

CITYLAB

Here Are the Cities Standing Up for Women's Health

ALASTAIR BOONE
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Demonstrators hold signs outside the U.S. Supreme Court
Kevin Lamarque/Reuters

Urban areas are battling state and federal authorities over reproductive rights, and some are doing better than others.

If you're looking for well-funded women's health clinics and sexually transmitted disease prevention, don't go to Jacksonville. The Florida city scored at the very bottom of a new report by the National Institute for Reproductive

Health, which ranked America's 40 most populous cities according to the breadth of their reproductive health, rights, and justice policies.

4.5 STARS	4 STARS	3.5 STARS	3 STARS	2.5 STARS	2 STARS	1.5 STARS	1 STAR
Los Angeles, CA New York, NY San Francisco, CA	Chicago, IL Philadelphia, PA	Seattle, WA Washington, DC	Austin, TX Boston, MA Minneapolis, MN Portland, OR San Diego, CA	Baltimore, MD Columbus, OH Denver, CO Fort Worth, TX Indianapolis, IN San Jose, CA St. Paul, MN	Dallas, TX Houston, TX Miami, FL Milwaukee, WI New Orleans, LA San Antonio, TX St. Louis, MO	Atlanta, GA Charlotte, NC Cleveland, OH Detroit, MI El Paso, TX Hartford, CT Las Vegas, NV Louisville, KY Memphis, TN Nashville, TN Oklahoma City, OK Phoenix, AZ Richmond, VA	Jacksonville, FL

(NIRH/Madison McVeigh/CityLab)

Jacksonville's one-star rating reflects the city's lack of numerous reproductive health protections, such as funding for abortion clinics, STI prevention campaigns, and community-based sexual education programming. Still, NIRH president Andrea Miller sees signs of hope: In February, Jacksonville passed historic legislation that prohibits discrimination against gay and transgender people. It's last city of its size to secure such protections.

"Jacksonville has taken this historic step of protecting LGBTQ people," Miller says. "That is a remarkable move. Because they've proven that the kind of organizing and engagement between the community and elected officials can move us forward. That's really what we hope people will take from this."

No city received a perfect score of five stars—meaning no city has matched each of the 37 policies tracked by the NIRH, a New York-based advocacy organization that promotes reproductive freedom. But the report, which is called the Local Reproductive Freedom Index, provides a blueprint for what cities are doing well already, and how they can increase access to reproductive healthcare for their residents—and often for the residents of the rural communities around them, too.

“Our urban centers are the linchpin for healthcare delivery for so many people,” Miller says. “Not just for their own residents, but for those who live tens if not hundreds of miles away.”

Indeed, in many rural counties in the Midwest, the average woman has to drive more than 180 miles to get an abortion. In comparison, women who live closer to large cities only have to drive about fifteen miles to reach a Planned Parenthood facility or another comparable clinic.

“Municipal elected officials have a really important bully pulpit.”

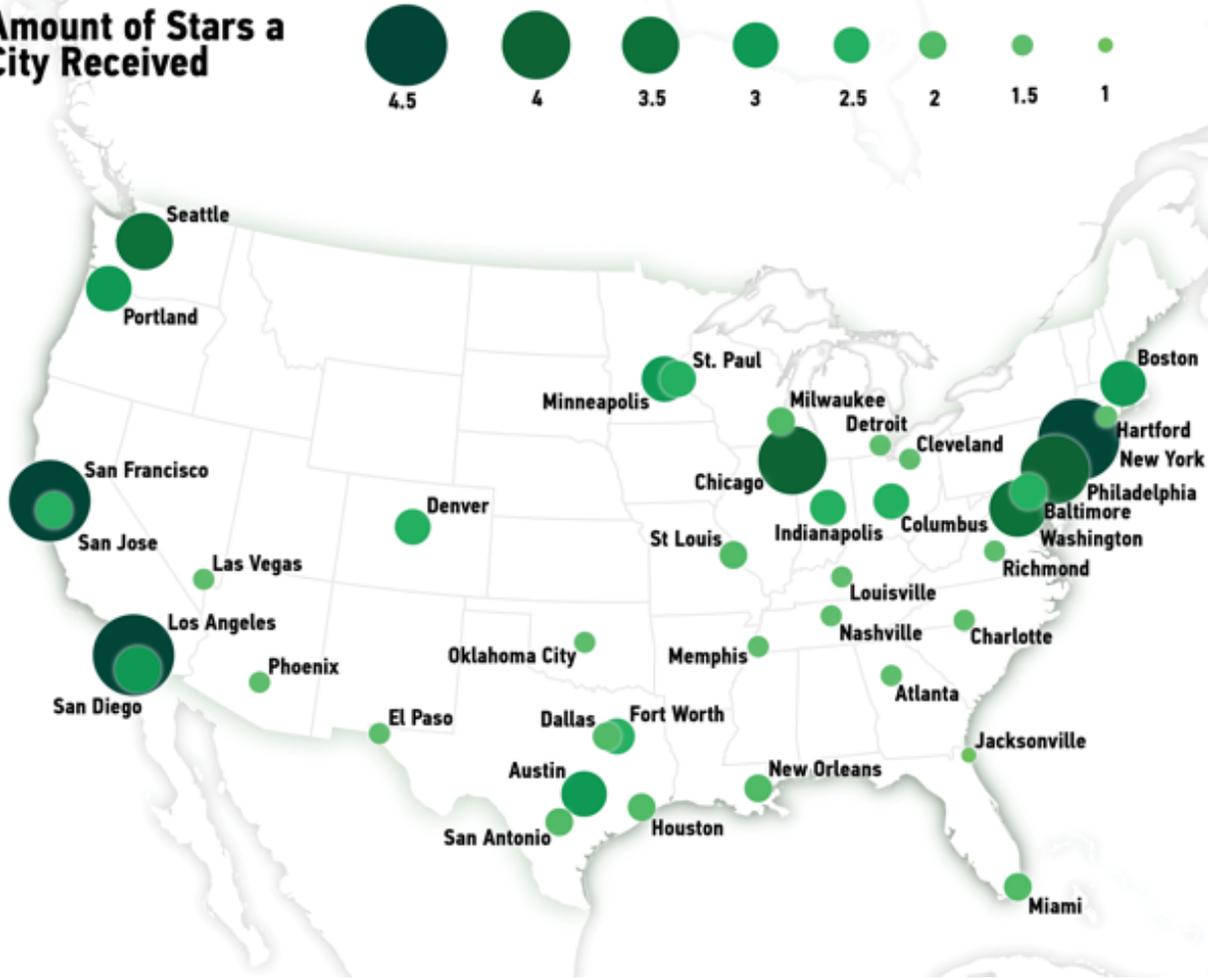
The reproductive rights ranking arrives as anxiety about reproductive health care is growing under the Trump administration. In January, the president appointed Supreme Court Justice Neil Gorsuch, who’s expected to be a foe of abortion rights, and reinstated the “global gag rule,” which halts U.S. funding to international NGOs that provide, or promote, abortion services. In July, the Trump administration cut the Teen Pregnancy Prevention Program two years short, in the middle of a five-year funding period that supported community-based approaches to ending teen pregnancy. And in October, the president announced a new rule that allows employers to opt out of birth control coverage in their health insurance plans.

Not surprisingly, it’s the progressive powerhouses of San Francisco, Los Angeles, and New York City that sit atop of the index, with 4.5 star ratings. These cities have adopted numerous protections for women and families, such as funding for abortion and sex-ed, support for anti-discrimination policies, and a \$15 minimum wage (New York City plans to raise its minimum wage to \$15 by 2019). On the whole, larger coastal cities with long histories of investment in social justice causes score the highest.

The average score of all 40 cities was two stars, and even high-scoring cities have room to make improvements. San Francisco, for example, lacks protective zoning regulations around abortion clinics, and New York City has yet to fully defund so-called crisis pregnancy centers, which sometimes masquerade as full-service reproductive health clinics.

Some cities are working to protect access to controversial women’s health services, even as their GOP-led state legislatures seek to eliminate those protections. Columbus, Ohio, for example, passed the “Healthcare Workers and Patient Protection Ordinance” in 2016 to establish 15-foot buffer zones around clinics, within which certain behaviors are strictly penalized. Similarly, in 2015, Illinois’ Cook County ensured abortion coverage for low-income women in a local effort led by the NIRH, the Chicago Abortion Fund, and the Illinois ACLU. In both of these cases, such efforts have come after state or federal actions that threaten these protections.

Amount of Stars a City Received



Rankings by NIRH. Map by Soren Walljasper.

The report offers creative solutions to pro-choice lawmakers in cities like St. Louis that might have to work harder against conservative state governments, or hometown cultures, to advance reproductive freedom. To get higher minimum wages and more paid family leave, for example, city officials can insist that tax incentives for companies are linked to living wage and comprehensive benefits requirements. Similarly, cities can ensure that health services for municipal employees include counseling on contraception and reproductive health options, including abortion.

“Every city has a budget. Every city makes decisions about how they use their budgetary power,” Miller says. “Municipal elected officials have a really important bully pulpit. Standing up not only sends a powerful message, but it’s also the beginning of change. That’s why we did this.”

About the Author

Alastair Boone

@ALASTAIRBOONE, Alastair Boone is an editorial fellow at CityLab.

LOCAL REPRODUCTIVE FREEDOM INDEX



2017 | EVALUATING U.S. CITIES

A PROJECT OF



The Local Reproductive Freedom Index: Evaluating U.S. Cities is a first-of-its-kind initiative that evaluates the reproductive health, rights, and justice policies of 40 cities across the United States.

Cities have a critical opportunity to innovate in ways that advance reproductive freedom for their residents, and to mitigate a hostile climate created by state and federal governments. The Local Index analyzes the policies in place in 40 of the nation’s most populous cities, identifies trends among cities that are successfully improving the reproductive health and lives of their residents, and offers suggestions for how cities can maximize their potential to gain ground on reproductive freedom.

Some examples of the ways that cities demonstrate a commitment to reproductive freedom include (1) protecting abortion clinic

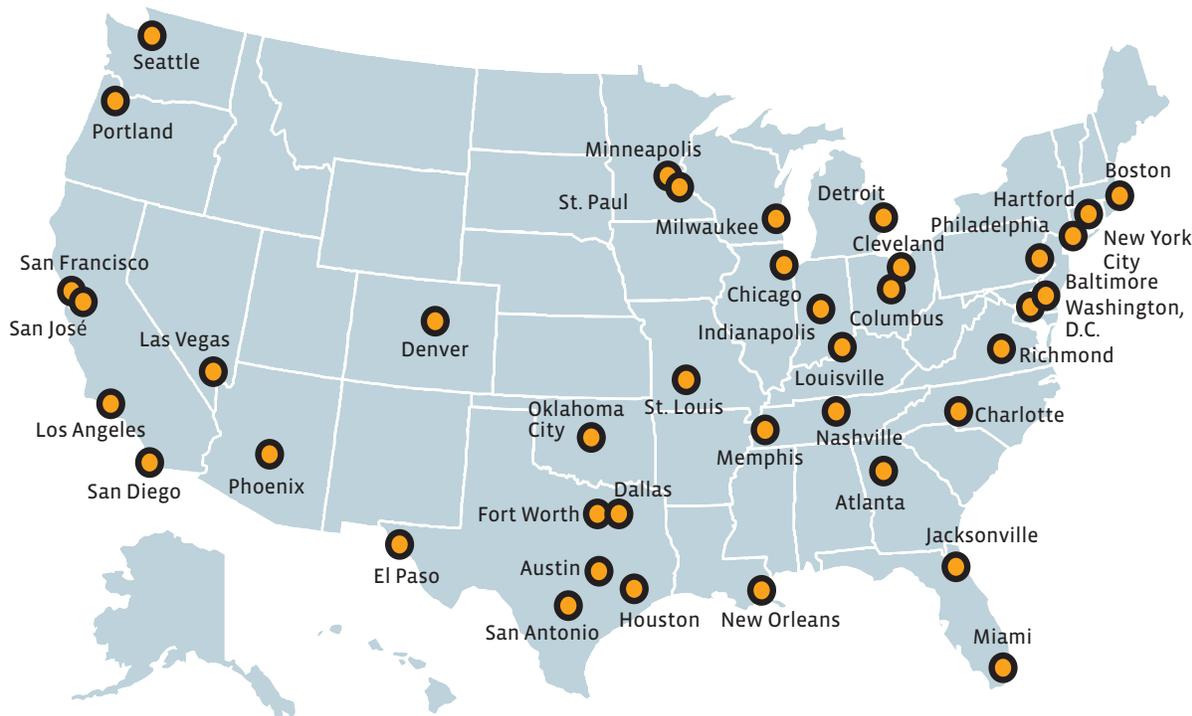
access, (2) providing funding and coverage for reproductive health care, (3) supporting young people’s access to reproductive health care, (4) supporting families’ ability to be financially stable and lead healthy lives, (5) advancing inclusive policies, and (6) taking a stand on reproductive health care issues at play at the local, state, or federal level.

How the Cities Scored

The National Institute for Reproductive Health (NIRH) tracked 37 possible policy indicators within the six categories above, most of which have been adopted by at least one city, and then assigned each city zero to five stars, based on which policies it has in place. Some of our findings include the following:

- The range of scores was 1-4.5 stars. The average score for the 40 cities was two stars.
- No city achieved a perfect score. **Los Angeles,**

Cities Featured in the Local Index



City Scores

4.5 STARS Los Angeles, CA
New York, NY
San Francisco, CA

4 STARS Chicago, IL
Philadelphia, PA

3.5 STARS Seattle, WA
Washington, DC

3 STARS Austin, TX
Boston, MA
Minneapolis, MN
Portland, OR
San Diego, CA

2.5 STARS Baltimore, MD
Columbus, OH
Denver, CO
Fort Worth, TX
Indianapolis, IN
San José, CA
St. Paul, MN

2 STARS Dallas, TX
Houston, TX
Miami, FL
Milwaukee, WI
New Orleans, LA
San Antonio, TX
St. Louis, MO

1.5 STARS Atlanta, GA
Charlotte, NC
Cleveland, OH
Detroit, MI
El Paso, TX
Hartford, CT
Las Vegas, NV
Louisville, KY
Memphis, TN
Nashville, TN
Oklahoma City, OK
Phoenix, AZ
Richmond, VA

1 STAR Jacksonville, FL

New York City, and **San Francisco** each received the highest scores of 4.5 stars. Of these three cities, San Francisco has the most policy solutions in place.

- The highest-scoring cities tend to be significantly larger and located in relatively progressive states on the coasts. These cities generally have large budgets that give them a greater ability to implement progressive policies. They also have a long history of advancing social justice causes and have made a renewed commitment in recent years to addressing racial disparities and building a more equitable culture.

Noteworthy City-Specific Highlights

Among top-scoring cities, some of the highlights include that **San Francisco** led the way in developing an innovative strategy to regulate the deceptive practices of crisis pregnancy centers (CPCs); **New York City** coordinated an initiative to increase quality training in abortion care for residents in city medical schools; and **Los Angeles** has made a commitment to comprehensive health care for all residents, including immigrants who are ineligible for federal health care.

Cities not typically recognized as coastal bastions of progressive politics, such as **Baltimore**; **Columbus, OH**; and **Oklahoma City** also established important milestones for reproductive freedom. In Baltimore, students are able to access the full range of contraception, including long-acting reversible contraceptives (LARCs), at their school-based health centers (SBHC). In Columbus, a citizen-led effort resulted in the passage of a clinic safety measure to protect patients and clinic staff from harassment by protesters. Oklahoma City recently passed a resolution to protect its LGBTQ population from discrimination in housing.

Finally, several other cities have adopted especially innovative policies worthy of special note. In **Cook County, IL (Chicago)**, and **Travis County, TX (Austin)**, local initiatives helped cover the cost of abortion for those without coverage; while Travis County's initiative was preempted by state policy, Cook County's remains in place. **Boston's** holistic District Wellness Policy for its school system provides a model of what comprehensive sexuality education (CSE) should be, recognizing the importance of K-12 education that is LGBTQ-inclusive. **St. Louis, MO** stepped up its advocacy in 2017 by passing an ordinance to protect its residents from discrimination based on their reproductive health decisions, despite threats from the state to preempt it.

Trends in Local Advances in Reproductive Freedom

Leading the resistance: One of the trends that quickly emerged from the 40-city analysis is the role that localities play in leading the resistance to the Trump administration's attempts to dismantle the country's safety net and target the most under-represented populations here and abroad. For example, by 2016, 21 cities¹ evaluated in the Local Index already had policies opposed to Trump's anti-immigrant agenda, and several cities have begun to reaffirm and even strengthen their policies that protect immigrants.

Protecting abortion access and speaking up for reproductive freedom: The open hostility to reproductive rights on the federal level has heightened and compounded the existing challenges to accessing abortion care, whether it is even more aggressive harassment from protestors at abortion clinics, the proliferation of deceptive CPCs, or further state-level restrictions on abortion. From 2015 to 2017, eight cities² in the Local Index have continued to enforce or have enacted new clinic safety ordinances to protect staff, volunteers, and patients. And city leaders have used their public platform to take a stand against the federal government's harmful rhetoric and destructive policies — nine cities³ have passed progressive resolutions urging Congress to take action on federal policy, such as by passing the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act, passing the Women's Health Protection Act (WHPA), and by opposing the Prenatal Nondiscrimination Act (PRENDA). Eleven cities⁴ passed resolutions endorsing an affirmative stance on other state or federal reproductive health care issues.

