Assessing and Strengthening a Reproductive Rights and Justice Infrastructure in Michigan

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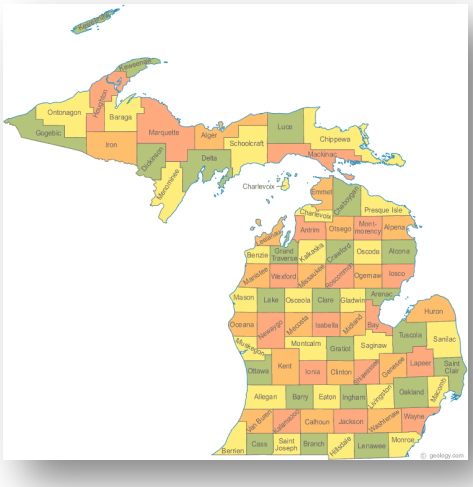
Overview and Purpose

This document provides a road map for understanding the contemporary context of sexual and reproductive health, rights, and justice in Michigan. Guided by core definitions of reproductive justice, we hope to identify enabling and constraining social, economic, cultural, legal, and health conditions that shape the abilities of Michiganders to have a child, not have a child, and parent that child in a healthy and supportive environment.



This document was created as a companion resource for our assessment of reproductive rights and justice organizations in Michigan, with the aim of signposting areas for capacity and infrastructure building. It is a work in progress to be informed by reproductive justice organizations through on-the-ground interviews and site visits. This document does not offer policy or advocacy recommendations.

Our geographic focus is lower Michigan (the "mitten," not including the Upper Peninsula), which contains 65 of 83 of the state's counties. Although we are attentive to longer historical patterns, we concentrate on the 21st century with heightened attention to the impact of the Great Recession of 2007 on Michiganders.

(continued)

What is Reproductive Justice?

Reproductive Justice is the complete physical, mental, spiritual, political, social, and economic wellbeing of women and girls, based on the full ***achievement and protection of women's human rights****.*

Reproductive Justice is grounded in these three principles:

1. ***The right to have a child***
2. ***The right not to have a child***
3. ***The right to parent our children in safe conditions and with dignity***

Reproductive Justice makes use of these three disciplines:

1. ***Reproductive health – service delivery***
2. ***Reproductive rights – legal issues***
3. ***Reproductive justice – movement building***

RJ analyses also incorporate ***intersectionality*** *– the recognition of the interconnection of race, class, gender, sexuality, disability, and other systems of oppression.*

The Reproductive Justice framework acknowledges that the ability to determine ***our reproductive destiny is linked directly to the conditions in our communities****. These conditions are not merely determined by individual choice and access, but are also deeply affected by the social realities of inequality. Consequently, this framework includes* ***government obligations to protect our human rights****. Our options for making choices must be* ***safe, affordable, and accessible****, the three minimal cornerstones of government support for all individual life decisions.*

These definitions are drawn from the work of SisterSong, Forward Together, and Kimberlé Crenshaw.

We are particularly interested in evaluating opportunities for and barriers to the expansion of reproductive rights and justice for women of color, LGBT communities, youth including trans- and HIV positive youth, as well as underserved poor and rural communities.

This context review suggests that building capacity and growing the infrastructure for reproductive rights and justice in Michigan will be very challenging given the state's struggling economy, political climate, restrictive legal environment, entrenched racial segregation and disparities, and suboptimal patterns related to reproductive and sexual health.

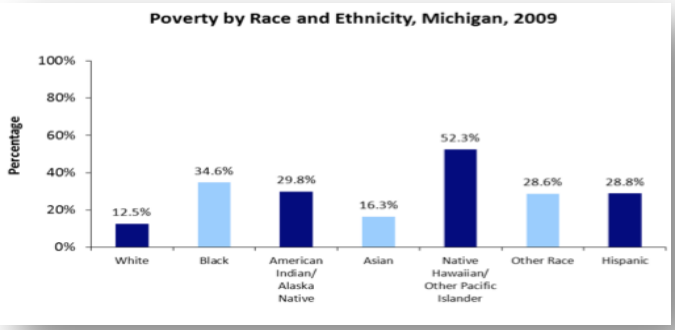
General Background

Comparative Indicators

Michigan is distinguished by average to poor performance and outcomes on many key social, economic, and health indicators. Already strained by deindustrialization and jolted by the 2007 Great Recession, Michigan was hit severely hard by the 2008-2010 collapse of the "Big Three" auto companies, an economic event that has had a cataclysmic impact on southeastern Michigan.[1] While there is some evidence of recent economic recovery in Michigan, these positive developments vary dramatically from region to region.[2]

Michigan does not fare poorly on all critical health indicators; according to state government reports, for example, the state's rates of insurance coverage and binge drinking are slightly better than national averages. However, the state performs worse than average on many crucial indicators, such as infant mortality, maternal mortality, life expectancy, hypertension, and cardiovascular disease, among others.[3]

In addition, after a long trend during which Michigan's poverty level was lower than the national average, since the 2007 Recession that rate, now 15.4%, has surpassed the U.S. average of 14.2%. More disconcerting is the fact the 44% of Michigan's children live in low-income families, half of these, or 22%, below the federal poverty threshold.[4]



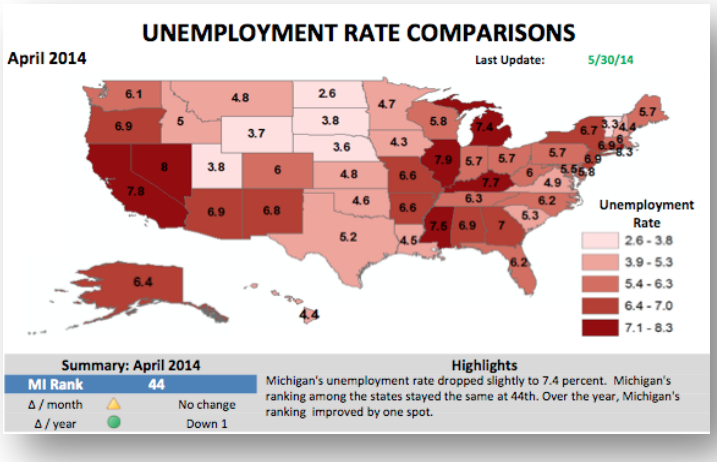
These socio-economic indicators are deeply stratified by race and ethnicity, with 52.3% of Native Hawaiian/Pacific Islands living in poverty, followed by 34.6% of African Americans, 29.8% of American

[1] Thomas J. Sugrue, *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit* (Princeton University Press, 2005).
[2] Donald Grimes and George Fulton, "The Economic and Demographic Outlook for Michigan through 2040" (Bureau of Transportation Planning Michigan Department of Transportation, March 2012), http://irlee.umich.edu/clmr/Docs/Outlook-Michigan-thru2040.pdf.
[3] Michigan Department of Community Health, "2011 Michigan Critical Health Indicators Comparison of Michigan to the United States," *Michigan 2011 Critical Health Indicators*, accessed June 2, 2014, http://www.michigan.gov/documents/mdch/CompToUS_381382_7.pdf.
[4] Ibid.

Indians/Alaskan Natives, and 28.8% of Hispanics, compared to 12.5% of whites. These correspond to U.S. averages, although Michigan Hispanics (albeit not including the undocumented population) fare moderately better than the U.S. average of 33%.[5]

Although child poverty rates reach high levels in the state's most urban counties, such as Wayne and Macomb, the highest rates recorded are from Michigan's largely white rural northern counties of Clare, Lake, and Roscommon, where 32% of children live in poverty.[6]

Michigan is comparable to other Midwestern and "rust belt" states in the indicators mentioned above. However, the state is particularly troubled by significant deficits that hinder the ability of many Michiganders to achieve reproductive justice.

