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The Women's Health Activist®

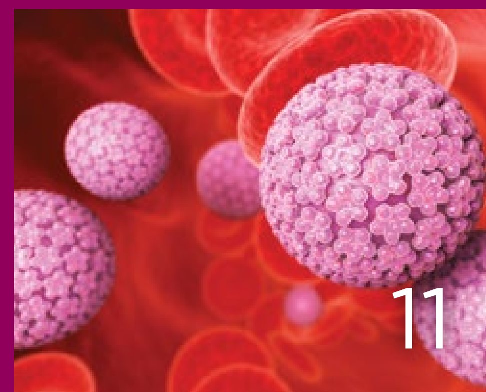
FEATURE STORY: PAGE 4

2018 Midterm Election Recap

By Sarah Christopherson

IN THIS ISSUE

Director's Message 2
RWV Roundup 3
An App is Not Birth Control 6
Join the Collective Champions.................. 7
Young Feminist 8
My "Baby Friendly" Hospital Harmed My Baby 9
Rx for Change 10
Since You Asked! 11
Snapshots 12



NATIONAL WOMEN'S HEALTH NETWORK

A VOICE FOR WOMEN, A NETWORK FOR CHANGE

DIRECTOR'S MESSAGE

It's the 46th Anniversary of *Roe v. Wade*... and the 1st

By Cynthia Pearson

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

"We must all continue to monitor our state legislatures, speak out against all restrictive laws, and support the legal organizations challenging onerous restrictions."

This is the first anniversary of *Roe v. Wade* with a new Supreme Court. And, it's the first time since state laws banning abortion were struck down 46 years ago that the Court has five justices who are explicitly hostile to the idea that ending a pregnancy is the concern of the person who is pregnant, not the government. What happens next? Will those five men vote to overturn *Roe v. Wade* and let states ban abortion again? That's certainly worth worrying about, but sometimes the emphasis on *Roe* distracts us from focusing on what's more likely to happen — and, in some cases, what's already happening.

Here's my advice to supporters of reproductive freedom: don't focus just on big cases that could ban all abortions outright. Although that's important, we also have to pay attention to laws that restrict *certain* procedures, or *certain* women, or *certain* clinics. The Court is much more likely to hear a case about clinic restrictions or 20-week bans than an outright ban. Such infringements on the legal right to abortion have been signed into law already and cases challenging them are working their way to the Supreme Court. Those restrictions are less sweeping, but they're tremendously important. Restrictive laws not only cause suffering for those directly affected, but also make it easier for the Court to uphold the next restrictive law. We must all continue to monitor our state legislatures, speak out against all restrictive laws, and support the legal organizations challenging onerous restrictions.

It's also important to realize that it's not just *new* laws that threaten access to abortion. *Roe* is still in effect, but a patchwork of state laws and health care budgets already hamper access for many people. Only 15 state Medicaid programs cover abortion care; 20% of those who need abortion care must travel more than 40 miles for the procedure. And, 31 million reproductive-aged women now live in a state that's hostile to abortion rights (up from 12 million in 2010). For many pregnant people, the post-*Roe* future has been here for a long time.

The NWHN believes that we need a wide range of tactics and messages to fight barriers to access and the threat of further, more extreme restrictions. People experience abortion differently, they need it at different times in their lives, and for different reasons. And, our trans allies correctly remind us that not everyone who needs an abortion is a woman. No single message or approach will ensure that everyone has the access and support they need when it's time to end a pregnancy.

Many strategies are already underway. Planned Parenthood Federation of American (PPFA) is building a network to fund travel to PPFA clinics in states where abortion will remain legal and accessible post-*Roe*. The National Network of Abortion Funds is raising awareness about the millions of dollars needed right now to fully fund the cost of travel and procedures for those who have difficulty accessing abortion care. The ACLU, the Center for Reproductive Rights, and the National Women's Law Center are collaborating on legal strategies to fight bad laws and pursue good laws. All* Above All is building support for a bold new law called the EACH Woman Act, which would do away with all restrictions on public and private abortion care funding.

The NWHN is focused on medication abortion to educate people about its safety and defend access to this type of abortion procedure. Mifreprex and misoprostol are FDA-approved to CONTINUED ON PAGE 11

RWV Roundup

By Kalena Murphy

Raising Women's Voices (RWV) has a special mission of engaging women who are not often invited into health policy discussions, including women of color; low-income women; immigrant women; young women; women with disabilities; and members of the lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQI) community. Our 30 Regional Coordinators (RCs) help represent the interests of these constituencies.

Speaking Out to Protect Health Care

We spoke out against two proposed Federal regulations that would harm women and LGBTQI people. We elevated the issues, facilitated the submission of organizational comments to the Department of Health and Human Services (HHS), and encouraged thousands of people to submit their own comments opposing the regulations. The first proposal would make it easier for health care providers to deny care based on religious, moral, or personal objections. The second would have undermined key provisions of the Title X Federal family planning program. Our RCs helped women and LGBTQI people learn about and speak out against these proposals by posting on RWV's social media and hosting a *#DontDenyUsCare* Twitter chat, which reached more than 1.4 million people. RCs created user-friendly overviews of the proposals' potential negative impact and shared them online and through social media. RCs also used RWV's template to submit their own comments on the proposals, and engaged their members by sharing our Take Action page, which had talking points and linked to the HHS comment page. Both proposals are still pending.

Protecting People with Pre-existing Conditions!

