HAWAII FILIPINO CHRONICLE

www.thefilipinochronicle.com
SEPTEMBER 22, 2018

WOMEN'S HEALTH *Supplement*

Women Quit Smoking and Taking A Healthier Approach to Better Health and Wellness

ARTICLES INSIDE

Most people are already aware of the harmful effects of smoking cigarettes. This awareness, coupled with the rising cost of cigarettes, have led to a drop in the number of smokers. Smoking rates are at an all-time low nationally in decline from 20.9 percent in 2005 to 16.8 percent in 2016. In Hawaii, the rate is below the national average at 14.1 percent of the population.

In our supplement cover story, we explore something that most people don't know -- that there are differences between women and men when it comes to quitting smoking. Women's brains respond differently to nicotine. They smoke for different reasons than men; and have a more difficult time quitting.

Find out what some of the other differences are in our cover story; as well as specific smoking cessation techniques that have been proven to be more successful for women.

If you are a female smoker, that inspiration to quit could come soon. Perhaps this article will at least guide you in that direction.

▸ Story on S4

Women Are Rising Beyond Sex Inequality, Thinking Outside the Box

By Elpidio R. Estioko

While there is a glaring inequality of the sexes, I don't believe that women are not capable of being equal or even more superior to men. They can!

In the past, men are always superior to women. They dominate all aspects of society, except of course in the household where cooking is their forte… although nowadays, the best chefs are men. Historically, power/control has been distributed among the sexes unequally with powerful positions going most often to men as opposed to women. But, as gender equality increases, women started to hold more and more important positions due to policy changes, social reforms, and the evolution of the political landscape. Slowly but surely, women are living up to the challenge where men have their dominance and control.

For those women who rise over and above gender equality, my research showed that they have shown creativity, guts, innovative skills, determination, and the will to think outside the box. They are not satisfied with ordinary solutions… always experimenting more options beyond the ordinary norms.

For many years, women never had the chance in politics and had not allowed women to play a significant role in government. Even in the early 1900s, politics were viewed almost exclusively as men's world. However, due to the changing environment and society's transformation, women gradually increased their rights and roles in politics and several factors contributed to the rising degree of female participation in governments. Women has evolved!

A 1999 study found: "… the electoral system structure, left party government, the timing of women's suffrage, the share of women in professional occupations, and cultural attitudes toward the role of women in politics each play a role in accounting for variation in the degree of gender inequality in political representation around the world".

According to the Pew Research Center, "the key barrier for why women either are not advancing in their careers or are not being viewed as competitors for top positions in companies and the government is because there are "many interruptions related to motherhood that may make it harder for women". That's right – pregnancy, household chores, taking care of the children, etc. – has been women's weakness. In fact Forbes even provides scenarios that even if women have full-time jobs, they are still the one responsible for any family dilemmas rather than men. This research indicates that one reason women are not advancing in top positions in businesses is because of gender norms that have perpetuated into the 20th century… but women were able to overcome these distractions and became successful in their respective fields.

On the Equality of the Sexes, also known as Essay: On the Equality of the Sexes, a 1790 essay by Judith Sargent Murray, she wrote on the rise of women's rights, which predated Mary Wollstonecraft's essay A Vindication of the Rights of Women which was published in 1792 and 1794.

In her essay, she noted that "nature has given men and women the ability to be intellectual equals, but any inferiority is a result of the culture and not nature…which means women cannot or would not take care of activities such as cooking or sewing, but that this will give them the liberty to reflect upon their education and come up with positive ideas, as opposed to negative ones".

She also acknowledged that there are passages in the Bible that could be used to back up the argument of male superiority, but that she considers these passages to be metaphors and not fact… and that women can find a way to balance both education and housework to make them successful… just like men.

A closer look of Hawaii shows that we have women who are outstanding and kept thinking outside the box to be equal, if not greater than men. Sen. Mazie Hirono (D), a junior senator and one of two US senators from Hawaii, is one of them. She has shown women superiority and serves as a good specimen for people who think outside the box.

Her records show that Hirono was never remiss in her job as senator, even during times of distress. On June 28, 2018, the Senate passed Hirono's provision to help volcano-impacted farmers on Hawaii Island in the 2018 Farm Bill. The provision allowed farmers and producers affected by the volcano's eruption to retroactively sign-up for catastrophic coverage under the Non-Insured Crop Assistance Program (NAP). The program provides assistance to producers of non-insurable crops – including papaya, leafy greens, floriculture, and aquaculture – in the event that natural disasters destroy crops, reduce yields, or prevent planting. Eligible producers suffering losses from volcanic activity have access up to $125,000 in assistance.

On immigration, "Senator Hirono has demonstrated outstanding commitment to immigrant communities through her leadership on family immigration issues, Filipino Veterans' concerns, and her strong support of comprehensive immigration reform. She's also incredibly dedicated to the health and well-being of immigrant communities, an issue close to our hearts. We very much rely on Senator Hirono for her vision and courage in this area and look forward to working with her for many years to come," Kamal Essaheb, National Immigration Law Center Director of Policy and Advocacy, commented.

Hirono vowed to continue to be the leading advocate in the Senate for comprehensive immigration reform with family unity as a guiding principle, and fighting against any attack on America's immigrant community. She vowed to be the champion for the Deferred Action for Childhood Arrivals (DACA) program. "These inspiring young people, aptly called DREAMers, simply dream of making a better life for themselves in the only country they know. They are not criminals—they are people who are part of the fabric of our country and our economy" she said.

