More Than Receptacles: An International Human Rights Analysis of Criminalizing Pregnancy in the United States

Vanessa Reid Soderberg
More Than Receptacles: An International Human Rights Analysis of Criminalizing Pregnancy in the United States

Vanessa Reid Soderberg†

ABSTRACT:

Pregnant women are arrested, detained, and forced to undergo invasive medical procedures at an alarming rate in the United States. In 2014, Tennessee was the first state to pass a law directly criminalizing drug use by pregnant women, making the crime of fetal assault applicable to pregnant women in relation to the embryos and fetuses they carry. At least thirty women in Tennessee have been arrested under this law since it went into effect. The common theme across these cases is that drug use by pregnant women is being dealt with as criminal assault and homicide or civil child abuse, rather than as a health care issue. Criminalizing pregnant women’s conduct creates an adversarial relationship between a woman and her fetus, prioritizing the rights of the fetus and treating women as mere receptacles who are void of rights. Tennessee’s fetal assault law violates numerous international human rights, including the right to be free from discrimination, and the right to health, liberty, and autonomy. Notably, Tennessee violates pregnant women’s human rights absent any evidence of actual harm to the fetus or newborn, including any evidence that drug use actually causes the alleged harm. Criminalizing drug use by pregnant women creates a separate legal system for anyone that becomes pregnant, deters pregnant women from seeking drug treatment, and ultimately results in a greater risk of harm to both pregnant women and the embryos and fetuses they carry.

I. INTRODUCTION ........................................................................................................ 300
II. HISTORY AND ILLUSTRATIVE CASES OF ARREST AND FORCED INTERVENTION ON PREGNANT WOMEN ................................................. 302
III. TENNESSEE CRIMINALIZES DRUG USE BY PREGNANT WOMEN ................... 307
   A. Tennessee’s Fetal Assault Law Criminalizing Drug Use ................................. 307
I. INTRODUCTION

Pregnant women are arrested and forced to undergo invasive procedures at an alarming rate in the United States. A study conducted by Lynn Paltrow and Jeanne Flavin found that between 1973 and 2005 more than 400 pregnant women were arrested, detained, and forced to undergo invasive medical procedures in the United States.1 Historically, states have deprived pregnant women of their dignity and rights without legislative authority by using existing criminal statutes that either target third parties who cause harm to a pregnant woman and her fetus or criminalize harm inflicted on a “child.” For example, states have invoked homicide, feticide, reckless endangerment, and chemical endangerment laws to punish drug use by pregnant women.2 Criminalizing pregnant women’s conduct creates an adversarial relationship between a woman and her fetus, placing the rights of the fetus above the rights of women and treating women as “mere receptacles.”3 In many of the cases where women were

2. Id. at 321.
3. WOMEN’S LINK WORLDWIDE, C-355/2006: EXCERPTS OF THE CONSTITUTIONAL COURT’S RULING THAT LIBERALIZED ABORTION IN COLOMBIA 50 (2007) (“[A] criminal law that prohibits abortion in all circumstances extinguishes the woman’s fundamental rights, and thereby violates her dignity by reducing her to a mere receptacle for the fetus, without rights or interests of constitutional relevance worthy of protection.”).
deprived of their rights, there was no evidence of actual harm to the fetus or newborn, or evidence that drug use actually caused the alleged harm. The common theme across states and cases is that drug use by pregnant women is treated as criminal assault, homicide, or civil child abuse, instead of a health care and treatment issue.

In 2014, Tennessee was the first state to pass a law directly criminalizing drug use by pregnant women, making the crime of fetal assault applicable to pregnant women in relation to the embryos and fetuses they carry. At least thirty women in Tennessee have been arrested since the law went into effect. An article describing nine of these arrests notes: “They are the examples, the cautionary tales: six in the city, three in the country, five black, four white, all poor.” To date, five other states—Louisiana, Oklahoma, Arkansas, Missouri and North Carolina—have introduced copycat legislation that would directly criminalize pregnant women’s drug use.

This Article explores various international human rights violated by Tennessee’s fetal assault law criminalizing drug use while pregnant. Many commentators have argued that laws criminalizing drug use during pregnancy violate United States constitutional rights, including due process, equal

9. S.B. 8, 2015 Reg. Sess. (La. 2015) (making it possible for women to be charged and prosecuted for murder if they miscarry and have used a controlled substance during pregnancy and for battery if their child is born addicted to or otherwise harmed by the use of a substance while pregnant); S.B. 559, 2015 Reg. Sess. (Okla. 2015) (making it possible for women to be charged and prosecuted for assault to their fetus or embryo at any stage of gestation if their child is born addicted to or harmed by illegal use of a narcotic while pregnant); H.B. 1376, 90th Gen. Assemb., 2015 Reg. Sess. (Ariz. 2015) (making it possible for women to be charged and prosecuted for assault and battery of their unborn child); H.B. 1284, 98th Gen. Assemb., 1st Reg. Sess (Mo. 2015) (creating the criminal offense of abuse of an unborn child if a woman uses a narcotic drug while pregnant; passed by a state house committee but did not reach the floor for debate); H.B. 1903, 98th Gen. Assemb., 2d Reg. Sess. (Mo. 2016) (creating the criminal offense of abuse of an unborn child if a woman is pregnant, or reasonably should have known she is pregnant, and uses a narcotic drug or controlled substance without a prescription and the child is born addicted to drugs, or is harmed by or dies as a result of the drug use); S.B. 297, Sess. 2015 (N.C. 2015) (creating the criminal offense of prenatal narcotic drug use).
This Article examines the legitimacy of Tennessee’s fetal assault statute under international human rights law. Part I of this Article outlines a brief history of how pregnant women suffering from drug addiction have been treated as criminals in the United States, leading to the adoption of Tennessee’s fetal assault law. Part II examines Tennessee’s fetal assault law and recent arrests made under its authority. Part III examines Tennessee’s fetal assault law and arrests pursuant to international human rights principles, including the right to be free from discrimination, and the right to health, liberty, and autonomy. Part IV considers whether Tennessee’s goal of protecting fetal health is a state objective sufficient to overcome violations of women’s human rights.

II. HISTORY AND ILLUSTRATIVE CASES OF ARREST AND FORCED INTERVENTION ON PREGNANT WOMEN

States have been criminalizing drug use by pregnant women since the 1970s. Policies punishing pregnant women flow from “[d]ecades of pernicious and distorted narratives about drug use during pregnancy [leading] to policies that harm families and communities.” In the 1980s, legislatures responded to


11. See, e.g., Reyes v. Super. Ct., 141 Cal. Rptr. 912 (Cal. Ct. App. 1977) (prosecuting a drug-addicted woman who gave birth to twin boys who were “addicted to heroin and suffered from withdrawal” after birth); Whitner v. State, 492 S.E.2d 777 (S.C. 1997) (affirming the conviction of a mother who pled guilty to criminal child neglect after her newborn baby tested positive for cocaine metabolites); McKnight v. State, 576 S.E.2d 168, 176–77 (S.C. 2003) (affirming mother’s conviction for homicide by child abuse after her baby was stillborn and she had used cocaine); McKnight v. State, 661 S.E.2d 354, 358 n.2 (S.C. 2008) (granting post-conviction relief because defense counsel failed to introduce evidence showing that cocaine is “no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor”); Ex parte Hicks, 153 So. 3d 53 (Ala. 2014) (affirming conviction following a guilty plea for chemical endangerment of a child for exposing her unborn child to a controlled substance).

media hype concerning pregnant women and drugs, particularly crack cocaine, with various legislative proposals. As a result, fourteen states passed laws creating preventative and educational programs, six states conducted studies on the scope of the issue, and eight states considered but did not pass bills that would criminalize being addicted to drugs and carrying a pregnancy to term. Notwithstanding legislatures’ rejection of the most punitive approaches, mothers who gave birth to drug exposed newborns were arrested, and states amended their civil child welfare laws to encompass drug use during pregnancy.

These arrests and prosecutions persist despite expert opinions that the effects of cocaine during pregnancy “are less severe than those of alcohol and are comparable to those of tobacco—two legal substances that are used much more often by pregnant women, despite health warnings.” One study found that poverty has a greater negative impact than cocaine on a child’s developing brain, and other studies report that a substantial number of stillbirths are linked to “environment, poverty, stress, diabetes, hypertension, and sexually transmitted diseases.”

Despite a growing awareness that the 1980s media hype regarding “crack babies” was scientifically unfounded and unduly stigmatizing, “[h]istory is repeating itself, and the newest wave of misinformed media and policies are targeting opioid use during pregnancy.” In the past few years headlines like “‘Oxytots’ Victims of Prescription Drug Abuse,” “Oxytots: A National Disgrace,” and “Helpless & Hooked: The Most Vulnerable Victims of


14. Id. at 463.

15. Forced Interventions on Pregnant Women, supra note 1, at 300, 311; Murphy, supra note 5, at 852 (“Since 1984, thirty-six additional states have legislatively defined fetuses as potential victims of homicide ”); see also Paltrow, Governmental Responses, supra note 13, at 464–65; GUTTMACHER INST., STATE POLICIES IN BRIEF, supra note 5.

16. Susan Okie, The Epidemic That Wasn’t, N.Y. TIMES, Jan. 26, 2009, at D1; see also Brief for The Lindesmith Center & Women’s Law Project et al. as Amici Curiae Supporting Petitioner at 5–6, Whitmer v. State, 492 S.E.2d 777 (S.C. 1997), cert. denied, 523 U.S. 1145 (1998) (summarizing research studies finding “no detectable increase in the rate or severity of birth defects associated with cocaine use during pregnancy” and noting a “genuine scientific debate as to whether a causal link exists between cocaine use and serious fetal harm”).


18. Goodwin, supra note 10, at 811 (citing various research findings).


America’s Opioid Epidemic” have created a new wave of hysteria, sparking punitive responses by legislatures and the judicial system. As with the lack of evidence of harm resulting from cocaine, there is “no scientific evidence that prenatal exposure to opioids results in any kind of lasting harm.” “Crack” or “meth” babies and “oxytots” simply do not exist. Nevertheless, since 2005, National Advocates for Pregnant Women has tracked an additional 380 cases of arrests of and forced interventions on pregnant women, and the number continues to grow.

Women have historically been arrested and prosecuted under laws prohibiting feticide, homicide, child endangerment, drug delivery, and child abuse statutes, which are meant to address violence against pregnant women by third parties and ensure child safety. For example, in 2010 Bei Bei Shuai was charged with feticide and murder after attempting suicide while pregnant in Indiana. Ms. Shuai’s newborn baby, delivered by cesarean section, died within days. Ms. Shuai was arrested, charged, and held in jail without bail for over a year, despite the fact that attempting suicide in Indiana is generally not a crime. Women have also been arrested and prosecuted for miscarrying based on a single positive drug test, without evidence that drug use caused the

---

25. Pregnant, and No Civil Rights, supra note 10; Gibbons, supra note 7 (“Twenty-eight cases had been initiated for prosecution as of December 31, 2014 (plus two additional 2015 cases pursuant to Tennessee’s fetal assault law.”); Melissa Jelsen, Why Some Tennessee Women Are Afraid to Give Birth at the Hospital, HUFFINGTON POST (Oct. 2, 2015), http://www.huffingtonpost.com/entry/pregnant-women-tennessee_560da1b2e4b0af3706e01fb3 (noting that at least thirty women have been arrested for drug use during pregnancy in Tennessee since 2014).
28. Id. at 623.
29. Id. After two and a half years and significant opposition, the murder and feticide charges were dropped. Thank You! Bei Bei Shuai Is Free and More! NAT’L ADVOCATES FOR PREGNANT WOMEN (Aug. 6, 2013) http://advocatesforpregnantwomen.org/blog/2013/08/thank_you_bei_bei_shuai_is_fre.php.
30. See Prudential v. Rice, 222 Ind. 231, 238 (Ind. 1944) (“We have no common law crimes in this State and there is no statute declaring an attempt to commit suicide a public offense.”); see also Robert Litman, Medical-Legal Aspects of Suicide, 6 Washburn L.J. 395, 395 (1966–1967); Katha Pollitt, Protect Pregnant Women: Free Bei Bei Shuai, THE NATION (Mar. 7, 2012), http://www.thenation.com/article/protect-pregnant-women-free-bei-bei-shuai/.
miscarriage. 31

Alabama uses its child endangerment law, intended to punish any person who exposes minor children in their care to environments where illicit drugs are manufactured, to punish pregnant women. 32 Amanda Kimbrough’s third child was delivered prematurely at twenty-five weeks by cesarean and lived for only nineteen minutes. 33 After Ms. Kimbrough tested positive for methamphetamine, her two daughters were removed from her custody. 34 Six months later, Ms. Kimbrough was charged with chemical endangerment of a child. 35 The Alabama Court of Criminal Appeals upheld a broad interpretation of the chemical-endangerment law, ruling that the dictionary definition of “child” includes “unborn child.” Ms. Kimbrough is currently serving ten years in prison. 36

Pregnant women are also forced to undergo invasive medical procedures and can face criminal prosecution if they defy doctors’ recommendations. 38 In Florida, Laura Pemberton wanted to have a vaginal birth after previously delivering a child by cesarean section. 39 Unable to find a physician that would allow her to deliver vaginally, Ms. Pemberton made arrangements to deliver the baby at home. 40 After more than a full day of labor, Ms. Pemberton, dehydrated and unable to eat, went to the emergency room and requested intravenous fluids so that she could return home and deliver vaginally. 41 Doctors at the hospital advised Ms. Pemberton that she required a cesarean section, but she refused and left the hospital. 42 Doctors, believing that Ms. Pemberton was posing a risk to

31. See Forced Interventions on Pregnant Women, supra note 1, at 317–18.
33. Ex parte Ankrom, 152 So. 3d 397, 403 (Ala. 2013).
34. Id.
35. Id. at 402; Ada Calhoun, The Criminalization of Bad Mothers, N.Y. TIMES MAG. (Apr. 12, 2012), http://www.nytimes.com/2012/04/29/magazine/the-criminalization-of-bad-mothers.html?r=2; see also McKnight v. State, 661 S.E.2d 354, 358 (S.C. 2008) (charging McKnight with homicide by child abuse after she unexpectedly suffered a stillbirth as a result of an infection and alleging that the stillbirth resulted from McKnight’s cocaine use).
36. Ex parte Ankrom, 152 So.3d at 404–05.
38. See, e.g., Anemona Hartocollis, Mother Accuses Doctors of Forcing a C-Section and Files Suit, N.Y. TIMES (May 16, 2014), http://www.nytimes.com/2014/05/17/nyregion/mother-accuses-doctors-of-forcing-a-c-section-and-files-suit.html (discussing the case of Rina Dray who was forced to have a cesarean section against her will); Francie Grace, Utah Section Mom Gets Probation, CBS NEWS (Mar. 12, 2004), http://www.cbsnews.com/news/utah-c-section-mom-gets-probation/ (Melissa Rowland was charged with first degree murder after she declined a cesarean section. Ultimately, Ms. Rowland agreed to the cesarean section, but one of her twins was stillborn.).
40. Id. at 1249.
41. Id.
42. Id.
the life of her unborn child, sought a court order mandating a cesarean section.\textsuperscript{43} After a judge ordered Ms. Pemberton to return to the hospital, the sheriff went to Ms. Pemberton’s home where she was in active labor, “took her into custody, strapped her legs together and forced her to go to the hospital.”\textsuperscript{44} After an emergency hearing in the hospital, a judge compelled Ms. Pemberton to have a cesarean section.\textsuperscript{45}

The Florida District Court held that Ms. Pemberton’s constitutional rights did not outweigh the state’s interest “in preserving the life of the unborn child.”\textsuperscript{46} Ms. Pemberton has since given birth vaginally to three children.\textsuperscript{47} Several other courts have found that a person cannot be legally compelled to undergo invasive surgery for the benefit of another, even if it would mean saving a life.\textsuperscript{48} For example, a state cannot force a mother to donate bone marrow or organs to save her child.\textsuperscript{49}

The justifications offered for these punitive measures are that they will deter pregnant women from using drugs, protect the fetus, and penalize drug-using women who deserve punishment.\textsuperscript{50} In reality, as discussed below, the

\textsuperscript{43} Id. at 1250.

