National Institute for Reproductive Health

PROACTIVE REPRODUCTIVE HEALTH AND RIGHTS LEGISLATION IN THE STATES

JANUARY 2019

GAINING GROUND

YEAR IN REVIEW 2018

A REPORT OF THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH (NIRH) builds power at the state and local levels to change public policy, galvanize public support, and normalize women's decisions about abortion and contraception. Through our partnership model, we provide state and local advocates with strategic guidance, hands-on support, and funding to create national change from the ground up. We build connections within and across states, arming our partners with the latest knowledge and best tools to advance reproductive freedom for the people in their communities.

National Institute for Reproductive Health
14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org
www.nirhealth.org

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ACKNOWLEDGMENTS

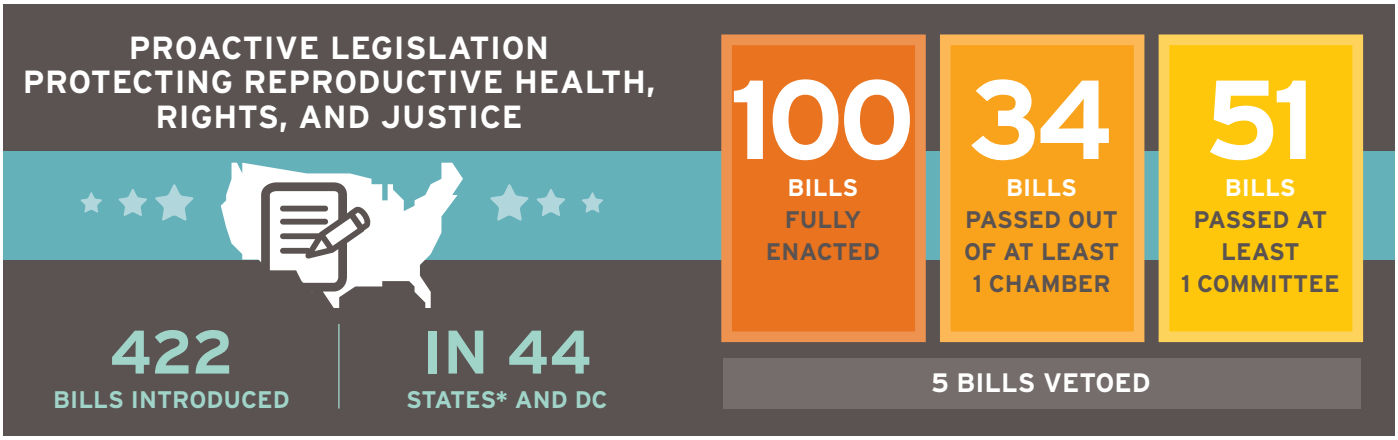
This report was written by Rose Mackenzie, Senior Policy Counsel; Jordan Goldberg, Director of Policy; and Winnie Ye, Policy and Program Coordinator; and edited by Kelly Novak, Deputy Director of Communications, with assistance from legal interns Bailee Brown, Sophia Elliot, Kimya Forouzan, and Christina Rhode. Staff of NIRH — including Andrea Miller, President; Shannon Carey, Chief Development Officer; Tara Sweeney, Vice President for Communications; and Annie Zegers, Communications Coordinator — contributed to and edited this report. NIRH is grateful to the advocates and partners across the country whose advocacy is increasing access to reproductive health care and strengthening the reproductive health, rights, and justice movements every day, and whose work on those critical issues inspired this report. NIRH also gratefully acknowledges the foundations and individual donors who make our work possible.

INTRODUCTION

The National Institute for Reproductive Health's (NIRH) mission is to help build a society in which everyone has the freedom and ability to control their reproductive and sexual lives.

In the face of our country's current political environment and hostile lawmakers at every level of government, proactive policy change may seem like a far-off dream, but in reality, advocates, legislators, and governors in many states are building off the momentum that has been years in the making to push forward innovative policies that will protect and expand our reproductive freedom. Today, this change is more necessary than ever before. The goal of this report is to document the tremendous and essential work of state advocates and lawmakers and to support their important advocacy to move forward affirmative policies in the years to come.

In 2018, facing unparalleled threats from a hostile federal government and 31 entirely anti-choice state legislatures, progressive communities continued to work in solidarity to protect and advance reproductive health, rights, and justice. This work took place against the backdrop of a political atmosphere dominated by revelations of widespread and systemic physical, emotional, and sexual abuse of women and the rise of the #MeToo movement, as well as a divisive U.S. Supreme Court confirmation process that brought these issues into sharp relief and concluded with the confirmation of a justice who is likely to undermine reproductive freedom for a generation or more. Partly as a result of these events, our political discourse has uniquely centered the experiences and voices of women, in both productive and painful ways, for the first time in many years.



*Montana, Nevada, North Dakota, and Texas did not have legislative sessions in 2018.

NIRH found that in 2018, building on the hard work by progressive and feminist activists and catalyzed by this political moment, advocates generated critical momentum to push forward bold, creative policies or to bring long-fought campaigns over the finish line. As the federal government attacked access to health care, including abortion access, and as the potential for future erosion of reproductive rights became even clearer, a number of states continued to shore up protections by eradicating their outdated and unconstitutional criminal abortion bans and codifying the important protections of the Patient Protection and Affordable Care Act (ACA) into their own laws. They also focused on historically oppressed communities by ensuring that incarcerated women have access to reproductive health care and are not subject to state coercion or abuse. Some states capitalized on electoral successes by achieving long-awaited victories, such as restoring family planning funding in New Jersey and Medicaid expansion in Virginia, which helps low-income residents across the state have access to much of the reproductive health care they need.

The 2018 "Gaining Ground" report hones in on six policy areas that NIRH believes must be priorities for any state that wants to protect and support reproductive health, rights, and justice: expanding access to abortion care, improving access to contraception, increasing access to pregnancy care, promoting comprehensive sexuality education for all young people, supporting parents and families, and prohibiting discrimination based on reproductive decisions or health.[1] We reviewed the movement of proactive policy across the country in each of these six arenas, analyzing which of these policy changes move us closer to a world in which every woman* has the right to choose whether or when to become a parent, and every person has the ability to choose to become a parent and to have a healthy family if they do so. While our analysis in these core areas continues to be greatly informed and influenced by the work of our colleagues in the reproductive justice movement, this report is focused on those policies specifically intended to advance reproductive freedom rather than reflecting the full range of policies encompassed in the reproductive justice framework.

Because policy change is often a lengthy process, this report includes not only legislation that became law, but also bills that moved through committees, statehouses, and sometimes onto governors' desks only to be vetoed. As experience shows, the bill that is introduced, considered, or even vetoed one year may become law in the next. This report is intended to provide both an analysis of the current policy landscape in the states and to serve as a source of inspiration for advocates and policymakers around the country as they consider how best to advance reproductive freedom in their states.

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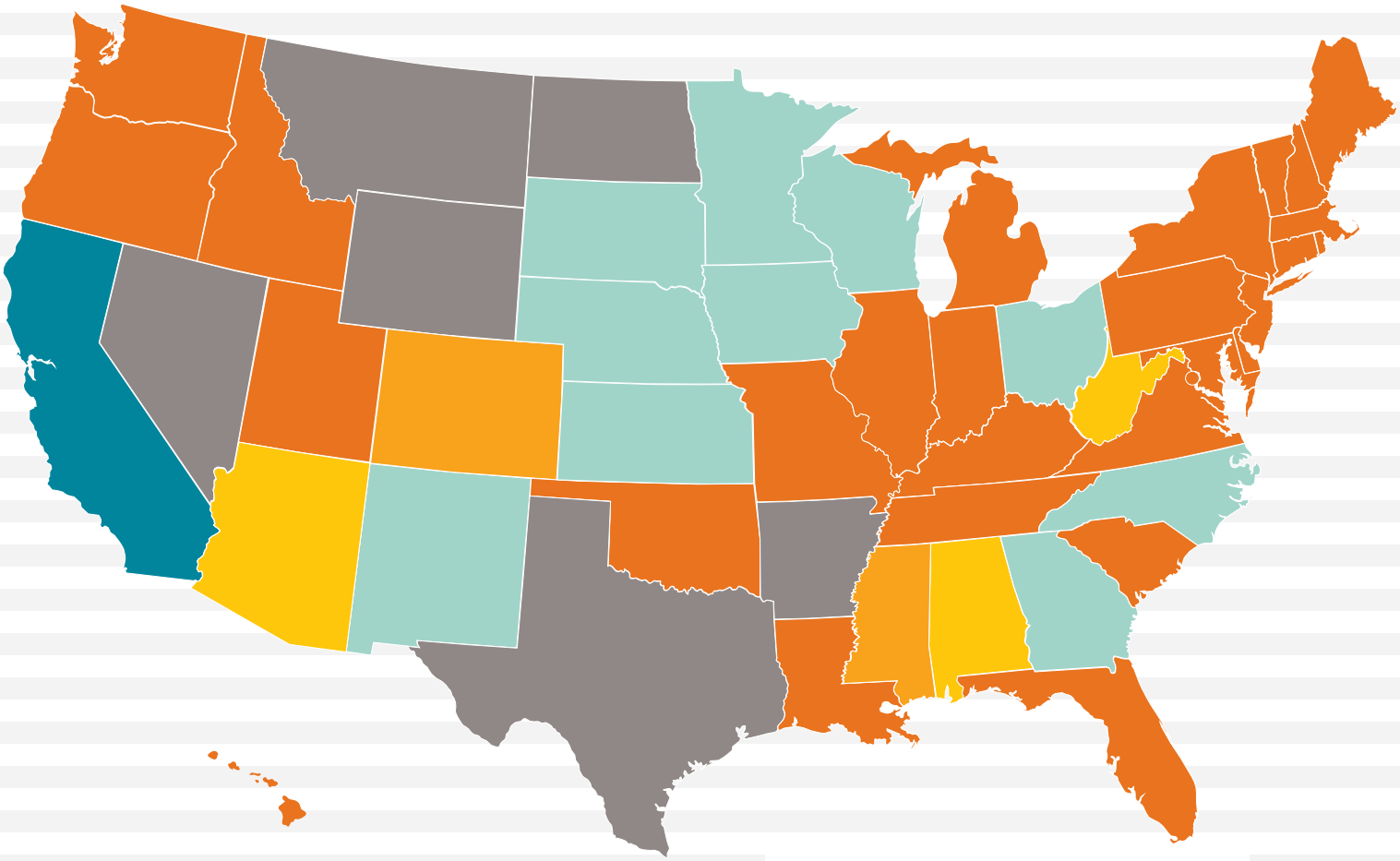
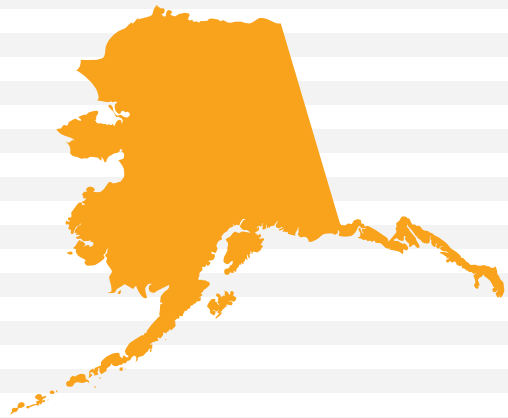
*In portions of this document, we use the terms "woman" and "women," but we recognize that other people, such as transgender, gender non-conforming, and gender non-binary people can become pregnant and need reproductive health care. We intend for them to be included in this analysis as well.

MOVEMENT OF PROACTIVE LEGISLATION FOR REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

AS OF DECEMBER 15, 2018





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EIGHT POLICY IDEAS TO CONSIDER FOR 2019

In 2018, advocates and legislators collaborated on new proactive policy initiatives, built on past successes, pushed for long-overdue change in existing policies that harm women and families, and showed new creativity about ways to protect women and others in their states from the disastrous policies pursued by the federal government.

As advocates and legislators come together to determine their policy agendas for 2019 and identify policies to preserve and protect reproductive rights in the face of potentially unprecedented future rollbacks, improve access to reproductive health care, and change the public conversation about reproductive health, rights, and justice, NIRH suggests considering the following:

1. **Protect the right to decide when and whether to become a parent, including the right to decide to have an abortion,** by repealing state laws that restrict rights and access, like waiting periods or bans on insurance coverage for abortion. [See discussion on pages 6 and 16.]

2. **Improve the health of women and families** by enacting legislation providing insurance coverage for the full range of reproductive health care, including contraception and abortion, prenatal care, postpartum care, and breastfeeding support and supplies. [See 2017's Oregon House Bill 339[2] for a legislative model.]

3. **Ensure that no woman or other person who becomes pregnant will be investigated, prosecuted, or imprisoned for managing their own abortion** by repealing laws that criminalize self-managed abortion and enacting legislation that makes it clear that no one can be prosecuted or jailed for ending their own pregnancy. [See discussion on page 7 and New York's Assembly Bill 1748 (Reproductive Health Act) for a legislative model.]

4. **Expand access to the full range of contraceptive options** by mandating that insurance companies cover all forms of contraception without additional barriers and by allowing patients to obtain a year's worth of birth control with one prescription. [See discussion on page 13.]

5. **Keep abortion patients and providers safe** by ensuring that employees, volunteers, or clients of reproductive health providers can request that their private, personal information — including where they live and information about their children — be kept off the internet and away from those who seek to harass and harm them. [See discussion on page 8 and New Jersey Senate Bill 1761 for a legislative model.]

6. **Protect and promote the health of incarcerated pregnant women and other pregnant incarcerated people** by prohibiting shackling during pregnancy, requiring prisons and jails to meet prenatal and postnatal health and nutrition standards, creating lactation and breastfeeding support programs for postpartum women, requiring courts and prosecutors to strongly consider alternatives to incarceration for anyone who is pregnant or lactating, and following through on all of those guarantees. [See discussion on pages 31 and 36 and 2014's Massachusetts Senate Bill 2063[3] for one possible legislative model.]

7. **Support the ability of pregnant and parenting young people to stay in school** by ensuring that pregnant students can take time off to get pregnancy care or abortion care, requiring schools to help students catch up when they return, and providing young parents with sick days specifically to take care of sick children without needing them to get a doctor's note. [See discussion on page 27 and California Assembly Bill 2289 for a legislative model.]

8. **Ensure that no one's reproductive decisions are coerced by the government** by prohibiting any court or other state entity from making a benefit from the state — such as a reduced sentence — contingent on agreeing to use contraception, be sterilized, or make any other decision about one's reproductive life. [See discussion on pages 33 and 37 and Tennessee Senate Bill 2133.]

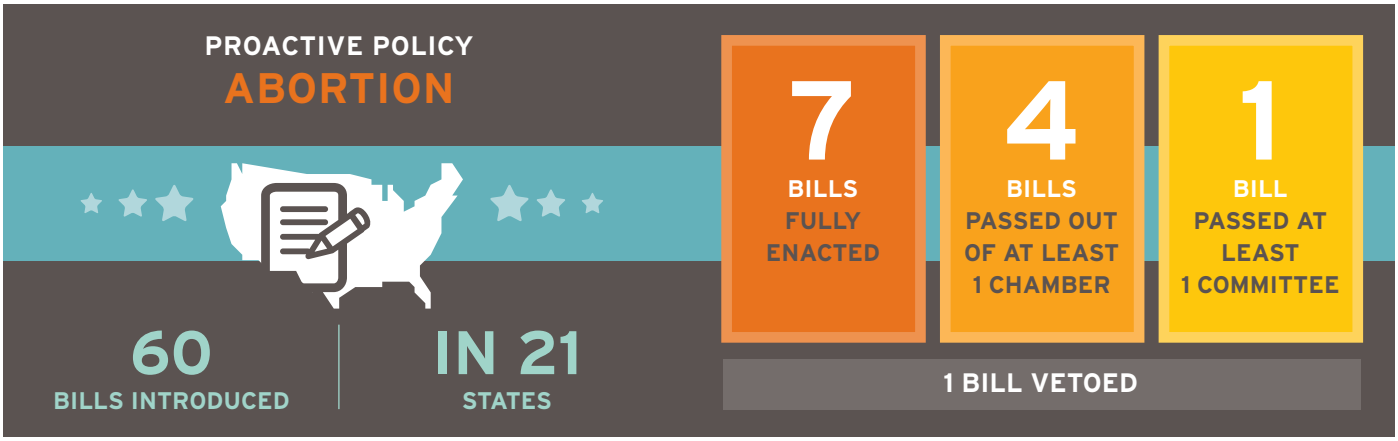
SECTION 1

EXPANDING ACCESS TO ABORTION CARE

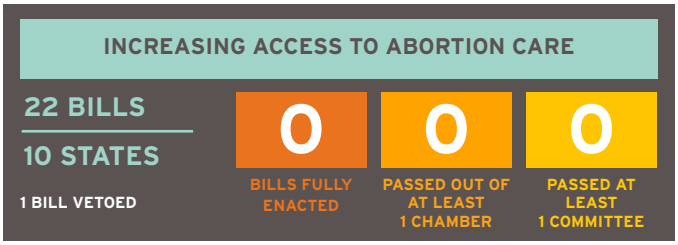
U.S. voters agree that when a woman has decided to have an abortion, she should be able to access that care safely, affordably, without shame, and in her own community.[4]

NIRH supports policies that enable any woman, trans man, or other person who can become pregnant to have access to quality, affordable, supportive, and safe abortion care without shame or harassment. Anyone seeking abortion care should have access to complete and medically accurate information about their options and should not be misled by politicians, third parties, or other actors who oppose abortion. No one should face prosecution for attempting or performing their own abortion. This is particularly critical for those who are historically underserved by the medical system and/or have faced racial discrimination or coercion with regards to their reproductive decisions.

