

Foreword

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Pregnancy has always been politicized. Which is to say that the reproductive capacity of women¹ and their traditional role as mothers has been used to exclude them from power; indeed, it was a basis for denying women the right to vote.² Instead of viewing reproductive capacity as the site of empowerment, liberation, and societal advancement, politicians have sought to control and exclude women from making decisions that impact their own bodies and lives. Today, there remains intense political debate about women's access to, and decision-making around, reproductive healthcare. This includes whether healthcare that only women need, such as contraception, abortion, and in vitro fertilization, should be covered by health insurance at all.³ There is so much political smoke around pregnancy that we forget that for people who can get pregnant, their ability to control their fertility and make decisions once pregnant is critical to protect their life and health.

During pregnancy, a woman will experience dramatic physical changes that bring risks to her life and health, which may include preeclampsia and gestational diabetes. If all goes well and she is able to carry to term, she will deliver her baby through labor or undergo a cesarean section, which is major abdominal surgery. Potential complications include hemorrhage, infections, and obstructed delivery. Maternal death can occur during pregnancy, labor, and delivery, or even in the weeks following childbirth.⁴

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¹ "Woman" is generally used throughout this Foreword, reflecting that most pregnancies involve females and that the policies, laws, and biases emanating from that have been applied to females. However, transgender men and gender non-conforming people also can become pregnant. See Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 OBSTETRIC MED. 4 (2016).

² See, e.g., Marina Koren, *Why Men Thought Women Weren't Made to Vote*, ATLANTIC (Jul. 11, 2019), <https://www.theatlantic.com/science/archive/2019/07/womens-suffrage-nineteenth-amendment-pseudoscience/593710/> [<https://perma.cc/568H-SPFG>] ("[I]f women overexerted their already inferior brains, the thinking went, their health could suffer . . . Women needed to channel their energy toward their reproductive systems rather than their mind. If women were voting and participating in politics and *thinking*, their ovaries would atrophy." (emphasis original)).

³ See, e.g., Summer Brennan, *The Trump Administration Goes After Birth Control*, SIERRA (Oct. 20, 2019), <https://www.sierraclub.org/sierra/2019-6-november-december/feature/trump-administration-goes-after-birth-control> [<https://perma.cc/2LN2-ZWPK>]; Adam Sonfield, *Restrictions on Private Insurance Coverage of Abortion: A Danger to Abortion Access and Better Health Coverage*, 21 GUTTMACHER POL'Y REV. 29 (2018); Elissa Strauss, *40 Years Later, Why is IVF Still Not Covered by Insurance? Economics, Ignorance and Sexism*, CNN (July 25, 2018, 12:48 PM), <https://www.cnn.com/2018/07/25/health/ivf-insurance-parenting-strauss/index.html> [<https://perma.cc/58SQ-QFLN>].

⁴ See *Pregnancy Mortality Surveillance System*, CTNS. FOR DISEASE CONTROL AND PREVENTION (Oct. 10, 2019), <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> [<https://perma.cc/K46D-4LV9>].

Without access to prenatal and quality obstetrics care, women can and do die. Every day hundreds of women around the world die from preventable causes related to pregnancy and childbirth.⁵ This has been true throughout history. The level of risk depends on a woman's race, access to healthcare, and other social determinants of health, such as housing, access to transportation, and income.

In Nigeria, a woman's lifetime risk of dying in connection to pregnancy is one in twenty-one.⁶ In Italy that risk is one in fifty thousand.⁷ There is nothing different biologically about women in Italy and Nigeria. What differs is their access to healthcare. In the United States, maternal mortality is much higher than in Italy at one in three thousand.⁸ Indeed, the United States has the highest maternal mortality ratio of all the world's developed nations and that ratio is on the rise.⁹ In the United States, structural racism and oppression primarily contribute to the disproportionately high rates of maternal mortality and morbidity amongst Black and Native women.¹⁰ In New York City, Black women are twelve times more likely to die during pregnancy and childbirth than white women.¹¹ The bottom line: pregnancy carries significant risks to a woman's health and life, and those risks are markedly unequal.

This appreciable risk is one reason why the advent of contraception was such a blessing to women. Without access to contraception, the average sexually-active heterosexual woman would experience the life-threatening risks of pregnancy over and over and over again—which is why contraception is so fundamental to women's health and lives. So too is the ability to access safe and legal abortion, because—in this country before *Roe v. Wade* and in many parts of the world today—women die preventable deaths due to unsafe abortion.¹²

Moreover, access to reproductive healthcare and bodily autonomy are central to women's dignity and conscience, as well as their right to be free from cruel, inhumane, and degrading treatment. Reproductive decision-making, free of coercion, is critical to a woman's ability to participate fully and equally in society. The right to access comprehensive reproductive

⁵ See WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY: 2000 TO 2017 71–76 (2019), https://www.unfpa.org/sites/default/files/pub-pdf/Maternal_mortality_report.pdf [<https://perma.cc/X74H-D9NH>].

