PRINCIPLE 2: Ensure Discriminatory Barriers in Health Care are Eliminated.

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

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

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

Kevin de Leon, President Pro Temp of California State Senate (D-S-24)
Guarantee Access to Health Care Coverage and Services for All People.

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

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

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

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

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

- Congress must pass and the administration should properly and swiftly implement the Equality Act.

- Congress must take concrete action to ensure that HHS-funded programs are delivering culturally and linguistically appropriate care. Many communities, including immigrant individuals, face significant challenges accessing culturally and linguistically appropriate health care and health insurance information. Initiatives to reform payment and care delivery models offer important opportunities to address these challenges and make progress in broader efforts to eliminate health inequities and bring about positive health outcomes for diverse populations. To take best advantage of these opportunities, the administration and Congress should:
  - Ensure that translation and interpretation services provided to people with Limited English Proficiency includes a broad range of languages to meet the needs of the community;
  - Prioritize the use of community health workers in ACA education and outreach programs to ensure access to culturally and linguistically appropriate information;
  - Establish standards for bilingual Exchange consumer outreach staff and ensure they are trained to offer adequate linguistic services to explain what Qualified Health Plans (QHPs) offer; and
  - Fully fund and provide resources to encourage providers to implement Culturally and Linguistically Appropriate Services (CLAS) standards as recommended by the National CLAS Standards Blueprint.

- The administration must ensure that reform efforts include robust consumer safeguards and that programs are accessible to all. In order to eliminate health inequities and bring about positive health outcomes for diverse populations, HHS should require that all delivery system reform efforts include robust consumer safeguards, including anti-discrimination policies, and measures to improve access to culturally and linguistically appropriate care. Programs must also ensure that technological innovations are equitably promoted, widely available, and evaluated fully for their impacts on access.

- Congress and the administration must expand enforceable nondiscrimination requirements and protections to all youth-serving, federally-funded entities. People of all ages, and particularly youth and young people under the age of 18, deserve to be treated with respect and understanding, regardless of any factor that constitutes their identity and lived experiences. Unfortunately, we know that this dignity is often inaccessible to young people being served by or engaged with federally-funded entities. Too often, programs operating under federal public resources perpetuate bias, discrimination, shame, and stigma related to sex (including sexual orientation and gender identity), parental status, race, ethnicity, ability, and immigration status. Congress and the administration should extend existing program-specific nondiscrimination protections for race, color, national origin, sex (including gender identity and
sexual orientation), age, disability, genetic information, marital and parental status, political affiliation, and veteran status to youth-serving federally-funded programs in all Departments, to the greatest extent that legal authority supports.

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

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

The Health Care Rights Law is a groundbreaking provision providing protection against discrimination in health care for women, LGBTQ patients, and anyone who faces gender-based discrimination as well as patients with limited English proficiency. But recent Trump administration proposed regulations would undermine the enforcement of this law, thereby attempting to limit access to comprehensive, nondiscriminatory health care and coverage. The Health Care Rights Law prohibits discrimination in health care on the basis of sex – including pregnancy, termination of pregnancy, sex stereotypes, gender identity, and sexual orientation – as well as race, color, national origin, age, and disability. In 2016, the Health and Human Services (HHS) Office of Civil Rights issued a final rule, “Nondiscrimination in Health Programs and Activities,” that made clear that protections from sex discrimination includes not “limit[ing] or deny[ing] coverage because the treatment someone is getting is related to their gender identity” or transgender status.42 However, the Trump administration issued a proposed rule in May 2019 attempting to rollback many of the 2016 rule’s important patient protections.

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

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

– Rescind or halt regulations, including the Trump administration’s May 2019 proposed rule, that would roll back the non-discrimination protections for transgender and nonbinary people, as well as all women, patients with limited English proficiency, and other communities historically marginalized in health care, in the Health Care Rights Law, Section 1557 of the Affordable Care Act.

– Ensure that all new guidance and rules are free of religious exemptions or other language enabling refusals of care.

– Thoroughly investigate and document complaints and take necessary actions in response to discrimination, including discrimination based on sexual orientation, gender identity, sex stereotypes, and abortion.

