduction or acknowledgment. Moreover, when a woman's entitlement to information and autonomous decision-making is viewed as inferior to that of her medical provider, she is placed at risk for violations that she may not even know about. For instance, in most U.S. states it is legal for doctors and medical students to practice performing pelvic exams on unconscious women who are under anesthesia for other treatment, have no medical need for a pelvic exam, and have not explicitly consented to one.¹⁸

Additionally, the U.S. has a highly medicalized maternity care system where women typically labor and deliver their babies in hospital units with hierarchical medical teams led by physicians trained in surgery. The rate of surgical interventions during childbirth exceeds the World Health Organization's recommended thresholds, with about one third of U.S. births occurring via cesarean section.¹⁹ Misaligned incentives (including payment structures, scheduling, and medical malpractice fears), along with a

cultural tendency to prioritize the well-being of the fetus over the well-being and autonomy of the pregnant person, contribute to high rates of unnecessary interventions. Women and girls in the U.S. have reported denial of informed consent and coercive tactics related to these procedures. In some cases, birthing people simply assume they must defer to the physician's order. In more extreme cases, women who have refused surgical procedures have been forcibly operated on or punished, contradicting established law and medical ethics.²⁰ In those cases, health care providers, systems, and legal actors have relied on the same arguments that animate opposition to abortion and undermine the autonomy of pregnant people.²¹

Pregnant and birthing women in the U.S. have also been told that if they do not comply with the directives or preferences of the hospital's medical staff, their baby will die and/or they will be reported to child welfare agencies for abusing their child.²² Women of color are particularly vulnerable to this type of coercion and hospital personnel routinely perceive and document their self-advocacy efforts as "non-compliance." Hospitals also engage in discriminatory surveillance of poor women and women of color, disproportionately testing pregnant women of color and their newborns for drugs without their consent.²³

Child welfare agencies use evidence of health challenges such as prenatal substance use, postpartum depression, and/or poverty to charge mothers with child abuse or neglect, collapsing legal distinctions between fetuses and children, discouraging women from seeking prenatal care or support, and subjecting new mothers to punitive supervision and surveillance systems and family separation. In addition to biased voluntary reporting by health care personnel, "mandatory reporting and mandatory investigation laws—requiring professionals to report and child protection agencies to investigate all instances of suspected neglect—inhibit a public health response by imposing a coercive legal regime on an overly broad category of cases and preventing professionals from making more effective interventions."²⁴ The Special Rapporteur on extreme poverty noted the discriminatory use of child welfare interventions in his report on poverty in the U.S., writing that "[w]hen a child is born to a woman living in poverty, that woman is more likely to be investigated by the child welfare system and have her child taken away from her."²⁵ *For more information, see submission of Movement for Family Power, National Advocates for Pregnant Women, Center for Constitutional Rights and others.*

Existing accountability mechanisms fail to address mistreatment of birthing people in medical facilities

The U.S. has a complex and fragmented health care system that encompasses a mixture of public and private actors and entities. This fragmentation can make it difficult to apply accountability mechanisms that protect women's human rights. Currently, neither the health care system nor the criminal and civil legal systems adequately ensure system-wide accountability for women's human and reproductive rights. Although patients may flag the problematic behavior of individual physicians by filing complaints with a facility or medical board, these processes are not designed to facilitate resolution or remedies for women who have been mistreated during facility-based births. Similarly, although criminal and civil law does prohibit certain abusive conduct, it does not cover all instances of mistreatment in facility-based birth settings and there are many practical barriers to leveraging these adversarial strategies.²⁶

The Office of the United Nations High Commissioner for Human Rights report to the Human Rights Council providing technical guidance on the application of a human rights-based approach to maternal health policy recommends replacing accountability gaps like these with monitoring mechanisms and

processes that facilitate continual feedback, adjustment, and future planning, as well as remedies for violations.²⁷ Under the current system, women in the U.S. who are affected by mistreatment in facility-based birth settings have few formal opportunities to engage providers, systems, and decision-makers in honest feedback processes that might prevent future mistreatment.

