



CityLights



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The Well-Woman

Reproductive Health, Rights, and Justice



Focusing Attention on “Well-Women”

Improving the Whole Woman’s Health

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The Well-Woman Visit has gained enormous traction and attention in the past few years. This annual, preventive health care visit gained much of its initial attention due to the fact that under the Affordable Care Act (ACA), this visit must be included as a no cost-sharing benefit.¹ Under the ACA, most insurance plans, including private insurance plans and Medicaid plans covering newly-eligible women, must include this preventive health care visit as a benefit to women without any cost-sharing.¹ In 2014, the Maternal and Child Health Bureau released the National Performance Measures for the 2015-2017 grant cycle.² Further increasing the attention and traction, the Well-Woman Visit was announced as the focus of Performance Measure #1, with the goal to increase the number of women who have had a preventive health care visit within the past year.²

Much of the initial attention was focused on the clinical components of the Well-Woman Visit, with many discussions focusing around what services should be included in this annual, preventive visit. However, there was clearly one area of needed focus that was not getting attention. What was the woman’s perception of well-woman care?

In 2016, only 66.5% of women reported receiving well-woman care in the past year. This percentage was even lower in women with lower educational attainment (less than a HS diploma, 59.9%) and for women living in poverty (annual income under \$25,000, 61.4%).³ This information leads us to ask, even though

well-woman care is more accessible from a cost perspective, why are women not attending Well-Woman Visits?

In 2014, CityMatCH and the University of Illinois Chicago (UIC) began a project, the Well-Woman Project, that sought to answer that question. What affects a woman’s ability to be well? What impacts a woman’s ability to seek health care? While this project will be talked about in greater detail later on

in this issue, it’s important to stress what was learned from this project. Through women’s voices, we learned about the realities and struggles



Regan Johnson, MPH

The well-woman is found at the intersection of reproductive health, rights, and justice. To improve women’s health and health outcomes, the MCH field must begin to focus on the health of the whole woman and ensure a woman-friendly health system for all women at the local, state and federal level. In order to create a woman-friendly health system, the focus must be placed equally on reproductive justice, health and rights. Addressing the complex health issues and health systems issues will require a complex solution. Simply addressing one component of women’s health will not be enough.

of their everyday lives. Communities and health systems are not women-friendly, and the public health field is doing a poor job at addressing the social determinants of health that play a critical role in a woman’s ability to seek health care. Women’s voices and stories are a powerful tool in catalyzing change and until we listen to them, things will not get better.

Whose responsibility is it to ensure women-friendly communities and health systems? Whose responsibility is it to support the creation of well-women?

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The field of Maternal and Child Health (MCH) has done an excellent job at addressing many of the health issues that occur directly before, during, or after pregnancy. The field has decreased the number of adverse birth outcomes, increased the rates of childhood vaccinations, and decreased the rate of infant mortality. The field has also made strides in addressing the health of the mother: improving the quality and visibility of preconception care, increasing the rates of early prenatal care, and addressing maternal mental health. However, we are beginning to see a shift in the population that MCH serves.

In today's society, women are waiting longer to have children^{4,5} and some women are even choosing to never have children.^{6,7} If the MCH field doesn't take responsibility for women's health outside of pregnancy, who will? As a field we have made such great strides in improving birth outcomes, infant and child health, and maternal health; now is the time we must start to expand our focus to the whole woman. We must focus our attention on creating "well-women".

The health of women in this country is not currently being adequately addressed. The following examples represent some gaps in care that exist when it comes to reproductive health, rights and justice.

Reproductive Health: Only 66.5% of women receive well-woman care on an annual basis.¹ This percentage is lower in women with lower educational attainment (Less than a HS Diploma, 59.9%) and for women living in poverty (Annual Income under \$25,000, 61.4%).¹

Reproductive Rights: In the United States the total number of reproductive age women (13-44 years old) in need of publicly-funded contraceptive services is 20,017,990.⁸ Of those women, 19,765,530 live in what is considered a contraceptive desert (defined as, "lack 'reasonable access' to a public clinic with the full range of methods").⁸

Reproductive Justice: In the United States, 75% of children live in what is considered a supportive neighborhood.³ A supportive neighborhood is defined as, "the percentage of children aged 0-17 whose parents report their child is 'usually' or 'always' safe in their community".⁹ While the national percentage is 75%, this number greatly varies by state with the percentage being as low as 65.9% in Nevada.⁹ Higher levels of support are associated with higher incomes and rural location. It is likely that other disparities exist; however they are not reported.⁹

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CityMatCH Reproductive Justice Ad Hoc Group

In 2016, CityMatCH's board of directors reviewed and finalized the 2017 strategic plan. The board collectively decided to explore how to incorporate a reproductive justice lens into local Maternal and Child Health (MCH) work.

CityMatCH formed a Reproductive Justice Ad Hoc group to guide the work. The group is co-led by Christina (Kiko) Malin, Director, Family Health Services Division, Alameda County Public Health Department and Deb Kaplan, Assistant Commissioner, Bureau of Maternal, Infant, and Reproductive Health, NYC Department of Health and Mental Hygiene. Leseliey Welch, Deputy Director, City of Detroit serves as an advisor to the group. Kara Foster, Senior Public Health Project Coordinator and Regan Johnson, Public Health Project Coordinator are CityMatCH staff co-leads.

The Ad Hoc group hosted a webinar in January with guest speakers Dr. Lynn Roberts, Assistant Professor Community Health and Social Sciences, The City University of New York, and Monica Simpson, Executive Director, SisterSong, to discuss reproductive justice and public health. The webinar highlights a commonly used framework for reproductive justice and the history behind its development, as well as key takeaways for health departments. To listen to the webinar visit www.citymatch.org and search "Learning Network, Reproductive Justice."