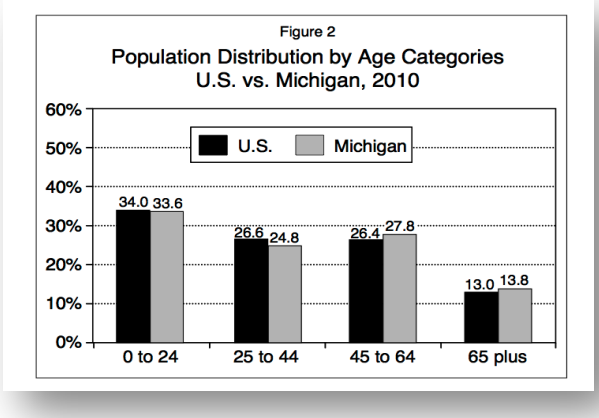


Examples of important Michigan indicators:

- Michigan has frequently experienced the highest unemployment rate in the country (peaking at 13.9% in 2009). In 2014 Michigan ranks 44th in the nation in unemployment, with a rate of 7.4%.[7]

- Michigan ranks 35th in per capita incomes with an average of $39,215 in the state as compared to $44,543 nationally.[8]

- According to the 2010 census, Michigan lost population, most noticeably in the 25-44 age bracket. Its residents include a disproportionate number of Baby Boomers. The state has struggled to keep its younger educated population from migrating out of state.[9]



[5] The Henry J. Kaiser Family Foundation, "State Health Facts: Poverty Rate by Race/Ethnicity," *The Henry J. Kaiser Family Foundation*, accessed June 2, 2014, http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/.
[6] "Michigan Poverty," *Michigan Community Action Agency Association*, accessed June 2, 2014, http://www.mcaaa.org/michigan-poverty.
[7] *Key Labor Market and Economics Metrics: May Update* (Bureau of Labor Market Information and Strategic Initiatives and the Treasury's Office of Revenue and Tax Analysis, May 30, 2014), http://milmi.org/admin/uploadedPublications/1985_Key_Labor_Market_and_Economic_Metrics.pdf.
[8] Ibid.
[9] Grimes and Fulton, "The Economic and Demographic Outlook for Michigan through 2040."

- Nearly one in four Michigan households, 23%, report an inability to afford enough food.[10]
- Detroit has the highest infant mortality rate in the country, 13.5 for every 1,000 live births; this figure is on par with infant mortality rates in Jamaica, Armenia, and Malaysia, and almost twice the general U.S. rate of 6.7%.[11]
- Perhaps even more unsettling is Michigan's rising rate of maternal mortality, which had fallen for decades and continues to fall in other industrialized countries. Yet Michigan's maternal mortality rate ranks 50th in the nation, at 22 deaths per 100,000 live births, as compared to the 15.6 U.S. average. Among African Americans, the rate is a startling 50.8 deaths per 100,000 live births.[12] [13]

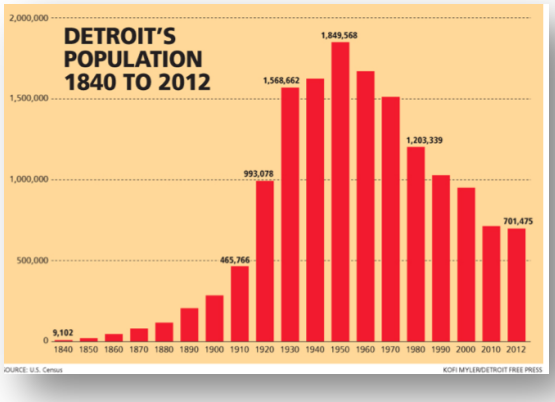
Table 2: Pregnancy-Related Mortality, by race-ethnicity per 100,000 live births, 1999-2010**

	Overall	NH White	NH African American	Rate Difference	Rate Ratio
Michigan	22.2	16.6	50.8	34.3	3.1
US	15.6	11.5	35.8	24.3	3.1

NH= Non-Hispanic

Socio-Economic Indicators

Since the 1970s, de-industrialization has depressed Michigan's economy and exacerbated patterns of racial and residential segregation. When the auto industry collapsed in 2008, an already unfolding pattern was hastened by the coterminous Great Recession of 2007 that hit Michigan particularly hard. Many manufacturing and industry jobs were lost, and blue and white collar workers, especially those in the 30-50 age range, lost their jobs as well as access to good pension and retirement plans.

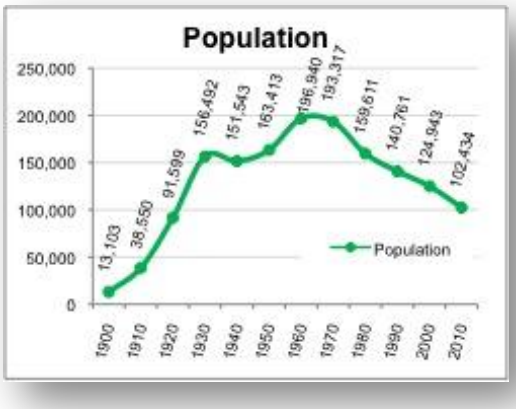


The state has pronounced patterns of racial residential segregation, fuelled in large part by white and middle-class flight, most notably from Detroit. From 1990 to 2010, for example, Detroit's population, once much more racially integrated, dropped from approximately 1.5 million to slightly over 700,000, gradually becoming more than 80% African American. The 4th largest metropolis in the mid-twentieth century, Detroit is now the 18th most populous U.S. city.[14] In 2013, up to 40 of the city's 139 square miles were classifiable as empty and at least 90,0000 properties vacant, with a

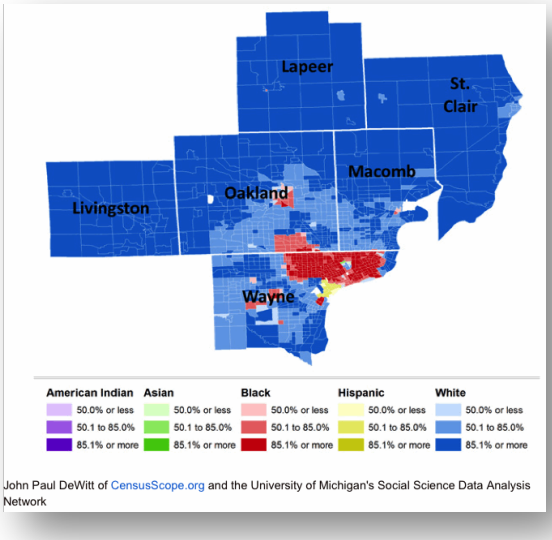
[10] Food Research and Action Center, "One in Four Households with Children in Michigan Report Inability to Afford Enough Food," September 18, 2013, http://www.ccj-mi.org/images/contentImages/file/food%20insecurity.pdf.
[11] Karen Bouffard, "Infant Mortality Rate in Detroit Rivals Areas of Third World," *The Detroit News*, January 30, 2014, http://www.detroitnews.com/article/20140130/LIFESTYLE03/301300005.
[12] Michigan Department of Community Health, *Pregnancy-Associated Mortality in Michigan - 2013*, 2013, https://www.michigan.gov/documents/mdch/2013Status_of_Michigan_Maternal_Mortality_445366_7.pdf.
[13] Violanda Grigorescu, "Lessons Learned from Michigan Maternal Mortality Surveillance, 1999-2004," 2009, http://www.michigan.gov/documents/mdch/MDCH_MCH_Epi_VG_2006PerinatalMSMSfinal_187654_7.pdf.
[14] Sugrue, *The Origins of the Urban Crisis*.

scattershot pattern of neighborhood abandonment and neglect throughout the city.[15] A similar depopulation occurred decades earlier in the City of Flint, once a principal hub of the auto industry and home to a thriving unionized working-class community.[16]

The economic downturn of the past seven years has had demonstrable negative effects on the health and security of Michiganders, particularly in southeastern Michigan, which became one of the country's foreclosure epicenters. For example, the period starting in 2007 saw rising housing instability, which affected approximately 30% of southeastern Michigan residents (and 53% of renters) and is associated with higher reported rates of depression, anxiety, and harmful or hazardous alcohol use.[17] In addition, Michiganders have experienced significant job insecurity, including unemployment, underemployment, and chronic labor uncertainty, which are associated with poor health outcomes.[18] It is reasonable to assume that these developments have disproportionately affected people of color living in southeastern Michigan as well as in the state's poorer counties, although more research is needed to demonstrate these associations.



In recent years, especially since the election of Governor Rick Snyder, several local governments and administrative services have been subject to emergency management, a process that shifts the bulk of fiscal and decision-making power from elected municipal bodies to an appointed state manager. While Detroit is the best-known case, Flint and Benton Harbor have also been subject to emergency management. Contention surrounds this issue in Michigan, particularly given the undeniable racial dynamic imputed to it, in which leaders from Lansing have determined how poorer and blacker municipalities are to be run and their dwindling public funds to be spent.



