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CERD



STUDY GUIDE

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Committee: Committee on the Elimination of Racial Discrimination
Agenda: Addressing Systemic Disparities in Health and Reproductive Autonomy: Eliminating Racial Bias in Maternal Infrastructure

Mandate:

The Committee on the Elimination of Racial Discrimination was the very first United Nations treaty body established to monitor a specific human rights convention, CERD holds a unique and vital position in the international legal framework. Founded in 1970, this committee is tasked with a singular, profound mission: to oversee, support, and enforce the implementation of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). Unlike general UN bodies like the General Assembly, CERD is a highly specialized, quasi-judicial mechanism. Its authority is strictly bound by the text of the ICERD, and its work bridges the gap between international law and domestic reality.

CERD's mandate stems directly from Article 1 of the ICERD, which defines racial discrimination as any distinction, exclusion, restriction, or preference based on race, colour, descent, or national or ethnic origin. The committee's primary goal is to ensure that State Parties: countries that have ratified the convention actively work to amend or nullify any domestic laws or customs that perpetuate discrimination. Furthermore, the mandate requires states to prohibit racial discrimination by any person, group, or organization within their jurisdiction.

To fulfill its mandate, CERD operates through four distinct mechanisms. As delegates, you must understand how these tools are utilized to hold nations accountable. Every state party is legally obligated to submit regular reports to CERD detailing how they are implementing the convention. The committee reviews these reports, cross-references them with civil society data, and issues Concluding Observations. These observations highlight progress and deliver frank criticisms and recommendations for reform. CERD uses Early-Warning and Urgent Action Procedures. This is one of CERD's most critical, proactive tools.

It allows the committee to step in immediately when a situation is escalating toward serious, systemic, or violent racial conflict. It does not wait for a routine report; it acts dynamically to prevent humanitarian crises. CERD possesses a quasi-judicial function. Under Article 11, states can complain about other states failing to uphold the convention. Additionally, under Article 14, if a state has explicitly opted in, CERD can receive and review petitions directly from individual victims or groups who have exhausted all local legal options. The committee regularly publishes comprehensive interpretations of the convention's articles. These "General Recommendations" provide states with concrete guidance on modern challenges, such as combating hate speech, protecting indigenous populations, or addressing algorithmic bias in law enforcement.

As you prepare for the committee remember that CERD is a committee of independent experts, not a legislative body. While political debate is not discouraged, your resolutions should mirror the CERD's powers. You cannot authorize military intervention, levy economic sanctions, or rewrite international law. Instead, your power lies in monitoring, recommending, advising, and holding states accountable to the legal commitments they have already made.

Introduction to the Agenda

Maternal mortality and severe maternal morbidity represent persistent global public health challenges, exposing fundamental gaps in healthcare equity, institutional infrastructure, and international human rights compliance. While international frameworks guarantee the right to the highest attainable standard of physical and mental health, systemic racial discrimination, structural inequalities, and implicit bias continue to compromise the delivery of maternal care worldwide. Women and birthing persons belonging to racial, ethnic, national, and indigenous minority communities consistently face disproportionate risks during pregnancy, childbirth, and the postpartum period disparities that persist across varied socioeconomic levels and geographic regions. As a result, racial disparities in maternal infrastructure have become an urgent priority for human rights bodies, healthcare systems, and civil society, with impacts extending beyond individual health to economic stability, family integrity, and social cohesion.

The Committee on the Elimination of Racial Discrimination (CERD) derives its mandate from the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).

Under Article 5(e)(iv) of the Convention, State Parties are bound to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to public health, medical care, social security, and social services. CERD has further elaborated on these obligations through General Recommendation No. 34 (on racial discrimination against people of Afro-descent) and General Recommendation No. 39 (on the rights of Indigenous Women and Girls), emphasizing that States must actively eliminate racial bias from healthcare institutions and ensure equitable, culturally appropriate, and non-discriminatory access to health services.

