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The Women's Health Activist®

FEATURE STORY: PAGE 4

Holding the Line: Challenges to Reproductive Rights in 2016

By Christina Cherel, MPH

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NATIONAL WOMEN'S HEALTH NETWORK
A VOICE FOR WOMEN, A NETWORK FOR CHANGE

DIRECTOR'S MESSAGE

Women's Week of Action...All Year Long

By Cynthia Pearson

Secretary of Health & Human Services (HHS) Sylvia Matthews Burwell and Cynthia Pearson at the White House ACA Open Enrollment Kickoff and Briefing.

"...the Federal government has turned to folks like us — women's organizations, consumer advocacy groups...to reach the uninsured."

Cindy Pearson is the Executive Director of the National Women's Health Network.

Later this month, the National Women's Health Network (NWHN) will be participating in a women's week of action to let uninsured women know that they can get help paying for insurance. During Open Enrollment season, people who don't have insurance can shop for affordable plans via the Affordable Care Act's marketplaces. Over 10 million people are eligible, but haven't gotten covered yet. Most of them would be able to find an insurance plan that's right for them in terms of price and coverage, but they have to act quickly. The deadline for signing up for coverage is January 31, 2016.

Why hold a women's week of action? To be honest, it's because Congress won't let the Federal Department of Health and Human Services (HHS) do the outreach and education needed to help people get covered. That's right, even though HHS runs the Federal *www.healthcare.gov* website, where millions of people shop and sign up for coverage, the agency lacks the resources to reach people who still haven't signed up. Congress won't give HHS the needed funds. So the Federal government has turned to folks like us — women's organizations, consumer advocacy groups, associations of health professionals, and civil rights organizations — to reach the uninsured. We use our grassroots networks, and the trust we've built up in our communities, to reach people with practical information and encouragement to sign up for coverage.

Through our Raising Women's Voices (RWV) initiative, we've connected with thousands of women and helped them understand how to sign up and use their new coverage. Read the "Network in Action" article for more information about these efforts, and our new health literacy tool, *My Health, My Voice: A Woman's Step-by-Step Guide to Using Health Insurance*. If you'd like to get involved in the January 18–24th women's week of action, visit the RWV website to learn more *(www.RaisingWomensVoices.net).*

Planning for the women's week of action on health insurance makes me think about how badly we need women's weeks of action *all year long,* not just during Open Enrollment season. Women are facing threats and challenges to their health on many fronts, perhaps most dramatically from the threat of pervasive violence. The horrific shooting at a Planned Parenthood clinic in Colorado Springs, Colorado, is just the latest example of the violence perpetrated by right-wing extremism. It's terrible that we need action to make changes so women and other vulnerable people aren't targeted for violence because of who they are, what they look like, who they are in a relationship with, where they were born, or what kind of health care services they seek.

And, unfortunately, we also have to address threats that come from legal efforts to restrict women's access to health care. In Christina Cherel's article about the challenges to reproductive rights in 2016, she explains that the U.S. Supreme Court is hearing yet another challenge to the ACA. The cases, known as *Zubik v. Burwell,* have been brought by religiously-affiliated non-profits. The employers in these cases are seeking a religious exemption from a law that guarantees that employees will receive contraception coverage through their health insurance. If the employers win, their employees will be denied a benefit guaranteed by law just because of their bosses' political views. The Court is expected to hear oral arguments in late March and to issue its decision by the end of June, 2016. The NWHN will *definitely* be active CONTINUED ON PAGE 11

The Network In Action

Raising Women's Voices (RWV) for the Health Care We Need

Cecilia Sáenz Becerra, the RWV Regional Field Manager, works with RWV's network of 31 regional coordinators to build states' support for Medicaid Expansion, advocate for policies that support access to comprehensive reproductive health services, and ensure that women know how to enroll and use their coverage. We will be profiling the regional coordinators in forthcoming issues of the *WHA,* to highlight their important work. The NWHN hosted a convening in DC last fall, which included a White House briefing for the coordinators.

The ACA has been hugely successful in expanding health insurance coverage, especially for low-income women. Over 50 percent of those enrolled in Marketplace plans are women, and 80 percent of them needed — and got — financial help to pay for coverage. But, we're hearing that women need more information about what to do once they're covered: how to use their insurance, find a doctor, and understand what's covered. RWV just released new print and on-line heath literacy materials, including *My Health, My Voice: A Woman's Step-by-Step Guide to Using Health Insurance.* The first run of the guide has been snatched up already, and the Obama Administration is poised to feature it in its outreach efforts, including the White House ACA Open Enrollment Kickoff event held on October 26, 2015. Cecilia Sáenz Becerra is leading a Spanish-language adaptation and translation of the guide.

