United States of America

Report of National Advocates for Pregnant Women
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Executive Summary

1. National Advocates for Pregnant Women (NAPW) submits this report to bring attention to a growing body of U.S. laws, policies, and practices that are being used to substantially undermine women's dignity, status as persons under the law, and ability to participate as full and equal citizens. As a result of a growing number of laws that seek to accord separate legal rights to fetuses, laws and policies that create barriers to abortion and other reproductive health care, and the fact that U.S. policy does not ensure that women have access to a range of appropriate, evidence-based health care options, women's lives, health, and dignity are in jeopardy. This report concludes that the United States is not meeting its human rights obligations in its treatment of pregnant women.[*] Moreover, it appears that the United States is regressing, rather than making progress, in meeting its human rights obligations with regard to pregnant women.

Background and Context

2. NAPW research shows that pregnancy can make women the target of criminal investigation, incarceration, counterproductive civil child welfare interventions, and forced medical procedures in the United States. At the same time, access to services that ensure dignity and informed medical decision-making are being limited arbitrarily.

3. For decades, abortion opponents have attempted to undermine the right to abortion by supporting laws that create barriers to this care[i] and by promoting laws that confer new, separate legal rights for fetuses and the unborn from the moment of fertilization. Rather than protecting potential human life by protecting pregnant women, abortion opponents have supported feticide laws, "unborn victims of violence" laws, and "unborn personhood measures" that are increasingly being used to justify deprivations of women's rights to life, liberty, due process, informed consent, and bodily and family integrity. Moreover, decades of anti-abortion propaganda focusing on pregnant women as "killers," "murderers," and part of an unprecedented "holocaust" of the unborn,[ii] have resulted in health care policies that prioritize politics over evidence-based medicine and distract public attention from the need for and value of such things as universal health care. The consequences of this are reflected in numerous public health and legal indicators.

4. Eighty-seven percent of counties in the US have no abortion provider.[iii] At least as many counties have no birth centers, and approximately 43% of U.S. hospitals do not allow vaginal birth after cesarean section,[iv] despite the fact that this mode of delivery is often safer and has a shorter, less painful recovery period than repeat surgery.[v] While at least seventeen states mandate that specific information—generally including biased, false, or misleading information—be given to women who are seeking abortion services,[vi] only two states[vii] mandate that specific information about a hospital's birth-related practices be given to women who are going to term.

5. Lack of universal health care, uneven access to coordinated[viii] and evidence-based[ix] maternity care, decreasing access to abortion services, and policies that encourage unnecessary cesarean surgeries[x] and other medical interventions during labor and delivery have all been associated with heightened rates of maternal mortality.[xi] Yet, the focus on the debate about abortion in the

[*] *Note on methodology:* This report is limited in its discussion and NAPW recognizes many additional human rights concerns both for pregnant and parenting women and in the realm of reproductive rights. National Advocates for Pregnant Women makes this statement based on the trends and cases observed and analyzed in the course of NAPW's litigation, advocacy and public education experiences.

U.S. has almost entirely overshadowed the high rates of maternal and infant mortality and the extraordinary racial disparities reflected in those rates.[xii]

6. Based on the claim that fetuses should be viewed as completely separate from the pregnant woman and given unprecedented autonomous legal rights, pregnant women have been incarcerated, civilly committed, forcibly subjected to medical procedures, and deprived of their right to parent through civil child welfare proceedings.[xiii] Although feticide laws purport only to protect fetuses from attacks from third parties, pregnant women have been charged under these laws, and these laws are being used to argue that existing criminal statutes, civil commitment statutes, and child protection laws may be interpreted to apply to "unborn children" in relationship to the pregnant women who carry, nurture, and deliver them.

7. Low-income women, women of color, and women with untreated drug problems are disproportionately targeted for arrest and other punitive interventions. Women in the U.S., however, face significant barriers to accessing appropriate drug treatment.[xiv] Some women have even been subjected to civil child welfare actions because they obtained federally recommended methadone treatment while pregnant.

8. Supporters of these punitive policies argue that fetuses are entitled to a completely healthy environment, while U.S. law and policy do not guarantee the women who carry them the health care, education, dignity, or safe environment necessary for healthy pregnancies.

