

Sexual & Reproductive Health



Reproductive Justice is a fundamental human right that supports all women, femmes, girls, and gender-expansive individuals, in all their identities, and allows them to make and direct their own sexual and reproductive health decisions. To ensure this right, policymakers must recognize and remedy the transgenerational racism, inhumanity, and inequality of access to information, services, and support that has historically endangered—and continues to affect—marginalized women. From state-sponsored

sterilization programs across 32 states in the 20th century to the present day's staggering maternal and infant mortality rates, Black women, femmes, girls, and gender-expansive individuals have borne a significant burden of poor health outcomes resulting from racial inequities.

This section examines key sexual and reproductive health issues that impact the health and well-being of Black women, femmes, girls, and gender-expansive individuals: maternal health, maternal health for

incarcerated individuals, contraceptive equity and reproductive health care, access to abortion care, sexual health education, chronic health conditions, reproductive cancers, mental health, and assisted reproductive technology and genetic engineering.

For each of the key areas, we provide policy recommendations for Congress and legislative officials.

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Reproductive Justice can only be achieved when Black women, femmes, girls, and gender-expansive individuals can experience pregnancy and childbirth without endangering our lives. Yet, Black birthing people have unacceptably poor outcomes in the U.S—including staggering rates of death related to pregnancy and childbirth. At the heart of America’s maternal health crisis is a woefully fragmented health care system that perpetuates vast racial disparities in both maternal and infant morbidity and mortality.

The United States’ overall rate—17.3 maternal deaths per 100,000 live births—is cause for alarm, since it is the highest among high-resource countries.⁹ It is important to note, however, that not all women face the same risks.

Black women have the highest rates of maternal mortality in the country, and are two-to-three times more likely to die of pregnancy- and childbirth-related causes than women of other races and ethnicities.¹⁰ Black newborns also have worse outcomes than their counterparts: they face the highest rate of infant death compared to all other races/ethnicities, with more than double the rate of white babies’ mortality.¹¹

Structural racism and the resulting biased health care system contribute to Black birthing people’s poor health outcomes, including maternal mortality. Black birthing people face systemic barriers that include racism, sexism, and income inequality that result in lower wages and accumulated wealth. As a result, too often, we have to choose between essential resources like safe housing, child care, food, and medical care.

Black birthing people are also more likely to be uninsured, face greater financial barriers to health care services, and have less access to timely prenatal care. Additionally, Black women experience higher rates of many preventable diseases and chronic health conditions—including diabetes, hypertension, obesity, and cardiovascular disease—that harm maternal and infant health outcomes.¹²

Research points to substandard care at hospitals, driven by anti-Black racism and discrimination, as another critical driver of disparities across the care continuum. These include overt acts of interpersonal discrimination. On a broader level, implicit biases, stereotypes, and institutional and structural discrimination harm Black birthing people and their families. The inequities and exposure to racism that Black people experience throughout their lives, including while seeking health

care, increases health risks and drives racial disparities in preventable maternal and infant deaths.

The impact of this structural racism is clearly indicated by findings about what happens when newborn Black babies are cared for by Black doctors. When Black babies are treated by Black providers (e.g., pediatricians, neonatologists, family practitioners), their mortality rate, compared to white newborns, is halved.¹³

Achieving better outcomes for Black women, birthing people, and their babies requires a commitment to birth justice. As defined by Ancient Song Doula Services:

Birth justice is achieved when individuals are able to make informed decisions during pregnancy, childbirth, and postpartum, that is free from racism, discrimination of gender identity, and implicit bias. Birth justice requires that individuals fully enjoy their human rights regarding reproductive and childbirth-related health decisions, without fear of coercion, including coercion to submit to medical interventions, reprisal for refusal of care, and/or face the threat of inadequate medical care. Birth justice centers the intersectional and structural needs of individuals and communities.¹⁴

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POLICY RECOMMENDATIONS

Reducing racial/ethnic disparities in maternal and infant health require multi-faceted, comprehensive, and holistic solutions to address the root causes of structural racism and gender oppression. Policy solutions to the maternal and infant mortality crisis must be grounded in an awareness of racism's impact, and in social justice frameworks that are intentionally designed to address these power imbalances.

- ***Establish a Federal Office of Sexual and Reproductive Health and Wellbeing***

To fully address racial/ethnic health disparities, a comprehensive and holistic approach to sexual and reproductive health must be prioritized at all levels of government. An Office of Sexual and Reproductive Health and Wellbeing (OSRHW) should be established and located at the White House. It should have the authority to inform, lead, and provide guidance for regulations that center the sexual and reproductive needs of marginalized individuals and communities. This authority cannot and should not be limited to one single entity, but must engage all agencies to ensure health equity and the human right to health care.

- ***Increase funding for doulas and midwifery care in federal healthcare programs***

Doulas provide non-medical physical and emotional support to birthing people that is effective in reducing stress and achieving better outcomes.¹⁵ Midwives are qualified medical practitioners who can deliver babies. Engagement of doulas and/or midwives during pregnancy and childbirth can help address Black maternal and infant mortality. These supports are, however, under-utilized by the health care system, and under-compensated by coverage systems. Moreover, doula training and education programs are not adequately supported on either the community or national levels.¹⁶ Increased access to doula and midwifery services can help address the needs of all birthing people—particularly those from underserved and low-income communities, communities of color, and communities facing linguistic and/or cultural barriers.

- ***Support and fund an epidemiological infrastructure that accurately tabulates morbidity and mortality across all states and U.S. territories***

Congress should create a Task Force or Maternal Mortality Review Board to provide guidance and oversight

for states and U.S. territories. Specifically, states and territories should be required to collect and disseminate maternal mortality and morbidity data that are disaggregated by race and ethnicity.¹⁷ The Congressional Task Force can use this information to better understand the specific groups that are at heightened risk, implement programs to reduce those risks, and address racially discriminatory policies and regulations.

- ***Pass legislation that guarantees comprehensive, holistic maternity care for a minimum of one year postpartum***¹⁸

Medicaid covers almost half of all U.S. births (42%) and two-thirds (66%) of Black births. This public insurance program also supports access to care during the prenatal period and for the first 60-days postpartum.¹⁹ After that, however, coverage depends on state policy and can vary widely—particularly in states that did not expand Medicaid as part of the ACA.

- ***Fund programs that ensure anti-Black racism as well as diversity and cultural competency training for health care and medical professionals***

To ensure that all individuals can access health care that is timely, respectful, and culturally relevant, the U.S. should strive to expand the diversity of medical professionals. In addition, legislators should mandate diversity and cultural competency training provided via medical school, board exams, and CME credits. Training based on patient-centered and trauma-informed care includes Critical Race Theory to address implicit bias. Until true culture change occurs, it will be necessary to incentivize cultural sensitivity training for medical providers. Federal funding should support training to address and eradicate medical bias against Black individuals, including stereotypes that result in providers not believing Black patients who say they are experiencing pain, not providing full information to prevent illness, and not offering the best treatment possible.

- **Implement monthly financial supplements or universal incomes for low-income pregnant people**

Guaranteeing a monthly income will ensure that Black birthing people have the resources needed to receive prenatal care and secure safe and appropriate housing, food, and support services needed to maintain a healthy pregnancy.

- **Remove cost-sharing for preconception care; labor-, delivery-, and pregnancy-related labs; mental health; and postpartum visits**

To reduce Black maternal mortality rates all barriers to health care before, during, and after childbirth must be removed. Medical costs can be a significant source of stress and strain for pregnant persons and new parents, and come at time when they can least afford mounting debt. Removing cost-sharing could make all the difference for a low-income person.

- **End coercive, non-consensual drug testing and criminalization of substance use for patients, including pregnant people**

Laws that limit pregnant people's autonomy and penalize them for substance use while pregnant harm Black birthing people and their families. Criminalization is not only discriminatory in practice but also physically and emotionally harmful for both the pregnant person and the baby.²⁰ Instead, legislators should strive to provide funding for effective treatment for substance use (including opioid use disorder).

- **The Black Maternal Health Momnibus Act**

The collection of 12 pieces of legislation was reintroduced in the 117th Congress by Representative Lauren Underwood (D-IL), Representative Alma Adams (D-NC), and Senator Cory Booker (D-NJ), and the Black Maternal Health Caucus. The Act seeks to comprehensively address the myriad issues and factors that contribute to the Black maternal health crisis. Its passage will be a critical step toward addressing the systemic and structural racism that contributes to health disparities driving the national maternal mortality crisis.

- **Mommies Act**

Congress should require a 12-month postpartum coverage expansion for all birthing people, as specified in the MOMMIES Act just reintroduced in 2021. Doing so will have significant benefits for women's health, and expand services for pregnancy-related complications, chronic conditions, family planning, and mental health needs.²¹

- **Pregnant Workers Fairness Act**

Introduced in 2019 by Representative Jerrald Nadler (D-NY) this legislation seeks to eliminate discrimination and promote women's health and economic security by ensuring reasonable workplace accommodations for workers whose ability to perform their job functions are limited by pregnancy, childbirth, or a related medical condition.

