FEATURE STORY: PAGE 4
Hormone Risk Throughout the Lifespan
By Christina S. Cherel, MPH

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I still remember how I felt when I saw the sign warning of potential traffic jams due to a special event at the Food and Drug Administration (FDA). It was early morning on July 19, 1996, and four NWHN colleagues and I were on the way to attend the FDA Advisory Committee meeting about mifepristone (known as “RU 486” or the “French abortion pill”). I was representing the NWHN and testifying in favor of approving this abortion care approach. We hoped to witness history being made when the Advisory Committee recommended the FDA approve the first-ever abortion pill.

Two more NWHN women were already on-site — they served as Advisory Committee members. Through them, and other conversations with various FDA staffers, we knew that senior officials feared anti-abortionists would disrupt the meeting. As a precaution, it was moved to an isolated building, where everyone in attendance could be searched.

I got into my car that morning thinking we were ready for whatever happened. But, when I saw that traffic alert, I realized the FDA was profoundly afraid about what might happen that day. I feared that the overwhelming evidence about mifepristone’s safety and effectiveness might not be enough to win FDA approval, and that the FDA might block approval in order to mitigate anti-abortion opposition.

My worst fears weren’t realized — mifepristone was eventually approved in 2000. But, the FDA’s fear about political opposition led it to impose unprecedented restrictions on mifepristone — restrictions that had nothing to do with mifepristone’s safe use, and everything to do with the FDA’s fears.

Under FDA restrictions, the manufacturer wasn’t allowed to supply mifepristone to pharmacies; instead, it had to ship it only to physicians who registered with the company. The physicians then had to pre-order mifepristone and keep it on hand for future use. The FDA label also included explicit instructions for clinical practice, including requiring women to take the follow-up medication on-site, rather than at home. This forced women to make another, unnecessary, appointment, compounding costs and challenges in using mifepristone. The FDA label also specified the exact drug dose, route of administration, and gestational limits — clinical parameters that were already outdated at the time of the FDA’s approval.

The FDA was wrong to restrict mifepristone in this way. The NWHN and other women’s health advocates protested these restrictions, pointing out that there was no scientific justification for restricting abortion care in this fashion.

Privately, we heard from FDA staff that they sought to prevent any complications that could justify anti-abortionists’ claim that mifepristone was too dangerous. They felt that the strict label led to the pill being used by relatively few, highly experienced physicians, to women’s long-term benefit. Simply put, the FDA was afraid of what would happen if mifepristone was approved for unrestricted use, as it should have been.

Tragically, the unusually strict label — which was intended to protect access to mifepristone — became a mechanism for anti-abortionists to further restrict access to abortion care.

Anti-abortion activists seized on the FDA label to stop providers from using the safer, more convenient, evidence-based...
Connections with the Network

By Natalie Hagan, Membership Coordinator

Spring is here and Summer is just around the corner. Many people spend the season traveling and being active. While you’re on the go, make sure you don’t miss any Network news. We have lots of ways to connect with us. You can sign up to get the electronic version of our e-newsletter, which is full of current information about Network activities, sent to your email inbox. That way, you’ll always get the most recent news about programs and advocacy initiatives, special events, and general information on women’s health. Its easy to sign up — just visit the Network’s website (www.nwhn.org), scroll to the bottom of the Home page, and provide your contact information under “Sign up for Email Updates.” No matter where this Summer finds you, e-updates will keep you up-to-date on what’s happening with the Network.

We love connecting with our current members, and we welcome new members! We’d love your help in growing the Network and reaching those who are not yet involved. Do you have a relative or friend with whom you’d like to share our message? Gift memberships are a great way to introduce the next generation to the Network and expand support for our essential work. When you give a Network gift membership, the recipient is welcomed into our vibrant group of those who are committed to improving women’s health. Your friends and loved ones will appreciate having unbiased health information, just as you have.

Recipients of gift memberships receive a personalized card welcoming them to the Network; the latest issue and a one-year subscription to our bi-monthly newsletter, The Women’s Health Activist; our most recent Annual Report; and invitations to Network events around the country.

Gift memberships help strengthen our voice as we advocate for better women’s health policy, and ensure that women continue to receive evidence-based, unbiased health information. Gift memberships can be easily purchased at www.nwhn.org (click on “Support Us,” then “Give a Gift Membership”). You can also give by mail, using the envelope inside this newsletter.

