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A Proactive State  
Policy Resource

for Promoting  
Reproductive Health,  
Rights, and Justice



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# ACKNOWLEDGEMENTS

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**MOVING IN A NEW DIRECTION: A PROACTIVE STATE POLICY RESOURCE FOR PROMOTING REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE WAS RESEARCHED, COMPILED, AND PRODUCED BY THE CENTER FOR REPRODUCTIVE RIGHTS. WE ARE GRATEFUL FOR THE COLLABORATION OF THE FOLLOWING NATIONAL AND STATE-BASED ORGANIZATIONS THAT DEVELOPED MANY OF THE POLICIES DISCUSSED IN THIS RESOURCE AND PROVIDED INVALUABLE INPUT ON THE CONTENT AND STRUCTURE OF THIS RESOURCE.**

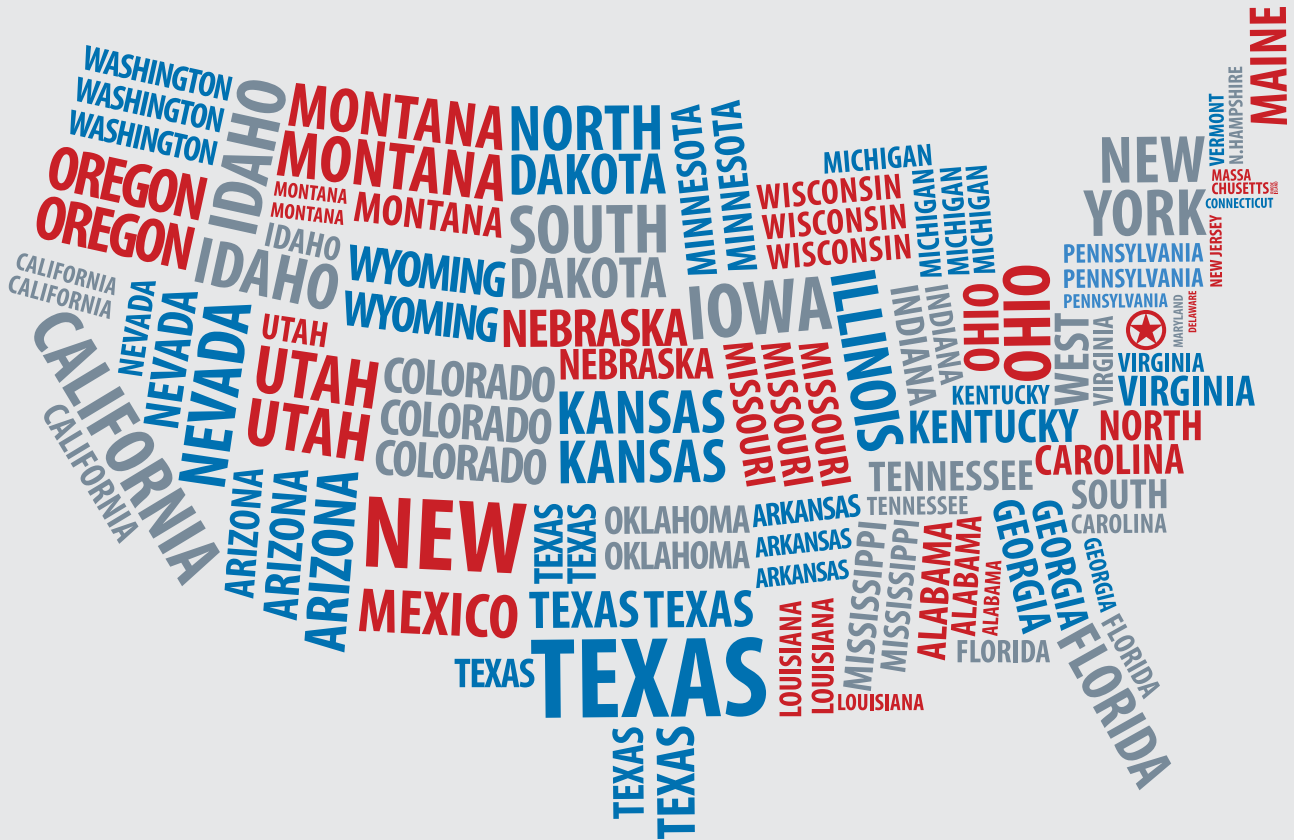
**PLEASE NOTE: INCLUSION OF AN ORGANIZATION IN THE ACKNOWLEDGEMENTS AND/OR LIST OF RESOURCES DOES NOT INDICATE ORGANIZATIONAL ENDORSEMENT OF EVERY POLICY REFERENCED.**

A Better Balance  
 American Civil Liberties Union  
 ACLU of Pennsylvania  
 Adoption Connection of Jewish Family and Children's Services  
 Advocates for Youth  
 American Congress of Obstetricians and Gynecologists  
 Advancing New Standards in Reproductive Health  
 Answer  
 Asian & Pacific Islander Institute on Domestic Violence  
 Backline  
 All\* Above All  
 California Family Health Council  
 Catholics for Choice  
 Center on Reproductive Rights and Justice  
 Choices in Childbirth  
 Colorado Organization for Latina Opportunity and Reproductive Rights  
 Community Legal Services of Philadelphia  
 Equality Federation  
 Forward Together  
 Futures Without Violence  
 Guttmacher Institute  
 Healthy Teen Network  
 Illinois Caucus for Adolescent Health  
 Justice Now  
 MergerWatch  
 Ms. Foundation  
 NARAL Pro-Choice America  
 National Abortion Federation  
 National Advocates for Pregnant Women  
 National Asian Pacific American Women's Forum  
 National Center for Lesbian Rights  
 National Coalition of STD Directors  
 National Domestic Workers Alliance - Atlanta Chapter  
 National Family Planning & Reproductive Health Association  
 National Health Law Program  
 National Institute for Reproductive Health  
 National Latina Institute for Reproductive Health  
 National Partnership for Women & Families  
 National Women's Law Center  
 New Morning Foundation  
 New Voices Pittsburgh  
 Oregon Foundation for Reproductive Health  
 Physicians for Reproductive Health  
 Planned Parenthood Federation of America  
 Planned Parenthood Votes Northwest  
 Progressive States Network  
 Raising Women's Voices  
 Reproductive Health Technologies Project  
 Sexuality Information and Education Council of the United States  
 SisterLove  
 SisterSong  
 SPARK Reproductive Justice NOW  
 Third Wave Fund  
 WV FREE (West Virginia Focus: Reproductive Education and Equality)  
 Women's Voices for the Earth  
 Women with a Vision  
 Young Women United

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# INTRODUCTION, PURPOSE, METHODOLOGY, AND LIMITATIONS

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After years of fighting back, one thing is becoming clear—we cannot realize our vision of the world if we are only playing defense. We must turn the tide by pushing forward a new agenda in our state legislatures.

## INTRODUCTION

State governments play an incredibly important role in shaping our rights and determining the status of our health. When it comes specifically to reproductive rights and health, this could not be truer. Sadly, for the last five years, we have witnessed more backtracking than progress at the state level with respect to women's health. Millions of women have been affected by these relentless and unprecedented attacks on family planning and abortion services in state legislatures across the country. As a result of these attacks, fundamental constitutional rights to privacy and equal protection under the law have been made hollow for many individuals; in many places, whether or not a woman has reasonable access to contraception and abortion care is dependent on the contents of her pocketbook and her zip code. For those who are young, low-income, of color, and/or living in rural areas, the barriers to accessing legally protected, high-quality, and affordable reproductive health care are pervasive and pernicious – and sometimes insurmountable.

Despite the fact that many states face growing disparities in reproductive health care outcomes, few states are taking steps to advance policies that increase access to sexual and reproductive health care services and information or address the structural barriers to care for low-income and underserved populations. And while many states are focused on depriving pregnant women of their rights and personhood, only a handful of others are putting commonsense policies in place to support the health and well-being of all pregnant women and their families.

There may be many explanations for the current state of affairs, but it is unquestionable that some of the poor health outcomes and barriers to access are the direct result of the misguided prioritization of some state governments. Far too often, state policymakers in these states are focused on restricting access to abortion, contraception, and comprehensive sexuality education rather than on promoting policies that will actually improve the health and lives of

people living within their borders. Women's health advocates at the state and national levels are thus forced to spend a significant amount of time and resources trying to protect reproductive rights from further erosion.

After years of fighting back, one thing is becoming clear—we **cannot realize our vision of the world if we are only playing defense**. We must turn the tide by pushing forward a new agenda in our state legislatures. We know that the state policy arena offers us an extraordinary opportunity to incubate new policy ideas, to expand rights beyond the floor set by federal law, and to tailor policies to the unique demographic characteristics and needs of our diverse communities. We must not lose sight of the fact that state governments have the power and ability to address many of the disparities plaguing certain communities; to expand reproductive rights and freedoms; to provide their constituents with the resources and information they need to lead healthy lives; and to build healthy families and communities.

The time has come for us to stand strong together in our commitment to women's health, rights, and dignity by pushing proactive policies that reflect our priorities and values. We need to stand up for our vision of a just and equitable society and reclaim our power as a movement for justice and freedom. *Moving in a New Direction: A Proactive State Policy Resource for Promoting Reproductive Health, Rights, and Justice* shows that there is great innovation, commitment, and energy in our movement that can be further harnessed in order to spread and expand throughout the country.

We hope that this guide will serve as a resource and inspiration for state advocates throughout the country who are advancing or considering proactive state policies to improve the reproductive health of women in the United States. The innovation and commitment shown in this resource can serve as a much-needed inspiration for all advocates. While we know we face significant challenges in ensuring that our

rights are respected and our health is protected, embracing the diversity, depth, and breadth of the reproductive health, rights, and justice movement can drive us forward and inspire our collective efforts to advance policies around the country that will improve the health and lives of women and their families.

### PURPOSE, METHODOLOGY, AND LIMITATIONS

Instead of focusing on how to defend against the constant attacks on our rights and the plethora of harmful laws on the books, *Moving in a New Direction: A Proactive State Policy Resource for Promoting Reproductive Health, Rights, and Justice* focuses on proactive policy solutions that have been introduced in at least one state in the last several years and show real promise of improving women's health and access to care. Compiling and sharing these policies represents an important step in the ongoing effort to generate, promulgate, and implement policies that reflect our values and support our communities.

*Moving in a New Direction* is intended as a resource for state advocates, activists, and policymakers. The resource is not intended to be a state-specific guide for advancing policy. Analysis

about how a policy intersects with current state law and regulations, as well as how it affects other strategic policy efforts, must be assessed with key stakeholders in each state before moving forward. Furthermore, each policy concept discussed in this publication is offered as a jumping-off point for further research and analysis—not a one-size-fits-all solution. We encourage readers to reach out to the organizations listed as resources for more information about each policy, including legal analysis, talking points, strategic guidance, and other crucial advice and support.

The concepts included in this resource are inclusive and expansive. For some readers, the policy range will be too broad; for others, too narrow. Utilizing a reproductive justice lens, we endeavored to include a range of reproductive health topics that reflect the intersectionality of our multiple identities and support our ability to parent, not to parent, and lead healthy sexual lives. We recognize that many systemic issues—including poverty, racism, sexism, homophobia, and xenophobia—all play a role in our reproductive health outcomes and the ability to exercise our reproductive rights. We also recognize that the quest for reproductive freedom must be intricately connected to the fight for social justice at large, including economic justice, gender justice, racial justice, and justice for immigrants and LGBTQ-identified people. That being said, this

## REPRODUCTIVE JUSTICE

Reproductive Justice as a theory and practice is rooted in core human rights principles, including dignity, accountability, equity, equality, and freedom. Reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.”

Strong Families (formerly Asian Communities for Reproductive Justice),  
“A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice” (2005)



*Moving in a New Direction* does not address all the state policies that fall under these intersecting justice areas. Ultimately, we reached compromises about what topics to include after soliciting input from a range of national and state advocates and recognizing our own collective limitations on expertise beyond women's reproductive health and rights.

For each section of the resource, we have included a brief background on the issue, a select group of policies that have been identified by experts in the field as salient and promising, and case studies and resources for the reader. Information about utilizing the budgetary process, administrative and regulatory action, innovative omnibus bills, and collaborative partnerships on broader social justice advocacy campaigns are also included throughout the guide. In order to make the resource manageable in size and scope, we had to limit the inclusion of policies for each topic area. For policies to be included, they needed to be some combination of innovative, evidence-based, timely, introduced in at least one state, responsive to the needs of our communities, and recommended by experts in the field. This resource is by no means exhaustive and there are many other important state-level policies that can and should be advocated for by the reproductive health, rights, and justice movement.

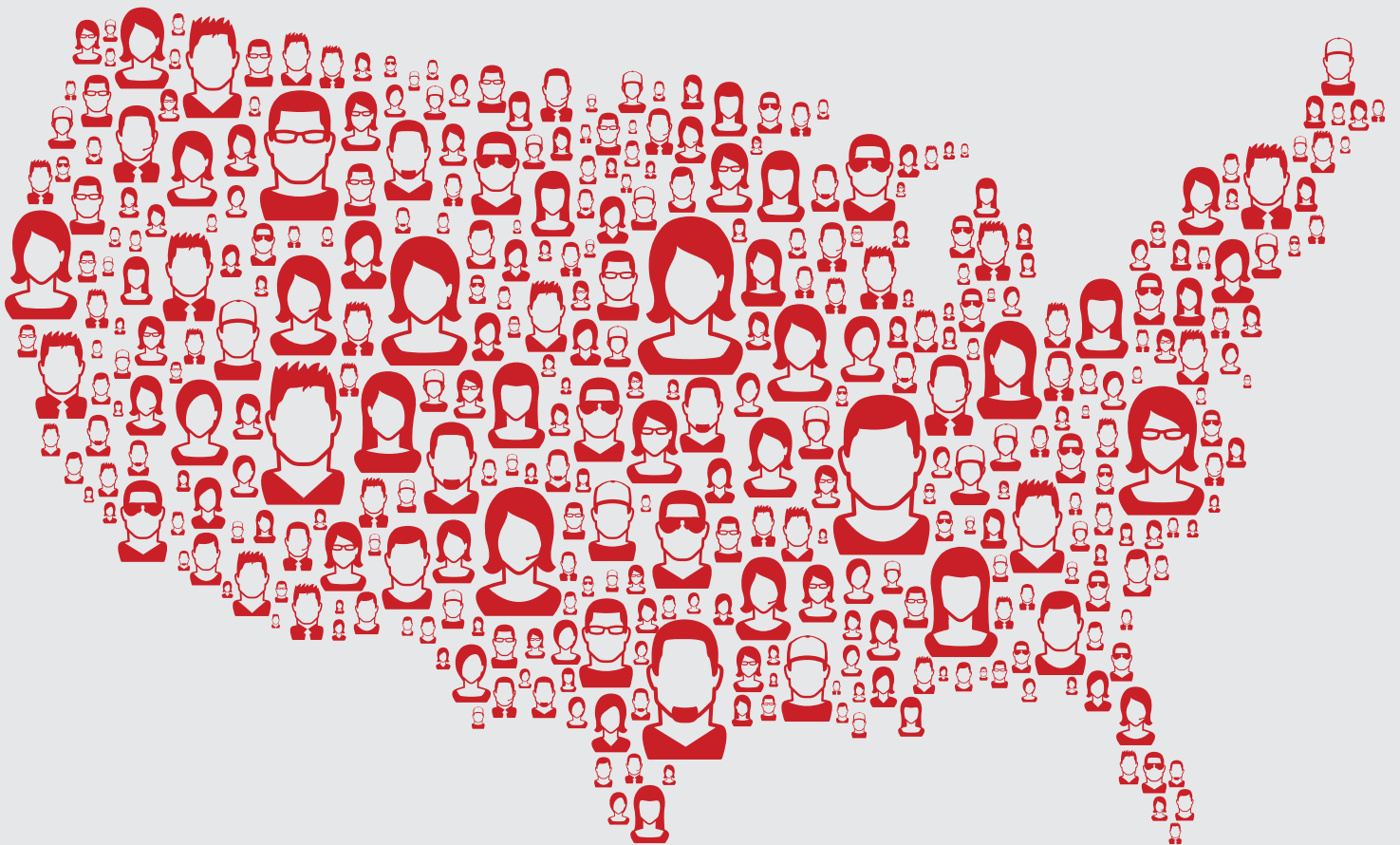
It should also be noted that no national or state organization is an expert or leader on every issue included in this resource, nor has every group that collaborated on this effort endorsed every policy concept discussed or legislation referenced within it. Moreover, many laws are the result of compromise and negotiation, which means state laws that are included in this document may not reflect the ideal policy or model legislation that specific organizations support. For this reason, we did not include model or draft legislation for specific policy topics, nor did we include the text of every version of a specific policy that has been introduced thus far. It should be noted that every policy included in the resource has been introduced in at least one chamber of one state legislature. Advocates are encouraged to solicit support from the organizations listed as resources throughout the chapters.



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# FULFILLING THE PROMISE OF THE AFFORDABLE CARE ACT

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The Patient Protection and Affordable Care Act (ACA) has undoubtedly led to significant gains in access to essential health care services for women. Moving forward, there are opportunities for state policymakers to build on the platform of the ACA to further expand coverage. The health care delivery system in the United States is complex and ever-changing; state lawmakers must continue to identify and promote policies to improve access to health care services for everyone.



## SINCE THE IMPLEMENTATION OF THE ACA, THE NUMBER OF UNINSURED NONELDERLY ADULTS HAS FALLEN BY 9.5 MILLION PEOPLE.

**O**n March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law, enacting comprehensive health insurance reforms that were to roll out over the course of several years.<sup>1</sup> While attacks on the ACA in the courts and in the states have made it challenging to implement the law as intended, the ACA has done much to increase access to coverage, including coverage for reproductive health (such as maternity care) and preventive services (such as birth control) without cost sharing. Importantly, the act also ensures that women have coverage so that they can see an OB/GYN and that women cannot be charged more than men for the same health care. Since the implementation of the ACA, the number of uninsured nonelderly adults has fallen by 9.5 million people.<sup>2</sup> However, there remain significant gaps in our health insurance system, leaving quality health insurance coverage out of reach for too many. While the Supreme Court decision upholding the constitutionality of the ACA allowed states to choose whether to accept federal money to expand Medicaid eligibility in their state, states that have expanded Medicaid have seen significant decreases in their uninsured rates.<sup>3</sup> However, people living in states that have not expanded Medicaid remain at a disadvantage when it comes to accessing health care coverage.

There is more work to be done not only to improve eligibility for insurance coverage, but also to improve the scope of coverage. For example, the ACA specifically requires coverage for maternity care services in the individual and small group health insurance

markets, closing significant gaps that existed prior to the ACA.<sup>4</sup> However, some health plans in the large employer group market, not subject to this ACA requirement, continue to exclude maternity coverage. This gap leaves women and dependent minors who receive coverage through these employer health plans without maternity coverage.<sup>5</sup>

Additionally, the ACA did not change the health coverage landscape for undocumented immigrants and thus gaps in coverage based on immigration status remain.<sup>6</sup> In particular, undocumented immigrants are not eligible for premium tax credits to help them pay for health insurance and are not permitted to purchase coverage in the health insurance marketplace. Undocumented immigrants also remain ineligible for non-emergency Medicaid altogether.<sup>7</sup> Some states use state funds to provide health coverage for individuals who would otherwise qualify for Medicaid, but this is often limited in terms of both eligibility and scope of services.<sup>8</sup>

Although the primary goal should be for states to embrace the expansion of Medicaid coverage for all populations, lawmakers can take action to at least provide greater health care access to individuals who need urgent and critical reproductive health care, such as family planning services. Since 1972, state Medicaid programs have been required to cover family planning services and supplies. Due to the public health benefits of expanded access to family planning, since the 1990s, many states have expanded eligibility to individuals by securing a waiver from the Centers for Medicare

and Medicaid Services (CMS).<sup>9</sup> These programs that expand family planning eligibility have been proven to reduce unintended pregnancy by increasing use of more effective contraceptive methods; in the first year of enrollment in an expanded Washington State program, use of more effective methods increased by 18%.<sup>10</sup> Beyond improving women's access to preventive health care though, family planning expansion is an economical choice: such programs save nearly \$6 for every \$1 spent.<sup>11</sup>

## MEDICAID EXPANSION

The primary goal of the Affordable Care Act (ACA) was to significantly increase the number of Americans with health insurance through the twin platforms of Medicaid and health insurance exchanges (or marketplaces). Traditional Medicaid has largely provided coverage to low-income pregnant women, children, individuals with disabilities, and the elderly. This meant that low-income childless adults—and many parents—were left without affordable coverage.<sup>12</sup> The ACA requirement that the states expand Medicaid eligibility to all adults whose incomes fall below 138% of the federal poverty line would have filled this important gap.<sup>13</sup> However in 2012, the Supreme Court held that states can choose whether or not to accept federal funding to expand Medicaid.<sup>14</sup> This resulted in a patchwork of Medicaid coverage nationally among people who need such coverage. The Congressional Budget Office has estimated that, as a result of the Court's decision, 3 million more people will be uninsured in 2022 than would have been had the Medicaid expansion been held mandatory.<sup>15</sup>

States should expand Medicaid at the next possible opportunity and many have taken varying routes to do so. Twenty-six states and the District of Columbia are implementing Medicaid expansion in 2014; as of September 10, 2014, some states were still debating the expansion and 21 were not moving forward.<sup>16</sup> Pennsylvania will implement expansion in 2015 pursuant to a waiver and Indiana's attempt to expand by such a waiver is pending federal approval for implementation in 2015.<sup>17</sup> In Arkansas, the so-called "private-option" Medicaid expansion plan authorized by state legislators uses a waiver from the Centers for Medicare and Medicaid Services to purchase health coverage for qualified residents.<sup>18</sup> States that have not expanded coverage have left many individuals without affordable coverage options for themselves and their families. In Texas alone, more than 1.7 million adults are excluded from Medicaid due to the state's decision not to expand coverage.<sup>19</sup>

The good news is that states that have chosen to expand their Medicaid programs have a new ability to cover previously uninsured adults. Nationally, 4.8 million people have newly enrolled in Medicaid or CHIP since open enrollment began in October 2013.<sup>20</sup> States that have expanded their Medicaid programs have been able to cover new enrollees and continue coverage that might have been unavailable if not for health care reform. For example, in Washington, during the same reporting period, the state surpassed its enrollment goals, signing up 285,000 individuals newly eligible for Medicaid and approved nearly 417,000 renewals and redeterminations.<sup>21</sup>

## PROTECTING CONFIDENTIAL COMMUNICATIONS REQUESTS

The ACA expanded health coverage to a new group of people, but also highlighted an acute need to protect personal health information. Confidentiality regarding health care information can be crucial to health care access. Explanation of Benefits (EOB) or other consumer notifications, which note the payments and coverage decisions made by the individual's insurance plan, are considered important for purposes of transparency and fraud protection. However, the consumer's interest in disclosure of payments rendered or denied and the individual's interest in maintaining privacy can be at odds. This is particularly true for minors or people aged 25 and younger who receive health coverage through a parent's plan, or for people who receive health coverage through someone else and who need or desire privacy and confidentiality for certain services.

Health insurance consumer communications are governed by a complex web of federal and state laws, including the federal *Employee Retirement Income Security Act (ERISA)*, and the federal Health Insurance Portability and Accountability Act (HIPAA).<sup>22</sup> Many state laws and regulations regarding consumer communications have been created to implement these two federal laws.<sup>23</sup> HIPAA protects individuals from inappropriate disclosure and use of personal health care information; and the HIPAA Privacy Rule, as it is referred to, protects health information sharing between covered entities, gives individuals the right to learn about disclosures, and gives patients the ability to access their own health records, among other things. The Privacy Rule also has a clause that allows an individual to request that communications be suppressed through what is called the Endangerment Clause. HIPAA limitations include the fact that consumers have not been well informed of this clause, nor are the insurance carriers required to alter communications; however, state legislatures can improve policy through regulation of insurance carriers.

Concerns that health disclosures could also put people in danger who are dealing with Intimate Partner Violence (IPV) heightens the need for confidential communications regarding health services and insurance. IPV can include physical and sexual violence between two people in a close relationship, including current or former spouses or dating partners. Almost three in ten women and one in ten men in the United States have experienced IPV and report an impact on their ability to fully function.<sup>24</sup> Research has shown that approximately one-third of women experiencing IPV also report reproductive coercion through birth control sabotage or through verbal or physical intimidation related to becoming pregnant.<sup>25</sup> It is essential that individuals going through such coercion can be ensured confidentiality to feel safe in accessing a full range of health care services. Additionally, the allowance for people under the age of 26 to be insured as dependents has led to an additional 7.8 million young adults who have coverage for reproductive health services, but who may want to maintain confidentiality about medical services rendered.<sup>26</sup>

Several states have taken steps to address the need for confidential health care communications requests. The most sweeping law to date will be implemented January 1, 2015, in **California**, where health plans in the state must respond to confidential communications for services such as reproductive health care and mental health care when requested, or if a patient feels that disclosure could lead to harm; one way to do this would be to allow insurers to communicate directly with the patient rather than the primary policyholder.<sup>27</sup> In **Maryland**, legislators passed a law requiring the state insurance commissioner to develop a standard form enabling consumers to take advantage of the HIPAA Endangerment Clause.<sup>28</sup> In **Washington State**, an individual can submit a written request to ensure that their nonpublic personal information concerning reproductive and mental health, sexually transmitted diseases, and chemical dependency remains private. Additionally, issuers cannot require individuals to obtain the policyholder's authorization to receive services or submit a claim.<sup>29</sup> Several states have also addressed confidentiality surrounding EOBs for minors; in Washington State, for example, minor patients must explicitly authorize disclosure of an EOB to the policyholder. In New York and Wisconsin, a minor patient can maintain confidentiality by receiving the EOB as long as there is no outstanding balance, which allows for confidential coverage for many reproductive health care services thanks to the ACA's no-copay preventive coverage.<sup>30</sup>



## HEALTH INSURANCE COVERAGE REGARDLESS OF IMMIGRATION STATUS

Immigrants face significant barriers to accessing health insurance. Forty-five percent of the 6.6 million immigrant women of reproductive age in the United States are uninsured.<sup>31</sup> This can be particularly problematic for immigrant women who are more likely to be low-income and of reproductive age. Barriers to affordable health insurance increase their risk of negative sexual, reproductive, and maternal health outcomes, with lasting health and economic consequences for women, their families, and their communities.