Since *Roe v. Wade* was decided in 1973, state legislators have imposed a patchwork of more than 1,193 restrictions on the provision of abortion care.[5] Just since 2011, more than 401 new laws against abortion have been enacted in statehouses across the country.[6] In the coming year, we may be facing a new apex in the threats to abortion access with a shift in the balance of the Supreme Court, which may no longer interpret the Constitution to provide protections for reproductive decisions. In contrast, in the last several years, state advocates and policymakers have also worked tirelessly to counter this wave of restrictions, moving to repeal harmful laws and enact new proactive policies to make abortion more accessible for all.



Increasing Access to Abortion Care



Even when abortion care is protected and available, it is meaningless if a woman cannot afford abortion services. Today, more than half of all states are classified as "hostile" or "extremely hostile" to abortion by the Guttmacher Institute, and only 30 percent of women live in a state that is considered "supportive" of reproductive rights.[7] Put simply, laws that restrict access to abortion and make it harder for health care providers to offer this care are now the norm in many states. As a result, these policies must be repealed and replaced with measures that expand access and support the provision of abortion care, especially for underserved communities.

In 2018, state advocates in California worked hard to increase access to abortion care within their borders through both repealing restrictions and putting in place policies that support true abortion access. Thanks to remarkable organizing by a large coalition led by ACCESS Women's Health Justice, ACT for Women and Girls, California Latinas for Reproductive Justice, Students United for Reproductive Justice at Berkeley (SURJ), and the Women's Policy Institute, **California's** legislature passed Senate Bill 320, which would have required each student health center at a public university to offer medication abortion, making it possible that every public university student in California could access at least one form of abortion on their campus. Unfortunately, Governor Jerry Brown vetoed the legislation, stating in his veto message that "because the services required by this bill are widely available off-campus, this bill is not necessary."[8] It is an explanation strikingly at odds with feedback from students on campus like Adiba Khan, SURJ co-founder, who noted that "the movement to get medication abortion on campus began when students recognized our need for it."[9] The bill's sponsor, State Senator Connie Leyva, expressed her disappointment in the veto and promised to reintroduce and continue fighting for the bill, which "[a]t its core … affirmed the constitutional right of college students to access abortion care promptly and without delay."[10]

Repealing Arcane Laws and Decriminalizing Abortion

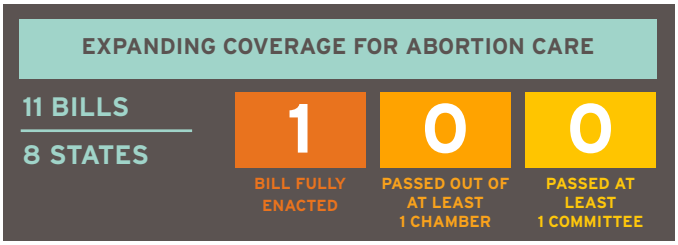
Before the Supreme Court decided *Roe v. Wade*, most states had laws that restricted access to abortion, including many that made it a crime to provide an abortion and, in some cases, a crime for a woman to perform her own abortion. Although generally unenforced, some of these unconstitutional laws remain on the books, causing uncertainty about what is legally permissible and sometimes limiting the type of care providers can offer their patients. These archaic abortion laws have also increasingly been used by prosecutors to investigate, arrest, or prosecute women, particularly women of color and low-income women, who are already subject to greater government surveillance and interference in their reproductive lives and health care decisions. Furthermore, as changes to the balance of the Supreme Court call into question the continued strength of federal protections for abortion, the existence of outdated laws on the books could cause added confusion or further limit abortion access in a state if the rights provided by *Roe* are further weakened or eliminated.

Some lawmakers capitalized on the power of this political moment to move legislation that would repeal or revise their criminal abortion laws to bring them in line with current constitutional standards and community attitudes. After more than a decade of organizing and advocacy work, a reproductive health coalition led by the American Civil Liberties Union (ACLU) of Massachusetts, NARAL Pro-Choice Massachusetts, and Planned Parenthood League of Massachusetts celebrated a huge success in 2018 when **Massachusetts** enacted Senate Bill 2260, which repealed the Commonwealth's criminal abortion ban dating back to the mid-1800s. The bill's passage "proves that Massachusetts is ready to lead the way in ensuring

EVEN WHEN ABORTION CARE IS PROTECTED AND AVAILABLE, IT BECOMES MEANINGLESS IF A WOMAN CANNOT AFFORD ABORTION SERVICES.

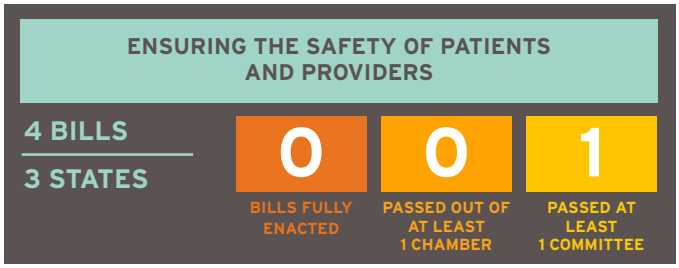
access to abortion and contraceptive care, especially given the threat to our basic rights on the federal level," said NARAL Pro-Choice Massachusetts President Rebecca Hart Holder.[11] The **New York** Assembly passed Assembly Bill 1748, the Reproductive Health Act, which would repeal the state's criminal abortion statute and explicitly decriminalize self-managed abortion. For more information on these bills, see page 16.

Expanding Coverage for Abortion Care



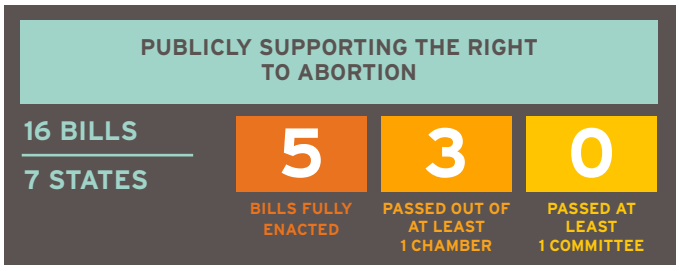
To ensure full access, everyone — regardless of their income level or immigration status — needs and deserves insurance coverage or access to other funding sources that adequately cover abortion services. **Washington** took one step toward making this a reality for its residents by enacting Senate Bill 6219, which requires any insurance plan covering maternity care to also cover abortion services. The bill's sponsor, State Senator Steve Hobbs, noted that abortion care "should be part of basic women's primary health" and that "no woman should have to seek or pay for an additional rider or copay or have any other means of delay or financial burden for this coverage."[12] The bill creates insurance coverage parity in the state and helps ensure that women have a more financially equitable choice between abortion and continuing a pregnancy, while also serving as a step toward a longer-term campaign to require abortion coverage in all plans for all residents. For more information on this important win, see page 17.

Ensuring the Safety of Patients and Providers



Historically, efforts to reduce access to abortion have not been limited to state legislatures enacting restrictive laws — some abortion opponents have also used violence and harassment to undermine the provision of abortion services. In 2018, **New Jersey** considered Senate Bill 1761 / Assembly Bill 1861, which would have created an address confidentiality program for reproductive health service employees and clients, allowing them to request that their address be kept confidential and thus helping them stay safe in their homes.

Publicly Supporting the Right to Abortion



Elected officials have a unique opportunity to use their positions of power to counter abortion stigma by standing up publicly for abortion care and abortion providers. For instance, adopting a resolution affirming support for abortion rights allows legislators to help normalize abortion care, communicate their support for women's reproductive decisions, and set the stage for

future policy change. Resolutions that call on federal lawmakers to protect women's rights or pass important new policy measures can also help connect local, state, and federal advocacy, building a more powerful movement from the ground up.

In 2018, **California** lawmakers proclaimed their support for the rights protected in *Roe v. Wade*, access to reproductive health care services, and clinics by passing Senate Resolution 72 / House Resolution 71, and for the Title X program by passing Assembly Joint Resolution 42. **New Jersey** enacted Assembly Resolution 181 / Senate Resolution 96, which calls on the president of the United States and Congress to ensure that a woman can freely make reproductive health decisions and access reproductive health care, including abortion, and urged them to reject and revoke the nomination of Brett Kavanaugh to the Supreme Court or any other nominee who would restrict reproductive rights. **Hawaii's** Senate passed and the House considered three similar bills (Senate Bills 2661, 2662, and 2664) that would have codified the state's commitment to the United Nations Sustainable Development Goals, including universal access to sexual and reproductive health care services, addressing the nutritional needs of pregnant and lactating women, ending preventable infant mortality, lowering the maternal mortality to live birth ratio, and achieving universal health coverage.

ELECTED OFFICIALS HAVE A UNIQUE OPPORTUNITY TO USE THEIR POSITIONS OF POWER TO COUNTER ABORTION STIGMA BY STANDING UP PUBLICLY FOR ABORTION CARE AND ABORTION PROVIDERS.

EXPANDING ACCESS TO ABORTION CARE

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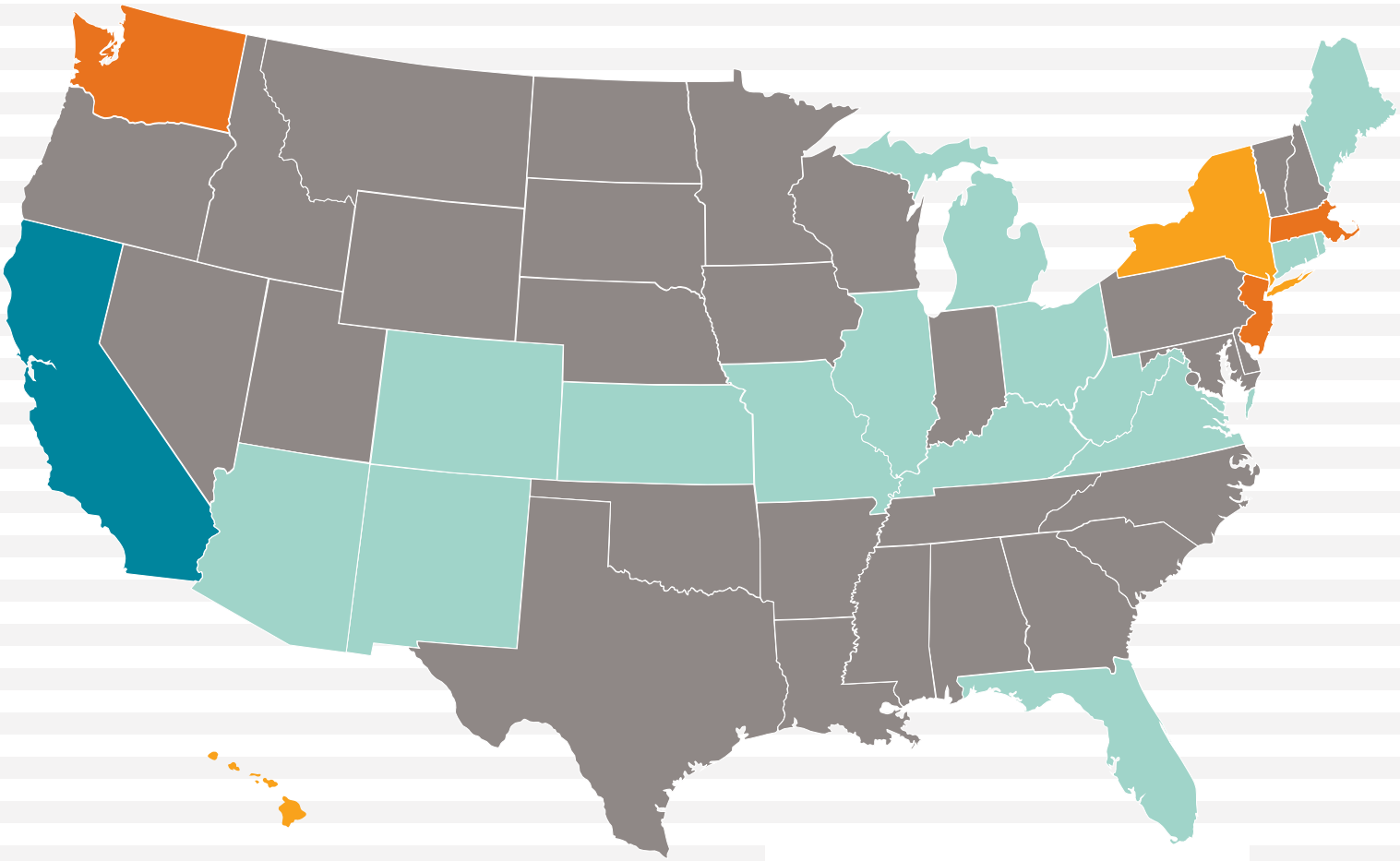

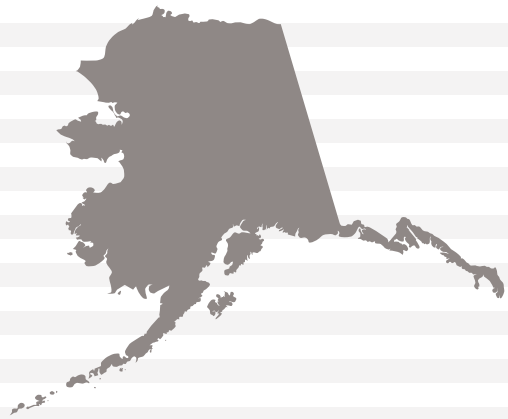

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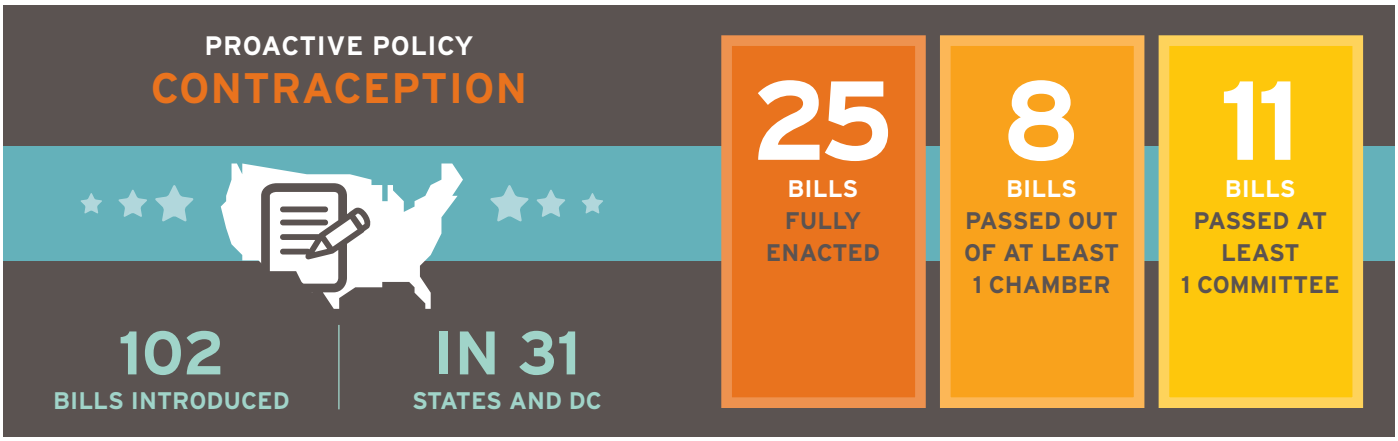
SECTION 2

IMPROVING ACCESS TO CONTRACEPTION

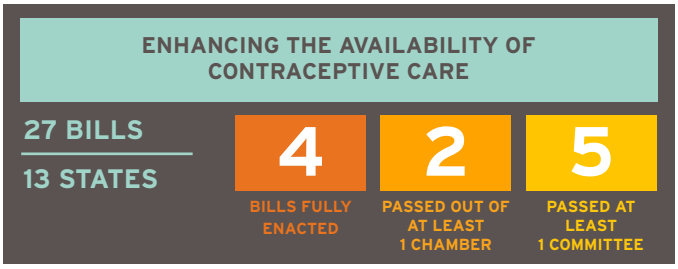
An individual's ability to control whether and when to have a child can determine the course of their life. Having meaningful access to contraception is essential to individual self-determination and to overall gender equity.

NIRH supports policies that ensure access to the full range of methods of contraception and non-coercive, inclusive contraceptive counseling, and is committed to increasing knowledge of and access to underutilized contraceptive options in ways that center and honor patient autonomy and decision-making.

Despite advances in contraceptive methods and their widespread availability in much of the United States, barriers to accessing or paying for the kind of contraception an individual wants or needs often remain. Insurance coverage for all forms of contraception from accessible providers is not always guaranteed – even with the advances in the ACA, which addressed some of these barriers by requiring coverage for all FDA-approved forms of female contraception with no copay.[13] Access to long-acting reversible contraception (LARC), for example, is often more difficult because of a lack of provider training, limited public awareness, and/or high cost to providers and consumers. Contraception is also often hard to reach for underserved communities – including low-income, rural, or immigrant populations – because of inadequate provider infrastructure, language barriers, and cost. Advocates and lawmakers continued to build upon the advances of the last several years to push forward both comprehensive policies to expand access as well as measures to address specific barriers through policy change.



