

The Women's Health Activist.®

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The Great LARC Debate: Facilitating a Balanced Approach to Education and Promotion of LARCs

By Coco Jervis, JD

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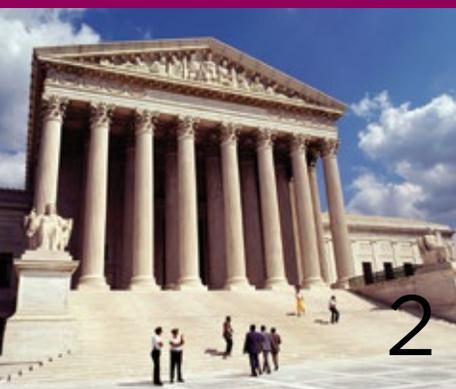
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NATIONAL WOMEN'S HEALTH NETWORK

A Voice for Women, a Network for Change

DIRECTOR'S MESSAGE



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

As Long As It Takes! Health Care for All is Worth It.

By Cynthia Pearson

As I write this, Network staffers are celebrating the Supreme Court decision in the *King v Burwell* case (and the marriage equality cases, too!). I am not afraid to admit that we were worried. If the Supreme Court had decided against us, 6.3 million people in 34 states would have lost the financial subsidies that make their health insurance affordable.¹ Instead, we're busy getting the word out that #ACAHereToStay.

This is the third time in four years that we've spent the month of June waiting, hoping...and planning. I really don't like having to pencil in "plan for Supreme Court decision" into my June calendar every year. It's downright annoying to have our work revolve around the Supreme Court's schedule. But, that's what it takes to ensure that women have access to health care, so that's what we do.

We were ready to respond to a bad decision, but it's much more rewarding to respond to a good decision. Now is the time to press forward and finish the job we started. We're speaking up about how much *more* needs to be done to cover the 12 percent of people who still remain without insurance.² We're mobilizing the network of Raising Women's Voices regional coordinators — who work all over the country, from Louisiana to Maine — and helping them partner with women in their states to expand access to coverage.

When I feel demoralized by the attacks against the ACA, I look to Medicare for inspiration. When Medicare was proposed in the early 1960s to provide insurance to older Americans and those with disabilities, it was vehemently opposed by the American Medical Association and many business associations.³ As a result, public opinion about the new program was divided.⁴ Opposition to Medicare continued for years, but eventually opponents accepted that the program was going to continue. Nowadays, Medicare is the most popular of all major Federal programs, and the attacks against it stopped long ago.⁵

Opponents of the ACA have dreamt up many ways to attack the law — lawsuits, repeal votes, Federal shutdowns. They've succeeded in restricting abortion coverage in many states, and contraceptive coverage in too many workplaces. They've fomented opposition to accepting Federal funds to expand Medicaid, leaving 4.8 million people in 21 states in a coverage gap.⁶ Public opinion about the law is split.⁷

This is our challenge. We have to keep fighting to right these wrongs, ensure that everyone who could be covered by the ACA gets covered, and then bring in everyone who is currently without coverage. I'm glad the Supreme Court didn't make this goal harder for us, but even if we have to go through another month of June with "plan for Supreme Court decision" on our calendars, I know that we're on right path and — as with Medicare — history will prove our support for the ACA to have been the right course of action. ❀

References are available online or from editor@nwhn.org.

"We have to keep fighting to right these wrongs, ensure that everyone who could be covered by the ACA gets covered, and then bring in everyone who is currently without coverage."

Transcending Generations and Growing Our Network

We love it when Network members recommend us to their mothers, sisters, daughters, nieces, and granddaughters by inviting them to a “friend-raising” party, buying them a gift membership, or simply talking about the Network with those they love. We’re delighted to highlight the mother-daughter member duo, Rena and Ronna Popkin, whose appreciation for the Network’s crucial work helped foster their involvement in health activism.

Ronna first heard about the Network 15 years ago when she took long-time board member Nancy Worcester’s well-respected women’s studies course at the University of Wisconsin. As part of her coursework, Ronna enjoyed the Network’s materials, commenting, “The organization’s framework was everything I had been hungry for.” Once she learned the Network didn’t take drug company money, she became a member. A year later, she made sure her mom joined, too!

Rena came of age in the 1950s; her decision to become involved in women’s health advocacy naturally evolved from conversations with her daughter and her experience as a cancer patient. Her first diagnosis, with breast cancer, came in 1980, when Ronna was four. “The doctor told my husband I had 3–6 months to live, but never told *me*. When I came back two years later I said, ‘I understand you thought I wasn’t going to be here today.’” Her premenopausal cancer pathology led to long-term treatment with tamoxifen. “I took the drug for 20 years. But there was an error in the lab. My estrogen receptors were not properly tested, although we were assured they were positive.” This dangerous misdiagnosis is one reason Rena and Ronna are so committed to ensuring women get trusted, unbiased health information from sources like the Network.

Becoming a women’s health activist may have been inevitable for Ronna, who grew up observing her mom survive multiple cancer diagnoses. Watching her mom fight through chemotherapy, and understanding her own cancer risks, prompted Ronna to develop an interest in health advocacy. She describes her family as having a great sense of strength and fortitude, as well as a progressive political orientation, noting these attributes “gave me an awareness and consciousness about women’s health since the time I was very young.”

Rena says, “We would send each other political emails and think of what we could do to try and change what was happening on a policy level, even at our different life stages.” They’ve become committed health activists and attended the first Raising Women’s Voices convening on health reform in Boston.