Areas of Concern Regarding the Human Rights of Pregnant Women

9. NAPW has documented hundreds of cases involving the policing and punishment of pregnant women and new mothers specifically because they were pregnant.[xv] These human rights violations have occurred in virtually every state over the last 30 years. In every case, the woman would not have been subjected to an investigation, conviction, incarceration, child welfare intervention, or punitive action if she were not pregnant. Recent cases and trends may indicate that the policing of pregnancy is accelerating. Some recent illustrations include:

10. In November 2006, R.G., a sixteen-year-old African-American girl in Mississippi, suffered a stillbirth. Instead of offering care or support to cope with the loss, medical personnel notified the police. R.G. was then arrested and charged—as an adult—with murder. The State of Mississippi alleged that R.G. "feloniously, willfully and unlawfully … and envincing [sic] a depraved heart" murdered her child, claiming, without any medical or scientific support, that her drug use caused the stillbirth. There is no written law declaring that a woman who experiences a stillbirth—for any reason—can be held criminally liable. The case is still pending.[xvi]

11. In 2009 in South Carolina, J.C., eight months pregnant, became despondent when the father of her baby threatened to leave her. In an apparent suicide attempt, she jumped out of a fifth floor window. J.C. survived with numerous severe injuries but lost the pregnancy. She was arrested and charged with homicide by child abuse. Held for months without bail, J.C. eventually pleaded guilty to manslaughter to avoid a conviction or years in jail while challenging the charges.[xvii]

12. Since 2006, at least 21 Alabama women have been arrested because they attempted to carry their pregnancies to term in spite of a drug problem.[xviii] No law in Alabama makes this a crime; however, prosecutors have charged the women through a new interpretation of Alabama's "chemical endangerment of a child" law, which was intended to protect children living in or near methamphetamine labs. There is no evidence that the legislature contemplated the application of this law to pregnant women in relation to their fetuses. At least 15 of these cases were initiated as a result of a drug test performed during the woman's routine prenatal or perinatal medical care.[xix]

13. A.L. was on probation for a minor, non-violent offense when she became pregnant. The terms of her probation mandated drug treatment, which she successfully completed. However, when her probation officer learned that she had suffered a relapse, the officer departed from normal practice and immediately filed for probation revocation. Whereas probationers typically would be more carefully monitored in the event of a relapse, A.L. was immediately arrested because, the state claimed, incarcerating her would protect her fetus. Even though A.L. presented a treatment plan at a facility that specifically addressed the needs of a pregnant woman, the state rejected her plan and instead placed her in a notoriously unsanitary and unsafe prison that refused to comply with her doctor's orders.

14. C.T., a young mother of two, fell down the stairs in her home while she was pregnant with her third child. She asked to be taken to the hospital out of concern for her baby. Hospital staff, however, reported her to the police, suggesting that she might have tried to induce a miscarriage by deliberately falling down the stairs. C.T. was arrested for "attempted feticide" and incarcerated for two days—unable to contact her young daughters. The state eventually decided not to prosecute, not because prosecutors recognized this as a radical and unauthorized interpretation of the law, but because it believed that this unauthorized and unprecedented use of the law should only be used against pregnant women in their third trimester of pregnancy, whereas C.T. was only in the second.

15. As a result of feticide and related laws, women who have or are perceived to have caused a miscarriage or stillbirth are being charged with murder.[xx] Moreover while legal abortion services by physicians are being made less accessible, some states are making clandestine abortions punishable as murder. On March 8, 2010, Utah enacted a law that criminalizes for homicide any pregnant woman who "intentionally [and] knowingly . . . cause[s] the death of . . . an unborn child at any state of its development" except in the context of a legal abortion. This law creates a basis for a criminal investigation into every miscarriage and stillbirth in Utah. If there is probable cause to believe the woman purposefully or knowingly caused the loss, she could be arrested.[xxi]

16. Despite recognition by medical societies that use of coercive or punitive tactics, such as resort to court order, for obtaining consent from an unwilling patient are virtually never justified,[xxii] NAPW has documented numerous cases in which claims of separate fetal rights have been used to force women to undergo medical procedures against their will. This has resulted in the death of both mother and child in one case,[xxiii] as well as an increasing number of pregnant women being threatened with court orders and child welfare intervention for endangering their "unborn child" if they exercise their right to informed refusal. Many of the women are either refusing repeat cesarean surgery when faced with a "VBAC ban" or attempting to deliver at home, which

is legal in all jurisdictions. In cases where child welfare authorities are notified, the investigation into the family can be severe and even result in the removal of their children from the home. Often these cases occur close to the woman's due date or even during labor, affording the woman no meaningful due process. For example:

