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The Women's Health Activist®

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The NWHN Celebrates the 12th Annual Barbara Seaman Awards Benefit

Guest Speaker Dr. Jamila Perritt

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

DIRECTOR'S MESSAGE

Asking Whether *Roe* will be Overturned is the Wrong Question

By Cynthia Pearson

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

"It's preferable, from the perspective of the anti-abortion Justices, to chip away at abortion access, case by case, restriction by restriction."

Several weeks ago, I was a panelist on a televised discussion of state abortion bans. At the very end of the discussion, the moderator asked us to answer, in one word, whether we thought *Roe* would be overturned in the near future. She was surprised when I said "No." How could I say that, when the threats to abortion are so extreme, including the bans that are obviously designed to challenge *Roe*?

I think it's much more likely that the Supreme Court will continue to chip away at *Roe* than overturn it in one fell swoop. Why? After all, the majority of the Court is now opposed to the right to abortion care. Why wouldn't the anti-abortion Justices take the opportunity overturn *Roe*? I believe that the anti-abortion Justices know that the country would erupt if states were suddenly allowed to outlaw abortion outright. I believe it's far more likely that the anti-abortion Justices will find ways to keep restricting access to abortion care, but they'll be sneakier about it, in hopes of getting away with a grave injustice.

Imagine what would happen if, this time next year, the Supreme Court upheld the Alabama ban, or near-total bans passed in Georgia and several other states. Imagine the protests, the speak-outs, the do-it-yourself teach-ins, the civil disobedience, the calls for judicial impeachment, the recall elections. An abrupt and dramatic overturning of *Roe* would shake the country's political and social structures, and quite possibly wouldn't last for long.

It's preferable, from the perspective of the anti-abortion Justices, to chip away at abortion access, case by case, restriction by restriction. That is the path the Supreme Court has taken for the last 25 years and, to our shame, the country didn't erupt when courts approved — and the Supreme Court upheld — one restriction after another. We didn't stand up for poor women, or minors, or doctors who wanted to use the safest technique, or people who wanted to get their abortion pills through telemedicine, or anyone who didn't want to lie or be lied to about the long-term health effects of abortion. All of these restrictions, and more, have been put in place by state lawmakers and upheld by the courts.

As it happened, on the same day I told a television audience that I don't think that the Supreme Court will overturn *Roe*, hundreds of #StopTheBans rallies were taking place in all 50 states. The rallies were organized to show Justices, judges, and policymakers that this country will not stand for a ban on abortion. The outpouring of support for abortion rights was impressive, and the NWHN was proud to be a part of the rallies. We need to be clear though, as we protest, that we're not just rallying *against* abortion bans, we're rallying *for* access to abortion care without any barriers. We're not rallying just to protect *Roe*, we're rallying against all restrictions on abortion care.

When I was on the television panel, I only had time for a one-word answer. Here's the answer I would have given if I had more time. Do I think *Roe* will be overturned? "No, at least not right away, and not all at once. If you support abortion rights, don't just focus on *Roe v Wade.* Don't stop worrying when the most recent decision from the Supreme Court on access to abortion isn't completely terrible. Don't let the white hot rage at the proposed bans and the wave of energy in support of abortion rights dissipate. Think long-term. Think local and state. Stay focused on the central message: People who need abortion care should be supported. No barriers."

The NWHN's Advocacy Efforts at the FDA

By Tessa Ruff

The NWHN has a proud history as an FDA watchdog for drug safety and efficacy. We've had a busy few months keeping an eye on the FDA's actions, and communicating with the agency about women's health concerns. Here's an update on those recent activities.

Pass on the Pink Pill, or Pass Out!

Back in 2015, the FDA approved flibanserin (brand name Addyi) despite the manufacturer's failure to study the effects of drinking alcohol while taking the drug. The FDA tried to mitigate the danger its decision created by requiring the drug to be marketed with a Black Box warning that women should completely avoid drinking alcohol while using Addyi, due to the risk of developing dangerously low blood pressure and fainting. The FDA also required the manufacturer to conduct three studies of the effect of drinking alcohol while taking Addyi.[1, 2] These alcohol interaction studies were especially important, we believed, because earlier clinical trials showed that the risk of accidental injury (including car accidents) although very low, doubled in women taking Addyi.

Now we finally know what happened in those long-awaited alcohol studies, and it isn't good. In April 2019, the FDA ordered Addyi's manufacturer to retain the Black Box warning and update it to warn women about the possibly severe side effects of taking Addyi within two to eight hours of consuming alcohol.[3] The FDA made a point of explaining that the agency required the warning to be retained because the new studies had so many missing data points that it was impossible to conclude it's safe to drink alcohol while taking Addyi. The NWHN applauds the FDA for ensuring that women get the safety information they need to decide whether or not to take Addyi.

Transvaginal Mesh

In April 2019, the FDA ordered manufacturers of surgical mesh used for the transvaginal repair of Pelvic Organ Prolapse (POP) to **stop** selling and distributing their products in the U.S.[4] The FDA's decision came just two months after the NWHN and other women's health advocates called upon the agency to take action in response to reports by thousands of women who suffered serious — and sometimes disabling — complications after having the mesh surgically implanted.