Questions? Contact the Membership Department at membership@nwhn.org or 202.682.2640 ext.226.

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Hormone Risk Throughout the Lifespan

By Christina S. Cherel, MPH

Millions of women take hormones every day, and yet many don’t fully realize the risks. People often forget that the birth control pill, revolutionary, game-changing medicine, is in fact, a drug. In its early form, “the Pill” had such high hormone levels and negative side effects that women, and the women’s health community, protested — and succeeded in making it safer. Thirty years ago, women going through the menopausal transition were liberally prescribed hormone therapy not only to help with menopause’s unwanted symptoms but also as preventive care. Doctors prescribed and women took menopause hormone therapy without knowing the serious consequences of long-term hormone use, including increased risks of breast cancer, endometrial cancer, and stroke.

Today, we know that both hormonal contraception (like the Pill) and menopause hormone therapy do carry risks — and must not be exempted from the scrutiny we conduct on other drugs. In this article, we discuss hormone use over a woman’s lifetime, the risks from hormonal birth control and menopause hormone therapy, and how you can decide if taking hormones is right for you.

Hormonal Birth Control

Many women begin using a hormonal birth control method — like the Pill, patch, vaginal ring, or intrauterine device (IUD) — in their teens or twenties and may continue using it for decades to prevent or delay pregnancy. Many women also use hormonal birth control for reasons unrelated to pregnancy prevention, including relief from menstrual pain and excessive menstrual bleeding. The Pill is the most commonly used form of birth control internationally. Of the 62 percent of U.S. women of reproductive age currently using contraception, over a quarter of them (10.6 million) use the Pill.

Many of us don’t think twice about using the Pill; it’s a symbol of revolution and freedom, for good reason. Hormonal contraception like the Pill has allowed women to take control of their reproductive lives in a revolutionary way, and has helped improve women’s social and economic standing immeasurably. This can sometimes mask hormone birth control’s negative side effects, and speaking out against the Pill can feel anti-feminist or anti-woman.

But, when the Pill was first introduced, its high estrogen levels carried large health risks, which...
women’s health advocates helped expose (the NWHN was founded out of these advocacy efforts). As a result, today’s hormonal contraception is much safer, but there are still risks. Newer formulations of the Pill that contain drospirenone, like Yaz and Yasmin, carry even greater risks, and the NWHN asked the FDA in 2011 to take these versions of the Pill off the market. And, because hormonal birth control is so popular, even statistically small risks can affect a significant number of people in the general population.

Combined hormonal contraceptives (containing both estrogen and progestin) increase the risk of developing a blood clot. As a result of increased blood clot risk, hormones also increase the risk of heart attack and strokes. Some people with a blood clot don’t experience any symptoms, while others may experience swelling, pain, tenderness, skin redness, depending on the clot’s location. It’s important to seek immediate medical care if you experience any of these symptoms.

“Hormonal contraception is a vital part of many women’s reproductive health care, but they deserve to know that certain hormonal contraceptives have higher-potency hormones, and therefore carry slightly more risk.”

In fact, grassroots movements are increasingly springing up to warn young women about the often overlooked or dismissed risks of hormonal contraceptives (see: hormonesmatter.com, and birthcontrolwisdom.com). Prompted by the deaths of their own daughters, these activists have made it their mission to make women more informed about hormonal contraception and its risks.

Similarly, Holly Grigg-Spall and Ricki Lake are currently working on a documentary called *Sweetening the Pill* (based on Grigg-Spall’s book of the same name), which investigates how women got “hooked” on hormonal birth control and discusses non-hormonal family planning methods. Hormonal contraception is a vital part of many women’s reproductive health care, but they deserve to know that certain hormonal contraceptives have higher-potency hormones, and therefore carry slightly more risk.

**Managing Risks and Making the Best Decisions** Unfortunately, no one knows in advance whether a drug or device will cause an adverse reaction in her body. And there is no simple yes or no when it comes to the question, “Are hormones right for me?” We do know, however, that people may have certain predispositions that increase their risk of blood clots, such as genetic clotting disorders, overweight/obesity, smoking, and prolonged inactivity. We also understand that many people choose to use hormones despite these risks because of the many benefits they offer. It’s important to know the risks of any drug or medical device you’re using and work with your doctor to make the health care decision that best fits your unique circumstances. Knowledge is power — and hormone use is not an exception to the rule this time.

