CSW 69 Beijing +30 Shadow Report

Women and Health

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According to the Beijing Platform for Action, women and girls have the right to enjoy the highest standard of physical and mental health (para 89) and to decide on all aspects of their health including their sexual and reproductive health without discriminatory norms and practices (paras 92, 96).[1] The Beijing Platform sets out five strategic objectives for women's health under Area of Concern C:

C.1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.
C.2. Strengthen preventive programmes that promote women's health.
C.3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.
C.4. Promote research and disseminate information on women's health.
C.5. Increase resources and monitor follow-up for women's health.

After 30 years, none of these have been achieved in the US despite federal regulations and national initiatives. Women and girls in the US still face multiple challenges to exercise their right to health. Three of the most concerning issues include: 1) unequal access to healthcare; 2) reproductive health and abortion rights; and 3) the maternal health crisis.

Unequal Access to Healthcare: Women in the US are more likely than men to have chronic conditions that require ongoing medical treatment and prescription medications. However, they have inadequate access to healthcare, worse health outcomes, and poor health standards.[2] Pervasive socioeconomic inequalities such as higher poverty rates, uninsurance rates, gender wage disparities, and out-of-pocket costs are the most important factors that contribute to these gender differences. Even when excluding pregnancy-related costs, working women with employer-sponsored insurance have 18% higher out-of-pocket annual medical expenses compared to men.[3] In addition, uninsured women receive a lower standard of care once they are in the health system.

In 2020, **12.6 million US women and girls lacked health insurance** and women were significantly more likely to be uninsured than men (18% vs. 14%).[4] Among women of reproductive age (15-44 years), those living in **southern states** (Texas, Georgia, Oklahoma) **have the highest rates of uninsurance.**[5] In addition to gender differences, there are racial disparities in poverty and healthcare access. As of 2022, American Indian/Alaska Native (AIAN, 48%), Black (43%), Native Hawaiian/Pacific Islander (NHPI, 41%), and Hispanic women (40%) of reproductive age are twice as likely as Whites (24%) to have low income (below 200% of the federal poverty level).[6] **Uninsurance rates are higher among American Indian/Alaska Native (22%), Hispanic (21%), and Black (11%) women compared to White women (7%)**.[7]

Reproductive Health and Abortion Rights: Women of diverse racial groups have limited access to contraceptives and other sexual health services for family planning and perinatal care due to long-standing social inequities, language barriers, lack of insurance, and higher poverty rates.[8] This disparity ultimately translates into higher rates of unplanned pregnancies, abortion rates, and maternal and infant mortality. The most recent abortion data disaggregated by race (2021) confirmed that Black women have the highest abortion rates compared to other racial groups (Black 28.6, Hispanic 12.3, White 6.4/1,000 pregnancies).[9]

The US Supreme Court decision overturning *Roe v. Wade* in 2022 has altered both access to reproductive health care services and treatment for pregnancy complications in the states that ban or restrict abortions. The Dobbs ruling eliminated the federal right to abortion, and abortion rights are now decided by states. As of December 2024, **13 US states have total abortion bans and 28 have gestational limits on abortion.**[10] While there have been inequities in abortion access for many years, the Dobbs ruling widened those differences with a disproportionate impact on women of color residing in the South and Midwest due to state-level restrictions and underlying socioeconomic inequities. Among women of reproductive age, 60% of Black and 59% of American Indian/Alaska Native women are more likely to live in states with abortion bans and restrictions than White (53%) or Hispanic women (45%).[11]

In addition, there are racial disparities in healthcare coverage in states with abortion bans. Non-white women of reproductive age have significantly higher uninsured rates than Whites (AIAN 22%, Hispanic 21%, NHPI 14%, Black 11%, White 7%).[12] This difference is concerning since **uninsured rates are 2 times higher in states that ban abortion** compared to those with broader access in each racial and ethnic group (Black 14% vs. 7%, Hispanic 33% vs. 15%, Asian 10% vs. 5%,

White 10% vs. 5%).[13] Across racial and ethnic groups, women in states that have banned or restricted abortion are more likely to have low income than women in states that allow abortions. Furthermore, the out-of-pocket cost of a medical or surgical abortion is $500-600, a prohibitive price when over 57% of Black and Hispanic women of reproductive age cannot cover an emergency expense of $500, more than the already high 36% of White women.[14]

