



GAINING GROUND

PROACTIVE REPRODUCTIVE HEALTH AND RIGHTS LEGISLATION IN THE STATES

2020 YEAR IN REVIEW



THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH

(NIRH) is an advocacy group that works directly with state and local reproductive health, rights, and justice organizations and allied groups to protect and advance access to reproductive health care. For more than 40 years, NIRH has been partnering with communities to build coalitions, launch campaigns, and successfully advocate for policy change. NIRH's strategy is to go on the offensive and focus on communities where change is needed, so the fabric of reproductive freedom becomes harder to tear apart.

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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

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This report was written by Jordan Goldberg, Director of Policy. Research and contributions by Hanna Ali, Legal Fellow; Arpita Appannagari, Policy and Partnerships Manager; Winnie Ye, Policy and Partnerships Manager; Sallie Thomas, Legal Intern; and Nina Henry, Legal Intern. Staff of NIRH, including Andrea Miller, President; Tara Sweeney, Vice President for Communications; and Kelly Novak, Deputy Director of Communications, contributed to and edited this report.

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INTRODUCTION

2020 has been a year like no other in recent history, with the COVID-19 pandemic upending daily life and uprisings protesting racism highlighting systemic inequities. All of this also took place during a critical election year, with seats from the White House to the statehouse on the line and reproductive health, rights, and justice hanging in the balance.



2020 LEGISLATION BY THE NUMBERS

	TOTAL	INTRODUCED	MOVED	VETOED	ENACTED
Legislation Expanding Access to Abortion Care	57	41	10	1	5
Legislation Improving Access to Contraception	77	50	16	0	11
Legislation Increasing Access to Pregnancy Care	167	116	29	2	20
Legislation Supporting Parents and Families	116	80	25	1	10
Legislation Promoting Comprehensive Sexuality Education for All Young People	16	11	4	0	1
Legislation Prohibiting Coercion and Discrimination In Reproductive Health Care	175	100	46	2	27
TOTAL LEGISLATION	608	398	130	6	74

Ultimately, voters rejected the anti-abortion, anti-reproductive health care administration and instead voted in a president and vice president who are committed to reproductive health care access. Although access to reproductive health care is largely a result of state policy – and notably, voters in Colorado resoundingly rejected a ballot measure ban on abortions later in pregnancy – the new Biden-Harris administration will be able to remedy some of the harms inflicted by the Trump-Pence administration and expand access to care.

The COVID-19 pandemic has laid bare existing gaps in the United States' safety net programs for parents and children, inequitable access to reproductive health care and insurance, and inadequate sexuality education. Parents with young children at home found themselves trying to do their jobs while caring for and helping to educate their children. For young people, the sudden switch to remote learning meant a loss of privacy and space to learn about the topics covered in the most effective curricula for sexuality education.¹

Moreover, the pandemic wreaked havoc for health care providers and those trying to access all types of health care, including reproductive health care. Hospitals and health facilities struggled to keep up with COVID-19 patient admissions while having limited access to personal protective equipment (PPE), state governments issued stay-at-home orders to help prevent the spread of the virus, and numerous businesses remained closed, including local pharmacies where individuals obtain contraception refills. Lower income communities and communities of color experienced both higher rates of COVID-19 infection and more dire outcomes. They were also disproportionately affected by the economic fallout and more likely to experience disruptions in access to abortion, contraception, and other reproductive health care services.²

Federal action was desperately needed. Instead, we experienced a failure of national leadership, leaving state officials, and in some cases local officials, to fend for themselves. Perhaps never has the critical role of governors, state legislatures, and state policy been as explicit as it was in 2020, when many (but not

all) of those acting on the state level rose to the occasion to take action to address residents' most urgent needs, including reproductive health, among a panoply of other issues. For example, in early March, many governors and executive branches issued shutdown orders, the majority of which allowed abortion and other pregnancy-related services to continue. Some went further, categorizing reproductive health care as essential services in their executive orders.

As the pandemic was unfolding, systemic racism became the focal point of activism and protest. After the brutal murder of George Floyd in May 2020, the already burgeoning Black Lives Matter movement took root in U.S. cities and towns, where demands to take Black lives seriously began to be linked with the specific demand to divest from police departments and reinvest in community support, including access to reproductive health care.³ The Movement for Black Lives recognizes health care for all, including abortion and other forms of reproductive health care access, as critical to ensuring that Black lives are respected, valued, and protected.⁴

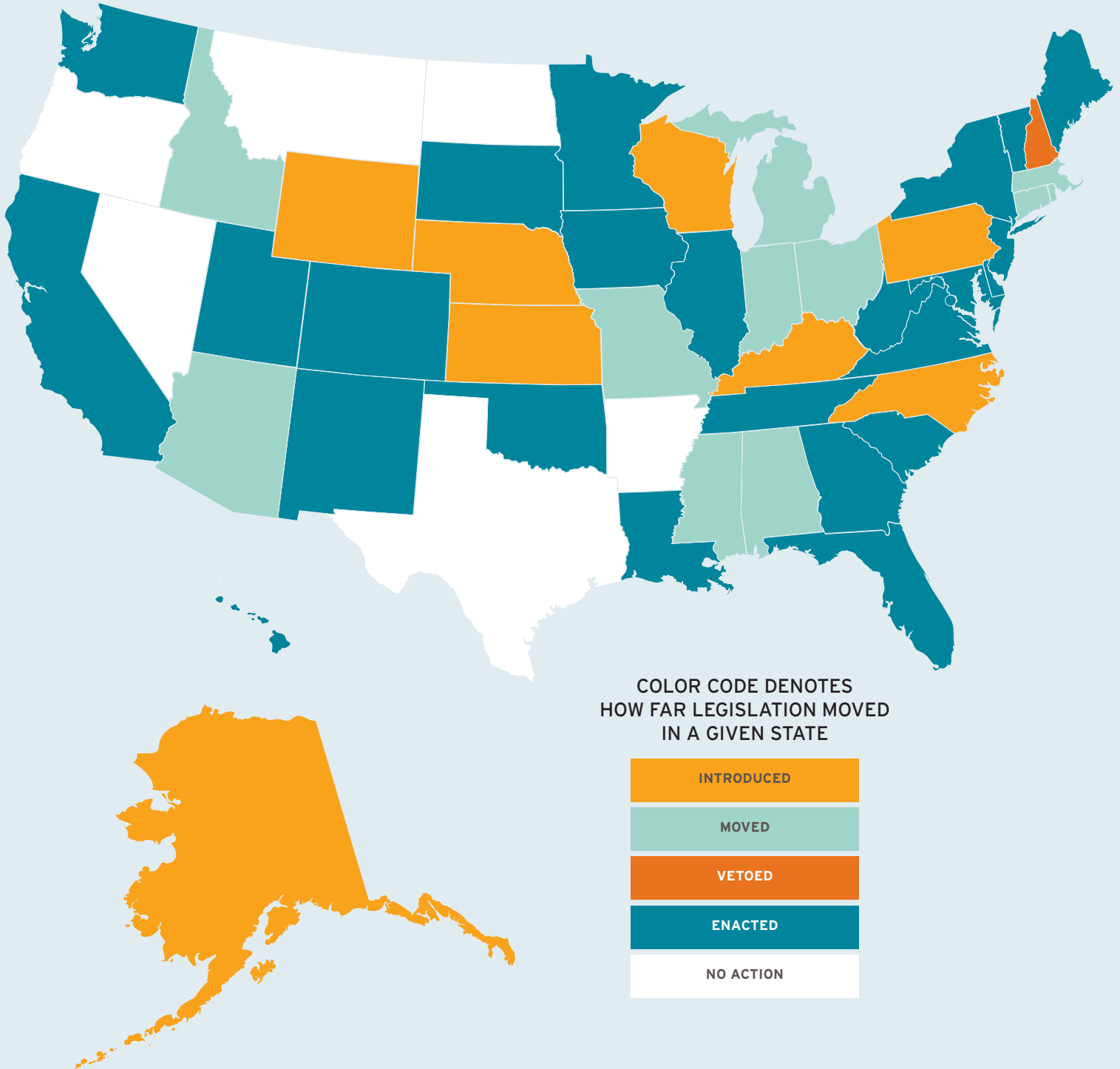
This report, released annually by the National Institute for Reproductive Health (NIRH) since 2014, provides a snapshot of the most significant proactive state policy work on reproductive health in the last year, with a specific emphasis on policies that are most likely to address racial health disparities and other barriers to care for women⁵ of color and communities of color.

This report canvasses state-level policy in NIRH's six priority policy areas: abortion, contraception, pregnancy care, support for parents and families, sexuality education, and preventing interference with reproductive decisions. This report identifies some of the most urgent policy problems in each issue area and highlights some of the most effective policy solutions.⁶ Taken as a whole, this report offers state-level advocates and lawmakers a menu of ways to address some of the most significant reproductive health policy challenges facing women, other people who can become pregnant, parents, and young people – during this pandemic and beyond.



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

AS OF DECEMBER 1, 2020



EXPANDING ACCESS TO ABORTION CARE

The ability to access safe and legal abortion has been a critical part of women's overall independence and ability to participate fully in society over the last 45 years. Access to abortion allows women and others who can become pregnant to determine whether to become parents and the timing and spacing of their children.

AS A RESULT, A WOMAN'S ABILITY to access safe and legal abortion when she needs it is critical to her ability to maintain her own health and dignity, as well as independence, freedom, and social and economic equality. When a woman is unable to get an abortion when she seeks it, studies have shown that she is more likely than someone who received an abortion to be living in poverty and lacking full-time employment six months later.⁷ Further, while abortion is one of the safest medical procedures in the United States, restrictions imposed on abortion access can increase health risks. Perhaps due to all of these factors, 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.⁸

NIRH supports policies that enable any woman, transgender 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 also 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 those who have faced racial discrimination or coercion with regards to their reproductive decisions.