For more information on hormone use, check out the NWHN’s Fact Sheet at: www.nwhn.org/health-information/fact-sheets.

References are available from info@nwhn.org.

Christina S. Cherel, MPH is the NWHN Program Coordinator.

“...today’s hormonal contraception is much safer, but there are still risks.”
The RWV Roundup
By Cecilia Sáenz Becerra

Raising Women’s Voices for the Health Care We Need (RWV) has been instrumental in ensuring that women’s voices are heard in the health care reform process — both as the Affordable Care Act (“ObamaCare”) was created and now, as it’s being implemented. RWV was founded in 2007 as a collaborative initiative between the NWHN and our co-founders at the MergerWatch Project of Community Catalyst, and the Black Women’s Health Imperative.

RWV brings together national, state, and local health advocates who are committed to making health reform’s promise a reality for women; for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) people; and for their families. Our field network’s 31 Regional Coordinators (RCs) work in 28 states, representing their communities’ interests and concerns as the ACA is fully implemented. This article introduces a great new RWV resource and describes our newest RC, in Tennessee; the organizing efforts of our Georgia RC; and expanded efforts in Arizona to work with migrant, LGBTQ organizations. We’ll feature various RCs’ important efforts and describe new RWV developments throughout the year.

New Resource: Cover Our Families Advocacy Toolkit
Expanded Medicaid eligibility is critical to ensure low-income people’s access to health coverage and services. But, because 19 states still refuse to expand Medicaid, 3 million people face enormous barriers to accessing the health care they need. Women (particularly women of color) and LGBTQ people are disproportionately affected by this Medicaid coverage gap.

In response, RWV developed a new resource, the Cover Our Families Community Organizing & Advocacy Toolkit. The Toolkit is designed to help RCs and their allies educate and mobilize people in states that have not expanded Medicaid, and change the situation. The Toolkit’s four sections include background information on the coverage gap’s impact, tips on messaging and communication, Fact Sheets and other resources, guidance on planning and hosting outreach events, and sample exercises and games to engage event participants. The Toolkit is supplemented with a separate Legislative Guide that contains advocacy tips and a sample letter to legislators about this issue’s importance.

You can get a copy of the free resource at www.raisingwomensvoices.net/download-the-cof-toolkit. If you’re interested in organizing an event or getting additional materials, please contact Cecilia Sáenz Becerra at csbecerra@nwhn.org.

SisterReach: RWV’s Newest Regional Coordinator from Tennessee
In September 2015, RWV welcomed its newest RC, SisterReach, a Memphis-based grassroots organization. Founded in 2011 by Cherisse Scott, SisterReach’s primary focus is to empower and mobilize women and girls about reproductive and sexual health, so they can make informed decisions about their health care, and become advocates for themselves and their families. SisterReach provides sexual and reproductive health education in order to support women and girls to lead healthy lives, have healthy families, and live in healthy communities. As an RC, SisterReach’s advocacy work now includes efforts to expand Medicaid and address other ACA implementation issues.

Organizing to Expand Medicaid in Georgia
Georgia’s RC, the Feminist Women’s Health Center (FWHC), has been part of RWV since 2013. Kwajelyn Jackson, RWV’s contact in Atlanta, created many effective organizing strategies for FWHC and played a key role in shaping the Toolkit materials so others can replicate her success. FWHC’s strategies include hosting house parties that incorporate educational activities to help community members
understand the impact of Georgia’s political climate — including the legislature’s lack of action on closing the Medicaid gap, which leaves many low-income Georgians without affordable coverage. A majority of house party attendees have signed up to get involved in the FWHC’s advocacy work on this issue. The FWHC also held a successful advocacy day at the Georgia State Capital in January, which was attended by 10 state legislators. FWHC actively collaborates with partners in the Cover Georgia Coalition, the Health Advocates Coalition, and the ProGeorgia Progressive State Voices Table. The groups supported the “Expand Medicaid Now Act” (House Bill 823), which would have closed the coverage gap in Georgia. Although the bill didn’t pass, its introduction provided a vehicle for educating policymakers and community members about the issue.

