NEVADA COUNTY citizens for CHOICE

Voices for Choice

Summer 2019

QUARTERLY NEWSLETTER

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

Voices for Choice

THE TRUTH ABOUT ANTI-CHOICE LIES—AND WHY THEY'RE WRONG

Anti-choice zealots often win the war of words about abortion. The time for those of us who are pro-choice to be pleasing or to attempt nuance is long past. By allowing the antis to call those of us who support accessible reproductive health care for all women "murderers," and clumps of cells "innocent babies," we allow them to decide the terms of the debate and to put us on the defensive. Here are some talking points. It's time for us to claim the high ground—to talk about how anti-choicers want to kill women (which no access to reproductive health care will do), leave babies in impoverished homes, and increase the suffering of all women across the globe. Remember, WE are pro-life—ALL life. Use the term and make them ask you why. Then tell them.

Abortion Causees Mental Suffering: For many women—the girl raped by a family member, the woman whose baby is not viable, the 17-year-old who wants to go to school, the poor woman or woman of color who has no insurance and does not want to give birth in a maternity care system that is deadly for black women, abortion is a reasonable choice. Research consistently says that women are more likely to report grief, anger and sadness about a pregnancy than an abortion. The emotion women were most likely to feel after an abortion is relief. Abortion does not cause depression or anxiety. And while we know that a small number of women experience emotional issues after abortion, this is common after every major life event.

The "Abortion Industry" is Only In It for the Money: The truth is, doctors and other medical professionals take large pay cuts to perform abortions. The average abortion doctor earns $105,000; the typical OB/GYN earns nearly $250,000. Medical professionals who perform abortions do it because they want to help others. And most clinics charge barely enough to cover their expenses.

The Anti-Choice Movement Wants to Save Women's Lives: The U.S. is the most dangerous place in the developed world to give birth and one of the few countries in the world in which maternal mortality has increased over the past 25 years. If we really cared about women, wouldn't we make giving birth a safe and medically non-dangerous procedure? Research consistently finds that banning abortion kills women. In nations that prohibit abortion, the rate of dangerous secret abortions skyrockets and suicide becomes a leading cause of maternal death. States that attempt to ban all abortions with no exceptions or who make the procedure a felony only succeed in subjecting women to punishment and, sometimes, death, as a penalty for being raped, for example.

Anti-Choice Laws Stop Abortion: This we know is patently untrue. Research confirms that the abortion rate has fallen slightly in recent years because of expanded access to birth control and to abortion under the ACA. Not restrictive abortion policies. In Latin America where abortion is banned, the rate is more than three times the rate in the U. S. And, if women are forced underground, they will die from botch abortion attempts.

Abortion is Bad for Women's Health: Anti-Choice fanatics have no concern for women's health. If you oppose affordable health care, want to treat pregnancy as a pre-existing condition and take no steps to reduce maternal mortality, your claim to care about women is specious and nonsensical. Peddling the lie that abortion causes breast cancer is another lie that harms women. The American College of Obstetricians and Gynecologists (ACOG), a nonpartisan professional organization for OB/GYNS emphasizes that abortion care is critical to women's health.

Pierce the myths and lies. Re-claim the moral high ground. Speak truth to protect and save women's lives.

Resource links for this article:
Link 1, Link 2, Link 3, Link 4, Link 5,

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Citizens for Choice

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Public Policy

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PUBLIC POLICY AND ADVOCACY

The onslaught of policy challenges to reproductive health and justice in recent years has grown to even more dangerous levels in 2019. Challenges come in the form of regulatory changes to federal programs and policies that aim to reduce access to sexual and reproductive healthcare; state laws restricting access to abortion and birth control; and the failure of our highest court, the U.S. Supreme Court, to exercise its historic role in protecting reproductive rights against such challenges.

In the face of such headwinds, Citizens for Choice is committed to maintain its bedrock principles in support of women's autonomy over their bodies and their rights to reproductive healthcare. That includes access to abortion and family planning services. And we remain committed to ensuring that all of our fellow Americans have access to essential sexual and reproductive healthcare.

EXPANDING MEDICATION ABORTION ACCESS

On the legislative front, a major priority is expanding access to medication abortion services on California campuses (SB 24). The bill would establish a funding mechanism to help ensure that all universities have the full funding and support necessary to begin providing medication abortion and improve family planning options in their on-campus clinics.

