



# Blueprint for Sexual and Reproductive Health, Rights, and Justice

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JULY 2019

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## ENDORISING ORGANIZATIONS

#VOTEPROCHOICE  
Abortion Care Network  
Advocates for Youth  
AIDS Alliance for Women, Infants, Children,  
Youth & Families  
All-Options  
All\* Above All  
American Atheists  
American Jewish World Service  
American Medical Student Association  
American Sexual Health Association  
AVAC  
Black Mamas Matter Alliance  
Black Women for Wellness  
Black Women's Health Imperative  
Catholics for Choice  
Center for Health and Gender Equity (CHANGE)  
Center for Reproductive Rights  
Civil Liberties & Public Policy Program  
Equity Forward  
Gender Justice  
Global Justice Center  
Guttmacher Institute  
Harambee Village Doulas  
Healthy Teen Network  
Ibis Reproductive Health  
If/When/How: Lawyering for Reproductive Justice  
In Our Own Voice: National Black Women's  
Reproductive Justice Agenda  
International Women's Health Coalition  
Ipas  
Jacobs Institute of Women's Health  
Jewish Women International  
Maroon Calabash  
NARAL Pro-Choice America  
National Abortion Federation  
National Asian Pacific American Women's Forum  
(NAPAWF)  
National Black Women's HIV/AIDS Network  
National Center for Lesbian Rights  
National Council of Jewish Women  
National Family Planning & Reproductive  
Health Association  
National Health Law Program  
National Institute for Reproductive Health  
National Latina Institute for Reproductive Health  
National LGBTQ Task Force  
National Network of Abortion Funds  
National Organization for Women  
National Partnership for Women & Families  
National Women's Health Network  
National Women's Law Center  
New Voices for Reproductive Justice  
Not Without Black Women  
PAI  
People For the American Way  
Physicians for Reproductive Health  
Planned Parenthood Federation of America  
Population Connection Action Fund  
Population Council  
Population Institute  
Positive Women's Network-USA  
Power to Decide  
Reproductive Health Access Project  
Secular Coalition for America  
Sexuality Information and Education Council  
of the United States (SIECUS)  
Sierra Club  
SisterLove, Inc.  
SisterReach  
Social Workers for Reproductive Justice  
SPARK Reproductive Justice Now!, Inc.  
Surge Reproductive Justice  
The Afiya Center  
The American Civil Liberties Union  
The Center for Sexual Pleasure and Health  
UltraViolet  
URGE: Unite for Reproductive & Gender Equity  
Wisconsin Alliance for Women's Health  
Woodhull Freedom Foundation

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# Executive Summary

**We hold true that in order for people to be free and equal they must be able to exercise complete autonomy over their bodies. That's why we, a coalition of nearly 80 organizations, have come together to set forth a policy agenda to advance sexual and reproductive health, rights, and justice for people in the U.S and around the world.<sup>1</sup>**

**As advocates for gender equity and advancing reproductive health, rights, and justice, we know that our reproductive and sexual autonomy are at the core of some of the most important decisions impacting our lives as individuals, families, and communities. Achieving the highest standard of sexual and reproductive health and rights is based on the fundamental human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; and have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.<sup>2</sup>**

Because sexual and reproductive health, rights, and justice intersect with numerous other issues, policy solutions must also seek to further gender equity, racial equity, economic justice, environmental justice, the right to community safety, immigrants' rights, indigenous people's rights, LGBTQ+ liberation, young people's rights, and the rights of people with disabilities. Indeed, individuals most

impacted by public policy surrounding sexual and reproductive health are those of us who have fewer resources and means to navigate systemic barriers. It is critical that U.S. lawmakers implement policies that will help ensure all individuals – no matter who they are, how much money they have, or where they are from – obtain and maintain sexual and reproductive autonomy.

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<sup>1</sup> Endorsement is an indication of solidarity within our movement and a recognition of the urgency of these policies. Endorsement does not necessarily mean that organizations have expertise on or are actively working towards each priority or policy listed in the Blueprint for Sexual and Reproductive Health, Rights, and Justice

<sup>2</sup> Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R.....Popinchalk A. (2018). Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *The Lancet Commissions*, 391, 2642-2692.

The Blueprint for Sexual and Reproductive Health, Rights, and Justice sets forth five key principles:

PRINCIPLE 1

**Ensure Sexual and Reproductive Health Care is Accessible to All People.**

PRINCIPLE 2:

**Ensure Discriminatory Barriers in Health Care are Eliminated.**

PRINCIPLE 3:

**Ensure Research and Innovation Advance Sexual and Reproductive Health, Rights, and Justice Now and in the Future.**

PRINCIPLE 4:

**Ensure Health, Rights, Justice, and Wellness for All Communities.**

PRINCIPLE 5:

**Ensure Judges and Executive Officials Advance Sexual and Reproductive Health, Rights, and Justice.**

## PRINCIPLE 1:

# Ensure Sexual and Reproductive Health Care is Accessible to All People.

**Sexual and reproductive health, rights and justice are essential for sustainable economic development, are intrinsically linked to equity and well-being, and are critical to maternal, newborn, child, adolescent, family, and community health. Health care cannot truly be comprehensive if it does not include sexual and reproductive health.**

Unfortunately, restrictions and barriers to accessing sexual and reproductive health care are ever-present both globally and domestically. It is imperative that policymakers do everything they can to make it possible for each individual to be able to make healthy and informed decisions about sexuality and reproduction in pursuit of comprehensive physical, mental, emotional, and social health and wellbeing.

Our vision for how the U.S. should guarantee all people access to sexual and reproductive health care includes the following:

- **Comprehensive sexual and reproductive health care services – including abortion – must be covered at no or low cost.** Meaningful access to care requires affordability, provider access, and robust coverage of care. Whether someone has private or government-funded health insurance, each of us should have coverage for a full range of pregnancy-related care, including abortion. Individuals – not income level – should guide health care decisionmaking. To ensure that every individual has the means and tools necessary to make their own health care decisions in line with their own beliefs, the religious or personal beliefs of others must not be used to deny or restrict coverage of sexual and reproductive health care. Additionally, coverage is meaningless if it is not accessible, affordable, and easy to retain. Congress and the administration must implement policies to drive down consumers' cost of insurance and encourage states to expand their Medicaid programs, without work requirements or other harmful barriers to access, so that more people with low incomes can access the care they need.
- **Foreign policy must prioritize and integrate sexual and reproductive health and rights.** No plan to improve sexual and reproductive health and rights is complete if it does not include a vision for how U.S. foreign policy can advance the health and rights of people around the world. Congress and the administration can expand access and transform lives by fully funding international family planning programs, UNFPA, and other global health and gender equality programs. The U.S. must prioritize and integrate sexual and reproductive health and rights in all settings: from the halls of the UN to humanitarian emergencies. Providing training to U.S. government staff serving overseas, adopting a shared set of definitions of key terms across government, advancing free and informed choice across a full range of sexual and reproductive health and rights issues, and reporting on comprehensive sexual and reproductive rights violations in annual human rights reports is key to mainstream and elevate these issues across foreign policy. The U.S. government can re-establish its role as a global leader on sexual and reproductive health and rights by promoting and advancing policies, programs, and financing to address barriers to access such as contraceptive stock outs.
- **Access to Abortion Care Domestically and Globally must be protected and expanded.** The ability to decide if, when, and how to have children or grow a family is fundamental to personal

autonomy, dignity, health and wellbeing, and economic security. Every individual must have unimpeded access to abortion care—regardless of where they live, how much money they have, their insurance, their age, or if they decide to self-manage their abortion. Indeed, a right is merely theoretical when care is inaccessible or unaffordable. Federal lawmakers must enact policies that guarantee abortion access across the country. This includes passing legislation to ensure coverage for abortion in private and government-funded insurance plans and programs and ending the Hyde Amendment, which withholds abortion coverage (except in the limited cases of rape, incest, and life endangerment) from those qualified and enrolled in Medicaid, as well as related restrictions on abortion coverage. Lawmakers must also reduce barriers to medication abortion and decriminalize self-managed abortions. Likewise, the U.S. should support the decriminalization of abortion worldwide and use multilateral spaces to promote normative guidance urging the decriminalization of abortion. Furthermore, Congress must end the Helms Amendment, which unjustly restricts federal global funding from covering abortion care.

- **Pregnancy care must be expanded and improved.** Access to respectful, high-quality, holistic pregnancy-related health services is not only a fundamental human right, it leads to better health outcomes for both pregnant individuals and children. Federal policymakers must require public and private insurance plans to have a robust network of reproductive health providers and provide comprehensive coverage of pregnancy-related health care (including postpartum care); ensure individuals can enroll in and retain their insurance coverage when they become pregnant; furnish states with the resources they need to

provide comprehensive medical treatment to pregnant and postpartum individuals with substance abuse disorders and/or mental health conditions; and encourage states not to criminalize pregnant individuals who suffer from substance abuse disorders. Federal policymakers must also ensure that all individuals have paid sick time and family and medical leave so that new parents can recover from childbirth and parents can care for their children and themselves.

- **Guaranteed access to qualified sexual and reproductive health care providers.** Health care providers are an important component to ensuring that individuals have the care, information, and services they need to care for their sexual and reproductive health. It is critical that policymakers bolster public programs that help deliver sexual and reproductive health care services such as the Title X Family Planning Program, Medicaid, and the international family planning program. In particular, the federal government must end harmful policies that restrict access to providers, including existing domestic and global “gag” restrictions that block providers from participating in programs or furnishing comprehensive care to patients. Policymakers must also create policies and programs that provide financial incentives to a larger and more diverse network of health care practitioners to enter into and remain in the field of providing sexual and reproductive health care. Furthermore, federal lawmakers must implement policies and practices to ensure there is a sufficient workforce to meet patient demand, including raising reimbursement rates and program funding for sexual and reproductive health care and taking action to end violence and harassment against sexual and reproductive health care providers, patients, and staff.

## PRINCIPLE 2:

# Ensure Discriminatory Barriers in Health Care are Eliminated

**Sexual and reproductive health care cuts across gender, race, age, sexual orientation, disability, economic status, geography, and citizenship. Health care systems in the U.S. and around the world must foster fairness and equity and be respectful and inclusive of every patient’s full identity. Health systems that do not recognize and respect the diversity of people will shortcut patient care and fail to address complex individual and community needs. While significant progress has been made to improve access to health care and promote human rights for all, disparities and inequities have grown both between and within countries, leaving too many communities behind. By centering the unique experiences and needs of those most harmed by inequity – no matter who they are or where they live in the world – U.S. policymakers can make a significant contribution to promoting health and wellness for all communities.**

Our vision for how the U.S. eliminates discriminatory barriers in sexual and reproductive health care includes the following:

- **Global and domestic health care entities and insurance plans must have robust non-discrimination protections for patients without exception.** Central to a patient’s autonomy, dignity, and safety is the ability to make their own health care decisions in line with their own personal needs. Health care systems should empower individuals to access care that is best for them unimpeded by policies that enable their insurance plan, hospital, or health care provider to deny them care, coverage, or referrals on the basis of religious or moral belief. This is a problem not only in the U.S. but in the global space as well: organizations that receive funding to combat HIV globally may refuse to provide even basic information, referrals, and services such as abortion, birth control, and gender affirming care without penalty. Federal policymakers must ensure that patients come first through non-discrimination protections to ensure that patients are not refused appropriate reproductive health care services, information, and referrals.
- **Health care entities must be required to ensure that all individuals can access quality and equitable health care no matter their identity or their circumstances.** Health equity and equal access must be central to our health care system. We must prioritize populations that face obstacles in obtaining quality health care from trusted providers, including: immigrants, young people in the U.S. and global south, Native Americans, people of color, and LGBTQ+ individuals. In particular, immigrants in detention settings should be treated with compassion, dignity, and respect: they should never face sexual violence while in detention, be shackled during birth, or be denied appropriate reproductive health care, including contraception, abortion, pregnancy care. Likewise, empowering adolescent girls and youth assigned female at birth globally is not possible if their sexual and reproductive health and rights are not fully addressed; young people cannot meaningfully determine their destiny when parental consent and notification is required for sexual and reproductive health care, including abortion. To rectify these barriers to health care, policymakers must reform our nation’s health care delivery system and global health and development approach writ large to ensure all people are able to obtain comprehensive, confidential,



and quality health care from trusted providers in a timely, culturally-competent, and dignified manner.

- **Policymakers must strengthen patient protections, including confidentiality and informed consent.**

A key component to ending discriminatory health care practices is centering the patient and their needs which must include being responsive to patient preferences, needs and values, that often vary across sex (including sexual orientation and gender identity), parental status, race, ethnicity, community, ability, and immigration status. Additionally, providing care, free from coercion and implicit or explicit bias is integral to a successful health care framework. Confidentiality and informed consent, among other patient protections must be strengthened to ensure patients are in full control of their medical treatment, planning and care.

- **Policymakers must increase the effectiveness of U.S. efforts to combat the HIV epidemic globally.**

In order to end the HIV epidemic globally, the

U.S. must scale up investments in global AIDS programs and abandon discriminatory policies that leave critical communities behind. This includes ending abstinence-only-until marriage funding and restrictions on how organizations can engage with sex workers or advocate or speak about their health and rights. An evidence-informed approach to combating the rise of HIV/AIDS necessitates comprehensive sexual health education and the engagement and empowerment of key populations and stakeholders, including young people – especially adolescent girls and young women, sex workers, men who have sex with men, people who inject drugs, transgender, nonbinary, and gender nonconforming persons, and those who are incarcerated. Federal policymakers should promote the delivery of integrated, rights-based, and non-discriminatory reproductive health and HIV care to ensure that taxpayer dollars are being used for effective programming to decrease the transmission of HIV, care for people who are living with or at risk of HIV, and uphold the rights of all.

## PRINCIPLE 3:

# Ensure Research and Innovation Advance Sexual and Reproductive Health, Rights, and Justice Now and in the Future.

**Technology and innovation are transforming the health care landscape. Patients, providers, and policymakers continue to express enthusiasm about the ways in which technology has the capability of making health care more accessible and affordable, which in turn could contribute to reduced health care disparities and improved health outcomes. New technologies and research to improve drugs and devices, increased efficiency and accuracy in data collection, and reforms to health care delivery that better coordinate patient care will also benefit the delivery of sexual and reproductive health care. However, given the intimate nature of sexual and reproductive health care, it is imperative that policymakers ensure that innovation and advancement in this area be modeled around the principles of bodily autonomy, health equity and be patient-centered.**

Our vision for how the U.S. utilizes research and innovation to advance sexual and reproductive health and rights includes the following:

- **Health care system reform and innovation must prioritize sexual and reproductive health care and health equity.** Significant efforts have been made to reform our nation's health care system to meet the "triple aim" of health care: better care, lower costs, and improved health outcomes. As these delivery reform initiatives continue to develop, it is critical that they include sexual and reproductive health care to ensure that individuals are able to receive the comprehensive health care they need from trusted providers and that health equity be an explicit goal of health care transformation. Likewise, health delivery reforms must be based on evidence-based policy rather than politics to ensure that individuals are able to get the services they need and access the qualified providers they trust without obstacle or judgment. Indeed, a health care system cannot be patient-centered and improve health equity if it does not address all aspects of a patient's health; reflect the unique ways people access the health care system; and receive input from a diverse group of stakeholders, including communities that have historically had limited access to health care, such as people of color, individuals with low incomes, immigrants, and LGBTQ+ individuals. Within the history and ongoing existence of reproductive coercion, particularly among women of color, individuals with low incomes, incarcerated individuals, and individuals with substance abuse disorders, as well as with the long-standing institutional racism in our health care system, it is vital that health care delivery reform policies that center on sexual and reproductive health care not coerce or steer individuals into using a particular method of contraception or restrict patient access to qualified reproductive health providers.
- Policymakers must prioritize development and broad adoption of delivery system and payment models that recognize how people of reproductive age define quality, value and choice and how they access comprehensive reproductive and sexual health care. Alternative payment and clinical care delivery models should view patients and their loved ones as valuable partners at all levels of care and focus on coordinated patient-centered care delivery that includes a commitment to care planning.

Care coordination and continuity should include appropriate interface with primary and specialty care. Financial incentives should reward delivery of high-quality care that is measured by high-value quality measures, including patient-reported outcomes measures and patient experience of care measures.

- **Federal policymakers must invest in research and development to improve sexual and reproductive health care.** Federal policymakers should work across sectors to develop and fund fellowships and grants for scientists and researchers to study reproductive health, increase investments in sexual and reproductive health research and development (including contraception, maternal health, and abortion), design new health care delivery platforms that make it easier for patients to access care, improve data collection on sexual and reproductive health care measures, and provide free and open access to sexual and reproductive health care-related databases, tools, and resources. Similarly, lawmakers should also ensure that the U.S. collaborates with other countries to fund, develop, and use global health innovations in an effort to meet global health goals related to sexual and reproductive health.
- **Policymakers must restore scientific integrity and transparency to support activities that affect sexual and reproductive health.** Sound policies must be informed by high-quality evidence, and likewise, policy proposals should accurately represent evidence. Unfortunately, in recent years, politicians have allowed their personal beliefs surrounding sexual and reproductive health to outweigh scientific evidence, resulting in the erosion of federal and state health programs and priorities that provide individuals with reproductive health care services. It is imperative that federal lawmakers reverse this trend and implement actions to ensure that our country is guided by science and not politics. The administration must appoint and Senate should confirm nominees who exhibit views and experience consistent with agency missions and who demonstrate respect for and sufficient understanding of relevant science, ensure that federal agencies and other policymaking entities rigorously investigate instances of abuses of scientific integrity, and that the general public, media outlets, and lawmakers receive scientific and accurate information about public health topics (including sexual and reproductive health care).

## PRINCIPLE 4:

# Ensure Health, Rights, Justice, and Wellness for All Communities.

**True health and wellness will only be achieved by transforming complex and interrelated systems and by addressing societal, environmental, and social factors that impact people’s health. Fair wages, affordable housing, safe and affordable water and sanitation, public transportation, paid leave, affordable childcare, and compassionate immigration policy are all interconnected to the vision to secure reproductive autonomy. Sexual and reproductive health, rights, and justice also require the promotion and integration of social determinants of health into the actual provision of health care. Simply put, federal policymakers must work across sectors, agencies, and stakeholders to address the intersectional issues that impact an individual’s ability to have control over their own body, health, and destiny.**

Our vision for how the U.S. ensures the health, rights, justice and wellness for all communities includes the following:

- **Policy makers must foster economic opportunity for all families.** All individuals deserve to achieve the life of their choosing and to adequately care for themselves and their families. This is impossible, however, without the structures in place to enable individuals to live with economic security and safety. Federal policymakers must create policies that guarantee individuals paid sick days and paid family and medical leave (which can be used for reproductive health care services), quality and affordable childcare, secure housing, access to nutritious food, high-quality education that is free from school violence, job training, and a livable wage.
- **Policy makers must ensure all communities are free from violence.** Sexual and reproductive autonomy and justice necessitates that individuals also be able to live their lives without fear of violence, intimidation, or retribution – regardless of who they are, where they live, where they come from, their age, or how much money they have. Policymakers must enact laws that shield individuals from gun violence, sexual violence and harassment, and race- and gender-based violence.
- **Policy makers must support and promote policies to develop a healthy and safe environment.** Every person has the right to a healthy environment that is free from toxic chemicals, and has accessible clean drinking water, wastewater services, safe food, and clean air. Policymakers must aggressively and quickly address the climate crisis and enact policies that provide strong regulation and oversight over environmental protections, including the regulation of emissions. These policies not only further critical public health goals and ensure that individuals can maintain their health and the health of their children and families, they are also moral imperatives as individuals can suffer grave health consequences and even death from unmonitored, unregulated, and unsafe toxins in their environment.
- **Policy makers must promote and ensure integration of the social determinants of health into the provision of health care.** Improving health outcomes requires addressing the social determinants of health: the conditions in which people are born,

grow, live, work, and age. As our nation continues its efforts to transform the health care system, it must also invest more resources and funding into meeting the demands of related issues that impact health outcomes such as housing, food access, crime, violence, and education. Federal lawmakers must commit to significant financial investment to develop an efficient infrastructure that allows individuals to access the care and services they need without penalty, discrimination, or barrier, so they can live whole, healthy, and dignified lives.

- **Policymakers must invest in programs that promote health and wellbeing and advance gender equity.** Our nation has the framework for an infrastructure to provide health care and

social services to individuals across the country. However, that framework lacks the funding, resources, and strength needed to serve as many people as it could in an efficient and timely manner. Federal lawmakers must fully fund the programs that already exist, including: Medicaid; Children's Health Insurance Program; Title X family planning program; Maternal and Child Health (MCH) Bureau; Title V MCH Services Block Grant; Supplemental Nutrition Assistance Program; Centers for Disease Control and Prevention; UNFPA; the President's Emergency Plan for AIDS Relief (PEPFAR); Maternal, Newborn and Child Health (MNCH); Global Fund to Fight AIDS, TB, and Malaria; and USAID HIV programs, among others.

## PRINCIPLE 5:

# Ensure Judges and Executive Officials Advance Sexual and Reproductive Health, Rights, and Wellbeing.

**The President and Congress hold significant influence over policy through the appointment and confirmation process of federal justices, agency heads and other appointees.<sup>3</sup> The President's appointment power, in particular, has a significant impact on sexual and reproductive health, rights, and justice. Executive agencies and federal courts play a crucial role in interpreting and defining our fundamental legal protections and civil rights. Likewise, efforts to integrate, elevate, and prioritize sexual and reproductive health, rights, and justice across the globe cannot occur without leadership that champions these ideals into their foreign policy. Indeed, executive, judicial, and diplomatic personnel shape our legal rights and ability to access them far into the future. That is why it is critical that people confirmed to federal posts are fair-minded, understand the intent of the law, and recognize the real impact of policy on an individual's liberty, equity, dignity, and integrity.**

Our vision for how the U.S. ensures that judges and executive officials advance sexual and reproductive health, rights, and wellbeing include the following:

- **The President must only consider and the Senate must only confirm judicial nominees who either have a positive record on reproductive health, rights and justice or in the context of the confirmation process, affirmatively declare that the Constitution protects individual liberty, equal protection of the law, and the right of all people to make personal decisions about their bodies and personal relationships, including the right to use contraception, have an abortion, and marry whom they choose.** Federal courts are charged with upholding our fundamental legal rights and rule on cases impacting reproductive freedom, racial justice, LGBTQ+ rights, immigrant rights, and myriad other intersectional issues that impact all individuals in the United States. Consequently, judicial
- nominees to the Supreme Court and the lower courts must demonstrate a commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional rights of equal protection, dignity, and privacy, including the right to have an abortion.
- **The President must only put forward and the Senate must only confirm executive nominees who have a demonstrated positive record on reproductive health, rights, and justice.** Federal agencies are charged with implementing and enforcing crucial legal protections, such as race and sex anti-discrimination laws; protections for access to comprehensive reproductive health care, including abortion access for all who need it, including for immigrants and those who are undocumented; prevention and prosecution of anti-abortion violence; insurance coverage of reproductive health services, including contraception with no copay; and the Health

<sup>3</sup> The ACLU, as a matter of policy, does not regularly endorse or oppose candidates for elective or appointive office.

Care Rights Law (section 1557 of the ACA), which ensures non-discrimination in health care. Federal agencies also lead in the advancement of sexual and reproductive health and rights access globally. Consequently, executive nominees must have a demonstrated positive record on and express a commitment to promoting the sexual and reproductive health and rights of all individuals in the United States and around the world.

- Senators must thoroughly question executive and judicial nominees regarding their

qualifications and commitment to reproductive health, rights, and justice. Robust interrogation is particularly important for nominees who do not have a record on reproductive health, rights, and justice, or have a record hostile to these fundamental rights. Senators must exercise their right to question nominees about their independence, fair-mindedness, lack of bias, commitment to following scientific evidence, and ability to uphold our constitutional rights, including the right to have an abortion.

***“When we talk about ‘reproductive rights’ this is what we mean. It’s the difference between people as objects, and people as agents: between regarding people as pawns on the policy chessboard and recognizing them as the players, the decision-makers, the drivers of policy; autonomous individuals intimately concerned with the direction of their own lives. Under these conditions women, especially, enjoy better health and live fuller lives.”***

*Nafis Sadik, Special Adviser to the UN Secretary General*

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# The Imperative

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**We are living in extraordinary times. There is both urgency for swift and transformative action and simultaneously more attacks on our freedoms than we've seen in recent history. This requires extraordinary collaboration and vision. It requires us to move forward a comprehensive agenda to defend our rights and ensure a safe and healthy world for future generations. We believe that in order for that broader vision to be realized that we need sweeping protections sexual and reproductive health, rights, and justice for all people.**

**We are at a time when our country faces an unprecedented attack on sexual and reproductive health, rights, and justice. In recent years, federal lawmakers have taken away health coverage from people with lower incomes; appointed judges who oppose abortion access, birth control, and antidiscrimination policies; and encouraged violence and discrimination against people of color, immigrants, LGBTQ+ individuals, people of Muslim faith and other religious minorities. Abortion access, in particular, has been under relentless attack in recent years. In the past five years, federal lawmakers have instituted an expansive global gag rule that withholds global health funds from international organizations that provide abortion care and information, and attempted to withhold federal public health dollars from providers who perform abortions in the U.S. At the same time, state policymakers have enacted an increasing number of laws to ban abortion in their states, cut abortion providers out of public programs, and withheld insurance coverage of abortion. In seventeen states, abortion is simply a theoretical right for many individuals, as laws and policies have made it virtually impossible for people to access safe and legal abortion.<sup>4</sup> When a state has only a few practitioners who perform abortion (or, as is the case in six states, only one provider) and criminalizes people who self-manage their own abortions, people are not able to control their bodies, their lives, and their futures freely.**

**Our nation and our world cannot afford this dangerous trajectory. That's why a coalition of nearly 80 organizations have come together to set forth this policy agenda to advance sexual and reproductive health, rights, and justice for people in the U.S and around the world. We call on policymakers across the country to reach toward progress for all people – rooted in the reality that sexual and reproductive health and rights are inextricably linked to economic justice, voting rights, immigrants' rights, LGBTQ liberation, disability justice, and the right to community safety and racial equity.**

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<sup>4</sup> The following states have only one abortion provider: Kentucky, Mississippi, Missouri, North Dakota, South Dakota, and West Virginia. The following states have three or fewer providers: Alaska, Arkansas, Delaware, Idaho, Louisiana, Nebraska, Oklahoma, Rhode Island, South Carolina, Utah, and Wyoming.



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# Introduction

**As advocates for gender equity and advancing reproductive health, rights, and justice, we know that our reproductive and sexual autonomy are at the core of some of the most important decisions impacting our lives as individuals, families, and communities. Achieving the highest standard of sexual and reproductive health and rights is based on the fundamental human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.<sup>5</sup>**

Sexual and reproductive health services, including abortion, have for too long been marginalized in ways that fundamentally undermine many people's ability to succeed. The impact of this marginalization has fallen most heavily on those who face disproportionate and unfair barriers to access. The burden falls particularly heavily on women and girls<sup>6</sup> living in poverty in developing countries, and in the United States, on people living in poverty and women of color. As we look ahead, it is clear there is an unparalleled imperative to tackle those inequities and set our nation and the world much more aggressively down a path of progress.

Policy solutions to address sexual and reproductive health, rights, and justice must be cross-cutting in order to achieve our shared goals of health equity and social justice—because the challenges we face are not siloed but intersecting. Sexual and reproductive health and rights are human rights and inextricably linked to economic rights, immigrants' rights, Indigenous rights, LGBTQ+ rights, gender equity, the rights of young people, the rights of people with disabilities, racial equity, environmental justice, and the right to community safety.

Nearly 80 organizations—representing experts and stakeholders from diverse communities in medicine, public health, scientific research, faith, legal rights, and advocacy—came together to develop this policy agenda for the U.S. government as a blueprint for advancing reproductive health, rights, and justice in the United States and around the world. Each of the organizations

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5 Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R.,...Popinchalk A. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *The Lancet Commissions*, 391, 2642–2692.