Similarly, in a news release, U.S. Rep. Colleen Hanabusa, D-Hawaii, another Japanese American woman who thinks outside the box, said Trump's assertion that Democrats are to blame "for his deliberate decision to prosecute all asylum seeking families at the border for illegal entry is the latest lie being peddled by his administration. Trump's policy vi-

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olates asylum laws and the constitutional rights of parents." According to Hawaii News Now, there are nearly 2,000 children were separated from their families over a six-week period in April and May, after Attorney General Jeff Sessions announced the new "zero-tolerance" policy that refers all cases of illegal entry for criminal prosecution.

In addition to the two women legislators, YWCA Oahu recognized four women business leaders for their inspirational work in the community. The four women, from different industries, were honored at the 41st Annual Leader Luncheon at the Sheraton Waikiki Hotel on Wednesday, May 16, 2018.

The 2018 honorees are: Julie Arigo, General Manager, Waikiki Parc Hotel; Catherine Ngo, President & Chief Executive Officer, Central Pacific Bank; Ginny Tiu, Pianist/Philanthropist; and Loretta Luke Yajima, Chair of the Board of Directors & Chief Executive Officer, Hawaii Children's Discovery Center.

Julie Arigo was recognized by national industry magazines, including Hotel Management's "Top 25 General Managers to Watch" in 2013 and Pacific Edge's "Leading Ladies of Hospitality" as one of the top executives from Oahu's hotel industry.

For her part, ***Catherine Ngo***, prior to her time at Central Pacific Bank, was a founding general partner of Startup Capital Ventures, an early-stage venture capital firm established in 2005, with investments in Silicon Valley and Hawaii, as well as in China.

Ginny Tiu, on the other hand, was discovered by Ed Sullivan when she was five, and her career took off. She has performed throughout the world and performed for President Kennedy and President Bush. Tiu is especially passionate and committed to helping those most vulnerable, and hopes to encourage others to do the same, through her philanthropic work, fundraising, educating, and advocacy.

We also had women in the past who served as mentors and models for Hawaii. Matthew Dekneef acknowledged in his article 15 extraordinary historic Hawaiian women who inspired the citizens of Hawaii. These women are filled with examples of powerful passion and commitment making progressive steps for women's, indigenous and minority rights across the Hawaiian Islands instilling pride in culture and identity, regardless of gender.

To name a few, Dr. Donnis Thompson, the former University of Hawaii women's director of athletics, was one of them. She was the champion for the university's women's sports program who eventually went on to become the first woman to serve as Superintendent of Education for the state of Hawaii.

Helen Lake Kanahale is another one who was considered as one of the first women labor leaders in Hawaii. She was deeply involved with the United Public Workers and the International Longshoremen and Warehousemen's Union Women's Auxiliary, working for the rights and wages of union workers.

Rosalie Enos Lyons Keliinoi was Hawaii's first elected woman legislator in the Territory of Hawaii, introducing bills that empowered women in public life. Notably she proposed and passed landmark pieces of legislation that still stand in the books of Hawaii Revised Statutes: Act 274, which gave married women the right to sell, without the consent of their husbands, property they brought into the marriage and Act 31, designating funds for programs to promote the welfare of pregnant women.

Emma Kailikapuolono Metcalf Beckley Nakuina is a highly regarded authority on Hawaiian water laws and unofficially considered Hawaii's first female judge because of her understanding of laws governing the traditional distribution of water in Hawaii—a "custodian of the laws of the Kamehamehas." Her published works on the subject, notably "Ancient Hawaiian Water Rights and Some Customs Pertaining to Them," have become a standard reference and primary source to this day.

Mary Kawena Pukui was a Hawaiian scholar whose published works are considered a cornerstone in the active preservation and perpetuation of the Hawaiian language and diverse fields of Hawaiian studies. Pukui published invaluable resources, references and translated manuscripts including the definitive "Hawaiian Dictionary – Hawaiian-English, English-Hawaiian," "Place Names of Hawaii" and "Olelo Noeau," a collection gathering 3,000 Hawaiian proverbs and poetical sayings.

These past and present women of distinction in the island of Hawaii serve as models and mentors for the citizens, especially the women. We need to emulate their extraordinary thinking outside the box and their creative approaches to problems needing extraordinary solutions!

(For further inquiries or comments, please email author at estiokoelpidio@gmail.com).

Fewer Women Smoke Than Men But Women Find Quitting Harder

By Edwin Quinabo

Who would have thought that there are differences between women and men when it comes to quitting smoking. Research suggests that there are because female brains respond differently to nicotine and that women tend to smoke for different reasons than men.

So in the challenging journey to quit smoking, what works for men might not work for women, and vice versa.

Women have a harder time quitting smoking

Some studies show that women have a harder time quitting smoking than men. In one study of 1,000 smokers attempting to quit, women had 33 percent lower odds of successfully quitting than men.

Success rates might be found in the different reasons why women and men smoke.

Among the top reasons why women smoke is to relieve stress and anxiety; while men tend to smoke for the nicotine rush. Women smoke to achieve a calmer state of mind; men smoke to get a "wake-up" nicotine boost.

It's arguable that there are more triggers in daily life (for women: juggling home and work life) that require less stress than there are triggers that need enhanced alertness, which could explain why women have a tougher time quitting smoking.

Women smokers also tend to have a fear of gaining weight more than men. It's true that smokers do put on additional weight. The average person who quits smoking gains between 4 and 10 pounds.

The fear of gaining weight is more pronounced in women because some women use smoking as a form of weight control to curb their appetite.