One of the key components of the Affordable Care Act (ACA) is the protection that ensures people with pre-existing conditions cannot be denied health insurance, charged more for it, or otherwise discriminated against. To highlight the critical need to maintain and protect this protection, RWV co-sponsored a successful Twitter Chat in August with Community Catalyst, the Black Women's Health Imperative, the American Heart Association, Little Lobbyists, Families USA, Protect Our Care, and the Service Employees International Union (SEIU). Many RCs participated, including California Latinas for Reproductive Justice (CLRJ), Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR), EverThrive IL, Consumers for Affordable Health Care, Consumer Health First, Northwest Health Law Advocates, and WVFREE. Our chat reached a wide audience and our hashtag, *#130MillionStrong,* trended in the top 10 nationally. We were delighted that Rep. Nancy Pelosi (D-CA) and the First Lady of New York City, Chirlane McCray, also joined the event. Many participants shared their personal stories about why protections for those with pre-existing conditions matter to them and their loved ones. Deneen Robinson, Program Director of The Afiya Center, our Dallas-based RC, shared her first-hand experience. "When I was diagnosed with HIV in 1991," Deneen says, "the doctors told me I only had three years to live. But I'm still here. I've raised two children, now 29 and 30 years old. Thanks to the ACA, I was able to get health care, despite my pre-existing health conditions, and to stay alive and healthy enough to take care of my family. In the course of this work, I've seen first-hand how many women, especially Black women, the ACA helps — and how many Texans would lose health care due to pre-existing conditions without the ACA's protections."

Meet RWV's Newest RC

In August 2018, we welcomed the Mississippi Black Women's Roundtable (MS-BWR) to RWV's RC network. BWR is the women and girls empowerment arm of the National Coalition on Black Civic Participation (NCBCP), which champions equitable public policies for Black women and girls state-wide, across the South, and nationally. BWR is a highly effective economic and social justice organizing network led by Black women, which focuses on expanding inter-generational leadership and addressing economic insecurity, education, and health disparities that perpetuate systemic, multi-generational poverty for too many Black women, families, and communities. The Mississippi affiliate, MS-BWR, is an intergenerational civic engagement network led by Cassandra Welchlin and CONTINUED ON PAGE 7

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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.

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2018 Midterm Election Recap

By Sarah Christopherson

The 2018 elections were a historic victory for health care and for women. You marched, called, wrote, protested, canvassed, and spoke out. And it worked! In exit polls nationwide, voters confirmed that health care was their top priority, and they punished officials who had sought to take it away. Even in races where health care proponents ultimately lost, the margin of victory was often significantly closer than anyone would have predicted two years ago in states won handily by Donald Trump — thanks to health care voters.

Strikingly, a number of the Affordable Care Act's (ACA) harshest foes were forced to lie about their opposition to the law's consumer protections in a sweeping reversal of health care politics from previous election cycles. In Arizona, for example, Congresswoman Martha McSally (R-AZ) famously rallied her GOP House colleagues to pass the bill gutting protections for pre-existing conditions in 2017 by urging them to "get this f****** thing done." But in 2018 she claimed to be "leading the fight to force insurance companies to cover pre-existing conditions."[1] She lost a Senate race against a fellow House member, Congresswoman Kyrsten Sinema (D-AZ), who had opposed GOP repeal attempts.

With Democrats taking control of the U.S. House of Representatives by a large margin, the door has been firmly closed on further legislative attempts to repeal the ACA, gut Medicaid, block low-income patients from receiving care at Planned Parenthood, and cut Medicare to pay for the GOP's tax cuts. The change in power also has significant implications for the kinds of oversight the House will conduct. House committees are now expected to investigate the administration's efforts to sabotage the ACA and its refusal to defend the law in court. And with newly confirmed Supreme Court Justice Brett Kavanaugh an ongoing threat to women's health, we may even get the full investigation from the House Judiciary Committee this year that the Senate Judiciary Committee refused to conduct last year.

The next two years could be particularly turbulent for House Republicans, two-thirds of whom have never served in the minority before. The 2006 wave elections, where a similarly long-standing Republican majority was defeated, may provide a good historical analog. Chafing in the minority and facing another tough re-election fight defined by an unpopular president, large numbers of Republicans who had survived 2006 announced their retirement for 2008. We'll have to see how such a scenario could affect a smaller, Trumpier GOP conference's approach to health care. With the possibility of ACA repeal dead, there is some hope that the incoming Congress could pursue bipartisan initiatives to lower health care premiums and curtail rising drug prices — but only if advocates keep up the pressure.

In the Senate, where Democrats were defending ten seats in states won by Trump (and Republicans were defending only one seat in a state won by Hillary Clinton), Republicans only increased their narrow majority by two seats. The loss of the House neuters Senate Republicans' ability to pass harmful legislation, but the increase from 51 to 53 seats gives them a larger buffer to confirm extremist conservative judges. Senate Majority Leader Mitch McConnell (R-KY) is expected to spend the next two years aggressively attempting to remake the Federal judiciary in Trump's image.

"The U.S. House will have more than 100 women members for the first time in history, up from 84 in 2018 — although that's still less than a quarter of its total membership."

As disturbing a prospect as this is, however, it's still a marked reversal in fortune from the filibuster-proof majority that Republicans had once envisioned for 2019.