Surgical mesh is used for gynecological procedures like POP repair and to treat stress urinary incontinence. But, it has never gone through the same kind of rigorous pre-approval testing required of prescription drugs. Why? Because the FDA accepted the manufacturer's claims that transvaginal mesh is similar to the mesh used in other procedures, such as hernia repair. In 2016, as reports of complications surpassed 20,000, and injured patients' demands for action mounted, the FDA responded by reclassifying transvaginal mesh as a "Class III device" — the highest risk category — and requiring companies to study the devices' effectiveness and safety.[5] The NWHN actively fought for this change, but we wanted more.[6]

This year, we spoke out once again. On February 12, 2019, the FDA's ObGyn Devices Panel held a meeting about transvaginal surgical mesh's safety and effectiveness. Manufacturers Coloplast and Boston Scientific submitted the interim results of studies about their transvaginal mesh products (Restorelle Direct Fix, Uphold LITE and Xenform, respectively) and asked to be allowed to continue marketing these devices. The NWHN's Executive Director, Cynthia Pearson, testified about the problems with the manufacturers' studies.[7] We told the FDA that the companies' studies were, in essence, *post-market* surveillance studies, which is research that is normally conducted after a product has been approved and is already on the market, not the rigorous *pre-market* studies that are essential to conduct before approval, in order to ensure a product is safe.

In her testimony, Pearson noted that it is the FDA's duty to keep women safe, and that doing so requires making decisions based on high-quality scientific research. Women from all over the country also attended the meeting, to make sure the panel members heard their voices and their experiences. They described serious complications, crippling pain, and repeated surgeries to remedy problems caused by transvaginal mesh. The FDA's 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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The NWHN Celebrates the 12th Annual Barbara Seaman Awards Benefit

On June 10th, NWHN members and supporters gathered at the Whittemore House in Washington, DC, for the 12th Annual Barbara Seaman Awards for Activism in Women's Health. The event celebrated the NWHN's achievements and recognized the work of three remarkable women.

Kimberly Robinson, chair of the NWHN's Board of Directors, served as the emcee for the event, and started the evening by recalling how Barbara Seaman, a NWHN co-founder, sparked change with her book *The Doctors' Case Against the Pill.* Barbara's book led to the Nelson Pill Hearings and, ultimately, the first informational insert for any prescription drug.

"Barbara understood the strength of words and the importance of using your voice to make a difference," said Kim. "Together, we are going to turn our words into a declaration and together make our voices roar."

The NWHN's Executive Director, Cindy Pearson, joined Kim in welcoming guests to the Awards Benefit. She started off with the number "512" — the number of days until the 2020 elections. And, while the passage of those days may feel sluggish, the NWHN isn't going to slow down its work to advance women's rights and access to health care. "We don't do slow. We never have and never will," said the lifelong women's health activist.

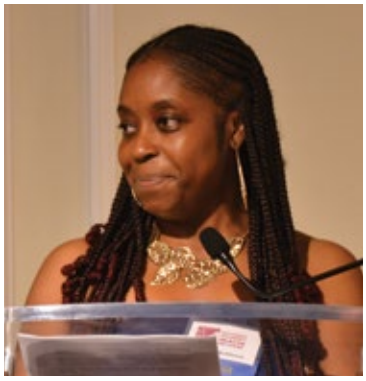
NWHN Board Member Kentina Washington-Leapheart presented the Award for Activism in Women's Health to Tarryn Bazemore Williams and Tamoyia Ragsdale, Coordinators of the Volunteer Doula Program at Community of Hope. As coordinators, Tarryn and Tamoyia are helping families who are the most in need. Community of Hope makes three primary promises: Caring for Families, Improving Lives, and Leading Change.

"And that's the best way to describe Tarryn and Tamoyia," shared Kentina. "They care for families, they improve lives each and every day, and they're leading change that will affect generations to come."

While Tamoyia couldn't attend the evening, Tarryn spoke about their work together and about their mentor who was present at the event. In keeping with her personality, Tarryn was quick

Board Member Kentina Washington-Leapheart presents the Emerging Activist Award to Tarryn Bazemore Williams

Administrative Vice Chair Francine Thompson presents the Lifetime Achievement Award to author Harriet A. Washington



ABOVE, LEFT: *NWHN Executive Director Cindy Pearson with Barbara and Steve Gold*

ABOVE, MIDDLE: *NWHN Board Chair Kimberly Robinson serving as the event's Emcee*

ABOVE, RIGHT: *All smiles: Victoria Kaestner and Vi Nguyen*

RIGHT: *The NWHN invited interns from allied and likeminded organizations to attend for free!*

to share credit with anyone who works to advance women's health care. "Doulas care for families, change lives, and inspire change," she said.

Francine Thompson, Administrative Vice Chair of the Board of Directors, presented the Award for Activism in Women's Health to Harriet A. Washington, author of *Medical Apartheid, Deadly Monopolies* and the upcoming *A Terrible Thing To Waste.* The book sheds light on many issues that affected people of color, including the true legacy of James Marion Sims, considered by many to be the "Father of Gynecology." Harriet details Sims' misdiagnosis of patients during his medical training, and his mistreatment of Black enslaved women that led to his medical breakthroughs. In New York, Harriet's work spurred the removal of Sims' statue, whose plaque offered only praise and failed to acknowledge those who suffered and died at his hands. Harriett's book, *Deadly Monopolies,* details an industry built around gene ownership. Scheduled for release this July, *A Terrible Thing to Waste,* takes apart the spurious notion of intelligence as an inherited trait, pointing instead to environmental racism—a confluence of institutional factors that relegate marginalized communities to living and working near sites of toxic waste, pollution, and urban decay — as the prime cause of the reported Black-White IQ gap.