⁶ See *id.*

⁷ See *id.*

⁸ See *id.*

⁹ See *id.* at 42, 71–76.

¹⁰ See Cristina Novoa & Jamila Taylor, *Exploring African Americans' High Maternal and Infant Death Rates*, CTR. FOR AM. PROGRESS (Feb. 1, 2018, 9:02 AM), <https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/> [<https://perma.cc/HM5Z-4V8V>].

¹¹ See BUREAU OF MATERNAL, INFANT AND REPROD. HEALTH, N.Y.C. DEP'T OF HEALTH AND MENTAL HYGIENE, PREGNANCY-ASSOCIATED MORTALITY 9 (2013), <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf> [<https://perma.cc/A7U6-GQSL>].

¹² See L. Say et al., *Global Causes of Maternal Death: A WHO Systematic Analysis*, 2 LANCET GLOB. HEALTH 323 (2014).

healthcare services directly impacts a woman's life, health, economic future, and family. For example, studies show that a woman who seeks an abortion, but is denied, is more likely to fall into poverty than one who is able to get an abortion.¹³ In addition, women who were denied an abortion and then gave birth report worse health outcomes up to five years later as compared to women who receive a desired abortion.¹⁴ Women who are denied abortion care are also more likely to remain in relationships where interpersonal violence is present and more likely to suffer anxiety.¹⁵ In sum, women's ability to control their reproductive capacity is essential for their equality and participation in the social, economic, and political life of a nation.¹⁶

Based on these realities, national courts and international human rights bodies have found that reproductive rights are fundamental constitutional and human rights.¹⁷ As such, reproductive rights should be removed from the realm of politics. Women should freely decide whether and when to have children, and those that can become pregnant must have access to safe and respectful maternal healthcare. Because pregnancy has significant health risks, bodily autonomy should not be up for political debate.

The first section of this Foreword describes the framework for understanding reproductive rights as human rights, which was first articulated at the International Conference on Population and Development (ICPD), held in Cairo in 1994. The second section applies this framework to three areas of reproductive health and rights where politics currently warps policy formation and prevents the adoption of evidence-based policies that are critically needed to advance women's equality and health.

I. THE CAIRO PROGRAM OF ACTION FRAMEWORK RECOGNIZES REPRODUCTIVE RIGHTS AS HUMAN RIGHTS

This year marks the twenty-fifth anniversary of the ICPD, where one hundred and seventy-nine governments adopted a landmark Programme of Action (PoA) recognizing for the first time in an international consensus document that reproductive rights are part of the human rights already en-

¹³ See Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. HEALTH 407 (2018).

¹⁴ See Lauren J. Ralph et al., *Self-Reported Physical Health of Women who Did and Did Not Terminate Pregnancy after Seeking Abortion Services: A Cohort Study*, 171 ANNALS INTERNAL MED. 238 (2019).

¹⁵ See *Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, UNIV. OF CAL. S.F., <https://www.ansirh.org/research/turnaway-study> [<https://perma.cc/GH3Q-GRZS>].

¹⁶ See *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 897; 912 (1992).

¹⁷ See *Sexual and Reproductive Health and Rights*, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMM'R, <https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx> [<https://perma.cc/2GM7-9S2M>].

shrined in domestic and international law.¹⁸ The PoA articulated a new vision whereby reproductive health and rights, women's empowerment, and gender equality are the cornerstones of global development and population policy. For the first time, the international community stated a bold and comprehensive definition of reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."¹⁹ The PoA also articulated the fundamental reproductive right of "all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health."²⁰

The PoA calls upon governments to strengthen their commitment to women's health by supporting a woman's right to make decisions about her reproductive capacity and body. With over 200 recommendations, a key feature of the PoA is the recommendation to provide comprehensive reproductive healthcare, including in the areas of maternal health, abortion care, and family planning services.

Specifically, the PoA recognized that women have the "right of access to appropriate health-care services that will enable [them] to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."²¹ The PoA acknowledged that a number of factors, including unsafe abortion, result in elevated maternal mortality rates and that the majority of maternal deaths occur in developing countries.²² It also recognized that education, nutrition, prenatal care, emergency obstetric care, delivery assistance, post-natal care, and family planning are all critical components for reducing maternal mortality.²³

To reduce maternal deaths, states agreed that they should pay greater attention to preventing unwanted pregnancies, as well as ensuring that diagnosis and treatment for complications of abortion are always available.²⁴ States further agreed that women must always have access to humane, quality post-abortion care²⁵ and committed to take measures to prevent, identify, and manage high-risk pregnancies.²⁶ Additionally, states committed to fo-

¹⁸ UNITED NATIONS POPULATION FUND, INT'L CONFERENCE ON POPULATION AND DEV., PROGRAMME OF ACTION [hereinafter ICPD PROGRAMME OF ACTION], https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf [<https://perma.cc/PJ6L-YVX2>].