Rena continues, says, “Each woman has a unique story. I relate the Network with trust and advocacy. That ‘home’ feeling. It’s a family. What is most important is that it continues.” Ronna describes the importance of engaging family members in activist efforts: “The Network tries to reflect the multiplicity of women’s voices. It’s inter-generational because issues don’t get solved overnight. It’s passing the torch *across* generations and *within* families to help understand the value of the work.”

After 40 years, we know that part of the Network’s mission is fully realized when our members so clearly articulate why they trust us and why our work matters. “I would encourage people to join because *they are the voice!* They are the only women’s health group that is research- and science-based, and has *never* been funded by industry. That was and still is important to me,”

says Ronna. If you’re a member who wants to know what else you can do to make difference, follow Ronna’s lead and show others the Network’s value, and encourage them to get involved as well! ❁

Ronna Popkin is a doctoral candidate of Socio-Medical Sciences at Columbia University’s School of Public Health. She lives in Woodside, NY and enjoys yoga and beading jewelry; she hopes her 13-month son, Huxley, will also become an activist. Her favorite part of the newsletter is the Young Feminist articles. Rena Popkin holds a BS and MS in early childhood development; she founded and directed two different child development centers to meet the needs of working women. She is a 40-year resident of Silver Spring, MD and enjoys crossword puzzles.



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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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Volume 40, Issue 4

July/August 2015
ISSN no. 1547-8823

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The Great LARC Debate: Facilitating a Balanced Approach to Education and Promotion of LARCs

By Coco Jervis, JD

Immediately after the birth of her twins, 21-year-old Chantal had an IUD inserted, at no cost to her. She has had a very positive experience with the IUD, although she had cramping and intermittent bleeding for a couple of weeks after it was inserted. For the most part, though, she describes having her IUD as “smooth sailing.” Now, five years later, Chantal is in a committed relationship and is eager to add to her family. “I’ve been looking to have my IUD removed, but I don’t have insurance and the self-pay price is over \$500, which I can’t afford” she says. “I’ve heard that the local clinic will remove it for free, but only if I am going on another form of birth control. I just don’t know what to do!”*

Over the last couple of years, there has been a significant surge in education and promotion of long-acting reversible contraceptives (LARCs). LARCs are reversible birth control methods that are effective in preventing conception for an extended period of time, and work without user action; they include (IUDs (short for intrauterine device) and contraceptive implants.

LARCs are known as “set it and forget it” birth control, since they don’t require any upkeep or attention, and can last anywhere from three to ten years. Many studies have shown that women using non-LARC contraceptive methods (like the Pill, patch, or condom) have, on average, a significantly higher risk of getting pregnant than women using LARCs.¹

(It’s not that the non-LARC methods are inferior, but they are more likely to be used inconsistently and/or incorrectly, leading to unintended pregnancy.)

Many in the mainstream reproductive health community are explicitly attempting to increase LARC use by young, low-income, and uninsured women due to their overall safety and effectiveness. Along with this, the Affordable Care Act’s mandate that insurers must cover contraceptives without any costs (like co-pays), have resulted in a recent surge in LARC use. In 2015, the Centers for Disease Control and Prevention reported that, over the last decade, the use of LARCs increased nearly fivefold among women aged 15–44 (from 1.5 to 7.2 percent).²

On a daily basis, we hear reports or announcements touting local or state-wide public health initiatives promoting LARCs as a magic bullet to address unintended pregnancies among young, low-income, and/or uninsured women. For example, Colorado has a program to provide more than 30,000 IUDs and implants for free, or at reduced cost, to low-income women; state officials heralded the program’s success at reducing the Colorado teen pregnancy rate by 40 percent.³

Hoping to replicate Colorado’s success, Illinois adopted a similar free LARC initiative targeted at low-income women within the state Medicaid program. Texas is making it easier for providers to get fully reimbursed

for providing IUDs to low-income women and girls; and the New York City Department of Health and Mental Hygiene is exploring the launch of a free LARC access campaign aimed at young, low-income, and uninsured women.

Arkansas is considering a state initiative to financially incentivize single, low-income mothers who are Medicaid recipients to get an IUD. Additionally, both the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have recently revised their guidelines to help expand provider familiarity with LARCs and increase their promotion. ACOG and the AAP advise clinicians to recommend the use of LARCs as a first-line contraceptive option (along with due consideration for other methods such as the Pill and patch) for young women.

The National Women’s Health Network (NWHN) strongly supports the development and access to the full range of safe and effective tools to prevent pregnancy and sexually transmitted infections (STIs) — along with accurate and complete information to help women make informed choices about what method is right for them.

We are encouraged by the tremendous progress made in the last 40 years in the design, safety, and efficacy of LARCs. Access to a bigger range of effective prevention methods is good for women’s ability to make choices about their health and well-being. We also support the elimination of financial, regulatory, and attitudinal barriers that prevent women from getting LARCs.

Yet, the NWHN is deeply concerned that institutional enthusiasm for LARCs runs the risk of hampering individual women’s ability to decide what methods are best for their unique circumstances. We raise our voice to caution against the aggressive promotion of LARCs to the exclusion of other appropriate methods.

Women in the U.S. have long been subjected to coordinated efforts to control and/or limit their fertility in the past — this is particularly true for the very groups targeted: young women, low-income women, and women of color. The NWHN has spoken out against such population control efforts for many years; this history underpins our concern that the unbridled enthusiasm for LARCs risks adoption

of programs that infringe on women's reproductive autonomy.