\textsuperscript{44} Forced Interventions on Pregnant Women, supra note 1, at 306–07; see also Jessica Valenti, You Can’t Cut Open Pregnant Women Because You Disagree With Their Choices, THE GUARDIAN (May 23, 2014), http://www.theguardian.com/commentisfree/2014/may/23/pregnant-women-forced-c-section.


\textsuperscript{46} Id. at 1251.

\textsuperscript{47} See Forced Interventions on Pregnant Women, supra note 1, at 306–07.

\textsuperscript{48} In re A.C., 573 A.2d. 1235, 1252–53 (D.C. 1990) (vacating a lower court order compelling a cesarean section, which had already been performed, on the grounds that a pregnant woman has the right to refuse medical treatment. The court would honor a pregnant woman’s wishes in “virtually all cases” unless there are “truly extraordinary or compelling reasons to override them,” although “some may doubt that there could ever be a situation extraordinary or compelling enough”); In re Baby Boy Doe, 632 N.E.2d 326, 393 (Ill. App. Ct. 1994) (refusing to grant a court order for cesarean surgery because “[a] woman’s competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus”); Burton v. State, 49 So. 3d 263, 265 (Fla. Dist. Ct. App. 2010) (vacating order for forced bed rest on the basis of “fundamental constitutional right to refuse medical intervention”).

\textsuperscript{49} See, e.g., McFall v. Shrimp, 10 Pa. D. & C.3d 90 (1978) (refusing to order Shrimp to donate bone marrow which was necessary to save the life of his cousin, McFall, even though refusal would mean death for McFall); In re A.C., 573 A.2d at 1243 (“[C]ourts do not compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person’s health.”) (citing McFall v. Shrimp, 10 Pa. D. & C.3d 90 (1978)). See also Kathryn E. Peterson, My Father’s Eyes and My Mother’s Heart: The Due Process Rights of the Next of Kin in Organ Donation, 40 VAL. U. L. REV. 169, 194 (2005) (“[W]hile the state interest in preserving life may vary by situation, the Supreme Court has reiterated that this interest is not sufficiently compelling to trump claims of individual liberty.”) (citing Planned Parenthood v. Casey, 505 U.S. 833, 857 (1992)); Cass R. Sunstein, Neutrality in Constitutional Law (With Special Reference to Pornography, Abortion and Surrogacy), 92 COLUM. L. REV. 1 (1992) (“Parents are not compelled to devote their bodies to the protection of children, even if, for example, a risk-free kidney transplant is necessary to prevent the death of their child . . . .”).

threat of arrest and prosecution deters women from seeking drug treatment, prenatal care, and delivery care, but does not deter drug use. Penalizing mothers suffering from drug addiction overlooks the reality of addiction, a recognized medical condition. Women dependent on drugs that become pregnant do not have greater access to health care and drug treatment or enhanced ability to overcome substance use. Further, there is no scientific evidence that babies born to drug using mothers are inevitably born addicted to drugs or are harmed by their mothers’ prenatal drug use.

III. TENNESSEE CRIMINALIZES DRUG USE BY PREGNANT WOMEN

A. Tennessee’s Fetal Assault Law Criminalizing Drug Use

In 2014, Tennessee became the first state to directly criminalize substance abuse by pregnant women through legislation. Tennessee Code § 39-13-107(c) authorizes the “prosecution of a woman for assault . . . for the illegal use of a narcotic drug . . . while pregnant, if her child is born addicted to or harmed by


53. See NAT’L PERINATAL ASS’N, SUBSTANCE ABUSE AMONG PREGNANT WOMEN (2013) (supporting a policy of comprehensive treatment programs for drug using pregnant women).

54. Susan FitzGerald, ‘Crack Baby’ Study Ends with Unexpected But Clear Result, PHILADELPHIA INQUIRER (July 22, 2013), http://articles.philly.com/2013-07-22/news/41f709969_1_hallam-hurt-so-called-crack-babies-funded-study; NAT’L ADVCS. FOR PREGNANT WOMEN, DON’T JUDGE PREGNANT DRUG-USING WOMEN BASED ON JUNK SCIENCE 1 (2014) [hereinafter DON’T JUDGE PREGNANT DRUG-USING WOMEN] (“Carefully constructed, unbiased scientific research has not found that prenatal exposure to any of the illegal drugs causes unique or even inevitable harm.”); ABRAHAMS ET AL., supra note 23 (“[D]ecades of studies reported in the professional literature have failed to demonstrate any long-term adverse sequelae associated with prenatal exposure to opioids, legal or illegal.”).

the narcotic drug.”56 The law allows prosecution of women for assault; the most severe crime a pregnant woman can be charged with under the statute is aggravated assault, carrying a maximum penalty of fifteen years in prison.57 The legislature passed this law despite the lack of unbiased scientific research finding that “prenatal exposure to any of the illegal drugs causes unique or even inevitable harm.”58 The term “addiction” in this context is “incorrect and highly stigmatizing.”59 Newborns cannot be born “addicted” to a substance, regardless of positive drug test results or physical dependence on drugs, because addiction requires “compulsive behavior that continues in spite of adverse consequences”—a condition with which babies cannot be born.60

Advocates of the law “claimed its purpose was to address Neonatal Abstinence Syndrome (NAS) and illegal use of ‘narcotics’ by pregnant women.”61 NAS, a physiologic dependence on opiates including methadone, is different than being addicted to drugs as it is readily treatable and “has not been associated with any long-term adverse consequences.”62 Tennessee officials described a need to confront the rising number of drug-addicted newborns as part of a “pain pill epidemic.”63 During the Senate Judiciary Committee’s deliberations on the bill, supporters of the legislation pointed to alarmist media coverage on prenatal opioid exposure, including the Tennessee news story, “Drug Addicted Babies,” to demonstrate the need for the law.64 Tennessee Governor Bill Haslam released a statement after signing the bill into law that noted the intent of the law was to “give law enforcement and district attorneys a tool to address illicit drug use among pregnant women through treatment programs.”65

57. § 39-13-102 (2015) (noting aggravated assault can be a Class C felony if a person commits assault under § 39-13-101 and the assault results in “serious bodily injury” or “death to another”); § 40-35-111(b)(3) (2007) (noting the authorized term of imprisonment for a Class C felony is “not less than three (3) years nor more than fifteen (15) years”).
58. DON’T JUDGE PREGNANT DRUG-USING WOMEN, supra note 54; see also ABRAHAMS ET AL., supra note 23 (“Decades of studies reported in the professional literature have failed to demonstrate any long-term adverse sequelae associated with prenatal exposure to opioids, legal or illegal.”).
59. ABRAHAMS ET AL., supra note 23, at 1; see also Paltrow & Jack, supra note 24, at 30.
60. ABRAHAMS ET AL., supra note 23, at 1; see also Paltrow & Jack, supra note 24, at 31.
64. UPR JOINT SUBMISSION, supra note 37, at 8; SB1391, SENATE-JUDICIARY COMM., at 2:08 (Mar. 18, 2014), http://tnlegislature.gov/mediaplayer.php?view_id=262&clip_id=9050&kmeta_id=168824. See also ‘Oxytots ’ Victims of Prescription Drug Abuse, supra note 20; Wulffson, supra note 21; Wilson & Shiffman, supra note 22.
Tennessee’s fetal assault law contains an affirmative defense if the “woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.” In practice, women are unwilling or unable to access treatment, making the defense nearly impossible to raise. There are 68 substance treatment facilities in Tennessee, but only 14 of those facilities treat pregnant women. Only 11 of 39 licensed residential detoxification programs in Tennessee will accept pregnant women, resulting in approximately 130 beds, often with an extensive waitlist, for all women seeking treatment in the entire state. TennCare, Tennessee’s Medicaid program, does not cover the expense of drug treatment, making recovery programs unaffordable for poor women disproportionately targeted for prosecution. At least three women arrested under Tennessee’s fetal assault law sought drug treatment while pregnant but were unable to access treatment due to facilities’ lack of space and unwillingness to treat pregnant women suffering from drug addiction.

In the months leading up to the birth of her daughter, Jamillah Falls sought treatment for her opioid addiction four times at two different locations, but was turned away because she was pregnant. Ms. Falls attempted to detox on her own and on one occasion was taken to the hospital after vomiting for fifteen hours. Both Ms. Falls and her baby tested positive for marijuana and opiates after birth, and Ms. Falls was subsequently charged with assault and detained.

Brittany Hudson sought drug treatment from at least two rehabilitation centers in the weeks leading up to the birth of her daughter, but was turned away
because the rehab centers were full with eight to nine-month waitlists or did not treat pregnant women.74 Ms. Hudson, afraid of being arrested if she went to the hospital, gave birth in her car.75 Her daughter later tested positive for drugs and Ms. Hudson was charged with assault.76

Carmen Wolf, pregnant and trying to stop using heroin, called every hospital and clinic she could find in an effort to get treatment, but was continually turned away.77 Nearly all of the treatment facilities refused to treat her because of liability issues.78 Ms. Wolf painfully attempted to detox on her own at home.79 She had to cross state lines into Mississippi to receive maintenance treatment.80 After giving birth by cesarean section, her newborn son tested positive for drugs and was taken away from her.81

These cases exemplify the difficulty that Tennessee women face in obtaining treatment that would allow them to successfully rely on the affirmative defense of addiction recovery treatment.

B. Arrests Under Tennessee’s Fetal Assault Law

Twenty-six-year-old Mallory Loyola was the first woman arrested under Tennessee’s new fetal assault law, less than two weeks after it went into effect.82 She was arrested while being discharged from the hospital and was charged with misdemeanor assault after she and her newborn tested positive for methamphetamine.83 Ms. Loyola was arrested and charged even though methamphetamine did not qualify as a narcotic as defined in the Tennessee legislation,84 did not result in NAS,85 and caused no reported harm to her

75. Id.
77. Goldensohn & Levy, supra note 8.
78. Id.
79. Id.
80. Id.
81. Id.
84. TENN. CODE. ANN. §39-17-402 (2010) (defining “narcotic drug” to include: “[o]pium and
newborn. In order to violate Tennessee’s fetal assault law, a baby must not only test positive for a narcotic but must be born “addicted to” or “harmed by” a narcotic drug used by the mother while pregnant. Monroe County Sheriff Bill Bivens stated that Ms. Loyola admitted to smoking methamphetamine in the days prior to giving birth, and he hoped her arrest would “send a signal to other women who are pregnant and have a drug problem to seek help.” Ms. Loyola pled guilty to a probation violation to avoid jail time and agreed to participate in treatment. Her assault case hearing was postponed, but the charge was not dropped, and she remained in custody until space became available in a treatment facility.

Following the arrest of Ms. Loyola, there have been at least twenty-nine additional arrests of new mothers under Tennessee’s fetal assault law, including the following cases. In July 2014, Jamillah Falls, a thirty-year-old woman, gave birth to her daughter who tested positive for opiates and marijuana. The media reported that her baby was “born addicted to drugs,” and was in a neonatal intensive care unit because of “drug withdrawals and other complications.” Afraid of being arrested, Ms. Falls left the hospital without her newborn baby. She was subsequently charged with assault and detained. Ms. Falls entered a state-mandated treatment program for the required twenty-eight day period, and was then released to a halfway house. The halfway house requires residents to find employment in order to remain housed there. Ms. Falls was unable to find a job as required by the halfway house, and was ultimately “forced back into jail because of poverty.” She decided to opt out of the “program” and serve her six months sentence in prison, minus forty-seven days of jail credit.

opiate, and any salt, compound, derivative, or preparation of opium or opiate . . . , [o]pium poppy and poppy straw; and Coca leaves”).


86. Culp-Ressler, supra note 82.
88. Mohney, supra note 82.
90. Id.
91. Gibbons, supra note 7; Jeltsen, supra note 25.
92. LOCALMEMPHIS.COM, supra note 73; Goldensohn & Levy, supra note 8.
93. LOCALMEMPHIS.COM, supra note 73.
94. Goldensohn & Levy, supra note 8.
95. Id.
97. Id.
98. Id.
time.  

In September 2014, thirty-four-year-old Tonya Martin was arrested after her newborn son’s drug test came back positive for opioids and he was diagnosed with NAS. Ms. Martin pled guilty, spent five days in jail, and gave her newborn son up for adoption. Two months later she committed suicide.

Amanda McKenzie was also charged with assault in September 2014 after her newborn baby tested positive for opiates, hydromorphine, and tramadol. One media report of her case incorrectly stated that it is “against the law in Tennessee for a woman to give birth to a baby who tests positive for drugs.” In order to violate Tennessee’s fetal assault law a baby must be born “addicted to” or “harmed by” a narcotic drug used by the mother while pregnant—a positive drug test, without more, is not a crime.

Police arrested Lauren Havener for fetal assault when officers responded to a disturbance call at her home. Police officers reported that Ms. Havener admitted to taking Roxicodone and shooting methamphetamine while pregnant, which resulted in her arrest for fetal assault. The local police chief incorrectly claimed Tennessee’s fetal assault law “covers the protection of an unborn child or fetus in this case for the protection of them until they’re born.” Ms. Havener was arrested while still pregnant, hence there was no demonstrated harm to a child as required by Tennessee’s fetal assault law.