**Stretching Far & Wide in Arizona**

In Arizona, RWV is working with two RCs focused on LGBTQ migrant rights: Arcoíris Liberation Team and Arizona Queer Undocumented Immigrant Project (AZ QUIP). These organizations promote the liberation of queer and trans migrant communities both inside and outside immigration detention. The groups have expanded their work to include health care, economic support, and housing for trans and queer communities of color. RWV is supporting these RCs and providing technical assistance to help them get more low-income LGBTQ people and immigrant women covered under the ACA and the state’s expanded Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS). In September, Arcoíris Liberation Team and AZ QUIP launched a unique new program, a free health care clinic that provides undocumented and uninsured LGBTQ people with access to affordable health services.

**Join Us**

To get RWV’s weekly updates, sign up on our website: www.nwhn.org/issues/raisingwomensvoices. You can also get instant updates on our work and the issues we follow via Facebook (search for “Raising Women’s Voices”) and Twitter @RWV4HealthCare.✨

Cecilia Sáenz Becerra is the NWHN’s Regional Field Manager for RWV.

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**Director’s Message**

**FROM PAGE 2**

Protocol. They helped pass state laws mandating the FDA label be followed exactly. (This is unusual: doctors usually have the professional right to use medications “off label,” to benefit patients.) Courts have prevented the laws from taking effect in some states, but women in North Dakota, Ohio, and Texas who want a medication-induced abortion had to make an extra clinic visit for the second medication dose, often driving long distances, taking time off work, and struggling to find child care. Women whose doctors were forced to use the higher dose required by the FDA label experienced more side effects, including dizziness and nausea.

Now, almost 16 years later, the FDA’s close to fixing most of what it got wrong before. On March 30th, the FDA announced three changes to the Mifepristone label, effective immediately. First, the recommended dose was lowered from 600 to 200 mg. Second, the gestational age limit was increased from 49 to 70 days. Third, the label no longer requires an in-person visit for follow-up medication. These changes were supported by solid safety and effectiveness evidence.

Many clinics in states with “FDA label” laws changed practices the very next day. Now, women who choose mifepristone for abortion care can get a procedure that’s just as effective as that mandated by the old label, but with fewer (unnecessary) clinic visits and side effects. That’s good news for women.

But, the FDA didn’t fix all of the problems it introduced in 2000. We’re frustrated that the FDA left the distribution restrictions in place. Doctors must still register with the company and pre-order mifepristone for later use. This is completely unnecessary and creates barriers to clinicians who want to provide abortion care but don’t use the drug often enough to justify keeping a supply on hand.

When I was driving to the FDA in 1996, I didn’t realize that the road to women’s access to evidence-based effective care would be so long, and beset with so many challenges and barriers. Anti-abortion forces are dedicated to creating as many roadblocks as possible to women’s access to abortion care, and providers’ ability to deliver needed care. Sometimes there are detours created by even well-intentioned stakeholders. But, we are getting closer to the destination. FDA...help us get the rest of the way!✨

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YOUNG FEMINIST
TRAP-ped: Americans United for Life and the Co-Optation of Women’s Health

By Bridget Freihart

I generally think of myself as being up to date on U.S. reproductive rights. As a Graduate Student Researcher involved in reproductive health research, I explore the forces that impact contraceptive decision-making and young couples’ pregnancy desires and intentions. As a young woman who identifies with a reproductive justice framework, I believe women have the right to reproductive autonomy and authentic sexual expression, and to parent or not parent on their own terms. In my personal and professional life, I try to arm myself with as much information as possible to advocate for women’s sexual and reproductive self-determination.

For instance, I’m aware that there has been a significant uptick in legislation to restrict abortion access in recent years. I’m aware that 288 state-based restrictions have been placed on abortion in the past 5 years alone, more than any previous 5-year period since Roe v. Wade was decided in 1972. I know that 2011 was a record-breaking year for abortion restrictions, with 94 new abortion restrictions passed in 24 states. I’m aware that the Guttmacher Institute now considers 27 states to be “actively hostile” towards reproductive rights (up from 13 in 2000).

So, how was I unaware that these attacks on reproductive rights are not random, but rather highly organized and intentional? Though alarmed by the numbers, I used to think TRAP laws (Targeted Restrictions on Abortion Providers) were the work of legislators independently attempting to further their anti-choice agenda.