[15] Ibid.
[16] Nancy Setara Alamy, "Deindustrialization and Political Identity: A Case Study of Residents in Flint, Michigan" (M.A., Georgetown University, 2012), https://repository.library.georgetown.edu/handle/10822/557540.
[17] Sarah A. Burgard, Kristin S. Seefeldt, and Sarah Zelner, "Housing Instability and Health: Findings from the Michigan Recession and Recovery Study," *Social Science & Medicine* 75, no. 12 (December 2012): 2215–24, doi:10.1016/j.socscimed.2012.08.020.
[18] Sarah A. Burgard, Lucie Kalousova, and Kristin S. Seefeldt, "Perceived Job Insecurity and Health: The Michigan Recession and Recovery Study," *Journal of Occupational and Environmental Medicine* 54, no. 9 (2012): 1101–6, doi:10.1097/JOM.0b013e3182677dad.

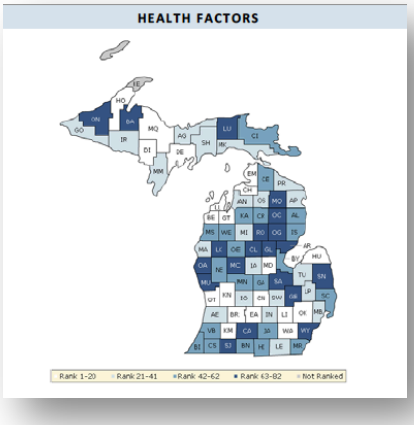
Racial Segregation and Disparities

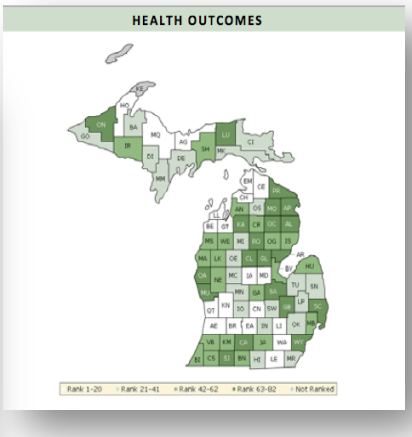
Like many parts of the country, Michigan suffers from a high degree of racial segregation, seen primarily in residential and educational patterns. Patterns of white flight and racial tensions have been amply documented for the Detroit metro area, as well as in Flint, Pontiac, and St. Joseph/Benton Harbor.[19]

In racial and ethnic composition, Michigan mirrors the U.S. as a whole. Eighty percent of Michiganders are white and 14.3% are African American. The state has a lower than U.S. average of Asian Americans (2.6% as compared to 5.1%) and of Hispanics (4.6% compared to 16% nationally, although this does not include undocumented and many migrant workers).[20] The state ranks second in the nation in number of Arab Americans with a population (adjusted for under-reporting) of about 500,000. The majority are immigrant families from Iraq, Lebanon, and Yemen; they live in Wayne, Oakland, and Macomb counties with substantial representation in the City of Dearborn.[21]

Any geographic and demographic review of health indicators in the state quickly reveals that the whiter and richer counties receive higher rankings in health factors and outcomes than poorer counties with higher percentages of people of color.[22] For example, Berrien, Genesee, Oakland, and Wayne Counties receive low scores in 2013 county health rankings, while Washtenaw, Leelanau, and Ottawa counties rank high.

Racial health disparities are evident in the most recent trends of HIV diagnosis. While in general the state's rates of diagnosis are stable, the HIV infection rate nevertheless increased an alarming 9% per year from 2008 to 2012 in the 20-24 age group. Strikingly, 82% of those newly diagnosed in this age bracket were black, as compared to 59% of those newly diagnosed in all other age brackets. Furthermore, the rate of diagnosis in all age brackets was 11 times higher for black males than white males and 20 times higher for black women compared to white women.[23]





[19] Daniel Denvir, "The 10 Most Segregated Urban Areas in America," *Salon*, March 28, 2011, http://www.salon.com/2011/03/29/most_segregated_cities/slide_show/1.

[20] United States Census Bureau, "State & County QuickFacts: Michigan," *U.S. Department of Commerce, United States Census Bureau*, March 27, 2014, http://quickfacts.census.gov/qfd/states/26000.html.

[21] Arab American Institute, "Michigan - Arab American Demographics," 2011, http://b.3cdn.net/aai/dfab1c90e9a819c9c1_tkm6iyilb.pdf.

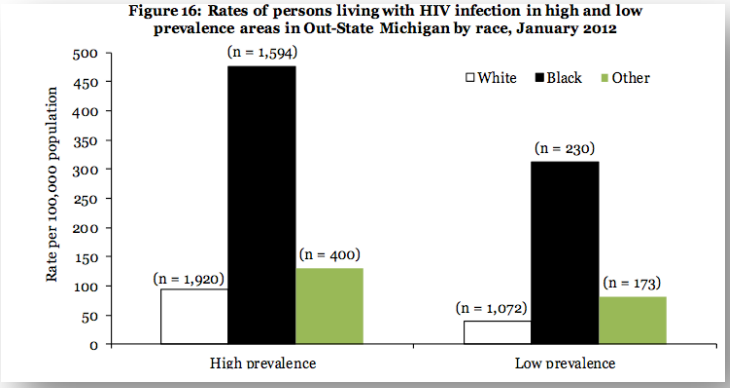
[22] University of Wisconsin Population Health Institute. et al., *Michigan County Health Rankings and Roadmaps: 2013 Rankings Michigan* (University of Wisconsin-Madison School of Medicine and Public Health Department of Population Health Sciences Population Health Institute), accessed May 22, 2014, http://www.countyhealthrankings.org/sites/default/files/states/CHR2013_MI_0.pdf.

[23] Michigan Department of Community Health, *Overall Trends in New Michigan HIV Diagnoses*, Annual Review of HIV Trends in Michigan (2008-2012) (Bureau of Disease Control, Prevention and Epidemiology HIV/STD/VH/TB

It is important to note that while the majority of new HIV diagnoses among young black men (largely MSM) and women are in Detroit, other counties demonstrate similar racial health disparities. For example, Berrien County in southwestern Michigan has the fourth highest HIV infection prevalence rate, with 161 cases per 100,000. An estimated 300 persons in Berrien County live with HIV as of 2012; 58% are black and 34% are white.[24] Similar patterns can be found in Oakland, Washtenaw, Ingham, and Kent Counties.[25]

Racial and ethnic health disparities are also markedly apparent in birth data. According to a recent study by the Michigan League for Public Policy, in almost all "legacy cities," or cities that "have borne the brunt of the state's long sustained economic decline and dwindling resources, but [they] continue to be the home for a substantial share of young children," indicators related to maternal and child health are much worse than in other parts of the state.[26] Women in legacy cities are more likely to be low-income and uninsured, and they are adversely affected by social determinants (such lower rates of high school education or GED, high rates of smoking, and little or no prenatal care) and exhibit poor health outcomes. All but two of Michigan's legacy cities report preterm birth rates in the double digits. Flint and Saginaw's rates, for example, nearly doubled between 2006 and 2012.[27] Consistently, the cities with the highest number of mothers and children of color fared the worst in terms of health outcomes. This recent study underscores the dire situation of racial health inequality in relation to maternal and infant morbidity in Michigan, which continues to perform worse than many industrialized and semi-industrialized countries.[28]

Figure 16: Rates of persons living with HIV infection in high and low prevalence areas in Out-State Michigan by race, January 2012



Epidemiology Section, April 2014), http://www.michigan.gov/documents/mdch/MIReport14_456013_7.pdf#page=1&zoom=auto,0,792.

[24] Michigan Department of Community Health, *2012 Epidemiologic Profile of HIV in Michigan* (HIV/STD/VH/TB Epidemiology Section, Bureau of Disease Control, Prevention and Epidemiology, 2012), www.michigan.gov/hivstd.

[25] Michigan Department of Community Health, *Quarterly HIV Surveillance Report, Michigan, April 2013* (HIV/STD/VH/TB Epidemiology Section Division of Communicable Disease Bureau of Disease Control, Prevention and Epidemiology, April 2013), http://www.michigan.gov/documents/mdch/April_2013_ALL_418616_7.pdf.