U.S. government and health systems responses to human rights violations during birth

Over the last several years, civil society, concerned researchers, and feminist media creators have successfully raised public awareness of U.S. birth inequities, including racial disparities in preventable maternal mortality and morbidity. During the last Congress, the Center for Reproductive Rights tracked around twenty proposed federal bills related to maternal health, two of which ultimately passed.²⁸

Unfortunately, the role of racism, bias, and discrimination in facility-based birth settings remains controversial and narratives that blame women's bodies and choices for poor maternal health outcomes and experiences still dominate the mainstream medical and political discourse.²⁹ The idea that women—and poor women of color in particular—cannot be trusted to make good decisions for themselves and their families undermines progress toward improved outcomes. Moreover, “[e]xclusively addressing individual behaviors as the basis for health outcomes, without a structural perspective, can lead to stigmatization, scapegoating, heightened surveillance, and criminalization, all of which disregard the bodily autonomy of pregnant women.”³⁰ To the extent that government, health care systems, facilities, and obstetric providers have been willing to accept some of the responsibility for needed improvements in U.S. maternal health care, these efforts have focused primarily on implementing clinical protocols that standardize technical responses to obstetric emergencies within and across facilities.³¹ While important and necessary, these safety improvement efforts tend not to address the role of structural racism and bias, or the importance of prioritizing patient autonomy and dignified, woman-centered care.

Good practices and other efforts to protect human rights surrounding birth

The Black Mamas Matter Alliance and its members are building new models of care and support for birthing individuals in their communities and are setting forth guidelines for respectful care during childbirth that are informed by human rights standards and the experiences of women directly affected by mistreatment. BMMA uses the birth and reproductive justice framework to advance a human rights-based approach to respectful birth care grounded in the scholarship of black feminist and womanist perspectives. Reproductive justice is a theory and a movement built by Black women in the U.S. who defend and promote the human rights of all people to (1) maintain personal bodily autonomy, (2) have children, (3) not have children, and (4) parent children in safe and sustainable communities.³²

BMMA published a paper in April 2018 titled, “Setting the Standard for Holistic Care of and for Black Women.” This paper acknowledges the racialized and gender-based violence that has shaped living conditions for Black women in the United States, and it offers recommendations to help mitigate and ultimately transform oppressive birth experiences. BMMA advocates for holistic care that addresses gaps and ensures continuity; is affordable and accessible; is confidential, safe and trauma-informed; ensures informed consent; centers Black mamas, families and parents and is patient-led; is culturally-informed and includes traditional practices; is provided by culturally competent and congruent providers; respects spirituality and spiritual health; honors and fosters resilience; includes the voices of Black mamas; is

responsive to the needs of all genders and family relationships; and provides wraparound services and connections to social services.³³

Additionally, many of BMMA's members are providing direct services to women and pregnant people in their communities, as doulas, midwives, nurses, physicians, and in other roles. Black doulas committed to racial and gender justice are playing a particularly powerful role in transforming expectations about how women should be treated during facility-based childbirth in the United States. Doulas are birth workers who provide non-clinical emotional, physical, and informational support to people who are pregnant, birthing, and/or postpartum. Research shows that doula care can promote human rights in maternal health settings by improving both birth outcomes and birth experiences.³⁴

Many of BMMA's member doulas are creating local models of service delivery that build the capacity of their own communities to care for one another and honor Black women's humanity. These community-based doula groups train women of color from within neighborhoods that are exposed to mistreatment during childbirth, increasing the diversity of the doula field and ensuring that marginalized women have free or low-cost access to doula care. In the process, they raise awareness about respectful birth care throughout the community, while empowering women of color with the knowledge that at least one person present at their birth will be sensitized to systemic issues of racism and inequality and can be counted on to support the birthing person's dignity and autonomy. In most cases, community-based doula groups are providing these critical services without adequate support or government funding.

Finally, in New York City, members of BMMA participated in a collaboration between the New York City Department of Health and Mental Hygiene and community members to develop a set of human rights-based "Standards for Respectful Care at Birth." These guidelines are being shared with both patients and providers, encouraging birthing people to claim their human rights, and building the capacity of government institutions and the health care system to uphold human rights within the city's birthing facilities.³⁵

Recommendations to the Special Rapporteur on violence against women

The Black Mamas Matter Alliance and the Center for Reproductive Rights respectfully urge the Special Rapporteur on violence against women to consider the following recommendations as she prepares her report on violence against women in facility-based birth care settings:

- Reinforce that states have an affirmative obligation to combat violence against women and girls, including violence that is committed by private actors in facility-based birth settings, and to prioritize groups that are most vulnerable to abuse in efforts to prevent and remedy violence.
- Recognize that the gender-based violence many women and girls experience is deeply intertwined with racial violence and that women and girls with marginalized racial and ethnic identities are subject to racialized forms of mistreatment during facility-based childbirth and when accessing other forms of reproductive health care.
- Recognize that poverty is a key factor in violations during facility-based childbirth, particularly in contexts where poor women and girls are viewed as undeserving of health care and may have few or no alternatives to the facilities and providers that mistreat them.

