THE HUMAN RIGHTS APPROACH TO ADDRESS BLACK MATERNAL MORTALITY: WHY POLICYMAKERS SHOULD LISTEN TO BLACK MOMS

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CONTENT WARNING

This article engages critically with issues of racism, sexism, and misogynoir. It also discusses maternal and infant death. This content has the potential to affect our readers. The *Northeastern University Law Review* feels this topic is important to address and amplify, but we urge readers to consider their own experiences and capacity before engaging with this article.

POSITIONALITY STATEMENT

I am a white, cisgender, straight woman who grew up in an upper middle-class family. I identify as disabled. I acknowledge my own positionality at the outset of this Note because it focuses on the lives, strategies, and empowerment of a marginalized identity group of which I am not a part. My identities do not qualify me to speak to the lived experiences of mothers or Black individuals. Nor do these identities qualify me to speak to the lived experiences of Black mothers. I did not interview Black mothers as a part of my writing process, and this Note will not use narratives or storytelling to illustrate arguments. Instead, this Note evaluates U.S. progress on a specific, internationally-recognized human rights objectives by utilizing a rubric created by Black mothers and their allies in the Reproductive Justice movement. It uses the human rights framework implemented by Reproductive Justice advocates to critically evaluate the U.S. maternal mortality crisis as it impacts Black mothers.

Most of the research materials I consulted to write this paper were written by woman-identifying Black, Indigenous, and people of color (BIPOC) individuals who have dedicated their careers to Reproductive Justice research and advocacy, and these leaders are my chosen teachers on this topic. Their research materials and writing are cited throughout this paper, and I would encourage every reader of this paper to consult those materials to engage further with this topic.

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INTRODUCTION

This Note argues that the United States (U.S.) government has a responsibility under international human rights standards to address the domestic crisis of Black maternal mortality. If the U.S. aims to meet its international obligations and build a robust policy framework to address maternal mortality as a human rights issue, it must center Black mothers'[1] advocacy and expertise. Centering the expertise, storytelling, and experiences of impacted individuals through participation is a central tenet of human rights advocacy work,[2] and in failing to center Black moms, the U.S. continues to ineffectively address Black maternal mortality. The current approach the U.S. uses to address Black maternal mortality fails to acknowledge the white supremacist ideologies upon which public perception of Black motherhood has been built, and, as a result, has perpetuated racist policies. This Note utilizes the Reproductive Justice movement's human rights framework, which has been advocated for by Black activists and scholars, to evaluate some of the recent U.S. policy initiatives.

Part I of this Note provides an overview of the crisis of maternal mortality in the U.S. This crisis demonstrates a dereliction of the country's international human rights obligations, and it evinces the moral failings of leaders who have neglected to address this crisis. In this Note, I specifically focus on the deaths of Black mothers, and the crisis of Black maternal mortality which demonstrates the failure by the U.S. to address racial discrimination in maternal health. This Note provides a brief historical overview of some U.S. government policies that have served to undermine the health of Black mothers, leading to discrimination, disproportionate negative health outcomes, and Black maternal deaths.

Part II defines the human rights framework for understanding maternal mortality by discussing the provisions of several international human rights treaties that protect maternal health. The human rights framework addresses the intersections of the right to life, the right to health, and the right to equality and nondiscrimination. The U.S. has legal obligations to prevent and reduce maternal death under these international treaties.

1 I use the terms "mother," "mom," "mama," and "maternal" throughout this paper to refer to all birthing individuals, including women, trans women, those that identify as nonbinary, and those with other gender identities. Please note that not all birthing people identify with these terms, and it is important to defer to birthing individuals themselves when describing their parenting identities.

2 *See The Approach to Human Rights*, Health and Human Rights Resource Guide, FRANCOIS-XAVIER BAGNOUD CTR. FOR HEALTH & HUM. RTS., https://www.hhrguide.org/153-2/ (last visited May 7, 2022).

In this section, I also contextualize the evolution of the global maternal health strategy through the United Nations' Millennium Development Goal (MDG) and Sustainable Development Goal (SDG) frameworks.

Part III introduces the Reproductive Justice movement, a movement founded and led by Black women that is rooted in international human rights principles. The Reproductive Justice movement has made strong efforts to address and attack the issue of maternal mortality and promote maternal health. This Note presents examples of several strategies implemented by Reproductive Justice advocates to forward the human rights framework in a maternal health context.

Part IV presents some recent examples of U.S. legislative initiatives to combat maternal mortality and improve maternal health. I argue that the U.S. policy plans to address maternal mortality would function more effectively by mirroring the human rights-centered approaches presented by Reproductive Justice activists and organizations.

I. Background

A. *Maternal Mortality in the United States*

The U.S. outspends every other country in the world on hospital-based maternity care, but this spending does little to ensure better results for those giving birth in the U.S.[3] The United Nations (UN) Maternal Mortality Estimation Inter-Agency Group ranks the U.S. fifty-fifth globally based on its maternal mortality ratio (MMR).[4] The World Health Organization (WHO) calculates the MMR using its definition of "maternal death," defining it as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[5] Most maternal deaths in the

3 *Maternal Health in the United States*, Maternal Health Task Force Harv. Chan Sch., https://www.mhtf.org/topics/maternal-health-in-the-united-states/ (last visited May 7, 2022).

4 Nina Martin, *The New U.S. Maternal Mortality Rate Fails to Capture Many Deaths*, ProPublica (Feb. 13, 2020), https://www.propublica.org/article/the-new-us-maternal-mortality-rate-fails-to-capture-many-deaths; *Executive Summary: Trends in Maternal Mortality 2000–2017*, U.N. Maternal Mortality Estimation Inter-Agency Grp. 6–12 (2019), https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?ua=1.

5 Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020*, Nat'l Ctr. for Health Stat. 1 (Feb. 2022), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf.

U.S. are caused by preventable or treatable complications, including heart conditions, severe bleeding, blood clots, infections, strokes, and high blood pressure.[6] In February 2022, the Centers for Disease Control and Prevention (CDC) released a report indicating that the 2020 MMR in the U.S. was 23.8 maternal deaths per 100,000 live births.[7] For comparison, in 2019, Canada had an MMR of 7.5, Australia had an MMR of 3.9, and six countries reported MMRs of 0.[8]

The MMR in the U.S. is shockingly high for an industrialized nation, but the MMR statistic alone does not paint a full picture of the senseless, preventable deaths suffered by birthing people in this country. Black mothers in the U.S. die at rates three to four times higher than white mothers and have for at least the last six decades.[9] For non-Hispanic, Black women in the U.S., the MMR in 2020 was 55.3 deaths per 100,000 live births,[10]—in the same range as the most recent MMRs reported for the countries Ecuador, El Salvador, Jordan, and Panama.[11]

However, even these facts do not encompass the full extent of maternal death in the U.S. The WHO definition of maternal death is used throughout the world to measure the MMR in a given country.[12] But because of the forty-two-day postpartum cap within the WHO definition, the UN MMR data may not capture maternal deaths related to postpartum depression anxiety, substance use disorder, and other health conditions that may result in mortality more than forty-two days after the end of pregnancy.[13] A fuller understanding of the maternal experience in the U.S. can be developed by looking at U.S. government statistics, which employ a broader definition. By

6 CTR. FOR REPROD. RIGHTS, BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE 21 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf [hereinafter BMMA TOOLKIT].

7 Hoyert, *supra* note 5.

8 In 2019, Estonia, Iceland, Ireland, Luxembourg, Norway, and Slovak Republic all reported MMRs of 0. *Health Status: Maternal and Infant Mortality*, ORG. FOR ECON. CO-OPERATION & DEV., https://stats.oecd.org/index.aspx?queryid=30116 (last updated Nov. 9, 2021) (select "Data by Theme" tab and select "Health", "Health Status", and "Maternal and infant mortality" indicators).

9 BMMA TOOLKIT, *supra* note 6, at 9, 26.

10 Hoyert, *supra* note 5.

11 *Maternal Mortality Ratio (Per 100 000 Live Births)*, WORLD HEALTH ORG., https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births) (last visited May 5, 2022).

12 *See* Martin, *supra* note 4.