17. In April 2006, V.M. went to the hospital to deliver her first child, where she was asked to sign a blanket consent for all possible medical interventions. V.M. pre-authorized many procedures, but did not want to authorize caesarian surgery until it became necessary. Although she was deemed competent to make medical decisions by two hospital psychiatrists, hospital employees were unsure whether pregnant women have the right to refuse medical care. V.M. delivered a healthy daughter vaginally, without any need for surgery. Nevertheless, hospital staff contacted the local child welfare authorities to report the medical neglect of a fetus.[xxiv] Based on this claim, the state took custody of her newborn, and V.M. and her husband were not allowed to take their baby home from the hospital. Although the finding of "medical neglect" has been modified, the "neglect" that has formed the basis of the subsequent termination of V.M.'s parental rights almost exclusively cites V.M's behavior prior to the birth and in response to the child protective investigations. Her child has never been in her care or control.

Evaluation Under Relevant Human Rights Obligations of the United States

18. Treatment of pregnant woman in the U.S. falls far short of standards set by the U.S. Constitution and international human rights standards as described in the Universal Declaration of Human Rights. This report highlights a trend of treating pregnant women differently than other people, depriving them of civil and human rights because they are pregnant. Singling out pregnant women is contrary to the basic human rights principles of equality among all people as most prominently noted in the UDHR (Art. 1). Making women the target of arrest, investigation, or denying the right to informed consent or the right to parent because of pregnancy does not comport with the principle of non-discrimination.

19. Targeting pregnant women for punitive state action creates a major barrier to women and children achieving the right to the enjoyment of the highest attainable standard of health as guaranteed by UDHR (Art. 25) and the International Covenant on Economic, Social, and Cultural Rights (Art. 12). The medical and public health consensus is that punitive responses to women's health conditions and decision-making during pregnancy "threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses."[xxv] Furthermore, the failure to promote evidence-based maternity care and curb overuse of medical interventions, as well as the failure to address racial disparities in maternal and infant mortality, prevents women from the enjoyment of the right to health.

20. The investigations and arrests that arise from these policies run afoul of the UDHR rights to be free from arbitrary arrest, detention or exile (Art. 9) and the right to not be held guilty of an offense for acts that did not constitute a crime at the time of commission (Art. 11). No state legislature has passed a law that makes it a crime for a woman with a drug problem to become preg-

nant, and state legislatures routinely reject such measures when introduced.* Many women are unaware that the charges against them are not authorized by law, plead guilty, and are then subject to significant criminal penalties for acts that do not constitute a crime under the law. In other cases, women are not afforded an effective opportunity to challenge their detention or arrest.

21. Article 12 of the UDHR articulates the right to be free from arbitrary interference with the family. In many jurisdictions around the country, families are being investigated and separated on the basis of a single positive drug test or a mother's informed refusal of medical intervention rather than on evidence of actual abuse or neglect. These unwarranted intrusions subject families to child protective systems that often have no incentive or means to help or preserve families.

22. Lastly, UDHR Art. 25(2) recognizes that motherhood is entitled to special care and assistance. Neither treaty law nor customary law suggests that "special care" should have any restrictive or punitive component. Rather, this promise reflects an understanding that pregnancy is a vulnerable time, requiring—among other things—special health care and adequate nutrition. Instead of conceptually separating the pregnant woman from her fetus, the human rights paradigm recognizes that a state protects fetuses by supporting and protecting the women who carry them.

Recommendations

23. The principle of non-discrimination requires that women be guaranteed their full rights at all times, regardless of pregnancy. We ask that the U.S. take steps to ensure that pregnant women realize this equality and protection. In order to ensure the equality of pregnant women, the U.S. should reject the creation of laws that grant new and separate legal rights to the unborn. As the cases discussed in this report demonstrate, the existence of wholly independent fetal legal rights provides the State with virtually limitless authority to intervene against a pregnant woman in ways that offend every notion of dignity, equality, and justice.

24. The UDHR, treaties, and even the U.S. Congress recognize that the family is the fundamental unit of society. We ask that the United States support policies that favor preservation and reunification of families.

25. Finally, we recommend the U.S. take steps to ensure access to health care to all people, that maternity care be evidence-based, and that the principles of informed consent apply to all patients. The U.S. should ensure that pregnant women can access health care without fear of arrest or investigation. In order to fully realize the human right to the highest standard of health, access to health care must include comprehensive reproductive health care, mental health care, and drug treatment.