¹⁹ *Id.* at 45.

²⁰ *Id.* at 46.

²¹ *Id.* at 45.

²² *See id.* at 68.

²³ *See id.* at 69.

²⁴ *See, e.g., id.* at 68 ("Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion.").

²⁵ *See* G.A. Res. S-21/2, at 17 (Nov. 8, 1999); ICPD PROGRAMME OF ACTION, *supra* note 18, at 53.

²⁶ *See* ICPD PROGRAMME OF ACTION, *supra* note 18, at 70.

ocusing on the health needs of adolescents²⁷ and providing them with sexual health education.²⁸

Recognizing that unsafe abortion is a leading cause of maternal mortality and morbidity, states committed in the PoA “to reduce greatly the number of deaths and morbidity from unsafe abortion”²⁹ and to take measures to prevent unsafe abortion, such as by expanding and improving family planning services.³⁰ States agreed that where abortion is legal, it should be safe and accessible through the primary healthcare system³¹ and that particular attention should be paid to adolescents and young women in the prevention of unwanted pregnancies and treatment of unsafe abortions.³² Finally, under the PoA, states agreed that “[i]n all cases, women should have access to quality services for the management of complications arising from abortion” and “[p]ost-abortion counselling, education and family-planning services should be offered promptly.”³³

The PoA recognized the right of women to benefit from advancements in science, including access to fertility treatment. While this issue was not as prominently discussed in Cairo as abortion and maternal health, states did agree that reproductive healthcare should include the “prevention and appropriate treatment of infertility.”³⁴ The PoA laid the groundwork for advocates to address access to fertility treatment as a human right.

By determining that reproductive rights are human rights, the PoA gave advocates the legitimacy to pursue legal and policy solutions to ensure safe and respectful maternal healthcare, contraception, abortion access and coverage, and fertility treatment for all who need it.

II. REPLACING THE POLITICS OF PREGNANCY WITH EVIDENCE- AND RIGHTS-BASED POLICIES

The politics of pregnancy—including failure to address the U.S. maternal health crisis, abortion bans and restrictions, and barriers to fertility treatment—has impeded the realization of the PoA recommendations. Internationally, there have been gains³⁵ and setbacks³⁶ in protecting and ad-

²⁷ *See id.*

²⁸ *See id.* at 69.

²⁹ *Id.*

³⁰ *See id.* at 70.

³¹ *See id.* at 47, 68.

³² *See id.* at 68.

³³ *Id.* at 70–71.

³⁴ *Id.* at 47; *see also id.* at 116–17.

³⁵ Since the adoption of the PoA, 35 countries have expanded the grounds for legal abortion. Grassroots activism fueled a groundswell of societal support for the liberalization of abortion laws. In 2018, one million women gathered outside of the Congress of Argentina in support of a law that would decriminalize abortion up to 14 weeks. *See* Uki Goñi, *Argentina Holds Historic Abortion Vote as 1M Women Rally to Demand Change*, *GUARDIAN* (Aug. 8, 2018, 1:00 AM), <https://www.theguardian.com/global-development/2018/aug/07/argentina-abortion-vote-legalisation-senate-mass-rally> [<https://perma.cc/S9V2-VAG8>]. Despite the massive

vancing reproductive health and rights. In this section, we examine what evidence- and rights-based policies should look like in three key areas.

A. Maternal Health

Since the ICPD at Cairo, it is now widely accepted that maternal mortality is generally preventable and that states have an affirmative obligation to prevent it.³⁷ Treaty monitoring bodies have since indicated that states should take targeted measures to address maternal mortality in especially vulnerable groups that have disproportionately elevated rates of maternal mortality and face additional obstacles in accessing reproductive healthcare.³⁸ The human rights framework that has been developed through international human rights treaties and their respective monitoring bodies recognizes that maternal mortality violates the rights to life,³⁹ health,⁴⁰ equality,⁴¹ and non-dis-

demonstrations, the Senate ultimately rejected the law. The momentum created by the movement carried on and, in May 2019, demonstrators gathered again to support the introduction of an abortion legalization bill and vowed to continue the fight until progress is made. *See Argentina Abortion: Crowds Gather to Back Pro-Choice Bill*, BBC NEWS (May 29, 2019), <https://www.bbc.com/news/world-latin-america-48444884> [<https://perma.cc/BN7R-N7WP>]. In Ireland, a referendum vote held in May 2018 saw the decisive repeal of the country's 8th Amendment, which allowed for abortion when a woman's life was at risk but, in practice, prevented access to services even when necessary. *See Irish Abortion Referendum: Ireland Overturns Abortion Ban*, BBC NEWS (May 26, 2018), <https://www.bbc.com/news/world-europe-44256152> [<https://perma.cc/96FS-2RRD>].