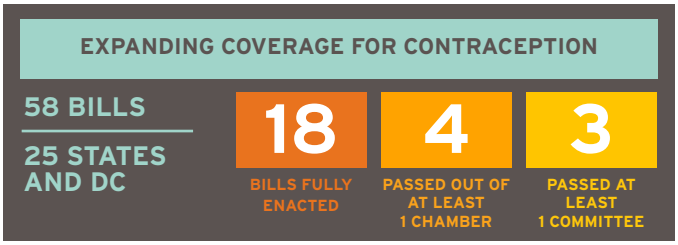
Enhancing the Availability of Contraceptive Care



For contraception to be truly available and accessible, an individual must be able to get the contraceptive care they want from a nearby provider who is appropriately trained to offer comprehensive, culturally competent counseling and the full range of services. In 2018, eight states considered bills that would expand such access, focusing on specific populations or specific methods of contraception. **Hawaii**, where 53 percent of all people experiencing homelessness live in unsheltered locations,[14] considered Senate Bill 2502, aimed at expanding services for the homeless community, including funding mobile clinics that would provide, among other things, family planning services and sexually transmitted infection (STI) testing. The **Illinois** Senate passed Senate Bill 2881, which would have lowered the tax rate for male and female condoms, making them more affordable. **New York** considered two bills (Assembly Bill 2674 / Senate Bill 3793 and Assembly Bill 6058 / Senate Bill 7367) that would have expanded education about and access to emergency contraception.

Although LARC is the most effective form of contraception,[15] use in the United States remains low relative to that of other Western countries. This is due to lack of awareness, persistent myths among both patients and providers about their dangers, insufficient training in insertion and removal, and the high cost of the devices, as well as concerns in some communities about the history and ongoing existence of reproductive coercion.[16] (For more information on reproductive coercion, especially for incarcerated communities, see page 33.) In 2018, five states took actions to alleviate some of these barriers. **Missouri** enacted Senate Bill 826, which addresses issues in stocking and payment, allowing for providers to use the devices they already have in stock. **Tennessee** enacted House Bill 1320 / Senate Bill 883, directing the Department of Health to set up a program to increase access to LARCs through training, funding, outreach, and education. **Utah** (House Bill 12) and **Vermont** (House Bill 404) enacted bills that address payment issues by allowing providers to be reimbursed for LARCs that are inserted after childbirth. **Missouri** (House Bill 1499) and **New Jersey** (Senate Bill 1347) considered similar bills that would address barriers in LARC provision.

Expanding Coverage for Contraception



To have true and full access to contraception, everyone – regardless of their income level or immigration status – must have insurance coverage and other funding sources that adequately cover the full range of contraception services, including comprehensive and culturally competent counseling; provider care, including insertion and removal of LARC; and coverage for the actual method, including over-the-counter access to contraception that is approved for such sale. Some insurance plans lack comprehensive coverage for all forms of contraception, or they prevent patients from accessing contraception at a location convenient to them. However, states can adopt policies to ensure broader coverage for contraception, and many legislatures considered such policies in 2018.

Lawmakers in three states considered easing barriers to access by mandating coverage for specific forms of contraception, methods of services, or information about those contraceptive services. **Maryland** enacted House Bill 249 / Senate Bill 33, which requires coverage of fertility awareness-based methods of contraception, and it considered Senate Bill 744 / House Bill 780, which would have required insurers to develop a document explaining the contraceptive coverage in their plans. **California's** Senate passed Senate Bill 1023, which would have ensured that sexual and reproductive health care provided through telehealth is covered by state-funded insurance plans. The **Washington** Senate passed Senate Bill 6102, which would have made it an unfair employment practice to fail to provide contraceptive coverage with no copay as part of an employee's benefit package.

SOME INSURANCE PLANS LACK COMPREHENSIVE COVERAGE FOR ALL FORMS OF CONTRACEPTION, OR THEY PREVENT PATIENTS FROM ACCESSING CONTRACEPTION AT A LOCATION CONVENIENT TO THEM.

Research has shown that having a year's supply of contraception on hand reduces a woman's odds of unintended pregnancy by 30 percent, and it is an identified best practice by the Centers for Disease Control and Prevention, yet many insurance companies will cover only three months at a time.[17] Two states – **Maryland** (House Bill 1283) and **New Hampshire** (Senate Bill 421) – enacted new laws requiring insurance companies to cover a dispersal of 12 months of contraception at one time.

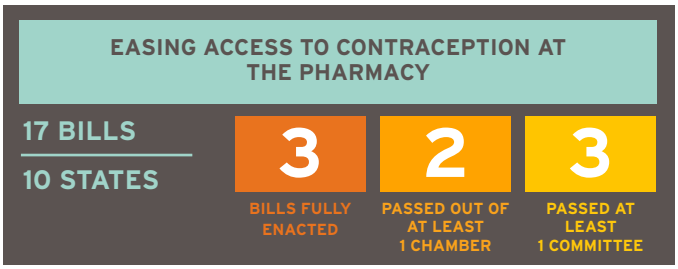
Two states enhanced their family planning programs in 2018. **Maryland** enacted House Bill 994 / Senate Bill 774, which improves the presumptive eligibility processes for its family planning program, meaning low-income Marylanders will have more streamlined and faster access to family planning coverage. In **New Jersey**, after seven years of tireless efforts by advocates and legislative champions who worked to consistently pass this legislation only to have it vetoed by Governor Chris Christie each year, the legislature passed and Governor Phil Murphy signed Senate Bill 105 / Assembly Bill 1656, expanding access to family planning to women with incomes at 200 percent or less of the federal poverty level.

Beginning in the 1990s, many states required "contraceptive equity," meaning that insurance plans that cover prescription drugs must also cover contraception. However, insurance companies often limited the types of contraception that were covered or charged high copays for some or all forms. While this cost barrier was largely addressed by the ACA, many advocates and legislators have worked to enshrine this requirement into their state laws and to broaden the coverage guarantee even further, such as including over-the-counter and/or male forms of contraception. In 2014, California became the first state to pass such a law, with Illinois, Maryland, and Vermont following suit in 2016. As Congress and the president devoted much of 2017 to attempts to repeal the ACA, and the federal administration explicitly threatened contraceptive access, Maine, Massachusetts, and Nevada enacted contraceptive equity bills, and the District of Columbia and Hawaii enacted even broader protections, passing laws to enshrine the full range of the ACA's required women's preventive services. In 2018, eight states and the District of Columbia considered bills that would guarantee no copay coverage for contraception, with five enacting them: **Connecticut** (House Bill 5210), **Delaware** (Senate Bill 151), the **District of Columbia** (Bills 106 and 680), **Maine** (House Bill 1015), **Rhode Island** (House Bill 7625 / Senate Bill 2529), and **Washington** (House Bill 1523). **Alaska** (House Bill 25) and **New York** (Assembly Bill 9957) both considered similar legislation. **Maryland** also enacted Senate Bill 986 / House Bill 1024, which expanded its existing contraceptive equity law to state employee health plans.

Finally, while the federal government is attempting to eliminate the broad protections of the ACA by allowing insurers to offer "short-term" plans that provide very little coverage instead of ACA-compliant plans, **California** enacted a law, Senate Bill 910, to ban the sale of those plans in the state.

RESEARCH HAS SHOWN THAT HAVING A YEAR'S SUPPLY OF CONTRACEPTION ON HAND REDUCES A WOMAN'S ODDS OF UNINTENDED PREGNANCY BY 30 PERCENT.

Easing Access to Contraception at the Pharmacy

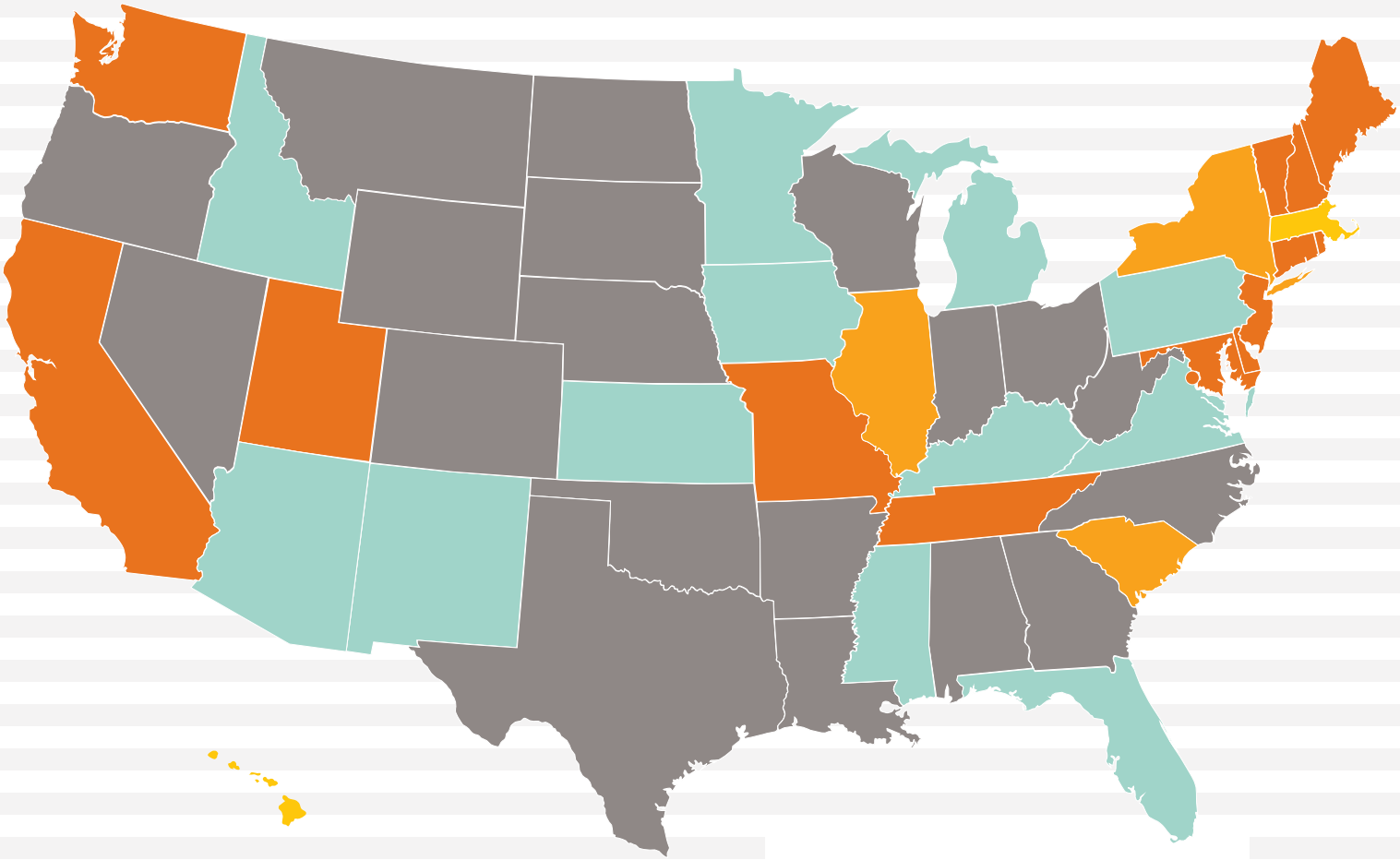


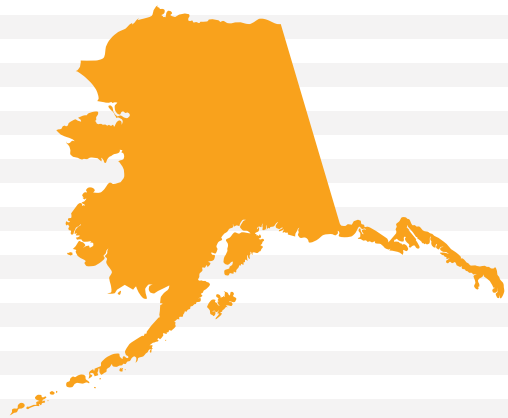
Although oral contraceptives are among the safest and most well-understood medications available, under federal law patients are still required to get a prescription to access them. Recent medical evidence suggests, however, that removing the prescription requirement could safely increase access and reduce unintended pregnancy.[18] While states cannot change the federal prescription requirement, six states considered policies that would adjust a pharmacist's scope of practice to help dismantle this barrier, and one considered a bill to help inform consumers about access to contraception directly at the pharmacy.

Two states – **New Hampshire** (House Bill 1822) and **Utah** (Senate Bill 184) – enacted bills giving pharmacists the ability to prescribe and dispense hormonal contraceptives, with some limitations, so that women can skip the doctor's visit and simply see their local pharmacists. Wilson Pace, a University of Utah pharmacy graduate student, drafted Senate Bill 184 for a leadership class after hearing about the delays his wife and other women faced in obtaining contraception.[19] Similar policies were considered in **Illinois** (House Bill 274), **Massachusetts** (House Bill 1214 / Senate Bill 1240), and **South Carolina** (House Bill 3064). Relatedly, **Maryland** enacted House Bill 1558, giving pharmacists the authority to dispense the full quantity of contraception prescribed up to 12 months at one time, and **Washington** considered House Bill 2570, which would have created a publicly searchable database for pharmacists who are providing contraceptives at the pharmacy without needing the patient to have a prescription.

IMPROVING ACCESS TO CONTRACEPTION

AS OF DECEMBER 15, 2018





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STATE GOVERNMENTS CAN PROTECT RIGHTS, EXPAND ACCESS, AND DEFEND RESIDENTS FROM A HOSTILE FEDERAL GOVERNMENT

While Congress and the president have enormous power to set — or to shift — policy on a national stage, access to reproductive health care, particularly abortion, has long been determined at the state level, leading to a troubling national landscape where a woman's access to abortion depends on her zip code and her financial means. With the balance of the Supreme Court shifting away from support for reproductive rights, the role of state and local governments in protecting reproductive freedom is more critical than it has been in generations. Officials in a number of states have already made it clear that they plan to protect their residents no matter what may be enacted, repealed, or overturned at the federal level.

In 2018, as the Trump-Pence administration and Congress continued to roll back access to contraception and abortion, state executive branch officials and legislative bodies grappled with the impact of harmful federal policies and sought ways to mitigate those harms and protect their residents. For instance, state attorneys general across the country have taken on a major role in protecting the rights of their citizens under this administration. In cases addressing a range of social justice issues, including abortion, many attorneys general have joined together to urge the federal courts to stop the Trump-Pence administration's intrusion on individual rights. For example, the Trump-Pence administration actively prevented pregnant unaccompanied immigrant minors in federal custody from accessing abortion. After the ACLU filed a lawsuit to end that policy, 19 attorneys general, led by Barbara Underwood of **New York**, filed an amicus brief urging the U.S. Court of Appeals for the D.C. Circuit to reject the administration's policy.

Threats to reproductive rights and health also come from outdated criminal abortion laws that have remained on states' statute books from generations, even centuries, ago. These laws, while arguably unenforceable today, could still result in women or health care providers being criminally prosecuted for abortion. The changed political and legal landscape — with the Supreme Court's balance shifting further away from its recognition of a constitutional right to end a pregnancy — increases the urgency to remove these outdated criminal laws from the statute books and ensure that no one is prosecuted for having an abortion and that providers do not face the threat of jail time for providing critical reproductive health care.

Since the 2016 election, lawmakers in three states have enacted laws to repeal outdated criminal abortion laws and ensure that rights will be protected in the future. Delaware and Illinois passed such measures in 2017 and, in 2018, **Massachusetts** joined them. Despite Massachusetts' strong record of protecting access to reproductive health care, 19th-century laws governing criminal abortion and contraception remained on the books. The state took an important step forward when, in a bipartisan effort between a Democratic legislature and a Republican governor, it repealed these arcane laws with Senate Bill 2260 (discussed on page 7).

Similarly, lawmakers in the **New York** State Assembly once again passed a bill, the Reproductive Health Act (RHA), that would have repealed New York's pre-*Roe*

abortion law, which currently criminalizes self-managed abortion as well as abortions later in pregnancy that are necessary to preserve a woman's health. While Governor Andrew Cuomo is strongly supportive of the bill, the New York State Senate has steadfastly refused to pass it. In striking contrast with lawmakers in Delaware, Illinois, and Massachusetts, who recognize the threat of such criminal laws to the people of their states, a slim majority of New York state senators have been standing in the way of New Yorkers' rights and health. However, in the 2018 midterm elections, New York voters made it clear they will no longer tolerate delay on this issue; a decisive pro-choice majority was elected to the New York State Senate for the first time in decades, with many newly elected senators who promised on the campaign trail to make the RHA a priority in the 2019 session.

Even with protections for abortion rights in place, having little or no insurance coverage for abortion can render abortion inaccessible. In **Washington**, which already has an explicit statute protecting individuals' rights to make their own reproductive health decisions, including abortion, lawmakers took a step further and passed Senate Bill 6219, requiring all insurance plans that cover maternity care to also cover abortion care. This bill shows that in Washington, lawmakers are committed to making sure women and others can effectuate the reproductive decisions they make.

In some cases, governors can take action themselves to protect or expand access to care through executive orders or regulatory measures. In **New York**, under Governor Cuomo's leadership, the Department of Health released a first-of-its-kind public education campaign, "Know Your Options," providing New Yorkers with comprehensive information about pregnancy options, including abortion, adoption, and prenatal care, along with information about how to obtain care from legitimate health care professionals. This major step followed a Supreme Court decision that called into question legislative efforts to regulate the deceptive practices of so-called "crisis pregnancy centers," fake clinics that pose as comprehensive reproductive health care facilities but, in reality, attempt to persuade, trick, or manipulate women out of seeking abortions. In its ruling, the Supreme Court noted that states and localities are free to engage in public education campaigns to educate their residents about the availability of comprehensive reproductive health care; Governor Cuomo and the Department of Health took them up on the invitation. New York's campaign creates a new model for other states and localities to consider in the future.