"Words can't describe what this award means to me," said Harriet after talking about the impact that Barbara Seaman and other activists before her had. She concluded her short and moving speech with a simple "Thank you."

The evening culminated with a speech by activist Dr. Jamila Perritt. An obstetrician and gynecologist with a comprehensive background in Family Planning and Reproductive Health,

Lifelong Women's Health Activists: Judy Norsigian, Amy Allina, Adriane Fugh-Berman, Dr. Vivian Pinn, Cindy Pearson and Harriet A. Washington

Jamila returned to her work as clinician after serving as the Medical Director at Planned Parenthood of Metropolitan Washington DC from 2011–2016. In addition to her clinical work, Jamila develops, organizes, and facilitates health education outreach events to diverse communities, including educating medical practitioners on self-managed abortion.

Jamila read directly from the first page of Harriet's book, *Medical Apartheid,* stating that she identifies with the book not just as an OB-GYN but also as a Black woman. "My existence as a Black doctor is in and of itself a revolutionary act. "I know that as a Black woman doctor," continued Jamila. "I have the opportunity to disrupt and rethink oppressive systems in pursuit of justice."

Cindy closed the evening talking about how, tomorrow, she'll feel both worried and hopeful. Worried about the current political climate we're in — but hopeful because, no matter what happens during the election 512 days from now, the NWHN will be there. The NWHN will always be there and, Cindy said, the organization knows that our supporters will be as well. "Our work yields results. We fight to enhance everyone's access to comprehensive reproductive health. We couldn't do it without you."

Each year, the NWHN's awards event reminds us where we've come from, where we are, and where we're going in women's health care. It provides us with the opportunity to celebrate our accomplishments and commit to achieving even more. It reaffirms why we fight for women's health care rights.

We hope to see you at the 2020 Barbara Seaman Awards Benefit!✤

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Being a Survivor on American University's Campus

By Hannah Camp

In the wake of nationwide news like Brock Turner, the #MeToo Movement, and Brett Kavanaugh, sexual violence is in the minds of people in the United States more than ever. One in four women will experience sexual violence in their lifetime, a statistic that is increasingly becoming common knowledge as people become more aware and vocal.[1] But, even as we become more aware, we're still afraid. We hold our keys between our knuckles, we carry our pepper spray in our bags, we take self defense classes, we let men pass us on the sidewalk so as not to be blindsided by an assault.

While women are at risk throughout our lives, college is a particularly vulnerable time in terms of experiencing sexual violence. Yet, colleges are not doing enough to protect their students and survivors, as evidenced by documentaries like "The Hunting Ground," which shows how US universities attempt to brush sexual violence under the rug, and activists like the Columbia University student, Emma Sulkowicz, who carried her mattress around campus after her sexual assault. Across the country, survivors are not being protected; they are not being listened to; and they are, more likely than not, watching their attacker go free with no consequences.

As a recent graduate of American University (AU), I'm in one of the most vulnerable and at-risk age brackets. Sexual violence is a part of my life, my friends' lives, and my loved ones' lives. That's why my senior year special project focused not only on the scary statistics about sexual violence, but also addressed college survivors' stories and experiences. I interviewed on-campus stakeholders, examined the resources and policies that AU offers, and compared the reality of what survivors actually experienced.

EVERFI, Inc, the nation's leading education technology innovator, recently awarded AU with the *Prevention Excellence Award* for the university's sexual assault prevention education programs. AU touts its high achievement levels for policies and practices about sexual violence prevention. That's a hard pill to swallow, however, when students' voices tell the opposite story — when students feel unsafe on their campus because their perpetrator was only put on probation instead of expelled; when an underground fraternity has terrorized women and men alike for almost two decades; when Title IX proceedings sometimes take longer than the survivor attends college; and when those deemed responsible for sexual violence by Title IX don't even have to register as sex offenders.

What I found in my research is that, while it's necessary to have prevention programs and policies in place, that's only half the battle. In juxtaposition with its prevention efforts, AU has had complaints filed against it for its handling of Title IX investigations in 2015, 2016, and 2017. With harmful changes at the U.S. Department of Education (DoE) during the Trump-Pence administration, staff changes at AU's Title IX office, and policy changes on how AU conducts Title IX investigations, these three complaints have fallen to the side. It is likely that they will continue to be unresolved. Is it irresponsible of EVERFI to award AU a prestigious award when there are multiple, active complaints being filed against the university for its poor handling of sexual violence?

AU isn't unique in having Title IX violations, however. The DoE currently has 305 open investigations against universities for Title IX violations. Title IX prohibits sex- and gender-based discrimination in educational institutions that receive federal funding. A Title IX violation occurs when a student experiences a hostile environment that inhibits their ability to freely and safely engage with academics — this includes sexual harassment, sexual violence, pregnancy-related discrimination, and athletics-based discrimination.

Title IX offers a post-assault reactionary measure, which American colleges and universities have historically focused on more than prevention. A reactionary approach gives universities greater control, including control over the narrative of the student who files the complaint; the outcome for both the student filing and the accused student; and how the institution shares its reports with the DoE. While universities are starting to shift to preventive efforts (such as bystander intervention), many are experiencing a deep tension in making the transition to a focus on prevention rather than reaction. For example, if colleges and universities try to more accurately capture sexual violence statistics (which is extremely under-reported, especially at colleges and universities) they face the potential perception that sexual violence has increased — rather than the reporting. This alone keeps universities from embracing reporting, because it places them at-risk for accusations that they are negligent and unable to protect their students.