- Recognize that women, girls, and gender minorities frequently suffer violence and human rights violations while birthing in custodial settings. In this context, denial of health care, shackling, and forced separation from newborn children are forms of violence against women that states should protect against. Further recognize that in many countries, women and girls living in poverty and women and girls from minority groups are disproportionately targeted for incarceration and detainment and recommend that states address the root causes driving the imprisonment of these populations.
- Recognize that in some instances, violence against women and girls during reproductive health care can amount to torture, cruel, inhuman and degrading treatment.
- To prevent, address, and eliminate violence against women, girls, and gender minorities during facility-based births, States should collect and publish data on the nature and prevalence of violence, disrespect, and abuse in these settings, disaggregated by race/ethnicity, gender, and socioeconomic status.
- States should enact and implement human rights-based national standards defining threshold requirements for accessible, available, acceptable, quality maternal health care, free from violence and discrimination, and should implement mechanisms to hold their health systems accountable for meeting respectful care standards.
- States should ensure that pregnant and birthing people are empowered to pursue appropriate health care and remedies when their human rights are violated, including access to different health care providers and access to legal counsel.
- States should promote human rights-based education on respectful maternity care for all health care system participants, including facility administrators, providers, and patients.
- States should ensure that women, girls, and gender minorities have a meaningful choice in where they birth and who they birth with by (1) ensuring that facility-based birth care is respectful, safe, and accessible to all who need it, and (2) by removing legal and financial barriers that hinder people's access to birth providers and settings that are not facility-based.
- States should fund and support doulas, community health workers, and other para-professionals who promote respectful care during birth and can help prevent or mitigate instances of mistreatment and violence against birthing people in facility-based birth settings. Funding should be sufficient to ensure birth workers earn a living wage and should not be tied to coercive policies, such as mandatory reporting.
- With the active participation of women and girls, States should review and revise laws and policies that impact facility-based birth care, ensuring that such laws and policies adequately protect the human rights of individuals who are pregnant, birthing, and postpartum. States should ensure that

women, girls, and gender minorities are never criminalized for the health care decisions they make while exercising bodily autonomy during pregnancy and birth.

- States should ensure that, regardless of pregnancy status, women, girls, and gender minorities are not subjected to detention or criminalization because they have sought out health services that are necessary to protect their lives and physical or mental health, including maternity services, substance use treatment, mental health services, and services related to abortion and contraception.

We appreciate this opportunity to provide input in advance of the Special Rapporteur's report. Should the mandate need any additional information, please do not hesitate to reach out to Pilar Herrero, *Senior Staff Attorney, U.S. Human Rights, Center for Reproductive Rights* at pherrero@reprorights.org and Angela Doyinsola Aina, *Co-Director and Research Lead, Black Mamas Matter Alliance* at ada@blackmamasmatter.org.

¹ Lynn Freedman et al., *To Reverse the Maternal Health Crisis, We Must Break the Cycle of Distrust*, REWIRE (April 11, 2019, 1:40 pm), <https://rewire.news/article/2019/04/11/maternal-health-crisis-cycle-of-distrust/> (describing a soon to be released study led by the Averting Maternal Death and Disability program with BMMA, the first of its kind in U.S., drawn from focus group discussions with members of community organizations and public and private hospital staff. The study focuses on the complex dynamics of distrust between marginalized communities and health systems and its findings explore the prevalence, drivers, and kinds of mistreatment experienced in hospital settings.).