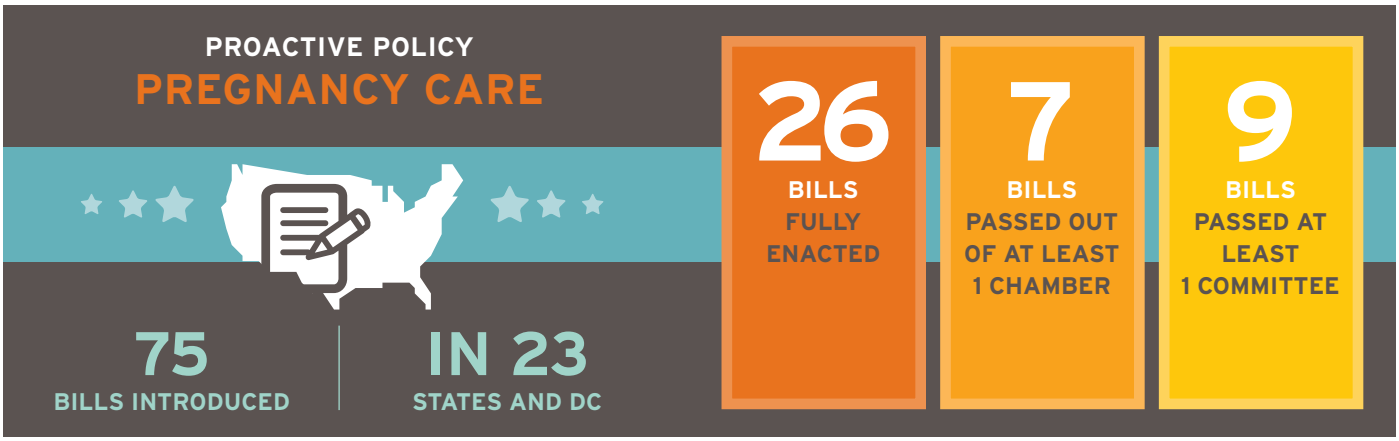
Officials at the city level have also started to speak out about the injustice of federal policy on reproductive health and rights. In 2018, mayors from 75 cities wrote a letter to the federal government opposing the U.S. Department of Health and Human Services' proposed changes to Title X, the federal family planning program, which would drastically reduce access to contraception and increase difficulty in accessing preventive reproductive health care; at least four city councils enacted resolutions supporting proactive state policy and opposing restrictions on the federal level; and one district attorney in Allegheny County, **Pennsylvania**, came forward with a statement that, regardless of the Supreme Court's decisions on abortion in the future, he will not prosecute doctors who perform, nor women who seek, abortions.

As we move forward in this era of relentless federal attacks on reproductive health and rights, along with the utter failure of the federal government to address the needs of women and families, progressive state lawmakers are harnessing the power of state government to protect rights and expand access to reproductive health care. While the right to make decisions about one's own body and the ability to access care should never depend on where one lives, today in the United States, this is the unfortunate reality. It is more critical than ever for state elected officials to recognize their obligation to step in and do whatever they can to eliminate barriers to care, protect rights, and use the powers of their offices to stand between a hostile federal government and their residents. In 2018, many did so, and in 2019, we hope to see more follow in their footsteps.

SECTION 3

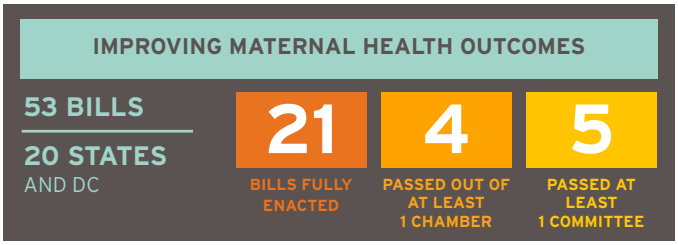
INCREASING ACCESS TO PREGNANCY CARE

Pregnancy and childbirth implicate important reproductive rights, including autonomy, dignity, and privacy, as well as critical aspects of public health, such as equitable access to quality health care and health outcomes.



NIRH supports policies that ensure that all women, trans men, and other people who can become pregnant, regardless of income level or immigration status, have affordable, convenient access to prenatal, labor and delivery, and postnatal care from the provider of their choice in the delivery setting of their choice. Effective public health policy should include collaboration between and among communities, governments, and health care providers to prevent maternal morbidity and mortality, and to address and eliminate the racial disparities in maternal health indicators that currently plague the United States.

Improving Maternal Health Outcomes



Despite otherwise advanced medical care in the United States, maternal health lags well behind, with the United States having the highest maternal mortality rate in

the developed world.[20] Maternal health outcomes here lag behind those of many other nations due in part to the reprehensible levels of maternal mortality and morbidity that exist among black women and other women of color.[21] Advocates, reproductive health care professionals, and lawmakers have been considering policy options to address these issues for many years and are continually refining the possible solutions. In particular, Black Mamas Matter Alliance[22] — a black women-led cross-sector alliance that advocates on behalf of black maternal health, rights, and justice — has led the charge to bring public attention to this issue and to seek change at the state level. In April 2018, they organized the Black Maternal Health Week, which helped community groups organize events on the local, state, federal, and global levels to amplify the voices of black mamas, women, and families, and increase attention for the issues around black maternal health.

Some important first steps toward addressing this public health crisis include studying maternal health to identify the points of failure in each state's health care delivery system; ensuring access to basic prenatal and postpartum care, including mental health care; and creating programs that specifically target vulnerable or disparately impacted groups. From there, states can expand access in areas with gaps in care and begin to build out a more comprehensive approach. Often, these broader approaches include assessments of infant mortality and health or the health of babies into their early childhoods.

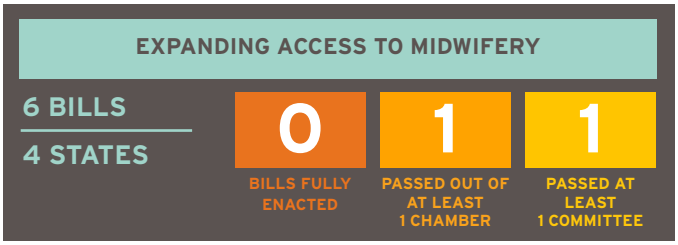
Building on the success of the three states in 2017 that established or expanded maternal mortality and morbidity task forces, in 2018, eight states and the District of Columbia considered similar committees or task forces. Four states and the District of Columbia established maternal mortality review commissions — **Connecticut** (Senate Bill 304), the **District of Columbia** (Bill 524), **Maryland** (House Bill 1518), **Oregon** (House Bill 4133), and **Pennsylvania** (House Bill 1869) — while two considered similar legislation: **New Jersey's** Assembly passed Assembly Bill 1862 / Senate Bill 495, and **New York's** Senate Bill 8907 / Assembly Bill 10346 passed the Senate. Two states and the District of Columbia considered similar task forces to look at various maternal health issues: The **District of Columbia** enacted Bill 172, creating a Maternal Mental Health Task Force to broadly study maternal health needs; **Louisiana** enacted House Bill 818, creating a Healthy Moms, Healthy Babies Advisory Council to investigate racial and ethnic disparities in maternal health outcomes; and **Illinois'** Senate passed Senate Joint Resolution 67, which would create a Home Birth Maternity Care Crisis Study Committee to address home birth issues.

Six states enacted policies that would increase broader access to maternal health services. **California** enacted Assembly Bill 2193, which requires health care practitioners who provide prenatal or postpartum care to screen mothers for maternal health conditions and develop a case management program. California also enacted Assembly Bill 1893, which now requires the state to apply for federal funding for maternal mental health services. **Florida** enacted House Bill 937, which will increase the resources for perinatal mental health information and services, including creating a public hotline and screening requirements for birth centers, and it considered a very similar policy in Senate Bill 138. **Maryland** enacted two new laws (House Bill 1685 and Senate Bill 912) that direct money toward postpartum services for low-income mothers. **New Jersey** enacted Assembly Bill 2366 / Senate Bill 1786, requiring the Commissioner of Health to develop a publicly available Report Card of Hospital Maternity Care for all New Jersey hospitals. **New York** enacted Assembly Bill 8953 / Senate Bill 7409, which requires the Department of Health and the Office of Mental Health to provide information to providers about maternal depression and resources for treatment.

Rhode Island enacted Senate Bill 2531 / House Bill 7193, which allows minors to consent to any medical services related to prenatal, delivery, and post-delivery care. (Unfortunately, the bill also explicitly states that this right to consent does not extend to abortion; Rhode Island currently requires parental consent or a judicial bypass order before a minor may obtain an abortion.)

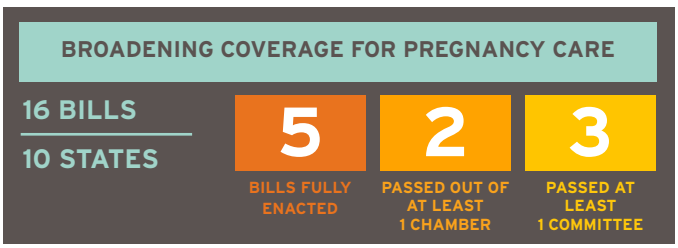
Five states considered resolutions that promoted maternal mental health awareness or urged the federal government to act to improve maternal mental health: **California** enacted Assembly Concurrent Resolution 180 and considered House Resolution 95, **Indiana** enacted Senate Resolution 31, **Michigan** enacted House Resolution 301, **New Jersey** enacted Assembly Resolution 113 / Senate Resolution 18, and **Utah** enacted Senate Concurrent Resolution 11. Michigan's resolution specifically lifted up the issue of black maternal mortality, declaring a Black Maternal Health Week in the state. This success, along with other state and federal advocacy, was a result of the work of Black Mamas Matter Alliance.

Expanding Access to Midwifery



Throughout history, women and others who can become pregnant have given birth in many different circumstances, sometimes with highly skilled medical professionals and compassionate assistance, but often without being able to control or influence the methods used to deliver their children or the medical treatment they receive. Today, many policymakers and reproductive health care professionals understand that the birth process should be driven by the birthing woman herself, rather than others making decisions for her. Enabling women to give birth attended by their chosen provider – whether a physician or a midwife – in the delivery setting they choose not only respects women's autonomy and dignity, but often leads to better health outcomes and fewer interventions.[23] In order to expand access to the type of providers women can choose and the birth setting they prefer, some states have moved to remove legal barriers to home births, expand access to birthing centers (as opposed to hospitals), and broaden the licensing categories for those permitted to deliver babies. In 2018, two states moved legislation to give midwives a greater ability to assist in births and to address the complications that can ensue – **California** (Assembly Bill 2682) and **Hawaii** (House Bill 2184) moved bills that would have created a licensing structure and scope of practice for midwives.

Broadening Coverage for Pregnancy Care



In order to have the ability to truly decide whether, when, and how to start a family, a woman must be able to afford the care she needs to become pregnant, have the resources for a healthy pregnancy and delivery, and receive the support she needs as a new mother. Legislation moved in eight states in 2018 that would expand insurance coverage for many forms of pregnancy-related care.

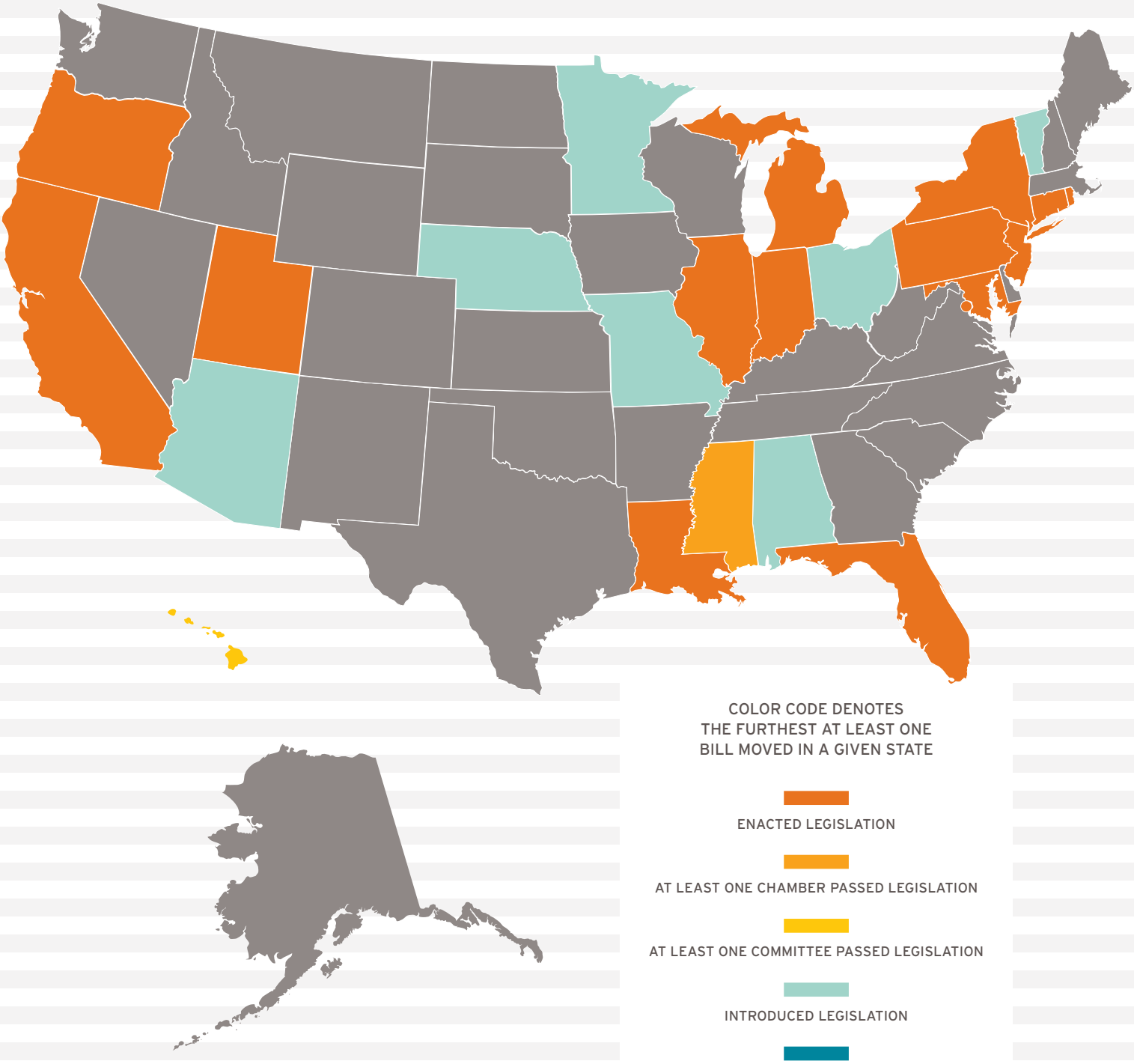
Three states focused on improving eligibility for insurance plans for pregnant women. After three years of advocacy, **Connecticut** enacted Senate Bill 206, which ensures pregnant women are eligible to sign up for health care plans outside of set enrollment periods, a step toward ensuring pregnant women can access the prenatal care they need. **Maryland** considered a similar piece of legislation, House Bill 1038. **California's** Assembly passed a somewhat similar policy, Assembly Bill 2579, which would allow pregnant women applying to the Women, Infants, and Children (WIC) program to obtain presumptive eligibility for Medicaid.

Two states looked to improve services pregnant women have access to when they are enrolled in the state's Medicaid program. **New Jersey** considered Senate Bill 1784 / Assembly Bill 1662, which would provide Medicaid coverage for doula care during pregnancy. **New York** considered Assembly Bill 5359, which would require Medicaid coverage of inpatient hospital care for 48-96 hours after delivery as well as parent education and assistance and training in breastfeeding or bottle-feeding.

Four states focused on ensuring that insurance coverage for fertility services is available to their residents. First introduced in 2017, **Illinois** (House Bill 2617) and **Maryland** (Senate Bill 271 / House Bill 908) both enacted laws requiring coverage for fertility services for women dealing with surgically or medically caused infertility. **Utah** enacted Senate Bill 181, which creates a pilot program to cover up to $4,000 towards the cost of assisted reproductive technology. **Mississippi's** House passed House Bill 1198, which would require any insurance that covers pregnancy care to also cover infertility treatments.

INCREASING ACCESS TO PREGNANCY CARE

AS OF DECEMBER 15, 2018



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SECTION 4

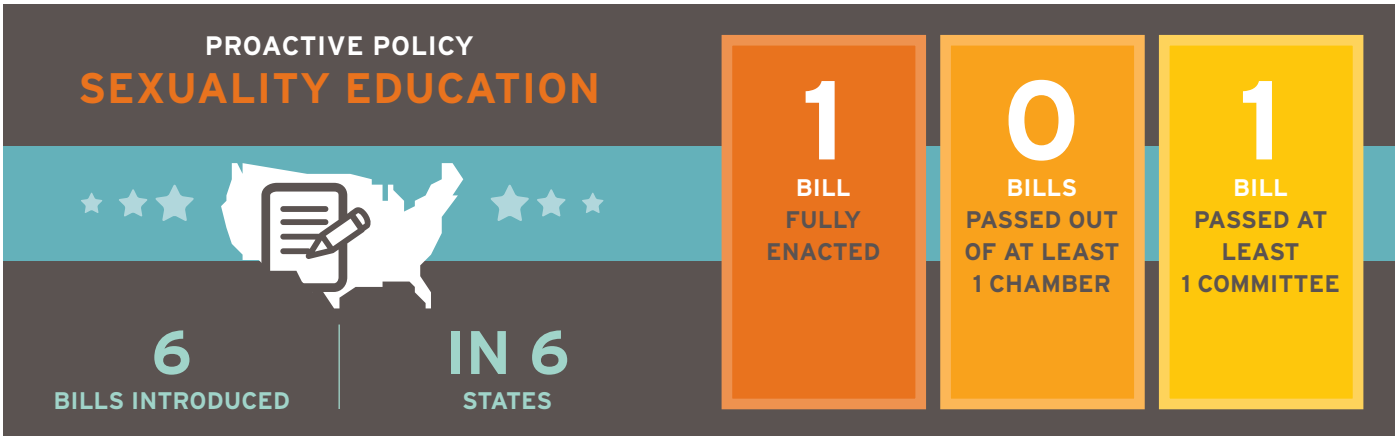
PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

Young people have a right to lead full and healthy lives, which means having information and resources to make informed and independent decisions about their reproductive and sexual health.