There was good news on the state level, as well. In Nebraska, Idaho and Utah, voters overwhelmingly passed Medicaid expansions by ballot initiative, closing the coverage gap for more than 360,000 people. In Kansas and Maine, voters elected pro-health care governors, potentially easing the path for their states to expand Medicaid, which would cover an additional 200,000 people. Kansas had previously passed Medicaid expansion legislation through its Republican-controlled legislature only to see its extremist governor veto the bill. In Maine, the outgoing Republican governor, Paul LePage, had not only vetoed multiple expansions passed by the legislature, but also had been illegally blocking a 2017 voter-passed Medicaid expansion. Pro-expansion gubernatorial candidates also won in states like Wisconsin (which currently has a partial expansion) and Michigan (which has sought to undermine its existing expansion through the waiver process).

In Nevada and New Mexico, newly-elected state leaders are considering Medicaid buy-in programs. These would allow residents with incomes above the threshold for Medicaid eligibility to use their own funds and ACA premium assistance dollars to purchase Medicaid coverage instead of a private plan. Nevada's legislature passed Medicaid buy-in in 2017, but the program was vetoed by outgoing Republican Governor Brian Sandoval. Incoming Governor Steve Sisolak (D-NV) is supportive of the program.

We are also celebrating a number of historic firsts for women. Debra Haaland and Sharice Davids became the first Native American women elected to Congress. Ayanna Pressley and Jahana Hayes became the first Black women elected to Congress from their respective states. And Rashida Tlaib and Ilhan Omar became the first Muslim women in Congress. The U.S. House will have more than 100 women members for the first time in history, up from 84 in 2018 — although that's still less than a quarter of its total membership.

But, even as we celebrate our health care victories, we know our work is far from over. A lawsuit to gut the ACA's consumer protections,

“Looking further ahead, we will also be working to overcome an information environment increasingly tilted toward far-right interests — with a big impact on women’s health.”

including those for people with pre-existing conditions, is likely headed to the Supreme Court. The Trump administration also continues to sabotage ACA marketplaces, push “junk” insurance plans on unsuspecting consumers, and promote bureaucratic obstacles to coverage in the Medicaid program. And, of course, the administration continues to attack private insurance coverage for both contraception and abortion.

Looking further ahead, we will also be working to overcome an information environment increasingly tilted toward far-right interests — with a big impact on women’s health. Forty-five percent of Americans say they primarily get their news from Facebook, according to the Pew Research Center.[2] During the fight in October over Kavanaugh’s Supreme Court confirmation, social media heavily promoted right-wing sources, which supported Kavanaugh’s appointment. *New York Times* social media reporter Kevin Roose discovered that the most widely distributed Facebook posts about Kavanaugh and Dr. Christine Blasey Ford came from Fox News, Breitbart, racist pundit Ben Shapiro, and far-right outlet The Daily Caller. Another media observer found that the first results for a YouTube search for “Christine Blasey Ford” were from hard-right media personalities Tucker Carlson, Lou Dobbs, and Glenn Beck.[3]

Meanwhile, the openly pro-Trump Sinclair Broadcasting has been quietly taking over local broadcasting stations and using its control to spread conservative propaganda, reaching the 37 percent of Americans who say they primarily get their news from local TV, according to Pew. The company made news in 2018 by requiring all of its 193 local affiliates — which reach almost half the country — to read the same canned on-air editorial parroting Trump’s rhetoric.

As Vox reported last year, “unlike Fox News, Sinclair programming comes to people on local TV, on channels affiliated with ABC or NBC or CBS or Fox, many of which have existed in their communities for decades before Sinclair bought them. Millions of these stations’ viewers have no idea that they’re watching conservative editorials rather than normal local news, which gives Sinclair incredible power to persuade viewers of conservative ideas.”[4] *The New Yorker* reported, “In the [2016] election, voters in areas with a high concentration of Sinclair stations chose [Donald] Trump over Hillary Clinton by an average of nineteen points.”[5]

Meanwhile, researchers have found evidence that watching just three additional minutes of Fox News per week in 2008 — say, when you were captive in a doctor’s waiting room — “would have made the typical Democratic or centrist voter 1 percentage point more likely to vote Republican that year,” as reported by Vox.[6]

Working to close that information gap and provide medically accurate, scientifically sound information about women’s health and the policies that affect us is one of our most important undertakings.✤

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

The Rhode Island ReSisters has a campaign to fight one of Sinclair’s take-overs, called

“Turn off 10.”

The website *(www.turnoff10.com)* describes the problem and offers background on Sinclair and their local advertisers. It’s a good model for others to adopt and help ensure the news we get is accurate and trustworthy.

Sarah Christopherson is the NWHN’s Policy Advocacy Director

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An App is Not Birth Control: Natural Cycles' Approval Raises Serious Questions

By Tessa Ruff

In August 2018, Natural Cycles became the first smartphone application ("app") for contraception to gain approval from the Food and Drug Administration (FDA). Natural Cycles is a high-tech version of the fertility awareness method (also called "natural family planning" or the "rhythm method"), in which people track their ovulation cycles in order to avoid pregnancy. Fertility tracking can play an important role in helping people better understand and care for their own bodies. Given the growing popularity of smartphones, the rise of fertility tracking apps is no surprise. But can an app replace your birth control? Natural Cycles says yes, but the NWHN isn't so sure.