PERSONAL STORY

Access to Care: "M" is a Black trans, masculine-presenting individual who lives in Philadelphia, PA. Their first pregnancy ended in abortion, which was not really their choice. The father of the baby was not in the picture. When M found out they were pregnant again, they filed for unemployment, WIC, and Medicaid, in an effort to mend the gaps in accessing care they experienced during the first pregnancy. They did not get prenatal care until they were about three months pregnant. Although they were receiving care at a teaching hospital and research facility, they did not feel supported, stating: "I felt like a burden, it was like an ER visit." They did not receive any counseling, resources, therapy, Lamaze, baby clinics, etc.

Without support from the baby's father, they chose to move to a women's home until six months after giving birth. At the women's home, M learned about baby massage class and relearned self-care. They said, "Mothers need to be: Safe, Educated, and Supported." M's interactions with the doctors were very brief and clinical, and they were induced before they received the epidural. As soon as they were induced, they felt all the pain that they had never had leading up to labor. The baby was preterm and needed to stay in the NICU. Immediately after birth, M was given Depo-Provera, but the doctors did not provide informed consent or clarify why M needed birth control. M bled for six months after giving birth and thinks it was due to the Depo-Provera, noting "It was a hormone that my body didn't want." Although M and the baby faced many challenges leading up to birth, having the shelter experience supported them to begin a new chapter as a Black transmasculine single parent. For more information about M's journey visit <https://www.natalstories.com/blog> (episode 3).

Reproductive Justice includes the right to access high-quality health care, including maternal health care for pregnant people who are incarcerated. Although the U.S. spends more on health care than any other country, our maternal health outcomes are among the worst on the planet. But not all women in America face the same risks: Black women face greater dangers. For incarcerated Black birthing people the dangers are even more dire.

A small but growing body of research suggests that mass incarceration is one driver of persistent health disparities—including higher rates of Black maternal mortality.²² The combination of structural racism and exposure to the toxic stress of mass incarceration exacerbates the risks to maternal and reproductive health in general, and to safe and healthy pregnancies, specifically.

According to the U.S. Bureau of Justice Statistics, Black women are almost twice as likely to be incarcerated as white women.²³ Black girls and other girls of color, similarly, are incarcerated at a rate almost three and a half times that of white girls. And, Black women, femmes, girls, and gender-expansive individuals are more likely to serve longer sentences for the same crimes, and to experience punitive treatment, gender-based violence, abuse and neglect during their incarceration. This is the new era of Jim Crow that affects Black women in America.

These experiences all increase stress and trauma that is extremely dangerous to pregnant people. For this reason, pregnant Black women, femmes, girls, and gender-expansive individuals who are incarcerated are among the most vulnerable in the “justice” system. Although prisons are constitutionally required to provide medical care, the environment is not one that promotes wellness. The criminal justice system was not designed to adequately support individual health needs, including access to maternal health care.

Nearly four percent of women are pregnant when they enter the carceral system.²⁴ Evidence suggests that pregnant, incarcerated Black women, femmes, and gender non-conforming people do not receive adequate, comprehensive reproductive and maternal health care. This includes both prenatal care and opportunities to breastfeed and bond with their babies during the postpartum period. They also continue to be inhumanely shackled during pregnancy and childbirth, despite numerous recommendations and policies against this barbaric practice.

In addition, more than three-quarters of the women involved with the U.S. criminal justice system (79%) are mothers of young children.²⁵ Programs that seek to keep families together—and as geographically close as possible during incarceration—provide families with much-needed opportunities to establish and sustain familial ties, thereby reducing future interaction with the justice system.

The combination of structural racism and exposure to the toxic stress of mass incarceration exacerbates the risks to maternal and reproductive health in general, and to safe and healthy pregnancies, specifically.

POLICY RECOMMENDATIONS

The federal government has fallen short in setting and enforcing comprehensive, trauma-informed standards of care and treatment for pregnant, incarcerated people. Changes must be implemented and coordinated at all levels of criminal justice systems that impact the lives of Black women, femmes, girls, and gender-expansive individuals. Congress needs to take seriously the urgent need to protect the full spectrum of reproductive health care for those within the carceral system, including the lives of those who are incarcerated.

- ***Establish trauma- and Reproductive Justice-informed federally mandated health care services in public and private jails and prisons***

Congress should create laws to enforce adherence to a minimum standard of gender-affirming health care services for pregnant detainees that include strict documentation, oversight, transparency, and reporting. Such care must include prenatal care, mental health care, and substance use treatment, reproductive health services (i.e., abortion, contraception, counseling, menstrual products), screening and treatment for STIs, wrap-around case management, and regular OB-GYN care. It should also eliminate the use of shackles, restraints, tasers, and violent force against pregnant people.

- ***Reduce the budget for construction of new federal prisons***

The Biden Administration has ordered the DoJ to end contracts with private prisons.²⁶ Congress should eliminate funding for the construction of new prisons. Funds should be redirected for federally funded diversion initiatives and workforce development programs, as well as maternal and mental health supports for incarcerated people, families and care-givers.

- ***No Money Bail Act***

Last introduced in 2019 by Representative Ted Lieu (D-CA), this legislation would end the use of secure bonds in federal criminal proceedings. It would also withhold funding from states that continue to use pretrial money bails systems and require more research around alternative reforms to eliminate racially unjust detention rates.

- ***Dignity Act***

Last introduced in 2017 by Senator Cory Booker (D-NJ), this legislation would amend the federal Criminal Code to establish requirements for the treatment of prisoners, similar to the Pathway to Parenting Act of 2018 (H.R.5575) introduced by Representative Scott Taylor (R-VA). It would mandate that the U.S. Bureau of

Prisons must place prisoners as close to their children as possible and provide free video conferencing, parenting resources, and family visitation. It would pilot an overnight visitation program for incarcerated parents who are primary caretakers for their families. The Act would establish federal requirements for the provision of trauma-informed care in prisons (including residential substance use treatment for pregnant prisoners or prisoners who are primary caretaker parents) and mandate access to free menstrual products.

- ***Pregnant Women In Custody Act***

Last introduced in 2020 by Representative Karen Bass (DA-CA), this legislation would set and strengthen minimum health care standards for pregnant women and newborns in custody. It would prohibit the use of restraints or restrictive housing on incarcerated individuals who are pregnant or have given birth in the last eight weeks. It would establish minimum health care standards for pregnant women and newborns in federal custody. It would collect data on incarcerated pregnant women's mental and physical health (including during the postpartum period) to improve treatment and care. It would direct the DoJ, in consultation with the Secretary of HHS, to fund state and local training and technical assistance programs to ensure adherence to federal standards and improve treatment of prisoners..

- ***Justice for Incarcerated Moms Act***

Reintroduced in 2021 by Representative Ayanna Pressley, and Senators Cory Booker (D-NJ), Dick Durbin (D-IL), and Mazie Hirono (D-HI), this legislation would create a comprehensive study to understand the full scope of the maternal and infant health crisis among incarcerated people. It would fund maternal health programs, including access to doulas, healthy food, mental health services, substance use counseling, and improved visitation policies. It would support primary caretaker diversion programs as alternatives to incarceration for individuals who are pregnant and/or the primary caretakers of minors. And, it would incentivize states to enact anti-shackling laws.

Reproductive Justice can only be achieved when Black women, femmes, girls, and gender-expansive individuals have the “economic, social and political power, and resources”²⁷ to make important personal decisions about whether, and when, to have children. Yet, access to family planning services and contraceptive use have a long, ongoing history of reproductive oppression in this country.

From the nation’s founding, control and exploitation of Black women’s bodies played a critical role in maintaining slavery through rape and forced childbearing. Efforts to control and exploit Black women continued through the eugenics movement (which restricted the reproductive rights of the most marginalized communities to achieve population control) and sterilization policies and practices that targeted marginalized groups (including women of color, low-income women, immigrant women, women with disabilities, and incarcerated women).²⁸

The ability of Black women, femmes, girls, and gender-expansive individuals to exercise self-determination—in all areas, not only our reproductive lives—is impacted by the history of reproductive oppression and by inequities that exist in our politics, institutions, economics, environments, and culture. Reproductive Justice addresses these inequities by using an intersectional critical analysis to highlight and address systemic inequalities

that impact access to reproductive health services and maintenance of bodily autonomy.²⁹

Issues of self-determination are particularly relevant with respect to contraception and planning for a family. Access to effective contraception has had enormous benefits to women’s health worldwide, and reduced the number of unintended pregnancies, high-risk pregnancies, and maternal and infant deaths. Additionally, contraception has been proven an effective option for addressing fibroids, minimizing endometriosis-related pain, and preventing ovarian cysts. Contraception has numerous benefits for Black women, femmes, girls, and gender-expansive individuals’ ability to improve personal health, economic stability, and educational outcomes.³⁰

Yet, reproductive oppression persists. Black women, femmes, girls, and gender-expansive individuals continue to face provider bias about recommended family planning services, coercion about contraceptive choices and services, and an inability to access the full range of contraceptives. Bias, discrimination, and stigma are still—regrettably—a factor for those who seek contraception and reproductive health services.