³⁶ In several Latin American countries, abortion is restricted or outright prohibited and it is often criminalized. *See* CTR. FOR REPROD. RIGHTS, THE WORLD'S ABORTION LAWS (2019), <https://reproductiverights.org/sites/default/files/documents/World-Abortion-Map.pdf> [<https://perma.cc/X4TT-L29Z>]. For example, in El Salvador dozens of women have been subjected to decades-long prison sentences under suspicion that they sought or induced abortions, even though several of these women experienced miscarriages or obstetric emergencies. *See Justice in El Salvador (Las 17)*, CTR. FOR REPROD. RIGHTS, <https://reproductiverights.org/justice-in-el-salvador> [<https://perma.cc/TF34-UWL3>]. These punitive laws disproportionately impact girls and adolescents, marginalized communities, rural communities, women with disabilities, and women from lower socioeconomic backgrounds. *See, e.g.*, CTR. FOR REPROD. RIGHTS, THEY ARE GIRLS: REPRODUCTIVE RIGHTS VIOLATIONS IN LATIN AMERICA AND THE CARIBBEAN (2019), <https://reproductiverights.org/sites/default/files/documents/20190523-GLP-LAC-EI Golpe-FS-A4.pdf> [<https://perma.cc/4U6T-HP3F>]; K.L. v. Peru, Human Rights Comm., ¶ 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005); L.C. v. Peru, Comm. on the Elimination of Discrimination Against Women, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 4, 2011).

³⁷ *See* UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 6 (2015), [https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf) [<https://perma.cc/KM3B-QZ5A>]; High Comm'r for Human Rights, *Technical Guidance on the Application of a Human Rights-Based Approach to Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality*, U.N. Doc. A/HRC/21/22 (July 2, 2012).

³⁸ CTR. FOR REPROD. RIGHTS, BREAKING GROUND 2018: TREATY MONITORING BODIES ON REPRODUCTIVE RIGHTS 23–28 (2018), <https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2018.pdf> [<https://perma.cc/P3E9-QUDQ>].

³⁹ *See, e.g.*, Human Rights Comm., Concluding Observations: Mali, 4, U.N. Doc. CCPR/CO/77/MLI (2003).

⁴⁰ *See, e.g.*, Alyne da Silva Pimentel Teixeira v. Brazil, Comm. on the Elimination of Discrimination Against Women, U.N. Doc. CEDAW/C/49/D/17/2008 (Aug. 10, 2011).

crimination.⁴² The UN Human Rights Council has passed multiple resolutions declaring maternal mortality a human rights violation and urged states to renew their emphasis on its prevention.⁴³ Treaty monitoring bodies have consistently linked elevated rates of maternal mortality to lack of comprehensive reproductive health services,⁴⁴ restrictive abortion laws,⁴⁵ unsafe or illegal abortion,⁴⁶ adolescent childbearing,⁴⁷ child and forced marriage,⁴⁸ and inadequate access to contraceptives.⁴⁹

The United States has failed to address the maternal health crisis, which includes the high rates of preventable maternal deaths, maternal morbidity, and disrespectful and discriminatory care. The United States has the highest maternal mortality ratio of all the world's wealthy countries and fares worse in this epidemic than many undeveloped nations.⁵⁰ A recent report shows that while the number of maternal deaths has decreased globally, the number has increased in the U.S.⁵¹ The U.S. maternal health crisis disproportionately impacts Black and Native American women. The Centers for Disease Control (CDC) reports that Black women are three times more

⁴¹ See, e.g., Human Rights Comm., Concluding Observations: Mongolia, U.N. Doc. CCPR/C/79/Add.120 (2000); Human Rights Comm., Concluding Observations: Peru, 5, U.N. Doc. CCPR/CO/70/PER (2000); Human Rights Comm., Concluding Observations: Trinidad and Tobago, 4, U.N. Doc. Doc.CCPR/CO/70/TTO (2000).

⁴² In the landmark case of *Alyne da Silva Pimentel v. Brazil*, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) ruled that states must provide adequate interventions to prevent maternal mortality, including appropriate maternal health services that meet the distinct needs of women and are inclusive of marginalized sectors of society. See *Alyne da Silva Pimentel*, U.N. Doc. CEDAW/C/49/D/17/2008 at 20.

⁴³ See Human Rights Council Res. 11/8 (June 17, 2009); Human Rights Council, Rep. on the Work of Its Eleventh Session, at 44, U.N. Doc. A/HRC/11/37 (2009).

⁴⁴ See Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Malawi, 8–9, U.N. Doc. CEDAW/C/MWI/CO5 (2006); Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Mexico, 6, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Morocco, 7, U.N. Doc. CEDAW/C/MAR/CO/4 (2008).