PRESERVING TITLE X

On the regulatory front, we are coordinating our actions with our allies at the California Coalition for Reproductive Freedom to maintain the highly successful federal family planning program known as Title X. Since 1970, it has provided funding for essential, time-sensitive health care for low-income women, men and teens across our state and throughout the country. California is home to the nation's largest and most diverse Title X provider network, serving 1,000,000 Californians each year. We oppose recent Title X regulations that threaten abortion and healthcare access, and patient-doctor relationships.

MAKING COMPREHENSIVE SEX EDUCATION A REALITY IN CALIFORNIA

On the administrative front, we support the ongoing implementation of the California Healthy Youth Act (enacted in 2015). Making the sex ed law fully effective in our state and our local school districts is a major undertaking. The most recent advance was the adoption by the State Board of Education of a Health Education Framework in May, 2019, to define and set curricula standards.

CONCLUSION

We occasionally ask that our supporters join in our advocacy, by contacting policy makers on specific measures. Thank you to all who take action to help make a difference, advancing reproductive health and rights and the cause of reproductive justice for us all.

Elaine L. Sierra, Esq.
Public Policy Director

Voices for Choice

30 YEARS
1989-2019

Please join us in Celebrating 30 Years of Choice in Nevada County!

Thursday, Sept 19th, 2019
5:00-8:00 p.m.

Please rsvp to:
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before September 12th.
Trolley Junction Restaurant
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Voices for Choice

JUNE 19, 2019 | Kathryn Kolbert | HEALTH, POLITICS

ABORTION RESTRICTIONS: WE HAVE BEEN HERE BEFORE, AND HERE IS WHAT WE LEARNED.

abortion restrictions proliferate, protesters around the country are making their voices heard. Photo by Fibonacci Blue from Minnesota, USA [CC BY 2.0].

Over the last several months, a plethora of states have passed onerous restrictions on abortion. Pundits have called this onslaught unprecedented. While it is certainly true that the number of states successfully passing anti-abortion bills within a short window of time is the worst we have ever seen, the tactics we are seeing today have been used repeatedly over the last several decades. These tactics include bans on abortion at particular stages of pregnancy, after there is a detectible cardiac activity, for example, or after 20 weeks of gestation; bans on abortions for particular reasons such as sex selection or fetal anomalies; or laws that ban particular types of abortion procedures, usually those used in the second trimester. The Alabama law, considered the most onerous of all time, prohibits all abortions except those necessary to save the life of the woman, an extremely rare occurrence. In the early 1990s, Utah, Louisiana, and Guam also banned nearly all abortions, and other states were considering such measures.

Other current legislative activity restricting access to abortion has its roots in earlier decades. Between 1988 and 1992, as now, state legislatures across the country considered and passed a host of restrictions intended to intimidate doctors or to make abortion more expensive for women or more difficult to obtain, particularly for poor women, young women, or rural women.

The flurry of activity in the 1990s and now were driven by the changing composition of the Supreme Court. Then as now, anti-abortion legislators believed that the Supreme Court was poised to overturn *Roe v. Wade* and wanted to push test cases to the Court to ensure review of the constitutional standards that protect legalized abortion.

In 1992, I represented the abortion providers of Pennsylvania who were challenging restrictions on abortion in the seminal case *Planned Parenthood v. Casey*. My co-counsel and I fully expected the Supreme Court to reverse *Roe v. Wade* in our case. In fact, the Court after oral argument voted to overrule Roe and permit states to recriminalize abortion. Any legislative restriction, so long as it was rational (and protection of fetal life was considered rational), would be permissible.

To our surprise, we got a reprieve. Justice Kennedy changed his vote and supported a joint ruling that preserved legal abortion up to viability and thereafter if necessary to protect women's health. At the same time, the Court gave states additional latitude to restrict abortion. In the intervening 27 years, abortion has remained legal and available in every state, albeit with additional hurdles that adversely affect poorer and younger women.