While the ACA created new coverage options for lawfully present immigrants, legal and financial barriers to purchasing health insurance coverage offered in a state's health insurance marketplace can be significant. The ACA enabled lawfully-residing immigrants, including those in the five year waiting period for Medicaid, to be eligible for tax credit assistance for plans purchased through the health insurance marketplace. However, under the ACA, not only are undocumented immigrants – including young immigrants often referred to as DREAMers, who have been granted temporary relief from deportation<sup>32</sup>—ineligible for those premium assistance credits, they are completely ineligible for purchasing plans sold on the marketplace—even at full cost.<sup>33</sup> The existing gaps in insurance coverage for immigrants after the ACA's passage indicate that undocumented immigrants are likely to remain uninsured, and they are projected to constitute approximately 25% of the total uninsured population in the United States once the ACA is fully implemented.<sup>34</sup>

Beyond the health insurance marketplaces, the ACA left in place existing restrictions on Medicaid coverage for all immigrants, including the five-year waiting period for lawfully residing immigrants. The exclusion of undocumented immigrants and some lawfully present immigrants from both traditional Medicaid *and* Medicaid expansion is hugely problematic, not only because of the impact to immigrants' health but as a policy matter for states. Because, as one estimate finds, "a substantial proportion of low-income uninsured adults will be ineligible for Medicaid because of their immigration status," states will need to analyze the capacity of other safety-net providers, including expensive emergency care systems, to provide needed care.<sup>35</sup>

Alternatively, states and localities can choose to use their own money to expand Medicaid to immigrant populations not covered by federal options. In California, **SB 1005** seeks to remedy these exclusions by using state funds to expand health care access for undocumented and lawfully present

immigrants in the state.<sup>36</sup> The bill would provide health care coverage to individuals who would otherwise be economically eligible for Medicaid, regardless of their citizenship status. The bill would also create a health insurance marketplace for the undocumented immigrants ineligible to purchase coverage on the state's marketplace.<sup>37</sup>

## CULTURAL COMPETENCY: ANOTHER COMPONENT OF EQUITY IN HEALTH CARE

Working to ensure health care services are provided in a culturally competent manner is critical to reducing health disparities. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) were developed in 2000 by the federal Office of Minority Health and are intended to support health care providers in developing and implementing culturally and linguistically appropriate services.<sup>38</sup> States have required cultural competency training in order to address health care disparities. California, Connecticut, New Jersey, New Mexico, and Washington all passed legislation requiring cultural competency training, and Maryland passed legislation strongly recommending National CLAS Standards.<sup>39</sup>

## PRENATAL CARE COVERAGE FOR IMMIGRANT WOMEN

To ensure healthy pregnancies, it is essential that all pregnant women have access to high-quality prenatal care. Pregnancy care improves the health and lives of women and children. Routine and ongoing care during a woman's pregnancy can reduce the likelihood of developing significant pregnancy complications, which in turn lowers maternal morbidity and improves the likelihood that the child will have a healthy birth weight.<sup>40</sup> When care is comprehensive, pregnant and postpartum women are able to receive the essential services they need to maintain their health during and after their pregnancy. For example, unfettered access to a woman's preferred contraceptive method during the postpartum period can help reduce the likelihood of future unintended pregnancies. And when women plan their pregnancies, they are more likely to obtain prenatal care for better maternal and child health outcomes.

Current policy does recognize, to some extent, the importance of prenatal care for all women. At the very least, Medicaid pays for emergency health care for all people, regardless of immigration status, including labor and delivery services. Beyond that, states have the option to waive the five-year ban for lawfully residing immigrant pregnant women and to provide prenatal care through Medicaid to eligible women. As of January 2013, 20 states offer this coverage to pregnant women.<sup>41</sup> In addition, states have the option to provide prenatal care to all immigrant women, regardless of status, by expanding the definition of "eligible low-income child" to include fetuses for the purposes of the Children's Health Insurance Program (CHIP).<sup>42</sup> Fifteen states have used this authority to provide prenatal care to undocumented women and other women who do not qualify for Medicaid.<sup>43</sup> While such a policy does result in the expansion of prenatal care coverage, it does so in a way that separates the health of a woman from the health of her fetus—a separation that is demonstrably false.

## EXPANDING MEDICAID ELIGIBILITY FOR FAMILY PLANNING AND CONTRACEPTIVE EQUITY FOR ALL

Due to the effectiveness of programs expanding Medicaid eligibility for family planning, Congress included a provision in the ACA to enable states to submit a State Plan Amendment (SPA) and cover family planning services for previously ineligible individuals, including non-pregnant adults whose income meets the criteria set by the state.<sup>44</sup> Today, 29 states have expanded their Medicaid family planning programs: 12 through a SPA and 17 through a time-limited waiver.<sup>45</sup> Twenty-six of these expansions qualify individuals on the basis of income and some of these states also extend coverage to individuals losing Medicaid coverage postpartum (Georgia, Iowa, Maryland, Montana, New York, Oklahoma, and Virginia) or for any reason (Illinois).<sup>46</sup> Three other states have more limited programs to cover individuals losing Medicaid postpartum (Rhode Island and Wyoming) or for any reason (Florida).<sup>47</sup>

Along with adopting and maintaining Medicaid family planning expansions, state lawmakers can improve Medicaid coverage for family planning in a number of ways. First, states can broaden eligibility for Medicaid family planning expansions to all individuals of reproductive age: currently, 17 states provide coverage to both women and men and 20 states cover individuals younger than 19 years of age.<sup>48</sup> Lawmakers can also expand coverage by permitting individuals to qualify for family planning expansion coverage based on their individual income, rather than household income.

Additionally, lawmakers can ensure that individuals with private insurance have coverage of every method of birth control.

Although the ACA requires most insurance plans to cover all FDA-approved contraceptive methods without additional cost sharing, federal regulations have permitted insurers—including Medicaid—to employ so-called “reasonable medical management techniques.” The Supreme Court’s decision in *Burwell v. Hobby Lobby Stores Inc.* has erected additional barriers for women whose employers object to contraceptive coverage. These barriers are preventing women across the country from accessing the best and most effective contraceptive methods for them. To date, 28 states have taken steps to ensure that every woman can use the birth control method that best meets her needs, and eight of these states prohibit refusal by employers or insurers.<sup>49</sup> Taking this one step further, it is essential that individuals are not inhibited in this access by such barriers

as prior authorization or step therapy (for example, providing coverage preference or requirements for generic contraceptives rather than brand name), which is addressed by California’s **SB 1053**, discussed in this section.

Expanded Medicaid coverage for family planning is essential to maintaining a continuity of care for individuals with variable incomes. Medicaid and plans on the state marketplace are income based, so program eligibility will shift over time—possibly resulting lengthy gaps in coverage, particularly individuals with income below 200% of the federal poverty line.<sup>50</sup> As such, state expansions of family planning programs are all the more important as a safety net for individuals with fluctuating income to maintain access to essential services and supplies.

## MAINTAINING THE PROMISE OF NO-COPAY CONTRACEPTIVE COVERAGE

One significant advancement of the ACA was to require insurance plans to include coverage of birth control alongside other preventive services, and to provide these services without additional cost sharing. This has been a tremendous step forward for women’s health and equality. Yet, attacks on this benefit continue, and some loopholes in the law mean that women are not receiving the coverage to which they are entitled.

In California, advocates are working to fulfill the promise of the ACA that all women have access to the contraceptive method that works best for them, without cost sharing or restrictions. California’s Contraceptive Coverage Equity Act (**SB 1053**) builds on current state and federal law. It requires that all FDA-approved contraceptive drugs, devices, and products be covered without cost sharing, and prohibits medical management techniques that are frequently employed in the contraceptive

coverage context like step therapy and prior authorization.<sup>51</sup> This bill was signed into law in September 2014.

States are also stepping forward to address the U.S. Supreme Court’s 2014 decision in *Burwell v. Hobby Lobby Stores, Inc.*, which diminished the promise of the ACA’s contraception benefit for some women.<sup>52</sup> In that case, the Court held that a closely held for-profit corporation can deny its employees insurance coverage for contraception as required by the ACA, because of a religious objection.<sup>53</sup> The *Hobby Lobby* decision gives employers breathtaking—and unprecedented—power to discriminate against women and dictate how their employees can and cannot use their own health insurance.

The *Hobby Lobby* decision compounds the discrimination many women already face in the workplace with respect to reproductive health decision-making. According to the National Women’s Law Center, “[w]omen remain at serious risk of workplace discrimination based on their reproductive health decisions, and based on an employer’s religious beliefs about such decisions.”<sup>54</sup> Notably, employer discrimination

extends beyond the decision of an employee to choose or refuse contraception; employers can discriminate against employees for making a range of reproductive health decisions, including using assisted reproductive technologies to build their families or becoming pregnant while unmarried.<sup>55</sup>

Even before the *Hobby Lobby* decision, state legislators began proposing policies to protect individuals from discrimination in the workplace due to decisions they make about starting a family. Several states and the District of Columbia introduced bills that would prohibit employers from discriminating against employees “on the basis of the employee’s or dependent’s reproductive health decision making.”<sup>56</sup> Since the *Hobby Lobby* decision was issued, pro-women’s health legislators in Ohio introduced HB 604/SB 355, which would amend the state’s employment discrimination law to expressly provide protections for employees’ reproductive health care decisions.<sup>57</sup> Advocates and legislators continue to evaluate the best approaches to ensure women have access to the full range of reproductive health care without interference from their employers.



#### CASE STUDY:

## THE MOVEMENT FOR MEDICAID COVERAGE IN GEORGIA

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The strength in fighting for access to better healthcare policy in Georgia lies in the sheer numbers of Georgians who would benefit from Medicaid expansion eligibility. Medicaid expansion in our beloved state would allow 650,000 more people to be eligible for healthcare, and approximately 3,693 lives would be saved each year.<sup>58</sup> Moreover, statisticians predict that investment in Medicaid would support an average of 70,343 new jobs in Georgia, and nearly half of those jobs would not be in the field of healthcare, but rather in such industry sectors as real estate, food services, and transit and ground transportation.<sup>59</sup>

Despite these clear benefits to Georgians of Medicaid expansion, we have faced legislative barriers. Although more than 300,000 Georgians have obtained health insurance through the federally-facilitated health insurance marketplace, more than twice as many are without health insurance because of the states' refusal to expand Medicaid.<sup>60</sup>

SPARK Reproductive Justice NOW (SPARK), based in Atlanta, GA, advocates for policies that protect and expand access to the full range of family planning options, abortion, and sexual health education for women and youth of color in the state of Georgia while ensuring the voices of women of color, young parents, and LGBTQQ youth of color living in the South are included in the reproductive rights and justice movements. The National Domestic Workers Alliance Atlanta Chapter (NDWA-ATL) is a member led grassroots organization that fights to improve the working conditions for domestic workers—the majority of whom do not have any type of health insurance—and to win respect, dignity, and recognition for the domestic work sector.<sup>61</sup>

In September of 2013, SPARK Reproductive Justice NOW joined the NDWA-ATL grassroots campaign to close the health insurance coverage gap in Georgia. After surveying their members in 2012, NDWA-ATL discovered that health insurance and concerns about eligibility for Medicaid under the ACA were priority issues. The chapter began building awareness around Medicaid expansion, talking with faith, union, and community leaders and partnering with the U.S. Human Rights Network, Moral Mondays GA, Atlanta Jobs with Justice, and Caring Across Generations to host a number of public events. SPARK's mission to develop the political leadership of our constituency, mobilize the base and our social justice allies to build power, and respond to reproductive justice threats led to a natural collaboration with NDWA, and we developed a Medicaid expansion campaign to ensure that the needs and voices of all of our constituencies were included in the process. The campaign research focused on how the ACA and Medicaid expansion directly impact those on the front lines of all our political work.

SPARK and NDWA-ATL have organized numerous visibility activities involving our staff, membership, and local and national partners on Medicaid expansion including: press conferences at the Georgia Capitol, town hall forums with the Georgia Citizens Coalition on Hunger, multiple LGBTQQ and reproductive justice conference presentations and workshops, and campus trainings at four state universities and colleges. Staff and youth leaders have utilized traditional and social media to get the coverage message out, and more than 500 signatures have been collected in favor of Medicaid expansion in Georgia. On the individual level, NDWA-ATL provides members with the opportunity to talk



to ACA navigators at chapter meetings and also generates paystubs for members, who are often paid in cash or checks, allowing them to take advantage of a discounted health services referral program with the Center for Black Women's Wellness. Domestic workers benefiting from the Chapter's health referral program were furious to learn they could have more than just a temporary fix; that their tax dollars were already being used to fund the expansion in other states; and that their political representatives in Georgia elected to not move forward with expanding Medicaid.

In February 2014, SPARK, NDWA-ATL, and Strong Families/Forward Together hosted the 7th annual "Legislate THIS!" day of action at the Georgia Capitol. With support from SisterSong, SisterLove, and the Feminist Women's Health Center, this event brought almost one hundred people to the Capitol to

The South has a strong history of grassroots organizing and resistance, despite being home to legislation that is often hostile to sexual and reproductive rights and justice. We know what it means to build community.

stand up for Medicaid expansion and engage in youth-led advocacy trainings. The day also included a comprehensive social media campaign presence with organizational partners such as National Latina Institute for Reproductive Health and Advocates for Youth committing to conduct social media activities using SPARK's hashtag. This led to more than 400,000 total social media impressions.

Our work to gain healthcare for all individuals in Georgia and within the South contradicts the so-called "Generation Me" label—a label that presumes that the millennial generation displays traits of invincibility, apathy, and entitlement. This narrative assumes that youth do not care about universal

healthcare or engaging the political process. We know this narrative to be false. Not only do the youth that SPARK works with care about and participate in the political process, but they are greatly affected by it. By acknowledging this, we intervene in this narrative on behalf of our young generation. We work with youth, specifically LGBTQ youth of color living within the South, who are a part of the underserved communities that fall into the coverage gap. We amplify those voices and their experiences by providing them with the opportunities and resources needed to showcase their solutions, strategies, tips, and tools around a variety of issues, including Medicaid expansion, with platforms such as op-eds, blogs, vlogs, and infographics. NDWA-ATL member stories are also central to the campaign. Domestic workers tell their stories at our press conferences, to the media, on the radio, to each other, while tabling at events, at conferences and convenings organized by our allies—every space where members can tell their stories, we utilize.

The South has a strong history of grassroots organizing and resistance, despite being home to legislation that is often hostile to sexual and reproductive rights and justice. We know what it means to build community. Centralizing the voices of the most marginalized and underrepresented, SPARK and NDWA-ATL are helping to build and sustain a reproductive justice movement that allows these communities to thrive. We ground our work for reproductive justice in a belief that individuals and communities have the right to make decisions affecting their bodies, gender, and lives, and we understand that communities of color often struggle to gain justice, liberation, and societal accountability from systems of oppression that are often dangerous to all our lives and well-being.

Over the course of the campaign, it has become clear that many Georgians are not involved in and/or aware of the political process, nor the parallels between failing health insurance and school systems and the decision-makers responsible for providing better conditions. Moving forward, SPARK and NDWA-ATL are integrating a comprehensive voter engagement and canvassing strategy into our programming as a way to enrich our work with youth and women of color leaders, grow our base, and build political power. As always, we will continue to publish our analyses and share the stories of those most impacted by the health care coverage gap.

## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
American Congress of Obstetricians and Gynecologists	<a href="http://www.acog.org">www.acog.org</a>
California Family Health Council	<a href="http://www.cfhc.org">www.cfhc.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center for Reproductive Rights	<a href="http://www.reprorights.org">www.reprorights.org</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Equality Federation	<a href="http://www.equalityfederation.org">www.equalityfederation.org</a>
Forward Together	<a href="http://www.forwardtogether.org">www.forwardtogether.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
MergerWatch	<a href="http://www.mergerwatch.org">www.mergerwatch.org</a>
Ms. Foundation	<a href="http://www.forwomen.org">www.forwomen.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Family Planning & Reproductive Health Association	<a href="http://www.nationalfamilyplanning.org">www.nationalfamilyplanning.org</a>
National Health Law Program	<a href="http://www.healthlaw.org">www.healthlaw.org</a>
National Institute for Reproductive Health	<a href="http://www.nirhealth.org">www.nirhealth.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
National Women's Law Center	<a href="http://www.nwlc.org">www.nwlc.org</a>
New Voices Pittsburgh	<a href="http://www.newvoicespittsburgh.org">www.newvoicespittsburgh.org</a>
Oregon Foundation for Reproductive Health	<a href="http://www.orfrh.org">www.orfrh.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Raising Women's Voices	<a href="http://www.raisingwomensvoices.net">www.raisingwomensvoices.net</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>

## ENDNOTES

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# PROMOTING HEALTHY SEXUAL LIVES AND ACCESS TO FAMILY PLANNING SERVICES

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The Centers for Disease Control and Prevention (CDC) has lauded family planning as one of the top 10 public health achievements of the 20th century.<sup>1</sup> Political attacks on access to contraception are direct attacks on the incredible advancements in women’s health and autonomy over the last five decades. With an estimated 20 million new cases of sexually-transmitted infections (STIs) every year in the United States,<sup>2</sup> access to prevention, education, and treatment—along with access to the full range of family planning services—is crucial to the health and lives of women. State lawmakers can embrace policies to build upon the advancements that access to family planning has created, and can take steps to help reduce STI rates.

## EXPANDING ACCESS TO CONTRACEPTION

Access to contraception is imperative to ensuring that a woman will be able to control her fertility and determine the course of her life. The average American woman spends three decades of her life trying to avoid pregnancy, making access to a full range of comprehensive family planning options and methods crucial to her ability to achieve her life goals and to plan a family, if she so chooses.<sup>3</sup> A 2011 survey conducted in 13 states found that most women, across socio-demographic groups, cited multiple “very important” reasons for using contraception, including: “not being able to afford a baby, not being ready for children, feeling that having a baby would interrupt their goals, and wanting to maintain control over their lives.”<sup>4</sup> The majority of women surveyed said that contraceptive use enabled them to better care for themselves and their families and reach educational, financial, and career goals.<sup>5</sup>

Currently, 62% of all women of reproductive age in the United States are using a contraceptive method, and more than 99% of women aged 15-44 who have ever had sexual intercourse have used at least one contraceptive method.<sup>6</sup> The most commonly used methods of contraception in the United States are the pill (27.5% of current contraceptive users), female sterilization or tubal ligation (26.6%), and the male condom (16.3%).<sup>7</sup> Yet despite widespread use of contraception, more than half (51%) of all pregnancies in the United States each year are unintended.<sup>8</sup> Although there are many reasons for the high

rate of unintended pregnancies, lack of access to reliable contraceptives and inconsistent use are the most commonly understood barriers to pregnancy prevention. Adherence to a birth control method is essential to maximize effectiveness, and the inability to access contraception can impede regular use. Not all women have equal access to contraception or the contraception that best suits their needs. Access to and choice of method are limited by financial and insurance coverage barriers, as well as method and provider availability by geographic region.<sup>9</sup> When the cost of contraception prohibits consistent use, otherwise highly effective methods of birth control cannot protect women from unintended pregnancy.<sup>10</sup>

For example, recent research shows that long-acting reversible contraceptives (LARCs) show promise for ensuring women can better prevent unintended pregnancies. LARCs, including the implant and the IUD, are the most effective methods of reversible contraception, with failure rates of less than 1% for typical use due to the limited amount of user intervention required by the methods.<sup>11</sup> However, prohibitively high cost and misguided concerns about safety have stopped many women from choosing LARCs as their preferred method. After intensive public education efforts and improved coverage options, the use of LARCs is starting to increase for women across age, race, education, and income groups.<sup>12</sup> It is important to note that given the history of forced sterilization and testing of contraceptive methods on women of color in the United States,



**THE MAJORITY OF WOMEN SURVEYED SAID THAT CONTRACEPTIVE USE ENABLED THEM TO BETTER CARE FOR THEMSELVES AND THEIR FAMILIES AND REACH EDUCATIONAL, FINANCIAL, AND CAREER GOALS.<sup>5</sup>**

every woman should have access to her birth control method of choice, free from coercion.<sup>13</sup> Efforts to ensure broad contraceptive access must ensure that every person can truly choose the method that works best for her.

Beyond preventing unintended pregnancy, the health benefits of contraceptive use are numerous. Many women use contraception to manage medical conditions such as irregular menstrual bleeding, endometriosis, and uterine fibroids, and approximately 58% of women using the pill to avoid pregnancy also cite non-contraceptive health reasons for using it.<sup>14</sup> Family planning is also crucial to healthy pregnancies. The ability to plan for and space wanted pregnancies allows women the time and opportunity to connect with health services necessary to identify preconception health issues, such as diabetes and hypertension.<sup>15</sup> International research has found that pregnancies that are spaced too closely together increase the risk of poor birth outcomes including pre-term birth, low birth weight, and irregularly small size.<sup>16</sup> It is our government's responsibility to promote and protect access to this essential element of health care that prevents millions of unintended pregnancies each year and saves billions in health care costs.<sup>17</sup>

Despite the demonstrated demand for and benefit of contraceptive access for women and their families, funding for family planning programs continues to be a topic of heated debate in the United States. In 2012, 20 million women were in need of publicly funded contraceptive services and supplies, but over the last several years, funding cuts, insurance coverage restrictions, and reproductive health center closures have all threatened women's ability to afford contraceptive services.<sup>18</sup> Since 2010, 19 states made drastic cuts to family planning programs resulting in huge decreases in the number of women served. In Congress, representatives have threatened to defund Title X, the nation's family planning funding program, multiple times.<sup>19</sup> Such reductions in coverage hit women living in poverty particularly hard, as they are significantly more likely to face barriers to insurance and health care and are five times more likely to experience unintended pregnancy than women who are at or above 200% of the federal poverty level.<sup>20</sup> Despite an initial promise of contraceptive equity with the passage of the ACA, many women continue to find contraception unaffordable; for more information on the underlying causes and policy debates, see *Fulfilling the Promise of the Affordable Care Act*.

## 365 DAYS OF CONTRACEPTION

One barrier to prescription contraceptive continuation is the practice of requiring a woman to fill her prescription in short intervals, such as monthly or every three months. There is no medical reason a woman must only receive a monthly supply of her contraceptive prescription.<sup>21</sup> In fact, researchers at the University of California, San Francisco confirmed that when low-income women relying on public coverage for contraception received a one-year supply of pills, as opposed to a one- or three-month supply, the pregnancy rate decreased by 30% and the abortion rate by 46%.<sup>22</sup> For women who use oral contraceptives, a year's supply can also defray prescription costs as insurance plans may only require one copayment, rather than twelve copayments made for a monthly supply. Furthermore, providing a 12-month prescription can be more cost-effective to the supplier, who may be able to purchase larger amounts of the drug at a lower unit cost.<sup>23</sup>

Two examples of states that have taken action to broaden access to contraception by allowing for a full year's supply of the birth control pill, patch, or ring are Rhode Island and Washington. In Rhode Island, [Senate Bill 2512](#) was introduced in 2014 to require every health insurance issuer offering a group or individual health insurance plan that covers prescription contraception to reimburse the dispensing of a 365-day supply of covered prescription contraceptives.<sup>24</sup> In Washington, all Medicaid managed care and fee-for-service plans are required to provide up to one year's worth of contraception ([Senate Bill 5034](#)).<sup>25</sup>

## BROADENING WHO CAN PROVIDE CONTRACEPTION

Aiming to make contraception more broadly available and accessible, state legislators can pursue measures within licensing and practice laws to position a broad range of medical professionals to provide contraceptives, including nurses, pharmacists, and naturopathic physicians. Legislators in Washington and California have introduced legislation to authorize registered nurses (RNs) to provide family planning drugs and devices. Under the Timely Access to Birth Control Act ([Assembly Bill 2348](#)), California RNs were authorized to provide hormonal birth control such as the pill, patch, ring, and Depo-Provera injections.<sup>26</sup> While the Nursing Practice Act already allowed RNs to provide drugs or devices by order of a physician or surgeon, the new act broadened the ability to provide by the order of a certified nurse-midwife, nurse practitioner, or physician



assistant within a specified clinic. The Washington bill ([House Bill 1538](#)) goes further, but has not yet been enacted. If passed, it would establish protocols to allow RNs employed at certain facilities to provide a drug or device for purposes of family planning.<sup>27</sup>

The state of California also allows pharmacists to provide prescribed self-administered hormonal contraceptives such as the pill, patch, or ring ([Senate Bill 493](#)).<sup>28</sup> To ensure the patient receives the birth control method best for her needs, she must use a self-screening tool to identify risk factors. If hormonal contraception is determined to be inappropriate for the individual, the pharmacist must refer the patient to her primary care physician or, if she does not have one, to a nearby clinic.