6 Please note that while we have tried to make the language throughout this document gender neutral, there are a number of places that it refers to girls or women, in most cases because the data is limited or not explicit. When we say women and girls, and when data specifically refers to women, it does so because data collection is likely limited to cisgender women and does not include data that is disaggregated based on sex assigned at birth, gender identity, or sexual orientation. As noted in more detail below, particularly under Principle 3, it is imperative that data collection in the future be inclusive of LGBTQ+ people so advocates and decision-makers know who exactly is included in studies about “women,” i.e. all women—including cisgender, transgender, heterosexual, lesbian, and bisexual women, or only people with gestational capacity, who may or may not identify as women.

listed below is committed to working with federal policymakers on the issues that align with its expertise

and priorities.<sup>7</sup> And each is committed to implementing a policy agenda centered on five key principles:

PRINCIPLE 1:

**Ensure Sexual and Reproductive Health Care is Accessible to All People.**

PRINCIPLE 2:

**Ensure Discriminatory Barriers in Health Care are Eliminated.**

PRINCIPLE 3:

**Ensure Research and Innovation Advance Sexual and Reproductive Health, Rights, and Justice Now and in the Future.**

PRINCIPLE 4:

**Ensure Health, Rights, Justice, and Wellness for All Communities.**

PRINCIPLE 5:

**Ensure Judges and Executive Officials Advance Sexual and Reproductive Health, Rights, and Justice.**

In each of these categories, this document describes an in-depth set of policy recommendations for executive branch and congressional action. Our commitment to this agenda is grounded in our belief that each individual has a human

right to the highest standard of sexual and reproductive health. We are pleased to share a federal policy agenda to deliver on that vision for all people, and we are ready to work with federal policymakers to achieve it.

<sup>7</sup> Endorsement is an indication of solidarity within our movement and a recognition of the urgency of these policies. Endorsement does not necessarily mean that organizations have expertise on or are actively working towards each priority or policy listed in the Blueprint for Sexual and Reproductive Health, Rights, and Justice

## PRINCIPLE 1:

# Ensure that Sexual and Reproductive Health Care is Accessible to All People.

**Sexual and reproductive health and rights are essential for sustainable economic development, are intrinsically linked to equity and well-being, and are critical to maternal, newborn, child, adolescent, family, and community health. Restrictions on reproductive rights compromise entire health systems and communities, as when an individual's rights are limited, so are their pathways to economic, social, and political empowerment.**

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Unfortunately, restrictions and barriers to accessing sexual and reproductive health care are ever-present both globally and domestically. As a global community, we have made significant progress in expanding access to health care for communities worldwide, yet these advancements have been uneven and often fail to reach those that face the greatest barriers to care. While the Affordable Care Act (ACA) has produced significant improvements in access to affordable sexual and reproductive health care in the United States, there are individuals and communities who continue to face barriers to services that are essential to achieving full sexual and reproductive health, autonomy, and well-being.

To be meaningful to all, efforts to advance sexual and reproductive health and rights must extend across every category that could divide us—across race, gender, sexual orientation, class, immigration status, disability status, economic status, age, and national origin. Initiatives that foster fairness and equity in this critical arena of health care are essential to our commitment to the goal of ensuring that each person is able to make healthy decisions about sexuality and reproduction in pursuit of comprehensive physical, mental, emotional, and social health and well-being.

***“It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for.”***

*United Nations Secretary-General Kofi Annan*

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# Promote Comprehensive Access to Sexual and Reproductive Health Services Domestically

**Policymakers must ensure comprehensive sexual and reproductive health services are covered – at no or low cost – by every health plan and coverage program.**

**Sexual and reproductive health services have historically not been covered in a manner consistent with other health services. The ACA requires most private insurance plans and Medicaid expansion plans to cover certain preventive services, including women’s preventive services, which include but are not limited to birth control, HPV testing, and well-woman visits, without cost-sharing. It is currently estimated that 62.8 million women have coverage that includes no-cost women’s preventive services.<sup>8</sup> Additionally, around 13 million people gained access to maternity and newborn care thanks to the ACA.<sup>9</sup> While these coverage requirements have significantly improved the quality of coverage, they have not extended to everyone and every service. It is critical that all sexual and reproductive**

**health care services be available to those who want or need them without cost in order for all people to achieve optimal sexual and reproductive health.**

- As a first step towards guaranteeing coverage, the administration must rescind the rules that limit the birth control benefit and defend the ACA’s birth control benefit to ensure coverage for contraceptives with no cost-sharing.
- Congress should ensure comprehensive sexual and reproductive health services are covered – at no or low cost – by every health plan and coverage program. To address the above mentioned coverage gaps, Congress should pass legislation, which would require private insurance, Medicaid (both the Medicaid expansion and traditional Medicaid), Federal Employee Health Benefit Plans, State Employee health plans, Veterans Affairs, the Indian Health Service, Medicare, Tricare, and other private plans and federal programs to cover a range of reproductive health services. The legislation should:

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8 National Women’s Law Center (2018). New Data Estimates 62.8 Million Women Have Coverage Without Out-Of-Pocket Costs. Washington: National Women’s Law Center. [Online]. Retrieved from <https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-4.pdf>

9 The Century Foundation (2017). Millions Could Lose Health Benefits if Congress Repeals and States Replace the ACA. Washington: The Century Foundation. [Online]. Retrieved from <https://tcf.org/content/commentary/millions-lose-health-benefits-congress-repeals-states-replace-aca/?agreed=1>

- Require all plans to cover abortion without restrictions;
- Require all plans to cover all FDA-approved contraceptive drugs, devices, and other products and services, including those prescribed by the covered person’s provider or as otherwise authorized under state or federal law, and coverage should be inclusive of multiple methods regardless of timing, to allow for a person to switch methods easily;
- Require all plans to cover a 12-month supply of contraception dispensed at once;
- Require all plans to cover over-the-counter contraceptives without a prescription;
- Require all plans to cover preventive services, including condoms, vasectomy/sterilization, vaccines, and STI testing;
- Require all plans to cover interpersonal violence screenings and brief counseling (which should include referrals to interpersonal violence service providers);
- Require all plans to cover maternity care and clearly spell out what that encompasses;
- Require all plans to cover gender-affirming care;
- Require all plans to cover infertility treatment and services, including in vitro fertilization and artificial insemination even when infertility is not indicated and for LGBTQ+ couples;
- Require all plans to cover all other services necessary to adhere to the Providing Quality Family Planning Services: Recommendations of the CDC and the US Office of Population Affairs;<sup>10</sup>
- Prohibit insurers from imposing medical management techniques, including prior authorization and step-therapy, on services that are required under this legislation; and
- Ensure that the benefit created under this legislation provides coverage for adolescents, consistent with medical guidelines, counseling, and follow-up care.

This legislation should ensure that access to the services covered under this newly created benefit are equally available to people without regard to race, sex (including sexual orientation and gender identity), marital or relationship status, nationality, socioeconomic status, immigration status, disability or other status. Additionally, the legislation should not include exemptions or accommodations based on religious or personal beliefs that impede access to care.

**Policymakers must ensure that universal coverage bills thoughtfully address access to sexual and reproductive health care, including abortion coverage and no-cost-birth control, for all people.**

**Single-payer, public option, and other proposals seeking to advance coverage in the U.S have the potential to expand**

**health care coverage to millions. However, if coverage expansions do not meaningfully address sexual and reproductive health**

<sup>10</sup> Family Planning National Training Center. Quality Family Planning Recommendations. [Online]. Retrieved from <https://www.fpntc.org/topics/qfp>.

**care, millions of people will be left with inadequate coverage that falls far short of their health care needs. It's essential that coverage expansion proposals include strong protections for sexual and reproductive health care and dismantle existing coverage and access barriers for immigrants, LGBTQ+ individuals, and others. Additionally, any proposal should not include provisions that allow religious or personal beliefs to impede access to care.**

- Every new insurance coverage proposal, at a minimum, must include coverage of comprehensive reproductive health care services, including abortion services and birth control, with no out-of-pocket costs to beneficiaries.

- Every new insurance coverage proposal should provide coverage to everyone (including individuals of all immigration statuses), a robust provider network (including both protections against discrimination and adequate reimbursement rates) and patient protections (including nondiscrimination protections and cultural competency standards) that ensures coverage actually translates into access.<sup>11</sup>
- Every new insurance coverage proposal must guarantee coverage to individuals of all immigration statuses, and undo the impact of current, legal and policy barriers that restrict access to affordable, comprehensive coverage for immigrant individuals and families.
- Every new insurance coverage proposal should ensure seamless access to culturally and linguistically competent care and services, including gender-affirming care for LGBTQ+ individuals, and promote health equity.

**Lawmakers must advance the goal of universal health care coverage by immediately reversing course on recent sabotage and build upon successful implementation of the ACA.**

**The ACA was a historic milestone for improving health and well-being, helping to expand access to health coverage and care for millions of people, including those historically disadvantaged under the health care system such as communities of color, LGBTQ+ people,**

**and people with low-incomes. Notably, through the ACA, coverage for women of color grew at more than twice the rate of women overall between 2013 and 2015,<sup>12</sup> and, the uninsurance rate for lesbian, gay, and bisexual people decreased nine percent between 2010**

<sup>11</sup> Sonfield, A., Keller, L.H. (2019). Principles for Reform: New U.S. Health Care Proposals Cannot Overlook Sexual and Reproductive Health. Guttmacher Policy Review, 22, 16–22.

<sup>12</sup> H. Williamson (2017). ACA Repeal Would Have Disproportionately Harmed Women of Color. Washington: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/women/news/2017/08/15/437314/aca-repeal-disproportionately-harmed-women-color/>

**and 2016.<sup>13</sup> Despite this progress, nearly 30 million people remain uninsured with enduring access inequities among Blacks, Latinos, transgender people, and people living in certain parts of the country such as the South. Additionally, the 2011 national survey from the National Center on Transgender Equality found that 19 percent of transgender, nonbinary, and gender nonconforming respondents reported lacking health insurance, compared to 17 percent of the overall U.S. population.<sup>14</sup> In the follow up survey in 2015, this number had declined to 14 percent, compared to 11 percent of the overall U.S. population.<sup>15</sup> Even more the ACA has repeatedly endured attacks, both through repeated repeal attempts and the Trump-Pence administration policies, which have undermined progress in coverage gains, quality of plans, and consumer protections.**

- **Congress and the administration must not only reverse policies that undermine the ACA but also build upon the ACA to expand health insurance coverage to all by:**
  - Banning substandard health plans, such as short-term health plans, association health plans, and health care sharing ministries, which have blanket exclusions of sexual and reproductive health services (including gender-affirming health services) and engage in discriminatory pricing.
  - Defending the Affordable Care Act in Court.
  - Restoring navigator funds and marketing funds to promote open enrollment.
  - Removing barriers to enrolling in plans available on the federal and state-based marketplaces.
  - Issuing guidance on 1332 waivers aimed at improving access to health benefits and services.
  - Increasing the financial assistance available to purchase private coverage on the marketplaces by expanding eligibility for tax credits to people with incomes above 400 percent of the federal poverty level and increasing funding available for tax credits and cost-sharing reductions.

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13 Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., Dawson, L. (2018). Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT). Washington: The Kaiser Family Foundation. [Online]. Retrieved from <https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/>

14 Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J., Keisling, M. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force. [Online]. Retrieved from [http://www.transequality.org/sites/default/files/docs/resources/NTDS\\_Report.pdf](http://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf)

15 James, S. E., Herman, J. L., Keisling, M., Mottet, L., Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force. [Online]. Retrieve from <http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf>

# The Administration and Congress should protect and expand Medicaid to ensure robust, accessible coverage in all states and should ensure Medicaid enrollees have access to the contraceptive method of their choice from the provider of their choice – free from coercion.

**Medicaid is the largest funding source supporting the delivery of family planning and related care in the country. Medicaid provides coverage to 1 in 5 women of reproductive age<sup>16</sup> and funds approximately half of the births in the U.S.<sup>17</sup> Increasing Medicaid access would, therefore, increase access to family planning services and supplies, as well as to other critical reproductive health care services. Women of color, in particular, would be among the populations that would benefit the most from increasing access to Medicaid. Due to systemic barriers, they are more likely to be covered under Medicaid. Women of color are also more likely to fall in the coverage gap because they reside in a state that refused to expand Medicaid under the ACA.**

Additionally, due to the high prevalence of poverty in the LGBTQ+ community, especially for people of color, transgender individuals, and people with disabilities,

Medicaid is critical for achieving health equity and providing coverage for care.<sup>18</sup> Unfortunately, in addition to the failure to expand Medicaid by states, the Trump administration has also supported and approved a number of attacks on the program undermining advancements towards health equity made under the previous administration. The administration and Congress must reverse the harmful damage that has been done to the Medicaid program in recent years, and commit to expanding eligibility and access to the program, taking the following steps:

- **Congress should investigate – and CMS should deny – unlawful Medicaid Section 1115 demonstration projects that do not promote Medicaid’s core objectives.** Despite limitations on their use, the current administration has approved waiver projects that undermine this central purpose.<sup>19</sup> Congress should exercise its oversight and investigation authority to vigilantly assess approved Medicaid waiver projects, such as those imposing work requirements, that threaten access to coverage and services.
- **Congress should protect Medicaid against efforts to fundamentally alter the program, including but not limited to transforming the program from an entitlement program to a per capita cap or block grant program.** Congress should oppose any attempt to undermine critical health

16 Guttmacher Institute (2017). Why Protecting Medicaid Means Protecting Sexual and Reproductive Health. Washington: The Guttmacher Institute. [Online]. Retrieved from [https://www.guttmacher.org/gpr/2017/03/why-protecting-medicare-means-protecting-sexual-and-reproductive-health?utm\\_source=Master+List&utm\\_campaign=f7f382a2b6-RHIC\\_GPR10S\\_2017\\_03\\_08&utm\\_medium=email&utm\\_term=0\\_9ac83dc920-f7f382a2b6-244281261](https://www.guttmacher.org/gpr/2017/03/why-protecting-medicare-means-protecting-sexual-and-reproductive-health?utm_source=Master+List&utm_campaign=f7f382a2b6-RHIC_GPR10S_2017_03_08&utm_medium=email&utm_term=0_9ac83dc920-f7f382a2b6-244281261)

17 Henry J. Kaiser Family Foundation (2016). Births Financed by Medicaid. Washington: Henry J. Kaiser Family Foundation. [Online]. Retrieved from <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicare/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

18 National Latina Institute for Reproductive Health (2018). Medicaid & Reproductive Justice. Washington: National Latina Institute for Reproductive Health. [Online]. Retrieved from <https://latinainstitute.org/sites/default/files/Medicaid%2520and%2520RJ%2520Factsheet.pdf>

19 42 U.S.C.A. § 1396-1



care coverage and access programs, including attempts to undermine the Medicaid program by shifting costs to states; by forcing states to cut benefits or provider payments; by lowering eligibility levels; or by otherwise undermining Medicaid's role in providing access to critical health services, including sexual and reproductive health care.

- Congress and the administration should increase incentives and encourage all states to expand their Medicaid programs as intended under the ACA. Medicaid expansion is the most effective tool states have to provide health insurance coverage of essential health services, including reproductive health services, to people with low incomes.<sup>20</sup>
  - **The administration should encourage states, especially states that have not expanded Medicaid, to implement state family planning expansions. Additionally, Congress should offer additional funding to incentivize states to implement these expansions.**
  - **Congress should prohibit any Medicaid funds for conversion therapy.**
  - **CMS should reinstate its 2016 guidance to ensure all Medicaid programs and plans provide comprehensive coverage for family planning services and supplies to all Medicaid enrollees, free of coercion. CMS issued guidance clarifying**
- that Medicaid enrollees have a right to receive covered services from any qualified provider and separate guidance to improve access to long-acting reversible contraceptives. To ensure enrollees truly have the right to their contraceptive method of choice, CMS should issue guidance that ensures Medicaid enrollees, have coverage for their choice of contraceptive.**
  - **CMS should provide oversight and enforcement of states and managed care plans to ensure they are complying with federal law, including covering the full range of services without coercive restrictions, covering removal of long-acting reversible contraceptives with no time or frequency restrictions, informing enrollees of their rights to access covered services out-of-network and ensuring out-of-network providers are reimbursed for that care, and ensuring that enrollees receive all care and information to which they are legally entitled, even when providers or Medicaid Managed Care Organizations assert religious or moral objections.**
  - **Policymakers must ensure that all federally-supported health programs, and health insurance plans of all types, are operated in a manner that does not discriminate against or otherwise limit the participation of reproductive health providers for reasons unrelated to their qualifications; and expand the scope of health care providers that are covered under health programs and insurance options so that all Medicaid patients are able to see the provider of their choice.**

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<sup>20</sup> Bair, Y., Ranji, U., and Salganicoff, A. (2016). Medicaid and Family Planning: Background and Implications of the ACA. [Online]. Retrieved from <http://kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/>

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# Use United States Leadership to Advance Sexual and Reproductive Health Globally

**The President should launch an initiative to integrate, elevate, and prioritize sexual and reproductive health and rights (SRHR) across foreign policy priorities and global health, development, and humanitarian programs.**

**The integration and elevation of SRHR into foreign policy and global programs must be a priority to advance the health and rights of all individuals and promote bodily autonomy. A presidential initiative should establish a clear mandate to coordinate across agencies to integrate SRHR in the implementation, review, and expansion of policies and programs across health, development, humanitarian, and human rights sectors. In order for this initiative to have a meaningful impact at a policy, programmatic, and diplomatic level, the President, in consultation with Congress, must set standards and codify definitions of sexual and reproductive health and rights and related terms to promote these rights in U.S. policy and champion their inclusion in international human rights frameworks.**

- **The U.S. government, led by the President, should support and advance the following proposed definitions of key terms:**

- **Sexual and reproductive health and rights:** Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.<sup>21</sup>

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21 Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R.,....Popinchalk A. (2018). Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *The Lancet Commissions*, 391, 2642–2692.

- **Gender:** the socially constructed set of roles, rights, responsibilities, entitlements, and behaviors associated with being a woman or a man in societies. The social definitions of what it means to be masculine or feminine, and negative consequences for not adhering to those expectations, vary among cultures, change over time, and often intersect with other factors such as age, class, disability, ethnicity, race, religion, and sexual orientation.
- **Gender Expression:** external appearance of one’s gender identity which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.
- **Gender Identity:** a person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. For transgender people, their birth-assigned sex and their own internal sense of gender identity do not match.
- **Comprehensive sexuality education:** Educational programs for young people in school and out of school which include age, developmentally, and culturally appropriate, science-based, and medically accurate information on a broad set of topics related to sexuality, including human development, relationships, personal skills, sexual behaviors, including abstinence, consent, sexual health, and society and culture.
- **The State Department should report on sexual and reproductive rights violations in their annual Country Reports on Human Rights Practices.** These reports provide critical monitoring and accountability of human rights violations, and provide a benchmark of progress and ongoing challenges to achieving full human rights for all. As a first step towards comprehensive reporting on sexual and reproductive rights, Congress should pass and the President should champion passage of the Reproductive Rights and Human Rights Act.
- **The U.S. should also encourage other nations to expand civil society engagement and increase budgetary support for sexual and reproductive health, in accordance with commitments to the Sustainable Development Goals and targets to achieve universal health coverage and ensure universal access to sexual and reproductive health care services.** The United States has the opportunity to assert leadership in the global community and leverage diplomatic capacity to urge other countries to respect, protect, and fulfill the sexual and reproductive health and rights of their people. The U.S. should play a leadership role in fulfilling these global commitments and in seeking new international commitments to advancing SRHR.
- **The U.S. must provide and require training for embassy and mission staff on the cross-cutting impact of SRHR on development, humanitarian, and national security priorities; guidelines and incentives to engage civil society at the Mission and headquarters level; and proactive guidance to diplomats and foreign service officers on priority SRHR policy and program areas.** The Interagency Task Force on SRHR or women and girls can further play a role of annually briefing the diplomatic corps to provide priorities and direction for diplomacy.

## The U.S. must protect and promote the highest standard of sexual and reproductive health and rights in multilateral fora.

**As a longtime champion and leader in the creation of multilateral mechanisms that strengthen sexual and reproductive health and rights, including the formation of the United Nations Population Fund (UNFPA) and strong consensus support for the International Conference on Population and Development in Cairo, the U.S. must continue to protect and promote the highest standard of sexual and reproductive health and rights in all multilateral fora. Over the last two years, the administration has used international forums, like the Commission on the Status of Women (CSW), the Commission on Population and Development (CPD), and the World Health Assembly (WHA) to question longstanding norms and definitions of sexual and reproductive health and rights. In addition to reversing these actions, the U.S. should support outcome documents, policies at negotiations, and civil society participation for CSW, CPD, WHA, Human Rights Council and within the UN and other multilateral bodies and executive boards, which strengthen access to full, evidence-based, sexual and reproductive health and rights.**

- The U.S. government can achieve this through the following actions:
  - Enshrine a definition of sexual and reproductive health and rights and negotiate from that position, as previously referenced.
  - Promote inclusion of civil society experts in multilateral forums, specifically by including diverse, evidence-based participants within the official delegations to international negotiations, like CSW, CPD and WHA. Participants and outside organizations should be representative of the populations and communities to which the outcome documents are related, promote evidence-based policies and programs for sexual and reproductive health and rights, and bring substantive professional expertise to the themes and topics being negotiated. The U.S. should not include organizations that promote harassment, discrimination, violence, or a non-rights based approach to sexual and reproductive health.
  - Ensure participants from around the world are granted visas to engage in convenings at UN headquarters, the Organization of American States, World Bank and other multilateral institutions located in the U.S. to ensure that negotiators can hear from a diversity of backgrounds.
  - Prioritize participating and serving on the Executive Board of UN Specialized Agencies related to sexual and reproductive health and rights and encourage the expansion of their programs and policies globally. The U.S. should also publicize its statements at these executive boards.

- Rejoin the Human Rights Council in order to have a seat at the table at critical discussions of human rights issues and to advance sexual and reproductive health and rights as human rights.
- Work with the UN Security Council to adopt resolutions which recognize the importance

**of sexual and reproductive health and rights for those impacted by conflict and call for improved access to comprehensive sexual and reproductive health services, including for survivors of conflict-related sexual and gender based violence.**

**The United States must commit to advancing free and informed choice across U.S. foreign assistance by replacing the politicized Kemp-Kasten language with comprehensive and enforceable anti-coercion protections across the full range of sexual and reproductive health and rights issues.**

**At the International Conference on Population and Development (ICPD) in Cairo, the U.S. joined 178 other countries in adopting a Program of Action that continues to serve as a comprehensive guide to development progress based on volunteerism and without coercion. Since that time, many governments have instituted new and effective safeguards against coercion in reproductive health programs. The U.S., however, has continued to rely on an outdated 35-year-old provision in law – the Kemp-Kasten Amendment – that is narrow, politically biased and ineffective at ending coercion. Current US law in this area should be replaced with clearer, enforceable, and more comprehensive protections against coercion that has the effect of actually helping end coercion.**

- Congress should replace Kemp-Kasten with a blanket prohibition on U.S. funding going to coercive activities in US foreign assistance in line with the ICPD. The U.S. should clearly and comprehensively define the parameters of coercion and what activities are prohibited. Reproductive coercion is any behavior that interferes with autonomous decision making about reproductive health outcomes. Coercive activities include, but are not limited to:
  - Use of incentives or disincentives to lower or raise fertility;
  - Use of incentives or targets for uptake of specific contraceptive methods;
  - Withholding of information on reproductive health options;
  - Forced sterilization;
  - Forced abortion; and
  - Forced pregnancy.

The U.S. commitment to human rights based approaches to sexual and reproductive health, free

from all forms of coercion, must be made clear in all requests for proposals, guidance, trainings, contracts, and cooperative agreements. There must be a robust

compliance monitoring system and a clear way to report and thoroughly investigate potential violations so that appropriate corrective action can be taken.

**The United States should strengthen global health systems and supply chains with the goal of ending contraceptive commodity stockouts and wastage resulting from mismanaged overstocks, and ensuring access to the full range of quality contraceptive methods.**

**In order to do so, the administration should:**

- Use diplomacy to encourage Ministries of Health and Finance to co-invest their own resources, alongside U.S. family planning assistance, to develop and implement clear policies and protocols that improve the supply chain and resolve stockouts.
- Streamline an indicator on contraceptive stockouts in USAID contracts.
- Improve method mix of contraceptives.
- Improve family planning graduation strategies to better monitor and address contraceptive stockouts and method mix with contingency plans for meeting serious pipeline and budget gaps that may result when transitioning from donor to domestic financing.
- Improve awareness of and access to emergency contraception.

**The U.S. must recognize the lifesaving nature of sexual and reproductive health care in humanitarian emergencies and prioritize the provision of sexual and reproductive health services, as well as gender-based violence (GBV) programming, in U.S. humanitarian and disaster relief assistance.**

**Around the world we are seeing some of the highest levels of displacement and humanitarian need in history. In 2018, more than 34 million of those individuals were**

**women of reproductive age, including more than 5 million women who were pregnant.<sup>22</sup> Many individuals want to delay or avoid pregnancy during times of conflict or crisis, but**

22 UNFPA. (2019). Humanitarian Action: 2019 Overview. New York: UNFPA. [Online]. Retrieved from [https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA\\_HumanitAction\\_2019\\_PDF\\_Online\\_Version\\_16\\_Jan\\_2019.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2019_PDF_Online_Version_16_Jan_2019.pdf)

**too often they lack access to contraceptives and other reproductive health services and supplies. Additionally, humanitarian emergencies lead to heightened risks of GBV, including rape, sexual harassment, assault and exploitation, trafficking, child, early, and forced marriage and interpersonal violence.**

The State Department's Bureau of Population, Refugees and Migration (PRM) and the Office of Foreign Disaster Assistance (OFDA) should prioritize and fully fund implementing partners to:

- **Ensure that the Minimum Initial Service Package (MISP) is prioritized and operational at the onset of any humanitarian crisis: The MISP is a series of critical coordination activities and life-saving health and protection interventions required to respond to the immediate sexual and reproductive health needs of those impacted by a humanitarian crisis.** These activities, combined with kits of the necessary equipment and supplies, are intended to address needs at the onset of a crisis and serve as a starting point for rebuilding comprehensive sexual and reproductive health services throughout protracted crises and recovery.
- Support and implement quality comprehensive reproductive health services for the duration of a crisis and through the transition to recovery. In addition to implementing the MISP, planning for and efforts to integrate comprehensive reproductive health services into primary health care should begin as soon as possible. Comprehensive reproductive health care activities include but are not limited to: establishment of critical reproductive health coordination mechanisms; prevention of transmission of HIV and other sexually transmitted infections (STIs) and provision of supplies and services necessary for the treatment of STIs and continuation of antiretroviral treatments; provision of maternal

health services, including antenatal and postnatal care and emergency obstetric and newborn care; provision of safe abortion and post-abortion services; ensuring consistent access to a full range of contraceptive supplies and services, including emergency contraception.