² See e.g., Monica McLemore et al., *Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth*, 201 SOC. SCI. MED. 127, 129 (2018); Julia Chinyere Oparah et al., *Battling Over Birth: Black Women & The Maternal Health Care Crisis in California*, Black Women Birthing Justice (2016), <https://www.blackwomenbirthingjustice.org/battling-over-birth>; Black Mamas Matter Alliance, Center for Reproductive Rights, *Advancing the Human Right to Safe and Respectful Maternal Health Care*, BMMA (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf (an advocacy toolkit informed by focus groups of Black women discussing prior reproductive health care encounters, and including quotes describing some of those encounters throughout); Farah Diaz-Tello and Lynn Paltrow, *NAPW Working Paper: Birth Justice as Reproductive Justice*, NAT'L ADVOCATES FOR PREGNANT WOMEN (May 2012), <http://advocatesforpregnantwomen.org/Birth%20justice%202012.pdf>; Women Enabled International (WEI), *Human Rights Committee Submission for List of Issues Prior to Reporting for the United States of America on Women, Girls, and Nonbinary Persons with Disabilities*, WEI 3 (2019), <https://www.womenenabled.org/pdfs/WEI%20LOIPR%20Submission%20to%20Human%20Rights%20Committee%20on%20the%20United%20States%20January%202014,%202019%20FINAL.pdf> (noting that [w]omen with disabilities ... frequently encounter pressure from doctors, guardians, social service workers, parents, and society to abort a pregnancy because of a misperception of the possibility of passing on disabilities to their children—even if the disability is not genetic).

³ *Hearing of the Committee on Energy and Commerce Subcommittee on Health on "Improving Access to Maternity Care Act" (H.R. 1209)*, 114th Cong. 8 (Table 3)(2015) (Testimony of the Am. College of Nurse-Midwives), <https://docs.house.gov/meetings/IF/IF14/20151209/104268/HHRG-114-IF14-Wstate-BreedloveG-20151209.pdf>; Kayla Holgash and Martha Heberlein, *Physician Acceptance of New Medicaid Patients*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION 6 (Jan. 24, 2019), <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf> (noting that about one third of providers currently do not accept new patients insured by Medicaid); North Carolina Rural Health Research Program, *106 Rural Hospital Closures: January 2010-Present*, U.N.C. CTR. FOR HEALTH SERVS. RES., <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited May 16, 2019) (tracking the closure of at least 106 rural hospitals across the country since 2010); Andreea A. Creanga et. al,

Performance of racial and ethnic minority-serving hospitals on delivery-related indicators, 211 AM. J. OF OBSTETRICS & GYNECOLOGY 647e.1-647 e.16 (2014) (finding that “black-serving hospitals provide lower quality maternity care,” have “higher rates of maternal complications than other hospitals,” and “perform worse on 12 of 15 birth outcomes, including elective deliveries, non-elective cesarean births, and maternal mortality”).

⁴ See generally KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* (2017) (investigating poor mother’s experiences when they do and do not receive public assistance and arguing that poor mothers in America have been deprived of privacy, familial, informational, and reproductive rights within the American healthcare system); KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RADICALIZATION* (2011)(developing an ethnography of pregnancy and birth at a large New York hospital and exploring the role of race in healthcare settings, including material harms and consequences for women navigating public healthcare systems influenced by social constructions of race that reproduce racial stereotypes).

⁵ Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (by Philip Alston).

⁶ During 2011-2014, the pregnancy related mortality ratios were 40 deaths per 100,00 live births for Black women versus 12.4 deaths per 100,000 live births for white women. See *Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 7, 2018), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm> (analyzing copies of death certificates for all women who died during pregnancy or within 1 year of pregnancy submitted voluntarily from 52 reporting areas (50 states, New York City, and Washington DC); see also Andrea A. Creanga et al., *Racial and ethnic disparities in severe maternal morbidity: a multistate analysis, 2008-2010*, 210 AM J. OBSTETRICS AND GYNECOLOGY 435.e1-435.e8 (2014), [https://www.ajog.org/article/S0002-9378\(13\)02153-4/pdf](https://www.ajog.org/article/S0002-9378(13)02153-4/pdf) (analyzing State Inpatient Databases from 6 states and using the *International Classification of Diseases* codes to create SMM indicators; finding that Black women are disproportionately affected by severe maternal morbidity and concluding there is a need for systematic review of SMM at all levels of government to guide the development of quality improvement interventions to reduce racial disparities in SMM).