– Ensure that any LGBTQ and/or civil rights or health care legislation are free of religious exemptions or other language enabling refusals of care.

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

The Department of Health and Human Services’ Office for Civil Rights (OCR) has a long and storied record of combating discrimination, protecting patient access to care, and eliminating health disparities. For example, as one of its first official acts in 1967 the Office of Equal Health Opportunity (OCR’s predecessor) undertook the massive effort of inspecting 3,000 hospitals to ensure compliance with Title VI’s prohibition against discrimination on the basis of race, color, or national origin. Since that time OCR has helped reduce discrimination in health care by ending overtly discriminatory practices such as race segregation in health care facilities, segregation of people with disabilities in health care facilities, categorical insurance coverage denials of care for transition related services, and insurance benefit designs that discriminate against people who are HIV positive, among other things. But in the last two years, OCR has abandoned this important role – instead focusing on expanding refusals of care and contracting laws prohibiting discrimination in health care.

• OCR must recommit to its critically important role and robustly enforce statutes prohibiting discrimination in health care and protecting individuals, including:

  – Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin by recipients of federal funds;
– Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs;

– Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability by recipients of federal funds;

– The Age Discrimination Act of 1976, which prohibits discrimination on the basis of age;

– Title VI and XVI of the Public Health Service Act, which requires health facilities that receive certain federal funds to provide certain services to members of its designated community; and

– Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, age, and disability and marks the first time sex discrimination was broadly prohibited in health care.

• HHS Must reverse the harmful changes made at OCR during the Trump administration, including:

  – Returning OCR’s mission statement to a focus on equal access to care and patient health from its recent iteration as a “law enforcement agency.”

  – Eliminating the so-called “Conscience and Religious Freedom Division” which emboldens discrimination and care refusal. OCR has diverted resources away from other parts of the Office committed to protecting patient care to fund this harmful new division.

  – Modifying the complaint forms to focus on anti-discrimination provisions, like Section 1557 of the Affordable Care Act, rather than the current focus on federal refusals of care laws and generating more complaints under the refusal of care laws in order to justify the dangerous changes at OCR.

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

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

• Congress and the administration must reaffirm that health care options and services should be provided in a non-coercive manner that emphasizes patient choice and fully informed consent. Health care providers must be able to provide complete, medically accurate information – free from political or institutional interference – about the options and services
available to patients, based on their particular health care needs and concerns. Once they’ve received such information, patients must have the comprehensive information they need to make the best choices for them and their families, free from coercion, and have those choices respected by medical professionals. This approach is fundamental to medical ethics and the principle of informed consent. ④³

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

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

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

  – Failed abstinence-only funding requirements:
    The President’s Emergency Plan for AIDS Relief (PEPFAR) has included, in various forms, a commitment to funding programs that prioritize, or focus solely on, abstinence as an HIV prevention tool. Extensive evidence shows abstinence programs do not work, and waste taxpayer funds. A 2016 Stanford University School of Medicine study examining PEPFAR’s over $1.4 billion investment in HIV prevention programs that promote sexual abstinence and marital fidelity between 2004–2013 found no evidence that these programs changed sexual behavior or reduced HIV risk. ④⁴ PEPFAR and the global AIDS response must be driven by public health evidence and human rights. Abstinence programming is supported by neither.

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


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

- **Broad and discriminatory refusal clause**: detailed below in section b.

- **The administration must prioritize evidence-informed, comprehensive HIV prevention, care and treatment programs grounded in a human rights approach.**

- **Increase integration of family planning, reproductive health and HIV programs**: HIV, family planning, and other reproductive health services should be fully integrated so that communities with barriers to access can receive holistic services. Improving integrated care will help people living with HIV to sustain healthy pregnancies and deliver HIV-negative children. The Office of the Global AIDS Coordinator should also make it clear that PEPFAR funds can be used to pay for contraceptive commodities to ensure individuals living with and at risk for HIV have access to a full range of voluntary contraception options; promote bidirectional referrals; encourage the co-location of services whenever possible; expand upon current integration indicators; maintain ongoing coordination and collaboration between PEPFAR’s implementing agencies and USAID’s Office of Population and Reproductive Health; and expand meaningful engagement of civil society from HIV/AIDS and SRHR communities.