While universities continue to experience this tension, Title IX is under attack at the federal level. DoE Secretary Betsy DeVos is attempting to make harmful changes that would weaken Title IX and its protections. She is proposing to narrow the definition of sexual harassment; hold schools responsible and potentially liable only for what happens on campus, not off; and only hold schools accountable when the institution is "deliberately indifferent" to sexual harassment. These proposals place greater emphasis on perpetrators than on victims, and hamper schools' efforts to helps survivors.

While my research focused on AU's unique circumstances, the lessons learned apply more broadly. Educational institutions across the country can do more to be trauma-informed and survivor-centric, focus on prevention and intervention, and embrace Title IX's guidelines. Perception is reality — my research indicates that, for many survivors, resources and support are sub-par. It's critical that schools look at students' perceptions about their resources, and make tangible improvements to increase safety and security to their survivors and other students. If you want to know more about your rights or about how you can get involved, End Rape on Campus is a nationwide organization committed to preventing sexual violence on college campuses by providing education and spreading awareness to the communities it serves.☘

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

Hannah Camp is the NWHN's new Development Associate. In her free time she enjoys spending hours at the National Gallery of Art and reading non-fiction.

NWHN's Advocacy Efforts at the FDA

FROM PAGE 3

decision to ask the manufacturers to take these products off the market will prevent more women from being harmed by devices that have not been shown to be safe and effective. We're glad the FDA finally listened to women.

Breast Implants

In March 2019, the FDA convened a meeting of its General and Plastic Surgery Devices Panel to discuss breast implants' benefits and risks. The meeting was held in response to reported links between textured breast implants and cancer (specifically, lymphoma)[8] and a range of systemic autoimmune symptoms collectively known as Breast Implant Illness (BII).[9, 10] From 2010 to September 2018, the agency received 660 medical device reports about breast implant-associated anaplastic large cell lymphoma (BIA-ALCL).[11] Many women are also speaking out about their life-threatening and devastating experiences after having breast augmentation and/or reconstruction surgeries; it's highly likely that the number of such adverse events is under-reported to the FDA.

At the panel meeting, it became clear that little is known about either BII or BIA-ALCL. Many women presented testimony about their struggle to persuade doctors to take their symptoms seriously and evaluate the possibility that the breast implants could be making them sick. The NWHN supports these women's calls for greater investment in research about BII and BIA-ALCL. We also recommend that textured implants, which have been associated with nearly all cases of BIA-ALCL, be taken off the market.

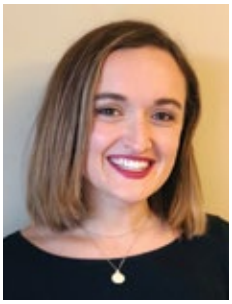
In May 2019, the FDA announced that it was allowing textured breast implants to stay on the market, stating: "While the majority of women who develop BIA-ALCL have had textured implants, there are known cases in women with smooth-surface breast implants."[12] For the first time, the FDA also acknowledged the existence of breast implant illness, noting, "...we have heard from patients [who are] concerned that their implants may be connected to health conditions involving their immune system's response to these devices, resulting in a variety of symptoms like chronic fatigue, cognitive issues, joint and muscle pain. While the FDA doesn't have definitive evidence demonstrating breast implants cause these symptoms, the current evidence supports that some women experience systemic symptoms that may resolve when their breast implants are removed, referred to by some patients and health care professionals as breast implant illness. We believe women considering a breast implant should be aware of these risks."[13]

The FDA hopes that these problems can be remedied by improving the information that women who are considering breast implants receive during their informed consent process. The NWHN is staunchly in favor of providing women with as much information as possible when they make important decisions about their health. We are skeptical, however, that the existing information is enough to help women understand whether, in what ways, and how often breast implants make healthy women sick. Implant manufacturers have shirked their responsibility to conduct long-term studies that have adequate follow-up.[14] Without that research, women won't have the information they need. We'll keep advocating for the FDA to prioritize women's health and well-being over that of medical device manufacturers.

Time for Dedicated Leadership

Following the resignation of former Commissioner Scott Gottlieb, the NWHN called upon the Trump-Pence administration to nominate an FDA Commissioner with a scientific background and demonstrated commitment to advancing women's health.[15] The next FDA Commissioner must be committed to the strongest standards of science and have a proven track record of standing up for women's health. We'll let you know what happens.☘

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



Tessa Ruff was the 2018–2019 NWHN policy fellow. She graduated from Colgate University in 2018, where she studied cellular neuroscience and sociology. She plans to apply to law school and continue a career in health policy.

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YOUNG FEMINIST

Climate Change Threatens Reproductive Autonomy

By Tessa Ruff

Although women's rights and climate change are two of the most talked about political issues, they have long been parallel yet disparate movements. Both reproductive and environmental activism have — at their core — maintaining scientific integrity and keeping ideological influence out of scientific research and innovation. Yet, both are challenged and debated in the political sphere, and are heavily affected by the reigning political party. So, it's important to shift perspectives and understand these movements to be one and the same.