⁷ Gopal Singh, Health Resources and Services Administration, Maternal and Child Health Bureau, *Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist*, U.S. DEP’T OF HEALTH AND HUMAN SERVS. 2-4 (2010), <http://www.hrsa.gov/ourstories/mchb75th/mchb75maternalmortality.pdf>; Arline T. Geronimus, *The weathering hypothesis and the health of African-American women and infants: evidence and speculations*, 2 ETHNICITY & DISEASE 207-221 (1992), <https://www.ncbi.nlm.nih.gov/pubmed/1467758> (finding a kind of toxic stress triggers the premature deterioration of the bodies of Black women as a consequence of repeated exposure racial discrimination and that this effect could lead to poor pregnancy outcomes.).

Only 4 percent of physicians are Black in the United States and studies have identified the lack of diversity among physicians as one factor contributing to racial health disparities in the United States. Research has examined how changing this ratio might improve health outcomes. See Section II: *Current Status of the U.S. Physician Workforce*, ASS’N AM. MEDICAL COLLEGES (2017), <http://www.aamcdiversityfactsandfigures.org/section-ii-current-status-of-us-physician-workforce/index.html#ref1> (providing an overview of demographic and practice characteristics physicians graduating from U.S. M.D.-granting medical schools and noting divert workforce is not increasing at the same pace as the nation’s demographic shift); see also e.g., Marcella Alsan et al., *Does Diversity Matter for Health? Experimental Evidence from Oakland*, STANFORD MED. SCHOOL CTR. FOR HEALTH POL’Y (2018), <https://malsan.people.stanford.edu/sites/g/files/sbiybj4136/f/people.stanford.edu/malsan/sites/default/files%20oakland.pdf> (studying the effect of diversity in the physician workforce on the demand for preventive care finding that subjects were more likely to talk with a black doctor about their health problems and black doctors were more likely to write additional notes about the subjects; finding the results consistent with better patient-doctor communication during the encounter).

⁸ Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations— United States of America*, para. 33, UN Doc. CERD/C/USA/CO/6 (May 8, 2008) (recommending that the state continue to “address

persistent racial disparities in sexual and reproductive health by (i) [i]mproving access to maternal health care, family planning, pre and post- natal care and emergency obstetric services”); CERD, *Concluding Observations—United States of America*, para. 15, UN Doc. CERD/C/USA/CO/7-9 (Sept. 25, 2014) (recommending that the U.S. ensure effective access to affordable and adequate health-care services; eliminate racial disparities in the field of sexual and reproductive health; standardize data collection on maternal and infant deaths; and improve monitoring and accountability mechanisms for preventable maternal mortality, including at the state level); Human Rights Council, *Report of the Working Group on the Universal Periodic Review— United States of America*, para. 176.316, UN Doc. A/HRC/30/12 (July 20, 2015) (recommending that the United States “[e]nsure equal access to equality maternal health and related services as an integral part of the realization of women’s rights” (Finland)); Human Rights Council, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice, on its Mission to the United States*, para. 72, 89, UN Doc. A/HRC/32/44/Add.2 (June 7, 2016) (recommending that the U.S. address racial disparities in maternal health); Human Rights Council, *Report of the Working Group of Experts on People of African Descent, on its Mission to the United States*, para. 117, UN Doc. A/HRC/33/61/Add.2 (Aug. 18, 2016) (noting that racial discrimination has a negative impact on Black women’s ability to maintain good health and recommending that the United States prioritize policies and programs to reduce maternal mortality for Black women); Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 57, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (by Philip Alston) (noting that the U.S. has the highest maternal mortality ratio among wealthy countries, and that Black women are three to four times more likely to die in childbirth).

⁹ Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018, 8:00 am), <https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018>; Elizabeth Daws Gay, *Serena Williams Could Insist That Doctors Listen to Her. Most Black Women Can’t.*, THE NATION (Jan. 18, 2018), <https://www.thenation.com/article/serena-williams-could-insist-that-doctors-listen-to-her-most-black-women-cant/>; Darlena Cunha, *The important lesson new moms should learn from Serena Williams’s scary childbirth experience*, CHI. TRIB. (May 16, 2019), <https://www.chicagotribune.com/lifestyles/health/ct-serena-williams-scary-childbirth-experience-20180113-story.html>; Allaya Cooks-Campbell, *Serena Williams’ traumatic birth experience isn’t rare for black women—and that needs to change*, MOTHERLY (Jan. 17, 2018), <https://www.motherly.com/news/serena-williams-traumatic-birth-experience-isnt-rare-for-black-womenand-that-needs-to-change>.