The Maternal Health Crisis: Pregnancy-related complications are one of the leading causes of morbidity and mortality of women of reproductive age. Women must have access to perinatal care to ensure a safe pregnancy, decrease maternal deaths, and guarantee their best chances of delivering a healthy child (Beijing Platform for Action paras 94, 97). However, due to socioeconomic factors and challenges with reproductive healthcare access for women and girls, the **US has the highest maternal mortality rate of any high-income nation** (19 deaths/100,000 live births),[15] more than double the rate in most other developed countries.[16] Maternal mortality is the highest in the poorest US regions such as the Mississippi Delta (Arkansas, Louisiana, Mississippi, and Tennessee).[17]

For several decades, the US has experienced major increases in maternal mortality rates across all racial and ethnic groups. The 2024 National Vital Statistics System data demonstrate dramatic racial inequities. Regardless of education and income level, **Black women are three times more likely to die of pregnancy-related complications** than Whites (51 deaths vs. 15 deaths/100,000 live births).[18] In addition, **Native American and Alaska Native women are two times more likely to die of pregnancy complications** than White women**,** and **rural women are 60% more likely to die**.[19] Blacks receive worse quality care than Whites on 52 indicators including measures of care process, ability to receive needed care, and outcomes (e.g. mortality).[20] Lack of health coverage is associated with late or no prenatal care, preterm birth, and low birthweight infants in minority women compared to Whites. This is especially concerning for non-white adolescents (15-19 years) who have birth rates over two times higher than Whites (AIAN 22.5, Hispanics 21, Blacks 20, NHPI 20/1,000 births vs. White 9/1,000).[21]

Lastly, lack of abortion access limits termination of pregnancy for medical reasons and many women are forced to continue the pregnancy even if it threatens their health.[22] Furthermore, abortion bans and restrictions prevent timely care for women with pregnancy loss (miscarriage and stillbirth) and jeopardize their health due to providers' concerns about criminal charges. **Fetal mortality rates are the highest in Black and Native Hawaiian/Pacific Islander women** (9.8 fetal deaths/1000 live births) compared to White women (4.8 per 1,000).[23]

To address the high rates of maternal mortality, the Biden administration launched several initiatives to address health inequities and correct system failures such as the White House Blueprint for Addressing the Maternal Health Crisis (2022), the White House Initiative on Women's Health Research (2023),[24] and the National Institutes of Health Pathways to Prevention Panel (NIH 2024).[25]

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[1] UN Fourth World Conference on Women 1995. *Beijing Platform for Action.*
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[3] Deloitte 2023. *Hiding in Plain Sight: The Health Care Gender Toll.*
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[6] Hill, Latoya et al. 2024. *What are the Implications of the Dobbs Ruling for Racial Disparities?*
[7] Hill, Latoya et al. 2024.
[8] Harper, C.C., Brown, K., Arora, K.S. 2024. *Contraceptive Access in the US Post-Dobbs.*
[9] Kortsmit, K. et al. 2023. *Abortion Surveillance United States 2021.*
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[13] Hill, Latoya et al. 2024.
[14] Hill, Latoya et al. 2024.
[15] National Center for Health Statistics 2024. *Provisional Maternal Mortality Rates.*
[16] White House 2022. *White House Blueprint for Addressing the Maternal Health Crisis.*
[17] Collins, Sara R. et al. 2024.
[18] National Center for Health Statistics 2024.
[19] White House 2022.
[20] Agency for Health Care Research and Quality 2023. *2023 National Healthcare Quality and Disparities Report.*
[21] Driscoll, A.K. et al. 2024. *Changes in First and Second Births to US Teenagers from 2000 to 2022.*
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[23] Ranji, U. et al. 2024. *Dobbs-Era Abortion Bans and Restrictions.*
[24] White House 2023. *Memorandum on the White House Initiative on Women's Health Research.*
[25] Davidson, K.W. et al. 2024. *Maternal Mortality: A National Institutes of Health Pathways to Prevention Panel Report.*