* Only one state's highest court has approved of using the criminal child abuse laws to punish women who continue their pregnancies to term in spite of a drug problem, and even this court recently recognized that a conviction had been based on outdated research. McKnight v. South Carolina, 661 S.E.2d 354 (S.C. 2008).

References

[i] Between 1995 and 2004, states enacted 409 anti-choice legislative measures. *Battle for Choice Rages Through Statehouses*, Women's E-News: March 3, 2005, http://womensenews.org/article.cfm/dyn/aid/2205 (last visited April 18, 2010). In the 2005 legislative session, over 650 bills were introduced that would directly or indirectly restrict access to abortion and contraception or advance the legal status of the fetus as if it were separate from the pregnant woman. Center for Reproductive Rights, Legislative Summary (2005) (on file with National Advocates for Pregnant Women).

[ii] *See, e.g.* Gregg Cunningham, The Center for Bio-Ethical Reform, *Why Abortion is Genocide: Rationale for the Genocide Awareness Project*, http://abortionno.org/pdf/abortion.pdf; Dan Gilgoff, *Rick Warren on His Saddleback Summit with McCain and Obama*, Beliefnet.com, http://www.beliefnet.com/News/Politics/2008/08/Rick-Warren-On-His-Saddleback-Summit-With-Mccain-And-Obama.aspx (likening silence on abortion to Holocaust denial).

[iii] Allen Guttmacher Institute, Facts on Induced Abortion in the United States, http://www.guttmacher.org/pubs/fb_induced_abortion.html (citing R.K. Jones et al., *Abortion in the United States: incidence and access to services*, 40 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH: 2005 6 (2005)).

[iv] International Cesarean Awareness Network, VBAC Policies in U.S. Hospitals, http://ican-online.org/vbac-ban-info. ICAN research reveals that 800 hospitals have policies stating that they will not provide services to pregnant women with a prior cesarean unless they have a scheduled surgery; another 400 hospitals have no provider who will attend VBACs.

[v] National Institutes of Health, Draft Consensus Development Conference Statement, Vaginal Birth After Cesarean: New Insights, (March 26, 2010) http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf.

[vi] Guttmacher Institute, State Polices In Brief, An Overview of Abortion Laws (April 1, 2010) http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf

[vii] N.Y. Pub. Health § 2803-j(2)(a-m); Massachusetts General Law, 111 Public Health Hospitals § 70E.

[viii] Amnesty International, Deadly Delivery: The Maternal Health Care Crisis in the USA (2010) *available at http://www.amnestyusa.org/dignity/pdf/DeadlyDelivery.pdf.*

[ix] Carol Sakala & Maureen P. Corry, Evidence-Based Maternity Care: What It Is and What It Can Achieve (2008) *available at* http://www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf.

[x] The most recent figures from the Centers for Disease Control and Prevention reveal a national cesarean rate of 32.3%. Brady Hamilton, Joyce Martin, & Stephanie Ventura, Nat'l Ctr. for Health Statistics, Births: Preliminary Data for 2008, 58 Nat'l Vital Stat. Reports (Apr. 2010). http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_16.pdf. The World Health Organization, however, suggests that a cesarean rate over 10-15% is never medically justified. World Health Org., *Appropriate Technology for Birth*, 2 LANCET 436 (1985).

[xi] Amnesty International, *supra* note 8.

[xii] See, e.g., Committee on the Elimination of Racial Discrimination, Concluding observations of the Committee on the Elimination of Racial Discrimination, United States of America, 5 March 2008, CERD/C/USA/CO/6, para.33. (noting that "wide racial disparities continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African-Americans"); National Center for Health Statistics, U.S. Department of Health and Human Services, Health, United States 176 (2009), available at http://www.cdc.gov/nchs/data/hus/hus09.pdf#017 (showing the infant mortality rate among African-Americans is more than double the rate among whites).

[xiii] Women have been deprived of their liberty by the state for delaying cesarean surgery, being critically ill, drinking alcohol, not getting to the hospital quickly enough on the day of delivery, being unable to overcome an addiction in the short length of a pregnancy, attempting suicide, having HIV, and refusing state ordered prenatal exams. *See* Nat'l Advocates for Pregnant Women, Open Letter to the Senate Judiciary Committee, June 19, 2009, at 2, *available at* http://advocatesforpregnantwomen.org/JointLetter-SotomayorConfHearing.pdf.