Supporting sexual and reproductive health: Cities are used to working to improve health care for residents, and a substantial number in the Local Index have made advances in this arena, such as by providing their own funding for sexually transmitted infection (STI) prevention and treatment (32 cities⁵) and family planning (23 cities⁶), training health care

providers in aspects of reproductive health care such as cultural competency or youth-friendly care (10 cities⁷), and funding for contraception (23 cities⁸).

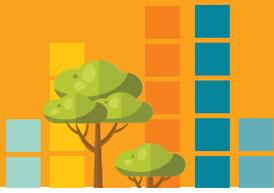
Educating the next generation: Education has long been considered primarily a local responsibility, making it a customary and high-level priority for many cities. As a result, cities often lead in developing creative ways to support young people in their communities. Seventeen cities⁹ in the Local Index have some form of a CSE curriculum. Twenty-eight cities¹⁰ provide some form of reproductive health care in at least one SBHC.

The Model City

Since none of the 40 cities evaluated — and, indeed, no city in the United States — has achieved everything it can to advance reproductive freedom, the Local Index also outlines a Model City. This is essentially the blueprint for a city that uses the full extent of its policy and programmatic powers to foster thriving families, support people's reproductive and sexual health decisions, and destigmatize abortion and contraception. The Model City is undoubtedly aspirational, but ultimately achievable.

This Local Index is the logical outgrowth of NIRH's history of advocacy for reproductive health, rights, and justice at the municipal level. It recognizes the leadership of those working in cities to improve the health and well-being of the women¹¹ and families in their communities. It also serves as a call to action and a roadmap, identifying opportunities for progress and providing models they can draw upon for inspiration. Advocates and policymakers can refer to the Local Index now and in the months and years to come for instructive guidance to push back against hostile state and federal climates and improve reproductive freedom for residents of their cities.

WHY A LOCAL REPRODUCTIVE FREEDOM INDEX?



NIRH envisions a world in which everyone has the freedom and ability to control their reproductive and sexual lives. Today, the prospects for achieving this vision may look bleak, as reproductive health, rights, and justice are under unprecedented attack at the federal and state levels. Yet, municipalities stand ready to resist and advance.

Nimble and powerful, cities frequently serve as engines of progress, directly challenging regressive federal and state policies with initiatives that strive to give their residents the opportunity to achieve their full potential and lead safe, healthy lives. Cities have also become the key access points for reproductive health care, even for those who may live many hours away from the nearest urban area.

For these reasons, it is an opportune time to build upon the impressive work that has already taken place at the local level to further enable cities and counties to become safe havens for reproductive freedom by sharing lessons learned and identifying new areas of promise.

Progressive, “blue” cities located in similarly “blue” states, for instance, have shown that they can be pioneers, developing cutting-edge policies that lead the way for their state and the nation.

In **St. Paul, MN**, for example, a successful city-level paid family leave policy became a catalyst for the state government to follow suit.¹² A recent **San Francisco** ordinance highlighted the importance of regulating CPCs, and the state of California soon followed with a statewide measure requiring these centers to make clear the services they do and do not provide. The **Cook County** Board of Commissioners’ resolution calling for both repeal of the Hyde Amendment and passage of the EACH Woman Act in Congress was an important factor in Rep. Jan Schakowsky’s (Illinois’ 9th Congressional District) decision to sign on as a sponsor of that federal legislation.

Blue cities located in more conservative, “red” states play a critical role in protecting access to reproductive health care, including abortion, particularly as their state legislatures seek to undermine, if not eliminate, those services.

Promoting proactive policy at the local level in these states can also serve to refresh and reenergize activists and advocates who, too often, face setbacks on the state level. Municipalities such as **Louisville, KY; New Orleans, LA; St. Louis, MO**; and several large cities in **Texas** have each taken important steps in this direction. NIRH celebrates the commitment and drive of the leaders in these cities in particular, who often have to work twice as hard to pass the policies and implement the programs discussed in this report, overcoming both political barriers and cultural stigma.

Yet while much that is documented in the Local Index deserves praise, it is also clear that cities can do more to expand access to abortion specifically and reproductive and sexual health information and services more broadly, and to voice their support for such policies at every level of government that can advance those goals. The demonstrated success of other social justice movements, evidenced by the economic, LGBTQ, and immigrants' justice policies

many cities have in place, suggests there is much potential for further progress. There is also a thriving progressive culture, to varying degrees, in the 40 cities profiled, and a growing reproductive justice movement, which, by its nature, is a local movement as it focuses on a broad range of intersecting issues and oppressions coupled with a strategy to build power in the communities most impacted by them.

In creating this Local Index, NIRH has built upon its long history of policy advocacy across the country, including a decade of experience at the local level. In 2008, NIRH launched the Urban Initiative for Reproductive Health to serve as a catalyst for progress for reproductive health, rights, and justice. At the time, not many advocacy efforts focused on the local level, despite the robust possibilities for cities and counties to improve reproductive health outcomes. Since then, through the Urban Initiative alone, NIRH has provided more than a million dollars in funding and millions more in strategic and technical support for local-level advocacy to 58 organizations in 50 cities, across 24 states and the District of Columbia. This is in addition to our state partnerships, which total 33 partners in 37 states. NIRH has also sustained a robust network that now connects hundreds of advocates, elected leaders, and public health officials across the country.

After years of unprecedented attacks on reproductive freedom in states across the country, cities have become centers of reproductive health care even for those who may live many hours away from the nearest urban area.

MODEL CITY



PROTECTING ABORTION CLINIC ACCESS

Abortion clinics are easily accessible and the city takes all measures to ensure comprehensive, safe, affordable, integrated reproductive health care.

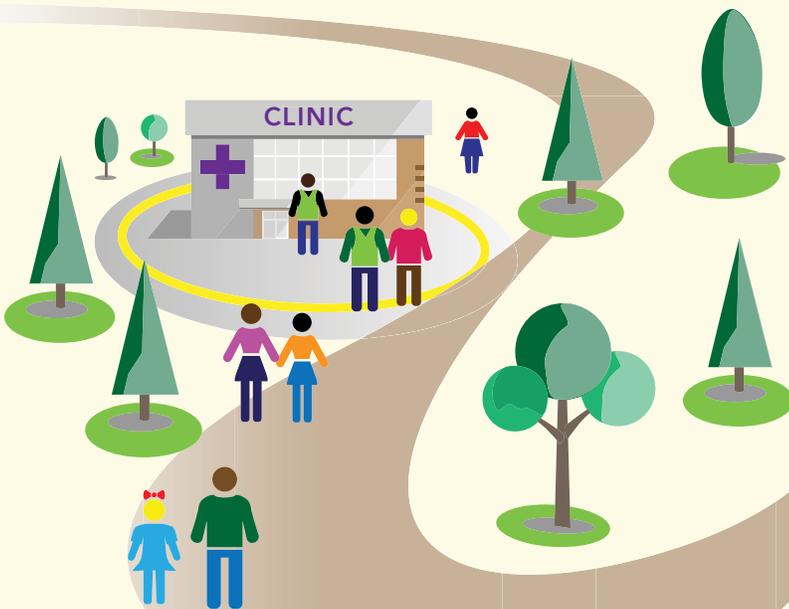
- Local government sees abortion clinics as a vital part of the health system.
- Clinic protections are in place and police respond quickly and supportively to clinic threats.
- The city regulates crisis pregnancy centers and informs the public about their deceptive practices.
- Comprehensive pregnancy-related care is accessible.



SUPPORTING YOUNG PEOPLE

Young people in the community have the information and services they need to lead full and healthy lives.

- The city requires age- and developmentally appropriate K-12, LGBTQ-inclusive comprehensive sexuality education.
- Every middle and high school has an LGBTQ-friendly school-based health center that provides reproductive health care.
- Schools have support services available for young parents.



BUDGET OFFICE



FUNDING AND COVERAGE FOR REPRODUCTIVE HEALTH CARE

The city uses its budget to convey its values of supporting reproductive health and rights.

- Funding is available for comprehensive sexuality education and reproductive health care, including abortion.
- The city supports training for family planning providers.
- Crisis pregnancy centers do not receive city funding.

The Model City uses the full extent of its policy and programmatic powers to support the freedom and ability of each person to control their reproductive and sexual lives, foster thriving families, and destigmatize abortion and contraception. Grounded in current realities rather than representing a utopia, the Model City provides a framework that all localities can strive to meet today.



ADVANCING INCLUSIVE POLICIES

The city is committed to nondiscrimination.

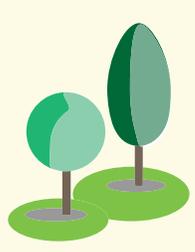
- All people are protected from discrimination on the basis of sex, gender identity, sexual orientation, pregnancy, familial status, childbirth or pregnancy-related conditions, reproductive health care decisions (including abortion), race, ethnicity, nation of origin, citizenship status, age, religion, ability, source of income, housing status, military or ex-offender status, age, and prior psychiatric treatment.
- The city forbids municipal employees and employers operating within the city from engaging in discrimination.



SUPPORTING FAMILIES

The city supports residents' right to parent, support themselves, and access health care in a safe environment.

- A strong health care safety net, including family planning services, is in place.
- The minimum wage is a living wage and paid family leave is available.
- Undocumented people can safely and confidently access reproductive health care.
- All incarcerated women can access non-coercive, comprehensive reproductive health and pregnancy-related care.
- Environmental regulations are in place to protect residents' reproductive health.



TAKING A STAND

The local government takes a stance on reproductive health, rights, and justice issues that impact its city.

- The city serves as a safe access point for reproductive health care for the surrounding region.
- The city develops cutting-edge policies and programs that increase access to reproductive health care, including abortion.
- The city is a leader in opposing restrictions on reproductive health and uses its voice to destigmatize reproductive health care.



LOOKING AHEAD

WHAT POLICYMAKERS AND ADVOCATES CAN DO



Advocates and policymakers, including mayors, city councils, county commissions, departments of health and education, and other local agencies, can use the Local Reproductive Freedom Index and their City Scorecard as an opportunity to work together to respond to the challenges specific to their municipality.

Effectively addressing pressing reproductive health issues at the community level requires collaboration between public officials, constituents, advocacy organizations, and other stakeholders. Working with community partners and health policy experts will ensure that city and county policymakers select the most-needed and appropriate solutions. Collaboration between government officials and the community to determine the most pressing reproductive health needs in any particular locality may lead cities to adopt some of the recommendations listed within this report, or may yield new and innovative ideas that are not yet included here but are the most appropriate for the local circumstances.

As a starting point for such discussions, NIRH offers the following recommendations.

1

Ensure safe access to comprehensive reproductive health care that includes abortion, options counseling, and the full range of contraceptives.

Cities serve as the sites where reproductive health care is accessed not only by city residents, but often by people who live in surrounding areas. Ensuring safe access to comprehensive reproductive health care entails a variety of protections to ensure safety and accessibility.

Strategies to Consider:

✓ Clinic safety is hyperlocal; every clinic has its own geography, community setting, and level of harassment or community support, and solutions must be based on each city's specific situation. Depending on the setting and circumstances,

policies to protect clinics may include “buffer” or “bubble” zones drawn around the clinics, anti-harassment ordinances with heightened penalties near health care facilities, noise ordinances that ensure that patients are not subjected to harassment, or residential picketing ordinances that protect providers and clinic staff.

✓ Identify the deceptive or otherwise harmful practices of CPCs within the locality and creating regulations to address them can ensure that those seeking reproductive health care are not misled or harmed by deception, fraud, or coercion. These types of regulations are also hyperlocal, and may include regulations on advertising or consumer fraud protections.

✓ City-funded health services should include comprehensive counseling on contraception and reproductive health options, including abortion.

2

Build healthy and safe communities by funding community-informed services and programs that advance access to reproductive health care.

Many cities and counties face tight budgets, and new challenges are yet to come from changes in state and federal funding streams that may stretch them even further. Nonetheless, investing city resources in reproductive and sexual health is one of the most direct ways to impact the health and lives of residents, raising the level of health and safety for all, and such an investment may ultimately conserve city resources down the line. Officials should work to find dollars in their budget to invest in needed initiatives.

Strategies to Consider:

✓ Provide access to abortion and the full range of contraceptive methods for those who cannot otherwise afford them can greatly enhance the health and well-being of low-income residents and

immigrants who are not eligible for Medicaid. Funding abortion is especially vital given federal and state bans on insurance coverage for abortion like those codified in the Hyde Amendment.

✓ The city’s advertising budget can be used to promote reproductive health, including developing and running public awareness campaigns on contraceptive choices or STI prevention, or to encourage city residents to seek pregnancy care at comprehensive reproductive health care facilities, rather than deceptive CPCs. Such campaigns should not use shame or stigma; instead, they can serve as an important culture change strategy by normalizing discussions of sexual health and sexuality.

✓ Invest in or seeking funding to train local service providers, including health care providers and clinic staff, social workers, and counselors, can enhance care to reflect the city’s values. Such trainings could cover topics such as cultural competency in health care provision, teen-friendly health care, or the reproductive health care needs of trans and gender non-conforming people. Health care providers may benefit from training in new skills such as LARC insertion or removal and abortion care; cities can also ensure that training in these skills is incorporated into the curricula for residents learning in local hospital systems.

✓ Communitywide collaborative projects are ideal ways to address racial or economic disparities in health outcomes, such as reducing infant and maternal mortality or local epidemics of specific STIs.

3

Support young people by providing the information and services they need to make informed and empowered decisions about their reproductive health.

Cities have an important role to play in ensuring that policies, services, and school curricula support young people in making informed choices about

their health and that they have access to the care they need. Initiatives focused on schools should offer carrots, not sticks, to overstretched school systems by offering the support they need to implement such policies.

Strategies to Consider:

- ✓ Require medically accurate, comprehensive, LGBTQ-friendly sexuality education from K-12th grade in schools. Policies should ensure adequate training for all teachers and should track, enforce, and evaluate the effectiveness of the mandate.

- ✓ Require SBHCs to offer reproductive health care, enabling students to get the care they need despite barriers like cost, transportation, and the need for confidentiality.

- ✓ Provide pregnant and parenting youth with the services and accommodations they need to continue and complete their education in a supportive, non-stigmatizing environment, including resources for breastfeeding, childcare options, and an appropriate policy on absences.

4

Build a community where each person is able to decide whether to “have children, not have children, and parent the children they have in safe and sustainable communities.”¹³

The reproductive justice framework was created by black women in 1994 to center the needs and experiences of the most marginalized women, families, and communities. It demonstrates that creating a community that supports individuals and families and ensures safety and justice for its residents requires work that goes beyond the reproductive rights framework and touches many different points of people’s lives. Cities can and should implement

policies that provide people with the resources and security they need to make real decisions about their pregnancies, their families, and their lives.

Strategies to Consider:

- ✓ Establish a \$15 minimum wage and a paid family leave policy to sustain individuals, families, and communities. Even in states that face preemption issues, cities can use creative strategies such as requiring that companies that receive local tax breaks offer a living wage and comprehensive benefits.

- ✓ Establish a policy of non-cooperation with Immigration and Customs Enforcement (ICE) and other sanctuary city policies that can help keep families together and enable people to access services within the city without fear.

- ✓ Support reproductive justice for incarcerated women, including banning shackling of pregnant and postpartum women; ensuring access to the full scope of comprehensive reproductive health care within jails, prisons, and detention centers; and implementing alternatives to incarceration.

- ✓ Protect all people living in the city, including trans and gender-nonconforming people, from discrimination in all areas of community life, including employment, housing, and public accommodations. People should also be protected from discrimination based on the decisions they make about pregnancy or reproductive health care.

- ✓ Create policies to reduce or eliminate the use of harmful chemicals in the workplace that pose a threat to maternal and reproductive health while still ensuring that small-business entrepreneurs can thrive.

- ✓ Local departments of health and education should consider publicly adopting a reproductive justice framework and using it to inform their policy decisions, as the New York City Department of Health and Mental Hygiene has done.¹⁴

5

Adopt proclamations, resolutions, and statements that boldly demonstrate that the city strongly supports reproductive health, rights, and justice.

While resolutions and other types of policy statements themselves are largely symbolic, they can be extremely meaningful when they address issues of high media salience, are relevant to state and federal politics or policy, and/or are coupled with a strategic grassroots engagement campaign.

Strategies to Consider:

- ✓ Endorse the value and importance of abortion coverage and call for the repeal of the Hyde Amendment and similar bans. This work highlights the urgency and importance of this issue, and a resolution can identify the direct impact on the city.
- ✓ Oppose bans on sex-selective abortion. The burgeoning movement for cities to declare their

opposition to sex-selective abortion bans offers a prime opportunity for advocates and officials alike to educate the community on an abortion restriction that is often difficult to understand and to challenge stereotypes about Asian and Pacific Islander communities.

- ✓ Demonstrate support for reproductive health care, including abortion rights and access, by taking a public position on state-level ballot initiatives or pending legislation. As states continue to face restrictive bills and ballot measures in the years to come, cities should use these as opportunities to educate their residents on the impact of the policy change and to advocate for an affirmative policy instead. When multiple cities in one state can pass similar resolutions, activists and lawmakers can build community across cities and create a powerful echo chamber for this position within their state.