Keep up with the latest from RWV by visiting: *www.raisingwomensvoices.net*

Securing Sexual & Reproductive Health and Autonomy

Despite Republican attacks on reproductive rights, the NWHN and our allies are working hard to build support for the Equal Access to Abortion Coverage in Health Insurance Act (EACH Woman Act). The Act would repeal the Hyde Amendment and ensure women have access to abortion care regardless of where they live or how much they make (see our Feature Article for more on the bill.) Christina Cherel, NWHN's Program Coordinator, led a NWHN team for the October 22nd *EACH Woman Act Lobby Day,* including current and former Board members, interns, and staff. Together, we visited more than 25 Congressional offices. We're currently working to get a companion bill in the Senate. Sign up for our e-alerts to follow this issue and find out how you can help protect women's reproductive health *(www.nwhn.org/health-information/e-alerts)*!

Challenging Dangerous Drugs & Devices

The NWHN was disappointed that the FDA approved flibanserin, the new drug to treat "female sexual dysfunction" — and we're making our voice heard to express that disappointment. The NWHN has been featured in a significant amount of media coverage of the new drug, the lack of information about its interactions with hormonal contraception, CONTINUED ON PAGE 11

Notice of Upcoming Election for NWHN Board of Directors

The Presidential elections aren't the only ones happening in 2016: this year is also an election year for our Board of Directors. Candidates will be announced in the March/April 2016 issue of the *Women's Health Activist.* All NWHN members are eligible to vote for their preferred candidates by either paper or electronic ballot, so make sure that your membership is in good standing. It's easy to renew online, at: *nwhn.org/renew.* Thank you for your continued support!

Board Meeting

The NWHN board of directors will meet next in March. NWHN members are welcome to join us for parts of the weekend. If you are interested in attending, please contact the office for more information about location and dates at 202.682.2640.

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Our Mission

The National Women's Health Network improves the health of all women by developing and promoting a critical analysis of health issues to influence public policy and support consumer decision-making. The Network aspires to a health care system that is guided by social justice and reflects the needs of diverse women.

The Women's Health Activist® is a bimonthly publication of the National Women's Health Network. We'd like to hear from you. Please email questions or comments to *editor@nwhn.org.* Please send change of address notices to *membership@nwhn.org.*

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Holding the Line: Challenges to Reproductive Rights in 2016

By Christina Cherel, MPH

Make no mistake — 2016 will be a monumental year for women and reproductive rights. From grassroots mobilization efforts to remove the harmful Hyde Amendment, to the increasingly contentious presidential election in November, a new era of reproductive rights and justice is in the making. Unfortunately, this new era includes battles on issues we have fought before — and will continue to engage in again.

Looking back on 2015, we achieved some undeniably major accomplishments to advance reproductive health and reproductive justice for women in this country. From the introduction of the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act in July, to the 6-3 Supreme Court ruling upholding the Affordable Care Act's (ACA) health insurance subsidies for more than 7.5 million people in June, we have moved toward a more inclusive, and progressive, health system. The National Women's Health Network (NWHN) celebrates these victories and their positive impact on women and families.

As the women's health community reflects on the past year's successes, though, we also look to the coming year with cautious optimism; optimism because we are fearless in our pursuit for improving health care for women and families in this country, and caution because we know our opponents will stop at nothing to roll back the progress we have made.

Abortion rights as a controversial issue is (sadly) not new. Republican Members of Congress and conservative elected officials in local and state governments have dramatically increased their attacks on women's reproductive health care services in recent years. In the first week of its 2015 term, 6 anti-choice bills were introduced in Congress. Racial tensions continue to rise; almost 15 percent of American families are considered to be "food insecure;" and we face both domestic and international threats of terrorism. But, rather than try to address these pressing problems, Congressional Republicans have been focused on trying to dismantle the health care system that provides women with vital reproductive health care services.

The states are no better. From 2011 to 2014, state legislatures enacted a staggering 231 new abortion restrictions. And, in 2015, almost 60 percent (57%) of women live in states considered to be "hostile" or "extremely hostile" to reproductive rights (in 2000, only 13 states were considered "hostile").[1]

We know that one in three women will have an abortion, and the majority of women will seek contraceptive and/or reproductive health care in their lifetime. Yet, too many elected officials are trying to take away these critical services, and to perpetuate shame and stigma regarding women's reproductive health needs and choices.

Given this context, the introduction of the EACH Woman Act was nothing short of groundbreaking. For decades, reproductive rights advocates have been forced to play defense, reacting to the onslaught of attacks on women's health care rather than being proactive. The EACH Woman Act — which ensures coverage for abortion, regardless of how much a woman earns, where she lives, or how she gets her insurance — changes that paradigm. With a pro-coverage abortion bill, we now have a chance to play offense, forcing anti-choice zealots to engage on our terms, not theirs.