Rowena Cruz of Waipahu says stress was the primary reason she started smoking over 15 years ago while working at her first job. "I worked for a law firm as a paralegal and constantly juggled multiple projects. I probably should have handled stress better and had a healthier outlet like exercising. But I was young.

"I have noticed that less people are smoking. Cost could have something to do with it. New laws that make it more difficult to smoke in public places could be another reason. Or more people are realizing the toll smoking takes on health through much more anti-smoking public service announcement and anti-smoking ads.

"Once you start, it's easy to get hooked. Then quitting is very hard to do. You just get used to smoking as a part of your daily life. It's a typical pattern, have a cigarette in the morning, after meals, before going to bed, and to relax or to get energy."

Like Cruz, most woman pick up the habit of smoking in young adulthood that is triggered by a stressful work or school environment.

Nicotine works differently on women

Studies show the effects of nicotine is less on women than men; suggesting that women's dependence on smoking is more behavioral than physical addiction to nicotine.

When a person smokes, the number of nicotine receptors in the brain increases. This is believed to reinforce a desire to smoke. For men who smoke, the number of nicotine receptors have been found to increase. In a study, surprisingly, women smokers did not develop more nicotine receptors than women who do not smoke.

The study found higher levels of progesterone were associated with a lower number of available nicotine receptors, the researchers said, suggesting progesterone may indirectly block these receptors.

Women are also found to have more severe withdrawal symptoms in part caused by fluctuating hormones during menstrual cycles.

Cruz said she tried to quit several times. She was successful on two occasion for a total of four years. But got back into it. All it took was smoking one or two cigarettes, then she got addicted to it again.

"The first time I quit, my then boyfriend who was also a smoker, quit. It was something we did together. He was able to quit for good. I am wanting to quit for good too. The second time I quit was during my pregnancy with my daughter.

"I started my journey to quit again two months ago. I didn't do cold turkey (just stop smoking immediately) this time. Instead I gradually reduced from 20 cigarettes a day to 5 a day, then got down to none. It was tough, even though I am familiar with the withdrawal process.

"I am not doing any special technique to quit like taking up a new hobby or exercising. I did put on a few pounds, but I am not as worried about this as I was when I was younger and quit. In the long run, I know quitting smoking is far more important to my health than adding a few pounds.

I think my desire to quit is stronger this time because I am older now and more concerned about my health. At some point, all that smoking is bound to catch up and get me sick. It's time to quit for good," said Cruz.

Women smokers more susceptible to heart disease

Studies show a difference in vulnerability to heart disease between the sexes.

For men, smoking one cigarette a day raised a person's risk of heart disease by 48% on average over a non-smoker, while smoking 20 cigarettes a day doubled the risk.

It was even worse for women. Having one daily cigarette increased their heart disease risk by 57%, while smoking 20 cigarettes a day raised the risk by 2.8 times.

Quitting Techniques that Work Better for Women

Because nicotine plays less a role on smoking addiction to women, smoking cessation aid like gums and patches or other types of treatment that involve nicotine such as nicotine-replacement therapies are less effective. Women smokers wanting to quit have higher rates of success in behavioral therapies.

Relaxing activities: Yoga, visualization, listening to calming music or getting a massage all help to reduce stress and the urge to smoke.

Smelling and Holding a Cigarette: Another technique found useful for women is a technique of smelling and holding a cigarette as if smoking it, but not actually smoking it. During the transition period of quitting, this technique could be tried until there eventually becomes less of or no need for it.

Full Breathing: Practicing full, deep breathing techniques in through the nose and out through the mouth can be helpful. Long, slow, deep breathing helps to relax the body.

Exercise and Walks: Working out and taking walks are healthy ways to distract from smoking urges.

Talk to your support circle: Women find communicating with family and friends during stressful moments effective in avoiding the urge to light up a cigarette.

Meditation and prayer: Both meditation and prayer have been found to help with relaxation and to strengthen women's will to quit smoking.

Vitamin C drops or candy: Smokers find the act of putting something in their mouth as a replacement to the act of smoking helps. Sucking on candy is common or chewing gum. Packing healthy sticks of raw carrots or nuts to carry throughout the day have been said to be helpful.

New hobby: Getting a new passion or hobby like running, painting, reading, journaling, needleworking, all help to replace one activity (smoking) for another.

Avoid trigger places: In the first weeks of quitting, avoid going to places like clubs, bars, parties, or even

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coffee houses if these are trigger places and situations for smoking.

Contemplate on the benefits of quitting: Thinking about the benefits of quitting each time a smoker has the urge has been found to be helpful. Think about the health benefits, saving money, keeping more energy, being around longer for loved ones.

Women have an extra incentive to quit smoking because it reduces risk for infertility; and during pregnancy it reduces a chance for complications or low birth weight of her baby.

Dr. Len Horovitz, a pulmonary specialist at Lenox Hill Hospital in N.Y., agreed "more attention should be paid to non-nicotine related smoking therapies."

"You can replace all the nicotine you want, and people might still want to smoke," Horovitz said. "For instance, smoking is a big stress reliever for some people. Even the act of deep breathing is a part of the habit, and breathing exercises may help smokers because they mimic puffing a cigarette," Horovitz said.

Looking at Numbers and Trends

An estimated 37.9 million adults in the U.S. smoke cigarettes. According to the CDC Behavioral Risk Factor Surveillance System, about 17 million of smokers are women and 21 million men.

More than 16 million Americans live with a smoking-related disease. Smoking is the leading cause of preventable death in the U.S.

Deaths due to smoking account for 1 out of every 5 deaths each year or about 480,000 lives.