Racialized disparities in maternal healthcare operate through complex structural mechanisms. Within medical institutions, minoritized patients frequently encounter obstetric violence, dismissive communication, denial of adequate pain management rooted in historical racial stereotypes, and non-consensual medical procedures that violate reproductive autonomy. Historically and in contemporary settings, racialized women have faced systemic barriers to bodily autonomy, including forced or coerced sterilization, discriminatory family planning policies, and inadequate access to emergency obstetric care. Furthermore, discriminatory resource allocation leaves healthcare facilities serving minority communities underfunded, understaffed, and equipped with outdated technologies, creating vast "maternity care deserts" in historically marginalized areas.

The consequences of these systemic failures extend beyond immediate physical health outcomes. Maternal mortality and severe morbidity destabilize families, exacerbate intergenerational poverty, and erode public trust in health systems. Recognizing these profound impacts, the international community has increasingly framed maternal mortality among racialized populations not merely as an inevitable clinical risk, but as a preventable human rights violation rooted in systemic discrimination. Addressing these disparities requires a holistic approach that integrates human rights enforcement, targeted legislative reforms, resource redistribution, diversity in medical education, and community-led models of care.

This agenda aligns directly with the United Nations 2030 Agenda for Sustainable Development. Specifically, Sustainable Development Goal (SDG) Target 3.1 aims to reduce the global maternal mortality ratio, while SDG Target 3.7 calls for universal access to sexual and reproductive healthcare services. Progress on this issue also supports SDG 5 (Gender Equality) by protecting bodily autonomy and eliminating gendered and racialized violence in healthcare, as well as SDG 10 (Reduced Inequalities) by dismantling institutional discrimination within public service infrastructure.

Delegates must recognize that a single, uniform solution cannot resolve these deeply rooted issues across varying global contexts. Differences in national healthcare infrastructure, constitutional legal frameworks, resource allocation, and historical patterns of marginalization mean that effective strategies must be both grounded in human rights and adaptable to local conditions. As delegates of the Committee on the Elimination of Racial Discrimination, participants are challenged to construct actionable, balanced recommendations that dismantle systemic racial bias, enforce clinical accountability, promote international cooperation, and protect reproductive autonomy for all birthing persons, all while respecting national sovereignty and the distinct capacities of Member States.

History and Background

The intersection of racial discrimination, colonial legacies, and institutional neglect has historically rendered safe maternity care an unequal privilege. Addressing racial bias in maternal infrastructure requires understanding how historical systems of subjugation created clinical disparities, how the international legal framework evolved to confront structural racism in healthcare, and how contemporary global movements have redefined maternal health as an issue of racial justice and bodily autonomy.

The roots of racial bias in maternal healthcare are deeply embedded in the history of colonialism, transatlantic slavery, and institutionalized eugenics. During the 18th and 19th centuries, Western clinical medicine developed foundational practices in gynecology and obstetrics through non-consensual experimentation on enslaved Black women and colonized Indigenous populations. Practitioners operated under pseudo-scientific biological racial theories, falsely claiming that racialized individuals possessed higher pain thresholds, thicker skin, or distinct physiological traits. These myths penetrated medical curricula and continue to unconsciously influence clinical decision-making, leading modern healthcare providers to under-treat pain and ignore life-threatening symptoms in minoritized birthing persons.

Throughout the 20th century, official state policies further weaponized maternal healthcare infrastructure against racial minorities. Eugenic sterilization laws across North America, Latin America, Europe, and colonial territories targeted Indigenous, Afro-descendant, Romani, and ethnic minority women. Rather than receiving supportive maternal care, racialized women frequently faced forced or coerced sterilizations, mandatory contraceptive programs, and segregated, underfunded healthcare wards.

These historical abuses established a legacy of deep-seated institutional mistrust between minoritized communities and public health systems, while cementing unequal resource distribution across regional healthcare networks.