- ✓ Honor the work of reproductive health care providers, including abortion providers, and officially recognize their contributions to the community. Such a stance fights the stigma abortion providers often face and highlights the important role they play in the local landscape of reproductive health care provision.

CONCLUSION: CITIES WILL LEAD THE WAY

Any list of recommendations to make cities more just will inevitably be incomplete, but each of these concepts can serve as a jumping-off point for further thought and innovation from city governments. Local advocates and interested officials should work in coalition to develop new ideas and evaluate existing plans, building a stronger relationship between government and the community through the process. It is well established that the majority of the public supports reproductive rights, including abortion access, and cities should work to reflect these values. As this nation faces unprecedented attacks on the state and federal levels, now is the time for cities to continue leading the way and to offer themselves as safe havens for reproductive freedom. It is their obligation and their opportunity.

CITY SCORECARDS EVALUATING U.S. CITIES



The Local Index evaluates the reproductive health, rights, and justice policies of 40 cities across the United States. To read the full report, and to see city-specific data for all 40 cities, visit localrepro.org.



ENDNOTES

* Asterisks in endnotes denote county-level action or data.

1. Cities that have supported undocumented people's access to reproductive health care include Atlanta, GA*; Austin, TX; Baltimore, MD; Boston, MA; Chicago, IL; Denver, CO; Detroit, MI; El Paso, TX; Hartford, CT; Los Angeles, CA*; Memphis, TN; Minneapolis, MN; New York, NY; Philadelphia, PA; Phoenix, AZ; Portland, OR; San Antonio, TX; San Diego, CA; San Francisco, CA; Seattle, WA; and Washington, DC.
2. Cities that have enforced or enacted clinic safety ordinances since McCullen include Chicago, IL; Columbus, OH; Los Angeles, CA; New York, NY; Phoenix, AZ; Portland, OR; San Diego, CA; and San José, CA.
3. Cities that have passed resolutions addressing support for abortion coverage, opposition to sex-selective abortion bans, and support for the Women's Health Protection Act (WHPA) include Austin, TX*, Boston, MA; Chicago, IL*; Houston, TX; Los Angeles, CA; New York, NY; Philadelphia, PA; San Francisco, CA; and Seattle, WA.
4. Cities that have passed resolutions endorsing a pro-choice stance on various ballot initiatives or state or federal legislation include Austin, TX; Chicago, IL; Dallas, TX*; Denver, CO; Houston, TX; Los Angeles, CA; New York, NY; Philadelphia, PA; San Francisco, CA; Seattle, WA; and St. Paul, MN.
5. Cities that fund STI prevention include Atlanta, GA*; Austin, TX; Baltimore, MD; Boston, MA; Charlotte, NC*; Chicago, IL; Columbus, OH; Denver, CO; El Paso, TX; Fort Worth, TX*; Indianapolis, IN*; Las Vegas, NV*; Los Angeles, CA; Louisville, KY; Miami, FL; Milwaukee, WI; Minneapolis, MN; Nashville, TN; New York, NY; Oklahoma City, OK*; Philadelphia, PA; Phoenix, AZ*; Portland, OR*; Richmond, VA; San Antonio, TX; San Diego, CA*; San Francisco, CA; San José, CA; Seattle, WA*; St. Louis, MO; St. Paul, MN; and Washington, DC.
6. Cities that fund family planning services include Atlanta, GA*; Austin, TX*; Baltimore, MD; Boston, MA; Charlotte, NC*; Chicago, IL*; Columbus, OH; Fort Worth, TX*; Indianapolis, IN*; Las Vegas, NV*; Los Angeles, CA; Minneapolis, MN; Nashville, TN; New York, NY; Oklahoma City, OK*; Philadelphia, PA; Portland, OR*; Richmond, VA; San Antonio, TX; San Francisco, CA; Seattle, WA*; St. Paul, MN; and Washington, DC.
7. Cities that fund training for health care providers in areas such as cultural competency or youth-friendly care include Baltimore, MD; Chicago, IL; Las Vegas, NV*; Los Angeles, CA; Miami, FL; New York, NY; Philadelphia, PA; Portland, OR*; San Francisco, CA; and Seattle, WA*.
8. Cities that fund contraception include Baltimore, MD; Boston, MA; Charlotte, NC*; Chicago, IL*; Denver, CO; Fort Worth, TX; Las Vegas, NV*; Los Angeles, CA; Minneapolis, MN; New York, NY; Oklahoma City, OK*; Philadelphia, PA; Portland, OR*; Richmond, VA; San Antonio, TX; San Francisco, CA; Seattle, WA*; St. Louis, MO; St. Paul, MN; and Washington, DC.
9. Cities that have some form of comprehensive sexuality education curriculum include Boston, MA; Chicago, IL; Cleveland, OH; Columbus, OH; Denver, CO; Los Angeles, CA; Milwaukee, WI; Minneapolis, MN; New York, NY; Philadelphia, PA; Portland, OR*; San Diego, CA; San Francisco, CA; San José, CA; Seattle, WA; St. Paul, MN; and Washington, DC.
10. Cities that provide reproductive health care in school-based health centers include Baltimore, MD; Boston, MA; Chicago, IL; Cleveland, OH; Columbus, OH; Dallas, TX; Denver, CO; Detroit, MI; Fort Worth, TX; Hartford, CT; Houston, TX; Indianapolis, IN; Jacksonville, FL*; Los Angeles, CA; Milwaukee, WI; Minneapolis, MN; New Orleans, LA; New York, NY; Oklahoma City, OK*; Philadelphia, PA; Portland, OR; San Diego, CA; San Francisco, CA; San José, CA*; Seattle, WA; St. Louis, MO; St. Paul, MN; and Washington, DC.
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The National Institute for Reproductive Health

(NIRH) builds power at the state and local level to change public policy, galvanize public support, and normalize women's decisions about abortion and contraception. Through our partnership model, we provide state and local advocates with strategic guidance, hands-on support, and funding to create national change from the ground up. We build connections within and across states, arming our partners with the latest knowledge and best tools to advance reproductive freedom for the people in their communities.

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14 Wall Street
Suite 3B
New York, NY 10005
Tel. 212-343-0114
info@nirhealth.org
www.nirhealth.org



Advancing Reproductive Freedom in Your City

A TOOL FOR LOCAL POLICYMAKERS

THE LOCAL REPRODUCTIVE FREEDOM INDEX: EVALUATING U.S. CITIES 2017 (LOCAL INDEX) is a first-of-its-kind initiative by the National Institute for Reproductive Health (NIRH) that evaluates the reproductive health, rights, and justice policies of the 40 most populous metropolitan areas/municipalities in the United States. As the federal government and many state legislatures continue to attack reproductive freedom, now is a pivotal time for cities to ensure that their residents and all who come there have the ability to control their reproductive and sexual lives. The Local Index can help local advocates, community leaders, elected officials, and others interested in encouraging a locality to use the full extent of its policy and programmatic powers to foster thriving families, support people’s reproductive and sexual health decisions, and destigmatize abortion and contraception.

This tool provides guidance to local policymakers and elected officials, including mayors, legislators, and administrators, on how to work with local advocates to use the Local Index to develop a vision and strategy to achieve reproductive freedom in their cities.

Engaging Advocates and Constituents

Policy development can most effectively be done in partnership with the advocates who have been working to advance reproductive freedom and the communities impacted by the problems that need to be solved, including the community-based organizations and grassroots leaders who know their communities well. Working with community groups and a wide array of stakeholders creates a mutually beneficial relationship that, among other things, will help you:

Uncover new perspectives on various issues and how they are impacting the community you serve;
Ensure your and/or your city’s effort is coordinated with existing work already happening;
Identify possible blind spots you have about a policy’s impact or potential unintended consequences;
Establish community trust and develop key validators for your work, who can directly connect you to the communities you and other policymakers are trying to reach; and
Create buzz for the project and build support to help mitigate any pushback you may receive from opponents.

What to Know Before You Start

Community engagement can happen at one-time or recurring events throughout your advocacy and implementation. Early and ongoing engagement will build stronger relationships and foster greater community understanding.

Consider using the following community engagement strategies based on your capacity and needs:

ONE-TIME EVENTS

Host a town hall Q&A or community conversation about the Local Index, its findings, and what it means for your city.

Convene a panel of experts or a facilitated roundtable conversation on a challenge you are facing in your community and a potential solution covered in the Local Index to educate stakeholders, colleagues, and yourself on the issue, and then ask for comments and ideas.

Share your City Scorecard or the Model City on social media and ask followers for their comments and feedback.

ONGOING PARTNERSHIPS

Develop an advisory board composed of experts and community members affected by the issues at hand. Create a feedback loop so you are tapped in to the impact of your work and new challenges or opportunities that arise.

Empower stakeholders to educate the community about the issue; consider using the Local Index as a starting point. Community members can also help you implement a new policy by educating the community about its impact, such as by running a “Know Your Rights” campaign. A diverse taskforce can help you reach individuals who might otherwise be left out.

Find a coalition of organizations and grassroots advocates dedicated to your area of interest. Cultivate a relationship with them and collaborate on advocacy, so they can inform your work and activate supporters when needed. Use the Local Index’s tools to help you develop your agenda with these partners.



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Make sure to ask your community what resources they need to participate, such as compensation, child care, or meetings at a specific time of day, and do your best to accommodate them. If there are needs you cannot meet, be transparent about that and, if possible, explain why and offer an alternative way people can offer feedback.

Be clear with participants from the beginning on how you will use their input, so they understand to what extent you are likely to use their advice in making final determinations. How much weight will their input have? What will happen if members of the City Council or another body disagree with their recommendations?

Establish next steps at the end of every conversation that outline how those who would like to stay involved can do so.

Always follow through on commitments you make and let community members know what you did with their feedback.

If you are not sure who the advocates in your community are, contact NIRH staff at localrepro@nirhealth.org, who can put you in touch with local organizations or individual community leaders.

Building Your Policy Agenda

You can use the Local Index to brainstorm potential policy solutions that will address the needs, concerns, and challenges you have heard. Together with the advocates that work in your community, review the Model City, the Scorecards, and the policy recommendations and assess the following:

Which policies relate to the most pressing challenges in your community?

Which policies seem to be in line with the values of your community and coalition?

Which policies seem the most achievable?

What policies have been instituted in cities similar to yours (whether in terms of geography, demographics, financial resources, or political makeup)?

Which policies are advocates and community members most supportive of and able to contribute to?

Then, work with your staff, advocates, and constituents to develop a campaign plan and identify how everyone can help move it forward and win.

How Your Office Can Advance Reproductive Freedom

No matter your position in government, the Local Index is a useful tool for moving your policy agenda forward. Drawing upon input and support from your community, you can:

Set forth a long-term, overarching vision for reproductive freedom in your city, creating a compendium of options appropriate for your city from the Model City and policy recommendations.



Introduce legislation, issue executive orders, or identify policies or initiatives that your agency can launch to advance reproductive health, rights, and justice.

Use the Local Index as a resource for educating fellow lawmakers or other policymakers.

Use the Comprehensive Scorecard as a benchmark for how your city is currently doing and to demonstrate your success after key policy achievements.

Identify cities that you can learn from, or provide guidance to, if they are facing similar challenges or pursuing similar policy goals.

Address your community's most pressing challenges, needs, or opportunities through creative strategies, such as public education campaigns to reduce stigma around reproductive health care or the establishment of a new data collection initiative.

How to Talk About Reproductive Freedom

Reproductive freedom is a winning issue across the country. Research shows that the vast majority of voters support abortion access, disagree with the rollback of our reproductive freedoms, and can be mobilized by strong support for defending and expanding access to reproductive health care, including abortion. However, policies supporting abortion access may still be seen by some as more controversial than other policies included in the Local Index. For that reason, NIRH has provided the following data and research-based message recommendations that policymakers can use to confidently advocate for these policies.

Important data you should know: ¹

FACT: The vast majority of voters steadily continue to support access to legal abortion

FACT: More than 70% of voters think that if a woman has decided to have an abortion, she should have access to safe, respectful, affordable, quality abortion care, without pressure.

FACT: More than 60% of voters disagree with and are angry about the trend of recent state laws restricting access to abortion.

FACT: When voters hear about these anti-abortion laws, they want to know who is responsible for passing them and how those politicians can be held accountable, and how they can show their support for abortion access.

NIRH has conducted extensive polling and public opinion research on support for policies and positions that advance access to abortion and other reproductive health needs. Contact localrepro@nirhealth.org for details.



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Message Recommendations

Be open and specific about your support for reproductive freedom. In addition to stating that you are pro-choice, talk about why you believe in reproductive freedom and are proud to support abortion rights, contraceptive access, and/or sexuality education, and discuss what equitable access to health care will mean for the people in your community.

Educate your constituents about how state and federal policies are harming their communities. Provide examples of the impact and intent of these harmful policies, e.g., “Politicians are trying to shame, pressure, and punish women who have decided to have an abortion.” Then talk about how your platform will support residents who need to access to reproductive health care.

Use positive messages that emphasize women’s autonomy and values that underlie reproductive health care, such as control over their own lives and empowerment:

“You should control your life **at the most basic level: your body, your family, your life’s path** — and that includes the right and ability to have an abortion.”

“We need to pass laws that **respect and empower women**. [I/Name] will ensure that everyone has access to **respectful, quality, and affordable reproductive health care, including abortion.**”

Focus on the woman and what her experience should be like in accessing care:

“When a woman has decided to have an abortion, she should be able to get **safe, supportive, respectful care** in her community, **without shame or pressure.**”

Instead of ...	Say ...
They, them	We, us
Women, families	A woman, her family
Choice	Personal decisions, important life decisions
Giving details about why a woman is having an abortion	When a woman has decided to have an abortion...
Pro-choice	Supporting abortion rights
Pro-life	Anti-abortion, opponents of abortion access
Demonizing government	Focus on “some policymakers” and anti-abortion leaders
Abortion should be safe, legal, rare	Abortion should be accessible, affordable, and available in a woman’s community, without shame or pressure



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Moving Forward

Every community is different, and NIRH encourages you to adapt this tool, and the resources in the Local Index, to your community's unique culture, opportunities, and challenges. NIRH is available to provide support and technical assistance to you as needed. Contact us at localrepro@nirhealth.org with questions or for individualized guidance on using the strategies or choosing policies included in these tools.

¹ Analysis of voters' opinions on abortion restrictions and affirmative policies, NIRH/Perry Udem, 2016



THE NATIONAL INSTITUTE FOR REPRODUCTIVE HEALTH (NIRH) builds power at the state and local level to change public policy, galvanize public support, and normalize women's decisions about abortion and contraception. Through our partnership model, we provide state and local advocates with strategic guidance, hands-on support, and funding to create national change from the ground up. We build connections within and across states, arming our partners with the latest knowledge and best tools to advance reproductive freedom for the people in their communities.

Contact us at localrepro@nirhealth.org | 14 Wall Street Suite 3B, New York, NY 10005 | Tel. 212-343-0114 | nirhealth.org



After *NIFLA*: What Cities Can Do Protect Their Residents from Deception and Expand Access to Reproductive Healthcare

November 2018

Local Regulation of Deceptive Practices of “Fake Clinics” or “Crisis Pregnancy Centers”

Fake clinics, sometimes called crisis pregnancy centers, are organizations that have the core goal of persuading pregnant women and teens to choose motherhood or adoption over abortion by pushing medically inaccurate information, using deceptive advertising, and engaging in a variety of other dishonest tactics to lure women who are seeking care and information about their full range of health care options into visiting their facilities. At these facilities, women are often given misinformation about pregnancy, abortion, their own health and their rights. These facilities have been steadily proliferating all over the country and now far outnumber abortion clinics nationally. Fake clinics also target low-income women, women of color, and women on college campuses by positioning themselves in or near these communities and advertising directly to them.

For over a decade, cities and counties around the country have considered ways to address the organizations’ deceptive practices in a few different ways. Baltimore, Montgomery County, Austin and New York City all passed ordinances requiring these types of facilities to post certain signs about the services they do and do not provide – while several of those were struck down, New York City’s law was upheld in large part and is currently in effect. Hartford, Connecticut recently enacted a similar ordinance. In Wisconsin, Dane County enacted an ordinance ensuring that any organization or facility that contracts with the county to provide medical care must provide only medically accurate information with those public funds. San Francisco took a different tact, enacting a law aimed at the deceptive advertising used by fake clinics to “lure” women seeking reproductive healthcare into their facilities. That law was also upheld. While the California law called the FACT Act, discussed in detail below, was struck down, cities around the country have recognized the problem and, after *NIFLA*, continue to have options for protecting their residents from deception and for promoting access to comprehensive, non-judgmental reproductive health counseling and services.

Background on *National Institute of Family and Life Advocates (NIFLA) v. Becerra*

On June 26, 2018, the Supreme Court decided *NIFLA v. Becerra*, a case considering the constitutionality of the California FACT Act. The FACT Act had two pieces: First, licensed pregnancy had to post or distribute a statement that “California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].” Second, unlicensed pregnancy centers had to post signs in their facilities and put disclaimers in their advertising and websites that: “[t]his facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services” in multiple languages and in a “clear and conspicuous” manner. NIFLA (the National Institute for Family and Life Advocates), which operates 100 unlicensed and licensed pregnancy centers (often called CPCs or fake clinics) in California sued the state, alleging that the statute violates its First Amendment speech and religion rights. The Court held that both provisions of the FACT Act are likely unconstitutional under the First Amendment’s Free Speech Clause and remanded the case down for further proceedings.