¹⁰ DEIRDRE COOPER OWENS, *MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGIN OF AMERICAN GYNECOLOGY* 11 (2017) (noting that key developments in the early field of gynecology were made by medical practitioners who performed brutal surgeries, without on enslaved Black women, without anesthesia); Mary S. Vaughan Sarrazin, *Racial Segregation and Disparities in Health Care Delivery: Conceptual Model and Empirical Assessment*, 44 HEALTH SERVS. RES. 1242-1444 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2739036/#b11> (finding that while “sanctioned forms of hospital segregation were essentially eliminated during the 1960s, de facto segregation remains); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 90 (2d ed. 2017)(describing a practice so common it came to be known as the “Mississippi appendectomy,” medical students in the South developed their surgical skills by performing unnecessary hysterectomies on poor Black women at teaching hospitals, without their informed consent).

¹¹ Lynn Freedman et al., *To Reverse the Maternal Health Crisis, We Must Break the Cycle of Distrust*, REWIRE (April 11, 2019, 1:40 pm), <https://rewire.news/article/2019/04/11/maternal-health-crisis-cycle-of-distrust/> (finding that personal, historic, and systemic factors contributing to distrust work corrosively to sabotage implementation of “even the most well-meaning, evidence-based biomedical interventions... feed[ing] on itself, fostering cynicism, burnout, lapses in quality care, and preventing pregnant women from seeking medical care when they need it.”).

¹² Kelly M. Hoffman et al., *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites*, 113 PROC. NAT’L ACAD. SCI. 4296-4301 (2016).

¹³ Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN’S RIGHTS L. REP. 36. (2014), <https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/57bef331197aeadebcbd1c41/1472131890592/L>

usero+FINAL.pdf; Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, SCHOLARLY WORKS (2004), <https://scholars.law.unlv.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1395&context=facpub>; Alicia D. Bonaparte, *The Persecution and prosecution of Granny Midwives in South Carolina, 1900-1940* (August 2007) (unpublished Ph.D. dissertation, Vanderbilt University) (on file with author), https://www.researchgate.net/publication/242665600_The_Persecution_and_Prosecution_of_Granny_Midwives_in_South_Carolina_1900-1940.

¹⁴ Tiffany Thomas, *Is Home Birth Legal In All States? The Right To Choose Applies Here, Too*, Romper (May 25, 2017), <https://www.romper.com/p/is-home-birth-legal-in-all-states-the-right-to-choose-applies-here-too-59624>.

¹⁵ In the civil system, the number of immigrant women experiencing miscarriage or stillbirth while in government detention has risen sharply since the Trump Administration enacted a new policy in 2018 ending the presumption that U.S. Immigration and Customs Enforcement will release pregnant individuals. Scott Bixby, *Immigrant Miscarriages in ICE Detention Have Nearly Doubled Under Trump*, THE DAILY BEAST (March 1, 2019), <https://www.thedailybeast.com/immigrant-miscarriages-in-ice-detention-have-nearly-doubled-under-trump?ref=scroll>; Tina Vasquez, *ICE Increased Risks for Pregnant Migrants in Detention. What is the Agency Doing About it?*, REWIRE (April 5, 2019, 1:10 pm), <https://rewire.news/article/2019/04/05/ice-increased-risks-pregnant-migrants-detention/>.

On the criminal side, the U.S. is home to more than 30% of the world's incarcerated women, a population that is disproportionately comprised of poor women and women of color. An unknown number of U.S. women enter jail or prison pregnant, and this number is likely to rise as more states enact and enforce laws that criminalize drug use and other behaviors during pregnancy. Victoria Law, *First-of-Its-Kind Study Fills in Decades-Long Blank About Pregnancy in Prison*, REWIRE (March 21, 2019, 4:00 pm), <https://rewire.news/article/2019/03/21/first-of-its-kind-study-fills-in-decades-long-blank-about-pregnancy-in-prison/>.