PROBLEM: ABORTION IS INCREASINGLY INACCESSIBLE FOR MANY IN THE UNITED STATES AS A RESULT OF HUNDREDS OF STATE-LEVEL ABORTION RESTRICTIONS, REDUCED PROTECTION IN THE COURTS, AND LACK OF HEALTH CARE ACCESS FOR MANY COMMUNITIES IN GENERAL

Since the Supreme Court decided *Roe v. Wade* in 1973, legislators in many states have imposed a patchwork of around 1,200 restrictions on access to abortion, including at least 483 in the last decade.⁹ Over the past few years, as conservative lawmakers and activists have successfully pushed the Supreme Court rightward, they have also ramped up efforts to restrict or even outlaw abortion, passing an unprecedented number of abortion bans in 2019 and attempting to do the same in 2020.¹⁰ The pandemic compounded the existing difficulties in accessing abortion care caused by clinic closures, travel time to providers, high cost and bans on insurance coverage, and the need to navigate the burdens of other medically unjustified restrictions. With children at home and no childcare or schools,¹¹ getting to a provider to access reproductive health care was challenging for many.

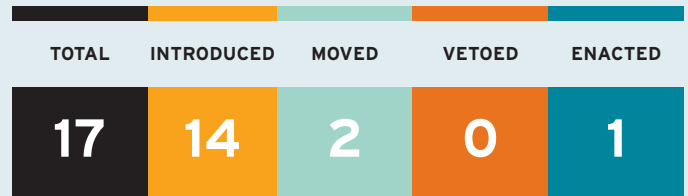
POTENTIAL SOLUTIONS

Beginning slowly in the early 1990s and with increasing momentum since 2016, advocates and lawmakers in some states worked to enact legislation designed to protect the right to have an abortion and expand access so that all who need one can get it safely, with dignity, affordably, and in their own communities.



2020 ABORTION LEGISLATION BY THE NUMBERS

Legislation that would decriminalize abortion and establish the right to an abortion



Legislation that would increase access to abortion care through means such as repealing barriers to care or expanding the types of medical providers who can provide care



Legislation that would expand insurance coverage for abortion



Legislation to protect the safety of abortion providers and patients



Legislation to curtail the deceptive practices of crisis pregnancy centers, which are often non-medical facilities that attempt to mislead patients seeking abortion care



Legislation or resolutions that publicly support abortion rights or call for the passage of other laws to expand abortion access at the federal or state level



TOTAL LEGISLATION IN THIS SECTION



There is a wide range of policies that a state can enact to expand and protect abortion access: In some states, repealing harmful laws already on the books – especially the many that are currently in effect – is the most critical first step to expanding access. In other states, the primary barriers might instead be issues such as cost, lack of insurance, or harassment at clinics. With more than four decades of advances in medicine, effective advocacy, and proactive lawmaking to study, new classes of lawmakers have the opportunity to emulate and build on others' successes. The best policy for any particular state will depend on the state of the law at the beginning of legislative session, as well as the particular challenges facing providers and patients in that state, whether from the burdens placed by ideologically motivated restrictions, COVID-19, or other non-abortion-specific burdens that impact abortion access directly, such as poverty or distance from health care providers.

SOLUTION: REPEAL MEDICALLY UNJUSTIFIED ABORTION RESTRICTIONS

Virginia went the furthest in 2020 to expand access to reproductive health care when it enacted the Reproductive Health Protection Act (RHPA). The RHPA repealed three of the most significant medically unjustified abortion restrictions on the books in the state: a law that prohibited qualified nurse practitioners from providing abortion care, a Targeted Regulation of Abortion Providers (TRAP) law that required almost all abortion providers to turn their clinics into ambulatory surgical centers, and a law requiring state-mandated counseling, an ultrasound, and a mandatory 24-hour delay before a patient was permitted to obtain an abortion. The

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RHPA was supported by advocates and lawmakers who had pushed for similar legislation for almost a decade, thereby preparing the ground for quick passage after the 2018 election resulted in pro-choice majorities in both chambers of state government and the governor's mansion. For more information about the RHPA, see [NIRH's 2020 Midyear Report](#), which goes into more detail about the passage of the law and its contents.

SOLUTION: ESTABLISH A CLEAR RIGHT TO REPRODUCTIVE AUTONOMY

By the beginning of 2020, at least 13 states had enacted some type of protection for abortion rights into their state laws, about half of which passed after the 2016 election.¹² In many cases, these laws were motivated by lawmakers and advocates who were determined to ensure that abortion will remain both legal and accessible in their own states, regardless of what happens at the Supreme Court level.

In 2020, the **District of Columbia** joined the list, taking expansive action to protect the exercise of reproductive decision-making and expand access by enacting the Strengthening Reproductive Health Protections Amendment Act of 2020. It prohibits any governmental entity from interfering with an individual's right to choose contraception, abortion, or to carry a pregnancy to term; ensures that any qualified health care professional acting within the scope of their practice may provide abortion care; prohibits any criminalization of self-managed abortion; and prohibits discrimination against individuals or health care providers for seeking or providing reproductive health care.

In addition, **New Jersey** took steps to join that list in October with the introduction of the Reproductive Freedom Act (House Bill 3030, Senate Bill 4848), one of the broadest and most protective bills introduced in recent years. Lawmakers and state advocates – including Cherry Hill Women's Center, New Jersey Policy Perspective, and the entire Thrive NJ coalition, including NIRH – worked to advance this legislation, which would establish a clear right to abortion and other reproductive health care in the state, repeal a host of outdated and medically unnecessary restrictions on abortion care, and require insurance coverage for both abortion and contraception for all New Jersey residents regardless of immigration status.

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SOLUTION: REQUIRE INSURANCE COVERAGE FOR ABORTION, REGARDLESS OF IMMIGRATION STATUS

Three states – **Hawaii**, **New Jersey**, and **Virginia** – began to move forward more comprehensive approaches to advancing access to the full range of reproductive health care, including abortion, to all who need it. These bills were modeled in part on legislation enacted in **Oregon** in 2017 called the Reproductive Health Equity Act (RHEA), which was a first-of-its-kind measure that requires all private and public insurers to provide coverage for all who need it, regardless of immigration status, for a comprehensive set of sexual and reproductive health care services. These range from pregnancy-related services including contraception, prenatal care, abortion, and labor and delivery to breastfeeding support and postpartum care, as well as STI testing and treatment. Much of the coverage must be provided without cost-sharing.

In **Hawaii**, before the COVID-19 pandemic shut down the legislature for much of the year, lawmakers in both the House and Senate introduced identical bills (HI H 2676) modeled almost entirely on Oregon’s RHEA. Both bills were strongly supported by Planned Parenthood of the Great Northwest and the Hawaiian Islands and both passed a committee. **New Jersey’s** Reproductive Freedom Act includes requirements for public and private insurance to cover abortion and contraception without co-sharing, and also creates a newly funded program to provide labor and delivery, abortion, and contraception coverage for undocumented people who would be eligible for Medicaid if not for federal immigration laws. In **Virginia**, House Bill 1445, which closely resembles the Oregon REA, was introduced and heard in committee, and was held for further study in 2021.

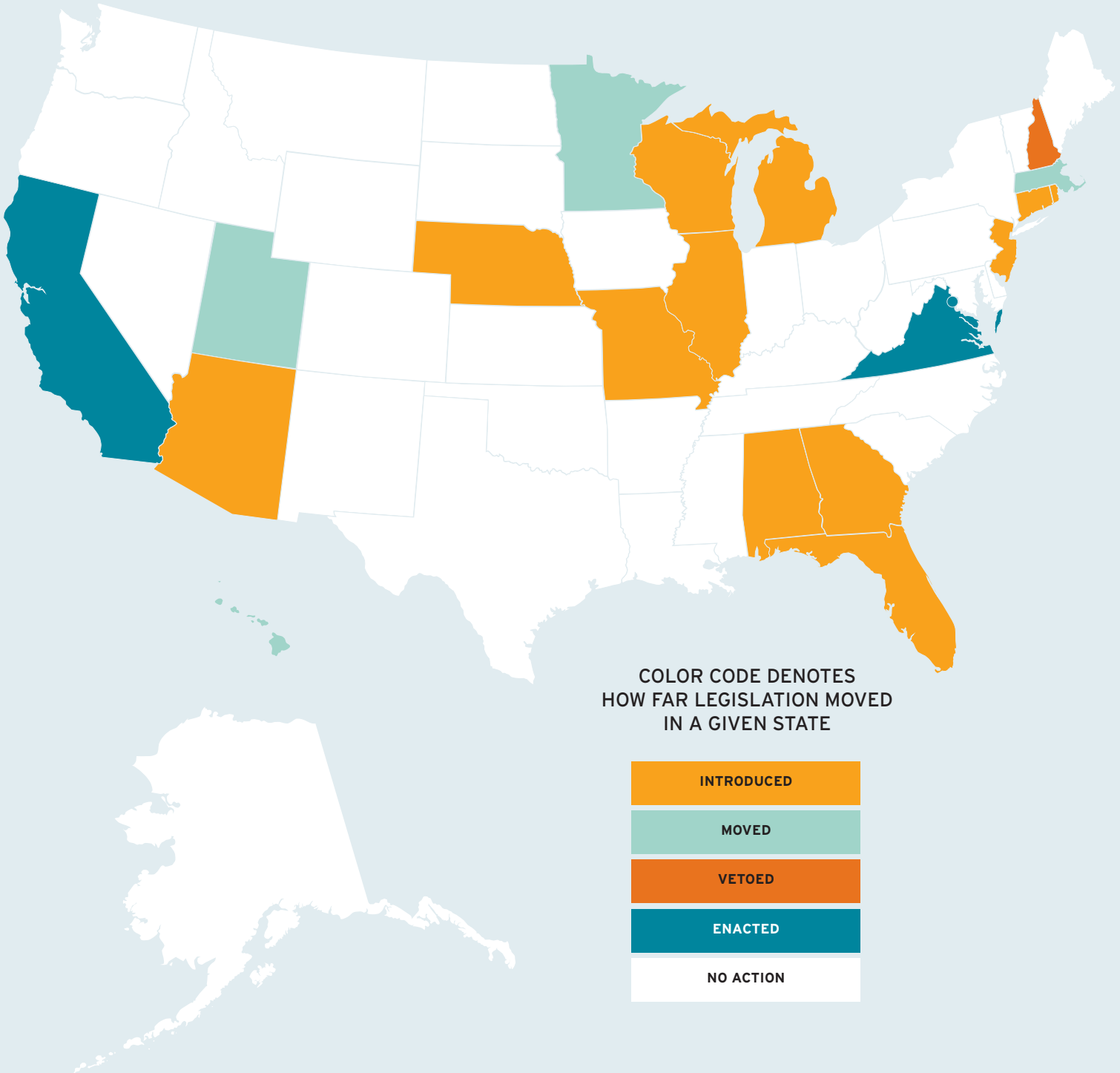
LOOKING TO 2021

In the next year, the policies that might be most useful in each state will again depend on that state’s policy landscape and needs. While many governors allowed abortion and other pregnancy-related services to continue during shutdown orders – with some classifying abortion specifically as essential (see our [Midyear report](#) more info) – policymakers should also take into account the impact the COVID-19 pandemic has had on access to all forms of health care, especially those most commonly accessed in health care settings that may be quite distant from a patient’s home, such as abortion care. Policymakers should consider working with health care providers to find creative solutions to expand access, such as repealing specific barriers to abortion care, making it easier to offer telehealth for abortion care, or allowing qualified health care professionals to provide abortion care rather than limiting that care to physicians only. Any policy that makes abortion more accessible during this exceptionally challenging time will contribute to broader access thereafter.