That is, until I heard about Americans United for Life (AUL). AUL is the legal arm of the “pro-life” movement with funding sources linked to the Koch Brothers. Often compared to the conservative “bill mill” American Legislative Exchange Council (ALEC), AUL writes model legislation for state legislators so they can introduce pro-life bills without having to conduct time-consuming research. AUL is responsible for drafting one-third of recent TRAP laws, and its periodic guide to recommended legislation, Defending Life, has inspired many recent abortion-restricting laws. AUL’s approach is to slowly chip away — one abortion-restricting law at a time — at the Constitutional protections affirmed by Roe v. Wade. This approach is known as “incrementalism” and it’s working. Charmaine Yoest, the organization’s Chief Executive Officer (CEO), refers to the strategy of restricting abortion at the state level as “leapfrogging Roe,” envisioning a “post-Roe nation” where states have complete control over abortion rights.

If you’ve never heard of AUL, it’s probably no accident. In an attempt to further its anti-choice agenda, the organization operates largely inconspicuously. CEO Yoest says that AUL takes a “military strategy. We don’t make frontal attacks. Never attack where the enemy is strongest. We don’t want to re-create Pickett’s Charge at Gettysburg. We pick our battles. What we do is very much under the radar screen and not very sexy.” Instead of aligning with the extremist ideologies and tactics that failed to produce significant abortion-restricting legislation in the past, AUL focuses on something markedly different: purported advocacy for women’s health.

Because of the provision of Roe v. Wade that stipulates, “In regard to second trimester pregnancies, states may promote their interests in the mother’s health by regulating abortion procedures related to the health of the mother,” AUL protects its legislation’s constitutionality by framing its bills as efforts to promote “the health of the mother.”

Many of AUL’s proposed bills sound as if they benefit women’s health, with model legislation titles including “Women’s Health Protection Act,” “Women’s Right to Know Act,” and “Women’s Health Defense Act.” These bills’ titles make it seem as though they seek to advance women’s rights but, in reality, they aim to hamper access to abortion care.

Common AUL legislation provisions include requirements that mandate waiting periods, sonograms and descriptions of fetal anatomical characteristics, that abortion clinics be outfitted as ambulatory surgical centers, that abortion providers have admitting privileges at a nearby hospital, and restrictions on abortions after 20 weeks. The focus on protecting women’s health is disingenuous, and these laws are unnecessary. Abortion is not only one of the most common medical procedures women can undergo, it is also among the safest. In fact, women are more likely to die in a dentist’s chair than during an abortion, and are 14 times more likely to die during childbirth.

This past year, AUL has been focusing much of its efforts on bills requiring mandatory counseling prior to an abortion, again while claiming to advocate for women’s mental health. Though the AUL claims that abortion causes depression and anxiety, the American Psychological Association has directly refuted this claim, reporting that there is no statistically significant association between abortion and depression.

It is abundantly clear that fetal rights, not women’s rights, are the only concern of the AUL, and that women’s health is suffering, not advancing, as a result of their efforts. As Willie Parker, the doctor who provides abortions at Mississippi’s last remaining abortion clinic tells his patients, “I tell her, ‘These people who are trying to close this clinic — they don’t think you’re smart enough to make your own decisions.’ And I explain change will only happen if she fights for it. Then I tell her to go vote.” Americans United for Life relies on our ignorance of their very existence for its survival, and by shedding light on their anti-choice agenda, we can make more informed voting choices, and specifically we can choose not to vote for politicians who support AUL-inspired legislation and other TRAP laws.

Though it is saddening that we must still fight for our constitutionally protected right to an abortion 42 years after Roe v. Wade, we must continue to vote, we must continue to fight, and we must continue to work towards a future in which there is legal recognition of women’s personal and political rights to make decisions about their bodies and their lives.

References are available from info@nwhn.org.
At the Court:  
Women’s Rights  
At Stake  
By Dipti Singh

The U.S. Supreme Court is considering two cases that could profoundly impact women’s rights and access to essential reproductive health care services. The Supreme Court heard oral arguments in both cases in March. This article gives you an update on those cases; we will also report on the final decisions (expected by July) and next steps.

“If HB 2 goes into effect, fewer than 10 abortion facilities will be able to comply with the onerous regulations in the entire state of Texas.”

Whole Woman’s Health v. Hellerstedt  
This case challenges a Texas law, House Bill 2 (HB 2), which requires any clinic providing abortion services to meet the same hospital-like building standards required for ambulatory surgical centers. It also requires doctors who provide abortions to have admitting privileges at a hospital within 30 miles from where they perform the procedure.

