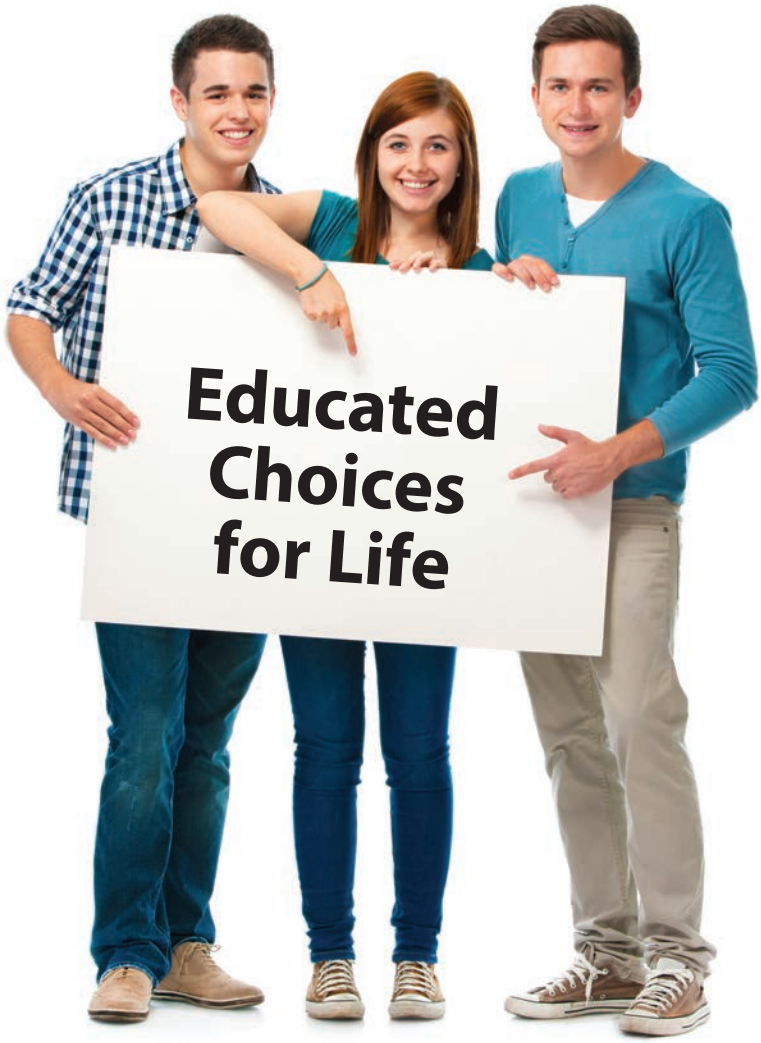
NEVADA COUNTY citizens for CHOICE

Voices for Choice

Summer 2020

QUARTERLY NEWSLETTER



Citizens for Choice promotes reproductive justice through education, health care access and advocacy. We exist to inform and enable choice.