The international response to healthcare discrimination began to formalize following World War II. The adoption of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) in 1965 established a legally binding obligation for States Parties to eliminate racial discrimination in all its forms under Article 5(e)(iv), explicitly guaranteeing the right to public health and medical care. Subsequent treaties expanded this rights-based approach. The Convention on the Elimination of All Forms of Discrimination against Women CEDAW (1979) reinforced these principles under Article 12, requiring States to ensure non-discriminatory access to healthcare services, specifically those related to pregnancy, confinement, and the postnatal period. Alma-Ata Declaration (1978) and The International Conference on Population and Development (ICPD) in Cairo represented a fundamental paradigm shift. It moved global policy away from demographic targets toward a framework centered on individual human rights, reproductive autonomy, and bodily integrity.

Despite these universal declarations, international health agendas during the late 1990s and early 2000s, including the UN Millennium Development Goals (MDGs) primarily measured maternal mortality through national averages. This aggregated approach masked severe internal inequities, allowing countries to report overall progress while racial, ethnic, and indigenous minorities continued to suffer disproportionately high maternal mortality rates.

In recent decades, civil society organizations, grassroots movements, and human rights bodies have re-evaluated maternal mortality not merely as a clinical failure or an indicator of poverty, but as a violation of the right to life and non-discrimination. The Reproductive Justice framework pioneered by Black women and Indigenous activists highlighted that true maternal health requires not only access to healthcare, but the structural conditions, safety, and autonomy necessary to raise families free from institutional violence. The Committee on the Elimination of Racial Discrimination (CERD) has progressively expanded its jurisprudence to address these intersecting harms with General Recommendation No. 34 (2011): Focused on racial discrimination against people of Afro-descent, calling on States to dismantle structural barriers in public services and General Recommendation No. 39 (2022): Formally recognized the intersectional discrimination faced by Indigenous women and girls, explicitly citing history, colonial legacies, land dispossession, and systemic healthcare neglect as core drivers of maternal health disparities.

Today, the global agenda on maternal infrastructure centers on dismantling institutionalized racial bias. UN bodies, the World Health Organization (WHO), and CERD emphasize that ending preventable maternal deaths requires disaggregated data collection, clinical accountability for obstetric violence, equitable healthcare financing, and the systemic integration of culturally respectful, community-led birthing models.

Adoption of the ICERD

December 21, 1965

The UN General Assembly adopts the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). Article 5(e)(iv) explicitly obligates States Parties to guarantee the right of everyone, without distinction as to race, colour, or ethnic origin, to public health and medical care.

Adoption of CEDAW

December 18, 1979

The UN General Assembly adopts the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 12 mandates that States eliminate discrimination against women in healthcare and ensure equal access to services related to family planning, pregnancy, and postnatal care.

International Conference on Population and Development (ICPD)

September 13, 1994

Delegates at the ICPD in Cairo adopt a landmark Programme of Action, officially shifting global reproductive health policy from demographic population control toward a rights-based framework emphasizing bodily autonomy, reproductive freedom, and gender equality.

World Conference Against Racism (Durban Declaration)

September 8, 2001

Held in Durban, South Africa, the conference produces the Durban Declaration and Programme of Action, explicitly recognizing that poverty, underdevelopment, and unequal access to healthcare among racial and ethnic minorities are directly linked to historical racism, racial discrimination, and xenophobia.

Adoption of UN Declaration on the Rights of Indigenous Peoples (UNDRIP)

September 13, 2007

The UN General Assembly adopts UNDRIP. Article 24 explicitly recognizes the right of Indigenous peoples to their traditional medicines, health practices, and access to all health and social services without discrimination.

UN Human Rights Council Resolution 11/8

June 17, 2009

The UN Human Rights Council adopts its first landmark resolution recognizing preventable maternal mortality and morbidity as a critical human rights imperative, establishing that failure to prevent maternal deaths often constitutes a violation of the right to life and health.

CERD General Recommendation No. 34

October 3, 2011

CERD issues General Recommendation No. 34 on racial discrimination against people of Afro-descent, urging States to adopt targeted policies to eliminate socioeconomic disparities, improve health facility infrastructure, and ensure equitable access to public healthcare for Afro-descendant populations.