In the 1992 Planned Parenthood v. Casey decision, a divided U.S. Supreme Court reaffirmed Roe v. Wade’s “core holding,” recognizing a woman’s constitutionally protected right to choose to have an abortion. The Court held that states can impose restrictions on this right, as long as the restrictions do not impose an “undue burden” on the woman. Under Casey, a state cannot implement a law with either the “purpose or effect” of imposing a “substantial obstacle” to a woman seeking a pre-viability abortion.

Texas claims that HB 2 is needed to protect women’s health and safety. The Center for Reproductive Rights (CRR), which is representing the Texas clinics, says the reality is exactly the opposite. It argues that the burdensome requirements are medically unnecessary and fail to promote the safety of abortion care or a woman’s health (abortion is, in fact, already one of the safest and most common medical procedures). Instead, the requirements are designed to shut down abortion clinics, and thereby reduce access to legal abortions. Indeed, leading medical experts, including the American Medical Association and the American College of Obstetricians and Gynecologists, submitted an amicus curiae (friend-of-the-court) brief to the Court opposing HB 2. Their brief makes clear that the Texas requirements are contrary to accepted medical practice, unsupported by scientific evidence, and not related to the quality or safety of abortion-related medical care.

If HB 2 goes into effect, fewer than 10 abortion facilities will be able to comply with the onerous regulations in the entire state of Texas. In a state with 5.4 million women of reproductive age, HB 2 would shutter most abortion clinics, forcing many women to travel more than 150 miles to the nearest abortion provider. Even more, if the Court upholds the Texas restrictions, similar (and possibly even more onerous measures) will be introduced and implemented elsewhere in the country. According to the Guttmacher Institute, between 2011 and 2015, 288 abortion-related restrictions were enacted by the state legislatures.

Justice Scalia’s recent death is likely to impact the Court’s decision. If the four liberal justices (Justices Ginsburg, Breyer, Kagan, and Sotomayor) decide for the clinics and against HB 2, the case could issue a 5-3 decision in favor of the clinics and against HB 2. The case would then set nationwide precedent. Its precise impact—in Texas and across the country; for abortion care and in the other contexts — will depend on the breadth or narrowness of the majority’s ruling. (For a picture of NWHN staff outside the Supreme Court building the day of oral arguments in Whole Woman’s Health, see page 10.)

Zubik v. Burwell  
The other case before the Court is Zubik v. Burwell—a consolidation of seven lawsuits by non-profit organizations bringing yet more challenges to the Affordable Care Act (ACA) and the contraceptive coverage requirement. To date, over 100 lawsuits challenging the contraceptive coverage requirement have been filed in Federal courts across the U.S.

The ACA’s contraceptive coverage rule requires most new health plans to cover all Food and Drug Administration-approved contraceptive methods, sterilization, and related education and counseling without cost-sharing (no co-pays, deductibles, or co-insurance). Federal regulations exempt houses of worship from the requirement. Women who get their insurance from these exempt “religious

CONTINUED ON PAGE 11
The Network In Action

Raising Women’s Voices for the Health Care We Need
Earlier in this issue you read about some of our Raising Women’s Voices (RWV) Regional Coordinators, and our most exciting RWV news: the launch of Cover our Families: A Community Organizing & Advocacy Toolkit! But that’s not the only area where we’ve been hard at work. In the spring, RWV released a research brief and hosted a webinar for advocates and policymakers about Medicaid Expansion waiver provisions’ impact on women’s health.

More than 30 states have expanded Medicaid for citizens with incomes up to 138 percent of the Federal Poverty Level, and most have done so as envisioned by the Affordable Care Act. Six states, however, have expanded coverage through a waiver process that allows them to impose a host of additional barriers to care. These include charging premiums and co-pays above current thresholds, limiting when coverage begins, denying coverage to individuals who miss payments, eliminating transportation support, and more. And several states that originally expanded Medicaid without these onerous barriers — e.g. Arizona, Kentucky, Ohio — are trying to reverse this progress after changes in their political leadership. Our brief details why women are particularly vulnerable to policymakers’ decisions during the waiver process. The report is available at tinyurl.com/RWVresearch.

We also launched the Spanish-language version of our popular health literacy guide, My Health, My Voice. Cecilia Sáenz Becerra, the NWHN’s Regional Field Manager for RWV, took the lead in ensuring that Mi Salud, Mi Voz was as precise, accessible, and culturally competent as possible for Spanish-speaking women, using the principles of language justice in the translation and approach to the overall guide. The guide will be available on the RWV website (www.raisingwomensvoices.net) later this spring.