[26] Jane Zehnder-Merrell, *Right Start in Michigan 2014: Maternal and Infant Well-Being in Michigan's Legacy Cities* (Michigan League for Public Policy, June 2014), http://www.mlpp.org/right-start-in-michigan-2014-maternal-and-infant-well-being-in-michigans-legacy-cities.

[27] Ibid.

[28] Haidong Wang, et al., "Global, Regional, and National Levels of Neonatal, Infant, and under-5 Mortality during 1990–2013: A Systematic Analysis for the Global Burden of Disease Study 2013," *The Lancet* Early Online Publication (May 2, 2014), doi:10.1016/S0140-6736(14)60497-9.

Legal and Health Policy Environment

Overview

Although Michigan voted Democratic in the last two presidential elections, the state's socially conservative Republican legislature generally opposes social welfare programs, while its fiscally minded Republican governor is often at odds with more extreme legislators. This political configuration has helped to create a legal and policy environment that is restrictive on the one hand and remiss on the other: it is characterized by shrinking abortion access, lawsuits challenging employer-provided birth control, a sex education program that prioritizes abstinence and lacks any required or standardized preventive K-12 education related to HIV/AIDS, STIs, and sexual violence, an absence of obstetrical care in about two dozen counties, an anti-licensure political climate that hampers the deployment of allied health care providers, and restricted options in pregnancy that affect women unevenly in depending on race, class, location, and insurance status.

Abortion

Michigan has long been considered hostile to abortion rights.[29] Its pre-*Roe v. Wade* statutes prohibiting abortion were declared unconstitutional but have not been repealed – and so lie in readiness for a possible U.S. Supreme Court overturn of *Roe* or *Casey* protections.[30] Many more legal constraints on abortion have followed, including a steady stream from 1973-2010, followed by a sharp uptick from 2011 to the present.

Restrictions 1973-2010:

Laws enacted in this time period focused on the traditional mode of preventing abortion: by placing roadblocks in the path of women seeking abortions, enabling third parties to expand those obstructions, and preventing access to education and redress for discriminatory actions.

- The 1999 Michigan Fetal Protection Act penalizes acts that "intentionally or in willful disregard cause a miscarriage, stillbirth, or aggravated physical injury to an embryo or fetus."[31] While this act exempts medical procedures – i.e. abortions – performed by licensed providers, it nevertheless follows similar laws in other states in providing a basis for prosecutions of pregnant women themselves for actions performed during pregnancy that the state believes harmed the fetus.[32]
- Access to abortion is restricted by a mandatory 24-hour waiting period before someone may obtain an abortion; a parental consent requirement that women under the age of 18;[33] and a heightened informed consent provision that physicians recite to patients a long list of particulars, including – but not limited to – the estimated age of the fetus, a photo and description of a fetus of that age, and

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[29] Elizabeth Nash et al., *State Trends for 2013 on Abortion, Family Planning, Sex Education, STIs and Pregnancy*, State Center (Guttmacher Institute, 2014), http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html.
[30] *Mich. Comp. Laws §§ 750.14-5*, 1931; *Mich. Comp. Laws § 750.322*, 1931.
[31] *Mich. Comp. Laws §§ 750.90a-f*, 1931.
[32] National Women's Law Center, "If You Really Care about Criminal Justice, You Should Care about Reproductive Justice!" *National Women's Law Center*, August 27, 2013, http://www.nwlc.org/resource/if-you-really-care-about-criminal-justice-you-should-care-about-reproductive-justice.
[33] *Mich. Comp. Laws § 722.903*, 1990.

possible medical complications of abortion.[34] Physicians must also distribute literature stating that "as the result of an abortion, some women may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger," and recommending professional assistance should these symptoms become extreme.

- The applicability of certain Michigan abortion laws is questionable, due to the rarity of the circumstances requiring such governance or the earlier imposition of identical restrictions by the federal government. Special protections are in place for infants "born alive" after attempted abortions.[35] A "partial-birth" abortion ban was passed *after* the federal ban[36] in expectation of its overturn.[37] The actions of the federal Hyde Amendment in forbidding the use of Medicaid for abortion services were repeated by Michigan in 1987 legislation.[38]

- Broad conscience clause provisions[39] allow providers and many additional classes of persons in a number of types of facilities great latitude in refusing to provide any service associated with abortion provision. The law exempts such acts from both criminal and civil liability. An enhanced "religious liberty and conscience protection act" introduced at the beginning of the current legislative session would extend refusals beyond abortion care to *any* services felt by the individual or the institution to be subject to objections conscience: contraception, sterilization, withdrawal of life support for a terminally ill patient, or any other health care service would fall under this umbrella. It would also enable payers to exercise such rights.[40]

- In K-12 public school sex education courses, abortion "shall not be considered a method of family planning, nor shall abortion be taught as a method of reproductive health."[41] The complete absence of Michigan case law clarifying the extent to which abortion may be introduced into the curriculum, combined with a significant monetary penalty that may be imposed against a district if any of its schools "makes referrals for abortions"[42] leads to a climate in which it may well be considered prudent to ban any mention of abortion from sex education courses.

- The state civil rights law that protects pregnant women from employment discrimination specifically exempts from this prohibition "nontherapeutic abortion not intended to save the life of the mother."[43] In other words, an employer may legally fire a woman because she had an abortion.

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[34] *Mich. Comp. Laws § 333.17014-5*, 1978.
[35] *Mich. Comp. Laws § 333.1073*, 2002.
[36] *Mich. Comp. Laws § 333.17016*, 1978.
[37] *Gonzales v. Carhart*, 550 U.S. 124 (2007).
[38] *Mich. Comp. Laws § 400.109a*, 1939.
[39] *Mich. Comp. Laws §§ 333.20181-3*, 1978.
[40] *S.B. 136, 97th Leg., Reg. Sess.*, Mich. 2013.
[41] *Mich. Comp. Laws § 380.1507*, 1976.
[42] *Mich. Comp. Laws § 388.1766*, 1979.
[43] *Mich. Comp. Laws § 37.2202*, 1976.

Restrictions 2011-present:

Since 2011, Michigan has joined a number of other states in passing progressively frequent and restrictive abortion legislation. The approach of these new laws increasingly places barriers in the path of providing abortions, in addition to obtaining them.

- Michigan statutes now require additional screening of women for possible coercion to obtain an abortion,[44] even though research has not yet determined any significant incidence of such coercion, while coercion to create and continue a pregnancy is common.[45]
- Telemedicine is banned in Michigan only for the purposes of abortion procedures,[46] a measure clearly intended to reduce access to abortion for inhabitants of areas lacking abortion providers. Telemedicine would allow a patient to be examined by a local provider and receive a prescription for abortifacient medication from a remote specialist. In the same session the legislature banned telemedicine abortions, it encouraged the use of telemedicine for other health care services.[47]
- Michigan laws characterized by abortion rights advocates as Targeted Regulation of Abortion Providers (TRAP) hold abortion facilities to the standards for outpatient surgical centers.[48] The

Policy Summary Table, as of May 1st, 2014

ABORTION	
Abortion Policy in the Absence of Roe v. Wade	
Pre-Roe abortion ban still in place	✔
Abortion Counseling and Waiting Periods	
Mandated counseling includes information designed to discourage abortion	✔
State imposes waiting period between counseling and abortion	24 hours
Parental Involvement in Minors' Abortions	
Parent must consent to an abortion	One parent
Restrictions on Private Insurance Coverage of Abortion	
No policy in effect	
Public Funding of Abortion for Poor Women	
Public funding is available in cases of life endangerment, rape or incest	Only life, rape or incest.
Refusal Clauses for Abortion Services	
Medical professionals may refuse	✔
Medical institutions may refuse	All institutions
ADOLESCENTS	
Minors' Consent to Contraceptive Services	
No policy in effect	
Minors' Consent to STI Services	
All or some minors explicitly permitted to consent	All minors
Parental Involvement in Minors' Abortions	
Parent must consent to an abortion	One parent
Sex Education	
Sex education must either stress or cover abstinence	Stress
State mandates STI/HIV education	✔
STI/HIV education must either stress or cover abstinence	Stress
CONTRACEPTION SERVICES AND FINANCING	
Emergency Contraception in Emergency Rooms	
No policy in effect	
Private Insurance Coverage of Contraceptive Services	
Insurance coverage mandated	✔
Employers may refuse to provide coverage	Religious employers
Medicaid Family Planning Expansions	
Eligibility for Medicaid family planning based on income	185% Federal Poverty Level
Contraceptive Access in Pharmacies	
No policy in effect	
Refusal Clauses for Contraceptive Services	
No policy in effect	
Minors' Consent to Contraceptive Services	
No policy in effect	