Too often, women of color are subtly—or not so subtly—encouraged to choose a long-acting reversible contraception (LARC), and then face challenges in ending their use of such methods. For example,

women may be encouraged to get an intrauterine device (IUD), but then not be able to get their IUD removed when they want it to be.³¹ Providers must trust Black women to make the best decisions and not assume they know what’s best for us.³²

The flip side is a lack of equitable access to services. Many women who lack economic power and, therefore, rely on public insurance have trouble accessing care, including reproductive health care and contraception services.³³ Approximately 21 million people rely on publicly funded family planning services, 3.7 million of whom are Black.³⁴ One in four Black women, and approximately 52% of Black girls under age 17, use Medicaid to cover their health care costs.³⁵

Public funding for family planning is provided by Medicaid (75% of funds), state sources (13%), and Title X of the Public Health Services Act (10%).³⁶ Title X, the only federal program devoted to family planning services, has been systematically dismantled or undermined.³⁷ As a result, there has been a 46 percent decrease in Medicaid, and state funds vary in terms of not only the services provided but also eligibility requirements. This has led to significant state-level variations and inconsistencies in ensuring race, gender, and socio-economic equity for contraceptive services as well as the Title X network’s capacity to provide services.³⁸

POLICY RECOMMENDATIONS

Policies to address this multifaceted problem must act intersectionality and address both barriers to access and the potential coercion of Black women, femmes, girls, and gender-expansive individuals who seek counseling to plan their families and contraception.

- ***Codify Title X family planning regulations***

Congress should ensure that the federal government provides a clear mandate that all people—regardless of their insurance coverage, employment, and/or immigration status—can access comprehensive family planning counseling and services. Congress should introduce legislation modeled after California’s Family PACT program and cover contraception and reproductive health care services regardless of an individual’s immigration status, race, religion, location, or other factors.

- ***Provide prescription contraceptives at no cost***

Black women, femmes, girls, and gender-expansive individuals need affordable access to the contraceptive method that best fits their own needs and requirements. Legislation to ensure that all family planning methods are equally affordable will increase the likelihood that individuals can access contraceptives and use them effectively.

- ***Expand Medicaid’s reimbursement for counseling about contraceptives***

Medicaid regulations do not currently require providers to offer (and pay for) counseling about contraceptives. Because Medicaid is jointly funded and regulated by the states in partnership with the federal government, too many decisions about coverage for contraception are left up to the vagaries of state governments. Requiring coverage of complete contraceptive counseling will enable medical personnel to be paid for the time spent discussing contraceptive options.³⁹

- ***Fund programs that combat anti-Black racism and expand diversity and cultural competency training for healthcare professionals***

To ensure that all individuals can access health care that is timely, respectful, and culturally relevant, legislators should expand medical professionals’ diversity in general, and their access to diversity and cultural competency training, specifically. Such training should be mandatory and can be provided via medical school, board exams, and Continuing Medical Education (CME) credits. Training should be based on patient-centered

and trauma-informed care, which includes Critical Race Theory to address implicit bias. Expansion and better training of providers can also help address and eradicate medical bias against Black individuals, including stereotypes that result in providers pressuring patients of color to adopt specific types of contraception over another and not presenting them with all the available options.

- ***Fund Federally Qualified Health Centers, Planned Parenthood, and other Title X providers to provide pregnancy, STI, and HIV testing***

Early identification of health conditions is necessary for the best outcomes, including in cases of pregnancy and STIs, including HIV/AIDS. Public funding for Federally Qualified Health Centers (FQHCs) and health clinics is vital for many Black women, femmes, girls, and gender-expansive individuals. These facilities must be funded at a level that ensures their ability to provide timely and comprehensive care to everyone who needs it.

- ***Access to Birth Control Act***

Introduced in 2019 by Representative Carolyn Maloney (D-NY) and Senator Cory Booker (D-NJ), this legislation would “establish duties for pharmacies to ensure provisions of Food and Drug Administration-approved contraception.” Re-introducing and passing this legislation will improve access for the millions of who need family planning but live in “contraceptive deserts, or counties in which they lack reasonable access to a health center.”⁴⁰

- ***Access to Contraception Expansion for Veterans Act***

Introduced in 2020 by Representative Lauren Underwood (D-IL) and Senator Tammy Duckworth (D-IL), this legislation would improve veterans’ access to family planning drugs and devices and their ability to use family planning consistently and effectively. It would provide clients with a full year’s supply of contraception—rather than the three-month supply, which is the current standard.

Sexual & Reproductive Health

ACCESS TO ABORTION CARE

Every person has the right to make fundamental decisions about how, when, and whether they have children and expand their family. For this reason, access to abortion care *is* Reproductive Justice, and unrestricted access to abortion services *must* be part of basic primary health care.

Abortion is a safe, legal, time-sensitive medical option. There are many reasons that a pregnant person might decide that abortion is their best option. We must trust Black women, femmes, girls, and gender-expansive individuals to make the personal decision that is best for themselves and their families. This right should not be infringed upon by the law. The only people who should *ever* be involved in decisions about abortion care should be the person seeking services, their trusted medical professional, and whoever the care-seeker may choose to include—not politicians.

Black women and girls account for more than one-third (38%) of all U.S. abortions, although they comprise just 13 percent of the population.^{41 42} Also, Black women are more likely to lack economic resources, to be unemployed and/or uninsured, and to be insured by programs that restrict coverage for abortion care.^{43 44 45 46 47 48}

For example, the Affordable Care Act (ACA) does not require private insurance companies to cover abortion care; as a result, numerous states have enacted bans on abortion coverage for private insurers.⁴⁹ Only a handful of states require coverage of abortion care.⁵⁰

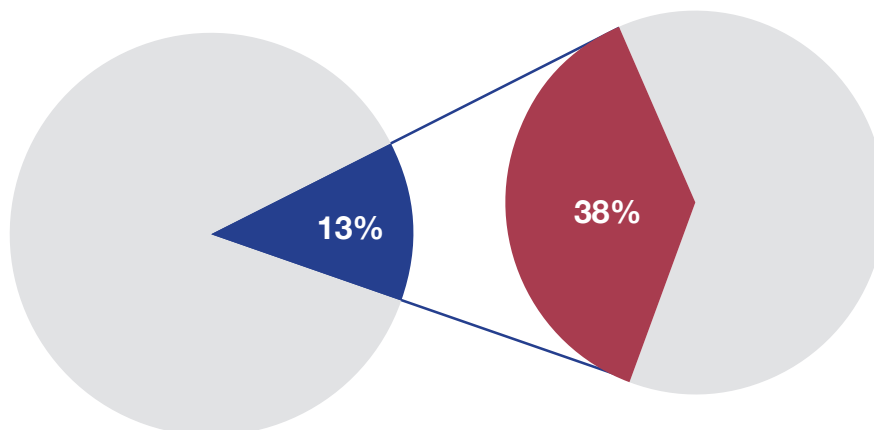
More than ever anti-choice activists are succeeding in their efforts to systematically dismantle the abortion care system and erect barriers that make services inaccessible—particularly for people who lack economic means and/or high-quality insurance. Between 2011 and 2017, states enacted more than 400 medically unnecessary restrictions to curtail access to needed abortion

care.⁵¹ As a result of these draconian laws, the number of abortion providers is decreasing, especially in rural areas, and the vast majority of people (87%) now live in a county without a known abortion provider.⁵²

Black women, femmes, girls, and gender-expansive individuals are being systematically denied the information and services they need to act in their own best interests.⁵³ This includes barriers to accessing health care (including abortion care) which centers on their bodily autonomy. Only once these barriers have been dismantled can we make advances in generational wealth and seize opportunities to grow and excel personally, socially, academically, and professionally.

Like most Americans, Black individuals support the right to choose. In a national survey, the majority (80%) of Black individuals said that abortion should “remain legal and women should be able to get safe abortions.” Three-quarters (76%) agree that health insurance should cover abortion care.⁵⁴

BLACK WOMEN AND GIRLS ACCOUNT FOR MORE THAN ONE-THIRD (38%) OF ALL U.S. ABORTIONS, ALTHOUGH THEY COMPRISE JUST 13 PERCENT OF THE POPULATION



POLICY RECOMMENDATIONS

Legislators and other elected officials must respect science, ethics, and public opinion, and undo medically unnecessary barriers to abortion care. Congress, policymakers, and the Biden-Harris administration must act to ensure that the right to abortion care is fully available to *all* people.⁵⁵

- ***End all federal bans on abortion care coverage***

The Biden-Harris administration should revoke bans on abortion care affecting people who get their insurance from federal programs, including ACA exchanges. This includes reversing President Obama’s Executive Order 13535, which reinforced a commitment to preserve the anti-choice Hyde Amendment, which prevents federal funds from being used for abortion care.