Natural Cycles combines data about your menstrual cycle and daily basal body temperature, measured every morning immediately upon waking and entered into the app, to predict the days when you're most likely to get pregnant, displaying either a green "infertile" reading, letting you know it's safe to have unprotected sex, or a red "fertile" reading, warning you to abstain from sex or use a barrier contraceptive method (like a condom).

Natural Cycles claims to be more effective than oral contraceptives (i.e., the Pill). The app's published failure rate is just 6.5%, whereas oral contraceptives have a failure rate of 9%. Typically, fertility awareness has a failure rate of 24%.[1] But the data the company submitted to the FDA for approval likely do not represent the average contraceptive user's experience—and may not even represent many of the people who try the app before ultimately quitting. When pressed about whether the app is really as effective as the Pill for most contraceptive users, the company demurred. Natural Cycles' chief executive described the app's users as "highly motivated" and "age 30 on average, in a stable relationship with a regular daily routine, and willing to take their temperature on a daily basis and use protection on fertile days."[2]

Yet, the company's aggressive marketing campaigns target

contraceptive users among the general public by promoting the idea that the Pill and the app are comparable in terms of pregnancy prevention. Many users are likely to find that correctly using the app is more difficult than correctly using the Pill and other hormonal contraceptives. For example, accurately recording one's basal body temperature is notoriously difficult, because it can be affected by everything from illness, to alcohol, to minor changes in sleep patterns.

Even the FDA may believe that the app's actual failure rate is higher, warning that "Natural Cycles should not be used by women who have a medical condition where pregnancy would be associated with a significant risk to the mother or the fetus."[3] The NWHN is also concerned that the app was approved in the first place, and that it was approved through a less rigorous process. We note that Annovera, the new vaginal ring approved the same day as Natural Cycles, has a similar typical use failure rate but did not carry this same warning.

But efficacy isn't our only concern. The Natural Cycles database stores highly personal medical information about users' sex lives, pregnancy intention, contraceptive use, body temperature, menstrual cycle, specific dates of intercourse, ovulation test results, and pregnancy test results. Despite this, the company is not required to comply with medical information privacy laws. Its privacy policy explicitly permits its owners to sell user information to third parties. And it warns users it "may disclose your Personal Data in order to comply with a legal or regulatory obligation." Moreover, like any cloud-based service, Natural Cycles is vulnerable to security breaches.

Worse, with reproductive rights at risk in the U.S. and elsewhere, there is no guarantee that Natural Cycles' data won't be used by law enforcement or hostile organizations to target individuals who have had abortions.

The Trump-Pence administration has been overtly hostile to contraception, packing key agencies with hard right religious conservatives who believe "contraception doesn't work"[4] and "chemical birth control causes abortions."[5] As part of its larger attack on the Title X family planning and teen pregnancy prevention programs, the administration is seeking to shift Federal dollars from true family planning clinics and fund fake clinics that only offer fertility awareness coaching and attempt to deter women from seeking abortion care. Unlike Natural Cycles, the FDA subjected Annovera to rigorous premarket testing before it gained approval. We know that the Trump-Pence administration has been promoting fertility awareness over other, more reliable forms of contraception. Was the goal to confer scientific credibility on fertility awareness, and take attention away from Annovera?

While we can't prove that the FDA's decision was politically influenced, it fits into a larger pattern of hostility to reproductive rights. Just as fake clinics work hard to mimic the look and feel of true health care providers and co-opt the public's trust in medical science, the Trump-Pence administration has found a way to brand fertility awareness an "FDA approved" method. Learn more at *www.nwhn.org/smartphone-contraception*. ✤

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

Tessa Ruff is the NWHN's Policy Fellow

Raising Women's Voices Regional Coordinators gather at the RWV Annual Convening in Washington DC in December 2018.

RWV Roundup

FROM PAGE 3

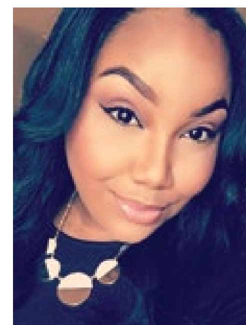
Debra Robinson. RWV is delighted to welcome you to the team!

Women Unite to Oppose Kavanaugh
In August, advocates in all 50 states participated in more than 200 events across the country on Women's Equality Day, warning that the confirmation of Justice Brett Kavanaugh to the U.S. Supreme Court would give opponents of women's reproductive rights a majority and could well result in the repeal of *Roe v. Wade.* The Unite for Justice Day of Action was the largest single-day action opposing a Supreme Court nominee in the country's history. RWV and our RCs promoted and participated in local events in 11 states (CO, GA, MA, ME, NJ, NM, NY, OR, TX, WA, and WV) to highlight the dire threat Kavanaugh poses to health care access and abortion rights. Although Kavanaugh was confirmed, we want to thank all of our RWV's for their incredible advocacy and work on this issue.

Dems Control the House, What's Next for RWV?
In December 2018, we gathered in DC for RWV's annual two-day convening, a time to reflect on the past year and discuss what's next. The convening outlined the midterm election outcomes' implications for RWV's. RCs Northwest Health Law Advocates (NoHLA), CLRJ, COLOR, Trans Queer Pueblo (TQP) shared experiences about their work on immigration and health justice. We heard from the Black Women's Health Imperative, The Afiya Center, and Planned Parenthood of Southern New England, which discussed working on the ground to address the country's dire maternal health disparities. MS-BWR, New Voices Pittsburgh, and CLRJ shared best practices for incorporating the Reproductive Justice framework to address social determinants of health. We strategized how RWV can support the groundwork to continue improving the health for women and families, especially low-income women, women of color, immigrant women, and LGBTQI people. Great things are planned for 2019!