Continuing this momentum, in October, more than 200 advocates from around the country descended on Capitol Hill to show their support for the EACH Woman Act, and for lifting the bans that deny abortion coverage to low-income women and other vulnerable communities. The 2015 Capitol Hill Day was a huge success; advocates attended over 140 meetings with Members of Congress and their staff, and urged them to be bold and end the discriminatory Hyde Amendment. Currently, the House version of the bill has more than 100 cosponsors, which is no small feat given the Hill's hostile climate for reproductive rights.

As advocates, we celebrate our Congressional champions for their bold actions, while remembering that too many communities — especially low-income women, women of color, and immigrant women (to name a few) — are still disproportionately left out of important discussions about their health care. To address this challenge, in 2007, the NWHN, in collaboration with Black Women's Health Imperative, and the MergerWatch Project of Community Catalyst, founded

Raising Women's Voices for the Health Care We Need (RWV). RWV is a national initiative that highlights women's voices and needs as the ACA is implemented. Through RWV, the NWHN is working to preserve abortion care coverage in the ACA Marketplaces, to persuade insurers to include abortion coverage in states that allow it and to expand Medicaid. We are working hard on abortion as part of ACA implementation because it is important to expand coverage for abortion care any way we can.

This year is expected to bring a major Supreme Court ruling on abortion access. In late 2015, the Supreme Court announced that it would consider *Whole Woman's Health v. Cole.* This case challenges HB2, the 2013 Texas law that requires abortion care facilities to comply with the same building specifications as ambulatory surgical centers, and abortion providers to have admitting privileges at local hospitals. This law was passed under the guise of protecting women's health, but the requirements are medically unnecessary. Several prominent medical associations, including American Medical Association, (AMA) American Public Health Association (APHA), and the American College of Obstetricians and Gynecologists (ACOG), have publicly declared their opposition to HB2, stating that it "jeopardizes the health of women in Texas," despite the law's ostensible intent to protect women's health.

The reality is that HB2 was designed to shut down abortion care facilities and would result in closing 75 percent of Texas' abortion clinics — thereby severely restricting women's access to safe abortion care. Before the law passed, Texas had more than 40 abortion care facilities; now there are just 19. If this restrictive law is upheld, only 10 clinics will remain to serve the more than 13 million women who live in Texas. A series of studies by the Texas Policy Evaluation Project (TxPEP) found that 100,000 to 240,000 Texas women age 18–49 have attempted to self-induce abortion at some point in their lives. In interviews with women who attempted self-induction, many highlighted barriers to clinic-based care as the primary reason why they attempted this. While many women reported using misoprostol to self-induce an abortion, which we know can be done safely, other women reported using "herbs or homeopathic remedies, getting hit or punched in the abdomen, using alcohol or illicit drugs, or taking hormonal pills."[2]

Whole Woman's Health v. Cole is the most important abortion rights case in almost 25 years. Its significance cannot be overstated: millions of women's lives and reproductive autonomy are at stake. But, it's not the only reproductive health care case being contested this term. The Supreme Court will also hear yet more challenges to the ACA contraceptive coverage mandate, which was brought by several religiously affiliated nonprofits.

These challenges (there are seven in total) mark the second time in two years that the Supreme Court will hear arguments related to the ACA's contraceptive coverage. Currently, religiously affiliated organizations (like schools and hospitals) must complete a form stating their moral objection to providing contraceptive coverage for employees. The groups are challenging this accommodation, claiming that they have a moral objection to filling out a form and stating their moral objection to contraception. This is absurd. Women need and deserve health insurance coverage for the comprehensive range of health care services, including reproductive services — not just for the services their employer deems to be appropriate.

It's going to be a busy year. Both the legislative and judicial branches of our government are expected to be battlegrounds this year. These are the key challenges as 2016 begins — there probably will be more as the year continues. As women's health advocates, we are prepared to fight, and to win. The coming months also offer opportunities to learn about the positions of various candidates at the local, state, and federal levels. While the presidential election is still months away, it is imperative that discussions about what this election means for women's health begin now. When you head to the polling booth in November, remember to vote as if your life depends on it — because for women, it does.✤

References are available from *info@nwhn.org.*

Christina Cherel is the NWHN Program Coordinator

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The Network Celebrates 40th Anniversary at the Barbara Seaman Awards Benefit: *A History of Accomplishments, A Force for Change*

On November 16th, more than 100 Network members and supporters gathered at the Whittemore House in Washington, DC, for the 8th Annual Barbara Seaman Awards for Activism in Women's Health. The event celebrated the 40th Anniversary of our founding and recognized the work of two remarkable women.

Zipatly Mendoza, Chair of the Network's Board of Directors, served as the emcee for the event, and welcomed members from all across the country. She noted, "When we leave this space tonight, the eagerness and enthusiasm for change cannot stop. We must remember the feeling we have today at this moment: of gratitude, pride and hope."