- ***Allow trained and licensed advance practice medical professionals to provide early abortion care***

There is significant need for more medical professionals who can provide abortion care, particularly in rural, predominantly Black and Brown, and/or economically challenged communities. Expanding the number of providers that can perform abortion services in pregnancy’s early stages will improve outcomes for a large number of women.⁵⁶ Nurse practitioners, certified nurse midwives, physician assistants, and nurses should be allowed to provide this medically safe care.⁵⁷

- ***Institute preclearance provisions for states and local governments with a history of restrictive and non-evidence-based reproductive policies***

This type of preclearance would require any law related to reproductive health, rights, or justice to be scrutinized and approved by a federal body before being implemented. It would function similar to Section 5 of the Voting Rights Act of 1965.⁵⁸ Preclearance should be required for states and local governments that have demonstrated a history of restrictive and medically flawed policies on abortion care.

- ***Prohibit the abuse of “religious freedom” to restrict and/or ban access to abortion care***

Religious or personal beliefs should never be allowed to impact or hamper personal decision-making about whether and when to continue a pregnancy. Federal legislation should not allow exemptions or accommodations based on religious “freedom.” In addition, existing policy riders—which are designed to curtail reproductive health care—should be permanently repealed and blocked from being attached to annual federal appropriations (see the Religion and Reproductive Justice Freedom section).

- ***Remove all cost-sharing for abortion services***

Abortion is a safe, legal medical procedure, and should be affordable and accessible to everyone who needs this type of care. Yet, some individuals face challenges in getting the health care they need, when they need it. According to the National Financial Capability Study, nearly “one in three Black Americans aged 18 to 64 has past-due medical bills.”⁵⁹ To fully address systemic health disparities and economic inequity, health care costs should not be transferred to anyone seeking services, including for abortion care.

- ***Eliminate funding for crisis pregnancy centers***

Pregnant individuals need full and accurate information to make the best decisions for themselves and their families. Crisis pregnancy centers intentionally mislead clients, often by posing as legitimate and licensed medical centers, and provide them with inaccurate, non-scientific information and services in an attempt to manipulate people into maintaining a pregnancy.

In a national survey, the majority (80%) of Black individuals said that abortion should “remain legal and women should be able to get safe abortions.”

- ***Stop Deceptive Advertising for Women’s Healthcare Services Act***

Introduced in 2019 by Representative Carolyn Maloney (D-NY), this legislation would prevent unregulated and/or unlicensed entities or individuals (often calling themselves “crisis pregnancy centers”) to use coercive or deceptive practices to pressure or dissuade people from accessing abortion care—including by using misleading advertisements and impersonating clinical professionals. The Act should be expanded to also prohibit health care providers from being forced to recite medically-unfounded, misleading, and false “information” to abortion patients, which is current law in several states.⁶⁰

- ***Equal Access to Abortion Coverage in Health Insurance (EACH) Act***

Introduced in 2021 by Representatives Barbara Lee (D-CA), Jan Schakowsky (D-IL), Ayanna Pressley (D-MA) and Diana DeGette (D-CO) and Senators Tammy Duckworth (D-IL), Mazie Hirono (D-HI) and Patty Murray (D-WA), this legislation would allow low-income individuals to use their health care coverage (i.e., through ACA, Medicaid, Medicare, etc.) for all reproductive health services, including abortion care and contraception.

- ***Abortion is Health Care Everywhere Act***

Introduced in 2021 by Representative Jan Shakowsky (D-IL), this legislation would repeal the harmful Helms’ Amendment and remove distinctions between providing abortion care versus other reproductive care in international aid programs.⁶¹ Restrictions on the use of U.S. funds are rooted in colonialism, and are an example of using white supremacy to control the bodies and reproduction of Black and Brown people.⁶² This Act would ensure that pregnant people have bodily autonomy and can seek reliable and effective care.⁶³

- ***Women’s Health Protection Act***

Introduced in 2021 by Representatives Judy Chu (D-CA) and Lois Frankel (D-FL) and by Senators Richard Blumenthal (D-CT) and Tammy Duckworth (D-IL), this legislation would preempt state efforts to limit access to reproductive health care through restrictions, regulations, or requirements that are medically unnecessary and/or create undue burdens on people seeking abortion care.⁶⁴

The Affordable Care Act (ACA) does not require private insurance companies to cover abortion care; as a result, numerous states have enacted bans on abortion coverage for private insurers. Only a handful of states require coverage of abortion care.

Reproductive Justice can only be attained when Black women, femmes, girls, and gender-expansive individuals have the sexual health education they need to make positive and informed decisions about their lives and activities. Yet, throughout the nation's history, Black women, femmes, girls, and gender-expansive individuals' sexuality has been stolen, denied, objectified, and over-sexualized in unhealthy and toxic ways.

The Trump-Pence administration and a complicit Congress actively opposed both sexual health education and the provision of reproductive and sexual health resources and services to young people. This hostility reflects systemic racism and the withholding of needed information and resources for Black women, femmes, girls, and gender-expansive individuals, contributing to health disparities and misconceptions regarding safety in relationships, self-esteem and sexuality. As just one example, 72 percent of Black youth surveyed believe the media sends the message that sex appeal is Black females' most important quality.⁶⁵

Sexual health education must include information and strategies to address social pressures; foster self-esteem; build skills to hold con-

versations with potential partners; and address the stigma that impacts decision-making processes on the part of Black women, femmes, girls, and gender-expansive individuals.

An indicator of the pressing need for sexual health education is Black youth's disproportionate risk of experiencing unintended pregnancy and STIs, including HIV, the virus that causes AIDS. These risks are caused by structural racism and inequalities that lead to poor social determinants of health.

Teen pregnancy rates have fallen dramatically for girls of all races and ethnicities (from 1991 to 2013 the rate fell 66 percent for 15-to-19-year-old Black girls).⁶⁶ Nonetheless, Black girls are more than twice as likely to become pregnant before age 19, compared to white girls.⁶⁷ And, while teen birth rates declined 41 percent from 2006 to 2014,⁶⁸ Black teens' birth rate is more than twice that of white teens.⁶⁹

Pregnant and parenting Black youth must be supported in making their own reproductive choices, including unfettered access to abortion, prenatal and post-partum care, and child care. They must have the same opportunities to continue their education and enter the workforce as youth who do not become pregnant or parents.

Black teens are also at higher risk of STIs including chlamydia, gonorrhea, and HIV. Compared to white girls aged 15-19, Black girls have chlamydia rates 4.5 times higher, and gonorrhea rates are 8.8 times higher.⁷⁰ More than one-third (34%) of all HIV infections occur among Black youth aged 13 to 24.⁷¹ Black girls in this age range have a rate of new HIV infections that is 6 times higher than Hispanic girls, and 20 times higher than white girls. Most Black girls' HIV infections are from heterosexual sex.⁷²

Sexual health education is a catalyst to the information and empowerment needed to navigate if, when, and how to engage in safe and consensual sexual activity.⁷³ Sexual health education that is comprehensive, medically accurate, and culturally sensitive is effective at reducing reproductive and sexual health disparities and enabling people to get the tools and information needed to make the best decisions about our own bodies.⁷⁴ Evidence-based programs promote agency and help delay initiation of sexual activity; reduce rates of unintended pregnancies and STIs; and increase the use of more effective forms of contraception.⁷⁵

An indicator of the pressing need for sexual health education is Black youth's disproportionate risk of experiencing unintended pregnancy and STIs, including HIV, the virus that causes AIDS.

POLICY RECOMMENDATIONS

Congress should support programs that provide comprehensive sexual health education that includes content on physical development, sexuality, contraception, STI/HIV, pregnancy prevention, informed decision-making, gender identity and expression, gender-based violence, and sexual orientation.⁷⁶ Programs should also address changes that occur across the lifespan and pay attention to both intersectionality and social determinants of health.

- ***Prevent “religious freedom” from blocking access to comprehensive sexual health education***

Sex education for young people must be evidence-based to provide youth with the information and tools they need to achieve lifelong sexual health and well-being. Moral and religious interpretation should never be allowed to justify withholding medically accurate information that can preserve the health and well-being of young people (see the Religion and Reproductive Justice Freedom section).

- ***Increase funding for the Teen Pregnancy Prevention Program***

Congress should expand the Teen Pregnancy Prevention Program (TPPP) by diverting funds from grants that promote ineffective and harmful abstinence-only programs.⁷⁷ The TPPP funds medically-accurate and age-appropriate programs to reduce teen pregnancy. Funding should be increased to \$150 million in order to restore implementation of evidence-based programming and serve approximately 125,000 additional youth.⁷⁸

- ***Expand funding for increased sexual and reproductive health education for vulnerable populations***

The Personal Responsibility Education Program (PREP) is authorized through the ACA, and focuses on youth at increased risk of teen pregnancy, especially those facing challenges in accessing comprehensive sexual health education (i.e., youth who live in foster care, are homeless, are living with HIV/AIDS, pregnant and parenting).⁷⁹ Congress should allocate more funding for the PREP program, specifically for vulnerable populations.