⁴⁵ See, e.g., Comm. on the Rights of the Child, Concluding Observations: Democratic People's Republic of Korea, 10, U.N. Doc. CRC/C/15/Add.239 (2004); Comm. on the Rights of the Child, Concluding Observations: Guatemala, 9, U.N. Doc. CRC/C/15/Add.154 (2001); Comm. on the Rights of the Child, Concluding Observations: Haiti, 10, U.N. Doc. CRC/C/15/Add.202 (2003).

⁴⁶ See, e.g., Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Eritrea, 4, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Mozambique, 7, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).

⁴⁷ See, e.g., Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Eritrea, 4, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); Comm. on the Elimination of Discrimination Against Women, Concluding Comments: Mozambique, 7, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).

⁴⁸ See, e.g., CRC Committee, Concluding Observations: Afghanistan, para. 53, U.N. Doc. CRC/C/AFG/CO/1 (2011).

⁴⁹ See, e.g., Comm. on the Rights of the Child, Concluding Observations: Chile, 10, U.N. Doc. CRC/C/15/Add.173 (2002).

⁵⁰ See Nina Martin & Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR (May 12, 2017, 10:28 AM), <https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world> [<https://perma.cc/K2ZR-DMTL>].

⁵¹ See TRENDS IN MATERNAL MORTALITY: 2000 TO 2017, *supra* note 5.

likely than white women to die from pregnancy-related complications and twice as likely to suffer severe maternal morbidity (or a “near miss”).⁵² Studies show that institutional racism drives these disparities in birth outcomes.⁵³ The CDC also reports that American Indian and Alaska Native women are nearly two and a half times as likely to die from pregnancy related complications than white women.⁵⁴ Native women face numerous barriers to accessing maternal healthcare, including a pervasive lack of health insurance, a severely underfunded Indian Health Services, and discriminatory care.⁵⁵

The Affordable Care Act (ACA) was a major advancement in evidence-based reproductive healthcare policy. The ACA requires that private health insurance plans in the U.S. cover dozens of preventative healthcare services without copayments, deductibles, or other out-of-pocket costs. The list of covered services includes 18 distinct contraceptive methods.⁵⁶ This policy, known as the “contraceptive coverage guarantee,” was based on a scientific panel’s analysis that contraception is preventative healthcare as required by the Women’s Health Amendment under the ACA.⁵⁷ This has allowed over sixty-two million women to gain guaranteed coverage of preventative services, including birth control, without co-pays.⁵⁸ The ACA also mandates all new health plans to cover a list of essential health benefits, including maternity care.⁵⁹ As such, an expectant parent can now obtain coverage in every state during open enrollment or during a special enrollment

⁵² See Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016*, 68 MORBIDITY AND MORTALITY WKLY REP. 762 (2019).

⁵³ See, e.g., Cristina Novoa & Jamila Taylor, *Exploring African Americans’ High Maternal and Infant Death Rates*, CTR. FOR AM. PROGRESS (Feb. 1, 2018, 9:02 AM), <https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/> [<https://perma.cc/HM5Z-4V8V>].

⁵⁴ See Petersen et al., *supra* note 52.

⁵⁵ See Lucy Truschel & Cristina Novoa, *American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities*, CTR. FOR AM. PROGRESS (Jul. 9, 2018, 11:00 AM), <https://www.americanprogress.org/issues/early-childhood/news/2018/07/09/451344/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/> [<https://perma.cc/PN5X-YVPX>].

⁵⁶ See HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *WOMEN’S PREVENTIVE SERVICES GUIDELINES*, (2016), <https://www.hrsa.gov/womens-guidelines-2016/index.html> [<https://perma.cc/K6Y6-WSAR>].

⁵⁷ See *id.* See also *Preventative Services Covered by Private Health Plans Under the Affordable Care Act*, KAISER FAMILY FOUND. (Aug. 4, 2015), <https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/> [<https://perma.cc/AS8X-4CVW>] (“The required preventive services come from recommendations made by four expert medical and scientific bodies—the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration’s (HRSA’s) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women’s clinical preventive services.”).

⁵⁸ See *New Data Estimate 62.4 Million Women Have Coverage of Birth Control without Out-of-Pocket Costs*, NAT’L WOMEN’S LAW CTR. (Nov. 6, 2018), <https://nwlc.org/resources/new-data-estimate-62-4-million-women-have-coverage-of-birth-control-without-out-of-pocket-costs/> [<https://perma.cc/UC34-DBW2>].