[44] *Mich. Comp. Laws § 333.17015a*, 1978.
[45] "Health Experts Challenge 'Coerced-Abortion' Laws," *RH Reality Check*, August 30, 2012, http://rhrealitycheck.org/article/2012/08/30/health-experts-challenge-coerced-abortion-laws/.
[46] *Mich. Comp. Laws § 333.17015a.*
[47] *Mich. Comp. Laws § 500.3476*, 1956.
[48] *Mich. Comp. Laws § 333.20115*, 1978.

regulations specify, among other particulars, when a physician must be available, the maximum distance of the facility from a hospital, the number of sinks required, and the minimum allowable door width.[49] Although the regulatory agency is granted the latitude to waive some of these requirements,[50] this very discretion allows for the possibility of uneven and biased enforcement.

- Abortion services are excluded from the minimum number of procedures demanded by the state's Certificate of Need (CON) framework. Hospitals and surgical facilities, which must obtain CON approval to stay in operation, are required by CON to perform a certain number of procedures. Because the law excludes abortion procedures from this total, it thus creates a disincentive for any hospital or surgical facility to also offer abortion services.[51]
- Fetal death must be reported when the fetus is over 20 weeks of gestation or weighs at least 400 grams (.88 pounds)[52] and physicians must submit detailed data to the state on abortion procedures and patients.[53] Medical examiners are required to conduct an investigation should an individual die as the result of an abortion.[54] Disposition of fetal remains is now regulated under cemetery rules rather than as medical waste,[55] causing increased expense to both parents and facilities.[56]
- No health insurance plan offered for sale in Michigan may include coverage for "elective abortion," forcing women to prospectively purchase such a rider when they obtain health insurance. No such riders are currently available.[57]
- Finally, in June 2014, a bill was introduced to prohibit any abortion after a fetal heartbeat can be detected,[58] precluding an abortion before many women even are aware they are pregnant.[59]

Only 14% of Michigan counties currently have abortion providers, although 66% of female residents live in these counties, which are concentrated in the lower band of the state. Over the past ten years, the number of abortion providers has decreased, conforming to national trends.[60]

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[49] *Mich. Admin. Code R. 325.3801-3877*, 2013.
[50] Ibid.
[51] *Mich. Comp. Laws § 333.22224*, 1978.
[52] *Mich. Comp. Laws § 333.2834*, 1978.
[53] *Mich. Comp. Laws § 333.2835*, 1978.
[54] *Mich. Comp. Laws § 52.202*, 1953.
[55] *Mich. Comp. Laws § 333.2836*, 1978.
[56] Esmé E. Deprez, "How State Governments Are Regulating Away Abortion," *BusinessWeek*, January 17, 2013.
[57] *Mich. Comp. Laws §§ 550.541-51*, 2013.
[58] *H.B. 5643-5, 97th Leg., Reg. Sess.*, 2014.
[59] Amy Lynn Smith, "Michigan Republicans Propose Fetal Heartbeat Bill to Ban Abortions at 8 Weeks—or Earlier," *Eclectablog - Progressive News and Commentary*, June 11, 2014, http://www.eclectablog.com/2014/06/michigan-republicans-propose-fetal-heartbeat-bill-to-ban-abortions-at-8-weeks-or-earlier.html.
[60] "State Center: Michigan," *Guttmacher Institute*, accessed March 8, 2014, http://www.guttmacher.org/statecenter/michigan.html.

Contraception

A handful of Michigan companies have challenged or are actively challenging the Affordable Care Act's birth control provision, which requires that employers providing insurance include birth control coverage as a preventive service.[61] When the U.S. Supreme Court issues an opinion in the case of *Hobby Lobby v. Sebelius* (*see text box)*,[62] a number of Michigan cases will also be resolved.[63]

Hobby Lobby

The plaintiffs in *Hobby Lobby*, owners of a family business, claim that the ACA contraception mandate violates their sincerely held religious beliefs. Because the plaintiffs (erroneously) believe certain contraceptives to cause abortions, they assert that it is contrary to their faith to make these contraceptives available through their employee health insurance plan.

Numerous similar cases originate in Michigan. Two of them, *Eden Foods* and *Autocam* have appealed their defeats in the Sixth Circuit Court of Appeals to the U.S. Supreme Court. *Michigan Catholic Conference* was also recently defeated in the Sixth Circuit, where three other cases are currently under review: *Legatus*, *Mersino Management*, and *Ave Maria Foundation*. Four more cases await judgment in Michigan federal district courts: *Infrastructure Alternatives*, *M&N Plastics*, *Mersino Dewatering, Inc.*, and *MK Chambers Company*.

While the greatest area of contention surrounding contraception is *Hobby Lobby*, of more immediate relevance in the Michigan health insurance landscape is the discontinuation of the state's *Plan First!* Program that provided family planning services to low-income adults who did not qualify for Medicaid.[64] Beneficiaries of this program are now expected to apply for the state's expanded Medicaid program or purchase individual plans through the federal Marketplace. While it may seem a logical goal to offer comprehensive health insurance to those who previously received only family planning services, such a change may nevertheless remove access to family planning services from those who have no desire to obtain comprehensive coverage, either because of the stigma and surveillance often associated with Medicaid, or the expense and complexity involved in obtaining individual coverage. More study is needed to determine the results of the shift from *Plan First!* to expanded Medicaid.

Michigan law does not expressly empower pharmacists to refuse to fill prescriptions for contraception or emergency contraception, but there is no impediment to their doing so beyond that of professional ethics.

As a result of a federal court decision, emergency contraception is now available over the counter and without age restrictions.[65] Bills introduced in the Michigan legislature before that decision require emergency rooms to offer emergency contraception to rape victims.[66]

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[61] 42 U.S. Code § 300gg–13(a)(4), 2010.

[62] *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F. 3d 1114 (10th Cir. 2013), *cert. granted*, (U.S. Nov. 26, 2013) (No. 13-354).

[63] ACLU, "Challenges to the Federal Contraceptive Coverage Rule," *American Civil Liberties Union*, May 21, 2014, https://www.aclu.org/reproductive-freedom/challenges-federal-contraceptive-coverage-rule.

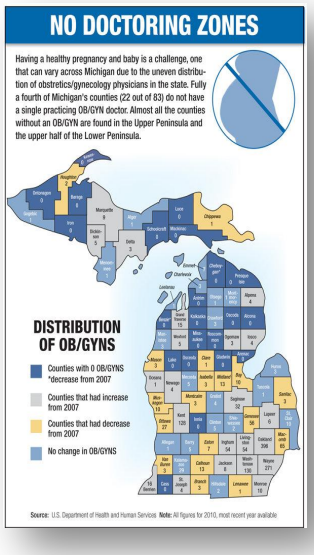
[64] Michigan Department of Community Health, "Plan First!," accessed April 10, 2014, http://www.michigan.gov/mdch/0,1607,7-132--146295--,00.html.

[65] *Tummino v. Hamburg*, Memorandum and Order, 12-CV-763 (2013).

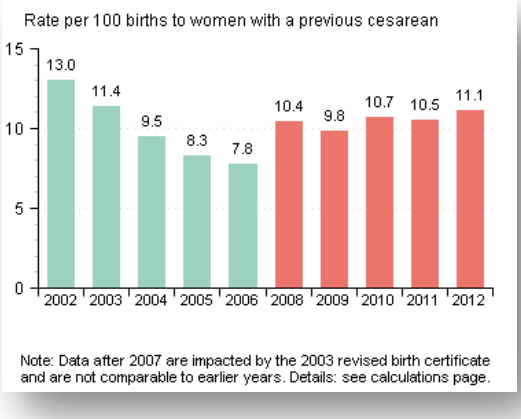
[66] *S.B. 369, 97th Leg., Reg. Sess.*, 2013; *S.B. 370, 97th Leg., Reg. Sess.*, 2013; *H.B. 4067, 97th Leg., Reg. Sess.*, 2013; *H.B. 4722, 97th Leg., Reg. Sess.*, 2013.