OHCHR Technical Guidance on Maternal Health and Human Rights

September 20, 2012

The Office of the High Commissioner for Human Rights (OHCHR) releases comprehensive technical guidance assisting states in applying a human rights-based approach to maternal mortality reduction, stressing the necessity of disaggregated data to track racial and ethnic health inequities.

UN Sustainable Development Goals (SDGs) Adopted

September 25, 2015

The UN General Assembly adopts the 2030 Agenda for Sustainable Development. SDG Target 3.1 sets a global goal to reduce maternal mortality to fewer than 70 per 100,000 live births, while Target 3.7 calls for universal access to sexual and reproductive healthcare services.

WHO Recommendations on Respectful Maternity Care

February 15, 2018

The World Health Organization releases clinical guidelines explicitly defining and condemning obstetric violence, disrespect, and abuse in health facilities. The guidelines advocate for respectful, person-centered maternal care that accommodates diverse cultural traditions and languages.

CERD General Recommendation No. 39

October 26, 2022

CEDAW and CERD frameworks align as General Recommendation No. 39 is adopted, focusing on the rights of Indigenous women and girls. It explicitly mandates that States eliminate racial bias in healthcare systems, safeguard indigenous birthing practices, and guarantee free, prior, and informed consent in medical settings.

UN Human Rights Council Resolution on Maternal Health Equity

July 12, 2024

The UN Human Rights Council passes an updated resolution calling on Member States to address structural racism, systemic bias, and intersecting forms of discrimination within national health systems as primary drivers of persistent maternal mortality gaps.

Key Terms and Definitions

1. Systemic Racism

Policies, institutional practices, and structural norms embedded within healthcare systems that result in unfair treatment, lower-quality care, and poorer health outcomes for racial and ethnic minorities.

2. Reproductive Autonomy

The right of individuals to make independent, informed decisions about their own bodies, fertility, pregnancy, and family planning without force, pressure, or discrimination.

3. Obstetric Violence

Abuse, neglect, physical mistreatment, humiliation, or unconsented medical procedures inflicted on patients by healthcare workers during pregnancy, labor, and postpartum care.

4.Maternal Mortality
The death of a person during pregnancy, childbirth, or within 42 days of the termination of pregnancy from any cause related to or aggravated by the pregnancy.

5. Severe Maternal Morbidity
Unexpected, life-threatening complications or outcomes of labor and delivery such as severe hemorrhaging, organ failure, or blood infections that cause major short- or long-term health consequences.

6. Implicit Bias
Unconscious attitudes, stereotypes, or assumptions held by medical staff that affect how they perceive patients, assess pain levels, make clinical judgments, and deliver treatment.

7. Maternal Care Desert
A geographic area, urban region, or rural district that lacks adequate healthcare facilities, maternity wards, specialized equipment, or certified birthing staff.

8. Intersectionality
A framework for understanding how overlapping identities such as race, ethnicity, socioeconomic class, indigenous status, and gender combine to create unique layers of discrimination or disadvantage.

9. Social Determinants of Health
The non-medical conditions in which people are born, live, work, and age—such as clean water, safe housing, income, and structural discrimination—that directly impact health risks and quality of life.

10. Informed Consent
The mandatory process in which a healthcare provider explains the risks, benefits, and alternatives of a medical procedure, allowing the patient to freely agree or decline before care is administered.

11. Institutional Neglect
A failure by public health authorities or hospital administrations to allocate adequate funding, equipment, staff, or maintenance to medical facilities serving marginalized communities.

12. Birthing Person
An inclusive term used in healthcare, public health, and human rights contexts to refer to anyone who gives birth or is pregnant, regardless of their gender identity.

Past International Actions

I. International Convention on the Elimination of All Forms of Racial Discrimination (1965)

In 1965, the UN General Assembly adopted the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). Article 5(e)(iv) explicitly legally obligates States Parties to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to public health, medical care, and social services. This established the foundational legal framework asserting that racial discrimination in healthcare infrastructure and service delivery is a direct violation of binding international human rights law.