When considering the constitutionality of these new laws, I start with the premise that the current Court is likely to use any abortion case, not just the bans on abortion, to give states the ability to recriminalize abortion. Why am I so pessimistic? First and foremost, the Supreme Court today is more conservative than in 1992 and Chief Justice Roberts, unlike Justice Kennedy, has shown his willingness to overturn precedent if five members of the Court disagree with the initial basis for the decision. Just this term, he joined the opinion of the Court in *Franchise Tax Board of California v. Hyatt*, in which the liberal dissenting justices cautioned that reversing "a well-reasoned decision that has caused no serious practical problems in four decades" caused them "to wonder which cases the Court will overrule next." And the chief justice has sided with anti-abortion advocates, voting in 2007 to uphold a federal late-term procedure ban and dissenting in 2016 when the Court struck down onerous Texas provisions that targeted abortion providers and restricted access in that state. It is not clear when the Court might accept a case for review, as they may want to avoid the issue before the 2020 elections, but I am confident that the end of federal constitutional protection for abortion will happen.

Contrary to many pundits, I also believe that once states are given the green light to recriminalize abortion, many will do so and do so quickly. Five states already have trigger laws that may automatically ban abortion with only very limited exceptions, once *Roe/Casey* are overturned, and at least two other states are considering similar laws. As noted by *The New York Times*, for the first time in over 100 years, Republicans control the governor's seat and both houses of the legislature in 21 states, and these legislative bodies are overwhelmingly opposed to abortion and indebted to the anti-choice lobby. State legislative gerrymandering and voter suppression in these states will make

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it very difficult to overturn this trifecta of power in many locales.

Third, I believe that those who oppose abortion will not stop when abortion is made illegal in some states. Anti-choice advocates will push to limit women's rights in a wide range of circumstances, pushing for restrictions on birth control, limiting funding for Planned Parenthood and family planning services, expanding fetal rights, diminishing protections for survivors of domestic violence and sexual abuse and harassment, rolling back marriage equality, and more.

What did we learn from our experience in *Planned Parenthood v. Casey?* What can we do now to help preserve the constitutional liberties that generations of women have relied upon for nearly 50 years?

I learned from Casey that pro-choice Americans must prepare for the likelihood that *Roe* will be overturned, and work to ensure that as many women in the nation as possible understand that future access to necessary health services is in jeopardy. We cannot wait until rights are lost. We need to begin now to fight for their preservation. Almost everywhere I go, there is the hope that this will not happen, that Justice Roberts will go slowly, that women are being alarmist. We need to believe that our rights are in jeopardy and work to preserve them.

I also learned that public resistance makes a difference. Between 1988 and 1992, pro-choice Americans attended large-scale demonstrations in Washington and at state legislatures, joined political campaigns to elect a pro-choice president and Congress, and made their voices heard in the public arena. This public resistance helped increase public support for *Roe v. Wade* and made abortion a big issue in the 1992 presidential campaign.

As we recently saw, public resistance did not derail the appointment of Justice Kavanaugh to the Supreme Court. Nevertheless, it activated women across the nation to become politically active in the 2018 elections and to run for office in unprecedented numbers. The pictures of women sitting in the halls of the Senate, challenging the status quo, helped spread the message that the federal courts are now in the hands of conservative forces and that we will need to find protections in other venues.

But in addition to public resistance, those who care about reproductive justice must become politically active — not just on social media or in the voting booth, but in both federal and state-level campaigns. Canvassing, texting, phone calls, and postcarding, as well as fundraising for pro-choice candidates, while tedious, is the best way to win elections.

The strategy is simple: At the federal level, we need to win back the presidency and the U.S. Senate. Some of the 23 Democrats running for president or prominent Democrats sitting on the sidelines should run for the Senate so that we can relegate Mitch McConnell to minority leader.

Equally important, we need to break up the trifectas, in which Republicans control the governorship and both houses of the legislature in 21 states. Flipping gubernatorial seats, reducing the margins of control, and where possible flipping control in one or both houses should be our primary goals.

There are currently only 18 states that are controlled by Democratic pro-choice lawmakers. Some of them have already moved to weave a patchwork of protections for reproductive choice for women in those states. We need to expand that number, and it can be done. For example, there are realistic chances of winning back one or both chambers in Virginia and Pennsylvania in 2020, and hard work at the state level will make a difference.

And of course, the election or appointment of state supreme court judges must be on our priority list. State courts have the ability to interpret their state constitutions in ways that protect women, even if that protection is not available at the federal level. The Kansas Supreme Court recently established a state right to abortion that will remain, even if Roe is overturned. The right wing has paid attention to state Supreme Courts and invested in running conservative candidates for the last decade. We need to do the same.