In Hawaii, 14.1 percent of the population are smokers. In national comparison, Hawaii has the second lowest rate of deaths due to cancer (155.4 to 100,000) and 5th lowest rate of premature deaths due to smoking (278.7 to 100,000).

Smoking is at an all-time low in the U.S. It has declined from 20.9 percent in 2005 to 16.8 percent in 2016.

Worldwide, about 250 million women are smokers; 22 percent of smokers in developed countries are women.

Health Risks of Smoking

Most people are already aware of the harmful effects of smoking like asthma, respiratory infections, chronic coughing, lung disease, lowered lung function, sudden infant death syndrome, low birth rate, small infant birth, stroke, heart disease and cancer.

Researchers say cutting back from smoking helps, but is still harmful. There is no safe level of smoking for cardiovascular disease. Coronary heart disease is the most widespread cause of death among cigarette smokers.

Average cigarette smoking reduces the total life expectancy by 6.8 years; for heavy smokers, life expectancy is reduced by 8.8 years.

Quitting is more psychological than physical

After about a week, the physical addiction to nicotine is greatly reduced and the rest of the battle to quit is a psychological one.

"It's the psychological withdrawal that people have the most difficulty with," says Heath Dingwell, Ph.D. He says it comes down to breaking the habit and finding better ways to manage stress.

For every one cigarette a smoker resists, that is one step closer to quitting. For woman like Cruz who tried to quit smoking on several occasions only to pick up the habit again, there's no shame in that. Just keep trying.

Hawaii Resources for Quitting Smoking

- Call the Hawaii Tobacco Quitline – 1-800-QUIT-NOW
  Free 24/7 coaching, patches, and Text2Quit program
- American Lung Association in Hawai'i
  (808) 537-5966
- HMSA
  (855) 329-5461
- Kaiser Permanente Hawai'i Region
  (808) 643-4622
- Castle Medical Center Live Well Tobacco Free Program
  (808) 263-5050
- Kapi'olani Medical Center
  (808) 945-1494
- Kalihi-Palama Health Center Smoking Cessation Program
  (808) 841-7981
- Kōkua Kalihi Valley Quit Tobacco Program
  (808) 791-9426
- Life Foundation
  (808) 853-3244
- Wai'anae Coast Comprehensive Health Center
  (808) 697-3599
- Waikiki Health Center
  (808) 791-9391
- Waimānalo Health Center Quit Smoking Treatment Program
  (808) 259-7948

Hawai'i Department of Health Reminds Public of Health Risks and Precautions During Heavy Rains and Potential Flooding

HONOLULU – As Tropical Storm Olivia moves through the Hawaiian Islands, the Hawai'i Department of Health (DOH) urges residents and visitors to be safe and take the following precautions to stay healthy as the storm continues its track through the state.

Avoid brown water and pay attention to advisories

Brown water advisories have been issued for the islands of Maui and Lāna'i, and parts of Kaua'i, O'ahu, and Hawai'i Island, due to pollution caused by recent heavy rains. The public is advised to stay out of floodwaters and storm water runoff due to possible overflowing cesspools, sewer, manholes, pesticides, animal fecal matter, dead animals, pathogens, chemicals, and associated flood debris. Children should not be allowed to play in floodwater areas.

If people must enter brown water along coastlines or in areas where water has pooled due to flooding, take precautions to cover any open wounds or injuries, and be sure to wash and rinse thoroughly with soap and clean water afterward. For the latest updates on brown water advisories, visit DOH's Clean Water Branch website at https://eha-cloud.doh.hawaii.gov/cwb/#!/landing and sign up for email alerts.

Practice food safety and proper handling

Severe weather conditions may cause power outages and disrupt refrigeration of food. Refrigerated food is safe as long as power is out no more than four hours. Discard perishable food that has been above 40°F for more than two hours. Throw away spoiled or unrefrigerated food to prevent foodborne illnesses. Use covered and sealed containers for disposal to minimize the presence of flies and rodents. Wash all produce carefully, no matter where it's from, under clean, running water, and cook food thoroughly. For information on food safety go to https://www.foodsafety.gov/keep/charts/refridg_food.html.

Wash hands often with soap and clean water to prevent spreading and contracting any illnesses, especially before handling and preparing food to avoid food contamination. If soap and clean water are unavailable, alcohol-based hand-sanitizers may be used instead. For more information on health risks during flooding, visit the U.S. Centers for Disease Control and Prevention's (CDC) site: https://www.cdc.gov/healthywater/emergency/extreme-weather/floods-standingwater.html.

Take steps to support good mental health

Natural disasters are stressful and can cause emotional reactions, which everyone experiences differently. Taking care of your emotional and mental health is important and shouldn't be overlooked. Talk to family members and friends to maintain a strong support system. Help your children by sharing age-appropriate information and set a good example by taking care of yourself. Take breaks and unwind periodically and ask for help if you need it. In the aftermath of a natural disaster, eligibility for mental health services is very broad and services are available to anyone with needs related to the disaster. DOH's Crisis Line of Hawaii is available 24 hours a day, seven days a week to provide assistance. On O'ahu, call (808) 832-3100. On the neighbor islands, call toll-free at 1 (800) 753-6879.

Hawaii Medication Drop Box Program Launched

Lieutenant Governor Doug Chin announced an easier way for the public to drop off unused prescription drugs at designated police stations across the state.

On Oahu, the public can drop off unused medication at the office of PSD's State Narcotics Enforcement Division. NED will also coordinate with the county police departments to ensure the environmentally-safe disposal of the unused drugs collected in the drop boxes.