Voices for Choice

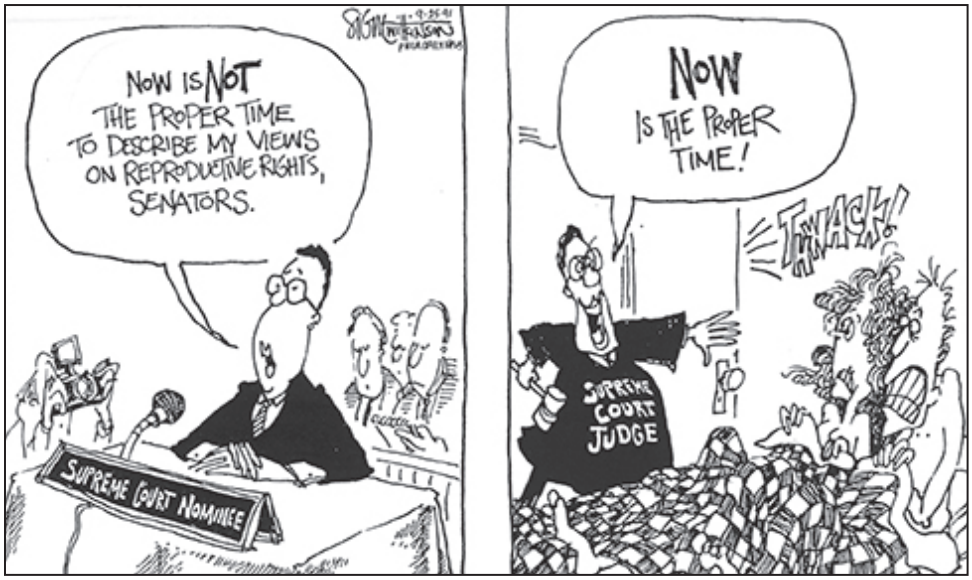
TELEPHONIC HEALTH CARE

By Marty DeKay Bemis

During this global pandemic, Telehealth is emerging as an effective and sustainable solution for precaution, prevention and treatment to stem the spread of COVID-19. Forty to fifty percent of Covid-19 cases are transmitted by people at least two days before they have any symptoms. That means wearing masks is crucial to stemming the spread of the disease. Women's Health Specialists and *The Clinic!* staff have been working diligently to implement safeguards to protect patients and staff from potential exposure to Covid-19. Precautions include mandatory face coverings while in *The Clinic!,* exposure screening and temperature checks prior to the visit, hand sanitizing and allowing only one person at a time in the waiting area.

There are two ways to accomplish patient visits without an in-person meeting. Telephonic is done via a simple telephone call and Telehealth is done via video using various remote communication technologies. HIPAA rules have been modified during Covid-19 to allow for these types of visits. In the year prior to the emergence of Covid-19, Women's Health Specialists has been working with the State of California to incorporate Telehealth into the medical abortion project (teleMAB). Because of their work on this project, when Covid-19 presented barriers to patient care, WHS began immediately implementing telephonic in an effort to continue to provide uninterrupted reproductive health services. Staff and patients alike have eagerly adapted to telephonic visits. For many patients, being able to access services from home has greatly improved access to care because of reduced fear of exposure to Covid-19, no need to arrange for childcare and transportation issues.

For teens, however, telephonic visits are a potential barrier due to confidentiality. For the foreseeable future, WHS will continue to offer telephonic visits with the plan to transition to Telehealth visits when the State of California finalizes details for this method of communication. Most reproductive health services can be accomplished by telephonic visits with the exception of IUD and Nexplanon implants and removals, surgical or medical abortions, annual and breast exams and STI checks if there are no symptoms present. Patients must also have a blood pressure check annually to receive hormonal contraceptive methods. All insurances cover the cost of Telephonic visits, including MediCal and private insurance. To schedule a Telephonic or in-person visit call the WHS call center at (800) 714-8151.



The Clinic! has moved!

Voices for Choice

Public Policy

Stay Informed! **Keep up on public policy by visiting: www.citizensforchoice.org/home/policy-activism/**

REAL LIFE AND REPRODUCTIVE HEALTH ACCESS

By Elaine Sierra, Public Policy Director

Take a walk in her shoes. You are young, impoverished and pregnant. Perhaps with limited English, you are what other people call a person of color. You have a low-paying job, for which you are so grateful, despite not having full-time hours. You fear that you will have no job to return to if you take pregnancy leave.

What might be done to improve the prospects for this young woman? How might we improve her chances for a healthy pregnancy and birth? How might we ensure a modicum of economic security at this vulnerable time in her life for her and for her child?

Can supporting changes in our laws help? We think so.

And that is why we support legislation that would:

- Address disparities in maternal and child health for people of color—by increasing access to certified nurse midwives, who can help fill the current shortage of OBGYN providers (SB 1237)
- Protect workers from losing their jobs when they take family leave to which they are entitled—(SB 1383); and
- Ensure that hospital mergers do not result in reduced access to reproductive healthcare—by requiring pre-approval from our Attorney General (SB 977).