Comprehensive sexuality education programs in school provide young people with the information and ability to make those choices, and they have been proven to delay the onset and frequency of sexual activity, increase condom and contraceptive use, and reduce the number of sexual partners.[24] NIRH supports policies that mandate age– and developmentally appropriate, medically accurate, comprehensive sexuality education in schools and communities so that all young people – regardless of where they live or what school they attend – have the opportunity to make healthy decisions about relationships, sexuality, and sexual behavior.

While state governments are sometimes responsible for creating sexual health education standards, it has often been considered a local responsibility as well – providing two levels of advocacy opportunities to improve on the status quo. Sexuality education curricula specifically are often determined by a combination of state and local laws and school district policies, which means each student's access and experience with sexuality education varies and is dependent on where they live and attend school.

In 2018, two states considered bills to promote comprehensive sexuality education for young people.



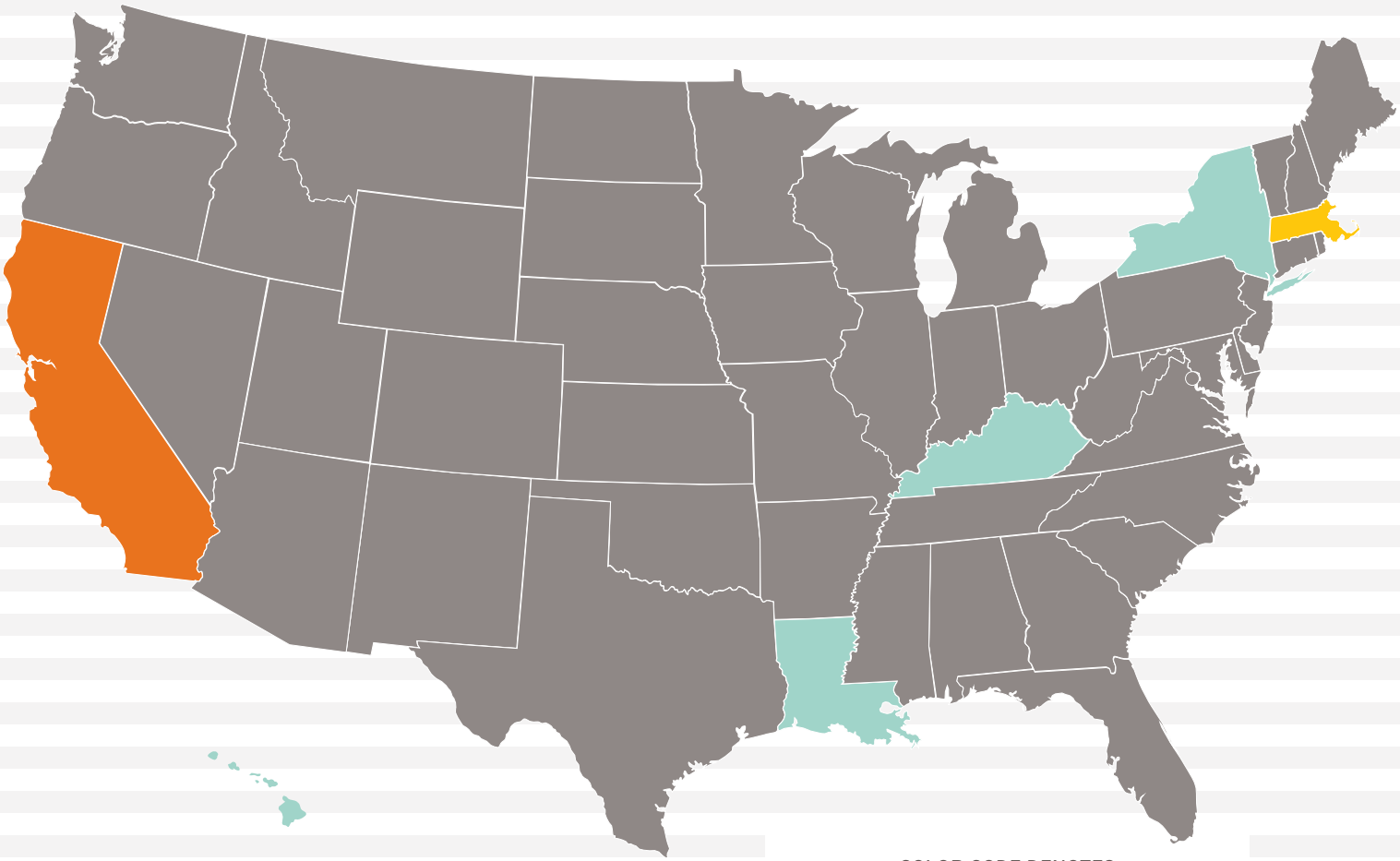
LIKE STATE GOVERNMENTS, LOCAL GOVERNMENTS AND SCHOOL BOARDS CAN TAKE ACTION BY PASSING LEGISLATION MANDATING COMPREHENSIVE SEXUALITY EDUCATION, MANAGING IMPLEMENTATION, CREATING TRACKING AND ENFORCEMENT MECHANISMS, FUNDING TEACHER TRAINING, AND PROVIDING OTHER RESOURCES. NIRH HAS A LONG HISTORY OF ADVOCATING FOR LOCAL EFFORTS TO ADVANCE REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE, INCLUDING CALLING FOR COMPREHENSIVE SEXUALITY EDUCATION AT THE MUNICIPAL LEVEL. TO LEARN MORE, VISIT LOCALREPRO.ORG.

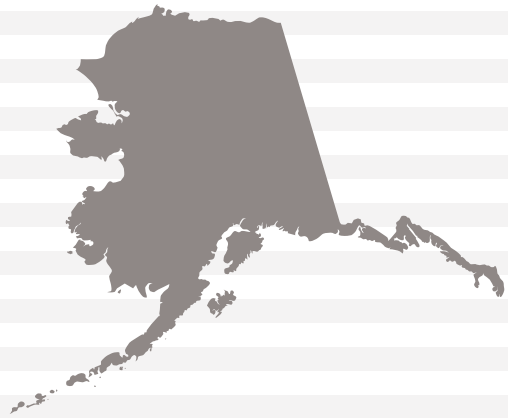
In **California**, where comprehensive sexuality education is already mandatory for public schools, the state enacted Assembly Bill 2601, mandating that it also be taught in charter schools. The **Massachusetts** legislature, for the third year in a row and after multiple revisions, moved House Bill 3704 through one committee. The bill would mandate that age-appropriate, medically accurate, comprehensive sexuality education be taught in all schools.

Both state and local lawmakers have a vital role to play when it comes to ensuring that school curricula support young people in making choices about their reproductive and sexual health. Cities especially are nimble and powerful engines of progress that can push back against state legislatures that are hostile to or apathetic about reproductive and sexual health.

PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

AS OF DECEMBER 15, 2018





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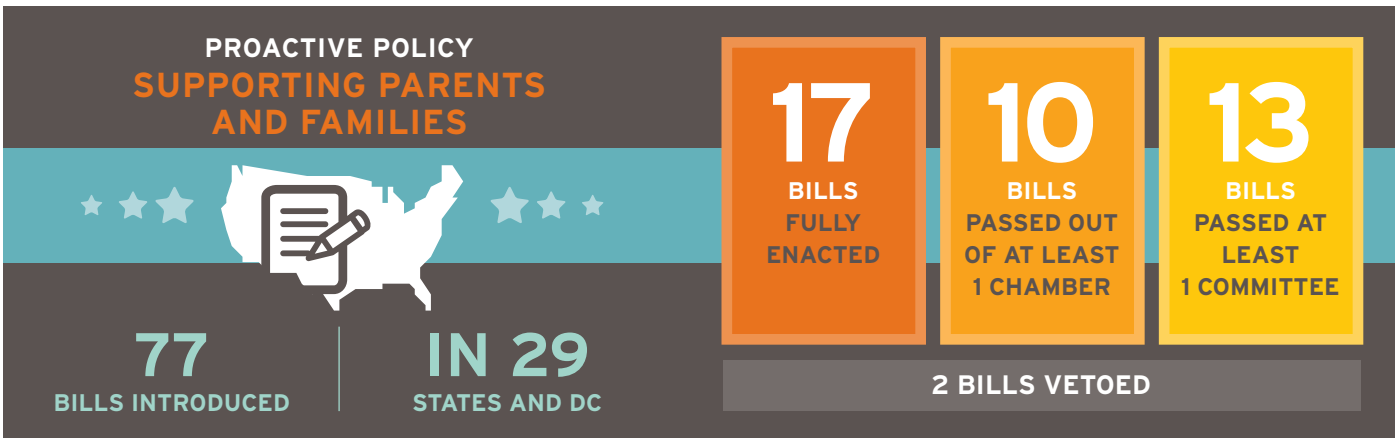
SECTION 5

SUPPORTING PARENTS AND FAMILIES

For more than two decades, the reproductive justice movement has pushed our nation to recognize the basic human rights we all share, including the right of all women, trans men, and other people who can become pregnant, to choose when and whether to become a parent, and the right of every person to parent their children with dignity and in safety.[25]

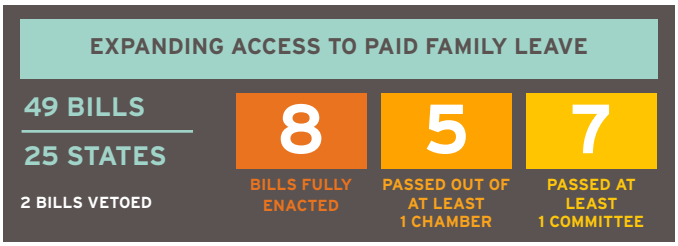
NIRH supports policies that enable parents to raise their children safely, in a healthy environment, and with dignity and support, and it opposes policies that coerce decision-making about parenting by withholding assistance or conditioning benefits based on a person's decision not to become a parent or to have additional children.

At almost all levels of government, the United States lacks policies to guarantee important rights and freedoms for all parents, including policies to ensure paid family and sick leave, support for mothers who want to breastfeed but also return to work, and pathways for young parents to continue school and enter the workforce as they choose without being



subject to stigmatization. Moreover, some federal and state policies penalize low-income parents and young children directly, such as through limits on Temporary Assistance for Needy Families, known as "TANF caps," which essentially cap the number of children low-income parents can have before they lose the ability to receive financial assistance to feed, clothe, and house those children.

Expanding Access to Paid Family Leave



The benefits of paid family leave are well documented and numerous, from ensuring that mothers have adequate time to heal after labor and delivery, to giving new parents of birth or adoptive children time to bond, to promoting gender equality in the home when all types of parents have time to learn and adjust to the tasks of child-rearing.[26] However, for many, time at home after the birth or adoption of a child simply is not possible because the family needs that parent's income to survive. With no federal paid family leave policy, advocates and lawmakers at the state level have considered a range of different options to support families in their state.

In 2018, five states considered legislation creating broad paid family leave benefits for everyone. **Massachusetts** became the sixth state to enact paid leave benefits for all working parents in legislation that has been characterized as the most generous paid leave program across the country.[27] Supported by Raise Up Massachusetts, a coalition of more than 100 labor, community, and faith-based groups, House Bill 4640 not only provides up to 12 weeks of paid leave for new parents, it also provides up to 20 weeks of paid sick leave for employees in the state. Moreover, the legislation was designed as an economic justice package and includes a statewide $15 minimum wage for most workers (it should be noted that compromises were made, particularly regarding the tipped minimum wage, and as a result, some organizations were not entirely supportive of the final package). Although the **Vermont** legislature also passed a similar expansive paid family leave program (House Bill 196), unfortunately, Governor Phil Scott vetoed the legislation. While the **Colorado** House (House Bill 1001) and the **New Hampshire** House (House Bill 628) once again passed bills that would have created paid family leave programs in their states, and **Connecticut** considered two similar bills (House Bill 5387, Senate Bill 1), none of them moved forward.

Delaware and Maryland also took major steps forward in 2018, joining the handful of states that provide paid family leave to public workers. **Delaware's** Governor John Carney signed House Bill 3, which will provide 12 weeks of paid family leave upon the birth or adoption of a child for all state employees, including employees of school districts, and **Maryland** enacted the very similar Senate Bill 859 / House Bill 775.

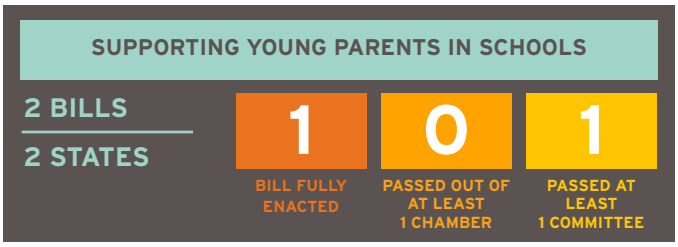
Three states took initial steps toward paid family leave by focusing on studying the need for such a policy in their states. **Hawaii** enacted Senate Bill 2990 / House Bill 2598, which creates a paid family leave implementation board that must study potential models for paid family leave and report back to the legislature by September 2019 with recommendations. It also creates a special fund that could ultimately administer the funding for paid leave. State Senator Jill Tokuda, the bill's sponsor, noted the need to balance residents' economic concerns with "individuals who are crying out for these benefits that were necessary to make sure that they could both earn a living for their families and care for their loved ones."[28] The bill, which has been gradually moving through the Hawaii legislature for a number of years, was supported by a broad coalition, including the ACLU of Hawaii and Planned Parenthood of the Great Northwest and the Hawaiian Islands, but it was opposed by a number of business organizations. In **Indiana**, the legislature adopted Senate Resolution 25, urging the creation of a study committee on paid leave; the **Maine** legislature passed a similar bill, House Bill 1091, which had originally been drafted as a full paid family leave program. The bill was amended through the legislative process and ultimately passed the legislature as a bill to study the creation of such a program, but even then, Governor Paul LePage vetoed the legislation.

Three states looked at small adjustments that could improve an existing leave program or help residents where one does not exist. **Hawaii** considered House Bill 2250, which would have allowed parents to use family leave in order to take their children to medical appointments. **New Jersey**, one of the handful of

states that already has a paid family leave program, considered Senate Bill 2528 / Assembly Bill 3975, which would have expanded the program to include foster children and children born as a result of a gestational carrier agreement and expanded who can be considered a "family member." The New Jersey Assembly passed Assembly Bill 2764, which would have required a state-run digital media "know your rights" public information campaign about employees' rights to family leave. **New York's** legislature also considered a bill to expand its existing paid leave program, Assembly Bill 10583, which would have made construction workers and others who are not covered under the existing law eligible for paid family leave.

Three states enacted laws that help strengthen employees' ability to store paid leave such as sick and comp time and use it for family-related leave. **Oklahoma** enacted Senate Bill 1581, allowing state employees to donate banked paid leave across agencies into "leave banks" that can be accessed by state employees wishing to take family leave. **Tennessee** enacted House Bill 2590, which extends to up to 12 weeks the number of days that state employees can take for maternity or paternity leave from their own banked sick and annual leave. **Washington** enacted a similar law, House Bill 1434 / Senate Bill 5295, adding disability due to pregnancy and parental leave to the reasons that state employees can access the existing banked leave program.

Supporting Young Parents in Schools

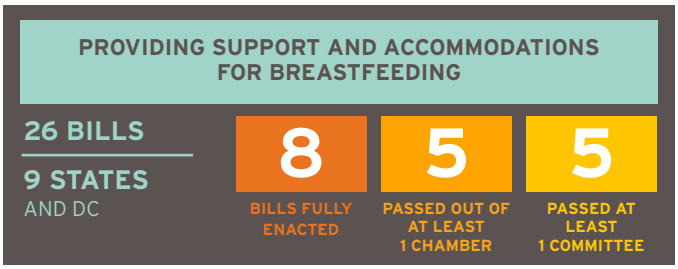


Young people who are parenting need support to continue their education, which is critical to their health, well-being, and future success, and to that of their children. In 2018, two states moved legislation intended to make education more accessible for young people who are parenting.

California enacted Assembly Bill 2289, which makes it easier for young pregnant and parenting people to continue their education in two major ways. First, the bill would add both pregnancy and termination of pregnancy to the list of temporary disabilities for which students are permitted to miss school, and it would then require schools to provide students with guidelines for making up the work missed due to those absences if they are unable to provide the student with individualized instruction. Second, the bill would add four absences per school year to care for a sick child to the list of excused absences for students and would prohibit schools from requiring a doctor's note for those absences. This bill was supported by a broad coalition that included medical organizations and reproductive justice organizations, such as ACCESS Women's Health Justice, Black Women for Wellness, the California Academy of Family Physicians, California Latinas for Reproductive Justice, the California School Nurses Organization, Essential Access Health, and Teen Success, Inc.

In **Washington**, House Bill 2670 passed one committee and would have provided childcare payment assistance for parents under 18 who were either attending high school or working towards their GEDs.