- Provide assistance to prevent and respond to gender-based violence (GBV) from the earliest stages of a crisis, including to address health, including sexual and reproductive health, as well as mental health and other psychosocial services, legal rights and access to justice. This includes, but is not limited to:
  - Enhancement of the health sector capacity to detect, prevent, and respond to gender-based violence through training for providers on quality, confidential care (including clinical management of rape); identifying GBV and integrating GBV into health services to ensure that survivors are able to access lifesaving and time-sensitive treatments, including both emergency contraception and Post-Exposure Prophylaxis for HIV, at the same location.
  - Survivors of gender-based violence should be provided with or referred for psychosocial services, emergency contraception and post-exposure prophylaxis and, when needed, abortion services.
  - Building local capacity and improving national systems whenever possible to promote risk reduction and better respond during crises, displacement, and recovery.
- **Support efforts to ensure women's meaningful participation in designing SRHR and other gender programming throughout the period of relief and recovery, as well as in efforts around peace building, to ensure that the human rights concerns of women, girls and other marginalized communities are considered and addressed.**

**To advance the health, rights, and well-being of individuals and communities around the world, U.S. international family planning and reproductive health programs must be supported by robust funding and sound policies. The U.S. should contribute its “fair share” of funding to international family planning and reproductive health programs and eliminate policy riders which undermine the effectiveness of U.S. aid.**

- **Congress should invest and the President should propose at least \$1.66 billion for international family planning and reproductive health programs, including \$111 million for UNFPA.** Across the globe, U.S. investment in international family planning and reproductive health programs serve as a lifeline. In FY18 alone, U.S. foreign aid provided contraceptive services for 24.3 million women and couples, averting 7.2 million unintended pregnancies, 3.1 million abortions (2 million of which would have been unsafe) and 14,690 maternal deaths.<sup>23</sup> A total of \$1.66 billion, including \$111 million for UNFPA, represents the US share<sup>24</sup> of total global expenditures necessary to address the current unmet need for contraceptives for 214 million women in developing countries.<sup>25</sup> UNFPA plays a critical role as the largest multilateral provider of family planning and reproductive health services. Investments in UNFPA expand the reach of our aid as it operates in more than 155 countries. UNFPA plays a critical role in ending maternal death, unmet need for family planning, and gender-based violence and harmful practices like female genital mutilation and child marriage. UNFPA has taken a lead role in responding to reproductive and community health needs in humanitarian emergencies, such as conflicts and natural disasters.
- **Congress should provide significant increased investments for other global programs that promote the health, rights, and well-being of individuals and communities and advance gender equality, including Maternal, Newborn and Child Health (MNCH), the President’s Emergency Plan for AIDS Relief (PEPFAR) (at least \$5.5 billion annually), U.S. contribution to the Global Fund to Fight AIDS, TB, and Malaria (\$1.56 billion in annual contribution), USAID HIV programs (\$350 million annually), the International Organizations and Programs account which supports U.S. contributions to international organizations and specialized agencies across a broad spectrum of development, humanitarian, and scientific activities, and gender equality programs, including those focused on gender-based violence, women’s leadership, women, peace and security, and women’s economic empowerment, as well as programming addressing the unique needs of adolescent girls, such as ending harmful practices such as child marriage and female genital mutilation/cutting.**
- **Congress should also:**

23 Guttmacher Institute (2019). Just the Numbers: The Impact of U.S. International Family Planning Assistance. New York: Guttmacher Institute. [Online]. Retrieved from <https://www.guttmacher.org/article/2019/04/just-numbers-impact-us-international-family-planning-assistance-2019>

24 PAI (2018). Just the Math: Methodology for Calculating the U.S. Share of the Cost of Addressing the Unmet Need for Contraception in Developing Countries. Washington: PAI. [Online]. Retrieved from <https://pai.org/newsletters/just-math-methodology-calculating-u-s-share-cost-addressing-unmet-need-contraception-developing-countries/>

25 Guttmacher Institute (2017). Unmet Need for Modern Contraception, 2018. Washington: Guttmacher Institute. [Online]. Retrieved from <https://www.guttmacher.org/infographic/2018/unmet-need-modern-contraception-developing-regions>



- **Remove the Livingston amendment**, which allows organizations that receive certain government grants to refuse to offer the full range of contraception based on their religious objections; this provision significantly undermines access to the full range of contraceptive methods, a critically important part of promoting health and respecting rights.
- **Eliminate onerous and unnecessary restrictions on the U.S. contribution to UNFPA** including the requirement to segregate the US contribution and the dollar-for-dollar withholding for any funding UNFPA provides to China.

***“If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.”***

*–Lilla Watson*

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# Protect and Expand Access to Abortion Care Domestically and Globally

Abortion care is health care, and access to abortion is critical for all people. If an individual is to make their own decisions and live their healthiest life possible—a fundamental human right—they must be able to control their reproductive life and obtain

quality sexual and reproductive health care and accurate information. When someone is denied the ability to care for or end their own pregnancy, they are denied the means to direct their own life, protect their health, and exercise their human rights.

**The President and Members of Congress should use their pulpits and authority to protect and expand access to abortion care, destigmatize abortion, and to lift up the importance of a federal guarantee that all have access to abortion care, no matter who they are or where they live.**

Access to abortion care is under attack across the United States and remains heavily restricted in countries around the world. While abortion is currently a constitutional right in the U.S., in many parts of the country, that right is solely theoretical. State legislatures have targeted providers with medically unnecessary restrictions that have shut down clinics and cut off access to care, they have passed laws that shame decision making, and attempted to ban abortion outright. Several states have only one or two abortion providers in their states, half of states restrict private insurance coverage of

abortion, and two-thirds of states withhold Medicaid coverage of abortion except in the most dire circumstances of rape, incest, and life-endangerment. In addition, some states prosecute individuals choosing to end their own pregnancies, a disturbing practice we have witnessed outside of the U.S. as well. Moreover, current federal law places unjust restrictions on abortion access, including the Hyde and Helms Amendments, which withhold federal funds from abortion in the U.S. and around the world, and the Weldon Amendment, which emboldens health care providers to deny access to abortion care. Health

**and wellbeing, not politics, should guide important medical decisions at every point in pregnancy.**

Opponents of abortion are accelerating passage of these laws and policies as a way to prompt legal challenges in hopes of ultimately securing a Supreme Court ruling that would reverse decades of case law and make abortion wholly inaccessible nationwide. The majority of justices on the U.S. Supreme Court have indicated willingness to uphold state and federal laws that restrict access to sexual and reproductive health care, and as such, it is more important than ever that we establish a federal guarantee that all individuals have unimpeded access to abortion.

No one is free without the ability to control their own body. All people—no matter where they live, where they are from, how much money they have, or their insurance coverage—should have the means, resources, and tools to access abortion in a timely manner without barriers so that they can control if, when, and how to become pregnant and grow their family if they chose. Because abortion restrictions fall hardest on those who have limited means to navigate around barriers to health care, such as people of color, individuals with low incomes, immigrants, young people, and people in rural areas, guaranteeing unimpeded abortion access is also crucial for improving health equity and ensuring that more people are able to curate their lives with respect, dignity, integrity, and autonomy.

The President and Members of Congress have tremendous power to create policy, pass legislation, and use the bully pulpit to influence the debate around issues of importance such as this one. It is not enough that federal lawmakers seek to safeguard the status quo: Congress must work with the President to guarantee all people in the U.S. and around the world access to surgical and medication abortion without impediment. Accordingly, we ask they use this power to:

- **Pass the EACH Woman Act and the Women’s Health Protection Act as necessary federal**

responses to the crisis in access to abortion care in the U.S.

- **End the Hyde Amendment and related restrictions and ensure that everyone has abortion coverage, regardless of their income or source of insurance.**
- **Repeal the Helms amendment, and replace it with endorsement of using U.S. funding for safe abortion services worldwide.**
- **Eliminate the Weldon Amendment, which emboldens health care providers to deny access to abortion care.**
- **Use the bully pulpit to:**
  - **Speak out against restrictions on access to abortion in the U.S. and around the world, including targeted regulation of abortion providers (TRAP) and other laws;**
  - **Denounce the unjust and stigmatizing criminalization of abortion, including those who end their own pregnancies by choosing self managed abortion and send strong messages that however a person chooses to end a pregnancy, they must be able to do so safely and effectively without fear of arrest;**
  - **Condemn anti-abortion violence and intimidation, and combat the inflammatory rhetoric used by anti-abortion individuals that can lead others to engage in violent activity. Public statements that condemn these acts would signal a deep commitment to protecting reproductive rights, civil rights, and the rule of law; and**
  - **Talk about abortion care in a way that normalizes it with other health care and de-stigmatizes those who have abortions and those who provide abortions.**

## Policyholders should ensure comprehensive insurance coverage of abortion domestically.

**Everyone should have access to abortion care regardless of their source of insurance and, whether that care is within or outside a clinic setting. Studies show that a woman who seeks an abortion, but is denied, is more likely to fall into poverty than one who is able to get an abortion. Each of us should be able to make decisions about our health and our futures with dignity. However, starting with the passage of the harmful Hyde Amendment in 1976, discriminatory restrictions on public insurance coverage of abortion continue to severely limit abortion access for people with low or no incomes, as well as others who receive their health coverage or care through the federal government. Further compounding the problem, since 2010 more than 400 laws have been enacted in the U.S. that restrict and regulate abortion for medically-unnecessary reasons. The cumulative effect of these numerous restrictions has been to severely limit the availability of abortion services in some areas, creating a patchwork system where access to abortion services are available in some states but not others.**

It is necessary for Congress and the administration to act to undo the barriers that make the right to have an abortion a right only in theory for too

many people. At a minimum, Congress must pass the EACH Woman Act to mandate coverage of abortion in government health plans and programs, and ensure that young people and their rights to confidential care are protected in federal legislation. Such legislation must not include exemptions or accommodations based on religious or personal beliefs that would impede patient care. It is critical that existing policy riders that are designed to cut off reproductive health services, information, and advocacy be permanently repealed and blocked from being attached to annual appropriations.

- Congress should end all abortion coverage bans affecting the following populations: (i) Medicaid, Medicare, and Children’s Health Insurance Program beneficiaries; (ii) federal employees and their dependents; (iii) Peace Corps volunteers; (iv) Native Americans; (v) people getting health services through CHAMPVA and the Department of Veterans Affairs; (vi) people in federal prisons and detention centers, including those detained for immigration purposes; and (vii) people with no or low incomes in the District of Columbia through the use of local funds. Congress should end coverage restrictions in the Labor-H, FSGG, SFOPs, and CJS bills. Congress should reauthorize CHIP, IHS, and DOD without coverage bans
- The President should put forth a President’s budget without abortion coverage restrictions and issue a Statement of Administration Policy (SAP) threatening to veto legislation that extends, reiterates, or incorporates abortion coverage restrictions such as the Hyde Amendment and the other harmful restrictions listed above.
- The President should strike language restricting abortion coverage from the President’s Budget

and issue a Statement of Administration Policy (SAP) threatening to veto legislation that extends, reiterates, or incorporates abortion coverage restrictions such as the Hyde Amendment and the other harmful restrictions listed above.

- **The administration and Congress should reverse restrictions on abortion coverage for people**

**who are enrolled in private health care plans.** Specifically, the administration should revoke EO 13535 and rescind any finalized 1303 regulations or guidance. In light of constant attacks on abortion coverage and attempts to expand coverage bans into the private market, Congress must strike 1303 of the ACA and compel private insurance coverage of abortion.

***“[T]he Hyde Amendment is a transparent attempt ... to impose the political majority’s judgment of the morally acceptable and socially desirable preference on a sensitive and intimate decision that the Constitution entrusts to the individual. Worse yet, the Hyde Amendment does not foist that majoritarian viewpoint with equal measure upon everyone in our Nation, rich and poor alike; rather, it imposes that viewpoint only upon that segment of our society which, because of its position of political powerlessness, is least able to defend its privacy rights from the encroachments of state-mandated morality.”***

*–Justice William Brennan dissenting in Harris v. McRae*

## **Policymakers should actively fund and promote access to safe, legal, and accessible abortion throughout the world.**

**As we advance the right to abortion as a critical health care service in the U.S., we must also advance this right globally. The Helms Amendment, which has been in place since 1973, prohibits the use of U.S. foreign assistance funds for “the performance of abortion as a method of family planning.” This provision restricts the ability of individuals to make their own personal medical decisions and undermines U.S. goals to advance gender equity and address maternal health and gender-based violence around the world. Furthermore, it has been overimplemented as a complete ban on U.S. funding for abortion, even in cases of rape, incest, or a life endangering pregnancy. Globally, one in three women will experience violence in her lifetime – a rate that is often higher in humanitarian crisis and conflict settings, where rape and other forms of sexual violence are used as tools of war and where displaced communities are particularly vulnerable.**

Unsafe abortion is a global health crisis driven by criminalization of the procedure and an inability to access safe abortion care. Annually, there are more than 25 million unsafe abortions worldwide that lead to millions of injuries and tens of thousands of preventable maternal deaths. The Helms Amendment exacerbates this crisis, and it is long past time for the U.S to support safe abortion services. Over the last two decades, many

countries have liberalized their abortion laws, magnifying the impact of the Helms Amendment as a significant barrier to patients receiving the care they need and to which they are legally entitled. U.S. restrictions must not stand in the way of access to legal health care.

In addition, in too many countries, laws criminalize abortion services. These laws are discriminatory – disproportionately affecting women, people living in poverty, and LGBTQ+ people – and they are a significant barrier to comprehensive reproductive health services by threatening both health care providers and people seeking care. International human rights bodies have repeatedly called for the decriminalization of abortion, and the World Health Organization reports that unsafe abortion remains a major cause of maternal mortality. Abortion laws use criminal codes to control people’s bodies and, in practice, may lead to other serious human rights abuses. For example, in countries like El Salvador where abortion is completely criminalized, women are frequently jailed for miscarriages. Despite these physical and legal risks, countries with highly restrictive abortion laws typically record higher abortion rates than countries with less restrictive laws.

The U.S. should use diplomatic engagement and foreign assistance to promote access to quality, comprehensive sexual and reproductive health care services for all people; this includes safe, legal, and accessible abortion. Stated U.S. policy should promote access to safe and legal abortion throughout the world, as a part of U.S. efforts to advance health and human rights through the following actions:

- **Congress should legislatively repeal the Helms Amendment, and replace it with endorsement of using U.S. funding for safe abortion services worldwide.**
- **The President should champion the permanent repeal of the Helms Amendment. While working**

with Congress to pass legislation to this end, the President should work to mitigate the harms of the Helms Amendment.

- Congress should modify the Siljander Amendment in the State and Foreign Operations appropriations bill to only prohibit the use of U.S. funds to lobby against abortion. Foreign policy funding decisions – particularly those around health – should be grounded in science and fact, and the evidence is clear that safe abortion access saves lives.

- The State Department should make an affirmative statement that the U.S. supports the decriminalization of abortion—including self-managed abortion—around the world. U.S. diplomats should carry this message throughout the world, and the U.S. should use multilateral spaces to promote normative guidance urging the decriminalization of abortion.

## Policymakers should promote and ensure improved access to medication abortion.

**Ever since mifepristone was approved for use in the United States nearly 20 years ago, it has offered those who want to end their pregnancies a way to do so in a setting where they may feel most comfortable. Medication abortion accounts for 45% of all abortions before nine weeks of gestation in the U.S.<sup>26</sup> Unfortunately, medication abortion has been subject to laws that limit access, and those limits—combined with medically unnecessary regulatory restrictions imposed at the time of**

**approval—have inhibited access to the highest standard of care for medication abortion.**

- HHS should encourage and pursue policies that support evidence-based protocols and implement programs that will improve access to this safe, private, and non-invasive option.
- The Department of Health and Human Services should proactively work with the World Health Organization’s (WHO) Expert Committee on the Selection and Use of Essential Medicines to remove the disclaimer notes attached to the combination use of mifepristone and misoprostol on the WHO’s List of Essential Medicines.

***“Reproductive Justice is built on the foundation of Human Rights. The framework of “Reproductive Justice” requires that the most vulnerable populations be kept in the center of our lens, not at the margins.”***

***—Loretta Ross***

<sup>26</sup> Guttmacher Institute (2018). Induced Abortion in the United States. Washington: Guttmacher Institute. [Online]. Retrieved from <https://www.guttmacher.org/factsheet/induced-abortion-united-states>

## The Administration should create and support public health resources used to increase people’s knowledge of the full range of abortion options, including self-managed abortion.

**Both clinic-based and non-clinical abortion options should be safe, affordable, and free from stigma or punishment for the people who need them. Clinic-based abortions are an essential component of abortion care; nevertheless, some pregnant people need abortions outside of the formal health care system. Non-clinical abortion, such as a self-managed abortion, occurs most commonly in the privacy and safety of one’s home and with the help of a caregiver, friend, or family member. Self-managed abortion may include the use of medication abortion pills (mifepristone and/or misoprostol), traditional herbs, or other means to end a pregnancy.**

Self-managed abortion (SMA) is generally safe and effective, especially when people have access to information and back up medical care if needed. There is no legitimate public health reason to prevent people from having access to the means to self-manage their abortion. Increased awareness about self-managed abortion, safe methods, and means of access—achieved through culturally competent communications accessible to people of all educational levels—will help destigmatize

self-managed abortion. Destigmatization will, in turn, ensure that people who end their own pregnancies will feel safe to seek medical care, and it will lessen the likelihood of criminalization.

Criminalization<sup>27</sup> of self-managed and supported non-clinical abortion poses serious threats to people’s health. The likelihood, or even possibility, of being turned in to law enforcement erodes trust in the medical system, making people less likely to seek medical help when they need it. Most of the people arrested for self-managing an abortion came to the attention of law enforcement when they sought emergency medical help. Public health resources could educate healthcare providers, patients, and the public at large about SMA, debunking myths with facts and overcoming stigma through normalization.

- **Materials for pregnant people, created or supported by HHS, should include information about how self-managed abortion with pills works, what the common side effects are, and under what conditions a person may need to seek medical help following a medication abortion or miscarriage.**
- **Materials geared toward health care providers, first responders, and social workers, created or supported by HHS and DOJ, should make clear that mandatory reporting laws do not apply to people who SMA and emphasize a harm reduction approach to treating patients in a supportive, non-stigmatizing manner.**

27 Adams, J.E., Diaz-Tello, F., Mikesell, M. (2018). Roe’s Unfinished Promise: Decriminalizing Abortion Once and For All. [Online]. Retrieved from <https://www.ifwhenhow.org/resources/roes-unfinished-promise/>



**Congress and the Administration should ensure that the federal criminal code cannot be used to prosecute people for self-managed abortion and ensure that law enforcement agencies cannot take action against those individuals.**

States have used a variety of criminal laws – the vast majority of which were never intended to be used against people who ended their own pregnancies – to prosecute people for self-managed abortion. There are as many as 40 different types of laws across the country that could be misused by a prosecutor intent on punishing a person for ending or losing a pregnancy. Specifically, there are six states with laws directly criminalizing self-managed abortion, as well as ten states with fetal harm laws and 14

states with criminal abortion laws that have been and could be misapplied to people who self-manage. There are various other laws that have been deployed when no other legal authorization to punish someone can be found, ranging from unlawful practice of medicine to child abuse to concealing a birth. In states throughout the country, even where fetal homicide laws expressly exempt pregnant people from prosecution, prosecutors have used other laws to target people who have self-managed abortion.

*“For too long, women in this country have been denied abortion coverage just because of their source of insurance or level of income. We know that these restrictions are nothing more than attempts to bully, shame, and punish those seeking abortion care. I remain resolved as ever to see the Hyde amendment dismantled once and for all.”*

*–Rep. Barbara Lee*

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# Improve and Expand Access to Pregnancy Care

**Access to respectful, high-quality, holistic pregnancy-related health services is a fundamental human right. Pregnancy care should fit the patient’s needs and preferences, regardless of race, ethnicity, socioeconomic status, immigration status, language, gender, gender identity, sexual orientation, marital status, family structure, disability status, age, source of insurance, or intent to parent. It is the government’s duty to respect, protect, and fulfill this human right. Further, the opportunity to improve maternal health outcomes begins years before pregnancy and requires continued support and access to non-discriminatory health care and wraparound services throughout the individual’s lifespan, including the pregnancy and postpartum period. Increased access to primary care throughout one’s life, as well as family planning, pre-pregnancy counseling, postpartum care, and necessary wraparound services are crucial to ensuring the best health outcomes for both pregnant individuals and infants.**

In order to support healthy pregnancies and ensure the best outcomes, it is critical to address rising maternal

mortality and morbidity, and long-standing health inequities that disproportionately harm Black and Native American communities. The U.S. is the only wealthy country in the world where maternal mortality is increasing, and Black women are between three to four times more likely to suffer maternal death, and twice as likely to suffer maternal morbidity as white women are.<sup>28</sup> American Indian and Alaskan Native women are also 2.5 times more likely to die from pregnancy complications as white women.<sup>29</sup> Disparities in pregnancy and birth outcomes are also tied to income and geographic location, but they do not explain the racial disparities that affect Black and Native women.

Pregnant individuals have the right to culturally competent, quality care that prioritizes their health care needs and preferences, and covers the full-range of services that research has proven to decrease their risk of maternal death and severe morbidity.

- **To ensure comprehensive and holistic care for pregnant and parenting individuals, the administration must increase access to supports and services across the reproductive health continuum** – including before, during, after, and between pregnancies.
- **Further, the administration must encourage the development of a culture of equity, dignity, respect, and empowerment in health care systems**, whereby accountability mechanisms are encouraged and implemented across systems to address discriminatory care, disrespect, mistreatment, and abuse of pregnant individuals based on race, age, gender identity, sexual orientation, immigration status, insurance coverage, perceived socioeconomic status, and other factors.

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28 The Department of Health and Human Services, Center for Disease Control and Prevention (CDC), Pregnancy Mortality Surveillance System, Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>

29 Creanga, A.A., Bateman, B.T., Kuklina, E., Callaghan, W.M. (2014) Racial and ethnic disparities in severe maternal morbidity: a multistate analysis, 2008–2010. *American Journal of Obstetrics and Gynecology*, 210(435), 1–8.

## **The Administration must clarify and mandate minimum standards of pregnancy care in insurance coverage.**

**The Affordable Care Act made maternity care and newborn services one of the ten Essential Health Benefits that every federally qualified health plan sold in the marketplaces must offer. However, the Affordable Care Act did not define what is included in maternity care. Thus, maternity care varies widely depending on your health plan, level of coverage, geographic region, and other factors.**

- HHS should issue regulations establishing a minimum threshold for maternity care that specifically defines which services health plans must provide to ensure adequate, equitable pregnancy care coverage.

- All health plans including pregnancy care should cover care for uncomplicated pregnancies, without cost sharing, at a minimum of the number of prenatal appointments as well-woman visits recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. This means a visit every four weeks for the first 28 weeks of pregnancy, a visit every two weeks until 36 weeks of pregnancy, and weekly visits thereafter.
- For complicated pregnancies, the number of prenatal visits covered under pregnancy care would be increased. All prenatal screenings and ultrasounds should be included without cost sharing. Individuals who have just given birth should also have insurance coverage, without cost sharing, for an appointment with their OB-GYN, midwife, or other provider within the first three weeks postpartum, and similar coverage for a comprehensive postpartum visit no later than 12 weeks after birth.

## **Policymakers must improve access to insurance coverage for pregnant individuals by establishing a special enrollment period.**

**Many pregnant individuals find they lack the coverage needed to be able to access timely and comprehensive health care that meets their needs. Many live in states that did not expand Medicaid and may not be eligible for their state's Medicaid pregnancy coverage. For this and many other reasons,**

**they might turn to their state's marketplaces to gain coverage. There, they might find they are unable to enroll simply because they missed the designated period for enrollment. Without coverage, many individuals forgo critical services such as prenatal care, with Black and Native American women**

**being more likely than other racial groups to receive late or no prenatal care during pregnancy.<sup>30</sup> As mentioned previously, Black and Native American women are also more likely to experience severe morbidity and/or die from pregnancy-related causes.**

- To improve access to critical services essential to healthy pregnancies, CMS should establish a special enrollment period for pregnant individuals to allow them to enroll in Marketplace coverage for at least 60 days after presentation of pregnancy or as established by the Secretary of HHS.

## **Congress should extend postpartum coverage to one year postpartum for individuals with pregnancy coverage under Medicaid and CHIP.**

**Although many pregnant individuals may not meet income requirements to qualify as a traditional enrollee of the Medicaid program, especially in non-expansion states, they are more likely to be eligible for their state’s Medicaid pregnancy coverage. Although the income threshold needed to qualify varies across states, pregnancy coverage is usually set at a higher percentage of the federal poverty line than the traditional program’s income requirements, with all states allowing pregnant individuals with incomes at or below 138 percent of the FPL to qualify for Medicaid pregnancy coverage. While**

**this coverage helps millions of pregnant individuals, many states end coverage at sixty days following childbirth.**

Extension of coverage for a full year beyond the end of pregnancy could help address the fact that many pregnancy-related complications that lead to maternal deaths, such as postpartum hemorrhage and peripartum cardiomyopathy, take place after the 60–90 day postpartum period. In fact, as many as two in three maternal deaths occur after childbirth, with 33 percent occurring between one week to one year postpartum.<sup>31</sup> In addition to extending coverage, the next administration and Congress should ensure eligibility standards are maintained or expanded. Prior to the end of the one-year postpartum period, assistance should be provided to Medicaid and CHIP enrollees to help them enroll and transition to private insurance.

<sup>30</sup> Child Trends (2019). Late or No Prenatal Care. Washington: Child Trends. [Online]. Retrieved from <https://www.childtrends.org/indicators/late-or-no-prenatal-care>

<sup>31</sup> CDC Vital Signs (2019). Pregnancy-related deaths: Saving women’s lives before, during and after delivery. [Online]. Retrieved from <https://www.cdc.gov/vitalsigns/maternal-deaths/>

## Congress should expand access to midwifery care and freestanding birth center services through public and private health plans.

**Pregnant and birthing individuals must be able to meaningfully exercise their rights to access maternity care and maintain bodily autonomy by deciding where and with whom they will give birth. To improve access to maternity care, providers must ensure that people giving birth have options. This includes the federal government expanding access to birthing centers and midwifery care.**

- Medicaid, Marketplace plans, and private insurance plans should be required to designate midwifery

care and freestanding birth center services as a covered benefit.

- Midwives that meet U.S. accredited education standards, and licensed and accredited freestanding birth centers must explicitly be included in managed care plans.
- Managed care enrollees must be affirmatively informed about and offered the services of midwives and freestanding birth centers.
- Medicaid, Marketplace, and private insurance plans should be required to pay certified nurse midwives licensed in the jurisdiction at 100% of the physician payment for providing the same service.

## Congress should pass legislation that expands access to doula support for pregnant individuals.

**Numerous studies demonstrate that doulas can help reduce the impacts of racism and racial bias in health care on pregnant people of color by providing culturally appropriate and patient-centered care and advocacy. Research indicates that individuals receiving doula care have experienced improved health outcomes for both themselves and their infants, including shorter labors and lower cesarean rates. While access to doula care would**

**benefit underserved populations, including people of color, immigrants, LGBTQ+ individuals, and individuals and families with low incomes, oftentimes members of these communities cannot afford to pay out of pocket for doula care.**

- Congress should require that Medicaid, Marketplace plans, and private insurance plans expand access to doula care as a covered benefit. This should include: Coverage of full spectrum, culturally-congruent doula support during

pregnancy, labor and birth, and the postpartum period, and around the time of miscarriage and abortion support.

- CMS should promote Medicaid coverage of doula support and provide guidance to the states on how best to set up an efficient and effective Medicaid coverage program for doula care that helps build a culturally competent doula workforce, reimburses doulas with a living wage,

and gives specific guidance to state agencies on reimbursement mechanisms, billing codes, and ensuring network adequacy and access for all managed care enrollees.

- Doulas must explicitly be included in managed care plans. Managed care enrollees who are pregnant must be affirmatively informed about and offered doula services.

## **Policymakers must discourage states from using substance use during pregnancy as grounds for prosecution or incarceration.**

**Women, particularly women of color with low incomes, regularly face the threat of criminal penalties for actions taken during pregnancy and for pregnancy outcomes. These policies drive women away from seeking prenatal care and other social services, and they drive poor maternal or infant health outcomes.<sup>32</sup> Additionally, no one who uses illicit drugs or licit substances such as alcohol, prescription opioids, or medication assisted treatment while pregnant should be subject to additional criminal penalties just because they are pregnant.**

- DOJ should end policies and practices that place people at risk of criminal charges for failing to seek medical help when they miscarry, have a stillbirth, or use illicit substances during pregnancy.
- DOJ should also urge states to repeal existing policies criminalizing pregnant people, which discourage people from seeking care;
- DOJ should also furnish states with the resources they need to provide comprehensive medical treatment to pregnant and postpartum individuals with substance use disorders and/or mental health conditions and ensure that treatment for substance use disorders is available and accessible to pregnant and parenting people.