Key Takeaways from the Decision

- The Court found that both provisions likely violated the First Amendment rights of these fake clinics because they compel the facilities to engage in speech to which they object.
- With regard to the licensed facilities, the Court specifically objected to the fact that the California law required the facilities, which are anti-abortion at their core, to mention abortion and to provide information about where to obtain a service that the Court deemed “controversial.” In addition, the Court held that California had other, more effective ways of communicating about its own Medi-Cal program that would not have burdened speech, and that this requirement was not “narrowly tailored” enough.
- With regard to the unlicensed facilities, the Court was most troubled by what it viewed as the burdensome nature of the specific requirements of the law rather than the overall concept of requiring such a disclosure. The Court pointed to the facts that the disclosures were required to be made in all advertisements, in potentially many languages and in large font that might “drown out” the facilities’ original message. The Court noted that it was not deciding here whether other laws with similar disclosure requirements but supported by a stronger record, with clearer evidence of the state’s interest, and with less burdensome requirements, could be constitutional.
- Although the decision seems to imply that the First Amendment offers incredibly strong protection against compelled speech, the Court also held that this decision was not broad enough to change the standards by which other types of laws should be

reviewed, such as abortion counseling requirements or standard disclosure laws mandated by the government from everything to cars to toothpaste.

- The entire Court, including the majority, concurrence and dissent, all seemed concerned about the way the statute appeared to be targeted at those who hold anti-abortion beliefs. Although the decision did not reach the issue, it is clear the Court would carefully review a similar statute for “viewpoint discrimination,” meaning discriminating against someone because of their viewpoint. Viewpoint discrimination is virtually always unconstitutional.

Regulating Fake Clinics After *NIFLA*

Depending on the needs of your community, NIRH believes that the below policy options are still available to cities and counties seeking to address the deception and harms caused by fake clinics.

- Consider publicly funded public education campaigns: The Court stated that California could have met its own goals in a variety of ways, including through a “public information campaign” or “could even post the information on public property near crisis pregnancy centers.” New York State and New York City have already begun engaging in public education campaigns, paired with educational materials about where women who are pregnant or think they might be can get comprehensive, non-judgmental reproductive healthcare.
- Engage in advocacy-based public education campaigns, which advocates in some states, including California, Colorado and West Virginia, have already done, such as putting up billboards informing the community that there are a certain number of fake clinics in their town or state.
- Prohibit false and misleading advertising at the city or state level.
- Determine whether the medical professionals who staff some of these facilities are following proper medical and ethical standards, and follow up with the right authorities if they are not.
- Enforce existing consumer fraud statutes where applicable.
- Ensure that any fake clinics receiving public money cannot use that money to lie to women.
- Because in some situations, requiring unlicensed facilities that pose as medical facilities to disclose that they are not medical facilities may be constitutional, such policies may be worth consideration in the future.

To learn more about these ideas and for assistance in determining what might be right for your city, contact Jenny Dodson Mistry, Senior Manager of Special Initiatives, at jmistry@nirhealth.org.



CityLights



Emerging MCH Issue | May 2017

The Well-Woman

Reproductive Health, Rights, and Justice



Focusing Attention on “Well-Women”

Improving the Whole Woman’s Health

Regan Johnson, MPH, Public Health Project Coordinator
CityMatCH

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



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.

about the realities and struggles 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.

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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

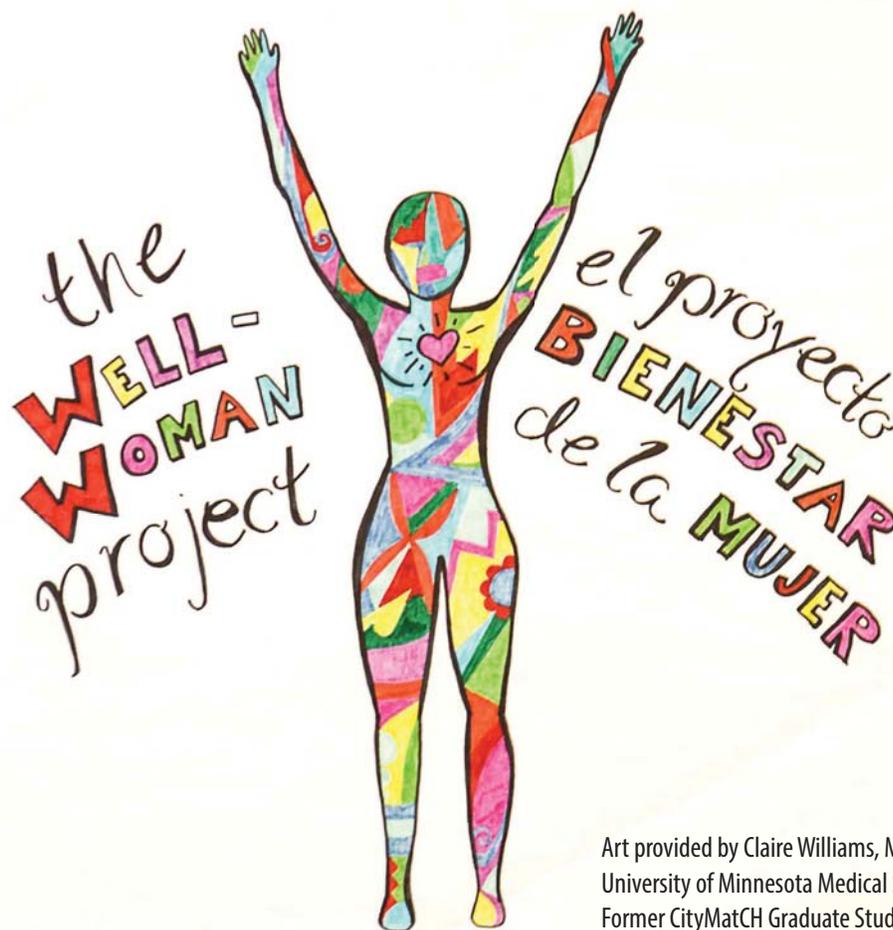
CityMatCH Reproductive Justice Ad Hoc Group

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**.



Art provided by Claire Williams, MPH
 University of Minnesota Medical School, M1, Class of 2020
 Former CityMatCH Graduate Student

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

“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.” ~ Silvia Beltran, NYC DOHMH

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=Mf-wWNYc3sUA>, “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 Tumblrseries 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

WH- 38 of 80

REPEAL HYDART PROJECT

Project Description & Background

The woman's annual preventive visit, or the Well-Woman Visit (WWV) is offered to most women at no cost to them through either their insurance or Medicaid. Although it is recommended that each woman receive at least one annual WWV, many women - even those with insurance - do not receive this care. Women without insurance have additional barriers but may be able to obtain well-woman care through community health centers or family planning clinics, although challenges remain. Receiving access to quality preventive care (e.g., age-appropriate screenings, immunizations, health education and promotion) is one factor that impacts a woman's ability to be healthy across her lifespan. However, understanding the contextual factors in women's lives, for example their opportunities for employment or good public transportation, can also help us better understand women's health. This document is based on Listening Sessions that were conducted with 156 women in 8 cities (Boston, Chicago, Detroit, Jackson, Nashville, New Orleans, Oakland, and Omaha) in the Spring of 2016 by the Well-Woman Project, as well as 104 Stories that were shared on a Well-Woman Project website/blog or phone line by women across the United States.

Themes and Recommendations from the Well-Woman Project

Theme #1: The healthcare delivery system is not woman-friendly.

- Adopt and promote a Charter which delineates the components of a woman and family friendly health delivery system.
- Engage in dialogue with large health system and Federally Qualified Health Centers (FQHCs) to encourage increased availability of appointments outside of traditional hours, drop-in/walk-in appointments, more time per patient to facilitate patient-provider interaction, and an increase in the availability of on-line phone consultation.

Theme #2: Women's competing demands and priorities make accessing healthcare difficult.

- As needed, 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.

Theme #3: Women weigh costs vs. benefits when deciding to access care.

- 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.
- Develop a city fund to cover uninsured women and families and/or to 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.

Theme #4: Relationships with providers are key to women's decisions about accessing care.

- Explore approaches to: development of a women-centered, consumer-driven mechanism to enable reviews of provider; enable women to have their health histories available on personal "apps" so that providers can readily access this information.
- Partner with: major health systems to develop and offer training to increase cultural competency/humility of the clinical workforce.

Theme #5: Health and insurance literacy empower women to advocate for themselves and others.

- Partner with health systems and other key stakeholders to support and develop health education campaigns that focus on women's understanding of the importance of their own health and health care.
- Ensure availability of 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.

Theme #6: Positive mental health is integral to being a healthy woman.

- Work with community partners to ensure the availability of community-based resources for self-care and respite.
- Support increased access to mental health care through initiatives such as psychiatric consultation lines for primary care providers and telemedicine options for patients.

Theme #7: Healthy food, safe environments, and opportunities for physical activity are vital for women.

- Explore "food prescription" approaches and/or community supported agriculture (CSA) programs through partnerships between local farms, providers, and health departments to increase accessibility to fresh fruits and vegetables.
- Work with health systems, FQHCs and other stakeholders, to explore ways to allow women and families to apply for Supplemental Nutrition Assistance Program (SNAP) through their healthcare providers.
- Work with community partners to support the provision of community-based programs focused on how to use and cook healthy foods.

Theme #8: Social support systems facilitate women's willingness and ability to seek care.

- Explore development of a cadre of women's health peer advocates who can be present at women's appointments and advertise their availability through mobile technology.
- Work with health systems, FQHCs, and other stakeholders to increase "group" approaches to care for specific types of care.

Theme #9: Lack of childcare and transportation are major impediments to accessing healthcare.

- Encourage large health systems and FQHCs to explore partnerships with ride-sharing organizations for patient transportation.
- Work with city Department of Transportation to explore and develop plans to provide child-friendly public transportation.
- Work with large health system and FQHCs to encourage: provision of free parking vouchers or free/discounted bus/train cards to attend appointments; development of play areas or supervised childcare facilities in health clinics/provider's offices.

Theme #10: Fear is a pervasive component of many women's healthcare experiences.

- Support the provision of training in trauma-informed care for providers.

Working Women Need Paid Sick Days

APRIL 2013

Every day, millions of workers in the United States are forced to jeopardize their wages and their jobs when they become sick or need to care for a sick child or loved one. For women, the inability to earn paid sick days can have particularly devastating consequences.

Women are the Backbone of Our Families and Communities

In every corner of the United States, women care for their families and also bring home a significant share of their families' income.

- ▶ Women make up nearly half the labor force.¹ Seven in ten mothers of children under 18 hold jobs,² and the vast majority contribute a substantial share of their families' income.³
- ▶ At the same time, women bear a disproportionate share of family caregiving responsibilities. Two-thirds of all family caregivers are female.⁴ Overwhelmingly, mothers have primary responsibility for selecting their children's doctors, accompanying children to appointments and helping to ensure they obtain recommended care.⁵

Too many women can't access the time they need to care for themselves and their families.

- ▶ Forty-three percent of women working in the private sector are not able to take a single paid sick day when they are ill.⁶
- ▶ More than half of working mothers (54 percent) do not have even a few paid sick days they can use to care for their sick children.⁷
- ▶ More than half of Latina workers (54 percent) and more than four in ten African American women who work (42 percent) are not able to earn paid sick days.⁸
- ▶ Workers in low-wage jobs – the majority of whom are women⁹ – are even less likely to be able to earn paid sick days. *Eighty-two percent* of workers making \$8.25 per hour or less don't have access to paid sick days.¹⁰

“One time, my son got really sick with a double ear infection, and I had to take four days off. [W]hen I returned to work I was written up and “cautioned.” I submitted notes from the doctor, but I was still disciplined. These four days were all unpaid, so I borrowed money from friends, family and neighbors for essentials like diapers and food.”

— Kim Ortiz, Retail Worker, Testimony before the Senate HELP Committee, May 2012

Women Who Can't Earn Paid Sick Days Face Impossible Choices

Women who can't earn paid sick time are forced to sacrifice their job security and ability to meet their families' needs when illness strikes.

- ▶ Forty-two percent of women have had the experience of being unable to take time off of work to care for a child; 27 percent were unable to take time off to care for a parent.¹¹
- ▶ One in five women with children (20 percent) report that they or a family member have been fired or disciplined by an employer for taking time off to cope with an illness or to care for a sick child or family member.¹²
- ▶ For the typical family without paid sick days, just 3.5 sick days without pay is equivalent to losing an entire month of groceries.¹³ For single-parent families, which are usually headed by women, the consequences are even more dire.

America's Working Families Deserve a Solution

Illness has no geographic boundaries. America's workers and communities need a national standard that allows all working people to earn paid sick days.

- ▶ Currently, no federal law guarantees workers the right to earn paid sick days. Connecticut is the only state with a law that gives some workers this basic right, along with the cities of San Francisco, Washington, D.C., Seattle and Portland, Oregon.
- ▶ The **Healthy Families Act (H.R. 1286/S. 631 in the 113th Congress)** would enable workers in businesses with 15 or more employees to earn up to seven paid sick days a year to recover from short-term illness, care for a sick family member, seek routine medical care or deal with the effects of domestic or sexual violence.
- ▶ A national paid sick days standard would ensure that working women have the job stability and economic security they need to take care of themselves and their family members.

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The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.NationalPartnership.org.

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The Black Maternal Mortality Rate in the US Is an International Crisis

Dr. Joia Crear Perry

9/30/16 5:56am

Last week I spoke at the United Nations Office of the High Commissioner for Human Rights to urge the United States to use a human rights framework to improve maternal mortality in the U.S. That's right: Black women are dying around the world, and black women in the U.S. need to be placed in the context of an international crisis.

The United States is the only developed country in the world where maternal mortality is on the rise. Black women in the South are acutely at risk. Black women in the U.S. die at three to four times the rate of white women. Despite clear evidence of this inequity, policymakers and, as a consequence, the government have not made this an urgent public health and human rights issue.

As a black mother from Louisiana who is also an obstetrician, I feel a deep desire to end this inequity, a desire that is amplified every time I look into the mirror and into the faces of my daughter and patients. In my own home state, black women die 3.5 times more than white women within one year of birth. Many of these women die from homicide or suicide. This is why my organization, the National Birth Equity Collaborative, joined the group Black Mamas Matter. Black Mamas Matter is adapting the United Nations' technical-guidance document on maternal mortality.

Black women cannot buy or educate their way out of dying at three to four times the rate of white mothers. Maternal mortality rates persist regardless of our class or education status. Deaths among mothers extend beyond the period of pregnancy or birth. Nine months of prenatal care cannot counter underlying social determinants of health inequities in housing, political participation, education, food, environmental conditions and economic security—all of which have racism as their root cause.

Many state governments, especially in the South, are resistant to sexual and reproductive rights or even state support for basic health care services. This recalcitrance impedes Southern women's access to the information, facilities, services and resources they need to plan and have healthy pregnancies.

Good maternal health outcomes depend upon implementation of all sexual and reproductive rights, from comprehensive sexual education to access to birth control. The U.S. has a privatized health system. Some families qualify for public health insurance or Medicaid, but income qualifications vary by state. Generally, in the South, you have to be very poor to qualify for Medicaid. So in the South, you can be poor and also lack insurance.

Even if women are insured, coverage of sexual and reproductive health services is not comprehensive. There is a strong political resistance to sexual and reproductive health services

in the South. Consequently, there are many legal barriers to services and information. This lack of a safety net for poor women produces gaps in access along the reproductive life course. There are impediments ranging from limited access to contraception in order to plan healthy pregnancies to inadequate postpartum care to help manage infections and identify risk factors for mortality.

The U.S.—a country that spends more per capita on health care than any other developed nation—has one of the most sophisticated, technologically advanced health care systems in the world, but we still have inequities. Black women are still suffering from preventable maternal deaths. A human rights framework provides a road map to solutions.

U.N. Human Rights Council resolutions on maternal mortality and the related technical guidance shift the discourse on maternal mortality from a solely public health or personal-responsibility problem to one of women's rights. The U.S. is an example of how investment in biotechnology and not people leads to the improvements of things and not human beings, especially women.

The human rights framework gives us a way to address structural racism in the U.S. Human rights law provides a more robust analysis of discrimination than the U.S. legal framework, which was constructed on the premise of inequality of human value based upon race. Consequently, recourse through the legal system only is built around finding discriminatory intent and not institutional racism. A human rights framework will help the U.S. legal system and policymakers understand how many forms of discrimination—in this case, gender, race and socioeconomic class—intersect to affect black women differently.

A human-rights-based approach helps to uncover discrimination by putting women who are most affected at decision-making tables and encourages participation of marginalized groups in reforming laws, policies and practices. Members of Black Mamas Matter are prioritizing engagement and leadership of black women as well as community-driven solutions that recognize the importance of local context.

The Black Mamas Matter toolkit uses the technical guidance as a framework to assess the policy solutions that are being proposed by various sectors and stakeholders. It puts forward ideas that will help ensure human rights compliance in maternal health. We already know some of the reasons that black women are dying. Now we are working on policy responses that can catalyze black women's reproductive and human rights.