Each drop box is made of 14-gauge powder-coated steel and weighs 150 pounds. They measure 61 inches tall, 21.5 inches wide and 22 inches deep. Participating police departments are implementing the Drop Box Program on their respective island according to their policies, protocols and designated locations.

The Drop Box Program will also help deter the public from discarding expired medicine in the trash or down the toilet, polluting the environment. Proper disposal helps reduce the risk of prescription drugs entering the human water supply or potentially harming aquatic life.

The Hawai'i Medication Drop Box Program will supplement, not replace the national drug take back events that state and federal law enforcement plan to continue twice a year. From 2010 to 2017, nearly 30,500 pounds of prescription drugs were collected here at previous events and disposed of safely.

"This is a game-changer for a serious public health issue," said Lt. Governor Chin. "We're being proactive and making it easier to remove dangerous drugs from our homes, schools and streets 365 days a year."

"The Honolulu Police Department continues to support the Hawai'i Medication Drop Box Program and the efforts of all the participating agencies," said Honolulu Police Chief Susan Ballard.

The Hawai'i Medication Drop Box Program is a public health and public safety partnership between the Department of the Attorney General (AG), Department of Health (DOH), Department of Public Safety (PSD), the Drug Enforcement Administration (DEA), and the Hawai'i, Maui, Honolulu, and Kauai Police Departments. After several meetings, the roles and responsibilities of these departments have been determined, with a cooperative understanding, to implement and sustain the Drop Box Program by utilizing federal, state, and county resources.

"The DEA applauds the efforts that the State of Hawai'i has made to offer year-round medication drop-boxes," said John Callery, Assistant Special Agent in Charge, U.S. Drug Enforcement Administration, Honolulu District Office. "This is another step in the right direction to thwart our nation's opioid crisis in our communities here in Hawai'i. Mahalo to the Governor's Office and our law enforcement leadership for spearheading this outstanding initiative."

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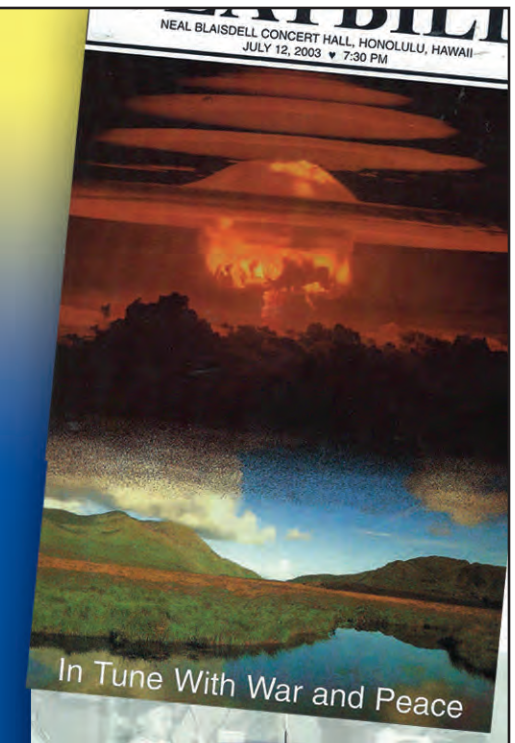