The Network's Executive Director, Cindy Pearson, joined Zipatly in welcoming guests to the Awards Benefit. She commented that, "At anniversaries we are prone to look back and bask in accomplishments, but I also want to inspire our members about our plans for the future. With your support, we launched a new website, expanded our communications and outreach efforts, and hosted house parties in cities across the country. The coming year, we hope to do even more."

Network Board Member Dazon Dixon Diallo presented the Award for Activism in Women's Health to Loretta Ross, co-founder of SisterSong Women of Color Reproductive Justice Collective. Dazon commented, "Loretta's work is groundbreaking to those of us who remember a time when we there wasn't a seat at the table for women, women of color, or other disenfranchised communities. It is important that we recognize this progress, appreciate it, demonstrate gratitude for it — but never stop our efforts to evolve further."

In accepting her award, Loretta recalled her experience as one of the women prescribed the Dalkon Shield and, subsequently, the first African American woman to sue the manufacturer after it made her sterile. In her comments, Loretta recognized many of the other women in the room. Former colleagues included women who worked with her at City Wide Housing Coalition in DC, such as Nkenge Touré, and women with whom she organized the March for Women's Lives in the late 1980s, such as Eleanor Smeal and Alice Cohan.

Charlea Massion, another Network Board member, presented the Emerging Activist Award to Laura Kirkpatrick for her work as the Chapter Leader of the Class of 2017's Medical Students for Choice chapter organized by students at Georgetown University. Charlea commented that "Laura is part of the next generation of medical doctors who demonstrate both altruism and empathy, specifically seek to work with communities of color, and are cognizant of the intersection between physical and mental health when accessing care."

In accepting her award, Laura reiterated the vital importance of organizations working to provide abortion training to physicians — as


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1 *Zipatly Mendoza, Chair of the N thanks sponsors for their gifts;* **3** *C Dixon Diallo introduces Loretta R thanks the Network for her Award Network for her Award;* **9** *Judy N*


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10 *Longtime Network members Ronna Popkin and Rena Popkin, with Former Network Board members Nancy Worcester and Mariamne Whatley;* **11** *Members of the Network's Board of Directors*


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etwork Board welcomes members to the Seaman Awards; **2** *Executive Director Cindy Pearson, Charlea Massion, Network Board member, introduces honoree Laura Kirkpatrick;* **4** *Dazon oss;* **5** *Laura Kirkpatrick accepts her Award from Charlea Massion;* **6** *Laura Kirkpatrick d;* **7** *Dazon Dixon Diallo presents the Award to Loretta Ross;* **8** *Loretta Ross thanks the orsigian, co-founder of Our Bodies, Ourselves, served as Guest Speaker* All photos by Peter Cutts


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12 *Ariel Tazkargy, former Law Students for Reproductive Justice Fellow, and Cecilia Sáenz Becerra, Network's Regional Field Manager, RWV, pass on the pink pill;*
13 *Network staff and interns;*
14 *Janet Stallmeyer, former Network Board member, with Network co-founders Alice Wolfson and Belita Cowan*

Medical Students for Choice does — to ensure that women can access reproductive health care.

The evening culminated with a keynote by renowned and beloved author, Judy Norsigian. As a cofounder — and later Executive Director — of the Boston Women's Health Book Collective, Judy led the organization in its efforts to ensure that *Our Bodies, Ourselves* (known to most as "OBOS") is in the hands of woman worldwide.

Network members and guests took part in the Network's "Pass on the Pink Pill" social media campaign to warn women about the dangers of the new drug targeted at women, Addyi. Photos from the event were also posted on Facebook and Twitter.

Thanks to our generous sponsors, the Network raised more than $55,000 to further our work. These funds will support all of our advocacy campaigns, including Raising Women's Voices and will help fund a Spanish language translation of *My Health My Voice: A Woman's Step-by-Step Guide to Using Health Insurance*.

We look forward to celebrating with all of you in 2016!✤

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YOUNG FEMINIST

Sex-Positive Feminism & Safety

By Sarah Jill Bashein

I identify as a sex-positive feminist. This means that, for me, sexual freedom is closely tied to my belief in gender equality and personal freedom, and that sex has the ability to empower me individually and in sexual and romantic relationships. It brings me physical pleasure, inspires pride in my body, and gives me both a positive self-image and a deeper understanding of my sexuality. While sex-positive feminism can be controversial, for me it is unmistakably positive, with one important qualifier: it has to be safe, which is easier said than done.

Although some have had growing pains in accepting the existence of "hookup culture," I firmly believe that all people should be able to have sex in whatever way they choose, as long as the sex is consensual. In the real world, many young women are seeking casual sex outside of committed relationships, and there are many reasons for this. Some young women simply don't want romantic partners or relationships at all; some don't feel ready for them at the current time. For a lot of us, chasing career and personal goal fulfillment, working on self-improvement, and schedules full of social and professional commitments do not leave time for romantic relationships.

But, while relationships may be placed on the backburner, having sex is still important for many people. In the real world, however, having an active, fulfilling sex life outside of a relationship can be complicated — and potentially dangerous.