In order to expand access to barrier contraceptives, such as a diaphragm, and to ensure that patients receive excellent care from certified medical professionals, seventeen states and the District of Columbia have passed laws establishing a licensing or registration procedure for naturopathic physicians.<sup>29</sup> Such laws expand the number of medical professionals who have been trained and certified to provide barrier contraception,

so that a woman can have access to contraception, while maintaining a choice of receiving care from the physician that best suits her needs. For example, Colorado passed [House Bill 1111](#) in 2013, to regulate the practice of naturopathic medicine and included within its parameters the ability to furnish barrier contraceptives, excluding IUDs.<sup>30</sup> When states pass such laws, naturopathic services also become more affordable because the Affordable Care Act disallows discrimination with respect to coverage of any health care provider acting within their license under state law.<sup>31</sup>

## PREVENTING SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infection (STI) rates in the United States continue to be a concern, with approximately 110 million people living with at least one STI. The most commonly reported STI is the Human Papillomavirus (HPV), followed by genital herpes (HSV-2).<sup>36</sup> Women account for a slightly higher number of known infections (54%) and young people experience high rates of STIs, comprising nearly half of new infections, with youth of color at a disproportionate risk.<sup>37</sup> The stigma associated with STIs frequently prevents people from

## ADMINISTRATIVE EFFORTS TO IMPROVE CONTRACEPTIVE ACCESS

While many states have cut funding for family planning programs, two states have taken administrative steps to expand access to affordable contraceptive methods. The Illinois Department of Healthcare and Family Services announced in August 2014

that the state Medicaid program would double reimbursements for IUDs and vasectomies and increase reimbursements for non-surgical sterilization kits.<sup>32</sup> Importantly, this policy change includes a mandate for patient education on a broad spectrum of contraceptive options to ensure that patients feel they can choose the method that best suits their needs.<sup>33</sup> The Illinois department took inspiration from another state, citing the Colorado Family Planning Initiative as one of its reasons for increasing funding. This program has seemingly decreased teen

birth rates in Colorado by 40% since 2008 by providing long-acting reversible contraceptives (LARCs) at low or no cost.<sup>34</sup> Through a private donation, the Colorado Department of Public Health and Environment partnered with 68 health clinics to distribute IUDs and contraceptive implants with great success: by 2011, one in 15 low-income young women had received a LARC method – a change from one in 170 in 2008.<sup>35</sup>

discussing such infections with sexual partners and medical professionals, as well as from seeking treatment. Stigma—defined here as “the social devaluation of people who are different” due to reasons like demographic features or health status—can contribute to the spread of STIs.<sup>38</sup>

Lack of information and discussion about STIs and under-treatment of such infections can pose significant health risks, such as infertility and even death.<sup>39</sup> Common STIs such as HPV, chlamydia, and gonorrhea can be very dangerous to women’s reproductive health if left untreated; between 10-20% of women develop pelvic inflammatory disease as a result of untreated chlamydia or gonorrhea, which can lead to adverse reproductive health outcomes such as ectopic pregnancy or tubal factor infertility.<sup>40</sup> HPV is a particular cause for concern because most cases of cervical cancer are associated with two forms of the virus.<sup>41</sup> Due to the asymptomatic nature of some STIs, it is essential that women be tested regularly. The CDC recommends that all sexually active women 25 and younger be tested for chlamydia and gonorrhea, and the HPV vaccination is widely recommended for girls and boys aged 11 and 12, all young people through age 21 who did not get the vaccine as children, and women up to the age of 26.<sup>42</sup> Testing is also necessary due to the stigma surrounding STIs, as sexual partners may be hesitant to share that they are infected, or may need encouragement to tell their partner.

Thirty years since the pandemic of HIV began to spread, it remains a global crisis. As of 2011, 1.1 million people in the United States were living with HIV.<sup>43</sup> While men who have sex with men are the group most affected by HIV, people of color are disproportionately impacted by HIV; although African Americans represented 12% and Latinos represented 16% of the population in 2010, they accounted for 44% and 21% of total new HIV infections, respectively.<sup>44</sup> The same holds true for women of color. Starkly, African American women experience the highest rates (64%) of new infections, which is four times the rate for Latinas and twenty times the rate for white women.<sup>45</sup> It is essential to advocate for increased preventive education, to tackle the social norms that can thwart efforts to reduce the spread of HIV, and to promote condom use and other safe sex practices.<sup>46</sup>

### EXPEDITED PARTNER THERAPY

Expedited partner therapy (EPT) is the practice of providing medication for the sexual partners of individuals that have been diagnosed with a sexually transmitted infection, without requiring those partners to come in for a medical evaluation

of their own.<sup>47</sup> This approach to reducing the spread of sexually transmitted infections has been found to be effective and safe.<sup>48</sup> The CDC recommends EPT for the treatment of gonorrhea and chlamydia in both men and women who have been exposed by a partner and also encourages that symptomatic partners seek medical attention in addition to accepting the expedited medication if possible.<sup>49</sup> EPT is an important public health tool to stop quickly spreading STIs; for example, chlamydia reinfection rates for adolescent and young women can be as high as 26% within a one-year period and EPT can play an important role in reducing that number.<sup>50</sup>

Currently, EPT is legally permissible in 35 states, potentially permissible in nine others, and explicitly restricted in six.<sup>51</sup> In a move applauded by public health and elected officials alike, several states have introduced legislation to allow EPT in the last two years, including Kentucky, New York, and West Virginia.<sup>52</sup> Most of the states in which EPT is permissible allow doctors to prescribe EPT antibiotic prescriptions for chlamydia and gonorrhea, and two states (New Mexico and Wisconsin) and the District of Columbia include treatment for trichomoniasis.<sup>53</sup>

### PROVIDING HIV TESTING FOR INCARCERATED PEOPLE

According to the CDC, one in seven people living with HIV passes through a correctional facility in the United States every year.<sup>54</sup> While the CDC recommends that HIV testing and treatment be available on an opt-out basis to all inmates during medical intake, there are significant challenges to providing care, including stigma, concerns about confidentiality, and insufficient connections to counseling and treatment resources.<sup>55</sup> Although most inmates do not contract HIV during their time in a correctional facility, it is often the first place that many people are diagnosed with the virus.<sup>56</sup> Most states provide testing in prisons and some states have policies in place that establish HIV testing availability and protocols in correctional facilities.<sup>57</sup> There are two million people in the prison and jail system, with people of color, primarily black men and women, comprising a disproportionately high percentage of inmates.<sup>58</sup> In 2008, 1.9% of women in prisons and jails were living with HIV.<sup>59</sup>

The transition out of incarceration has been identified as a key window for HIV education and testing, and states are taking action to expand access to information about avoiding infection once released. For example, [Senate Bill 6488](#) was introduced in New York in 2011 to provide released inmates with information about HIV prevention, free testing resources, and referrals to prevention, education, and counseling

services in the area in which they will be residing after their release.<sup>60</sup> Mississippi introduced a bill in 2011 requiring the Department of Corrections to provide HIV testing upon discharge from the facility.<sup>61</sup> California lawmakers have taken steps for years to address the spread of sexually transmitted diseases, including HIV, among incarcerated populations. In August 2014, the legislature passed the **Prisoner Protections for Family and Community Health Act**, requiring the Department of Corrections and Rehabilitation to develop a five-year plan to expand the availability of condoms in all California prisons; Governor Jerry Brown signed the bill into law the following month.<sup>62</sup>

### PROHIBITING THE USE OF CONDOMS AS EVIDENCE AGAINST SEX WORKERS

The use of condoms as evidence of prostitution is a discriminatory practice and a threat to the health and safety of individuals engaging in sex work. There are numerous stories of police in cities across the country targeting people on the street, particularly transgender individuals, and searching their bags and pockets for condoms as evidence of sex work.<sup>63</sup> Fear of police harassment, arrest, and deportation for undocumented people can deter sex workers from carrying enough condoms—or any condoms at all—to protect themselves adequately.<sup>64</sup>

In New York City, the population of sex workers living with HIV is significantly higher than the rate in the general population, and in 2007 the city unveiled the first municipally branded free condom distribution program.<sup>65</sup> Using those very same condoms as evidence to arrest and prosecute people sends mixed messages about sexual safety and diminishes public health efforts to promote safer sex in the sex worker community. In 2011, **Senate Bill 1379** was introduced in the New York legislature to prohibit the introduction of condoms as evidence in any trial, hearing, or proceeding related to prostitution.<sup>66</sup> While the legislation has not yet been enacted in New York State, in 2014, the New York City Police Department announced a new policy to limit the use of condoms as evidence in cases involving sex trafficking.<sup>67</sup>

## CREATING TASK FORCES AND PUBLIC EDUCATION INITIATIVES TO IMPROVE REPRODUCTIVE HEALTH

HPV is the most commonly reported STI, and its link to cervical cancer makes it especially crucial that awareness of HPV is widespread. Black women and Latinas are diagnosed with cervical cancer at higher rates than women of other races or ethnicities, making cervical cancer education, diagnosis, and treatment vital to issues of reproductive justice.<sup>68</sup> Many states have early detection breast and cervical cancer screening programs, and states can go farther in spreading HPV awareness by creating task forces to study the issue and recommend a plan of action.

Noticing his state's alarmingly high rates of cancer deaths, Kentucky Governor Steve Beshear included HPV issues in his health goals and plans, aiming to increase HPV vaccination rates by 25% and launch an educational campaign about the vaccine.<sup>69</sup> The Governor's directive to address HPV led to the creation of the HPV Initiatives Team led by the state's public health commissioner and including a host of government, university, corporate, and nonprofit partners. Having established goals and a strategic planning vision, the Team continues to meet to tackle the HPV crisis in the state via policy change, education, research, and access to prevention and treatment services.

## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
Advocates for Youth	<a href="http://www.advocatesforyouth.org">www.advocatesforyouth.org</a>
American Congress of Obstetricians and Gynecologists	<a href="http://www.acog.org">www.acog.org</a>
California Family Health Council	<a href="http://www.cfhc.org">www.cfhc.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Illinois Caucus for Adolescent Health	<a href="http://www.icah.org">www.icah.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
Ms. Foundation	<a href="http://www.forwomen.org">www.forwomen.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Coalition of STD Directors	<a href="http://www.ncsddc.org">www.ncsddc.org</a>
National Family Planning & Reproductive Health Association	<a href="http://www.nationalfamilyplanning.org">www.nationalfamilyplanning.org</a>
National Health Law Program	<a href="http://www.healthlaw.org">www.healthlaw.org</a>
National Institute for Reproductive Health	<a href="http://www.nirhealth.org">www.nirhealth.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
New Morning Foundation	<a href="http://www.newmorningfoundation.org">www.newmorningfoundation.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Raising Women's Voices	<a href="http://www.raisingwomensvoices.net">www.raisingwomensvoices.net</a>
Reproductive Health Technologies Project	<a href="http://www.rhtp.org">www.rhtp.org</a>
Sexuality Information and Education Council of the United States	<a href="http://www.siecus.org">www.siecus.org</a>
SisterLove	<a href="http://www.sisterlove.org">www.sisterlove.org</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>

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# EMPOWERING YOUNG PEOPLE TO MAKE INFORMED SEXUAL AND REPRODUCTIVE HEALTH DECISIONS

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Providing young people with the information, resources, and skills to make informed choices and proactive health decisions enables them to develop healthy behaviors and relationships and access complete sexual and reproductive health care. State lawmakers must ensure young people have the tools they need to reduce sexual health risks, prevent unintended pregnancies, understand healthy relationships, and embark on healthy sexual lives in order to shape their futures.



## YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH

Young people must navigate a number of obstacles when making decisions related to sex and contraception. Both American and European adolescents engage in similar amounts of sexual activity, yet young people in the United States are more likely to experience unintended pregnancies and health risks.<sup>1</sup> Data suggests that though most female teens in the United States have received some form of sexual health education, only six in ten are provided with materials that explain the significance of both abstinence and effective contraceptive use.<sup>2</sup> In addition, for most sexually active adolescent girls, no form of formal sexual health education preceded their first sexual intercourse.<sup>3</sup>

Young people in the United States account for approximately half of the new cases of sexually-transmitted infections (STIs) each year, despite representing only one-quarter of the sexually active population.<sup>4</sup> Using condoms properly can lower the risk of transmitting STIs as well as reducing the risks of unintended pregnancy; however, only 68% of females and 80% of males used a condom at the time of first intercourse.<sup>5</sup> Although parental intervention and communication is shown to reduce sex-related risks in adolescents, almost a fourth of girls aged 15–17 years have not spoken with their parents about sex or any methods of birth control.<sup>6</sup> Thirty-five percent of adolescents have concerns about privacy, related to their parents or others, which can prevent them from seeking adequate and necessary medical care.<sup>7</sup>

All states guarantee young people some confidential services, and all clinics that receive Title X funding through the Public Health Service Act have to provide federally guaranteed confidential contraceptive services regardless of age.<sup>8</sup> However, neither young people nor health care providers necessarily know the scope of these rights, and this lack of awareness can prevent adolescents from seeking services.<sup>9</sup> Moreover, though some states may not require adolescents to inform their parents about their contraceptive choices, research indicates that adolescents tend to forgo or postpone sexual health care in order to keep their sexual activity private from their parents.<sup>10</sup> Allowing those insured as dependents to access care confidentially is key to ensuring their access to sexual health services.

Even though teen birth rates in the United States have declined in recent years, about 305,000 infants were born to young people aged 15-19 in 2012.<sup>11</sup> Thirty percent of high school-aged girls who drop out of school cite pregnancy or parenthood as a reason, with nearly four in ten Latina and black girls citing these as reasons for dropping out.<sup>12</sup> The needs of pregnant and parenting teens tend to be overlooked by policymakers and within school systems, which often deem them “at-risk” youth and fail to understand the complexity of their lives as both parents and students.<sup>13</sup> Structural barriers in the system can lead to further stigmatization.<sup>14</sup> Teenage parents are also disadvantaged due to a general



**ALL STATES GUARANTEE YOUNG PEOPLE SOME CONFIDENTIAL SERVICES, AND ALL CLINICS THAT RECEIVE TITLE X FUNDING THROUGH THE PUBLIC HEALTH SERVICE ACT HAVE TO PROVIDE FEDERALLY GUARANTEED CONFIDENTIAL CONTRACEPTIVE SERVICES REGARDLESS OF AGE.<sup>8</sup>**

lack of material resources reserved for their needs, such as financial support and child care.<sup>15</sup>

Young people need both information and access to services, and that includes young people of all gender identities and sexual orientations. Information and services for young people must be culturally competent and responsive to the needs of the community. This is especially crucial considering that young men who have sex with men make up most of the new HIV infections among young people, and young African American men who have sex with men are disproportionately affected.<sup>16</sup>

## COMPREHENSIVE SEXUAL HEALTH EDUCATION

All discussions of young peoples' sexual and reproductive lives must begin with tremendous attention to the role of comprehensive sexual health education. Although curricula can be influenced by funding from the state or federal government, sexual health education is largely controlled at the local, district, or school level in the United States. However, statewide policies outlining basic standards or guidelines can play an important role in ensuring young people have access to the information they need. For example, state standards or guidelines can identify important topics and skill sets that all classes should cover, such as HIV and other STI prevention and putting a stop to dating violence.

A blight of abstinence-only-until-marriage (AOUM) funding in the form of grants that require recipient districts to follow strict rules regarding curricula has resulted in a proliferation of ineffectual sex education programs. For fiscal year 2014, 36 states and three territories applied for and received federal AOUM funding from the federal government.<sup>17</sup> This divide has created a generation of people with inadequate knowledge or skills to manage their sexual and reproductive health. Studies have shown that AOUM programs are ineffectual in that they do not delay the initiation of sexual activity or reduce teen pregnancy rates.<sup>18</sup> Despite the continued funding of AOUM programs, the federal government began supporting the implementation of evidence-based and innovative programs in 2009.<sup>19</sup> This promising shift has enabled states to invest in more comprehensive approaches.

Instead of promoting abstinence to the exclusion of other information, state policies addressing sexual health education should be comprehensive; in addition to providing information about abstinence, they should also ensure that contraceptive methods and HIV/STI prevention are covered in detail. Information taught in schools should also be medically accurate and the practices promoted should be evidence-

informed. While legislation need not dictate evolving medical and scientific information, information students receive should be based on current knowledge accepted by the medical and public health communities. Currently, 13 states require that sexual health education be medically accurate, and 18 states plus the District of Columbia require curricula to cover contraception.<sup>20</sup> Policies should also ensure that sexual health education is culturally sensitive and inclusive, providing for discussion of gender, gender identities, sexual orientation, and body image, as well as information about communication, healthy relationships, and dating violence prevention.

States have adopted a range of approaches to sexual health education in schools. For example:

- **Oregon law mandates** that sexual health education be taught in public schools, and that it be comprehensive, medically accurate, age appropriate, and non-biased.<sup>21</sup> It requires that abstinence be stressed, but not “. . . to the exclusion of other material and instruction on contraceptive and disease reduction measures.”<sup>22</sup>
- **In California**, school districts may elect to provide comprehensive sexual health education, so long as it is medically accurate, objective, and appropriate for students of all genders and sexual orientations, among other requirements. Starting in seventh grade, it must also “provide information about the value of abstinence while also providing medically accurate information on other methods of preventing pregnancy and sexually transmitted diseases.”<sup>23</sup>
- Similarly, Washington's “**Healthy Youth Act**” requires that if a school offers sexual health education, it must be medically and scientifically accurate, age-appropriate, appropriate for students regardless of gender or sexual orientation, and abstinence may not be taught to the exclusion of instruction on contraceptives and disease prevention.<sup>24</sup> Additionally, it requires the school superintendent develop a list of curricula and resources for schools to use.<sup>25</sup>
- California and Louisiana are unique in that their laws specifically prohibit the promotion of religion in sexuality education.<sup>26</sup>
- **Vermont's law** requires instruction on various life skills including healthy relationships and decision-making and family communication.<sup>27</sup>
- **Colorado** does not mandate comprehensive sexual health education, but it does limit the ability of school districts to

use direct or indirect federal funds to teach abstinence-only programs.<sup>28</sup>

Although the need for sexual health education does not end with high school graduation, there is little guidance or precedent for policies related to collegiate sexual health education. Mississippi, which requires school districts to adopt either an “abstinence-only” or an “abstinence-plus” program, recently enacted [Senate Bill 2563](#) requiring university officials to develop a plan of action for informational and awareness programs to address unintended pregnancy.<sup>29</sup> Though this may serve as one example of how states could begin to implement or improve post-secondary sexual health education, it also speaks to the need for more comprehensive, effective programs prior to college.

### MINORS' ACCESS TO CONFIDENTIAL FAMILY PLANNING CARE

In 1977's *Carey v. Population Services International*, the U.S. Supreme Court invalidated a New York statute making it a crime to sell or distribute contraceptives to minors under 16, thus expanding the right to obtain and use contraceptives established in previous cases to minors.<sup>30</sup> Allowing minors to consent to family planning care, including services related to STIs, promotes access to preventive care and STI diagnosis and treatment. Because of the personal nature of family planning care, laws that require parental involvement can prevent minors from seeking this care altogether.<sup>31</sup> In a 2002 study, 60% of young women receiving confidential care at family planning clinics stated they would stop using “some or all sexual health services if the clinic enforced mandatory parental notification for contraceptives.”<sup>32</sup>

The U.S. Supreme Court has affirmed that privacy rights extend to a minor's decision to access contraceptives, but many states have also explicitly legislated this right.<sup>33</sup> Twenty-one states and the District of Columbia have enacted legislation allowing all minors to consent to contraceptive services and another 25 states allow certain classes of minors to do so.<sup>34</sup> For example, Colorado allows minors to consent to any contraceptive methods available, with the exception of permanent sterilization.<sup>35</sup> The statute also specifies that it is consistent with state policy for authorized persons at schools and other public institutions to “[disseminate] medically acceptable contraceptive information.”<sup>36</sup> Additionally, all states and the District of Columbia allow all minors to consent to their own care for STI testing and treatment.<sup>37</sup> However, 18 of these states allow, but do not require, a physician to inform a minor's parents that he or she is seeking or receiving STI services when the doctor deems it in the minor's best

interests.<sup>38</sup> Wisconsin allows minors to consent to family planning services, including STI testing, regardless of age, but requires minors to be 14 or older to consent to HIV testing.<sup>39</sup> In addition, the Wisconsin Medicaid Family Planning Waiver Program allows minors who are at least 15 years old to apply for insurance coverage for family planning services without taking their parents' income into account.<sup>40</sup> Services can be provided immediately due to a presumption of eligibility.<sup>41</sup>

### PREGNANT MINORS' ACCESS TO CONFIDENTIAL HEALTH CARE

Allowing pregnant minors to consent to confidential prenatal and other medical care ensures that they do not delay care to avoid informing their parents of the pregnancy, and consequently risk poor health outcomes.<sup>42</sup> Thirty-two states and the District of Columbia explicitly allow all minors to consent to prenatal care.<sup>43</sup> However, 13 of these states allow, but do not require, a physician to inform a minor's parents that he or she is seeking or receiving STI services when the doctor deems it in the minor's best interests.<sup>44</sup> On the other hand, [Illinois](#) allows pregnant minors to consent to health care generally.<sup>45</sup> Minors, however, may not know that they can consent to these services on their own—a survey of minors in Illinois showed that 27% incorrectly thought a pregnant minor needed parental permission to seek medical care.<sup>46</sup> Statewide requirements that protect not only a pregnant minor's ability to consent to care, but also her confidentiality, are essential to ensuring that young women can access care quickly and safely.<sup>47</sup> Additional information about young peoples' access to confidential health care is provided in *Fulfilling the Promise of the Affordable Care Act*.

### SUPPORT PREGNANT AND PARENTING STUDENTS

Given the increasing importance of formal education to securing a well-paying job, it is more important than ever for teens to finish high school and move on to post-secondary education when possible. Nonetheless, pregnant and parenting teens often receive little or no support from their schools, and in some cases they may even be pushed out of school, often in violation of the law. Just 38% of teen girls who have a child before they turn 18 get a high school diploma by the time they turn 22.<sup>48</sup> Even fewer—less than 2%—go on to get a college degree by age 30.<sup>49</sup> Moreover, these inequities tend to perpetuate; the children of teen mothers are at greater risk for a variety of economic, social, and health challenges.<sup>50</sup> Research indicates that poverty is both a cause and a result of teenage childbearing.<sup>51</sup>

While school policies often vary from district to district, lawmakers can adopt policies to protect all pregnant and parenting students in a state and make it easier for them to finish their education. Such laws can help to ensure that those students and their children are more equipped to succeed. For example, New Mexico recently responded to this need by adopting a **statewide excused absence policy** for pregnant and parenting students.<sup>52</sup> The law guarantees that pregnant students and those parenting children under the age of 13 have an opportunity to make up work that they miss due to pregnancy, delivery, and parental obligations.<sup>53</sup> Parenting students in New Mexico may now miss an additional four school days per semester with the number of days equal to the absence to make up their classwork.<sup>54</sup> **Florida** also exempts pregnant and parenting students from standard absence policies, provided they make up any missed classwork.<sup>55</sup> Furthermore, Florida law mandates that all schools offer “teenage parent programs,” which give pregnant and parenting students the option of participating in regular classroom activities or enrolling in a special program to fit their needs.<sup>56</sup> Moreover, the state requires local districts to provide child care or coordinate with existing programs so parenting students can continue attending class.<sup>57</sup>

Similarly, legislation has been introduced in Illinois as part of the Ensuring Success in School Initiative to make it easier for pregnant and parenting students to stay in school through a variety of supportive policies: **House Bill 2213** would require school districts to recognize absences related to pregnancy or parenting as valid absences that are not to be counted against a student for truancy purposes.<sup>58</sup> Districts would also be required to offer correspondence courses for students unable to attend school because of pregnancy, pregnancy-related conditions, or parental responsibilities, and educators would be prohibited from penalizing students enrolled in such courses for missing regular classes.<sup>59</sup> These policies help ensure schools are meeting their obligations under Title IX—a federal law that prohibits discrimination against students based on pregnancy—by ensuring pregnant students have access to the same education as their peers.<sup>60</sup>



#### CASE STUDY:

## EXPECTANT AND PARENTING YOUNG PEOPLE IN NEW MEXICO

*By Tannia Esparza and Young Women United*

For 15 years, Young Women United (YWU) has led reproductive justice organizing and policy initiatives by and for young women of color in New Mexico. YWU works to build communities where all people have access to the information, education, and resources necessary to make real decisions about their own bodies and lives, including the decision to parent.

In our early years, YWU, alongside other public health and reproductive rights partners, advocated for teen pregnancy prevention models in an effort to bring comprehensive sexuality education into New Mexico schools. A decade ago, we began to reflect on the harm to young parents caused by teen pregnancy prevention models, and started to look closer at the research used to frame young parents in a negative

way.

Over time, YWU has become a leader in a national conversation about the need to shift from teen pregnancy prevention models to strategies in preventing unintended pregnancies for all people. Central to YWU's efforts is a move away from prevention models that place the onus of negative social, economic, and health outcomes on young families instead of addressing root causes of disparities.

According to national data over many years, New Mexico has some of the highest adolescent birth rates in the country; it follows that New Mexico has high numbers of parents who had their first children in their teenage years.<sup>61</sup> As a young mama shared with YWU, “we aren't just teens having babies; we are young parents who are raising families.” As YWU argued in *The Albuquerque Journal*, the age one becomes a parent is too often and erroneously said to be the cause of negative outcomes in young families, and young parents are blamed for being a burden to our shared economies because of a supposed reliance on government-funded health care, child welfare, and the higher incarceration rates of children of teen moms.<sup>62</sup> Yet the studies that have fueled these myths have not accurately accounted for social determinants of health and have failed to consider data that shows that the age one becomes a parent will not shift their economic trajectory.<sup>63</sup> What this means is that whether someone has their first child as a teenager, in their 20's or even 40's, their financial stability and economic standing is not likely to change for better or worse.<sup>64</sup>

We are honored to share some of YWU's path to culture shift and policy wins in New Mexico through building education equity for young parents. This case study reflects our commitment to centering the expertise of those most impacted by an issue, and provides a model that others in reproductive rights and justice movements can cultivate and grow.