Ultimately, what black women in the U.S. need is accountability. We need to know that our lives are valued. The United States is slowly making progress voluntarily on maternal-death review processes through the Centers for Disease Control and Prevention, which can make systems-level recommendations about clinical factors. However, to ensure true equity and improvement, we need to push the role of racism and nonbiomedical factors. Black women need a lens that sees black women as having solutions—not as being the problem.

The Root aims to foster and advance conversations about issues relevant to the black Diaspora by presenting a variety of opinions from all perspectives, whether or not those opinions are shared by our editorial staff.

Dr. Joia Crear Perry is president of the National Birth Equity Collaborative. She has previously been executive director of the Birthing Project USA and director of Women's and Children's Services at Jefferson Community Healthcare Center.

BLACK MAMAS MATTER

ADVANCING THE
HUMAN RIGHT TO
SAFE AND RESPECTFUL
MATERNAL HEALTH CARE



CENTER
FOR
REPRODUCTIVE
RIGHTS

I. KEY TALKING POINTS

This section provides advocates with key talking points regarding U.S. challenges with maternal mortality and morbidity and the human right to safe and respectful maternal health care. These points are offered as suggestions, and more research is needed to determine the most effective communication strategies and framing for improving maternal health. Advocates are further encouraged to develop and use messages that reflect their own goals, strategies, and advocacy environments.

Our Values:

Black Mamas Matter. All women have the right to safe and respectful maternal health care that supports healthy pregnancies and births. Before, during, and after pregnancy, every woman needs access to quality health services and information, and the social and economic resources that will help her be as healthy as she can.

The Problem:

In the U.S., too many women are suffering from pregnancy complications that lead to serious injury and death. The U.S. currently ranks lower than all other developed countries when it comes to maternal death ratios. Some women are more at risk than others. Black women are 3 - 4 times more likely to die from pregnancy-related causes than White women, and women in Southern states have a higher risk of pregnancy-related death than women in most other parts of the country.

The Solution:

Many of these deaths and illnesses are preventable. The U.S. could avoid about 40% of maternal deaths if all women—regardless of age, race, and zip code—had access to quality health care. In addition to improving health care access and quality, government actors need to address the root causes of Black maternal mortality and morbidity—including socioeconomic inequalities and racial discrimination in the health care system and beyond.

Every level of government has a duty to advance policies that promote safe and respectful maternal health care. Ensuring safe pregnancies and births for all women in the U.S. will require sustained political will and long-term investments in the health and well-being of Black women and girls especially. There are a number of steps that states can take immediately to improve maternal health outcomes.

Articulate a vision:

- Safe and respectful maternal health care is a recognized human right throughout the U.S., and state governments adopt a human-rights based approach to ensuring safe pregnancy and childbirth.
- Black women lead a movement to improve maternal health, and are valued decision-makers in health care spaces.
- Black women's health and survival are prioritized by all levels and branches of government.
- Women and girls receive safe, respectful, affordable, quality health care where they live, throughout the course of their lives.
- Black women have full access to culturally competent, community-based models of care.
- Black women in the South survive and thrive before, during, and after pregnancies.

Articulate the problem:

- **Black women's lives and families are at stake.** Black women in the U.S. suffer from life-threatening pregnancy complications twice as often as White women, and they die from pregnancy-related complications four times as often as White women. When mothers die, it breaks apart families and can lead to negative health consequences for their children.
- **Preventable maternal mortality is a human rights crisis in the United States.** The U.S. is one of only 13 countries in the world where pregnancy-related deaths are on the rise. Women in the U.S. are more likely to die from pregnancy complications than women in 45 other countries, including the United Kingdom, Libya, and Kazakhstan.
- **Poor maternal health outcomes are getting worse.** Both the likelihood of experiencing a severe pregnancy complication and dying from it are on the rise in the United States. Although the U.S. spends more on health care per capita than any other country, maternal health outcomes are deteriorating overall and racial disparities are as wide as they were in the 1930's.
- **The risk of dying from a pregnancy complication should not depend on one's race or zip code.** But the reality is that women in the South are at much higher risk than women in other areas of the country. A Black woman in Mississippi is almost twice as likely to die as a White woman in Mississippi or a Black woman in California.
- **Maternal mortality affects Black women of all socio-economic backgrounds.** Racial disparities in pregnancy-related deaths show that across all income and education levels, Black women in the U.S. are at higher risk for poor outcomes than White women.

“The toolkit allows us to take our power back as birthing women. What happens in birth becomes apart of our life forever. We use this toolkit to demand humane treatment but also to inform ourselves. Having a baby is sometimes seen as something we don't have control over. We actually have power and choice in birth. The Black Mama Matter Toolkit gives us the language we need to speak up for ourselves.”

—KETURAH ALBRIGHT, BI
DOULA PROGRAM MANAGER
HEALTHY START @ SYRACUSE
COMMUNITY CONNECTIONS

- **To tackle the problem of maternal mortality, we need to address racial discrimination and structural racism.** Poor maternal health outcomes expose inequalities in U.S. society that go beyond the health system. Improving those outcomes will require more equitable access to health care and the social determinants of health.

Articulate solutions:

To improve U.S. maternal health outcomes we must prioritize Black women’s health and lives and commit to taking meaningful action. **Every state must take steps to ensure safe and respectful maternal care for all women.**

At a minimum, these steps include policy measures that address the following areas:

- **Respect:** States must trust Black women with the decisions and resources that empower them and their families. Health care providers and systems must approach every woman with respect and compassion, build her capacity to engage in informed health care decision-making, and honor her autonomy to make decisions about her body and care.
- **Education:** States must ensure that women are equipped with the knowledge, tools, and power to determine if and when they want to become pregnant and have a child. At a minimum, this requires: comprehensive, evidence-based information about sexual, reproductive, and maternal health.
- **Access:** Every woman must have access to health care before, during, and after childbirth. States must ensure health coverage for low-income women before they get pregnant, promote continuity of care and insurance coverage as women’s life circumstances change, address barriers to prenatal and postpartum care, and reach women in the communities where they live.
- **Prevention:** Every state must take action to address and prevent risk factors for poor maternal health outcomes such as obesity, chronic conditions like heart disease and diabetes, and underlying determinants of health. Policymakers influence the structural conditions in which women live, work, and grow, and in turn, these conditions influence maternal health.
- **Quality:** States must ensure that every pregnant woman has access to facilities, health care providers, and support persons that are capable of safely and respectfully managing chronic conditions, identifying, monitoring, and appropriately addressing obstetric emergencies, and providing unbiased care.
- **Equity:** To prevent pregnancy-related deaths and sustainably improve maternal health, states must make transformative investments in the health and well-being of Black women and girls throughout the life course, including in the areas of housing, nutrition, transportation, violence, environmental health, and economic justice.
- **Data:** Every state must have a process in place to collect and disaggregate data about maternal health in a timely manner. Data collection should include both quantitative and qualitative methods, including community-based participatory data, in order to understand the impact of race and socio-economic inequality on Black women’s health.
- **Accountability:** States must create systems to design and implement recommendations, and hold institutions accountable when they fail women. These include independent and fully funded maternal mortality review boards, supportive maternal health programs that implement review findings, and attention to social determinants of health.



De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color

July 20, 2018

Four-point plan will address implicit bias, increase surveillance, enhance maternity care and expand public education

NEW YORK—Today First Lady McCray and Deputy Mayor for Health and Human Services Dr. Herminia Palacio announced New York City’s first comprehensive plan to reduce maternal deaths and life-threatening complications of childbirth among women of color. The five year plan aims to eliminate disparities in maternal mortality between Black and White women – where the widest disparity exists – and reduce by half the number of severe maternal morbidity events in the five boroughs. Severe maternal morbidity is defined as life-threatening complications of childbirth; maternal mortality is defined as a death of a woman while pregnant or within one year of the termination of pregnancy due to any cause related to or aggravated by the pregnancy or its management.

The City will invest \$12.8 million over the next three years in this plan. Funding will go towards four initiatives: 1) Engaging relevant private and public health care providers across the City in adopting implicit bias training – the unconscious attitudes or stereotypes that can affect behaviors, decisions and actions in their treatment of women of color who are pregnant; 2) supporting private and public hospitals to enhance data tracking and analysis of severe maternal mortality and maternal morbidity events to improve quality of care and eliminate preventable complications; 3) enhancing maternal care at NYC Health + Hospitals’ facilities; and 4) expanding public education in partnership with community-based organizations and residents.

In New York City, more than 3,000 women experience a life-threatening event during childbirth, and about 30 women die from a pregnancy-related cause each year. Preliminary data shows that in New York City, Black non-Hispanic women are eight times more likely to die of pregnancy-related complications than White women, much higher than the national average.

“We are losing far too many mothers – especially women of color – to pregnancy-related complications,” said **Mayor Bill de Blasio**. “That is unacceptable. This new plan will put our hospitals and healthcare system on track to save the lives of mothers and make healthier the futures of their children.”

“New York City is making women’s health care priority number one,” said **First Lady Chirlane McCray**. “No mother, in this great City of world class health providers, should ever worry about the quality of care she’ll receive when building her family, before, during or after childbirth.”

“Maternal mortality is not just a health crisis but also a human rights issue. It is a heartbreaking fact that maternal mortality greatly affects women of color. This investment is the City’s commitment to provide the best healthcare services to all New York women and the next step in ensuring the protection of all women, especially women of color. I thank Council Member Helen Rosenthal for bringing attention to the maternal mortality crisis, and I applaud the Administration for working with us on making New York City safe for all pregnant people,” said **Council Speaker Corey Johnson**.

“The birth of a child should be a joyous moment for all families, and it is unacceptable that in 2018 we have so many Black mothers who are dying because of complications during childbirth,” said **Deputy Mayor for Health and Human Services Dr. Herminia Palacio**. “This ambitious plan is an example of joining medicine and hospital delivery systems with public health systems to help close health inequities and save the lives of mothers across New York City.”

“We know one of the key drivers of racial disparities in maternal mortality is structural racism. Decades of inequitable distribution of resources across neighborhoods and unequal treatment within healthcare settings have resulted in racial differences in birth outcomes,” said **Health Commissioner Dr. Mary T. Bassett**. “We want to thank First Lady Chirlane McCray and Deputy Mayor Palacio for investing in a bold plan to address maternal deaths. This builds upon the efforts of the Health Department to improve maternal health and close the racial gap by transforming how mothers, and specifically women of color, are cared for and supported throughout their pregnancy.”

“Despite years of work by the Health Department and many others, the stark and unacceptable racial and ethnic disparities in maternal death and life-threatening complications of childbirth have persisted,” said **First Deputy Health Commissioner Dr. Oxiris Barbot**. “We are excited that as a City we are prioritizing investing new resources to improve women’s and maternal health. We are confident that by aligning and coordinating efforts of our public health and public hospital systems in partnership with community leaders, organizations, and residents, we can move the needle in a positive direction.”

“Every incidence of maternal mortality is a tragedy, and we believe many such tragedies can and must be prevented,” said **Machelle Allen, MD, Chief Medical Officer of NYC Health + Hospitals**. “We believe a good number of other incidents that are life-threatening to women during childbirth, and especially women of color, are also avoidable—which is why we are excited to play an active role in embracing the steps New York City is announcing. We owe our patients nothing less than the best of care possible.”

Issues around maternal mortality rates are complex, particularly for Black women. Contributing factors to this epidemic include the health status of Black women, such as the prevalence of obesity and decreased access to care; issues of poverty, such as inadequate housing; residential segregation and lower educational attainment; and the stressors stemming from racism. Even when controlling for socioeconomic and educational status, Black women are still more likely to suffer from severe maternal morbidity and maternal mortality than women of other races and ethnicities.

Components of the plan include:

1. **Creating A New City-Wide Maternal Hospital Quality Improvement Network:** The Health Department will create a Maternal Hospital Quality Improvement Network aimed at developing hospital-specific recommendations to reduce the number of life-threatening complications during and after childbirth. The Department will target a total of 23 of the 38 public and private maternity hospitals in NYC over a four year period, prioritizing providers in neighborhoods with the highest rates of pregnancy related complications – South Bronx, North and Central Brooklyn, East and Central Harlem, and Jamaica and St. Albans in Queens. Hospitals will collect and review severe maternal morbidity data to identify problem areas in care and incorporate best practices to improve patient outcomes. Hospital staff will participate in practice drills to help them recognize and treat these events in a timely manner.
2. **Creating Comprehensive Maternity Care at NYC Health + Hospitals:** Building upon the efforts already undertaken by NYC Health + Hospitals to ensure safe maternity care, the public healthcare system will implement the following initiatives:
 - Embed simulation training in all hospital obstetric units to focus on identification and response to the two top causes of pregnancy-related deaths for women of color—postpartum hemorrhage (bleeding) and thromboembolism (blood clots).
 - Hire maternal care coordinators to assist an estimated 2,000 high-risk women in the prenatal and postpartum periods to keep appointments, procure prescriptions, and connect women to eligible benefits.
 - Co-locate newborn and postpartum appointments to increase the number of women receiving postpartum care from 60 percent to 90 percent. Postpartum care will include contraceptive counselling, breastfeeding support and screening for maternal depression.
 - Establish primary care interventions to identify women who are planning to have a child within six to 12 months. Providers will assess hemorrhage risks and establish a care plan for women seeking to give birth within that timeline.
3. **Enhancing Data Quality and Timeliness:**
 - The NYC Maternal Mortality and Morbidity Review Committee, launched by the Health Department in December 2017, will drive data quality improvement by examining maternal deaths and analyzing and compiling data on severe complications experienced by expectant and new mothers.
 - To address the challenge of data having historically been on a two to three-year time lag, the Health Department will provide preliminary estimates of mortality annually. The City will also request the NY State Health Department to release relevant hospital data within one year.
4. **Launching Public Awareness Campaign on Pregnancy-Related Health Risks:** The Health Department will expand its targeted public education campaign with community residents and providers, emphasizing safe and respectful childbirth, prenatal and post-partum care starting in 2019.

This plan builds on the City’s significant commitment to improve maternal health, including increased screening for maternal depression through the ThriveNYC Maternal Depression Learning Collaborative, which has 30 participating hospitals to screen and treat pregnant women and new mothers for maternal

depression, and the creation of the Maternal Mortality and Morbidity Review Committee, which reviews deaths and severe complications related to pregnancy and childbirth. Additionally, the City became the first municipality in the nation to establish a severe maternal mortality surveillance program in 2016. The Health Department also is focused on supporting women's health before and during pregnancy to ensure optimal outcomes. In May, the Department announced the Maternal Care Connection, a collaboration with SUNY Downstate Medical Center to improve obstetric care and chronic disease management, both of which contribute to racial disparities in birth outcomes. The Department also supports a Nurse-Family Partnership program and Newborn Home Visiting Program, the By My Side program, which provides doula support services through Healthy Start Brooklyn, and new Family Wellness Suites at the Neighborhood Health Action Centers.

"This comprehensive plan will ensure that new mothers, especially women of color, are provided the necessary level of healthcare to not only give birth safely, but to prevent them from developing life-threatening complications after birth," said **State Senator Gustavo Rivera, ranking member of the Senate Health Committee**. "With our City working to eliminate the entrenched health disparities that continue to plague low-income communities and people of color, this plan will provide new mothers, especially Black mothers who are disproportionately impacted, with the support system they need to help their new families thrive."

"Our women and babies deserve access to life-saving, high-quality care. One incident of child mortality is one too many. I commend First Lady Chirlane McCray and Deputy Mayor Palacio for addressing the issue of maternal deaths in New York," said **State Senator Roxanne Persaud**. "Improving the quality of care for mothers and newborns is paramount in securing the total and overall well-being of families within the district I serve."

"Maternal mortality rates for New York State and the City are shocking, compared with most of the country, and dramatically worse for women of color," said **Assembly Member Richard N. Gottfried, Chair of the Assembly Health Committee**. "Mayor de Blasio and his team are building on previous efforts to help turn this around and protect our new mothers and their families."

"The Mayor and the First Lady's four-point plan to reduce mortality among Black infants and Black women will have a powerful impact and address the disparities present in black maternal communities," said **Assembly Member Rodneyse Bichotte**. "Women of color and their infants are more likely to experience health complications and even death than their White counterparts. I am, unfortunately, intimately familiar with this phenomenon due to the loss of my son. I am particularly enthusiastic about this decision to partner with community-based organizations, a facet of public health policy too often overlooked. Such policies are noted in my Bill A11206 the Jonah Bichotte Cowan's Law."

"New York has long been plagued with a very high maternal mortality rate that places expectant mothers – particularly women of color – at risk of losing their lives or being permanently injured as a result of childbirth," said **Assembly Member Latoya Joyner**. "As a leader in the State Legislature on the issue of maternal safety, I appreciate the de Blasio administration taking these vital first steps to

address what is clearly a major public health crisis. I look forward to working with them to ensure the health of all New York's women is protected.”