Reproductive rights cannot be obtained without environmental justice. Communities of color face barriers to bodily autonomy, health, and sexuality that encompass more than "choice."[1,2] This is why women of color-led organizations in the reproductive justice (RJ) movement have a comprehensive view of reproductive rights. One activist notes:

> For too long many of us within the Reproductive Justice movement have been forced into the 'pro-choice' category by default, because we support abortion access. In fact, I consider myself pro-life: I support every woman's right to live her best and most healthy life possible. But I haven't been able to embrace that label, which has been hijacked by people who call themselves pro-life but are really pro-privilege and pro-White supremacy.[3]

Women and children shoulder environmental hazards' harmful effects. Scientific and social science research are both increasingly documenting the impacts of toxic exposure and environmental degradation on women, children, and families.[4] Climate change is an RJ issue, particularly when viewed with respect to RJ's three core tenets: **the right to have children, not have children, and raise children in a safe and healthy environment.**

Women of color are particularly impacted by threats to the *right to have children,* having long been targets of sterilization abuse. From an environmental perspective, some chemicals can negatively impact reproductive health, and that communities are vulnerable to these environmental toxins through exposure pathways via food products, home care products, personal care products, and the workplace.[4] Women of color are more likely to live in low-income communities where landfills, incinerators, power plants, and other factories are disproportionately located.

Little to no research has been conducted on the long-term effects on these communities, and the Trump-Pence administration certainly won't prioritize such research. These communities' frustrated residents are mobilizing in response to the pervasive health problems they experience, including breast cancer, infertility, spontaneous abortions, and birth defects. For example, in East Oakland (CA), two incinerators located in low-income communities of color emitted excessive levels of dioxin and mercury. (Dioxin is a known human carcinogen that has been linked to increased rates of endometriosis and infertility; mercury can cause adverse developmental outcomes in children exposed during fetal development.) Environmental justice and reproductive health advocates banded together and succeeded in getting the incinerators closed in 2001.[5]

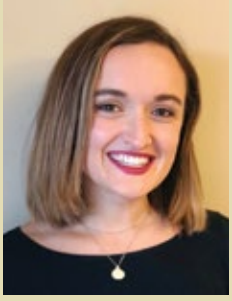
Climate change also affects women's *right not to have children,* which is dependent on access to medically-accurate sexual health education, comprehensive contraception options, and safe abortion care. Climate change is driving extreme weather and natural disasters, which create financial and logistical barriers to reproductive health care. For example, many of Houston's abortion clinics closed after Hurricane Harvey struck in 2017,[6] and transportation became more difficult. Given that 90% of U.S. counties do not have an abortion clinic, any decline in the number of clinics or decrease in access to transportation will hamper access to care. Self-managed abortion via telemedicine could help alleviate these logistical barriers, yet anti-choice legislation has curtailed this option in many states.

Climate change explicitly affects the *right to raise a child in a healthy, safe, and sustainable environment.* (Underfunded schools,[8] gun violence,[9] and other harmful policies are, therefore, also RJ issues.) Environmental contamination, like air pollution in neighborhoods around factories or water pollution undermine the health and safety of women and their families. Flint Michigan's water crisis become national news in 2014, but local women had been speaking out about it for over a year before. They noted adults were losing their hair and children were breaking out in rashes. Mothers noticed changes in their children's behavior, including slower cognitive capabilities and even difficulty speaking — clear signs of lead poisoning.[3] When the water was finally tested, lead levels were more than *26 times* higher than that which the Environmental Protection Agency warns can cause "irreversible" damage to a child's developing brain.[10] The Flint Health Center[11] has urged women to "pump and dump" breast milk and advised men about the possibility that lead contamination could reduce their sperm count.[3]

Flint's crisis illustrates the larger RJ crisis for low-income women of color around the country.[3] "We are seeing so many intersecting issues — from economic justice to environmental justice to health-care access — meeting right in the middle, and landing in a community that is overwhelmingly Black and where low-income communities of color are bearing the brunt of this collision in the most horrific ways," says Monica Simpson, Executive Director of SisterSong Women of Color Reproductive Justice Collective.[3]

Thinking about activism to address climate change often evokes images of starving polar bears on melting ice caps, which do little to frame climate change as RJ and human rights issues. When examined using the RJ framework, climate change undeniably undermines women's rights and bodily autonomy, disproportionately so for women of color and low-income women. Incorporating environmental justice and climate change topics into pro-choice organizations' work demonstrates our commitment to a full range of reproductive rights, including, but not limited to, family planning and abortion care. These are not the isolated topics they've been framed to be.✤

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



Tessa Ruff was the 2018–2019 NWHN policy fellow. She graduated from Colgate University in 2018, where she studied cellular neuroscience and sociology. She plans to apply to law school and continue a career in health policy.

Since You Asked!

Question: What can I do to show support and solidarity with the reproductive rights movement?

Answer: Across the country, we are seeing a renewed wave of extreme bans on abortion care and stripping away of women's reproductive freedom. As state legislative sessions end, multiple bans on abortion care have been passed and signed into law; these test cases are an effort to overturn *Roe v. Wade* now that the Supreme Court has an anti-choice majority. These laws are extreme and deeply troubling. As just one example, under the new Alabama law, providers risk 99 years in prison for carrying out the procedure — a far longer sentence than one for a second-degree rape conviction.