If you would like to get involved with the Reproductive Justice Ad Hoc group, or to share about your health department's work around reproductive justice, rights and health, **contact Regan Johnson, regan.johnson@unmc.edu**.

Women's Voices

A Powerful Tool in Catalyzing Change



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The passage of the Patient Protection and Affordable Care Act of 2010 (ACA) provided healthcare coverage to millions of uninsured and underinsured Americans, eliminated discriminatory coverage practices such as gender rating and pre-existing condition exclusions, and improved access to preventive care by prohibiting cost sharing requirements for the provision of preventive services and screenings including a preventive services visit for women,¹ or the Well-Woman Visit (WWV). Although increasing awareness of, access to, and utilization of the WWV is a key strategy for engaging women of reproductive age in health care and has become a key strategy in an effort to promote the use of preconception/interconception care,² it is also recognized that medical care is only one piece of the puzzle related to improving women's health and infant health (among women who become pregnant). Emphasis on upstream factors and the Social Determinants of Health (SDOH) has gained increasing attention as structural forces are increasingly understood to be a main driver of health status and health inequities.^{3,4}

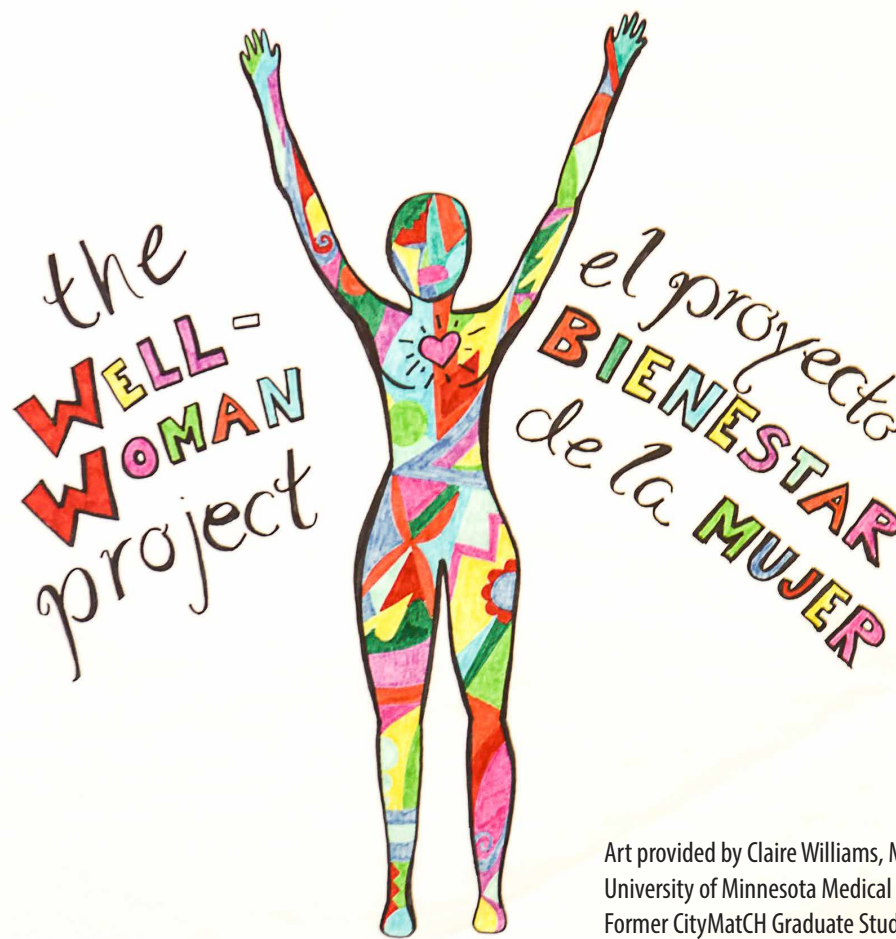
Given this context, the W.K. Kellogg-funded Well Woman Project, a collaboration between investigators at the University of Illinois School of Public Health and CityMatCH, aimed to gather women's views and stories with respect to the Well-Woman Visit and the conditions of women's lives that affect their ability to be well-women and seek well-woman care. This was accomplished by gathering women's stories through Listening Sessions in conjunction with 8 urban health departments, and through a 24/7 VOIP Story phone line and a confidential WWP Story blog/web-site available to women across the 8 cities as well as nationally. During the Spring of 2016, 156 women participated in the Listening Sessions in the 8 participating cities, with an additional 104 Stories collected via the phone line and blog. Data from both sources were transcribed, translated when necessary, and analyzed using Dedoose, a qualitative software program.

Analysis of Listening Sessions and Stories was conducted by examining and documenting patterns ("themes") present within the Listening Session discussion and shared Stories transcripts. The themes which emerged are based on commonality of ideas and opinions expressed by women in each respective city, across all cities, and across the shared Stories; no theme was based on comments from just one or two women. In response to the themes, recommendations were generated through an iterative process and are comprised of ideas that came from: 1) the women who shared their experiences; 2) the research team's partners/stakeholders; and, 3) the research team itself. The themes and recommendations for change generated by the Well-Woman Project are provided below and on pages 5 & 8 of this publication.