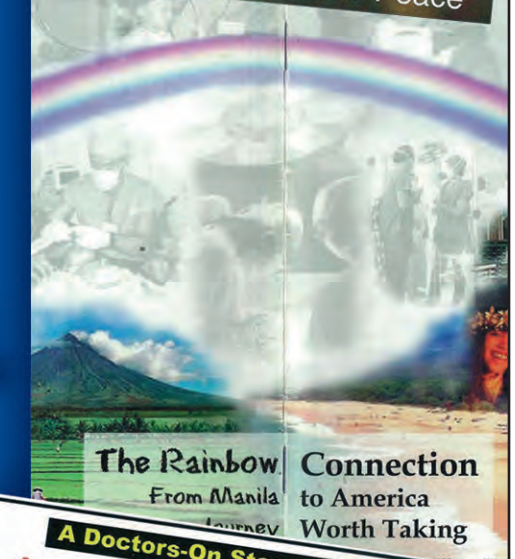

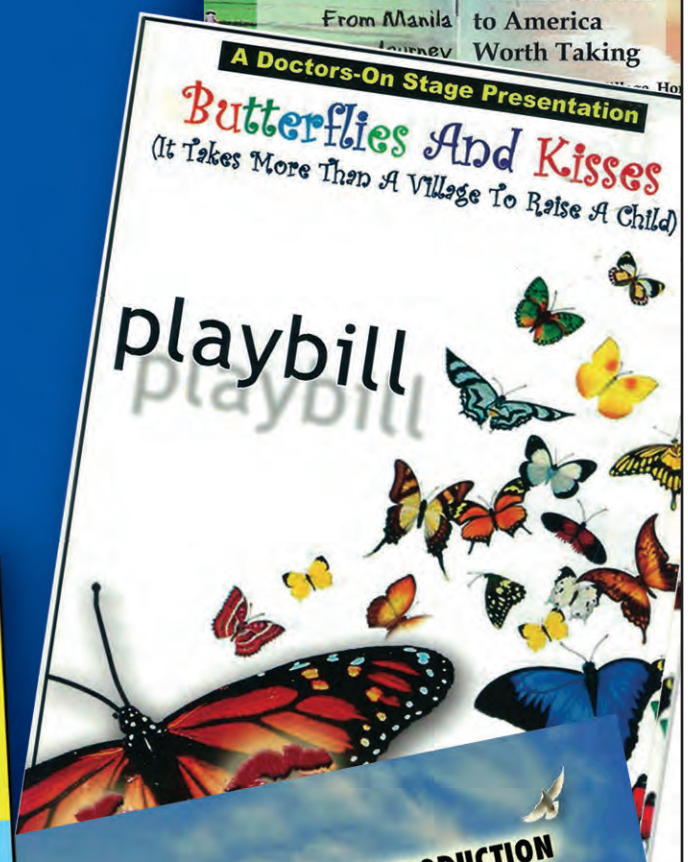

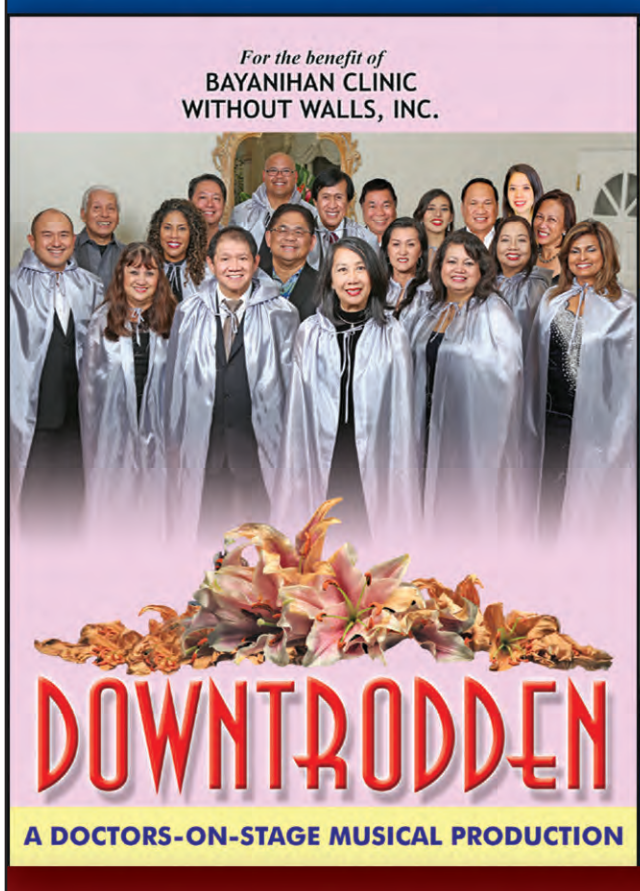

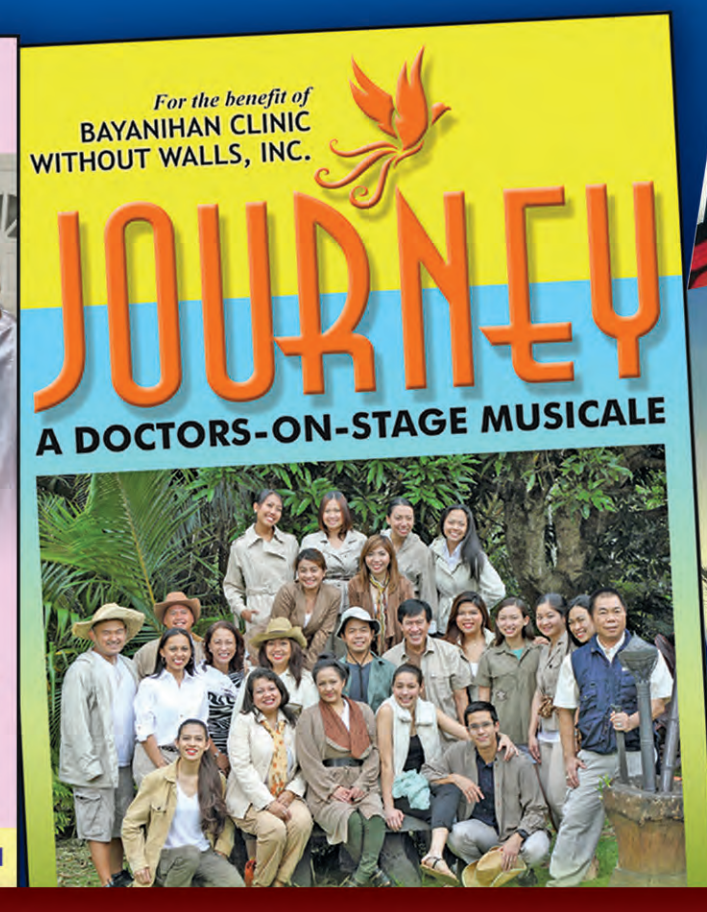

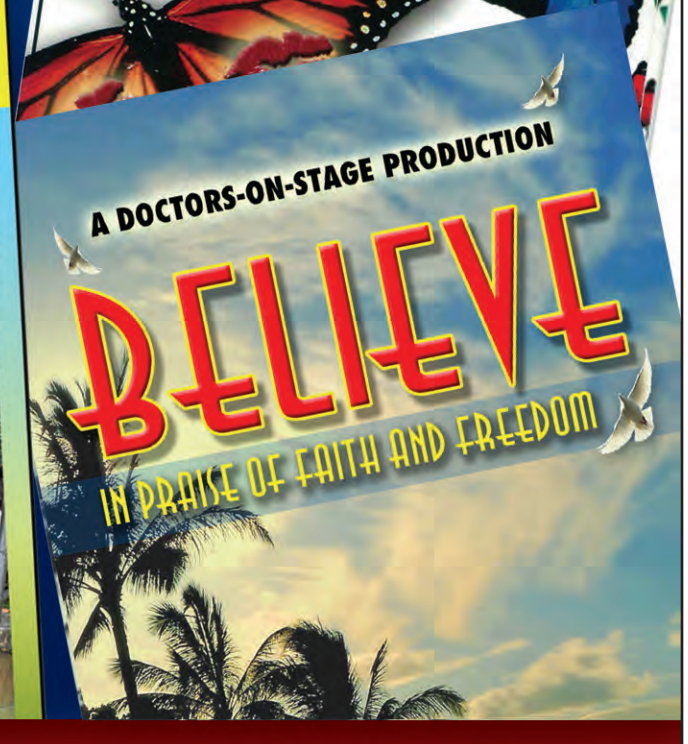

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By Raphael Ryan Malilay, M.D.

