January 31, 2014

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United Nations Office at Geneva
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Switzerland

To: Members of the Committee on the Elimination of Racial Discrimination

Re: Information to Inform the Committee’s List of Themes for the U.S. Periodic Review at its 85th Session

The Center for Reproductive Rights, with the collaboration of the CUNY School of Law International Women’s Human Rights Clinic, submits this letter to assist the Committee on the Elimination of Racial Discrimination in preparing its List of Themes for the periodic review of the United States at its 85th Session in August 2014. In particular, this letter contains information omitted from the 2013 U.S. Report in order to assist the Committee in analysing the gender-related aspects of racial discrimination in the context of reproductive rights. The letter focuses on two issues: (1) reproductive health disparities affecting non-citizen women, especially Latinas and (2) disparities in maternal mortality affecting African American women.

I. Concluding Observations from 2008 Review of the United States - Article 5(e)(iv)

In its 2008 review of the U.S., the CERD Committee expressed concern about persistent disparities in health affecting racial, ethnic and national minorities due to inadequate health insurance coverage and numerous other obstacles these groups face in accessing health care. Specifically, the Committee recommended the U.S. eliminate obstacles such as lack of health insurance coverage, unequal distribution of health resources, and racial discrimination in health care provision. It also requested better data on health disparities disaggregated by gender, among other factors.

With respect to sexual and reproductive health disparities, the Committee expressed concern over persistent disparities in maternal and infant mortality, as well as high rates of unintended pregnancy, abortion, and sexually transmitted infections affecting primarily African American women. The Committee urged the U.S. to continue to address these disparities by:

(i) improving access to maternal health care, family planning, pre- and post-natal care and emergency obstetric services, inter alia through the reduction of eligibility barriers for Medicaid coverage;
(ii) facilitating access to adequate contraceptive and family planning methods; and
(iii) providing adequate sexual education aimed at the prevention.
The U.S. Government’s 2013 periodic report to CERD does not include gender disaggregated data on health disparities as requested, nor adequate information about efforts taken to reduce disparities in sexual and reproductive health. Information gathered by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health, as summarized below and in our attached report – Nuestra Salud, Nuestra Voz, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley – demonstrates that the U.S. has failed to make significant progress towards fulfilling its obligations under ICERD to reduce health disparities.

II. Sexual and Reproductive Health Disparities Affecting Non-Citizen Women

1. Persistent Obstacles to Health Care for Non-Citizens

The purpose of the 2010 Affordable Care Act (ACA) was to extend health insurance coverage to at least 26 million of the nation’s 55 million uninsured by 2023 by expanding Medicaid (the nation’s public health insurance program for low-income people) to cover more low-income people who cannot afford private health insurance, and by creating more affordable private health insurance options through regulated marketplace insurance exchanges. The U.S. Supreme Court upheld a major legal challenge to the ACA in 2011, but the Court struck down the provision requiring states to participate in Medicaid expansion. Subsequently, despite significant federal matching funding, many states refused to participate in the program, leaving 8 million low-income people in a coverage gap: unable to qualify for Medicaid, and unable to afford private insurance.

Some are explicitly barred from health insurance benefits offered by the ACA based on their immigration status. Since 1996, lawfully present immigrants have been subjected to a federal five-year waiting period to enroll in Medicaid—a restriction preserved in the ACA. States may impose additional conditions on eligibility. Undocumented immigrants are completely barred from federal public assistance, including Medicaid, and are prohibited from purchasing insurance on the private health insurance exchanges.

The U.S. Report highlights the Administration’s efforts to eliminate health disparities through the ACA, estimating for example that as many as 5.4 million Latinos will gain health insurance by 2016 through expansion of Medicaid and the creation of Affordable Health Exchanges. However, the Report fails to address the fact that 23 individual states have declined to participate in the Medicaid expansion, and many of these include border states with high immigrant populations. The Report also does not address the impact of Medicaid eligibility exclusions on immigrants, or the gendered consequences that lack of coverage imposes on immigrant women’s access to health care.


Restrictions on public insurance coverage for immigrants disproportionately impact poor and low-income immigrant women seeking women’s health services. For decades, these women
have relied on family planning clinics, such as Planned Parenthood, that provide rural and uninsured women with access to low-cost family planning and other reproductive health services. These clinics are subsidized by both federal and state funds and provide services including breast and cervical cancer screenings, contraception, and testing and treatment for sexually transmitted infections including HIV/AIDS. But in the past several years, this reproductive health safety net has come under attack at the federal and state level. Funding at the federal level through the Title X family planning program has sustained significant cuts. Meanwhile, states have severely cut their own family planning budgets and passed unnecessary restrictions on the use of state funds for reproductive health services.