In October 2014, twenty-four-year-old Brittany Nicole Hudson gave birth to a baby girl in her car because she had taken drugs during her pregnancy and was afraid of being arrested if she delivered at the hospital. One month after her daughter tested positive for drugs, Ms. Hudson was charged with assault. According to the media, Ms. Hudson’s baby, now healthy and happy, was born

99. Id.
101. Beyerstein, supra note 100.
102. Goldensohn & Levy, supra note 8; Beyerstein, supra note 100.
104. Id.
106. Gatlinburg Woman Charged with Assault on Fetus for Taking Drugs While Pregnant, EAST TENNESSEE TIMES (May 23, 2015, 11:08 PM), http://www.easttntimes.com/News%202014/10012014/gatlinburgwomancharged.htm#Vvcf1DOJsc4.email.
107. Id.
108. Id.
109. Wade, supra note 74.
110. Id.; Pape, supra note 76.
dependent on opiates. 111

Tennessee’s fetal assault law has also been used to charge pregnant women with reckless endangerment of their fetus. 112 Eighteen-year-old Rachel Blankenship was five months pregnant when the police stopped her for driving erratically. 113 Ms. Blankenship was arrested and charged with a DUI after failing field sobriety tests. 114 Officers discovered “a syringe and other drug materials in her purse.” 115 Ms. Blankenship admitted to using two drugs, one of which was Suboxone, while pregnant. 116 As a result, she was charged with reckless endangerment of her fetus under Tennessee’s fetal assault law. 117

Similarly, twenty-two-year-old Christina Kohr was charged with felony reckless endangerment after she failed to stop at a stop sign, drove without a seat belt and then evaded police while nine months pregnant. 118 Ms. Kohr was charged under Tennessee’s reckless endangerment law “due to her being 9 months pregnant,” despite the fact that she had not used a narcotic drug and there is nothing in Tennessee’s reckless endangerment law pertaining to a human embryo or fetus. 119

These eight cases represent only a quarter of the thirty known arrests under Tennessee’s fetal assault law. 120 The police and media reports describing the

111. Wade, supra note 74.


113. Id.

114. Id.

115. Id.

116. Id.

117. Id.


119. Greene County Sheriffs Department, supra note 118; see TENN. CODE ANN. § 39-13-103 (2013).

above arrests indicate that at least five of the women arrested to date are women of color, at least eleven are white, and at least nine are poor.121 These women were detained with bonds ranging between $3,500 and $100,000.122 In all of the cases discussed in this section there was no reported actual harm to the newborn baby; instead, the baby was described as being born “addicted” to drugs,123 testing positive for drugs,124 or, in a few cases, diagnosed with NAS.125

IV. INTERNATIONAL HUMAN RIGHTS VIOLATIONS

A. The United States’ International Human Rights Obligations

“[H]uman rights are understood as the basic rights and freedoms to which all human beings are entitled by virtue of being human.”126 All persons, including pregnant women, have inherent dignity, and equal and inalienable rights, that should be protected from interference.127 These rights are identified in the International Bill of Rights and other human rights instruments, and include the right to be free from discrimination and the right to liberty, autonomy, and health—including reproductive health.128 International human
rights law places an obligation on states to respect, protect, and fulfill the fundamental human rights of all people equally. 129 Tennessee’s fetal assault law recognizes new rights for fetuses, and subordinates the rights of pregnant women to the rights of the fetuses they carry. Advocates argue that this “emerging trend to extend a right to life before birth, and in particular from conception, poses a significant threat to women’s human rights, in theory and in practice.” 130

The United States has only ratified three international human rights treaties: the International Covenant on Civil and Political Rights (ICCPR), which encompasses the right to liberty, equality, and privacy; the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), condemning racial discrimination and undertaking to eliminate racial discrimination in all its forms; and the Convention against Torture (CAT). 131 Once the United States ratifies these treaties, they are legally binding, and the United States thereby accepts the obligation to protect, respect and fulfill these rights. 132 The United States has signed but not ratified the International Covenant

129. See Comm. on Econ., Soc. and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para. 33, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), http://www.ohchr.org/EN/HRBodies/Pages/TBGeneralComments.aspx [hereinafter CESCR, Gen. Comment 14]; ICCPR, supra note 128, art. 2(1) (“Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant”); ICESCR, supra note 128, art. 2(1) (“Each State Party to the present Covenant undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”); CERD, supra note 128, art. 3 (“State Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure [sic] the full development and advancement of women”); Human Rights Comm. General Comment No. 3: Article 2 (Implementation at the National Level), U.N. Doc. HRI/GEN/1/Rev.1 (July 29, 1981), http://www.ohchr.org/EN/HRBodies/Pages/TBGeneralComments.aspx; International Human Rights Law, OFF. OF THE U.N. HIGH COM’N FOR HUM. RTS., http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx (last visited Apr. 21, 2016) [hereinafter International Human Rights Law].

130. CTR. FOR REPROD. RIGHTS, WHOSE RIGHT TO LIFE? WOMEN’S RIGHTS AND PRENATAL PROTECTIONS UNDER HUMAN RIGHTS AND COMPARATIVE LAW (2014) [hereinafter WHOSE RIGHT TO LIFE].

131. ICCPR supra note 128; CERD supra note 128; G.A. Res. 39/46, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Dec. 10, 1984) [hereinafter CAT]; Status of Ratification: Interactive Dashboard, UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COM’R, http://indicators.ohchr.org/ (last visited Apr. 21, 2016) [hereinafter Status of Ratification]. Although the United States has ratified these treaties, it has attached reservations. Id.

on Economic, Social and Cultural Rights (CESCR), which encompasses the right to health and equality, and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). As a result, the United States is required to refrain from actions that undermine the object and purpose of those treaties. While the Universal Declaration of Human Rights (UDHR) is not a binding human rights treaty, it is “widely understood to have become customary international law, imposing universal obligations (i.e., obligations that apply to all states globally).”

Regionally, within the Inter-American system, the United States has signed but not ratified the American Convention on Human Rights “Pact of San José, Costa Rica,” (American Convention). As a result, unless a party can successfully argue that the American Convention is regional customary international law, the United States is not bound by it. However, as with the CESCR and CEDAW, by signing the American Convention the United States is mandated to not take any action that undermines the object and purpose of the Convention. Further, the United States is bound by the American Declaration of the Rights and Duties of Man (American Declaration), which encompasses the right to liberty, equality, privacy, and family life, and also provides protection that the United States has signed but not ratified the Vienna Convention, yet the “United States considers many of the provisions of the Vienna Convention on the Law of Treaties to constitute customary international law on the law of treaties”;

International Human Rights Law, supra note 129 (“Through ratification of international human rights treaties, Governments undertake to put into place domestic measures and legislation compatible with their treaty obligations and duties.”); ICCPR, supra note 128, art. 2(2) (“Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps . . . to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.”).

133. ICESCR, supra note 128; Status of Ratification, supra note 131.

134. See Vienna Convention, supra note 132, at 18.


137. See American Convention, supra note 128, arts. 45, 62 (explaining that for the authority of the Court and Commission to be binding, states must declare recognition of their authority upon ratification or adherence); see also ORG. OF AM. STS., BASIC DOCUMENTS IN THE INTER-AMERICAN SYSTEM: INTRODUCTION, 1, 11 (2011) [hereinafter OAS: INTRODUCTION]; ORG. OF AM. STS., PETITION & CASE SYSTEM INFORMATION BROCHURE: INTER-AMERICAN COMMISSION ON HUMAN RIGHTS (2010) [hereinafter OAS: PETITION & CASE SYSTEM]. The United States also has not signed nor ratified the “Protocol of San Salvador,” the Additional Protocol to the American Convention on Economic, Social and Cultural Rights. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights “Protocol of San Salvador”: Signatories and Ratifications, ORG. OF AM. STS., http://www.oas.org/juridico/english/sigs/a-52.html (last visited Apr. 20, 2016). But see David Forsythe, Human Rights, the United States and the Organization of American States, 13 HUM. RTS. Q. 66, 69 (1991) (“[T]he Commission has argued that the Convention or some part of it is binding even on states that have not ratified it. The supporting interpretation is that the Convention is an expression of regional customary law, and thus the Convention is binding on . . . . the United States . . . .”).

138. See Vienna Convention, supra note 132, at 18.
for mothers during pregnancy.  

There are various mechanisms to hold nation states accountable for international human rights violations. Each United Nations human rights treaty has a treaty monitoring body, referred to as a Committee, comprised of independent human rights experts that monitor the implementation of treaty obligations by states. Committees “provide for up to three distinct mechanisms: a reporting procedure, a general comments procedure, and an individual petition procedure.” The reporting process requires states to periodically submit written reports to the Committee providing an update on the country’s compliance and implementation of its human rights obligations. Civil society, including nongovernmental organizations and intergovernmental organizations, may also submit “shadow reports” providing additional information on a particular country’s human rights situation. After examining the country reports and shadow reports, the Committee publishes “concluding observations” that acknowledge positive steps, identify concerns about non-compliance, and recommend action to enable improved implementation. Concluding observation recommendations are not enforceable; however, the reporting process does “encourage and facilitate, at the national level, public participation, public scrutiny of State policies, laws and programmes, and constructive engagement with civil society.” Committees also publish “general comments” interpreting the substantive rights and freedoms under their treaties.

The ICCPR, CESC, CEDAW, and CERD also have mechanisms that permit individuals from countries that have ratified the treaty to lodge

---

139. See American Declaration, supra note 126; Inter-Am. Comm’n H.R. Res. 1/2013, Rules of Procedure of the Inter-American Commission on Human Rights, art. 51 (Aug. 1, 2013) [hereinafter IACHR, Rules of Procedure] ("The Commission shall receive and examine any petition that contains a denunciation of alleged violations of the human rights set forth in the American Declaration of the Rights and Duties of Man in relation to the Member States of the Organization that are not parties to the American Convention . . . ."); OAS: INTRODUCTION, supra note 137, at 3 ("Both the Commission and the Court have established that despite having been adopted as a declaration and not as a treaty, today the American Declaration constitutes a source of international obligations for the Member States of the OAS.").

140. See FACT SHEET NO. 30/REV.1, supra note 128, at 2, 19; see also Econ. Soc. Council Res. 1985/17 (May 28, 1985) (establishing the Committee on Economic, Social, and Cultural Rights); ICCPR, supra note 128, arts. 28–39 (establishing the Human Rights Committee); CEDAW, supra note 128, art. 17 (establishing the Committee on the Elimination of Discrimination against Women); CERD, supra note 128, art. 8 (establishing the Committee on the Elimination of Racial Discrimination).


142. Id. at 299; see also ICESCR, supra note 128, arts. 16–18; ICCPR, supra note 128, art. 40; CEDAW, supra note 128, art. 18; CERD, supra note 128, art. 9.

143. Forman & Bomze, supra note 126, at 55; FACT SHEET NO. 30/REV.1, supra note 128, at 27.

144. FACT SHEET NO. 30/REV.1, supra note 128, at 28 ("The examination of reports culminates in the adoption of ‘concluding observations’ intended to give the reporting State practical advice and encouragement on further steps to implement the rights contained in the treaty.").

145. Id. at 24, 29.

146. Id. at 36; Helfer, supra note 141, at 299.
complaints with the treaty monitoring body.  

Because these mechanisms are optional, many States, including the United States, do not recognize the jurisdiction of the treaty monitoring bodies to receive individual complaints. Committee decisions on individual petitions are viewed as persuasive legal interpretations of the treaty in question, but decisions are not legally binding and there are no enforcement mechanisms.

Reports on UN Member States’ human rights situations are also submitted through the Universal Periodic Review (UPR) process of the United Nations Human Rights Council. The UPR process involves reviewing the human rights records of all 192 UN Member States, regardless of treaty membership, every four years. During this process, Member States report on the human rights situation in their country. Nongovernmental organizations, national human rights institutions, and other stakeholders may also submit information on a country’s human rights situation. For example, in 2015, several organizations submitted a report regarding “the United States of America’s failure to address and curtail the growing body of counterproductive and regressive state laws, policies, and practices that are increasingly being used to substantially undermine women’s dignity and status as persons under the law.” The report discusses the arrest and incarceration of pregnant women and new mothers, violations of international human rights, and recommendations to the United States. The UPR process provides additional transparency on a country’s compliance with international human rights law.

In the regional Organization of American States (OAS) system there are two monitoring bodies: the quasi-judicial mechanism of the Inter-American Commission on Human Rights (the Commission), and the Inter-American Court of Human Rights (Inter-American Court). The Commission “has the principal

147. See G.A. Res. 2200 (XXI), annex, Optional Protocol to the International Covenant on Civil and Political Rights (Dec. 16, 1966); G.A. Res. 63/117, annex, Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (Dec. 10, 2008); G.A. Res. 54/4, annex, Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (Oct. 6, 1999); CERD, supra note 128, art. 14 (“A State Party may at any time declare that it recognizes the competence of the Committee to receive and consider communications from individuals or groups of individuals within its jurisdiction . . . .” But note that “[n]o communication shall be received by the Committee if it concerns a State Party which has not made such a declaration.”); see also OFF. OF THE U.N. HIGH COMM’N FOR HUMAN RIGHTS, INDIVIDUAL COMPLAINT PROCEDURES UNDER THE UNITED NATIONS HUMAN RIGHTS TREATIES: FACT SHEET NO. 7/REV.2 (2013).

148. Helfer, supra note 141, at 299–300; see also Status of Ratification, supra note 131 (showing that the United States has not recognized the jurisdiction of any Committee to hear individual complaints).

149. See Helfer, supra note 141, at 300–01.


151. See id.

152. Id.

153. FACT SHEET NO. 30/REV.1, supra note 128, at 44.

154. UPR JOINT SUBMISSION, supra note 37, at 1–2.

155. See id.
function of promoting the observance and defense of human rights in the Americas.” 156 The Commission can consider petitions alleging human rights violations by OAS Member States, if the state has recognized the Commission’s authority pursuant to the American Convention and other instruments. 157 The Commission may also receive complaints against Member States that have not ratified the American Convention, such as the United States, pursuant to the American Declaration. 158 The Commission then drafts reports with its conclusions and recommendations for a particular case. 159 If a Member State does not comply with the Commission’s recommendations, the Commission may publish the case or refer the case to the Inter-American Court. 160 In addition to receiving and analyzing individual petitions, the Commission monitors the human rights situation in Member States, publishes reports on specific topics, recommends measures to protect human rights, and issues “precautionary measures” to prevent irreparable harm of human rights in grave and urgent cases. 161

The Inter-American Court, created by the American Convention, is “an autonomous judicial institution whose purpose is the application and interpretation of the American Convention on Human Rights.” 162 The Court possesses adjudicatory and advisory functions. 163 The Commission, as well as state parties to the American Convention that have recognized the jurisdiction of the Court, is authorized to submit cases to the Court after the case has exhausted available recourse at the Commission. 164 Cases against the United States cannot be submitted to the Court because the United States has not ratified the American Convention or accepted the contentious jurisdiction of the Court. 165

156. OAS: INTRODUCTION, supra note 137, at 8; see also Charter of the Organization of American States art. 106, Apr. 30, 1948, 119 U.N.T.S 3.
158. See OAS Res. 447, supra note 157, art. 20; IACHR, Rules of Procedure, supra note 139, arts. 51 –52 (“The Commission shall receive and examine any petition that contains a denunciation of alleged violations of the human rights set forth in the American Declaration of the Rights and Duties of Man in relation to the Member States of the Organization that are not parties to the American Convention . . . .”); OAS: PETITION & CASE SYSTEM, supra note 137.
159. See American Convention, supra note 128, arts. 50–51; IACHR, Rules of Procedure, supra note 139, art. 44.
160. See American Convention, supra note 128, art 51; IACHR, Rules of Procedure, supra note 139, arts. 45 & 47; OAS: PETITION & CASE SYSTEM, supra note 137.
161. OAS: INTRODUCTION, supra note 137, at 8, 9.
162. Id., art. 2.
163. Id., art. 2.
164. See American Convention, supra note 128, art. 61; IACHR, Rules of Procedure, supra note 139, art. 45.
165. See American Convention, supra note 128, art. 61 (“Only the States Parties and the Commission shall have the right to submit a case to the Court”); Rules of Procedure of the Inter-American Court of Human Rights, art. 2(14) (Nov. 28, 2009) (“States Parties’ refers to States that have ratified or have adhered to the Convention”); American Convention on
But all OAS Member States “may consult the Court regarding the interpretation of the American Convention or other treaties concerning the protection of human rights in the American States.” 166 The Court “may issue Advisory Opinions when requested to do so by the Commission or by other organs of the [OAS], regardless of whether the state involved has accepted the Court’s jurisdiction” including “regarding the United States’ obligations under the American Declaration.” 167

Pursuant to the United States Constitution, the federal government has the power to enter into and enforce international treaties. 168 The Supremacy Clause in Article VI of the Constitution provides that the United States’ treaty obligations are the supreme law of the land and take primacy over state law. 169 As such, the United States federal government has to answer for individual states’ compliance with human rights treaties. 170 However, when ratifying treaties, the United States has made declarations that the treaties are not self-executing, meaning they do not create a private right of action in domestic courts. 171 Congress has the power to implement treaties domestically through

166. American Convention, supra note 128, art. 64; see also OAS: INTRODUCTION, supra note 137, at 11.


168. U.S. CONST. art. II, § 2, cl. 2 (stating the President “shall have Power, by and with the Advice and Consent of the Senate, to make Treaties, provided two thirds of the Senators present concur”), art. III, § 2, cl. 1 (defining the jurisdiction of federal courts as extending to “all Cases . . . arising under this Constitution, the Laws of the United States, and Treaties”).