13 *See id.*; *see also* Usha Ranji et al., *Expanding Postpartum Medicaid Coverage*, KAISER FAM. FOUND. (May 9, 2021), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

U.S. statute, "pregnancy-related death" is defined as: "[A] death of a woman that occurs during, or within 1 year following, her pregnancy, regardless of the outcome, duration, or site of the pregnancy–from any cause related to, or aggravated by, the pregnancy or its management; and not from accidental or incidental causes."[14]

While the definitions of "maternal death" and "pregnancy-related death" are related, the two measurements of maternal mortality in the U.S. create significant obstacles in understanding the extent of the problem and constructing an accurate narrative about the extent of maternal mortality.[15] The CDC's most recently released MMR for the U.S., 23.4, does not account for the accidental or incidental causes encompassed within the "pregnancy-related death" definition provided by U.S. statute.[16] This is a particularly deceiving statistical nuance in the U.S., where the ongoing epidemic of overdose deaths has only escalated during the COVID-19 pandemic.[17] 24% of pregnancy-related deaths in the U.S. occur between 43 and 365 days postpartum,[18] which highlights the seriousness of undercounting in the MMR metric. The crisis of maternal mortality in the U.S. is likely far more expansive than the MMR measurement system enumerates.

In April 2021, the Biden-Harris administration released what it deemed the "first-ever presidential proclamation" tackling "Black maternal mortality and morbidity."[19] The proclamation and accompanying statement outlined investments the administration intended to make in already-existing health care and maternal health programs.[20] The statement characterized the funding changes as "initial steps" in an ongoing commitment "to address [the] maternal mortality crisis, close disparities in maternal care and outcomes for all birthing people, and address the systemic racism that has allowed these inequities to exist."[21] While the Biden Administration explicitly addressed that Black maternal mortality in the U.S. is a product of "systemic racism," it was less than explicit about the centuries of U.S. policy that have

14 42 U.S.C. § 247b-12(e)(3).

15 *See* Martin, *supra* note 4.

16 Hoyert, *supra* note 5.

17 *See* Press Release, Ctrs. for Disease Control & Prevention, Overdose Deaths Accelerating During COVID-19 (Dec. 17, 2020), https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html; *see also Suicide*, Nat. Inst. Mental Health, https://www.nimh.nih.gov/health/statistics/suicide.shtml (last visited May 7, 2022).

18 Martin, *supra* note 4.

19 *Fact Sheet: Biden-Harris Administration Announces Initial Actions to Address the Black Maternal Health Crisis*, The White House (Apr. 13, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/13/fact-sheet-biden-harris-administration-announces-initial-actions-to-address-the-black-maternal-health-crisis/.

20 *Id.*

21 *Id.*

the laid the foundation for the disparities and inequities to which it alludes.[22]

B. *The U.S. Has Historically Sabotaged the Health of Black Moms*

The Black maternal mortality crisis has been shaped by the myriad of social ideologies, societal practices, and public policies implemented by the U.S. federal and state governments to sabotage Black mothers' health, often with intentions of economic development or profit. Racism in maternal health is not the product of one isolated policy or initiative, but instead must be understood as a pervasive public health crisis with historical roots older than the U.S. itself. While this section details many of the atrocities officials in the U.S. (including before the founding of the country) have committed against Black mothers, I preliminarily caution readers against viewing the history of Black mothers as one of passivity or victimhood. For every atrocious act committed by the U.S. government, there are stories of Black mothers who sought freedom, resisted, and revolted against the oppression they faced.[23]

Government violence against Black mothers in the U.S. can be traced back to before the founding of the country. Most Black women, though not all,[24] who entered the present-day U.S. before the Revolutionary War, were forcibly removed from their homes, families, and lives in Africa and transported to the U.S. as a part of the transatlantic slave trade.[25] White enslavers[26] exerted power over Black women's bodies to exploit Black women's labor and childbearing as a part of the slave trade.[27] Enslavers exploited African women who were brought to the U.S. for their farming knowledge and skills, which helped to build an agricultural economy from which they were legally excluded from profiting, and for which they were put to work doing manual labor.[28] Additionally, enslavers profited from Black women's capacity to produce more enslaved people, and enslavers used rape and forced

22 *Id.*

23 For an overture to the vast array of these stories, see generally DAINA RAMEY BERRY & KALI NICOLE GROSS, A BLACK WOMEN'S HISTORY OF THE UNITED STATES, 10–11 (2020). *See also* ANGELA Y. DAVIS, WOMEN, RACE, AND CLASS (1983).

24 The first Black women in the U.S. arrived as early as the sixteenth century as a part of Spanish exploratory expeditions in what is now the American Southwest, as evidenced by Daina Ramey Berry and Kali Nicole Gross's research into Spanish archival records from this time period. *See* BERRY & GROSS, *supra* note 23, at 9–11.

25 *See id.*

26 This word and its meaning are borrowed from Ramey Berry and Gross, who use the term to refer to non-Black individuals who owned slaves. BERRY & GROSS, *supra* note 23.

27 Deirdre Cooper Owens & Sharla M. Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, AM. J. PUB. HEALTH 1342, 1342–43 (2019).

28 BERRY & GROSS, *supra* note 23, at 2.

marriage as tools to control and manipulate the enslaved population.[29] The colony of Virginia secured the fate of children born to enslaved mothers in 1662 when it enacted a law clarifying that a child's status as enslaved or free was defined by the status of their mother, not their father, as had been the English tradition.[30] Other colonies soon enacted their own versions of this law, exemplifying the widespread government control the states had over the bodies of Black mothers and their children at the earliest stages of the republic.[31] When the U.S. cut off participation in the transatlantic slave trade by banning the importation of enslaved people in 1808, Black mothers' bodies increased in value and were increasingly exploited to support the system of enslavement that much of the U.S. economy had been built upon.[32] Black mothers were also subjected to inhumane treatment at the hands of white doctors experimenting in gynecological science, a practice which continued long after the system of enslavement came to an end.[33]

The period of enslavement also set a foundation for the enduring tradition of policymakers blaming Black mothers for their own ailing health or prosecuting them for the health of their children, both of which are often out of the mother's control due to government policies impacting the quality and availability of healthcare. Enslaved nurses and midwives provided most maternal health care for enslaved mothers, but when mothers lost children during childbirth, white doctors often blamed both Black mothers and their predominately Black caretakers for such losses.[34] Many of the country's founders believed that Black people were incapable of self-control and rational thought.[35] This "scientific racism" by the country's founders embedded an ideology of white superiority within the nation's founding documents and legislation.[36] "Scientific racism" manifested itself as a narrative that Black mothers were unable to, or unfit to care for their

29 Jael Silliman et al., Undivided Rights: Women of Color Organize for Reproductive Justice 13 (2016).

30 2 William Waller Hening, The Statutes at Large: Being a Collection of All the Laws of Virginia from the First Session of the Legislature, in the Year 1619, 170 (1823); *Legislating Reproduction and Racial Difference,* N.Y. Hist. Soc'y Museum & Libr., https://wams.nyhistory.org/early-encounters/english-colonies/legislating-reproduction-and-racial-difference/ (last visited Jan. 7, 2022); *see also* Berry & Gross, *supra* note 23, at 33–34.

31 Berry & Gross, *supra* note 23, at 34.

32 Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty 24 (20th ed. 2017).

33 Owens & Fett, *supra* note 27, at 1343.

34 *Id.*

35 *See* Roberts, *supra* note 32, at 8–9.

36 *See id.*

children because of biological deficits.[37] In the twentieth century and into today, this led to the creation of measures to control Black reproduction and the Black population instead of supporting Black mothers through social programs that were seen as a waste of resources.[38]

The U.S. did not pass any laws to address the social welfare until 1921, the year after the passage of the Nineteenth Amendment.[39] The Shepperd-Towner Act, also called the Maternity and Infancy Act, provided $1 million in aid to support state programs for prenatal and postpartum care for mothers and babies.[40] The Act was not renewed after its first seven years,[41] but it provided an important social welfare model for future maternal and child health advocates to build upon in later decades. Notably, the language of the Sheppard-Towner Act did not discriminate with regard to race and ethnicity, and some historians suggest that Black women benefitted from the home visiting programs and public health centers funded through the Act.[42] However, because the program's services were implemented state by state, there was variation in who was ultimately served, and Black women were likely to experience discrimination and inferior care as a result of pervasive racism.[43]

The implementation of the Aid to Dependent Children (ADC) program, a part of the Social Security Act, demonstrated evidence of pervasive government discrimination against Black mothers on both state and federal levels.[44] The ADC program (later renamed the Aid to Families with Dependent Children or AFDC)[45] was funded by the federal government and administered by the states, providing cash assistance to low income

37 *See id.*

38 *Id.* at 8.

39 *The Sheppard-Towner Maternity and Infancy Act*, HIST., ART, & ARCHIVES: U.S. HOUSE OF REPS., https://history.house.gov/Historical-Highlights/1901-1950/The-Sheppard%E2%80%93Towner-Maternity-and-Infancy-Act/ (last visited Jan. 18, 2021); Protecting Mothers and Infants, U.S. CAPITOL VISITOR CTR., https://www.visitthecapitol.gov/exhibitions/april-2010-september-2011/protecting-mothers-and-infants (last visited May 4, 2022).