In 2012-2013, the Center for Reproductive Rights and the National Latina Institute for Reproductive Health documented the impact of these policies on Latinas living in the Rio Grande Valley ("the Valley") of the state of Texas. Latinas in the Valley are predominately rural, immigrant, poor, and uninsured. For two decades, Texas had steadily built a network of family planning clinics to reach this population, but state actions in 2011 dismantled this system virtually overnight. The legislature slashed the state budget for family planning by two-thirds, from $111 million to $37.9 million. It also prohibited state distribution of family planning funds to Planned Parenthood, the state’s largest provider of reproductive health services.

Although these changes caused significant clinic closures in the state of Texas as a whole, the Valley was especially affected. In the four counties of the Valley, nine state-funded family planning clinics closed in the Valley from 2011-2012, and the remaining ones were forced to drastically cut hours and raise fees. Women receiving family planning services in the Valley at state-funded clinics dropped 72% in a two-year period compared to a 40% drop statewide. Facing the economic consequences of a surge of unintended pregnancies, Texas lawmakers reinstated family planning funds in 2013. However, these funds were not allocated to reach the most vulnerable population – Latinas in the Valley. As our attached report explains, Latinas in the Valley can no longer afford contraception and are forgoing screenings for cervical and breast cancer. As a result, they are experiencing a spike in unintended pregnancy, pain from chronic reproductive conditions, and stress and anxiety about whether a life-threatening illness—such as cervical cancer—is going undetected and untreated.

The U.S. Report boasts that that approximately 75% of U.S. counties have at least one Title X-funded clinic. However, the Report fails to discuss: (1) efforts to ensure that women have access to family planning service in the other 25% of counties without Title X clinics, (2) the 12% cut in funding to the Title X program since 2011, (3) the role that state governments like Texas can play in undermining the effectiveness of federal grants, and (4) the failure of some state governments to properly allocate resources to women’s preventive health care.

3. **Suggestions for List of Themes**

- Please provide data disaggregated by gender, race, ethnicity and age on sexual and reproductive health disparities including reproductive system cancers (cervical, breast and uterine), sexually transmitted infections including HIV/AIDS, and unintended and teen pregnancy.
Please provide information about policy barriers and other obstacles that discriminate against non-citizen women in their access to sexual and reproductive health care, including the impact of Medicaid eligibility exclusions and state level family planning policies.

III. Racial Disparities in Maternal Mortality

1. Higher Rates of Preventable Maternal Mortality and Persistence of Racial Disparities

Every day more than two women die in childbirth in the United States—yet more than half of all maternal deaths in the US are preventable. Since 2005, the US has dropped ten places in world rankings of the safest country for pregnant women, from 40th to 50th place. The U.S. maternal mortality rate (MMR) is 24 maternal deaths for every 100,000 live births, compared to 12 in the United Kingdom. Despite the fact that the US spends an estimated $98 billion per year—far more than any other developed country—on hospitalization during pregnancy and childbirth, the MMR has doubled in the past 25 years.

Although it is difficult to ascertain the cause or causes behind the rise in the maternal mortality rate in the U.S., racial discrimination is an important factor. African American women are more than three times as likely to die in childbirth as their white counterparts. The MMR is especially high in cities and states with a high African American population, such as Fulton County (includes the city of Atlanta), Georgia, where the overall rate is four times the national average—there are 62 maternal deaths per 100,000 live births for African Americans, while the rate for white women is too insignificant to report at all. In New York City, the MMR for African American women is 79 deaths per 100,000 live births, nearly eight times their white counterparts. In Washington, D.C., the total MMR is higher than the national average at 42 deaths per 100,000 live births for a population that is 51% African American.

Despite this health crisis, little is understood about the root causes of maternal mortality among African American women in the U.S., and particularly why racial disparities exist across socio-economic class. The Centers for Disease Control’s bi-annual Health Disparities and Inequality Report does not include information on maternal mortality, signifying the government’s lack of adequate data and de-prioritization of addressing disparities in maternal mortality. The CDC collects and publishes data annual through its “Pregnancy Mortality Surveillance System,” but this relies on non-standardized data voluntarily submitted by states. The lack of standardized data collection across states, the lack of data disaggregated by race and gender, and the unwillingness of states and hospitals to release public information on maternal deaths thwarts progress in understanding the real problems and finding effective solutions. In addition, approximately 30 U.S. states lack monitoring and accountability mechanisms to document and review maternal deaths. Moreover, such mechanisms vary widely in their scope and efficacy, and none take a holistic, rights-based approach to the problem.