The Shape of Fish Oil

"THE STATE OF RESEARCH THUS FAR SHOULD MAKE ONE THINK: IS IT WORTH SPENDING ON WHAT MAY BE INSIGNIFICANT BENEFITS?"

There's something fishy about fish oil.

This isn't because it's a multi-billion dollar global industry that's predicted to make 2.63 billion by 2020. And it's not because this profit rides on the back of unsustainable ecological practices. Neither is it because China and India are poised to supply more and more of this product. It's not even because the research that started the fad – concluding Eskimos don't die from heart disease because of their high fat diet – has already been debunked.

It's because we're still not sure if it works, even after decades of research.

Before the pitchforks and harpoons come out, let me first assure everyone that there's no doubt that the very-long-chain Omega-3 fatty acids EPA and DHA, found in seafood and the main ingredient in fish oil capsules, help with triglyceride levels and have anti-inflammatory and antioxidant properties. But any claims more than that would be arguably controversial, including its benefits in heart disease. There are compelling studies, new and old, for both sides of the debate.

Particularly for heart disease, significant research has been done not just into whether an effect is present or not, but in what age groups, what kind of patient demographic and history, as well as what specific kind of heart disease. Regardless, the findings have been mixed, with no small part being due to the fact that the studies have different strengths (i.e. meta-analyses, randomized control trials, observational cohorts), target outcomes (primary or secondary prevention of heart disease, mortality), inclusion/exclusion criteria, and demographics.

This is without even mentioning the dilemma regarding dietary Omega-3, which essentially is found in seafood and only seafood. While we can imagine that it should always be better to get your daily dose from food as opposed to supplements, it turns out it's not that simple. To achieve a 250mg Omega-3 dose, the US Dietary Guidelines for 2015-2020 recommend 2 servings of certain seafood weekly for adults, specifically high Omega-3 and low mercury seafood (tilapia, herring, anchovies, salmon, Atlantic/Pacific mackerel), while avoiding those with high mercury content (predatory fish such as shark, swordfish, marlin, and King Mackerel). Where it gets complicated is the ecological burden of eating fish, including farmed fish. While most Hawaiians would likely have no problem meeting and eating these servings, most US adults consume only 1 serving of seafood weekly, and doubling this serving to meet guidelines would cause further exploitation of ocean fisheries. Choosing farmed fish is not quite the answer either, as feed is made from other marine organisms, and depending on the feed, mercury content may even be higher than in wild fish. Ultimately, the best solution may be to eat a variety of seafood, and only as part of a balanced diet.

Expecting mothers are certainly no stranger to the confusion on fish and fish oil. Mercury has been established to be toxic to developing fetuses, and yet maternal seafood intake of less than 8 ounces weekly (approximately 2 servings) has likewise been shown to be detrimental to childhood neurocognition and development. Current dietary guidelines for seafood in pregnancy limit servings to 2-3 weekly. In terms of fish oil, while there has been recent research that supplementation at the last trimester of pregnancy may reduce asthma and wheezing, this has been inconsistent, and current guidelines do not recommend it as part of standard-of-care.

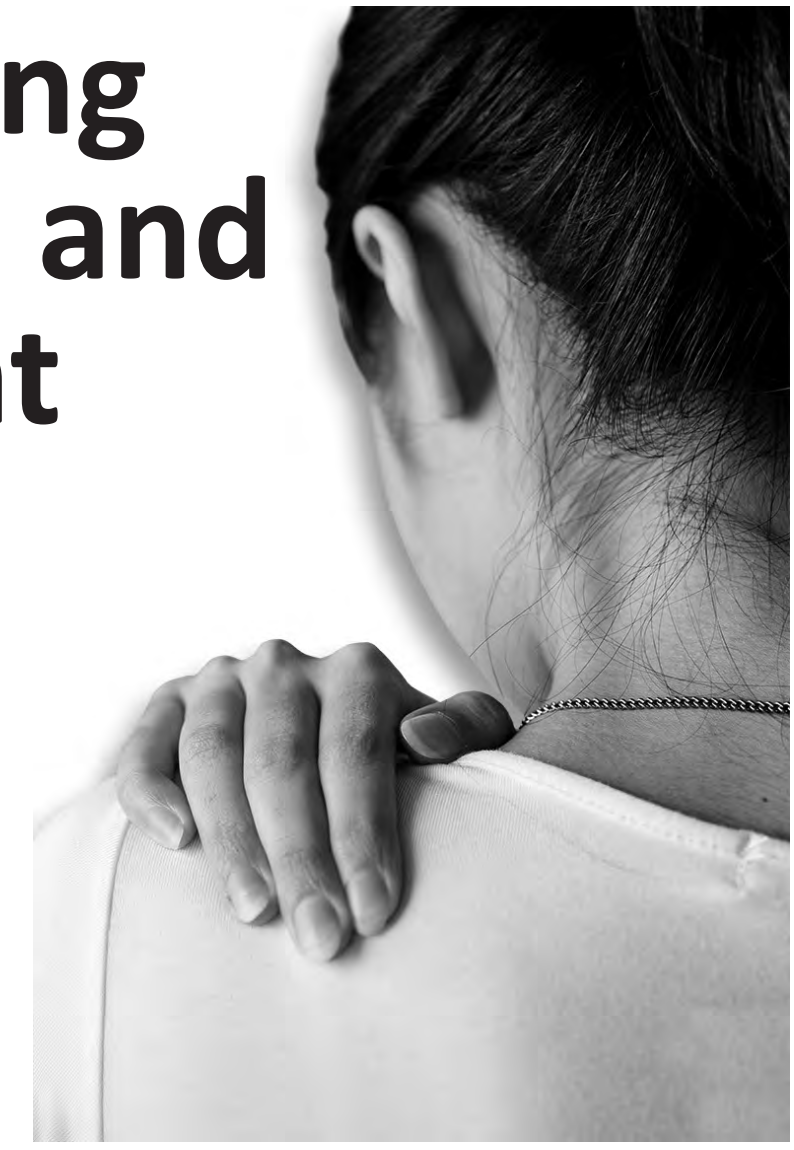
Now some might ask if there's anything to lose by taking too much fish oil. While there has been no real harm seen in high dose supplementation, the state of research thus far should make one think: is it worth spending on what may be insignificant benefits?