- **Expand DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) Initiative to prevent HIV among adolescent girls and young women** (including those who may be transgender): Work to advance the sustainable continuation and scale up of evidence-based, multi-sectoral approaches within DREAMS across PEPFAR countries and support the scaleup of voluntary medical male circumcision and treatment for people in DREAMS countries.

- **Advance non-discrimination protections to ensure that PEPFAR-funded programs do not discriminate on the basis of age, disability, race, sex (including sexual orientation, gender identity, and gender expression), marital status, or immigration status.**

- **Champion the development of multipurpose prevention technologies that increase the available options to prevent both pregnancy and HIV and better meet women’s needs.**

- **Increase funding for the Key Populations Fund to serve those most at-risk for HIV, including men who have sex with men, people who inject drugs, sex workers, transgender, nonbinary, and gender nonconforming persons, and those who are incarcerated.**

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

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

- The administration should remove the Weldon amendment from the annual budget, and Congress should pass a Labor-HHS spending bill that is free of this rider.
- The administration and Congress should also oppose all legislation that would expand or entrench the Weldon Amendment.
- HHS should rescind the May 2019 health care refusal rule that drastically expands the scope of existing federal refusal laws, including the Weldon Amendment, far beyond what Congress intended.
- HHS should eliminate the so-called “HHS Office of Conscience and Religious Freedom,” which carries out discriminatory policies such as the Weldon Amendment.
Policymakers must ensure that the Religious Freedom Restoration Act is not misused to undermine access to sexual and reproductive health care or to discriminate against those seeking health care based on the religious beliefs of employers, insurers or providers.

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

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

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

Many government programs that provide vital services, including health care information, services, and referrals, are administered by non-governmental health care or social service agencies. Unfortunately, sometimes those organizations—which receive taxpayer funding—attempt to impose their own religious or moral restrictions on these
programs, limiting access to the sexual and reproductive health care services, information, or referrals that beneficiaries are guaranteed by the program.

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

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

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

- Congress and the administration should vigorously oppose any efforts to write religious or moral exemptions into law, regulations, or guidance related to taxpayer funded programs that provide health care and social services. This includes strong opposition to any legislative or regulatory language that would make it easier for grantees and contractors to discriminate or to impose their beliefs on the people their programs are intended to serve.

- Congress should repeal the broad religious refusal clause in the President’s Emergency Plan for AIDS Relief (PEPFAR) and pass the Greater Leadership Overseas for the Benefit of Equality (GLOBE) Act. PEPFAR has an extremely broad refusal clause, which allows an organization to deny even basic information or referrals about any service that they deem morally objectionable. This policy ignores the needs and circumstances of people who count on our global AIDS programs by disregarding their right to receive information, referrals, or services to meet their basic health needs and deprives them access to safe and legal health services. The GLOBE Act would not only repeal the PEPFAR refusal clause, but would insert strong anti-discrimination language to protect LGBTQ individuals seeking quality comprehensive health care through U.S. foreign assistance programs.

- The administration should expand enforceable non-discrimination protections to all federally-funded entities. A young person's civil rights should not vary based upon whether a federally-funded program they are participating in happens to fall under Title IX or the Health Care Rights Law nondiscrimination protections. Unfortunately, far too many youth-serving programs supported by federal funds, such as HHS programs that fund non-health provider entities, serving millions of young people each year, fall outside of these protections.
Policymakers must ensure that hospitals and other health care facilities, regardless of their religious affiliations, do not discriminate or refuse essential care to their patients.

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

- Medically indicated care to individuals experiencing miscarriages, ectopic pregnancies, and other potentially life-threatening conditions associated with pregnancy such as preeclampsia, eclampsia, and premature rupture of membranes;

- Tubal ligations at the time of a cesarean-section delivery, even when a physician has warned that any future pregnancies could risk the person’s health or life;

- Emergency contraception to victims of sexual assault;

- Gender affirming care to transgender, nonbinary, and gender nonconforming patients; and

- Information about medically appropriate treatment options.