- ***Real Education for Healthy Youth Act***

Introduced in 2021 by Representatives Barbara Lee (D-CA) and Rep. Alma Adams (D-NC) and Senators Cory Booker (D-NJ) and Mazie Hirono (D-H), this legislation affirms the right for young people to have access to medically accurate, inclusive, and comprehensive sexual education. It would provide needed investments for youth sexual education programs and help underserved young people connect to sexual education services.

- ***PrEP Access and Coverage Act***

Introduced in 2019 by Representative Adam Schiff (D-CA) and then-Senator Kamala Harris (D-CA), this legislation would expand access to and coverage of pre-exposure prophylaxis (PrEP) medication, which is effective at significantly reducing HIV transmission.

Sexual & Reproductive Health

CHRONIC HEALTH CONDITIONS

Reproductive Justice can only be achieved when Black women, femmes, girls, and gender-expansive individuals no longer experience disproportionate rates of health conditions that adversely impact our lives and lead to early death.

Systemic institutional racism leads to health disparities—particularly when it comes to chronic conditions. Lack of access to health care, receipt of lower-quality care, and high rates of daily stress—including the stress of racial and gender discrimination—increase Black women’s, femmes’, girls’, and gender-expansive individuals’ susceptibility to preventable and treatable chronic health conditions.

Black women, femmes, girls, and gender-expansive individuals suffer from alarming and dangerous rates of chronic health conditions, including cardiovascular disease (CVD), diabetes, obesity, and overweight. These health conditions directly impact our reproductive health and autonomy, as well as quality of life and well-being. In some high-poverty localities, excess mortality rates increased among Black women residents between 1990 and 2000, largely due to deaths attributed to chronic disease.^{80 81}

In fact, the federal Study of Women’s Health Across the Nation (SWAN) suggests that Black women aged 49–55 are 7.5 years older, biologically speaking, than white women.⁸² Perceived stress and poverty account for more than one-quarter (27%) of this difference.⁸³

Beyond increased susceptibility, Black individuals have worse outcomes because they are less likely to seek preventive services. This reluctance is likely driven, in part by lack of access, lack of trust in medical professionals, and/or by experiences with discrimination and/or bias from white providers. Black individuals have better outcomes, and experience less pain, when they receive services from a doctor who is a person of color.^{84 85 86}

Cardiovascular Diseases

Cardiovascular disease (CVD) is the term for the diseases that affect the heart and its blood vessels; CVD includes heart disease, including clogged arteries, which cause heart attacks; strokes; congenital heart defects; and peripheral artery disease.⁸⁷

Heart disease is the leading cause of death for men and women in the U.S., and stroke is the fifth-leading cause of death.⁸⁸ According to the American Heart Association (AHA), Black adults are 32 percent more likely to die from CVD, and more than twice as likely to die from heart disease, than individuals of other races/ethnicities.^{89 90}

Black women have a three-fold greater risk of developing CVD than other Americans.⁹¹ Almost half (49%) of all Black women aged 20 and older have heart disease,⁹² yet only one-fifth of Black women know that they might personally be at risk.⁹³ Heart disease is the leading cause of death among Black women, and stroke is the third-leading cause.⁹⁴ Cardiovascular complications are also the leading cause of Black women’s pregnancy-related deaths.

These higher risks have multiple causes. CVD and heart disease’s major risk factors disproportionately impact Black women, femmes, girls, and gender-expansive individuals—including high rates of chronic conditions such as hypertension, diabetes, obesity, and overweight.⁹⁵

⁹⁶

Lack of access to health care, receipt of lower-quality care, and high rates of daily stress—including the stress of racial and gender discrimination—increase Black women’s, femmes’, girls’, and gender-expansive individuals’ susceptibility to preventable and treatable chronic health conditions.

Hypertension

Hypertension, also called “high blood pressure,” is one of the leading risks for CVD.⁹⁷ Black women develop high blood pressure at earlier ages, and have higher average blood pressures, compared to white women.⁹⁸ By age 55, three-quarters (75.7%) of Black women have developed high blood pressure.⁹⁹ Black women are 60 percent more likely to have hypertension compared to white women. Hypertension is the tenth-leading cause of death for Black women.¹⁰⁰

Diabetes

The Black community is at high risk for diabetes, which can lead to multiple severe health problems, including CVD, end stage renal disease, and retinopathy. Compared to those of other races and ethnicities, Black individuals are more likely to be diagnosed with diabetes, to be hospitalized for lower limb amputations due to complications of diabetes, and to die from diabetes.¹⁰¹ Black women are almost twice as likely to be diagnosed with diabetes than white women, and more than twice as likely to die from diabetes.¹⁰² Diabetes is the fourth-leading cause of death for Black women.¹⁰³

Obesity & Overweight

Obesity and overweight are complicated medical conditions with a wide range of causes, including lack of access to healthy food, opportunities for physical activity, and high-quality health care, including nutritional services and mental health services. The conditions can lead to a variety of negative health outcomes, including high rates of hypertension, bad cholesterol, diabetes, and CVD.¹⁰⁴ ¹⁰⁵ Black women have the highest rates of obesity and overweight in the U.S,¹⁰⁶ with 80 percent experiencing these conditions.¹⁰⁷ ¹⁰⁸ Black women are 50 percent more likely to be obese than white women.¹⁰⁹

POLICY RECOMMENDATIONS

Chronic health conditions are influenced and/or driven by social determinants of health, “the circumstances in which people are born, grow, live, work, and age, and the systems put in place to deal with illness.”¹¹⁰ ¹¹¹ Systemic racism, persistent stress, and the resulting social determinants of health are literally killing Black women, femmes, girls, and gender-expansive individuals.

- ***Ensure health care coverage for all people regardless of pre-existing conditions***

Everyone needs access to comprehensive, affordable, and high-quality health care.¹¹² Having good health care is a major protective factor for many chronic health conditions and their outcomes, including CVD, hypertension, diabetes, and obesity.¹¹³ Congress should expand the ACA and include the public option provision to ensure that all Americans can access free or minimal-cost insurance and be able to get timely, high-quality preventive and treatment services, including medications.¹¹⁴ Health care coverage is a right—not privilege.

- ***Increase funding for programs and education for Black women, femmes, girls, and gender-expansive individuals about chronic conditions’ prevention, screening, and treatment***

Congress should increase funding for programs that specifically focus on chronic conditions that disproportionately impact women of color—including Black women, femmes, girls, and gender-expansive individ-

uals. These include CVD, hypertension, diabetes, and obesity. Funding should support programs in a variety of settings (i.e., educational facilities, workplaces, community centers, faith-based organizations). Programs should promote healthy decision-making, such as getting enough physical exercise, not smoking, and eating a nutritious diet. These programs have the potential to lower the risk of chronic conditions among Black women, girls, and gender-expansive individuals.

- ***Stabilize costs for insulin and other medications to treat chronic conditions***

Even for those with insurance, the rising costs of medications for chronic conditions is a life-threatening danger—this is particularly true for insulin, which is necessary to treat diabetes. The most common types of insulin cost 10 times more in the U.S. than in other high-resource countries, and costs have risen faster than the rate of inflation.¹¹⁵ Legislators should act immediately to cap and reduce the costs of life-saving medications, including insulin.

- ***Fund programs to address racism, diversity, and cultural competency for health care and medical professionals***

All individuals benefit from being able to access health care that is timely, respectful, and culturally relevant, competent care and services. To meet this goal, the U.S. should expand both medical professionals' diversity and access to diversity and cultural competency training provided via medical school, board exams, and Continuing Medical Education (CME) credits. Training should be based on patient-centered and trauma-informed care that includes Critical Race Theory to address implicit bias. Until true culture change occurs, cultural sensitivity training for medical providers must be mandatory. Federal funding should support training to address and eradicate medical bias against Black individuals, including stereotypes that result in providers disbelieving Black patients who are experiencing pain, providing incomplete information, and providing insufficient care and treatment.

- ***Increase federal funding for the identification and amelioration of health disparities, including those caused by social determinants of health***

As noted, many chronic health conditions are driven by social determinants of health—including poverty and lack of access to high-quality health insurance, nutritious food, opportunities for physical activity, and

culturally competent health care providers. Congress should expand funding for research to identify and ameliorate disparities that exacerbate chronic conditions and drive poor health outcomes.

- ***Increase funding for investments in predominantly Black communities***

Congress should increase funding opportunities for community-based and led Black organizations that support health promotion and reduce chronic conditions. This should include incentives to encourage banks and other lenders to invest in and prioritize Black community-based entrepreneurs who want to invest in under-served, disadvantaged, and disenfranchised communities (i.e., supporting an entrepreneur who wants to start an affordable gym in an urban area).