Imagine an even more dire situation. Imagine your being a young woman arriving at a jail or prison, to be incarcerated when you are, or believe you may be, pregnant. You fear that you will not be seen by qualified medical staff in a timely way. You fear that you will receive substandard care during your pregnancy or delivery, or that your newborn will get deficient care. You even have concerns that you may be subjected to solitary confinement during your pregnancy, or shackled during labor.

There is legislation that would address those fears. It would ensure that, in real life, such a young woman would be given adequate care. It would set standards for her being treated with dignity and respect during her pregnancy and birthing and for her newborn getting the care needed. We support that bill. (AB 732).

These are just a few examples of the injustices that women face that may be remedied through our advocacy. Our aim is to advance reproductive health and rights—particularly for our most vulnerable fellow citizens—real people dealing with real life crises. The need is only greater during these difficult times: COVID-19 threatens our health, our livelihoods and our very lives. We stand ready to do our part to help protect those in need, through our ongoing pro-choice advocacy.

—Elaine Sierra
Public Policy Director

Voices for Choice

THIRTY-ONE YEARS AND COUNTING!
Nevada County Citizens For Choice (C4C) Is Here For You!

C4C's longstanding commitment to serve the reproductive health needs of all without bias or discrimination, has never felt more important. Women matter. C4C listens, learns and contributes to conversations about reproductive justice in our local community as well as state-wide and countrywide. We remain focused on our goals and work devotedly to support the values of inclusion and intersectionality.

C4C is here for you, no matter your race, ethnicity, religion, sexual orientation, gender identity, ability, immigration or economic status. C4C, in partnership with Women's Health Specialists (WHS) at the Clinic!, strive continually to ensure you receive the highest quality care and that each client feels safe and welcome.

(Left to Right) Visiting from Chico, Linda McCrea, Board of Directors for Women's Health Specialists (WHS) and Katrina Cantrell, Executive Director of WHS , recently enjoyed a warm and wonderful breakfast meetup with Elaine Sierra, Director of Public Policy and Fund Development for Citizens for Choice (C4C) at South Pine Cafe.

From all of us at Citizens for Choice, Thank You!

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Nevada County
Citizens for Choice

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OUR NEW VOLUNTEERS!

Welcome Xochitl Husted And Syenna Velasquez!

Xochitl Husted is a rising Junior at Pitzer College pursuing a double major in Political Studies and Sociology. She has always been passionate about advocating for social justice groups through engagement and research. She has collaborated with Communities Beyond Bias to promote empathy in Nevada County and is currently a Mellon Mays Undergraduate Research Fellow, working towards diversifying higher academia. She hopes to further dialogue about reproductive and sexual health in our community in partnership with Citizens for Choice.

Syenna Velasquez is a rising Sophomore at UC Berkeley pursuing a pre-law degree. Throughout high school and college, Syenna volunteered for environmental outreach organizations such as SYRCL and Sierra Harvest. Along with her passion for environmental protection, she has always been in support of social justice and hopes to further the progress of the women's rights movement via her engagement with Citizens for Choice.

Voices for Choice

The Coronavirus Pandemic Gave Us a Look at a Post–Roe v. Wade World

Excerpts from an op-ed by Jennifer Dalven, director of the ACLU Reproductive Freedom Project, Teen Vogue, June 12,2020. Compiled by Judith McCarrick

As the country tried to make sense of how to handle the pandemic, politicians who had been pushing anti-abortion agendas for years seized on it as an opportunity. Medical experts issued a unified, clarion call that abortion was essential, time-sensitive health care and must not be restricted during a pandemic, but politicians plowed ahead. At the federal level, the Hyde Amendment and related bans deny insurance coverage for abortion for those enrolled in Medicaid and other government programs. As a result, poor women, and particularly poor women of color, are too often forced to choose between paying for the care they need and paying for rent, bills, food, and other necessities. One in four Medicaid-eligible people who seek an abortion have been denied care altogether, forcing them to carry a pregnancy to term.