This all-out assault on abortion access also risks criminalizing miscarriages. From a medical perspective, there is no significant difference between a medication abortion (also called an "abortion with pills") and a miscarriage.[1] In both cases, the symptoms (such as vaginal spotting or bleeding), risks, complications, and treatments are likely to be the same. The result is that any woman who has a miscarriage could be prosecuted on the suspicion that she received abortion care. We know these attacks will land hardest on the very women who are already the most vulnerable, including women of color, young women, immigrant women, and trans folks.

What Can You Do?

- If you have the financial means, support your local abortion clinics' and abortion funds' critically important work by donating. You can find a list of these clinics and funds, by state, on the National Network of Abortion Funds' website: *https://abortionfunds.org/need-abortion/#funds.*
- You can volunteer to be an abortion clinic escort. Escorts support people who are seeking reproductive health care as they walk into the clinic to help protect them from harassment.[2]
- Be an engaged and active citizen. Research your legislators' and candidates' views on choice and other issues that matter to you, and then vote like your rights depend on it (hint: they do!). The 2019 and 2020 elections are going to be critical to women's health advocacy.[3]
- Oppose anti-choice judicial appointments. Right now, the Trump administration is stacking the federal courts with anti-choice judges, which will have a lasting and negative impact. When an anti-choice individual is nominated to the federal Judiciary, contact your Senator and ask her to vote against confirmation.
- Speak up! Abortion has been stigmatized for too long. It's time for the majority of Americans — those of us who support the right to abortion care — to be more vocal. Have critical conversations about the importance of reproductive justice. Make sure that your friends and acquaintances understand the magnitude of what's going on — this is a big deal.
- Share your own story through efforts like Advocates for Youth's "1 in 3 Campaign" (*www.1in3campaign.org*) and the National Network of Abortion Fund's "We Testify" project (*https://wetestify.org/*). Most people have no idea how common abortion is, or that one-quarter of women will have an abortion by the time they're 45.[4] It's important to stress that people have very different feelings about having an abortion. This helps make others feel supported, helps reduce stigma, and raises awareness that abortion narratives are often characterized by relief. The idea that everyone has a hard time deciding to have an abortion is neither helpful nor accurate. For many, the hardest part of having an abortion is dealing with the stigma attached to the procedure.

We cannot forget that:

- A patient who needs abortion care is just like any other person.
- Someone who needs abortion care should be respected and supported, not treated as if they don't know what is best for themselves and their family.

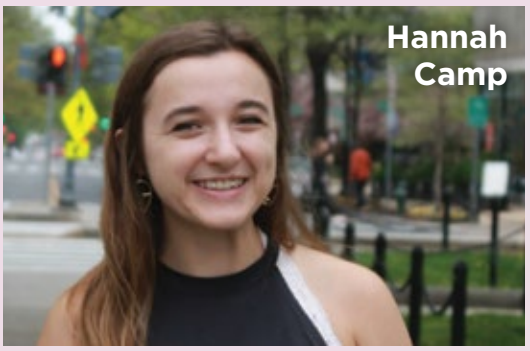
Sadly, we will have to continue these everyday actions even in the unlikely event that attacks on reproductive freedom lose traction in the courts, media, or ballot boxes. The NWHN has been in this fight for a long time; we promise you we'll keep supporting women's health for as long as it takes to ensure that every woman can attain reproductive justice.✤

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

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

NWHN Welcomes New Staff

Hannah Camp is the new Development Associate, responsible for maintaining the NWHN database and supporting NWHN's generous members. Hannah is a former NWHN Development Intern and recently graduated from American University in Washington, DC, with a Bachelor's degree in Public Health and Women's, Gender, and Sexuality Studies. As a student, Hannah worked at AU's Health Promotion and Advocacy Center as a Peer Health Educator, where she provided presentations on a variety of health topics to college students. She also spent a semester abroad in Kenya, interning at Women's Empowerment Link as Gender-Based Violence Intern, conducting research on the link between child marriages and reproductive and sexual health.



Rx for Change: Transgender Gender-Affirming Hormone Treatment

By Nancy Worcester and Mariamne Whatley

Nancy Worcester and Mariamne Whatley are Professors Emeritae of Gender and Women's Studies at the University of Wisconsin-Madison. They are long-time women's health educators, writers, and activists who have both served on the NWHN's Board.

The NWHN's leadership and advocacy on hormone safety has saved numerous lives by educating about hormonal contraceptives;[1] advocating for the Women's Health Initiative;[2] promoting findings on menopause hormone therapy's dangers; and critiquing testosterone's marketing for industry-hyped "Low T."[3, 4] With hormone safety and effectiveness still key issues, it's ironic that we also must make hormones **more** available to improve trans people's health — and possibly save their lives. As cisgender lesbian long-time feminist activists, we can fantasize that a more equitable society might mean everyone could choose to live in the gender(s) of their choice without body-changing procedures or hormones. BUT, our experiences and research tell us that the actual urgent message is that life-saving transgender health care needs to be available to more transgender people.

"Transgender issues have emerged from the periphery of the general conscious to a center-stage cultural, human rights, and medical topic,"[5] and the sharp increase in the number of children, adolescents, and adults seeking gender-affirming medical care is expected to continue.[6, 7, 8] Meeting this need is complicated by the fact that trans people experience life-threatening discrimination, abuse, poverty, and barriers to medical care — challenges that intensify as gender intersects with race and/or age.[9, 10, 11, 12, 13] As a result, this population has above-average rates of anxiety, depression, substance abuse, and self-harm behaviors.