Lastly, we need to pay attention to voting rights, for voting rights is a women's issue. Gerrymandering and voter suppression enable conservative minorities to preserve power, even in the face of public opposition. Expanding the electorate is a key way to win more support in states that are passing these draconian laws. The recent close election in Georgia is but one example of how voter suppression skewed the election, and there are many more.

My experience in *Planned Parenthood v. Casey* has taught me that there is no substitute for public resistance and political activism. Please share these lessons and get to work.

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THE TURNAWAY STUDY

Presented by the Bixby Center for Global Reproductive Health, the University of California San Francisco (UCSF) and Advancing New Standards in Reproductive Health (ANSIRH).

It is estimated that more than 4,000 women are denied wanted abortions due to facilities gestational limits every year. **As more states pass gestational limit laws, thousands more will be affected.**

The Turnaway Study was the first study to rigorously examine the effects of receiving versus being denied a wanted abortion on women and their children. Nearly 1,000 women seeking abortion from 30 facilities around the country participated. Researchers conducted interviews over five years and compared the trajectories of the women who received a wanted abortion to those who were turned away because they were past the facility's gestational age limit. **As legislators pass more and more laws to restrict access to abortion care, it's important to document what happens to women who are unable to obtain an abortion.**

RESULTS

Abortion does not harm women. It does not increase women's risk of having suicidal thoughts, or the chance of developing PTSD, depression, anxiety, low self-esteem, or lower life satisfaction. Abortion does not increase women's use of alcohol, tobacco or drugs. 95% of women said abortion was the right decision for them. Women who received a wanted abortion were more likely to have a positive outlook on the future and achieve aspirational life plans within one year.

BEING DENIED AN ABORTION REDUCES WOMEN AND CHILDREN'S FINALCIAL SECURITY AND SAFETY.

Women denied an abortion had almost four times greater odds of a household income below the federal poverty level and three times greater odds of being unemployed. There was an increased likelihood that women didn't have enough money to pay for basic family necessities like food, housing and transportation if they were denied an abortion. Women unable to terminate unwanted pregnancies were more likely to stay in contact with violent partners, putting them and their children at greater risk than if they had received the abortion. Continuing an unwanted pregnancy and giving birth is associated with more serious health problems than abortion.

WHEN WOMEN HAVE CONTROL OVER THE TIMING OF PREGNANCIES, CHILDREN BENEFIT

Existing children of women denied abortions were more than three times more likely to live in households below the federal poverty level and they were less likely to achieve developmental milestones than the existing children of women who received abortions. Nine percent of children born because an abortion was denied met the threshold for poor maternal bonding, compared to three percent of children born subsequently to women who received an abortion.

OUT-OF-POCKET COSTS

Out-of-pocket costs for women whose insurance or Medicaid did not cover abortion were $575. For more than half, out-of-pocket costs were equivalent to more than one-third of their monthly personal income. It cost closer to two-thirds of their monthly personal income for those receiving abortions after 20 weeks.

For more information about the Turnaway Study and detailed references, visit http://bit.ly/TurnawayStudy.

Thank you to participating condom fairy locations throughout Nevada County!

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RHETORIC VS. REALITY: SETTING THE RECORD STRAIGHT ON MEDICATION ABORTION

Excerpted from a June 2019 article from the Center for American Progress
By Nora Ellmann, Kelly Rimar and Jamila Taylor

Medication abortion can be a key tool in the fight for reproductive choice: It has the potential to bring abortion access to those who need it most—particularly people of color, low-income people, people in rural areas, and others who cannot easily access providers giving individuals greater agency over their health care decisions.

Medication abortion, or abortion with pills, is safe, effective, and less invasive than a surgical procedure and gives people the option to have an abortion outside of a clinic in the comfort and privacy of their own homes. Yet despite the proven record and benefits of the medication abortion regimen, anti-choice groups continue to spew false claims about its safety.

As access to quality reproductive health care is under siege, it is crucial to recognize and correct the lies around medication abortion that anti-abortion groups have propagated in order to influence federal and state policies. Ellmann, Rimar and Taylor have detailed the truth behind myths about medication abortion.