<sup>32</sup> The American College of Obstetricians and Gynecologists (2011). Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologists. Washington: ACOG. [Online]. Retrieved from <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Substance-Abuse-Reporting-and-Pregnancy-The-Role-of-the-Obstetrician-Gynecologist>

## **Policymakers should require all public and private insurance to cover all types of breast pumps, including double electric breast pumps.**

**According to the CDC, breast milk provides the best source of nourishment for most babies, and may even provide additional health benefits for both mother and infant protecting them from both short- and long-term illnesses. Breastfeeding puts babies at a lower risk for developing asthma, type 2 diabetes, infections, sudden infant death syndrome (SIDS), and other health conditions that could result in infant mortality. Mothers who breastfeed have a lower risk of developing breast and ovarian cancers, type 2 diabetes and high blood pressure.<sup>33</sup> The ability to breastfeed should be accessible, autonomous, simple and convenient.**

The ACA has made substantial progress for maternal and infant health by requiring that most private insurers cover breast pumps; however, significant gaps

still remain. While the ACA mandates that private health plans provide breastfeeding support, counseling and equipment with no cost sharing, plans have discretion over which type of breast pump they will cover, and there is no guaranteed access to equipment for traditional (non-expansion) Medicaid enrollees at all. The Centers for Medicare and Medicaid Services (CMS) should issue a rule requiring all public and private plans:

- Cover all of the three main types of breast pumps, including manual, battery-powered, and electric, as well as single and double pumps, for all individuals if requested;
- Ensure access to the selected equipment for at least one month prior to the individual's scheduled delivery date;
- Clarify that a lactating individual may have access to a new breast pump if the one originally selected does not suit their needs;
- Lengthen the covered rental period for breast pumps to one full year postpartum

***“You cannot have maternal health without reproductive health. And reproductive health includes contraception and family planning and access to legal, safe abortion”***

*Hillary Clinton, former US Secretary of State*

<sup>33</sup> The Department of Health and Human Services, Center for Disease Control and Prevention, Breastfeeding Recommendations and Benefits, 2018.

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## Ensure Access to Qualified Providers

Politicians shouldn't interfere with health care providers and their patients in the U.S. or around the world. Yet policies like the domestic and global gag rules violate this trusted relationship by blocking qualified

providers from participating in critical health programs in the U.S. and around the world. They also deny people the ability to get comprehensive information and care at their provider of choice.

**Policymakers must ensure there is robust access to family planning services and providers who provide evidence-based sexual and reproductive health services domestically and globally.**

While the Affordable Care Act (ACA) has produced unmatched improvements in access to affordable reproductive health care in the United States and there has been hardfought global progress on addressing both rights and access issues through innovative and persistent advocacy, there are individuals and communities who continue to face barriers to services that are essential to achieving full

sexual and reproductive health, autonomy, and well-being. We must strengthen and expand access to the providers and programs that deliver these essential forms of health services in accordance with recognized standards of care, and ensure that services and supplies are available to all who seek them by strengthening the Title X, global health, and Medicaid programs.

*“I raise up my voice – not so I can shout, but so that those without a voice can be heard...we cannot succeed when half of us are held back.”*

*–Malala Yousafzai*



## **Policymakers must defend and strengthen the Title X national family planning program.**

**Every year, millions of U.S. adults and young people rely on safety-net providers supported by the Title X family planning program. Title X sites serve as critical sources of care, particularly for the uninsured, underserved, and other individuals in need of publicly-funded family planning services, which include contraceptive services and supplies, STI screening and treatment, cancer screening, sexual and reproductive health education, pregnancy options counseling, and basic infertility services. Of the approximately 4 million people served through Title X funded health centers in 2017, 31% (1.2 million) self-identified with at least one of the Office of Management and Budget’s nonwhite race categories: Black or African American, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, or more than one race. Thirty-three percent (1.3 million) of Title X patients identified as Hispanic or Latino. Importantly, the life-saving care of Title X clinics also extends throughout the U.S. territories; for example, in Puerto Rico, 15,172 people**

**were served in 2017.<sup>34</sup> LGBTQ+ people also rely heavily on Title X centers for culturally competent family planning and preventative care and for gender-affirming health care services. For many individuals, particularly those who have low incomes, are under- or uninsured, or are adolescents, Title X is their main access point to obtain affordable and confidential contraception, cancer screenings, STI testing and treatment, complete and medically accurate information about their family planning options, and other basic care. In fact, a 2017 study found six in ten women seeking contraceptive services at a Title X-funded health center saw no other health care providers that year.<sup>35</sup> Access to the family planning safety net must be protected and expanded – particularly in the face of recent ideological attacks on these providers and the funding streams that support them.**

As the nation’s only federal grant program focused exclusively on family planning and sexual health care, the Title X program should be modernized to reflect and continue to keep pace with best practices in the delivery of compassionate, comprehensive care. In order to better serve our communities, the program should

<sup>34</sup> U.S. Department of Health & Human Services (HHS), Office of Population Affairs (OPA). Title X Family Planning. Rockville (MD): HHS, 2017. [Online]. Retrieved from <https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html>

<sup>35</sup> Zolna, M.R., Kavanaugh, M.L., Hasstedt, K. (2018). Insurance-related Practices at Title X-funded Family Planning Centers under the Affordable Care Act: Survey and Interview Findings. U.S. National Library of Medicine National Institutes of Health, 28(1): 21–28. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/29108987>

be implemented according to nationally recognized standards of care and administered consistently, while still allowing providers to respond to local and regional health needs. Title X must support the inclusive delivery of care for all patients, especially those who are low-income.

- **The administration should rescind the entirety of the Title X final rule, sometimes referred to as the “gag rule,” and protect the ability of highly qualified providers to participate in Title X, regardless of the non-Title X services they also offer.**
- **The administration should reaffirm that all providers receiving Title X funding are bound by the program’s fundamental tenets and congressional intent for the program, including providing confidential care, access to a broad range of contraceptive methods and counseling on all methods, and nondirective options**

**counseling for patients with a positive pregnancy test.**

- **The administration should support advances in service delivery through the promotion of clinical standards, namely *Providing Quality Family Planning Services: Recommendations of the CDC and the US Office of Population Affairs*; through the development of quality measures, especially for contraceptive care; through providers’ consistent collection of metrics to track trends in service delivery; and through providers’ leveraging of existing and emerging technologies, with a focus on patient-centered care.**
- **Congress should increase investments in the Title X family planning program to \$737 million. In spite of the critical importance of equitable access to family planning services for all people, regardless of their income or insurance status, Title X remains woefully underfunded.<sup>36</sup>**

## The U.S. should end the Global Gag Rule.

**It is wrong for the U.S. to force a health care provider in another country to choose between limiting the information and/or care they can give to patients and keeping critical funding. Yet, for 35 years, the global gag rule has played politics with people’s health and lives around the world, and now President Trump has put in place an unprecedented version of the policy, which extends its harm to even more people and communities. In its current expanded version, it prohibits foreign organizations from receiving any U.S. global**

**health assistance if they provide information, referrals, or services for legal abortion, advocate for the legalization of abortion in their country, or fund organizations that undertake these activities, even if these activities are supported solely with non-U.S. funds.**

Health care providers pledge to do no harm. By forcing health care providers to deny legal health services and/or withhold information about legal health services, the global gag rule violates the trusted relationships between an individual and their provider—sometimes at the cost of their life.

<sup>36</sup> August, E.M., Steinmetz, E., Gavin, L., Rivera, M.I., Pazol, K., Moskosky, S.,... Ku, L. (2016). Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act. *American journal of public health*, 106(2), 334–341

The expanded global gag rule blocks health care access, stifles local advocacy efforts, and undermines reproductive rights worldwide. This policy creates mass fear and confusion and puts lifesaving services out of reach for communities who already face systematic barriers to care.

- **Congress must legislatively repeal the global gag rule and block any future President from reinstating it by passing the Global Health, Empowerment and Rights (HER) Act.**
- **The President should champion the permanent repeal of the global gag rule and proactively work to restore relationships with communities and organizations who have been harmed by the policy.**
  - Rescind the presidential memorandum reinstating and expanding the global gag rule.
  - Vocally support the Global Health, Empowerment and Rights (HER) Act and other legislative

efforts to permanently repeal the policy, including through appropriations.

- Provide clear and proactive communication to all agencies that administer global health programs and U.S. Missions that the global gag rule is no longer in place and direction to update all relevant training, compliance, contracts, requests for proposals, and related materials.
- Develop a plan to proactively reach out to organizations previously impacted by the global gag rule to make sure they know U.S. policy has changed, understand the gaps and harm created by the global gag rule to inform future funding and programmatic decisions, and ensure that they are aware of future opportunities to collaborate with the U.S. government, including by applying for U.S. global health funding.
- Stand with other governments who are committed to funding comprehensive sexual and reproductive health and rights, including through SheDecides.

**The Administration should require state Medicaid programs to sufficiently reimburse providers for all services and supplies to ensure that Medicaid enrollees have timely access to all covered services from the provider of their choice.**

**Medicaid and CHIP are essential to the U.S. health care system, covering more than 72.5 million people,<sup>37</sup> including one in five women of reproductive age.<sup>38</sup> LGBTQ+ people are almost twice as likely as the**

**overall U.S. population to receive Medicaid benefits.<sup>39</sup> Providers participating in Medicaid and CHIP offer high-quality care, including sexual and reproductive health care. Yet, they are typically reimbursed considerably**

37 The Department of Health and Human Services, Center for Medicaid and Medicare Services (CMS), Medicaid Eligibility, 2019.

38 Planned Parenthood Action Fund (2019). Medicaid and Reproductive Health. Washington: Planned Parenthood Action Fund. [Online]. Retrieved from <https://www.plannedparenthoodaction.org/issues/health-care-equity/medicaid-and-reproductive-health>

39 Rooney, C., Whittington, C., Durso, L.E. (2018). Protecting Basic Living Standards for LGBTQ People. Washington: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/>

**less for their services than by other types of public and private health insurance - often significantly less than the actual cost of service.<sup>40</sup> For safety-net providers that do not turn away patients in need, low reimbursement rates hinder provider capacity to accept new patients, limit the number of available providers in a community, and cause appointment delays that can be troublesome for patients needing time-sensitive care.<sup>41</sup> The administration should:**

- Issue regulations that require Medicaid and CHIP reimbursement rates, whether fee-for-service or managed care, be at least equal to Medicare reimbursement.
- Support any congressional effort to boost the federal share of rate increases for a range of providers.
- Clarify and implement policies that ensure providers have access to discounted drugs. This is necessary to ensure that Medicaid and CHIP enrollees have access to timely, high-quality care and services.

***“Of all the forms of inequality, injustice in health is the most shocking and inhumane.”***

*–Dr. Martin Luther King, Jr.*

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<sup>40</sup> Advisory Board (2016). Low reimbursement rates are limiting Medicaid expansion's potential, report finds. Washington: Advisory Board. [Online]. Retrieved from <https://www.advisory.com/daily-briefing/2016/06/20/low-reimbursement-limit-medicaid-expansion>

<sup>41</sup> Ibid.

**Policymakers must ensure that all federally-supported health programs are operated in a manner that does not discriminate against or otherwise limit the participation of reproductive health providers for reasons unrelated to their qualifications; and expand the scope of health care providers that are covered under health programs and insurance options.**

**Increasingly, state governments have tried to deny or restrict the participation of reproductive health providers that provide comprehensive services in federally supported health programs. These attacks put access to care at risk, particularly for low-income and underserved populations, and thereby threaten to compromise public health and prevention goals. In order to have timely access to quality health care, patients must be able to use their health coverage or leverage publicly-funded programs to see the sexual and reproductive health care providers that they trust. However, health care access, particularly for people of color and people with low incomes, has increasingly been put at risk by state efforts to deny the**

**participation of qualified, reputable providers in federally-supported health programs. *Congress and the administration must ensure that certain providers of sexual and reproductive health care are not discriminated against, and must expand access to the providers that people trust.***

***This includes:***

- Ensuring that qualified providers of reproductive health care are not prevented from participating in public health programs – including in key programs that provide access to birth control, STI/HIV prevention, cancer screenings, and sexual health education – for reasons unrelated to their qualifications.
- Leveraging the administration’s full authority to issue strong rules that ensure reproductive health providers can continue to participate in the range of federally supported health programs.

**Congress should pursue policies that incentivize the creation of a larger and more diverse network of reproductive health care providers. More specifically, Congress should encourage broader diversity of race, ethnicity, language proficiency, gender, sexual orientation, and provider type to expand access to comprehensive reproductive health care, increase culturally competent care, reduce health disparities, and ensure that providers reflect the populations they serve.**

- **Congress should create a Reproductive Health Care Provider Service Corps.** There are not enough reproductive health care providers to meet current needs. This program, which would include advanced practice clinicians (APCs), would incentivize providers to provide the full range of reproductive health care, including abortion, in underserved areas. The program should emphasize enrollment of providers of color and bilingual providers, offer loan forgiveness, and provide resources on how to manage the pressures of providing reproductive health care.
- **Congress should increase Graduate Medical Education (GME) funding.** The demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 42,600 and 121,300 physicians by 2030 with predicted shortages in both primary and specialty care. Physicians are a critical element of our health care workforce, and if we do not address this impending problem, patient access to care will continue to suffer. Medicare provides an important source of funding that helps offset some of the costs associated with educating residents. However there is a Congressionally imposed limit to the number of training slots Medicare can support. Lifting this antiquated cap on the number of slots for medical school graduates and increasing the available GME funding to Medicare would expand the number of providers available to provide reproductive health care.
- **Congress should commission a comprehensive study into barriers for people of color becoming health care providers and initiate a pilot program to create a pipeline for providers of color.** Studies have shown that there is a correlation between better health outcomes and patients having access to providers that come from similar backgrounds, including race, ethnicity, gender identity, sexual orientation, and religion. But the nation has continued to struggle with efforts to build a more diverse health care workforce. Impediments to the inclusion of more providers of color in the health care system start long before medical training or undergraduate education and are multivariable, so further research to better understand these barriers is needed.
- **Congress should encourage states to enter into compacts for state Medicaid programs.** Reproductive health care services can be out of reach for individuals that live far from Medicaid providers in their own states but close to providers in neighboring states. Congress should encourage states to facilitate providers in other states getting reimbursed by their Medicaid programs.

**Policymakers must advance federal initiatives and support state efforts to protect the privacy and safety of reproductive health care providers and patients, and assess ways for the federal government to strengthen existing protections.**

**In a climate of escalating anti-abortion rhetoric, reports illustrate that reproductive health care facilities are experiencing an increase in vandalism, trespassing, hate mail, internet harassment, and obstruction of their entrances. Death threats and threats of harm directed at individual providers remain high. Reproductive health care providers face a barrage of harassment and intimidation at their workplaces, homes, in their communities, and online.**

Additionally, many reproductive health care providers fear public disclosure of their identities or other personally identifiable information because this information has historically been used to target providers and their families with violence, harassment, and intimidation tactics, including at their homes, churches, and in their residential neighborhoods. Reproductive health care providers, like any other professional engaged in lawful business activities, should not be forced to live fearing for their safety or the safety of their loved ones. State legislators must be made aware of how their public licensing processes, and other state policies, may be putting the lives and safety of reproductive health care providers at risk.

- The administration must prioritize investigation and prosecution of those who target and commit acts of violence and harassment against reproductive health care providers, patients, staff, and others who support the right to access abortion care, and fully fund efforts to prevent violence against abortion providers
- The administration should direct the Department of Justice to Monitor and Combat Violence Against Reproductive Health Providers to develop policies, protocols, and guidelines concerning the prevention, investigation, and prosecution of violence against abortion providers, patients, staff, and others who support access to abortion care.
- The federal government should, through grants and other technical assistance, support state efforts, like California's Safe at Home program, to protect the home addresses of providers and others who fear harassment and violence from public disclosure through state records.
- The administration must find ways to leverage federal and state resources to collaborate between authorities, including training for state and local law enforcement, and support for state efforts to protect providers.

## PRINCIPLE 2:

# Ensure Discriminatory Barriers in Health Care are Eliminated.

**To be meaningful to all, our efforts to advance sexual and reproductive health and rights must extend across every category that could divide us – race, sex (including gender identity and sexual orientation), socioeconomic status, disability status, immigration status, age, and national origin. Initiatives that foster fairness and equity in health care are essential to ensuring that each person is able to make healthy decisions about sexuality and reproduction in pursuit of comprehensive physical and mental health and well-being. There is enormous opportunity, and a deep societal responsibility, to pursue policies that promote fairness and give all people the**

**ability to take care of their health and the health of their families.**

Health inequities prevent the opportunity for all people to prosper. In order for the health care systems in the U.S. and around the world to foster fairness and equity, sexual and reproductive health care must become integrated into the health care system in a way that respects and is inclusive of all identities, including those associated with income, race, sex (including sexual orientation, gender identity and gender expression), immigration status, national origin, Indigenous identity, disability, and age. While significant progress has been made to improve access to health care and promote human rights for all, disparities and inequity have grown both between and within countries, leaving too many communities behind. By centering the unique experiences and needs of those most harmed by inequity – no matter who they are or where they live in the world – U.S. policymakers can make a significant contribution to promoting health and wellness for all communities.

***“I believe that every family – it doesn’t make a difference who you are or where you come from – deserves to have quality healthcare. It is a universal right. It’s not the exclusive privilege of the elite and the wealthy.”***

*Kevin de Leon, President Pro Temp of California State Senate (D-S-24)*



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# Guarantee Access to Health Care Coverage and Services for All People.

**Policymakers should ensure that the federal government protects against – and does not perpetuate – discrimination in access to health care and related services and supports on the basis of race, national origin, ethnicity, sex (including gender identity and sexual orientation), disability status, immigration status, employment status, marital status, socioeconomic status, age, or geographic location.**

**A web of legal and policy barriers to public and private insurance options prevent millions of people of color, immigrants, people with no and low incomes, LGBTQ+ people, young people, and many others from accessing affordable coverage and basic health care, including sexual and reproductive health care services. Policymakers and advocates must work towards a system that ensures all can**

**access quality and equitable health care, no matter the circumstances.**

LGBTQ+ individuals face tremendous and unnecessary barriers to accessing health care coverage and services. All individuals deserve culturally-competent care that includes but is not limited to, language access, proper usage of pronouns, access to restrooms and/or changing rooms, proper understanding of the differences between sex assigned at birth, gender identity, sexual orientation, and sex stereotyping, as well as the provision of care absent discrimination based on religious or moral beliefs.

***“I am not free while any woman is unfree, even when her shackles are very different from my own.”***

***–Audre Lorde***

**Policymakers should ensure that the federal government protects against – and does not perpetuate – discrimination in access to health care and related services and supports on the basis of race, national origin, ethnicity, sex (including sexual orientation and gender identity), disability status, immigration status, employment status, marital status, socioeconomic status, age, or geographic location.**

- **Congress must pass and the administration should properly and swiftly implement the Equality Act.** standards as recommended by the National CLAS Standards Blueprint.
- **Congress must take concrete action to ensure that HHS-funded programs are delivering culturally and linguistically appropriate care.** Many communities, including immigrant individuals, face significant challenges accessing culturally and linguistically appropriate health care and health insurance information. Initiatives to reform payment and care delivery models offer important opportunities to address these challenges and make progress in broader efforts to eliminate health inequities and bring about positive health outcomes for diverse populations. To take best advantage of these opportunities, the administration and Congress should:
  - Ensure that translation and interpretation services provided to people with Limited English Proficiency includes a broad range of languages to meet the needs of the community;
  - Prioritize the use of community health workers in ACA education and outreach programs to ensure access to culturally and linguistically appropriate information;
  - Establish standards for bilingual Exchange consumer outreach staff and ensure they are trained to offer adequate linguistic services to explain what Qualified Health Plans (QHPs) offer; and
  - Fully fund and provide resources to encourage providers to implement Culturally and Linguistically Appropriate Services (CLAS)
- **The administration must ensure that reform efforts include robust consumer safeguards and that programs are accessible to all.** In order to eliminate health inequities and bring about positive health outcomes for diverse populations, HHS should require that all delivery system reform efforts include robust consumer safeguards, including anti-discrimination policies, and measures to improve access to culturally and linguistically appropriate care. Programs must also ensure that technological innovations are equitably promoted, widely available, and evaluated fully for their impacts on access.
- **Congress and the administration must expand enforceable nondiscrimination requirements and protections to all youth-serving, federally-funded entities.** People of all ages, and particularly youth and young people under the age of 18, deserve to be treated with respect and understanding, regardless of any factor that constitutes their identity and lived experiences. Unfortunately, we know that this dignity is often inaccessible to young people being served by or engaged with federally-funded entities. Too often, programs operating under federal public resources perpetuate bias, discrimination, shame, and stigma related to sex (including sexual orientation and gender identity), parental status, race, ethnicity, ability, and immigration status. Congress and the administration should extend existing program-specific nondiscrimination protections for race, color, national origin, sex (including gender identity and sexual orientation), age, disability, genetic information,

marital and parental status, political affiliation, and veteran status to youth-serving federally-funded programs in all Departments, to the greatest extent that legal authority supports.

- **Congress must pass budgets for data collection that is disaggregated by sex assigned at birth, gender identity, sexual orientation, race, ethnicity, national origin, age, income, and geographic location.**

**Policymakers must ensure access to nondiscriminatory health care and coverage by ensuring that the Health Care Rights Law (Section 1557 of the Affordable Care Act) is fully enforced without exemptions or accommodations based on religious or personal beliefs.**

**The Health Care Rights Law is a groundbreaking provision providing protection against discrimination in health care for women, LGBTQ patients, and anyone who faces gender-based discrimination as well as patients with limited English proficiency. But recent Trump administration proposed regulations would undermine the enforcement of this law, thereby attempting to limit access to comprehensive, nondiscriminatory health care and coverage. The Health Care Rights Law prohibits discrimination in health care on the basis of sex—including pregnancy, termination of pregnancy, sex stereotypes, gender identity, and sexual orientation—as well as race, color, national origin, age, and disability. In 2016, the Health and Human Services (HHS) Office of Civil Rights issued a final rule, “Nondiscrimination in Health**

**Programs and Activities,” that made clear that protections from sex discrimination includes not “limit[ing] or deny[ing] coverage because the treatment someone is getting is related to their gender identity” or transgender status.<sup>42</sup> However, the Trump administration issued a proposed rule in May 2019 attempting to rollback many of the 2016 rule’s important patient protections.**

The Health Care Rights Law must be protected, strengthened, and used as a starting place to enact additional laws and policies that provide further protections against discrimination. In addition, the HHS Office for Civil Rights, tasked with enforcing the Health Care Rights Law and addressing health disparities, must be returned to an office that protects individuals’ and communities’ civil rights. HHS must carry out its civil rights enforcement obligations in ways that ensure and expand—rather than undermine—access to health care.

- **The administration must robustly enforce and protect the Health Care Rights Law.**

42. Schaaff, B. (2018). Using Federal Anti-Discrimination Laws to Avoid ERISA: Securing Protection from Transgender Discrimination in Employee Health Benefit Plans. *Duke J. Gender Law & Policy*, 45, 50-51.

- Rescind or halt regulations, including the Trump administration’s May 2019 proposed rule, that would roll back the non-discrimination protections for transgender and nonbinary people, as well as all women, patients with limited English proficiency, and other communities historically marginalized in health care, in the Health Care Rights Law, Section 1557 of the Affordable Care Act.
- Ensure that all new guidance and rules are free of religious exemptions or other language enabling refusals of care.
- Thoroughly investigate and document complaints and take necessary actions in response to discrimination, including discrimination based on sexual orientation, gender identity, sex stereotypes, and abortion.
- Ensure that any LGBTQ and/or civil rights or health care legislation are free of religious exemptions or other language enabling refusals of care.

**The Secretary of Health and Human Services must recommit the Office for Civil Rights to improving health, addressing health disparities, and ensuring all patients have equal access to care.**

**The Department of Health and Human Services’ Office for Civil Rights (OCR) has a long and storied record of combating discrimination, protecting patient access to care, and eliminating health disparities. For example, as one of its first official acts in 1967 the Office of Equal Health Opportunity (OCR’s predecessor) undertook the massive effort of inspecting 3,000 hospitals to ensure compliance with Title VI’s prohibition against discrimination on the basis of race, color, or national origin. Since that time OCR has helped reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with**

**disabilities in health care facilities, categorical insurance coverage denials of care for transition related services, and insurance benefit designs that discriminate against people who are HIV positive, among other things. But in the last two years, OCR has abandoned this important role – instead focusing on expanding refusals of care and contracting laws prohibiting discrimination in health care.**

- OCR must recommit to its critically important role and robustly enforce statutes prohibiting discrimination in health care and protecting individuals, including:
  - Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin by recipients of federal funds;

- Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs;
  - Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability by recipients of federal funds;
  - The Age Discrimination Act of 1976, which prohibits discrimination on the basis of age;
  - Title VI and XVI of the Public Health Service Act, which requires health facilities that receive certain federal funds to provide certain services to members of its designated community; and
  - Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, age, and disability and marks the first time sex discrimination was broadly prohibited in health care.
- **HHS Must reverse the harmful changes made at OCR during the Trump administration, including:**
    - Returning OCR’s mission statement to a focus on equal access to care and patient health from its recent iteration as a “law enforcement agency.”
    - Eliminating the so-called “Conscience and Religious Freedom Division” which emboldens discrimination and care refusal. OCR has diverted resources away from other parts of the Office committed to protecting patient care to fund this harmful new division.
    - Modifying the complaint forms to focus on anti-discrimination provisions, like Section 1557 of the Affordable Care Act, rather than the current focus on federal refusals of care laws and generating more complaints under the refusal of care laws in order to justify the dangerous changes at OCR.

## **Policymakers must strengthen patient protections, including confidentiality and informed consent.**

**A key component to ending discriminatory health care practices is centering the patient and their needs and should include being responsive to patient preferences, needs and values, that often vary across sex (including sexual orientation and gender identity), parental status, race, ethnicity, community, ability, and immigration status. Additionally, providing care, free from coercion and implicit or explicit bias is integral to a successful healthcare framework. Confidentiality and informed consent, among other patient protections,**

**must be strengthened to ensure patients are in full control of their medical treatment, planning and care. For many, receiving health care comes with a variety of anxieties and fears that can be assuaged with stronger protections in place, including the following:**

- **Congress and the administration must reaffirm that health care options and services should be provided in a non-coercive manner that emphasizes patient choice and fully informed consent.** Health care providers must be able to provide complete, medically accurate information—free from political or institutional interference—about the options and services available to patients, based on their

particular health care needs and concerns. Once they've received such information, patients must have the comprehensive information they need to make the best choices for them and their families, free from coercion, and have those choices respected by medical professionals. This approach is fundamental to medical ethics and the principle of informed consent.<sup>43</sup>

- **Congress and the administration must protect confidential access to health care, particularly to sensitive health services for vulnerable populations, such as young people and survivors of intimate partner violence.** Lack of confidentiality,

or concerns about confidentiality, can prevent individuals from seeking health care services. This is particularly true if someone fears physical or emotional harm if a parent, spouse, or partner finds out. As we move toward more integrated approaches to care and recognize the valuable role that family caregivers can play in improving an individual's health, the federal government must recognize and balance the need for confidentiality and privacy of health information. This includes giving patients options to withhold third-party payer sources, and receive health-related communications by alternative means or at alternative locations.

## **Policymakers must increase the effectiveness of U.S. efforts to combat the HIV epidemic globally, including for adolescent girls and young women, LGBTQ+ individuals, sex workers, and other communities who face systematic barriers to care.**

- **Congress must fully fund the global response to HIV and promote policies that help programs effectively reach all people affected by the global epidemic.** This includes ending policies that have undermined the global response to HIV, including:

- **Failed abstinence-only funding requirements:** The President's Emergency Plan for AIDS Relief (PEPFAR) has included, in various forms, a commitment to funding programs that prioritize, or focus solely on, abstinence as an HIV prevention tool. Extensive evidence shows abstinence programs do not work, and waste taxpayer funds. A 2016 Stanford University School of Medicine study examining PEPFAR's over \$1.4 billion investment in HIV prevention programs that promote sexual abstinence and marital fidelity between 2004–2013 found no

evidence that these programs changed sexual behavior or reduced HIV risk.<sup>44</sup> PEPFAR and the global AIDS response must be driven by public health evidence and human rights. Abstinence programming is supported by neither.

- **Harmful anti-prostitution loyalty oath:** PEPFAR codifies the conflation of sex work and trafficking by requiring foreign organizations to adopt the position, throughout their organization, that they "oppose prostitution and sex trafficking." This policy excludes some of the most valuable organizations from PEPFAR's global AIDS response. An effective AIDS response requires the engagement and empowerment of key populations, including sex workers. This speech restriction has caused the exclusion of sex-worker led groups from PEPFAR, and driven

<sup>43</sup> Hasstedt, K. (2018). Unbiased Information on and Referral for All Pregnancy Options Are Essential to Informed Consent in Reproductive Health Care. *Guttmacher Policy Review*. 21, 1–5.