In addition to incidents of shackling, reports of extreme medical neglect and indifference towards birthing women in the criminal justice system have surfaced, including the case of a mentally ill Black woman who spent seven hours birthing alone in her Florida jail cell in early May after her requests for help were denied. Elliott C. McLaughlin, *Pregnant woman asked jail staff for help, lawyers say. Hours later, she was alone in a cell, holding her newborn*, CNN (May 6, 2016, 1:01 pm), <https://www.cnn.com/2019/05/06/us/woman-gives-birth-jail-cell-broward-florida/index.html>.

¹⁶ Victoria Law, *First-of-Its-Kind Study Fills in Decades-Long Blank About Pregnancy in Prison*, REWIRE (Mar. 21, 2019, 4:00pm), <https://rewire.news/article/2019/03/21/first-of-its-kind-study-fills-in-decades-long-blank-about-pregnancy-in-prison/> (describing the first study to track the number of pregnant people behind bars in more than a decade and noting that prison pregnancy data, including research on individual experiences of pregnant people that are incarcerated, are critical in ensuring pregnancy-related needs are addressed for those incarcerated).

¹⁷ See First Step Act of 2018, 18 U.S.C. § 4322 (2018) (prohibiting the shackling of pregnant women in federal custody); see also Ashley Southall and Benjamin Weiser, *Police Forced Bronx Woman to Give Birth While Handcuffed, Lawsuit Says*, N.Y. TIMES (Dec. 6, 2018), <https://www.nytimes.com/2018/12/06/nyregion/pregnant-inmate-shackled-lawsuit.html> (reporting that “New York is one of 26 states that prohibit shackling women in labor,” according to Dr. Carolyn Sufrin, an assistant professor in gynecology and obstetrics at Johns Hopkins Medicine.); Victoria Law, *Pregnant Women Are Being Shackled in Massachusetts-Even Though It's Been Illegal for Years*, REWIRE (June 15, 2016), <https://rewire.news/article/2016/06/15/pregnant-women-shackled-massachusetts-even-though-illegal-years/>; Jason Silverstein, *Dozens of Milwaukee County Jail Inmates have been forced to give birth while shackled, lawsuit alleges*, DAILY NEWS (Mar. 19, 2017), <https://www.nydailynews.com/news/national/milwaukee-jail-inmates-forced-give-birth-shackles-suit-article-1.3002630>; see also U.S. Immigr. And Customs Enf't, 2011 Operations Manual ICE Performance-Based National Detention Standards 204 (revised Dec. 2016), <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (prohibiting the use of restraints on detained pregnant women or women in post-delivery recuperation absent “truly extraordinary circumstances (...) as documented by a supervisor and directed by the on-site medical authority;” restraints prohibited without exception for women who are in active labor or delivery); U.S. IMMIGR. AND CUSTOMS ENF'T, ICE DIRECTIVE NO. 11032.3, IDENTIFICATION AND MONITORING OF

PREGNANT DETAINEES 2 (2017),

https://www.ice.gov/sites/default/files/documents/Document/2018/11032_3_PregnantDetainees.pdf (holding ICE officials in charge responsible for ensuring agents are aware of “policy related to the use of restraints for pregnant detainees”); Ema O’Connor and Nidhi Prakash, *Pregnant Women Say They Miscarried in Immigration Detention and Didn’t Get the Care They Needed*, BUZZFEED.NEWS (July 9, 2018),

<https://www.buzzfeednews.com/article/emaconnor/pregnant-migrant-women-miscarriage-cpb-ice-detention-trump#.qgyrKyz9e> (describing incidents of denial of medical care, shackling and abuse of pregnant women in immigrant detention centers).

¹⁸ Shawn Barnes, *Practicing Pelvic Examinations by Medical Students on Women Under Anesthesia: Why Not Ask First?*, 120 OBSTETRICS & GYNECOLOGY 941-943 (2012).

¹⁹ WHO Statement on Caesarean Section Rates, WORLD HEALTH ORG. (2015),

https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=A43B97E03594A2A263124FE03FE55FAB?sequence=1 (considering the “ideal rate for caesarean sections to be between 10% and 15%”); National Center for Health Statistics, *Births - Method of Delivery, Data are for the U.S.*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/nchs/fastats/delivery.htm> (last visited May 16, 2019) (noting that 32% of all deliveries in the United States are by Cesarean).