169. U.S. CONST. art. VI, cl. 2.

170. See Missouri v. Holland, 252 U.S. 416, 434 (1920) (“No doubt the great body of private relations usually fall within the control of [a] State, but a treaty may override its power.”); United States v. Belmont, 301 U.S. 324, 331 (1937) (“In respect of all international negotiations and compacts, and in respect of our foreign relations generally, state lines disappear.”); Lori F. Damrosch, The Role of the United States Senate Concerning ‘Self-Executing’ and ‘Non-Self-Executing’ Treaties, 67 CHI.-KENT. L. REV. 515, 530 (1991) (“[T]he treaty-makers may make supreme law binding on the states as to any subject, and notions of states’ rights should not be asserted as impediments to the full implementation of treaty obligations.”); LOUIS HENKIN, FOREIGN AFFAIRS AND THE U.S. CONSTITUTION 238 (2d ed. 1996) (noting that “[f]ifty states could have fifty different views on some issue of international law and the federal courts might have still another view”); Peter J. Spiro, The States and International Human Rights, 66 FORDHAM L. REV. 567, 572 (1997) (“The federal government has consistently refused to correct state practices which may violate international human rights.”); S. REP. NO. 102–23, at 18 (1992) (including that “[t]he United States understands that this Covenant shall be implemented by the Federal Government to the extent that it exercises legislative and judicial jurisdiction over the matters covered therein, and otherwise by the State and local governments; to the extent that State and local governments exercise jurisdiction over such matters, the Federal Government shall take appropriate measures to the Federal system to the end that the competent authorities of the State or local governments may take appropriate measures for the fulfillment of the Covenant.”).

171. LOUIS HENKIN ET AL., HUMAN RIGHTS 958 (2d ed. 2009); S. REP. NO. 102–23, supra note 170, at 19 (“For reasons of prudence, we recommend including a declaration that the
legislation that creates “private rights of action that allow individual plaintiffs to sue to enforce international legal obligations,” but it has not passed such implementing legislation for the ICCPR or CERD.

This lack of implementing legislation in the United States curtails individuals’ ability to bring cases before domestic courts to enforce international treaty obligations and human rights violations. In general, “[i]nternational human rights treaties and the laws of foreign nations are not viewed by American courts as controlling authority.” While domestic United States judges may be reluctant to apply international law in their courtrooms, courts may look to treaties and customary international law when interpreting statutes and the United States Constitution. Advocates may use the United States’ ratification or signature of a human rights treaty to argue that federal or state policy should be consistent with treaty obligations. Some scholars believe that a “treaty may be invoked defensively by a private party if a private individual is prosecuted or sued under a statute that is inconsistent with a treaty provision.”

substantive provisions of the [ICCPR] are not self-executing. The intent is to clarify that the Covenant will not create a private cause of action in U.S. courts.”); 140 CONG. REC. 14284, 14326 (1994) (declaring that CERD provisions are not self-executing); see also Sosa v. Alvarez-Machain, 542 U.S. 692, 734–35 (2004) (rejecting that the ICCPR was a direct basis for suits under the Alien Torts Statute because “although the Covenant does bind the United States as a matter of international law, the United States ratified the Covenant on the express understanding that it was not self-executing and so did not itself create obligations enforceable in the federal courts.”); Medellin v. Texas, 552 U.S. 491, 506 n.3 (2008) (endorsing, in dicta, a presumption against finding private rights or a private right of action, stating in a footnote, “[e]ven when treaties are self-executing in the sense that they create federal law, the background presumption is that ‘international agreements, even those directly benefiting private persons, generally do not create private rights or provide for a private cause of action in domestic courts.’”).


174. Hathaway et al., supra note 172, at 53.

175. Dana Sussman, Bound by Injustice: Challenging the Use of Shackles on Incarcerated Pregnant Women, 15 CARDOZO J. L. & GENDER 477, 496 (2009) (citing articles that have explored strategies to turn international human rights law into domestic law); see also Hathaway et al., supra note 172, at 90.


177. Hathaway et al., supra note 172, at 84.

178. Id. (“Defensive enforcement is generally permitted even for treaties that do not provide private rights of action or even confer private rights. That is because a cause of action exists
The remainder of this Article will consider whether Tennessee’s fetal assault law violates the human rights treaties that the United States has signed or ratified.

B. The Right to be Free from Discrimination

The right to be free from discrimination, equality before the law, and equal protection are “basic and general principle[s] relating to the protection of human rights.” As such, this human rights analysis begins by examining the discriminatory impact of Tennessee’s fetal assault law. Nearly all international human rights treaties “explicitly recognize that gender equality is essential to the realization of human rights.” Specifically, all relevant treaties protect the right of both men and women to enjoy equal human rights, the right of everyone to fundamental human rights without any distinction, and equal protection of the law without discrimination on any ground, including race, color, sex or “other status.” While these treaties only explicitly refer to sex-based discrimination, this has been interpreted to include both biological differences between men and women and gender difference. Gender difference involves “socially constructed identities, attributes and roles for women and men and society’s social and cultural meaning for these biological differences,” including stereotypes and prejudices that have created obstacles to the equal fulfillment of rights. “Other
“status” captures other social groups that are vulnerable to or have suffered and continue to suffer from marginalization. The CESCR Committee has recognized “health status,” including physical and mental health, as a prohibited ground of discrimination, which would include pregnant women living with drug addiction. These rights are impaired whenever a person is denied full and equal enjoyment of any right, including health, liberty, autonomy, and privacy. States are obligated to ensure the equal right of men and women to enjoy the rights covered in the various treaties, and equal protection “prohibits discrimination in law or in fact in any field regulated and protected by authorities.”

The ICCPR and the CESCR do not define discrimination, but interpretations of these treaties rely on the definition of “discrimination against women” offered by the CEDAW committee:

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

The CESCR “explicitly mentions the principles of non-discrimination and equality with respect to some individual rights”; in particular, Article 10 affords special protection to mothers during a reasonable period before and after childbirth.

The CESCR mandates that “discrimination must be eliminated, both

183. CESCR, Gen. Comment 20, supra note 179, para. 27.
184. Id., para. 33.
185. ICCPR, supra note 128, art. 2; CESCR, Gen. Comment 20, supra note 179, para. 2 (“[N]ondiscrimination and equality are fundamental components of international human rights law and essential to the exercise and enjoyment of economic, social and cultural rights.”).
186. CEDAW, supra note 128, art. 1; ICCPR, supra note 128, art. 3; ICESCR, supra note 128, art. 3; HRC, Gen. Comment 18, supra note 179, para. 12.
187. CEDAW, supra note 128, art. 1; see also CESCR, Gen. Comment 20, supra note 179, para. 7; HRC, Gen. Comment 18, supra note 179, para. 7 (“[A]ny distinction, exclusion, restriction or preference” or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the “purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms.”); CERD, supra note 128, art. 1(1) (defining racial discrimination as “any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of human rights and fundamental freedoms”).
188. ICESCR, supra note 128, art. 10(2) (“Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.”); CESCR, Gen. Comment 20, supra note 179, para. 4.
formally and substantively.” 189 To eliminate formal discrimination, states must ensure that their laws do not have the purpose or effect of discriminating on prohibited grounds. 190 Substantive equality requires eliminating discrimination in practice by “paying sufficient attention to groups of individuals which suffer historical or persistent prejudice instead of merely comparing the formal treatment of individuals in similar situations.” 191

As the CESCR Committee notes, “[b]oth direct and indirect forms of differential treatment can amount to discrimination.” 192 The Committee defines indirect discrimination as “laws, policies, or practices that appear neutral at face value, but have a disproportionate impact” on the exercise of rights. 193 It defines direct discrimination as “when an individual is treated less favourably than another person in a similar situation for a reason related to a prohibited ground [and includes] detrimental acts or omissions on the basis of a prohibited ground where there is no comparable similar situation (e.g. the case of the woman who is pregnant).” 194

States are obligated to respect, protect and fulfill human rights. 195 Respecting the equal rights of men and women includes refraining from discriminatory actions that directly or indirectly impact their enjoyment of those rights, and obliges states to eliminate laws that do not conform with the right to equality. 196 Fulfilling human rights requires states to ensure that, in practice, men and women enjoy rights equally: “[t]he obligation to fulfill further contains duties to provide, promote and facilitate.” 197

The CEDAW specifically requires states to condemn discrimination against women in all its forms, refrain from engaging in any act or practice of discrimination against women, and repeal all national penal provisions that constitute discrimination against women. 198 The CEDAW Committee requires state parties to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family


190. CESCR, Gen. Comment 20, supra note 179, para. 8.

191. Id.

192. Id., para. 10.

193. Id., para. 10(b).

194. Id., para. 10(a).

195. CESCR, Gen. Comment 16, supra note 189, para. 17.

196. Id., para. 18.

197. Id., para. 17.

198. CEDAW, supra note 128, art. 2.
This requirement “implies an obligation to respect, protect, and fulfill women’s rights to health care.”

Differential treatment based on a prohibited ground is only permitted when “the justification for differentiation is reasonable and objective.” The aims and effects of the measures must be “legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society.” Additionally, the measures and their effects must be proportionate to the aims sought to be achieved.

Tennessee’s fetal assault law is discriminatory in two ways. First, the law facially discriminates directly against women on the basis of sex and gender by making pregnancy an element of the crime, undermining women’s rights to health, liberty, autonomy, and privacy. As only women can become pregnant, it is sex-based discrimination to create a crime that only women can commit. Moreover, the law is a moral attack on drug-addicted women, in so far as it perpetuates gender stereotypes of a “good mother” who would not “choose” to harm her fetus by using drugs. Second, as demonstrated by the historical regulation of pregnant women, Tennessee’s fetal assault law will likely have an indirect discriminatory impact on drug-addicted women who are marginalized by their racial and socioeconomic statuses. Tennessee’s objective of protecting fetuses and embryos may be reasonable. However, the harmful effects of the

199. Id., art. 13.
201. CESCR, Gen. Comment 20, supra note 179, para. 13.
202. Id.
203. Id.; see also HRC, Gen. Comment 18, supra note 179, para. 13 (noting that differential treatment will not be considered discrimination “if the criteria for such differentiation are reasonable and objective”); Access to Maternal Health Services, supra note 182, para. 68 (according to the Inter-American Commission and the European Court of Human Rights, “a distinction is only discriminatory when it lacks an objective and reasonable justification.”).
204. See, e.g., TENN. CODE ANN. § 39-13-107(c)(2) (2014) (permitting “prosecution of a woman for assault. . . if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant”) (emphasis added); see also CESCR, Gen. Comment 20, supra note 179, para. 10 (noting that “[d]irect discrimination also includes detrimental acts or omissions on the basis of prohibited grounds where there is no comparable similar situation (e.g. the case of a woman who is pregnant”); CESCR, Gen. Comment 16, supra note 189, para. 11 (defining discrimination against women to include “differential treatment of women because of their biology”).
205. See Goodwin, supra note 10, at 853–54 (discussing the image of the “bad mother” and “bad motherhood” and stating that “states seek to protect the purported dignity interests of fetuses against the perceived reckless, lazy, and negligent conduct of “bad mothers’”’); Calhoun, supra note 35.
206. See Forced Interventions on Pregnant Women, supra note 1, at 311, 333 (finding that a disproportionate number of low-income and minority women experienced attempted and actual deprivations of liberty where pregnancy was a necessary factor); Roberts, supra note 10, at 1422, 1432.
fetal assault law are not legitimate, and the means used—denying treatment and detaining mothers—are not proportionate to the aim of protecting fetuses. 207

The persistent prejudice against drug-addicted pregnant women in the United States should be remedied by addressing their discriminatory treatment. State parties must take steps to address gender stereotypes and traditional gender roles, and change institutions in order to address these inequalities. 208 Finally, as the Center for Reproductive Rights explains, “[s]tates should recognize that women and men experience different kinds of rights violations due to discriminatory social norms, including in the context of health, and that equal treatment may not be sufficient to overcome inequalities.” 209

1. Direct Discrimination Against Drug-Addicted Pregnant Women on the Basis of Sex and Gender

Tennessee’s fetal assault law, which targets drug-dependent pregnant women, directly discriminates against women on the basis of sex, violating the duty to ensure freedom from discrimination and equal protection of the law. 210

Discrimination on the basis of sex includes differential treatment of women because of their biology, including their reproductive capacity. 211 Incorporating pregnancy discrimination within sex discrimination is a more expansive equal protection interpretation than United States domestic law, which has held that discrimination on the basis of pregnancy is not sex discrimination. 212 Under an

207. See NAT’L PERINATAL ASS’N, supra note 53, at 2 (“Using the criminal justice system is a misguided attempt to protect the fetus, undermines maternal and fetal wellbeing, and discourages the development of programs that address the needs of these women and their children.”); ACOG, COMM. OP. NO. 473, supra note 51, at 1 (stating that “[d]rug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus”); Comm. on Substance Abuse, Am. Acad. of Pediatrics, Drug-Exposed Infants, 96 PEDIATRICS 364, 365–66 (1995) (“Punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health . . . .”).

208. BREAKING GROUND, supra note 180, at 3–4.

209. Id. at 3.

210. See CEDAW, supra note 128, art. 1; ICCPR, supra note 128, art. 26; UDHR, supra note 126, art. 7; American Convention, supra note 128, art. 1; American Declaration, supra note 126, art. II.