40 *The Sheppard-Towner Maternity and Infancy Act*, *supra* note 39.

41 Carolyn M. Moehling & Melissa A. Thomasson, *Saving Babies: The Contribution of Sheppard-Towner to the Decline in Infant Mortality in the 1920s* 13–14 (Nat'l. Bureau of Econ. Rsch., Working Paper No. 17996, 2012), https://www.nber.org/papers/w17996.

42 *See id.* at 13–14.

43 *Id.* at 15.

44 Lucy A. Williams, *The Ideology of Division: Behavior Modification Welfare Reform Proposals*, YALE L. J. 719, 723 (1992).

45 Linda Gordon & Felice Batlan, *Aid to Dependent Children: The Legal History*, VA. COMMONWEALTH UNIV. LIBRS., https://socialwelfare.library.vcu.edu/public-welfare/aid-to-dependent-children-the-legal-history/ (last visited May 7, 2022).

families.[46] Although ADC funds were intended to serve children living with their widowed mothers, some states made eligibility for these programs contingent upon maternal behavior and created provisions that prevented Black mothers from accessing the program.[47]

In 1965, Assistant Labor Secretary Daniel Patrick Moynihan released a report titled *The Negro Family: A Case for National Action*, which blamed the matriarchal family structures of Black American families for the perceived lag in attainment of higher social status by Black people.[48] When advocates successfully expanded Black families' access to the ADC program in the 1960s and 1970s, conservatives responded by deploying the ideology introduced in the Moynihan Report, and developing programs that began to chip away at access to ADC through narratives about deservedness.[49] These racialized narratives painting Black mothers as undeserving of government funding and support ultimately culminated in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which had the stated purposes of ending single-parent families' dependence on government support, encouraging marriage, and reducing the number of children born out of wedlock.[50] PRWORA had, and continues to have, devastating consequences for Black mothers who relied on welfare funding to create healthy living environments for their families. The program gave states broad powers to administer welfare benefits based on their own criteria, and many made benefits contingent upon work requirements, mandatory family planning programming, and invasive investigation into mothers' lives.[51]

Today, Black mothers are forced to contend with a government whose present-day policies were largely built upon historic and pervasive racism against them and their families. State and federal prosecutors across the U.S. have continued to find new ways to prosecute Black and

46 *Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF) - Overview*, Office of the Assistant Sec. for Plan. & Evaluation, https://aspe.hhs.gov/aid-families-dependent-children-afdc-temporary-assistance-needy-families-tanf-overview (last visited Jan. 28, 2022); *see also* Gordan & Batlan, *supra* note 45.

47 Williams, *supra* note 44, at 723–24.

48 Daniel Geary, *The Moynihan Report: An Annotated Edition*, Atlantic, (Sept. 14, 2015), https://www.theatlantic.com/politics/archive/2015/09/the-moynihan-report-an-annotated-edition/404632/.

49 Williams, *supra* note 44, at 724–25.

50 *See generally* Personal Responsibility & Work Opportunity Reconciliation Act, 42 U.S.C. § 1305.

51 *See* Shruti Rana, *Restricting the Rights of Poor Mothers: An International Human Rights Critique of "Workfare"*, 33 Colum. J.L. & Soc. Probs. 393 (2000); *see also* A Welfare Check, Reveal (July 16, 2016), https://revealnews.org/podcast/a-welfare-check/.

BIPOC moms for crimes related to pregnancy and parenting,[52] including by characterizing still-births and miscarriages as attempts to terminate their pregnancies.[53] As of January 2020, there were still twenty-three states in which it remained legal for incarcerated mothers to be shackled during childbirth, a practice that health experts have widely recognized has health risks for both moms and babies.[54] These indignities are the result of the same horrific, sexist, and white supremacist beliefs that have persisted since the founding of the U.S.—specifically that Black mothers are unfit to mother, so their bodies must be subject to regulation by the predominately white male-controlled government. The Black maternal health crisis in the U.S. is not a new problem; widespread human rights abuses in the U.S. reflect the racist ideologies that have been perpetuated against Black moms in this country for centuries.

II. HUMAN RIGHTS LEGAL FRAMEWORKS AND MATERNAL MORTALITY

The right to maternal health is protected by several international human rights treaties, though not always explicitly. Maternal health lies at the intersection of more than one fundamental human right, as defined by the UN, including the right to life; the right to health; and the rights to race and gender equality, and nondiscrimination.[55] When governments fail to protect maternal life and health, these failures constitute violations of human rights principles.[56] The U.S. has not signed and ratified all of the international human rights treaties that protect maternal health; however, Congress has ratified treaties that protect the right to life and the right to racial equity and nondiscrimination.[57] The U.S. policy frameworks to address maternal mortality and health have primarily focused upon health care, without provisions aimed at remedying and preventing systemic racism in health care. However, the obligations that the U.S. has assumed through

52 ROBERTS, *supra* note 32, at xii (stating that from 1973–2017, more than 700 women have faced prosecution, sanctions, or punishment by government authorities for actions related to their pregnancies).

53 Robin Levinson-King, *U.S. Women Are Being Jailed for Having Miscarriages*, BBC NEWS (Nov. 12, 2021), https://www.bbc.com/news/world-us-canada-59214544.

54 *Shackling of Pregnant Women in Jails and Prisons Continues*, EQUAL JUST. INITIATIVE (Jan. 29, 2020), https://eji.org/news/shackling-of-pregnant-women-in-jails-and-prisons-continues/.

55 Luisa Cabal & Morgan Stroffregen, *Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation*, 16 HUM. RIGHTS BRIEF 2, 2–6 (2009).

56 *Id.* at 2.

57 *Where the United States Stands on 10 International Human Rights Treaties*, THE LEADERSHIP CONF. EDUC. FUND (Dec. 10, 2013), https://civilrights.org/edfund/resource/where-the-united-states-stands-on-10-international-human-rights-treaties//.

the ratification of some international human rights treaties demand a far broader, more rigorous approach to our policy addressing maternal health.

A. *Right to Life*[58]

Article 6 of the International Covenant on Civil and Political Rights (ICCPR) protects every human's "inherent right to life," as well as every human's right not to be "arbitrarily deprived" of their right to life.[59] The international community has interpreted this right, as espoused in the ICCPR, as not only the prevention of killings, but also as a broader duty to prevent arbitrary, needless death.[60] In particular, the UN Human Rights Committee has stated that the right to life as it relates to maternal mortality demands that a country work toward accessible health services, family planning and sexual education programs, and emergency obstetric care.[61] The U.S. ratified the ICCPR in 1992,[62] but since that time pregnancy-related death in the U.S. has steadily increased from 10.8 deaths per 100,000 in 1992, to 17.3 in 2017.[63] This trend demonstrates a disconnect between the U.S. ratification of the ICCPR and the implementation of the treaty's calls to action as related to maternal mortality.

B. *Right to Health*

The U.S. signed the Universal Declaration of Human Rights (UDHR) seventy-four years ago.[64] In doing so, the U.S. agreed to the articles of the UDHR on an international stage, signaling the country's intention to lead and define human rights policy in the post-World War II era. However, the UDHR is not an international treaty; it is merely a declaration, and the

58 While the term "right to life" in the U.S. has been used by the anti-abortion movement to specifically point to the rights of a fetus, the international human rights movement uses a different, broader definition of the "right to life" that encompasses the rights of human beings from their birth to their deaths.

59 G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights, art. 6 (Dec. 16, 1966).

60 Cabal & Stroffregen, *supra* note 55, at 2, 2–3.

61 U.N. Hum. Rts. Comm., *Consideration of reports submitted by States parties under article 40 of the Covenant: International Political Rights: Concluding Observations of the Human Rights Committee: Mali*, ¶ 14, U.N. Doc CCPR/CO/77/MLI (Apr. 16, 2003).

62 The Leadership Conf. Educ. Fund, *supra* note 57.

63 *Pregnancy Mortality Surveillance System*, CDC, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#:~:text=Since%20the%20Pregnancy%20Mortality%20Surveillance,100%2C000%20live%20births%20in%202017 (last visited May 8, 2022).