²⁰ See Farah Diaz-Tello and Lynn Paltrow, *NAPW Working Paper: Birth Justice as Reproductive Justice*, NAT’L ADVOCATES FOR PREGNANT WOMEN (May 2012),

<http://advocatesforpregnantwomen.org/Birth%20justice%202012.pdf>; Farah Diaz-Tello, *Invisible Wounds: obstetric violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016); Wendy Chavkin and Farah Diaz-Tello, *When Courts Fail: Physicians’ Legal and Ethical Duty to Uphold Informed Consent*, 1 Col. Med. Rev. 6-9 (2017).

²¹ *Id.* at 4-6.

²² See Farah Diaz-Tello, *Invisible Wounds: obstetric violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016).

²³ See *Our Systems Meant to Help Are Hurting Black Families*, Nat’l Inst. for Children’s Health Quality, <https://www.nichq.org/insight/our-systems-meant-help-are-hurting-black-families> (last visited May 16, 2019).

²⁴ Josh Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 91 NEB. L. REV. 897 (2014).

²⁵ Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 56, U.N. Doc. A/HRC/38/33/Add.1 (May 4, 2018) (by Philip Alston).

²⁶ Tort liability is the primary mechanism that patients have to legally assert and recover for violations of domestically recognized rights, such as allegations that their provider physically abused them, did not obtain consent, or provided substandard care. However, the legal system is difficult to navigate, expensive to access, and many claims are subject to time limitations. See Farah Diaz-Tello, *Invisible Wounds: obstetric violence in the United States*, 24 REPROD. HEALTH MATTERS 56-64 (2016).

²⁷ Human Rights Council, *Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, para. 18, UN Doc. A/HRC/21/22 (July 2, 2012).

²⁸ The Preventing Maternal Deaths Act of 2018, 42 U.S.C. § 247b-12 (2018) (creating a federal initiative to support states and tribal organizations establishing and maintaining MMRCs, and reporting their findings to the Centers for Disease Control (CDC)); Improving Access to Maternity Care Act, 42 U.S.C. §254e(k)(2018) (addressing the shortage of maternity care professionals by identifying rural, underserved, and low-resource areas across the country and eliminating those gaps).

²⁹ Karen Scott et al., *The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in “Mother Blame” Narratives.*, 32 J. PERINATAL NEONATAL NURSE 108-115 (2019) (proposing new care models and providing “tools to dismantle structural racism specific to ‘mother blame’ narratives” in perinatal care for Black women.).

³⁰ *Id.* at 109.

³¹ The Preventing Maternal Deaths Act of 2018 requires MMRCs to use CDC best practices “to reliably determine and include all pregnancy-associated deaths and pregnancy-related deaths.” See The Preventing Maternal Deaths Act of 2018, 42 U.S.C. § 247b-12 (2018); *Report from Maternal Mortality Review Committees: A View Into Their*

Critical Role, CTRS. FOR DISEASE CTR'L FOUND. Appendix A(1)-(4) (2017), <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIARepor.pdf> (including best practices and suggested Maternal Mortality Review Committee Decision Form listing factors to consider when determining cause(s) of death); *see also AIM-Supported Safety Bundles*, Council on Patient Safety in Women's Health Care, <https://safehealthcareforeverywoman.org/aim-supported-patient-safety-bundles/> (last visited on May 17, 2019) (identifying "[a] collection of 10-13 best [clinical] practices that have been vetted by experts in practice" in order to standardize approach to improving maternity care in hospital networks, systems, and other maternity care providers).

³² *Reproductive Justice*, Sister Song, <https://www.sistersong.net/reproductive-justice> (last visited May 16, 2019).

³³ Sunshine Muse, *Setting the Standard for Holistic Care of and for Black Women*, BLACK MAMMAS MATTER ALLIANCE 6 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf.

³⁴ Ancient Song Doula Services, Village Birth International, Every Mother Counts, *Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities* (2019), https://docs.wixstatic.com/ugd/f36f23_7d936f97617a4e34aadd8a052ac1de6.pdf?org=801&lvl=100&ite=434&lea=2996&ctr=0&par=1&trk=.

³⁵ NYC Health, *New York City Standards for Respectful Care at Birth*, NYC.GOV (2018), <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/respectful-care-birth-brochure.pdf>.