Listening Session and Stories Themes

1. The healthcare delivery system is not woman-friendly.
2. Women's competing demands and priorities make accessing healthcare difficult.
3. Women weigh costs vs. benefits when deciding to access care.
4. Relationships with providers are key to women's decisions about accessing care.
5. Health and insurance literacy empower women to advocate for themselves and others.
6. Positive mental health is integral to being a "healthy" woman.
7. Healthy food, safe environments, and opportunities for physical activity are vital for women.
8. Social support systems facilitate women's willingness and ability to seek care.
9. Lack of childcare and transportation are major impediments to accessing healthcare.
10. Fear is a pervasive component of many women's healthcare experiences.

** View recommendations on pages 5 and 8. Citations available on page 8.*



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Recommendations for City Health Departments

Employ strategies that mitigate the complexity of the healthcare delivery system and make navigating care easier.

- Adopt and promote a Charter which delineates the components of a woman and family friendly health delivery system.
- Engage in dialogue with large health systems and Federally Qualified Health Centers (FQHCs) to encourage increased availability of online appointment scheduling and appointments outside of traditional hours, drop-in/walk-in appointments, more time per patient to facilitate patient-provider interaction, an increase in the availability of on-line/phone health care consultation, and the ability of providers to conduct home visits and/or provide care through mobile clinic sites.

Employ strategies that assist women in prioritizing healthcare.

- Depending on city context, create a city-wide task force to include key stakeholders to consider adoption of paid sick leave for both public and private employees.
- Develop policy and educational materials focused on city-specific sick and personal leave policies.
- Develop policies or laws which require employers to allow people one day off per month.

Increase transparency and lower healthcare costs.

- Partner with major health systems, FQHCs, and other key stakeholders to provide women and families with access to insurance navigators on a year-round basis. Initiatives such as a city-wide insurance navigation hotline and on-line insurance navigation support can help women understand insurance and network options.
- Develop a city fund to cover uninsured women and families and/or help women and families struggling with high deductibles for their privately obtained insurance.
- Partner with major health systems and FQHCs to sponsor "One Day" Medicaid/free care several times a year for all.
- Increase the presence of school-based health centers as a way to improve access to contraception and family planning for younger women (e.g., college campuses).
- Provide "cost estimators" for procedures and specialty care that are easily accessible and user-friendly for women and healthcare providers.
- Work with insurance carriers to increase transparency with respect to costs and coverage. For example, insurance carriers might:
 - Increase messaging and outreach about the fact that preventive care is covered without cost-sharing for plans purchased through the health insurance marketplace and for newly eligible Medicaid recipients.
 - Provide incentives to women and their families for obtaining preventive services.



A Vested Interest In Sexual & Reproductive Justice

The New York City Department of Health and Mental Hygiene is engaging communities to address inequities in sexual and reproductive health.

What began as a public awareness campaign in 2015 by the New York City Department of Health and Mental Hygiene to increase awareness and access, to a continuum of sexual and reproductive health services has grown into a five-year, community-driven campaign to address inequities in sexual and reproductive health.

For two years, the Health Department has sought the expertise and participation of professionals who advocate for Reproductive Justice from local Reproductive Justice stakeholders who serve the vast communities of New York City, and positioned themselves as a neighborhood partner with a vested interest. The shared decision-making process has elevated the conversation throughout the city.

“There is great momentum and a shared feeling that we are just getting started,” said Silvia Beltran, Special Assistant to the Assistant Commissioner of the Bureau of Maternal, Infant & Reproductive Health, New York City Health Department. “The Reproductive Justice framework is so integrative—especially for people who deserve the right to raise children with the necessary social supports in safe environments and healthy communities. As to a shared leadership approach to community engagement, as a health department you have to be willing to be uncomfortable and ask if your policies and programs align with your community or create barriers.”

Community Engagement Group (CEG)

In 2015, the Health Department’s Division of Family and Child Health developed the “May-

be the IUD” campaign, a campaign to raise awareness of the intrauterine device (IUD) and provide information about the full range of birth control options. The campaign stressed getting accurate information about contraceptive options so that every individual can choose the method that best meets their needs and lifestyles. As the division developed the campaign, they learned about community concerns around the promotion of the IUD over others, because there is a history in the U.S. of oppressive policies and practices against people of color around contraception and other reproductive health concerns.

Per the suggestion of an intern, the Health Department invited Dr. Lynn Roberts, a Reproductive Justice expert and champion from the City University of New York (CUNY) School of Public

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Health to speak during a staff retreat. The team believed that there was an opportunity to incorporate the Reproductive Justice framework into the “Maybe the IUD” campaign, and felt Dr. Roberts could help them engage in seeking community input.

The division engaged a cross-agency workgroup that reached out to Reproductive Justice experts and began planning a community stakeholder meeting in the summer of 2015. The turnout was staggering. There were 95 attendees, 65 from community-based organizations who serve the majority of the communities of New York. “Engaging the community and self-evaluation are really important pieces to starting this work,” Beltran said.

Important themes surfaced during the meeting including the need for more transparency and a genuine partnership between community and government. Attendees also expressed the need for more inclusivity and male engagement, an acknowledgement of the history of reproductive oppression and the adoption of an intersectional approach to the work.

“We knew that we didn’t want to wait long to reconvene the group, because they were invested,” said Alzen Whitten, Director, Sexual and Reproductive Health Unit, Bureau of Maternal, Infant & Reproductive Health, New York City Health Department.