211. CEDAW, Gen. Recommendation 24, supra note 200, para. 12(a); Comm. on the Elimination of Discrimination against Women, Alyne da Silva Pimentel Teixeira v. Brazil, Comm. No. 17/2008, para. 8(2)(a), (d), U.N. Doc. CEDAW/C/49/D/17/2008 (Sept. 27, 2011) [hereinafter Alyne da Silva Pimentel Teixeira v. Brazil] (finding that women require specialized services because of pregnancy and a lack of services is discriminatory); HRC, Gen. Comment 28, supra note 182, para. 20 (“States may fail to respect women’s privacy relat[ing] to their reproductive function.”).

212. Geduldig v. Aiello, 417 U.S. 484 (1974). Although the Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), overrules Geduldig in Title VII employment discrimination cases, pregnancy discrimination has yet to be recognized as unconstitutional sex discrimination under the Equal Protection Clause of the Fourteenth Amendment; but see Goodwin, supra note 10, at 869 (arguing pregnancy discrimination is sex discrimination under the Equal Protection Clause in the context of fetal protection laws); Neil S. Siegel & Reva B. Siegel, Struck By Stereotype: Ruth Bader Ginsburg on Pregnancy Discrimination as Sex
international human rights analysis, different criminal treatment for women as a result of Tennessee’s fetal assault law is not only unequal treatment between pregnant and non-pregnant women, but discrimination between men and women. In Tennessee, drug-dependent women are treated less favorably than drug-dependent men for reasons related to sex and gender.

Direct discrimination occurs when different treatment “relies directly and explicitly on distinctions in sex and characteristics between men and women.” Tennessee’s law makes pregnancy an element of assault, singling out women for punishment. Biologically, only women can be drug-addicted and pregnant, making it impossible for a man to be punished for drug use under this statute. As a result, women are deprived of their liberty on an unequal basis and cannot enjoy their right to health, autonomy, and privacy on an equal footing with men.

Treaty monitoring bodies have held that pregnancy discrimination is sex discrimination. For example, in Gretel Artavia Murillo et al. v. Costa Rica, the Inter-American Commission found that a prohibition on in vitro fertilization prevented infertile women from utilizing this medical treatment and had a disproportionate impact on women. The Commission noted “while infertility is a condition that can affect both men and women, the use of assisted reproductive technologies places greater demands on a woman’s body” and the prohibition had a direct effect on women’s bodily autonomy. Similarly, while drug use is a condition that can affect men and women, criminalizing drug use during pregnancy and providing inadequate access to treatment has a direct effect on women, inhibits women’s ability to overcome drug use, and places a greater demand on women’s bodies.

In Alyne v. Brazil, the CEDAW Committee found that Brazil had discriminated against Alyne, an Afro-Brazilian woman who had died following pregnancy and postnatal complications, on the basis of her gender, race, and socioeconomic status by denying her necessary maternal health services. The Committee rejected Brazil’s argument that the situation did not contain a causal link between gender and access to health care, finding that Brazil denied Alyne appropriate health services related to pregnancy and that her death was

213. See CESC, Gen. Comment 20, supra note 179, para. 10; CESC, Gen. Comment 16, supra note 189, para. 11.
218. Id., para. 131.
maternal. According to the former UN Special Rapporteur on the Right to Health, a United Nations independent expert that examines the right to health throughout the world and reports to the Human Rights Commission or the United Nations General Assembly, “[e]nsuring non-discrimination in the provision of health-care services is an essential component of the right to health[,]” especially for “[m]arginalized populations [who] face particular obstacles when seeking to access reproductive health services.” In Tennessee, many women are turned away from drug treatment centers because they are pregnant and, as a result, are arrested and detained. This creates a similar causal link between health care and gender, resulting in discrimination against women on the basis of sex.

In Tennessee, the possession and the sale of drugs are criminalized for all men and women, but drug use is not criminalized for any other group except pregnant women. In fact, the United States Supreme Court has held that states may not make it a crime simply to suffer from drug addiction, as it is a status. The Human Rights Committee (HRC) has stated that under the equal protection clause of the ICCPR, laws “which impose more severe penalties on women than on men for adultery and other offences [such as assault] violate the requirements of equal treatment.”

Tennessee’s fetal assault law punishes women for drug use and pregnancy outcomes in ways that men cannot be punished, making women solely responsible for the health outcomes of their fetuses and uniquely susceptible to punitive sanctions. This infringes on pregnant women’s right to equal protection, affords special status to fetuses, and enables the government to punish women for a crime that men cannot commit.

Tennessee’s fetal assault law disadvantages drug-addicted pregnant women
as compared to drug-addicted men with respect to their enjoyment of the right to health, specifically their access to drug treatment and reproductive health care. The Inter-American Commission has found that barriers to reproductive health care:

are related to the absence or inadequacy of a gender perspective in public policies addressing women’s health needs . . . [and] involve various forms of discrimination historically faced by women at different levels . . . generating health inequalities among women and between women and men in terms of their enjoyment of human rights.228

The United States “should ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women’s right to equality before the law and to equal enjoyment of all Covenant rights.”229 Implementing the right to equality in the context of the right to health “requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefiting from health care on a basis of equality.”230 As discussed in more detail below, Tennessee’s fetal assault law creates multiple barriers to drug treatment programs and prenatal care for pregnant women.231

Tennessee’s fetal assault law also encompasses gender discrimination by reinforcing gender stereotypes of the “good woman” or “good mother,” who would never endanger her fetus by using drugs.232 The extra responsibility placed on women to advance fetal health may “reify stereotypes and ignore medical facts.”233 These stereotypes support discrimination against women suffering from drug addiction, a medical condition, and assume that these women can stop using drugs but choose not to, despite potential harm to their fetuses.

Media reports, including those relied upon by the Tennessee legislature, contain provocative statements that paint a picture of mothers who do not want to overcome their addiction and choose to harm their children. For example, a report on Jamillah Falls’ case stated “[t]hese people who get addicted to drugs and alcohol don’t want to get clean and sober sometimes . . . [s]o, she’s got to

---

228. Access to Maternal Health Services, supra note 182, para. 5.
229. HRC, Gen. Comment 28, supra note 182, para. 5.
230. CESCR, Gen. Comment 16, supra note 189, para. 29; Access to Maternal Health Services, supra note 182, para. 3 (“Protecting women’s right to personal integrity in the area of maternal health includes the obligation to guarantee that women have equal access to the health services they require according to their particular needs as they relate to pregnancy . . . .”).
231. See infra Part IV(C).
232. Goodwin, supra note 10, at 853–54 (discussing the image of the “bad mother” and “bad motherhood” and stating “states seek to protect the purported dignity interests of fetuses against the perceived reckless, lazy, and negligent conduct of ‘bad mothers’”); Roberts, supra note 10, at 1432; but see NAT’L PERINATAL ASS’N, supra note 53, at 1 (“Drug abuse . . . is a chronic disease that impacts the brain, which makes stopping more than a matter of will power.”).
233. Goodwin, supra note 10, at 859.
get her mind right and get herself into a position to want to do it.” The fetal assault bill’s sponsor Terri Lynn Weaver said the law was aimed at “[t]he worst of the worst. These ladies are not those who would consider going to prenatal care.”

In reality, addiction is a chronic medical issue of dependence; “prenatal substance abuse by an addicted mother does not reflect willful maltreatment of a fetus. . . .” The American College of Obstetricians and Gynecologists views addiction as “not primarily a moral weakness . . . but a ‘brain disease’” that should be treated like any other medical illness. Treating drug addiction through the legal system is inappropriate; women suffering from a medical condition should not be judged as unworthy of protection and punished. Drug dependency does not make a woman a bad person or a bad mother, and women should not be discriminated against on the basis of inaccurate, socially constructed stereotypes.

The Tennessee statute’s objective of protecting fetuses is insufficient to justify these discriminatory distinctions based on sex and gender. While fetal health may be a reasonable government objective, Tennessee’s law singles out women for discriminatory prosecution without valid justification. The lack of scientific evidence supporting the alleged harm that prenatal drug use causes,

---


236. NAT’L INST. ON DRUG ABUSE, supra note 52; Paltrow, Governmental Responses, supra note 13, at 477.


238. CESCR, Gen. Comment 14, supra note 129, para. 34 (noting that the obligation to respect the right to health includes “abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs”); CESCR, Gen. Comment 20, supra note 179, para. 33 (“States . . . should ensure that a person’s . . . health status is not a barrier to realizing the rights” under CESCR and “should also adopt measures to address widespread stigmatization of persons on the basis of their health status.”).

239. Paltrow, Governmental Responses, supra note 13, at 480–81; See also CESCR, Gen. Comment 20, supra note 179, para. 20; CEDAW, Gen. Recommendation 28, supra note 182, paras. 9, 22.

coupled with the increased risks posed when drug-addicted women are deterred from seeking prenatal care and/or drug treatment, is counterproductive to the state’s goal of promoting fetal health. 241 Tennessee “uniquely and exclusively calls upon women, but not men, to advance fetal health,” suggesting that Tennessee believes women alone bear this responsibility. 242 The fetal assault law seeks to punish “bad mothers,” who are often from marginalized communities, in the name of fetal and infant protection. 243 But the most effective means of ensuring fetal health is protecting maternal health, before and after childbirth, by providing drug treatment and prenatal services. 244 The effect of Tennessee’s law is to dissuade women from seeking prenatal care, stifling the best avenue for achieving the healthiest outcomes for babies and their mothers. 245

2. Indirect Discrimination Against Drug-Addicted Pregnant Women on the Basis of Race and Socioeconomic Status

Tennessee’s fetal assault law will likely have an indirect discriminatory impact on the most marginalized pregnant women. Many women experience distinct forms of discrimination due to the intersection of sex with other axes of oppression such as race, color, and socioeconomic status. 246 Intersectional discrimination may limit access to reproductive health care. 247

241. Grover, supra note 240, paras. 41–42 (“Where women fear criminal prosecution, they may be deterred from accessing health services and care, as well as pregnancy-related information. . . . [I]t has been well documented that the public health goals are not realized through criminalization; rather, they are often undermined by it.”); ACOG, COMM. OP. NO. 473, supra note 51 (“Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.”).

242. Goodwin, supra note 10, at 859, 873; see also Lyttle, supra note 10, at 793.


244. Grover, supra note 240, para. 42 (“In order to realize public health outcomes effectively and simultaneously promote the right to health of women, States should not criminalize such conducts during pregnancy, but rather ensure the provision of health-care goods, services and information that promote health throughout pregnancy and childbirth.”); ACOG, COMM. OP. NO. 473, supra note 51, at 2 (noting that “[s]ubstance abuse treatment programs integrated with prenatal care have proved to be effective in reducing maternal and fetal pregnancy complications and costs”).

245. See Grover, supra note 240, para. 42; ACOG, COMM. OP. NO. 473, supra note 51, at 2.

246. HRC, Gen. Comment 28, supra note 182, para. 30 (“Discrimination against women is often intertwined with discrimination on other grounds such as race, colour, language, religion, political or other opinion, national or social origin, property, birth or other status.”); CEDR, Gen. Comment 16, supra note 189, para. 5 (“Many women experience distinct forms of discrimination, due to the intersection of sex with such factors as race, colour . . . .”); CERD, Gen. Recommendation 25, supra note 181, para. 1 (“[R]acial discrimination does not always affect women and men equally or in the same way. There are circumstances in which racial discrimination only or primarily affects women, or affects women in a different way, or to a different degree than men.”).

247. BREAKING GROUND, supra note 180, at 13. See, e.g., Comm. on Econ., Soc. and Cultural Rights General Comment No. 22: The Right to sexual and reproductive health, para. 30,
Treaty monitoring bodies have recommended that states focus on the maternal health needs of women, including poor women and minority women.248 The CEDAW Committee recognizes that “biological differences between women and men may lead to differences in health status.”249 But there are “societal factors which are determinative of the health status of women and men and can vary among women themselves,” and “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups . . . .”250 The United Nations Special Rapporteur on the Right to Health noted that “[c]onsidering non-discrimination in the provision of health-care services is an essential component of the right to health. Marginalized populations face particular obstacles when seeking access to reproductive services.”251 In Alyne, a case regarding access to maternal health services, the CEDAW Committee found that Ms. da Silva Pimentel Teixeira suffered de facto and “multiple” discrimination because she was Afro-Brazilian and from a low socioeconomic background.252 The Committee noted the disparity in the treatment received by women of African descent in Brazil and stated that “discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity . . . [and] health.”253

Indirect discrimination refers to laws or policies that appear neutral on their face but have a disproportionate impact on certain groups’ exercise of their rights.254 While Tennessee’s fetal assault law appears to apply equally to all women, it will likely have a disproportionate discriminatory impact on poor women of color.255 One study found that approximately the same percentage of white women (15.4%) and African-American women (14.1%) use drugs while pregnant.256 Another study found that educated white women are more likely to

---

249. CESCR, Gen. Recommendation 24, supra note 200, para. 6.
250. Id., para. 6; see also CESCR, Gen. Comment 20, supra note 179, para. 17 (“Cumulative discrimination has a unique and specific impact on individual and merits particular consideration and remedying.”).
251. Hunt, supra note 222, para. 42.
252. Alyne da Silva Pimentel Teixeira v. Brazil, supra note 211, para. 7.7.
253. Id.
254. Access to Maternal Health Services, supra note 182, para. 58 (noting that for seemingly neutral policies and practice, the “principle of effective equality and non-discrimination . . . includes . . . discriminatory impact”).
rely on prescription medications during pregnancy, and their dependency on these medications increases with age. In Tennessee, “people who are educated, married or successful with their careers are three times more likely to use prescription drugs than others and thus find themselves addicted.” Yet pregnant African-American women are almost ten times more likely than pregnant white women to be reported to health authorities for drug use. In a nationwide study of prosecutions of pregnant women, 59% of the pregnant women deprived of their liberty were women of color (African American, Latina, Indigenous, or Asian/Pacific-Islander); African American women were particularly overrepresented (52%). In addition, “[o]verwhelmingly, and regardless of race, women [deprived of their liberty] were economically disadvantaged.” According to Tennessee’s Department of Health, in 2014 there were at least 874 NAS births in the state. However, the select women arrested under Tennessee’s fetal assault law “represent some of the state’s poorest areas, and all but one used a public defender.”