Providing Support and Accommodations for Breastfeeding



After giving birth, many mothers choose to breastfeed for a variety of reasons. Across the globe, health organizations like the American Academy of Pediatrics,[29] the American Congress of Obstetricians and Gynecologists,[30] and the World Health Organization[31] have linked breastfeeding with many positive health outcomes for both women and their babies. Those organizations and others recommend that women breastfeed exclusively for six months and up to a year or more, if possible.[32] However, many policies in the United States create barriers for women who want to breastfeed their babies, including limiting access to lactation consultants and/or by failing to

create spaces where women can breastfeed or pump while in public places, in school, or on the job. The lack of support for breastfeeding in insurance coverage policies, public accommodation laws, and education policies has contributed to the drop in women who are able to breastfeed as long as they would like to, and has also resulted in racial disparities among women who are able to start and continue breastfeeding their children.[33] In order to ensure that every woman who wants to breastfeed has the opportunity to do so and resources to continue as long as she would like to, states need to enact policies that support breastfeeding and make it possible to nurse and pump in public and private spaces. For more information about protections for nursing mothers against discrimination in the workplace, see page 31.

Idaho (House Bill 448) and **Utah** (House Bill 196) became the last two states to join the rest of the country in explicitly providing that women may breastfeed in any place of accommodation. These laws, which have often been inspired by public outcry over restaurants and other public places preventing women from breastfeeding or forcing women to nurse in the restroom, have passed in the other 48 states and the District of Columbia over the last two decades, but Idaho and Utah only reluctantly joined the list in 2018. Utah's bill also prohibits discrimination on the basis of pregnancy in any place of public accommodation.

Two states and the District of Columbia considered expansions to the lactation support offered nursing mothers. The **District of Columbia** passed Bill 203, which expands support for nursing mothers and broadly expands access to lactation support in parts of the city where there are existing barriers as part of a broad initiative to improve and expand health care for all infants and toddlers up until the age of 3. **New Jersey** considered Assembly Bill 1829 / Senate Bill 1633, which would provide a licensing structure and scope of practice for lactation consultants. The **New York** Assembly passed a narrower but related bill, Assembly Bill 8788, which would have removed the existing requirement that patients get a referral from a health care provider before they can make an appointment with a lactation consultant.

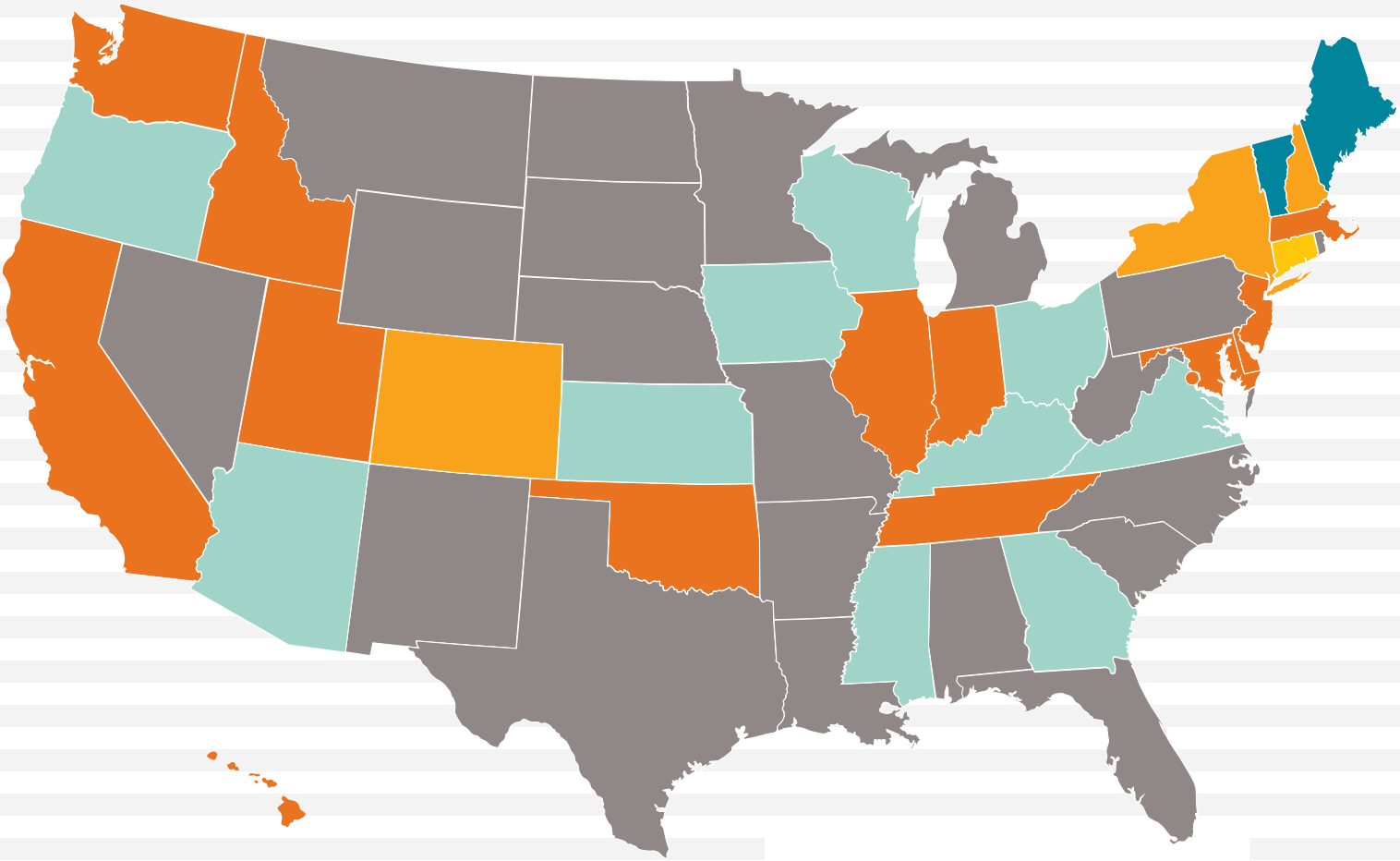
A number of state legislatures have also recognized that members of the public who are employed by or conduct business with the government also need accommodation for pumping and nursing in order to be able to fully participate in government or access their public benefits. In 2018, four states considered proposals to address this need. **Illinois** enacted House Bill 5745, joining 17 other states[34] that excuse nursing mothers from jury duty upon request. In addition, Illinois passed Senate Bill 3503, which requires all circuit courts to provide a lactation room for members of the public that is not a restroom and meets certain basic requirements. **Hawaii** considered two similar bills, House Resolution 132 and House Concurrent Resolution 149, which would have required a lactation room to be set up in the Hawaii State Capitol. The **New Jersey** State Senate and a committee in the Assembly passed Senate Bill 1735 / Assembly Bill 1663, which would have required a number of government offices to set up a lactation room along with a public education campaign about the rights of breastfeeding mothers. The bill further would have required the state Department of Education to study and report back to the governor and legislature about the lactation policies in state schools, colleges, and universities. The **New York** Assembly passed a similar bill, Assembly Bill 6775, which would require that most public buildings have a lactation room available to members of the public. The New Jersey Assembly (Assembly Bill 2504) and New York Assembly (Assembly Bill 7032 / Senate Bill 1817) passed bills that would have required similar accommodations in most area airports.

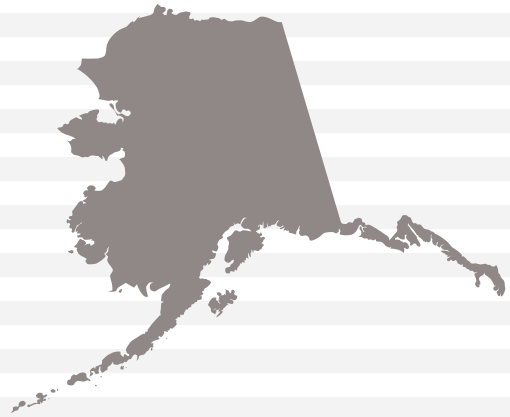
California already requires state community colleges to provide accommodations for lactating students, but it does not mandate all of the types of accommodations that are most important for students who need to pump. **California's** Assembly Bill 2785, which passed both the Assembly and the Senate and was signed into law by the governor, amends those requirements to serve students better, including by requiring that any newly built lactation rooms include sinks. California also enacted Assembly Concurrent Resolution 234 to create a Breastfeeding Awareness Month.

Finally, **New Jersey** also enacted Senate Bill 1870, aimed at improving infant health, including by addressing racial and ethnic disparities in breastfeeding initiation and developing new ways to support breastfeeding among racial and ethnic populations throughout the state.

SUPPORTING PARENTS AND FAMILIES

AS OF DECEMBER 15, 2018





COLOR CODE DENOTES THE FURTHEST AT LEAST ONE BILL MOVED IN A GIVEN STATE

- ENACTED LEGISLATION
- AT LEAST ONE CHAMBER PASSED LEGISLATION
- AT LEAST ONE COMMITTEE PASSED LEGISLATION
- INTRODUCED LEGISLATION
- VETOED LEGISLATION
- NO LEGISLATIVE ACTION

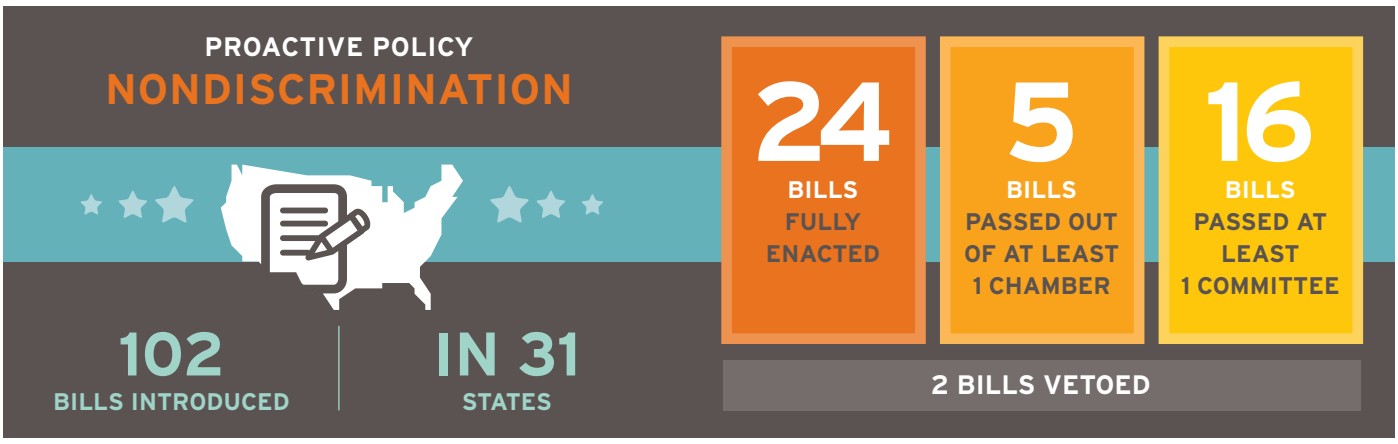
SECTION 6

PROHIBITING DISCRIMINATION BASED ON REPRODUCTIVE DECISIONS OR HEALTH

The ability to make reproductive decisions and access health care without coercion caused by discriminatory policies or practices is central to reproductive freedom.

No one should face discrimination by an employer, a school, or a government institution on the basis of their reproductive health needs or decisions, family status, pregnancy, or parenting. NIRH supports policies that move our society away from all institutionalized, accepted, and de facto forms of discrimination based on reproductive health choices. As part of this, all incarcerated women should have full access to reproductive health care, including contraception and counseling, abortion, menstrual supplies, STI testing and treatment, prenatal care, adequate nutrition and other basic care during pregnancy, labor and delivery services, and breastfeeding services. Furthermore, no incarcerated woman should be shackled during her pregnancy at any point, including during transportation to health care or court, labor and delivery, or postpartum recovery.

Unfortunately, some forms of discrimination on the basis of reproductive decisions or health are still pervasive, particularly for pregnant and parenting women, who continue to face disparate treatment in the terms and conditions of their employment and in their access to and use of public accommodations. Over the last few years, advocates and policymakers have had increased success in advancing proposals that would address some of these forms of discrimination. Furthermore, thanks in large part to the work of reproductive justice advocates, there is greater recognition that when pregnant women are incarcerated, their reproductive decisions, freedom, and health are at risk. Incarceration, by its very nature, involves a temporary loss of a number of freedoms, but the freedom to be healthy, to decide whether and when to bear a child, and to have a healthy pregnancy should not be among them.



Protecting Against Employment Discrimination

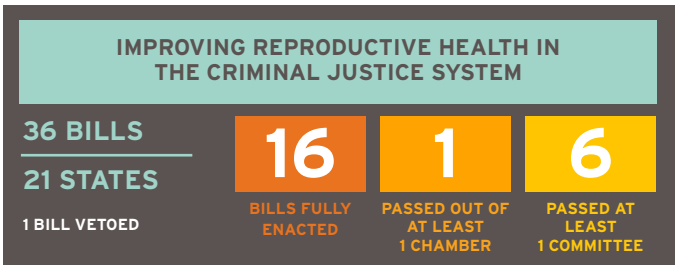
In order for everyone to exercise reproductive freedom and control their reproductive lives, they must live free from discrimination on the basis of their reproductive health needs and decisions about where they live and work.

Some employees face discrimination based on their decisions about whether and when to become a parent. In 2018, two states considered bills that would create protections from this kind of discrimination. **Hawaii** considered House Bill 2018, which would prohibit discrimination based on the reproductive decisions of an employee or their dependents; a similar bill, Assembly Bill 566 / Senate Bill 3791, passed the Assembly in **New York**.

Pregnant women and nursing mothers also often face high levels of discrimination at work. Three states considered adding job protections for nursing employees (for more information about broader accommodations outside of the workplace, see page 27). **Maryland** enacted House Bill 306, which requires all state employers to provide nursing employees with a reasonable amount of break time to pump or nurse, as well as a place to pump or nurse that is not a bathroom, but it does not require that the state compensate employees for that time. **South Carolina** enacted House Bill 3865, joining 22 other states and the District of Columbia in requiring employers to provide reasonable accommodations for workers experiencing pregnancy, childbirth, and all related medical conditions, including lactation. The new law requires employers to modify a number of their policies and provide nursing mothers with a place to nurse or pump. Passage of this law was supported by a number of organizations, including the Women's Rights and Empowerment Network. **Virginia** considered a similar bill, House Bill 1080, which would have required all employers to provide nursing employees with reasonable, unpaid break time in which to nurse or pump and a place in which to do so that is not a bathroom.

Two states enacted changes to their pregnant workers fairness acts in order to better meet the needs of nursing mothers. **California**, which also already has a pregnant workers fairness law that mandates certain accommodations for nursing mothers, considered several additional options to ensure that employees who are not necessarily in a single consistent physical space are still required to be given the accommodations. The state enacted Assembly Bill 1976, which provides guidelines for "temporary" accommodations when employers are unable to create permanent lactation rooms and also specifies how agricultural employers are required to accommodate nursing or pumping employees. The state legislature also passed a similar bill, Senate Bill 937, which would change the existing law so that employers would be required to provide these accommodations rather than simply to make "reasonable efforts to do so," but also allowing employers to apply for specific hardship exemptions. However, the governor vetoed the bill after he signed Assembly Bill 1976 into law, saying that it was duplicative and not necessary. **Illinois**, which already has a pregnant workers' accommodation law, enacted House Bill 1595, which improves the existing law by requiring that nursing mothers be able to take paid breaks to pump or nurse each time it is necessary during the day, rather than being entitled only to unpaid breaks once a day.

Improving Reproductive Health in the Criminal Justice System



As the number of incarcerated women has grown, state advocates have documented the unconscionable treatment these women are subjected to while incarcerated, especially during their pregnancies. In response to the many reports and investigations demonstrating the clear human rights violations

occurring in jails, detention centers, and prisons all over the country, lawmakers in many states have enacted laws that begin to address the health and well-being of pregnant women who are incarcerated. The original set of these laws generally prohibited only the shackling of incarcerated pregnant women during labor and delivery, and 23 states now have such laws on the books.[35] In recent years, advocates have pushed state legislators to propose new, more expansive legislation aimed at fully meeting incarcerated women's needs, especially access to the full range of reproductive health care, including abortion and prenatal care; health care supplies such as menstrual hygiene products; proper nutrition; support during labor and delivery; and breastfeeding and parenting support after birth.

In 2018, three states addressed the use of shackles during pregnancy. **Rhode Island** enacted House Bill 7182 and Senate Bill 2268 to prohibit the use of handcuffs, shackles, or other restraints on incarcerated women during transportation in the third trimester of pregnancy, and **New Jersey** considered Assembly Bill 2186 / Senate Bill 2732 to limit the use of shackling during labor and recovery. **Massachusetts**, one of the first states to outlaw the shackling of pregnant women during labor and delivery beginning in 2014, moved forward House Bill 2494, which would have provided training to staff who transport or supervise pregnant and postpartum incarcerated women and created mechanisms for oversight.