In the fall of 2011, YWU partnered with the ACLU of New Mexico to conduct focus groups with young mothers in different parts of New Mexico. Our focus groups were designed to learn more about their experiences accessing education as expectant or parenting young people. The ACLU, in New Mexico and nationally, was invested in ensuring the protections Title IX offered to pregnant people in public education were being upheld. YWU had begun to push back on the misleading portrayals of young parents that are core

to many teenage pregnancy prevention models. Collectively, YWU and the ACLU of NM were committed to leveraging our organizational strengths to learn about the experiences of young parents in our New Mexico schools and began building efforts to improve educational outcomes for their families.

During the focus groups, young parents shared insight about some of the barriers they faced in schools, as well as stories about how fellow students, teachers, and administrators

**In New Mexico and across the country, young parents are working every day to build healthy families, and young parents are thriving in spite of the shame and stigma they face.”**

made them feel unwelcome. In Albuquerque, students spoke about a teacher who yelled at pregnant students, promising that their children would be “screwed up because of their mistake.”<sup>65</sup> Many young parents spoke about how their teachers refused to allow them to make up assignments they missed due to childbirth or taking care of their children. One young mom missed a school day for labor and delivery and was then required to return and take her final exams the following day.<sup>66</sup> The focus groups also highlighted district policies and procedures that created obstacles for expectant and parenting students in completing their education and too often have forced these students out of school.<sup>67</sup>

As YWU noted in an opinion piece, “What's Wrong with Blaming Teen Parents,” much of the teen pregnancy prevention argument is built by reporting annual costs said to be associated with mothers having their first child at age 17 or younger.<sup>68</sup> A research brief, “The Public Costs of Teen Childbearing” measured “the reduced earning capacity of teen mothers and their partners due to lower levels of educational attainment—all of which translate into lost tax revenue.”<sup>69</sup> These numbers are often used to paint young parents as a drain on our economy. YWU called to shift this discourse and take action to address the overwhelming educational push-out young parents are facing. For YWU, it wasn't fair to blame young parents for making less money and paying less in taxes over their lifetime when social determinants of health, beyond

the age they became a parent, were at play, and when our school systems have the obligation of educating all young people, regardless of their parenting status.

As a way to step into culture shift work by and for young parents, and to carry energy from focus groups forward, YWU met with young parent leaders to co-author [2012 Senate Memorial 25](#) that established August 25<sup>th</sup> as the New Mexico Day in Recognition of Young Parents.<sup>70</sup> YWU was proud to host the first Young Parents Day of Action alongside young parent leaders and allies who testified in committee hearings, connected with our state legislators, and held honest conversations about the real barriers young parents were facing in school. Senate Memorial 25 was passed in 2012 with bipartisan support, and since then, YWU has partnered to host eight Young Parents Day celebrations in five New Mexico communities. The passage of the Memorial marked an important moment in this work as it provided an opportunity to test the political climate around issues pertaining to young parents and also contextualized the root causes of negative outcomes inaccurately put on young parents. As explained in the Memorial, “positive change in the lives of all young people is rooted in equal access to educational opportunities, living wage jobs, affordable health care, and safe housing.”<sup>71</sup>

To capture the exciting momentum for change-making opportunities, YWU and the ACLU of New Mexico created a statewide Young Parents Working Group to positively impact the access pregnant and parenting students have to public schools. This group included young parents, educators and educational administrators, community organizing projects, public health professionals, and advocates for civil and women’s rights. New Mexico GRADS was a particularly important partner, as a state-based in-school graduation support program for expectant and parenting students serving over 800 young parents annually.<sup>72</sup> The Working Group ultimately released a report called “Investing in the Future: Reforming Absence and Leave Policy for Pregnant and Parenting Students in New Mexico,” which called for specific policy changes to be made.<sup>73</sup>

In the 2013 legislative session, YWU and some Working Group partners worked with state legislators to introduce [HB 300](#), legislation requiring school districts and charter schools to establish an excused absence policy for expectant and parenting students in middle and high school.<sup>74</sup> The legislation recognized that pregnant and parenting students need

flexibility to balance their educational goals and their parenting responsibilities, such as being able to attend prenatal doctor’s appointments or stay home when their children are sick.<sup>75</sup> The HB 300 legislation provides 10 days of excused absences for the documented birth of a child and four excused absences per semester for expectant and parenting students when pregnancy or caring for a child necessitates missing class.<sup>76</sup> This legislation was gender neutral and applies to all young parents; the legislation standardized the minimum excused absences a school must provide, though schools can provide additional supports.<sup>77</sup> This bill was passed by a Democratic-led legislature and signed into law by New Mexico’s Republican Governor Susana Martinez, making New Mexico the first state to pass an excused absence policy for expectant and parenting young people.

YWU works year-round to build trust and cultivate relationships with our elected officials to ensure the voices and expertise of those most impacted by an issue are heard and considered in decision-making spaces. We know that in all of our work, relationship building with state legislators across party affiliations is key to our success. In this case, YWU and partners created a bi-partisan strategy that focused on the issues, not ideology, with an end to address what’s really on the line for our communities and families.

The excused absence law is now being implemented in New Mexico, and YWU and others are in conversation with groups in other states that are looking to pass similar legislation. In addition, YWU and our partner Strong Families New Mexico supported Senator Tom Udall (D-NM) by providing New Mexico-specific expertise towards his introduction in Congress of the Pregnant and Parenting Student Access to Education Act of 2013.<sup>78</sup>

In New Mexico and across the country, young parents are working every day to build healthy families, and young parents are thriving in spite of the shame and stigma they face. The reality is many young parents are raising wonderful, healthy, and happy children. This framework and understanding is something we have built into our work at YWU. Our movements for reproductive health and rights have an opportunity to become more effective in addressing real needs in our communities. The expertise of young parents has been indispensable to the shift in our New Mexico work and continues to inform our vision for reproductive justice across the country.

## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
Advocates for Youth	<a href="http://www.advocatesforyouth.org">www.advocatesforyouth.org</a>
Answer	<a href="http://answer.rutgers.edu/">http://answer.rutgers.edu/</a>
California Family Health Council	<a href="http://www.cfhc.org">www.cfhc.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center on Reproductive Rights and Justice	<a href="http://www.law.berkeley.edu/reprojustice.htm">www.law.berkeley.edu/reprojustice.htm</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Forward Together	<a href="http://www.forwardtogether.org">www.forwardtogether.org</a>
Futures Without Violence	<a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Healthy Teen Network	<a href="http://www.healthyteennetwork.org">www.healthyteennetwork.org</a>
Illinois Caucus for Adolescent Health	<a href="http://www.icaah.org">www.icaah.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
Ms. Foundation	<a href="http://forwomen.org">forwomen.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Coalition of STD Directors	<a href="http://www.ncsddc.org">www.ncsddc.org</a>
National Family Planning & Reproductive Health Association	<a href="http://www.nationalfamilyplanning.org">www.nationalfamilyplanning.org</a>
National Institute for Reproductive Health	<a href="http://www.nirhealth.org">www.nirhealth.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
New Morning Foundation	<a href="http://www.newmorningfoundation.org">www.newmorningfoundation.org</a>
New Voices Pittsburgh	<a href="http://www.newvoicespittsburgh.org">www.newvoicespittsburgh.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Sexuality Information and Education Council of the United States	<a href="http://www.siecus.org">www.siecus.org</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
Third Wave Fund	<a href="http://www.thirdwavefund.org">www.thirdwavefund.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>
Young Women United	<a href="http://www.youngwomenunited.org">www.youngwomenunited.org</a>

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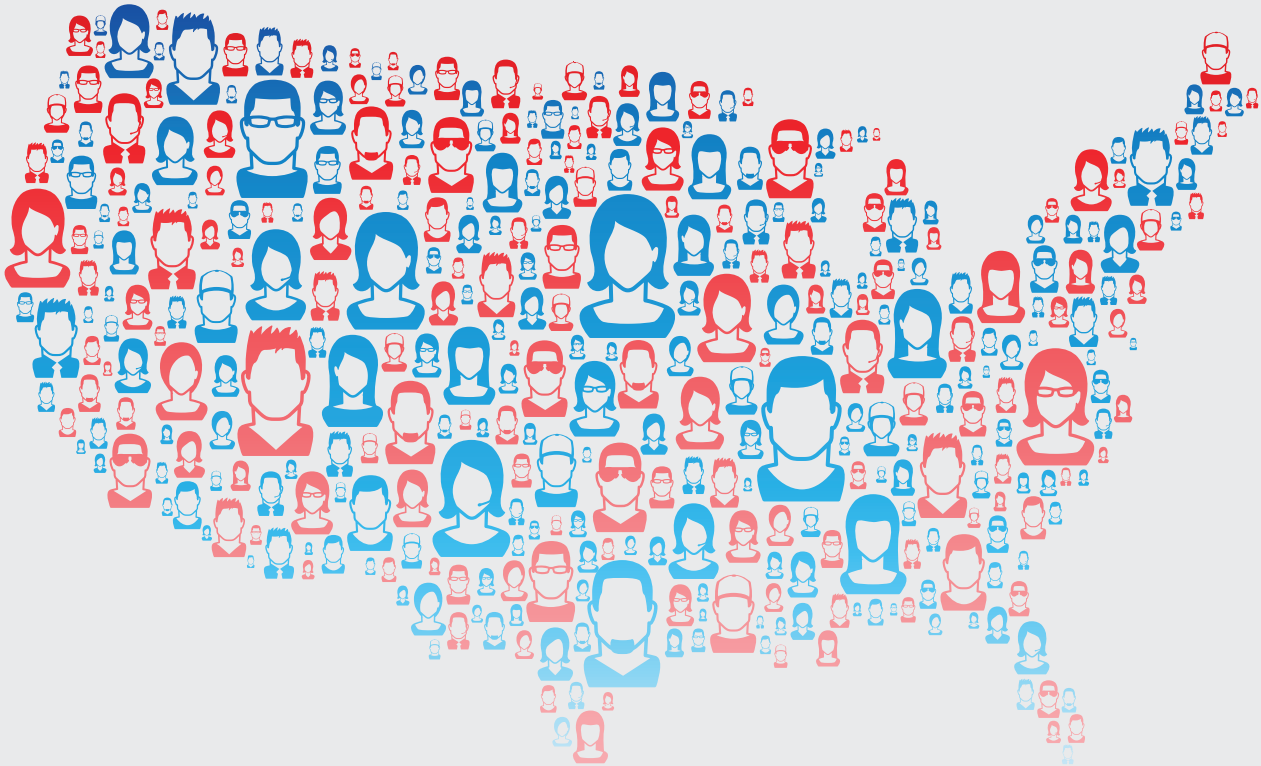


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# ADVANCING THE HEALTH AND RIGHTS OF PREGNANT WOMEN

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More than six million women will become pregnant every year in the United States.<sup>1</sup> Access to quality health care and resources before, during, and after pregnancy are crucial to ensuring healthy outcomes for women, children, and families.

A woman's ability to maintain a healthy pregnancy is heavily influenced by the social and physical environments in which she lives and works; environmental factors, the increasing rates of incarcerated women, and gender violence all impact a pregnant woman's health and rights. While preventive care and prenatal care are known to improve maternal and infant health, striking disparities in access to services and health outcomes exist among women of reproductive age. State lawmakers can and should take steps to ensure pregnant women can get the health care they need and maintain their rights.

### ADDRESSING THE MATERNAL MORTALITY CRISIS

Despite high health care expenditures in the United States, the maternity care system is underperforming compared to many other developed countries—especially regarding maternal mortality rates.<sup>2</sup> Low socioeconomic status, lack of health insurance, inaccessible health care, immigration status, and exposure to discrimination can all have a significant impact on a person's pregnancy experience and outcomes. Poor maternal health outcomes are often preventable, and it is crucial that federal and state policymakers recognize the importance of services that promote healthy pregnancies and postpartum health as well as address the structural and social inequalities that impact a pregnant woman or baby's health.

Maternal mortality in this country is perhaps the most striking and troubling indicator of the state of women's pregnancy health. In fact, with maternal mortality rates having more than doubled in the United States between 1990 and 2013—despite declining rates in the overwhelming majority of countries in that same time<sup>3</sup>—it is a growing human rights crisis. The CDC estimates that at least half of maternal deaths in the United States are preventable,<sup>4</sup> and there are stark disparities when it comes to the populations most affected; African American women are four times more likely to die from pregnancy related complications than white women.<sup>5</sup> This outrageous fact points to serious structural barriers—including discrimination and poverty—in health care access and treatment throughout pregnancy and childbirth, as well as higher rates of pre-existing health conditions, for African American women.<sup>6</sup> Factors such as less prenatal care; higher rates of pre-existing conditions; greater likelihood to develop certain pregnancy complications; and skepticism regarding the health care industry are all speculated to contribute to this crisis—but in truth, the lack of adequate reporting on maternal death rates in the United States means there is no clear singularly identifiable root cause.<sup>7</sup>

While the federal government has not yet sufficiently addressed the issue of maternal mortality and federal funding to support state efforts is minimal, at least 21 states have established or reactivated maternal mortality review committees.<sup>8</sup> Maternal mortality review committees are groups, often comprised of physicians and state epidemiologists, organized to examine the medical and non-medical circumstances of women's deaths that occur during pregnancy or up to one year after pregnancy. Review committees make important contributions to public health by improving the identification of pregnancy-related deaths; identifying gaps in services and systems that should be improved to prevent future deaths as well as strengths in the system of care that should be supported or expanded; and disseminating best practice recommendations to clinicians, facilities, and the community. The work of these entities is confidential and nonjudgmental, protecting the privacy of women who have died and their families. Review committees have evolved from groups of physicians reviewing only clinical aspects of maternal deaths to multidisciplinary teams that review medical and non-medical considerations such as environment, social, and economic factors. Some review committees have expanded their focus to include severe maternal morbidities, which may reveal significant opportunities for prevention.

State lawmakers can take a positive step to address maternal mortality in their state by creating and funding confidential, peer-reviewed maternal mortality review committees; requiring mandatory and confidential case reporting of pregnancy-related deaths to the state health department; and making sure their state is using the recommended U.S. Standard Death Certificate, which includes a set of questions that help identify a deceased woman's pregnancy status at the time of death, within 42 days of death, or within 43-365 days of death, including a pregnancy check-box. Not all states are using the recommended certificate, yet states that ask about pregnancy on the death certificate see significant increases in reported maternal deaths—vital information in assessing and addressing maternal mortality.<sup>9</sup>

In 2013, Texas enacted [Senate Bill 495](#), a comprehensive law establishing a maternal mortality and morbidity task force administered by the Texas Department of State Health Services.<sup>10</sup> The law specifically names a range of medical, non-medical, and administrative professionals required to participate in the 15-member task force. It also requires that task force members represent diverse populations in the state, represent communities most affected by maternal mortality and severe morbidity, and reflect the racial and

linguistic diversity of the state. The Texas law provides for quarterly task force meetings and a biannual report to the Governor and the legislature.

## PREVENTING OR ADDRESSING REPRODUCTIVE HEALTH RISKS FROM ENVIRONMENTAL TOXINS

Personal care products and everyday household products can contain a host of chemicals that may impact a person's reproductive health care and safety. Infertility, miscarriage, and reproductive tract cancers are just some of the negative health outcomes linked to exposure to certain chemicals.<sup>11</sup> Pregnant women in particular who come into contact with certain chemicals may face an increased risk of miscarriages, and birth defects.<sup>12</sup> State leaders have taken action to regulate certain chemicals proven to have negative impacts on health and have called for more research and public education on this issue. For example, the use of ineffective flame retardant chemicals in products like upholstered furniture or children's products has been addressed by bills advanced in several states, including California, Maryland, New York, and Washington.<sup>13</sup> Such flame retardants include a chemical that may lower sperm count in men and negatively affect fetal development in pregnant women.<sup>14</sup> States have also taken action to promote the use of greener cleaning products in schools, ban the use of Bisphenol-A in reusable food and drink containers, and require that information about toxic chemicals be given to pregnant women during prenatal screenings.<sup>15</sup>

In West Virginia, a devastating chemical spill on January 9, 2014, created a water safety crisis in the state that demanded action from policymakers. Thousands of gallons of a coal-washing chemical spilled into the Elk River from an above-ground storage tank, putting residents at risk from drinking the water or even using it for bathing and other household uses. Pregnant women in particular were impacted, and were advised by the CDC to refrain from using the water even after the ban was lifted on other residents. The CDC lifted that advisory three weeks later, but the message was clear: the safety of pregnant women from environmental hazards needs particular attention.<sup>16</sup> In response to the crisis, the state legislature passed **Senate Bill 373** in order to regulate all above-ground water storage tanks of a certain size.<sup>17</sup>

State policies addressing chemical safety and other environmental issues can help shed light on the fact that African Americans and Latinos disproportionately reside in areas considered "chemical facility vulnerability zones," areas surrounding factories that house dangerous chemicals.<sup>18</sup> Residents in these areas also tend to have lower incomes,

property values, and high school graduation rates than the national average.<sup>19</sup> Truly addressing chemical safety requires an approach that considers the myriad of factors that play into these disparities.

## ACCOUNTING FOR THE HEALTH NEEDS OF PREGNANT WOMEN FACING ADDICTION

Women who are pregnant and experiencing addiction have particular health care needs that demand attention. The 2010 National Survey on Drug Use and Health found that 4.4% of pregnant women aged 15-44 reported using illicit drugs, and substance abuse and addiction rates are similar across demographic and socioeconomic groups.<sup>20</sup> For women who struggle with drug use or addiction, pregnancy does not represent an automatic fix from the relapsing nature of addiction.<sup>21</sup> While maternal use of legal substances such as drugs, alcohol, and tobacco do present risks to fetal and newborn health, including cognitive impairments and death, the popular discourse on drugs has sensationalized and exaggerated the long-term medical impacts and minimized the important role of socioeconomic and environmental factors such as poverty on adverse birth and child health outcomes.<sup>22</sup> Preconception and prenatal care visits are an important time to address substance abuse and reduce health risks associated with drug use during pregnancy, but many states have punitive systems in place that deter women from seeking prenatal care for fear of their drug use being discovered and used against them.<sup>23</sup>

An increasing number of states have passed laws that stigmatize—and even criminalize—women who use substances while pregnant. For example, a number of states treat pregnancy and drug use as child abuse, and some states allow for civil commitment for treatment or even termination of parental rights. In 2014, Tennessee **enacted a law**—the first of its kind in the nation—which specifically authorizes the prosecution of pregnant women for drug use, treating their substance addiction as a crime of assault or even homicide.<sup>24</sup>

While proponents of these punitive measures claim that the laws incentivize women to stop using once pregnant, such laws actually prevent women from seeking drug treatment and interfere with women's ability to access prenatal care. In fact, every major medical association in the United States has taken a stand against the criminalization of mothers for substance use.<sup>25</sup> Rather than punishing women who are experiencing addiction, state lawmakers can address the underlying issue by increasing access to appropriate drug treatment for pregnant women. For example, during the 2008 legislative session, Utah passed **House Bill 316**,<sup>26</sup> an important first step which requires substance

abuse treatment programs that receive public funding to ensure priority access to pregnant women.

Research shows that women of color are reported and arrested for crimes related to illegal drug use during pregnancy at vastly higher rates than white women, despite similar or higher rates of drug use during pregnancy by white women.<sup>27</sup> Ensuring equitable access to treatment for pregnant women—rather than criminalizing them—is the best way to address the health needs of pregnant women facing addiction and to improve the health outcomes of their children.

### PROMOTING TRAINING AND PROTOCOLS FOR HEALTH CARE PROVIDERS IN RESPONSE TO GENDER VIOLENCE

The health care system can be a crucial space for interventions that address interpersonal violence (IPV) in women's lives. In the United States, more than one in three women has experienced rape, physical violence, or stalking by an intimate partner in their lifetime.<sup>28</sup> Furthermore, an estimated 324,000 pregnant women experience IPV each year and research suggests that the severity of existing violence may escalate during pregnancy.<sup>29</sup> IPV is considered to be one of the leading causes of maternal mortality in the United States, and while federal efforts to build a more robust screening protocol in the health care setting are encouraging, there is plenty of opportunity at the state level to improve services and provide women with necessary resources and support.<sup>30</sup>

Screening during health care visits allows providers to identify and address any past, current, or future health concerns related to IPV, as well as provide counseling on strategies to escape violent relationships.<sup>31</sup> Pregnancy is a unique window of opportunity for health care providers to reach women experiencing IPV, the American College of Obstetricians and Gynecologists recommend screening for IPV prenatally, once per trimester, and again at postpartum visits.<sup>32</sup> The ACA's preventive coverage mandate recognizes the urgent need to address IPV incidence and includes the Institute of Medicine's recommendation that all women and adolescent girls be screened when they present for care.<sup>33</sup>

Four states—California, New York, Pennsylvania, and Virginia—have implemented laws that mandate clinical screening for IPV. California and Pennsylvania adopted evidence-based protocols and procedures for IPV screening, while New York requires screenings for individuals and partners of individuals being diagnosed with HIV-positive results, and Virginia requires screening for pregnant women and new mothers specifically.<sup>34</sup>

In addition to screening laws, there are a limited number of state laws that require protocols for the standard of care and information provided to victims of IPV. As of 2010, 17 states had laws requiring that health care providers be trained on issues of domestic and intimate partner violence. The Pennsylvania Agenda for Women's Health (introduced in 2013) includes provisions protecting emergency reports by or on behalf of a victim of crime as well as protection against 'revenge by invasion of privacy' (also known as revenge porn).<sup>35</sup> With an alarmingly high number of people affected by IPV, there is a great need for improvement in identification and intervention; a 2010 review of protocol, training, and screening policies for IPV found that only three states (California, New York, and Pennsylvania) had policies in all three areas, and 30 states did not have any policy in place.<sup>36</sup>

### PROVIDING ACCESS TO DOULAS

States have a role to play ensuring that women are informed about their pregnancy care options—the benefits, risks, limitations, and advantages of their care location, care practices, and provider—and have access to all members of the maternity care team they desire, such as midwives and doulas. A doula provides physical, emotional, and informational support and assists pregnant women in expressing their wishes regarding their health care. Improving access to doulas for pregnant women who might otherwise lack outside birthing support can help address disparities in birth outcomes. Recent reviews of existing research found that both midwives and doulas improve pregnancy outcomes, including higher rates of vaginal births and shorter labor times.<sup>37</sup> Women who receive continuous support from a doula during labor are also less likely to have cesarean procedures.<sup>38</sup> In 2013, the Minnesota legislature introduced [Senate Bill 699](#), which would require the state's Medicaid program to cover services provided by a certified doula.<sup>39</sup> Providing for greater access to doulas can have both public health and state fiscal benefits.<sup>40</sup>

### RESPECTING WOMEN'S ADVANCED MEDICAL DIRECTIVES

Despite state and federal laws that guarantee adults the right to an advanced directive regarding the end-of-life care they want, 26 states have discriminatory laws that require hospitals to keep deceased or permanently comatose pregnant women on life support, with no regard for their advanced directives or the wishes of their health care proxy.<sup>41</sup> Five states have enacted measures that empower women to determine the course of their medical treatment by promoting the inclusion

of their wishes regarding pregnancy in advanced directives and guaranteeing that their instructions will be respected.<sup>42</sup> Most of these laws include sample language to be used in advanced directive paperwork to prompt women to describe the care they would like to receive while pregnant.<sup>43</sup> Such laws serve a complementary purpose: many women are unaware that once they are pregnant, their wishes can be ignored, and thus these laws serve as a way to alert a woman that once pregnant, she must take action to ensure that her wishes are respected.



### SUPPORTING THE REPRODUCTIVE HEALTH CARE NEEDS AND RIGHTS OF INCARCERATED WOMEN

As the overall incarceration rate has increased in the United States over the last 30 years, so too has the number of inmates who are mothers. Since 1980, there has been a 646% increase in the number of women residing in state and federal prisons, 60% of whom report having an average of two children. Meanwhile, 4% of women in state prisons report being pregnant at point of intake.<sup>44</sup> Nearly one in 50 children in the United States has at least one parent in prison and over half of those prisoners are incarcerated for nonviolent offenses. Moreover, due to mandatory minimum sentencing and the failure to provide alternatives to incarceration, 63% of women are incarcerated for nonviolent crimes— often minor drug offenses.<sup>45</sup> These women may face mistreatment and abuse, including shackling while pregnant and during delivery, as well as premature or inappropriate termination of parenting rights. Additionally, failure to address disparities caused by institutional racism and economic inequalities has led to an incarcerated parenting population that is disproportionately made up of women of color. In fact, black females are incarcerated at two to three times the rate of white females, and Latinas are one to three times more likely to be imprisoned.<sup>46</sup>

While policymakers can debate the public safety benefits of imprisoning a growing number of nonviolent offenders, it is clear that the incarceration of a sizeable number of nonviolent parents will have negative effects on their families and the state. Outcomes of increased incarceration include weak mother-child attachment, fragmented families, intensified economic and emotional stress on single-parent breadwinners, negative public health outcomes, and financial constraints on state-funded child protection and welfare programs.<sup>47</sup>

The United States is one of the few countries in the world that continues to use restraints on pregnant incarcerated women during transport, labor, delivery, and recovery.