Disparities in the United States criminal justice system based on race and wealth are systemic, and “[r]acial bias thrives in situations in which individuals must make snap decisions.” Minorities are five times more likely to be arrested for drug related offenses than white people. As a result, prosecutors and judges will likely “wield [Tennessee’s] law against Black women more so than white women, based on a long tradition of deeply embedded racial stereotypes about Black motherhood.” Additionally, Tennessee’s law will likely have a discriminatory impact on poor women. In effect, some women will be singled out and held responsible for birthing healthy babies while others

258. TAADAS, supra note 68, at 3.
259. Ira J. Chasnoff et al., The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida, 322 NEW ENG. J. MED. 1202, 1204 (1990); see also Adams, supra note 10, at 104; Brosh & Miller, supra note 10, at 452; Roberts, supra note 10, at 1432–34.
260. Forced Interventions on Pregnant Women, supra note 1, at 311.
261. Id.
263. Id.
265. Adams, supra note 10, at 103.
266. Gandy, supra note 243.
267. Goldensohn & Levy, supra note 8; To Prison for Pregnancy, HEALTHY & FREE TENNESSEE (Jan. 10, 2016), http://healthyandfreetn.org/news/brave-new-films-pregnancy-criminalization-laws [hereinafter To Prison for Pregnancy] (“It is low-income women who utilize non-prescription opioids who have been arrested under Tennessee’s law, but the fact remains that prescription opioids were involved with most of the neonatal abstinence (NAS) cases in Tennessee.”).
Special attention should be paid to the impact Tennessee’s law has on marginalized groups that face barriers to accessing health care and drug treatment, making them more susceptible to fetal assault charges.

C. The Right to Health

Everyone, including pregnant women who use drugs, has the right to the highest attainable standard of physical and mental health. The right to health, including reproductive health, is protected in the UDHR, CESCR, CEDAW, CERD, and American Declaration. The Beijing Platform for Action, created at the Fourth World Conference on Women, recognizes the right to access “appropriate health-care services that will enable women to go safely through pregnancy and childbirth.”

The CESCR provides the most comprehensive declaration on the right to health. Article 12 of the CESCR obliges state parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” States must take steps to achieve the full realization of the right to health, including those which reduce stillbirth and infant mortality rates, and promote healthy child development. This requires “measures to improve child and maternal health, sexual and reproductive health services, . . . pre- and post-natal care . . . access to information, as well as to resources necessary to act on that information.” Article 10(2) of the CESCR explicitly affords special protection to mothers before and after childbirth.

The CESCR Committee states that health facilities, goods, and services must be available, accessible, acceptable, and of good quality. The CEDAW Committee applies these principles to women’s health, including reproductive health. Availability includes states’ obligation to provide a sufficient number

---

268. See Goodwin, supra note 10, at 874; Roberts, supra note 10, at 1472.
269. UDHR, supra note 126, art. 25(1); ICESCR, supra note 128, art.12(1); CEDAW, supra note 128, art. 5(e)(iv); CEDAW, supra note 128, art. 12(1).
270. ICESCR, supra note 128, arts.10(2), 12(1).
271. CEDAW, supra note 128, art. 12(1)–(2), 14(2).
272. CEDAW, supra note 128, art.5(e)(iv).
273. American Declaration, supra note 126, art. XI.
275. ICESCR, supra note 128, art.12(1).
276. Id., art. 12(2)(a).
278. ICESCR, supra note 128, art. 10(2); see also American Declaration, supra note 126, art. VII (“All women, during pregnancy and the nursing period . . . have the right to special protection, care and assistance; UDHR, supra note 126, art. 25(2) (recognizing that motherhood is entitled to special care and assistance).
280. CEDAW, Gen. Recommendation 24, supra note 200, paras. 1, 21, 26–27 (“[A]ccess to
of health facilities. Accessibility requires physical accessibility, ensuring that women do not have to travel long distances to health facilities, as well as economic accessibility, ensuring that health services and goods are affordable. Acceptability means sexual and reproductive health services must respect the right to confidentiality and women’s dignity, and “be sensitive to [their] needs and perspectives.” Quality requires health services to be scientifically and medically appropriate.

Tennessee does not provide available, accessible, or acceptable drug treatment programs for pregnant women. There is a serious deficit in the availability of Tennessee facilities that are able and willing to treat pregnant women suffering from drug addiction. It is nearly impossible for a pregnant woman to receive drug treatment: only 15% of drug treatment centers in Tennessee accept pregnant women, and approximately 4,700 pregnant women in Tennessee need treatment for addiction to illicit drugs each year. Tennessee did not create or provide funding for additional treatment programs under the fetal assault law. Tennessee has only “12 licensed methadone centers,” payment for treatment must be made in cash, and the cost is not covered by TennCare or indigent care funding. Treatment program waitlists can have hundreds to over a thousand people on them.

The CESC\R Committee notes that the right to health contains both freedoms and entitlements. The right to health is not . . . a right to be healthy,” but rather an “entitlement . . . to a system of health protection which

__health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women . . . . States parties should report on measures taken to eliminate barriers that women face in access to health-care services . . . to ensure women timely and affordable access to such services . . . to ensure women appropriate services in connection with pregnancy . . . [and] how they supply free services where necessary to ensure safe pregnancies, childbirth and post-partum periods for women.”); OFF. OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS & WORLD HEALTH ORG., THE RIGHT TO HEALTH: FACT SHEET NO. 31, 13 (2008) (“Sexual and reproductive health is also a key aspect of women’s right to health.”).

282. CESC\R, Gen. Comment 14, supra note 129, para. 12(b).
283. Id., para. 12(c); CEDAW, Gen. Recommendation 24, supra note 200, paras. 21–22.
284. CESC\R, Gen. Comment 14, supra note 129, para. 12(c); CEDAW, Gen. Recommendation 24, supra note 200, para. 22.
286. Beyerstein, supra note 100 (stating that Mary Linden Salter of the Tennessee Association of Alcohol, Drug and Other Addiction Services, estimates that 4,700 pregnant women need treatment); Facility Locator, supra note 67; Roberts, supra note 10, at 1448.
287. Beyerstein, supra note 100; see Jeltsen, supra note 25; Advocacy Organizations Oppose Fetal Assault Law, HEALTHY & FREE TENN. (Jan. 26, 2016), http://healthyandfreetn.org/news/advocate-letter-against-in-fetal-assault-law [hereinafter Advocacy Organizations Oppose Fetal Assault Law] (“Proponents of the law claimed it was aimed at getting women into treatment, but no new funding has been made available to increase access to appropriate services for people who have diagnosed drug dependency problems.”); Facility Locator, supra note 67.
288. TAADAS, supra note 68, at 9.
289. Id. at 10–11; Advocacy Organizations Oppose Fetal Assault Law, supra note 287.
290. CESC\R, Gen. Comment 14, supra note 129, para 8.
provides equality of opportunity for people to enjoy the highest attainable level of health,” including “a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health.”

Entitlement encompasses the right to nondiscrimination, which prohibits discrimination in access to health care and in underlying determinants of health on the basis of race, sex, health status, and other grounds. Freedoms include “the right to control one’s health, including the right to be free from non-consensual medical treatment and experimentation.”

Tennessee’s law violates women’s entitlement to health care by failing to provide drug-addicted pregnant women with adequate drug treatment facilities, providers, services, and conditions to realize their highest attainable level of health. Tennessee’s discriminatory treatment of pregnant women also violates women’s entitlement to access health care. Pregnant women may have to travel to other states to obtain treatment because of the lack of accessible treatment centers in Tennessee. At least three of the women arrested under Tennessee’s fetal assault law to date have unsuccessfully sought treatment at multiple facilities and were turned away due to inadequate space or unwillingness to treat pregnant women. When introducing a bill criminalizing drug use by pregnant women in North Carolina, Senator Brent Jackson noted that since Tennessee passed its fetal assault law, North Carolina emergency rooms have “experienced an influx of pregnant women with substance abuse issues” who are presumably trying to avoid incarceration in Tennessee. The lack of accessible treatment centers is exacerbated by the fact that Medicaid does not cover the expense of drug treatment, making treatment unobtainable for poor women who are disproportionately prosecuted for drug use during pregnancy.

Any drug treatment programs or doctors in Tennessee that report drug use to authorities would violate a pregnant women’s right to confidentiality.
Inter-American Commission on Human Rights has noted that laws that “fail to respect women’s right to confidentiality may constitute barriers limiting access to maternal health services, particularly for adolescents.”300 Drug-addicted pregnant women in Tennessee, fearing that they will be reported to law enforcement by health care providers, will be deterred from seeking treatment.301 Tennessee’s fetal assault law does not respect the right of pregnant women suffering from addiction to have the highest attainable standard of health and deters women from seeking health services.302

The CESCR and CEDAW Committees list core obligations related to reproductive health care, including ensuring that individuals are free from gender discrimination in the realm of health services.303 States cannot justify noncompliance with these obligations.304 Under the CESCR, the right to health “requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefiting from health care on a basis of equality.”305 The core obligations “guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups.”306 Under the CEDAW, the right to health requires ensuring men and women have equal “access to health services, including those related to family planning.”307 As discussed previously, Tennessee’s law discriminates against pregnant women on the basis of sex and gender, imposing gender-based barriers to drug treatment and violating the obligation to respect the right to health.308 Women willing to seek treatment face practical barriers due to the lack of treatment facilities and limited insurance coverage.309 The failure to provide

---

300. Access to Maternal Health Services, supra note 182, para. 37.
301. Lyttle, supra note 10, at 790.
302. See Jeltsen, supra note 25 (“We are getting lots of anecdotal information about women not seeking critical prenatal care, and avoiding going to the hospital to give birth, because they are scared of being arrested and having their baby taken away.”).
303. CESCR, Gen. Comment 14, supra note 129, para. 43(a); CESCR, Gen. Comment 22, supra note 247, para. 49; see CEDAW, supra note 128, art. 12; see also CEDAW, Gen. Recommendation 24, supra note 200, para. 2.
304. CESCR, Gen. Comment 14, supra note 129, para. 47 (“[A] State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”).
305. CESCR, Gen. Comment 16, supra note 189, para. 29.
306. CESCR, Gen. Comment 22, supra note 247, para. 49(c).
307. CEDAW, supra note 128, art. 12(1); see also CEDAW, Gen. Recommendation 24, supra note 200, para. 27.
308. See CESCR, Gen. Comment 14, supra note 129, para. 50.
309. TAADAS, supra note 68, at 9–11; Advocacy Organizations Oppose Fetal Assault Law,
quality maternal health services violates the right to equality and nondiscrimination, as these are services that only women need to meet their particular health needs.  

Drug treatment is not a health issue that is particular to women. However, imposing criminal penalties solely on pregnant women who fail to receive treatment makes drug treatment a health service that only pregnant women require to avoid special criminal consequences. The UN Special Rapporteur on the Right to Health described this effect:

Criminal laws and other legal restrictions disempower women, who may be deterred from taking steps to protect their health, in order to avoid liability and out of fear of stigmatization. By restricting access to sexual and reproductive health-care goods, services and information these laws can also have a discriminatory effect, in that they disproportionately affect those in need of such resources, namely women. As a result, women and girls are punished both when they abide by these laws, and are thus subjected to poor physical and mental health outcomes, and when they do not, and thus face incarceration.

Another obligation under the CESCR requires states to “ensure reproductive, maternal (prenatal as well as postnatal) and child health care.” States violate their obligation to fulfill the right to health by failing to adopt a gender-sensitive approach to health. Contrary to ensuring reproductive and child health, Tennessee’s fetal assault law causes increased risk of harm to both a pregnant woman and her fetus. Women may avoid prenatal care and drug treatment or, driven by a fear of being arrested, detox on their own and risk greater harm to themselves and their fetuses. “Abrupt discontinuation of

---

310. Alyne da Silva Pimentel Teixeira v. Brazil, supra note 211, paras 7.6–7.7; CEDAW, supra note 128, art. 12; CEDAW, Gen. Recommendation 24, supra note 200, paras. 2, 27.
311. Grover, supra note 240, para. 17.
312. CESCR, Gen. Comment 14, supra note 129, para. 44(a).
313. Alyne da Silva Pimentel Teixeira v. Brazil, supra note 211, para 7.6 (finding a violation of the right to health under article 12 of CEDAW because Brazil did not ensure appropriate medical treatment in connection with pregnancy); CEDAW, supra note 128, art. 12(2) (explaining that state parties are required “to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period”).
314. DON’T JUDGE PREGNANT DRUG-USING WOMEN, supra note 54 (“Every leading medical group to take a position on the issue of drug use and pregnant women has concluded that punitive responses will undermine, rather than further, maternal, fetal, and child health.”); ACOG, COMMIT. OP. NO. 473, supra note 51.
315. Am. Medical Assoc., Bd. of Trs., Legal Interventions During Pregnancy, 264 JAMA 2663, 2667 (1990) [hereinafter Legal Interventions] (“Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physicians’ knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.”); AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, OPIOID ABUSE,
opiates in a dependent pregnant woman... carries much greater risks to the fetus, and medical authorities agree that withdrawal must be avoided. The American Congress of Obstetricians and Gynecologists take the position that “[d]rug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus.” Tennessee’s fetal assault law “is designed to humiliate and punish, not treat or protect,” because it does not protect mothers nor reduce stillbirth rates.

Authorities in the United States and throughout the world, including the World Health Organization, “have determined that drug addiction is not a ‘bad habit’ or willful indulgence in hedonism, but a chronic medical condition that is treatable but—as yet—not curable.” Drug abuse is “a chronic disease that impacts the brain, which makes stopping more than a matter of will power.” Leading medical organizations oppose criminalizing drug use by pregnant women, recognizing that this is a health care issue, and that criminalization will deter women from seeking prenatal care and treatment.

The American College of Obstetricians and Gynecologists has acknowledged that “[t]he relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses.” Threat of prosecution will deter pregnant drug users from seeking or discussing treatment with health care providers. The American Medical Association (AMA) has warned that laws criminalizing substance abuse during pregnancy will pressure women to forgo prenatal care and doctors’ visits in general in an effort to avoid a jail sentence. The White House has also spoken out against policies criminalizing drug use: “It doesn’t seem to serve anyone well to attach criminal penalties to people who have addiction disorders, particularly pregnant women.” Tennessee’s law is already deterring women from accessing prenatal care and treatment, and may even deter women from going to a hospital to deliver (as in the case of Brittany Hudson’s difficulties finding treatment at the hospital).

316. UPR JOINT SUBMISSION, supra note 37, para. 13; see also ACOG, COMM. OP. NO. 524, supra note 315, at 1 (“Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise.”).
317. ACOG, COMM. OP. NO. 473, supra note 51.
318. Diaz-Tello, supra note 61; CESCR, Gen. Comment 14, supra note 129, para. 52.
319. ABRAHAMS ET AL., supra note 23, at 3.
320. NAT’L PERINATAL ASS’N, supra note 53, at 1.
321. Paltrow, Governmental Responses, supra note 13, at 463–64 (listing numerous leading medical and public health groups that oppose criminalizing drug use).
322. ACOG, COMM. OP. NO. 321, supra note 237, at 9.
324. Legal Interventions, supra note 315, at 2667.
Hudson), resulting in more negative birth outcomes. Criminalization may also increase the number of abortions, because some pregnant women suffering from drug addiction may choose to terminate their pregnancies to avoid criminal punishment.

All substance abusers should receive adequate care, and pregnant women in particular can benefit from treatment. Drug treatment promotes the health of women and their children, and methadone treatment is often the best option for the baby and mother. NAS may result from methadone treatment, but is recognized by medical authorities worldwide as simple to diagnose and treat in newborns. No long-term harm to the newborn is directly attributable to prenatal opiate exposure, regardless of whether the mother’s use is prescribed or illicit. Studies show that “babies exposed prenatally to buprenorphine require even less post-delivery medical assistance than those exposed to methadone, significantly reducing the babies’ length of stay in the hospital.” Research has also demonstrated that “controlled and stable dosing of methadone . . . is safe for the baby and mother.” Consistent with the obligation to afford special protection to mothers, drug treatment should be viewed as part of prenatal health care when a pregnant woman is suffering from drug addiction.