- ***Chronic Condition Copay Elimination Act***

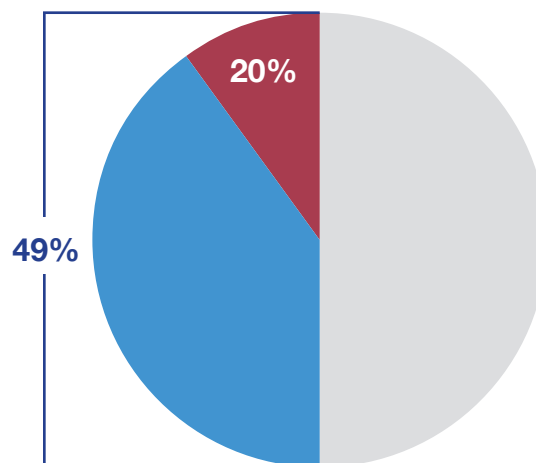
Introduced in 2019 by Representative Lauren Underwood (D-IL), this legislation would eliminate cost-sharing requirements for additional preventive care for individuals with chronic health conditions including co-pays, coinsurance, and deductible-related fees. This would reduce some of the financial barriers that inhibit Black women, girls, and gender-expansive individuals from accessing needed care in a timely manner.

PERSONAL STORY

In 2015, I went without a doctor visit for nearly a year due to scheduling issues with my physician, who partially worked out of the publicly funded hospital here in Atlanta, GA. I called to schedule appointments several times... not only was I rerouted several times but I also never spoke to the person I needed to and never received an appointment. I finally took an entire day off work to sit in the hospital for hours—only to finally be given an appointment for another day a month away. I missed two days off work to get my prescriptions, and was dangerously close to being out of my life-saving diabetes medication. It was finally discovered that I was being treated as such because it was assumed that I was using public insurance (Medicare/ Medicaid) because I was seeing my doctor at the public hospital. I had only chosen this location because it was closer to my home than his office on the other side of town.

Once it was established that I did indeed have private insurance, I was treated differently. This story highlights the disparity of care that happens to those who are publicly insured, and the need for other ways to access care, like telemedicine, to avoid missing out on needed medication and health care. All Americans deserve the access to affordable, competent, compassionate, and culturally sensitive health care. Unfortunately, many Black people living with diabetes often do not get it. We demand that our legislators take the necessary steps to help alleviate some of these disparities.

Almost half (49%) of all Black women aged 20 and older have heart disease, yet only one-fifth of Black women know that they might personally be at risk.



- ***Protecting Access to Post-COVID-19 Telehealth Act***

Introduced in 2021 by Representatives Mike Thompson (D-CA), Doris Matsui (D-CA), Peter Welch (D-VT), Bill Johnson (R-OH), and David Schweikert (R-AZ), this legislation would expand telemedicine regulations permanently. During the COVID-19 pandemic, the federal government expanded the ability of health care programs to use telemedicine for appointments and prescription renewals. Telemedicine is popular with both providers and patients because it eliminates barriers to care, including the lack of transportation or child care. The Act should be expanded to provide resources that improve access—especially for those who lack technological access, such as those who are low-income or who live in rural areas with limited broadband.

- ***Treat and Reduce Obesity Act***

Introduced in 2019 by Representative Ron Kind (D-WI) and Senator Bill Cassidy (R-LA), the Treat and Reduce Obesity Act would expand Medicare coverage to include obesity screening and treatment by a diverse range of health care providers.¹¹⁶ The Act would also include coverage of FDA-approved medications for chronic weight management.¹¹⁷

- ***Allied Health Workforce Diversity Act***

Introduced in 2019 by Representative Bobby Rush (D-IL) and Senator Robert Casey (D-PA), this Act would ensure a diverse and inclusive health care workforce.¹¹⁸ Programs to improve the healthcare workforce's diversity include low-interest grants, loan repayment programs, scholarships and fellowship.¹¹⁹

Federal funding should support training to address and eradicate medical bias against Black individuals, including stereotypes that result in providers disbelieving Black patients who are experiencing pain, providing incomplete information, and providing insufficient care and treatment.

Reproductive Justice can only be achieved when Black women, femmes, girls, and gender-expansive individuals have access to high-quality health care; effective prevention and screening programs; and timely treatment to prevent, identify, treat, and survive reproductive cancers—reproductive cancers affect the breasts, uterus, cervix, and ovaries.

As a result of systemic racism, Black women, femmes, girls, and gender-expansive individuals face challenges in all of these areas.¹²⁰ The outcome is that Black people experience cancer at significantly higher rates than other racial/ethnic groups. Black women are more likely to receive a cancer diagnosis at a later stage (when it is less treatable) and, as a result, have lower survival rates at each stage of diagnosis. Studies have shown that queer women have a greater risk for gynecologic cancers, and that lesbians and bi women have higher rates of morbidity and mortality as a result of reproductive cancers.¹²¹ There are also specific variations in the types of cancer that Black women, femmes, and gender-expansive individuals are more likely to experience than those of other races/ethnicities.

Breast Cancer

Breast cancer is the second-leading cause of cancer-related deaths in the U.S. While Black women are diagnosed with breast cancer at about the same rate as white women, they have significantly higher rates of death, compared to other racial and ethnic groups.¹²²

White women are more likely to be diagnosed at an earlier stage, leading to better outcomes. For reasons that are not yet clear, Black women are also more likely than white women to be diagnosed with an aggressive type of cancer called triple negative breast cancer (TNBC).¹²³

With early detection and effective treatment, breast cancer is now more treatable than ever. Yet, Black women, femmes, and gender-expansive individuals are less likely to have high-quality insurance (and, hence, access to timely screening and prevention services) and sufficient medical leave to ensure they can get treated, once diagnosed.¹²⁴

Cervical Cancer

Cervical cancer is one of the most preventable and treatable cancers, as long as women have access to screening and treatment services.¹²⁵ The vast majority of cervical cancers are caused by the Human Papilloma Virus (HPV), an extremely common STI.^{126 127} Screening using the Pap test is critical to identify and treat HPV before it develops into cervical cancer. Beyond screening, the HPV vaccine can reduce cervical cancer rates by as much as 90 percent.¹²⁸

Black women experience higher rates of HPV-related cervical cancer, and lower five-year survival rates, compared to other racial and ethnic groups.^{129 130} Lack of access to insurance and high-quality health care makes it harder for Black women, femmes, girls, and gender-expansive individuals to access cancer screening, including Pap tests and

the HPV vaccine. And, medical mistrust has slowed uptake of the HPV vaccine among some Black communities.

Complicating the situation is the recent discovery that the HPV vaccine may not work as well for Black women. This occurs because the HPV vaccine protects against cancer-causing strains of HPV (16 and 18) that are far less common in Black women, and does not protect against the cancer-causing strains (31, 33, 45, 56, 58) more frequently experienced by Black women.¹³¹

Ovarian and Uterine Cancer

Ovarian cancer is the leading cause of women's deaths from reproductive cancer and is called the "silent killer" because its symptoms can be mistaken for less serious health issues either by the patient who postpones seeking medical care or the provider who is not trained on to consider or screen for ovarian or uterine cancer. Yet early detection and treatment of these cancers is critical to survival. For this reason, early detection and treatment is critical to survival. Because of health disparities, including reduced access to health insurance and screening, Black women, femmes, girls, and gender-expansive individuals are more likely to be diagnosed at a later stage of ovarian cancer, leading to increased mortality.¹³² With early diagnosis, the five-year survival rate for uterine cancer is more than 50 percent higher for women diagnosed while the cancer

was still localized.¹³³ Because of later diagnosis, Black women experience fewer new cases of ovarian cancer annually, but have five-year survival rates that are lower than women of other races and ethnicities.¹³⁴

Another risk factor is toxic ingredients in the personal care products marketed to, and used by, Black women, femmes, girls, and gender-expansive individuals—particularly baby powder (see “Exposure to Dangerous Chemicals” section).

Talc, a key ingredient in baby powder, can be contaminated with asbestos, a cancer-causing agent.¹³⁵ For decades, Johnson & Johnson knew that its baby powder contained asbestos, but failed to alert regulators or its customers. Instead, the company specifically targeted women of color as customers, in order to maintain sales. Multiple studies have found increased risk rates of ovarian cancer among Black women who use talc-based baby powders.¹³⁶

The CDC reports that non-Hispanic white and Black women have similar incidences of uterine cancer, but that Black women are more likely to be diagnosed with the more aggressive form of uterine sarcoma.¹³⁷ Additionally, the CDC reports that Black women are more likely to be diagnosed at a later stage of disease, compared to women of other races and ethnicities.

POLICY RECOMMENDATIONS

Research focused on the health of Black women, femmes, girls, and gender-expansive individuals; better access to cancer screening and treatment; and robust public health education are needed to improve outcomes of those diagnosed with reproductive cancers.

- ***Increase funding for federal agencies engaged in cancer research***

It is critical to support research to understand why Black women are more likely to die from reproductive cancers as well as public health plans to decrease our morbidity and mortality. Consistent and robust funding for agencies that support cancer research is necessary to support life-saving investigations and program development, including those directed by the National Institutes of Health (NIH), the National Cancer Institute (NCI), and the CDC’s Division of Cancer Prevention and Control.