Challenging Dangerous Drugs & Devices
As we described in the March issue, the Food and Drug Administration (FDA) recently announced its decision on Essure, the controversial non-surgical, non-hormonal sterilization device. The FDA incorporated most, but not all, of the NWHN’s recommendations. It will now require the manufacturer to add a warning label describing adverse events experienced by the Essure’s users, provide a patient information checklist of risks, and conduct a follow-up study to determine the device’s long-term effects. In the NWHN’s comments to the FDA, we continued to push it to require the manufacturer to fund an independent registry to track Essure patients.

On the same day as the Essure announcement, NWHN Program Director Sarah Christopherson was at the FDA reiterating the need to include women, people of color, and the elderly in clinical trials for drugs and devices. There have been a number of highly-publicized failures in this area; in 2013, for example, the FDA was forced to cut its approved dose for women taking the sleeping aid Ambien in half, after belatedly learning that the drug affected men and women differently. So, you might think the FDA’s learned its lesson by now. Instead, officials suggested that advocates needed to “rethink our approach,” and move away from categories like gender and race. We testified that, “Unless industry is prepared to do genetic testing on all study participants, unless physicians can do so on patients, sex, race, ethnicity, and age are now — and will be for years to come — the
best proxies we have for determining how widely-used drugs and medical devices are likely to affect certain individuals.” We’ll keep you posted on the discussion.

**Securing Sexual & Reproductive Health and Autonomy**

When we wrote in January that 2016 was going to be a big year for women’s health at the Supreme Court, we had no idea that Justice Antonin Scalia would pass away the next month. His death altered the balance of power on the Court and set up a high-stakes showdown in Washington over filling his seat. While the Senate wrestles with whether or not to do its job in holding hearings on Obama’s nominee to fill the seat, we didn’t miss a beat doing ours.

On March 2, the Court heard oral arguments on *Whole Woman’s Health v. Hellerstedt* — arguably the most consequential case for abortion rights in a generation. Of course, the NWHN was there. At stake in this case is whether state legislators can use the claim of “protecting women” as a Trojan Horse to shut down abortion clinics. On March 23, the Court heard oral arguments in *Zubik v. Burwell* to determine once and for all (we hope!) whether employers can use their religious beliefs to deny women contraception coverage. Again, the NWHN was there. The Court’s power is immense, but so is the power of women to show the justices that comprehensive reproductive health care, including abortion, is critical to our health, our children’s lives, and our economic stability. That’s why the NHWN and other women’s health advocates made our physical voices heard before the Court. We also raised our digital voices: live-Tweeting, creating shareable graphics for our members to post on social media, and distributing information about the cases. We also urged our members to contact their senators with one simple message about the Court vacancy: do your job!

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**At the Court: Women’s Rights At Stake**

**FROM PAGE 9**

employers” will have insurance policies that do not cover contraception.

Other non-profit organizations with religious affiliations are offered an “accommodation” to the requirement. Under the accommodation, these entities can opt-out of covering contraception in their employer- or school-based health policies. The objecting entity can take advantage of the accommodation by filling out a form that serves as notice of its religious objection. The insurer then removes contraception from the non-profit’s health plan. Federal rules make the insurer financially responsible for the employees’ contraception. (For an overview of this issue, see the Sept/Oct 2015 issue of the WHA, “What to Do If Your Employer Is a Religious Refuser.”) (The Supreme Court addressed challenges to the contraceptive coverage requirement by for-profit employers in 2014.)

Yet — despite the numerous allowances the government has made to address the employers’ religious beliefs — the non-profits bringing these lawsuits remain unsatisfied. They object to even providing notice of their objection, arguing that doing so makes them “complicit” in facilitating contraceptive coverage. Their lawsuits claim that the accommodation violates the Religious Freedom and Restoration Act, a Federal statute that says the government cannot “substantially burden a person’s exercise of religion” unless the government’s action “is the least restrictive means” of furthering a “compelling government interest.”

The government maintains that the notification requirement is not burdensome. By filling out a form, an objecting employer can relieve itself of any obligation to cover contraception. Instead, the government uses its authority to ensure that women receive contraception through a third-party insurer or administrator.