Join Us
Sign up for RWV's weekly newsletter at *http://raisingwomensvoices.net/*. You can also get instant updates on our work and our issues via Facebook and Twitter (@RWV4HealthCare).❖

RWV is a national initiative to ensure women's voices are heard and women's concerns are addressed as the Affordable Care Act is implemented. Founded in 2007 by the Black Women's Health Imperative, the National Women's Health Network, and the MergerWatch Project of Community Catalyst, RWV has 30 RCs in 29 states (*http://raisingwomensvoices.net/*).



Kalena Murphy is the NWHN's Regional Field Manager for RWV

Join the Collective Champions and Stand Beside the NWHN Each Month!

Collective Champions are a special group of the Network's most passionate and forward-thinking supporters — leaders just like you. They care deeply about investing in our work, and do so by contributing each month through automatic monthly gifts. Each month, their voices are being heard by millions of women all across our country.

Join the Collective Champions by committing to a monthly gift. It doesn't matter if the amount you can give seems small — if just 20 people give $15 a month, that's an extra $300 a month, and $3,600 a year for the Network to help women. Trust us: that matters to women and their ability to access health care!

You're never alone as a Collective Champion. Make your stand today and become our newest Collective Champion at *donate.nwhn.org/collectivechampions!*

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COLLECTIVE Champions
National Women's Health Network

YOUNG FEMINIST

The Feminist Sound Wave: How Music Changed My Body Image

By Lily O'Connor-Coates

High school is a time for finding your sound and your voice through music. As one of the millions of teenage girls struggling with body image, music became vital to my healing and my positive self-image.

I first noticed how my thighs took up the whole chair when I sat at my desk in fifth grade. It was a sunny day and I was wearing shorts. I remember looking down and thinking, "Do my legs always look this fat?" Surely a 10-year-old shouldn't be thinking about her weight and she certainly shouldn't be afraid of the way she looks. But there I was, 10 years old and questioning whether I was too fat.

I spent a lot of time looking down, looking in the mirror, not liking what I saw. I hid my body with jeans and oversized hoodies, worried that anything form-fitting would reveal the hideousness that was my body. When I did have a tight shirt on, I spent all day sucking in my stomach so I could be attractive. I just ended up with a sore abdomen.

Food was an enemy of my mind and body. I remember thinking that, if I cut out meals, I'd be much happier in the end. So, I did what my society told me to and I restricted my diet. Although body positive movements have spurred change across the nation, the forefront of fashion, beauty, and style still contain flawless women. No cellulite, stretchmarks, acne, freckles, hair, or fat. When I was in high school, I saw these women everywhere, from magazines to television. I spent days walking through the halls and feelings dizzy, not thinking of the harm, but instead thinking of how well I could fit in now. I would have the body pretty women had.

I took my first psychology class when I was a junior in high school, years after I first started questioning my body image and restricting my diet. Looking back, I am thankful for this class, which encouraged me to speak up about my health. We started the year learning about depression, anxiety, and different eating disorders. I always knew something was wrong and decided to talk to my parents when the symptoms I was studying were too similar to what I was doing.

After telling the truth, I quickly learned how much harm I was doing. I spent months underweight, orthostatic, and dizzy. Doctors would weigh me and shake their heads, hiding what the scale said. My parents were scared and confused the whole time, not understanding why I was hurting my body. I almost fainted every time I had my blood drawn and was even rushed to an EKG when my heart rate was fluttering too much. I was told that, if I kept going down this path, I wouldn't be able to go school or even have a baby in the future.

Throughout this time, I listened to music that reflected how I felt. It was dark, sad, and the lyrics focused more on angst and anxiety than on positive body image and self-love. To me, it was normal to feel this way and listen to music that projected my feelings. I never thought that changing my music would change the voice in my head.

Around the time I started therapy, I made new friends and became very close to someone whose life revolved around music. He introduced to several new artists and musical genres, which led me to start exploring more varieties of music. I started small, just listening to songs that came on the radio, like Mary Lambert's "Secrets" or Demi Lovato's "Confident." I found that this new musical voice told me my body didn't need to be starved or altered to make it better.

"I started small, just listening to songs that came on the radio, like Mary Lambert's 'Secrets' or Demi Lovato's 'Confident.' I found that this new musical voice told me my body didn't need to be starved or altered to make it better."

As I continued to find more music, I specifically looked for songs with positive messages. I also discovered body and fem-positive music within the genres I usually listened to. I found artists and songs that really resonated with me. This is how I discovered feminist music groups. I stumbled onto bands like Misterwives and was introduced to others such as T-Rextasy and Skating Polly. I found the sound that I loved with a message that reminded me how my mental health and self-care mattered.

I won't pretend that other factors didn't help me overcome my negative body image. I saw a therapist, communicated with my parents, and worked hard to reshape the "ideal" body in my head. I still have days when I look in the mirror and I'm not satisfied. But those are rare now. And I always turn to my music, friends, and family to boost my mood. I am much more confident in myself and my body. I can stand up, proud of who I am.❖

"I won't pretend that other factors didn't help me overcome my negative body image. I saw a therapist, communicated with my parents, and worked hard to reshape the "ideal" body in my head. I still have days when I look in the mirror and I'm not satisfied. But those are rare now."