MOVEMENT OF PROACTIVE LEGISLATION TO EXPAND ACCESS TO ABORTION CARE

AS OF DECEMBER 1, 2020



IMPROVING ACCESS TO CONTRACEPTION

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

NIRH SUPPORTS POLICIES that ensure access to the full range of contraception methods and non-coercive, inclusive contraceptive counseling, and it is committed to increasing knowledge of and access to underutilized contraceptive options in ways that center and honor patient autonomy and decision-making. True access to contraceptive care exists when anyone seeking contraception can get the full range of services, including comprehensive and culturally competent counseling, from an appropriately trained, accessible, affordable health care provider.

PROBLEM: MANY PEOPLE LACK ACCESS TO CONTRACEPTION DUE TO COST, LACK OF INSURANCE, LOGISTICAL BARRIERS, AND SYSTEMIC RACISM

Despite scientific and medical advances in contraceptive methods, there continue to be many barriers to contraceptive access, especially for low-income people, Black women and other women of color, people who live in rural locations, undocumented people, and others who face challenges accessing health care in general and reproductive health care in particular. Some of those barriers include lack of insurance coverage, uneven and complex insurance coverage that may not cover all forms of contraception from accessible providers, inadequate provider infrastructure, language barriers, and cost. Moreover, systemic racism can directly impact Black women and other women of color who seek comprehensive, non-coercive reproductive health care. The United States' long history and current mistreatment of women of color through unconsented medical care and myths about Black women feeling less pain than other people have resulted in Black women and other women of color receiving inadequate

medical care and led to an understandable distrust of the medical community that creates further barriers.¹³

In theory, federal policy could help address many of these barriers and fill critical gaps. Indeed, on the federal level, several important programs – such as the Affordable Care Act's contraception mandate of coverage for many without any copay and the low-cost or free contraception provided to some individuals under Title X – have done much to broaden access throughout the country.¹⁴ Unfortunately, the Trump-Pence administration has done everything in their power to limit the scope of those programs and to roll back expansions of care,¹⁵ aided by anti-contraception state lawmakers in several states.¹⁶ As a result, at the close of 2020, the federal government had limited, rather than expanded, access to contraception, leaving yet another issue for states to step up to fill the gaps.¹⁷

The COVID-19 pandemic has led women who already faced barriers to care struggling with an avalanche of additional obstacles. As noted earlier, the pandemic has led to the loss of employment and therefore insurance for many,¹⁸ and obviously has led to greater difficulty accessing in-person medical appointments. One survey conducted by the Guttmacher Institute concluded that more than a third of women of color respondents had trouble accessing contraception or other reproductive health care as a result of the pandemic.¹⁹

POTENTIAL SOLUTIONS

As in many areas of policy, a number of state policy options are available that could help expand access and ensure that all who need to are able to access affordable contraception with full autonomy and counseling. Determining which policies makes sense for a particular



2020 CONTRACEPTION LEGISLATION BY THE NUMBERS

	TOTAL	INTRODUCED	MOVED	VETOED	ENACTED
Legislation to ensure and expand insurance coverage for contraception	25	19	1	0	5
Legislation that would increase access to contraception through methods such as increasing the amount of contraception through one prescription or enabling nurse practitioners to prescribe	27	16	7	0	4
Legislation that would allow pharmacists to provide or prescribe contraception directly	20	11	7	0	2
Legislation that provides additional state funding to family planning clinics that experienced dire federal cuts as a result of a gag rule prohibiting discussion of abortion	3	3	0	0	0
Resolutions in support of access to contraception or urging the federal government to repeal harmful contraceptive restrictions	2	1	1	0	0
TOTAL LEGISLATION IN THIS SECTION	77	50	16	0	11

As in many areas of policy, a number of state policy options are available that could help expand access and ensure that all who need to are able to access affordable contraception with full autonomy and counseling.

state will depend on the state's budget and the gaps in care that already exist there, as well as the state's internal politics. Over the last few decades, states have enacted laws to require insurers to cover contraception when they cover other prescription drugs; to increase access to specific forms of contraception that are more expensive, such as long-acting reversible contraceptives (LARCs); and to increase the amount of contraception every insured person can obtain at one time. Other states have considered policies to ensure that more marginalized populations, such as young people, incarcerated people, and those otherwise under state control or supervision, can access contraception.

SOLUTION: MANDATE INSURANCE COVERAGE FOR CONTRACEPTION, ENSHRINING THE PROTECTIONS OF THE AFFORDABLE CARE ACT

For many years, the majority of states have required at least some insurers that cover prescription drugs to cover contraception equally.²⁰ In 2010, the Affordable Care Act made that mandate nationwide while expanding it to require almost all insurers to provide coverage for all FDA-approved forms of female contraception and to do so with no cost-sharing requirement.²¹ Since then, a number of state advocates and lawmakers have pushed forward state laws to enshrine those protections in state law or to further broaden the requirements, such as by also covering male forms of contraception. By 2020, 13 states and Washington, D.C.,²² had all enacted a version of this type of law. At the same time, those who opposed the ACA's passage have continued to push for it to be repealed or struck down in the federal courts by attacking both the whole law and challenging the contraceptive mandate in particular. While efforts to repeal the law have failed repeatedly in Congress, multiple lawsuits against the contraceptive mandate have weakened its scope, allowing religious employers of many different types to avoid its terms.²³ Moreover, additional cases are making their way through the federal courts

– including a case now pending in the Supreme Court – seeking to strike the law down in its entirety.²⁴

With this backdrop, it is even more critical that states act directly to shore up access to contraception by enacting some version of the ACA's mandate to require insurers to cover the full range of FDA-approved contraceptive methods. In the abbreviated session most states had in 2020, only **Colorado** moved such a bill forward, although it did not pass. As important threats loom in 2021, state advocates and lawmakers should consider carefully reviewing their own state codes and ensuring that, were the ACA mandate for contraceptive coverage with no copay to be struck down, their own states' residents would still have affordable access to these critically important health services.

SOLUTION: PROVIDE A 12-MONTH SUPPLY OF CONTRACEPTION

As became clear to many at the onset of the pandemic, obtaining contraception monthly at a pharmacy can be burdensome and costly. Insurance plans typically cover 30- to 90-day supplies of prescription contraceptives at a time. However, securing a 12-month supply of contraceptives all at once and having the prescription mailed to an individual's home would eliminate many barriers, including cost, travel, and other complications associated with traditional employer-based health care. During the pandemic, access to a 12-month supply of contraceptives could be even more critical to ensuring access in a time of upheaval, economic crisis, and lack of health care providers. Over the past few years, many state lawmakers and advocates have urged adoption of such annual dispensing policies²⁵ (often with bipartisan support), and 17 states and Washington, D.C., have enacted them.²⁶ This year, even before the COVID-19 pandemic, **West Virginia** joined this growing list by passing House Bill 4198, which allows almost all insured individuals in the state to obtain a 12-month supply of contraceptives at one time.

SOLUTION: ALLOW PHARMACISTS TO PRESCRIBE CONTRACEPTION

Allowing more people to get contraception prescribed directly by a pharmacist mitigates barriers such as the need to get a prescription from a health care provider, lack of insurance, lack of time off for doctor's appointments, or other challenges that are often present but made all the more difficult during a pandemic. Over the last few years, several states have expanded the ability or authority of pharmacists to prescribe contraception as a way to expand access.²⁷ It should be noted that in order to be an effective expansion of care, such policies must ensure that individuals can use their insurance coverage while filling prescriptions directly from a pharmacist.²⁸ In 2020, **Minnesota** enacted Senate Bill 13, joining the list of 11 states and Washington, D.C.,²⁹ that allow pharmacists to directly prescribe hormonal contraception, although Minnesota's bill only allows direct prescriptions for patients 18 and older.

LOOKING TO 2021

Allowing patients to get a year's worth of contraception at one time has the potential to address many of the most significant barriers imposed by COVID-19 and larger socioeconomic considerations. It may be the most promising policy to consider for 2021. In addition, as those who opposed the ACA's original passage continue to mount challenges to the law in Congress and the courts, enshrining the contraception mandate of the ACA into state law should be a priority.