All of the above-mentioned initiatives that promote free or reduced-cost LARCs for vulnerable women are being promoted at the expense of providing women with comparable incentives for *other* contraceptive methods like the Pill, patch, or condoms. (It's important to note that male and female condoms have the advantage of also reducing the spread of STIs).

We are hearing reports that providers are counseling women to use LARCs regardless of the women's independent sexual and reproductive health needs, desires, or family planning priorities. Furthermore, we're also hearing troubling reports that young women, like Chantal, face formidable cost and access barriers when they want to *stop* using LARCs and have their devices removed.

The NWHN rejects the belief that LARCs can single-handedly address unintended pregnancy, and that preventing unintended pregnancy is a cure-all for economic and social inequality. Reproductive justice principles recognize that the main reproductive challenge facing young, low-income, and uninsured women is *not* unintended pregnancy; rather, it is the socio-economic and cultural factors that penalize certain women for having children and prevent them from fully participating in society.

While we continue to fight the rampant, on-going attacks on access to contraception and abortion care, we must also be cognizant of the need to continue to protect and defend women's reproductive autonomy from coercive programmatic or provider practices. Women should have complete information about *all* contraceptives and should be able to choose, without cost or access barriers, the one that is right for her. ❀

**Names and identifying details have been changed.*

References are available online or from editor@nwhn.org.

Coco Jervis is the NWHN Policy Director. She thanks Amy Allina, the NWHN's former Deputy Director, and current board members (particularly Anu Manchikanti Gomez) for informing this discussion and shaping much of this piece.



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Finding the Real Causes of Migraine

By C. M. Shifflett

Migraine has been recognized for thousands of years but modern research into this painful affliction has been slow. Worse, treatment lags behind medical discoveries that could relieve it, in favor of old beliefs. Researchers now divide migraine into many subcategories, but, in the everyday world, it is still thought of as a single condition, managed only by avoiding all good food and taking expensive but often ineffective drugs.¹

These approaches often fail because they do not address migraine's root causes. Like other pain, migraine is best thought of as a warning signal — an alarm bell. Potential triggers, of which there are many, range from the biochemical to neuromuscular and vascular problems, often arising from structural distortions and other stressors.

“Chemical imbalances” behind migraine can be as simple as poor quality food, water, air, light and sleep. Women's migraines may be due, in part, to hormonal fluctuations of the menstrual cycle, to endocrine disruptors in personal care products,² and to vitamin and mineral deficiencies that impact their nerves and muscles.

Muscular triggers of migraines have long been dismissed, although poor posture alone can strain muscles and impinge on neurovascular supply. Traditionally, pain starting at the back of the head or neck was diagnosed as “tension” (even if it converted to a full-blown vascular migraine). But, consider the 1995 discovery that *tight neck muscles can pull directly on the lining (dura) of the brain and upper spinal cord.*³ This 20-year-old link between muscles and migraine is thoroughly documented,⁴ but has yet to appear in standard medical textbooks or popular articles on migraine.⁵

The old notion that the brain does not feel pain is partly true: neurons do not feel pain, but blood vessels, connective tissue (fascia) and the dura do.

The pain-sensitive dura is supplied by the trigeminal nerve that controls constriction and vasodilation of the brain's blood vessels — the hallmark of true migraine. This nerve is also the link between migraines that hurt right down to your teeth or are triggered by Temporomandibular Joint Dysfunction (TMJ). It also underlies the 1998 discovery that Botox injections relieve lifelong migraines.⁶ The target is the corrugator supercili, a muscle

that, in frowning, can irritate a branch of the trigeminal nerve. In the medical literature, this nerve has been linked to migraine for over 40 years. In what you've read, have you ever heard of it?

Women suffer from migraines at a rate three times that of men; in addition to the horrific pain and disability, they

also die from suicide and strokes from migraines that are improperly diagnosed, but profitably treated by the drug industry. While we wait for standard medical practice to catch up with migraine research, see the box for ways you can identify the causes and possible treatments for your migraines. ❀

Self-Help for Migraine

Here are approaches that address migraines' actual causes and can help break the cycle of pain and dysfunction.

1. Eliminate the obvious. Make sure you get good food, water, air, and sleep. Avoid known trigger foods,⁷ MSG, artificial sweeteners, and physical and emotional stressors. Maintain a regular schedule and good posture. Breathe, and don't frown!

2. Rule out infections and disease. Migraine can be symptomatic of everything from gluten sensitivity, to viral and bacterial infections, including ulcers caused by the *Helicobacter pylori* bacteria (a common side effect of antacids). Include a dental checkup to assess cavities and/or damaged teeth.

3. Make a detailed pain map. There's a big difference between a headache that starts in the back of the head and one that starts in front. Notice where it starts, where it goes, and what happens next — *throughout the body.*⁸ If your fingers ache or tingle, *which* fingers and *where*? If your head hurts right down to your teeth, *which* teeth hurt? Head pain can come from a calf muscle (soleus)⁹ and symptoms of Carpal Tunnel Syndrome are linked to rates of migraine 34% above controls.¹⁰ These patterns have meaning for knowledgeable eyes.

4. List falls, fender benders, and head or neck trauma. Migraines are extremely common after such injuries. Many symptoms date back to childhood falls that happened while learning to walk or ride a bike.