[xiv] A 2006 US Department of Health and Human Services report showed that 13% of public and private drug treatment facilities nationwide do not accept any women into their programs. Of the facilities accepting women, only 41% offered programs or groups specific to women, and only 17% offered services for pregnant or postpartum women. *See* Office of Applied Studies, Substance Abuse & Mental Health Serv. Admin., *Facilities Offering Special Programs or Groups for Women: 2005*, DASIS REP., May 15, 2008 , *available at* http://www.oas.samhsa.gov/2k6/womenTx/womenTX.htm. The 2006 National Survey on Drug Use and Health showed that in 2006, 7.4 million women aged 18 and over needed treatment for a substance use problem, but only 822,000 (11.2%) received treatment. Office of Applied Studies, Substance Abuse & Mental Health Serv. Admin.,

Substance Use Treatment Among Women of Childrearing Age, NSDUH REP., Oct. 4, 2007, *available at* http://oas.samhsa.gov/2k7/womenTX/womenTX.htm.

[xv] A major report documenting and analyzing these cases is forthcoming this fall/winter 2010. NAPW invites readers to check back on its website (www.advocatesforpregnantwomen.org) for updates on the release. Many of the cases have been discussed in media reports, legal cases, and scholarly articles.

[xvi] *See* Motion to Dismiss, State v. R.G. (Miss. Cir. Ct. Nov. 2009) (on file with National Advocates for Pregnant Women).

[xvii] See Jason Foster, *Woman Faces Charge of Killing Unborn Child During August Suicide Attempt*, Spartanburg Herald, Feb. 21, 2009, available at http://www.heraldonline.com/2009/02/21/1152282/woman-faces-charge-of-killing.html.

[xviii] Adam Nossiter, *In Alabama, a Crackdown on Pregnant Drug Users,* N.Y. TIMES, Mar. 15, 2008, *available at* http://www.nytimes.com/2008/03/15/us/15mothers.html.

[xix] See, e.g., Brief of Nat'l Advocates for Pregnant Women et al. as Amici Curiae in Support of Defendant, Alabama v. S.W. No. CC-2008-103 (Ala. Cir. Ct. June 19, 2008), available at http://advocatesforpregnantwomen.org/main/publications/brief_bank/alabama_v_shekelia_ward_amicus_brief.php.

[xx] See, e.g., McKnight v. South Carolina, 661 S.E.2d 354 (S.C. 2008).

[xxi] Criminal Homicide and Abortion Revisions, H.B. 462, 2010 Gen. Sess. (Utah 2010) (amending, inter alia, UTAH CODE ANN. § 75-5-201 and § 76-7-301), *available at* http://le.utah.gov/~2010/bills/hbillenr/hb0462.htm.

[xxii] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 321*, 106 Obstetrics & Gynecology 1127 (2005).

[xxiii] In re A.C., 573 A.2d 1235, 1253 (D.C. 1990) (en banc) (vacating a court order for an unconsented cesarean surgery, which was listed as a contributing factor to the mother's death on her death certificate).

[xxiv] Brief of *Amici Curiae* Experts in Maternal and Neonatal Health, Birth, and Child Welfare, Division of Youth and Family Serv. v. V.M., No. A-04627-06T4 (N.J. App. Div. Oct. 24, 2008) available at http://advocatesforpregnantwomen.org/main/publications/brief_bank/new_jersey_division_of_youth_and_family_services_v_vm_and_bg.php.

[xxv] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion 321*, 106 Obstetrics & Gynecology 1127 (2005) (also noting that "[p]regnant women should not be punished for adverse perinatal outcomes" because " [t]he relationship between maternal behavior and perinatal outcome is not fully understood."). In the context of HIV treatment during pregnancy, the U.S. Public Health Service Task Force Perinatal Guidelines explicitly states: "Coercive and punitive policies are essentially counterproductive in that they may undermine provider-patient trust and could discourage women from seeking prenatal care and adopting health behaviors that optimize fetal and neonatal well-being." U.S. Public Health Service Task Force, Perinatal HIV Guidelines Working Group, *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States*, Apr. 29, 2009, at 1. As the American Medical Association has stated: "Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment." Am. Med. Ass'n Bd. of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 267 (1990).