MYTH 1: MEDICATION ABORTION IS UNSAFE

Reality: The medication abortion regimen is used in the first 10 weeks of pregnancy and consists of two medications: mifepristone and misoprostol. Mifepristone is taken first, generally in a clinic or health center, followed by misoprostol one to two days later, usually at home. Mifepristone, the first of the two pills, has extremely low rates of adverse events and is safer than many medications, including Tylenol and Viagra.

In 2016, after a thorough review of medical evidence, the U.S. Food and Drug Administration (FDA) extended the eligibility period from seven weeks to 10 weeks gestation and reduced the approved dosage from 600 mg to 200 mg.

In March 2018, the U.S. Government Accountability Office (GAO) issued a report affirming that the FDA acted appropriately in revising the Mifeprex label in 2016, despite anti-choice advocates' claims to the contrary.

Mifepristone remains much more heavily regulated than other prescription drugs as a result of the politicization of abortion care. The FDA has required a Risk Evaluation and Mitigation Strategy (REMS) for mifepristone. The mifepristone REMS limits its distribution; providers must register to be permitted to distribute mifepristone, and it can only be distributed in hospitals, clinics, or medical offices. This means that under the REMS, mifepristone is not available at pharmacies and can only be prescribed by a limited number of providers, which significantly and unnecessarily restricts access to medication abortion—particularly for people who live far from a clinic or do not have an approved provider in their area. ***The American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) support lifting the REMS, as they are not medically necessary!***

MYTH 2: MEDICATION ABORTION IS TRAUMATIC

Reality: Everyone experiences abortion differently, and those who have abortions are entitled to the full range of emotions about their experience. However, research and powerful personal storytelling indicate overwhelmingly that people do not regret their abortions. So-called post-abortion syndrome, which anti-choice groups often point to as evidence of the traumatic effects of abortion, is not recognized by the American Psychological Association and decades of research have disproven the claim that abortion compromises mental health.

As for the physical experience of a medication abortion, most people report bleeding, nausea, cramping, and fatigue. These symptoms resemble those of a heavy period, and over-the-counter medications such as Ibuprofen are recommended for pain management. Most people may resume normal activity within a day or two after a medication abortion.

If there is any trauma involved in abortion care, it is the struggle of having to navigate unjust restrictions on abortion access and attacks from anti-choice protesters and politicians. The landmark *Turnaway Study* from Advancing New Standards in Reproductive Health (ANSIRH) provides evidence of this experience. The study found that while having an abortion was not associated with mental health issues, being denied a wanted abortion was associated with anxiety and low self-esteem in the short-term. The option to end a pregnancy at home provides patients with greater access to care and prioritizes autonomy and comfort in the abortion experience.

MYTH 3: MEDICATION ABORTION IS INEFFECTIVE AND REVERSIBLE

Reality: Medication abortion is more than 95 percent effective and has been used safely in the United States for nearly two decades. Although the two-drug protocol is recommended, misoprostol—the second medication—is about 75 percent to 90 percent effective in terminating an unplanned pregnancy when taken alone.

The medical community overwhelmingly agrees that claims of "abortion reversal" are unsupported by medical and scientific evidence. Promoters of this myth claim

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that abortion may be reversed after mifepristone is taken as long as the second drug, misoprostol, is not taken and the hormone progesterone is administered throughout the first trimester. However, **this simply is not true.** This implies that those who choose to have abortions second-guess themselves and later regret the decision. In reality, people who have abortions take their reproductive health decisions seriously and, as previously discussed, almost universally do not regret the decision.

CONCLUSION

Medication abortion is a proven safe and effective method that can significantly improve the availability and experience of abortion care. It is a powerful enabler of reproductive autonomy, allowing people to choose the abortion setting that is safest and most comfortable for them. To ensure access to this crucial health care option, we must put an end to the lies that undermine the health care decisions of all people seeking abortion care.

MODERNIZING SEX EDUCATION

Excerpted by Connie Di Cristina from Momentum Is Building to Modernize Sex Education by Catherine Brown and Abby Quirk

Lauren Atkins, a high school student from Norman, Oklahoma, was sexually assaulted by a classmate in 2017. In response, she collaborated with state lawmakers to write legislation that she believes would have prevented her attack. "I really don't think he did this to be a terrible human being," she said. "He didn't know that this wasn't allowed." How could the perpetrator have been so confused? Lauren's response was to advocate for more extensive and specific sex education in schools to combat the seduction of social media.