Lily O'Connor-Coates is a student at the University of California, Davis. She is pursing degrees in communication and psychology with the goal to work in editing and publishing.

My "Baby Friendly" Hospital Harmed My Baby: Why Structural Reform Matters

By Sarah Christopherson

The decision to breast- or bottle-feed is highly personal, and the right answer varies from parent to parent. One of the NWHN's founding values is that when women have good information, they can make the right decisions for themselves and their families. But this isn't an article about breastfeeding's benefits or drawbacks; an overview of formula companies' long, coercive history; or the feminist case for bottle-feeding.[1] It's a story about what happens when good information *isn't* enough.

As background. I'm white, middle-class, and well-educated, with all the status and privilege that affords. I work in health policy and this is my third child. Before joining the NWHN, I was a senior aide to two members of Congress, so I have experience telling powerful people why they're wrong. Few patients are better positioned to stand up for themselves and their children. And yet, I didn't. Not until my daughter was so dehydrated she couldn't give enough blood to fill a pen cap.

When I gave birth the first time, the country's "baby-friendly hospital" movement was in its infancy. The Dept. of Health and Human Services only endorsed the movement's principles in 2010, including "rooming-in" (where the baby stays with the mother during her recovery instead of in the hospital nursery) and soft bans on pacifiers and formula.

However well-intentioned, the principles — imposed on exhausted parents by hospital staff and enforced through bureaucratic rules and incentives — can turn coercive in practice. In 2014, the *Washington Post* reported, "If a mom wants to send her newborn [to the nursery], *staff members often have to ask why and then fill out paperwork explaining the reason.*"[2] As I discovered, "Formula may be provided, but only on request, and only after, in some instances, *mothers sign a waiver acknowledging that using a bottle could impede breast-feeding.* Lactation consultants roam the floor."[2] [emphases mine.]

Writing in *JAMA Pediatrics* in 2016, pediatricians warned about "the emerging evidence that full compliance with the 10 steps of the initiative may inadvertently be promoting potentially hazardous practices and/or having counterproductive outcomes."[3] The article highlighted the dangers of mandatory rooming-in and unsupervised skin-to-skin contact when mothers are exhausted or medicated and the questionable practice of banning pacifiers, when pacifiers reduce the incidence of sudden infant death syndrome; it also raised concerns about coercing mothers into exclusive breastfeeding.

I first noticed things weren't right 24 hours after giving birth. My daughter was too sleepy to nurse very long and none of the lactation consultant's tricks worked. With my other children, I'd satisfactorily supplemented nursing with formula, so I asked for a bottle. The nurse was stern and disapproving. To "give up" on breastfeeding, I'd have to sign a waiver acknowledging the risks associated with my terrible choice. "Reasons for supplementation" included mothers "who are critically ill," have "intolerable pain during feeding unrelieved by interventions," or have "breast pathology." For mothers who simply *choose* to supplement, the form warned: "The American Academy of Pediatrics says that routine supplements of formula for breastfed newborns should not be used."

I was recovering from a C-section, dependent on hospital staff for food, pain medication, and assistance using the bathroom and shower. Interrupted throughout the night by an endless parade of doctors, residents, nurses, techs, and support staff — all with their own, uncoordinated schedules — I had the jellied brain of a torture victim. So I signed the form...then didn't use the formula! I wanted to talk to the pediatrician about the baby's listlessness before I gave her an allergy, destroyed my milk supply, or risked the other horrors listed on the waiver. I asked to see the pediatrician, and was sent the lactation consultant instead.

So I delayed another day, with the signed waiver and pre-made formula in reach but too afraid to oppose the hospital staff who controlled every aspect of my existence. Looking back, it's incomprehensible to me. Dehydration in newborns can lead to blood clots, strokes, permanent brain damage, and death. I should have fed my baby right away, and I knew it — yet somehow I didn't.

Fortunately, jaundice set in and, with it, the need to draw blood for a bilirubin test. The nurses sliced my baby's heel, she screamed weakly, they squeezed her foot, and collected a single drop of blood. But then the cut clotted closed. So they had to do it again. And again. Slice, squeeze, repeat, while she screamed in pain and I watched helplessly. They only needed a tiny amount, but she was too dehydrated. She'd lost 15% of her birthweight by then. After 20 agonizing minutes, they handed my impossibly small girl back to me. I flung open the cabinet and attached nipple to bottle with shaking hands. With the first sip, her eyes shot wide open and her tiny hands flew instinctively to the bottle. She looked like a starving person eating for the first time. Which, of course, she was.

I've thought a lot about the NWHN's leadership on reproductive coercion, particularly on long-acting reversible contraceptives (LARCs) and sterilization. Good information is necessary for good health outcomes, but it's not sufficient. That's why, in addition to providing women with good information, the NWHN supports systemic reform to support women making well-informed choices without coercion. In 1979, we recognized doctors might take advantage of women at their most vulnerable to enforce racist or classist agendas, and fought for mandatory waiting periods for sterilization. In 2019, we fight LARC-first policies and quotas and train providers, counselors, and policymakers to build patient-centered systems so women get the sexual and reproductive health care that's right for them.

I've always known how important that structural reform is. But it wasn't until I fed my starving child for the first time that I really lived it.❖

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

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Rx for Change: The ABCs of Hospice and Palliative Care

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An 83-year-old woman dies on a ventilator in the ICU. She's been hospitalized for five of the last six months of her life.