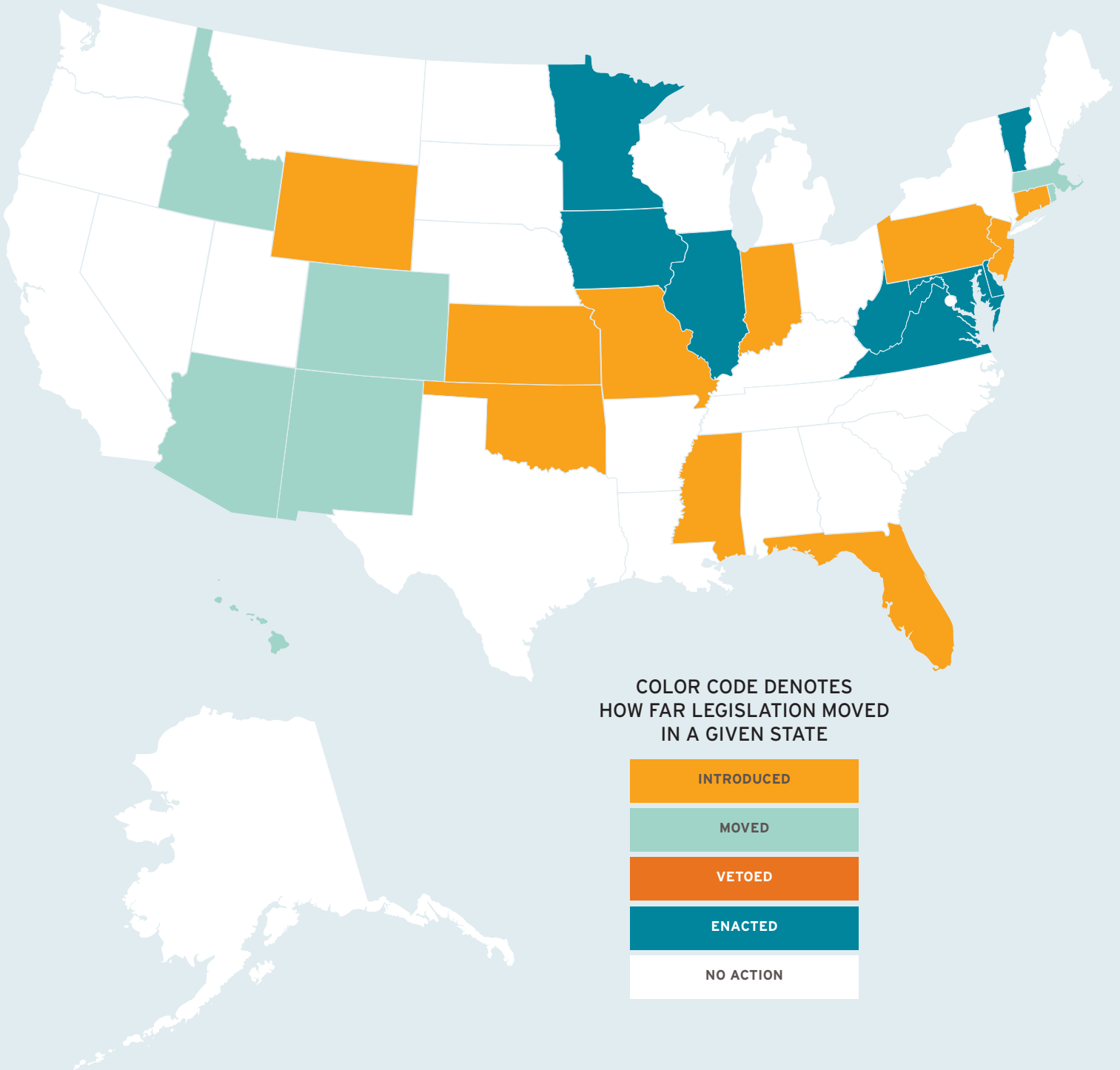
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As we continue to live through the pandemic and the tremendous challenges it poses – both to our society and specifically to our health care institutions – state advocates and lawmakers should consider new and creative solutions to ensuring access to contraception without requiring patients to leave their homes or enter health care facilities, as well as policies that allow patients to obtain multiple services at once. These efforts should center those most likely to be impacted by lack of access to reproductive health care, especially Black women and other women of color, as well as low-income women, undocumented people, and those otherwise living in situations that make ongoing access to health services a challenge. The pandemic has already given rise to new policies in states interested in increasing access, such as allowing those needing contraception to access their health care providers through telemedicine and their contraception through pharmacies or by mail³⁰ – expansions worth carrying forward even after the pandemic. While those options do not apply to all contraceptive methods, there are other ways to create greater access, such as expanding immediate postpartum LARCs, making it easier for birthing patients to access an IUD or implant while already in the hospital for their child's birth.³¹



MOVEMENT OF PROACTIVE LEGISLATION TO IMPROVE ACCESS TO CONTRACEPTION

AS OF DECEMBER 1, 2020



INCREASING ACCESS TO PREGNANCY CARE

Pregnancy and childbirth are matters of bodily autonomy, dignity, and privacy, and they implicate critical aspects of public health, such as equitable access to quality health care and health outcomes. NIRH supports policies that ensure that all women, transgender 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 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, with an explicit focus on Black maternal mortality.

PROBLEM: THE UNITED STATES HAS A MATERNAL MORTALITY CRISIS, PARTICULARLY IMPACTING BLACK WOMEN

The United States has been woefully negligent in ensuring access to high-quality care during the prenatal, labor and delivery, and postnatal periods. Indeed, it has the highest level of maternal mortality in the developed world, due in large part to the disproportionate number of Black women who die in or shortly after childbirth each year.³² Black and Indigenous women are up to three times more likely to die for pregnancy-related reasons than white women are.³³ The maternal mortality crisis for Black women is both caused and exacerbated by the quality and timeliness of care they do or do not receive from existing medical institutions, what they can afford to pay for based on their insurance, and the facilities they are able to access. It is a crisis that must be urgently and directly addressed at the local, state, and federal levels.

With the onset of the COVID-19 pandemic, pregnant people found themselves in an uncharted birthing landscape, with limited visits to their provider, unclear data about the risks to themselves and their new newborns from COVID-19, and limits or even prohibitions on birth partners in the delivery room – further exacerbating the risks associated with pregnancy and childbirth.

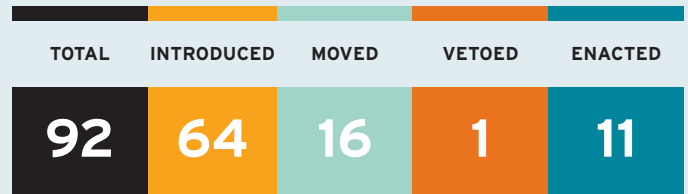
POTENTIAL SOLUTIONS

Despite the historic and systemic failures around pregnancy-related care in the United States, there is a great deal of public health data about the types of policies that could improve pregnancy outcomes and experiences, as well as reduce maternal mortality and morbidity. After many years of study, it has become clear that there is no one single policy that will address the growing problem of maternal mortality, in part because two significant and contributing factors to Black maternal mortality – systemic racism and poverty³⁴ – must be addressed by tackling a multitude of societal problems at once. Even so, there are a group of policies that may, when employed together, begin to address the root causes of the problem.³⁵ Those policy solutions must include access to quality, culturally competent, and unbiased prenatal, birthing, and postpartum care, including mental health care, particularly for Black women and other marginalized or disparately impacted groups. Every aspect of these potential solutions is complex and requires multiple stakeholders at the table, significant



2020 PREGNANCY LEGISLATION BY THE NUMBERS

Legislation to address maternal health, including the maternal mortality crisis



Legislation to expand insurance coverage for pregnancy-related care



Legislation to expand access to midwives and doulas



Legislation to provide coverage for fertility care



TOTAL LEGISLATION IN THIS SECTION



A critical first step to addressing maternal mortality is to study maternal health and collect accurate data on racial disparities in outcomes, a process that enables policymakers to identify failures in each state's health care delivery system and create policies to rectify those failures.

levels of investment and analysis, and careful policy changes that are fully implemented. From studying the facts on the ground in each state, to increasing access to affordable, culturally competent pregnancy care, to addressing the postpartum risks to maternal health, states have a long menu of options to choose from.³⁶

SOLUTION: IDENTIFY CAUSES OF MATERNAL MORTALITY, INCLUDING BY CONSULTING WITH COMMUNITY-BASED EXPERTS

A critical first step to addressing maternal mortality is to study maternal health and collect accurate data on racial disparities in outcomes, a process that enables policymakers to identify failures in each state's health care delivery system and create policies to rectify those failures.³⁷

Over the last two decades, at the behest of many health care providers and advocates for health equity and reproductive justice,³⁸ a growing number of states have created maternal mortality task forces and commissions to study all cases of maternal mortality in their states and attempt to identify and address their causes.³⁹ The efficacy of these task forces and commissions varies,⁴⁰ in part based on how much data they have access to, what recommendations result from their analyses, and what is done with their recommendations.⁴¹

In 2000, **Maryland** was one of the earliest states to create a Maternal Mortality Review (MMR) Program.⁴² Since then, the state has continually improved its MMR law. In 2020, it enacted House Bill 286, again expanding and shifting the program in an effort to ensure that the most impacted people inform the process and are part of the decision-making. This includes requiring that the program involve representatives of families of women who have experienced maternal mortality or morbidity or other significant complications or women who

have themselves experienced a near-maternal death, high-risk pregnancy, or other significant complications. Moreover, this group of mandated stakeholders must reflect the racial and ethnic diversity of women most impacted by maternal deaths in the state, and recommendations for those stakeholders must be sought from a list of community groups, such as CASA de Maryland, Catholic Charities, MOMCares, NARAL Pro-Choice Maryland, and Reproductive Justice Inside.

SOLUTION: MAKE PREGNANCY-RELATED HEALTH CARE AFFORDABLE BY EXPANDING MEDICAID COVERAGE TO A YEAR POSTPARTUM FOR THOSE WHO BECAME ELIGIBLE ONLY BECAUSE OF THEIR PREGNANCY

Research into the nation's maternal health crisis and its extreme impact on Black women has found that "[a]n increasing number of maternal deaths – which are defined as deaths during pregnancy and up to 365 days after – are occurring in the postpartum period. Data from the Centers for Disease Control and Prevention confirms that roughly one-third of all pregnancy-related deaths occur one week to one year after a pregnancy ends. In some states, the number is much higher."⁴³ Extending access to Medicaid for a year following birth allows postpartum women who might otherwise be unable to seek medical care to see a health care provider quickly and affordably if they experience complications, potentially preventing more serious illness or death.⁴⁴ States have two options to expand postpartum Medicaid: by enacting legislation, as California has done, or by petitioning the federal government for a waiver, which a number of other states are doing.⁴⁵ In 2020, **Georgia** took the most significant legislative action of the year, enacting House Bill 1114 to require coverage for six months postpartum as well as lactation services. While not a full year of coverage, it is a step in the right direction.