By the end of the stakeholder meeting, 33 organizations had expressed interest in being part of a group that uses health equity and sexual and reproductive justice as frameworks to inform the development of public awareness campaigns. The CEG aims to increase awareness of and access to a continuum of sexual and reproductive health and related services,

including the full range of contraceptive methods, so that all New Yorkers can make informed decisions about their sexual and reproductive health and act on those decisions. The Health Department reconvened the group later that summer and hired a team of Reproductive Justice consultants to facilitate monthly meetings. The group developed a shared strategic plan and formed various workgroups. “We’ve had success because the Community Engagement Group’s work is built on trust and a shared vision,” Whitten said.

CEG in Action

- The Community Engagement Group developed a video which can be found on **YouTube**: <https://www.youtube.com/watch?v=MfwWNYc3sUA>, “What is Sexual and Reproductive Justice?” (launched November 2016) and is in the process of developing a complimentary discussion guide.

- The group determined that the ‘S’ for sexual needed to be included in the Health Department’s ‘RJ’ work, so as to ensure that the work considers sexual health issues not related to reproduction. “Sexual and reproductive justice (SRJ) exists when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction,” said Whitten.

“Sexual and reproductive justice (SRJ) exists when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction.” ~ Alzen Whitten, NYC DOHMH

- The CEG has convened 10 community gatherings—totaling more than 250 city residents—which informed proposals for a future public awareness campaign. The selected proposal, chosen through a one vote per member

organization process, will focus on birth justice and understanding an individual’s rights around the pregnancy, birth and postpartum periods. “It ties in nicely to all our work around maternal morbidity and mortality, as well as our birth equity work,” Beltran said.

- The group developed a speaker’s bureau to ensure that the Health Department had a way to include community voices when presenting at conferences such as the 2016 CityMatCH Leadership & MCH Epidemiology Conference, and the American Public Health Association (APHA) Conference. The Health Department was able to advocate and secure funding for CEG members to attend these conferences. “It makes sense to have our community be a part of this,” Alzen said. “We had to get creative and really communicate how this work aligns with our long-term outcomes.”

- The CEG group has grown to 57 organizations. They seek involvement from more community leaders, activists and nonprofit organizations to promote Sexual and Reproductive Justice (SRJ) in New York City. They are encouraging individuals and organizations to get involved by signing up for an e-monthly blast and engaging through the Health Department’s SRJ Tumblr series and “Doing it NYC” Facebook page.

Those interested in more information can visit nyc.gov/health and search “SRJ”.

Recommendations for City Health Departments (Women's Voices, Continued)

Increase trust, comfort, and rapport between women and providers, including providers' staff.

- Explore approaches to the development of a women-centered, consumer-driven mechanism to enable reviews of providers and enable women to recommend women-friendly provider sites.
- Partner with major health systems and FQHCs: to develop and offer training to increase the cultural competency/humility of the clinical workforce; to facilitate the implementation of "One Key Question for Patient Provider Communication": (e.g., Is there anything I can describe again to make sure you understand what we just discussed?); to increase the number of health navigators and interpreters at clinics/provider's offices; and, to develop electronic communication/telehealth strategies which allow patients to communicate with providers outside of office visits.
- Explore approaches that enable women to have their health "herstories" available on personal "apps" so that providers can readily access this information.
- Support the provision of training in trauma-informed care for providers.

Increase access to health education and improve health literacy to empower women to advocate for themselves and others.

- Partner with health systems and other key stakeholders: to support and develop health education campaigns, including the *Show Your Love* campaign, that focus on women's understanding of the importance of their own health and health care; to ensure the availability of a city-wide Women's Health Hotline as a go-to-resource for up-to-date information on changing health and health care recommendations and guidelines; to explore the development of a cadre of women's health peer advocates (volunteer or paid) who can be present at women's appointments; to provide interactive education in clinics while women are waiting to be seen by providers (e.g., videos, education kiosks, health educator on-site to answer questions); to develop health care materials in plain language; and, to offer women's health discussion groups/support groups in which women can discuss their health concerns and questions about how to navigate the health care system.
- Provide resources and trainings for women and families focused on how to advocate for oneself/family with both providers and insurance companies.
- Provide updated lists of available providers, including the types of insurance policies they accept, as well as providers or healthcare facilities that offer free or sliding scale services.
- Offer an "Ask the Doctor Day" in health department, health care, or community settings.
- Work with city school systems to increase the emphasis on preventive care during school-based health and sexual education.
- Develop health department sanctioned online chat sites in which health care providers, pharmacists, nurses, insurance providers, etc. are available to answer health-related questions in different languages.

Improve access, affordability, and social acceptability of mental health care.

- Work with community partners to ensure the availability of community based resources for self-care and respite (e.g., yoga, mindfulness, stress reduction, exercise, drop-in centers, etc.).
- Support increased access to mental health care through initiatives such as a psychiatric consultation line for primary care providers, and telemedicine options for patients.

- Partner with major health systems and FQHCs to increase care coordination between mental health and primary health care providers, to educate communities about the importance and realities of mental health care to prevent stigma, and to support strategies to diversify the mental health workforce.

Improve accessibility to quality food and safe, affordable environments for physical activity.

- Explore "food prescription" approaches and/or community supported agriculture (CSA) programs through partnerships between local farms, health care providers, and health departments to increase access to fresh fruits and vegetables.
- Work with major health systems, FQHCs and other stakeholders, to explore ways to improve women's and families' ability to apply for SNAP at their health care providers' offices.
- Work with community partners to support the provision of community-based programs focused on how to use and cook healthy foods (e.g., Cooking Matters).

Promote personal and system-facilitated social support networks to increase women's willingness and ability to seek care.

- Explore the development of a cadre of women's health peer advocates (volunteer or paid) who can be present at women's appointments.
- Work with health systems, FQHCs, and other stakeholders to increase "group" approaches for specific types of care (e.g., prenatal, family planning, diabetes, obesity, cardiovascular health, etc.).