<sup>44</sup> Lo, N.C., Lowe, A., Bendavid, E. (2016). Abstinence Funding Was Not Associated With Reductions in HIV Risk Behavior in Sub-Saharan Africa. *Health Affairs*. 35(5), 856–863.

organizations to abandon programs out of fear that they will lose funds if they provide services to sex workers. While the executive branch should work to align government position with the health and human rights of sex workers, and remove the barriers to doing so (including National Security Presidential Directive 22), Congress should remove the anti-prostitution loyalty oath from PEPFAR.

- **Broad and discriminatory refusal clause:** detailed below in section b.
- **The administration must prioritize evidence-informed, comprehensive HIV prevention, care and treatment programs grounded in a human rights approach.**
  - **Increase integration of family planning, reproductive health and HIV programs:** HIV, family planning, and other reproductive health services should be fully integrated so that communities with barriers to access can receive holistic services. Improving integrated care will help people living with HIV to sustain healthy pregnancies and deliver HIV-negative children. The Office of the Global AIDS Coordinator should also make it clear that PEPFAR funds can be used to pay for contraceptive commodities to ensure individuals living with and at risk for HIV have access to a full range of voluntary contraception options; promote bidirectional referrals; encourage the co-location of services whenever possible; expand upon current integration indicators; maintain ongoing coordination and

collaboration between PEPFAR’s implementing agencies and USAID’s Office of Population and Reproductive Health; and expand meaningful engagement of civil society from HIV/AIDS and SRHR communities.

- **Expand DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) Initiative to prevent HIV among adolescent girls and young women (including those who may be transgender):** Work to advance the sustainable continuation and scale up of evidence-based, multi-sectoral approaches within DREAMS across PEPFAR countries and support the scaleup of voluntary medical male circumcision and treatment for people in DREAMS countries.
- Advance non-discrimination protections to ensure that PEPFAR-funded programs do not discriminate on the basis of age, disability, race, sex (including sexual orientation, gender identity, and gender expression), marital status, or immigration status.
- Champion the development of multipurpose prevention technologies that increase the available options to prevent both pregnancy and HIV and better meet women’s needs.
- **Increase funding for the Key Populations Fund to serve those most at-risk for HIV, including men who have sex with men, people who inject drugs, sex workers, transgender, nonbinary, and gender nonconforming persons, and those who are incarcerated.**

***“My hope is that feminist, racial justice, reproductive rights and LGBT movements build a coalition that centers on the lives of women who lead intersectional lives and too often fall in between the cracks of these narrow mission statements.”***

*–Janet Mock*

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# Ensure Patients are Not Refused Health Care

**Congress must eliminate the Weldon Amendment, which embolden a health care providers to discriminate by denying people access to abortion.**

**A patient’s health should always come first, but the Weldon Amendment prioritizes a provider’s personal beliefs over a patient’s health needs. The Weldon Amendment is a harmful annual appropriations rider that bars Labor, HHS and Education (Labor-HHS) funds from going to any federal, state or local program that subjects a health care entity to “discrimination” based on that entity’s refusal to provide, pay for, cover, or refer for abortions. It has been invoked by opponents of abortion in attempts to block policies at the federal, state, and local levels that would expand abortion access by threatening policymakers with**

**the loss of critical federal health and education dollars.**

- The administration should remove the Weldon amendment from the annual budget, and Congress should pass a Labor-HHS spending bill that is free of this rider.
- The administration and Congress should also oppose all legislation that would expand or entrench the Weldon Amendment.
- HHS should rescind the May 2019 health care refusal rule that drastically expands the scope of existing federal refusal laws, including the Weldon Amendment, far beyond what Congress intended.
- HHS should eliminate the so-called “HHS Office of Conscience and Religious Freedom,” which carries out discriminatory policies such as the Weldon Amendment.



**Policymakers must ensure that the Religious Freedom Restoration Act is not misused to undermine access to sexual and reproductive health care or to discriminate against those seeking health care based on the religious beliefs of employers, insurers or providers.**

**When it was originally enacted into law, the Religious Freedom Restoration Act (RFRA) was intended to be used as a shield to preserve the ability to freely exercise religious beliefs. However, it has since been misused to erode access to care in ways that result in harm to others, exemplified by the Supreme Court's decision in *Burwell v. Hobby Lobby*. That case not only set a harmful precedent for individuals seeking contraceptive coverage, but opened the door to efforts to limit access to other types of sexual and reproductive health care, including tubal ligations, IVF, and gender-affirming care. In addition,**

**state RFRA's modeled after the federal statute are increasingly being invoked to undermine the rights of individuals seeking reproductive health care or other services.**

- DOJ should reverse the Trump administration's guidance interpreting RFRA, issued under AG Sessions in October 2017.
- The administration should work with Congress to pass the Do No Harm Act, which would amend RFRA to ensure that it cannot be misused to undermine federal laws that protect against discrimination and guarantee access to health care.
- The administration should also work with Congress to oppose any legislation that would allow RFRA to be misused to undermine access to health care.

**Policymakers must ensure that health care and social service providers that receive taxpayer dollars do not refuse program participants' access to reproductive health care or information that are part of the program.**

**Many government programs that provide vital services, including health care information, services, and referrals, are administered by non-governmental health care or social**

**service agencies. Unfortunately, sometimes those organizations—which receive taxpayer funding—attempt to impose their own religious or moral restrictions on these**

**programs, limiting access to the sexual and reproductive health care services, information, or referrals that beneficiaries are guaranteed by the program.**

Often, women, young people, LGBTQ+ people, survivors of sexual assault and human trafficking, immigrants, refugees, asylum seekers, people living with HIV, people with disabilities, sex workers, and other marginalized populations who seek access to services through these programs are particularly vulnerable, have significant language barriers, and have little to no resources of their own, making it unlikely that they will be able to access medical services without help from these government-funded programs.

Health programs and activities and organizations receiving HHS funding are prohibited from discriminating on the basis of factors such as age, disability, sex, and race. However, the Trump administration has already demonstrated its willingness to waive these protections. For example, HHS has exempted a federally funded foster care and adoption agency in South Carolina from the nondiscrimination protections, allowing the agencies to turn away potential parents and volunteers who cannot meet their religious requirements. Allowing organizations to receive federal grants while they impose religiously motivated restrictions neglects the needs and basic rights of the people they serve, undermining the government's mandate to safeguard the separation of religion and state and its ability to meet its public health and development goals.

- **The administration should ensure that program participants' access to the full range of information, services and referrals never depends on the religious or moral objections of the organization contracting with the government.**

- Congress and the administration should vigorously oppose any efforts to write religious or moral exemptions into law, regulations, or guidance related to taxpayer funded programs that provide health care and social services. This includes strong opposition to any legislative or regulatory language that would make it easier for grantees and contractors to discriminate or to impose their beliefs on the people their programs are intended to serve.
- Congress should repeal the broad religious refusal clause in the President's Emergency Plan for AIDS Relief (PEPFAR) and pass the Greater Leadership Overseas for the Benefit of Equality (GLOBE) Act. PEPFAR has an extremely broad refusal clause, which allows an organization to deny even basic information or referrals about any service that they deem morally objectionable. This policy ignores the needs and circumstances of people who count on our global AIDS programs by disregarding their right to receive information, referrals, or services to meet their basic health needs and deprives them access to safe and legal health services. The GLOBE Act would not only repeal the PEPFAR refusal clause, but would insert strong anti-discrimination language to protect LGBTQ individuals seeking quality comprehensive health care through U.S. foreign assistance programs.
- The administration should expand enforceable non-discrimination protections to all federally-funded entities. A young person's civil rights should not vary based upon whether a federally-funded program they are participating in happens to fall under Title IX or the Health Care Rights Law nondiscrimination protections. Unfortunately, far too many youth-serving programs supported by federal funds, such as HHS programs that fund non-health provider entities, serving millions of young people each year, fall outside of these protections.

**Policymakers must ensure that hospitals and other health care facilities, regardless of their religious affiliations, do not discriminate or refuse essential care to their patients.**

**Often religiously affiliated hospitals and health care facilities abide by religious directives that ban many types of reproductive health care, even when a patient's life or health is in jeopardy. In fact, one in six hospital beds in the U.S. is in a facility that complies with Catholic directives that prohibit a range of reproductive health care services. Patients at these facilities may be deprived of comprehensive and medically necessary health care services, including:**

- Medically indicated care to individuals experiencing miscarriages, ectopic pregnancies, and other potentially life-threatening conditions associated with pregnancy such as preeclampsia, eclampsia, and premature rupture of membranes;
- Tubal ligations at the time of a cesarean-section delivery, even when a physician has warned that any future pregnancies could risk the person's health or life;
- Emergency contraception to victims of sexual assault;
- Gender affirming care to transgender, nonbinary, and gender nonconforming patients; and

- Information about medically appropriate treatment options.

Such denials of care take place regardless of patient religious affiliations. Indeed, in some instances patients of the medical facility may not even be aware it has a religious affiliation, and the care they are receiving is dictated by something outside medical standards of care. Other patients may live in a community where a religiously affiliated hospital or health facility is their only option. In some states, more than 40 percent of all hospital beds are in a Catholic-run facility, leaving entire regions with no options for certain reproductive health care services. Women of color are disproportionately affected by these refusals, as they are more likely than other women to live in areas primarily served by Catholic hospitals which follow the directives.<sup>45</sup> Some of the religious directives also increase the likelihood that young people, unmarried women and LGBTQ+ individuals and their families will face discrimination trying to access health care services consistent with their medical needs and human rights.

- **The administration and Congress must develop policies to ensure that hospitals and other health facilities do not refuse appropriate reproductive health care services, information, and referrals, regardless of their religious affiliation, including strong guidance, oversight, and enforcement from CMS to ensure that facilities comply.**

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<sup>45</sup> Shepard, K., Platt, E.R., Franke, K., Boylan, E. (2019). Bearing Faith The Limits of Catholic Health care for Women of Color. New York: Columbia Law School. [Online]. Retrieved from <https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf>

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# End Barriers to Care for Young People

**Young people (including those under the age of 18) deserve the right to all sexual and reproductive health services, including access to safe, legal abortion.**

Young people deserve the right to access all sexual and reproductive health services – including but not limited to abortion. While advocates all over the world vehemently fight to protect abortion, many often fail to address the needs of young people under the age of 18, who are subject to even further abortion restrictions. As of March 2019, 37 states required parental involvement in a youth's decision to have an abortion.<sup>46</sup> This involvement comes in two forms: notification and consent, with state-by-state variations.<sup>47</sup> In most states with parental involvement laws, judicial bypass allows young people to petition the courts for permission to access abortion without involving their parents.

While most young people under 18 do involve their parents in their abortion decisions, requiring parental involvement can put them at risk in homes with dysfunctional family environments. Parental involvement policies put young people who are victims of sexual and physical assault, incest, or neglect at further risk of physical harm or being kicked out of their homes. Parental involvement laws are an attempt to delay abortion procedures. Further, they have no recognized impact on birth or abortion rates, and fail to change the

likelihood that a young person will involve their parents in their abortion decision.<sup>48</sup> Importantly, these policies also disproportionately impact young people of color, as they experience disproportionate rates of unintended pregnancy and are more likely to live in states with parental involvement laws.<sup>49</sup>

Young people under the age of 18 may seek judicial bypass to obtain permission to receive abortion care, but this alternative is still riddled with obstacles. Young people may not know how to navigate the process even if they are aware that judicial bypass is an option. They may also lack the transportation, money, or other resources necessary to travel to the courts or the time to delay abortion. Additionally, resistant or biased judges can simply deny young people's requests. Requiring minors to obtain court approval also further jeopardizes their confidentiality.<sup>50</sup> Recognizing these egregious impediments to abortion access for young people, several prominent health professional organizations oppose mandatory parental involvement in abortion decision-making. These organizations include: the American Medical Association, the Society for Adolescent Health and Medicine, the American Public Health Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.<sup>51</sup> The fight for abortion access must include the needs of young people, who – like all people – are deserving of access to the full range of sexual and reproductive health services. Without it, their health and well-being are at risk.

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46 Guttmacher Institute (2019). Parental Involvement in Minors' Abortions. Washington: Guttmacher Institute. [Online]. Retrieved from <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions>

47 Advocates for Youth (2013). Abortion and Parental Involvement Laws. Washington: Advocates for Youth. [Online]. Retrieved from [https://advocatesforyouth.org/resources/fact-sheets/abortion-and-parental-involvement-laws/#\\_edn10](https://advocatesforyouth.org/resources/fact-sheets/abortion-and-parental-involvement-laws/#_edn10)

48 Ibid

49 Ibid

50 American Civil Liberties Union (2000). Laws Restricting Teenagers' Access to Abortion. Washington: American Civil Liberties Union. [Online]. Retrieved from <https://www.aclu.org/other/laws-restricting-teenagers-access-abortion>

51 Advocates for Youth (2013). Abortion and Parental Involvement Laws. Washington: Advocates for Youth. [Online]. Retrieved from [https://advocatesforyouth.org/resources/fact-sheets/abortion-and-parental-involvement-laws/#\\_edn10](https://advocatesforyouth.org/resources/fact-sheets/abortion-and-parental-involvement-laws/#_edn10)

## **Policymakers must increase access to and provision of confidential reproductive and sexual health care and services that respects young people’s decision-making.**

**Our current federal regulatory scheme can and must increase access to confidential reproductive and sexual health services and care for young people, so that they have the necessary information to make autonomous decisions about their health.**

**As such:**

- Policies that end restrictions on coverage of abortion in federal health plans should also ensure that young people are not required to notify or seek consent from a parent or guardian prior to obtaining abortion care.
- The CMS director should issue a “Dear State Medicaid Director” letter, and other guidance, to
- make provider-based sexuality education efforts in Medicaid more robust. This guidance should inform Medicaid programs that they or relevant Managed Care Organizations must remind providers treating youth enrolled in Medicaid that a health education component of a complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child screening must encourage disease prevention, and that sexuality education within a provider setting is a critical component.
- CMS should issue guidance to state Medicaid programs that federal law does not mandate the use of EOBs and initiate a public and private stakeholder effort to develop additional recommendations and guidance to balance the need for consumer protections with the need for confidentiality, especially when it comes to sensitive health services.

***“I speak for young girls who are fighting with their societies to access basic education. I speak for the young women breaking glass ceilings and achieving greater heights. I speak for young people, who are not willing to give up, even if conflict and grief have wreaked havoc in their lives. I speak for all of us, and the generations to come, who have the right to a better world.”***

*Secretary-General’s Envoy on Youth, Jayathma Wickramanayake*

**Policymakers should be vocal in their support for the rights of young people to have the education and access to care they need to make healthy decisions and must fund efforts that support and promote sexual health information and education for our nation’s young people.**

**All young people – no matter who they are, where they live, or their economic status – deserve information, education, and access to the full spectrum of sexual and reproductive health care to support their autonomy, personal decision-making, and dignity. Policymakers’ language around young people’s sexual and reproductive health and rights must recognize that well-being and positive health are more than the absence of unintended pregnancy and disease. In all discussions about sexual health, education, and young people, policymakers should be supportive of youth sexual health and not deem young people as problems to be fixed.**

Policymakers must also back up this language with actions that meet the unique needs of young people—addressing the barriers to sexual health education and reproductive health care they face.

Specifically, Congress must:

- Continue and increase funding for medically-accurate and science-based programs that support information, education, and access to care for young people, and maintain the integrity of these programs ~ ensuring they are administered according to congressional intent.<sup>52</sup>
- Establish new funding streams dedicated to comprehensive sexuality education and linkages to care.
- Eliminate funding for abstinence-only-until-marriage programs, including the Title V “Sexual Risk Avoidance Education” program and the discretionary “Sexual Risk Avoidance Education” program.
- Advance the sexual and reproductive health and rights of young people by supporting comprehensive sexuality education, as well as access to sexual health services for marginalized young people, through passage of the Real Education for Healthy Youth Act and the Youth Access to Sexual Health Services Act.

***“In the wealthiest nation on Earth, no one should go broke just because they got sick.”***

***– President Barack Obama***

<sup>52</sup> These include the Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH), the Teen Pregnancy Prevention (TPP) Program and Pregnancy Assistance Fund (PAF), the Family and Youth Services Bureau’s (FYSB) Personal Responsibility Education Program (PREP), the Title X Family Planning Program, and Title IV of Every Student Succeeds Act.

**Policymakers should advance the sexual and reproductive health and rights of adolescent girls and young women around the world as part of a comprehensive, whole of government approach to empower adolescent girls globally by addressing their unique challenges and needs.**

**Sixty-two million girls are not in school and 250 million adolescent girls are living in poverty worldwide.<sup>53</sup> Adolescent girls worldwide face multiple challenges to making autonomous choices about their health and futures, including lack of economic opportunities, staggering rates of illiteracy, early and forced marriage, high rates of sexually transmitted infections and HIV, and early pregnancy. Advancing the health and rights of adolescent girls promotes global development, security, and prosperity. The administration should build on existing initiatives and policies such as the U.S. Global Strategy to Empower Adolescent Girls (March 2016),**

**Let Girls Learn Initiative, PEPFAR’s DREAMS Partnership, the U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally (June 2016), the U.S. National Action Plan on Women, Peace, and Security (June 2016), and the U.S. Action Plan on Children in Adversity, to implement an evidence-based approach and coordinated inter-agency efforts to address the needs of adolescent girls. These efforts must ensure girls are educated, healthy, and empowered, and promote community level change to address harmful norms and practices in addition to strengthening policy and legal frameworks and accountability.**

***“The message from young people is clear – there is no way we can justify a new development framework that does not put young people’s issues at the centre of the agenda, including sexual and reproductive health and rights.”***

***– Samuel Kissi, Curious Minds***

<sup>53</sup> Center for Health and Gender Equity (CHANGE) (2016). United States Global Strategy to Empower Adolescent Girls & Sexual and Reproductive Health and Rights. Washington: CHANGE. [Online]. Retrieved from [http://www.genderhealth.org/files/uploads/change/publications/Adolescent\\_Girls\\_Fact\\_Sheet1\\_1.pdf](http://www.genderhealth.org/files/uploads/change/publications/Adolescent_Girls_Fact_Sheet1_1.pdf)

**The Administration must advance the sexual and reproductive health and rights of adolescent girls ages 10-19 and young people ages 20-29 across the globe by implementing and documenting a comprehensive and multi-sectoral approach through foreign assistance programs and ensuring the USAID Youth in Development Policy is fully implemented.**

The administration should fully implement and build upon existing multi-sectoral policies and programs to advance the health and rights of adolescents and youth. Furthermore, under the State Department and USAID, the administration should expand current age-disaggregated data collection and tracking of financial and programmatic investments in young people across the foreign aid portfolio. The USAID Youth in Development Policy provides a starting point to drive policies and programs to improve the capacities and enable the aspirations of youth so that they can contribute to and benefit from more stable, democratic, and prosperous communities and nations. Full implementation will mean that:

- Young people are better able to access economic and social opportunities, share in economic growth, live healthy lives, and contribute to household, community, and national well-being.
- Young people fully participate in democratic and development processes and play active roles in peace-building and civil society.
- Young people have a stronger voice in, and are better served by, local and national institutions, more robust and youth-friendly services, including comprehensive sexual and reproductive health services.



# End Discriminatory Treatment of Immigrants

**Policymakers must ensure that all individuals and their families, of all immigration statuses, can access private and public health care coverage.**

**Immigrant individuals in the United States face significant challenges to obtaining comprehensive and affordable health insurance coverage and care, including sexual and reproductive health services.<sup>54</sup> This is due to myriad policy, legal, and systemic barriers restricting people's access to coverage and care based on their immigration status. These barriers have created and sustained deep disparities. For example, in 2017, immigrant women of reproductive age who are not U.S. citizens had more than three times the uninsured rate of U.S.-born women of reproductive age.<sup>55</sup> That gap grew wider between 2013 and 2017, likely because many immigrants are barred from eligibility for**

**subsidized private coverage under the ACA and for Medicaid coverage. In fact, nearly half of noncitizen immigrant women aged 15-44 living at or below the poverty level remained uninsured in 2017.**

Moreover, the Trump administration's anti-immigrant rhetoric and actions, increasingly harsh enforcement of immigration policies, and abhorrent treatment of families and children at the U.S.-Mexico border have heightened fear and distress among immigrant communities, hindering individuals from seeking health insurance coverage for which they are eligible and obtaining needed health services for fear of being detained or deported, or subjecting a loved one to such treatment.<sup>56,57</sup> Moreover, the Trump administration is subjecting individuals to harsh detention conditions with harmful outcomes for their health and wellbeing.<sup>58</sup> Transgender individuals, particularly women, consistently face harassment, assault, and mistreatment at the hands of ICE officers and have faced longer

54 Hasstedt, K., Desai, S., and Ansari-Thomas, Z. (2018). Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States. Washington: Guttmacher Institute. [Online]. <https://www.guttmacher.org/article/2018/11/immigrant-womens-access-sexual-and-reproductive-health-coverage-and-care-united>

55 Guttmacher Institute (2018). Dramatic Gains in Insurance Coverage for Women of Reproductive Age are Now in Jeopardy. Washington: Guttmacher Institute. [Online]. [https://www.guttmacher.org/sites/default/files/article\\_files/attachments/immigrant\\_womens\\_access\\_to\\_sexual\\_and\\_reproductive\\_health\\_coverage\\_and\\_care\\_in\\_the\\_united\\_states.pdf](https://www.guttmacher.org/sites/default/files/article_files/attachments/immigrant_womens_access_to_sexual_and_reproductive_health_coverage_and_care_in_the_united_states.pdf)

56 Artiga, S., and Ubri, P. (2017). Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, and Health. Washington: Henry J. Kaiser Family Foundation. [Online]. <https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/>

57 Vargas, E., Sanches, G and Juarez, M. (2017). Fear by Association: Perceptions of Anti-Immigrant Policy and Health Outcomes. *Journal of Health Politics, Policy and Law*, 42(3): 459-483

58 Henry J. Kaiser Family Foundation. (2018). Key Health Implications of Separation of Families at the Border (as of June 27, 2018). Washington: Henry J. Kaiser Family Foundation. [Online]. Retrieved from <https://www.kff.org/disparities-policy/fact-sheet/key-health-implications-of-separation-of-families-at-the-border/>

periods of detention than their peers.<sup>59</sup> Specific to reproductive health and rights, the Office of Refugee Resettlement's extreme efforts to keep undocumented minors detained by HHS from obtaining wanted abortions represent unconstitutional and coercive denials of these young people's rights. Revisions to ICE policies are forcing pregnant women into unsafe detention facilities where they are at risk of miscarriage and other medical complications.

The web of legal and policy barriers to public and private insurance options for immigrants also means that many immigrants' access to care depends on the ability and willingness of local safety net providers to serve them. As such, continuity of care can be negatively impacted if a provider is unable or unwilling to serve them, disrupting families' ability to access care. Removing these barriers would advance the health and economic well-being of immigrants, their families, and society as a whole.

- **Congress must pass legislation to ensure all immigrants granted relief under any current or future deferred action program, including Deferred Action for Childhood Arrivals (DACA), are rightfully considered lawfully present for all purposes, including eligibility for health care coverage.**
- **The administration must reverse the 2012 federal regulations and CMS guidance to states that blocks DACA grantees' eligibility for Medicaid or CHIP coverage for lawfully residing children under 21 and pregnant women, and for the ACA's coverage and affordability programs.**
- **The administration must approve 1332 waivers that seek to allow undocumented immigrants to purchase insurance coverage through the health insurance Marketplaces and encourage states to use 1332 waivers to expand access.**

## **The U.S. should explicitly allow individuals to seek asylum on the basis of domestic violence and those facing persecution from reproductive coercion.**

**The inability to live free from intimate partner violence and risk of imprisonment for voluntary and involuntary pregnancy outcomes amounts to persecution of women and violates their most basic human rights.**

- **The President should work with the Department of Justice to ensure individuals experiencing domestic violence and reproductive coercion may seek asylum in the U.S., including by rescinding former Attorney General Sessions' opinion changing developed Board**

of Immigration Appeals case law on asylum standards based on gang violence and domestic violence.

- **The administration should urge Congress to update legislation outlining grounds for asylum to include domestic violence and reproductive coercion.** Under current U.S. and international law, to be eligible for asylum, a person must show a well-founded fear of persecution on the grounds of race, religion, nationality, political opinion, or membership in a particular social group. This latter category has been used to obtain asylum by domestic violence survivors who are unable to secure protection in their home countries, yet the

<sup>59</sup> Gruberg, S. (2018). ICE's Rejection of Its Own Rules Is Placing LGBT Immigrants at Severe Risk of Sexual Abuse. Washington: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/lgbt/news/2018/05/30/451294/ices-rejection-rules-placing-lgbt-immigrants-severe-risk-sexual-abuse/>

Trump-Pence administration has attempted to eliminate domestic violence as grounds for seeking asylum despite precedent.

- There is also precedent within the U.S. for providing asylum for certain coercive practices, such as forced abortions performed under China's one-child policy.

This should be expanded to address all forms of reproductive coercion, including those defined earlier in this document, with particular attention to women who face persecution and incarceration for abortion, miscarriage, and still births in their home countries where abortion is criminalized.

## **The administration must end the practice of detaining pregnant individuals in immigration detention facilities.**

**Detaining pregnant individuals not only severely risks the health of the pregnant individual and their fetus, it also infringes on their dignity and agency as a human being. Pregnant individuals, like other vulnerable populations, should not be detained. Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) must find humane, community-based alternatives to detention for pregnant individuals and other vulnerable populations. In December 2017, ICE announced that the agency would eliminate the presumption of release for pregnant people that the agency had**

**put in place in 2016. That policy change allowed ICE to remove critical reporting procedures, making it extremely difficult to monitor the treatment of pregnant women. Although ICE does not publicly report this information, media statements indicate that 1,655 pregnant people were booked into ICE custody over a 10-month period between 2017-2018 and that 28 women may have miscarried in ICE custody over the past two years.**

- ICE should immediately reinstate, and CBP should adopt, the presumption of release for pregnant individuals and implement strong reporting requirements to aid with oversight.

## **Policymakers must act to rescind the public charge rule and reverse its harms to immigrant individuals and families with low incomes otherwise eligible for Medicaid coverage.**

**The term “public charge” has been used in immigration processes, particularly when immigrants seek to adjust their status, to determine whether an individual is likely to become “primarily dependent” on government resources. The test has assessed whether an immigrant is likely to become a public charge based on their use of cash benefits or long-term care. Immigrants who are deemed public charge are typically denied admission to the U.S., denied lawful permanent resident (LPR) status, or in rare cases, deported. In fall 2018, Department of Homeland Security proposed a rule that would greatly expand the definition of public charge to include not only use of cash benefits or long term care but to a far more expansive set of criteria examining whether an immigrant is receiving, or is likely to receive, any one of a range of public benefits.**

Public benefits included in the expanded definition of public charge in the new rule include most Medicaid

programs, Medicare Part D, the Supplemental Nutrition Assistance Program, and some housing programs. It also negatively weighs having a costly health condition, limited English proficiency, limited formal education, and lack of employment in making immigration determinations when determining admissibility. The proposed rule and multiple leaked drafts of the rule prior to its publication have already caused a significant chilling effect on access to a range of services for immigrants with no or low incomes, including basic preventive health care, and particularly for pregnant or postpartum people, young people, and people living with HIV.<sup>60</sup> The Trump administration’s public charge rule would essentially penalize use of services that enable immigrants to attain economic security. No immigrant or their family should ever be placed in a situation where they must decide between their immigration status and their family’s health, housing status, or food security.