5. Get appropriate tests.

- **CT/MRI can check for cysts / tumors, hematoma, bleeds, and structural problems.** Note if the cervical curve is normal (A), straight (B), or reversed (C) — abnormal curves can cause severe pain and herniated discs. (See photo.) Are vertebrae rotated out of place? The pain-sensitive dura attaches to the upper three vertebrae. Is the first rib elevated?¹¹ This entraps nerves and blocks circulation; a first sign is intractable migraine and symptoms of Carpal Tunnel Syndrome. Range-of-motion testing evaluates related muscular issues.¹²



- **Take your temperature.** Migraineurs' cold hands and feet are usually attributed to autonomic dysfunction, but can come from compression of blood vessels from strained or shortened muscles. Learning to relax muscles and raise peripheral temperatures can calm the autonomic nervous system. Practice with a digital biofeedback thermometer. Once you can raise hand temperatures to 95 degrees, practice with the probe taped to the big toe. Persistent cold suggests thyroid dysfunction, so testing should include reverse T3 for thyroid resistance.

- **Do a sleep study.** Even home observation with a watch and inexpensive oxygen dosimeter can provide valuable information. “Apneas” are pauses in breathing lasting several seconds or more, occurring five or more times per hour, reducing oxygen levels and starving the brain.

- **Measure electrolytes.** The Exa Test is far more accurate than traditional blood tests and has revolutionized electrolyte research, especially for magnesium, a key factor in menstrual migraine.^{13,14} It also reveals imbalances created by years of women being told to overdose on calcium. ❀

References are available online or from editor@nwhn.org

C. M. Shifflett, a former migraineur, is the author of *Migraine Brains & Bodies: A Comprehensive Guide to Solving the Mystery of Your Migraines*, and co-author of *Conquering Concussion*.

Standing Tall Against Falls and Fractures

By Christina ChereI, MPH

There's no denying that we live in a hyper-medicated society. Each week, it seems like the pharmaceutical industry develops a new drug or device — many of which are designed to treat newly invented conditions (see our article in the May/June issue on “binge eating disorder”)! We are inundated with advertisements for miracle drugs claiming to fix all of our health problems, but offered little information about effective prevention measures to protect our health. This is a serious problem when it comes to falling — a major public health problem that affects one in three older adults (both men and women).

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of both fatal and nonfatal injuries for adults over age 65, as well as the most common cause of traumatic brain injuries (TBI).¹ Falls often cause breaks and/or fractures, particularly among older adults whose bones are weaker and less dense than younger people's. In 2013, the direct medical cost of falls was estimated at around \$34 billion, and falls also have enormous non-medical costs to both individuals and communities as well.²

Seeing a lucrative market, pharmaceutical companies have, for many years, misleadingly pushed bisphosphonates as a bone fracture prevention measure for older women.

While bisphosphonates *can* be an effective treatment for women with osteoporosis, the Network advises against their use as a preventive measure, given their risk of complications and small benefit that's speculative, at best.

Further, while drug makers tout the risks of “osteopenia,” it's important to recognize that this is yet another invented disease. Osteopenia simply means your bone mineral density is below the statistical average for young women. Taking bisphosphonates to try to prevent osteoporosis may actually *increase* your risk of bone fracture later on!^{3, 4} In fact, in 2010, the Food and Drug Administration added a warning about the increased risk of thigh bone fractures associated with long-term use of bisphosphonates and acknowledged that the ‘optimal

duration of use’ has yet to be determined.

Osteoporosis and bone fractures are serious public health concerns that require effective prevention and treatment measures, not harmful speculative drugs.

Being proactive about improving or maintaining your bone health is important, but not all preventive measures need to or should be approached biomedically to be effective. The best way to prevent breaks and fractures is to prevent the fall in the first place. Incorporating simple behavioral changes can drastically reduce the risk of experiencing a fall and resulting breakage or fracture. And, preventing falls doesn't have to be costly or time-consuming to be effective, either. In fact, you can greatly reduce your risk of falling by exercising regularly, checking your vision, reviewing your medications with your prescriber, and removing potential trip hazards from your home.

Being physically active has many advantages for health, including reducing the risk of falling and bone fractures. Exercises like Tai Chi and yoga, which help improve balance, and strength training like weight lifting, can significantly reduce the chance of suffering a fall. Exercising regularly and performing exercises to maintain and develop strength can also help prevent the fear of falling. After suffering a fall, many people develop a further *fear* of falling, which can lead to a decrease in physical activity, which may, in turn, actually increase the risk of falling! Maintaining a regular exercise regimen is a great way to reduce your risk of falling.

Another risk factor for falling is poor vision. Limited vision and incorrect prescriptions can impair your ability to judge distances or see potential hazards — both of which may increase the risk of falling. That's why it is so important to have your vision checked regularly by an optometrist. Scheduling and attending an annual checkup with your optometrist is a great way to ensure that your vision is not placing you at risk for falling.

Another critical measure for preventing falls is to work with



your doctor to regularly check your prescription medication and adjust dosing or specific medicines, as needed. Some medicines (even those you've taken for years) may metabolize or react differently as you age. The same dose may cause dizziness or lethargy now, even though you did not experience these symptoms ten years ago when you started the drug. Speaking with your doctor about any new side effects or changes you experience can go a long way to helping prevent falls.

One last simple and effective fall prevention tactic is to improve your home's safety by removing any potential trip hazards. This may seem common sense, but a lot of falls result from things like a loose rug or dark room. Making your home safer doesn't need to be expensive or time-consuming! Placing non-slip mats in the bathtub, replacing burned-out light bulbs, wearing shoes inside the house, removing items from your pathway, and eliminating loose rugs are all great ways to reduce your risk of falling.