With multiple barriers to medical care, it's common for transgender people to resort to finding their *own* hormone sources. The prevalence of medically unmonitored hormone use is as high as 60% among trans females in the U.S. and Canada.[14] On-line hormone shopping is incredibly easy — but potentially harmful. One study found *96%* of online drug-sellers exist outside regulations, often selling unapproved drugs; drugs containing the wrong active ingredient or wrong amount of the active ingredient; or drugs containing dangerous ingredients.[15] Trans people who lack insurance may seek crowd-funding to support hormone purchases,[16] which is generally unsuccessful for medical needs,[17] and particularly so for transgender health care.[18]

"Standards of Care" for serving transgender patients are available from The World Professional Association for Transgender Health and UCSF Center of Excellence for Transgender Health.[19] All major U.S. medical associations recognize the medical necessity of transition-related care to improve transgender people's physical and mental health, and advocate for insurance coverage for transgender people and research funding for associated medical issues.[20, 21, 22]

Meanwhile, Trump/Pence-influenced policies are encouraging dangerous discrimination. Federal law bans health care discrimination against transgender people, but practitioners and patients alike are confused by Trump's messages that individual providers *can* refuse treatment.[23] Trump's falsehoods about transgender care's expenses have encouraged some insurance providers to deny this care.[24, 25] Yet, research clearly indicates there's minimal or no cost increase from including gender-affirming care in a large group insurance plan; it's actually cost-effective compared to the high financial and human costs of *not* providing treatment.[26, 27, 28] Employers are increasingly offering trans-inclusive coverage in order to attract the best workers; no Fortune 500 company provided insurance for gender-transition in 2002, but 50% did by 2016.[29]

In testimony advocating for Wisconsin's Medicaid to cover transgender medical needs, Kathy Oriel, MD, emphasized the risks of *not* providing coverage: "I have personally cared for two persons who attempted self-castration. One had to be rushed to emergency services to stop her bleeding… I have also cared for scores of people who obtained hormones illicitly because they lacked insurance coverage. One transgender woman took such large doses of estrogen she suffered a life-threatening blood clot, which traveled to her lungs."[30]

More Study & Monitoring Needed

We need appropriate data collection and vigilant medical monitoring of risks for both "born with" (organs, genetic history) and transition body issues. For example, a large study demonstrated that trans women have increased risks for venous thromboembolism (VTE), highlighting the importance of monitoring for cardiovascular diseases.[31]

Hormone treatment may also alter breast cancer risks in transgender people. A Dutch study found that trans women have an increased risk of breast cancer compared with cis men, and that trans men had a lower breast cancer risk than cis women, but a higher risk than cis men.[32] We need increased awareness of the need to monitor and encourage those who are either not used to breast cancer screening (trans women) or who may think they have no more need post-mastectomy (trans men). Practitioners also need to address the complex issues of contraception, future fertility, disease prevention, and maintaining adequate bone mass.[33]

Yet, significant gaps exist in research knowledge and clinical practice.[34] Most published research on

transgender issues consists of case reports, retrospective, or cross-sectional short-term studies that don't always control for previous hormonal history or confounding baseline factors.[35, 36, 37] High-quality research and data collection on transgender hormones requires designing research that respects the dangers of outing for this discriminated-against population, recognizes tensions between identity and behavior, and considers that placebo-controlled clinical trials of transgender hormones may not be ethically acceptable.[38, 39, 40]

From Gender Dysphoria to Gender Euphoria

"Nothing about us, without us" was a key organizing slogan of early LGBTQ health activism,[41] and it is policy-informing to hear what committed practitioners have learned by working **with** their transgender patients.[42, 43, 44] While being transgender is (thankfully) no longer deemed a mental illness, transgender patients consider it problematic when they have to provide a letter from a mental health practitioner to qualify for medical care, or have their records coded for "gender dysphoria" or "gender identity disorder."[45, 46, 47] One trans person commented, "I'm not gender dysphoric, I'm gender euphoric!"[48]

Standardized gender-affirming medical protocols (i.e., DSM, WPATH-SOC) can cause mistrust between trans people and clinicians, with practices being described as gate-keeping and pathologizing.[49] Practitioners say they have to learn much about gender-affirming medicine on their own, through interactions with trans patients to figure out their own individual best practices of "work-arounds." Such micro-level **individual** approach — vs. creating macro-level, policy changes — perpetuates our health care system's inequities.

The most promising life-saving change is the shift to "informed consent" pathways to hormone initiation, enabling medical providers to initiate gender-affirming hormones without a prior assessment or referral from a mental health provider. The most radical changes are also the most basic: ensure trans people know they're seen and heard; make health data forms, signage, and information appropriate for a range of genders; provide unisex restrooms; use preferred pronouns; and ensure gender-affirming medical education in all clinical and professional settings.[50, 51, 52] As one provider says, "providing medical care for gender dysphoria, and seeing the ways my patients' lives have improved, has been the most rewarding part of my medical career — and I delivered babies for 20 years."[53]

Sex Hormones 101

Sex hormones are often referred to as "male" (androgens, typically predominant in males) or "female" (estrogens, typically predominant in females), respectively. Both men and women produce and respond to both categories, and hormone levels overlap between sexes, with wide variations within each sex. The hormones are produced primarily in the gonads (testes, ovaries) and adrenal glands, and in fat and muscle tissue. As steroids, they've got similar structures with small differences between the molecules, allowing the body to convert one category into another.