II. International Conference on Population and Development Programme of Action (1994)

In 1994, representatives from 179 countries gathered at the International Conference on Population and Development (ICPD) in Cairo and adopted a groundbreaking Programme of Action. The agreement marked a fundamental shift away from demographic targets toward individual rights, bodily autonomy, and reproductive healthcare. It formally established that safe motherhood and reproductive rights are central to sustainable development, placing dignity and non-discrimination at the core of global maternal health policy.

III. Durban Declaration and Programme of Action (2001)

Adopted at the World Conference Against Racism in South Africa, the Durban Declaration explicitly linked health disparities among racial, ethnic, and Indigenous minorities to historical legacies of racism, colonialism, and xenophobia. It called on Member States to eliminate institutional barriers in public service systems and ensure equal access to comprehensive healthcare. The declaration served as a key catalyst for framing uneven health infrastructure as a structural racism issue rather than a simple matter of resource scarcity.

IV. UN Declaration on the Rights of Indigenous Peoples (2007)

In 2007, the UN General Assembly adopted the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Article 24 specifically recognized the right of Indigenous peoples to their traditional health practices, traditional medicines, and equal access to all public health and social services without discrimination. UNDRIP established that maternal care systems must respect cultural birthing traditions and eliminate structural neglect against Indigenous women and birthing persons.

V. Human Rights Council Resolution 11/8 on Preventable Maternal Mortality (2009)

In 2009, the UN Human Rights Council passed Resolution 11/8, its first landmark decision recognizing preventable maternal mortality and morbidity as a critical human rights violation. The resolution established that high maternal mortality rates often reflect systematic discrimination in public health systems, urging governments to align national healthcare infrastructure with international human rights standards to safeguard the right to life and health.

VI. CERD General Recommendation No. 34 on Afro-Descendant Populations (2011)

In 2011, the Committee on the Elimination of Racial Discrimination (CERD) issued General Recommendation No. 34 focusing on racial discrimination against people of Afro-descent. The Committee urged States Parties to urgently dismantle structural socioeconomic barriers, improve hospital infrastructure in minoritized communities, and ensure equitable access to maternal and reproductive healthcare for Afro-descendant women who face disproportionately high mortality rates.

VII. OHCHR Technical Guidance on a Human Rights-Based Approach to Maternal Health (2012)

In 2012, the Office of the High Commissioner for Human Rights (OHCHR) submitted comprehensive technical guidance to the Human Rights Council to assist states in applying human rights standards to maternal health policies. The guidance emphasized that governments must collect disaggregated health data by race, ethnicity, and region, while enforcing accountability for clinical neglect, lack of informed consent, and systemic bias within hospital infrastructure.

VIII. UN Sustainable Development Goals – 2030 Agenda (2015)

In 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development, establishing 17 global goals. Sustainable Development Goal Target 3.1 aims to reduce the global maternal mortality ratio to fewer than 70 per 100,000 live births, while Target 3.7 mandates universal access to sexual and reproductive healthcare services. Achieving these targets requires dismantling structural racial disparities that keep maternal mortality artificially elevated among minoritized populations.

IX. WHO Recommendations on Respectful Maternity Care (2018)

In 2018, the World Health Organization released a comprehensive global strategy on intrapartum care, formally defining and condemning obstetric violence, verbal abuse, and non-consensual medical intervention in maternity wards. The guidelines established a new global benchmark prioritizing dignity, bodily autonomy, informed consent, and culturally safe care as essential components of clinical quality, directly addressing systemic bias in healthcare settings.

X. CERD General Recommendation No. 39 on Indigenous Women and Girls (2022)

In 2022, CERD adopted General Recommendation No. 39, offering specific guidance on protecting the rights of Indigenous women and girls. The recommendation explicitly recognized the intersectional discrimination faced by Indigenous birthing persons, calling on States Parties to eliminate institutional racial bias, ensure free, prior, and informed consent for all medical procedures, and fund culturally centered, community-led birthing facilities.