Public school sex education programs in Michigan must emphasize abstinence over other methods of contraception.[67] A school may not distribute family planning drugs or devices, at risk of forfeiting 5% of its total state aid appropriation.[68]

Maternity Care and Early Parental Accommodations



Michigan presents a marked and uneven lack of access to reproductive health services. In part, this reflects wide variation in distribution of conventional OB-Gyn providers, as shown in the map at right. Twenty-two of the state's counties are without obstetrical care, including 15 in lower Michigan. For example, Ionia County, with a population of 64,000 and located near the city of Grand Rapids, has no OB-Gyn providers. Residents of rural areas are particularly affected as hospitals in those regions continue to close their maternity care services.[69] Allied health professionals like Advance Practice nurses (APRNs), a category that includes Certified Nurse-Midwives, are limited by law in their ability to practice autonomously to the full extent of their training and education, which in turn limits their ability to practice in the neglected counties detailed on the map. The legislature has shown hostility to enacting licensure for APRNs, currently licensed only as nurses, or for Certified Professional Midwives, who currently are unable to be licensed at all[70] and practice illegally in all parts of the state – as do other, uncertified midwives of every gradation of skill, training, and experience.



Because midwives represent a minute portion of Michigan's maternity care providers, the state's high infant and maternal mortality rates reflect rather the quality of conventional maternity care, in which morbidity rates are high and often associated with medically non-indicated cesarean sections. Options are limited, especially for patients who wish to give birth vaginally following a previous c-section (VBAC), as reflected by this graph showing a successful Michigan VBAC rate of only approximately 10%.[71] Legal tools for pursuing a VBAC are virtually nonexistent, even though it is considered a

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[67] *Mich. Comp. Laws § 380.1507.*
[68] *Mich. Comp. Laws § 388.1766.*
[69] *Health Professional Shortage Areas for Obstetrical and Gynecological Services, FY2011 Appropriation Bill, 96th Legislature, P.A. 187*, Mich. 2010.
[70] "Certified Professional Midwives (CPMs) Legal Status By State," *The Big Push for Midwives 2014: Certified Professional Midwives NOW*, accessed June 3, 2014, http://pushformidwives.org/cpms-by-state/. CPMs are legally authorized to practice in 28 states.
[71] "Vaginal Birth after Cesarean Deliveries: Michigan, 2002-2012," *March Of Dimes Peristats*, accessed June 3, 2014, http://www.marchofdimes.com/Peristats/ViewSubtopic.aspx?reg=26&top=8&stop=90&lev=1&slev=4&obj=1.

medical standard of care.[72] In some regions of the state, the fetus's risk tends to be prioritized over risk to the mother,[73] causing providers to see VBAC as far more dangerous than evidence actually reveals; consequently, they refuse to accept patients seeking VBACs. Nationally, 40% of hospitals refuse to offer VBACs, effectively condemning patients most limited by finances, health insurance, and location to mandatory surgery.[74]

Disadvantaged populations are also least likely to access resources that might strengthen their autonomy in pregnancy and birth and thus help them to advocate for their choices. Doula services and independent pregnancy and childbirth education classes are of great assistance in such cases,[75] but are inaccessible to many. A growing movement of community-oriented doulas and childbirth educators holds great hope for bridging these gaps.[76]

Michigan's advance directive law also limits choice in pregnancy.[77] It resembles a Texas law that was initially interpreted as banning the removal of mechanical support from a pregnant woman, even though she had been declared legally dead. Only once the fetus was shown to be non-viable was support withdrawn.[78]

Until very recently, Michigan protections for people who wish to breastfeed in public have been relatively weak compared to most other states.[79] State code excluded public breastfeeding from municipalities' public indecency provisions[80] and permitted breastfeeding mothers to claim exemption from jury service;[81] however, the state failed to guarantee people the right to breastfeed anywhere they themselves are permitted to be. That legal guarantee was recently enacted and took effect immediately.[82] Additional bills were introduced to designate breastfeeding a protected category of the state civil rights act, but have not yet succeeded.[83]

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[72] American College of Obstetricians and Gynecologists, William Grobman, and Ecker, Jeffrey, "Vaginal Birth After Previous Cesarean Delivery," *Obstetrics & Gynecology*, Practice Bulletin, 116, no. 2 (August 2010): 450–63.
[73] Jamie R. Abrams, "Distorted and Diminished Tort Claims for Women," *Cardozo Law Review* 34 (2013 2012): 1955.
[74] Cristen Pascucci, *Vaginal Birth Bans in America: The Insanity of Mandatory Surgery*, 2014, https://gumroad.com/l/birthmonopoly.
[75] Shafia M. Monroe, "Systemic Racism Is Killing Black Babies in America -- But There Is Something Black Women Can Do About It!," *BlackNews.com*, June 16, 2014, http://www.blacknews.com/news/racism-killing-black-babies-what-black-women-can-do101.html#.U6Ejli9ZndS.
[76] See, for example, this association from the Detroit area. "Metro Detroit Doulas and Childbirth Educators," *Metro Detroit Doulas and Childbirth Educators*, accessed June 3, 2014, http://www.metrodetroitdoulas.com/.
[77] *Mich. Comp. Laws § 700.5507*, 1998.
[78] Grimes, "Hospital Agrees to Obey Court Ruling and Removes Mechanical Support From Munoz Corpse," *RH Reality Check*, January 26, 2014, http://rhrealitycheck.org/article/2014/01/26/hospital-agrees-obey-court-ruling-removes-mechanical-support-munoz-corpse/.
[79] "Breastfeeding State Laws," *National Conference of State Legislatures*, August 2011, http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx#State.
[80] *Mich. Comp. Laws § 117.4i*, 1909; *Mich. Comp. Laws § 117.5h*, 1909; *Mich. Comp. Laws § 67.1*, 1895; *Mich. Comp. Laws § 41.181*, 1945.
[81] *Mich. Comp. Laws § 600.1307a*, 1961.
[82] *Breastfeeding Antidiscrimination Act, Pub. L. No. 197*, 2014.
[83] *H.B. 4733, 97th Leg., Reg. Sess.*, 2013; *S.B. 464, 97th Leg., Reg. Sess.*, 2013.

The federal Women, Infants and Children (WIC) program that provides supplemental nutrition to low-income women and children has intensified its breastfeeding advocacy efforts in the last several years.[84] Accordingly, Michigan's WIC program has mounted a breastfeeding campaign.[85]

Michigan law provides no parental leave. Parents may avail themselves of up to twelve weeks of *unpaid* leave under the federal Family Medical Leave Act, if they qualify in length of employment and if the employer is not exempted through having fewer than 50 employees.[86]

The Affordable Care Act (ACA) and Medicaid Expansion

After some initial hesitation, Michigan implemented a Medicaid expansion as part of the state ACA rollout. Given this development, the Center for Healthcare Research and Transformation projects that the rate of uninsured in Michigan will decrease, from 17% in 2011, to 10% in 2014, to 6% by 2019.[87] Many more Michiganders now have access to federal Marketplace plans with no pre-existing conditions clauses and with a federal tax credit to lower premiums.

The majority of Michiganders that have signed up or are likely to sign up on the Marketplace are employed full- or part-time and fall into the 19-64 age bracket. Since the existing Medicaid program provides coverage to pregnant women whose income is up to 185% of the federal poverty level, broadened Medicaid enrollment will produce a greater impact on men.

Further improving access to care are the Essential Health Benefits as defined by the ACA: a mandated level of benefits in ten critical areas, including maternity and newborn care, that is "equal to the scope of benefits provided under a typical employer plan."[88] Previously, individual plans were able to categorize pregnancy as a pre-existing condition and deny coverage of maternity care unless the insured had purchased a special rider before becoming pregnant.[89]

The ACA's provider non-discrimination clause, know as the Harkin Amendment, is currently undergoing notice-and-comment rulemaking.[90] Depending on the final formulation of these rules, health care insurers will be prohibited from withholding coverage for any class of provider that is licensed by the state in which the insurer is offering policies. This might have the effect of making independent birth centers run by CNMs (or CPMs, should they eventually gain Michigan licensure) more financially viable, thus enhancing access to care and providing alternatives, for example, to hospital VBAC bans, particularly in areas not served by many conventional providers.