In early developmental stages, embryos' sexual and reproductive organs are undifferentiated and anatomical sex is indistinguishable. In a genetic female, bipotential gonads develop as ovaries; other undifferentiated structures develop as uterus, oviducts, vagina, clitoris, and labia. In genetic males, a signal from the Y-chromosome causes bipotential gonads to develop as testes, which produce androgens, causing male development (penis, scrotum, and vas deferens). Visible genitalia (vulva or penis/scrotum) are the basis for assigning a newborn infant's sex.

In puberty, estrogens and androgens are actively produced and stimulate development of reproductive systems, sexual systems, and secondary sex characteristics (i.e., breast growth, body hair and fat distribution, skeletal changes). When pubertal changes begin, adolescents may be eligible for short-term, reversible puberty-blocking hormone treatments to temporarily suppress changes and give adolescents time to explore their gender identity without developing unwanted body changes that are difficult or impossible to reverse.[54]

The terms "gender" and "sex" are often incorrectly used interchangeably. "Sex" refers to biological markers (i.e., gonads, chromosomes, anatomy, hormones); "gender" is the socially constructed attributes of what it means to be a girl/woman or boy/man in a particular society and time. Gender identity is the individual's view of their own gender: "cisgender" when biological sex and gender identity align; "transgender" when the assigned sex doesn't match their gender identity. A biological male may identify as a girl/woman (trans woman); a biological female as a boy/man (trans man). Individuals may not identify completely as one or the other, but view themselves along a gender continuum, with characteristics associated with both genders (non-binary, gender fluid, gender non-conforming). Some trans people seek gender-affirming medical treatment to masculinize or feminize their body, which often involves hormonal treatments to stimulate desired secondary sex characteristics and block undesired ones from developing further.

Testosterone (an androgen) is the principal treatment for biological females who desire masculinization (trans men). Effects include facial hair development and frontal hair recession; voice changes; redistribution of facial and body subcutaneous fat; increased muscle mass and body hair; change in sweat and odor patterns; increased libido, clitoral growth, vaginal dryness; and cessation of menses.[55] The changes' onset ranges from 1 month to 1 year, with maximum effects ranging from 1 to 5 years.[56] As with puberty, changes occur at different times.

A dual hormonal approach (estrogens and anti-androgens) is used for biological males who desire feminization (trans women), to stimulate female secondary sex characteristics and suppress male secondary sex characteristics. Effects include breast development; redistribution of facial and body subcutaneous fat; reduction of muscle mass, body hair, and sperm count; changes in sweat and odor patterns; arrest of scalp hair loss; libido changes; reduction of erectile functions, sperm count, ejaculatory fluid, and testicular size.[57] Changes' onset range from 1 month to 1 year, and maximum effects range from 1 to 3 years.[58]

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

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SNAP SHOTS

Medicaid expansion is generally good for people's health, because it improves access to prevention and treatment services. Here's more proof. **Researchers assessed infant birth outcomes** in more than 15 million births from 2011 to 2016, using data from the National Center for Health Statistics, **and compared how babies fared in states that did vs. did not expand Medicaid.** They also reviewed changes in relative health disparities between Black, White, and Hispanic infants. Black infants are about 2 times as likely to be born at low birth weight and 1.5 times as likely to be born prematurely, compared to White infants. During the study years, in Medicaid expansion states, **Black infants showed better outcomes** with respect to low birth weight, preterm birth, very low birth weight, and very preterm birth — presumably because their mothers had better access to health care. Researchers said the effect size for these infants was between 5–15%, a level that could have potentially large health implications across the lifespan.

JAMA Network, April 2019

Opioid deaths are at epidemic levels in the U.S., making it essential for people struggling with opioid use disorder (OUD) to have access to effective treatments, including drugs that doctors can prescribe from the office setting. Researchers combined data from 13.4 million outpatient visits using the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey, and analyzed how often buprenorphine was prescribed from 2012 to 2015. (Buprenorphine is one of the three effective OUD treatments doctors can prescribe on an outpatient basis.) Results indicate that **White patients were 35 times more likely to receive a buprenorphine prescription compared to people of color.** And, the majority of prescriptions were given to those using self-pay (40%) or private insurance (35%) to fund the health care visit. The authors advocate for policies and research efforts to address and resolve racial and socioeconomic differences in access to OUD treatment. The benefits of this lifesaving treatment should never be limited to one group of patients over another.

JAMA Psychiatry, May 2019

Women need complete reproductive and sexual counseling so they have the information needed to make decisions for their unique circumstances. Sadly, this doesn't always happen, particularly for sexual minority women. A study assessed 2006–2015 National Survey of Family Growth data to determine if sexual minority women who had sex with men received appropriate reproductive health and contraceptive counseling. Of 20,703 women in the study, 87% reported having had a male partner in the last year, including 83% of bisexual women and 17% of lesbians. About half the women received counseling about condoms and other contraceptives; only 9% received counseling on Emergency Contraception. Lesbians were less likely than heterosexual women to receive contraceptive counseling and prescriptions; they were more likely to receive STD testing. Providers may vary health care recommendations and practices based on patient's sexual identification, rather than an understanding of the woman's full history. More research is needed to address **disparities in health services provided to women with varying sexual histories.**

Journal of Women's Health, January 2019