If these challenges are successful, employers could make it difficult, perhaps even impossible, for women to obtain and/or use health insurance coverage for contraception. Employers would be allowed to impose their beliefs on women, and could create a situation where their employees simply cannot afford to access contraception, increasing their likelihood of unintended pregnancy.

To date, 8 out of 9 Federal appellate courts that have considered challenges to the accommodation have disagreed with the non-profits and have upheld it.6 The Eighth Circuit is the only circuit to have sided with the non-profits.

If the Supreme Court splits 4-4, it could decide to let the lower court rulings stand, creating a legal patchwork across the country. Women would likely have coverage of essential contraceptive care in every state in the U.S., unless they live within the Eighth Circuit (Arkansas, Iowa, Minnesota, Missouri, and Nebraska). Because there are still dozens of other similar lawsuits still pending, however, the issue will likely find its way back to the Court in the future. Alternatively, as with *Whole Woman’s Health*, if the Court splits 4-4, it could decide to defer a decision.

If, on the other hand, Justice Kennedy sides with the liberal justices, he would provide the decisive fifth vote to uphold the accommodation, setting nationwide precedent (and, hopefully, laying this issue to rest for once and for all).

A lot is at stake for women: the right to receive abortion and contraceptive care and to make their own health care decisions. These cases underscore the pivotal role that the Supreme Court plays in our lives. And, Justice Scalia’s death raises the stakes of the 2016 presidential election.7 References are available from info@nwhn.org.

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Dipti Singh, J.D., is a NWHN Board member.

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SNAP SHOTS

Allowing Certified Nurse-Midwives (CNMs) to practice independently results in positive benefits for mothers and babies, and lower health care costs. A new study analyzed birth outcomes using data on 12 million births occurring nationwide from 2009 – 2011. In 22 states and the District of Columbia, CNMs are allowed to practice independently; 28 states require CNMs to be supervised by a physician or have ‘collaborative agreements’ with a physician. The study found that women who gave birth in the CNM-friendly states were 13% less likely to have a c-section, 13% less likely to have a preterm birth, and 11% less likely to have a low-birth-weight baby. This supports earlier research finding that, compared to midwives, obstetricians are more likely to intervene unnecessarily (i.e., with c-sections or labor induction), with increased health risks for women and infants. C-sections, which account for 32% of US births, have substantial health risks and are 50% more expensive than vaginal deliveries. Hopefully these facts will help change licensing laws to expand women’s access to midwifery services and their resulting benefits.

Women’s Health Issues, February 2016

By age 50, about three-quarters of women will develop a type of benign uterine tumor called fibroids, which can lead to complications including irregular bleeding, pelvic pain, infertility, and miscarriage. A new study suggests that women with higher levels of both testosterone and estrogen may be at greater risk for developing uterine fibroids. The study involved 3,240 women who enrolled in the Study of Women’s Health around the Nation (SWAN). Approximately 1,400 women completed follow-up visits almost annually for 13 years to assess the incidence of fibroids and measure testosterone and estrogen levels. More than 500 (512) women reported a single incidence of fibroids; 478 women had recurrent fibroids. Those with higher testosterone levels were 1.3 times more likely to have a single incidence of fibroids, compared to women with lower testosterone levels. Women with high levels of both testosterone and estrogen were more likely to have a single incidence of fibroids, but less likely to have a recurrence, compared to those with low levels of the hormones. Testosterone had not previously been identified as a factor for uterine fibroids. Identifying risk factors may help improve prevention and treatment of fibroids.

Journal of Clinical Endocrinology & Metabolism, December 2015

New research appears to confirm that the menopausal transition is associated with an increase in migraines. A new study analyzed information on menstruation and migraine from the 2006 American Migraine, Prevalence and Prevention study survey. It examined data from 3,664 women aged 35 to 65 who had reported experiencing migraines both before and during the menopausal transition. (Women who had never menstruated or were pregnant, breastfeeding, or using exogenous sex hormones were excluded.) Researchers found a 76% increase in migraines during menopause; prevalence was highest during the later stage of perimenopause, when estrogen levels are low. Twelve percent of perimenopausal and postmenopausal women were in the “high-frequency” headache group, experiencing 10 or more migraines a month, vs. 8% of premenopausal women. Women who suffer from migraines may experience an increased frequency as menopause approaches.

Headache: The Journal of Head and Face Pain, January 2016