The next time you hear an advertisement for drugs to help prevent bone fractures, remember to be skeptical. There are plenty of simple and effective measures you can take to stay healthy that *don't* involve risky and ineffective medications. Your bones will thank you! ❁

References are available online or from editor@nwhn.org.



Christina ChereI is the NWHN Program Coordinator

YOUNG FEMINIST Make the Speculum a Part of Your Health Care!

By Amanda Lynen

I grew up in a house of health care professionals — my mom's a labor and delivery nurse and my dad's a gynecologist. So, it was inevitable that I became interested and involved in women's health. As a kid, there were always medical journals and textbooks around the house with diagrams and images that would gross out most kids, but that didn't faze me. What did frighten me, though, was when I accompanied my mom on her OB/GYN visit.

I must have been around 10; I seem to remember being offered crayons to color with in the waiting room. But I wasn't interested in coloring; I wanted to get to the bottom of the disturbing images I saw in a waiting room patient guide about pelvic examinations. I was horrified and immediately asked my mom what it was. She explained it was something women do to make sure they're healthy. She assured me it wasn't something I'd have to worry about for a long time. I felt relieved and hoped that, by the time I was old enough to need a pelvic exam, there'd be a better way to have it done than by using the speculum pictured in the brochure.

Fast forward to last summer. Just after my 21st birthday, I scheduled the dreaded pelvic exam. To be honest, a lot of the fear and anxiety I felt as a kid flooded back when I found out I had to have one. I had a lot of questions to answer before stepping foot in the gyno's office. Will it hurt? Is it awkward? How long does it take? I asked my mom. I did research online. What does the exam include? How will I survive the exam? Okay, maybe I got a little dramatic, but it's pretty intimidating. I didn't welcome the idea of a cold metal object being put inside me (do a Google image search for "speculum" — it looks like a torture device)!

My gynecologist was very nice and probably had lots of experience with seeing other nervous young patients for their first exams. She talked through the exam before we

began and explained its three parts: the external exam, speculum exam, and bimanual exam. In the external exam, the provider looks for anything unusual on the outside of the body. In the speculum exam, the speculum separates the vagina's walls (I'm sorry, what?!) so the provider can examine the cervix and take a small swab for the Pap test to detect cervical cancer and HPV. Third, in the bimanual exam, the doctor inserts one or two fingers into the vagina and uses the other hand to push on your lower abdomen to check for swelling in the uterus, ovaries, or fallopian tubes.¹

“How will I survive the exam? Okay, maybe I got a little dramatic, but it's pretty intimidating. I didn't welcome the idea of a cold metal object being put inside me (do a Google image search for 'speculum' — it looks like a torture device)!”

In addition to briefing me beforehand, my doctor also explained what she was doing as it happened. This was helpful for me, because I don't like surprises, but some women may prefer not to have things explained. It's up to you! As the exam began, I reminded myself that the more I tensed up the worse it would be. I tried to take deep breaths and think pleasant thoughts. After some initial discomfort, the exam was finished in few minutes. I was pleasantly surprised by how quickly it went. Was it uncomfortable? Yes. Was it painful? No. (And I'm not an exception, the exam should not be painful.) My doctor asked me throughout the exam if I was doing okay, and I felt comfortable voicing any concerns and asking questions about what was happening. After my experience — which was much less traumatic than expected — I talked about it with friends, many of whom hadn't had their first pelvic yet. In addition to being nervous or scared about the exam, many of my friends

weren't really clear on *when* to start getting pelvics. Some were planning to put it off for only a little while longer, but others had no intention of making an appointment and didn't realize they should.

As a Public Health major, I think everyone should be informed about how they can promote their own health and prevent disease, so I shared the importance of getting a well-woman exam and encouraged them to set up a gynecologist visit.

The fact is, I found the guidelines somewhat confusing to me, even with my parents in the field. The consensus is that women should have their first pelvic exam at age 21, unless there are other signs or symptoms that require one earlier.^{2,3,4} (Sexual activity is sometimes a reason to have an earlier pelvic.) There are different views about how often women should have a pelvic after that: opinions range from annually to every three years, depending on your medical history or other symptoms. The American College of Obstetrics and Gynecology (ACOG) recommends yearly pelvic examinations.^{5,6} The bottom line is, it's important to communicate with your doctor and decide what is right for you and your health.

I'm fortunate to have parents who know a lot about women's health, so I stay well-informed about how to be healthy. I've never felt like I couldn't talk to my parents about something like periods or birth control, and I always felt comfortable asking questions. I've even asked my parents questions for friends who were nervous to talk to their own parents or doctors. I'm passionate about health promotion and disease prevention, and I thank my parents for that. I recognize the importance of being aware of and in control of my own health, even when it means getting a pesky pelvic exam. Now I'm just hoping there will be an easier way to get a mammogram before that time comes...❖

References are available online or from editor@nwhn.org.



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My Vaginal Birth after C-section

By Suzanne Bauguess

My son Jack's birth in August 2014 was an exhilarating experience that left me exhausted and fulfilled. During the months that followed, I spent many hours reliving the moments leading to his birth. I can still remember the tempered excitement, pain, fear of more pain, and the wonder of seeing a little naked perfect body for the first time. These are precious memories of motherhood that I am grateful to have experienced.

I had a much different experience two and a half years earlier on the January morning when my daughter Amelia was delivered by cesarean section. The prospect of a C-section emerged in the 30th week, when the midwife-physician practice we used commented that Amelia was too small for her biological age. She was labeled with intrauterine growth restriction (IUGR); as time progressed, additional complications arose, including breech position, and low amniotic fluid.