There are many inherent risks for young women who attempt to live a sex-positive lifestyle outside a relationship. If you are a heterosexual woman, attempting to find a male partner can be a struggle, not only in terms of sexual compatibility, but also in terms of very serious health and safety risks. When young women attempt to create relationships with men that aren't predicated on romantic attachment and affection, the risk of rape or aggressive sexual behavior can feel very present. You risk all manner of horrible things that can happen to women (and men) every day — being drugged, kidnapped, raped, or sexually and/or physically assaulted, to name a few.

My personal fears in these situations are heightened because of the nature of what I am seeking: casual sex. Young women in the United States are well-aware of our country's rape culture, and we know the struggle to gain respect from men in all areas of life. Intentionally arranging to have sex with a man without a long-term relationship — which often helps foster respect and emotional attachment — can feel very risky. When I attempt to make these arrangements, a voice in the back of my head often whispers, "He's not dating you, so he doesn't owe you anything. If he's not invested in your emotional well-being, why would he treat you with respect?"

Unfortunately, that little voice is sometimes right. No matter how comfortable and confident I am with my own decision to have sex outside of traditional relationships, it doesn't mean that my male partner will meet me halfway. Although there are many men who respect women as equals and can have wonderful, respectful casual sex with a woman, others view women who embrace their sexuality as "loose" and "easy."

"I have tried to live a sex-positive lifestyle where relationships are not the main goal in my interactions with men, and I wholeheartedly support other women who seek sex outside of traditional relationships."

Because they mistakenly believe that women like me lack self-respect, these men don't demonstrate respect on *their* part. Casual sex is also risky due to our culture of victim blaming and slut shaming. Events like the Slut Walk have emerged to raise awareness and combat slut-shaming, but many people continue to blame victims of sexual assault. As a result, many women, including me, fear that, if they were assaulted, they would be blamed for engaging in sex acts at all.

Sarah Jill Bashein is a graduate student of social work at the University of Maryland, Baltimore and works helping young adults transition out of foster care. She has spent the last few years traveling through Africa and spends her free time making art and music.

As a young woman, the difficulty comes from not being able to tell which type of man you are trying to have sex with: the type who will embrace and welcome your openness, or the type who views your openness as an invitation to shame, embarrass, or control you.

Meeting potential sex partners can feel like a safety gamble, but taking the necessary precautions for safety — like meeting someone first to make sure they seem normal and respectful, not sexist or dangerous — can start to feel like dating, which can be just what the woman wants to avoid. The only solution I have found is to trust my gut. I take the usual safety precautions, like telling a friend where I am going and with whom, and having friends check in with me throughout the night via text. I also use condoms consistently and make sure, to the best of my abilities, that both myself and my partner have been recently tested for HIV. So far, I have not faced any safety issues, but the fear and threat is ever-present.

I have tried to live a sex-positive lifestyle where relationships are not the main goal in my interactions with men, and I wholeheartedly support other women who seek sex outside of traditional relationships. Until our culture catches up with women and stops stigmatizing women's sexuality, and women who enjoy it, this is easier said than done.✤

LETTERS TO THE EDITOR

The NWHN deeply values feedback from our members and stakeholders. If you have comments on our articles or activities, please let us hear from you at editor@nwhn.org.

Dear Editor,

I write as a physician, and lifetime member of NWHN. I have relied on the Network, since its founding, to offer me a perspective that organized medicine does not. But I also rely on the Network for factually correct information. I do not think the article on migraines ("Solving the Mystery of the Migraine," July/August, 2015) meets that standard. I feel strongly that, while it has a few helpful suggestions, the article does a huge disservice to people with migraines.

The article contains unsupported assertions, gross generalizations, general attacks on the established medical community, and recommendations that are contrary to the Network's usual approach to minimize unnecessary medical interventions. Migraine is, indeed, one of the most misdiagnosed and under-diagnosed common conditions, and it does affect women disproportionately. In my own clinical experience, far too many people with migraines believe they have sinus headaches, and waste money on inappropriate medications. But the article's assertion that "migraine is…thought of as a single condition managed…by avoiding all good food and taking expensive but often ineffective drugs" does not reflect current medical practice guidelines. (Silberstein SD, "Practice parameter: evidence-based guidelines for migraine headache (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology," *Neurology* 2000; 55(6):754.)

I know of **no** evidence to support the statement that migraine is a symptom of multiple infectious diseases. The statement that migraine, similar to pain in general, is a warning signal is simply incorrect. Migraine describes a complex syndrome whose most common manifestation is headache, but that can include abdominal pain, visual disturbances, and numbness in arms and legs mimicking a stroke. Migraine has a strong inherited component. By stating that medical approaches fail because they do not address root causes suggests that a root cause is known, although none is offered.