A 57-year-old woman with recurrent metastatic breast cancer develops cancer-related fluid inside her chest cavity. She has aggressive surgery to prevent the fluid from reaccumulating. She dies in the hospital two days later.

Perhaps you've witnessed similar situations. In our high-tech healthcare system, aggressive treatment is the standard approach. Sometimes it is tremendously beneficial. However, in other circumstances, aggressive treatment causes a patient and their family great suffering with little benefit.

Why do we inflict drastic procedures and treatments on people who are dying? Because we can then say we did everything we could? Unfortunately "everything we could" often sacrifices the patient's comfort for futile hopes. Even worse, surgeries, chemotherapy, etc. can weaken or disable someone who is dying. Focusing on disease treatment also precludes optimum management of end-of-life symptoms (pain, nausea, anxiety, insomnia, etc.) and absorbs precious time better spent with loved ones and settling one's affairs.

Aggressive treatment also often prevents someone from being home, which is where most Americans hope to die — but don't.

Charlea is a hospice and palliative care physician who sees these situations all too frequently. Choosing hospice or palliative care isn't "giving up" — it's supporting exploration of ALL options, not just what aggressive intervention to try next. As feminists, we must empower ourselves and our loved ones with knowledge about hospice and palliative care. Learning about palliative care and end-of-life care is just as crucial as a pregnant woman learning about childbirth and developing a birth plan. It is essential to advocate for what you want, either with or without your physician's approval.

Here are the basics of hospice and palliative care:

Palliative Care

Palliative care is usually for someone with an estimated one to two years to live. Patients who receive palliative care services can continue to pursue interventions like surgery or diagnostic tests. Palliative care physicians are specialists who help patients with complex symptoms, including pain, nausea, anxiety, and/or insomnia. These physicians also facilitate "goals of care" discussions with patients and families about continuing aggressive care or shifting to "comfort goals" and focusing solely on quality of life.

Palliative Care Versus Hospice Care

Hospice services are reserved for people with an estimated six months or less to live, and focus on comfort and quality of life. When someone starts hospice care, they stop pursuing curative treatments and interventions to prolong life (e.g., dialysis, surgery, chemotherapy, radiation, etc.). Hospice patients usually receive care where they live: home, assisted living, nursing homes, or homeless shelters. Hospice patients with symptoms that cannot be well-managed where they reside receive care in a hospital or inpatient hospice facility.

Advance Care Planning

In previous columns, we've covered "advance care planning" documents you can use to guide end-of-life care (see *www.nwhn.org/dying-america-better-ever/* and *www.nwhn.org/be-your-own-death-panel/*). These direct your physicians to provide the care you want in a life-limiting illness — and, even more important, the interventions you do NOT want. Hospice and palliative care physicians, nurses, and social workers can assist patients and families with advance directives, Five Wishes, and Physician Orders for Life-Sustaining Treatments (POLSTs). Although these all are legal documents in most states, we urge you to check your state's legal requirements.

Code Status

"Code status" indicates if you want cardiopulmonary resuscitation (CPR) if your heart or breathing stops. It also states if you want defibrillation (shocking the heart) and/or "intubation" (inserting a breathing tube for life support on a ventilator). Both hospice and palliative care providers can help you determine your code status, communicate your choice to your physicians, and document your code status in electronic health records. It is important to note: Although CPR often appears easy and successful on TV, it's actually a very traumatic procedure that causes bruising, rib fractures, liver lacerations, and other injuries. For someone with multiple chronic illnesses, advanced

cancer, severe heart or lung disease, or end-stage kidney or liver disease, CPR is almost always **unsuccessful**. Even if someone **is** resuscitated, they are at risk for brain injuries, often have another cardiac arrest within a day, rarely leave the hospital alive, and are unlikely to ever regain their previous level of function.

Palliative Care at Home or in the Hospital

Inpatient palliative care (provided in the hospital) is available in most major hospitals and increasingly in smaller community hospitals as well. Outpatient palliative care (outside the hospital) is often provided by a team of physicians, nurses, social workers and/or mid-level providers (nurse practitioners and physician assistants). This team can also help with symptom management; ongoing review of treatment goals as someone's health changes; and "care coordination," which facilitates communication among all the providers involved in caring for someone with life-limiting illness.

Finding Hospice Providers in Your Community

We encourage you to choose non-profit, community-based hospices. Consider asking your family, friends, and neighbors for recommendations. Many communities have several hospices and there may be significant differences in the quality of care provided. Avoid for-profit hospices. During the last 15 years, the major growth in the "hospice industry" has been in for-profit hospices, which are corporations with hospice chains across many states and with different incentives than nonprofit community hospices.

Finding Palliative Care Providers in Your Community

If you or a loved one is hospitalized, ask your hospital physician for a palliative care consultation or ask the staff to contact the hospital's palliative care service. In many places, outpatient palliative care options are limited, and you may need to look more diligently. Ask your friends, family, neighbors, and your health care providers for recommendations of palliative care practices in your area. Your insurance plan also may have information on local palliative care services. ✤

RESOURCES

- Center to Advance Palliative Care (CAPC): *https://palliativeinpractice.org/*
- Hospice Compare: *https://www.medicare.gov/hospicecompare/*

Since You Asked!

Question: What is the most recent information on the HPV vaccine?