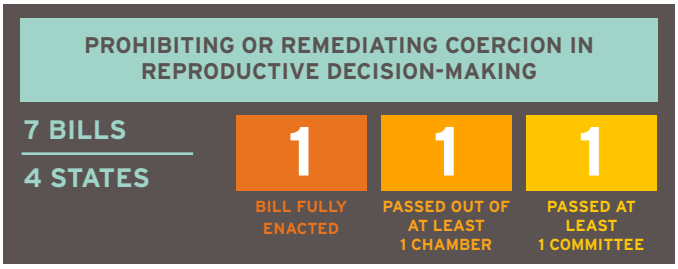
Six states considered a more comprehensive approach, moving beyond shackling to ensure that pregnant women who are incarcerated have access to the health care and nutrition they need to stay healthy. **Connecticut**, **Kentucky**, and **Oklahoma** passed comprehensive bills (Senate Bill 13, Senate Bill 133, and House Bill 3393, respectively) aimed at improving the lives and health of incarcerated women. These bills not only ban the use of restraints during childbirth, but also ban shackling of pregnant women during transportation to and from a medical facility and during the postpartum period, require prisons to provide adequate nutritional meals and access to health care for pregnant incarcerated women, and allow pregnant women who are struggling with addiction to be released upon their own recognizance to seek treatment.

Maryland enacted House Bill 787 / Senate Bill 629, requiring correctional facilities to establish a written policy outlining the right of incarcerated women to, and procedures for, access to reproductive health care, including pregnancy testing, prenatal care, abortion care, resources for adoption, labor and delivery, postpartum care and recovery, hygiene products, and breastfeeding accommodations. The bill was championed by Reproductive Justice Inside, a statewide coalition advocating for increased access to quality sexual and reproductive health care in Maryland's correctional and detention facilities, and was sponsored by Delegate Kathleen Dumais, who affirmed that pregnant women who are incarcerated "are not any less deserving of proper medical care to ensure their own health and the health of their child."[36] **New Jersey** considered another type of comprehensive legislation, Assembly Bill 3979 / Senate Bill 2540, that would have established policies to support incarcerated parents by promoting visitation, providing parenting classes, and creating an overnight visit pilot program; prohibited shackling of pregnant women; provided products to manage menstruation, including sanitary pads and ibuprofen; and appointed an ombudsman to monitor the health and safety of incarcerated women. **New York's** Assembly Bill 8764, which passed one committee, would similarly have improved conditions for incarcerated pregnant women, including by requiring facilities to provide prenatal care and nutrition that meets the medical standard in the community and allowing support people to accompany incarcerated individuals while in labor.

Ten states also worked on standalone legislation that would address specific issues impacting incarcerated women. **California** enacted Assembly Bill 2507, which requires county jails to develop and implement a policy supporting breastfeeding mothers and outlining guidelines for breast milk expression, storage, retrieval, and delivery. **Illinois** enacted House Bill 1464, which provides alternatives to custody for individuals who are pregnant or recently gave birth before their trials. Ilinois also considered House Bill 5104, which would have removed all copays for any medical or dental treatment for incarcerated people, but the governor partially vetoed the legislation and sent it back to the legislature, where it died in the senate. **Louisiana** enacted a law requiring correctional facilities to provide free health care products such as soap, toothbrushes, and toothpaste (Senate Bill 558), and **Alabama** considered similar legislation (House Bill 363). **Delaware**, **Maryland**, **New York**, and **Virginia** enacted Senate Bill 166, House Bill 797 / Senate Bill 598, Senate Bill 8821 / Assembly Bill 588, and House Bill 83, respectively, providing free menstrual supplies to incarcerated women. The **Arizona** House moved forward similar legislation, (House Bill 2222). Notably, days after activists sent pads and

tampons to state legislators, and Arizona House Bill 2222 passed its first committee, the Arizona Department of Corrections agreed to increase the number of menstrual products available to incarcerated women. Representative Athena Salman, the bill's sponsor, called the move a "[h]uge victory for women,"[37] and resolved to pass the bill next year and "see this new policy codified in a way that can't be undone by a new director or governor."[38] **Washington** enacted House Bill 2016, which will increase access to midwifery and doula services to incarcerated women.

Prohibiting or Remediating Coercion in Reproductive Decision-Making

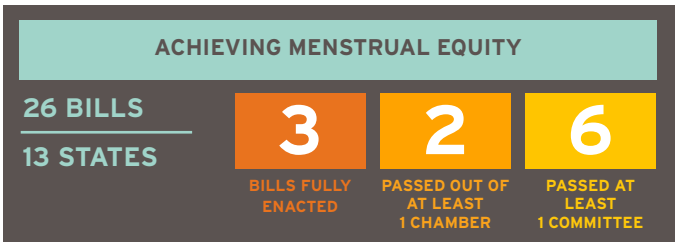


In the United States and in many places around the world, governments have had a long and ugly history of reproductive violence and coercion, including forced sterilizations, abortions, pregnancies, and births. Forced sterilization has occurred for a variety of discriminatory reasons based on racism, sexism, ableism, and other types of harmful social engineering goals pursued at various times by different leaders of nations and states.[39] In this century, the United States and other countries have begun a slow reckoning with that history, often led by reproductive justice advocates, and states have begun to examine policies to address reproductive coercion and abuse by state actors.

Women in the criminal justice system, in particular, often lack power and agency to make decisions about their bodies and lives while incarcerated, and may have historically experienced reproductive coercion and abuse, including the threat of incarceration to force them to make reproductive decisions they would not otherwise make. For example, in 2017 in Tennessee, a judge was found to have offered individuals who were or were about to be incarcerated the opportunity to take a 30-day reduced sentence if they agreed to be sterilized or to obtain a form of long-term contraception.[40] Pushed by reproductive justice advocates in the state, lawmakers in **Tennessee** enacted Senate Bill 2133 / House Bill 2520 in 2018, prohibiting this type of coercive practice by preventing sentencing courts from considering, as part of an individual's sentence, an individual's consent or refusal to consent to any form of birth control, sterilization, or family planning services – regardless of whether consent could be considered voluntary. This pioneering legislation ensures that each person can control their reproductive and sexual life, even when facing potential incarceration, and creates a model that other states should consider to help confront and move away from this country's history of coerced sterilization and forced contraception.

California has a particularly fraught history of forced sterilization upon people in state institutions, specifically targeting Latinas, which has endured until well into present day.[41] During the 20th century, California had several institutionalized programs to force certain individuals to be sterilized, including patients living in state homes or hospitals and other people with disabilities. Although the state repealed the law permitting such sterilizations in 1979 and recognized and apologized for those practices in 2003, a state audit report found that California continued to forcibly sterilize other people within its control, including women in prison, as recently as 2013.[42] In 2018, **California** Senate Bill 1190, which passed the Senate and is being considered by the Assembly, proposes the Eugenics Sterilization Compensation Program, which would compensate a limited number of individuals subjected to state-imposed sterilization between 1909 and 1979. The bill is being supported by a wide array of groups, including California Latinas for Reproductive Justice, Disability Rights Education & Defense Fund (DREDF), and other reproductive health, rights, and justice organizations, medical groups, and disability and immigrant rights organizations. While this bill cannot fix the legacy and continued practice of sterilization, it is a modest offer of restitution and would, as DREDF staff attorney Carly Myers said, "[p]rovide a material acknowledgement to the survivors of these harms."[43]

Achieving Menstrual Equity



In order to have a fully equitable and participatory society, menstrual hygiene products must be safe, accessible, and available to all who need them. Despite the fact that nearly half of the world's population menstruates, women, girls, transgender men, and other people who menstruate still face financial and logistical challenges when it comes to managing their periods. An average woman menstruates for roughly four decades of her life – meaning that each month for 40 years, she must purchase menstrual supplies. The tax burden alone on any one package of pads or tampons can be overwhelming for women and girls living in poverty, who are often forced to choose between purchasing menstrual supplies or their next meal. Having access to menstrual products is vital to participating in public life, school, and work, and women who are unable to afford sanitary pads or tampons risk isolation and infection.

Many states tax menstrual supplies as "luxury items" instead of treating them as necessities like food and medicine (notably, many states tax diapers in the same way). Over the past few years, a number of states have enacted laws to end the so-called "Tampon Tax" by removing the tax on menstrual supplies. Recently, some states have expanded on these laws to provide free menstrual products in schools, homeless shelters, and jails (read more under "Reproductive Health in the Criminal Justice System" on page 36), and to ensure that menstrual products are safe and free of harmful chemicals.

In 2018, Nevada's voters approved a ballot measure to repeal the state's 6.85% tax on menstrual supplies and to treat menstrual products as medically necessary items, keeping them tax free; with this approval, Nevada joins nine other states with similar policies. Two other states considered bills to remove the so-called "Tampon Tax" and expand access to menstrual hygiene products. **Maryland**, a state that categorizes sanitary pads and tampons as medical supplies and thus already exempts them from sales tax, enacted Senate Bill 81 to also exempt menstrual sponges, menstrual cups, and other similar products. **Arizona** considered House Bill 2217, which would remove the tax on menstrual supplies and diapers.

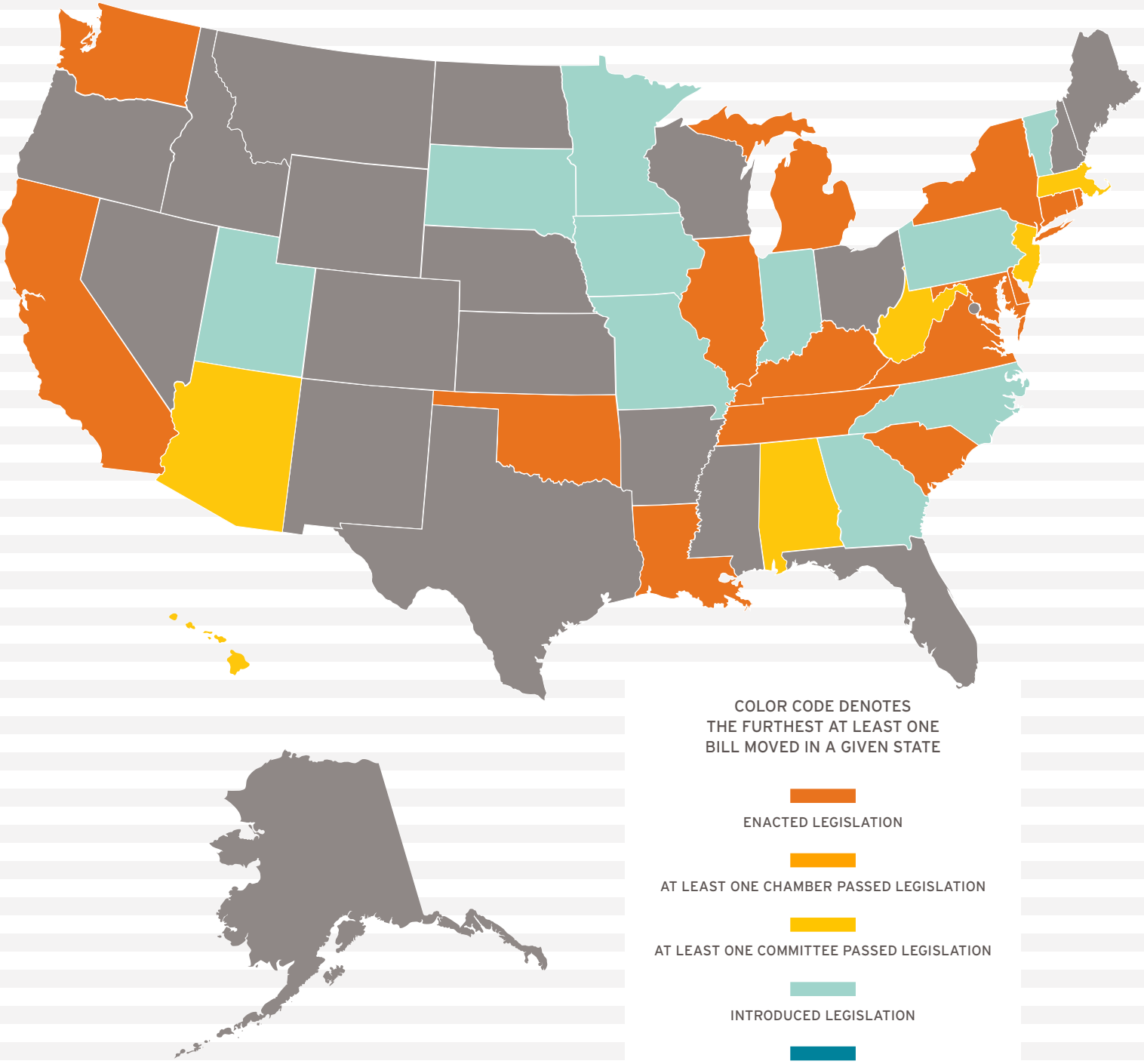
In addition, three states moved bills to provide free menstrual products in schools. **New York's** legislature considered three bills and enacted Assembly Bill 9506, which mandates free menstrual products in public schools, while Assembly Bill 10601, which would have included charter schools on that list, passed one committee. **Washington** House Bill 2863 passed a committee and would have provided free menstrual supplies to students in community and technical colleges. **West Virginia** moved forward Senate Concurrent Resolution 50, which would have created a study analyzing the feasibility and cost of providing free menstrual supplies in schools.

Michigan enacted House Resolution 354, commemorating Menstrual Hygiene Day and recognizing the importance of increasing access to menstrual supplies and health information and removing societal stigma about talking about menstruation. **New York's** Senate passed Senate Bill 8543 / Assembly Bill 10763, which would have educated students about menstrual disorders and symptoms, and **Rhode Island's** House passed House Bill 7570 to provide students with over-the-counter products to treat menstrual cramps or vaginal yeast infections.

In 2013, a report by Women's Voices for the Earth examined the potential health hazards associated with menstrual products such as tampons and sanitary pads, which are used by 70 percent to 85 percent of women, based on the chemicals used in those products.[44] An increasing number of states are now moving legislation that would provide transparency around the types of ingredients in these products. **New York's** Assembly Bill 521 passed a committee and would have required manufacturers to print the list of ingredients on menstrual product packaging, enabling consumers to choose products that are clean, safe, and free of pesticides, dioxins, and other toxins, and that are better for the environment.

PROHIBITING DISCRIMINATION BASED ON REPRODUCTIVE DECISIONS OR HEALTH

AS OF DECEMBER 15, 2018



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- ENACTED LEGISLATION
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- INTRODUCED LEGISLATION
- VETOED LEGISLATION
- NO LEGISLATIVE ACTION

REPRODUCTIVE HEALTH IN THE CRIMINAL JUSTICE SYSTEM

"WE ORGANIZE BECAUSE EACH PERSON INSIDE THE JAILS AND PRISONS...HAS A FAMILY, HAS THE RIGHT TO FAMILY CREATION, TO DEFINE FOR THEMSELVES WHAT THAT MEANS TO THEM. WE ORGANIZE BECAUSE THOSE OF US WHO HAVE BEEN INCARCERATED VERY RARELY GET JUSTICE."

Marianne Bullock, *Prison Birth Project Co-Founder*[45]

Thanks to the tireless work of reproductive justice advocates, the importance of reproductive health within the criminal justice system and the dangers of state-sanctioned reproductive coercion have become increasingly visible. Incarceration, by its very nature, involves a temporary loss of a number of freedoms, but the freedom to be healthy, to decide whether and when to bear a child, and to have a healthy pregnancy should not be among them. State policies are beginning to reflect that truth by putting in place protections for pregnant incarcerated women, requiring access to adequate reproductive health services, and guarding against coercive acts by individual actors within the criminal justice system.

State advocates, particularly reproductive justice organizations, began to document the unconscionable treatment of pregnant women in the criminal justice system, partly in response to the rise of the number of incarcerated women over the past two decades. Advocates in many states have produced reports demonstrating the clear human rights violations occurring in jails, detention centers, and prisons all across the country, in turn prompting action by lawmakers to begin to address these issues. The original wave of laws generally prohibited only the shackling of incarcerated pregnant women during labor and delivery, and 23 states now have such laws on the books.[46] In recent years, advocates have pushed state legislators to propose new, more expansive legislation aimed at fully meeting incarcerated women's needs.

Changes have taken place in states across the political spectrum, not just in states considered more favorable to reproductive freedom. In fact, in 2018, traditionally conservative states such as Kentucky, Oklahoma, and Tennessee were at the forefront of the fight for true reproductive freedom and dignity for incarcerated women. While the legislatures in those states are typically opposed to expanding rights and access to health, incredible organizing by grassroots advocates has forced lawmakers to look inclusively at the full spectrum of reproductive health needs that incarcerated women have, to face our nation's ugly history of state coercion, and to begin to put in place protections to prevent further reproductive abuse.

Specifically, **Connecticut**, **Kentucky**, and **Oklahoma** passed comprehensive bills (Senate Bill 13, Senate Bill 133, and House Bill 3393, respectively) aimed at improving the lives and health of incarcerated women. These bills not only ban the use of restraints during childbirth, but also ban shackling of pregnant women during transportation to and from a medical facility and during the postpartum period; require prisons to provide adequate nutritional meals and access to health care for pregnant incarcerated women; and allow pregnant women who are struggling with addiction to be released upon their own recognizance to seek treatment. This kind of holistic approach to the needs of pregnant women who are incarcerated should be the next frontier of work around these issues. Tiheba Williams-Bain, founder of Women Against

Mass Incarceration and a member of the ACLU of Connecticut Smart Justice campaign, said, "[W]hen you are incarcerated, you are constantly told that you're not human. This law takes valuable steps toward rejecting that false message to instead affirm the humanity and dignity of incarcerated people."[47] Women within the criminal justice system need more than to simply be free from restraints during active labor and delivery — states must ensure that women's comprehensive reproductive health needs are being met before, during, and after pregnancy in order to fully support and honor the rights of incarcerated women.