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

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

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End Barriers to Care for Young People

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

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

While most young people under 18 do involve their parents in their abortion decisions, requiring parental involvement can put them at risk in homes with dysfunctional family environments. Parental involvement policies put young people who are victims of sexual and physical assault, incest, or neglect at further risk of physical harm or being kicked out of their homes. Parental involvement laws are an attempt to delay abortion procedures. Further, they have no recognized impact on birth or abortion rates, and fail to change the likelihood that a young person will involve their parents in their abortion decision.48 Importantly, these policies also disproportionately impact young people of color, as they experience disproportionate rates of unintended pregnancy and are more likely to live in states with parental involvement laws.49

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

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

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

- Policies that end restrictions on coverage of abortion in federal health plans should also ensure that young people are not required to notify or seek consent from a parent or guardian prior to obtaining abortion care.

- The CMS director should issue a “Dear State Medicaid Director” letter, and other guidance, to make provider-based sexuality education efforts in Medicaid more robust. This guidance should inform Medicaid programs that they or relevant Managed Care Organizations must remind providers treating youth enrolled in Medicaid that a health education component of a complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child screening must encourage disease prevention, and that sexuality education within a provider setting is a critical component.

- CMS should issue guidance to state Medicaid programs that federal law does not mandate the use of EOBs and initiate a public and private stakeholder effort to develop additional recommendations and guidance to balance the need for consumer protections with the need for confidentiality, especially when it comes to sensitive health services.

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

Secretary-General’s Envoy on Youth, Jayathma Wickramanayake
Policymakers should be vocal in their support for the rights of young people to have the education and access to care they need to make healthy decisions and must fund efforts that support and promote sexual health information and education for our nation’s young people.

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

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

Specifically, Congress must:

- Continue and increase funding for medically-accurate and science-based programs that support information, education, and access to care for young people, and maintain the integrity of these programs ensuring they are administered according to congressional intent.52

- Establish new funding streams dedicated to comprehensive sexuality education and linkages to care.

- Eliminate funding for abstinence-only-until-marriage programs, including the Title V “Sexual Risk Avoidance Education” program and the discretionary “Sexual Risk Avoidance Education” program.

- Advance the sexual and reproductive health and rights of young people by supporting comprehensive sexuality education, as well as access to sexual health services for marginalized young people, through passage of the Real Education for Healthy Youth Act and the Youth Access to Sexual Health Services Act.

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

–President Barack Obama

52 These include the Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH), the Teen Pregnancy Prevention (TPP) Program and Pregnancy Assistance Fund (PAF), the Family and Youth Services Bureau (FYSB) Personal Responsibility Education Program (PREP), the Title X Family Planning Program, and Title IV of Every Student Succeeds Act.
Policymakers should advance the sexual and reproductive health and rights of adolescent girls and young women around the world as part of a comprehensive, whole of government approach to empower adolescent girls globally by addressing their unique challenges and needs.

Sixty-two million girls are not in school and 250 million adolescent girls are living in poverty worldwide. Adolescent girls worldwide face multiple challenges to making autonomous choices about their health and futures, including lack of economic opportunities, staggering rates of illiteracy, early and forced marriage, high rates of sexually transmitted infections and HIV, and early pregnancy. Advancing the health and rights of adolescent girls promotes global development, security, and prosperity. The administration should build on existing initiatives and policies such as the U.S. Global Strategy to Empower Adolescent Girls (March 2016), Let Girls Learn Initiative, PEPFAR’s DREAMS Partnership, the U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally (June 2016), the U.S. National Action Plan on Women, Peace, and Security (June 2016), and the U.S. Action Plan on Children in Adversity, to implement an evidence-based approach and coordinated inter-agency efforts to address the needs of adolescent girls. These efforts must ensure girls are educated, healthy, and empowered, and promote community level change to address harmful norms and practices in addition to strengthening policy and legal frameworks and accountability.