64 G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

U.S. government's commitment to the principles espoused in the declaration are symbolic—not legally binding.[65] Article 25 of the UDHR includes specific provisions about health and well-being as it relates to motherhood:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.[66]

Despite the specific symbolic commitment to maternal health it affirmed and embraced in the UDHR, the U.S. has failed to take steps to uphold its actual treaty commitments to health equity under the International Convention of the Elimination of All Forms of Racial Discrimination (CERD), and has failed to ratify the two treaties that focus most particularly on maternal health: the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[67] Both the ICESCR and CEDAW establish explicit expectations for countries' obligations to mothers related to childbirth. Article 10 of the ICESCR states, "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth."[68]

Because the U.S. has not ratified the ICESCR, the right to health embedded within the ICESCR is not enforceable in the U.S. and lacks the teeth of international accountability mechanisms. Without the obligation of reporting to a UN treaty body, protecting and ensuring the right to health and health care in the U.S. must be driven by domestic policy movements. However, U.S. ratification of treaties that protect equality and nondiscrimination rights provides some arguments that denying equal opportunities to health services to specific populations runs counter to the

65 Chandler Green, *70 Years of Impact: Insights on the Universal Declaration of Human Rights*, U.N. FOUND. (Dec. 5, 2018), https://unfoundation.org/blog/post/70-years-of-impact-insights-on-the-universal-declaration-of-human-rights/.

66 Universal Declaration of Human Rights, *supra* note 64.

67 THE LEADERSHIP CONF. EDUC. FUND, *supra* note 57.

68 International Covenant on Economic, Social, and Cultural Rights art. 10, Jan. 3, 1976, 993 U.N.T.S. 3.

country's international human rights obligations, both those espoused in treaties and those inherently owed by a government to its citizens.

C. *Right to Equality and Nondiscrimination*

As demonstrated by the disproportionate rates of maternal death among Black mothers in the U.S., maternal mortality must be examined through both a race discrimination lens and a gender discrimination lens. Race and gender discrimination pervade the U.S. healthcare system, systemically and individually.

In interpersonal interactions between patients and care providers, Black moms often report experiences of racial stereotyping that lead providers to offer care that is unnecessary, absent, or improperly tailored to meet their specific needs.[69] In recent reporting by ProPublica and National Public Radio, Black mothers and their surviving relatives from across the country have shared stories of severe health issues or death during childbirth and postpartum, resulting from conditions including hemorrhaging, fibroids, preeclampsia, uterine rupture, spontaneous coronary artery dissection, and peripartum cardiomyopathy.[70] In particular, hemorrhaging is a condition that the medical profession has developed best practices to prevent and treat if due care is taken during pregnancy and postpartum periods, but Black mothers are more likely to die if they experience hemorrhaging than other racial groups.[71] Medical research has also shown that mothers who deliver babies in hospitals that primarily serve Black populations often receive inferior care and have worse health outcomes for both mothers and babies:[72]

69 *See Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care*, Ctr. for Reprod. Rts. 20 (2014), https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_17560_E.pdf.

70 *See* Adriana Gallardo, *Black Women Disproportionately Suffer Complications of Pregnancy and Childbirth. Let's Talk About It*, ProPublica (Dec. 8, 2017), https://www.propublica.org/article/black-women-disproportionately-suffer-complications-of-pregnancy-and-childbirth-lets-talk-about-it.

71 *See id.*; *see also* Nina Martin & Renee Montagne, *Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, ProPublica (Dec. 7, 2017), https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth; *see also* Annie Waldman, *How Hospitals Are Failing Black Mothers*, ProPublica (Dec. 27, 2017), https://www.propublica.org/article/how-hospitals-are-failing-black-mothers.

72 Elizabeth A. Howell et al., *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 Am. J. Obstet. & Gynecology 122.E1 (2016) (finding that "women who delivered in high and medium [B]lack-serving hospitals had elevated rates of severe maternal morbidity rates compared with those in low [B]lack-serving hospitals."); Andreea A. Creanga et al., *Performance of Racial and Ethnic Minority-serving Hospitals on Delivery-related Indicators*, 211 Am. J. Obstet. & Gynecology 647.E1 (2014) (finding that

evidence of systemic racism produced by both health provider biases and histories of geographic segregation. Additionally, Black moms repeatedly reported "the feeling of being devalued and disrespected by medical providers," and the data about Black maternal mortality and childbirth-related health complications back up their claims.[73]

Race and gender discrimination are also evinced in the construction of the multiplicity of systems which inform maternal health. Due to the longstanding and continuing impacts of systemic racism, Black women are two times as likely as white women to live in poverty in the U.S.[74] There are significant gaps in economic security between white women and Black women: Black women have higher rates of unemployment and are subjected to pay equity discrimination at higher rates.[75] In health care, Black people delivering babies at U.S. hospitals that serve mostly Black populations have the highest rates of severe maternal morbidity (maternal risk of death) in the nation.[76] A medical literature review of research from 1995–2018 recently found that while Black women and white women use substances and suffer from substance use disorders at approximately the same rates in the U.S., Black women are far more likely to face access barriers to substance use treatment.[77] And in a nation where Black people are two times as likely as white people to be killed by a gun, perhaps no collective of gun violence-survivors has more stories to tell than Black mothers, who have protested against gun violence against their children for generations.[78] Because Black mothers live at the intersections of race and gender discrimination, the rights to equality and nondiscrimination are crucial to understanding Black

"Black-serving hospitals performed worse than other hospitals on 12 of 15 indicators."); Waldman, *supra* note 71.

73 Martin & Montagne, *supra* note 71; *see also* Serena Williams, *How Serena Williams Saved Her Own Life*, ELLE (Apr. 5, 2022), https://www.elle.com/life-love/a39586444/how-serena-williams-saved-her-own-life/ (stating that "[b]eing heard and appropriately treated was the difference between life or death for me.").

74 BMMA TOOLKIT, *supra* note 6, at 22; *see also* Melissa Harris-Perry, *How Our Country Fails Black Women and Girls – And Why We Need to Talk About It*, ELLE (Apr. 28, 2016), https://www.elle.com/culture/career-politics/a35983/melissa-harris-perry-congressional-testimony-black-women-and-girls/.

75 BMMA TOOLKIT, *supra* note 6, at 22.

76 *Id.* at 25; Waldman, *supra* note 71.

77 Michelle L. Redmond et al., *Exploring African American Women's' Experiences with Substance Use Treatment: A Review of the Literature*, 48 J. CMTY. PSYCH. 337, 338 (2020).

78 Arionne Nettles, Opinion, *Black Mothers Are the Real Experts on the Toll of Gun Violence*, N.Y. TIMES (May 6, 2021), https://www.nytimes.com/interactive/2021/05/06/opinion/gun-violence-black-mothers.html; Nidhi Subbaraman, *Homicide Is a Top Cause of Maternal Death in the United States*, NATURE (Nov. 12, 2021), https://www.nature.com/articles/d41586-021-03392-8.

maternal mortality as a human rights issue.

CERD, a treaty which the U.S. has ratified, protects every person's right to enjoy "public health, medical care, social security, and social services" without the experience of racial discrimination.[79] In 2013, the Obama administration provided a periodic report to the CERD committee which detailed some efforts to address systemic discrimination in health care and health outcomes in the U.S.[80] The report identified the Affordable Care Act (ACA), the 2011 Action Plan to Reduce Racial and Ethnic Health Disparities, and the Healthy People 2020 health prevention goals as actions the U.S. has taken to reduce health disparities rooted in racial and ethnic discrimination.[81] The CERD committee was not satisfied with these efforts. In response to the U.S. report, the CERD committee expressed concerns about the state option to opt-out of the expanded Medicaid program under the ACA, thereby weakening the overall effectiveness of the policy, and called upon the U.S. to eliminate racial disparities in sexual and reproductive health and to improve accountability measures to for preventing maternal death.[82]

As discussed above, CEDAW, a treaty which the U.S. has signed, but has not ratified, uses specificity when outlining women's rights to health care and health services.[83] Article 12 demands that countries "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning."[84] Article 12

79 G.A. Res. 2106 (XX), International Convention of the Elimination of All Forms of Racial Discrimination, at 3–4 (July 3, 1966).

> . . . States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably enjoying the following rights: . . . . . .(e) Economic, social, and cultural rights, in particular: . . . . . .(iv) The right to public health, medical care, social security, and social services . . . .

Id.; *see also* The Leadership Conf. Educ. Fund, *supra* note 57.

80 U.N. Comm. on the Elimination of Racial Discrimination, *Reports Submitted by States Parties Under Article 9 of the Convention Seventh to Ninth Periodic Reports of States Parties Due in 2011 United States of America*, at 46–47, U.N. Doc. CERD/C/USA/7-9 (Oct. 3, 2013).

81 *Id.*

82 U.N. Comm. on the Elimination of Racial Discrimination, *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America*, U.N. Doc. CERD/C//USA/CO7–9 (Sept. 25, 2014).