For most of the pregnancy, I was in denial that there could be something wrong with my first baby, despite the fact that doctors and nurses continually reminded me about all of the possible bad outcomes. They dutifully described how the baby could arrive with brain damage or other severe defects. While my prenatal appointments increased in frequency in response to these emerging problems, I suppressed my fears and remained committed to having our baby delivered at full term. But, at 38 weeks, following the emphatic advice of my doctors and midwives, we gave in and my husband and I went to the hospital for a planned cesarean.

I can't recall every detail, but I do remember that I was scared and felt a dark guilt that I'd done something that had irreparably harmed our baby. Then I found myself being rolled into the OR, a passive participant in the birth of my first child.

Amelia was born at 4 lbs 12 oz and, to everyone's relief, healthy by all measures. I was in worse shape. Numb and traumatized by major surgery, I did not immediately feel the bonding attachment or love for my newborn — a hard admission to make. After some unwelcome nudges from my midwife and husband, I managed to start breast-feeding our little girl



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shortly after the delivery.

I don't second-guess the decision to have the cesarean — how can you when your baby comes out healthy? There are many aspects about the experience and ensuing recovery, however, which I regret. The two days spent in the hospital were miserable. I experienced a post-anesthesia headache that felt like a metal claw was lodged into the back of my skull every time I sat up. The breastfeeding consultants, while well-meaning, promoted techniques that involved resting Amelia's weight on my surgical wound, causing pain and preventing the joyful bond that only came later.

After arriving home, getting upstairs to our bedroom was so onerous that I didn't want to come back down. Walking and turning remained painful and difficult because of the destabilizing effect of the surgical wound on my lower abdomen. Amelia's innocent and inadvertent kicks to my wound caused me to resent my choice to breastfeed her. Even a year after Amelia's birth when, by outward appearance I may have been a youthful and energetic mother, I could still feel a weird tightness and discomfort from the incision when I ran or lifted my child.

Only now do I fully understand how

my cesarean adversely impacted the birth experience. I was fortunate, with Jack, that I was able to find a practice committed to vaginal birth after cesarean (VBAC) and an experienced doula willing to help me with the labor, most of which I had hoped to do at home.

When I went into labor, our doula came over, confirmed our birth plan, and then left after telling us to call back when contractions were consistently four minutes apart. My husband, not knowing what else to do, fired up the grill and made BBQ chicken. And then we went to bed.

At 2:00 am the contractions reached the requisite rhythm. Our doula arrived shortly after I vomited my dinner, but just in time to provide the necessary back support to make my contractions just bearable. At one point, I wondered whether the sweating, shaking, and screaming through contractions was better than a cesarean. But then my body's natural endorphins began to blunt the pain and I actually fell asleep between contractions. By 7:30 am, the doula said we were getting close. With no sense of urgency, we got ready. We arrived at the hospital at 8:35 am. My water broke upon entering

CONTINUED ON PAGE 11

Singing the Part D Medicare Blues

By Laura Kaplan

One of the few things I looked forward to when I approached 65 was becoming Medicare eligible. Before becoming eligible for Medicare, I found a high deductible plan that I could afford as a self-employed person. Since I'm a really healthy person, it worked fine until I broke my ankle and needed surgery and a hospitalization. Then the high deductible kicked in and I found myself with thousands of dollars in medical expenses. Especially for older people who are self employed and for those whose employer doesn't provide adequate (or any) insurance, Medicare provides good coverage with minimal out-of-pocket expenses.

Medicare, passed by Congress in 1965, is a national health insurance program for the elderly (OMG, do I fit that category?) and the disabled. It was designed when medical care was quite different than it is now. One of the biggest differences has been the explosion of medications to treat a myriad of ailments. Many of these drugs are lifesavers and we are all better off for them. But, these medications can be quite expensive. Medicare, in its original form, didn't cover most drug costs. As the years marched on and more drugs came on the market, Medicare recipients were going broke trying to pay for their prescriptions.

To remedy that situation, Congress passed the Medicare Modernization Act in 2003, adding both Medicare Advantage (managed care) plans and Part D Medicare, prescription drug coverage. The new law took effect in 2006. I won't go into Medicare Advantage Plans here, but Part D attempted to address prescription drugs' problematic high costs. Unfortunately, the law does not allow Medicare to negotiate with pharmaceutical companies on costs (the VA, another Federal program, is allowed to do this). The drug plans, though overseen by CMS (Centers for Medicare and Medicaid Services), are independent. They decide on costs and change their formularies regularly.

So, let's get back to why I'm singing the blues. When I signed up for Medicare a couple of years ago, I had a lot of choices to make. Did I want regular Medicare (yes I did) or a Medicare Advantage Plan? In regular

Medicare, I was automatically enrolled in Part A, hospitalization. Part B is for doctor visits and the monthly premium is deducted from my Social Security payment. As to Part D, drug coverage, I had many options including plans with an annual deductible and plans with a range of monthly premiums. At the *medicare.gov* site, you can put in your personal information plus the drugs you regularly take and get a list of all the plans in your area that cover those drugs. *Medicare.gov* also provides information on what your monthly premiums and co-pays for those drugs will be in each plan.