In 2008, the Federal Bureau of Prisons outlawed the use of restraints on pregnant women in federal prisons in nearly all circumstances, and now the impetus is on state systems to ensure incarcerated women's human rights are protected.<sup>48</sup> In 2011, Rhode Island passed one of the strongest anti-shackling bills to date, the Healthy Pregnancies for Incarcerated Women Act. This law prohibits shackling prisoners in the second or third trimester of pregnancy, finding that restraints can interfere with medical care through all stages of pregnancy and delivery.<sup>49</sup> As of June 2014, 21 states had passed legislation prohibiting the use of shackles during at least some part of childbirth and four states plus the District of Columbia are considering new or stronger laws.<sup>50</sup> Continued policy strengthening is possible by prohibiting shackles beyond labor and delivery to all stages of pregnancy, including transportation and recovery.<sup>51</sup> For example, states such as California and Illinois, which initially led the charge to prohibit the shackling of pregnant women, have recently passed improved versions of earlier laws.<sup>52</sup> Other innovations are also possible; in New York, legislation has been introduced to encourage healthy pregnancies by restricting the placement of pregnant prisoners in solitary confinement.<sup>53</sup>

In Minnesota, a 2014 law created a host of improvements for incarcerated women's reproductive health care, such as: restricting the use of restraints for pregnant incarcerated women; requiring correctional facilities to offer pregnancy and STD tests to inmates; requiring facilities to provide materials related to prenatal care, childbirth, and parenting; allowing access to mental health care for incarcerated women during pregnancy and the postpartum period; and allowing pregnant incarcerated women access to a certified doula provided there is no extra cost to the state. The law also allows for the potential of more improvements to be determined by a committee in the future.<sup>54</sup>

Nursery programs and community-based residential programs are essential to child development and strengthened families. Most children born to incarcerated mothers are immediately removed to receive care from relatives or in foster care, but prison nursery and community-based residential programs allow a mother to establish and maintain a bond with her infant.<sup>55</sup> At least eight states run prison nursery programs and several others participate in community alternative residences.<sup>56</sup> For example, New York coordinates the oldest prison nursery in the country, which also accommodates infants born prior to incarceration.<sup>57</sup> Alternatively, Maryland law authorizes post-delivery leave or parole for inmates to bond with their infants by participating in residential or non-residential programs.<sup>58</sup> Research indicates that women who complete such programs are taught to mobilize their

support networks following release and have a low likelihood of recidivism.<sup>59</sup> In fact, the Ohio Department of Rehabilitation and Correction reported an 18.6% decrease in recidivism after establishing a prison nursery program.<sup>60</sup> Studies indicate a reduction in taxpayer spending due to decreased recidivism; for example, Nebraska residents save \$39,472 per year for every woman who does not return to prison.<sup>61</sup>

A parent's incarceration alone should not be grounds for restrictions on access to children or the termination of parental rights—especially for the large number of parents incarcerated for nonviolent crimes. However, the federal 1997 Adoption and Safe Families Act instituted a rule that parental rights can be stripped if a guardian fails to parent for 15 months out of a 20-month period while their child is in foster care.<sup>62</sup> Often, women's prisons are located in rural areas, potentially far away from the women's homes, which makes it difficult for their children's caregivers to facilitate family visits and puts these inmates at a high risk of losing parental rights.<sup>63</sup> However, states are pushing back by eliminating incarceration as a reason for termination of parental rights; Colorado law provides an exception to the grounds for termination when the duration of a child's stay in foster care is due to circumstances beyond the control of the parent (e.g. incarceration), and six additional states provide that a parent's incarceration alone is not grounds for termination.<sup>64</sup> Prison nursery programs also support a mother's ability to maintain custody by continuing to parent.



#### CASE STUDY

## PENNSYLVANIA'S ANTI-SHACKLING EFFORTS: FROM POLICY CHANGE TO IMPLEMENTATION

In 2010, as the result of extensive collaboration among advocates and legislators, Pennsylvania became the tenth state to pass a law banning shackling of incarcerated pregnant women.

The Working Group to Enhance Services for Incarcerated Women, a Philadelphia-based coalition led by the Pennsylvania Prison Society, established an Anti-Shackling Committee that worked with state legislators to create and advance a bill to limit the shackling of pregnant women during incarceration in Pennsylvania.<sup>65</sup> The effort was led by Community Legal Services and several reproductive health, rights, and justice groups participated in the Working Group, including the American Civil Liberties Union of Pennsylvania (ACLU of PA), Women's Law Project, New Voices Pittsburgh, Maternity Care Coalition, and others. Having received model bill language from national organizations, advocates revised the language to make it relevant for their state.

The lobbying and grassroots advocacy began in earnest, framing advocacy efforts around ensuring the health of mothers and children. At this time, lead sponsor State Senator Daylin Leach embarked on efforts to pass this legislation. For example, Sen. Leach reached out to potential opponents of the bill, including the Pennsylvania Department of Corrections and the Pennsylvania Warden's Association, in order to explain the purpose and need for the legislation. His work ultimately resulted in these organizations taking a neutral position on the bill. Meanwhile, to increase public interest and support for the legislation throughout the state, advocates engaged in a grassroots letter-writing campaign to accompany media stories of women being shackled during pregnancy or childbirth.

Reflecting back on the legislation's success, several of the coalition members cited the important role of the media and felt it was one of the major reasons so many legislators voted for the bill. Multiple editorials in support of the anti-shackling legislation were written in newspapers across the state. One such story came from Tina Torres, who was pregnant when she was placed in a Philadelphia Correctional Facility awaiting trial. In October 2008, she went into labor and for 17 hours was handcuffed to her gurney with her legs shackled together; she still has scars from where her shackles cut into her ankles.<sup>66</sup> Torres said, "It was horrible, demeaning, and something I will never forget. . . . Even animals in captivity don't have to give birth in chains. I felt even less than an animal."<sup>67</sup> The charges that placed Torres in prison were ultimately dropped, and Torres became a vocal advocate for the anti-shackling bill in multiple venues including on the BBC News and in local newspapers.<sup>68</sup> Such media coverage raised attention to the problem and encouraged legislators to respond.

After the bill was passed, advocates continued to remain involved in order to monitor the implementation of the bill. Many felt the legislation contained insufficient compliance requirements and that there was a lack of education about the new policy for those required to implement it. As a result, the ACLU of PA published in 2014 the results of a two-year investigation showing that many jails and prisons had continued to illegally shackle pregnant prisoners across the state.<sup>72</sup> Additionally, the ACLU of PA wrote a letter to State Attorney General Kathleen Kane, calling on her to take

steps to eliminate the use of illegal restraints on pregnant inmates in violation of the law.<sup>73</sup> "The passage of the Healthy Birth Act was a tremendous victory for incarcerated women, but unfortunately, the practice in real life does not always reflect the law," said Reggie Shuford, executive director of the ACLU of PA. "Four years after the passage of the act, education about the law and its proper implementation remain challenges."<sup>74</sup>

Additionally, New Voices Pittsburgh worked in their local area to monitor the implementation process and improve the reproductive health and rights of incarcerated women. As La'Tasha D. Mayes, executive director of New Voices Pittsburgh pointed out, "Winning the legislation is the first step, implementation is most important."<sup>75</sup> As a part of this work, New Voices Pittsburgh worked with the National Institute for Reproductive Health to hold a Policymaker Leadership Institute in October 2010, focused on protecting the rights of incarcerated women to reproductive health care within the local Allegheny County Jail. New Voices Pittsburgh, along with the Women's Law Project, are in talks with legislators and advocates about proposing stronger legislation as part of the Pennsylvania Agenda for Women's Health that will improve the anti-shackling policy within the state.

Problems with implementation of proactive policies exist across the country. It is important to ensure that advocates work not just to pass proactive legislation, but also to ensure that it is enforced and implemented to the greatest degree possible.



## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

A Better Balance	<a href="http://www.abetterbalance.org">www.abetterbalance.org</a>
American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
American Congress of Obstetricians and Gynecologists	<a href="http://www.acog.org">www.acog.org</a>
Backline	<a href="http://www.yourbackline.org">www.yourbackline.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center for Reproductive Rights	<a href="http://www.reprorights.org">www.reprorights.org</a>
Choices in Childbirth	<a href="http://www.choicesinchildbirth.org">www.choicesinchildbirth.org</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Advocates for Pregnant Women	<a href="http://www.advocatesforpregnantwomen.org">www.advocatesforpregnantwomen.org</a>
National Asian Pacific American Women's Forum	<a href="http://www.napawf.org">www.napawf.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Health Law Program	<a href="http://www.healthlaw.org">www.healthlaw.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
New Voices Pittsburgh	<a href="http://www.newvoicespittsburgh.org">www.newvoicespittsburgh.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Reproductive Health Technologies Project	<a href="http://www.rhtp.org">www.rhtp.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>
Women's Voices for the Earth	<a href="http://www.womensvoices.org">www.womensvoices.org</a>
Women with a Vision	<a href="http://www.wwav-no.org">www.wwav-no.org</a>
Young Women United	<a href="http://www.youngwomenunited.org">www.youngwomenunited.org</a>

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**Real**

**Solutions**

# ENSURING MEANINGFUL ACCESS TO ABORTION



Despite the fact that abortion care is an incredibly safe<sup>1</sup> and common procedure—one in three women in her lifetime will have an abortion<sup>2</sup>—politicians continue to single out the health care providers who perform this service and the patients who need it by imposing barrier after barrier on abortion care. State lawmakers must address the major challenges that reproductive health care providers and their patients face as a result of the relentlessly hostile environment that has dictated women’s health policy in recent years.

In 1973, the U.S. Supreme Court held in the pivotal decision *Roe v. Wade* that a woman has a constitutional right to decide whether to have an abortion prior to viability.<sup>3</sup> That core tenet of *Roe* was affirmed in 1992 in *Planned Parenthood v. Casey*.<sup>4</sup> In that case, however, the Court announced a new legal standard by which to assess the constitutionality of state abortion restrictions. Under that standard—the “undue burden” standard—states may not enact abortion restrictions if their “purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion.”<sup>5</sup>

The *Casey* decision upheld a Pennsylvania law that imposed several types of abortion restrictions, including state-mandated waiting periods<sup>6</sup> and requiring the provision of specific information<sup>7</sup> before a woman can obtain abortion care. In the ensuing years, many states enacted such restrictions in order to advance their purported interest in ensuring a woman’s decision to have an abortion is “informed.”<sup>8</sup> More recent state legislative trends, however, have exposed the true intentions of anti-abortion legislators, who have increasingly proposed laws intended to underhandedly close abortion clinics<sup>9</sup> and impose all-out abortion bans.<sup>10</sup> The onslaught of abortion restrictions in recent years have closed high-quality reproductive health clinics and imposed countless barriers on patients seeking care, disproportionately harming low-income women, women of color, immigrant women, and rural women. These restrictions include requirements that abortion clinics meet the same building regulations as ambulatory surgical centers and laws that require abortion providers to have local hospital admitting privileges—both designed to shutter reproductive health clinics while doing nothing to protect women’s health.

State legislatures have also targeted insurance coverage for abortion care in recent years, enacting ban after ban on coverage in private plans, plans purchased in state health insurance marketplaces under the Affordable Care Act, and in plans offered in compensation packages to public employees. But poor women have long been left out of insurance coverage for abortion care: the Hyde Amendment, in effect since 1977, bans federal funds from being used to provide insurance coverage for abortion care for women who qualify for public health insurance through the federal-state Medicaid program, with very few exceptions.<sup>11</sup>

The multi-faceted tactics employed by the anti-abortion movement are designed to discourage and shame women seeking abortion care and make it too dangerous for clinics provide it. One such tactic is the creation of hostile, threatening environments at reproductive health clinics and

the homes of providers in order to deter women from seeking care and to terrorize the staff. Another related strategy is illustrated by the litany of restrictions in state law that both limit health care providers’ ability to provide individualized care to abortion patients and shame women seeking that care. These include laws that require health care providers to give patients anti-abortion lectures and to perform state-mandated ultrasounds prior to performing abortion care. A third strategy aimed at dissuading women seeking abortion care is employed by the network of crisis pregnancy centers (CPCs) proliferating across the country. Many CPCs engage in tactics deliberately calculated to lure women into their offices by pretending to be legitimate health care providers. These CPCs then give clients misleading information about the risks of abortion and attempt to delay women until they can no longer access abortion care. The goal of these various strategies is to ensure that as long as abortion is legal, it is increasingly stigmatized and difficult to access and provide.

### EXPANDING ACCESS TO FIRST-TRIMESTER ABORTION CARE

A first-trimester aspiration abortion is a simple procedure that can be provided safely by trained non-physician clinicians using aspiration (sometimes called surgical) techniques or medications.<sup>12</sup> A recent nationwide study comparing early aspiration abortions provided by physicians and trained nurse practitioners, certified nurse midwives, and physician assistants concluded that complication rates—in addition to being “extremely low”—were “clinically equivalent” between the groups.<sup>13</sup> Likewise, medication abortion, which involves using medications to terminate a pregnancy up to at least 63 days can be provided safely by trained non-physician clinicians.<sup>14</sup> Despite the fact that clinicians can provide first-trimester abortion care safely, 38 states currently have laws that require abortion to be provided by licensed physicians.<sup>15</sup>

Expanding the types of clinicians who can provide early abortion care can address at least two of the challenges facing women seeking care. First, there is a significant shortage of abortion providers in the United States—in 2011, 89% of all counties in the United States did not have an abortion clinic, affecting the 38% of women who live in those counties without access<sup>16</sup>—and data suggests that the number of providers continues to decrease.<sup>17</sup> As a result, many women experience a delay in finding an abortion provider and obtaining care. And because first-trimester abortion care is less expensive and carries a lower risk of complications than care at later gestational periods,<sup>18</sup> the result of expanding the pool of trained health care providers is that more women will receive earlier, safer, and less costly abortion care.<sup>19</sup> Second,

underserved women are less likely to have access to first-trimester abortion care.<sup>20</sup> Therefore, increasing the types of qualified clinicians who may provide early abortion care may also serve as an initial step in ensuring earlier access to care for all women.<sup>21</sup>

In 2013, California passed [Assembly Bill 154](#), which authorizes trained, licensed nurse practitioners, certified nurse-midwives, and physician assistants to provide first-trimester aspiration abortion care.<sup>22</sup> Other states, such as Washington and Connecticut, allow non-physician clinicians to provide medication abortion.<sup>23</sup>

## KEY POLICY CONSIDERATIONS FOR EXPANDING ACCESS TO EARLY ABORTION CARE

**Whether the legislation will govern both aspiration and medication abortion.** For example, a regulation in Rhode Island allows medication abortion to be provided by a “licensed health care practitioner acting within his/her scope of practice.”<sup>24</sup>

**Which types of clinicians the legislation will cover.** For example, the California legislation authorizes nurse practitioners, physician assistants, and certified nurse-midwives to perform first-trimester aspiration abortion.<sup>25</sup> Rhode Island allows medication abortion to be performed by a “licensed health care practitioner acting within his/her scope of practice.”<sup>26</sup> The Washington State Attorney General interpreted that state’s law to allow “advanced registered practice nurse practitioners” to provide medication abortion.<sup>27</sup>

**How the legislation should ensure the clinician is qualified to perform early abortion care.** For example, the California legislation requires the clinician to “complete training recognized by the Board of Registered Nursing.”<sup>28</sup> Others require that the clinician is “acting within his/her scope of practice.”<sup>29</sup>

## CODIFYING REPRODUCTIVE FREEDOM IN STATE LAW

Measures to ensure women retain the decision-making power when it comes to their reproductive health and lives can take many forms. One conceptual framework to consider is a state-level [Freedom of Choice Act \(FOCA\)](#).<sup>32</sup> Adopted by seven states as of 2014, these laws were written to ensure that, in the event *Roe* and *Casey* are overruled by the U.S. Supreme Court and the right to abortion becomes a matter of state law, a woman’s right to decide whether to have an abortion and access to other reproductive health care services remains intact.<sup>33</sup> A bill advanced by legislators in Colorado in 2014, the [Reproductive Health Freedom Act](#), illustrates one state’s approach to codifying the protections of *Roe* in state law.<sup>34</sup> The Reproductive Health Freedom Act would enact a law acknowledging every individual’s “fundamental right of privacy with respect to reproductive health care decisions” and provide that “every individual is entitled to make reproductive health care decisions free from discrimination, coercion or violence.”<sup>35</sup> It would prohibit the state from denying or interfering with an individual’s reproductive health care decisions

## ADMINISTRATIVE ADVOCACY TO ADVANCE EARLY ABORTION ACCESS

Note that a variety of legal and advocacy mechanisms can be pursued to expand access to early abortion. In several states, this type of policy change has been the result of attorneys general opinions that have interpreted state law to allow for non-physician dispensation of medication abortion.<sup>30</sup> In other states, regulations have clarified that early abortion care is within the scope of practice of certain clinicians.<sup>31</sup> This policy concept presents an opportunity to explore non-legislative advocacy avenues if a state attorney general or department of health is interested in expanding access to health care for women.



and bar the government at all levels from enacting policies regarding reproductive health care that are either inconsistent with current evidence-based scientific data and medical consensus or that interfere with access to information based on such data or consensus.<sup>36</sup>

## RESTORING AND PROTECTING INSURANCE COVERAGE FOR ABORTION

Since 1977, the Hyde Amendment has discriminated against low-income women by withholding coverage for basic health

care.<sup>48</sup> It prohibits federal funding for abortion under the Medicaid program, except in cases of rape, incest, or life endangerment. Because of this policy, millions of women who qualify for public health insurance like Medicaid are denied coverage of abortion care. In all but 17 states, poor women have virtually no access to coverage for abortion care.<sup>49</sup> The 17 states that have policies in place that require coverage for abortion care for indigent women beyond instances of rape, incest, and life endangerment do so with their own state dollars.<sup>50</sup> What's more, the ACA opened the door for more discriminatory restrictions by allowing states

### KEY POLICY CONSIDERATIONS FOR CODIFYING REPRODUCTIVE FREEDOM

**Definitions of key terms**, including the types of reproductive health care services or information that fall within its purview. For instance, the Colorado bill defined “reproductive health care” broadly to include “treatment, services, procedures, supplies, products, devices, or information related to human sexuality, contraception, pregnancy, abortion, or assisted reproduction.”<sup>37</sup> Maine’s law, limited in scope to protecting a woman’s right to choose abortion pre-viability, accordingly defines “abortion” and “viability.”<sup>38</sup>

**Whether to frame the operative language as codifying positive or negative rights.** The operative language of the legislation can create an affirmative right to reproductive health care services, or conversely, it can prohibit

the state from taking certain actions. Connecticut’s FOCA takes the former approach by providing that “[t]he decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician.”<sup>39</sup> The proposed legislation in Colorado took the latter approach by barring the state and its subdivisions from denying or interfering with individuals’ reproductive health care decisions,<sup>40</sup> as do several of the state FOCA laws.<sup>41</sup> Similarly, Maryland’s FOCA prohibits the state from interfering with the decision of a woman to terminate her pregnancy pre-viability.<sup>42</sup> Note that these options are not mutually exclusive. For instance, Washington’s FOCA provides that every individual has the fundamental right to choose or refuse birth control and that every woman has the fundamental right to choose or refuse to have an abortion while also prohibiting the state from denying or interfering with a woman’s fundamental right to choose or refuse to have an abortion.<sup>43</sup>

These policy decisions will be governed by a number of factors, such as current state law, messaging considerations,

and the desired breadth of protection in the legislation. For example, the Colorado model is quite broad in that its protections extend beyond the abortion decision, such as barring the government from enacting policies that interfere with access to evidence-based information.<sup>44</sup> While most state-level FOCAs protect access to abortion only, Washington and California’s laws also protect individuals’ right to choose or refuse contraception.<sup>45</sup>

**Legislative findings.** The legislation can include findings to ensure the drafters’ intent is clearly set forth. Findings can also be useful in order to convey core messages and values that are important to the legislators and advocates supporting the legislation. For example, the Colorado legislation included five legislative declarations, including a legislative declaration that individuals are “entitled to make reproductive health care decisions free from discrimination, coercion or violence.”<sup>46</sup> California and Washington’s FOCA laws are similar in that they both include findings that “every individual possesses a fundamental right of privacy with respect to personal reproductive decisions.”<sup>47</sup>

to ban coverage for abortion care in private plans purchased on the health insurance marketplaces created by the law. While the ACA has led to improvements for women and families, including affordable health insurance and the contraception benefit, it has also allowed for half of the states in our country to prohibit insurance plans from including abortion as part of the comprehensive health insurance provided in the marketplace.<sup>51</sup> Outside of the marketplaces established by the ACA, 10 states force all private insurance companies to withhold coverage for abortion,<sup>52</sup> and 19 states restrict abortion coverage in insurance plans for public employees.<sup>53</sup> These harmful and discriminatory policies force many women to choose between paying for basic necessities and accessing a constitutionally protected health service.<sup>54</sup> When it comes to a decision about whether or not to end a pregnancy, it is important that a woman has health coverage so she can afford to make a real decision.

Restrictions on abortion coverage not only interfere with a woman's ability to make personal decisions, but they amplify existing health disparities, disproportionately harming women who already face barriers to accessing health care, including lower-income women and women of color. In order for a woman to make the best decision for herself and her family, a woman needs to have coverage for all pregnancy-related care, including abortion care, no matter where she gets her insurance. It is better that a woman's insurance covers a full range of legal medical procedures so that she can decide what's best for her health and her family; study after study by national and international experts have shown that restrictions on abortion don't reduce its frequency, but rather increase women's reliance on illegal and unsafe procedures.

One potential policy strategy that would alleviate some of the harms caused by discriminatory insurance policies was introduced in 2013 and again in 2014 in Washington State. The [Reproductive Parity Act](#), which would require private insurance companies in the state that cover maternity care to cover abortion care services in a "substantially equivalent" manner, passed the House both years it was introduced but ultimately stalled in the Senate.<sup>55</sup>

A second policy solution is to require funding of abortion care for low-income women in a state. Of the 17 states that use their own dollars to fund abortion, four do so by state statute.<sup>56</sup> For example, similar to its proposed Reproductive Parity Act, Washington law provides that if the state provides maternity care benefits through a state-administrated or state-funded program, that the program must provide "substantially equivalent" coverage for abortion care.<sup>57</sup> A different approach is in place in New York, where state law mandates covering abortion care for low-income women when "medically necessary."<sup>58</sup>

## PROTECTING REPRODUCTIVE HEALTH SERVICE PROVIDERS AND PATIENTS

Clinic violence and harassment are serious threats to both providers of reproductive health care and their patients. There have been eight reported murders of physicians who perform abortion care and abortion facility clinic staff since

### KEY POLICY CONSIDERATIONS FOR RESTORING INSURANCE COVERAGE FOR ABORTION CARE

**Definitions of key terms.** Legislation may need to define terms like "maternity care" or "prenatal care," if not defined in current law. Standards such as "substantially equivalent" or "medically necessary" may also need to be defined.

**Whether to pursue coverage "parity" or require coverage regardless of maternity care coverage.** Both the Washington law requiring abortion coverage for low-income women and the proposed Reproductive Parity Act tie the abortion coverage requirements to a plan's existing coverage of maternity benefits. New York and Hawaii require coverage for low-income women regardless of maternity care coverage.<sup>59</sup>

### LOCAL RESOLUTIONS TO ADVANCE ABORTION ACCESS

The renewed focus on how abortions are paid for and whether they are covered by insurance has energized policymakers and constituents across the country seeking to protect and expand coverage for abortion—whether a woman's insurance is provided by her employer or the government, or purchased individually. To date, local advocates have taken action in at least five cities across the country supporting insurance coverage of abortion care and urging Congress to reinstate coverage for the full spectrum of reproductive health services.

1977.<sup>60</sup> From 2007 to 2013, there were at least eight arsons, six attempted arsons or bombings, 41 incidents of assault and battery, and 43 death threats reported against abortion providers in the United States and Canada.<sup>61</sup> On top of this, providers and patients have to contend with disruptive behavior by abortion opponents outside clinics, including obstructing entrances and driveways, shouting at patients and their companions, and photographing those who enter and leave the clinic. And incidents of online harassment are increasing: reports of email and other forms of internet harassment more than doubled between 2012 and 2013.<sup>62</sup> The federal Freedom of Access to Clinics Act (FACE) was enacted in 1994 to respond to some forms of clinic violence and harassment by prohibiting a range of violent, obstructive, and threatening activities aimed at reproductive health care providers and their patients, but FACE does not prohibit all forms of disruptive or intimidating behavior that occur outside of clinics.<sup>63</sup>

Despite passage of FACE, reproductive health providers and their patients continued to face a barrage of obstruction and harassment blocking them from providing or obtaining care. More than ten states have enacted enhanced, state-level FACE Acts.<sup>64</sup> These measures ensure that state and local authorities, as well as health care providers, have “broader opportunities for enforcement of the law.”<sup>65</sup> States and localities have also responded to the problems caused by disruptive and dangerous protest behavior by enacting “buffer zones”—generally, fixed areas within which protesters cannot enter—and “bubble zones”—floating areas around the patients themselves that prohibit protestors from approaching the patient within a fixed area surrounding a reproductive health clinic. Colorado, for example, enacted a bubble zone law in 1993, which created an eight-foot “no-approach” zone around a patient within one hundred feet of the entrance of any health care facility.<sup>66</sup> In 2000, the Supreme Court upheld the constitutionality of the Colorado bubble zone statute in *Hill v. Colorado*.<sup>67</sup> Massachusetts initially enacted a bubble zone in 2000, which created a “no-approach” zone within six feet of a patient within 18 feet of a reproductive health facility.<sup>68</sup> However, the bubble zone proved difficult to enforce, and in 2007, the legislature enacted a buffer zone law prohibiting any individual from occupying 35 feet around an entrance or driveway of a reproductive health facility providing abortions.<sup>69</sup>

In 2014, the U.S. Supreme Court dealt a blow to safe passage to reproductive health care facilities with its decision in *McCullen v. Coakley*.<sup>73</sup> In that opinion, the Court struck down the Massachusetts buffer zone as unconstitutional under the First Amendment. The court made clear that governments have a significant interest in protecting a woman’s freedom

## LOCAL ACTIONS TO PROTECT PROVIDERS AND PATIENTS

Municipalities have enacted a variety of other legal mechanisms to protect abortion providers and patients. Many localities have enacted ordinances that prohibit residential picketing in response to anti-abortion protests and harassment at the homes of abortion providers. For example, an ordinance recently enacted in Bernalillo County, New Mexico, prohibits picketing “focused on and taking place in front of or next to a particular residence” without the occupant’s consent.<sup>70</sup> Several other localities have enacted similar prohibitions.<sup>71</sup> Additionally, New York City enacted an ordinance that prohibits following and harassing another person within 15 feet of a reproductive health care facility.<sup>72</sup>

to seek pregnancy-related services—including abortion—and that states can constitutionally pass laws that protect access to clinics.<sup>74</sup> Indeed, according to the Court, governments have “undeniably significant interests in maintaining public safety” on public streets and sidewalks and in “preserving access to adjacent healthcare facilities.”<sup>75</sup> However, the Court found that the Massachusetts law “burden[ed] substantially more speech than necessary” to achieve the state’s interests.<sup>76</sup> The Court encouraged the Commonwealth to explore “more targeted means”<sup>77</sup> of satisfying its interest in promoting public safety and protecting access to reproductive health care facilities.