- ***SAME Act (Senate) and the Incentivizing Medicaid Expansion Act (House)***

Introduced in 2021 by Representative Marc Veasey (D-TX) and Senator Mark Warner (D-VA), this legislation would incentivize states to expand Medicaid and enhance funding for services. Millions of Black women, femmes, girls, and gender-expansive individuals live in states that have not expanded Medicaid coverage under the ACA. As a result, these individuals lack access to the health insurance and services needed to effectively screen and treat health conditions, including reproductive cancers.

- ***Jeanette Acosta Invest in Women’s Health Act***

Introduced in 2021 by Representative Jimmy Gomez (D-CA) and Senator Patty Murray (D-WA), this legislation would expand access to HPV vaccines, Pap tests, and other diagnostic tests to screen for reproductive cancers. It would offer grants to community health and family planning centers to expand gynecological cancer screenings. It would also fund research on the availability and awareness of screening options for women who are disproportionately affected by reproductive cancers, including Black women.

- ***Triple-Negative Breast Cancer Research and Education Act***

Introduced in 2021 by Representative Sheila Jackson Lee (D-TX), this legislation would provide funding for research and education on TNBC, which is more common among Black women. It would support the research needed to learn more about TNBC’s risk factors, screening mechanisms, and effective treatments.

- ***Endometrial Cancer Research and Education Act***

Introduced in 2020 by Representative David Scott (D-GA), this legislation would increase funding for endometrial cancer research, including specific funding for research on racial disparities in diagnosis and mortality.

Reproductive Justice can only be achieved when Black women, femmes, girls, and gender-expansive individuals can safeguard our mental health and get the help we need for emotional distress, including distress caused by anxiety, depression, or trauma.

Black people experience mental health issues at the same rate as other racial and ethnic groups in the U.S.¹³⁸ But, in addition to traditional mental health challenges people face (like depression or anxiety) Black Americans experience profound mental and emotional distress that is uniquely and directly linked to racial oppression—and, for Black women, femmes, girls, and gender-expansive individuals—to the intersection of “racial and gender oppression.”¹³⁹

Yet, mental health providers of color, who are “known to give more appropriate and effective care to Black and African American help-seekers, make up a very small portion of the behavioral health provider workforce.”¹⁴⁰ Fewer than four percent of licensed mental health practitioners are Black,¹⁴¹ meaning that the mental health workforce is inadequate to meet the needs of Black and Brown communities. The mental health field has yet to broadly implement clinical training that would increase awareness and understanding of the

unique psychosocial needs of Black women, femmes, girls, and gender-expansive individuals.

Other barriers to accessing culturally competent and responsive mental health services include personal and community stigma against help-seeking behaviors, negative experiences with health care providers, lack of access to mental health services, and inadequate health care coverage.¹⁴² As a result, only about 30 percent of Black people who need mental health care receive it, compared to almost half of white Americans.^{143 144}

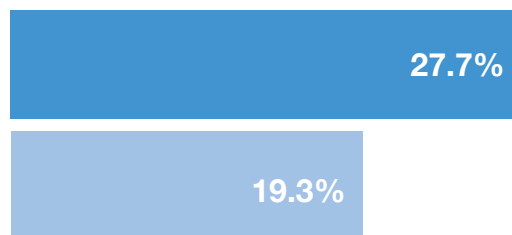
And, historically, mental health research has been grounded on Western, white, middle-class male experiences. Women in general, and women of color specifically, have not been engaged in participatory research. This failure contributes to the risk that Black women, femmes, girls, and gender-expansive individuals may be misdiagnosed, mistreated, criminalized, and/or labeled as inferior.¹⁴⁵ While the field of Feminist Psychology is growing, a gap remains in available research literature that is centered on the lived experiences and mental health needs of Black women, femmes, girls, and gender-expansive individuals.

Meanwhile, the COVID-19 pandemic is highlighting U.S. health disparities, particularly among

people of color. Black Americans are 2.9 times more likely to be hospitalized and 1.9 times more likely to die of COVID-19 than non-Hispanic whites.¹⁴⁶ The CDC has found that, during the pandemic, specific groups are experiencing mental health conditions at disproportionately high rates. These groups include young adults, Black and Hispanic individuals, essential workers, unpaid caregivers for adults, and those being treated for preexisting psychiatric conditions.¹⁴⁷ At the beginning of the pandemic (April-May 2020) 27.7% of Black individuals reported symptoms of depression,¹⁴⁸ up from 19.3% percent in 2019.¹⁴⁹ Black individuals also report higher rates of increased substance use and having seriously considered suicide in the past month, compared to white and Asian individuals.¹⁵⁰

The stereotype of the “strong Black woman” has historically described Black women’s response to the sheer need to persevere and be resilient in the face of staggering levels of misogyny and racism—and resulting widespread economic and health disparities. This label, however, places an undue burden on Black women, femmes, girls, and gender-expansive individuals, often at significant cost to our mental and emotional well-being.

At the beginning of the pandemic, 27.7% of Black individuals reported symptoms of depression, up from 19.3% percent in 2019.



POLICY RECOMMENDATIONS

Black women, femmes, girls, and gender-expansive individuals need mental health services now more than ever given the racial reckoning in the country (which is largely being led by Black women) as well as a global pandemic that is disproportionately impacting Black and Brown communities. We can no longer ignore the pandemic of mental, emotional, and behavioral needs of Black women, femmes, girls, and gender-expansive individuals.

- ***Increase funding for racial- and gender-specific research on mental health and substance use experiences***

There is a need for a better understanding of the mental health stressors faced by Black women, femmes, girls, and gender-expansive individuals. Without it, culturally-responsive and evidence-based interventions and treatments will remain limited, at best. This research should address the psycho-emotional and mental health impacts of white supremacy; historic trauma; systemic racism; a biased health care system; and law enforcement's and politicians' over-policing of Black women, families, and communities.

- ***Expand the mental health and substance use workforce and improve its cultural competency***

To ensure that all individuals can access health care that is timely, respectful, and culturally relevant, legislators should expand medical professionals' diversity in general, and their access to diversity and cultural competency training, specifically. Such training can be provided via medical school, board exams, and CME credits. Training should be based on patient-centered and trauma-informed care, that includes Critical Race Theory to address implicit bias. Training should also include support for programs to help those in the educational and criminal justice systems recognize early signs of mental illness and/or substance use, and train them to respond without bias or discrimination, to ensure that people get the help they need and are not further traumatized in the process.

- ***Expand access to mental health services and medications via telemedicine***

COVID-19 has highlighted the convenience and popularity of remote access to providers and prescription orders. To ensure consistent access to needed care, clinicians should be allowed to provide mental health care via telemedicine, and to have prescriptions mailed to clients. Insurance companies should also be encouraged to provide reimbursement for 90-day rather than 30-day prescriptions, depending on the class of medication.

- ***Provide rehabilitative funding and support for drug-dependent pregnant people***

Mental health problems can sometimes lead to substance use disorders (SUD) if people try to self-medicate with drugs or alcohol. This can be particularly harmful for pregnant people who become drug-dependent and, as a result, risk incarceration and/or loss of custody. Congress should support programs that help individuals who are experiencing SUD to create addiction recovery plans centered on meeting their individual and family goals. Funding should be expanded for behavioral health and treatment programs for parents as well as those who are pregnant and/or at-risk of pregnancy due to substance abuse. Incarceration is not the answer. (See the Maternal Health section.)

Legislators should expand medical professionals' diversity in general, and their access to diversity and cultural competency training, specifically.

A gap remains in available research literature that is centered on the lived experiences and mental health needs of Black women, femmes, girls, and gender-expansive individuals.

• **Tele-Mental Health Improvement Act**

Introduced in 2020 by Senators Tina Smith (D-MN) and Lisa Murkowski (R-AK), this legislation would extend coverage for telehealth services for those who are school-aged, have a current mental health diagnosis, or are experiencing SUD. It would ensure that these individuals have the audio-video support they need to maintain their well-being and counteract the social isolation and economic insecurity resulting from the COVID-19 pandemic.

• **Resilience Investment, Support, and Expansion (RISE) from Trauma Act**

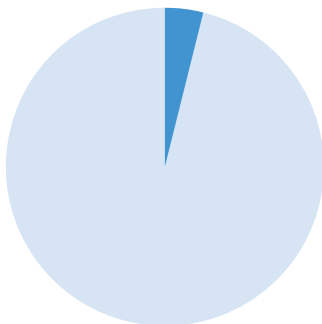
Introduced in 2019 by Representative Danny Davis (D-IL) and Senator Dick Durbin (D-IL), the legislation would support data collection related to mental health conditions; SUD; and trauma that results from race/ethnicity, gender, gender-identity, sexuality, and/or disability. It should include funding for Black women and femme researchers to expand knowledge and understanding of this population's unique mental and behavioral health needs, with a goal to expand culturally competent and appropriate interventions that are specific to the community.