Improve transportation provided through Medicaid/insurance and increase accessibility of public transportation for women and children.

- Work with large health systems and FQHCs to: encourage their partnerships with ride-sharing organizations to transport patients and their families to and from their medical appointments; encourage the provision of free parking vouchers or free or discounted bus/train cards to attend appointments; and, encourage health provider sites to provide play areas or supervised childcare facilities in their clinics/offices.
- Engage with the City Department of Transportation to explore and develop plans to provide women and child friendly public transportation (e.g., special seating that allows for the placement of car seats and strollers).

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Time to Use a Reproductive Justice Framework To Inform Local Work

As the current national climate surrounding reproductive health further elicits discussion, local Maternal and Child Health (MCH) may be on the brink of a pivotal opportunity to codify its role in safeguarding health around this issue.

“People are fired up and wanting to make sure that we ensure reproductive justice in our county in light of all the potential threats to it,” said Kiko Malin, Director, Family Health Services Division, Alameda County Public Health Department.

To date, Alameda County’s work to ensure reproductive justice for its community members has largely been responsive to immediate needs within the community—as identified and driven by staff in programmatic roles, and supported by administration. This includes addressing the false marketing of crisis pregnancy centers and taking a woman-centered approach to Healthy Start.

“It’s time to really make a commitment to using the reproductive justice framework to inform our work in a meaningful and structured way,” Malin said.

Crisis Pregnancy Centers’ False Marketing
Alameda County’s Perinatal Services and Family Planning unit convene a community forum on perinatal health, multiple times a year. This is where Alameda’s Reproductive Justice Workgroup got its start a few years ago. The workgroup took on the role of addressing false marketing efforts of crisis pregnancy centers (CPC) within the county. CPC advertising suggested they would provide unbiased counseling and support around prenatal care; but this was inaccurate.

“CPCs were doing some aggressive and deceptive advertising, mostly in communities of color and targeting women of color,” Malin said. “They were intimating that women would be getting comprehensive prenatal care, but that was not the case.”

The health department’s response was two fold. First, it included a public education campaign that directed people to the health department

for information about available options and referral to Comprehensive Perinatal Services Programs or certified providers. The health department recently relaunched the educational campaign in 2017 (adds depicted below).



Second, the health department testified and submitted a letter in support of a City of Oakland ordinance that further enforced a state law that required CPCs to be forthcoming with services they were or were not providing.

“We were essentially coming from the standpoint of wanting to ensure that pregnant women are getting adequate prenatal care and the information they need to make informed decisions on when, if, and how to become pregnant,” Malin said.

Woman-Centered Healthy Start Approach
Alameda County Healthy Start home visiting case managers, along with those who are managing the work, are driving the philosophy of embracing women’s points of view.

“Many of our staff want to stretch the paradigm beyond, ‘we’re working with pregnant women who want to be pregnant and we’re helping them to have healthy babies,’ to include a realization that we may be working with women who are conflicted about being pregnant,” Malin said. “It’s more of a woman-centered approach, that takes into account a woman’s history, emotions, and decisions about being pregnant.”

ENVIRONMENTAL JUSTICE IS

GENDER IDENTITY IS

BUILDING FAMILY ON YOUR
OWN TERMS IS

RACIAL JUSTICE IS

ENDING INCARCERATION IS

SUPPORTING TEEN PARENTS IS

FREEDOM FROM VIOLENCE IS

FOOD SECURITY IS

IMMIGRATION JUSTICE IS

ACCESSIBLE ABORTION IS

SUPPORTING BIRTHPARENTS IS

PAID LEAVE IS

DISABILITY JUSTICE IS

QUEER FAMILIES ARE

SAFE COMMUNITIES ARE

DECOLONIZATION IS

REPRODUCTIVE JUSTICE.





YOU ARE
THE REVOLUTION.

Harnessing the Power of Human Rights and Community Voices To Improve Maternal Health



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Maternal mortality is rising in the United States (U.S.), and Black women are nearly four times more likely to die of pregnancy-related complications than White women. To reverse this trend, health professionals and policymakers alike must understand and confront the racial inequalities that shape these outcomes. As advocates for maternal health, human rights, and reproductive justice, we believe that maternal health equity is an urgent issue, and that centering Black women's voices in this effort is a public health imperative.

The human rights and reproductive justice frameworks provide valuable strategies for improving maternal health, requiring us to center the needs, knowledge, and experiences of those most impacted by poor maternal health outcomes. Both advocates and health officials can use methods like community engagement and storytelling as tools to empower impacted communities and transform health outcomes. For example, in 2014, The Center for Reproductive Rights and SisterSong Women of Color Reproductive Justice Collective partnered to bring racial disparities in U.S. maternal health to the attention of a United Nations treaty monitoring body (the Committee on the Elimination of Racial Discrimination). Our joint human rights shadow report, *Reproductive Injustice*, included both quantitative data on maternal mortality, as well as personal narratives about reproductive health experiences.

The narratives presented in *Reproductive Injustice* were shared by Black women in Georgia and Mississippi who participated in

SisterSong's "storytelling circles." During these gatherings, Black women described violations of trust and respect during health care encounters, inadequate information about sexual and reproductive health, concerns about chronic illnesses, and social and economic conditions that threatened their health and well-being.