A state who is unable to comply with its right to health obligations under the CESCR is treated more leniently than a state who is merely unwilling to comply. Tennessee (and other U.S. states with similar legislation) made a choice to punish pregnant women instead of provide treatment for them. If Tennessee’s goal is to protect fetal health, it should do so in a nondiscriminatory

326. Wade, supra note 74; Jeltsen, supra note 25; see also ACOG, COMM. OP. NO. 473, supra note 51.
328. Kellett, supra note 227, at 472; U.S. DEP’T OF HEALTH AND HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., METHADONE TREATMENT FOR PREGNANT WOMEN, PUBL’N NO. 14-4124 (2014) [hereinafter METHADONE TREATMENT FOR PREGNANT WOMEN] (“By blocking withdrawal symptoms, MMT can save your baby’s life. Additionally, MMT can help you stop using needles, which is a primary route of infection for drug users. More importantly, it can allow you to regain your quality of life.”).
329. NAT’L ADVOCS. FOR PREGNANT WOMEN, FREQUENTLY ASKED QUESTIONS (FAQ) ABOUT METHADONE AND PREGNANCY 1 (2009).
330. ABRAHAMS ET AL., supra note 23, at 3; METHADONE TREATMENT FOR PREGNANT WOMEN, supranote 328, at 2.
331. ABRAHAMS ET AL., supra note 23, at 3.
332. UPR JOINT SUBMISSION, supra note 37, para. 14 (citing Hendree E. Jones et al., Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure, 363 NEW ENG. J. MED. 2320, 2326 (2010)).
333. UPR JOINT SUBMISSION, supra note 37, para. 14; ACOG, COMM. OP. NO. 473, supra note 51.
334. See ICESCR, supra note 128, art. 10(2); see also UDHR, supra note 126, art. 25 (recognizing that “motherhood is entitled to special care and assistance”); CESCR, Gen. Comment 14, supra note 129, para. 44(a).
335. CESCR, Gen. Comment 14, supra note 129, para. 47 (“A State which is unwilling to use . . . available resources” violates its obligations, while if “resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources.”).
manner that does not curtail women’s rights: it should provide greater access to
drug rehabilitation for pregnant women suffering from drug addiction. Ensuring
the highest attainable standard of health, as defined by the CESCR and CEDAW,
includes access to treatment for drug addiction, particularly for vulnerable and
marginalized pregnant, drug-addicted women.

D. The Right to Liberty

The UDHR, ICCPR, American Convention, and American Declaration
protect the right to liberty and security of the person. ICCPR Article 9 states
that everyone has the right to liberty and security of the person and “[n]o one
shall be subjected to arbitrary arrest or detention. No one shall be deprived of his
liberty except on such grounds and in accordance with such procedure as are
established by law.” Liberty of the person encompasses freedom from
confine ment of the body, not general freedom of action. Deprivation of liberty
includes police custody, detention, and imprisonment after conviction.

The right to personal liberty recognized in major human rights treaties is
not absolute. For example, deprivation of liberty may be justified by enforcing
criminal laws, but is prohibited if that enforcement is unlawful or arbitrary.
For example, it may be justified “to prevent flight, interference with evidence or
the recurrence of a crime.” Deprivation of liberty is unlawful if it is not
“imposed on such grounds and in accordance with such procedure as are
established by law.” Arbitrariness has been interpreted broadly by the HRC to
“include elements of inappropriateness, injustice, lack of predictability and due
process of the law,” as well as reasonableness, necessity and proportionality.
Arrest or detention on discriminatory grounds is also arbitrary. Any
substantive ground for arrest or detention “must be prescribed by law and should
be defined with sufficient precision to avoid overly broad or arbitrary
interpretation or application.”

336. UDHR, supra note 126, art. 3; ICCPR, supra note 128, art. 9(1); American Convention,
supra note 128, art. 7(1); American Declaration, supra note 126, art. 1.

337. ICCPR, supra note 128, art. 9.

338. Human Rights Comm. General Comment No. 35—Article 9 (Liberty and Security of the
Gen. Comment 35].

339. Id.

340. Id., paras. 10–11.

341. Human Rights Comm., Van Alphen v. The Netherlands, Comm. No. 305/1988, para. 5.8,

342. Id. para. 11.

343. Id.; Human Rights Comm., Gorji-Dinka v. Cameroon, Comm. No. 1134/2002, para. 5.1,
U.N. Doc. CCPR/C/83/D/1134/2002 (May 10, 2005); see also Human Rights Comm.,
(Jul. 21 1994).


345. Id., para. 22.
Tennessee women are being unlawfully arrested and detained under the fetal assault law based on a single positive drug test (even for drugs such as methamphetamine, which is not criminalized in the legislation), even when there is no proof of harm to their newborns. 346 For example, Mallory Loyola’s arrest after a single positive drug test, with no demonstrated harm to her newborn, exceeds the scope of Tennessee’s fetal assault law. The law does not criminalize putting a child in danger of physical harm; it criminalizes causing actual harm. 347 Methamphetamine, the drug found in Ms. Loyola’s newborn’s system, “is in no way related to symptoms of Neonatal Abstinence Syndrome upon which this law was formed.” 348

Equally problematic is the arrest of Rachel Blankenship, who was stopped for driving erratically. Ms. Blankenship failed several field sobriety tests while pregnant and police charged her with a DUI. 349 After admitting to using two drugs while pregnant, Ms. Blankenship was also charged with reckless endangerment of a fetus. 350 Tennessee’s fetal assault law requires more than just consuming illegal narcotics while pregnant; it also requires that the child is “born addicted to or harmed by the narcotic drug.” 351 As such, the arrest of Ms. Blankenship exceeded the scope of Tennessee’s fetal assault law, was not imposed on grounds in accordance with an established law, and was thus unlawful. 352

Lawful arrests under Tennessee’s law—for example, arrests of women who used illegal narcotics while pregnant that resulted in “addiction” or “harm” to newborns 353—are still arbitrary violations of women’s right to liberty. The arrests outlined in Part III of this Article demonstrate that Tennessee’s fetal assault law is vague and applied inconsistently, resulting in arbitrary enforcement. The ACLU claims that “the law fails to define the terms ‘addicted to’ or ‘harmed by’ thus giving prosecutors and law enforcement unlimited discretion to determine whether and when an alleged violation has occurred.” 354

Proponents of Tennessee’s fetal assault law allege that it is intended to

346. See TENN. CODE ANN. § 39-13-107(c)(2) (2014) (“[N]othing in this section shall preclude prosecution of a woman for assault . . . for the illegal use of a narcotic drug . . . while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is the result of her illegal use of a narcotic drug taken while pregnant.”) (emphasis added); see, e.g., Culp-Ressler, supra note 82 (reporting that Ms. Loyola was arrested and charged even though methamphetamine does not qualify as a narcotic, the legislation feared NAS caused by opiates, and there was no reported harm to her newborn).


348. UPR JOINT SUBMISSION, supra note 37, at 7.

349. Pregnant Claiborne Co. Teen Arrested for DUI, supra note 112.

350. Id.


352. See Pregnant Claiborne Co. Teen Arrested for DUI, supra note 112; HRC, Gen. Comment 35, supra note 338, para. 11.

353. § 39-13-107(c)(1).

address NAS. But there is no evidence that NAS, which is treatable, results in long-term harm to a child. Thus, NAS should not fall within the ambit of the “harm” requirement in Tennessee’s fetal assault law. Multiple causes may harm a fetus during pregnancy “and it is notoriously difficult to isolate and identify any one of these factors in a specific case.” It is equally problematic that even though newborns cannot be born “addicted” to substances, regardless of positive drug test results or physical dependence, Tennessee’s fetal assault law permits arbitrary arrest and detention of women based on the inaccurate conclusion that a newborn is “addicted” to drugs. The arrests to date demonstrate uncertainty about what types of drugs trigger the law, and the law fails to define what treatment programs are sufficient to raise an affirmative defense. This ambiguity makes it difficult for pregnant women to predict whether and when they will be arrested and detained for their actions.

Further, the law does not specify at what point a pregnant woman suffering from drug addiction is required to seek treatment in order for the affirmative defense to protect her. In a recent New Jersey case, the trial court ruled that the state’s civil child abuse law applied to women who received medically prescribed methadone treatment while pregnant. The New Jersey Supreme Court overturned the decision, finding that a mother who participated in a bona fide methadone maintenance program, without more, could not support a finding of abuse or neglect. However, the court held that timeliness and undue delay

356. Sunderlin & Huss, supra note 12 (“Most critically, NAS has not been associated with any long-term adverse consequences.”); Paltrow & Jack, supra note 24 at 31–32.
357. ACLU Letter to Bill Haslam, supra note 354; see also ABRAHAMS ET AL., supra note 23, at 3.
358. See, e.g., Culp-Ressler, supra note 82; LOCALMEMPHIS.COM, supra note 73; Riley, supra note 103; Jones & Bryson, supra note 120; Watson, supra note 120.
359. Culp-Ressler, supra note 82 (reporting that Ms. Loyola was arrested and charged for non-narcotic, methamphetamine use without demonstrated harm to her newborn); Smith, supra note 120 (describing how another woman was arrested for non-narcotic marijuana and barbiturate use); Gatlinburg Woman Charged with Assault on Fetus for Taking Drugs While Pregnant, supra note 106 (reporting on the arrest of Ms. Haverner while pregnant); WBIR, supra note 112 (reporting on the arrest of Ms. Blankenship while she was pregnant); Greene County Sheriffs Department, supra note 118 (arresting Ms. Kohr without her having used a narcotic drug); Riley, supra note 103 (describing how a woman was arrested after her newborn was “born addicted” without any demonstrated harm to the baby); Watson, supra note 120 (describing how another woman was arrested after newborn tested positive for drugs without any demonstrated harm to the baby); see also Beyerstein, supra note 100 (“Further, the law only allows an affirmative defense if a woman successfully completes a treatment program, but unlike a 28-day detox, medication-assisted recovery doesn’t have a clear end date.”).
360. TENN. CODE. ANN. § 39-13-107(c)(3) (2014) (“It is an affirmative defense . . . that the woman actively enrolled in an addiction recovery program before the child is born”) (emphasis added).
362. N. J. Div. of Child Prot. & Permanency, v. Y.N., 104 A.3d 244, 256 (“We therefore reverse the Appellate Division’s determination that the withdrawal symptoms experienced by Paul resulting from Yvonne’s participation in a bona fide methadone maintenance program was,
in obtaining treatment might be relevant to an abuse or neglect analysis. Similar questions could also be raised in Tennessee regarding the timeliness of treatment.

The scope of Tennessee’s fetal assault law is unclear. The law specifically targets women who use narcotics illegally, with an exception for “any lawful act or lawful omission” by the pregnant woman. As Christina Kohr’s case demonstrates, law enforcement officials are using the statute to arrest women for her conduct while pregnant, such as driving erratically. In Tennessee, “any woman who gives birth to a baby with health problems, or who loses a pregnancy at any stage, could be subject to criminal investigation, ‘because criminal investigation is the only way to rule out an unlawful act.’”

Pregnant women and new mothers should not be arrested or detained for their actions while pregnant, particularly when reasonable alternatives exist. Drug treatment is a more effective and proportional way to address drug use by pregnant women and reduce fetal harm. As stated by the World Health Organization, “[t]he imprisonment of pregnant women and women with young children should be reduced to a minimum and only considered when all other alternatives are found to be unavailable or are unsuitable.” It is nonsensical that a woman has a right to terminate her pregnancy, yet she can also be imprisoned for unintentionally causing harm to her fetus. Women should not

363. Id. (“We do not pass on whether there is sufficient credible evidence to support an abuse or neglect finding on some other basis referenced by the family court, such as the timeliness of Yvonne’s seeking drug treatment—that is, whether an unjustified delay might have adversely affected her newborn’s later withdrawal symptoms.”); N.J. Div. of Youth and Family Servs. v. Y.N, 2014 WL 8181569 at *1 (N.J. Super. Ct. App. Div. Mar. 18, 2015) (remanding the case for a fact finding hearing de novo on the new issues, including timeliness of receiving treatment).


365. Greene County Sheriffs Department, supra note 118.

366. Emily Crockett & Jessica Mason Pieklo, Tennessee Legislature Passes Far-Reaching Bill That Could Make Pregnant Women Criminals, REWIRE (Apr. 10, 2014), http://rewire.news/article/2014/04/10/tennessee-legislature-passes-far-reaching-bill-make-pregnant-women-criminals/ (quoting Farah Diaz-Tello). Tennessee’s fetal assault law could theoretically extend to other behavior such as smoking, alcohol consumption, accidental falls, delaying or refusing a medical treatment, poor nutrition, or excessive exercise. See, e.g., Pregnant, and No Civil Rights, supra note 10; Beyerstein, supra note 100; McKnight v. State, 661 S.E.2d 354, 358, n.2 (S.C. 2008) (describing expert testimony opining that cocaine is “no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor”).

367. See Grover, supra note 240, para. 42.

368. UNDOC AND WHO EUROPE, WOMEN’S HEALTH IN PRISON: CORRECTING GENDER INEQUITY IN PRISON HEALTH para. 4(2) (2009).

369. Mary-Ellen L, Stripping Your Constitutional Rights: Miscarriages of Justice, INTENTIOUS (Jul. 24, 2011), http://intentious.wordpress.com/2011/07/24/stripping-your-constitutional-rights/ (“If it’s not a crime for a mother to intentionally end her pregnancy, how can it be a crime for her to do it unintentionally [or to harm her fetus], whether by taking drugs or smoking or whatever it is.”); see, e.g., Crockett & Pieklo, supra note 366 (“Even some anti-choice groups spoke against the bill, Diaz-Tello noted, because it could encourage more abortions.”).
be compelled to exercise their right to abortion for fear of being prosecuted if they continue their pregnancies. To ensure the health and safety of both mothers and children, drug addiction should be addressed as a health care issue and women should not be unlawfully and arbitrarily deprived of their liberty.

E. The Right to Privacy and Family Life

Ensuring women’s right to nondiscrimination and substantive equality “requires that women are able to exercise autonomy and make important life decisions without undue influence or coercion.”\(^\text{370}\) The right to privacy and family life includes this principle of autonomy.\(^\text{371}\) Reproductive health care must be provided in a manner consistent with women’s rights to personal autonomy.\(^\text{372}\) The ICPD Programme of Action, created at the 1994 International Conference on Population and Development, and Beijing Platform of Action recognize that reproductive rights include women’s right to make decisions concerning reproduction and to be free from discrimination, coercion, and violence.\(^\text{373}\) They also recognize women’s rights to have freedom and control over their sexuality and reproductive health.\(^\text{374}\)

The ICCPR and American Convention protect everyone from arbitrary or unlawful interference in family life and private matters.\(^\text{375}\) The Inter-American Commission has noted that deciding “to have biological children is within the most intimate sphere of . . . private and family life,” and a couple’s route to that decision “is part of a person’s autonomy and identity” protected by the American Convention.\(^\text{376}\) Punishing drug addicts who choose to carry their pregnancies to term interferes with their right to make autonomous reproductive decisions.\(^\text{377}\) Thus, unless a drug-addicted pregnant woman is one of the few who can access treatment, she “has only one realistic avenue to escape criminal charges: abortion.”\(^\text{378}\) In effect, Tennessee’s fetal assault law penalizes women for

\(^{370}\) Breaking Ground, supra note 180, at 8.