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[84] Women, Infants and Children, "Breastfeeding Promotion and Support in WIC," *USDA Food and Nutrition Services*, January 14, 2014, http://www.fns.usda.gov/wic/breastfeeding-promotion-and-support-wic.
[85] Michigan Department of Community Health, "Breastfeeding Campaign: Breastfeeding Is Best for Baby," *State of Michigan WIC*, accessed April 13, 2014, https://www.michigan.gov/mdch/0,4612,7-132-2942_4910-242520--,00.html.
[86] *Family Medical Leave Act, 29 U.S.C. §§ 2611-19*, 1993.
[87] *The ACA's Coverage Expansion in Michigan: Demographic Characteristics and Coverage Projections*, Cover Michigan Survey 2013, Access to Health Care in Michigan (Center for Healthcare Research & Transformation, March 2013), http://www.chrt.org/publications/cover-michigan/the-aca-s-coverage-expansion-in-michigan-demographic-characteristics-and-coverage-projections/.
[88] *42 U.S.C. § 18022*, 2010.
[89] Linda Burke-Galloway, "Pregnancy As A 'Pre-Existing Condition,'" *Better Health*, December 3, 2010, http://getbetterhealth.com/pregnancy-as-a-pre-existing-condition/2010.12.03.
[90] *Request for Information Regarding Provider Non-Discrimination, 79 Fed. Reg. 14,051*, 2014.

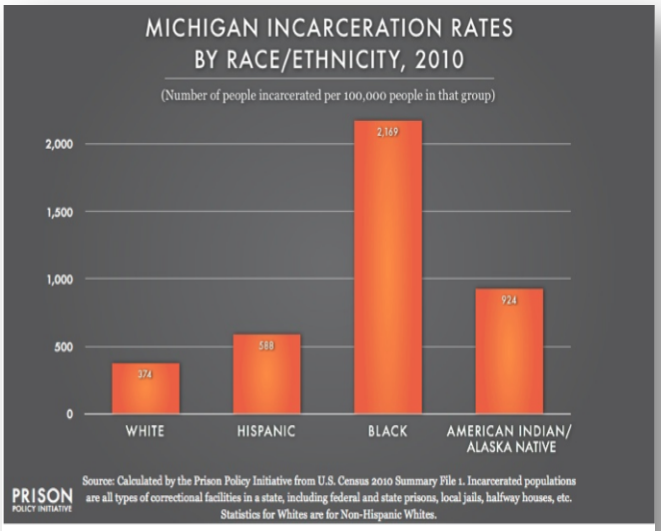
The ACA also offers federal protections for parents pumping breast milk in the workplace: employers of 50 employees or more must provide reasonable (unpaid) break time for an employee to pump breast milk in a private place that is not a bathroom.[91] However doubt exists concerning the strength of these protections, particularly in the absence of an enforcement mechanism.[92]

Attaining Reproductive Justice

The current environment in Michigan is unfavorable to attaining full sexual and reproductive rights, health, and justice. Although the Medicaid expansion promises added benefits, the state's dismal maternal and infant mortality rates require systemic interventions that are guided by explicit attention to racial health disparities and income inequality.

Throughout Michigan, the basic components of wellbeing for women of color and poor white women grew even more precarious with the economic downturns of 2007-2008. Particularly disconcerting are high rates of child poverty, which can be found in demographically diverse counties throughout the state. In addition, deep-seated racial health disparities exist in maternal and infant mortality and morbidity. Finally, unemployment, underemployment, and housing insecurity all contribute to a context in which a lack of core human rights and social infrastructure render reproductive rights and justice elusive. In cities like Detroit, young women and men of color often must navigate the difficulties of parental loss and household instability.[93]

The wellbeing of people of color is further compromised by rising incarceration rates for minor offenses. Michigan has long held the distinction of one of the highest incarceration rates in the Midwest: 489 per 100,000, as compared to 351 in Illinois and 400 in Ohio (and 435 nationwide).[94] However, in keeping with broader trends, African Americans and Latina/os are disproportionately imprisoned in Michigan. Moreover, while prison populations have declined in many U.S states in the past several years, Michigan's rates have continued to rise. In 2012, nearly 44,000 men were in federal or state correctional facilities, and close to 2,000



Data Source: U.S. Census 2010, Summary File 1. (Graph: Leah Sakala, May 2014)

[91] *29 U.S.C. § 207*, 2010.

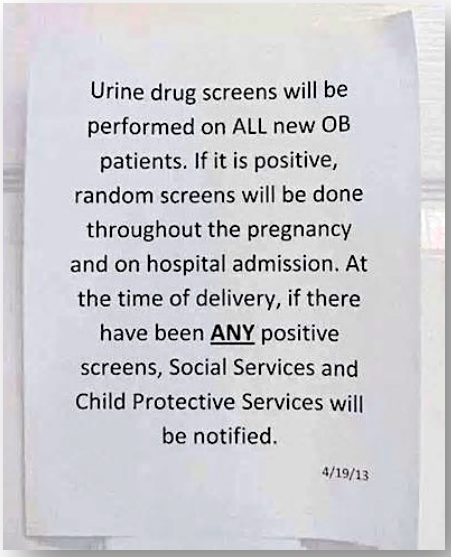
[92] Jake Marcus, "Curb Your Enthusiasm About the New Federal Workplace Pumping Law," *Sustainable Mothering: Mothering as a Human and Civil Right*, May 10, 2010, http://www.sustainablemothering.com/2010/05/10/curb-your-enthusiasm-about-the-new-federal-workplace-pumping-law/.

[93] Leslie R. Berman et al., "Parental Loss and Residential Instability: The Impact on Young Women from Low-Income Households in Detroit," *Journal of Child and Family Studies*, 2013, doi:10.1007/s10826-013-9852-9.

[94] *Growth in Michigan's Corrections System: Historical and Comparative Perspectives* (Citizens Research Council of Michigan, June 2008), http://www.crcmich.org/PUBLICAT/2000s/2008/rpt350.pdf.

women, an increase from 2011 of 1.5% and 4.2% respectively.[95]

Pregnant people and parents in Michigan's jails and prisons face a number of reproductive justice violations including, in some cases, a sheriff's refusal to permit access to abortion services,[96] inability to breastfeed or pump,[97] and termination of their parental rights.[98] Some judges also consider pregnancy as a sentencing factor – sentencing pregnant women who face drug addiction to jail for the duration of their pregnancy, when they might otherwise have sentenced them to probation.[99] [100]



The national trend of control and criminalization of the behavior of pregnant women, whether for the use of controlled substances, adverse pregnancy outcomes, or autonomous choices in pregnancy, has been gaining publicity in both the scholarly and mainstream press.[101] It is unknown to what extent these practices extend to Michigan jurisdictions. However, because governing law requires physicians to report any suspicion of alcohol, controlled substances, or metabolite of controlled substances in a newborn's body,[102] ample possibility for such criminalization exists. In addition to the traditional reporting of live births and newborn deaths, a 2012 act requires reporting of all deaths of fetuses that have completed 20 weeks of gestation or weigh at least 400 grams.[103] This provision introduces an intensified medical and legal scrutiny of pregnancy losses, with the potential of linking maternal use of controlled substances to adverse fetal or neonatal outcomes, without any evidence-based causal link between the mother's behavior and the child's condition.