By placing statistics about maternal health problems alongside excerpts from individual Black women's lived experiences, the report provided readers with an additional layer of context, while simultaneously affirming that Black women's voices are sources of knowledge

Right now, one of the most important things that health departments can do to protect human rights in their cities, is to ensure that members of marginalized communities are empowered to participate in decisions about research, resources, leadership, and policy that will impact their health.

and critical information. In 2016, the Center released an advocacy resource, *Black Mamas Matter: A toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care*, which also incorporates Black women's stories alongside their proposed solutions. Beyond creating reports, the Center and SisterSong have been convening leaders on Black maternal health for the last two years. From that network of leaders, the Black Mamas Mat-

ter Alliance (BMMA) was formed. BMMA is an independent, Black women-led cross-sectoral alliance that centers Black mamas to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice. Members of the alliance are currently building platforms for empowered self-advocacy, and are committed to lifting up the voices and stories of Black women through future, community-informed research, advocacy, and cultural endeavors.

City and county health departments have an important role to play in improving maternal health, and we encourage maternal and child health leaders to join us in taking a human rights-based approach that promotes reproductive justice. Right now, one of the most important things that health departments can do to protect human rights in their cities, is to ensure that members of marginalized communities are empowered to participate in decisions about research, resources, leadership, and policy that will impact their health.

Learn more at:

Center for Reproductive Rights

<https://www.reproductiverights.org>

SisterSong

<http://sistersong.net/reproductive-justice/>

Black Mamas Matter Alliance

<http://blackmamasmatter.org>

Access to Contraceptive Coverage Autonomy to Control Own Fertility

*Katherine Suellentrop, MPH, Vice President of Programs
The National Campaign to Prevent Teen and Unplanned Pregnancy*

In recent years, there have been important improvements in contraceptive coverage in the United States. Due in large part to the Affordable Care Act, out-of-pocket cost for these methods have decreased dramatically and in most cases, all categories of methods are covered by most insurance plans, making them even more universally affordable. However, access to the full range of contraceptive options remains less than optimal. In fact, only one in 50 women in need—more than 19 million women across the country—have access to the full range of birth control methods in the counties in which they live. These “contraceptive deserts”—places where women have unequal access to birth control based on their zip codes—are found nationwide. This lack of reasonable access to all birth control methods contributes to the wide disparities in rates of unplanned pregnancy and subsequent outcomes such as timely entry to prenatal care, preterm birth, and optimal birth spacing. Interactive access maps are available here: <https://thenationalcampaign.org/resource/accessmap>.

While access issues are particularly acute in rural communities, urban cities are not immune to access barriers. While clinical infrastructure exists to offer contraceptive services, in many urban areas clinics themselves do not offer the full range of methods, including the most effective, lowest maintenance methods like IUDs

and the implant. As a result, many women live in communities with less than reasonable access to the full range of contraceptive methods. They must often visit multiple providers for a particular method and/or experience long wait times for both an appointment with a provider who offers the full range of methods or the appointment itself. In other words, not only is access to the method a barrier, but time, cost, and a frustrating number of logistical issues play a role in preventing many women from obtaining the contraceptive method of their choice. In addition to supply challenges, knowledge of the full range of contraceptive methods remains universally low. Approximately three-quarters of adults report knowing little to nothing about the IUD and two-thirds report the same about the implant. Low knowledge of these methods may contribute to low demand; and as is the case with any product, when there is low demand, there is consequently a low supply. If patients are not requesting a particular method or service, many clinics decide it is not necessary to provide these methods and services.

In the context of reproductive justice and ensuring women have the autonomy to control their own fertility, the existence of contraceptive deserts is a stark reminder of the work that remains to guarantee more equitable availability of high quality reproductive health services. Women who lack access to the full range of methods or who are uninformed about the

birth control options available to them are at a distinct disadvantage with regard to their fertility and reproductive health. That disadvantage of access or education should

not be the sole reason a woman chooses—or is forced to choose—a particular method of contraception. Thus, initiatives to reduce the prevalence of contraceptive deserts should be multifaceted, community-driven, and focused on both supply of and demand for these methods.

The National Campaign to Prevent Teen and Unplanned Pregnancy is developing a sustainable framework to guide efforts to improve access to the full range of methods. More details will be available in the coming months at www.thenationalcampaign.org.



Katherine Suellentrop, MPH

That disadvantage of access or education should not be the sole reason a woman chooses—or is forced to choose—a particular method of contraception.

~ Katherine Suellentrop, The National Campaign to Prevent Teen and Unplanned Pregnancy

20,017,990

Total number of women, 13-44, in need of publicly funded contraceptive services the U.S.