- **The proposed public charge rule has not been finalized yet. DHS should immediately rescind the proposed rule in its entirety and work to reverse the chilling effects of the proposed rule to immigrant individuals with low incomes and families eligible for Medicaid coverage. Furthermore, the administration should refrain from issuing any rules in which immigrants could be placed in a situation in which they must choose between providing health care and basic needs for their family and their immigration status.**

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<sup>60</sup> Parrott, S., Gonzales, S., Schott, L. (2018). Trump “Public Charge” Rule Would Prove Particularly Harsh for Pregnant Women and Children. Washington: Center on Budget and Policy Priorities. [Online]. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/trump-public-charge-rule-would-prove-particularly-harsh-for-pregnant>

**Policymakers must guarantee that all immigrants in detention settings have full access to abortion, contraception, and all other comprehensive sexual and reproductive health care through executive action, agency guidance, and strong congressional oversight.**

**Immigrants in detention often lack adequate health care and sometimes have no access to sexual and reproductive health care. Many travel to the U.S. to escape desperate circumstances in their home countries, and some have endured sexual, physical, and emotional abuse both at home and en route to the U.S. which makes access to sexual and reproductive health care services all the more urgent. Moreover, LGBTQ+ immigrants, particularly transgender immigrants, experience high rates of sexual abuse and assault in immigrant detention facilities.<sup>61</sup> During the Trump administration, HHS' Office of Refugee Resettlement blocked a young woman known as Jane Doe, along with a number of other minors in its custody, from accessing abortion care. A federal court had to step in to put a stop to the government's obstruction of these young women's rights.**

Detained immigrants must have access to comprehensive sexual and reproductive health care including abortion services, contraception including emergency contraception, prenatal care and maternal health services, screening and treatment for HIV, Hepatitis C, and other sexually transmitted infections, and hormone therapy. Providing the range of necessary services requires access to trained providers as well as transportation services to such providers, including access to medical facilities if treatment is not available onsite. For those who give birth while incarcerated, every effort should be made to honor their right to parent and promote parent-infant bonding.

- **DOJ, HHS, and DHS should release immigrants or utilize community based alternatives to detention rather than immigration detention.** Until then, guidelines and standards of care for comprehensive sexual and reproductive health care for all incarcerated people should be strengthened, including those in immigration detention facilities and facilities that contract with the government to detain immigrants.
- The administration should strengthen standards of care for people in immigration detention, including guaranteed access to comprehensive sexual and reproductive health care.

61 Gruberg, S. (2018). ICE's Rejection of Its Own Rules Is Placing LGBT Immigrants at Severe Risk of Sexual Abuse. Washington: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/lgbt/news/2018/05/30/451294/ices-rejection-rules-placing-lgbt-immigrants-severe-risk-sexual-abuse/>  
James, S.E. et al. (2016). The Report of the 2015 U.S. Transgender Survey. Washington: National Center for Transgender Equality. [Online]. Retrieved from <https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>

**The Administration should designate sexual and reproductive health service providers as “sensitive locations” from which immigrant individuals can obtain care without fear of penalization or deportation.**

**The U.S. Department of Homeland Security (DHS), which oversees both Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP), has policies that restrict immigration enforcement actions in certain “sensitive locations,” including schools, places of worship, and health care facilities. These limits on enforcement activities help ensure that immigrant individuals don’t have to choose between access to crucial services and keeping their families together at risk of deportation. Nevertheless, health care**

**providers have reported a noticeable drop in patient visits with recent ramped up immigration enforcement.<sup>62</sup> No one should fear receiving care for their sexual and reproductive health needs.**

- DHS should explicitly recognize providers of sexual and reproductive health services among health care providers recognized as sensitive locations.
- DHS should be held accountable for adhering to the restrictions on detaining or deporting immigrant individuals obtaining care, services or social supports at sexual and reproductive health service providers and all other sensitive locations.

***“People do not lose their human rights by virtue of crossing a border without a visa.”***

***–Zeid Ra’ad Al Hussein, Former UN High Commissioner for Human Rights***

<sup>62</sup> Ehley, B., Colliver, V., Rayasam, R. (2017). Fearing deportation, immigrants forgo medical care. Arlington, VA: Politico. [Online]. Retrieved from <https://www.politico.com/story/2017/07/17/deportation-fears-under-trump-have-immigrants-forgoing-medical-care-240635>

# Ensure Access to Care for Individuals in Detention Settings

**Policymakers must ensure that incarcerated and detained women and youth, transgender men, nonbinary and gender nonconforming individuals have access to comprehensive sexual and reproductive health care, including abortion and prenatal care; health care supplies such as menstrual hygiene products; proper nutrition; support during labor and delivery; lactation and parenting support after birth; and access to substance abuse and mental health treatment.**

**Women, especially queer and transgender women, and youth represent an increasing proportion of inmates in the U.S. correctional system.<sup>63</sup> This is particularly true for Black women, who are incarcerated at twice the rate of their white peers.<sup>64</sup> Black transgender women are incarcerated at ten times the rate of the overall U.S. population.<sup>65</sup> LGB people are three times as likely to be incarcerated as the general population, and over 40% of incarcerated women are lesbian or bisexual.”<sup>66</sup> The**

**United States has the responsibility to provide comprehensive health care services to all populations, including those who are incarcerated or held in immigration detention facilities.**

Incarcerated individuals often come from historically marginalized communities and have high rates of chronic illness, mental health conditions, substance use disorders, backgrounds of untreated trauma, and undetected health problems. Parents who are incarcerated or in detention centers are separated from their children, families, communities, and health care providers. Those who are pregnant and postpartum do not receive the special consideration necessary to protect their health

63 Meerwijk, E.L., Sevelius, J.M. (2017). Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples. [Online]. National Institute of Health. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227946/>

64 The Sentencing Project (2015). Incarcerated Women and Girls. Washington: The Sentencing Project. [Online]. Retrieved from <https://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf>

65 National Center for Transgender Equality (2018). LGBTQ People Behind Bars: A Guide to Understanding the Issues Facing Transgender Prisoners and Their Legal Rights. Washington: National Center for Transgender Equality. [Online]. Retrieved from <https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf>

66 *ibid.*

and well-being. Pregnant individuals have been forced to give birth in restraints<sup>67</sup> and denied breast pumps.<sup>68</sup> Transgender people are nearly ten times more likely to be sexually assaulted by guards or other incarcerated people than the general prison population.<sup>69</sup> Lesbian, gay, and bisexual individuals are roughly three times as likely to experience sexual abuse as other incarcerated people.<sup>70</sup> In ICE custody, LGBTQ+ people are 97 times more likely to experience sexual violence than non-LGBTQ people in detention.<sup>71</sup>

Additionally, many jails, prisons, and detention centers still house transgender, nonbinary, and gender nonconforming people strictly according to their genital anatomy or the sex they were assigned at birth, increasing the risk of sexual and physical abuse.<sup>72</sup> Facilities often deny people access to gender-appropriate clothing, grooming items, hormone therapy, and other gender-affirming care.<sup>73</sup>

The administration should develop a written policy outlining the right of incarcerated individuals to pregnancy testing, prenatal care, abortion care, resources for child care, kinship care, and adoption, labor and delivery, postpartum care and recovery, hygiene products, breastfeeding accommodations, and support for parenting. Policies and procedures must be developed to ensure that comprehensive reproductive health care

is available to detained individuals and that detention settings are monitored and held accountable for the delivery of such services, including timely, quality pregnancy related services and supplies.

- **The Department of Justice (DOJ) should work with the Department of Health and Human Services (HHS) to ensure that those incarcerated and held in detention centers have access to comprehensive sexual and reproductive health care including abortion services, screening and treatment for HIV, Hepatitis C, and other sexually transmitted infections.**
- **DOJ should ensure that juvenile justice institutions work with specialists to integrate trauma-informed mental health treatment and comprehensive sexuality education into reproductive health services for incarcerated youth and should also assure that all survivors of violence in the juvenile justice system have access to those services.** Providing the range of necessary services requires access to trained providers as well as transportation services to such providers, including access to medical facilities if treatment is not available onsite. For those who give birth while incarcerated, every effort should be made to honor their right to parent and promote parent-infant bonding.

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67 <https://www.law.uchicago.edu/ihrcc>.

68 Schenwar, M. (2013). Female prisoners' babies shouldn't be sentenced to life without breast milk. London, UK: The Guardian. [Online]. Retrieved from <https://www.theguardian.com/commentisfree/2013/oct/22/women-prison-babies-no-breast-pump>

69 National Center for Transgender Equality (2018). LGBTQ People Behind Bars: A Guide to Understanding the Issues Facing Transgender Prisoners and Their Legal Rights. Washington: National Center for Transgender Equality. [Online]. Retrieved from <https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf>

70 *ibid.*

71 Gruberg, S., ICE'S Rejection of Its Own Rules is Placing LGBT Immigrants at Severe Risk of Sexual Abuse (2018). Washington: Center for American Progress. [Online]. Retrieved on <https://www.americanprogress.org/issues/lgbt/news/2018/05/30/451294/ices-rejection-rules-placing-lgbt-immigrants-severe-risk-sexual-abuse/> ("LGBT" rather than "LGBTQ" is used to reference the study's findings, which were limited to LGBT individuals).

72 National Center for Transgender Equality (2018). LGBTQ People Behind Bars: A Guide to Understanding the Issues Facing Transgender Prisoners and Their Legal Rights. Washington: National Center for Transgender Equality. [Online]. Retrieved from <https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf>

73 *ibid.*



**Policymakers must end the dehumanizing and dangerous practice of shackling pregnant individuals in the custody of ICE, CBP, the Bureau of Prisons or US Marshals Service, once a person is known to be pregnant, including during transportation, childbirth, and the postpartum period; and encourage adoption and enforcement of anti-shackling policies in state prisons and jails.**

**The dangerous and degrading practice of using restraints on pregnant and birthing individuals (including pregnant young people) in prisons and detention facilities undermines health care delivery, violates an individual’s human right to be free from inhumane and degrading treatment, and is rarely necessary.<sup>74</sup> The alleged purpose of shackling is to keep incarcerated people from escaping or harming themselves or others; however, there is no data to support applying this rationale to individuals who are pregnant, birthing, or recovering postpartum. No escape attempts have been reported among incarcerated pregnant individuals who were not shackled**

**during childbirth.<sup>75</sup> Preserving the health and dignity of incarcerated pregnant individuals is not only feasible, it is a fundamental human rights obligation. Ensuring the provision of compassionate health care in all detention settings (civil and criminal) will prevent the significant physical and emotional harm that results from shackling during and after pregnancy.**

- Congress should pass the Stop Shackling and Detaining Pregnant Women Act, which would reinstate the presumption of release of pregnant women and youth from immigrant detention, set minimum standards for health care, prohibit shackling or use of restraints at any time during pregnancy, labor, and postpartum recovery, and require public reporting on the detention of pregnant women.

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<sup>74</sup> American Civil Liberties Union (2012). ACLU Briefing Paper: The Shackling of Pregnant Women & Girls in U.S. Prisons, Jails & Youth Detention Centers. Washington: American Civil Liberties Union. [Online]. Retrieved from [https://www.aclu.org/files/assets/anti-shackling\\_briefing\\_paper\\_stand\\_alone.pdf](https://www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf)

<sup>75</sup> Ibid.

**Policymakers must prioritize treatment over detention or incarceration, and family preservation when possible for pregnant individuals and families experiencing a substance use disorder.**

**With the increased awareness and focus on opioid use during pregnancy and infants born with neonatal abstinence syndrome, it is imperative that solutions focus on a comprehensive, non-punitive public health approach, with an emphasis on healthy pregnancies. Maintaining intact families, reducing recidivism, and promoting better health outcomes for parents and children should be the priority. Evidence-based treatment during pregnancy includes the use of medication assisted treatment, and obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children based solely on substance use disorder, either suspected or confirmed.**

Incarcerated pregnant individuals should be moved out of incarceration settings and placed in treatment facilities or programs that provide them with the full range of care they need, including reproductive health services, substance use disorder treatment, mental health services, and other necessary social supports. If a pregnant individual is detained or incarcerated, they should be provided with substance use disorder treatment options that can respond to their unique health care needs.

Policies should be evidence-based and prioritize reducing barriers to prenatal care and treatment, family preservation, reducing incarceration and recidivism, and promoting better health outcomes for parents and children.

- **DOJ and the Substance Abuse and Mental Health Services Administration (SAMHSA) should prioritize treatment over detention or incarceration by increasing the number of programs for pregnant individuals that are designed to serve as alternatives to incarceration.**

## PRINCIPLE 3:

# Ensure that Research and Innovation Advance Sexual and Reproductive Health, Rights, and Justice Now and in the Future.

**Increasingly, policymakers, health systems, and health insurance companies are pursuing new ways of delivering and paying for health care – all with an eye towards shifting health care systems from paying for volume to paying for value. Innovative technologies for patient and provider use, including modes of telehealth delivery, are often key components of these changes. There is enormous excitement and energy around what transformation means for improving people’s experience with the health care system, preventing illness, and improving health outcomes. Perhaps most importantly, these system changes hold great promise for addressing the health inequities people with low incomes and people of color face and putting more emphasis on the non-clinical social determinants of health.**

Reforms to our health care system in the U.S. and to systems around the world are necessary to improve health care quality, equity, and affordability, and policymakers have an unprecedented and timely opportunity to ensure reproductive health care and reproductive health care providers are central to health care system transformation in its many dimensions. To be successful, though, such reforms must account for reproductive and sexual health needs and address life-threatening reproductive health inequities experienced by the hardest to reach communities in developing countries and LGBTQ+ people, women of color, and women with low incomes in the U.S. as a result of historic and ongoing racism, sexism, homophobia, and transphobia in the health care system. Current efforts at systemic reform in Medicare and Medicaid are generally lacking adequate policy foundations to address reproductive health and equity, at the cost of individual’s lives and wellbeing. Additionally, global agreements on universal health coverage must include comprehensive coverage of sexual and reproductive health services and commitments to meeting the health care needs of the communities that face the greatest barriers to care to ensure we leave no one behind.

Investment in scientific research and development with the goal of developing safe, effective, and patient-centered technologies and knowledge is needed to achieve domestic and international reproductive health, justice, and equity goals.

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# Invest in Health System Innovation that Promotes Sexual and Reproductive Health

**CMS must continue to ensure that the quality measures used to focus and evaluate programs' progress include basic sexual, reproductive and preventive health care measures, address the health needs of different populations, and are not used inappropriately.**

**Quality measurement in health care has become increasingly important under the Institute for Healthcare Improvement's "Triple Aim" pursuit of better care, improved outcomes, and lower costs as an approach to optimizing health system performance. While the National Quality Forum (NQF) has over 600 measures dedicated to assessing patient and population health and improving the quality of health care systems, only recently have any addressed the provision of family planning services. The contraceptive care measures assess the percentage of women of reproductive age: 1) at-risk of unintended pregnancy provided with a most or moderately effective contraceptive method; 2) who have had a live birth and are provided with a most or moderately effective contraceptive method within three to sixty days of childbirth; 3) at-risk of unintended pregnancy provided**

**with a LARC method. Having endorsed contraceptive quality measures presents significant and long-awaited opportunities to advance policy goals to improve people's health and their access to high-quality sexual and reproductive health care.**

In addition to the inclusion of the family planning quality measures in both federal and state initiatives, to truly develop innovative models that will improve outcomes it is essential to include preventative health care measures that reflect the services and care most needed by young people with low incomes and young people of color. Measures of reproductive health care quality, including contraceptive care, are especially useful to identify gaps in equitable access as well as areas for clinical quality improvement.

Because of the history and ongoing existence of reproductive coercion, particular scrutiny should be applied to measures that could have the unintended consequence of coercion in women's reproductive health decision making. In implementing measure adoption programs, protections should be included to prevent measures from being utilized in a manner that results in coercion towards a particular intervention or outcome such as incentives for using a particular method of birth control.

- CMS should safeguard against patient coercion or steering toward a particular method of contraception.
- CMS should require quality measure reporting be stratified by variables including race, ethnicity, sex (including sex assigned at birth, gender identity, and sexual orientation), age, disability status, primary language, and other demographic characteristics, as this facilitates identifying disparities and quality gaps, as well as intervention points and strategies.
- CMS should work to incentivize the widespread adoption and use of the contraceptive measures in the quality programs administered by Medicaid, Medicaid managed care entities, and Marketplace plans. CMS and private-sector stakeholders, also, will be strongly urged to start measuring contraceptive care in multi-payer quality improvement efforts.
- CMS should incentivize the use of measurement to hold the system accountable for equity gains and population health outcome improvements.
- CMS should develop more SRH-focused measures, including a patient-reported outcome measure and measures that reflect that health needs of LGBTQ+ people.
- CMS should develop safeguards against unfriendly use of measurement and reporting requirements to undermine providers' capacity to offer comprehensive sexual and reproductive health care.

**Policymakers must prioritize development and broad adoption of delivery system and payment models that recognize how people of reproductive age define quality, value and choice and how they access comprehensive reproductive and sexual health care, including family planning, LGBTQ+-inclusive counseling, prenatal and pregnancy care, abortion, related preventive services, and gender-affirming care, in a range of settings including self-managed care and care accessed by telehealth means.**

**Alternative payment and clinical care delivery models should view patients and their loved ones as valuable partners at all levels of care and focus on coordinated patient-centered care delivery that includes a commitment to care planning. Care coordination and continuity should include appropriate interface with primary and specialty care. Financial incentives should reward delivery**

**of high-quality care that is measured by high-value quality measures, including patient-reported outcomes measures and patient experience of care measures. Care should be delivered in a range of settings according to patient preference, including with a greater emphasis on providing resources, training, and equipment for telehealth in all medical specialties and disciplines.**

Alternative payment and clinical care delivery models should never intentionally or unintentionally allow for coercion towards a particular clinical intervention or outcome; instead models should acknowledge the history and continued existence of reproductive coercion, and

must center the needs, perspectives and leadership of those most harmed by reproductive oppression including but not limited to people of color, Indigenous people, cis and trans women and femmes, people with low incomes, LGBTQ+ people, immigrants, and young people.

## Achieving health equity should be an explicit goal of efforts to transform the health care system.

**Everyone should have a fair and just opportunity to live their healthiest life possible. Therefore, achieving health equity should be an explicit goal of all efforts to transform health care and the health care system. Racism plays a direct role in health outcomes and contributes to negative social determinants of health, for instance by creating barriers to educational attainment and earning capacity. Without making equity an explicit goal, unintended consequences of systemic change can further perpetuate and worsen existing health disparities.**

Women of color, specifically, face overlapping issues of systemic oppression, racism, sexism, and the legacy of coercion and exploitation within the healthcare system. To begin to account for historic and ongoing oppression, new models of care delivery should seek to be trauma-informed, culturally sensitive, designed based on the specific needs of communities with direct input and/or participation from the affected communities, and centered on empowerment and choice. Policymakers

and health care providers should be committed to reducing racial and ethnic disparities for women of color, including by addressing how racism and other forms of oppression negatively affect health in our current system.

- **The administration must take action to make achieving health equity an explicit goal for new models of care delivery and payment.** This should include requirements to disaggregate data by race, ethnicity, sex assigned at birth, gender identity, and sexual orientation; training and assessment of delivering culturally sensitive care and combatting implicit bias by health care providers; support for workforce diversity and increased development and access to alternative models of care, such as community health workers; and specific metrics for reducing disparities within patient populations.
- New models should provide greater investment and financial support for safety net providers – particularly reproductive health providers – who are essential sources of care for many communities of color.
- The administration should support transformation efforts that are grounded in the needs of communities of color and should seek to provide care that is equitable, trauma-informed, reflects the health care needs of all women of color, and fully integrates reproductive health care.

**Policymakers must ensure reproductive health providers can fully participate across innovative delivery system models; and that patients can see the provider of their choosing.**

**The Affordable Care Act (ACA) encourages innovative models of care coordination systems such as Accountable Care Organizations (ACOs) and other integrated models. It is critical that patients of these new care models have access to a robust choice of reproductive health providers, as they are an important source of primary care for many individuals. A lack of integration of these providers in delivery system models will mean that efforts to**

**coordinate care for women with chronic diseases and other comorbidities will fail to address their reproductive health needs.**

- The administration should implement policies to support reproductive health providers in innovative delivery system models and direct resources to support their participation.
- The administration should protect patients' choice of reproductive health provider, choice of contraceptive methods, offer a range of options, and promote informed and empowered health care decision-making between providers and patients.

**Congress should require CMMI to develop more innovative, Medicaid-focused models of care and payment.**

**The Center for Medicare and Medicaid Innovation (CMMI) is a significant driver and funder of health care innovation. Currently, the vast majority of CMMI models are focused on the Medicare population, where new ways of delivering care, such as through accountable care organizations, have expanded and taken root. CMMI, however, has devoted less**

**attention to the Medicaid population, which is a critical source of coverage for people of reproductive age.**

- To ensure that all people are benefitting from evidence-based, patient-centered, equitable innovation, Congress should explicitly require the Center to focus on the needs of reproductive age people, including individuals who are LGBTQ+, who are more likely than the overall U.S. population to use Medicaid benefits due to systemic barriers and inequalities in the health care system.

**Policymakers should incentivize leveraging new technologies to improve the quality of provider-patient interactions, to enhance telehealth and virtual health care experiences, and to expand self-directed care.**

**There is currently an unprecedented opportunity to encourage fresh technological approaches to expanding care, as well as novel problem-solving partnerships between academic institutions, foundations, nonprofit organizations including patient advocacy groups, companies, and government agencies. Increasingly, policymakers, health systems, and health insurance companies are pursuing new ways of delivering and paying for health care – all with an eye towards shifting our health care system from one that pays for volume to one that pays for value. Innovative technologies for patient and provider use, including modes of telehealth delivery, are often key components of these changes. There is enormous excitement and energy around what transformation means for improving people’s experience with the health care system, preventing illness, and improving health outcomes.**

Perhaps most importantly, these system changes hold great promise for addressing the health inequities people with low or no incomes and people of color face and putting more emphasis on the non-clinical

social determinants of health. As we promote important uses of health technology and data, we must also prohibit misuses of data for health – for example, targeting certain individuals or groups, collecting data without meaningful consent, using data to discriminate or deny services. To prevent repeating the abuses of the past we must erect guardrails to ensure that communities of color, people with low incomes, persons with disabilities, and others are not more likely to have their most sensitive data siphoned and used without their knowledge, meaningful consent and/or active participation.

- **The federal government should lead the way in working across sectors to develop and implement an actionable health technologies innovation plan, to include recommendations for:**
  - Novel health care delivery platforms;
  - Clinical record-keeping systems, including novel pathways toward improved patient access control, and use of their own clinical records and other health information, which would be available in multiple languages;
  - Connecting bench, clinical, and behavioral research to policy and practice;
  - Expanding quality improvement efforts that focus on patient-centered decision-making—especially for those who have limited or no access to care; and
  - Increasing access to high-quality sexual and reproductive health care by reducing technological and information barriers.



- **The administration should create and Congress should support cross-sector incentives to foster innovation in:**

- Health database and clinical records systems;
- Sexual and reproductive health service delivery methods to relieve workforce fatigue, including novel virtual platforms and evidence-based self-care technologies; and
- New technologies in contraception and HIV/STI prevention, such as the emerging field of

multipurpose prevention methods currently in early development, particularly those under the control of the receptive partner.

- **The administration and Congress should encourage development of innovative technologies and web-based platforms that work toward free and open access to sexual and reproductive health-related databases, tools, and resources.** Such innovations must be introduced through programs that ensure adoption is not limited to high-resource settings but instead are available to all types of entities and communities.

**Policymakers should continue to invest in the Saving Lives at Birth (SL@B) Grand Challenge program given the demonstrated effectiveness of the initiative's partnership structure and catalytic funding model.**

**USAID has pioneered innovative approaches to bring business-minded approaches to the development and roll-out of new global health technologies and accelerate progress against some of the world's most important health issues. By investing seed capital in the most promising ideas, and leveraging funding, partnerships, and expertise to advance the next generation of global health technologies, the Agency maximizes the impact of U.S. taxpayer dollars, transforming targeted investments into cutting-edge innovations. For example, the Saving Lives at**

**Birth (SL@B) Grand Challenge has successfully leveraged \$20 million in U.S. government funding to attract more than \$150 million from outside donors to fund a pipeline of 116 innovations aimed at saving the lives of mothers and newborns, with potential to save 150,000 lives by 2030. By making funding available to the brightest innovators around the world, SL@B is an important way USAID is supporting countries as they develop their own health systems. Congressional support is important to ensure such innovative and effective programs continue.**

# Invest in Research & Development that Promotes Sexual and Reproductive Health

**Policymakers should fund and require research and data collection that identifies disparities in health care access and barriers to quality care.**

**In order to address health inequities in a comprehensive and integrated way, it is essential that we gain a better understanding of both the overall health status and the sexual and reproductive health status and experiences of all communities, including those for whom research data are frequently lacking, such as communities of color, LGBTQ+ people, and young people.**

- **By improving data collection on abortion, contraception, sexually transmitted infections, sexual orientation and gender identity, formal sex education, and social determinants of health for under-researched groups, we can meaningfully expand capacity to address sexual and reproductive health inequities.** National- and state-level government surveys must collect data about the sexual and reproductive health of all communities while soliciting specific data on race, ethnicity, age, sexual orientation, sex assigned at birth, and gender identity so that data may be disaggregated for Asian and Pacific Islander American (AAPI) communities, for young people, and for LGBTQ+ people. This will help reveal important findings about groups that are frequently made invisible by research designs that obscure their identities and experiences. AAPI communities, for example, are often grouped

together in studies for convenience, but this masks substantial differences in the circumstances of different ethnic groups. Additionally, in most federal and administrative surveys conducted, questions regarding sexual orientation or gender identity are not routinely asked, which leads to a lack of information about how sexual orientation and gender identity intersect with other data points in any given survey. It is important to note that, given the particular personal and political sensitivities surrounding the issue of abortion in the United States, any moves to improve state abortion surveillance must safeguard the privacy, rights, and needs of abortion patients and providers. Governmental public health reporting systems must be limited to collecting basic incidence and demographic data for legitimate public health purposes. Official governmental reporting systems that go beyond this limited scope have the effect of stigmatizing women obtaining abortions or harassing abortion providers for the purpose of promoting an anti-abortion policy agenda. Using a public health surveillance system for this purpose cannot be justified on any grounds.

- **The administration must take action to produce comprehensive data that is disaggregated by sex assigned at birth, gender identity, sexual orientation, race, ethnicity, national origin, age, income, and geographic location.**
  - **The President must propose a budget that includes funding for research on the lives and experiences of LGBTQ+ people.**

- Agencies should ensure that their data collection tools use multi-step identification questions. Identification questions in surveys and research should go beyond a singular question about gender question. For instance, in most surveys and forms, one question asks about “gender” and the options are only “male” or “female.”<sup>76</sup> This data collection tool should also be implemented into applications for federal health programs, such as Medicaid, so that electronic systems do not bypass reproductive health and pregnancy-related questions for transgender men and nonbinary and gender nonconforming people.
- The Department of Health and Human Services must conduct research on the experiences of LGBTQ+ people seeking and/or receiving reproductive health care.
- Congress must hold oversight hearings of administrative agencies conducting data collection to ensure that all LGBTQ+ people are being accounted for, and that no population is left behind.
- The administration must conduct comprehensive, non-partisan research into the barriers to access that individuals and communities face, and particularly the barriers imposed by recent regulatory changes such as illegal 1115 waivers, the 2019 Title X final rule, changes to ACA provisions, expanded global gag rule, and more. These types of policies have a significant impact on people’s health and well-being, and disproportionately harm people of color, people who live in rural communities, LGBTQ+ people, Native Americans, and young people. We must have a full and clear accounting of the barriers to access and negative health outcomes that result from these policies

**Policymakers should increase funding for research and development and improve appropriate contraceptive, abortion, and multipurpose (MPT) technologies by \$122 million annually for NIH and USAID.**

**The field of reproductive health research and development (R&D) is grossly underfunded. Greater financial and policy support are required for the discovery and development of new and improved contraceptives, abortion and multipurpose technologies. The current method mix of contraceptives remains inadequate; user acceptance is limited and discontinuation rates of current technologies remain**

**high (25-50%) because of experienced or perceived side effects, amongst other reasons. Each year, 40 percent of pregnancies are unintended worldwide, and in the United States, nearly half (3.1 million) of pregnancies are unintended. The vast majority of unintended pregnancies in the United States occur because of incorrect or inconsistent use of contraceptives – or because they are not used at all.<sup>77</sup> Moreover,**

<sup>76</sup> Baker, K., McGovern, A., Gruberg, S., Cray, A. (2016). The Medicaid Program and LGBT Communities: Overview and Policy Recommendations. Washington.: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/lgbt/reports/2016/08/09/142424/the-medicaid-program-and-lgbt-communities-overview-and-policy-recommendations/> (discussing problematic implications of the “gender question” on the online Medicaid application).

<sup>77</sup> Tanne, J.H. (2008). Problems with contraception play big part in unplanned pregnancies, study says. U.S. National Library of Medicine. 336(7653): 1095.