In response to the *McCullen* decision, the Massachusetts legislature enacted [Senate Bill 2283](#) in order to protect patients and their companions seeking unobstructed care at reproductive health facilities within the state.<sup>78</sup> This statute gives law enforcement officers the authority to order the immediate withdrawal of one or more individuals who have “substantially impeded” access to or departure from an entrance to a reproductive health care facility. It then requires individuals who have been ordered to withdraw to remain at least 25 feet away from an entrance or driveway to a reproductive health facility for that day. The bill also

codifies elements of the federal FACE Act on the state level and prohibits blocking vehicles that are attempting to access reproductive health care facilities.

In the wake of *McCullen*, it is unclear which of the different approaches states and localities have taken to ensure safe access to reproductive health care facilities and to protect reproductive health care providers will withstand future legal challenges. However, it is clear that in this area in particular, advocates play a crucial role in establishing a concrete record documenting the problems outside of clinics and the steps law enforcement has taken to remedy those problems. It is critical that state and local advocates consider the specific issues they face when evaluating which tools are the most strategic to pursue.



## PROTECTING THE PROVIDER-PATIENT RELATIONSHIP

The sanctity of the provider-patient relationship has been under attack in recent years, with state legislatures imposing repeated restrictions on health care providers' ability to provide the best care to their patients. In the context of abortion care, these restrictions have taken the form of state-mandated ultrasounds, biased counseling requirements for abortion patients, prohibitions on evidence-based provision of medication abortion, and more. Although it would be preferable to repeal laws that impose ideology on health care without regard to medical need or evidence, legislation to protect the provider-patient relationship can serve, at a minimum, as a vehicle to start the conversation about why these laws are medically inappropriate. These measures recognize that state laws mandating providers give—and women receive—care that is not in line with medical standards undermine patients' health care and seriously infringe on the patient-provider relationship. Depending on the circumstances, these measures could allow an abortion provider to bypass, for instance, giving state-mandated medically inaccurate information or performing a state-mandated ultrasound to a patient if the provider believes that the requirement is medically inappropriate.

Introduced in 2014, [Ohio HB 585](#) would protect “health care professionals,” including physicians and other specified clinicians, from civil liability for declining to follow specific state-mandated requirements for abortion care for a given patient if the health care professional deems that compliance with those laws would be “inconsistent with accepted, evidence-based medical practices and ethical standards.”<sup>79</sup> In Pennsylvania, the Patient Trust Act would prohibit the government from requiring a health care practitioner to

provide medically inaccurate or medically inappropriate information regardless of the type of health care services the patient is seeking.<sup>80</sup> It would also ban requiring a health care practitioner to provide a medical service to a patient in a manner that is not evidence-based and medically appropriate for the patient. Conversely, the bill would prohibit the government from barring a health care practitioner from providing a patient with medically accurate, appropriate information or evidence-based, medically appropriate services.

## MINIMIZING THE HARMS CAUSED BY CRISIS PREGNANCY CENTERS

Crisis pregnancy centers (CPCs) are institutions run by anti-choice organizations that do not offer abortion care or even

## KEY POLICY CONSIDERATIONS FOR LEGISLATION PROTECTING THE PROVIDER-PATIENT RELATIONSHIP:

**Definitions of key terms.** Terms used to prescribe the types of health professionals covered by the legislation may need to be defined,<sup>81</sup> as well as descriptive terms such as “medically accurate” or “evidence-based.”<sup>82</sup> Depending on the wording of the operative language, other terms may need to be defined.

**Clarifying that current standards still apply.** Both the Pennsylvania and Ohio bills include language clarifying that the legislation does not abrogate a health care practitioner's duty to follow existing professional standards of care to make it clear that existing malpractice, informed consent, and other laws and ethical standards apply.

**The breadth of the legislation.** The reach of this legislation depends on whether it is written to apply to abortion specifically, or if it is written to apply more broadly and thus could reach laws that infringe on the patient-provider relationship in other areas such as counseling on gun safety and environmental hazards.

abortion referrals and often provide women with inaccurate or misleading information about abortion and contraception. CPCs often also engage in other manipulation tactics to deter women from seeking abortion care or prevent them from obtaining care altogether. As the National Abortion Federation has put it, “CPCs exist to keep women from having abortions.”<sup>83</sup>

CPCs pose several problems that concern women’s health advocates. First, they often use deceptive advertising practices to trick potential clients into thinking that a CPC is a legitimate medical provider, such as locating themselves near actual abortion care providers.<sup>84</sup> Once a client is in the office, CPCs often continue to intentionally deceive and mislead her into thinking they are in a legitimate health care facility: some go as far as to have staff wear scrubs and outfit their offices to appear like a medical clinic, complete with waiting rooms, examination rooms, and ultrasound machines.<sup>85</sup> Once a CPC has disingenuously established itself as a legitimate medical facility, its staff or volunteers proceed to give clients false, misleading, and biased information about abortion and contraception. CPCs’ provision of medically inaccurate information has been well documented.<sup>86</sup> That CPCs counsel clients using blatant falsehoods about the safety of abortion is doubly harmful because clients may think they are at a legitimate health care provider, receiving unbiased counseling and accurate information about their health care options.

All of these tactics can lead to delays for a woman seeking abortion care. In more extreme instances, CPCs deliberately coerce clients to carry an unwanted pregnancy to term by delaying her past the legal limit for abortion in her state, or conversely, telling a woman that she is further along in her pregnancy than she actually is to discourage her from seeking an abortion.<sup>87</sup> These tactics are more than just misleading and outrageous, they are harmful to women’s health: earlier abortions are safer, less expensive and more accessible—and CPCs know that the longer a woman delays obtaining care, the harder it will be for her to access or afford an abortion.

Several municipalities around the country have enacted legislation to address the harms caused by CPCs mentioned above. While the examples discussed here were all enacted on the local level, advocates have explored their applicability at the state level as well. In 2011, San Francisco enacted an ordinance prohibiting CPCs from disseminating or advertising false or misleading information about their services.<sup>88</sup> The ordinance also prohibits CPCs from using false or misleading statements that suggest they are an abortion provider.<sup>89</sup> This measure sets important limits on how CPCs can present themselves to the public to help ensure that clients seeking

reproductive health services have not been misled about what they truly offer. The ordinance was challenged in 2012 by a CPC and remains in effect, pending future proceedings.<sup>90</sup>

In 2013 Dane County, Wisconsin, enacted an ordinance that requires health care providers with whom the county contracts to provide “comprehensive, non-directive reproductive health care information, including but not limited to family planning, birth control, pregnancy, and postpartum” to all of the county’s clients.<sup>91</sup> That ordinance also ensures that health care providers that contract with the county do not refer county clients to CPCs that do not meet those requirements. Policies like this set a requirement that an entity provide non-directive counseling that provides full, complete, and accurate information about a client’s reproductive health care options.

It should be noted that the legal landscape surrounding CPCs is evolving, and some of the policies enacted in recent years to counter the harms caused by CPCs have not ultimately held up in court. Like clinic protection policies, it is essential that advocates establish a concrete record documenting the problems CPCs are creating in the community and closely align the proposed policy to those problems.

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## A NOTE ON LOCAL CPC ORDINANCES

Several municipalities have enacted ordinances requiring CPCs to post signs providing a range of disclaimers, such as information about the types of services offered or not offered at the CPC and whether licensed medical providers are on staff. Baltimore was the first locality to enact such legislation; the ordinance requires CPCs to provide disclaimers to clients and potential clients that they do not provide or refer for abortion or contraception services.<sup>92</sup> These laws are the subject of ongoing litigation concerning whether CPCs have a First Amendment right to deceive the public about the scope of services they provide. It will be several years before this litigation is fully resolved and the constitutionality of this type of regulation is settled.<sup>93</sup> For these reasons, other options may be more effective at this time.

**CASE STUDY:**

## **USING RESEARCH TO EXPAND ABORTION PROVISION IN CALIFORNIA: CONVERSATION WITH MOLLY BATTISTELLI, PROJECT DIRECTOR, ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH**

In 2002, California's Reproductive Privacy Act codified *Roe v. Wade* in state law and allowed some medical providers like certified-nurse midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs) to provide medication abortion to patients, but for years after the existing law lacked clarity on whether CNMs, NPs, and PAs were legally able to provide first-trimester aspiration abortion.<sup>94</sup> Recognizing that the pool of abortion providers in California had been in steady decline since the 1980's and that there was an aging and shrinking population of physician providers—a challenge not limited to California—advocates decided to push for a clarification and expansion of the regulations around abortion provision. Low-income and rural women were particularly affected by this provider shortage, having to travel long distances to receive abortion care from a physician instead of being able to see a CNM, NP, or PA—the same clinicians who routinely provide their reproductive and primary health care. While two studies on the safety of clinician provision of first-trimester aspiration abortion had already been published, stakeholders agreed that more evidence was required before the potential pool of first-trimester abortion providers could be expanded.<sup>95</sup> Members of the California Legislature and the state medical establishment expressed willingness to consider such an expansion, should someone be able to produce comprehensive evidence of the safety of this proposal. The researchers at Advancing New Standards in Reproductive Health (ANSIRH), along with coalition members at Planned Parenthood Affiliates of California, the American Civil Liberties Union of California, ACCESS Women's Health Justice,

California Latinas for Reproductive Justice, NARAL Pro-Choice California, and Black Women for Wellness, accepted that challenge.

ANSIRH is a social science research organization and think tank at the Bixby Center for Global Reproductive Health at the University of California, San Francisco committed to conducting interdisciplinary research on reproductive health care issues and improving reproductive well-being. Molly Battistelli, MPH, is a Project Director at ANSIRH with an extensive background in public health and health service delivery research and many of her projects explore the relationship between policy and access to reproductive health care. Molly directed the CNM/NP/PA abortion provision study for the first six years and recently returned to evaluate the implementation of the resulting law. She provided her insight on conducting and using research to inform meaningful policy change.

### **Q: How do you begin conducting research on abortion with an eye toward policy change?**

In order to determine the safety of abortion provision by certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs), the researchers designed a non-inferiority study that would compare the rate of complications between physician and CNM/NP/PA providers and determine whether the difference in rates was within a pre-determined clinically acceptable margin.<sup>96</sup> The next step for ANSIRH and their strong coalition of partner organizations was to find a way to conduct research on the provision of a service that was not already legal in the state (aka CNM, NP, and PA provision of first-trimester aspiration abortion). Diligent research by coalition advocates and attorneys unearthed the Health Workforce Pilot Project (HWPP)—a little known state government mechanism that grants waivers of certain scope of practice laws to allow researchers to test the safety and acceptability of providing an existing health care service with a new kind of provider. The multiple public hearing requirements, bureaucracy of working with two major state agencies (the University of California and the Office of Statewide Health Planning and Development), and general political controversy surrounding abortion care all contributed to a particularly long application process, but, two years later the waiver for the study was granted and in 2007 ANSIRH began recruiting providers and patients.

The extended timeline was in fact a blessing in disguise, allowing the study coordinators to fully invest in relationship-building with key stakeholders in the health professional fields. It became clear early on that frequent and clear communication on research decisions was imperative to gaining and maintaining the engagement of the many groups involved in the liberalization of abortion law in the state. Between 2007 and 2013, 47 trained CNMs, NPs, and PAs and 96 physicians were enrolled in the study and data was collected on 16,998 first-trimester aspiration abortion procedures (9,063 by the CNM/NP/PA group and 7,935 by the physician group) at a total of 26 Planned Parenthood and Kaiser clinic locations.<sup>97</sup>

### **Q: How was the research process tied to the evolution of the policy?**

At the end of the study the overall complication rate associated with the procedure was 1.3% and complication rates for physician and CNM/NP/PA providers were clinically equivalent.<sup>98</sup> While the overwhelmingly positive findings of the study were no surprise to many in the reproductive health community, it was the first time that many people in the state departments had been exposed to real-time data on the safety of abortion care. The long study timeline and close working relationship between the state and the researchers helped to start a process of normalizing abortion care as part of comprehensive women's health care in the minds of key policy stakeholders.

### **Q: How did working with a broad array of stakeholders impact the research process?**

Researchers adhered to rigorous scientific methods while simultaneously incorporating the expertise and feedback of a broad array of advocates in the reproductive health, rights, and justice fields. The commitment to collaborative work, although time intensive, was well worth the effort. In 2012 (six years into the study) the first of two bills to codify the provision of first-trimester abortion care by CNMs, NPs, and PAs was introduced in the California Legislature.<sup>99</sup> This first bill did not pass, and although ANSIRH had enough data by then to produce a scientifically rigorous analysis, they took the coalition's concerns into consideration and decided to continue the study for an additional two years. This ensured that the CNMs, NPs, and PAs in the study could continue to

provide abortion care to women while legislative advocacy efforts continued. By the time the next iteration of the bill, AB 154, was in front of the legislature in 2013, an additional 5,511 women had received abortion care, the California Women's Health Alliance formed with 40 organizations signed on as supporters, and the researchers had conducted a large scale study that could be drawn upon to change policy in California and beyond.<sup>100</sup>

### **Q: What were some of the main takeaways from the CNM/NP/PA Abortion Provision Project?**

The research found that CNMs, NPs, and PAs can perform first-trimester aspiration abortion just as safely as physicians and confirmed previous findings on the very low risk of complications related with abortion procedures. In addition to the clinical study, the coalition work was a study in relationship-building and flexibility; the introduction and ultimate passage of proactive abortion legislation in 2013 required investment from researchers, advocates, health care organizations, providers, patients, government officials, legislators, state leadership, and the public. It was imperative that all stakeholders were at the table from the beginning to the end. Two years of hearings, legislative committee reviews, legislative visits, staff tutorials, and public testimony after the completion of the study required frequent trips to the capitol and strong messaging coordination to ensure that the research was translated accurately and effectively to legislators and the public.

### **Q: What's next?**

Now that there is evidence-based legislation on the books and a new cohort of abortion providers, ANSIRH and members of the California Women's Health Alliance continue to work on improving access to abortion and the implementation of the law. Current projects include the institutionalization of abortion training in nursing schools, the expansion of CNM, NP, and PA abortion training into more underserved and rural areas of the state, and monitoring and evaluation research on the integration of new providers in the clinic setting.

## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
American Congress of Obstetricians and Gynecologists	<a href="http://www.acog.org">www.acog.org</a>
Advancing New Standards in Reproductive Health	<a href="http://www.ansirh.org">www.ansirh.org</a>
Backline	<a href="http://www.yourbackline.org">www.yourbackline.org</a>
All* Above All	<a href="http://www.allaboveall.org">www.allaboveall.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center for Reproductive Rights	<a href="http://www.reprorights.org">www.reprorights.org</a>
Center on Reproductive Rights and Justice	<a href="http://www.law.berkeley.edu/reprojustice.htm">www.law.berkeley.edu/reprojustice.htm</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Forward Together	<a href="http://www.forwardtogether.org">www.forwardtogether.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Illinois Caucus for Adolescent Health	<a href="http://www.icaah.org">www.icaah.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
MergerWatch	<a href="http://www.mergerwatch.org">www.mergerwatch.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Abortion Federation	<a href="http://www.prochoice.org">www.prochoice.org</a>
National Advocates for Pregnant Women	<a href="http://www.advocatesforpregnantwomen.org">www.advocatesforpregnantwomen.org</a>
National Asian Pacific American Women's Forum	<a href="http://www.napawf.org">www.napawf.org</a>
National Institute for Reproductive Health	<a href="http://www.nirhealth.org">www.nirhealth.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
National Women's Law Center	<a href="http://www.nwlc.org">www.nwlc.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Reproductive Health Technologies Project	<a href="http://www.rhtp.org">www.rhtp.org</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>



## ENDNOTES

- 1 "A first-trimester abortion is one of the safest medical procedures, with minimal risk—less than 0.05%—of major complications that might need hospital care." Guttmacher Institute, "Induced Abortion in the United States," July 2014, available at [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.html#2](http://www.guttmacher.org/pubs/fb_induced_abortion.html#2), citing Tracy Weitz, et al., "Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver," *American Journal of Public Health*, 103, no. 3 (2013).
- 2 Guttmacher Institute, "Induced Abortion in the United States," citing Stanley K. Henshaw, "Unintended pregnancy in the United States," *Family Planning Perspectives* 30, no. 1 (1998); Rachel K. Jones and Megan L. Kavanaugh, "Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion," *Obstetrics & Gynecology*, 117, no. 6 (2011).
- 3 410 U.S. 113, 153-54, 164-65 (1973).
- 4 505 U.S. 833, 879 (1992) ("reaffirm[ing]" the central holding of *Roe*).
- 5 *Ibid.*
- 6 *Ibid.* at 887 (upholding portion of challenged statute requiring state-mandated counseling and 24-hour waiting period prior to obtaining an abortion).
- 7 *Ibid.* at 881-85 (upholding portion of challenged statute requiring physician to provide patient with information about the procedure, the health risks of abortion and childbirth, and the probable gestational age of the fetus).
- 8 See, e.g., Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. Ill. L. Rev. 939, 940 (2007). "Blocked from flatly prohibiting abortion by *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, anti-abortion advocates in the past two decades have pushed for the enactment of ever more stringent 'informed consent' statutes" (internal citations and quotation marks omitted).
- 9 See, e.g., Miss. Code Ann. § 41-75-1(f) (requiring all physicians associated with an abortion facility to have admitting privileges at a local hospital and staff privileges to replace local hospital on-staff physicians), available at [http://msdh.ms.gov/msdhsite/\\_static/resources/108.pdf](http://msdh.ms.gov/msdhsite/_static/resources/108.pdf); La. H.B. 388 (2014) (requiring physicians who perform abortions to have "active admitting privileges at a hospital that is located not further than thirty miles from the location at which the abortion is performed or induced and that provides obstetrical or gynecological health care services"), available at <http://www.legis.la.gov/legis/ViewDocument.aspx?d=914189&n=HB388%20Act%20620>; Tex. Health & Safety Code Ann. §§ 171.0031, available at <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.171.htm>; 245.010, available at <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.245.htm> (requiring physicians who perform abortions to have "active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced" and requiring Texas abortion facilities to meet requirements for ambulatory surgical centers).
- 10 See, e.g., N.D. Cent. Code § 14-02-1-05.2(1) (2013) (six-week abortion ban), available at <http://legis.nd.gov/assembly/63-2013/session-laws/documents/DOMRP.pdf>; Ark. Stat. § 20-16-1304 (2013) (twelve-week abortion ban), available at <http://www.arkleg.state.ar.us/acts/2013/Public/ACT301.pdf>; Ohio H.B. 125 (2011) (six-week abortion ban), available at [http://www.legislature.state.oh.us/BillText129/129\\_HB\\_125\\_PH\\_Y.pdf](http://www.legislature.state.oh.us/BillText129/129_HB_125_PH_Y.pdf).
- 11 Federal law requires coverage for abortion for pregnancies resulting from rape, incest or life endangerment.
- 12 Tracy A. Weitz et al., "Safety of Aspiration Abortion"; see also National Abortion Federation, 2014 Clinical Policy Guidelines 1, available at <https://www.prochoice.org/documents/2014NAFCPGs.pdf>.
- 13 Tracy A. Weitz et al., "Safety of Aspiration Abortion," 1.
- 14 Guidelines 1 and 11. National Abortion Federation, "2014 Clinical Policy Guidelines," (2014) available at <http://prochoice.org/wp-content/uploads/2014NAFCPGs.pdf>.
- 15 Guttmacher Institute, "State Policies in Brief: An Overview of Abortion Laws," last modified September 1, 2014, available at [http://www.guttmacher.org/statecenter/spibs/spib\\_OAL.pdf](http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf).
- 16 Guttmacher Institute, "Induced Abortion in the United States," citing Rachel K. Jones and Jenna Jerman, "Abortion incidence and service availability in the United States, 2011," *Perspectives on Sexual and Reproductive Health*, 46, no. 1 (2014).
- 17 "The total number of abortion providers declined by 4% since 2008." Guttmacher Institute, "Induced Abortion in the United States."
- 18 Guttmacher Institute, "Induced Abortion in the United States," citing Rachel K. Jones and Jenna Jerman, "Abortion incidence and service availability in the United States, 2011," *Perspectives on Sexual and Reproductive Health*, 46, no. 1 (2014).
- 19 Tracy A. Weitz et al., "Safety of Aspiration Abortion."
- 20 See Rachel K. Jones and Lawrence B. Finer, "Who Has Second-Trimester Abortions in the United States?" *Contraception*, 85, no. 6 (2012). Finding that Black women, women with less education, and adolescents more likely to have second trimester abortions.
- 21 See Tracy A. Weitz et al., "Safety of Aspiration Abortion."
- 22 A.B. 154, 2013 Leg., Reg. Session (Cal. 2013), available at [http://leginfo.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB154](http://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB154).
- 23 Wash. Op. Att'y Gen. No. 2004-1 (Jan. 5, 2004); Conn. Op. Att'y Gen. No. 2001-15 (July 2, 2001).
- 24 R.I. Admin. Code § 31-1-2:5.0, available at [http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH\\_132\\_.pdf](http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH_132_.pdf).
- 25 A.B. 154, 2013 Leg., Reg. Session (Cal. 2013)
- 26 R.I. Admin. Code § 31-1-2:5.0, available at [http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH\\_132\\_.pdf](http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH_132_.pdf).
- 27 Wash. Op. Att'y Gen. No. 2004-1 (Jan. 5, 2004).
- 28 Ca. Bus & Prof. Code § 2725.4(a), available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2725-2742>.
- 29 E.g., R.I. Admin. Code § 31-1-2:5.0, available at [http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH\\_132\\_.pdf](http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH_132_.pdf).
- 30 Conn. Op. Att'y Gen. No. 2001-15 (July 2, 2001) (interpreting state statutes governing non-physicians not to preclude them from administering mifepristone "in accordance with the scope of their respective practices"); Ill. Op. Att'y Gen. No. 09-002 (March 5, 2009) (interpreting state law to permit physician assistants or advanced practice nurses to provide medication abortion).
- 31 According to NAF, in 2006, "The Oregon State Board of Nursing determines that the performance of manual suction/aspiration abortion is not outside the scope of practice of a Family Nurse Practitioner given that the FNP is both educationally prepared and clinically competent." National Abortion Federation, "Timeline,