19,765,530

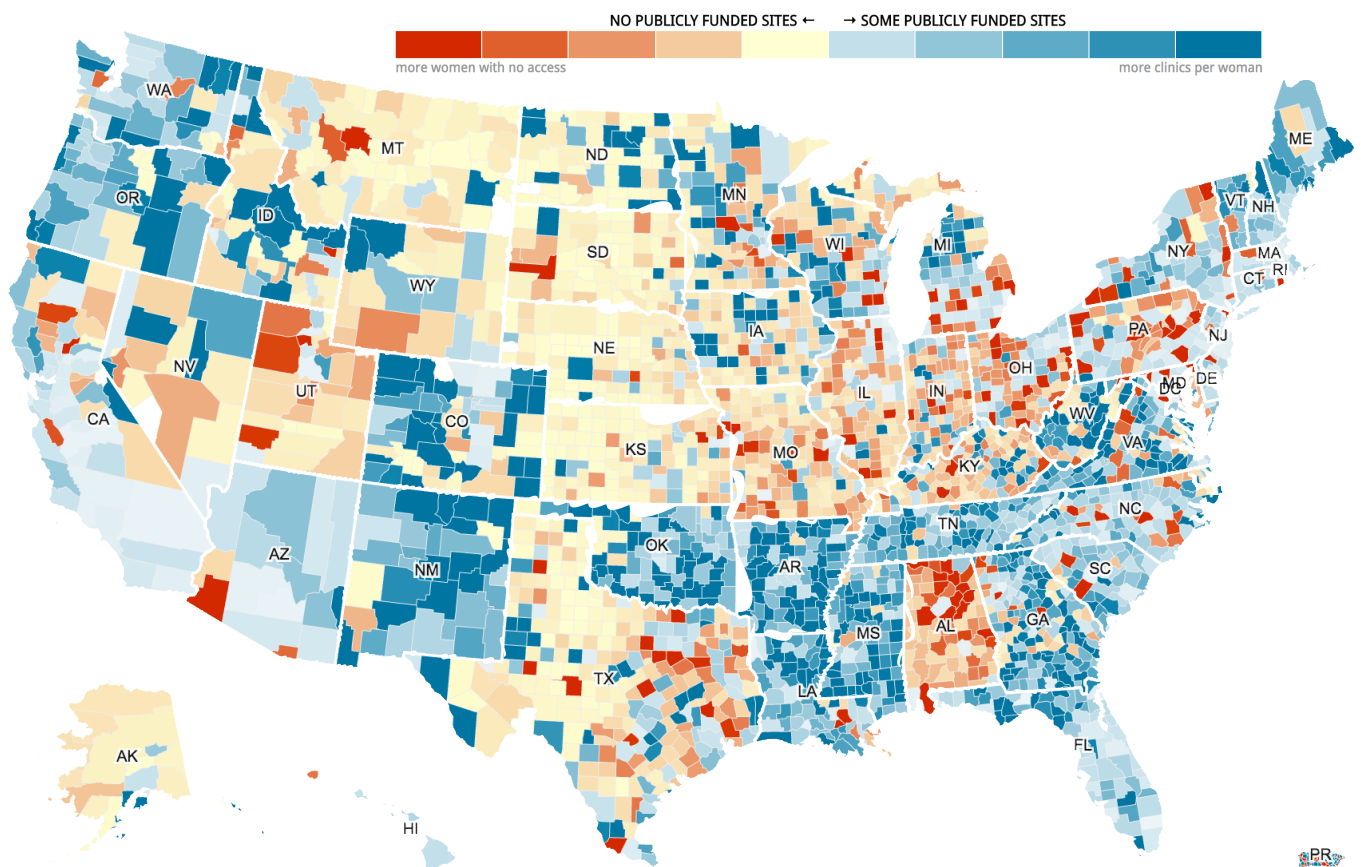
Total number of women in need who live in contraceptive deserts meaning they lack “reasonable access” to a public clinic with the full range of methods. “Reasonable access” is a county where the number of public clinics, and estimated number of providers in those clinics, are enough to meet the needs of the county’s population, defined as at least 1 clinic/provider to every 1,000 women.

3,115,910

Number of women in need in counties without a single public clinic that offers the full range of contraceptive methods.

PUBLICLY FUNDED SITES OFFERING ALL BIRTH CONTROL METHODS

Interactive access maps are available here: <https://thenationalcampaign.org/resource/accessmap>.



Showing Love in U.S. Communities Elevating Local Conversations to a National Level

Suzanne Woodward, Communications Director

National Preconception Health & Health Care Initiative, UNC Center for Maternal and Infant Health

What you do before pregnancy matters. Getting that message to resonate with every young adult across the country is easier said than done. The very word ‘preconception’ is a tough sell, and the concept itself is not well known or understood by young adults, their support systems – even many clinicians.

Addressing the clear need to improve preconception health care and maternal and infant mortality in the US, The National Preconception Health & Health Care Initiative (PCHHC), with support from the Centers for Disease Control and Prevention and the W.K. Kellogg Foundation, launched the first national preconception health resource and campaign, Show Your Love. Show Your Love encourages young women ages 18-30 to ‘show love’ to themselves by being an active health consumer.

The National Preconception Health and Health Care Initiative (PCHHC), is working to support all women and men of reproductive age to achieve optimal health and wellness, fostering a healthy life course for them and any children they may have.

~ Suzanne Woodward, National Preconception Health & Health Care Initiative

A cornerstone of the campaign is two-way dialogue and learning. First, we listen and learn from populations that have long been underserved and marginalized about how to engage and message in a way that makes an impact.



Suzanne Woodward

PCHHC funded 14 organizations nationwide to engage with diverse communities and help us learn how to better resonate with their culture, language, circumstances, and perspectives. A variety of communities worked with us, even though the funds we offered were minimal. The groups worked with young African American men, African American women in urban and rural areas, Asian Pacific Islander young adults, the Latinx community, Native American young adults and families, and LGBTQIA young adults. We sought geographic diversity partnering with groups from across the U.S.

Read about the Show Your Love Grantees and their key learnings at www.showyourlovetoday.com. Grantee strategies included digital, mobile message campaigns, creating new videos, public service announcements, posters, digital ads, doctor dialogue toolkits, healthy habits checklists, and more; all had a social media component.

Community Grantee Spotlight: Black Women for Wellness, LaShea Brown

Black Women for Wellness organized focus groups to test preconception health messages and images in Los Angeles. Our “Aha” moment: it’s more than diversifying messages and materials for different audiences and cultures. To relate and create an impactful campaign, images need to represent the women in their community – down to the skin tone, hairstyle, outfit color/accessories, varying class background and environments.