States have also been urged to examine policies addressing the long history of reproductive coercion and abuse by state actors, particularly on women of color and low-income women. It is important to note the historical experiences of these communities of women, who were often deemed as being unworthy or incapable of motherhood and thereby coerced into giving up their right or ability to become pregnant. Women in the criminal justice system in particular often lack power and agency to make decisions about their bodies and lives while incarcerated, and our nation has a long history of engaging in reproductive coercion and abuse towards them — including by threatening incarceration to force them to make reproductive decisions they would not otherwise make. For example, in 2017 in Tennessee, a judge was found to have offered people who were or were about to be incarcerated the opportunity to take a 30-day reduced sentence if they agreed to be sterilized or to obtain a form of long-term contraception.[48] Pushed by advocates in the state, including SisterReach, a black woman-led reproductive justice organization, lawmakers in **Tennessee** enacted Senate Bill 2133, which prevents sentencing courts from considering, as part of an individual's sentence, an individual's consent or refusal to consent to any form of birth control, sterilization, or family planning services regardless of whether consent could be considered voluntary. Cherisse Scott, CEO and founder of SisterReach, supported the end of this practice yet warned of the impact this and similar practices still have on women across the state.[49] This pioneering legislation ensures that each person can control their reproductive and sexual life, even when facing potential incarceration, and creates a model that other states should consider to help confront and move away from this country's history of coerced sterilization and forced contraception.

CONCLUSION

This past year was turbulent in politics and policy. Elected officials at the federal level and in many states acted to harm women and restrict reproductive freedom, while the replacement of Supreme Court Justice Anthony Kennedy with Justice Brett Kavanaugh increases the likelihood that our nation may soon have a high court that is unwilling to continue to recognize the constitutional right to end a pregnancy. In the face of, and sometimes inspired by, these challenges, state advocates and lawmakers pushed forward, centering the needs of the people in their states and championing important policies that will protect and advance reproductive freedom. And by the end of 2018, it became clear that the voters in many parts of the United States support them.

Policy shifts in 2018 have demonstrated again the mantra "elections matter," as we saw long-awaited victories in states like New Jersey, Virginia, and Washington after shifts in political power. This fall, in states all across the nation, voters pushed back against the retrograde and punishing policies of the existing political power structure, voting into office progressive state legislators, governors, and congressmembers who campaigned on their commitment to support women and families and to fight at the state and local level for reproductive freedom.

There are opportunities at every level of government to help secure reproductive freedom for all. NIRH is extremely grateful to the reproductive health, rights, and justice movements in the states, including our many partners, who work tirelessly to push for change — often against seemingly insurmountable odds. We applaud the extraordinary efforts and exciting successes of advocates and policymakers who have led these efforts, and we look forward to supporting similar initiatives in 2019. Together, we can continue the forward progress toward making our country a place where everyone has the freedom and ability to control their reproductive and sexual lives.

APPENDIX: BILL INDEX BY STATE

ST	BILL	TITLE AS FILED	SECTION	PAGE(S)
AK	AK H 25	Insurance Coverage for Contraceptives	Improving Access to Contraception	13
AL	AL H 363	Department of Corrections	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
AZ	AZ H 2217	Transaction Privilege Tax	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
AZ	AZ H 2222	Feminine Hygiene Products and Requirements	Prohibiting Discrimination Based on Reproductive Decisions or Health	33
CA	CA A 1893	Maternal Mental Health: Federal Funding	Increasing Access to Pregnancy Care	19
CA	CA A 1976	Employment: Lactation Accommodation	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
CA	CA A 2193	Maternal Mental Health	Increasing Access to Pregnancy Care	19
CA	CA A 2289	Pupil Rights: Pregnant and Supporting Parents and Families Pupils	Supporting Parents and Families	5, 27
CA	CA A 2507	County Jails: Infant and Toddler Breast Feeding	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
CA	CA A 2579	Special Supplemental Nutrition Program	Increasing Access to Pregnancy Care	20
CA	CA A 2601	Pupil Instruction: Sexual Health Education	Promoting Comprehensive Sexuality Education for All Young People	23
CA	CA A 2682	Nurse-Midwives	Increasing Access to Pregnancy Care	20
CA	CA A 2785	Student Services Lactation Accommodation	Supporting Parents and Families	28
CA	CA ACR 180	Maternal Mental Health Awareness Month	Increasing Access to Pregnancy Care	19
CA	CA ACR 234	Breastfeeding Awareness Month of 2018	Supporting Parents and Families	28
CA	CA AJR 42	Title X: Family Planning	Expanding Access to Abortion Care	9
CA	CA HR 71	Planned Parenthood	Expanding Access to Abortion Care	9
CA	CA HR 95	International Day for Maternal Health and Rights	Increasing Access to Pregnancy Care	19
CA	CA S 320	Public Health: Expanding Access to Abortion Care by Medication Techniques	Expanding Access to Abortion Care	7
CA	CA S 910	Short-term Limited Duration Health Insurance	Improving Access to Contraception	13
CA	CA S 937	Lactation Accommodation	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
CA	CA S 1023	Reproductive Health Care Coverage	Improving Access to Contraception	12
CA	CA S 1190	Eugenics Sterilization Compensation Program	Prohibiting Discrimination Based on Reproductive Decisions or Health	33
CA	CA SR 72	The 45th Anniversary of the Roe v. Wade Decision	Expanding Access to Abortion Care	9
CO	CO H 1001	Family Medical Leave Insurance Program	Supporting Parents and Families	26
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CT	CT S 1	Earned Family and Medical Leave	Supporting Parents and Families	26
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DC	DC B 203	Infant and Toddler Developmental Health Services	Supporting Parents and Families	28
DC	DC B 524	Maternal Mortality Review Committee Establishment	Increasing Access to Pregnancy Care	19
DC	DC B 680	Defending Access to Women's Health Care Services	Improving Access to Contraception	13
DE	DE H 3	Full Time Employees	Supporting Parents and Families	26
DE	DE S 151	Insurance Contraceptive Coverage	Improving Access to Contraception	13
DE	DE S 166	Free Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	32

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FL	FL S 138	Perinatal Mental Health	Increasing Access to Pregnancy Care	19
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HI	HI H 2184	Licensure of Midwives	Increasing Access to Pregnancy Care	20
HI	HI H 2250	Family Leave	Supporting Parents and Families	26
HI	HI H 2598	Paid Family Leave	Supporting Parents and Families	26
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HI	HI HR 132	Breastfeeding Private Room	Supporting Parents and Families	28
HI	HI S 2502	Mobile Clinic	Improving Access to Contraception	12
HI	HI S 2661	Sustainable Development Goals	Expanding Access to Abortion Care	9
HI	HI S 2662	Sustainable Development Goals	Expanding Access to Abortion Care	9
HI	HI S 2664	Sustainable Development Goals	Expanding Access to Abortion Care	9
HI	HI S 2990	Paid Family Leave	Supporting Parents and Families	26
ID	ID H 448	Exemptions from Indecent Exposure	Supporting Parents and Families	28
IL	IL H 274	Pharmacy Practice	Improving Access to Contraception	14
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IL	IL H 1595	Nursing Mothers	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
IL	IL H 2617	Health Insurance Fertility Preservation Services	Increasing Access to Pregnancy Care	20
IL	IL H 5104	Prisoner Medical Or Dental Services Co Pay	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
IL	IL H 5745	Jury Commission Act	Supporting Parents and Families	28
IL	IL S 2881	Personal Care Sales Tax	Improving Access to Contraception	12
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IL	IL SJR 67	Home Birth Maternity Care Crisis Study Committee	Increasing Access to Pregnancy Care	19
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LA	LA S 558	Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
MA	MA H 1214	Pharmacist Performance of Certain Medical Procedures	Improving Access to Contraception	14
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MA	MA H 3704	Healthy Youth	Promoting Comprehensive Sexuality Education for All Young People	23
MA	MA H 4640	Minimum Wage and Medical Leave	Supporting Parents and Families	26
MA	MA S 1240	Pharmacist Medical Procedures	Improving Access to Contraception	14
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MD	MD H 249	Fertility Awareness-based Methods Instruction Coverage	Improving Access to Contraception	12
MD	MD H 306	Nursing Mothers	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
MD	MD H 775	Parental Leave	Supporting Parents and Families	26
MD	MD H 780	Contraceptive Coverage	Improving Access to Contraception	12
MD	MD H 787	Pregnant Inmates	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
MD	MD H 797	Menstrual Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
MD	MD H 908	Fertility Preservation Procedures	Increasing Access to Pregnancy Care	20
MD	MD H 994	Medical Assistance Program	Improving Access to Contraception	13

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MD	MD H 1038	Health Benefit Plans	Increasing Access to Pregnancy Care	20
MD	MD H 1283	Prescription Contraceptives Coverage	Improving Access to Contraception	13
MD	MD H 1518	Maternal Mortality Review Committee	Increasing Access to Pregnancy Care	19
MD	MD H 1558	Prescription Drugs	Improving Access to Contraception	14
MD	MD H 1685	Infant Care Coordination Services	Increasing Access to Pregnancy Care	19
MD	MD S 33	Fertility Awareness Instruction Coverage	Improving Access to Contraception	12
MD	MD S 81	Sales Tax Exemption for Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
MD	MD S 271	Fertility Preservation Procedures	Increasing Access to Pregnancy Care	20
MD	MD S 598	Menstrual Hygiene Product	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
MD	MD S 629	Pregnant Inmates	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
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MD	MD S 859	Parental Leave for State Employees	Supporting Parents and Families	26
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MO	MO H 1499	Transfer of Long Acting Reversible Contraceptive	Improving Access to Contraception	12
MO	MO S 826	Disposal of Unused Controlled Substances	Improving Access to Contraception	12
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NH	NH H 628	Family and Medical Leave Insurance Program	Supporting Parents and Families	26
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NJ	NJ A 1656	Family Planning Services Medicaid Coverage	Improving Access to Contraception	13
NJ	NJ A 1662	Doula Care Medicaid Coverage	Increasing Access to Pregnancy Care	20
NJ	NJ A 1663	On-Site Lactation Room Requirements	Supporting Parents and Families	28
NJ	NJ A 1829	Lactation Consultants Licensing Act	Supporting Parents and Families	28
NJ	NJ A 1861	Address Confidentiality Program for Certain Employees	Expanding Access to Abortion Care	8
NJ	NJ A 1862	Maternal Mortality Review Commission	Increasing Access to Pregnancy Care	19
NJ	NJ A 2186	Prisoners Childbirth Restraint	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
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NJ	NJ A 2504	Airport Lactation Rooms	Supporting Parents and Families	28
NJ	NJ A 2764	Temporary Disability Family Leave Insurance Webinar	Supporting Parents and Families	27
NJ	NJ A 3975	Family and Disability Leave	Supporting Parents and Families	27
NJ	NJ A 3979	Dignity for Incarcerated Primary Caretaker Parents	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
NJ	NJ AR 113	Maternal Health Accountability Act	Increasing Access to Pregnancy Care	19
NJ	NJ AR 181	Presidential and Congressional Resolution	Expanding Access to Abortion Care	9
NJ	NJ S 105	Medicaid Coverage for Family Planning Services	Improving Access to Contraception	13
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NJ	NJ S 1663	On-Site Lactation Room Requirements	Supporting Parents and Families	28
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NJ	NJ S 1761	Address Confidentiality Program	Expanding Access to Abortion Care	5, 8
NJ	NJ S 1784	Medicaid Coverage for Doula Care	Increasing Access to Pregnancy Care	20
NJ	NJ S 1786	Report Card of Hospital Maternity Care	Increasing Access to Pregnancy Care	19
NJ	NJ S 1870	Infant Mortality Study	Supporting Parents and Families	28
NJ	NJ S 2528	Family and Disability Leave	Supporting Parents and Families	27
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NJ	NJ S 2732	Prisoners Childbirth Restraint Prohibition	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
NJ	NJ SR 18	Maternal Health Accountability	Increasing Access to Pregnancy Care	19
NJ	NJ SR 96	Presidential and Congressional Resolution	Expanding Access to Abortion Care	9
NY	NY A 521	Tampon Package Labeling	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY A 566	Discrimination Based on Reproductive Health Decision	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
NY	NY A 588	Feminine Hygiene Products in Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
NY	NY A 1748	Reproductive Health Act	Expanding Access to Abortion Care	5, 7-8, 16-17
NY	NY A 2674	Dispensing Emergency Improving Access to Contraception	Improving Access to Contraception	12
NY	NY A 5359	Insurance Policies and HMO Contracts	Increasing Access to Pregnancy Care	20
NY	NY A 6058	Public University Emergency Improving Access to Contraception Act	Improving Access to Contraception	12
NY	NY A 6775	Establishment of Lactation Rooms in Public Buildings	Supporting Parents and Families	28
NY	NY A 7032	Lactation Accommodations in Airports	Supporting Parents and Families	28
NY	NY A 8764	Women's Health in Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
NY	NY A 8788	Lactation Counseling Services	Supporting Parents and Families	28
NY	NY A 8953	Maternal Depression Treatment	Increasing Access to Pregnancy Care	19
NY	NY A 9506	State Education Budget	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY A 9957	Comprehensive Improving Access to Contraception Coverage Act	Improving Access to Contraception	13
NY	NY A 10346	Maternal Mortality Review Board	Increasing Access to Pregnancy Care	19
NY	NY A 10583	Paid Family Leave Benefits for Certain Employees	Supporting Parents and Families	27
NY	NY A 10601	Feminine Hygiene Products Offered in Charter Schools	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY A 10763	Informational Materials Concerning Menstrual Disorders	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY S 1817	Provision of Lactation Accommodations in Airports	Supporting Parents and Families	28
NY	NY S 3791	Discrimination Based on Reproductive Health Decisions	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
NY	NY S 3793	Dispensing of Emergency Contraception	Improving Access to Contraception	12
NY	NY S 7367	Public University Emergency Contraception Act	Improving Access to Contraception	12
NY	NY S 7409	Maternal Depression Treatment	Increasing Access to Pregnancy Care	19
NY	NY S 8543	Informational Materials Concerning Menstrual Disorders	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
NY	NY S 8821	Feminine Hygiene Products in Correctional Facilities	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
NY	NY S 8907	State and NYC Maternal Mortality Review Boards	Increasing Access to Pregnancy Care	19
OK	OK H 3393	Prisons and Reformatories	Prohibiting Discrimination Based on Reproductive Decisions or Health	32, 36
OK	OK S 1581	State Employees Benefits	Supporting Parents and Families	27
OR	OR H 4133	Establishes Maternal Mortality and Morbidity Review	Increasing Access to Pregnancy Care	19

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RI	RI H 7182	Incarcerated Women Healthy Pregnancies	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
RI	RI H 7193	Medical and Surgical Consent	Increasing Access to Pregnancy Care	19
RI	RI H 7570	Student Menstrual Cramp Permissible Treatment	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
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RI	RI S 2268	Pregnant Prisoners	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
RI	RI S 2529	Accident and Sickness Insurance Policies	Improving Access to Contraception	13
RI	RI S 2531	Medical and Surgical Care Consent	Increasing Access to Pregnancy Care	19
SC	SC H 3064	Hormonal Contraceptives	Improving Access to Contraception	14
SC	SC H 3865	Increasing Access to Pregnancy Care Accommodations Act	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
TN	TN H 1320	Long Acting Birth Control Information Act	Improving Access to Contraception	12
TN	TN H 2520	Sentencing Court	Prohibiting Discrimination Based on Reproductive Decisions or Health	33
TN	TN H 2590	State Employees	Supporting Parents and Families	27
TN	TN S 883	Long Acting Birth Control Information Act	Improving Access to Contraception	12
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UT	UT H 12	Family Planning Services Amendments	Improving Access to Contraception	12
UT	UT H 196	Breastfeeding Protection Act	Supporting Parents and Families	28
UT	UT S 181	Infertility Insurance Coverage	Increasing Access to Pregnancy Care	20
UT	UT S 184	Self-Administered Hormonal Contraceptives	Improving Access to Contraception	14
UT	UT SCR 11	Awareness and Treatment of Maternal Depression/Anxiety	Increasing Access to Pregnancy Care	19
VA	VA H 83	Feminine Hygiene Products for Inmates	Prohibiting Discrimination Based on Reproductive Decisions or Health	32
VA	VA H 1080	Employee Breast Milk Feeding Break	Prohibiting Discrimination Based on Reproductive Decisions or Health	31
VT	VT H 196	Paid Family Leave	Supporting Parents and Families	26
VT	VT H 404	Medicaid Reimbursement for Long Acting Contraceptives	Improving Access to Contraception	12
WA	WA H 1434	Shared Leave for Employees	Supporting Parents and Families	27
WA	WA H 1523	Preventive Services	Improving Access to Contraception	13
WA	WA H 2016	Midwifery and Doula Services for Incarcerated Women	Prohibiting Discrimination Based on Reproductive Decisions or Health	33
WA	WA H 2570	Collaborative Drug Therapy Agreements	Improving Access to Contraception	14
WA	WA H 2670	Services and Supports to Pregnant and Supporting Parents and Families Minors	Supporting Parents and Families	27
WA	WA H 2863	Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	34
WA	WA S 5295	Use of Shared Leave	Supporting Parents and Families	27
WA	WA S 6102	Employee Reproductive Choice Act	Improving Access to Contraception	12
WA	WA S 6219	Health Plan Coverage of Reproductive Health Care	Expanding Access to Abortion Care	8, 17
WV	WV SCR 50	Free Feminine Hygiene Products	Prohibiting Discrimination Based on Reproductive Decisions or Health	34

ENDNOTES

1. In 2017, this report evaluated seven policy areas, identifying "ensuring comprehensive reproductive health care coverage for all" as its own category. Since coverage for a service is so integrally tied to access, coverage is now incorporated as an aspect of the individual sections discussing access to abortion, contraception, and pregnancy care.
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National Institute for Reproductive Health
14 Wall Street
Suite 3B
New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org
www.nirhealth.org