SOLUTION: MAKE PREGNANCY CARE ACCESSIBLE AND SUPPORTIVE BY EXPANDING ACCESS TO COMMUNITY-BASED, CULTURALLY COMPETENT DOULAS

Particularly for low-income and Black patients, having a doula present at a birth is proven to have a positive impact on birth outcomes,⁴⁶ resulting in “shortened labor, decreased need for analgesia, fewer operative deliveries, and increased maternal satisfaction post labor.”⁴⁷ Doulas can specifically help address the impact of systemic racism on individual patients by providing a calming and supportive presence and intervening with health care providers who may be, knowingly or unknowingly, delivering substandard care as a result of implicit bias.⁴⁸ Doula care is rarely covered by insurance; if it is covered, it is seldom reimbursed at an appropriate level, making it difficult for a sufficient number of individuals to become or remain doulas working in the most impacted communities.⁴⁹

Providing coverage for doula care has not yet been widely adopted or attempted as a policy response to maternal mortality. In 2020, six states⁵⁰ considered legislation to expand access to doulas, which in some cases would have created certification programs to allow doulas to be reimbursed through Medicaid. **Virginia** passed the only legislation in 2020 related to expanding access to doulas: House Bill 826 directed the state Department of Medical Assistance Services to convene a work group to study the issue. It is not yet clear which policies would be most effective in broadening access to culturally competent, community-based doulas, but

Doula care is rarely covered by insurance; if it is covered, it is seldom reimbursed at an appropriate level, making it difficult for a sufficient number of individuals to become or remain doulas working in the most impacted communities.

their potential to make a significant impact on Black maternal health suggests that policymakers should carefully consider this issue in the future.

In the early months of 2020, the need for and benefit of having a doula, or another helper, in the delivery room was thrown into stark relief when some hospitals responded to COVID-19 by prohibiting laboring patients from having anyone other than medical personnel in the room during labor and birth. Given the mountain of data suggesting that a support person helps improve health outcomes for both the birthing patient and the newborn, lawmakers quickly pushed back through executive orders and later legislation. For example, **New Jersey** Assembly Bill 3942, enacted in May 2020, requires hospitals to allow each birthing patient to be accompanied by at least one birthing partner.⁵¹ As 2021 begins, state lawmakers should consider acting quickly to ensure that the tradeoffs being made to prevent COVID-19 transmission do not lead to harmful lasting impacts on maternal and infant health.⁵²

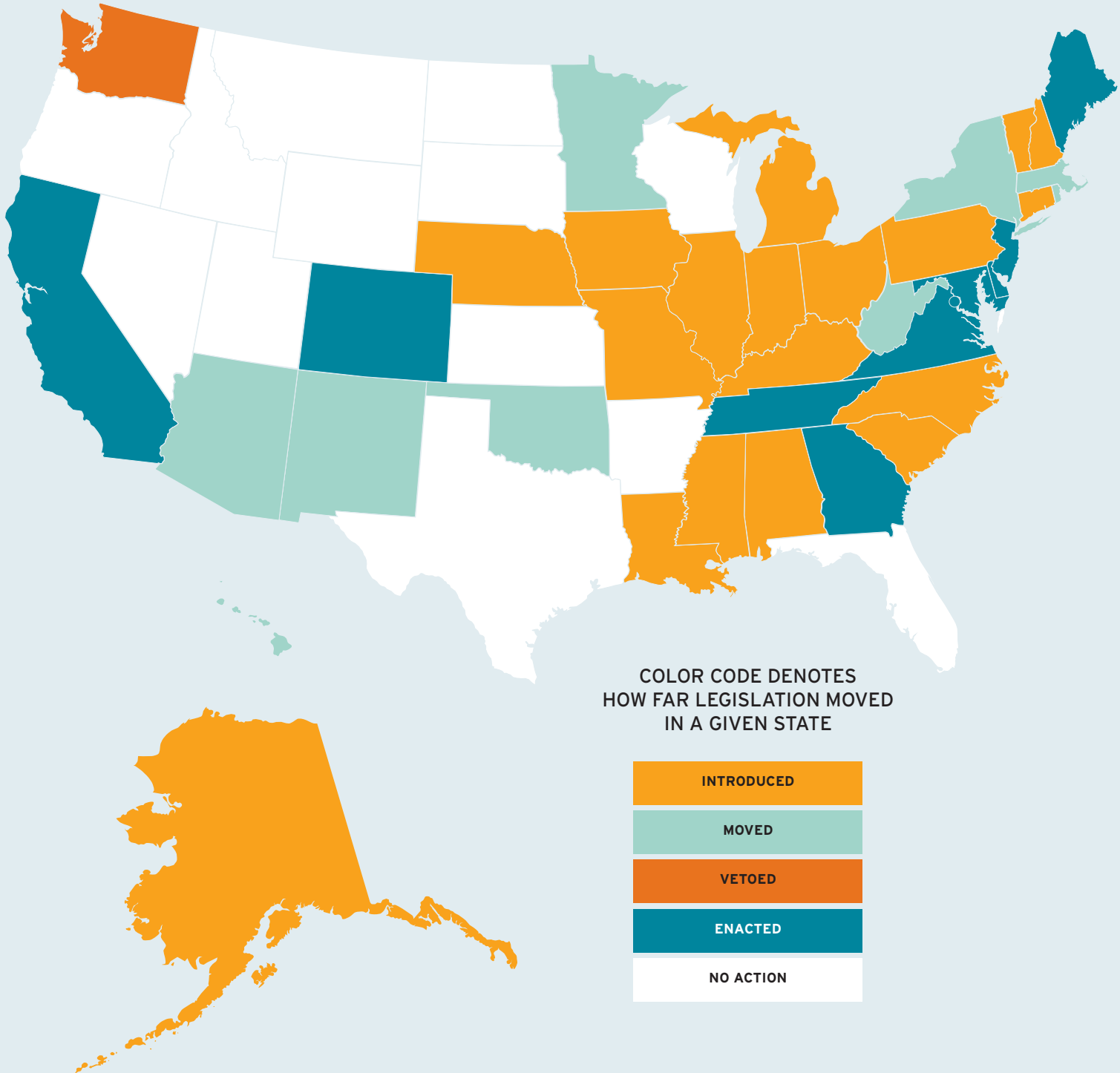
LOOKING TO 2021

There is no question that the COVID-19 pandemic has further exacerbated already devastating racial disparities in maternal health in the United States, while imposing previously unheard-of obstacles for pregnant patients, such as preventing them from having a birthing partner present during labor and delivery. In 2021, state advocates and lawmakers should consider focusing their efforts on policies that have been shown to work and aim to improve health care access and address disparities, such as requiring at least one year of Medicaid coverage postpartum and allowing all birthing patients to have a partner, doula, or other person with them in the labor and delivery room. In addition, as with all policy areas, this pandemic demands creativity and commitment from policymakers to recognize and address the unique needs of communities that are already underserved, and to work with those in communities, such as doulas and health advocates, to identify new solutions.



MOVEMENT OF PROACTIVE LEGISLATION TO INCREASE ACCESS TO PREGNANCY CARE

AS OF DECEMBER 1, 2020



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, transgender men, and other people who can become pregnant to choose when and whether to become parents, and the right of every person to parent their children with dignity and in safety.⁵³

NIRH SUPPORTS POLICIES THAT ENABLE parents to raise their children safely, in a healthy environment, and with dignity and support. NIRH 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.

PROBLEM: PUBLIC POLICY OFTEN IGNORES THE REALITIES OF PARENTING, LEAVING FAMILIES WITHOUT THE SUPPORT THEY NEED TO TAKE CARE OF THEIR CHILDREN

At all levels of government, the United States lacks sufficient policies to guarantee important rights and freedoms for parents, including ensuring paid family and sick leave, support for mothers who want to return to work but also breastfeed, and pathways for young parents to continue school and enter the workforce as they choose without being subject to stigmatization. Moreover, the pandemic put childcare and schooling burdens on parents, and in particular on women, in a way that has not been felt similarly in a generation or more, making it clear that without new policy protections, such as paid leave, women's progress towards economic equality may be significantly rolled back.⁵⁴

While states such as **California, New Jersey, and New York** have stepped up and created policies that allow for new parents to care for their children, many other states

lacked basic, adequate paid family leave policies at the start of 2020. The COVID-19 pandemic radically amplified these gaps, as parents entered an unprecedented crisis around balancing the demands of family, work, and schooling. Those without paid family and medical leave protection faced the added challenge of having no infrastructure in place to address the sudden and prolonged closure of schools and the new burdens of remote learning. Once again, low-income parents – and in particular Black and other parents of color – were the hardest hit. More likely to hold “essential worker” jobs, putting them at greater risk of exposure to the coronavirus, these parents also couldn't be present to supervise their children or guide them through remote school.⁵⁵

Thankfully, some states acted right away by passing new forms of paid leave laws, while the federal government took a time-limited approach to providing such leave. Yet, as 2020 drew to a close, COVID-19's continuing impact on parents – and particularly mothers – seemed likely to roll back at least a generation of gains for women.⁵⁶

Because of the proven health benefits for both women and their babies, leading health organizations like the American Academy of Pediatrics,⁵⁷ the American Congress of Obstetricians and Gynecologists,⁵⁸ and the World Health Organization⁵⁹ recommend that women breastfeed exclusively for six months and, if possible, for up to a year or more.⁶⁰ Yet, until very recently, there were extremely few policies to accommodate the logistical and physical needs of breastfeeding mothers who venture out of their homes for employment or other



2020 PARENTING LEGISLATION BY THE NUMBERS

	TOTAL	INTRODUCED	MOVED	VETOED	ENACTED
Legislation to provide or expand paid family and medical leave	88	61	17	1	9
Legislation to support breastfeeding	24	15	8	0	1
Legislation to support the unique needs of young parents	4	4	0	0	0
TOTAL LEGISLATION IN THIS SECTION	116	80	25	1	10

For the first time in two decades, the federal government took steps to provide some safety net for parents, who faced a wholly new challenge of juggling the demands of paid employment while also caring for and helping guide their children through school at home.

necessary activities. The lack of support for breastfeeding in insurance coverage, 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 resulted in significant racial disparities – especially between white and Black mothers – among those who are able to breastfeed their children.⁶¹

PROPOSED SOLUTIONS

Given the lack of federal leadership in this area, states play an important role in supporting healthy families and communities by enacting policies that allow parents the time and support they need to take care of their children and the ability to balance the need to provide for their families while caring for their own health.