Show Your Love Ambassador Program:

As part of the Show Your Love social media campaign, PCHHC recruits community ambassadors: young adults ages 18-30 who will help model and promote healthy behaviors and life choices online and in their communities. The ambassadors share their health journey and daily health choices on their social channels. There is no time/monetary requirement to be involved and can contribute to their comfort level. All ambassadors are prominently featured on the Show Your Love social media, website, newsletters and partner sites.

An authentic voice in the community: We’ve seen great success linking the ambassadors with each other, building an online forum for sharing and support, and better reaching consumers in an authentic way.

Show Your Love Ambassador: LaTiana Ridgell, President Preconception Peer Educators Club at Drexel University

“As president of Drexel Preconception Peer Educators, I wanted my peers to see how they could incorporate preconception health practices in their everyday life.”

We’re just getting started! PCHHC is creating a hub for virtual connecting and collaborating in the preconception field. Continuing to establish a national network of community members, organizations and professionals, we’re now getting on-the-ground to expand our partnership, further engage and create change in the lives of young adults.

Raising Women's Voices for the Health Care We Need Health Insurance Literacy that Works

Amy Zarin, BA, MA, Outreach Fellow

Raising Women's Voices for Health Care We Need

In Fall 2014, an enroller on the South Side of Chicago helped a woman in her 20's get health insurance for the first time. The young woman had not been to a doctor since an acute medical issue years ago, so the enroller offered to schedule an appointment for her at a federally qualified health center. The woman replied, "That's fine, but how do I know I'm going to be sick then?"

Scenarios like this were playing out all over the country. Raising Women's Voices' Regional Coordinators in 28 states told us that the women they helped enroll in health insurance were confused about how to use their coverage. The concept of preventive care -- let alone the term "Well-Woman Visit" -- was totally foreign to many.

Our Regional Coordinators made it clear that they didn't need more of the usual corporate --looking brochure-ware to hand out. Together we set goals for our communications:

1. Make it simple!
2. Use graphics to increase understanding.
3. Boost women's levels of confidence about using their health insurance.
4. Make it a resource women will actually use on an ongoing basis.

We tapped into experts including women's primary care providers, insurance policy experts, a professor of health literacy and professional graphic artists. We developed a health insur-

ance literacy campaign called "My Health, My Voice." It includes a website, a guide, a journal, and fact sheets in English and Spanish. Below are excerpts from the "What Is a Well-Woman Visit?" fact sheet, created to help women understand and use this preventive care benefit, which became free in health insurance through the Affordable Care Act.

In addition to educating women about what happens during a Well-Woman Visit, we empowered them to get the most out of their appointment. We created a Personal Health Journal for women to take to their Well-Woman Visit and other appointments. Designed to fit in a handbag, it is a place women can record their thoughts, organize family health history, and take notes during provider visits.

Before finalizing the materials, we tested them with the actual women for whom they were intended. Our Regional Coordinators hosted focus groups in 14 states and shared with us what they learned. We also analyzed pre- and post-surveys from participants. We learned that the materials really worked!

Some of the comments from our Regional Coordinators who led the focus groups were:

"They found the materials very easy to use, really liked the graphics and said that they would definitely find it helpful." (Oregon)

"Participants thought the multi-ethnic cartoons were refreshing." (Georgia)

"A recent immigrant, who had limited English proficiency, said these were especially helpful for her as it gave her the right words to use." (Illinois)



Amy Zarin

In the past two years, advocates have distributed over 20,000 printed My Health, My Voice materials to women through workshops, tabling events and enrollment sessions. All the materials we created in English and Spanish are available as free downloads at www.myhealthmyvoice.com/get-a-copy. In addition we have a limited supply of printed copies of My Health, My Voice: My Personal Health Journals and three fact sheets ("5 Steps to Using Your Health Insurance Wisely," "The 4 Kinds of Costs You May Pay," and "What Is A Well-Woman Visit?").

About Raising Women's Voices
RAISING WOMEN'S VOICES for the Health-Care We Need is a national initiative working to ensure women's voices are heard and our concerns are addressed in health care reform. The RWV Health Literacy Team specializes in making complex health care concepts easy for low-literacy populations to understand.

Please feel free to contact me for help with your projects, Amy Zarin at:
amy@raisingwomensvoices.net. Learn more at: www.raisingwomensvoices.net.

What happens at a well-woman visit?

1. You and your Primary Care Provider (doctor or nurse practitioner) will talk about your health history, your family's health history and how your lifestyle may affect your health. Then you will discuss goals for your health.
2. Your doctor will examine you and do screening tests to see if you have health conditions that need to be treated. She or he will also give you any vaccines you need, like a flu shot.
3. Your doctor should ask you whether you want to become pregnant or need contraception. Birth control is now covered without any additional cost to you. This includes both birth control pills and methods like IUDs, which cost more to get, but work much longer.

What happens during your well-woman visit may depend upon your age, your health conditions and how long it has been since you had your last check-up.



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The 2017 CityMatCH MCH Leadership Conference & Healthy Start Convention, 'Creating Harmony: Every Voice Counts' is a great opportunity for Maternal and Child Health (MCH) professionals nationwide to network, share successes, enhance knowledge, and generate new ideas for protecting and promoting the health of urban women, children and families. Whether it is your first CityMatCH conference or you've attended many over the years, all interested persons and organizations who have a stake in MCH, including Healthy Start grantees, are encouraged to register!

08/18/2017 - Early-bird registration rates end

09/17/2017 - Preconference training

09/18-20/2017 - Conference

Learn more and register at www.citymatch.org

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