Answer: Human papillomavirus (HPV) is the most common sexually transmitted infection (STI) in the United States: 1 in 4 people is currently infected and 14 million new HPV cases occur every year.[1] More than 100 different strains of HPV can be passed between sex partners, causing genital warts, cervical lesions, and cancer. Every year, there are 33,700 new cases of HPV-caused cancer among men and women in the U.S.[2]

The Gardasil 9 HPV vaccine protects people not only against nine strains of HPV, but also against six distinct types of cancer that can affect both men and women, including cervical, vulvar, vaginal, penile, anal, and throat cancers.[1, 3] Originally approved for use in 9- to 26-year-olds, in October 2018, the U.S. Food and Drug Administration expanded approval for HPV's use with people aged 27- to 45-year-olds, as well.[4] Dosage is different for various age groups: children aged 9 to 14 receive 2 shots, 6 to 12 months apart, while people aged 15 to 45 receive 3 shots over a 6-month period.[1]

Concerns that the HPV vaccine would lead pre-teens to become sexually active have not been borne out in reality. In a 10-year study published by the *Canadian Medical Association Journal,* researchers found that young people who had received the HPV vaccine started having sex later in their teen years, and practiced safer sex, compared to their non-vaccinated peers.[5]

Sexually active people may have already been exposed to one of the nine strains of HPV that Gardasil 9 protects against, but the vaccine still protects against other strains the individual hasn't been exposed to, or treated for, before.[6] For this reason, doctors recommend that all individuals get vaccinated, even if they are already sexually active, or have been treated for HPV.[6] The most recent estimates are that the HPV vaccine prevents the development of HPV-based cancers in 31,200 men and women each year.[2] This number will continue to grow, with older individuals now being able to access this vaccine. ✤

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

Online women's health column: *www.nwhn.org/since-you-asked*

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Director's Message

FROM PAGE 2

end pregnancy up to 10 weeks of gestation and have excellent safety records. Yet, the FDA has issued regulations preventing medication abortion pills from being stocked in pharmacies, making it impossible for most clinicians to write a prescription for them and creating yet more barriers to abortion care.

The NWHN is also providing education and resources about "self-managed abortion," having a medication abortion without medical oversight. We have also developed educational materials about medication abortion and miscarriage. We are proud to be fiscal sponsor of "Plan C," an educational effort dedicated to helping people learn about getting abortion pills on-line. Another strategy we support is "Aid Access," led by a feminist doctor in Europe, which provides on-line counseling and prescriptions for abortion pills to people in the U.S. The pills are shipped directly to the user, like other on-line services that prescribe and ship contraceptives and Viagra. Apparently the FDA is investigating, so who knows how long it will last, but it's a good tactic.

Remember to stay vigilant and fight all attacks on reproductive rights; the NWHN will keep you informed about our critical work to protect women's health. ✤

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SNAP SHOTS

A Danish study found that **combination hormonal contraception** (pills, patches, or rings that contain both progestin and estrogen) **is linked to preventing ovarian cancer.** Researchers analyzed results from the Danish Sex Hormone Register, which collected data from 1995 to 2014, on 1,879,227 women aged 15–49 who were divided into three groups: women who had never used combination birth control; current users and those who had stopped within the last year; and women who had stopped using the method more than one year earlier. Results indicated that ovarian cancer risk was highest among women who had never used hormonal contraceptives, and lowest among those who had ever used the method. Risk appears to be reduced with longer use of the method, and to decrease once women stopped using the method. **The researchers estimated that the use of hormonal contraception prevented 21% of ovarian cancers that would otherwise have occurred among the study participants.**

BMJ, July 2018

Sexual harassment and assault has a devastating impact when it occurs; new research suggests that the long-term physical and mental health impacts may also be profound. A study investigated the relationship between sexual harassment and assault and negative health outcomes. The study, which involved 304 non-smoking women aged 40–60, analyzed clinical measurements of blood pressure, depression, anxiety, and sleep problems. Almost one-fifth (19%) of participants reported a history of sexual harassment; 22% reported a history of sexual assault, and 10% reported both. Sexual assault was correlated with worse outcomes on depression and anxiety; sexual harassment was linked with high triglycerides, a key risk factor in heart disease, which is a leading cause of death for U.S. women. A history of workplace sexual harassment was linked with higher blood pressure, which increases risks of stroke, aneurysm, kidney disease, and cardiovascular disease. Individuals who have experienced assault or harassment are encouraged to seek care, and providers are advised to keep these findings in mind when treating patients with these health problems.

JAMA Internal Medicine, October 2018

Cervical cancer is the fourth-most common cancer among women, with more than 570,000 cases diagnosed annually. **The vast majority of cases are caused by the human papillomavirus (HPV).** In 2007, Australia was one of the first countries to introduce a national, publicly funded HPV vaccination program, resulting in vaccination rates over 70% for girls and boys. The country is on track to radically decrease cervical cancer rates from the current level of 7 cases per 100,000 Australian women (the U.S. rate is 8.1 cases per 100,000 women). Maintaining Australia's high vaccination and screening rates will result in cervical cancer being eliminated by 2028 (i.e., 4 or fewer new cases per 100,000 women annually). Cervical cancer could be classified as "rare" by 2020 (i.e, 6 new cases per 100,000 women). Cervical cancer deaths are expected to decline to 1 per 100,000 women by 2034. **This shows the positive impact of a national government that is committed** to expanding health care prevention and screening services to all citizens.

The Lancet, October 2018