“There is no reason why here in New York City, the greatest city in the world, that Black women should be eight times more likely to die of pregnancy-related complications than White women. We need to have this conversation now, and the city's \$12.8 million investment will go a long way to beginning that education and introducing solutions. The Council's Committee on Hospitals is committed to working with the city's public and private hospitals to improve implicit bias training and enhance maternity care, both pre- and post-birth,” **said Council Member Carlina Rivera, Chair of the Council's Committee on Hospitals.**

“Maternal mortality is a crisis, and the racial disparity in health outcomes is a profound injustice. For too long, this crisis has been hidden in plain sight,” **said Council Member Helen Rosenthal, Chair of the Committee on Women.** “While nearly every woman I talk to has had or knows someone who has had a negative or dangerous childbirth experience, the medical profession has been slow to confront its biases and reevaluate its procedures. This initiative, with its emphasis on changing processes within hospitals and ensuring greater accountability, is a critical step toward protecting all pregnant people. I applaud this plan and look forward to working with the Administration to support these and other steps to turn the tide on maternal mortality and morbidity.”

“Today's announcement sends a clarion call to the nation that our elected leaders must do all that we can to put an end to the structural racism that threatens the lives of Black women and women of color,” **said Council Member Margaret S. Chin, Co-Chair of the Women's Caucus.** “The alarming disparity in maternal mortalities for different communities is unacceptable, and I thank First Lady Chirlane McCray and Deputy Mayor Palacio for launching a bold effort to shed light on this issue and help close the racial gaps in our city's healthcare system.”

“Black women die at a rate 8 times that of white women in New York City due to pregnancy and childbirth, and the rate of severe maternal morbidity is also alarmingly high,” **said Patricia O. Loftman, member of the American College of Nurse Midwives Board of Directors.** “Having worked as a midwife in Harlem Hospital for 30 years, I know that the Health Department's work will benefit the women and families we care for. I support the City's plan to expand the surveillance of severe maternal morbidity and mortality throughout all Health + Hospital facilities. No woman should die for wanting to have a baby.”

“We must collectively strive to shift the narrative of birthing in NYC to one that addresses implicit bias and racism within maternal health,” **said Founder and Executive Director of Ancient Song Doula Services Chanel L. Porchia-Albert.** “It is only through collective community in addressing patient education, seeing communities as stakeholders, researching intersections of care and measuring accountability that we can truly achieve our human rights and begin the collective reconciliation of the trauma that Black women face while birthing.”

“As someone who has worked closely with the Birth Justice Defenders — a growing group of community members who are passionate about promoting birth justice — I can attest to the importance

of continued efforts to amplify the voices and honor the input of Black and Latinx individuals to address the maternal health care crisis in New York City,” said **Nicole Jean-Baptiste, Founder and Lead Doula of Sésé Doula Services and Member of the Sexual and Reproductive Justice Community Engagement Group** convened by the New York City Health Department. “In order for the Mayor’s new plan to reduce maternal deaths and life threatening complications of childbirth to meet these outcomes, true community engagement and the application of implicit bias and anti-racist trainings within maternal healthcare institutions must be at the core of this initiative.”

pressoffice@cityhall.nyc.gov

(212) 788-2958

City advocates, gently, for use of IUD

By ADDY BAIRD

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Where posters used to suggest eating smaller portions and cutting back on smoking, now on New York City subway cars there are ads advocating IUD as an option.

“You spent the night in Brooklyn, but you left your birth control in Staten Island,” reads one of the brightly colored ads, which look hand-drawn. “Maybe the IUD is right for you.”

With their “Maybe the IUD” campaign, the city’s health department and the reproductive rights advocacy group NARAL New York aim to present the intrauterine device as a choice to women who might not otherwise consider it.

The IUD, a small T-shaped device that is inserted into the uterus and lasts between three and 12 years, is widely considered the most effective method of birth control available.

But promoting it requires a cautious approach, public health advocates say. Pushing too forcefully for an invasive option that keeps users from having children could serve as a reminder of recent public health missteps and alienate the very women public health officials seek to reach.

“When it comes to IUDs or any kinds of long-acting reversible contraception, there’s sort of a dark history we have of coercion,” said NARAL New York communications director Tara Sweeney. “That’s a history that we live with in America.”

And so public health officials and providers pushed posters recommending the IUD even as they tried to avoid outright promotion — a delicate balance that led to some awkward phrasing that almost, but doesn’t quite, say the IUD is the best option.

The “Maybe the IUD” ads hit the subways from October to December of last year. (There were no “Maybe the pill” or “Maybe the shot” sister ads.)

It’s one word, coercion, that makes so many providers and public health advocates cautious about singing the praises of the IUD and other long-acting reversible contraceptives, despite their effectiveness, ease of use and general safety.

Long-acting reversible contraceptives like the IUD boast 99 percent success rates at preventing pregnancy in their users. Birth control pills are also considered 99 percent effective when taken correctly, at the same time each day. But considering the difficulty many women have in taking the pill at exactly the same time every day, the pill’s effectiveness is generally closer to 92 percent.

But for all the IUD's benefits, caution in promoting it is top of mind for Sweeney and city health officials, who say the "Maybe the IUD" campaign is intended to promote better education about the IUD, not the device itself.

There is particular concern for how women of color, who are statistically more likely to have unplanned pregnancies, might receive contraceptive recommendations.

"Some women, particularly women of color, may feel a lack of trust about their provider," said assistant health commissioner Dr. Deborah Kaplan. "This is still a lived experience of women of color today, in terms of facing racism and concerns about if things are being recommended to them because it's best for them or to control their population."

"How do we take what we know about the history and ongoing issues around bias, coercion, racism, and how do we make that resonate in a campaign?" she asked.

Indeed, acknowledging anxiety about the IUD requires acknowledging that history, in particular the 1990s-era long-acting reversible contraceptive Norplant. It was aggressively marketed to women of color, who were also disproportionately affected by earlier forms of contraceptive coercion, including forced sterilizations under Depression-era eugenics laws that made it legal to sterilize women who were sick, had epilepsy or were "feebleminded." (As late as 1956, 27 states still had laws on the books allowing for sterilization without a woman's consent.)

"The main reason more black children are living in poverty is that the people having the most children are the ones least capable of supporting them," said a 1990 op-ed published in The Philadelphia Inquirer soon after Norplant's release. "What if welfare mothers were offered an increased benefit for agreeing to use this new, safe, long-term contraceptive?"

The Inquirer published an apology the next day for suggesting such a move, but across the country, bills were proposed to do just that. In Texas, policymakers looked to offer women on welfare \$300 to have the implant and another \$200 if they kept it for five years. In other states, bills were proposed that would require Norplant for women who had had publicly funded abortions, and in 1991, a judge ordered a woman to have Norplant implanted or spend three more years in jail.

Norplant stopped being distributed in the United States in 2002, but its effects linger, particularly for women of color. In October 2010, a study out of the University of California, San Francisco, found that "low socioeconomic status Latinas and blacks were more likely to have intrauterine contraception recommended than low socioeconomic status whites." It concluded that "providers may have biases about intrauterine contraception or make assumptions about its use based on patient race/ethnicity and socioeconomic status."

The city health department aims to push back against these assumptions with its campaign.

"We're all influenced by biases in our society," Kaplan said. "One of the ways providers can deal with that is through values clarification and other training that helps sensitize people to their biases."

Reproductive justice advocates encourage providers to consider that some women might want contraceptive benefits beyond simply preventing pregnancy at all costs. For instance, some women might want the hormonal benefits of the pill, which can shorten periods and manage acne, while others might want a method, like the shot, that doesn't interfere with their sex lives. But if preventing pregnancy is the ultimate goal, the IUD is undeniably effective.

Dr. Sofya Maslyanskaya, a doctor at Montefiore Medical Center in the Bronx, recently found that six months after they first came into her clinic for contraception, only about 38 percent of teen girls who had chosen a birth control method other than the IUD — either the pill, the patch or the shot — were still using the method they were originally prescribed. But of those who had chosen the IUD, 88 percent were still using it. The rest, four women in the study, had had it removed.

“The IUD is easy, because you don’t have to remember it,” Maslyanskaya said. But she’s careful not to advocate for it too strongly, even for young women actively seeking out birth control, citing “an increased awareness of how important it is not to coerce adolescents and young women into picking a certain contraceptive because of your own belief.”

For the city health department, that increased awareness has come with a focus on cultural competency. That has meant, in developing the “Maybe the IUD” campaign and others, using the reproductive justice framework developed in the 1990s by SisterSong Women of Color Reproductive Justice Collective — a framework that focuses on ensuring a woman’s right to decide whether to prevent or end pregnancies, to decide whether and when to give birth and to parent her children with social support and in healthy, safe environments.

Moving forward, Kaplan said, the city health department aims to balance the twin goals of helping women prevent unplanned pregnancies while ensuring they aren’t coerced into using methods with which they’re not comfortable.

“One, it’s critical that all people have the information they need to make informed decisions about their sexual and reproductive life, including all of the different methods of birth control to prevent pregnancy if they don’t want to be pregnant,” she said. “The second key part is bringing voices to the table that haven’t been heard before from the community and establishing an organized method to do that.”

To that end, the agency has formed a community engagement group made up of public health advocates and women’s health providers across the city “to elevate the conversation about sexual and reproductive justice.” The agency has been meeting with that group on a monthly basis to consider the “Maybe the IUD” campaign’s next steps and to fine-tune the larger balancing act that public health advocates must perform.

“[We’re] working to make sure providers know that their role is to help women make an informed choice of what’s best for them — not what the provider thinks is best,” Kaplan said. “This is focused on undoing injustice and promoting health equity.”

A version of this article originally appeared in the [spring 2016 issue](#) of POLITICO New York magazine.



SisterFriends Detroit is Creating a Support Network for Pregnant Women and Their Families

This Detroit Health Department program connects women to resources and to each other.

July 2018

CONTENT BROUGHT TO YOU BY DETROIT HEALTH DEPARTMENT



Finding connections, resources and support as a pregnant woman in Detroit is not always easy. Yet with 13 percent of babies dying in Detroit before their first birthday, according to Dr. Joneigh Khaldun, director and health officer for the Detroit Health Department, the need is dire. And while there are plenty of programs in the region focusing on infant mortality, Khaldun says, that isn't enough to prevent these grim statistics. How do you actually connect this with the community – and get women the

support they need? [SisterFriends Detroit](#) has become the answer.

Launched in August 2017, this grassroots Detroit Health Department-helmed program seeks to "connect pregnant moms and families to existing programs and resources – and to each other," as its website explains. It establishes "Little Sister" relationships between a mentor and mentee during the course of an expecting mom's pregnancy through her baby's first birthday. The program is modeled after the Birthing Project USA framework, a national nonprofit that pioneered "SisterFriending" three decades ago.

To date, SisterFriends Detroit has seen over 220 volunteer mentors answer the call. These women have helped their Little Sisters in a variety of ways, from driving them to prenatal care appointments to being on-call during the birth experience. Mentees also have access to trainings, parenting classes and Sister Circles, which focus on building important skills. "Over 70 mothers have delivered in the program," Khaldun says, "and almost 90 percent of them delivered a full-term baby – and (we've seen) similar numbers, as far as those that delivered a baby at healthy weight."

Khaldun, a practicing ER doctor at Detroit's Henry Ford Hospital, says that many other cultures around the world use similar approaches, where a community embraces and supports women successfully through pregnancy. "When you connect the community and bring those resources to families, to mothers, you can be successful," Khaldun says. "The

way our program works, we also have an incredibly passionate, committed, capable set of community health workers that we employ at the Detroit Health Department to really make sure that the moms are connecting to these resources."

Connecting mentors to expectant mothers starts online and is similar to social connection websites, says Detroit's Stephanie Young, who has been involved since the program's inception. Young is a politically engaged Michigan State University graduate who currently serves as an appointee to Detroit Mayor Mike Duggan. It's this community work that bonds Young and her Little Sister. "It's almost like a Match.com," Young says, referring to the popular dating website. "They put together this algorithm based on one another's interest – they even look at where you're located and different things like that. My Little Sister, she likes community work – she worked for Habitat for Humanity," and was connected to "somebody whose whole life is dedicated to community work and service." (That would be Young.)

Young, whose first job out of college was at the state Capitol, didn't foresee herself as a mentor, but now, she wouldn't change the experience. For those interested, she says, you don't have to have any particular background in medical, clinical training. "It's about people being themselves," Young says, "and bringing who you are into developing a new relationship with someone." Native Detroit's Cynthia Williams, another SisterFriends Detroit mentor who works with the nonprofit Black Family Development, Inc. of Detroit, says that SisterFriends Detroit aligns with who she is as a person. "The reduction of infant mortality is very key and very important," Williams says. "A lot of our young mothers – and older mothers – have limited access to community resources."

That's why, as part of SisterFriends' mission, it offers monthly workshops and orientations designed to educate both mentors and Little Sisters on many key topics, all focused on a healthy pregnancy and first year of baby's life. Beyond that, there's "the networking with their own peers," Williams adds, "to have a conversation with someone who's going through the same thing you're going through." Williams' Little Sister is in her 30s, but she has seen mothers as young as 15 – and some in their 50s. "I think it will be a lifelong experience," Williams says. "It's a lifelong journey that I will embrace and continue to participate in."

It's deeply personal for Khaldun, as well. In her late 20s, she almost died after giving birth to a son. "An African-American woman (dies) at a rate three-to-four-times higher than a Caucasian woman in this country, and that's regardless of socioeconomic status," Khaldun says. "Community support can change that. It doesn't take a lot of time. It doesn't take a lot of effort. All you have to do is show up and care – and you can really make a significant difference in a mom's, in an infant's, life."

For more information about this Detroit Health Department initiative or to sign up as a mentor, call 313-961-BABY or visit sisterfriendsdetroit.com.



iDecide Detroit Improves Access to Reproductive Healthcare for Teens

The healthcare providers offer services like condoms, birth control and STD/STI testing and treatment.
October 2018

CONTENT BROUGHT TO YOU BY DETROIT HEALTH DEPARTMENT

Teens have plenty to worry about. From social awkwardness and rising academic expectations to struggling for independence, yet, access to information on contraception shouldn't be one of them. As a new initiative launched by the Detroit Health Department and Mayor's Office, **iDecide Detroit** fills this gap by promoting confidential, teen-friendly and reproductive health services and supports. To this end, iDecide Detroit is a network of teen-friendly reproductive health providers that offer teens and adults services like condoms, birth control, STD/STI testing and treatment in an effort to protect a teen's sexual health.

While the national teen pregnancy stats appear to be on the decline, urban areas and minorities – especially African-Americans – are not reflected in the national numbers, according to Dr. Joneigh Khaldun, director and health officer for the Detroit Health Department. "Unintended teen pregnancy is certainly a public health issue in the city of Detroit," Khaldun says. "Although teen pregnancy rates overall have been declining across the country, in Michigan and in Detroit, there still exists a disparity between those various areas. We want to make sure that all teens across the city of Detroit have access to the services and knowledge that they need so that they can make the right choices for themselves when it comes to their sexual health and when they want to become a parent. That's why we're launching this initiative."

The iDecide Detroit initiative is collaborative in that it partners with 23 healthcare providers from all over the city. This means that even if a teen doesn't have health insurance, they can still be provided the services they need. The Detroit Health Department recently opened its first iDecide Teen Health Center at the Butzel Family Center at 7737 Kercheval in Detroit. To get the word out about the campaign, the Detroit Health Department and Teen HYPE are working in tandem to ensure the iDecide Detroit campaign is, at its core, youth-friendly and engaging.

Teen HYPE is a youth movement empowered to strengthen young people through evidence-based programs including health, safety, education and the arts. Detroit-based Teen HYPE youth are prominently featured in the iDecide marketing materials and website. For good reason: "Through this project young people have been given an active role in developing an initiative that matters to them," says Ambra Redrick, CEO of Teen HYPE. "Youth have worked side by side with adults and served as partners rather than subjects of study. Consistently, research has shown that youth who feel empowered and supported in their communities are less likely to engage in risky behaviors. This campaign sends a strong message of investment in the well-being of Detroit's youth."

An investment that entails robust community engagement and involvement, including support from the faith-based community. "As a member of the faith community in Detroit, a female leader, mother and educator, I wholeheartedly support the iDecide Detroit initiative knowing this will change the trajectory of outcomes within our female teenage community," says Bishop Corletta Vaughn, senior pastor of Holy Cathedral Church. "As a pastor, I have seen so many girls impacted by teenage pregnancy, and as a mother, I've experienced it personally." For some context: the teen

pregnancy rate in Detroit is nearly 2.5 times greater than the rest of the state of Michigan and each year in Detroit, teens between the ages of 15-19 years old become pregnant. Khaldun finds these stats not just alarming, but unacceptable and at the very least, changeable.

"It's a reproduction health access issue," she says. "It's a knowledge issue. What we often talk about when we talk about contraception and preventing unplanned pregnancies, we're talking about Long Acting Reversible Contraception otherwise known as LARCS, and that is the number one recommended form of contraception that the American Academy of Pediatrics recommends for adolescents." Khaldun adds that in Detroit, about 1.8 percent of teens are using LARCS as a form of contraception, but if you contrast that across the state of Michigan, it's a little over 3 percent and across the entire country it's about 7 percent. The demographics, Khaldun says, tends to skew toward "folks who have access to private insurance" and "people who are more affluent."

Some might perceive iDecide Detroit as "forcing people to get contraception," but that couldn't be further from the truth, Khaldun insists. "This is about working with the youth, making sure that they have options and connecting them with those options," she says. Walk-ins are welcome at Detroit Health Department clinics and at iDecide Detroit network partners – all visits are confidential. "We'll be taking anyone regardless of their insurance status," Khaldun says. "What we'll also be doing is supporting transportation. Transportation is a challenge in the city of Detroit – not everyone has a car, or can easily get to their medical appointment. We're actually partnering and working with Lyft to provide transportation (for) our clients that qualify."