83 The Leadership Conf. Educ. Fund, *supra* note 57.

84 G.A. Res. 34/180, Convention on the Elimination of All Forms of Discrimination Against Women, art. 12 (Sept. 3, 1981).

goes on to add that countries "shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[85] Article 14 goes on to demand that the same measures employed to eliminate discrimination be applied to women who live in rural areas to ensure equal accessibility to the services described in Article 12.[86] Failure by the U.S. to ratify CEDAW has been critiqued internationally,[87] and the impact of the decision not to ratify is felt acutely by Black mothers. The provisions that protect women from discrimination in rural maternal health could be of specific assistance to Black mothers in the South, who have the lowest rates of health insurance coverage in the country.[88] They are often faced with provider shortages and a lack of health care infrastructure that limit access to care even before pregnancy.[89]

In many cases, U.S. Supreme Court jurisprudence actively works against the principles encompassed in CERD and CEDAW. The Court has taken a hard stance against characterizing state-implemented policies and practices that unintentionally create disparate impact as illegal,[90] except for a few protections under civil rights statutes like the Fair Housing Act and the employment provisions of the Americans with Disabilities Act.[91] The Court's lack of recognition of disparate impact in a health context will

85 *Id.*

86 *Id.*

87 *See generally* Judith Resnik, *Comparative (in)equalities: CEDAW, The Jurisdiction of Gender, and the Heterogeneity of Transnational Law Production*, 10 INT'L J. CONST. L. 531–50 (2012); *see also* Melanne Verveer & Rangita de Silva de Alwis, *Why Ratifying the Convention on the Elimination of Discrimination Against Women is Good for America's Domestic Policy*, GEO. INST. FOR WOMEN, PEACE, & SEC. (Feb. 18, 2021), https://giwps.georgetown.edu/why-ratifying-the-convention-on-the-elimination-of-discrimination-against-women-cedaw-is-good-for-americas-domestic-policy/; *see also* Liane Schalatek, *CEDAW and the USA: When Belief in Exceptionalism Becomes Exemptionalism*, HEINRICH BÖLL STIFTUNG FOUND. (Dec. 10, 2019), https://www.boell.de/en/2019/12/10/cedaw-and-usa-when-belief-exceptionalism-becomes-exemptionalism.

88 BMMA TOOLKIT, *supra* note 6, at 24.

89 *Id.*

90 *See* Washington v. Davis, 426 U.S. 229, 242 (1976) ("Disproportionate impact is not irrelevant, but it is not the sole touchstone of an invidious racial discrimination forbidden by the Constitution."); *see also* Alexander v. Sandoval, 532 U.S. 275, 281 (2001) (finding that providing a driver's license test in only one language did not discriminate on the basis of national origin because § 601 of the Civil Rights Act (Title VI) prohibits only intentional discrimination).

91 The Supreme Court has found that the Fair Housing Act and the Americans with Disabilities Act allow disparate impact claims. Tex. Dep't of Hous. & Cmty. Affairs v. Inclusive Cmtys. Project, Inc., 576 U.S. 519, 534 (2015); Raytheon Co. v. Hernandez, 540 U.S. 44, 53 (2003); *see also* 42 U.S.C. § 12112(b).

continue to create a giant roadblock for targeted maternal health equity programs that seek to call out the disproportionate impact of racism, sexism, and misogynoir on Black moms.

D. *UN Development Goals*

The UN uses an international goals framework to address major policy initiatives reflected in human rights treaties and other international law. In 2015, the UN adopted seventeen Sustainable Development Goals (SDGs), the third of which is to "[e]nsure healthy lives and promote well-being for all at all ages."[92] The first subsection of this third goal is to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births" by 2030.[93] Prior to the enactment of the SDGs in 2015, the global maternal mortality ratio decreased three percent during the first fifteen years of the new millennium, while the U.S. saw an MMR increase of three percent from during the same period.[94]

Developed in 2015, the SDGs served as a replacement framework for the previous Millennium Development Goals (MDGs), which had focused on developing nations and were established in 2000.[95] The SDGs are both broader, applying to all countries, and more detailed, with subsections that focus on specific implementation metrics.[96] This transition is of particular note in the area of maternal health. There were only eight MDGs, one of which was to improve maternal health, with a target of reducing the global MMR by three quarters between 1990 and 2015.[97] Years before the 2015 deadline, human rights advocates concluded that the goal of reducing maternal mortality by three quarters was the MDG least likely to be achieved.[98] Unfortunately, they were correct; there was only a forty-

92 G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, at 16 (Oct. 21, 2015).

93 *Id.*

94 U.S. Gov't Accountability Off., GAO-20-248, Maternal Mortality 1 (2020).

95 *The Sustainable Development Agenda*, U.N. Sustainable Dev. Goals, https://www.un.org/sustainabledevelopment/development-agenda/ (last visited Aug. 7, 2021); *see also Background*, U.N. Millennium Dev. Goals & Beyond 2015, https://www.un.org/millenniumgoals/bkgd.shtml (last visited Jan. 28, 2022) (noting that world leaders came together in September 2000 to commit their nations to poverty-reducing targets that became known as the Millennium Development Goals); *see also The 17 Goals*, U.N. Dep't of Econ. & Soc. Affs., https://sdgs.un.org/goals (last visited Mar. 9, 2022).

96 *The Sustainable Development Agenda*, *supra* note 95.

97 *Goal 5: Improve Maternal Health*, U.N. Millennium Dev. Goals & Beyond 2015, https://www.un.org/millenniumgoals/maternal.shtml (last visited Jan. 18, 2021).

98 Cabal & Stroffregen, *supra* note 55, at 2.

five percent reduction in the global MMR between 1990 and 2015.[99] In a publication assessing the success of the MDGs in 2015, the UN noted that "improving maternal health" remained "an unfinished agenda" and that "[i]n-depth analyses reveal[ed] insufficient and greatly uneven progress."[100] However, rather than separating out an SDG to specifically address maternal health, the UN moved the maternal health target under the overall health goal.[101] Reducing the global MMR now sits alongside all the UN's health and wellness targets.

III. THE REPRODUCTIVE JUSTICE MOVEMENT GROUNDS MATERNAL HEALTH IN A HUMAN RIGHTS FRAMEWORK

The Reproductive Justice movement uses a human rights framework to address maternal health and a range of other issues impacting mothers in the U.S. The work of several key, related organizations, including SisterSong, Women of Color Reproductive Justice Collective, and the Black Mamas Matter Alliance, have helped grow and develop this movement, while maintaining a particular focus on the Reproductive Justice matters that most impact Black mothers, including maternal mortality.

A. *The Origins of Reproductive Justice*

In 1994, a group of Black women's movement activists united in Chicago and formed what would later be named the Reproductive Justice movement: a movement that would be driven by women of color and poor women, rather than white women with privilege.[102] In the same year, American women of color united at the International Conference on Population and Development in Cairo, Egypt, and coined the term "Reproductive Justice" to describe the movement's principles.[103] The Reproductive Justice movement aims to protect four major rights: (1) the right to not to have a child, (2) the right to have a child, (3) the right to raise children in safe

99 *Goal 5: Improve Maternal Health*, *supra* note 97.

100 U.N., THE MILLENNIUM DEVELOPMENT GOALS REPORT 43 (2015), https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf.

101 *See Goal 3: Ensure healthy lives and promote well-being for all at all ages*, U.N. MILLENNIUM DEV. GOALS & BEYOND 2015, https://www.un.org/sustainabledevelopment/health/ (last visited Jan. 28, 2022).

102 *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice (last visited Jan. 17, 2021).

103 BMMA TOOLKIT, *supra* note 6, at 16.

and healthy environments, and (4) the right to safe and healthy childbirth.[104] These advocates determined that the Reproductive Justice movement must be rooted in the international human rights framework established by the UDHR, and that it must de-emphasize the "choice" framework traditionally touted by the reproductive rights movement.[105] In their compiled history of the organizing of the Reproductive Justice movement, authors Jael Sillman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez define Reproductive Justice as "a theory, a practice, and a strategy," which highlights the movement's focus on supporting BIPOC mothers in developing research, policy, and community organizations that protect their human rights.[106]

Critically, the Reproductive Justice movement differentiates itself from the reproductive rights movement that has historically been utilized by lawyers to defend abortion and contraception rights.[107] While the reproductive rights movement, or more narrowly, the pro-choice movement, has focused on a woman's right to access contraceptives and abortions (i.e., the right to not have a child), this approach does not address rights that have often historically been denied to marginalized mothers. BIPOC mothers, disabled mothers, and mothers without economic resources have, throughout American history, been denied bodily autonomy, the right to have children, and the right to raise their own children.[108] The reproductive rights legal framework deploys U.S. case law protecting privacy rights as a core legal strategy, but that privacy right does not serve to protect individuals whose reproductive freedoms depend upon social welfare programs, government action, or the eradication of discrimination.[109] The Reproductive Justice movement does not center litigation; it instead uses human rights principles to advocate through community-based organizing, research, and policymaking.[110]

Early Black Reproductive Justice advocates also distinguished their priorities from the civil rights framework, and they pushed leading civil rights groups to discuss reproductive freedoms more broadly.[111] As former NAACP

104 *See id.*; Dorothy Roberts, *Reproductive Justice, Not Just Rights*, Dissent (Fall 2015), https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights.