⁵⁹ Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18021–18022 (2012).

period. Prior to the ACA, only twelve percent of individual market plans covered maternity care.⁶⁰

However, until recently, the U.S. maternal health crisis, which disproportionately impacts Black and Native women, went unnoticed in national politics.⁶¹ Only recently has there been increasing support in Congress, often on a bipartisan basis, to raise awareness of disparities and develop policy solutions. For example, approximately twenty-five maternal health bills were introduced in the 115th Congress and two were signed into law.⁶² Legal, policy, and community-based advocates find that legislation that addresses racial disparities in maternal healthcare is critically important to realizing the human right to non-discrimination.⁶³ In the 116th Congress there are several bills under consideration in both the House of Representatives and the U.S. Senate that aim to address this crisis. For example, some bills would extend Medicaid coverage post-partum to up to one year, address the unique needs of rural mothers, support perinatal quality collaboratives, and improve access to culturally-competent care throughout the care continuum by providing implicit bias training.⁶⁴ Such evidence- and rights-based policies are not only critical to closing the maternal health gap, but also to realizing the PoA's goals of eliminating preventable maternal deaths and ensuring access to safe and respectful care.

B. *Abortion Care*

While the ACA was a remarkable achievement for women's health, the accessibility and affordability of abortion care remains mired in politics rather than public health. Despite the fact that treaty monitoring bodies have repeatedly condemned absolute bans on abortion as being incompatible with international human rights norms⁶⁵ and have urged states to eliminate

⁶⁰ See NAT'L WOMEN'S LAW CTR., *WOMEN AND THE HEALTH CARE LAW IN THE UNITED STATES* (May 2013), https://nwlc.org/wp-content/uploads/2015/08/us_healthstate_profiles.pdf [<https://perma.cc/AL3Y-8YYD>].

⁶¹ See Linda Villarosa, *Why America's Black Mothers and Babies are in a Life-or-Death Crisis*, N.Y. TIMES (Apr. 11, 2018), <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html> [<https://perma.cc/2LB4-R6SU>].

⁶² See, e.g., Preventing Maternal Deaths Act of 2018, H.R. 1318, 115th Cong. (2018); Improving Access to Maternity Care Act, H.R. 315, 115th Cong. (2018).

⁶³ See CTR. FOR REPROD. RIGHTS, *GUIDING PRINCIPLES FOR MATERNAL HEALTH POLICY CHANGE*, https://reproductiverights.org/sites/default/files/documents/MHRI/USPA_MH_OnePager_Principles-Center.pdf [<https://perma.cc/E24Z-YXAH>]; BLACK MAMAS MATTER ALLIANCE, *ADVANCING HOLISTIC MATERNAL CARE FOR BLACK WOMEN THROUGH POLICY* (2018), <https://blackmamasmatter.org/wp-content/uploads/2018/12/BMMA-PolicyAgenda-Digital.pdf> [<https://perma.cc/3TFA-LK4N>].

⁶⁴ See, e.g., Maternal Health Quality Improvement Act, H.R. 4995, 116th Cong. (2019); Helping Medicaid Offer Maternity Services Act, H.R. 4996, 116th Cong. (2019).

⁶⁵ See, e.g., Comm. Against Torture, *Concluding Observations: Nicaragua*, 5, U.N. Doc. CAT/C/NIC/CO/1 (2009); Human Rights Comm., *Concluding Observations: El Salvador*, 3-4, U.N. Doc. CCPR/C/SLV/CO/6 (2010); Comm. on Econ., Soc. and Cultural Rights, *Concluding Observations: Chile*, 4, 7, U.N. Doc. E/C.12/1/Add.105 (2004).

such laws, many women in the U.S. do not have access to abortion care. This is true even though there is a constitutional right to abortion.⁶⁶

Accessing abortion has become increasingly difficult in the U.S. due to state-imposed laws, restrictions, and bans. According to the Center for Reproductive Rights, “[i]n the last decade, states have enacted over four hundred and fifty restrictive abortion laws, and in 2019 numerous states enacted blatantly unconstitutional abortion bans as part of this coordinated strategy.”⁶⁷ Specifically, in 2019, eighteen states passed forty-six laws restricting or banning abortion, including six-week bans in Georgia, Kentucky, Mississippi, Louisiana, and Ohio that, if allowed to stand, would prohibit abortion before many people know they are pregnant.⁶⁸ While these kinds of severe bans on abortion are being successfully blocked in court as unconstitutional under *Roe v. Wade*, other laws and restrictions are already severely limiting women’s access to abortion care. As a result, today nearly eighty-nine percent of American counties are without a single abortion provider,⁶⁹ and six states are down to their last abortion clinic.⁷⁰

Reproductive rights advocates have developed a policy solution to overcome the politics surrounding pregnancy. The Women’s Health Protection Act (WHPA)⁷¹ was first introduced in 2013 and has been reintroduced in each subsequent Congress.⁷² WHPA would create a federal safeguard against restrictions and bans on abortion that single out abortion like no other healthcare procedure and impede access to services. The bill creates a statutory right for providers to provide, and for their patients to receive, abortion services free from these medically unnecessary restrictions and bans. It would ensure that the right to abortion first recognized in *Roe* is a reality for women across the country, regardless of the state in which they live. By passing WHPA, Congress could protect a woman’s right to abortion access.