We are nearly half-way there. Only 24 of our 50 states mandate sex education. As of May, 2018, only 11 states and Washington, D.C., included references to healthy relationships, consent, or sexual assault. One year later, the number has grown to 21 states, and legislation is pending in six more. Students like Lauren and the newly elected female lawmakers are leading the way on this issue.

In addition to adding explicit language about consent and healthy relationships, four states (California, Missouri, New Jersey, and Wyoming) have enacted legislation to include discussion of the legal and emotional consequences of sharing explicit material through digital media. Sexting is rampant. In 2009, approximately 4% of 12- to 17-year-olds in the US had sent a sexually explicit message. In 2018, that number had more than tripled. Girls report feeling more pressure to send explicit content, and often their texts are sent on to others without their permission. Social pressure to engage in these actions can have devastating consequences, even suicide. It is imperative that every sex-education class include discussions regarding online consent and coercion.

LGBTQ youth have perhaps the most need for information and tools to stay healthy. According to the CDC's Youth Risk Behavior Survey, lesbian, gay, and bisexual youth are less likely to use condoms than heterosexual youth. They report their first sexual intercourse before 13, and are more likely to encounter physical dating violence, including forced sexual intercourse. LGBTQ youth also face unique forms of coercion such as the threat of being outed. Teachers must provide students with strategies to address the issues of consent and abusive behavior. Fortunately, California recently updated its sex education guidance to help teachers discuss gender identity as early as kindergarten and to give LGBTQ-specific advice about healthy relationships and safe sex.

One factor behind the growing momentum for changes to sex education standards may be student activism, as young people have bolstered most of the recent bills that have been proposed and enacted. Students have spoken about their personal experiences and the difference that better sex education could have made in their lives. Female legislators have also had an outsize impact on this issue. One-third of all bills currently moving through the legislative process were introduced by women who began their tenures in 2019. Yet, there is still more work to do. Topics of consent must reflect the ways in which today's young people interact, and discussions about healthy relationships are incomplete if they do not represent a diverse array of relationships.

Voices for Choice

SEX ED: CALIFORNIA GOING FORWARD

California teachers have a brand-new framework for teaching sex education, but not everyone is happy. LGBTQ advocates praise the new recommendations for including communities that are often left out of sex education, but other parents and conservative groups consider the document an assault on parental rights. They fear the new curriculum exposes children to ideas about sexuality and gender that should be taught at home. Yes, the guide includes tips for discussing masturbation with middle-schoolers, reassuring them it is not physically harmful. The guide also advises transgender teens on how to cope with puberty. Above the specific details is the overarching focus of teaching students how to navigate healthy relationships with others and with oneself. Michele McNutt, mother of two daughters aged 11 and 9, avidly endorsed the new curriculum: "Withholding medically accurate, scientific information actually causes more harm and does not protect innocence. If you don't give kids accurate information about their own body…how are they able to make good choices?" Beyond sex education, the new course extends and supports those "good choices" with traditional health-education subjects such as nutrition, physical activity, and combating alcohol and drug abuse. Still, some parents—and even teachers—rail against the course content. They prefer to keep their children in the dark. Thankfully California continues going forward.

WHOEVER SAID NUMBERS DON'T LIE?

In 2017, the CDC was proud to announce that 26 states had met the 2000 target of 6.0 infant deaths per 1,000 live births. Time to celebrate? Unfortunately, a closer look at the data reveals a disturbing inequity. For non-Hispanic White mothers, the infant mortality rate was 4.9. For African-American mothers, the rate was 11.4. Geographically, infant mortality rates were highest among the southern states of Oklahoma, Arkansas, Tennessee, North Carolina, Mississippi, Alabama, and Georgia. Rates were also higher in the midwestern states of Indiana and Ohio. Clearly, culture is a factor, and the cumulative stress of racism and sexism inordinately undermines the health of African-American mothers and their offspring.

In light of this data, the Center for American Progress has called for policymakers to improve the quality of care for African-American mothers and their infants by taking these steps:

- Provide more and easier access to affordable health care
- Recruit a diverse, compassionate, and respectful workforce
- Screen for and address each mother's mental health as well as physical health
- Continue to support both mother and child after birth through home visits and connections to community programs

Finally, federal policymakers have a responsibility to continue to collect and disseminate reliable, consistent data on maternal and infant mortality in order to identify data-driven solutions.

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