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

– Samuel Kissi, Curious Minds

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

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

- Young people are better able to access economic and social opportunities, share in economic growth, live healthy lives, and contribute to household, community, and national well-being.

- Young people fully participate in democratic and development processes and play active roles in peace-building and civil society.

- Young people have a stronger voice in, and are better served by, local and national institutions, more robust and youth-friendly services, including comprehensive sexual and reproductive health services.
End Discriminatory Treatment of Immigrants

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

Immigrant individuals in the United States face significant challenges to obtaining comprehensive and affordable health insurance coverage and care, including sexual and reproductive health services. This is due to myriad policy, legal, and systemic barriers restricting people’s access to coverage and care based on their immigration status. These barriers have created and sustained deep disparities. For example, in 2017, immigrant women of reproductive age who are not U.S. citizens had more than three times the uninsured rate of U.S.-born women of reproductive age. That gap grew wider between 2013 and 2017, likely because many immigrants are barred from eligibility for subsidized private coverage under the ACA and for Medicaid coverage. In fact, nearly half of noncitizen immigrant women aged 15-44 living at or below the poverty level remained uninsured in 2017.

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


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

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

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

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

• The President should work with the Department of Justice to ensure individuals experiencing domestic violence and reproductive coercion may seek asylum in the U.S., including by rescinding former Attorney General Sessions’ opinion changing developed Board of Immigration Appeals case law on asylum standards based on gang violence and domestic violence.

• Congress must pass legislation to ensure all immigrants granted relief under any current or future deferred action program, including Deferred Action for Childhood Arrivals (DACA), are rightfully considered lawfully present for all purposes, including eligibility for health care coverage.

• The administration must reverse the 2012 federal regulations and CMS guidance to states that blocks DACA grantees’ eligibility for Medicaid or CHIP coverage for lawfully residing children under 21 and pregnant women, and for the ACA’s coverage and affordability programs.

• The administration must approve 1332 waivers that seek to allow undocumented immigrants to purchase insurance coverage through the health insurance Marketplaces and encourage states to use 1332 waivers to expand access.

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

• There is also precedent within the U.S. for providing asylum for certain coercive practices, such as forced abortions performed under China’s one-child policy. This should be expanded to address all forms of reproductive coercion, including those defined earlier in this document, with particular attention to women who face persecution and incarceration for abortion, miscarriage, and still births in their home countries where abortion is criminalized.

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

Detaining pregnant individuals not only severely risks the health of the pregnant individual and their fetus, it also infringes on their dignity and agency as a human being. Pregnant individuals, like other vulnerable populations, should not be detained. Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) must find humane, community-based alternatives to detention for pregnant individuals and other vulnerable populations. In December 2017, ICE announced that the agency would eliminate the presumption of release for pregnant people that the agency had put in place in 2016. That policy change allowed ICE to remove critical reporting procedures, making it extremely difficult to monitor the treatment of pregnant women. Although ICE does not publicly report this information, media statements indicate that 1,655 pregnant people were booked into ICE custody over a 10-month period between 2017–2018 and that 28 women may have miscarried in ICE custody over the past two years.

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

Public benefits included in the expanded definition of public charge in the new rule include most Medicaid programs, Medicare Part D, the Supplemental Nutrition Assistance Program, and some housing programs. It also negatively weighs having a costly health condition, limited English proficiency, limited formal education, and lack of employment in making immigration determinations when determining admissibility. The proposed rule and multiple leaked drafts of the rule prior to its publication have already caused a significant chilling effect on access to a range of services for immigrants with no or low incomes, including basic preventive health care, and particularly for pregnant or postpartum people, young people, and people living with HIV.

60 The Trump administration’s public charge rule would essentially penalize use of services that enable immigrants to attain economic security. No immigrant or their family should ever be placed in a situation where they must decide between their immigration status and their family’s health, housing status, or food security.