\(^{371}\) See ICCPR, supra note 128, art. 17; UDHR, supra note 126, art. 12; American Convention, supra note 128, art. 11(2); CEDAW, supra note 128, art. 16; American Declaration, supra note 126, art. V.


\(^{374}\) ICPD, Programme of Action, supra note 373, para. 7.3; Beijing Declaration and Platform of Action, supra note 275, para. 96.

\(^{375}\) ICCPR, supra note 128, art. 17(1); American Convention, supra note 128, art. 11(2); see also American Declaration, supra note 126, art. V.

\(^{376}\) Murillo et al., Inter-Am. Comm’n H.R., supra note 217, para. 76.

\(^{377}\) See Roberts, supra note 10, at 1425; Lyttle, supra note 10, at 796–97.

\(^{378}\) Roberts, supra note 10, at 1445; see also Stone-Manista, supra note 50, at 833–34.
choosing to have a baby. Just as a state cannot arbitrarily interfere with a woman’s decision to terminate her pregnancy by lawful abortion, Tennessee should not interfere with a woman’s decision to carry her pregnancy to term and to have a child, as it violates the woman’s right to privacy.379

In *K.L. v. Peru*, the HRC held that the right to privacy is an important aspect of protecting women’s reproductive choices.380 K.L. sought a therapeutic abortion to terminate her pregnancy after a doctor diagnosed the fetus with anencephaly and informed K.L. that continuing the pregnancy would put her life at risk.381 Despite this medical advice, K.L. was denied access to reproductive services.382 The Committee held that refusing to honor K.L.’s decision to terminate her pregnancy violated her right to privacy under Article 17 of the ICCPR.383

According to the HRC, a woman’s right to privacy is compromised when states impose obstacles that limit women’s reproductive decision-making.384 In Tennessee, women are being advised that drug treatment will minimize health risks to their fetuses, but they are unable to decide whether to seek treatment and to actually access recommended services.385 All women, including women suffering from drug addiction, have the right to decide whether to carry a pregnancy to term or terminate, and whether to seek treatment.386 State interference with these decisions “perpetuates stereotypes that value women solely for their procreative capacity” and violates women’s right to privacy.387

Criminalizing drug use interferes with pregnant women’s right to make decisions about treatment affecting their bodies and their private lives.388 Women should not lose their right to privacy simply because they become pregnant. In *R.R. v. Poland*, a case decided by the European Court of Human Rights, a pregnant woman was repeatedly denied genetic testing, preventing her

---

380. *Id.*
381. *Id.*, para. 2.2.
382. *Id.*, para. 2.1–2.2.
383. *Id.*, para. 8 (“[T]he State party is required to furnish [K.L.] with an effective remedy, including compensation.”); see *Journey to Justice*, CTR. FOR REPROD. RIGHTS (Dec. 17, 2015), http://www.reproductiverights.org/feature/journey-to-justice (noting that fifteen years after being denied an abortion, K.L. was paid reparations by the Peruvian government).
385. Jeltsen, supra note 25; see *Advocacy Organizations Oppose Fetal Assault Law*, supra note 287.
386. Grover, supra note 240, para. 15 (“Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health.”); ICCPR, supra note 128, art. 17; HRC, Gen. Comment 28, supra note 182, para. 20; CEDAW, supra note 128, art. 16(e); CEDAW, Gen. Recommendation 24, supra note 200, paras. 10, 21–22, 28; CESCR, Gen. Comment 14, supra note 129, para. 8.
388. Grover, supra note 240, para. 12 (“[W]here the criminal law is used as a tool by the State to regulate the conduct and decision-making of individuals in the context of the right to sexual and reproductive health the State coercively substitutes its will for that of the individual.”).
from obtaining timely information regarding the health of the fetus and ultimately from obtaining a lawful abortion. As a result, she gave birth to a girl with Turner syndrome. The Special Rapporteur on Health’s submission stated that “because the decision to continue or terminate a pregnancy ha[s] a profound effect on a woman’s private life, including her physical and moral integrity, any interference with this decision must be analysed in light of a woman’s right to privacy.” The United Nations Special Rapporteur noted that “[a]ccurate knowledge of an individual’s health status was necessary to enable that individual to understand her health care options and protect her bodily integrity by deciding which health care treatment she would avail herself of.” In the same way, Tennessee must respect the right of all women, including women suffering from drug addiction, to determine if and when to have children and whether to access treatment. The state cannot interfere with these private decisions that impact women’s autonomy.

Tennessee may also have an obligation to fulfill the right of pregnant women to access drug treatment. The European Court of Human Rights has held that the concept of private life includes the right to receive respect for decisions to become or not to become a parent. In R.R. v. Poland, the European Court reiterated that “‘private life’ is a broad concept, encompassing, inter alia, the right to personal autonomy and personal development,” including decisions about whether to have children. Whenever a woman becomes pregnant, her private life becomes closely connected with the developing fetus. The Court held that once a state adopts statutory regulations allowing abortion in some situations, “it must not structure its legal framework in a way which would limit real possibilities to obtain it.” The state is under a positive obligation to “create a procedural framework enabling a pregnant woman to exercise her right” to abortion.

Tennessee’s fetal assault law allows for an affirmative defense if a

390. Id., para. 37.
391. Id., para. 122 (emphasis added).
392. Id., para. 123.
393. See CEDAW, supra note 128, art. 16(e); CESCR, Gen. Comment 14, supra note 129, para. 14, (Reproductive health “include[s] access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”).
394. See Grover, supra note 240, para. 15.
397. Id. para. 181.
398. Id. para. 200.
399. Id.
pregnant woman enrolls in an addiction recovery program before the child is
born, remains in the program after delivery, and completes the program
successfully.\textsuperscript{400} Tennessee has failed to implement any regulations governing
access to addiction recovery programs for pregnant women battling substance
abuse, even though access to such treatment is necessary for pregnant women to
avoid incarceration.\textsuperscript{401} Applying the European Court’s reasoning from \textit{R.R.},
which imposed a positive obligation on States to create a procedural framework
enabling women to access lawful abortion,\textsuperscript{402} the affirmative defense in
Tennessee’s fetal assault law imposes a positive obligation on the state to enable
access to drug treatment programs.

\section*{V. IS PROTECTION OF THE FETUS FROM POTENTIAL HARM
SUFFICIENT TO OVERCOME THE HUMAN RIGHTS VIOLATIONS?}

The decision to deny treatment and punish drug-addicted pregnant women is “influenced by the stereotype that protection of the foetus should prevail over
the health of the mother.”\textsuperscript{403} Proponents of Tennessee’s law argue that
prosecuting women protects fetuses from harm, especially from the dangers of
NAS.\textsuperscript{404} Such advocates justify criminalization by arguing that “the fetus
deserves the right to potential life, the right to be born free from birth defects,
and the right to a healthy mother.”\textsuperscript{405}

Previous efforts to grant a right to life before birth, recognize prenatal legal
personhood, and “bestow rights on a zygote, embryo, or fetus that would be
equal or superior to the rights of women” have been unsuccessful.\textsuperscript{406} Article 1 of
the UDHR states: “All human beings are born free and equal in dignity and
rights.”\textsuperscript{407} Importantly, “the history of negotiations indicate that the word ‘born’
was used intentionally to exclude a prenatal application of the rights protected in
the Declaration.”\textsuperscript{408} Drafters of the ICCPR rejected a proposal to extend the right
to life from the moment of conception.\textsuperscript{409} The HRC also recently rejected
attempts to extend the right to life to prenatal life.\textsuperscript{410} Lastly, the CEDAW

\begin{flushleft}
\textsuperscript{400} TENN. CODE ANN. § 39-13-107(c)(3) (2014).
\textsuperscript{401} Jeltsen, \textit{supra} note 25; \textit{To Prison for Pregnancy}, \textit{supra} note 267; Beyerstein, \textit{supra} note 100.
\textsuperscript{403} L.C. v. Peru, \textit{supra} note 240, para. 8.15.
\textsuperscript{404} \textit{See} Diaz-Tello, \textit{supra} note 61.
\textsuperscript{405} Kellett, \textit{supra} note 227, at 466.
\textsuperscript{406} \textit{See WHOSE RIGHT TO LIFE}, \textit{supra} note 130, at 1 (defining prenatal legal personhood).
\textsuperscript{407} UDHR, \textit{supra} note 126, art. 1.
\textsuperscript{408} \textit{WHOSE RIGHT TO LIFE}, \textit{supra} note 130, at 6 (citing U.N. GAOR 3\textsuperscript{rd} Comm., 99th mtg., para.
\textsuperscript{409} \textit{Draft International Covenants on Human Rights}, Rep. of the 3d Comm., General Assembly,
12th Sess., U.N. Doc. A/3764, paras. 96, 119 (Dec. 5, 1957); \textit{WHOSE RIGHT TO LIFE}, \textit{supra}
note 130, at 6; \textit{see also} ICCPR, \textit{supra} note 128, art. 6(1).
\textsuperscript{410} Human Rights Comm., \textit{Draft General Comment 36: Article 6 Right to Life}, para. 7, U.N.
the rights of unborn children, including to their right to life. In the absence of subsequent
agreements regarding the inclusion of the rights of the unborn within article 6 and in the
Committee emphasized that “the fundamental principles of non-discrimination and equality require that the rights of a pregnant woman be given priority over an interest in prenatal life.”

The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights have found that protection of fetal rights is not absolute. In *Artavia Murillo et al. (“In Vitro Fertilization”) v. Costa Rica*, the Inter-American Court held that the “right to life should not be understood as an absolute right, the alleged protection which can justify the total negation of other rights,” but instead should be understood as “an adequate balance between competing rights and interests.” The European Court of Human Rights affirmed that “the unborn child is not regarded as a ‘person’ directly protected by Article 2 of the Convention and that if the unborn do have a ‘right’ to ‘life’, it is implicitly limited by the mother’s rights and interests,” including respect for her private life. These interpretations of the right to life indicate that fetal rights, even the life of the fetus, cannot be prioritized over women’s rights without qualification.

Protecting fetal health may be a valid government objective; however, it cannot trump all rights of a pregnant woman and turn her into a reproductive receptacle. Protections for fetal health “must not perpetuate discrimination against women, as non-discrimination is one of the founding principles of human rights law.” Criminalizing drug use by pregnant women is not necessary to achieve the objective of fetal health; in fact, it is counterproductive and results in

absence of uniform State practice which establishes such subsequent agreements, the Committee cannot assume that article 6 imposes on State parties an obligation to recognize the right to life of unborn children.”; see also, *Equality Now, Re: Human Rights Committee—Preparation of General Comment No. 36 on the Right to Life* (2015) (requesting that the HRC interpret Article 6(1) of the ICCPR “[a]s protecting the right to life starting from birth”); *Ctr. for Reprod. Rights, Joint Statement for the Human Rights Committee’s Day of Discussion on the Right to Life* (2015).

411. See, e.g., *L.C. v. Peru, supra* note 240, para. 8.15 (finding a violation of a pregnant woman’s right to health and sex role stereotyping when the government denied her spinal surgery and a therapeutic abortion in order to protect her fetus).


417. *Whose Right to Life, supra* note 130, at 12; *See HRC, Gen. Comment 18, supra* note 179, para. 2; *CESCR, Gen. Comment 20, supra* note 179, para. 2.
an increased risk to the fetus.418 A health care based approach, including treatment for pregnant women suffering from drug addiction rather than punishment, is the most effective way to protect the rights and health of a pregnant woman and her fetus.419

VI. CONCLUSION

Criminalizing pregnant women suffering from drug addiction burdens some of the most vulnerable members of society and violates numerous fundamental human rights laws. It is not an effective means of deterring drug use or protecting fetal health. Tennessee, and all states in the United States, should treat everyone equally and fairly, including pregnant women. Tennessee’s arbitrary and discriminatory fetal assault law should be repealed. Treating drug dependency through education and treatment will fulfill women’s right to bodily autonomy and achieve the state’s goal of promoting healthy pregnancies.

The ability to hold the United States accountable for these human rights violations is limited. The United States is a party to the ICCPR and CERD, but has not ratified either of the ICCPR Optional Protocols, nor has it made a declaration allowing individuals to bring complaints before the HRC or the CERD Committee.420 The United States has signed, but has not ratified, the CESCR and CEDAW, reducing its obligations under those treaties such that it must only refrain from actions that undermine their object and purpose.421 At the regional level, the United States has signed but has not ratified the American Convention and cannot be compelled to appear before the Inter-American Court.422 However, if an individual has exhausted all domestic remedies, the Inter-American Commission can hear a complaint against the United States for violations of the American Declaration of the Rights and Duties of Man.423

Despite these limitations, it is important to recognize how Tennessee’s fetal assault statute violates numerous international human rights and, consequently, the importance of pressuring states to protect, respect and fulfill the rights of all persons, including pregnant women. Civil society and its members should continue to use the treaty monitoring system and the UPR process to highlight domestic human rights violations. Relying on an international human rights framework may get advocates farther than an analysis under the United States Constitution.

418. Grover, supra note 240, paras. 41–42; ACOG, COMM. OP. NO. 473, supra note 51.
419. Grover, supra note 240, paras. 41–42; ACOG, COMM. OP. NO. 473, supra note 51.
420. Status of Ratification, supra note 131.
421. Vienna Convention, supra note 132, art. 18; OFF. OF THE U.N. HIGH COMM’N FOR HUMAN RIGHTS, CIVIL AND POLITICAL RIGHTS: THE HUMAN RIGHTS COMMITTEE, FACT SHEET NO. 15 (REV. 1), 3 (2005) (“A state can become a party to a treaty in one of two main ways. Firstly, it can sign a treaty, following which, according to the rules of international law, the State may not act contrary to the objects and purposes of the treaty.”).
422. American Convention Ratification, supra note 165.
international human rights law recognizes a right to health that includes reproductive health, it has a more expansive definition of sex discrimination that includes pregnancy discrimination, and it explicitly protects a right to privacy that includes the right to make reproductive decisions. 424 Tennessee’s fetal assault law violates women’s human rights and may be effectively challenged using an international human rights analysis.

424. See, e.g., CEDAW, Gen. Recommendation 24, supra note 200, para. 12, 23; Murillo et al., Inter-Am. Comm’n H.R., supra note 217, paras. 128, 130; Alyne da Silva Pimentel Teixeira v. Brazil, supra note 211, paras. 7.3–7.7; ICCPR, supra note 128, art. 17(1); HRC, Gen. Comment No. 28, supra note 192, para. 20.