Root Causes

Political Causes

Historic Policy Neglect and Systemic Disenfranchisement

Racial and ethnic minority populations have historically been excluded from political decision-making processes, leading to public policies that fail to prioritize their basic healthcare needs. When minoritized communities lack voting power, legislative representation, or influence over municipal planning, their neighborhoods and districts are routinely overlooked during the planning and building of critical healthcare infrastructure.

Legal Gaps and Lack of Clinical Accountability

In many nations, public health legislation fails to explicitly define, prohibit, or penalize obstetric violence or institutional racial discrimination in medical settings. Without legal mandates requiring hospitals to track clinical outcomes by race or enforce anti-discrimination protocols, healthcare providers face few legal consequences for medical neglect, unconsented procedures, or unequal pain management administered to racialized patients.

Sovereign Immunity and Weak Human Rights Enforcement

While many Member States have ratified binding international human rights instruments such as ICERD and CEDAW national legal mechanisms often lack the administrative power to enforce compliance within public and private health systems. Judicial recourse for minoritized birthing persons who experience medical malpractice or rights violations remains inaccessible, costly, and burdensome.

Economic Causes

Underfunding of Public Healthcare Systems and Care Deserts

Municipalities and regional health authorities with high concentrations of racial, ethnic, or Indigenous minorities are consistently underfunded. Lower tax revenues in historically segregated or economically depressed areas lead to hospital downsizing, maternity ward closures, and severe shortages of specialized medical technology, creating vast maternity care deserts where emergency obstetric care is physically inaccessible.

Socioeconomic Disparities and Out-of-Pocket Costs

Systemic economic inequality including wage gaps, informal employment, and housing instability prevents minoritized birthing persons from affording private health insurance, prenatal transportation, or nutritious food during pregnancy. Even in countries with nationalized health systems, indirect out-of-pocket costs (such as taking time off work, childcare, or travel to distant medical centers) force low-income racialized patients to delay or forego essential prenatal and postpartum care.

Dual-Tier Healthcare Delivery Models

In many nations, healthcare infrastructure is divided into a well-resourced private sector for high-income groups and a severely under-resourced public sector relied upon by marginalized populations. This economic segregation results in starkly unequal nurse-to-patient ratios, overworked medical staff, longer wait times for critical interventions, and lower quality of equipment in facilities serving minoritized communities.

Social Causes

Implicit Bias and Medical Stereotypes

Decades of uncorrected pseudo-scientific myths and racial stereotypes continue to permeate medical education and clinical culture. Healthcare workers frequently hold unconscious biases regarding pain tolerance, biological differences, or compliance among racialized patients. These biases lead providers to dismiss severe medical symptoms such as preeclampsia warnings, internal bleeding, or extreme pain—resulting in delayed diagnosis and preventable deaths.

Cultural Insensitivity and Linguistic Isolation

Healthcare facilities are frequently designed without considering the linguistic or cultural needs of Indigenous, migrant, or minority communities. A lack of professional medical interpreters, alongside clinical hostility toward traditional birthing practices, alienates patients. Fearing discrimination, verbal abuse, or cultural disrespect, many birthing persons avoid hospital settings until life-threatening emergencies arise.

Violations of Bodily Autonomy and Historic Mistrust

A historical legacy of state-sanctioned medical abuse including forced or coerced sterilizations, non-consensual medical experimentation, and child welfare policies targeting racialized mothers has fostered deep-seated institutional mistrust toward state healthcare systems. This legacy, compounded by ongoing clinical mistreatment, deters birthing persons from seeking early prenatal care or engaging with formal health infrastructure.

Impacts

Political Impacts

Erosion of Public Trust in State Institutions

Persistent, unaddressed healthcare disparities weaken public confidence in state health systems and administrative bodies. When minoritized populations consistently experience discrimination, neglect, or harm within state-run hospitals, public trust in broader governmental authority, rule of law, and civil infrastructure severely deteriorates.

Increased Diplomatic Scrutiny and State Accountability

Failure to eliminate racial bias in healthcare exposes Member States to formal reprimands from UN treaty bodies (such as CERD and CEDAW) and international human rights watchdogs. States with severe, unaddressed racial disparities face international diplomatic pressure, negative human rights reviews, and potential conditioning of international health assistance.