In fact, newer medical hypotheses about migraines have veered away from previous beliefs about blood vessel changes in the brain, and toward theories regarding abnormal discharges of nerves and activation of inflammation. Current medical guidelines acknowledge that medicine is still unsure of migraines' root cause, but that attention to headache characteristics and multiple possible individual triggers leads to an appropriate treatment plan, and that most treatment plans are part "trial and error" and require communication and revision between the practitioner and the "migraineur."

I was disturbed by the recommendation for expensive and unnecessary testing. The most important diagnostic test for migraine is a very careful history with a description of the headache, and a search for triggers. CAT scans and MRIs are not recommended. In fact, Choosing Wisely's campaign to eliminate expensive and unnecessary medical testing actively discourages such tests, unless the headache is a brand new symptom, or has particular characteristics that suggest a different diagnosis. (See *www.choosingwisely.org/societies/american-headache-society.*)

Further, the benefits of the suggested $750 blood test are subject to debate and the test is unlikely to be covered by insurance.

Finally, the article's references do not support the conclusions. In particular, a cited article about anatomy and the relationship between muscle and dura is from an anatomic autopsy study. It, and another study done on cadavers, may have implications for headache syndromes, but draw no conclusions regarding migraine syndrome.

I want to emphasize that my concerns do not represent an aversion to non-pharmaceutical approaches to migraines. There is good evidence for dietary approaches, exercise, acupuncture, and behavioral treatments, among others. All of these, and over-the-counter and prescription medications, represent standard medical care for the right person at the right time. The article ignored many options for approaches to diagnosis and treatment of migraines, including non-pharmacologic ones. I think the National Women's Health Network can do better.

In sisterhood,

Gene Bishop, MD
Clinical Associate Professor of Medicine
Perelman School of Medicine
University of Pennsylvania
Philadelphia PA

Dear Editor,

I read your article on Long-Acting Reversible Contraceptives (LARCs) with great interest ("The Great LARC Debate: Facilitating a Balanced Approach to Education and Promotion of LARCs," July 2015). This issue is important to those of us who are interested in sexual and reproductive health and have, for many years, worked to improve clients' and clinicians' knowledge about these methods, and to expand access to them.

High-quality family planning and sexual reproductive education should be a cornerstone of good care. The article describes "coercive programmatic or provider practices," which have no role in any clinician's or health system's rubric. No one suggests that LARCs (i.e., injections, intrauterine devices, and subdermal contraceptive implants) will single-handedly address the nation's high rates of unintended pregnancy, or be a "cure-all for economic and social inequality," as the article states. LARCs **can,** however, help adolescents, women, and couples achieve their reproductive goals in a safe, simple, and less burdensome fashion.

As the article notes, there is a critical need both to inform clients about their contraceptive options *and* to ensure clients are empowered to choose the method that best fits their unique circumstances. Clinicians must be reliable partners in helping patients pursue their reproductive goals. When this happens, everyone benefits.

Washington University's "Contraceptive CONTINUED ON PAGE 11

Hepatitis Drugs and Skyrocketing Health Care Costs

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U.S. drug prices are out of control and unsustainable. We're the *only* developed country where public programs cannot negotiate drug prices with pharmaceutical manufacturers; as a result, the U.S. generally pays more for branded prescription drugs than any other country. In 2014, we spent a stunning $3 trillion on healthcare — almost $10,000 ($9,523) per person. Although this partly stems from expanding insurance coverage through the Affordable Care Act, a large contributor was prescription drug spending, which increased by more than 12% to $297.7 billion.[1]

Drugs to treat Hepatitis C — especially Gilead's Sovaldi (sofosbuvir) — accounted for an astounding one-third ($11.3 billion) of increased prescription drug spending in 2014. In 2011, Gilead acquired PharmAsset, sofosbuvir's developer, in a multibillion-dollar acquisition, then set the price at an eye-popping $1,000 per pill ($84,000–$168,000 per treatment course). Sovaldi's much cheaper elsewhere: Egypt, for example, pays $908 per treatment course.[2]

Despite a tsunami of outrage, Gilead remained steadfast in its greed. According to a recent Senate Committee on Finance investigation, an internal email from Gilead's Executive Vice President for commercial operations stated: "Let's not fold to advocacy pressure…Let's hold our position whatever competitors do or whatever the headlines." [3, 4]

In 2014, Medicare and Medicaid spent about $5 billion just on Sovaldi, and the drug was the 1st- or 2nd-most costly pharmaceutical outlay by 29 states.[5] Many of those states and private insurers have restricted Sovaldi's use to the sickest patients. In response, Gilead offered a measly 10% rebate, often with the condition that access restrictions be lifted. This creates an impossible situation for payers, which cannot afford to treat every Hep-C-positive patient.