- The proposed public charge rule has not been finalized yet. DHS should immediately rescind the proposed rule in its entirety and work to reverse the chilling effects of the proposed rule to immigrant individuals with low incomes and families eligible for Medicaid coverage. Furthermore, the administration should refrain from issuing any rules in which immigrants could be placed in a situation in which they must choose between providing health care and basic needs for their family and their immigration status.
Policymakers must guarantee that all immigrants in detention settings have full access to abortion, contraception, and all other comprehensive sexual and reproductive health care through executive action, agency guidance, and strong congressional oversight.

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

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

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

- The administration should strengthen standards of care for people in immigration detention, including guaranteed access to comprehensive sexual and reproductive health care.

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

The U.S. Department of Homeland Security (DHS), which oversees both Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP), has policies that restrict immigration enforcement actions in certain “sensitive locations,” including schools, places of worship, and health care facilities. These limits on enforcement activities help ensure that immigrant individuals don’t have to choose between access to crucial services and keeping their families together at risk of deportation. Nevertheless, health care providers have reported a noticeable drop in patient visits with recent ramped up immigration enforcement.62 No one should fear receiving care for their sexual and reproductive health needs.

• DHS should explicitly recognize providers of sexual and reproductive health services among health care providers recognized as sensitive locations.

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

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

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

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Ensure Access to Care for Individuals in Detention Settings

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

Women, especially queer and transgender women, and youth represent an increasing proportion of inmates in the U.S. correctional system.63 This is particularly true for Black women, who are incarcerated at twice the rate of their white peers.64 Black transgender women are incarcerated at ten times the rate of the overall U.S. population.65 LGB people are three times as likely to be incarcerated as the general population, and over 40% of incarcerated women are lesbian or bisexual.66 The United States has the responsibility to provide comprehensive health care services to all populations, including those who are incarcerated or held in immigration detention facilities.

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

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

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

The administration should develop a written policy outlining the right of incarcerated individuals to pregnancy testing, prenatal care, abortion care, resources for child care, kinship care, and adoption, labor and delivery, postpartum care and recovery, hygiene products, breastfeeding accommodations, and support for parenting. Policies and procedures must be developed to ensure that comprehensive reproductive health care is available to detained individuals and that detention settings are monitored and held accountable for the delivery of such services, including timely, quality pregnancy related services and supplies.

- The Department of Justice (DOJ) should work with the Department of Health and Human Services (HHS) to ensure that those incarcerated and held in detention centers have access to comprehensive sexual and reproductive health care including abortion services, screening and treatment for HIV, Hepatitis C, and other sexually transmitted infections.

- DOJ should ensure that juvenile justice institutions work with specialists to integrate trauma-informed mental health treatment and comprehensive sexuality education into reproductive health services for incarcerated youth and should also assure that all survivors of violence in the juvenile justice system have access to those services. Providing the range of necessary services requires access to trained providers as well as transportation services to such providers, including access to medical facilities if treatment is not available onsite. For those who give birth while incarcerated, every effort should be made to honor their right to parent and promote parent-infant bonding.

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67 https://www.law.uchicago.edu/ihrc.
70 ibid.
73 ibid.
Policymakers must end the dehumanizing and dangerous practice of shackling pregnant individuals in the custody of ICE, CBP, the Bureau of Prisons or US Marshals Service, once a person is known to be pregnant, including during transportation, childbirth, and the postpartum period; and encourage adoption and enforcement of anti-shackling policies in state prisons and jails.

The dangerous and degrading practice of using restraints on pregnant and birthing individuals (including pregnant young people) in prisons and detention facilities undermines health care delivery, violates an individual’s human right to be free from inhumane and degrading treatment, and is rarely necessary. The alleged purpose of shackling is to keep incarcerated people from escaping or harming themselves or others; however, there is no data to support applying this rationale to individuals who are pregnant, birthing, or recovering postpartum. No escape attempts have been reported among incarcerated pregnant individuals who were not shackled during childbirth. Preserving the health and dignity of incarcerated pregnant individuals is not only feasible, it is a fundamental human rights obligation. Ensuring the provision of compassionate health care in all detention settings (civil and criminal) will prevent the significant physical and emotional harm that results from shackling during and after pregnancy.

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

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

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

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

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

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