**many existing methods are challenging for users and providers, especially in low resource settings in the U.S. and globally, because of cost or how these contraceptives must be administered. Innovation of new methods to better meet user needs and preferences would lead to increased contraceptive uptake, improved access, and effective use of high-quality family planning options worldwide.**

Many contraceptive users could also benefit from multipurpose technologies (MPTs) that offer protection not just against pregnancy, but also from HIV, HPV, or other sexually transmitted infections. Every day, approximately 6,300 individuals worldwide acquire HIV,<sup>78</sup> and more than 1 million individuals contract sexually transmitted infections (STIs) that can cause cancer, infertility, pregnancy complications, and increased HIV risk.<sup>79</sup> Despite decades-long calls for more innovative and flexible contraceptive and STI prevention products that work better for people, there has been inadequate attention and resources paid to research and development in this critical space. Indeed, the overwhelming majority of new contraceptive products introduced in the past few decades have been adaptations of existing

technologies, instead of technological innovations or breakthroughs. There are very few MPTs under development.

It is critical to invest in the discovery, development, and preparation for market launch of new or improved contraceptive technologies that can better serve millions of users whose contraceptive needs are not currently met by existing technologies. Among the new contraceptive technologies needed are methods that are private and user-controlled; long-acting methods that do not require skilled providers; methods that can be used on demand around the time of intercourse; non-hormonal methods for users who should not use, dislike, or are concerned about the side effects of hormonal methods; and new and better male contraceptives. New technologies also need to be developed for users who are harder to reach for socio-economic and geographic reasons.

The U.S. Government is the world's largest family planning bilateral donor. Throughout history, USAID has been involved directly or indirectly in the R&D of almost every contraceptive method available today. In a field where few other actors have invested, the U.S. government continues to have a key role to play in correcting this problem and ensuring there are more comprehensive options available to all people, and that this investment has engendered benefits in lives saved, opportunities for women expanded, and health sector costs contained.

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78 Auld, A.F., Agolory, S.G., Shiraishi, R.W., Wabwire-Mangen, F. ... Ellerbrock, T.V. (2014). Antiretroviral Therapy Enrollment Characteristics and Outcomes Among HIV-Infected Adolescents and Young Adults Compared with Older Adults - Seven African Countries, 2004–2013. CDC: Morbidity and Mortality Weekly Report (MMWR), 63(47): 1097–1103

79 World Health Organization (2019). Sexually Transmitted Infections. Geneva: World Health Organization (WHO). [Online]. Retrieved from [https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-\(stis\)](https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis))

## The Administration and Congress must restore scientific integrity and transparency to support activities that affect sexual and reproductive health.

**Successful, evidence-based programs to advance high-quality family planning and other aspects of sexual and reproductive health have suffered under an administration that disregards and mischaracterizes science while obfuscating the reasons for its actions. Appointees with histories of making inaccurate statements about contraception and abortion have assumed positions responsible for family planning programs. Important research projects funded under the Teen Pregnancy Prevention Program (TPPP) and Title X grant programs, as well as research involving fetal tissue, have been cut short with apparent political motives, while projects that have not undergone sufficient vetting for their consistency with programs' statutory goals have received funding. Trump administration officials have attempted to eliminate the high-quality evidence standards that characterize TPPP, and have mischaracterized evidence on contraceptive effectiveness and safety in a rule rolling back the employer contraceptive mandate. Such erosion**

**of scientific integrity is a trend across agencies under the Trump administration.<sup>80</sup>**

Restoring scientific integrity is essential to ensure that federal investments translate to improvements in public health. Policies should be informed by high-quality evidence, and policy proposals should accurately represent evidence. Nominees, executive branch appointees, and other policy makers must use evidence-informed and medically accurate data and research, and must not interfere with agencies using science to carry out their missions. Funding decisions and evaluations should be consistent with programs' statutory goals and made by those with relevant expertise, and once funding has been awarded it should not be rescinded based on new priorities that deviate from programs' statutory goals. Agencies should be transparent about the evidence and other considerations that guide their decisions on policies and grant decisions, and about findings that affect public health. Government scientists, as well as contractors and grantees engaged in research and data collection, should be able to communicate their findings to Congress, the media, the public, and their scientific peers, free from censorship or other forms of interference by political appointees.

- **Congress must pass legislation requiring agencies that fund or conduct scientific research to develop scientific integrity policies.** The Obama administration's 2010 Scientific Integrity Directive instructed agencies to develop scientific integrity policies that ensure a culture of scientific integrity; strengthen credibility of government research; facilitate the free flow of scientific information; and establish principles for conveying scientific information to the public. By the end of the Obama administration, 28 agencies had created scientific

80 Climate Science Legal Defense Fund et al. (2018). Protecting Science at Federal Agencies: How Congress Can Help. [Online]. Retrieved from [https://publichealth.gwu.edu/downloads/research/Protecting\\_Science\\_at\\_Federal\\_Agencies.pdf](https://publichealth.gwu.edu/downloads/research/Protecting_Science_at_Federal_Agencies.pdf)

integrity policies of varying strength and scope, addressing topics such as scientists' communication with the media, scientists' ability to review press releases describing their work, and infrastructure to oversee scientific integrity.<sup>81</sup>

- Congress must exercise oversight and investigate instances of abuses of scientific integrity, including problems with censorship, inappropriate cancelation of grants or research projects, and political interference with science-based decision-making. When concerns about scientific integrity arise, Congress should exercise its oversight role by requesting information from agency leadership, holding hearings, requesting investigations by Inspectors General or the Government Accountability Office, and/or conducting its own investigations.
- **The administration must appoint and Senate should confirm nominees who exhibit views and experience consistent with agency missions and who demonstrate respect for and sufficient**

**understanding of relevant science.** President Trump has appointed individuals who have histories of promoting abstinence over comprehensive contraceptive care and advancing claims not supported by scientific evidence to roles that include responsibility for family planning programs.<sup>82</sup> While these positions are not subject to Senate confirmation, the appointments indicate a willingness to select appointees whose views and experiences are inconsistent with administering a public health program that should be based on science. Members of Congress should question all administration appointees who oversee health programs, policy, or research about their commitment to scientific integrity.

- Government communications about public health topics should use medically and scientifically accurate terminology that is commonly used in the relevant field. Agencies that address family planning should use medically accurate terms regarding pregnancy and medical interventions.

## **Congress and the Administration should prioritize funding research for improving maternal health and pregnancy outcomes, ensuring healthy lives for all.**

**Between 1990 and 2015 when the global maternal mortality rate decreased by approximately 44 percent,<sup>83</sup> the maternal mortality ratio for the U.S. significantly increased from an estimated 16.9 to 26.4**

**maternal deaths per 100,000 births<sup>84</sup> and the country has now a higher ratio than those reported for most high-income countries. The majority of maternal deaths in the U.S. and around the world are**

81 Berman, E., Carter, J. (2018). Policy Analysis: Scientific Integrity in Federal Policymaking Under Past and Present Administrations. *Journal of Science Policy & Governance*. 13(1), 1–26

82 Lanktree, G. (2017). Trump's Family Planning Pick Teresa Manning Called Contraceptives "Medically Irresponsible." *New York: Newsweek*. [Online]. Retrieved from <https://www.newsweek.com/trump-contraception-abortion-family-planning-funding-592942>

83 World Health Organization (2018). *Maternal Mortality*. Geneva: World Health Organization (WHO). [Online]. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

84 Kassebaum, N.J. (2016). Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *The Lancet*, 388, 1775–1812.

**preventable. Among others, one key factor is the general lack of good data – and related analysis – on maternal health outcomes. Not all states have maternal mortality review boards and the data that are collected are not systematically used to guide changes that could improve prenatal care and reduce maternal mortality, morbidity, and prematurity.**

Research into methods for addressing the impact of racism on maternal health disparities is also essential, and such research must involve affected communities as partners.

- **Congress and the administration should support the development and evaluation of a range of methods for eliminating racial disparities in maternal health outcomes, from efforts to eliminate bias in provider care and systems of care delivery to initiatives addressing social determinants of health.**
- **Congress and the administration should support greater investment in maternal health outcome data and greater research about the effects of most medications and therapeutics on pregnancy.** Higher quality data is needed to help individuals who are pregnant and their providers manage health problems in the safest possible manner, no matter where they
- **Congress must fund additional research into the risks of substances suspected to harm fetal development or pregnant people’s health,** and the Centers for Disease Control and Prevention and the Environmental Protection Agency should report back to Congress on the findings including making them publicly available.
- **The administration should develop a resource tool, which should be regularly updated, for providers and health care professionals providing guidance on best practices when communicating environmental risk factors to all patients, including pregnant women and women of reproductive age.**

live. The ability to make informed decisions about medications and pregnancy hinges on the availability of better data.

Moreover, Health care providers must be fully equipped with the information necessary to properly communicate about environmental risk factors to patients. While providers tend to discuss regularly with pregnant patients the risks of consuming alcohol, drug abuse and smoking, environmental hazards such as pesticides, certain cosmetic products, mercury in fish, and air pollution often go unmentioned and undetected. Almost nine out of ten OB/GYN’s surveyed in the Bixby’s Center study admitted to not being equipped with the adequate knowledge necessary to fully inform patients about the relationships between environmental exposures and pregnancy outcomes.<sup>85</sup>

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85 Trowbridge, J., Sutton, P., Stotland, N., Charlesworth, A., Atchley, D., Woodruff, T.J. (2012). Clinicians and their role in reproductive environmental health. San Francisco: Bixby Center for Global Reproductive Health. Retrieved from <https://apha.confex.com/apha/140am/webprogram/Paper268860.html>

**The Department of Health and Human Services must develop a robust research and outreach initiative on U.S. maternal mortality in the form of an interagency task force.**

**In order to address the high rates of mortality and morbidity related to pregnancy in the U.S., the President should develop a robust research and outreach initiative at HHS, in the form of an interagency task force comprising of representatives from the National Institutes of Health, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and other relevant agencies. This task force should be responsible for collecting data, enhancing coordination and communication among relevant federal agencies, and determining**

**and exploring the causes for persistent high rates of maternal mortality, particularly as experienced by Black and Native American individuals, and charged with presenting public health solutions. The task force should also ensure that all federal health quality measures and payer incentives are tied to robust data collection and draw on relevant research to help address inequities uncovered through the interagency task force. Additionally, the task force must have a formal mechanism for meaningful involvement and input by affected communities.**

**Policymakers should require increased transparency of USAID investments in global health technologies and annual report on health-related research.**

**The Global Health Innovation Act requires USAID to report annually for five years on the development and use of global health innovations in the programs, projects, and activities of the Agency, as well as a description of collaboration and coordination with other Federal departments and agencies, including the Centers for Disease Control**

**and Prevention, in support of global health product development. Continued reporting is important for transparency and oversight and for ensuring that USAID's work in global health research and development aligns with and fully supports the agency's global health goals. The report required by the Global Health Innovation Act should include**



**information about the Agency’s collaboration and coordination with Federal departments and agencies including the Department of Defense, the National Institutes of Health, the Food and Drug Administration, and the Office**

**of the Global AIDS Coordinator, in addition to the Centers for Disease Control and Prevention, to fully capture how critical gaps in product development for global health are being filled.**

**Policymakers should fund investment fellowships and grants to support PhD post-doctoral individuals and early career investigators to increase the capacity of reproductive health scientists and the productivity of their labs. Trainees should be paired with institutions, either civil society or university, to facilitate mentorship and collaboration.**

**There is significant need to invest in a new generation of reproductive health scientists. The lack of reliable sources of support for contraceptive R&D – and even more so for abortion research – stifles the careers of biomedical and biotechnology scientists who wish to pursue work in the relevant sciences. Without sufficient funding or incentives by pharmaceutical companies or donors, the cadre of trained investigators in this field has dwindled as career trajectories are limited. Significant**

**developments are unlikely to occur if top scientists do not enter the field and funding is not available to them to move the science forward with discovery and translational research.**

- This next generation of scientists will play significant roles in developing new reproductive health technologies while continuing to develop skill sets needed to succeed as researchers.
- NIH grants will be critical in expanding the pool of next generation reproductive health researchers by providing the funding necessary for mentorship and career development.

## The President must propose increased funding for reproductive health technology research and development.

- **At least double the National Institutes of Health (NIH) and United States Agency for International Development (USAID) funding available for the research and development of contraceptives that are more effective, affordable, and easier to deliver – as well as for the research and development of multipurpose prevention technologies (MPTs), which are products that simultaneously protect against unintended pregnancy, HIV, or other STIs.** This increase should include the following:
  - An additional \$80 million to the National Institute of Child Health and Human Development to accelerate the research and development of contraceptives and MPTs;
  - An additional \$12 million to the National Institute of Allergy and Infectious Diseases for the expansion of the research and development of MPTs;
  - An additional \$30 million to USAID’s Office of Population and Reproductive Health to accelerate the research and development of contraceptives and MPTs; and
  - Continuing \$45 million annually for USAID’s Office of HIV/AIDS for the research and development of microbicides to prevent HIV.

## PRINCIPLE 4:

# Ensure Health, Rights, Justice and Wellness for All Communities.

**A person's health should never depend on who they are, how much money they have, or where they live. Every person has the human right to quality health care, and no individual or community should be left behind. All individuals should have the chance to live safe, healthy lives and be free to determine their own paths, including if, when, and how to create a family. All individuals should also be able to raise and care for children with dignity and freedom from violence, discrimination, or denial of our human rights and needs.**

Sexual and reproductive health and rights are inextricably linked to economic justice, voting rights,

immigrants' rights, LGBTQ+ liberation, disability justice, and the right to community safety and racial equity. True health and wellness will only be achieved by making progress throughout complex and interrelated systems and by addressing societal, environmental, and social factors that impact people's health. For too many in these communities, a broad range of barriers interfere with their health, including inadequate wages, stigma, discrimination, lack of affordable housing, safe and affordable water and sanitation, transportation, lack of paid leave, lack of childcare, and the threat of criminalization, detention and deportation.

All policy proposals should center the experiences of people with low incomes, women, immigrants, people of color, adolescents and youth, LGBTQ+ people, Indigenous peoples, people living in the Global South, people with disabilities, and people living with HIV, among others.

## **Policymakers must foster economic opportunity for all families.**

**If young people encounter an inadequate school system, a toxic environment, or racial or gender bias, it will be much harder for them to achieve intellectual, economic, and overall societal gains. If a caretaker lives in a community with an insufficient amount of jobs, particularly jobs that pay a livable wage, the entire family unit is**

**likely to suffer. All individuals have the right to achieve the life of their choosing and to adequately care for themselves and their families.**

- **Policymakers must support the right of all individuals to have fair opportunity for educational and career success. Everyone worldwide should have access to high-quality education free from barriers and school violence.**

- **Policymakers should ensure basic living standards through investments in programs that provide financial, housing, and nutrition supports.** Ensuring access to high-quality, affordable child care allows working families the security of knowing their children are well cared for while they work to provide economic security and advancement for their loved ones.
- **Policymakers must enact policies that address race and gender pay gaps, particularly for women of color, including by raising wages – and support the passage of strong, inclusive and sustainable paid family and medical leave plans that meet the needs of new parents, especially young parents, people who care for seriously ill family members, and workers with serious health issues and disabilities, as well as paid sick days policies so that people don't have to choose between accessing**

reproductive health care and losing wages or even their jobs .

- **Policymakers must strengthen policies around adult education and job training** to help families find and keep jobs and build strong, sustainable careers necessary to fostering true economic opportunity and addressing workforce issues.
- **Policymakers must fully ensure pregnant individuals are not penalized in their work and careers as a result of their pregnancy.**

Economic opportunity for all families must be broad and robust. Access cannot be separated from affordability when discussing such initiatives, as the ability for all families to access high quality childcare should not be dependent on their socioeconomic status.

## **Policymakers must ensure all communities are free from violence.**

**Policymakers must protect the rights of all people in the U.S. and around the world – including but not limited to Black people, immigrants, LGBTQ+ people, Indigenous peoples, religious minorities, people with disabilities, women, and young people – to live and raise children free from violence, including gun violence in schools and community institutions, including houses of worship, gender-based violence (including sexual harassment and gender-based violence in the workplace), conflict-related violence, police and other state violence, and violence imposed through the criminal justice and immigration systems.**

- **For people held in jails, prisons, and detention centers, policymakers should ensure access to comprehensive health care and to continued family visits and contact, while continuing to pursue strategies that will reduce and eventually eliminate the harm caused by the mass incarceration, predominantly of Black and brown communities.**

Sexual violence and harassment and other forms of gender-based violence, such as interpersonal violence, are an epidemic problem in the U.S. and around the world. Deeply rooted in harmful gender norms and inequality, this violence often directly impacts an individual's mental and reproductive health and violates their rights and bodily autonomy, including in some cases the right to choose if, when, how, and with whom they engage in sexual activity. Specific communities face disproportionate rates of gender-based violence, including Native American women, who are much more likely to be raped or murdered by a partner than other women in the United States.<sup>86</sup>

<sup>86</sup> Indian Law Resource Center (2019). Ending Violence Against Native Women. Helena, MT: Indian Law Resource Center. [Online]. Retrieved from <https://indianlaw.org/issue/ending-violence-against-native-women>

- Policymakers must support efforts to reduce sexual and gender-based violence and ensure justice and comprehensive care for survivors of sexual and

interpersonal violence, including through domestic and global federal programs and policies.

## **Policymakers must support and promote policies to develop a healthy and safe environment.**

**Every person has the right to a healthy environment that is free from toxic chemicals and includes clean drinking water, wastewater services, and safe food. Everyone has the right to know that the products they use are safe and to have information about what is in those products. Policymakers must work to build healthy and safe environments for all communities, with a focus on communities and individuals with low incomes in the U.S. and throughout the world who have been disproportionately harmed by environmental degradation and climate change. Additionally, the overall health and wellbeing of people across the globe is dependent on policymakers aggressively and quickly addressing the climate crisis, which has devastating effects on health, food, and livelihoods – disproportionately**

**affecting women, children, adolescents and young people, Indigenous people, people in the Global South, and people of color.**

- To better protect everyone from toxic substances in the environment, it is imperative that the administration more closely monitor and regulate emissions. Unfortunately, the Trump administration has rolled back a number of these critical environmental protections implemented under the Obama administration and previous administrations. Regulatory changes have severely weakened regulations for air and water quality and disposal of toxic wastes.
- All rules, regulations, and protections preceding the Trump administration related to regulating and monitoring toxins and creating a cleaner and safer environment should be reinstated effective immediately, including a recommitment to the Paris Climate Agreement.
- The federal government also has a moral imperative to ensure clean and safe drinking water void of all toxic substances is available for all communities. This includes taking executive action to fix the water system in Flint, Michigan and other communities in similar predicaments.

## **Policymakers must promote and ensure integration of the social determinants of health into the provision of health care.**

**Addressing the social determinants of health is recognized as a key strategy to improve health outcomes and reduce health disparities. Social determinants of health are the conditions in which people are born, grow, live, work, and age. They include, but are not limited to an individual's income, housing, social environment, and ability to access health care. These non-clinical factors affect everyone's health and well-being, including their physical, behavioral, and mental health. Women, including queer and transgender women, and women of color in particular, frequently face unique health inequities due to social determinants that negatively affect their access to and experience of care. Due to historic and ongoing oppression, women, especially queer and trans women of color, are more likely to live in poverty, be uninsured, or experience food insecurity – all of which affect their ability to get and stay healthy. Indeed, racism, sexism, and discrimination based on gender identity, gender expression, sexual orientation, national origin, immigration status, disability, or**

**age significantly contribute to the social determinants of health.**

- **The administration should better integrate social determinants of health within efforts to transform the health care system and invest more resources in the public health and social services sectors.** As the Administration funds and implements new models of care delivery and payment to transform the healthcare system, they should encourage the health care sector to meaningfully engage with public health, behavioral health, and social services, including community-based organizations, to identify key issues and successfully improve health care outcomes.

Improving health outcomes by improving or alleviating social and behavioral risk factors requires ongoing investment to support and sustain community interventions. Current public health and social service funding is insufficient. Its infrastructure must be adequately supported and strengthened. Additionally, safety-net providers – particularly providers of reproductive health care – are vital partners in improving the health of individuals and communities. Significant financial investment is necessary in order to meet their demands and increase their capacity, including by supporting community-based organizations to develop the infrastructure to fully participate in new care models and programs.

- **Efforts to address social determinants of health should not undermine the Medicaid program's core purpose of providing health coverage by withholding benefits and services and penalizing beneficiaries under the pretext of addressing social determinants of health such as imposing work requirements.**

# Policymakers must invest in programs that promote health and wellbeing and advance gender equity.

**Policymakers must advance health equity and improve maternal and infant health outcomes in the U.S. by making significant investments in social, health, economic, and educational support for underserved communities. This effort must focus on maintaining and increasing funding for programs that support healthy pregnancies and families for all people, including for pregnant and parenting students and LGBTQ+, as well as investments in programs led by people of color that promote healthy outcomes for people of color. As such, policymakers must make significant investments in the following programs, as well as others addressed separately, among others.**

- Maternal and Child Health (MCH) Bureau and Title V MCH Services Block Grant
- Medicaid
- Children's Health Insurance Program (CHIP)
- Title X Family Planning Program

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Supplemental Nutrition Assistance Program (SNAP)
- National Health Service Corps Program
- Centers for Disease Control and Prevention (CDC) Division of HIV, TB, and STD Prevention
- CDC Division of Reproductive Health
- CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funding for breast and cervical cancer screening
- School Based Health Centers
- Ryan White HIV/AIDS Program
- Temporary Assistance for Needy Families (TANF)
- Prevention and Public Health Fund
- Federally Qualified Health Centers
- Programs of the Substance Abuse and Mental Health Services Administration
- Indian Health Service
- Programs of the Office of the Assistant Secretary of Health

***“There is no such thing as a single-issue struggle because we do not live single-issue lives.”***

*Audre Lorde*

## PRINCIPLE 5:

# Ensure Judges and Executive Officials Advance Sexual and Reproductive Health, Rights, and Justice.

**The President’s appointment power has a significant impact on sexual and reproductive health, rights, and justice. Article III federal judicial nominees and specific executive positions have the ability to shape, protect, and advance our reproductive well-being, and the ability to do the opposite. Federal courts and executive agencies each play a crucial role in interpreting and giving meaning to fundamental legal protections and civil rights, including the inherent rights to equality under the law and to make personal decisions – such as whether to have an abortion or use contraception.**

The President’s executive and judicial nominees should be committed to reproductive freedom, highly qualified, reflect our nation’s diverse population, and trained to ensure an understanding of the intersectionality of the lives of the people who will interact with the programs or courts they oversee.

Executive agencies and federal courts play a crucial role in interpreting and giving meaning to our fundamental legal protections and civil rights. As a result, executive and judicial nominees will shape our legal rights and ability to access them far into the future. It is critical that nominees are fair-minded and understand the intent of the law and its real impact on individuals’ liberty, equity, and dignity. In addition, nominees should understand and work to decrease the disproportionate impact of harmful policies and laws on individuals with low incomes, people of color, LGBTQ+ individuals, young people, immigrants, people with disabilities, Indigenous people, and other marginalized people.<sup>87</sup>

Finally, implementation of efforts to integrate, elevate, and prioritize sexual and reproductive health and rights across foreign policy and global health, development, and humanitarian programs cannot occur without leadership from political appointees and training and clear mandates for career staff. The President must nominate political appointees who will champion SRHR in foreign policy and educate and train the diplomatic corps to advance sexual and reproductive health and rights through bilateral outreach to governments, multilateral institutions, and direct engagement with U.S. and local civil society.

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<sup>87</sup> The ACLU, as a matter of policy, does not regularly endorse or oppose candidates for elective or appointive office.



**The President should prioritize putting forth and the Senate should expeditiously confirm judicial and executive nominees with a demonstrated commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional rights of equal protection, dignity, and privacy, including the right to abortion and contraception.**

- **The President should only put forward and the Senate should only confirm executive nominees who have a demonstrated positive record on reproductive health, rights, and justice.** Federal agencies are charged with implementing and enforcing crucial legal protections, such as race and sex anti-discrimination laws; protections for access to comprehensive reproductive health care, including abortion access for all who need it, including for immigrants and those who are undocumented; prevention and prosecution of anti-abortion violence; insurance coverage of reproductive health services, including contraception with no copay; and the Health Care Rights Law (section 1557 of the ACA), which ensures non-discrimination in health care. They also lead in the advancement of sexual and reproductive health and rights access globally. Consequently, executive nominees should have a demonstrated positive record on and express a commitment to promoting the sexual and reproductive health and rights of all individuals in the United States and around the world.
- **The President should only consider and the Senate should only confirm judicial nominees who either have a positive record on reproductive health, rights and justice or, in the context of the confirmation process, affirmatively declare that the Constitution protects individual liberty and the right of all people to make personal decisions about their bodies and personal relationships, including the right to use contraception, have an abortion, and marry whom they choose.** Federal courts are charged with upholding our fundamental legal rights and rule on cases impacting reproductive freedom, racial justice, LGBTQ+ rights, immigrant rights, and myriad other intersectional issues that impact all individuals in the United States. Consequently, judicial nominees to the Supreme Court and the lower courts should demonstrate a commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional rights of equal protection, dignity, and privacy, including the right to have an abortion.
- **Senators should thoroughly question both executive and judicial nominees regarding their qualifications and commitment to reproductive health, rights, and justice.** It is critical, particularly for nominees who do not have a record on reproductive health, rights, and justice, or have a record hostile to these fundamental rights, that senators ask during nominees' hearings and in questions for the record strong questions to clarify nominees independence, fair-mindedness, lack of bias, and ability to uphold our constitutional rights, including the right to have an abortion.

**The President should prioritize putting forth and the Senate should expeditiously confirm highly-qualified individuals to the federal bench who would improve the diversity of the judiciary to better reflect the composition of the country and the legal system and refine decision-making, by considering identities, backgrounds, and professional experiences.**

- **The President should nominate and the Senate should confirm individuals who are fair and independent, demonstrate strong legal skills and the qualities necessary in a judge, and have a robust understanding of the complexities of constitutional law.** It is critical that only fair and independent judicial nominees with a demonstrated commitment to fundamental legal rights be appointed to the federal courts, including the Supreme Court and the lower courts. Judicial nominees should be highly-qualified to serve as a member of the federal judiciary. The President should nominate individuals who meet the necessary requirements of honesty, integrity, character, temperament, empathy, and intellect. Because reproductive rights litigation is typically fact-dependent, judges must understand the burdens that restrictive laws place on individuals trying to access abortion or other reproductive health care services. Judicial nominees must respect existing legal protections, abide by established precedents, and safeguard the constitutional right to privacy.
- The President should nominate and the Senate should confirm individuals who have diverse identities, including but not limited to race, national origin, sex, gender identity and expression, pregnancy and family status, sexual orientation, past or current immigration status, disability status, and religion and belief system. A nominee's background—both professional and personal—informs their work. When the courts are reflective of the diverse population of the nation,

individuals may have more confidence that the courts understand the real-world implications of rulings and thereby better understand the court or agency's decision. Diversity on the bench, and the consequent understanding nominees have of the disparate impact on intersectional identities, enriches the court's understanding of how best to realize the intended purpose and effect of the constitution and laws that the courts are charged with applying, improving the quality of justice for all.

Diversity enhances legal decision making. People are shaped by their identities, backgrounds, and experiences. And when judges are met with litigants or issues affecting the most marginalized, unheard, and unrepresented among us, it is important that they understand the views of those people or communities in order to render a fair decision. Such representational diversity is critical to maintain or improve the public's trust in our government. We should expect our president to care about the diverse composition of both the federal bench and executive agencies. As of April 2018, of the 1,643 judges sitting in the federal bench, only 396 (24.1%) identify as women, 168 (10.2%) as Black or African American, 113 (6.9%) as Hispanic/Latinx, 35 (2.1%) as Asian American Pacific Islander (AAPI), 2 (0.1%) as American Indian or Alaskan Native (AIAN), 12 (0.7%) as lesbian, gay, bisexual, transgender, or queer (LGBTQ), 7 (0.4%) persons with disabilities.<sup>88</sup> By comparison, the United States population is approximately 51% female, 13.4% Black or African

88 Alliance For Justice (2019). Judicial Selection Snapshot. Washington: Alliance for Justice. [Online]. Retrieved from [https://www.afj.org/wp-content/uploads/2015/01/Judicial\\_Selection\\_Snapshot.pdf](https://www.afj.org/wp-content/uploads/2015/01/Judicial_Selection_Snapshot.pdf).