Advocates have also sought to repeal the Hyde Amendment because women cannot meaningfully exercise their constitutional right to access abortion care if they cannot afford such healthcare. The Hyde Amendment is an annual appropriations rider attached to federal budgets that restricts government funds from being used to cover abortion, except in extremely

⁶⁶ See *Roe v. Wade*, 410 U.S. 113 (1973); *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

⁶⁷ CTR. FOR REPROD. RIGHTS, WHAT IF ROE FELL 2 (2019), <https://reproductiverights.org/sites/default/files/2019-11/USP-2019-WIRF-Report-Web.pdf> [<https://perma.cc/5C4Y-ADMD>].

⁶⁸ See *id.* at 8.

⁶⁹ See *State Facts About Abortion: Texas*, GUTTMACHER INSTIT. (Sep. 2019), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-texas> [<https://perma.cc/K4M4-JCZ6>].

⁷⁰ See Sabrina Tavernise, *New Illinois Abortion Clinic Anticipates Post-Roe World*, N.Y. TIMES (Oct. 22, 2019), <https://www.nytimes.com/2019/10/22/us/missouri-illinois-planned-parenthood.html> [<https://perma.cc/M88R-4R3P>].

⁷¹ Women’s Health Protection Act, H.R. 2975, 116th Cong. (2019).

⁷² As of the date of this publication, WHPA has 215 co-sponsors in the House of Representatives.

limited circumstances.⁷³ The Hyde Amendment has systematically denied abortion coverage to millions of low-income people and people of color, military personnel covered under the TRICARE program, veterans that receive hospital and outpatient care operated by the Department of Veterans Affairs, and federal employees for decades, curtailing their constitutional right to abortion.⁷⁴ Advocates have proposed a partial policy solution to the current regime in the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act.⁷⁵ The Act eliminates federal coverage restrictions on abortion services, such as the Hyde Amendment's ban on coverage for Medicaid enrollees, and protects insurance providers from interference in their decision to cover abortion.⁷⁶

The PoA first recognized that access to safe, legal abortion care is a matter of human rights and is necessary to prevent unsafe abortions, which could lead to maternal deaths. Recent studies have built upon this finding and show an even stronger link between abortion restrictions and maternal health. According to a longitudinal study that is frequently cited in peer-reviewed journals, women who are denied abortion care are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy.⁷⁷ One study found that restrictions on abortion contribute to the rising maternal mortality rates in the U.S.⁷⁸ Research also shows how abortion restrictions and maternal mortality disproportionately harm Black women.⁷⁹ These studies, as well as evidence- and rights-based policies like WHPA and the EACH Woman Act, demonstrate that access to high-quality and respectful reproductive healthcare is critical to realizing the objectives of the PoA.

C. Assisted Reproduction

In the past twenty-five years, there have been significant scientific advancements in, and increased use of, in vitro fertilization (IVF) to have children, in some cases as a means to overcome infertility and in others to

⁷³ Alina Salganicoff et. al., *The Hyde Amendment and Coverage for Abortion Services*, Kaiser Fam. Found. (Jan. 24, 2020) <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/> [<https://perma.cc/6N24-ZK62>].

⁷⁴ ALL* ABOVE ALL, *Hyde Amendment Fact Sheet*, (Jan. 25, 2019), <https://allaboveall.org/resource/hyde-amendment-fact-sheet/> [<https://perma.cc/R4M9-XWXP>].

⁷⁵ Equal Access to Abortion Coverage in Health Insurance (Each Woman) Act, H.R. 1692, 116th Cong. (2019). The Act was first introduced in the House of Representatives in 2015 and, as of the date of this publication, has 180 co-sponsors in the House.

⁷⁶ All* Above All, *About The EACH Woman Act*, (Mar. 15, 2019), <https://allaboveall.org/resource/about-the-each-woman-act/> [<https://perma.cc/2GY4-GPUB>].

⁷⁷ See *Turnaway Study*, *supra* note 15.

⁷⁸ See Summer Sherburne Hawkins et al., *Impact of State Level Changes on Maternal Mortality: A Population-Based, Quasi-Experimental Study*, 58 AM. J. PREVENTATIVE MED. 165 (2019).