SOLUTION: PROVIDE PAID FAMILY AND MEDICAL LEAVE

For the first time in two decades, the federal government took steps to provide some safety net for parents, who faced a wholly new challenge of juggling the demands of paid employment while also caring for and helping guide their children through school at home.⁶² Congress enacted the Families First Coronavirus Response Act (FFCRA), which provided some sick time for employees who have become ill with or been exposed to COVID-19, as well as up to 12 weeks of partially paid leave for some parents whose children had to learn remotely. The law expired in December 2020.⁶³

In addition to the FFCRA, some states considered employment protections and partially paid leave for parents who had to stop working to care for or homeschool children because their childcare centers or schools were closed due to COVID-19. In April, **New Jersey** became the first state to enact such a law, passing Senate Bill 2374, which expanded the state's existing paid family leave program to apply when childcare or in-person school is not available because of the COVID-19 pandemic.

SOLUTION: PROVIDE BREASTFEEDING SUPPORT AND ACCOMMODATIONS

Over the past few years, states have enacted new laws to require lactation rooms or breastfeeding accommodation areas in spaces like airports,⁶⁴ official buildings,⁶⁵ and schools,⁶⁶ as well as excusing breastfeeding mothers from jury duty.⁶⁷ States have also begun to require insurers to provide coverage for breastfeeding supplies and lactation consultants to ensure that those who want to breastfeed and pump have the medical supplies and support to do so.

Although fewer laws in general passed in 2020, one novel bill specifically examined the racial disparity in breastfeeding. **New York** enacted Assembly Bill 6986, requiring the state's Department of Health to study racial and ethnic disparities in breastfeeding rates in the state and to make recommendations within a year as to the effects of these disparities and how the legislature can act to address them, including steps to increase access to health care and breastfeeding support. Similar legislation was proposed in Minnesota in 2019. Depending on the findings of the New York study, this may be a model for other states to consider in the future.

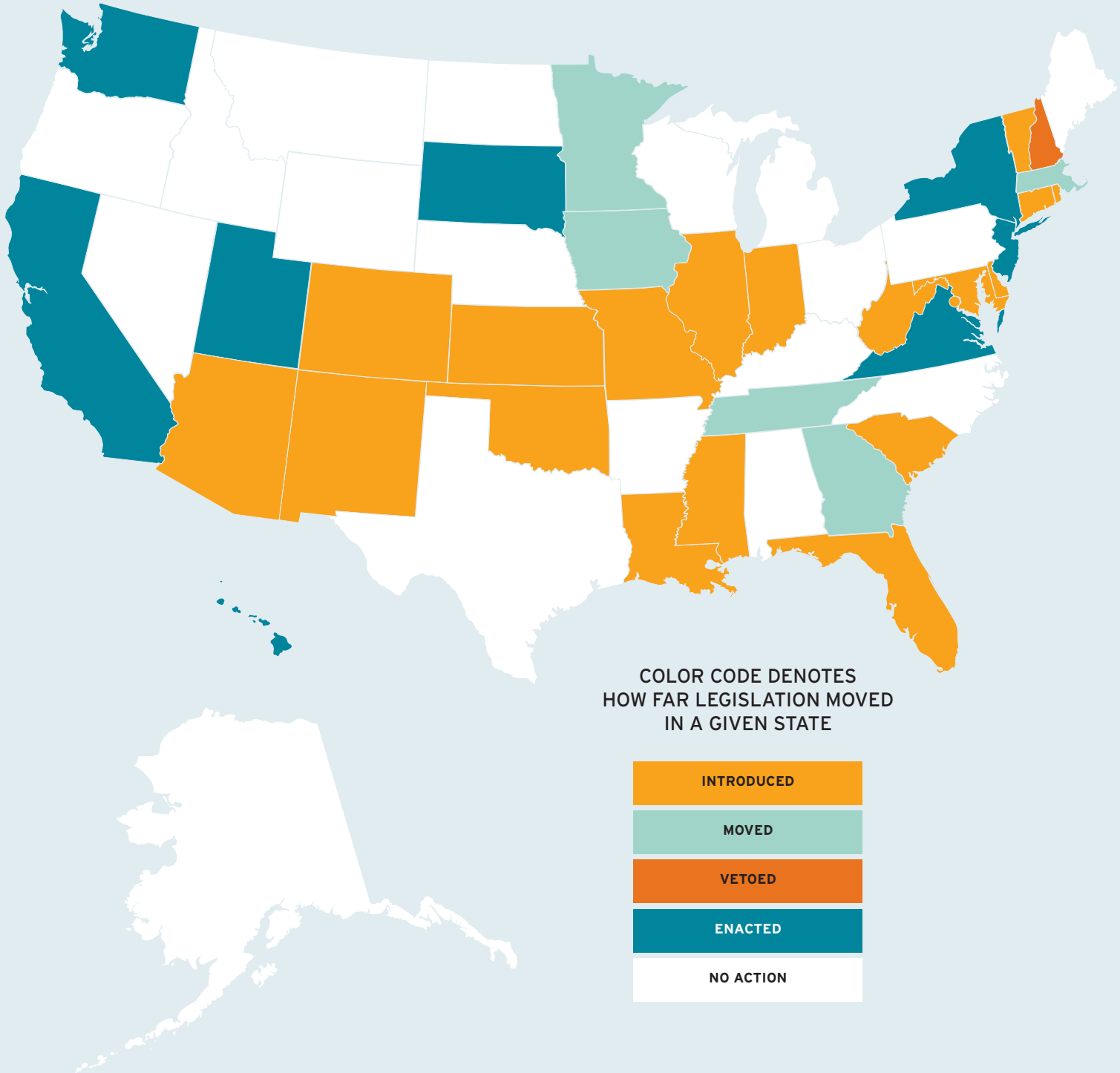
LOOKING TO 2021

As we enter 2021 and parents' struggles continue, state lawmakers must think carefully about how to balance society's ongoing needs for education, childcare, and employment. The pandemic has caused an ongoing societal problem to become a crisis that needs immediate solutions. However, even after the pandemic ends, more is required from our policymakers to enable families to care for their children and provide for their own needs and health over the long term.



MOVEMENT OF PROACTIVE LEGISLATION TO SUPPORT PARENTS AND FAMILIES

AS OF DECEMBER 1, 2020



PROMOTING COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

NIRH supports policies that mandate age- and developmentally appropriate, medically accurate, comprehensive sexuality education, rooted in principles of non-discrimination, equity, and empowerment, in schools and communities. All young people – regardless of where they live or what school they attend – should have the opportunity to make healthy decisions about relationships, sexuality, and sexual behavior.

THESE PROGRAMS COVER topics such as human development; sexual health, including HIV and other sexually transmitted infections; unintended pregnancy prevention; sexual behaviors, including abstinence, healthy relationships, personal skills, and communication; and sexuality within society and culture.⁶⁸ Sexuality education is both a state and local responsibility, providing two avenues to improve on the status quo. While state governments tend to be responsible for setting sexual health education standards, sexuality education curricula are often determined by a combination of state and local laws and school district policies, and implementation largely falls on school districts or even individual schools.

PROBLEM: YOUNG PEOPLE NEED ACCESS TO COMPREHENSIVE SEXUALITY EDUCATION THROUGHOUT THEIR EDUCATION, BUT FEW STATES HAVE ENACTED ADEQUATE LEGISLATION GOVERNING THE CURRICULA AND EVEN FEWER ENFORCE THEIR MANDATES

In 2020, like every other part of life, sexuality education was affected by the COVID-19 pandemic, as basic access to K-12 education itself suddenly became an unprecedented challenge for the first time in the modern era. In March and April, as virtually all school systems moved to remote learning, much of the burden of education fell on parents. And experts agree that the education K-12

students received in the last few months of the 2019-2020 school year was deficient in a plethora of ways.⁶⁹ In that environment, sexuality education was not and could not be a major priority, as students struggled to even connect to the online resources they needed to learn anything at all.⁷⁰ In addition to the challenges shared by students of every subject – such as limited access to devices, high-speed internet, or a space for learning – students intending to learn sexuality education also faced the new challenge of learning this topic at home. In general, lower-income communities and communities of color were again disproportionately affected by the move to remote school, as the means to engage in remote learning and the ability of adults in these families to work from home and support at-home schooling were even more limited.⁷¹ School closures brought other inequalities to the forefront, such as food deficits, inadequate access to and mental health care, and unstable housing.⁷²

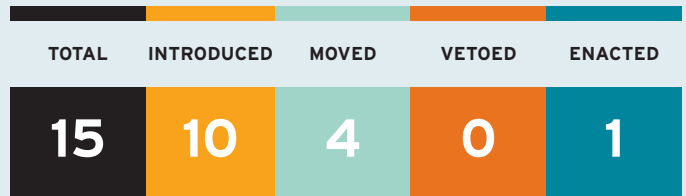
SOLUTION: ENACT, IMPLEMENT, AND MONITOR COMPREHENSIVE SEXUALITY EDUCATION REQUIREMENTS IN ALL K-12 SCHOOLS

While the majority of states have some type of required sexuality education, those laws vary widely in scope and efficacy, and a minority of those laws require comprehensive sexuality education from kindergarten through twelfth grade.⁷³ California, New Jersey, and Oregon are often pointed to as models,⁷⁴ but even where such man-



2020 COMPREHENSIVE SEXUALITY EDUCATION LEGISLATION BY THE NUMBERS

Legislation to require comprehensive sexuality education for students in K-12 schools



Legislation to require comprehensive sexuality education for students in settings other than K-12 schools, such as educational settings like community colleges or state facilities, such as fosterhomes or juvenile detention centers



TOTAL LEGISLATION IN THIS SECTION



dates exist, implementation of those policies is often left to individual school districts and can be uneven or non-existent.⁷⁵ In March, just before the 2020 legislative session ground to a halt, **Washington State** enacted a comprehensive sexuality education law that mandates all public schools in the state to begin providing medically and scientifically accurate, age-appropriate, inclusive sexuality education in the 2022 school year if not earlier. Parents have the right to opt their children out of the curriculum. Although the law passed with strong support in the legislature, a small grassroots group organized an unprecedented effort to repeal the law on the ballot. On election night 2020, Washington voters overwhelmingly affirmed their support for comprehensive sexuality education, voting down the repeal effort by a 60 to 40 majority.