- State by State: Expanding CNM, NP, and PA Provision of Abortion Care,” NAF Resource Center (2010), available at <http://prochoice.org/health-care-professionals/clinicians-for-choice/resource-center/>; R.I. Code § R23-1-TOP: 5.1 available at [http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH\\_132\\_.pdf](http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/DOH_132_.pdf) (authorizing licensed health care practitioners acting within his/her scope of practice to provide medication abortion).
- 32 A federal Freedom of Choice Act was introduced in Congress in 2007. H.R. 1964/S. 1173 (110th Cong. 2007).
- 33 “7 states have codified a woman’s right to choose, making the protections of *Roe v. Wade* part of state law: CA, CT, HI, ME, MD, NV, WA.” NARAL Pro-Choice America, “Freedom of Choice Acts,” accessed September 29, 2014, available at <http://www.prochoiceamerica.org/what-is-choice/fast-facts/foca.html>.
- 34 S.B. 175, 2014 Leg., Reg. Session (Colo. 2014), available at [http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/\\$FILE/175\\_01.pdf](http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/$FILE/175_01.pdf).
- 35 *Ibid.*
- 36 *Ibid.*
- 37 *Ibid.* (defining “reproductive health care” as “treatment, services, procedures, supplies, products, devices, or information related to human sexuality, contraception, pregnancy, abortion, or assisted reproduction”).
- 38 22 Me. Stat. § 1598(2), available at <http://www.mainelegislature.org/legis/statutes/22/title22ch263-B.pdf>.
- 39 Conn. Stat. § 19a-602(a) (1990), available at <http://www.dir.ct.gov/dcf/policy/Health-Care44/44-5-4.html>.
- 40 S.B. 175, 2014 Leg., Reg. Session (Colo. 2014), available at [http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/\\$FILE/175\\_01.pdf](http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/$FILE/175_01.pdf).
- 41 See, e.g., Haw. Rev. Stat. § 453-16(c) (“The State shall not deny or interfere with a female’s right to choose or obtain an abortion of a nonviable fetus or an abortion that is necessary to protect the life or health of the female.”), available at [http://hawaii.gov/dcca/pvl/hrs/hrs\\_pvl\\_453.pdf](http://hawaii.gov/dcca/pvl/hrs/hrs_pvl_453.pdf); Cal. Health & Safety Code § 123462(c) (“The state shall not deny or interfere with a woman’s fundamental right to choose to bear a child or to choose to obtain an abortion.”), available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=123001-124000&file=123460-123468>; Me. Stat. tit. 22, § 1598(1) (“It is the public policy of the State that the State not restrict a woman’s exercise of her private decision to terminate a pregnancy before viability.”), available at <http://www.mainelegislature.org/legis/statutes/22/title22ch263-B.pdf>.
- 42 Maryland Health Code § 20-209(c), available at <http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.12.01>. The MD law also authorizes the Department of Health to adopt regulations governing abortion care, but requires that those regulations to necessary, the least intrusive method to protect the life or health of the woman, and consistent with established medical practice. *Id.* § (c).
- 43 Wash. Stat. § 9.02.100, available at <http://app.leg.wa.gov/rcw/default.aspx?cite=9.02.100>.
- 44 S.B. 175 § 1, 2014 Leg., Reg. Session (Colo. 2014), available at [http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/\\$FILE/175\\_01.pdf](http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/$FILE/175_01.pdf).
- 45 Cal. Health & Safety Code § 123462(a), available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=123001-124000&file=123460-123468>; Wash. Rev. Stat. § 9.02.100(1), available at <http://app.leg.wa.gov/rcw/default.aspx?cite=9.02.100>.
- 46 S.B. 175, § (a), 2014 Leg., Reg. Session (Colo. 2014), available at [http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/\\$FILE/175\\_01.pdf](http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont2/815A63900AD79C6087257C300006B1BC/$FILE/175_01.pdf).
- 47 Cal. Health & Safety Code § 123462, available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=123001-124000&file=123460-123468>; Wash. Rev. Stat. § 9.02.100, available at <http://app.leg.wa.gov/rcw/default.aspx?cite=9.02.100>.
- 48 See Dep’t of Labor, Health and 22, 2010); Hum. Serv., and Educ. and Related Agencies Appropriations Act, Pub. L. No. 105-78, §§ 509-510, 111 Stat. 1467 (1997), available at <http://www.gpo.gov/fdsys/pkg/PLAW-105publ78/pdf/PLAW-105publ78.pdf>.
- 49 The Hyde amendment requires funding in cases of rape, incest, and life endangerment.
- 50 These states are Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia.
- American Civil Liberties Union, “Public Funding for Abortion,” last modified July 21, 2004, available at <https://www.aclu.org/reproductive-freedom/public-funding-abortion>.
- 51 Guttmacher Institute, “State Policies in Brief: Restricting Insurance Coverage of Abortion,” last modified September 1, 2014, available at [http://www.guttmacher.org/statecenter/spibs/spib\\_RICA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf).
- 52 National Women’s Law Center, “State Bans on Insurance Coverage of Abortion Endanger Women’s Health and Take Health Benefits Away from Women,” (May 5, 2014), available at <http://www.nwlc.org/resource/state-bans-insurance-coverage-abortion-endanger-women%E2%80%99s-health-and-take-health-benefits-awa>.
- 53 Guttmacher Institute, “State Policies in Brief: Restricting Insurance Coverage of Abortion.”
- 54 Many women surveyed delayed or did not pay bills to cover the cost of the abortion, and even that “relatively small” amounts of money needed for transportation and missed work can prove “impossible to procure” and could prevent women from obtaining wanted abortion care altogether. Rachel Jones, et al., “At What Cost? Payment for Abortion Care by U.S. Women,” *Women’s Health Issues* 23, no. 3 (2013), available at <http://www.guttmacher.org/pubs/journals/j.whi.2013.03.001.pdf>.
- 55 H.B. 1044, 2013-14 Leg., Reg. Session (Wash. 2014), available at <http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/House%20Bills/1044.E.pdf>.
- 56 Haw. Admin. Rules § 17-1722.3-18(c) (3), available at <http://humanservices.hawaii.gov/wp-content/uploads/2013/10/HAR-17-1722.3-Basic-Health-Hawaii.pdf>; Md. Regs. Code tit. 10, §§ 09.02.04(G), 09.34.04(A)(5), 09.34.04(B)(2), available at [https://mmcp.dhmf.maryland.gov/docs/Phys-svcs-prov-fee-man\\_2013.pdf](https://mmcp.dhmf.maryland.gov/docs/Phys-svcs-prov-fee-man_2013.pdf); N.Y. Soc. Serv. Law § 365-a(2), available at [http://www.oms.nysed.gov/medicaid/services/speech\\_therapy/udo\\_definition.pdf](http://www.oms.nysed.gov/medicaid/services/speech_therapy/udo_definition.pdf). The other 13 states fund abortion care for low-income women pursuant to court orders.
- 57 Wash. Rev. Code Ann. § 9.02.160, available at <http://app.leg.wa.gov/rcw/default.aspx?cite=9.02&full=true#9.02.160>.
- 58 N.Y. Soc. Serv. Law § 365-a(2), available at [http://www.oms.nysed.gov/medicaid/services/speech\\_therapy/udo\\_definition.pdf](http://www.oms.nysed.gov/medicaid/services/speech_therapy/udo_definition.pdf).
- 59 *Ibid.*; Haw. Admin. Rules § 17-1722.3-18(c)(3), available at <http://humanservices.hawaii.gov/wp-content/uploads/2013/10/>

- HAR-17-1722.3-Basic-Health-Hawaii.pdf.
- 60 National Abortion Federation, "NAF Violence and Disruption Statistics" (2013), available at [http://prochoice.org/wp-content/uploads/Stats\\_Table2.pdf](http://prochoice.org/wp-content/uploads/Stats_Table2.pdf).
- 61 Amicus brief of National Abortion Federation, *McCullen v. Coakley*, 573 U.S. ---, at 2-3; National Abortion Federation, "NAF Violence and Disruption Statistics" (2013), available at [http://prochoice.org/wp-content/uploads/Stats\\_Table2.pdf](http://prochoice.org/wp-content/uploads/Stats_Table2.pdf).
- 62 National Abortion Federation, "NAF Violence and Disruption Statistics" (2013)
- 63 See National Abortion Federation, "Freedom of Access to Clinic Entrances (FACE) Act," available at <http://prochoice.org/education-and-advocacy/violence/freedom-of-access-to-clinic-entrances-act/>; 18 U.S.C. § 248 (1994), available at <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-part1-chap13-sec248.pdf>.
- 64 See, e.g., Cal. Penal Code §§ 423-423.6 available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=00001-01000&file=423-423.6>; N.Y. Penal Law §§ 240.70-.71 [http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=\\$PEN240.70\\$@TXPEN0240.70+&LIST=-SEA3+&BROWSER=BROWSER+&TOKEN=26102042+&TARGET=VIEW](http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=$PEN240.70$@TXPEN0240.70+&LIST=-SEA3+&BROWSER=BROWSER+&TOKEN=26102042+&TARGET=VIEW); *McCullen v. Coakley*, Brief for State of New York et al. as Amici Curiae 13 n.6 (listing 12 states). NOTE: See, e.g. should be italicized.
- 65 National Abortion Federation, "Legal Remedies to Address Clinic Violence and Harassment," (2014) available at <http://prochoice.org/resources/legal-remedies-to-address-clinic-violence-and-harassment/>.
- 66 Colo. Rev. Stat. § 18-9-122(3), available at [http://www.state.co.us/gov\\_dir/leg\\_dir/olls/sl1993/sl\\_115.htm](http://www.state.co.us/gov_dir/leg_dir/olls/sl1993/sl_115.htm).
- 67 530 U.S. 703 (2000).
- 68 Mass. General Laws, ch. 266, § 120E1/2 (West 2000), available at <https://malegislature.gov/Laws/GeneralLaws/PartIV/TitleI/Chapter266/Section120E1-2>.
- 69 Mass. General Laws, ch. 266, § 120E1/2(a), (b) (West 2012).
- 70 Bernalillo Cnty. Code Ch. 54, art. III, div. 1, Sec. 54-57. Available at [https://www.municode.com/library/nm/bernalillo\\_county/codes/code\\_of\\_ordinances?nodeId=BECOCO\\_CH540FMIPR\\_ARTIII0FAGPU-](https://www.municode.com/library/nm/bernalillo_county/codes/code_of_ordinances?nodeId=BECOCO_CH540FMIPR_ARTIII0FAGPU-)
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- 71 See, e.g., Lincoln, Neb., Mun. Code § 9.40.090 (2010), available at <https://www.lincoln.ne.gov/City/attorn/lmc/ti09/ch940.pdf>; Mich. Comp. Laws Serv. § 423.9f (2010), available at [http://www.legislature.mi.gov/\(S\(0yxru545f4khjzb44zqwry45\)\)/mileg.aspx?page=getObject&objectName=mcl-423-9f&highlight=423.9f](http://www.legislature.mi.gov/(S(0yxru545f4khjzb44zqwry45))/mileg.aspx?page=getObject&objectName=mcl-423-9f&highlight=423.9f); Sioux Falls, S.D., Mun. Code § 38-145 (2010), available at [http://www.amlegal.com/nxt/gateway.dll/South%20Dakota/siouxfalls\\_sd/cityofsiouxfallsouthdakotacodefordinan?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:siouxfalls\\_sd](http://www.amlegal.com/nxt/gateway.dll/South%20Dakota/siouxfalls_sd/cityofsiouxfallsouthdakotacodefordinan?f=templates$fn=default.htm$3.0$vid=amlegal:siouxfalls_sd); Ariz. Rev. Stat. § 13-2909 (2001), available at <http://www.azleg.gov/ars/13/02909.htm>.
- 72 N.Y. City Admin. Code § 8-803(a) (3) (2014). Available at [http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=\\$ADC8-803\\$@TXADC08-803+&LIST=LAW+&BROWSER=BROWSER+&TOKEN=37034786+&TARGET=VIEW](http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=$ADC8-803$@TXADC08-803+&LIST=LAW+&BROWSER=BROWSER+&TOKEN=37034786+&TARGET=VIEW).
- 73 573 U.S. ---, 134 S. Ct. 2518 (June 26, 2014).
- 74 *Ibid.* at 2535.
- 75 *Ibid.* at 2518 (emphasis added).
- 76 *Ibid.* at 2524.
- 77 *Ibid.* at 2538.
- 78 S.B. 2283, 2014 Leg., Reg. Session (Mass. 2014), available at <https://malegislature.gov/Bills/BillHtml/138548?generalCourtId=11>.
- 79 H.B. 585, 2014 Leg., Reg. Session (Ohio 2014), available at [http://www.legislature.state.oh.us/BillText130/130\\_HB\\_585\\_I\\_Y.pdf](http://www.legislature.state.oh.us/BillText130/130_HB_585_I_Y.pdf).
- 80 The Pennsylvania legislation's reach is broader than just protecting the provider-patient relationship in the context of abortion care, prohibiting governmental interference in the medical care or information given to a patient regardless of the services he or she are seeking. Because of this broad reach, the Pennsylvania legislation is supported by advocates for reducing gun violence and environmental groups, creating a unique new coalition. S.B. 1456, 2014 Leg., Reg. Session (Pa. 2014), available at <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2013&sessInd=0&billBody=S&billTyp=B&billNbr=1456&pn=2245>.
- 81 The Ohio legislation includes a definition for "health care professional" and includes a variety of physician and non-physician clinicians. The Pennsylvania legislation uses the definition of "health care practitioner" currently in the state's Medical Practice Act. 63 Penn. Stat. § 422.2; 35 Penn. Stat. § 448.103 (defining "health care practitioner" as "[a]n individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board").
- 82 The Pennsylvania legislation defines "evidence-based" using current Pennsylvania law and defines "medically accurate" based on existing state legislation in which the term was used.
- 83 National Abortion Federation, "Crisis Pregnancy Centers: An Affront to Choice" 1 (2006), available at [http://www.prochoice.org/pubs\\_research/publications/downloads/public\\_policy/cpc\\_report.pdf](http://www.prochoice.org/pubs_research/publications/downloads/public_policy/cpc_report.pdf).
- 84 See, e.g., NARAL Pro-Choice New York Foundation and the National Institute for Reproductive Health, "A Report On: The Lies, Manipulations, and Privacy Violations of Crisis Pregnancy Centers in New York City" (2010) 7-8, available at <http://www.prochoice.org/assets/bin/pdfs/cpcreport2010.pdf>.
- 85 NARAL Pro-Choice North Carolina, "The Truth Revealed: North Carolina's Crisis Pregnancy Centers" (2011), available at [http://www.prochoicenc.org/assets/bin/pdfs/2011NARAL\\_CPCReport\\_V05\\_web.pdf](http://www.prochoicenc.org/assets/bin/pdfs/2011NARAL_CPCReport_V05_web.pdf).
- 86 See NARAL Pro-Choice America, "Crisis Pregnancy Centers" (CPCs), <http://www.prochoiceamerica.org/what-is-choice/abortion/abortion-crisis-pregnancy-centers.html> (listing all affiliate investigative reports on CPCs). For example, many CPCs give women inaccurate information about the safety of abortion, falsely claiming that abortion causes infertility, breast cancer, suicide, and carries other harmful psychological effects. See NARAL NY, "A Report on" at 9 ("Nearly every CPC investigated provided misleading—or sometimes entirely false—information about abortion . . . They portrayed abortion as a painful, dangerous procedure that leads to a range of physical and emotional damage: future infertility, higher risk of breast cancer, 'post-abortion syndrome,' and other health complications, including sexual dysfunction, infection, cervical scarring, and death."); NARAL NC, "The Truth" at 20 (reporting that CPC volunteers told investigators that it is 'a 100 percent proven fact that abortions cause breast cancer.'). Some CPCs use other coercive and emotionally manipulative strategies,

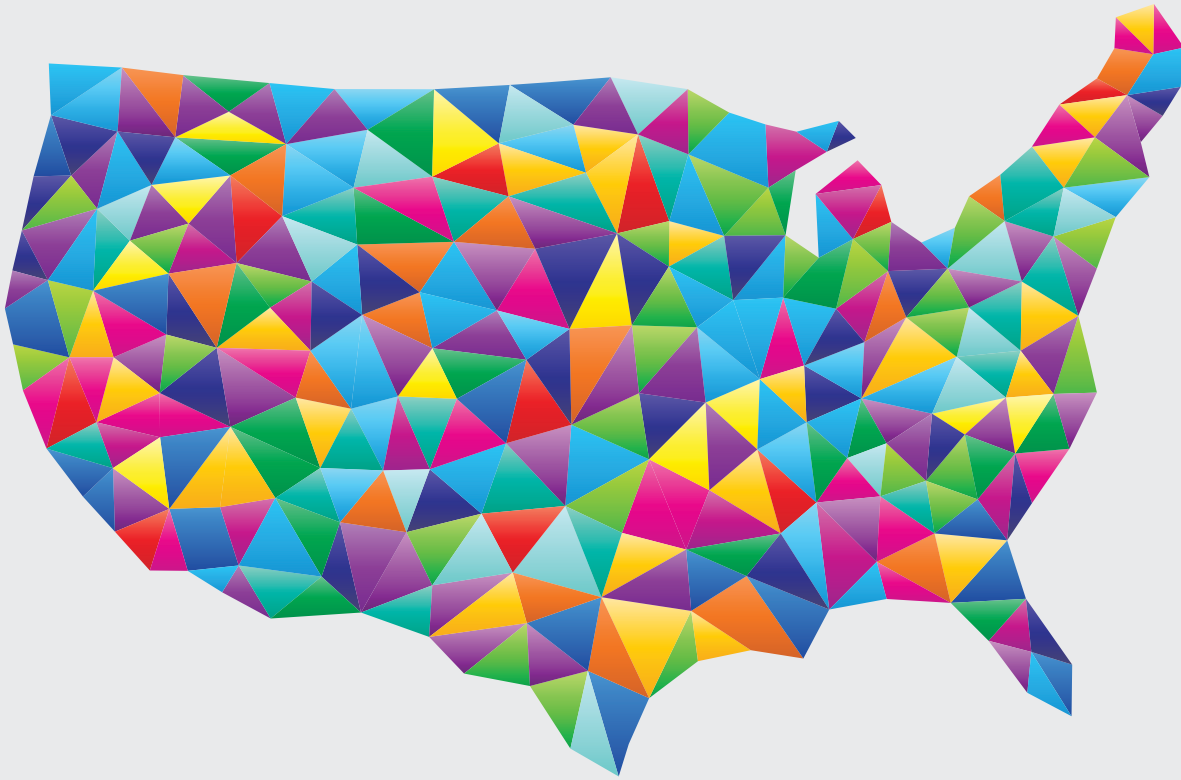
- such as showing women graphic images and videos about fetal development in an attempt to shame them for considering abortion. See, e.g., NARAL NY, "A Report on" at 12-13. See also *Evergreen Ass'n v. City of New York*, 801 F. Supp. 2d 197, 207 (S.D.N.Y. 2011) ("the record before the [New York] City Council included, inter alia, anecdotes about pregnancy service centers that (i) falsely told a woman she needed multiple ultrasounds before an abortion could be performed; (ii) misrepresented that abortions are available through the nine month of pregnancy; and (iii) redirected a woman to its facility using an employee posing as a Planned Parenthood staff member.") (internal citations omitted).
- 87 In North Carolina, where a woman cannot obtain an abortion after 20 weeks into her pregnancy in most instances, an investigation showed that 24% of the CPCs studied suggested that clients delay seeking abortion care as "they may have a miscarriage and end the pregnancy naturally." NARAL NC, "The Truth" at 24. In New York, one investigator pretending to be 9.3 weeks pregnant was told she could get an abortion "up to nine months" and that she had "time to think about it." NARAL NY, "A Report on" at 11.
- 88 San Francisco, Cal., Admin Code §§ 93.1-5 *et seq.* available at [http://www.amlegal.com/nxt/gateway.dll/California/administrative/chapter93pregnancyinformationdisclosurea?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:sanfrancisco\\_ca\\$anc=JD\\_93.1](http://www.amlegal.com/nxt/gateway.dll/California/administrative/chapter93pregnancyinformationdisclosurea?f=templates$fn=default.htm$3.0$vid=amlegal:sanfrancisco_ca$anc=JD_93.1).
- 89 *Ibid.* § (b). A similar measure has also been introduced in Congress, the Stop Deceptive Advertising for Women's Services Act. H. Res. 2030 (113<sup>th</sup> Cong. 1<sup>st</sup> Sess) (2013), available at <http://www.gpo.gov/fdsys/pkg/BILLS-113hr2030ih/pdf/BILLS-113hr2030ih.pdf>.
- 90 *First Resort, Inc. v. Herrera*, No. C 11-5534 SBA, 2012 WL 4497799 (N.D. Cal. Sept. 28, 2012).
- 91 Dane County, Wis., Ordinances ch. 30 §§ 1-3 (2013), available at <http://danedocs.countyofdane.com/webdocs/pdf/ordinances/ord030.pdf>.
- 92 Baltimore, MD, City Health Code §§ 3-502(A), available at <http://legistar.baltimorecitycouncil.com/detailreport/?key=4550>.
- 93 *Greater Baltimore Pregnancy Concerns Inc. v. Mayor and City Council of Baltimore*, 721 F.3d 264 (4th Cir. 2013) (en banc) (preserving injunction against ordinance, vacating lower court judgment and remanding for further proceedings); *Centro Tepeyac v. Montgomery Cnty.*, 722 F.3d 184, 186 (4th Cir.) (en banc) (affirming partial injunction against ordinance); *The Evergreen Association v. City of New York*, 740 F.3d 233 (2d Cir. 2014) (affirming partial injunction against ordinance); *Austin LifeCare, Inc. v. City of Austin*, Civ. No. A-11-CA-875-LY (June 23, 2014) (order granting permanent injunction).
- 94 The Reproductive Privacy Act, Cal. Health & Safety Code § 123460-123468 (2012) available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=123001-124000&file=123460-123468>
- 95 There was some debate among the reproductive health and nursing communities about whether CNMs and NPs were legally prohibited from providing first trimester aspiration abortion care. It was the intention of the advocates and researchers to make it official.
- 96 Tracy A. Weitz et al., "Safety of Aspiration Abortion."
- 97 Tracy A., Weitz, Diana Taylor, Ushma D. Upadhyay, Sheila Desai, and Molly Battistelli, "Research Informs Abortion Care Policy Change In California," *American Journal of Public Health* 104, no. 10 (2014): e3-e4, available at <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2014.302212>.
- 98 *Ibid.*
- 99 S.B. 1338, 2011-2012 Leg., Reg. Sess. (CA 2012), available at [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=2011201205B1338](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=2011201205B1338).
- 100 A.B. 154, 2013-2014 Leg., Reg. Sess. (CA 2013), available at [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB154](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB154); The California Women's Health Alliance included over 30 organizations, see Tracy A. Weitz, "Using research to make policy change in abortion care in California," slide 100 (Presentation, Department of Ob/Gyn & RS Grand Rounds, San Francisco, CA, December 10, 2013), available at <http://lecture.ucsf.edu/ETS/Play/0c7a118dbca943c1bf70f7502096bc1a1d?catalog=a7c81124-a8a4-42fe-9104-6751550f432b>.



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# SUPPORTING THE RIGHT TO PARENT AND PARENTS IN THE WORKPLACE

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Women comprise 47% of laborers and nearly two-thirds of women work during their first pregnancy, with more than eight out of ten of these women continuing to work during their last trimester.<sup>1</sup>

In 2013, women were the sole or primary breadwinner in four out of ten families.<sup>2</sup> With pregnant and parenting women playing such an integral role in the workforce, there is a need to address the unique circumstances and challenges that they face as employees. States must respect and support pregnant women and parents in the workforce so that they are able to continue to provide for themselves and their families. For people seeking to become parents, states should ensure they have the ability to do so, free from discrimination.

### ADVANCING EQUITY IN INFERTILITY CARE AND COVERAGE

For many couples, the pathway to becoming parents is marked by loss, frustration, and high medical bills. Almost 11% of women aged 15-44 in the United States are diagnosed with impaired fecundity, or the impaired ability to become pregnant and carry a pregnancy to term.<sup>3</sup> With 7.4 million women reporting use of infertility services, the ability to access and afford such services is critical, especially for LGBT families.<sup>4</sup> There are many medical interventions to address infertility in women, including medication, surgery, and Assisted Reproductive Technologies (ART). The most common and effective method of ART, in vitro fertilization (IVF), can also be expensive and time consuming for many women and families.<sup>5</sup> One study in California found median out-of-pocket ART costs to be \$5,338, but identified study participants who had paid as much as \$19,000 for IVF treatment.<sup>6</sup>

All individuals deserve access to health care services that permit them to become parents if and when they choose to start a family. Some individuals face biological barriers that require medical assistance, including diagnostic testing. Although insurance companies sometimes cover these services, insurance policies may be outdated and fail to cover same-sex couples. However, state lawmakers have the power to ensure that all individuals can utilize insurance coverage for infertility care. In 2013, California enacted [Assembly Bill 460](#), which requires insurance coverage for infertility treatment to be offered and provided without discrimination based on an individual's gender identity, sexual orientation, race, disability, genetic information, or marital status.<sup>7</sup>

### PARENTING EQUALITY FOR LGBT PARENTS

Currently, there are same-sex couples raising approximately 250,000 children in families throughout the states.<sup>8</sup> However,

due to the large variety of state laws governing adoption and because of discrimination by some adoption agencies, it is common that these children have only one legal parent, despite the existence of co-parenting. In some cases, state law prohibits second-parent and parentage recognition adoption, only recognizing the biological parent, and in other cases, adoption agencies may prohibit same-sex parents from adopting together.<sup>9</sup> Second-parent adoption law allows the non-biological parent to adopt without terminating the rights of the "first parent," thus granting the child the protections of having two legal parents, such as health and life insurance benefits.<sup>10</sup> Additionally, such laws must guarantee both legal parents the same rights with regards to custody, child support, and visitation.<sup>11</sup> Similarly, joint-parent adoption guarantees parenting rights to both guardians when they adopt a child who was previously in state custody or when they adopt a child from the child's biological parents.<sup>12</sup> While many states recognize these rights as a result of case law, some states have provided for these rights in statute. For example, Connecticut became the first state to create a statutory mechanism for both second-parent and joint adoption in 2000 with the passage of [HB 5830](#).<sup>13</sup> While the state of Colorado does not have marriage equality, the state legislature has nevertheless guaranteed second-parent adoption – whether or not the couple is in a civil union – by passing [HB 1330](#) in 2007.<sup>14</sup>

### ACCOMMODATING PREGNANT WORKERS FAIRLY

The rights of pregnant and newly parenting women in the workplace are protected by a number of federal laws. Protections for many pregnant workers are guaranteed by the Pregnancy Discrimination Act, which makes it illegal for employers to discriminate against or harass employees on the basis of pregnancy.<sup>15</sup> The act also requires that any employee whose ability to perform her job is affected by pregnancy or a pregnancy-related medical condition must be treated by her employer the same as any employee who is similar in ability to work, such as an employee affected by a non-pregnancy-related disability; for example, the employer might assign her to lighter duties or grant disability or unpaid leave, based on how the employer treats other workers similar in ability to work.<sup>16</sup>

Additionally, under the Family Medical Leave Act (FMLA), eligible pregnant employees who work for employers with 50 or more employees are guaranteed 12 weeks of unpaid, job-protected leave due to childbirth, care of a newborn or

newly adopted or fostered child, care of a family member who is seriously ill, and “incapacity due to pregnancy.”<sup>17</sup> Some nursing mothers are also guaranteed the right to express breast milk when they return to the workplace. The Affordable Care Act amended the Fair Labor Standards Act to require employers to provide “reasonable break time” and a private place other than a bathroom to hourly, non-exempt employees who need to express breast milk for up to one year after the birth of their child.<sup>18</sup> Despite these important federal protections afforded to pregnant women and mothers, in practice the laws often fall short, making it critical that states find ways to address the challenges that pregnant women and parents may face in the workplace.