• **Mental Health Services for Students Act**

Introduced in 2019 by Representative Grace Napolitano (D-CA) and Senator Tina Smith (D-MN), this legislation would invest in resources to address Black children's mental and emotional needs without violence and aggression. This Act would redirect funding from school policing and expand support for school counselors and social workers in order to ensure that schools can be a safe haven for Black youth.

• **LGBTQ Essential Data Act**

Last introduced by Representative Sean Patrick Maloney (D-NY) in 2019, this legislation directs the Centers for Disease Control and Prevention to increase and improve data about sexual orientation and gender identity of deceased individuals through the National Violent Death Reporting System, which includes suicides.¹⁵¹ (See the Religion and Reproductive Justice section.)



Fewer than four percent of licensed mental health practitioners are Black, meaning that the mental health workforce is inadequate to meet the needs of Black and Brown communities.

Reproductive Justice can only be achieved when Black women, femmes, girls, and gender expansive people have the rights, information, and opportunity to make and act upon their own decisions about whether and how to apply medical and technological advances to their lives.

While these advancements have the potential to be good and improve health outcomes—they also stem from a troubling legacy. For example, Black women’s bodies have historically been used to advance science, often without informed consent. This history includes Anarcha, Betsy, and Lucy, the enslaved Black women experimented on by J. Marion Simms, and Henrietta Lacks, whose cells were cultured without her informed consent or compensation, and have since been used for countless medical research studies and advancements.

Medical and technological advancements raise critical ethical and safety questions. Policies and regulations often lag far behind science, complicating questions about what is morally acceptable and socially beneficial. These issues are particularly salient with respect to assisted reproductive technology and genetic engineering.

Black women’s bodies have historically been used to advance science, often without informed consent.

Assisted Reproductive Technology

Since its development in the 1980s, assisted reproductive technology (ART) has been widely used to help people address fertility issues, including among heterosexual couples, same-sex, queer, and gender-expansive couples and individuals of all sexual orientations and gender identities turn to ART as a viable way to become pregnant. (See the LGBTQ+ Liberation section.)

The Centers for Disease Control and Prevention (CDC) defines ART as: “fertility treatments in which either eggs or embryos are handled. In general, ART procedures involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman.”¹⁵² Two common forms of ART are *in vitro* fertilization (IVF) and intracytoplasmic sperm injection (ICSI), which can address some male infertility issues.¹⁵³

Black women are more likely, perhaps twice as likely, to experience problems with fertility, compared to white women.^{154 155} The reasons

for this are both complicated and inter-connected. Black women are less likely to have high-quality health care that includes infertility treatment;¹⁵⁶ more likely to experience health conditions that impair fertility (including fibroids,¹⁵⁷ STIs, obesity, and overweight¹⁵⁸); more likely to use products that contain harmful endocrine-disrupting chemicals (EDCs);¹⁵⁹ and have an increased likelihood of exposure to environmental poisons that impact reproductive health.

Despite experiencing higher rates of infertility, Black women are less likely to seek and/or access treatment for infertility, including ART,¹⁶⁰ largely due to costs. There are stark racial/ethnic and socio-economic divisions in who can access ART. For example, IVF is very expensive, and is often not covered by health insurance; as a result, it is disproportionately underutilized by Black women. A single IVF cycle can cost between \$12,000 and \$17,000—not including medication.¹⁶² And, more than one cycle is almost always required.¹⁶³ In addition to the costs for medical procedures, there are expenses associated with the purchase and storage of donor eggs/sperm, legal fees to solidify agreements between parties in writing, and other expenses. These costs exceed the reach of many Black individuals and families, making fertility treatment inaccessible.¹⁶⁴

In addition to concerns about access and costs, ART also raises questions about autonomy and consent. Gestational surrogacy,*

* In traditional surrogacy, the person’s own egg is used, and is artificially inseminated with sperm from a donor. In this case, the pregnant person carries their own pregnancy

egg donation, and egg harvesting are three areas where these questions are particularly profound. With these procedures, one woman provides either the uterus (gestational surrogacy) or the eggs (egg donation or harvesting) to advance another person's pregnancy.

It is important to protect both the surrogate/donor and the future parents when these forms of ART are used. This is particularly necessary, given the increase in both domestic and international surrogacy; the CDC notes that rates of gestational surrogacy tripled from 2007 to 2015.¹⁶⁵

As rates of international and domestic surrogacy rise, close attention must be paid to surrogates' decisions about continuing or ending a pregnancy; autonomy over having a vaginal or cesarean birth; postpartum care; ensuring informed consent and autonomy of movement; and decisions about keeping the baby, once born.¹⁶⁶ The proliferation of "baby farms," where women's bodies are exploited to gestate children is a particular danger.¹⁶⁷

to term.



Henrietta Lacks circa 1945–1951. Henrietta Lacks' cancer cells are the source of the HeLa cell line, the first immortalized human cell line and one of the most important cell lines in medical research. An immortalized cell line reproduces indefinitely under specific conditions, and the HeLa cell line continues to be a source of invaluable medical data to the present day.

Genetic Editing

Genetic editing is a process with the potential to do great good—or great harm. There are two types of genetic editing: somatic and germline. *Somatic gene editing*, more commonly known as “gene therapy,” makes changes to the individual's genes that are not inherited by their offspring. *Germline editing* makes changes to the individual's genes that are inherited by their offspring (and by future generations).

Both processes are used in medical research and agriculture; the debate around using gene editing—particularly germline editing—to control, promote, or eradicate human conditions raises many ethical questions. Germline editing has the potential to alter a species' evolution by creating changes that are passed down to future generations and creating the ability to engineer human embryos. The range of specific conditions or characteristics to which this technology could be applied is vast and includes specific

conditions; genders; and attributes, such as enhanced night vision or sense of smell.

In 2018, a Chinese researcher created genetically modified embryos designed to be resistant to HIV (the virus that causes AIDS) by disabling the CCR5 gene.¹⁶⁸ The resulting embryos were placed into two women, who subsequently gave birth to the world's first genetically modified babies.¹⁶⁹ Since HIV is preventable, treatable, and primarily affects marginalized communities, these genetic modifications raised concerns about using medical advancements to address problems created by inequality, oppression, and disenfranchisement.

The situation is further complicated by the fact that the researcher appears to have violated numerous scientific and medical standards, such as not obtaining complete informed consent from the women who became pregnant. The World Health Organization (WHO) has since started tracking research on human genome editing, after a call to halt this practice.¹⁷⁰

POLICY RECOMMENDATIONS

For both ART and gene editing, it is critical to balance concerns about historic abuse and marginalization with addressing long-standing barriers to accessing medical and scientific advancements. Black and Brown communities have historically been used for harmful reproductive experimentation. At the same time, these communities are too often unable to financially afford scientific advancements and their potential benefits. Legislators should look carefully at how to address and balance these important issues.

- ***Create a Congressional committee to specifically address new biotechnologies and their bioethical implications***

Congress needs to ensure effective oversight of these new medical technologies. A new Committee to address biotechnologies and their ethical implication would facilitate an assessment and evaluation of their impact on society, particularly with respect to race/ethnicity, socio-economic status, gender, and gender expression.

- ***Create a new federal department to evaluate and monitor advancements in genetic engineering, use of synthetic biology and other emerging technologies***

A federal department is needed to make specific recommendations about laws and regulations that are needed to protect the public, particularly disenfranchised and marginalized communities. These include requirements and protections for ART (i.e., de-incentivizing implementation of multiple embryos, storage and handling of human gametes, etc.) and for commercial surrogates, including protections that center the surrogate's autonomy. The new department would also strive to ensure diversity among research teams and clinical trial participants—this is necessary to ensure that Black women, girls, femmes, gender-expansive individuals, and people with disabilities are represented and their health concerns addressed.

- ***Pass legislation that ensures equitable and ethical practices for ART and reduces disparities in access***

Congress should set parameters for the equitable and ethical practice of ART. These parameters must expand access to infertility treatments (i.e., intrauterine insemination, IVF) through insurance and coverage plan mandates, including the ACA. It should also include funding for research, including research on ART's short- and long-term side effects, particularly on Black women, girls, and gender-expansive individuals, trans men, and people with disabilities. And, it should identify and address the causes of infertility (i.e., environmental factors, genetics, health conditions, etc.) while continuing to research additional causes, screening and treatment methods for infertility. Such legislation should establish a national registry of egg donors that tracks donors' race/ethnicity, age, and income level. Finally, legislation should ensure that individuals who want to have children do not face barriers based on their gender identity or expression, chronic health conditions, or disabilities.

- ***Diversify science, technology, engineering, and medicine education, scholarships, and fellowships***

Science, technology, engineering, and medicine (STEM) programs should be expanded to ensure that more people can benefit from technological advances and all individuals are aware of, informed about, and contributing to scientific advancement. Fellowships and internships should be paid opportunities, with marginalized communities given priority. All STEM programs should have robust training and curricula on ethics, racial and gender inequalities, and anthropology.