In part due to the pandemic, very few other legislatures took up the issue of comprehensive sexuality education, with only a few bills even introduced on the topic.

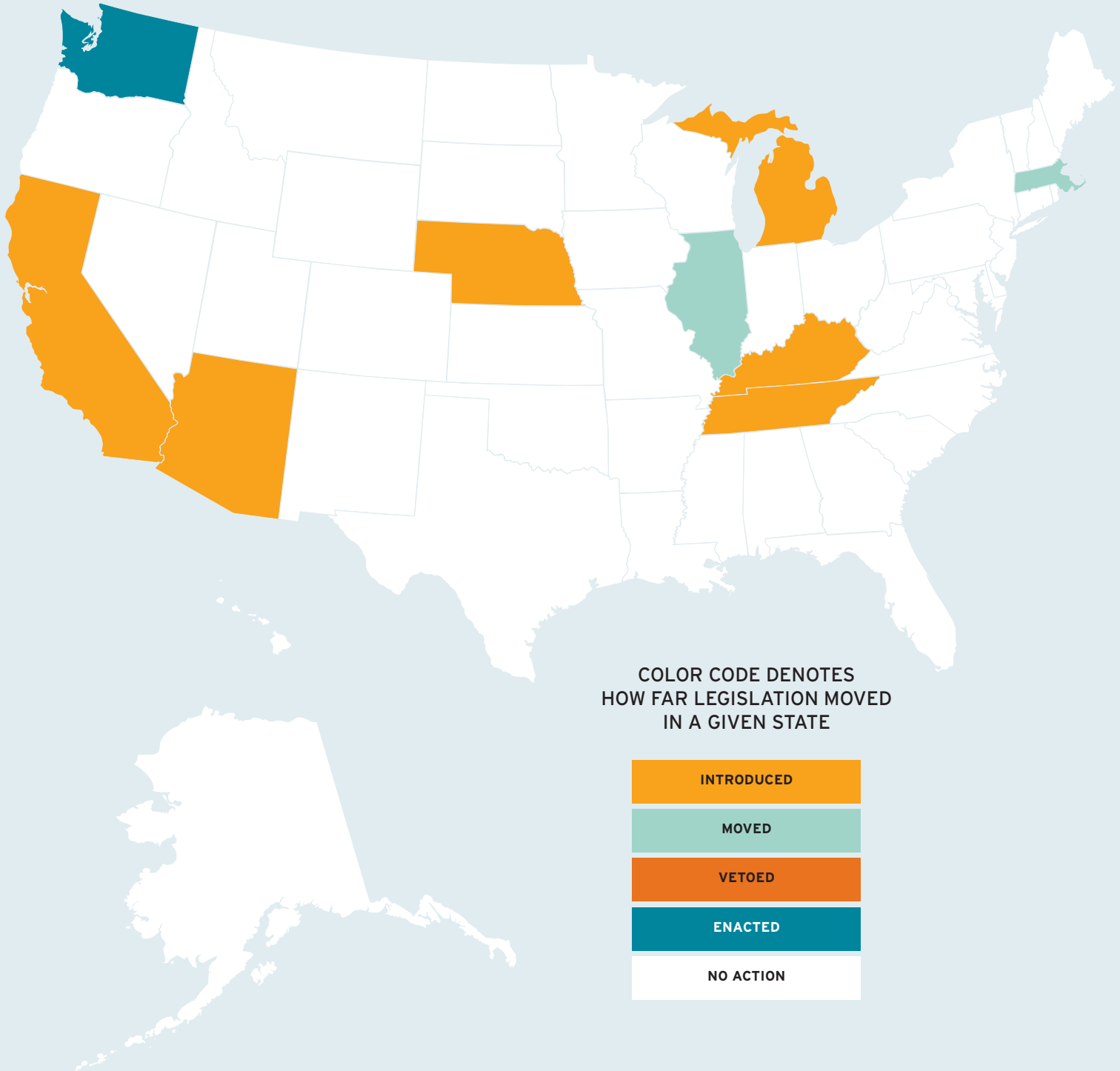
LOOKING TO 2021

The continued need for learning to take place extensively or entirely in a virtual setting should prompt schools to evaluate how to safely teach their existing curricula and state legislatures to carefully consider whether new policies are needed to ensure that every student receives age-appropriate, culturally competent, comprehensive sexuality education, even in these complicated times. In the process, advocates and lawmakers have an opportunity to consider the educational needs students have over the long term, while also exploring temporary or emergency measures that might address specific struggles associated with learning during a pandemic – especially for those who face the greatest challenges with virtual learning (those with lower incomes, students of color, and those without adult support in the home).



MOVEMENT OF PROACTIVE LEGISLATION TO PROMOTE COMPREHENSIVE SEXUALITY EDUCATION FOR ALL YOUNG PEOPLE

AS OF DECEMBER 1, 2020



PROHIBITING COERCION AND DISCRIMINATION IN REPRODUCTIVE HEALTH CARE

The ability to make reproductive decisions and access health care without interference, coercion, or discrimination is central to reproductive freedom. NIRH supports policies that move our society away from all institutionalized, accepted, or de facto forms of interference, discrimination, and coercion based on reproductive health decisions.

NO ONE SHOULD FACE DISCRIMINATION by or coercion from an employer, a school, or a government institution on the basis of their reproductive health needs or decisions, family status, pregnancy, or parenting. Moreover, when the state plays a significant role in a person's access to reproductive health care and services, such as for incarcerated people, those in foster care, those in public schools, and those in other state-run institutions, the state has an obligation to address gaps in access, cease any policy that interferes with full access to reproductive health care. The state also has an obligation to create policies that ensure 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. And although it should go without saying, no one within the state's control or custody should ever be forced to give up their reproductive capacity, whether temporarily or permanently, and no incarcerated person should be shackled during their pregnancy at any point, including during transportation to health care or court, labor and delivery, or postpartum recovery.

PROBLEM: STATES FAIL TO PROVIDE ACCESS TO ADEQUATE REPRODUCTIVE HEALTH CARE AND COERCE THE REPRODUCTIVE DECISIONS OF THOSE WITHIN STATE CUSTODY OR CONTROL

Myriad systemic problems and inequities plague the path that people, particularly Black women and other women of color, experience as they navigate institutions to access reproductive health care. In the workplace, in schools, interacting with law enforcement, and in many other settings, individuals have their reproductive decisions and access to care limited by discriminatory policies and practices. Women and others who can become pregnant who are within the control or custody of the state have been the most likely to suffer both deprivation of access to the full range of reproductive health care,⁷⁶ coercion by the state,⁷⁷ and interference with their basic reproductive health decisions and ability to be safe while accessing care.⁷⁸ In particular, pregnant people who are incarcerated have been the subject of neglect and abuse, including a lack of adequate nutrition, clothing, and access to breastfeeding or pumping supplies, as well as being subjected to shackling during pregnancy or labor and delivery, practices that have been deemed torture by international human rights bodies.⁷⁹

As the COVID-19 pandemic upended life, those in prison settings were among the most impacted, including those who were pregnant while incarcerated.⁸⁰ Indeed, a tragic



2020 NON-DISCRIMINATION LEGISLATION BY THE NUMBERS

	TOTAL	INTRODUCED	MOVED	VETOED	ENACTED
Legislation addressing the reproductive health care needs of incarcerated women or incarcerated pregnant people	47	27	12	1	7
Legislation to provide menstrual products to those who need them	71	49	16	0	6
Legislation to prohibit reproductive coercion	13	6	4	0	3
Legislation to prohibit employment discrimination on the basis of pregnancy or other reproductive health status or decisions	44	18	14	1	11
TOTAL LEGISLATION IN THIS SECTION	175	100	46	2	27

story unfolded early in the pandemic when a pregnant incarcerated woman contracted COVID-19 and died only 28 days after the birth of her baby, leading medical and legal experts to call for the release of pregnant incarcerated individuals during COVID-19.⁸¹ Then in September, reports surfaced of forced sterilizations at the Immigration and Customs Enforcement (ICE) Irwin County Detention Center in Ocilla, Georgia. This forced the nation to once again confront the continuation of its long history of reproductive coercion – and specifically sterilization – of women, particularly Black and brown women. Because the concept of informed and meaningful consent is questionable for people who are detained by the state, the American College of Obstetricians and Gynecologists has recommended that, generally, incarcerated women should not undergo any sterilization procedure.⁸²

POSSIBLE SOLUTIONS

State advocates and lawmakers who are eager to remedy these historic and continuing inequities have many options and a lot of work to do. They would do well to focus first on those who are incarcerated or otherwise under state control and who have been subjected to government-sanctioned coercion or abuse. There are a range of policies lawmakers can consider, such as ensuring the reproductive health of those who are incarcerated, providing free menstrual products to anyone who needs them, and establishing alternatives to incarceration for pregnant women and other pregnant individuals who are incarcerated.