Now that President Trump — who promised to appoint only justices opposed to Roe v. Wade to the Supreme Court — has had two appointments to the court, anti-abortion politicians are doing everything they can to get the court to further roll back people's rights and their ability to access abortion care, with the ultimate goal of overturning Roe v. Wade completely.

During the first few months of the COVID-19 crisis, with abortion largely unavailable for periods of time across the South and Midwest, we got a grim preview of what that world would look like. Entire states were without abortion access, with patients forced to traverse the country attempting to get the care they needed — and those were the "lucky" ones. Seventy-five percent of people who seek abortion care are poor or low income and, if access is further curtailed, more will be unable to get the care they need and will be forced to continue their pregnancies against their will.

The coronavirus pandemic has exposed and amplified deep, pervasive inequalities and injustices in so many areas: From the precarity of low-income workers to the fatal disparities in maternal health affecting Black women to the unequal access to health care in neighboring zip codes,

Continued on next page....

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You help us provide services at *The Clinic!*, education programs and advocacy for us all.

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E-scrip Contributions–They Really Help!

Thank you! Contributions may be made to Citizens for Choice through e-scrip at Safeway, Save-Mart, and SPD Market.

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The Coronavirus Pandemic Gave Us a Look at a Post–Roe v. Wade World

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COVID-19 has laid bare the way that socioeconomic status and race shape daily life, and health, in our country.

While many are eager to resume our pre-COVID-19 lives, it is clearer than ever that there was much about the old "normal" that must change. If we want to ensure that people who have decided that abortion is the best decision for themselves and their families can get the care they need, we cannot go back to the pre-pandemic status quo.

To start, we must demand that Congress pass the EACH Woman Act, legislation to ensure that everyone who needs an abortion can get one — no matter where they live or how much money they make. We also need to push Congress to pass the Women's Health Protection Act, a federal law that would make it illegal for states to pass politically motivated laws designed to prevent people from getting abortion care. And we must vote this November like our reproductive rights depend on it—because as we've seen all too clearly, they do.

State Action to Limit Abortion Access During the COVID-19 Pandemic

From the Kaiser Family Foundation--Laurie Sobel Follow @laurie_sobel on Twitter, Amrutha Ramaswamy Follow @amrutha__ram on Twitter, Brittni Frederiksen, and Alina Salganicoff Follow @a_salganicoff on Twitter

The response to the COVID-19 pandemic has prompted several states to place restrictions that have effectively banned or blocked the availability of abortion services. The American College of Obstetricians and Gynecologists (ACOG) and other leading medical professional organizations issued a statement defining abortion as a time sensitive and "essential component of comprehensive health care" and that delay, even days, "may increase the risks or potentially make it completely inaccessible." The World Health Organization also classifies abortion "essential" to women's rights and health.

Abortion providers forced to close their services to patients may not be able to reopen after the emergency bans are lifted as was the case after many clinics in Texas closed after a restrictive set of laws were enacted. Although the laws were successfully challenged at the Supreme Court in *Whole Women's Health v Hellerstedt,* many of the clinics were unable to reopen after the law was overturned.

BANS IN EFFECT

The Arkansas Department of Health ordered Little Rock Family Planning, the only clinic providing "surgical" abortions in Arkansas, to immediately cease and desist the performance of "surgical" abortions, except where immediately necessary to protect the life or health of the patient. Effective May 18th, the Arkansas Department of Health released another directive modifying the time frame for a negative test to within 72 hours prior to the elective procedure.

BANS THAT ARE CURRENTLY BLOCKED BY COURT ORDER

Some of these state actions have been successfully challenged by abortion provider groups and reproductive rights advocates. In Alabama, Ohio, and Tennessee, the orders granted by federal district courts have allowed clinics to provide abortion services.