As a healthy senior, older person, whatever they're calling me these days, I wasn't taking any regular medications, but I decided to sign up for a Part D plan for two reasons: 1. Insurance is about hedging your bets and I could afford the monthly premium. 2. You pay a penalty if you don't have creditable coverage (i.e., as good as Medicare's) and you wait until you need Part D rather than signing up right away. So, I thought, let me sign up now. You never know what the future holds. I looked for an inexpensive plan with no deductible that covered the one drug I occasionally take for sleep.

That first fall, a few months after I was Medicare-eligible, my Part D plan must have sent me a notice of a rate hike but I didn't see it. So, as of January 1, my monthly premium almost doubled — now not so affordable. Open enrollment, for a few months in the fall, allows you to switch plans. But since I didn't see the rate hike notice, I was locked into that rate and plan for a year.

Then that summer I went through a bad period of no sleep and my usual medication stopped working. A friend turned me on to her sleep drug of choice. I asked my doctor for a prescription but, when I went to the pharmacy, I was told that, even though the new drug was an older medication and a generic, my plan didn't cover it and it cost over \$5 a pill. I bit the bullet and bought a few. The following fall, during open enrollment, I switched to a lower premium plan that covered both my old sleep medication and the new one I wanted to use.

A month after my new plan went into effect, I went to my optometrist and was diagnosed with a sty. He prescribed the only generic eye drop to treat it, but my pharmacy told me that my co-pay would be \$47! It turns out that my plan has it classed as a tier 3 generic (there are several tiers, tier 1 being the least expensive). I called

the plan and they said that Medicare determines the tiers.

I have subsequently found out a few things: a brand name can be cheaper than a generic (always check) and Medicare does not determine the tiers. Each plan does. There are appeals (both expedited and regular) that you can, and should, pursue whenever a plan classes a drug out of reach or denies coverage for a prescribed drug. The other thing I found out from the Medicare Rights Center (see below) is that the problems I experienced, both non-coverage and an unaffordable tier, are the most common Part D problems that people call the Center for help with.

So what's a girl to do? First, read everything your plan sends you. Second, don't believe what your plan tells you and never take no for an answer: appeal, appeal, appeal. Third, be a savvy consumer and understand, as best as possible, the rules.

And, finally, know where you can get help: 1. Your local State Office for Aging. The staff can help you pick a plan and help with any problems you're having with your plan. They can also give you information about what programs are available to help pay for Part B and Part D premiums. I am currently training with my local office as a volunteer with the Health Insurance Information, Counseling and Assistance Program (HIICAP) so I can help others navigate the complexities of Medicare. 2. The Medicare Rights Center: *medicarerights.org*. The Center is a national non-profit consumer services organization, based in New York City, that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Their consumer helpline (1-800-333-4114) is staffed by knowledgeable people who can help with any problems you are having. Their website (*www.medicareinteractive.org*) is chock full of information, including videos, to help you understand your rights in Medicare. Join them in advocating to make Part D simpler and easier for consumers. ❖



Many thanks to the Center's staff for being extremely generous with their time and expertise about Part D for this article. Laura Kaplan is a life-long women's health activist and the author of *The Story of Jane*. She is a former NWHN board member.

the delivery room. And, much to everyone's surprise, Jack emerged shortly thereafter, at 9:04 am.

I then experienced the wonder of meeting my newborn child; feeling his soft skin against mine; memorizing his every little feature. No sensation of pain distanced us in those first few hours. There was no discomfort when I breastfed. I could move around as needed. Absent were any distractions to the bonding process. I enjoyed my son's infancy in a way that I couldn't with my daughter. I can't help but think that this meeting and falling in love between mother and infant was stolen in my previous cesarean birth.

In 2013, one-third (32.9%), of U.S. births were by cesarean; over one-quarter (26.9%) of these occurred in low-risk pregnancies and were medically unnecessary. Only about 10% of women who have had a cesarean have a vaginal birth in a subsequent pregnancy.¹ Why do women have this repeated major surgery, with all of its attendant risks? Possible reasons for high cesarean and repeat cesarean rates include the current medical/legal climate, hospital staffing, more favorable insurance coverage for cesareans, and the increased time physicians spend to achieve a VBAC versus cesarean.² Many physicians

believe VBAC is dangerous, and finding a physician or hospital willing to allow a trial of labor (TOLAC) rather than automatic VBAC can be difficult for many women. A 2010 NIH consensus on VBAC found that, since 1996, an estimated one-third of hospitals and half of all physicians no longer offered TOLAC to women.³

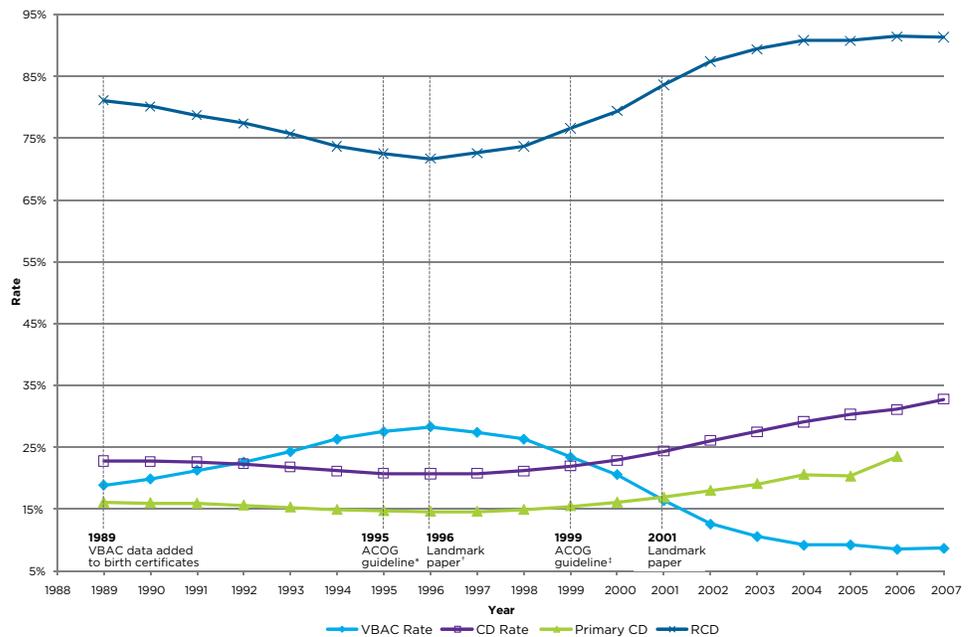
Doctors have clear incentives to recommend cesareans: the procedure may increase physician's reimbursement, takes a predictable amount of time and can be conveniently scheduled, are relatively simple and safe, and lower liability risk.