105 Kimala Price, *What is Reproductive Justice?: How Women of Color Activists Are Redefining the Pro-Choice Paradigm*, 10 Meridians 42, 47 (2010).

106 Silliman et al., *supra* note 29, at viii.

107 Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 Ann. Rev. L. & Soc. Sci. 327, 333 (2013).

108 *Id.*

109 *Id.* at 334–36.

110 *Id.* at 338.

111 *See* Charlotte Rutherford, *Reproductive Freedoms and African American Women*, 4 Yale J. L. & Feminism 255, 255 (1992).

Legal Defense Fund (LDF) counsel Charlotte Rutherford wrote, until the 1990s, LDF did not add reproductive choice or reproductive freedoms to their platforms because there was polarization about the topic of abortion amongst many civil rights leaders, particularly the male leadership.[112] Following *Webster v. Reproductive Health Services*[113] in 1989, a group of Black women's group leaders met with staff at the LDF to advocate that LDF take a position on reproductive health for Black women, which LDF had never done previously.[114] In response to this meeting and continued follow-up conversations with advocates and experts, LDF identified a list of reproductive health priorities, stating that:

> At a minimum, reproductive freedoms for poor women should include: 1) access to reproductive health care; 2) access to early diagnosis and proper treatment for AIDS, sexually transmitted diseases, and various cancers; 3) access to prenatal care, including drug treatment programs for pregnant and parenting [people who use drugs]; 4) access to appropriate contraceptives; 5) access to infertility services; 6) freedom from coerced or ill-informed consent to sterilization; 7) economic security, which could prevent possible exploitation of the poor with surrogacy contracts; 8) freedom from toxins in the workplace; 9) healthy nutrition and living space; and 10) the right to safe, legal, and affordable abortion services.[115]

Like the Black advocates who approached LDF in the early 1990s, Reproductive Justice movement organizers have succeeded in pushing reproductive rights advocates toward a narrative that better reflects intersectional justice and at responding to racism that harms Black mothers' health. In 2004, as reproductive rights advocates organized what they planned to call "The March for Freedom of Choice," organizers from the Black Women's Health Imperative and the National Latina Institute for Reproductive Health pushed against this title, and the march was renamed "The March for Women's Lives."[116] The resulting march was one of the

112 *Id.* at 256–57.

113 Webster v. Reprod. Health Servs., 492 U.S. 490, 520 (1989) (finding that a Missouri statute requiring maternal care providers to test the "viability" of a fetus before referring a woman to abortion care was constitutional because of "the State's interest in protecting potential human life").

114 Rutherford, *supra* note 111, at 256–57.

115 *Id.* at 258–59.

116 SILLIMAN ET AL., *supra* note 29, at ix; Sangeeta Ahmed et al., *March for Women's Lives*, THE FEMINIST COMBINING PROCESS, http://avery.wellesley.edu/Economics/jmatthaei/transformationcentral/combining/combiningmarchwomenslives.html (last visited May 8, 2022).

largest marches in U.S. history.[117] In 2010, when a racist, anti-abortion billboard campaign launched in states around the country, using slogans including "The Most Dangerous Place for an African American is in the Womb," the organizations SisterSong, SPARK Reproductive Justice NOW, Black Women's Health Imperative, and others united to form the Trust Black Women Partnership and successfully fought to have the billboards removed from these regions.[118] Since the advent of the Hyde Amendment, a provision of the federal budget that prevents individuals from using federal funds—such as Medicaid—to fund elective abortion procedures, the Reproductive Justice movement has pushed back against the oppressive impact of the Hyde Amendment on poor mothers and BIPOC mothers.[119] In 2021, the Reproductive Justice movement's years of advocacy against the Hyde Amendment paid off when President Biden chose not to include the amendment in his proposed budget to Congress, and the House initially approved a budget that did not include the Hyde Amendment.[120] Though the Senate added the Hyde Amendment back into the 2022 budget in March 2022, the Biden Administration's 2023 budget proposal also excludes Hyde.[121]

There are also many examples of Black mothers throughout the country who have taken it upon themselves to educate and uplift other moms who may face discrimination or racism in their motherhood experiences and to provide them with the infrastructures to survive and birth babies safely.

117 Silliman et al., *supra* note 29, at ix.

118 *Id.* at x; Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty xiv–xv (2017) (20th anniversary ed.); *see also* Shaila Dewan, *Anti-Abortion Ads Split Atlanta*, N.Y. Times, (Feb. 5, 2010), https://www.nytimes.com/2010/02/06/us/06abortion.html?_r=0; Lisa Eadicicco & Larry McShane, *Anti-abortion Billboard by Life Always Goes Up in SoHo, Riles Up Pro-choice New Yorkers, Politicians*, N.Y. Daily News, (Feb. 23, 2011), https://www.nydailynews.com/new-york/anti-abortion-billboard-life-soho-riles-pro-choice-new-yorkers-politicians-article-1.138682.

119 *See Hyde Amendment: Going Back to Basics*, Nat'l Network of Abortion Funds (Oct. 6, 2019), https://abortionfunds.org/hyde_back_to_basics/; Mackenzie Darling, *No More Hyde and Seek: Biden's Removal of the Hyde Amendment From the Proposed Budget Is A Win for Abortion Access*, Northeastern Univ. L. Rev. F. (July 30, 2021), https://nulronlineforum.wordpress.com/2021/07/30/nomorehydeandseek/.

120 Darling, *supra* note 119.

121 Burgess Everett & Jennifer Scholtes, *Senate Gives Final OK to $1.5T Government Funding Bill*, Politico (Mar. 10, 2022), https://www.politico.com/news/2022/03/10/senate-spending-bill-vote-00016079; *Biden-Harris Administration Releases Its Second Presidential Budget Without Hyde Amendment; Includes Critical Domestic and Global Family Planning Investments*, Planned Parenthood (Mar. 28, 2022), https://www.plannedparenthood.org/about-us/newsroom/press-releases/biden-harris-administration-releases-its-second-presidential-budget-without-hyde-amendment-includes-critical-domestic-and-global-family-planning-investments.

In 1991, Shafia M. Monroe moved across the country during a pregnancy and discovered that her new location lacked any Black midwives to deliver her newborn at home.[122] Already an infant and maternal health activist, the experience catalyzed her founding of the International Center for Traditional Childbearing (ICTC), an organization which has since trained thousands of midwives and doulas throughout the U.S., with a particular focus on training midwives of color and amplifying their voices.[123] After surviving a postpartum cardiomyopathy in 1992, as well as ongoing, life-threatening heart complications, Anner Porter founded Fight Against Peripartum and Postpartum Cardiomyopathy, a nonprofit organization dedicated to educating other women about the condition.[124] She authored a book on the topic and now hosts a podcast titled "Cardiac Emergency for Pregnant Women."[125] Porter had a successful heart transplant in 2020, and she continues to share her story through speaking engagements, publishing writings, podcasting, and engaging in other forms of activism.[126] After being profoundly impacted by her positive experience giving birth to her child in 2003, Latham Thomas, a wellness advocate and birth worker, founded MamaGlow in New York City, a company that trains doulas and other birth care workers, and offers a "full spectrum approach to holistic wellness" for mothers-to-be and new moms.[127] Kay Matthews, a mother in Texas, delivered a stillborn baby in 2013 and experienced declining mental health as a result.[128] She founded Shades of Blue Project, an organization whose mission is "to help[] women before, during and after child-birth with community resources, mental health advocacy, treatment and support" and "to change the way women are currently being diagnosed and treated after giving birth and experiencing any adverse maternal mental health outcome."[129] She also published a self-help book about mental health recovery and a guided journal to support other mothers recovering from adverse maternal health experiences.[130] In 2021, actress Tatyana Ali testified

122 *Shafia M. Monroe's Biography*, SHAFIA MONROE CONSULTING, https://shafiamonroe.com/about-shafia-monroe/shafia-monroe/ (last visited Mar. 19, 2022).