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Classic Tattoo | Clock Tower Records | Common Goals | Community Beyond Violence | Cooper's
CoRR (Community Recovery Resources) | Crazy Horse Saloon and Grill
Foggy Mountain Music | FoxHound Espresso & Coffee Roaster
Gary's Place Saloon | Goodtimes Boardstore | Mine Shaft Saloon | Nevada Club
N.S.J.-Sierra Family Medical Clinic | Sierra Care Physicians (PV) | Sierra College Health Center
Spirit Farmer Acupuncture | The Open Book | Tribal Weaver
Valentina's Organic Bistro and Bakery

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State Action to Limit Abortion Access During the COVID-19 Pandemic

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• **ALABAMA:** On April 12th, the federal district court in Alabama issued a preliminary injunction allowing providers to determine on a case by case basis if an abortion is necessary to avoid additional risk, expense, or legal barriers. Effective April 30th, dental, medical, and surgical procedures were allowed to proceed in Alabama unless the State Health Officer or his designee determined that performing these procedures would reduce access to PPE or other resources necessary to diagnose and treat COVID-19.

• **OHIO:** The 6th District Court of Appeals denied Ohio's request to overturn the district court's Temporary Restraining Order (TRO) allowing abortion services to continue. On May 1st, Ohio Department of Health's Stay Safe Ohio Order allowed non-essential surgeries and procedures to resume.

• **OKLAHOMA:** On April 20th, the federal district court issued a preliminary injunction permitting medication abortion services and abortions for pregnancies reaching the legal limit in Oklahoma on April 24th to continue in the state.

• **TENNESSEE:** On April 17th, a federal district court blocked Tennessee's order to suspend abortions, allowing providers to resume procedures.

BANS NO LONGER IN EFFECT

These bans were either lifted by a settlement outside of court, the state's new executive order, or governor action.

• **ALASKA:** In Alaska, the governor, the Alaska Department of Health and Social Services, and the chief medical officer for the state of Alaska updated their health mandate on April 7th, to specify that "healthcare providers are to postpone surgical abortion," without a listed restriction of medication abortion. On May 4th, "non-urgent/non-emergent elective surgeries and procedures" were able to resume.

• **IOWA:** In Iowa, state officials and the American Civil Liberties Union (ACLU) (who challenged the policy) settled out of court that abortion services could continue.

• **KENTUCKY:** The Kentucky Cabinet for Health and Family Services has not declared abortion a non-essential procedure, despite the request of Kentucky's Attorney. The only abortion clinic remaining in Kentucky is continuing to provide abortion services.

• **WEST VIRGINIA:** On March 31st, the Governor of West Virginia issued an executive order prohibiting all elective medical procedures not immediately medically necessary to preserve the patient's life or long-term health. The Governor issued another executive order lifting the suspension of all elective procedures, including abortions, on April 30th.

• **LOUISIANA:** On March 21st, the Louisiana Department of Health issued a directive postponing medical and surgical procedures for 30 days, except those (1) "to treat an emergency medical condition" or (2) "to avoid further harms from underlying condition or disease," On May 1st, the clinics settled with the state, permitting abortions to continue.

• **MISSISSIPPI:** On April 10th, the Governor of Mississippi issued an executive order requiring the delay of all non-essential adult elective surgeries and medical procedures. Mississippi's executive order expired on May 11th, allowing "non-emergent, elective medical procedures and surgeries" to resume.

• **TEXAS:** In Texas, the state and the providers had been in a complicated legal battle over whether abortions remain available to women in the state during this current crisis. After a month of contentious litigation, abortion services have resumed in Texas.

OTHER STATE ACTIONS AND FACTORS AFFECTING ABORTION AVAILABILITY

Some states, such as New Jersey, Virginia, and Washington have specifically protected access to abortion in their executive orders addressing COVID-19 response. Even in states that have not taken action to suspend abortion, access may be limited. All of the states that have tried to deem abortion a non-essential service have existing gestational age limits on abortion that are more restrictive than the SCOTUS limit of viability, and most have mandatory waiting periods ranging from 24 to 72 hours and other restrictions which create additional challenges for accessing abortion services in a timely manner. For women seeking abortions in those states, access is further challenged by difficulties traveling when a stay at home order is in effect, additional costs related to waiting periods and other delays, the loss of jobs, the risk of exposure to the coronavirus, and the uncertain future of the COVID-19 outbreak.