Competition has entered the market in the form of AbbVie's Viekira Pak, which is only slightly less expensive. But AbbVie's willing to negotiate discounts with payers, which has reduced Gilead's resistance to negotiations.[6] Meanwhile, Gilead introduced Harvoni, which costs $94,500 for a 12-week course.

Are these expensive drugs even necessary? Although useful for some, Sovaldi and its relatives have been overhyped. Hep-C, spread via blood transfusions and intravenous drug use, affects 1–2% of the U.S. population. About 25% of these people will clear the active infection on their own, without medication. For others, Hep-C infection progresses over decades, and can lead to cirrhosis, liver failure, liver cancer, and death. Progression is generally slow, however, and varies significantly by individual. About 75–85% percent develop a chronic infection; of those, 60–70% develop chronic liver disease, and 1–5% die of cirrhosis or liver cancer.[7] Not every treatment with Sovaldi averts a liver transplant — although that's what Gilead wants us to believe!

Lost in the media coverage is the fact that, before Sovaldi, we treated Hep-C with other drugs, some of which have a 40-80% success rate, depending on disease stage, therapy adherence, and comorbidities. That's a good success rate!

Yet, in 2013, the Food and Drug Administration (FDA) approved Sovaldi and other outrageously priced products under an expedited process for "breakthrough" drugs, which sets a lower standard for success than previously required. The new drugs have fewer side effects and better **short-term** success rates than older drugs, but Sovaldi's superiority may not reflect real-world results. Most Sovaldi studies were industry-funded, and, astoundingly, although several studies stated they'd include testing for residual Hepatitis C virus 24 weeks after treatment was completed, this crucial information was absent in all published reports.[8]

That's problematic, because "there is evidence that relapse rates after Sovaldi treatment may be substantial, ranging from 5–28% even among patients who are fully treated with these regimens."[9] An additional report notes it is unclear how well short-term clearance of Hepatitis C virus predicts long-term outcomes.[10] So, although the newer drugs have been feted as "cures," they may not be after all. Also, few clinical trials have compared the effectiveness of different regimens.

To sell Sovaldi, Gilead trained 293 health care professionals, mainly physicians, in 46 states to promote the company's Hepatitis C drugs to clinicians. The speakers were paid an average of $1,379 per talk. In 2014, this equaled $2.1 million in promotional speaking fees for Harvoni and $2.9 million for Sovaldi.[11]

Then, to get consumers to demand Sovaldi, Gilead set up a "disease

awareness" campaign, including a hotline and website. The campaign provides information about Hep-C and Gilead's Hep-C drugs, and makes referrals to Gilead's "Support Path" program. The program helps patients "get started on therapy and move toward treatment completion," provides financial assistance for drug purchases, and offers pre-prepared "letters of medical necessity" for health care providers to send to insurers, pressuring them to cover Gilead's treatments.

But, have we been duped by Gilead? The real clinical trial of Sovaldi is going on right now, at taxpayer expense. It will take years to know if Sovaldi's effects are lasting — or if many patients just relapse.

Although Sovaldi's and Harvoni's pricing is carefully constructed highway robbery, it's only the most recent outrageous example of Americans being strong-armed by Big Pharma. Many drugs that are under development now — especially cancer and chronic disease drugs — are projected to cost as much, or *more,* than these Hep-C drugs. We need a radical legislative shift that allows the Federal government to negotiate drug prices, and we need it fast.✤

References are available from *info@nwhn.org.*

DIRECTOR'S MESSAGE

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on this issue next year, so the Court knows how important contraceptive coverage is for women's health and women's lives.

Christina describes the reproductive rights environment for this year, and, of course, there's *another* big event occurring in 2016 that will have an impact — the elections. We are encouraging all of our supporters to pay close attention to what candidates at all levels have to say about women's rights, women's health (including reproductive health), and access to health care. Right now, we're hearing a lot from the various Presidential candidates — and there are a *lot* of candidates. As the election season continues to heat up throughout the year, we'll also start to hear from candidates who are running for state and federal offices. All of those people have the power to affect our health, so it's important to pay attention, get involved, and let the candidates know that you want policies that support good health for everyone.

We'll keep you informed throughout the year on all of these developments.✤

The Network in Action

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and the health risks to women who use it. We have a new Fact Sheet, *Top Ten Things Women Need to Know about Addyi,* for women who are considering the drug (*www.nwhn.org/addyi*), and a current Change.org campaign, building support for our efforts to get the word out about this risky and ineffective drug. Christina Cherel recently testified at the Food and Drug Administration (FDA) about the need for more studies of the interaction between hormonal contraception and a whole range of medications. It is crucially important for women to know if their birth control makes flibanserin's complications more likely, for example, or if the drug makes birth control less effective.