When it comes to spearheading an initiative as important as iDecide Detroit, one where it's about teen empowerment, the mission is not only *possible*, it has real implications for the city's future. "We know that young people are the future of Detroit and if we can empower them and give them the tools and services they need to be healthy, we'll be able to have a significant impact on the future of Detroit," Khaldun says.

iDecide Healthcare Providers:

Advantage Family Health Center (Advantage)

CHASS

DMC Sinai Grace Wayne State University Physicians Group

East River Health Center (DCHC)

Feleta Wilson Health Center (DCHC)

Henry Ford – Harbortown St John's Professional Building OBGYN

Henry Ford – New Center Corktown Health Center

Henry Ford Northwest Wayne State Health Center

Hutzel Women's Health (Dr. Kmak)

Nolan Family Health Center (DCHC)

Oscar Pascal Health Center (DCHC)

Planned Parenthood

Sophie Womack Health Center (DCHC)

Thea Bowman Health Center (Advantage)

Waller Health Center (Advantage)

Woodward Corridor Family Center (DCHC)

Youthville – Henry Ford Butzel Family Rec. iDecide Detroit (DHD)

*Face-to-Face Navigation: **Delray Community Center, Adams Butzel Rec and Heilmann Rec Centers***

The Washington Post

How to solve D.C.'s maternal health crisis? A health advocacy group proposes some ideas



Warren Lewis looks over a photo collage he created for the memorial service for his cousin Somesha Ayobo (at left in montage of photos) and her baby Phoenix Carpenter, at right on screen. Ayobo died June 24th, 2017 and her baby died four days later on June 28th at United Medical Center in D.C.. Medical errors made in the case caused regulators to shut down the hospital's obstetrics ward. (Photo by Michael S. Williamson/The Washington Post)

By [Samantha Schmidt](#)

September 12, 2018

What is clear is that D.C. has among the worst maternal mortality rates in the country. What is clear is that if you're a black mother in D.C. you're twice as likely to have a preterm birth than a white mother.

What is less clear is how to change these outcomes.

On Wednesday, medical providers, policy makers and community organizations gathered to tackle that goal at the district's first-ever Maternal and Infant Health Summit at the Walter E. Washington Center.

Hosted by D.C. Mayor Muriel Bowser, days after she introduced the world to her 4-month old daughter, the summit focused on sharing best practices among local and national stakeholders, including mayors from Flint, Mi., Rochester, N.Y., and Gary, Ind. The event comes at an urgent time for the district, where maternity wards in two hospitals on the east side of the city closed within the past year, leaving many pregnant mothers in poor neighborhoods multiple bus rides away from the nearest hospital.

D.C. regulators shuttered the maternity ward and nursery at United Medical Center in Southeast after an investigation found numerous errors in treatment for [Somesha Ayobo](#), a pregnant woman who died soon after being admitted to the hospital. That was weeks after Providence Hospital in Northeast also closed its maternity ward.

But one of the key dilemmas facing the players at the conference dealt not with access to hospital delivery rooms, but rather with the months of a woman's pregnancy leading up to childbirth. According to the 2018 [DC Perinatal Health and Infant Mortality Report](#), about half of black women and more than 1 in 3 Hispanic women are not entering prenatal care until their second or third trimester or not receiving care at all.

The issue is not insurance, Bowser said, since 97 percent of D.C. residents are covered by insurance. "It means getting more people connected to the right people at the right time," she said. "Why are people avoiding the doctor their first three months of pregnancy?"

Asked to suggest concrete steps they are taking to fill these gaps, Bowser and LaQuandra S. Nesbitt, D.C.'s Director of Health, spoke in broad terms about finding ways to reach women more proactively, as soon as they become pregnant. Bowser suggested using technology to connect pregnant mothers with medical providers.

"If people can swipe to the right to find dates why can't they figure out how to get better access to our service," she said. "We can't continue to only do the things we've done in the past."

For one organization, the [D.C. Primary Care Association](#), a key solution lies in something called "Centering," a form of group prenatal care, according to a report released by the association on Wednesday. The report's researchers conducted 31 in-depth interviews with medical providers as well as low-income women of color in D.C.

"Centering" involves a recommended schedule of 10 prenatal visits, each 90 minutes to two hours long, in groups of eight to 10 expectant mothers all in the same stage of pregnancy.

Centering encourages teaching expectant mothers how to play a role in their own medical care, engaging them in taking their own weight and blood pressure, for example. Most importantly, it provides a support system, said DCPCA President and CEO Tamara Smith.

Expectant mothers, particularly low-income women of color, "often times feel alone," Smith said. "There's nobody that you're talking to in the same stage of your pregnancy with the same fears."

"Word of mouth is really powerful in these communities," said Robyn Russell, a fellow with DCPCA who worked on the report. "It's almost like a tipping point."

In D.C., centering is currently offered at two organizations, Mary's Center and Community of Hope, covering only a small segment of the population. But all of the current providers offering it said they are relying on grants that are set to expire. DCPCA is recommending that the city expand the program to more community centers, particularly Unity Health, and invest in the staff needed to coordinate and facilitate the group classes. Such an expansion, including hiring six personnel to coordinate the programs, could cost less than \$1.5 million, DCPCA estimates.

The cost estimates would allow for six new Centering programs, with the capacity to reach 1,200 women, according to DCPCA.

Ebony Marcelle, Director of Midwifery at Community of Hope, helps coordinate and facilitate Centering classes, and says the program is essential for empowering women, particularly African American women, in a relaxed setting in which "we're not talking at them."

"There's a huge level of distrust that's generational, with medicine with healthcare," Marcelle said. "We acknowledge that, we honor that, we respect that and we try to meet them where we are."

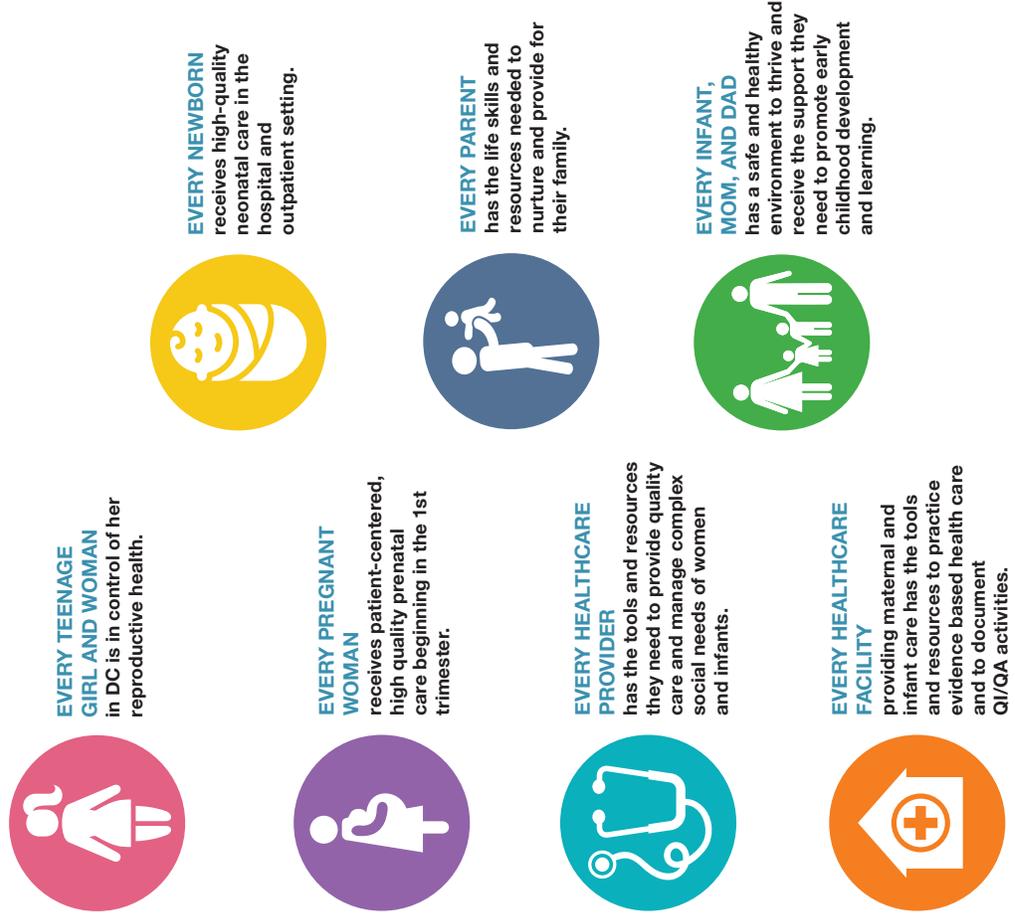
According to America's Health Ranking's [2018 analysis](#) of CDC data, about 36 women die for every 100,000 live births in D.C. compared to 20.7 deaths nationally. Only four states have worse rates.

DC Health Strategy to Improve Perinatal Health Outcomes

OUR FRAMEWORK to improve perinatal health outcomes is based on the overarching goal to ensure every community understands its health risks and role in improving perinatal health outcomes. DC Health identified seven core priorities that drive our programmatic efforts.

OUR APPROACH aligns with nationally-recognized best practices, and reflects the core principles identified to decrease perinatal health disparities and improve maternal and child health (Figure 1). The driving principles include:

- Using a life course perspective, recognizing that a person's health is determined by factors present prior to conception.
- Addressing social determinants of health, recognizing that poverty and racism profoundly affect psychosocial well-being and are major contributors to disparities in birth outcomes.
- Implementing systems level interventions, recognizing that addressing underlying [social] policies have broad impacts on improving health.
- Building collective impact, recognizing that sectors beyond public health and medicine must have a role in addressing preventable infant deaths to realize long lasting equitable outcomes for all of our families, regardless of race or place.



DC Health Approach to Improve Perinatal Health Outcomes

Perinatal Health

Accessed 1/9/2019



Improving Perinatal Health Outcomes

Improving perinatal health outcomes starts with every community understanding its health risks and its role. To achieve this goal, DC Health's comprehensive approach works to ensure the following priorities:

- Every teenage girl and woman in DC is in control of her reproductive health.
- Every pregnant woman receives patient-centered, high quality prenatal care beginning in the 1st trimester.
- Every healthcare provider has the tools and resources they need to manage complex social needs of women and infants.
- Every maternal and infant care facility and provider has the tools and resources to practice evidence-based health care and to document QI/QA activities.
- Every newborn receives high-quality neonatal care in the hospital and outpatient setting
- Every parent has the life skills needed to nurture and provide for their family
- Every infant, mom, and dad has a safe and healthy environment to thrive and receive the support they need to promote early childhood development and learning.
- These seven priorities fall within four overall strategic areas to eliminate preventable infant deaths and reduce preterm and low-birth-weight births: improving preconception health; assuring high-quality healthcare; strengthening families as they prepare and care for children; and, promoting safe and healthy environments.

[DC Health Perinatal and Infant Mortality Report 2018](#) **NEW!**

Meetings

[Improving Perinatal Health in the District Meeting \(10/23/18\)](#)

Perinatal Health Programs

Baby Friendly Hospital Initiative

Initiative to implement evidence-based maternity care in District hospitals and birthing centers to achieve optimal infant feeding outcomes and mother/baby bonding.

[Chronic Disease Self-Management Program](#)

Evidence-based program to teach DC residents skills (such as learning healthier eating habits; communicating with doctors and making informed treatment decisions) to improve chronic disease (diabetes, hypertension) outcomes.

[DC Healthy Start](#)

Comprehensive assessments and linkages, health promotion and education for preconception, prenatal, interconception, and postpartum women and their families.

DC Hears

Ensures all infants born in the District of Columbia receive a newborn hearing screening and all abnormal screens receive appropriate follow up care.

DC Quitline Pregnancy Program

Offers education, nicotine replacement therapy and individual counseling for all District residents. The Pregnancy Program offers enhanced behavioral support through additional counseling sessions and postpartum follow up to prevent relapse.

Greater Access Program

Provides community navigators for residents facing barriers to employment enrolled in a work readiness program at the Department of Employment Services. Navigators assist with providing supports for parenting, behavioral health and other social needs (ex. housing, healthcare, food access).

Healthful Food Access Programs

Programs include farmers market incentive programs and free pop up markets at elementary schools.

Help Me Grow

Systematically connects children at-risk for developmental delays and disabilities with needed services through comprehensive physician and community outreach and centralized information and referral centers.

Immunization Program

Works with families, providers and community partners to ensure children and adults in the District are protected against vaccine-preventable disease.

Maternal, Infant Early Childhood Home Visitation (MIECHV)

Evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.

Newborn Metabolic Screening Program

Ensures all newborns born in the District of Columbia have screening for metabolic and genetic disorder, and ensures all abnormal screens receive appropriate follow up care.

Perinatal Hepatitis B Prevention Program

Works with clinical providers and birthing facilities to identify Hepatitis B infected mothers and ensure protocols to decrease transmission to their infants.

Perinatal HIV Program

Links HIV positive pregnant women to care and services and following up on the health-status of the infants.

Perinatal Oral Health Program

Education and training to increase awareness of early childhood and prenatal oral health prevention and care for maternal and child health providers and community based organizations.

Place-Based Initiatives

Innovative programs located in neighborhoods or housing communities to improve health outcomes for children ages zero to five and their families. These programs meet a critical need to provide multi-generational supports for all the District families who do not want a home visit.

Safe Sleep and Fetal Alcohol Spectrum Disorder (FASD) Program

Safe sleep and FASD education for all District residents in community based settings. Program participants receive free Pack-‘N-Plays for DC residents to provide safe sleep environments for infants. DC Health provides trainings to maternal and child health partners and community-based organizations.

School-Based Health Centers

Comprehensive primary care clinics located within schools to reduce barriers to adolescents accessing primary healthcare services, including medical, oral and behavioral health. Centers also care for children of enrolled students.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Program services include health assessments, nutrition intervention, education and counseling, breastfeeding promotion and peer counselor support along with a monthly, nutritionally prescribed tailored food package that includes healthful food options.

Supplemental Nutrition Assistance Program: Nutrition Education and Obesity Prevention (SNAP-Ed)

Behavior-based health and wellness educational activities to prevent obesity by promoting increased consumption of healthful foods and daily physical activity for SNAP-eligible residents.

Teen Pregnancy Prevention Programs

Seven evidence-based or evidence-informed programs are being implemented in clinical, school or community-based

settings to promote youth social-emotional development and to increase access to adolescent-friendly health services. Programs includes Children's National Medical Center Generations Program, Sasha Bruce Teen Outreach Program, Florence Crittenton Services of Greater Washington SNEAKERS and PEARLS programs, the Urban Institute PASS program, Healthy Babies Inc., Big Brothers Big Sisters, and Young Women's Project.

Tobacco Control Program

Provides awareness and education on the harmful effects of secondhand smoke exposure. Efforts include targeted public health campaigns for pregnant women and mothers on the impact of smoking during pregnancy and secondhand smoke exposure; and, training and technical assistance on the health effects of smoking and tobacco use to programs that directly serve mothers and children.

The Hartford Courant

Hartford Moves Forward With Restrictions On Faith-Based Pregnancy Centers

By JENNA CARLESSO | JCARLESSO@COURANT.COM | SEP 19, 2018 | 6:00 PM



A public hearing on the city's ordinance to ban deceptive practices at faith-based pregnancy centers in Hartford drew hundreds of people last fall.

(John Woike / Hartford Courant)

Hartford leaders will press ahead with enforcement of a controversial ordinance banning deceptive practices at so-called crisis pregnancy centers, which critics say sometimes pose as medical clinics to

lure women and hand out misleading information about abortions.

The city council adopted the ordinance in December, with the aim of enforcement beginning July 1. The mandate requires faith-based pregnancy centers to disclose whether their staff carry medical licenses, and it prohibits the establishments from engaging in false or deceptive advertising practices.



Anti-Abortion Groups Rally After U.S. Supreme Court Ruling Prompts Hartford To Suspend Pregnancy Center Restrictions

JUN 26, 2018 | 7:15 PM

The city suspended its plans for enforcement in late June after the U.S. Supreme Court overturned a California law that required the centers to tell clients they can access free and low-cost abortion plans. Justice Clarence Thomas wrote in the court's majority opinion that California had unlawfully compelled the faith-based centers to give women information inimical to their beliefs.

But Mayor Luke Bronin said Wednesday that, after consulting with lawyers, Hartford plans to move forward with enforcement. Starting Oct. 1, pregnancy centers in the city that do not have a licensed medical provider on staff or on site must post a sign in the window and in the reception area saying so. Signs must be in English and Spanish. The centers are also required to disclose it on telephone calls and on their websites.

"The California law required a lot more affirmative statements by the centers," Bronin said.

"This is a very simple, narrowly tailored disclosure. ... We have consulted widely, we have talked to a legal expert in this area and we are confident that our ordinance as enacted will withstand challenge."

The city's health and human services department will be in charge of enforcement. Fines of \$100 a day may be levied against centers that violate the ordinance.

In Hartford, officials have targeted a facility on Jefferson Street called the Hartford Women's Center, located just steps from an independent abortion clinic. They say the Women's Center was set up there to intercept patients heading for the clinic.