Compiled and reported by Judith McCarrick

Nevada County citizens for CHOICE

Voices for Choice

CALL IT BY NAME—Why Black Mothers Keep Dying

Following decades of decline, maternal deaths began to rise in the U. S. around 1990. By 2013, rates had more than doubled. The CDC now estimates that 700 to 900 new and expectant mothers die in the U. S. each year and an additional 500,000 experience life-threatening postpartum complications. More than half of the deaths are from preventable causes and a disproportionate number of the women suffering are black. For black women far more than white women, giving birth can be a death sentence. African-American women are three to four times more likely to die during or after delivery than are white women. According to the WHO, their odds of surviving childbirth are comparable to those of women in such countries as Mexico and Uzbekistan.

In a survey conducted in 2017 by NPR, the Robert Wood Johnson Foundation and the Harvard T. H. Chan School of Public Health, 33 percent of black women said that they personally had been discriminated against because of their race when going to a doctor or health clinic, and 21 percent said they have avoided going to a doctor out of concern they would be racially discriminated against.

Investigative reporter Nina Martin, speaking at a symposium hosted by the Maternal Health Task Force at the Harvard T. H. Chan School of Public Health in 2018, noted telling commonalities in the stories she's gathered about mothers who died. Once a baby is born, she becomes the focus of medical attention. Mothers are monitored less, their concerns dismissed, and they are sent home without adequate information. For African American mothers, the risk jump way up. When black mothers expressed concern about their symptoms, attention was delayed, and they were frequently not believed. According to the U. S. Agency for Healthcare Research and Quality, pre-eclampsia—one of the leading causes of maternal death—and eclampsia are 60 percent more common in African American women than in white women and more severe. Arline Geronimus, when a Princeton student and a research assistant for a professor studying teen pregnancy among poor urban resident and as a volunteer for Planned Parenthood, felt a chasm open between what some of her white male professors were explicating about the lives of black adolescents, including the conventional wisdom that teen pregnancy was the main cause of maternal and infant deaths.

Black women are more likely to be uninsured outside of pregnancy, more likely to start prenatal care later and to lose coverage in the postpartum period. The hospitals where they give birth are often the products of historical segregation and lower in quality.

Geronimus began to vigorously explore the ways that social disadvantage corrodes health, a concept for which she coined the term "weathering." White women in their 20s were more likely to give birth to a healthy baby than those in their teens. But among black women, the opposite was true: The older the mother, the greater the risk of maternal and newborn health complications and death. Geronimus' study suggests that black women may be less healthy at 25 than at 17. Now a professor at the University of Michigan School of Public Health, Geronimus asked—if young black women were already showing signs of weathering, what could be done to stop it? "No one wanted to look at what was wrong with how our society works and how that can be expressed in the health of different groups," says Geronimo.

It's a type of stress for which education and class provide no protection. It's the experience of having to work harder then anybody else just to get equal pay and equal respect. It's being followed around when you're shopping at a nice store or being stopped by the police when you're driving in a nice neighborhood.

In 1993, researchers identified a physiological mechanism that explained weathering: allostatic load. "We as a species are designed to respond to threats to life by having a physiological stress response," says Geronimus. "Stress hormones cascade through the body. Pro-inflammatory cytokines are produced to help heal any wounds that result." These reactions siphon energy from other bodily systems, including those that support healthy pregnancies. If the threat is short term, there is no problem—the body quickly returns to normal. But for people who face chronic threats and hardships—like witnessing racist police brutality or experiencing chronic struggles to make ends meet—the fight or flight response never stops, and the damage is compounded over time. A TEDMED talk by Harvard's David R. Williams about his Everyday Discrimination Scale includes questions that measure experiences such as being treated with discourtesy, receiving poorer service or seeing people act as if they're afraid of you, and how it chips away at health on a daily basis.

Black mothers in the U. S. die at three to four times the rate of white mothers—a black woman is 243 percent more likely to die from pregnancy or childbirth-related causes.