2. Lack of Information on Efforts to Address Persistent Disparities in Maternal Mortality

Since the last periodic review of the U.S., much progress has been made at the global level in developing standards of accountability for preventable maternal mortality. From 2009-
2012, the Human Rights Council adopted successive resolutions recognizing preventable maternal mortality and morbidity as a human rights issue, and one exacerbated by poverty, gender inequality, multiple forms of discrimination, and a general lack of access to health facilities and infrastructure. The Council called on states to take a human rights based approach to address preventable maternal mortality and morbidity based on the principles of accountability, transparency, and non-discrimination. In 2012, the Council endorsed the United Nations Technical Guidance on reducing preventable maternal morbidity and mortality, and called on states to ensure a just and effective health system through improved data collection, monitoring of health delivery systems, and accountability processes for maternal deaths.

The U.S. 2013 periodic report to CERD omits data on the increase in maternal mortality as well as the gross racial disparities reflected in its MMR. Instead, the U.S. Report “recognizes that more can be done to increase women’s access to health care, reduce unintended pregnancies, and support maternal and child health.” The U.S. Report frankly acknowledges that even its own national action plan to reduce disparities has not achieved its goals: “few disparities in quality of care are narrowing, and almost no disparities in access to care are getting smaller.”

3. Suggestions for the List of Themes

➢ Please provide data on maternal mortality rates disaggregated by race, ethnicity, age, and national origin.

➢ Please provide more information on measures adopted by the State party to reduce the high maternal mortality rate among women of color, particularly African American women, including efforts to improve data collection, monitoring of health delivery systems, and accountability processes for maternal deaths.

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3 Id.

4 Id. at para 33.


Title X of the Public Health Service Act, 42 U.S.C. §300(1001) is the federal program that provides funding to states for family planning services. Title X of the Public Health Service Act, 42 U.S.C. §300(1001); U.S. Dep’t of Health & Hum. Services, About Title X Grants, available at http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/about-title-x-grants/#section-1001.


The Rio Grande Valley borders Mexico, and is made up of four counties: Starr, Hidalgo, Willacy, and Cameron. See Texas State Historical Association, Rio Grande Valley, available at http://www.tshaonline.org/handbook/online/articles/ryr01. Most of the Valley has been designated by the federal government as medically underserved, meaning that the population has a shortage of health services and providers while facing elevated health risks and numerous socioeconomic barriers to health access. Center for Reproductive Rights, Nuestra Salud, Nuestra Voz, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley, pg. 15 (2013).


See other Concluding Observations of CERD on the topic of non-citizens and access to health care, e.g., CERD Concluding Observations: Slovakia, 2004, para. 338 (“The Committee is alarmed at the critical health situation of some Roma communities, which is largely a consequence of their poor living conditions.”); Republic of Moldova, 2002, para. 226 (“The Committee expresses its concern about reports that minorities experience in the areas of… health care… The Committee recommends that the State party undertake effective measures to eradicate practices of discrimination against minorities and, in particular, the Roma population…”); United Kingdom of Great Britain and Northern Ireland, 2003, para. 542 (“The Committee expresses concern about the discrimination faced by Roma/Gypsies/Travellers that is reflected, inter alia, in their… limited access to health services…”); Argentina, U.N. Doc., CERD/C/65/CO/1, para. 5 (2004) (welcoming the State’s Immigration Law No. 25871, which provides for “Migrants’ access to basic rights such as education and health irrespective of their migration status.”); Saudi Arabia, U.N. Doc., CERD/C/62/CO/8, para. 6 (2003) (welcoming “the recent initiative to include non-Saudis in a health insurance system.”); Azerbaijan, CERD/C/AZE/CO/4, para. 12 (2005) (“the Committee expresses its concern that asylum-seekers, refugees, stateless persons, displaced persons and long-term residents residing in Azerbaijan experience discrimination in the area[ ] of . . . health”); Georgia, CERD/C/GE0/CO/3, para. 16 (2005) (“[t]he Committee regrets the lack of information in the State party report on the fundamental rights of non-citizens temporarily or permanently residing in Georgia, regarding the effective enjoyment, without discrimination, of the rights mentioned in article 5 of the Convention (art. 5)” and “recommends that the State party ensure the effective enjoyment, without discrimination, of the rights mentioned in article 5 of the Convention, in particular their… right to health”).