We are also urging the FDA to think carefully about how to respond to a group of well-known gynecologists, who petitioned the agency to remove warnings about blood clots and stroke from low-dose vaginal estrogen products. The current label warns about dangers of estrogen and estrogen-plus-progestin products used for menopause hormone therapy, regardless of the dose or delivery method (pill, patch, ring, or cream. It took activists nearly 30 years to get the right studies done about HT's potential harms to women, which include stroke, blood clots, and breast cancer, and including this information in the label of all estrogen HT products has helped women avoid exposing themselves to these risks unnecessarily. In November, Cindy Pearson testified before the FDA that women need sound information and that product labels should represent the best evidence available. Women using very low doses of estrogen to relieve vaginal symptoms may not need the full-blown warning label, but they do need accurate and useful information on which to base their health care decisions.✤

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Letters to the Editor

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CHOICE Project" clearly demonstrates this balance. In this large study, over 9,200 women received high-quality, comprehensive counseling on ***all*** methods and barriers were eliminated (including costs and access to trained clinicians). Of note, participants could discontinue using LARCs or other methods at any time. Over three years, about 75 percent chose LARCs; most were still using LARCs two to three years later, with high satisfaction rates, fostering sexual and reproductive autonomy. In comparison, approximately 8–10 percent of individuals nationwide use LARCs.

This resembles consumer behavior in other areas; for example, when people have clear information and no economic barriers, most will choose a Smart phone over a flip phone. Likewise, with contraceptives, given good, clear information, most will choose an effective, simple, and safe method over a less effective, more complicated method with potential side effects.

I also found the opening quotation from Chantal almost tabloid-ish. She states: "I've heard that the local clinic will remove [the IUD] for free, but only if I am going on another form of birth control. I just don't know what to do!" While I don't dispute she heard this, follow-up with this clinic would have been informative. I know of ***no*** clinics and/or systems with such policies against removing an IUD. Chantal's misinformation highlights the need for enhanced efforts to ensure clients are not only empowered but also have accurate information upon which to base their decisions.

Social justice is about leveling the playing field and promoting economic and social equality. As the World Health Organization notes in recent guidance, client autonomy is critically important in such efforts — but so is proactively discussing the most effective methods (i.e., LARCs) during contraceptive counseling so that more women and couples are empowered to make informed decisions (see *doi: 10.9745/GHSP-D-15-00096*).

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SNAP SHOTS

Soybeans may be more than just a tasty snack: they might help prevent bone fractures as well. Osteoporosis causes bones to weaken and results in 9 million fractures worldwide every year. Because estrogen helps protect bone health, women who have undergone the menopausal transition, and have lower estrogen levels, are at higher risk for bone fractures. Soybeans contain chemicals that are structurally similar to estrogen (called isoflavones), so they could help enhance bone health and reduce the risk of fractures. Researchers studied 200 women who were early in the menopausal transition; participants were randomized to take either a supplement containing soy protein alone, or one with 66 mg of isoflavones. Changes in the women's bone activity were assessed by measuring specific blood proteins that indicate bone loss. After six months, women taking the isoflavone supplement had significantly lower levels of these blood proteins than women taking just soy protein. (They also had lower risk of cardiovascular disease.) **The findings suggest that a diet rich in soybeans might help slow bone loss and prevent osteoporosis.**

Society for Endocrinology, November 2015

Human papillomavirus (HPV) vaccines prevent cancers caused by the virus (including cervical cancer) – but only if people get vaccinated. **Alarmingly, a new study finds that many providers fail to recommend the vaccine** consistently, on the right schedule, and in a manner that meets national guidelines. Of the 776 pediatricians and primary care physicians surveyed, one-quarter (27%) report they do not strongly endorse vaccination to parents. Over half (59%) recommended vaccination more often for adolescents they perceive to be at higher risk for HPV infection, instead of making a routine recommendation for all adolescents. Only 41% report recommending vaccination for all adolescents regardless of perceived HPV risk. Vaccination recommendations were made at the wrong time (based on the child's age) 26% of the time for girls, and 39% for boys. Physician recommendation is the most important factor in a parent deciding to get their child vaccinated; the result, according to the author, is missing "many opportunities to protect today's young people from future HPV-related cancers."

Cancer Epidemiology, Biomarkers & Prevention, October 2015

Although **heart disease is the leading cause of death among U.S. women,** it is too often considered a "man's disease." As a result, both doctors and patients themselves may fail to act in the best interests of women who experience a heart attack. A Canadian study examined records from 12,000 adults who had a heart attack at least one year earlier, and found significant gender discrepancy in treatment, particularly among young women. Women under age 55 who had had a heart attack were much less likely than men to take recommended medications (ACE inhibitors, beta blockers, and statins) to stay healthy. Among the patients, only 65% of younger women had filled all of their prescriptions, compared to 75% of younger men. Yet, women who started treatment were just as likely as men to continue taking their medications. The authors suggest that providers and **patients need better education about women's significant heart attack risks, and the importance of good medical care and medication adherence to prevent future heart attacks.**

Circulation: Cardiovascular Quality and Outcomes, October 2015