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CALL IT BY NAME—Why Black Mothers Keep Dying

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Beginning in 2008, human rights groups around the world began calling on the U. S. to do more to keep its mothers from dying. The United Nations Committee on the Elimination of Racial Discrimination (CERD) expressed concern about inequities in maternal mortality, recommending that steps be taken to improve access to maternal health care, family planning and sexuality education and information. But a 2012 Amnesty International report declare that these steps weren't enough and the U. S. government needed to be held accountable.

Four years later, representatives from SisterSong, the Center for Reproductive Rights and the National Latina Institute for Reproductive Health issued a report to CERD with recommendations including addressing stereotypes that promote discrimination in medical settings and standardizing data on maternal death. In 2015, Black Mamas Matter came out of this effort to push the agenda forward. Some women reported that they avoided prenatal care because of the way they were treated by providers; many were low-income or lived in rural areas and they wanted more education about themselves and their babies.

One central fact was clear: Racism is an undeniable thread running through the stories of black mothers who died.

Physicians and others in the field are pushing for wider adoption of Maternal Mortality Review Committees (MMRC's), now operating in about 30 states. Every time a mother dies, these expert panels meet to review official data as well as other information about the mother's life in order to develop guidelines for action. Colleagues at the CDC are gathering through a new system called MMRIA (Maternal Mortality Review Information Application) which may help identify under-recognized barriers to safe delivery. In its first report, published in January 2018, data from nine states found that the reasons women died varies by race. White mothers were less likely to have died from pre-eclampsia than black mothers, and more likely to have died from mental health issues such as postpartum depression and drug addiction.

THE BACK WOMEN'S HEALTH STUDY

Every two years, participants in the Black Women's Health Study (BWHS), an ongoing cohort study of 59,000 black women, are sent questions about their health, their habits and various experiences in their lives. With the National Cancer Institute as a major sponsor, breast cancer emerged as an early area of focus. Researchers already recognized that while black women and white women have a similar chance of developing breast cancer, black women are 40 percent more likely to die from the disease, especially the most aggressive and less treatment-responsive form known as estrogen-receptor-negative (ER).
It was found that childbearing without breastfeeding leads to an increased risk of ER breast cancer—breastfeeding is markedly less common among black mothers in the U. S. for a variety of reasons. It was also found that early-life exposure to Jim Crow laws was associated with negative health effects decades later. Among U. S. women diagnosed with breast cancer, being born in a Jim Crow state raised black women's risk of being diagnosed with ER breast tumors.

Will a growing body of data attesting to black women's increased risk of death during and after childbirth shape policymaking? Geronimus argues that the solution to racial inequities in maternal mortality is to change the way society works. Race should regularly be taken into consideration during prenatal risk screenings. Risk status by maternal age should be reappraised as well. While most women in their 20s and 30s are considered low-risk, black women may be weathered and biologically older than their chronological age, making them more subject to health complications at younger ages. This is true even among highly educated or professional women. Failure to recognize the effects of weathering in black women of higher socioeconomic position happens because the U. S. lacks policies that support women who want or need both careers and parenthood, a gap that can lead working women to postpone childbearing until their late 30s or 40s.
"As a group," says Geronimus, "black mothers in their mid-to-late 30s have five times the maternal mortality rate of black teen mothers…" A 2010 Amnesty International report said that most women in the U. S. weren't dying during childbirth because of the complexity of their health conditions, but because of the barriers they faced in accessing high-quality maternal care—particularly those who faced racial discrimination.

Elizabeth Dawes Gay of Black Mamas Matter addressed the racial disparities in maternal mortality: "Those of us who want to stop black mamas from dying unnecessarilyhave to name racism as an important factor in black maternal health outcomes and address it through strategic policy change and culture shifts…It requires us to examine and dismantle oppressive and discriminatory policies." As Linda Blount of the Black Women's Health Imperative has noted: "Race is not a risk factor. It is the lived experience of being a black woman in this society that is the risk factor."

Thanks to Nina Martin, ProPublica, Renee Montagne from NPR, Amy Roeder of the T. H. Chan School of Public Health at Harvard from which much of this article is taken.