⁷⁹ See NAT'L PARTNERSHIP FOR WOMEN & FAMILIES & IN OUR OWN VOICE, *MATERNAL HEALTH AND ABORTION RESTRICTIONS: HOW LACK OF ACCESS TO QUALITY CARE IS HARMING BLACK WOMEN* (Oct. 2019), <https://www.nationalpartnership.org/our-work/resources/repro/maternal-health-and-abortion.pdf> [<https://perma.cc/AY3N-4XG9>].

become pregnant outside of heteronormative relationships. However, the ability to access IVF is often undermined by a range of barriers and factors. These can include poor healthcare infrastructure, a lack of providers, prohibitive costs, a lack of—or restrictions on—health insurance coverage, and a range of legal prerequisites to access, including those related to age or marital or relationship status.⁸⁰ These barriers often have exacerbated impacts on specific marginalized groups and can give rise to discrimination on the basis of race and ethnicity, income and financial means, disability, marital and relationship status, and sex and sexual orientation.⁸¹ Laws, policies, and practices regarding access to IVF not only implicate the rights of individuals who seek to access these technologies, but also require consideration of the rights of gamete donors and children who have been born following the use of IVF. Access to IVF implicates the human rights of these individuals to health, autonomy, and non-discrimination.⁸²

While U.N. human rights bodies have yet to decide cases regarding access to IVF treatment, there are a few decisions from regional human rights bodies. For example, in *Artavia Murillo et al. ("In Vitro Fertilization") v. Costa Rica*,⁸³ the Inter-American Court of Human Rights—focusing on the rights of infertile couples—found that a ban on IVF violated the couples' rights to physical, mental, and moral integrity, personal liberty, freedom from interference with private life and family, and the right to raise a family.⁸⁴ This decision lays the foundation for the U.N. human rights bodies to address IVF-related cases on similar or additional grounds.

Similarly, policies ensuring access to IVF treatment are still being developed in the U.S. However, the ICPD at Cairo would suggest that states should ensure that fertility treatment, including IVF, is available, accessible, acceptable, and of good quality on a non-discriminatory basis because decision-making around one's fertility is essential to their rights to life and health.

⁸⁰ CENTER FOR REPROD. RTS., *Infertility and IVF Access in the United States: A Human Rights-Based Policy Approach*, https://reproductiverights.org/sites/default/files/2020-02/647850_06_Infertility%20and%20IVF%20Access%20in%20the%20U.S.%20Fact%20Sheet_2.5.2020_Final.pdf [<https://perma.cc/S86L-DLYL>].

⁸¹ See generally ETHICS COMMITTEE, AM. SOC'Y FOR REPROD. MED., DISPARITIES IN ACCESS TO EFFECTIVE TREATMENT FOR INFERTILITY IN THE UNITED STATES: AN ETHICS COMMITTEE OPINION (2015), https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committeeopinions/disparities_in_access_to_effective_treatment_for_infertility_in_the_us-pdfmembers.pdf [<https://perma.cc/LAX5-QR93>]; Angela Kelley et al., *Disparities in Accessing Infertility Care in the United States: Results from the National Health and Nutrition Examination Survey, 2013-16*, 112 FERTILITY & STERILITY 562 (2019); NAT'L COUNCIL ON DISABILITY, *Chapter 11: Assisted Reproductive Technologies, ROCKING THE CRADLE: ENSURING THE RIGHTS OF PARENTS WITH DISABILITIES AND THEIR CHILDREN* (2012), <https://ncd.gov/publications/2012/Sep272012/Ch11>, [<https://perma.cc/Q375-GFPV>].

⁸² See CENTER FOR REPROD. RTS., *Infertility and IVF Access in the United States: A Human Rights-Based Policy Approach*, *supra* note 80.

⁸³ Preliminary Objections, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 257 (Nov. 28, 2012).

⁸⁴ *Id.*

CONCLUSION

In light of these political challenges and policy solutions, it is important and timely for the *Harvard Law & Policy Review* to devote this issue to the theme of “The Politics of Pregnancy.” These articles explore the seemingly inescapable politics facing pregnant women in a variety of contexts.

Professor Courtney Joslin, Lauren Kuhlik and Professor Caroyln Sufrin, Professor Grace Howard, Rachel Johnson-Farias, and Professor Natalie Nanasi’s articles explore how forms of reproductive control infuse U.S. society, law, and politics, including in permissive surrogacy regulation, institutions of incarceration, immigration enforcement policy, and in domestic violence contexts.

Professor Monica McLemore and the Black Mamas Matter Alliance Research Working Group, Professor Samuel Bagenstos, Professor Stephanie Bornstein, and Professor Lynn Daggett’s articles address the intersectionality of pregnancy, focusing on racial disparities in maternal health outcomes, the disability rights movement, pregnancy accommodation and workplace equality, and student medical privacy.

On this twenty-fifth anniversary of the ICPD at Cairo, these articles serve as a reminder that the ICPD agenda is not negotiable; it is premised upon fundamental human rights. Governments must be held accountable for ensuring these human rights, both by the people they represent and by the international community. It is time to revisit the promises made at the 1994 conference and recommit to making reproductive health and rights for women a priority.