123 *Id.*

124 Gallardo, *supra* note 70; *Who is Anner Porter*, ANNER T. PORTER & CO., https://www.annerporterco.com/ (last visited Mar. 19, 2022).

125 *Who is Anner Porter*, *supra* note 124.

126 *Id.*

127 *About MamaGlow*, MAMAGLOW, https://mamaglow.com/about/ (last visited Mar. 19, 2022); Nina Bahadur, *9 Organizations Working to Save Black Mothers*, SELF (Oct. 22, 2019), https://www.self.com/story/organizations-activists-fighting-black-maternal-mortality.

128 Bahadur, *supra* note 126.

129 *Mission*, SHADES OF BLUE PROJECT, https://www.shadesofblueproject.org/ (last visited Mar. 19, 2022).

130 *Founders & Volunteers*, SHADES OF BLUE PROJECT, https://www.shadesofblueproject.org/

in the House Committee on Oversight and Reform in Congress about her own traumatic experience of giving birth as a Black mother in the U.S. in order to educate decision-makers.[131] She recounted her experience of being dismissed by her doctor when asking a question, and she described being pushed forcefully by a doctor in the delivery room.[132] The Reproductive Justice movement is anchored by Black mothers who have chosen to speak out about their experiences, educate and organize their own communities, and who are uniquely positioned to transform the birth systems in the U.S. through their storytelling.

These wins demonstrate that when communities led by BIPOC women and mothers organize at the intersections of race, gender, and class, they have the power to uproot the status quo. Whether the Reproductive Justice movement is challenging the branding of a predominantly white feminist movement, pushing back against the racism of anti-abortion organizations, or fighting for federal funds to support reproductive freedoms, this movement has shown that its human rights framework and organizing principles have the power to lead to lasting, anti-racist change.

B. *Black Mamas Matter Alliance and Strategies of the Reproductive Justice Movement*

In 2015, an existing partnership between SisterSong, Women of Color Reproductive Justice Collective, and the Center for Reproductive Rights gave rise to the Black Mamas Matter Alliance (BMMA), after the organizations convened a meeting of experts, activists, and stakeholders.[133] The BMMA centers human rights in its approach to Black maternal health.[134] It describes itself as "a national cross-sectoral, multidisciplinary network of Black women leaders and organizations working to improve equity and outcomes in U.S. maternal health."[135]

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founders-and-volunteers (last visited Mar. 19, 2022).

131 Donna M. Owens, *Birthing While Black Congressional Hearing Amplifies Black Maternal Health Crisis*, Essence (May 11, 2021), https://www.essence.com/news/birthing-while-black-congressional-hearing-amplifies-black-maternal-health-crisis/.

132 *Id.*

133 *About*, Black Mamas Matter All., https://blackmamasmatter.org/about/ (last visited Jan. 18, 2021).

134 *Id.*

135 Letter from Black Mamas Matter All. & Ctr. for Reprod. Rts. to Dubravka Simonovic, UN Special Rapporteur on Violence against Women 1 (May 17, 2019), https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Black%20Mamas%20Matter%20Alliance%20and%20the%20Center%20for%20Reproductive%20Rights.pdf [hereinafter *Letter to UN Special Rapporteur on Violence Against Women*].

One of the strategies for change that emerged out of the 2015 conversation was the Black Mamas Matter Toolkit, titled *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care*, which was first published in 2016, and updated in 2018.[136] The toolkit expounds upon a framework for technical guidance from the Office of the UN High Commissioner on Human Rights and uses this document to frame some of the policy solutions identified as necessary to address and improve Black maternal health.[137] Using general principles from the technical guidance report, the toolkit breaks the principles into five categories as applied to the U.S.: improving health care access and quality; addressing underlying determinants of health; eliminating discriminatory laws and practices; ensuring accountability; and inclusion and empowerment.[138]

BMMA, SisterSong, the Black Women's Health Imperative, and other allied organizations have used both international and domestic advocacy tactics to promote a Reproductive Justice policy agenda. Some of these tactics have included submitting shadow reports to treaty monitoring bodies of the UN and responding to calls from UN Special Rapporteurs for specific information on human rights issues in the U.S.

In 2014, the Center for Reproductive Rights, SisterSong, and the National Latina Institute for Reproductive Health submitted a shadow report to the UN Committee on the Elimination of Racial Discrimination, the treaty monitoring body for CERD, detailing the disparities in maternal mortality rates and maternal health for Black women and noncitizen women in the U.S.[139] Their recommendations to improve maternal health for Black mothers called upon the U.S. to increase access to health insurance for mothers living in states that have not expanded Medicaid and to increase access to pre and postnatal public health services.[140] Additionally, they called upon the U.S. to improve accountability mechanisms for preventing maternal mortality by tracking data about health disparities and aggregating

136 BMMA TOOLKIT, *supra* note 6, at 5.

137 *Id.* at 16.

138 *Id.* at 16–17; *see also* U.N. High Commissioner for Human Rights, *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: Rep. of the Off. of the U.N. High Comm'r for Human Rts.*, U.N. Doc. A/HRC/21/22. (July 2, 2012) (presenting human rights-based maternal health strategy recommendations for world policymakers developed by the U.N. Human Rights Council to the U.N. General Assembly).

139 *See generally Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care*, *supra* note 69 (NGO reporting on the intersection of race and gender discrimination in the health care system to the UN CERD committee, a treaty-monitoring body for the UN).

140 *Id.* at 28.

maternal mortality data by gender, race, and age.[141]

Similarly, in 2019, BMMA and the Center for Reproductive Rights wrote to the UN Special Rapporteur on Violence Against Women in response to an open call for submissions about violence against women during childbirth.[142] In their report, they provided specific examples of disrespect, abuse, and mistreatment by health care facilities during birth and prenatal care.[143] They also outlined how the U.S. medical delivery system places significant burdens on patients, particularly patients who already face race and poverty barriers, and they explained how the existing legal accountability mechanisms in the U.S. make it difficult to hold actors accountable for human rights violations.[144] Amidst many recommendations, the report called on the UN Special Rapporteur to recommend that member countries "enact and implement human rights-based national standards," and the report cited strategies that had been effective on a smaller scale when implemented by BMMA and their partner organizations.[145] Some of these recommendations included promoting human rights-based education on respectful maternity care to health care providers, funding doulas and other community-based birth workers, and involving women and girls in the revision of maternal health policies.[146]

BMMA has also engaged in domestic advocacy to influence legislation at the federal level. In 2017, BMMA hosted the first Congressional briefing on Black maternal health in Washington, D.C.[147] In 2018, BMMA began an annual Black Maternal Health Week campaign.[148] BMMA and allied organizations also encourage engagement in local and state-level advocacy solutions; the BMMA toolkit calls on advocates to encourage state governments to embrace human rights approaches to health systems and to drive local policy solutions.[149]

IV. U.S. Federal Policy Will Always Fall Short If It Fails to Center Black Moms

U.S. health policy does not focus on or center the unique intersections between race, gender, and motherhood. Despite enormous movement in

141 *Id.*
142 *See generally Letter to UN Special Rapporteur on Violence Against Women*, *supra* note 135.
143 *Id.* at 2–4.
144 *Id.* at 2, 5.
145 *Id.* at 6–8.
146 *Id.* at 8.
147 BMMA Toolkit, *supra* note 6, at 4.
148 *Id.*
149 *Id.* at 15.

American health policy in the twenty-first century, efforts to stretch health insurance coverage and expand resources have often missed the very people who most require these services, especially Black mothers.

In 2010, the passage of the Affordable Care Act (ACA) included a provision for the expansion of the Medicaid program, a program that provides low-income Americans with health coverage.[150] Many pregnant mothers already had access to Medicaid coverage prior to the passage of the ACA because pregnant women who met the income eligibility requirements were one of the covered populations,[151] but shortages of healthcare providers and lack of healthcare system infrastructure still made it difficult for many to access preconception care.[152] In many states, the expansion of Medicaid makes health insurance available to low-income mothers prior to pregnancy and after sixty days postpartum.[153] But, the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* gave states the option to opt out of the federal expanded Medicaid program.[154] The majority of states that have opted out of the expanded Medicaid program are Southern states with high Black maternal mortality rates, leaving Black mothers, already facing limited healthcare options and systemic racism in those options that they can access, without coverage.[155]

In addition to the expansion of the Medicaid program, the ACA made health insurance available to more people by creating a marketplace that allowed those without employer-sponsored health insurance to purchase it online.[156] The ACA marketplace includes income-based cost-sharing subsidies for individuals making 400% of the poverty level or less, meaning an individual may qualify to have some percentage of their premium payments covered by the federal government, depending on their yearly income.[157] However, the premium and deductible payments for this

150 *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also Affordable Care Act Medicaid Expansion*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/research/health/affordable-care-act-expansion.aspx (last visited Jan. 28, 2022).