Political Mobilization and Legislative Friction

Systemic maternal health failures act as major catalysts for grassroots political activism, legal challenges, and civil rights movements. This leads to heightened legislative friction between marginalized voting blocs demanding legal accountability for obstetric violence and government administrations reluctant to reform structural healthcare financing or enforce clinical oversight.

Economic Impacts

Long-Term Loss of Macroeconomic Productivity

Preventable maternal mortality and severe maternal morbidity (SMM) remove prime-age individuals from the national workforce. The loss or chronic incapacitation of birthing persons reduces labor force participation, lowers household earnings, and decreases long-term tax revenues, stifling national GDP growth particularly in developing economies and marginalized regional districts.

Escalating Public Healthcare Costs

Delayed interventions caused by clinical neglect or lack of early prenatal care cause manageable pregnancy conditions (such as preeclampsia or gestational diabetes) to escalate into life-threatening emergencies. Emergency surgeries, extended intensive care unit (ICU) stays, and lifelong disability management place immense financial strains on national public health budgets.

Intergenerational Poverty and Economic Instability

The death or severe health impairment of a primary caregiver frequently pushes vulnerable families into severe financial distress. Surviving children face higher rates of school dropouts, malnutrition, and economic dependency, cementing intergenerational cycles of poverty within racialized communities and increasing state expenditure on social safety-net programs.

Social Impacts

Generational Trauma and Weathering (Toxic Stress)

Lifelong exposure to institutional racism and clinical mistreatment creates chronic physiological stress a phenomenon known as "weathering". This continuous toxic stress triggers premature biological aging and cardiovascular wear, resulting in higher baseline health risks for minoritized birthing persons and passing physiological and psychological trauma down across generations.

Disruption of Family Structures and Child Welfare

Preventable maternal deaths and severe postpartum complications destabilize core family structures. The loss of a mother increases infant mortality risks, leads to higher rates of child institutionalization or foster system entry, and undermines childhood development, eroding the social stability of entire racial and ethnic communities.

Normalization of Reproductive Injustice

Unchecked racial bias in medical infrastructure normalizes the devaluation of racialized lives within public services. When medical staff under-treat pain, dismiss complaints, or perform procedures without consent, it reinforces societal prejudices and deepens systemic inequality, entrenching second-class citizenship for minoritized and Indigenous populations.

Case Studies

The United States: Racial Disparities in Modern Maternal Infrastructure and the "Weathering" Hypothesis

Despite spending more per capita on healthcare than any other nation, the United States maintains the highest maternal mortality rate among high-income countries. Black women are 2.6 times more likely, and American Indian and Alaska Native women are twice as likely, to die from pregnancy-related causes compared to White women. These stark disparities persist regardless of socioeconomic status or educational attainment, as even college-educated Black women face higher maternal mortality risks than White women without a high school diploma. At the structural level, Black and Indigenous birthing persons disproportionately deliver in low-resource "safety-net" hospitals characterized by higher nurse-to-patient ratios, outdated protocols, and limited emergency response capacity, while widespread rural hospital closures continue to create vast "maternity care deserts." Concurrently, medical staff routinely exhibit implicit bias by underestimating pain, delaying diagnostic testing for severe conditions like preeclampsia, and dismissing patient concerns. This clinical neglect is further compounded by "weathering" a process where lifelong exposure to systemic racism causes chronic physiological stress, accelerating biological aging and heightening baseline risks for cardiovascular complications during childbirth.

Brazil and Latin America: Afro-Descendant Women and Institutional Obstetric Violence

In Latin America, structural inequalities within public health frameworks severely compromise maternal health outcomes for Afro-descendant populations. In Brazil, where over half the population identifies as Afro-descendant, Black women account for more than 60% of all maternal deaths, experiencing a mortality rate nearly double that of White women due to preventable complications such as hypertensive disorders and hemorrhaging. Within public healthcare facilities like the *Sistema Único de Saúde* (SUS), Afro-descendant women report disproportionately high rates of institutional obstetric violence, including verbal abuse, unconsented procedures, and the denial of pain relief driven by persistent biological racial myths regarding pain tolerance. Furthermore, public facilities serving marginalized communities suffer from chronic overcrowding and resource shortages, frequently resulting in "wandering labor," where racialized patients in active labor are turned away and forced to travel between multiple overloaded hospitals before receiving emergency obstetric care.