In situations like ours, the overall risk to the delivery process may be reduced.

Low risk and high reward is a nice combination for medical professionals. But, the overall cost should *also* include the emotional and physical costs from recovery, non-pecuniary costs that medical professionals may not weigh in their calculus of the best options. The overall birthing experiences in this country would improve with careful consideration of these effects.✿

References are available online or from editor@nwhn.org.

Rates of vaginal birth after cesarean (VBAC rate), total cesarean deliveries (CD rate), primary cesarean deliveries (Primary CD), and repeat cesarean delivery (RCD)^{8, 9}



*ACOG guidelines from 1995 states "In the absence of contraindications, a woman with one previous cesarean delivery with a lower transverse uterine incision is a candidate for VBAC and should be counseled and encouraged to undergo a trial of labor."
 †Landmark paper published by McMahon¹⁰
 ‡ACOG guidelines from 1999 states "VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care."
 §Landmark paper published by Lydon-Rochelle, 2001¹¹
SOURCE: Agency for Healthcare Research and Quality (AHRQ), *Vaginal Birth after Cesarean: New Insights Evidence Report/Technology Assessment No. 191* Rockville, MD: AHRQ, 2010.

To learn more about VBAC and childbirth-related issues, contact the Women's Health Voice via email (healthquestions@nwhn.org) or phone (202.682.2646).

- The National Institutes of Health Consensus Development Conference Statement on Vaginal Birth After Cesarean: New Insights: http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf
- Childbirth Connection: <http://www.childbirthconnection.org/article.asp?ck=10212>
- American Congress of Obstetricians and Gynecologists: <http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Obstetrics/Vaginal-Birth-After-Previous-Cesarean-Delivery>
- The Mayo Clinic: <http://www.mayoclinic.org/tests-procedures/vbac/basics/definition/prc-20020457>
- Web MD: <http://www.webmd.com/baby/guide/vaginal-birth-after-cesarean-vbac-overview>



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SNAP SHOTS

A Dept. of Veteran Affairs (VA) study found that few female service members who experience sexual assault seek post-assault health care, despite clear needs and the military's (slowly) growing awareness of this issue. The study examined 1,339 servicewomen: 207 (15%) reported being sexually assaulted during military service, but just 33% sought health care related to the assault. Of those seeking care, only 25% sought both physical and mental health care and just 4 (.01%) received both medical and mental health care within 6 months of reporting the assault. This reinforces research indicating that, although more than 45% percent of servicewomen experience sexual trauma during military service, only 33% seek health services. The findings are notable because sexual assault survivors have significant health care needs stemming from Post-Traumatic Stress Disorder (PTSD), sexual dysfunction, and chronic pain. The military must do better to protect servicewomen and ensure those who experience trauma get needed services.

Medical Care, April 2015

It can be hard to motivate people to quit smoking if they think they benefit from it. In a study on the likelihood of quitting that examined 10,000 smokers from the U.S., Canada, Australia, and the United Kingdom (UK), American women who believe smoking helps control their weight were less likely to quit in response to cigarettes' rising cost and prevalent anti-smoking messages. Among U.S. women smokers who *don't* subscribe to the link between smoking and weight management, a 10% increase in cigarette prices was associated with a 6% increase in quitting efforts, and a 10% increase in exposure to anti-smoking messages was associated with a 12% increase in quitting efforts. Those who believe smoking helps weight management showed no increase in quitting efforts. (Similar patterns were found among smokers of both genders in the U.K.) Public education on smoking must address the perceived benefit of weight management in order to be effective.

Tobacco Control, April 2015

Women who breast-feed their children and later develop breast cancer are less likely to experience a cancer recurrence, compared to women who did not breast-feed. Researchers analyzed over 1,600 women with breast cancer and found that those who previously breast-fed had a 30% overall decreased risk of breast cancer recurrence; this link was not as strong among women who breast-fed for less than 6 months. Women who breast-fed had a 28% reduced risk of dying from their breast cancer. Researchers speculate that women who breast-feed get less aggressive forms of breast cancer, although the link indicates correlation, not causation. Breast-feeding reduces a woman's number of menstrual cycles, thereby lowering her accumulated exposure to hormones that foster some cancer growth. Breast-feeding may also lead to cellular differentiation that makes breasts more resistant to cancer. (Previous research indicates that women who breast-feed reduce the risk of developing breast cancer by 5-10%.)

Journal of the National Cancer Institute, April 2015