SOLUTION: PROTECT AND PROMOTE THE HEALTH OF WOMEN, TRANSGENDER MEN, AND OTHER PEOPLE WHO CAN BECOME PREGNANT WHO ARE INCARCERATED

One of the most urgent areas for regulation is reproductive health care for people who are incarcerated and who have the capacity to become pregnant. Over the past two decades, a number of states have taken small steps towards addressing the health care crisis facing pregnant incarcerated individuals, first by prohibiting shackling in some situations, and later, in some cases, adopting more expansive policies that intend to support reproductive health rather than, as in the case of anti-shackling legislation, simply prevent egregious harm. Several states, including Maryland and Massachusetts, have attempted to address the most urgent needs of pregnant incarcerated individuals, building on initial

anti-shackling legislation to later require correctional facilities to adopt policies 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. While no state has adopted a perfect system, these policies have taken important steps towards improving the pregnancy experiences and outcomes.

In 2020, **California** enacted one of the nation's most expansive measures to address reproductive health care for incarcerated pregnant people. With its own dark and coercive history of mistreating women in its prison system, the state had already taken some steps to remediate its past behavior, including by prohibiting sterilization of individuals under control of the state.⁸³ California had also already enacted several laws specifically intended to ensure access to comprehensive reproductive health care for incarcerated individuals who may become pregnant, and to ensure that they have access to contraception, abortion, pregnancy care, and potential alternatives to incarceration. However, Assembly Bill 732 goes further, now requiring specific types of care, such as pregnancy testing upon arrival at the jail or prison. For those who are pregnant, it requires providing “comprehensive and unbiased options counseling that includes information about prenatal health care, adoption, and abortion,” as well as an appointment with a qualified health care provider within seven days of arrival, development of a clear plan of care and schedule for prenatal care for the entire pregnancy, referral to social services and community-based programs, and specific treatment during labor and delivery, including being allowed a support person. The law also provides for access to community-based programs serving pregnant, birthing, or lactating incarcerated individuals and limits the ability of the prison to use solitary confinement or segregation for any pregnant person. The measure was strongly supported by a broad coalition of organizations, including Access Women's Health Justice, American College of Obstetricians and Gynecologists, ACLU of California, Black Women for Wellness Action Project, California Latinas for Reproductive Justice, Drug Policy Alliance, If/When/How, NARAL Pro-Choice California, Positive Women's Network-USA, Riverside Sheriffs' Association, URGE, Women's Policy Institute, and many, many others.

As forced sterilization continues to occur in some parts of the United States, California specifically has been grappling with its recent history and attempting to make amends.

SOLUTION: ENSURE THAT NO ONE'S REPRODUCTIVE DECISIONS ARE COERCED BY THE GOVERNMENT

As forced sterilization continues to occur in some parts of the United States, California specifically has been grappling with its recent history and attempting to make amends. In 2014, **California** enacted legislation banning sterilization of those in state custody under almost all circumstances. In 2020, for the second year in a row, a bill (A 1764) was proposed that would award financial reparations to victims of the state-sponsored sterilization program (in existence from 1903 to 1979) and those sterilized after 1979 while incarcerated or otherwise held by the state. Although the bill passed a committee, it once again did not pass the legislature, indicating that – despite the urgent need – there is clearly not sufficient political will to move this legislation forward.

SOLUTION: PROVIDE MENSTRUAL SUPPLIES TO EVERYONE WHO NEEDS THEM AND CANNOT AFFORD THEM, THROUGH PUBLIC INSTITUTIONS, SCHOOLS, AND PRISONS

Many other states took first or small steps towards advancing equity in reproductive health care, with a significant focus in 2020 on legislation that would require menstrual products to be provided for free to certain groups, such as students in public schools (such as **Virginia** House Bill 405, which became law), for young people in foster care, or for anyone in a public building (such as **South Carolina** House Bill 4784, which was introduced this year). However, in this unprecedented pandemic year, with many state institutions closed to the public or limited in other ways, it would be worthwhile for lawmakers to consider how else they can fulfill the intention to make these products accessible for those who cannot afford them. For example, although it is not yet been tried at the state level, a New York City elected official and enterprising young women arranged for the city's free menstrual supplies to be provided

along with school lunches as part of COVID-19-era meals programs.⁸⁴ COVID-19 is requiring all of us to be creative in solving problems, so it may be that lawmakers should enter 2021 considering models more akin to diaper banks and food distribution centers than to providing products in government buildings.

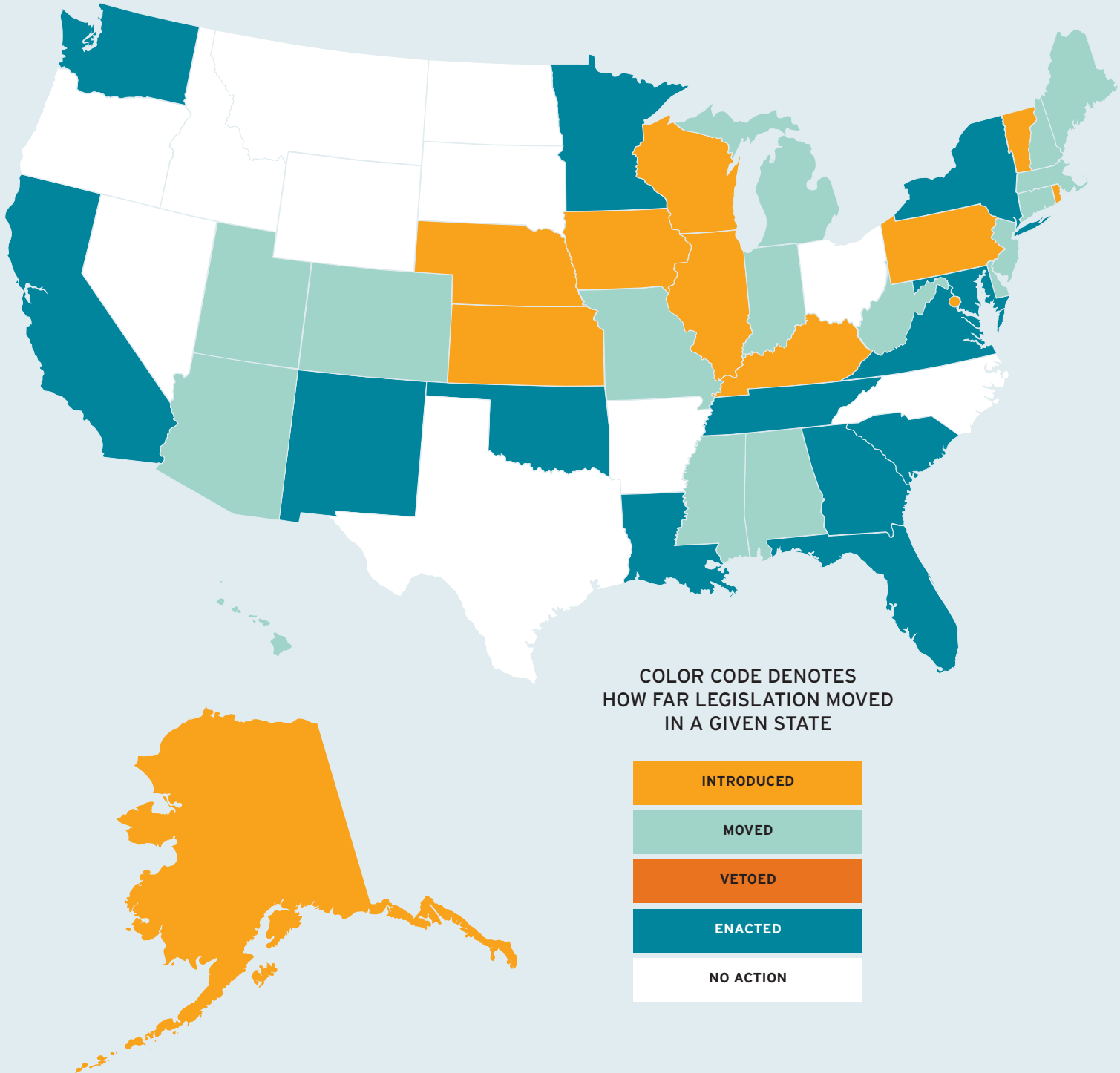
LOOKING TO 2021

Between the way the COVID-19 pandemic has impacted those in prisons, including pregnant incarcerated individuals, and horrific revelations about forced sterilization in at least one ICE facility, lawmakers have been confronted with the serious and ongoing threats to reproductive autonomy and health in government settings. As the pandemic continues, policies that prevent pregnant women and other pregnant individuals from being incarcerated in the first place – such as alternatives-to-incarceration programs – should potentially be first to be considered. Furthermore, in 2020, the National Commission on Correctional Health Care and the American College of Obstetricians and Gynecologists put forth a recommendation for comprehensive standards for pregnancy-related care in detention settings,⁸⁵ which may help states set a new standard for appropriate pregnancy care in criminal justice and other state-controlled settings.



MOVEMENT OF PROACTIVE LEGISLATION TO PROHIBIT COERCION AND DISCRIMINATION IN REPRODUCTIVE HEALTH CARE

AS OF DECEMBER 1, 2020



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- Mary Tuma, *City Council Redirects APD Funds to Abortion Support Access*, THE AUSTIN CHRON. (Aug. 14, 2020 11:27 AM), <https://www.austinchronicle.com/daily/news/2020-08-14/city-council-redirects-apd-funds-to-abortion-support-access> (last visited Nov. 4, 2020).
- THE MOVEMENT FOR BLACK LIVES, *Housing And Healthcare For All!* <https://m4bl.org/policy-platforms/housing-and-healthcare-for-all/> ("Provide free, safe, and accessible family planning and reproductive health care and abortions. Without regard for state restrictions or limitations.") (last visited Oct. 6, 2020).
- In portions of this document, we use the terms "woman" and "women," but we recognize that other people, such as transgender men, gender non-conforming people, 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.
- It should be noted that this report generally contains policy solutions that have at least been proposed and usually those that have been enacted in some state or locality. NIRH believes strongly that new and creative policy solutions should be developed by lawmakers working closely with community-based advocates and those most impacted by the policies. NIRH is eager to support the development of community-based policy solutions and is available to consult with advocates and lawmakers who are considering new approaches.
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National Institute for
Reproductive Health

National Institute for Reproductive Health

14 Wall Street

Suite 3B

New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org

www.nirhealth.org