American, 18% Hispanic/Latino, 6% AAPI, 1.3% AIAN,<sup>89</sup> 4.5% LGBTQ,<sup>90</sup> 8.7% persons with disabilities. In order for the judiciary to fulfill its duty to enforce equal justice under the law, the bench must reflect the demographic makeup of the nation. However, it is critical that the President appoint candidates who are not only diverse but also have the legal skills and experience necessary to serve as judges and are committed to reproductive health, rights and justice and centering the most marginalized. Anything less would amount to tokenization and defeat the purpose of diversifying the voices of justice on the federal bench.

- **The President’s judicial nominees should also have diverse backgrounds and experiences, including but not limited to class, educational background, and professional experience.** The federal judiciary is currently lacking in judges with experience working for public interest organizations, such as civil rights attorneys, legal aid attorneys, public defenders or

indigent criminal defense attorneys, and those representing individual clients—like employees, consumers, or personal injury plaintiffs—in private practice. This is important for reproductive rights because, like any of us, judges are the product of their background and experiences, including their professional lives before taking the bench. As a judge renders decisions through the course of a trial or proceeding, their determination is necessarily influenced by the nature of their work as a lawyer up to that point. Therefore, when judges have varied professional backgrounds, they are better equipped to understand the experiences of each litigant before them, and to render more informed, thorough decisions. Judges who have experience representing clients with low incomes are well-positioned to help the courts understand the disparate burdens that laws often place on people who are living with low incomes or otherwise marginalized and to ensure that the lived realities of such individuals are not lost in the calculus.

**For all executive-branch positions, the President should nominate and the Senate should confirm individuals who are experts in their field, committed to the core mission of the agency, possess a positive record on reproductive health, rights, and justice, and who will contribute to the diversity of the executive branch.**

- **The President should nominate and the Senate should confirm executive nominees who are experts in the field of the agency, office, or program they will lead, and who possess a demonstrated track record of leadership in that field.** Federal agencies directly oversee implementation and enforcement of many laws and legal protections related to reproductive health care. From no-copay contraception to safe access to clinic

entrances to protection from discrimination, the ability of people living in the U.S. and communities served by U.S. foreign aid programs to freely access the care they need is dependent on federal agencies and the appointees who run them. These nominees should possess knowledge of and commitment to the work of the agencies and programs that they are charged with leading, and experience in managing multi-layered networks of experts with respect

89 U.S. Census Bureau (2019). 2018 Quickfacts. [Online]. Retrieved from <https://www.census.gov/quickfacts/fact/table/US/PST045218>

90 Newport, F. (2018). In U.S., Estimate of LGBT Population Rises to 4.5%. Washington: Gallup. [Online]. Retrieved from <https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx>

and integrity. These appointees must respect, the legitimacy of Supreme Court precedents that affirm the constitutional right to privacy. These appointees must also respect the international commitments to sexual and reproductive health and rights outlined in international human rights agreements, including the ICPD Programme of Action, which is the foundational UN agreement defining sexual health and reproductive rights, and the Sustainable Development Goals, which includes specific targets on achieving universal access to sexual and reproductive health care by 2030. Nominees should be committed to scientific integrity, and to ensuring that evidence-based findings will not be suppressed, distorted, or manipulated to advance a political agenda. Where relevant, they should display a commitment to promoting the health and rights of individuals in the United States and around the world. Additionally, for international posts, especially Ambassadors, nominees should have experience living and working in the regions and/or country posts to which they are appointed and preferably speak the national language.

- **The President should put forward and the Senate should confirm executive nominees who have diverse identities, including but not limited to race, national origin, sex, gender identity**

**and expression, pregnancy and family status, sexual orientation, past or current immigration status, and religion and belief system.** A nominee's background—both professional and personal—informs their work. Increased diversity in executive agencies enriches the ability to understand all angles of a problem and the real-life impact of regulations. It is important that executive agencies and their leaders reflect the composition of the country and refine decision-making by considering identities, backgrounds, and professional experiences. Diversity enhances decision-making at executive agencies. People are shaped by their background and experiences. And when executive appointees interact with people or issues affecting the most marginalized, unheard, and unrepresented among us, it is important that they understand the views of those people or communities in order to render a fair outcome. Such representational diversity is critical to maintain or improve the public's trust in our government. Under the Trump administration, more than twice as many men have been appointed than women, and male appointees outnumber women in every single agency.<sup>91</sup> In addition, 83% of Trump's initial cabinet and cabinet-level appointees were white.<sup>92</sup> These disparities should be promptly corrected by the next administration.

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91 Lowrey, A., Johnson, S. (2018). The Very Male Trump Administration. Washington: The Atlantic. Retrieved online from <https://www.theatlantic.com/politics/archive/2018/03/the-very-male-trump-administration/556568/>

92 Boesch, D. (2017). Declining Diversity in the Federal Government Under President Trump. [Online]. University of Minnesota. Retrieved from <https://genderpolicyreport.umn.edu/declining-diversity-in-the-federal-government-under-president-trump/>

## The President should prioritize putting forth and the Senate should expeditiously confirm executive nominees for specific cabinet-level and sub-cabinet level positions.

The **Secretary of HHS** leads the important work of implementing programs and initiatives that directly impact the health and well-being of individuals in our country. In particular, HHS provides critical care and services for individuals and communities that have historically and continue to experience the disproportionate impact of our nation's directly and indirectly harmful policies. Overseeing several departments, offices, and agencies, HHS manages the operation of critical public health programs that ensure access to care such as the Title X Family Planning Program and Medicaid, and implements far-reaching policy on a range of issues related to Medicaid, NIH, private insurance benefits, and contraceptive drugs and devices. Strong leadership from the Secretary of HHS is necessary to ensure meaningful access to quality sexual and reproductive health care, especially for women, individuals with low incomes, people of color, LGBTQ+ individuals, young people, immigrants, people with disabilities, indigenous people, and other marginalized people. It is imperative that the nominee have a steadfast commitment to improving abortion access, creating policy solutions that address long-standing health care inequities in sexual and reproductive health care, and taking meaningful action to implement and enforce policies that shield patients and health care providers from discrimination.

As the nation's chief law enforcement official, the **Attorney General** is responsible for enforcing federal laws, including laws with a significant impact on reproductive and civil rights such as Title VII, Title IX, the Freedom of Access to Clinic Entrances Act, the Violence Against Women Act, the Affordable Care Act, and the Fair Housing Act, as well as core constitutional protections. The Attorney General also oversees the DOJ's Executive Office for Immigration Review (EOIR)—an entity in which immigration judges conduct removal proceedings and adjudicate asylum claims for immigrants, among other responsibilities.

The Attorney General nominee must be willing to provide federal leadership in all of these areas and specifically to strongly and publicly condemn violence against reproductive health care providers, patients, and staff; leverage the power of the DOJ to prevent and combat this violence; and prioritize the investigation and prosecution of illegal anti-abortion activity. The actions of the Attorney General have a serious impact on the legal rights and very futures of all individuals across this country, in particular women, low-income individuals, people of color, LGBTQ+ individuals, young people, immigrants, indigenous people, and other marginalized people. The Attorney General, as the head of the U.S. Department of Justice, has the responsibility to enforce federal criminal and civil rights statutes that protect reproductive health providers, patients, and staff. The Attorney General should not only vigorously enforce the law, but also publicly champion the need to combat anti-abortion violence and intimidation, which has resulted in murders, attempted murders, bombings, arsons, clinic invasions, butyric acid attacks, physical attacks or batteries, burglaries, and other criminal acts. Public statements from both the President and the Attorney General that condemn these acts would signal a deep commitment to protecting reproductive rights, civil rights, and the rule of law.

As a global leader, the United States is uniquely situated to leverage its diplomatic power to promote human rights, freedom and dignity around the world, and in particular, to help ensure that all nations respect, protect, and uphold sexual and reproductive health and rights. In order to accomplish this task, the U.S. must have a visionary and effective **Secretary of State**. The next Secretary of State must be a champion for ensuring that US foreign policy works to promote the equity and human rights of people everywhere. This includes asserting leadership in the global community and leveraging diplomatic capacity to urge all countries and

global leaders to respect, protect, and fulfill the sexual and reproductive health and rights of their people.

The **Secretary of Labor** serves a critical role overseeing the work of DOL to ensure opportunities in the workplace. Among other crucial protections, DOL enforces: the federal guarantee that workers can take job-protected family and medical leave; wage and hour protections that protect workers from exploitation and abuse and help lift millions of people out of poverty; equal employment opportunity protections that help safeguard against discrimination; and, in conjunction with the Treasury and HHS, key provisions of the Affordable Care Act, including the birth control benefit. It also houses the Women's Bureau, whose mission is to improve the status and working conditions for wage-earning women. The Secretary of Labor must be someone who will vigorously protect and promote the interests of working people, and especially workers in low-wage occupations and in dangerous industries, women workers, immigrant workers, workers of color, and LGBTQ+ workers.

The **Secretary of Education** is responsible for leading ED's implementation and enforcement of federal laws that protect all students from discrimination on the basis of race, color, national origin, sex (including sexual orientation and gender identity) and disability and those laws that provide for educational opportunity from early childhood through graduate school. Among other crucial issues, the ED specifically enforces Title IX, which prevents discrimination on the basis sex by requiring fair treatment for pregnant and parenting students and requiring schools to address sexual harassment, including sexual assault. The nominee to lead this department must recognize the importance of equal educational opportunity, commit to high-quality public education that enables every student to live up to their potential, and ensure that no student is denied access to education, because of LGBTQ+ status, family income, race, ethnicity, home language, gender, religion, disability or immigration status.

The **Secretary of Homeland Security** heads DHS, which is the third largest department in the United States government. Among other duties, the Secretary of Homeland Security leads DHS in border security efforts and the administration and enforcement of the country's immigration laws. DHS also houses U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and

Border Protection (CBP). Given the increased reports of human rights violations in ICE detention centers and at the border—particularly reports of sexual violence and denial of access to health care, including abortion care and menstrual hygiene products—it is imperative that the nominee be committed to ensuring humane treatment of all immigrants in DHS's purview. The nominee must support community based alternatives to detention. Additionally, the nominee should condemn sexual violence in detention centers and at the border and, if immigrants are to be detained, be committed to providing them with the health care services and resources they need and deserve.

The **U.S. Ambassador to the United Nations** is a critical role that must be occupied by an individual who will promote sexual and reproductive health and rights worldwide. The U.S. Ambassador to the UN plays a key role in defining and representing U.S. interests on the global stage and advising the president on key foreign policy decisions. This position has significant influence over the rights, health, and lives of people around the world. The Ambassador plays a central role in negotiating, implementing, and promoting global agreements such as the Sustainable Development Goals, ICPD Programme of Action, Beijing Platform for Action, and other foundational human rights agreements. The U.S. Ambassador to the UN must play a leadership role in fulfilling these global commitments and in seeking new international commitments to advancing SRHR. We need a U.S. Ambassador to the UN who will promote global development and champion the human rights of all people.

The **Administrator of the EPA** oversees the EPA's work in enforcing and implementing environmental policies, including the Clean Air and Water Acts. The EPA's mission is to protect human health and the environment, yet too many communities, particularly communities with low incomes and communities of color, do not live in safe and healthy environments free from toxins. This directly impacts people's ability to make decisions about if, when, and how to parent, and often results in devastating health implications for individuals, their families, and their communities. It is imperative that this nominee respects scientific integrity, commits to implementing evidence-based environmental policies, condemns environmental racism, and is willing to resist and speak out against political intimidation and interference.

Using less than one percent of the federal budget, USAID, led by the **Administrator of USAID**, works in more than 100 countries to promote human rights, global health, gender equality and women's empowerment, economic growth, education, and environmental sustainability. USAID's work is particularly vital for promoting the health and rights of women and girls – from child marriage (1 in 9 girls are married before age 15<sup>93</sup>) to gender-based violence (experienced by 1 in 3 women worldwide<sup>94</sup>) to family planning (214 million women in developing countries have an unmet need for modern contraception<sup>95</sup>). USAID's global health programs have been severely undercut by policies like the expanded global gag rule, and the next Administrator must not only work to reverse the harm of this policy, but also commit programmatic resources and political leadership to advancing sexual and reproductive health and rights through U.S. global health, development, and humanitarian programs.

The **FDA Commissioner** oversees the work of the FDA, which is responsible for, among other things, approving contraceptive and medication abortion options – or, conversely, stalling them, as previous appointees have done. Filling this position with a principled leader who respects scientific integrity and evidence-based medicine, and resists and speaks out against political intimidation and interference, is essential to advancing the reproductive health for all individuals in this country.

The **Director of NIH** is responsible for the vast majority of the United States' health research, both done at NIH and through grants to researchers across the country. An essential component of NIH's research includes reproductive health, as well as research into factors that impact a person's health, such as sex assigned at birth, gender identity, sexual orientation, race, culture, environment, and socioeconomic status. In particular, the Office of Research on Women's Health and the National Institute of Child Health and Human Development (NICHD) drive much of

the important NIH research that can improve sexual and reproductive health, including: contraceptive research and development; research and development of multipurpose prevention technologies (MPTs), which are products that simultaneously protect against unintended pregnancy, HIV, or other STIs; improving pregnancy and childbirth outcomes; preconception and postpartum health; maternal mortality and morbidity; infertility; STIs and related diseases, including HIV/AIDS; and more. It is vital that the Director of NIH understand and value both the importance of sexual and reproductive health research and the necessity of NIH's intersectional approach to research.

The **Administrator of CMS** oversees one of the largest federal agencies that administers vital health care programs to over 100 million Americans. CMS works with the states to administer the Medicaid program. Medicaid pays for half of the births in the United States and is the largest payer of family planning care. Medicaid provides coverage to 1 in 5 women of reproductive age. The majority of Medicaid enrollees are women. About one-third of women in poverty use Medicaid to get the health care they need. LGBTQ+ people, and particularly transgender people, queer and trans people of color, and queer and trans people with disabilities are more likely than the overall U.S. population to use Medicaid. LGBTQ people are over 1.5 times more likely to use Medicaid than non-LGBTQ people.<sup>96</sup> LGBTQ people of color reported receiving Medicaid benefits at a rate of 24% compared to 18.8% of white LGBTQ people. LGBTQ with disabilities reported receiving Medicaid benefits at a rate of 44.4%, as compared to 11.8% of non-disabled LGBTQ people. Transgender people reported receiving Medicaid benefits at a rate of 21.4%, compared to 13.4% of cisgender people.

The Administrator is a key influencer on whether state Medicaid programs include and expand coverage for family planning services for people with no or low incomes who would not otherwise have coverage. The Administrator of CMS must be an individual dedicated

93 UNFPA (2013). *The State of the World Population 2013: Motherhood in Childhood: Facing the challenge of adolescent pregnancy*. New York: UNFPA. [Online]. Retrieved from <http://www.unfpa.org/publications/state-world-population-2013-0>

94 World Health Organization (2016). *Violence Against Women*. Geneva: World Health Organization. [Online]. Retrieved from <http://www.who.int/mediacentre/factsheets/fs239/en/>

95 Singh, S., Darroch, J.E., & Ashford, L.S. (2014). *Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health*. [Online]. New York: Guttmacher Institute. Retrieved from <https://www.guttmacher.org/report/adding-it-costs-and-benefits-investing-sexual-and-reproductive-health-2014>

96 Rooney, C., Whittington, C., Durso, L.E. (2018). *Protecting Basic Living Standards for LGBTQ People*. Washington: Center for American Progress. [Online]. Retrieved from <https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/>

to truly furthering HHS' mission and to protecting and expanding women's access to reproductive health care.

The **Assistant Secretary for Health** leads development of HHS-wide public health policy recommendations and oversees 11 public health offices – including the Office of Population Affairs (OPA), the Office on Women's Health, the Office on Minority Health, and the Office of Adolescent Health, among other important public health offices. OPA administers the Title X program and provides advice to the Secretary of HHS on a wide range of reproductive health services. Filling this position with a principled leader who respects evidence-based decision-making and resists and speaks out against political intimidation and interference is essential to advancing the reproductive health of all individuals in this country.

The Department of Justice Civil Rights Division is led by the **Assistant Attorney General for Civil Rights** (AAG). The Division enforces federal statutes prohibiting discrimination on the basis of race, color, sex (including sexual orientation and gender identity), disability, religion, familial status and national origin. In addition, the Special Litigation Section within the Civil Rights Division is responsible for protecting the

civil rights of people to have safe access to reproductive health care clinics, as the enforcer of the Freedom of Access to Clinic Entrances Act (FACE). Having an AAG who is committed to protecting and enforcing civil rights and ensuring safe and unfettered access to reproductive health care clinics is essential to preserve access to reproductive health care.

**Positions that do not require Senate confirmation are also critical to reproductive health, rights, and justice, and care should be taken to select qualified, knowledgeable appointees for those positions.**

Within Health and Human Services, these positions include, but are not limited to, Director of the Office of Civil Rights, Assistant Secretary for Public Affairs, Deputy Assistant Secretary for Population Affairs, and Counselor for Human Services Policy. Positions within the State Department and U.S. Agency for International Development include Deputy Assistant Secretary for the Bureau of Population, Refugees and Migration and Deputy Assistant Secretary for Democracy, Human Rights, and Labor, and policy advisors appointed to support these bureaus, as well as policy advisors appointed to the U.S. Mission to the UN focused on economic and social affairs and the State Department's Office of Global Women's Issues.



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# Appendix

## Legislative and Congressional Agenda: Congress must vocally introduce, support, and pass, and the President must sign legislation that advances sexual and reproductive health and rights, including, but not limited to the following bills:<sup>97</sup>

- **21<sup>st</sup> Century Women’s Health Act**, which addresses a range of critical sexual and reproductive health issues.
- **Access to Birth Control Act**, which would ensure that people are able to access birth control in a timely manner by prohibiting pharmacies from refusing to fill a customer’s valid prescription for birth control.
- **Access to Contraception for Servicemembers and Dependents Act**, which would improve US military servicemember’s access to contraceptive services by expanding access to no cost birth control and ensuring people in the military have access to quality contraceptive counseling.
- **Access to Infertility Treatment and Care Act**, which would require private health plans that cover obstetrical services to also cover infertility treatments, including in vitro fertilization. This coverage would be extended to federal employees, military members, and veterans.
- **Affordability is Access Act**, which would require health-insurance plans to cover over-the-counter oral contraceptives without cost-sharing, if and when the Food and Drug Administration approves an over-the-counter application.
- **Census Equality Act**, which would require the Census Bureau to continue its testing on sexual orientation and gender identity questions, to begin asking sexual orientation and gender identity questions on the 2020 American Community Survey and the 2030 Census, and would require the Census Bureau to report out on the sexual orientation and gender identity information it collects, as it does for other characteristics.<sup>98</sup> The Census is used to direct federal funding to programs and to determine our representation in Congress. Because LGBTQ+ people are more likely than non-LGBTQ+ people to use federal programs, they must be counted in the Census.
- **Dignity for Detained Immigrants**, which would, among other things, establish enforceable civil detention standards for all immigration detention facilities, and require robust oversight, accountability, and transparency for those facilities.

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97 Endorsement of the Blueprint for Sexual and Reproductive Health, Rights, and Justice does not necessarily mean that every organization has endorsed the below legislation.].

98 National LGBTQ Task Force Action Fund (2019). Legislative Priorities for the 116th Congress. [Online]. Retrieved from [https://www.thetaskforceactionfund.org/wp-content/uploads/2019/01/TF\\_116-Congress-Agenda6-FINAL.pdf](https://www.thetaskforceactionfund.org/wp-content/uploads/2019/01/TF_116-Congress-Agenda6-FINAL.pdf)

- ***DREAM and Promise Act***, which would create paths to citizenship for Dreamers and beneficiaries of Temporary Protected Status (TPS) and Deferred Enforced Departure (DED). This legislation should be passed exclusive of riders for border wall funding or increased immigration enforcement and detention.
- ***Do No Harm Act***, which would clarify that the Religious Freedom Restoration Act is intended to protect religious freedom without allowing the infliction of harm on other people. It would amend RFRA in order to restore the original intent of the legislation by specifically exempting areas of law where RFRA has been used to bypass federal protections. These include well-settled areas of law designed to protect our most vulnerable populations including child labor and abuse, equal employment and non-discrimination, health care, federal contracts and grants, and government services.
- ***EACH Woman Act***, to ensure coverage for abortion for everyone, regardless of their income or insurance. The legislation would restore abortion coverage to those enrolled in government health insurance plans, government-managed health insurance programs, and receiving health care from a government provider or program. It would also prohibit political interference with decisions by private health insurance companies to offer coverage for abortion care.
- ***Equality Act***, which would provide consistent and explicit non-discrimination protections for LGBTQ+ people in employment, housing, credit, education, public spaces, federally funded programs, and jury service.
- ***Exchange Inclusion for a Healthy America Act***, which would make progress towards the ACA's promise of health equity by allowing all families, of all immigration statuses, to purchase insurance and qualify for subsidies under the ACA Marketplaces.
- ***Family and Medical Insurance Leave Act***, which would create a national family and medical leave insurance program to provide workers with a portion of their wages for up to 12 weeks to address their own serious health condition, including pregnancy or childbirth; to deal with the serious health condition of a parent, spouse, domestic partner or child; to care for a new child; and/or for specific military caregiving and leave purposes.
- ***Global Health, Empowerment, and Rights (HER) Act***, which would end the global gag rule and prevent any future president from reimposing the policy.
- ***Global Women and Climate Change Act***, a bill calling for recognition of the disproportionate impact of climate change on women and girls globally and calls for an intergovernmental task force to support policies that support women-centered and led responses to climate disasters.
- ***Greater Leadership Overseas for the Benefit of Equality (GLOBE) Act***, which addressed a number of foreign policy areas to improve the lives of LGBTQ people around the globe, including creating an interagency LGBTQ task force, requiring reporting on anti-LGBTQ human rights violations in the State Department's annual Human Rights Reports, codifying non-discrimination policies to ensure inclusion of LGBTQ people in all U.S. funded programs, establishing LGBTQ identities as a "social group" for the purposes of claiming asylum in the U.S., and repealing policies that undermine LGBTQ health access and outcomes globally.
- ***Health, Equity and Access under the Law (HEAL) for Immigrant Women & Families Act***, which would restore access to Medicaid and the Children's Health Insurance Program for all lawfully present, eligible immigrants by eliminating the five-year bar on enrollment and the outdated, restrictive list of "qualified" immigrants. Further, the bill specifically removes existing barriers to Affordable Care Act (ACA) coverage options for those granted relief through deferred action, including lawfully present young people (known as DREAMers) granted status under the Deferred Action for Childhood Arrivals program.

- ***Health Equity and Accountability Act***, which would help eliminate health inequities for communities of color and other underserved groups who are denied full access to health care due to immigration status, income, age, sex (including sexual orientation and gender identity), disability, limited English proficiency, or other characteristics. It provides for more robust data collection and reporting; culturally and linguistically appropriate health care; health workforce diversity; and for key improvements designed to expand access to health care services and promote better health outcomes.
- ***Healthy Families Act***, which would set a national paid sick days standard by allowing workers in businesses with 15 or more employees to earn up to seven job-protected paid sick days each year for use to recover from an illness, access preventive care, provide care to an ill family member, or attend school meetings/events related to a child's health condition or disability. This legislation would also allow workers who are survivors of domestic violence, stalking, or sexual assault to use their paid sick days to seek assistance related to the abuse.
- ***LGBT Data Inclusion Act***, which would require the collection of voluntary, self-disclosed information on sexual orientation and gender identity in certain federal population surveys.
- ***Maternal Care Access and Reducing Emergencies (Maternal CARE) Act***, which would create a new grant program with a focus on reducing racial health disparities in maternal health by supporting evidence based implicit bias training. The grants would be awarded to medical and nursing schools and prioritize obstetrics and gynecology. The bill would also create pregnancy medical home demonstration projects, which award states grants to deliver integrated health care services to pregnant and postpartum parents in an effort to reduce adverse maternal health outcomes, maternal deaths, and racial disparity in maternal mortality and morbidity.
- ***Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services (MOMMIES) Act***, which would enhance Medicaid for postpartum women by increasing the postpartum period from 60 days to one year, as well as increasing access to primary care providers and expanding access to doula care. It would also establish a maternity home care demonstration project, which would seek to improve access to prenatal and postpartum care and decrease severe morbidity and mortality.
- ***Military Access to Reproductive Care and Health for Military Women (MARCH) Act***, which would lift the ban on military facility's ability to provide abortion services beyond the narrow exceptions of life endangerment, rape, or incest.
- ***Modernizing Obstetric Medicine Standards (MOMS) Act***, which would authorize the Alliance for Innovation on Maternal Health (AIM) Program to support the adoption and implementation of evidence-based maternal safety best practices.
- ***Mothers Offspring Mortality and Morbidity Awareness (MOMMA's) Act***, which would provide technical assistance for states with respect to reporting maternal mortality; establish best practices for the prevention of maternal mortality; authorize the Alliance for Innovation on Maternal Health (AIM) Program to support the adoption and implementation of evidence-based maternal safety best practices; support state perinatal quality collaboratives; expand Medicaid and CHIP coverage for pregnant and postpartum parents by increasing the postpartum period from 60 days to one year; and support implicit bias and cultural competency training for health care professionals.
- ***Personal Care Products Safety Act***, which would require cosmetics companies to register their facilities with the Food and Drug Administration (FDA); submit the cosmetic ingredient statements with the amount of each ingredient to the FDA; require companies pay a facility registration fee based on the annual gross sales of cosmetics, which would be used for cosmetic safety activities.

- ***Pregnant Workers Fairness Act***, which would ensure that workers with limitations related to pregnancy, childbirth, or related medical conditions are not forced out of their jobs or denied reasonable workplace accommodations—protecting their ability to support their families without jeopardizing their health or the health of their pregnancies.
- ***Protecting Sensitive Locations Act***, which would codify restrictions on enforcement actions at or focused on sensitive locations and expand “immigration safe zones.”
- ***Quality Care for Moms and Babies Act***, which would support state perinatal quality collaboratives and the development of maternal and infant quality measures in Medicaid and CHIP.
- ***Real Education for Healthy Youth Act (REHYA)***, which expands quality sex education across the nation. REHYA amends the Public Health Service Act and Every Student Succeeds Act to enable education that does not stigmatize sex, is non-shaming of LGBTQ students, and is inclusive of contraceptive access in schools. REHYA eliminates and reprograms the Social Security Act’s Title V abstinence-only “Sexual Risk Avoidance” state grant program to fund the new comprehensive sex education and training grant programs.
- ***Reproductive Rights are Human Rights Act***, which would require the State Department to report on reproductive rights violations in their annual country Human Rights Reports.
- ***SAFE Act***, which would help break down economic barriers for survivors of domestic violence, sexual assault, and stalking by ensuring survivors who need medical attention, legal support, or other services can take leave from work, and allow survivors who have to leave their jobs to receive unemployment insurance. The legislation would also protect survivors from being fired because of an incident of violence or because of requests to have protections put in place in the workplace for safety.
- ***Scientific Integrity Act***, which would promote the public interest by ensuring scientists can carry out their research—and share it with the public—without fear of political pressure or retaliation by prohibiting political appointees from altering or suppressing scientific findings and give scientists final review over how agencies use their work.
- ***Stop Shackling and Detaining Pregnant Women Act***, which would end the practice of shackling pregnant women and holding them in migrant detention facilities.
- ***Violence Against Women Act***, which would improve the criminal justice, health care, and community-based responses to domestic violence, dating violence, sexual assault and stalking for all survivors and their families. The legislation would help ensure that survivors have safe homes and economic security, as well as preserve programs for communities of color and Native American Women.
- ***Women’s Health Protection Act***, a federal law that would protect abortion access and prevent state abortion bans and medically unnecessary restrictions by establishing a statutory right for a provider to provide abortion services, and a corresponding right for their patients to obtain abortion services, free from bans and restrictions that single out abortion and impede access to care.
- ***Youth Access to Sexual Health Services Act (YASHS)***, which would support young people of color, immigrant youth, LGBTQ youth, youth in foster care, homeless youth, youth in juvenile detention, and other young people facing barriers to sexual health care and provides communities with resources to support partnerships and programs that equip young people with medically-accurate, complete, and age-appropriate information and skills on how to access sexual health care and related services.