Sample signs created by the city of Hartford demonstrated the type of disclosures that the so-called crisis pregnancy centers will have to make beginning in October. (Jenna Carlesso / Hartford Courant)

Sarah Croucher, head of NARAL Pro-Choice Connecticut, an abortion rights group based in Hartford, said the women's center patterned its signage after the clinic's to confuse people.

"The problem with these centers is not that they are religiously based counseling centers that are opposed to abortion. It's the deception that they practice," she said. "They set themselves up to look to people who are seeking medical services as though they are actually medical centers offering genuine, unbiased medical advice."

Staff at the Hartford Women's Center could not be reached for comment Wednesday.



Hundreds Spar Over Proposed Pregnancy Center Ordinance At Hartford Council Hearing

NOV 20, 2017 | 9:55 PM

Molly Hurtado, executive director of the ABC Women's Center in Middletown, a faith-based pregnancy facility, called Hartford's new rules "obnoxious" and "unfair." She said her center and others in the coalition it belongs to do not mislead women seeking help. The Hartford Women's Center is not part of that coalition.

"It's so disheartening," Hurtado said. "On average, we all service thousands of women every year who freely

choose to come to our centers, so to paint this image that we are intentionally deceiving women is not only offensive to me ... but to all of the women who have freely chosen to come year after year."

Peter Wolfgang, executive director of the Family Institute of Connecticut, said he has arranged for a lawyer to assist the Hartford Women's Center, which is weighing whether to bring a lawsuit against the city.

He accused city leaders of colluding with Hartford's abortion clinic to draw clients away from the women's center.

"I hope it does end up in court and I hope the city ends up paying," Wolfgang said. "I think they're standing on very shaky ground."



Pregnancy Information Disclosure and Protection Ordinance Rule

Pursuant to an Ordinance of the Court of Common Council of the City of Hartford “Amending Chapter 17 of the Hartford Municipal Code To Add Article VI – Pregnancy Information Disclosure And Protection”, the Department of Health and Human Services issues the following Rule.

Specifically, Sec. 17-140 of the Ordinance of the City of Hartford requires that each pregnancy service center, as defined in the Ordinance, shall be required to disclose information regarding the services it provides in a manner “determined in accordance with rules promulgated by the City Department of Health and Human Services” as follows:

Sec. 17-140-1. Required Disclosures

- (a) Every pregnancy services center shall display at its facility(s), signs provided by the Department of Health and Human Services stating in English and Spanish: **“This facility does not have a licensed medical provider on site to provide or supervise all services” (Este centro no tiene un proveedor médico con licencia disponible para proporcionar o supervisar todos los servicios.)**
- (b) The Department will provide the sign on its website for downloading by pregnancy services centers. Each sign shall measure eleven (11) inches by seventeen (17) inches and the lettering shall be one inch high.
- (c) Every pregnancy services center shall post at least one of the signs in English and Spanish in a conspicuous place at the entrance of the pregnancy services center.
- (d) Every pregnancy services center must post the signs at every public entrance. If the pregnancy services center is located in an office building or other structure containing two or more independent units, the signs must be posted at each entrance used exclusively for entry to the pregnancy services center. The sign must be (1) posted on the outside of the entrance door and so that the distance from the top of the sign to the floor is between sixty-six (66) and seventy (70) inches and the distance between the frame of the door and the closest edge of the sign is not more than twelve (12) inches; (2) clearly and conspicuously visible to the client as she or he enters the pregnancy services center; and (3) laminated or protected by a clear sheeting or other suitable material so that the text will not be destroyed, soiled, distorted, or rendered illegible.
- (e) Every pregnancy services center shall post at least one sign in English and Spanish in any area where clients wait to receive services. If the waiting area contains a reception desk, the sign must be posted on the reception desk or on a wall at a location not greater than twelve (12)

inches from the reception desk. If the sign is posted on a wall, it shall be posted so that the distance from the top of the sign to the floor is between sixty-six (66) and seventy (70) inches. Each sign shall be laminated or protected by a clear sheeting or other suitable material so that the text will not be destroyed, soiled, distorted, or rendered illegible.

- (f) Every pregnancy services center shall post the required disclosure in English and Spanish in a conspicuous manner in at least a 14 pt. font size on the front page of its website.
- (g) Whenever a client or prospective client requests, either in person or by telephone communication, any of the following services: (1) abortion; (2) emergency contraception; or (3) prenatal care, every pregnancy services center shall orally disclose that its **“facility does not have a licensed medical provider on site to provide or supervise all services” (Este centro no tiene un proveedor médico con licencia disponible para proporcionar o supervisar todos los servicios.)**

This Rule shall be effective October 1, 2018.

Two years after opening new facility for domestic abuse survivors, Sojourner Family Peace Center keeps growing

Ashley Luthern, Milwaukee Journal Sentinel

Published 10:32 a.m. CT Nov. 9, 2017 | Updated 10:00 a.m. CT Nov. 10, 2017



(Photo: Mike De Sisti / Milwaukee Journal Sentinel)

She can remember when she knew it was time to leave.

Her husband shoved her as she was holding their 4-month-old daughter, sending them tumbling backward.

Grateful her daughter was not hurt but still shaken by what happened, she called a crisis hotline in Washington County.

Minutes later, West Bend police were at her door and her husband was in handcuffs.

"You realize you have to go, right? This is your chance," the officer told her.

"No, he will lose his job, we will lose the house," recalled Emily, who asked to be identified by her first name because of the sensitive nature of domestic violence.

She bailed him out of jail that night and did not press charges, but she seriously began thinking of leaving him.

A couple of months later, he beat her until "she saw stars," she said. She got up, grabbed their daughter and drove to her parents' house in Milwaukee.

Suddenly, she became a 28-year-old single parent, with no college degree, no insurance, no independent housing, no health care.

She called the hotline and was referred to Sojourner Family Peace Center in Milwaukee.

Within a week, advocates and partners at the center had helped her file for divorce, enroll her daughter in day care, get health insurance, apply for food assistance and gave her a gift certificate to Goodwill to buy furniture.

Her experience shows the benefit of having all those services and partners together in the multimillion-dollar center, located at the corner of N. 6th and W. Walnut streets in Milwaukee.

"In the first year or two, we were in a new reality," said Carmen Pitre, the organization's chief executive, in a recent interview.

"In a lot of ways, Sojourner is pivoting toward more normal operations," she said.

The center opened nearly two years ago, bringing under one roof representatives from Sojourner, Children's Hospital of Wisconsin, Milwaukee Public Schools, Jewish Family Services, the Milwaukee Police Department's Sensitive Crimes Unit and the district attorney's office, among others.

The large investment of private and public dollars — the state provided a \$10.6 million grant — put Milwaukee at the forefront of a movement to centralize services for domestic violence victims and their children.

As officials expected, more people have continued to come to the new center:

- Nearly 9,000 clients have been helped so far this year, a roughly 16% increase from the same time in 2016.
- More than 14,000 hotline calls have come in, about 3% more than last year.
- In total, Sojourner has had more than 60,000 contacts with clients in the community.

Prosecutors are seeing more domestic violence cases referred for charges — up 25% so far this year, compared with last year — and in an increase in victims willing to sit down and discuss cases, Chief Deputy District Attorney Kent Lovern said.

"It helps us to hear from them to know exactly what's going on within the relationship and what could be the right steps to take," he said.

But that increase has come with challenges.

The volume of referrals and having two locations to meet with victims — the center and the court facility — has stretched resources, especially after a cut in federal funding resulted in one fewer domestic violence prosecutor, he said.

Pitre says she wants to get further upstream of the problem before the criminal justice system gets involved.

"Why do we wait until an arrest is happening?" she said. "Why am I not talking to you when the baby's born?"

She envisions a possible future in which a hospital social worker talks to a new mother, discussing how life will change, pressures she might feel with a new child and asking about her relationship and if she feels safe.

"I think the future of the work is to try to open those types of doors," Pitre said.

For Emily, her focus is on the future. She is enrolled in college to study marketing and has received several scholarships for abuse survivors to help her pay for school.

"Their reach is everywhere, it's not just this building," she said.

When she described how grateful she is for Sojourner, a staff member turned the conversation back to her.

"You're the one doing all the work," said Julie Yeado, Sojourner's supervisor of life skills and strategic partnerships.

"We simply laid it out for you and showed you your options," she said.

The Sojourner Family Peace Center in Milwaukee operates a 24-hour hotline at (414) 933-2722. The Milwaukee Women's Center offers a 24-hour crisis line at (414) 671-6140.

Pacific Standard

ONE SMALL CITY IN NEW YORK IS FINDING INNOVATIVE WAYS TO COMBAT DOMESTIC ABUSE

For years advocates have wondered: How can abusers effectively be held accountable for stalking, harassing, assaulting, threatening, or killing their current and former partners? Kingston, New York, might have an answer.

NATALIE PATTILLO

MAY 4, 2018

When Ulster County District Attorney Holley Carnright trains police officers on responding to domestic violence calls, he has one ask: Have a "give a damn approach." Officers and anyone working with those affected by domestic violence, he says, must be sensitive about victims' fears of their abuser retaliating, and an understanding of the ongoing cycle of violence in which offenders can trap victims. He tells officers to respond to victims' calls swiftly and thoroughly, without shaming or doubting victims who have trouble leaving abusive relationships, even if they've called for help before.

"Take some pictures, for God's sake. Do the same investigation you do in a burglary," Carnright tells me. "A call today for a low-level domestic violence incident, the next time [the victim] calls, this could be a homicide. Statistically, that's what happens. These cases escalate."

More than 10 million women and men throughout the country are abused each year, according to the National Coalition Against Domestic Violence; domestic abuse now accounts for 15 percent of all violent crime.

The majority of abuse victims are women. And those women who do flee a physically or emotionally abusive relationship are often at the highest risk. According to a report from the Domestic Violence Intervention Program, "women are 70 times more likely to be killed in the two weeks after leaving than at any other time during the relationship."

Some cities and states have begun to combat domestic violence by improving access to social services and engaging police departments in mandatory arrests, precipitated by victims' calls.

But mandatory arrests can prove ineffectual when offenders are released a day or even hours after the incident, or when law enforcement officers and judges let the offender off with a warning: A 2014 study found that only 59 percent of misdemeanor domestic violence cases result in conviction. For years advocates have wondered: How can abusers effectively be held accountable for stalking, harassing, assaulting, threatening, or killing their current and former partners? And how can their violent behavior be deterred?

Carnright, who has been district attorney for New York's Ulster County for 11 years, understands the data and the dilemmas. Last month, Kingston, New York (a city of about 23,000; also where Carnright's office is based), launched a pilot program, in partnership with the National Network for Safe Communities, that will both offer more government support to victims and provide offenders with

resources like anger management counseling and job training. Abusers are warned that, if their violent behavior continues or gets worse, legal action will be taken. In essence, abusers are being held accountable by prosecutors, police, and community victim advocacy groups. The program is the first of its kind in New York state.

As part of the program, the NNSC reviewed data from Kingston's Domestic Incident Report—which is made up of forms that police must complete every time they respond to a domestic incident, whether or not an arrest is made—to create a four-tier system to classify offenders and a system to hold them accountable. David Kennedy, one of the country's most celebrated criminologists and director of the NNSC, developed this strategy, also known as "focused deterrence." Focus deterrence has shown success in High Point, North Carolina (population: about 111,000), where there has been a reported decline in intimate partner homicides since 2015, when the strategy was implemented.

According to *Governing Magazine*, High Point's district attorney's office and arresting officers used a four-tier system, similar to Kingston's. D-Class offenders are first-time offenders; they were also given resources, anger management training, and warnings about escalating charges from patrol officers. Repeat offenders were reclassified as C-Class offenders, accompanied by a visit from the sergeant of Kingston's police department, and increasingly severe punishment. The next offense leads to reclassification as a B-Class offender; offenders are required to meet with a multi-department task force of officers, prosecutors, social services providers, and city representatives to offer rehabilitation services and a stern warning—one more incident, and they'd be labeled an A-Class offender, a classification that means prosecutors would be seeking the maximum punishment allowed by law. First-time offenders who have committed egregious domestic violence offenses using a weapon or causing significant injury can also be classified as an A-Class offender.

The intervention cannot be done, especially if the victim is still with the abuser, without local police, prosecutors, and domestic violence advocacy groups working in tandem to provide victims with safety through trauma-informed support and resources simultaneously.

When High Point services followed up with victims, they learned that the offenders had taken the increasing warnings seriously. The abusers were initially angry that they couldn't charm their way out of trouble, but, for the most part, they didn't retaliate against their partners for the law enforcement's intervention. A year into the program, High Point officers found that only 9 percent of listed offenders had assaulted again, in comparison to 20 to 34 percent of abusers nationally. In 2016, recidivism rates were so low that High Point didn't have to schedule a call-in for B-Class offenders.

While it's hard to gauge whether the program will be as effective in Kingston, prioritizing interdepartmental cooperation and victim safety is paramount to success.

"Family of Woodstock is very pleased to be working with the DA, his staff and other partners to hold perpetrators more accountable for their violence," executive director Michael Berg said in a press release. "The more perpetrators are held accountable, the more likely they will not re-offend."



BY NATALIE PATTILLO



In Columbus, Expectant Moms Will Get On-Demand Rides to the Doctor

LAURA BLISS

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To address high rates of infant mortality, the Ohio city will pilot a novel ride-hailing service designed for low-income pregnant women.

Next year, Columbus, Ohio, will use 21st century transportation technology to address a health crisis that should belong in the Victorian era: rising rates of infant mortality.

Running from June to November 2019, a pilot program will aim to connect pregnant women with on-demand rides to doctor's appointments and other daily errands, such as grocery shopping and pharmacy trips. The pilot will include 500 women in the early months of pregnancy who are enrolled in Medicaid, and who live in one of the eight Columbus neighborhoods where the most babies are dying within the first year of life.

In an email to CityLab, Courtney Lynch, a professor of obstetrics at the Ohio State University who is co-leading the evaluation of the pilot, called the program "a completely novel intervention," designed to research whether lowering barriers to prenatal care and reducing gaps in transportation for low-income women can eventually treat the city's darkest public health issue. "The long-term goal is to use the information gathered to reduce infant mortality," she said.

Access to prenatal medical care is considered essential for preventing preterm births and congenital anomalies, two of the main drivers of infant mortality. Another critical force behind preterm births is stress, which is abundant in the lives in many poor women who may lack stable jobs, housing, and transportation, medical research shows. Black women can also face the added stress of racism in daily life.

Currently, Medicaid subscribers in Ohio can schedule rides on paratransit shuttles to travel to medical appointments, but these services are unreliable and difficult to coordinate, according to users who rely on them.

Under the pilot, participants will be able to book free rides on the Uber-like service via app, text, or call center; the app will also notify healthcare providers when patients are on the way. The service will remain available to mothers in the first two months after they give birth.

The prenatal trip assistance pilot will be funded with part of Columbus's \$50 million Smart City Challenge grant. The 2016 grant competition by the U.S. Department of Transportation was designed to spur local governments to solve big urban problems with cutting-edge transportation technology. Columbus's winning proposal included a suite of projects, such as a multimodal transportation app, expanded car-sharing, and autonomous vehicles roving around key destination points. (Low-speed, self-driving shuttles debuted at four Columbus tourist attractions earlier this month.) But addressing the plight of Columbus's vulnerable new mothers through mobility was a focal point of its proposal, and was cited by officials as a primary reason for the city's victory over competitors like Denver and San Francisco.

As of late last year, however, that key social promise seemed to have slipped off the list of the city's prioritized projects. A CityLab investigation found that, as plans were moving ahead for other components of the grant, the needs of vulnerable moms were at risk of being left behind. After the investigation was published, the city altered its portfolio of DOT-approved grant projects to include a service for low-income, expectant mothers. Earlier this month, the Columbus city council approved the use of \$1 million from the Smart City grant fund to pay for the 2019 pilot.

The United States has higher rates of infant mortality than any other wealthy nation in the world, with 5.8 deaths per every 1,000 live births. The public health crisis disproportionately affects black families, with black babies dying at 2.4 times the rate of white babies nationwide. Ohio has long landed towards the bottom of national rankings, and Franklin County is one of the state's hotspots, with about 150 infant deaths per year. Although the state's rate fell slightly in 2017 overall, the disparity between white and black infant mortality rates grew.

Once hidden away by taboo and shame, the conversation around infant mortality is changing in Columbus, said Jessica Roach, the executive director of R.O.O.T.T., a local reproductive and racial justice organization. With more voices like hers calling for radical action, more medical literature identifying stress as a physiological health risk, and a wave of national reporting around the twin issues of maternal and infant mortality, "the needle is moving here," Roach said.

To her, the fact that the transportation pilot includes trips to grocery shopping and other daily errands signals a greater recognition by city officials that infant mortality is about more than getting moms to doctor's offices. "You can't have an impact by just addressing prenatal care," she said. "You have to look at the overall holistic picture of women's lives."

About the Author

Laura Bliss

@MSLAURABLISS

Laura Bliss is a staff writer at CityLab, covering transportation and technology. She also authors MapLab, a biweekly newsletter about maps ([subscribe here](#)). Her work has appeared in the *New York Times*, *The Atlantic*, *Los Angeles* magazine, and beyond.