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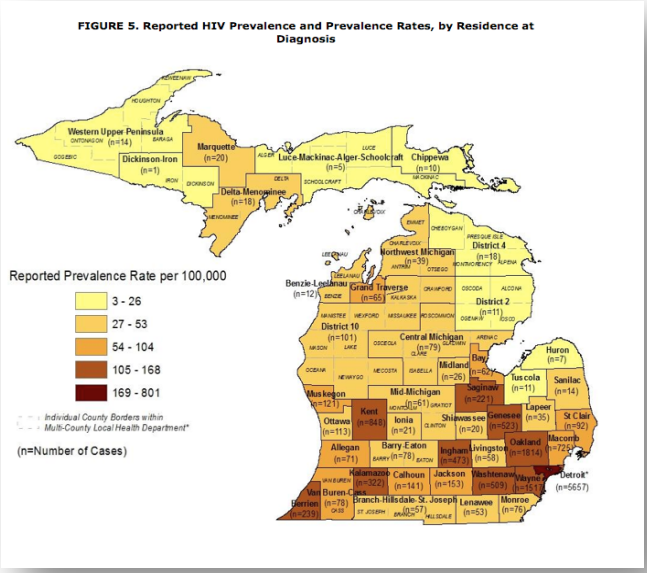
[95] E. Ann Carson and Daniela Golinelli, *Prisoners in 2012: Advance Counts* (US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2013), http://bjs.gov/content/pub/pdf/p12ac.pdf.
[96] Rob Alway, "Sheriff's Refusal to Allow Abortion Results in a New Family," *MasonCountyPress.com*, April 30, 2014, http://www.masoncountypress.com/2014/04/30/sheriffs-refusal-to-allow-abortion-results-in-a-new-family/.
[97] Kristina Jeffers, "How Michigan Lost a Pioneering Program to Help Women and Babies by Kristina Jeffers," *Mothering Justice*, March 21, 2014, http://www.motheringjustice.org/1/post/2014/03/how-michigan-lost-a-pioneering-program-to-help-women-and-babies.html.
[98] Amanda Alexander, "After Mason: Assessing the Rights of Incarcerated Parents in Michigan," *The Michigan Child Welfare Law Journal* 15, no. 11 (May 2013): 4–14.
[99] Heather Lynn Peters, "Pregnant, Incarcerated and Addicted to Heroin: Muskegon County Jail's Latest Problem," *MLive.com*, May 27, 2014, http://www.mlive.com/news/muskegon/index.ssf/2014/05/pregnant_incarcerated_and_addi_1.html; Heather Lynn Peters, "Housing Pregnant Inmates in a County Jail: 'The Liability Is Huge,' Says Muskegon County Sheriff," *MLive.com*, May 14, 2014, http://www.mlive.com/news/muskegon/index.ssf/2014/05/hold_housing_pregnant_inmates.html.
[100] The authors gratefully acknowledge Amanda Alexander's authorship of this paragraph. Ms. Alexander is the Soros Justice Fellow at the Detroit Center for Family Advocacy, Child Advocacy Law Clinic.
[101] Jeanne Flavin and Lynn M. Paltrow, "Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense," *Journal of Addictive Diseases* 29, no. 2 (2010): 231–44, doi:10.1080/10550881003684830.
[102] *Mich. Comp. Laws § 722.623a*, 1975.
[103] *Mich. Comp. Laws § 333.2834.*

A check on this association is a 1991 court opinion stating that the presence of any controlled substance in the pregnant woman alone does not warrant any reporting or legal action.[104] Nevertheless, intimidation in the form of provider-issued threats of CPS involvement continue to jeopardize the autonomy of women to make informed choices during pregnancy.

Problematic CPS involvement extends to the arena of parental and family rights. A 2008 study of Michigan's child welfare system found that African American families were more likely to have their children removed, less likely to be able to divert child protective services involvement, and more likely to be identified as incapable of caring for their families.[105]



Flagged Areas of Concern

This brief overview of the state's legal, social, economic, and health context demonstrates that Michiganders, especially women of color, poorer women in urban and rural counties, trans youth, and LGBTQ communities face moderate to major obstacles when it comes to attaining sexual and reproductive health, rights, and justice. While some problems, such as maternal mortality and housing insecurity, have been evinced by statistical surveys and qualitative studies, a range of other issues barely register on the scholarly or policy radar screen, but deserve further inquiry. These include the increasing criminalization of pregnant women and poor mothers by medical and legal authorities, the impact of rapidly shrinking abortion services on the physical, reproductive, and mental health of women, and the potential avenues of expanded reproductive health services as the state's Medicaid program expands.

With these in mind, we have identified several areas of concern for further research that are discussed below. The research process for this document has underscored how little we know about the status of sexual and reproductive health, rights, and justice in Michigan, particularly in the southwestern, northeastern, and more rural parts of the state. Regions that demand more investigation include southwestern Berrien County, which has a high African American population as well as one of the highest rates of HIV infection rates in the state, and Genesee county, home to Flint, where it remains to be seen if the seemingly successful expansion of basic medical care to low-income uninsured citizens will include meaningful access to reproductive health services.[106]

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[104] *People v. Hardy*, 469 N.W.2d 50 (Mich. App. 1991).
[105] Hollie Parker and Carrie Floyd, *Alleviating Poverty in Michigan: Report and Recommendations to Governor Granholm and the Michigan Legislature* (The Commission for Community Action and Economic Opportunity, November 2009), http://www.clasp.org/documents/MI-Final_Commission_Report_300737_7.pdf.
[106] Mark A. Hall, Linda Hamacher, and James M. Johnson, "The Costs and Adequacy of Safety Net Access for the Uninsured in Genesee County, Michigan," *Journal of Health Care for the Poor and Underserved* 23, no. 1 (2012): 327–38.

AREAS OF CONCERN

Lack of reliable data about reproductive health and rights for many Michigan counties

Data about sexual and reproductive rights, health, and justice is exceedingly limited for all parts of the state except Detroit and to a lesser extent Flint. Research partnerships such as Detroit Youth Passages (DYP) have expanded greatly our knowledge of the vulnerable life contexts of youth of color and trans youth, and their project provides a model to be replicated in other parts of the state where communities of color and poorer communities are struggling.

The state's infant mortality rate constitutes a significant barrier to SRHRJ in Michigan

Women and families of color are the most negatively affected by Michigan's high infant mortality rate. Governor Snyder made reducing infant mortality a "dashboard" issue at the beginning of his term. However, the Republican super-majority legislature initially zeroed out funding for Hutzel Hospital's National Institutes of Health Perinatology Research Branch, and ultimately restored only half of the earlier appropriation – thus also losing half of the federal two-to-one matching funding, about $10 million.[107] Hutzel is located in Detroit, the site of one of the highest infant mortality rates in the nation, and without substantial state and federally matched investment, this rate is unlikely to improve.

Potential growing criminalization of pregnant women and mothers for minor offenses, prescription drug use, mental illness, and autonomy in pregnancy

Anecdotal reports suggest that Child Protective Services (CPS) is particularly aggressive in Michigan, and regularly removes children from their parents for minor offenses and infractions, thus depriving low-income and women of color of their right to parent in what can be described as a situation of stratified family formation. This attack on parenting is coupled with suspicion of pregnant women of color and poorer women. Given the state's legal climate and a legislature sympathetic to fetal protection laws, we are concerned about potential intensification of the criminalization of pregnant women and poorer parents. The conditions are primed for the arrest and conviction of pregnant women using prescription opioids or suffering from mental illness during pregnancy.

Not enough is being done to lower the state's abysmal maternal mortality rate, which disproportionately kills women of color

Michigan ranks 50th in maternal mortality and despite efforts by the Michigan Department of Community Health to improve preconception care and train providers in racial health disparities and cultural competencies this high rate has not fallen.

Shrinking access to reproductive health including abortion services for rural women

Low-income women and youth in Michigan's rural communities have very limited access to reproductive health services and health services in general. Abortion access in particular is minimal and shrinking. One of the few studies conducted on Latina migrant workers suggests a similar pattern of underutilization of reproductive health services, often for reasons having to do with the constraints of seasonal labor and temporary residence.[108]

Medicaid expansion and the ACA offer the potential to increase access to sexual and reproductive health services, but the state's legal and policy climate is likely to stymie such potential

Reproductive health services access and knowledge may nevertheless grow (the abortion rider notwithstanding) as more residents enroll in the new Marketplace health insurance plans. The initial years of Medicaid expansion may provide an opportunity to incorporate reproductive health services into primary care, preventive health, and women's health services.

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[107] Jack Lessenberry, "Lansing Cuts Funding to Hutzel Hospital," *MetroTimes*, March 18, 2014, sec. Politics & Prejudices, http://metrotimes.com/news/politics-and-prejudices/lansing-cuts-funding-to-hutzel-hospital-1.1652632.
[108] Charlene Galarneau, "Farm Labor, Reproductive Justice: Migrant Women Farmworkers in the US," *Health and Human Rights* 15, no. 1 (June 2013): 144.