Women and men work outside of the home in nearly equal numbers, and despite the federal protections outlined above, pregnant workers are sometimes denied reasonable accommodations in the workplace. Some pregnant women may be fired or pushed to leave their job on a temporary or permanent basis.<sup>19</sup> Although many women can work without adjustments or accommodations during their pregnancy, others find that job sites have not been updated to meet the needs of pregnant workers, both in jobs traditionally held by men, such as law enforcement, and in those traditionally held by women, such as domestic work.<sup>20</sup>

Federal legislation has therefore been proposed in Congress to make it unmistakably clear to employers that they must provide reasonable accommodations to pregnant workers who have a medical need for them, unless doing so would impose an undue hardship on the employer. Known as the Pregnant Workers Fairness Act, this bill allows an employee to continue her job and support her family while pregnant and prohibits employers from firing a pregnant employee or forcing her to take unpaid leave when reasonable accommodations would allow her to continue working.<sup>21</sup> Workplace accommodations can include permission to take more frequent bathroom and water breaks, permission to sit during a shift or to stay off high ladders, temporary job restructuring, modified work schedules, and acquiring or modifying equipment.

In addition, 12 states already explicitly require some forms of workplace accommodations for at least some pregnant workers, with eight of those states (California, Delaware, Hawaii, Illinois, Maryland, Minnesota, New Jersey, and West Virginia) having adopted broad pregnancy accommodation laws similar to the robust protections in the federal bill.<sup>22</sup> Similar municipal laws have passed in New York City, Philadelphia, and Providence and Central Falls, Rhode Island. In 2014 alone, six additional states and the District of

Columbia considered legislation on the issue of pregnancy accommodations.<sup>23</sup>

## PROMOTING THE RIGHT TO BREASTFEED

The short- and long-term health benefits of breastfeeding for both mother and child are well documented and include reduced incidence of infant ear and respiratory infections and diarrhea, as well as reduced risk of premenopausal ovarian and breast cancer and potential for a faster return to pre-pregnancy weight for mothers.<sup>24</sup> With these benefits in mind, the United States has a long-standing national public health goal to increase the proportion of women who breastfeed. HealthyPeople, the government program that identifies and tracks health indicators, set the national goal for the proportion of infants who have ever been breastfed by 2020 at 81.9%.<sup>25</sup> In 2013, 57.3% of women with children under one year of age, the recommended window for breastfeeding, were participating in the labor force.<sup>26</sup> Research has shown that working full time outside of the home and the intention to work full time outside the home are both associated with shorter durations of breastfeeding. A survey of primarily low-income women found that those working in administrative positions and manual labor were more likely to stop breastfeeding earlier on than women in other occupations or who did not work outside the home.<sup>27</sup> Workplace investment in simple accommodations has the potential to help women successfully integrate breastfeeding into their personal and professional lives.

Federal law establishes protections for many breastfeeding mothers in the workplace, but social and state-level challenges remain. Existing policies that promote a woman's right to breastfeed address the acceptability and ease of breastfeeding in health facilities and public spaces, the availability of spaces and break times to breastfeed or pump milk in the workplace, and jury duty exemption allowances for breastfeeding mothers.<sup>28</sup> Other state laws discussed elsewhere in this chapter, such as paid or unpaid family leave programs, can also help foster breastfeeding.

Beyond federal law, which does not apply to all workers, 25 states and DC ensure that there are policies in the workplace to accommodate breastfeeding mothers.<sup>30</sup> New York's Breastfeeding Bill of Rights outlines a full spectrum of rights before, during, and after delivery, including the right to information about breastfeeding before delivery, the right to refuse bottle and formula feeding and materials, and the right to information about community resources and safe milk collection and storage practices.<sup>31</sup> State policies that address



breastfeeding mothers and jury duty allow for postponement to complete exemption from duty and each state sets their own parameters regarding the age of the infant and the level of proof that a woman must supply to show that she is the primary caregiver to a breastfeeding infant.<sup>32</sup>

### PAID PARENTAL LEAVE

Millions of Americans provide for their families both financially and as caregivers but, unlike 181 other countries in the world, the United States does not guarantee a form of paid maternity leave.<sup>33</sup> Eighty-one countries have policies providing paid paternity or parental leave but the United States is, again, not one of them.<sup>34</sup> The federal Family Medical Leave Act only applies to public employees and private employees with more than 50 employees within a 75-mile radius.<sup>35</sup> This leaves 41% of workers, primarily low-wage workers, part-time workers, and employees of small businesses with no coverage.<sup>36</sup> Even with these protections, many workers do not take parental leave because they can't afford to take unpaid time off of work if their state or employer offers no additional coverage. A survey of family and medical leave in 2012 found that a third of all people who took FMLA leave received no pay and "64.4% of employees who needed but did not take leave in the past 12 months" were women.<sup>37</sup>

Three states offer paid family leave coverage beyond the federal standard: California, New Jersey, and Rhode Island.<sup>38</sup> A fourth state, Washington, has passed a paid family leave law that will be implemented in October 2015.<sup>39</sup> A study of California's paid family leave program found positive effects on the ability of parents to provide and arrange care for their child,

an increase in breastfeeding duration for women using the program, and an increase in men claiming parental leave time.<sup>40</sup> In addition to directly benefiting families, paid parental leave benefits employers and the economy overall as worker retention and a greater sense of economic security ensure a stronger, more stable workforce.<sup>41</sup>

The paid family leave programs in California, New Jersey, and Rhode Island are operated through the state's disability program and funded by employee payroll taxes.<sup>42</sup> Coverage varies among the three states with wage replacement ranging from 55% in California to 66% in New Jersey. Rhode Island's law offers job protection for all workers, regardless of the number of employees their employer has.<sup>43</sup> A handful of states have also taken steps to expand access to unpaid family leave to broader populations of workers (workers at smaller businesses or with less time on the job, for example) and nine states allow parents a certain number of unpaid hours off per year to attend their children's school related activities, ranging from four hours in North Carolina to forty hours in California.<sup>44</sup>

### PAID SICK LEAVE

Paid sick leave allows people to care for themselves and their families without fear of losing a vital day's pay – or their job altogether. The United States is the only country out of 22 countries ranked highly by the United Nations in terms of economic and human development that does not have some form of national paid sick leave policy.<sup>45</sup> Over 40 million workers in the United States do not have any paid sick leave at all and low-wage jobs are significantly less likely to have a paid sick leave policy than are high-wage jobs (33% versus



**THE VAST MAJORITY OF STATES (45 PLUS DC) HAVE LAWS RECOGNIZING A WOMAN'S RIGHT TO BREASTFEED IN ANY PUBLIC OR PRIVATE LOCATION THAT SHE IS OTHERWISE AUTHORIZED TO BE IN.** <sup>29</sup>

8%), a disparity that the U.S. Department of Health and Human Services itself recognizes as “discouraging low-income populations from seeking health care.”<sup>46</sup> Of those workers who do have paid sick time, many cannot use that time to care for a sick child or other family member. Working women are both more likely to be low-wage workers and to be primary caregivers for their families.<sup>47</sup> Public health guidelines recommend that workers and children stay home when they are sick, but the lack of paid sick days can make it difficult for many people to follow those best

practices without considerable hardship, increasing the risk of spreading illness in work and school settings.<sup>48</sup> Families should not be required to shoulder the burden of missed pay to take care of themselves or their children, and for many employers the minimal financial cost of offering paid sick leave is in fact outweighed by the benefits of having a physically and economically healthy workforce.<sup>49</sup> One study found that the ‘working sick’ (people who come into work while sick) cost the national economy \$160 billion a year in lost productivity and spread of illness.<sup>50</sup>

## RAISING THE MINIMUM WAGE: AT THE INTERSECTION OF ECONOMIC JUSTICE AND REPRODUCTIVE JUSTICE

Raising the minimum wage is good for all Americans working to support their families, but it is particularly important for women, who comprise 62% of hourly wage workers earning the federal minimum wage or less.<sup>54</sup> Furthermore, women of color comprise 22% of minimum wage workers,<sup>55</sup> underscoring the centrality of minimum wage increases to discussions around women’s abilities to live healthy lives and raise healthy families.

The Congressional Budget Office estimates that a federal minimum wage increase to \$10.10, as proposed by President Obama in his 2014 State of the Union Address, would boost wages for millions of Americans and pull approximately 900,000 people out of poverty.<sup>56</sup> Until Congress takes action to increase the federal minimum wage standard, states have the power

to legislate a wage increase to ensure the economic security of women and families by keeping pace with cost of living. Currently, 23 states have a minimum wage above the federal standard and in 2014, **Connecticut**, **Hawaii**, and **Maryland** raised their minimum wage to \$10.10 while **Vermont** and **Massachusetts** legislated increases to \$10.50 and \$11.00 respectively.<sup>57</sup> Ten states have taken an alternative route to increase minimum wage by passing legislation that ties wage increases to an inflation index, leveraged annually to meet the cost of living.<sup>58</sup>

A federal policy that has been in place for more than 20 years allows employers to pay some workers significantly less than the federal minimum wage standard—a law that disproportionately harms women, who comprise the majority of the tipped workforce. While seven states require that all workers earn at least the state minimum wage, federal law dictates that certain types of tipped workers, such as restaurant servers and nail salon technicians, can be paid as little as \$2.13 per hour—and farm laborers and domestic workers are excluded entirely from minimum wage protections.<sup>59</sup> Women are more negatively affected by this loophole as nearly 73% of tipped workers are

female.<sup>60</sup> While tipped workers are twice as likely to fall under the federal poverty line, policy change can improve their situation; research shows that poverty decreases as tipped minimum wage increases.<sup>61</sup>

Legislators are taking action to improve conditions for laborers who earn below the federal minimum wage standard. The majority of states require employers to pay tipped workers above the federal tipped minimum wage and seven require that such wages equal the state minimum wage, before tips.<sup>62</sup> Other states, such as Delaware, have legislated a guaranteed earnings base, such that an employee’s hourly wage combined with tips must be equal to the state minimum wage.<sup>63</sup> Coalitions of domestic workers and their allies are also demanding fair labor and wage standards. For example, a California coalition won a multi-year fight for a Domestic Workers Bill of Rights.<sup>64</sup> Among other provisions, the law includes overtime pay for an estimated 200,000 California housekeepers and caregivers.<sup>65</sup> Once fair wage standards are enacted, enforcement can be a challenge: it is essential that such laws are accompanied by education for employees about their rights, especially regarding the new standard base wage, the impact of overtime pay, and the illegality of tip pooling.<sup>66</sup>

Paid sick leave has recently seen momentum at the state and local levels. Connecticut is the only state that has a paid sick leave law, which requires private sector employers with 50 or more employees to provide 40 hours of sick leave per year on an accrual basis.<sup>51</sup> California, the District of Columbia, and the cities of Eugene, Jersey City, Newark, New York, Portland, San Diego, San Francisco, and Seattle have all passed some form of paid sick leave legislation and paid sick day campaigns are ongoing in states and cities across the country.<sup>52</sup> All of the city policies mentioned

above allow employees to care for a range of family members or themselves, and some states and cities have specific provisions for ‘safe time’ to allow people who are experiencing domestic or intimate partner violence to make arrangements that extend beyond medical care.<sup>53</sup>



## CASE STUDY

# PREGNANT WORKERS’ RIGHTS IN WEST VIRGINIA

Every year, millions of women become pregnant in the United States. The majority of these women work and their families depend on their salaries to survive. In fact, in 2010, 41% of working mothers were their family’s primary breadwinner.<sup>67</sup> As a result, women often work for as long as they can into their pregnancy. According to a report from the US Census Bureau, two-thirds of women who had their first child between 2006 and 2008 worked during pregnancy, and 88% of these first-

time mothers worked into their last trimester.<sup>68</sup> Many of these women continue to work safely throughout their pregnancy, but some women may find that their work activities pose a challenge, such as lifting, standing, or repetitive motions. If small changes were made—such as providing a stool for them to sit down, allowing them to drink water at work, providing additional break time, or staying off tall ladders for a few months—these women would be able to keep working. However, too often when a pregnant woman requests a temporary change employers force her out of the job, at the moment her family can least afford it. As a result, pregnant women are often forced to choose between the health of their pregnancy and their ability to financially support their families.

WV FREE (West Virginia Focus: Reproductive Education and Equality) is a reproductive health, rights, and justice organization that works to “improve education on reproductive options, increase access to affordable birth control, reduce teen pregnancy and improve adolescent health, and protect personal decision-making, including decisions about whether or when to have a child.”<sup>69</sup> WV FREE is committed to working on behalf of women and families in West Virginia, including protecting the lives of pregnant workers.

In 2013, WV FREE led an effort to improve maternity coverage through insurance plans and researched other potential policies to improve the lives of pregnant women and their families in the state. In the process, they learned more about the problems arising from the lack of accommodations for pregnant women in the workplace.<sup>70</sup>

WV FREE reached out to national partners to learn more about this issue and they provided additional information about the need for accommodations for pregnant women in the workplace and the federal Pregnant Workers Fairness Act that

had been introduced to address this issue. As the federal bill had not passed, WV FREE worked with the ACLU of WV and National Women's Law Center to create their own state-based version of the bill that would address this issue for pregnant women in the state of West Virginia. They researched where it would fit within the state code and what changes would need to be made for a state-specific version.

To garner support, WV FREE led a statewide coalition, as this issue provided a great opportunity to bring together a broader coalition beyond reproductive rights and health organizations. The coalition included more than 20 organizations working on a wide range of issues, such as Planned Parenthood, West Virginia Coalition Against Domestic Violence, Prevent Child Abuse West Virginia, and West Virginia Nurses Association. WV FREE reached out to a diverse array of allies and gained new partners, including the West Virginia Council of Churches. They also worked with the West Virginia Healthy Kids and Families Coalition, a coalition dedicated to anti-poverty work. A partnership with labor organizations also played an essential role. They helped to get their members out to legislative meetings and to reach out to legislators. In addition, labor organizations reached out to their members to find people with personal stories they would be willing to share. The coalition aimed for true collaboration on this issue.

WV FREE and their coalition partners worked to line up support from state legislators. There was new leadership in the West Virginia Legislature at the time, and the leadership wanted this in their policy platform. After the West Virginia Pregnant Workers Fairness Act (HB 4284)<sup>71</sup> was introduced, they worked to fight off anti-choice amendments, and debates were held on the floor. There were some concerns raised that the bill would place a burden on employers; however, the coalition worked with legislators to dispel those myths. They pointed out that only a little more than 1% of employed West Virginians give birth each year, and only a fraction of those workers would require accommodations.<sup>72</sup> In addition, they highlighted that employer experiences with disability accommodations demonstrated that the cost for providing accommodations for pregnant workers would likely be quite minimal.<sup>73</sup>

On March 6, 2014, the West Virginia Pregnant Workers Fairness Act (HB 4284) passed the legislature with

overwhelming bipartisan support. The new legislation allows "pregnant women to continue to do their jobs and support their families by explicitly requiring employers to make the same sorts of accommodations for pregnancy, childbirth, and related medical conditions that employers already must make for temporary disabilities not related to pregnancy."<sup>74</sup>

WV FREE staff members have learned several lessons from their success. The first was to think broadly about working in coalition. They found it was important to establish what it means to be a partner in legislative advocacy and to set the expectation that everyone needs to contribute. They also found it very helpful to map all the stakeholder interests and to figure out where the opposition may be and address it early. For instance, they met with the local Chamber of Commerce early on, and ultimately, the Chamber did not oppose the bill. They also said that seeing where the law will be placed in code is very important. One of the things they found most helpful in their success was being able to work with national partners, like National Women's Law Center. They said they could always call on them for expert input and assistance.

In addition, WV FREE also provided advice and lessons learned from working with state legislators to pass this bill. For this work, they mapped the legislative targets and had the best-placed organization or person reach out from the coalition. They provided expert information and talking points to allies and partners so others could speak with authority when speaking with legislators. They found it was important to be both resource and motivator for allies and legislators to make the case. In the outreach, they found it was very helpful to use personal stories that might resonate with the specific legislator.

WV FREE became the tenth state in the nation to pass legislation protecting pregnant women from being pushed out of their jobs due to the need for modest accommodations. They are working on implementation now in West Virginia. In the absence of a federal response, other states are looking at similar legislation and some have reached out to West Virginia to learn from their example. West Virginia can serve as an example and resource for state advocates seeking to advance this important legislation.

## WOMEN'S HEALTH AND EQUALITY: LEGISLATIVE PACKAGES TO ADVANCE REPRODUCTIVE RIGHTS

An omnibus bill (or package of bills) that includes reproductive health, rights, and justice policy goals can serve many objectives. Omnibus bills present advocates and legislators with the opportunity to connect different issues under a unified framework—such as equality or health—that is compelling to the public. They also provide advocates with invaluable opportunities to broaden single-issue coalitions, forging new alliances across the spectrum of the social justice movement.

In 2013, New York Governor Andrew Cuomo announced the introduction of the Women's Equality Agenda, a comprehensive approach to addressing 10 key issues for women's rights in the state. The **Reproductive Health Act**, a plank to update and strengthen the state's abortion law, was packaged into the Women's Equality Agenda alongside bills related to pay equity, workplace discrimination against parents, housing protection for people experiencing intimate partner violence,

trafficking, and sexual harassment.<sup>1</sup> This omnibus bill, which positioned abortion rights in an equality framework, led to the creation of a coalition comprised of hundreds of organizations and businesses throughout the state, and saw success in passage of the full 10-point Women's Equality Act in 2014 by the New York State Assembly. However, efforts to pass the full act in the Senate were stalled, and legislators decoupled the Reproductive Health Act from other parts of the bill. Efforts to pass the full Women's Equality Act in New York State continue.

Inspired in part by the work in New York, as well as the real health care needs and challenges in their own state, Pennsylvania advocates and lawmakers from the bipartisan Women's Health Caucus of the state legislature worked together to announce phase one the **Pennsylvania Agenda for Women's Health**.<sup>2</sup> The January 2014 phase saw the introduction of bills seeking to address workplace accommodations for pregnant women, sanitary conditions for nursing mothers, buffer zones for reproductive health clinics, equal pay legislation, increased eligibility for breast and cervical cancer screenings, equitable protections for domestic violence victims, and a ban on so-called "revenge porn," which was enacted in July 2014.

Phase two was announced in June 2014 and included additional policy proposals that would protect the doctor-patient relationship from politically motivated interference with patients' medical care, establish a task force to study health issues facing women veterans, require a study of family work support programs, and increase the monthly TANF benefit for women and children in need, among other provisions.

The coalition and lawmakers committed to the Pennsylvania Agenda for Women's Health continue to promote these various policies as integral to women's overall health and well-being and continue to see success on some provisions of the Agenda. As Pennsylvania State Representative Dan Frankel said, "Women's health cannot be defined by one simple procedure or one complicated decision. Women want legislators to promote legislation that treats them as whole people; people who should be living longer, healthier lives."

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## RESOURCES

For additional information on the topics covered in this section, please consider contacting the following organizations. Please note: inclusion of an organization in this list of resources does not indicate organizational endorsement of policies referenced.

A Better Balance	<a href="http://www.abetterbalance.org">www.abetterbalance.org</a>
American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
Adoption Connection of Jewish Family and Children's Services	<a href="http://www.adoptionconnection.org">www.adoptionconnection.org</a>
Advancing New Standards in Reproductive Health	<a href="http://www.ansirh.org">www.ansirh.org</a>
Backline	<a href="http://www.yourbackline.org">www.yourbackline.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center on Reproductive Rights and Justice	<a href="http://www.law.berkeley.edu/reprojustice.htm">www.law.berkeley.edu/reprojustice.htm</a>
Choices in Childbirth	<a href="http://www.choicesinchildbirth.org">www.choicesinchildbirth.org</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Futures Without Violence	<a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Illinois Caucus for Adolescent Health	<a href="http://www.icaah.org">www.icaah.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
National Advocates for Pregnant Women	<a href="http://www.advocatesforpregnantwomen.org">www.advocatesforpregnantwomen.org</a>
National Asian Pacific American Women's Forum	<a href="http://www.napawf.org">www.napawf.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
National Women's Law Center	<a href="http://www.nwlc.org">www.nwlc.org</a>
New Voices Pittsburgh	<a href="http://www.newvoicespittsburgh.org">www.newvoicespittsburgh.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Reproductive Health Technologies Project	<a href="http://www.rhtp.org">www.rhtp.org</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>
Women with a Vision	<a href="http://www.wwav-no.org">www.wwav-no.org</a>
Young Women United	<a href="http://www.youngwomenunited.org">www.youngwomenunited.org</a>

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# RESOURCES AND POLICY INDEX

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## COMPREHENSIVE RESOURCES LIST

A Better Balance	<a href="http://www.abetterbalance.org">www.abetterbalance.org</a>
Adoption Connection of Jewish Family and Children's Services	<a href="http://www.adoptionconnection.org">www.adoptionconnection.org</a>
Advancing New Standards in Reproductive Health	<a href="http://www.ansirh.org">www.ansirh.org</a>
Advocates for Youth	<a href="http://www.advocatesforyouth.org">www.advocatesforyouth.org</a>
All* Above All	<a href="http://www.allaboveall.org">www.allaboveall.org</a>
American Civil Liberties Union	<a href="http://www.aclu.org">www.aclu.org</a>
American Congress of Obstetricians and Gynecologists	<a href="http://www.acog.org">www.acog.org</a>
Answer	<a href="http://answer.rutgers.edu/">http://answer.rutgers.edu/</a>
Backline	<a href="http://www.yourbackline.org">www.yourbackline.org</a>
California Family Health Council	<a href="http://www.cfhc.org">www.cfhc.org</a>
Catholics for Choice	<a href="http://www.catholicsforchoice.org">www.catholicsforchoice.org</a>
Center for Reproductive Rights	<a href="http://www.reprorights.org">www.reprorights.org</a>
Center on Reproductive Rights and Justice	<a href="http://www.law.berkeley.edu/reprojustice.htm">www.law.berkeley.edu/reprojustice.htm</a>
Choices in Childbirth	<a href="http://www.choicesinchildbirth.org">www.choicesinchildbirth.org</a>
Colorado Organization for Latina Opportunity and Reproductive Rights	<a href="http://www.colorlatina.org">www.colorlatina.org</a>
Equality Federation	<a href="http://www.equalityfederation.org">www.equalityfederation.org</a>
Forward Together	<a href="http://www.forwardtogether.org">www.forwardtogether.org</a>
Futures Without Violence	<a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a>
Guttmacher Institute	<a href="http://www.guttmacher.org">www.guttmacher.org</a>
Healthy Teen Network	<a href="http://www.healthyteennetwork.org">www.healthyteennetwork.org</a>
Illinois Caucus for Adolescent Health	<a href="http://www.icaah.org">www.icaah.org</a>
Justice Now	<a href="http://www.justicenow.org">www.justicenow.org</a>
MergerWatch	<a href="http://www.mergerwatch.org">www.mergerwatch.org</a>
Ms. Foundation	<a href="http://forwomen.org">forwomen.org</a>
NARAL Pro-Choice America	<a href="http://www.prochoiceamerica.org">www.prochoiceamerica.org</a>
National Abortion Federation	<a href="http://www.prochoice.org">www.prochoice.org</a>
National Advocates for Pregnant Women	<a href="http://www.advocatesforpregnantwomen.org">www.advocatesforpregnantwomen.org</a>
National Asian Pacific American Women's Forum	<a href="http://www.napawf.org">www.napawf.org</a>
National Center for Lesbian Rights	<a href="http://www.nclrights.org">www.nclrights.org</a>
National Coalition of STD Directors	<a href="http://www.ncsddc.org">www.ncsddc.org</a>

National Family Planning & Reproductive Health Association	<a href="http://www.nationalfamilyplanning.org">www.nationalfamilyplanning.org</a>
National Health Law Program	<a href="http://www.healthlaw.org">www.healthlaw.org</a>
National Institute for Reproductive Health	<a href="http://www.nirhealth.org">www.nirhealth.org</a>
National Latina Institute for Reproductive Health	<a href="http://www.latinainstitute.org">www.latinainstitute.org</a>
National Partnership for Women & Families	<a href="http://www.nationalpartnership.org">www.nationalpartnership.org</a>
National Women's Law Center	<a href="http://www.nwlc.org">www.nwlc.org</a>
New Morning Foundation	<a href="http://www.newmorningfoundation.org">www.newmorningfoundation.org</a>
New Voices Pittsburgh	<a href="http://www.newvoicespittsburgh.org">www.newvoicespittsburgh.org</a>
Oregon Foundation for Reproductive Health	<a href="http://www.orfrh.org">www.orfrh.org</a>
Physicians for Reproductive Health	<a href="http://www.prh.org">www.prh.org</a>
Planned Parenthood Federation of America	<a href="http://www.plannedparenthood.org">www.plannedparenthood.org</a>
Raising Women's Voices	<a href="http://www.raisingwomensvoices.net">www.raisingwomensvoices.net</a>
Reproductive Health Technologies Project	<a href="http://www.rhtp.org">www.rhtp.org</a>
Sexuality Information and Education Council of the United States	<a href="http://www.siecus.org">www.siecus.org</a>
SisterLove	<a href="http://www.sisterlove.org">www.sisterlove.org</a>
SisterSong	<a href="http://www.sistersong.net">www.sistersong.net</a>
SPARK Reproductive Justice NOW	<a href="http://www.sparkrj.org">www.sparkrj.org</a>
Third Wave Fund	<a href="http://www.thirdwavefund.org">www.thirdwavefund.org</a>
Women with a Vision	<a href="http://www.wwav-no.org">www.wwav-no.org</a>
Women's Voices for the Earth	<a href="http://www.womensvoices.org">www.womensvoices.org</a>
WV FREE (West Virginia Focus: Reproductive Education and Equality)	<a href="http://www.wvfree.org">www.wvfree.org</a>
Young Women United	<a href="http://www.youngwomenunited.org">www.youngwomenunited.org</a>

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