Eastern Europe: Romani Women and Segregated Maternity Wards

Romani women across Central and Eastern Europe face severe, institutionalized discrimination within state healthcare systems, resulting in maternal and infant mortality rates up to three times higher than national averages. In several regional hospitals in countries such as Slovakia, Hungary, and Romania, Romani mothers are subjected to physical segregation, being confined to unhygienic, poorly equipped rooms separate from the general patient population. These segregated spaces often lack basic sanitation and modern medical equipment, while patients face restricted access to main hospital facilities. Beyond physical neglect, Romani women experience verbal harassment from medical personnel and face severe violations of bodily autonomy, including a documented history of coerced or unconsented sterilizations performed during emergency procedures without informed consent or translation services, directly violating international non-discrimination standards.

Australia and Canada: Indigenous Birthing Persons and Colonial Eviction Policies

Indigenous birthing persons in Australia and Canada experience maternal mortality and severe morbidity rates two to three times higher than non-Indigenous populations, largely due to public health policies that disconnect care from community structures. Under state maternal evacuation guidelines, pregnant Indigenous women in remote northern or rural areas are routinely forced to leave their families at 36 to 38 weeks of gestation to travel thousands of kilometers to distant urban tertiary hospitals, where they remain isolated for weeks. These urban medical environments frequently lack culturally safe care, Indigenous healthcare workers, or language interpreters. This institutional alienating environment, combined with historical trauma and fear of child welfare interventions, creates deep mistrust in state institutions, leading many Indigenous birthing persons to avoid formal healthcare facilities until severe, life-threatening complications arise.

QARMA (Questions A Resolution Must Answer)

- How can Member States strengthen anti-discrimination oversight within public and private healthcare facilities to eliminate racial bias in maternal care while respecting differences in national healthcare models and sovereign legal structures?

- What evidence-based clinical protocols and medical training reforms can health institutions implement to eliminate implicit bias, eradicate biological racial myths, and prevent obstetric violence against minoritized birthing persons?

- How can governments address the geographical and financial maldistribution of medical resources to eliminate "maternity care deserts" in historically segregated, rural, or economically marginalized minority communities?

- What legal and regulatory frameworks should Member States establish to enforce strict clinical accountability, ensure informed consent, and provide accessible judicial recourse for victims of unconsented medical procedures or racial neglect?

- How can Member States expand and integrate culturally safe, community-based care models such as certified midwives, traditional birth attendants, and doulas into national health infrastructure to improve outcomes for racial, ethnic, and Indigenous populations?

- What measures can strengthen cross-sectoral cooperation between ministries of health, justice, civil rights commissions, and human rights bodies to develop coordinated national strategies against institutional healthcare discrimination?

- How can UN bodies including CERD, WHO, OHCHR, and UNFPA enhance technical assistance, capacity-building, and policy monitoring for Member States seeking to reform racially biased health infrastructure?

- What policies can effectively address the broader social determinants of health such as housing insecurity, environmental racism, and economic inequality that exacerbate physiological stress ("weathering") and baseline maternal mortality risks?

- How can Member States standardize and expand disaggregated health data collection by race, ethnicity, indigenous status, and region while safeguarding patient privacy, ethical standards, and data sovereignty?

- What strategies can governments employ to rebuild institutional trust between racialized communities and public health systems, ensuring minoritized birthing persons feel safe seeking early prenatal and emergency obstetric care?

- How can Member States ensure that proposed maternal health solutions directly contribute to the achievement of Sustainable Development Goal (SDG) Target 3.1 and Target 3.7 while simultaneously advancing SDG 5 (Gender Equality) and SDG 10 (Reduced Inequalities)?