151 42 C.F.R. § 435.116 (2022).

152 BMMA TOOLKIT, *supra* note 6, at 24.

153 *Medicaid Postpartum Coverage Extension Tracker*, KAISER FAM. FOUND. (Mar. 31, 2022), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

154 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

155 BMMA TOOLKIT, *supra* note 6, at 24.

156 *See generally* HEALTHCARE.GOV, https://www.healthcare.gov/ (last visited Jan. 28, 2022).

157 Daniel McDermott et al., *Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums*, KAISER FAM. FOUND. (Mar. 15, 2021), https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/.

program are notoriously expensive and cost-prohibitive for individuals who are impacted by the ACA's subsidy cliff, and before the American Rescue Plan Act was passed in response to the COVID-19 pandemic, an estimated 8 million individuals who qualified for ACA marketplace coverage were paying a nonsubsidized or full price.[158] Although the American Rescue Plan Act, which passed in 2021, has lowered the cost-sharing burden for most individuals with marketplace plans and raised enrollment rates, if the Act expires, the costs of ACA marketplace insurance may return to their previously inaccessible rates.[159]

While expansive, the ACA has failed to serve many Black mothers. Black women continue to have lower rates of health insurance coverage than the rest of the population, especially in Southern states that have not authorized expanded Medicaid.[160] Even for those with insurance, health insurance access alone does not ensure Reproductive Justice. While universal health insurance is a critical part of the right to health, health insurance alone cannot achieve an end to racism experienced by mothers in the U.S. that too often results in death.

One recent legislative measure related to maternal mortality in the U.S. has made its way into law. In 2018, then-President Trump signed the Preventing Maternal Deaths Act (PMDA).[161] Though a federal act, the PMDA's structure instructs states to implement strategies to gather better data on maternal death.[162] The statute creates a structure for "Maternal Mortality Review Committees" made up of medical professionals and experts at the state or tribal level, whose primary roles are to improve data collection about maternal death and to receive and address confidential complaints.[163] While the PMDA's funding of such committees creates a better data system for understanding of the U.S. maternal mortality crisis, the role of the Maternal Mortality Review Committees, as legislated, does not serve to prevent maternal death. The PMDA allocates funding to the Maternal Mortality Review Committees to review data about maternal mortality; it does not provide funding for these committees to implement evidence-based solutions in their communities, and it therefore does not take

158 *Id.*

159 *See id.*; *see also* Kate Masters, *Virginia Health Insurance Premiums Are Still Too High for Many Customers, Report Finds*, Va. Mercury (Nov. 16, 2021), https://www.virginiamercury.com/2021/11/16/virginia-health-insurance-premiums-are-still-too-high-for-many-customers-report-finds/.

160 BMMA Toolkit, *supra* note 6, at 24.

161 *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047, 5048 (2018).

162 *Id.*

163 *Id.*

active steps towards achieving a lower MMR.[164] The Act does not make any mention of race or racial health disparity, which legal anthropologist scholar Khiara M. Bridges argues was unfortunately essential to ensure passage of the law.[165] She states that a problem with the Act "is that the failure to acknowledge the maternal health tragedy as a tragedy of racial inequality limits the Act's potential to be an effective means of reducing or eliminating racial disparities in maternal mortality."[166]

In the maternal health space, there is a striking disconnect between federal U.S. policy and community-centered, human rights-driven Reproductive Justice models. U.S. government materials often consider racial disparity in maternal health as a passing afterthought, rather than imbuing solutions to address this issue into policies. A GAO report released in March of 2020 broke down maternal mortality across racial groups,[167] but dove no deeper into the causes of the death rate disparities between non-Hispanic Black mothers and other segments of the population. While programs like the Maternal and Child Health block grants deploy institutional experts to channel funding to proposed data collection strategies,[168] BIPOC women-led organizations like SisterSong, BMMA, and their affiliated community organizations provide trainings for activists, advocates, and care providers who address on-the-ground needs.[169] What U.S. policymakers fail to consider in casting aside the Black maternal death rate as an outlier problem are the ways that centering the tragedy of Black maternal death could decrease the maternal mortality rate across all racial groups and uphold international treaty obligations that the U.S. has long failed to meet.

CONCLUSION

The Black maternal health crisis in the U.S. is a representation of the human rights American policymakers are willing to ignore to preserve the false narratives that uphold white supremacy. If policymakers centered the effective, system-wide strategies proposed by Black mothers to improve Black maternal health, we would likely see change not only in the maternal mortality rate, but in health outcomes throughout the nation. Pregnant women

164 *See id.*, *see also* Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1236 (2020).

165 Bridges, *supra* note 164.

166 *Id.*

167 *See* U.S. GOV'T ACCOUNTABILITY OFF, *supra* note 94, at 2.

168 *Id.* at 24–25.

169 *See* BLACK MAMAS MATTER ALL., *supra* note 133; *RJ Training & Leadership Development*, SISTERSONG, https://www.sistersong.net/ (last visited May 8, 2022).

and Black individuals were not proportionately represented in COVID-19 vaccine trials, but by centering the needs and perspectives of Black mothers in future vaccine development, we might see both populations adequately represented in future vaccine studies.[170] We might see robust efforts to fund social welfare programs such as cash assistance, expanded Medicaid, and food assistance, rather than many of the non-evidence-based programs that the PRWORA currently grants states block grants to fund.[171] We might see more salient efforts from more policymakers to provide affordable health insurance to everyone through an effort like Medicare for All. And we might see more resources invested in sexual education programs, substance misuse prevention programs, mental health services, and public education and training programs for our youth. These solutions combat Black maternal mortality, but they do so much more. Simply put, if U.S. policymakers are not focused on preventing our country's systems from disproportionately killing Black mothers, they are likely negating opportunities to transform the national health care system, opportunities to address racial injustice, and opportunities to provide stronger futures for our children. Addressing Black maternal death forces U.S. policymakers to holistically confront our human rights abuses and develop nuanced solutions that uplift not only Black moms, but individuals throughout our national systems.

A shining light in February 2021 was the introduction of the Black Maternal Health Momnibus Act of 2021 by the Congressional Black Maternal Health Caucus, led by Congresswomen Alma Adams and Lauren Underwood.[172] This legislation includes twelve individual bills that have now been combined into one set of legislation to address Black maternal health priorities.[173] These priorities range from the social determinants of health, to health insurance coverage, to further research on Black maternal death.[174] The reach of the Momnibus Act includes meeting needs that have an impact on maternal health, including providing housing, transportation, and healthy food, as well as funding the community-based organizations that

170 *See* Stacey D. Stewart, *We Need to Enroll Pregnant Women in Clinical Trials for the Coronavirus Vaccines*, Wash. Post (Feb. 9, 2021,) https://www.washingtonpost.com/opinions/2021/02/09/covid-vaccines-pregnant-women-clinical-trials/; *see also* Rueben C. Warren et al., *Perspective: Trustworthiness Before Trust — Covid-19 Vaccine Trials and the Black Community*, 383 New England J. Med. 121 (2020), https://www.nejm.org/doi/full/10.1056/NEJMp2030033.

171 *See* A Welfare Check *supra* note 51.

172 *Black Maternal Health Momnibus*, U.S. House of Representatives Black Maternal Health Caucus, https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus (last visited Jan. 7, 2022).

173 *Id.*

174 *Id.*

are already doing maternal health work.[175] Additionally, the Momnibus Act calls for the diversification of the maternal health workforce so that mothers receive care that is culturally competent.[176] It addresses meeting the needs of specific populations, including moms who are veterans, incarcerated moms, and moms with mental illness or substance use disorders.[177] Comprehensive legislative packages like the Momnibus legislation are a direct result of the Reproductive Justice movement's persistent organizing and activism. Though groups like SisterSong, BMMA, and Center for Reproductive Rights have focused their human rights advocacy on international reporting mechanisms, the Momnibus bill is evidence that Reproductive Justice advocates have packaged the human rights framework as an effective policy strategy for reducing maternal mortality.

The work of the Reproductive Justice movement, BMMA, SisterSong, and allied organizations demonstrates that Black mothers organizing know how to prevent maternal death in the U.S. Through the Reproductive Justice movement tactics, grounded in human rights principles, they have provided the U.S. with a playbook to decrease maternal mortality and save Black lives. It is past time policymakers listened to them.

175 *Id.*
176 *Id.*
177 *Id.*