In closing: eat fish and a variety of it, but take your fish oil with a grain of salt, unless you're literally eating it as *ulam*. Like any other medication, consult your doctor to know if fish oil supplementation is right for you.

As a child, **RAPHIE MALILAY** *won first place in National poetry and essay writing contests in the Philippines. This marked the peak of a short-lived writing career. He has since finished medical school, and is currently undergoing a rigorous preceptorship under Dr. Charlie Sonido.*

Understanding Chronic Pain and Its Treatment

By Dr. Jerald Garcia, M.D.



At any one point in our lives, all of us will experience some type of pain. Fortunately for most, the pain resolves and goes away on its own. This type of pain is called acute pain. It is what pain experts refer to as a "good pain" because it serves as a protective measure to allow our bodies to heal. For example, if you accidentally cut yourself with a knife, an inflammatory process ensues. It is this inflammation that makes the damaged area very sensitive and painful such that even touching it slightly brings about exquisite pain. As such, you become less prone to use the wounded area and this protection allows the damaged tissues to regenerate and heal. Over a short period time, both inflammation and pain go away and our normal functions are restored. Generally speaking,there is nothing you need to do for acute pain other than wait for it to take its course. You may "rest" the affected area and take anti-inflammatory pain medications such as ibuprofen or naproxen as needed for breakthrough pain. With acute pain, you are reassured by the fact that, over time, as the tissues heal and the inflammation subsides, the pain gradually disappears.

Unfortunately for others, there is a type pain that lingers or worsens over time. This type of pain is what experts refer to as "chronic pain"or pain that persists over several months or even years. Chronic pain serves no protective function and only causes a lot of suffering and disruption in a person's ability to perform day to day activities and live life to the fullest. This pain may come in several forms such as low back pain, sciatic pain, migraine headaches, arthritic pain and neuropathic/nerve pain. Because chronic pain is yet poorly understood despite the many advances in science and research, it can be quite challenging to treat. As such, doctors who specialize in chronic pain management utilize what is called a "multi-disciplinary approach" to treat this type of pain. Put simply,this multi-disciplinary approach utilizes a combination of different strategies and specialties addressing the biological, psychological and social needs of a chronic pain sufferer in order to arrive at the best possible treatment outcome. What follows is a brief synopsis of techniques and strategies used by pain management doctors in treating chronic pain:

Medications. Pain is a complex pathway that starts with the site of injury transmitting pain signals through the spinal cord and ultimately, to the brain. Once the pain signal reaches the brain, this is when pain is actually felt or experienced by the individual. Therefore, there are several areas in the pain pathway where different types of medications can act in order to stop the pain signal from reaching the brain. For example, anti-inflammatory medications such as ibuprofen, naproxen and even steroids are utilized to minimize or take away inflammation and therefore stop the pain signals from being created in the first place. As was alluded to earlier, inflammation is considered the first step in the initiation of pain. If the inflammatory process becomes too overwhelming,doctors can stop the pain by diminishing the transmission of the pain signal via the nerves to the spinal cord and ultimately to the brain. This can be done through neuropathic and nerve blunting medications such as gabapentin, some antiseizure and even some antidepressant medications. Yes, these medications are not only used for seizures and depression. They can help with pain as well. Muscle relaxants can minimize painful muscle spasms which is a common response mechanism a muscle tissue utilizes in response to pain. Opioids such as oxycodone or hydrocodone blocks the brain's and spinal cord's reception of the pain signal thereby minimizing the patient's experience of pain. Although opioids can be initially quite effective,a word of caution about them is that they should be used very sparingly due to its potential to cause more harm with long term use in the form of addiction, dependence, overdose and death. In general, opioids are never the answer to the treatment of chronic pain.

Physical Therapy. People who suffer from chronic pain tend to consciously decrease their activity level and increase their amount of rest thinking that doing so will keep the pain from worsening.On the contrary, this tendency towards inactivity is actually detrimental for the patient as as it may lead to decompensation, loss of muscle tone, delayed recovery and worsening of symptoms. Remember, for acute pain, rest is good but for chronic pain, rest can be disadvantageous. Physical therapy works by altering one's physiologic response to pain. It may reduce pain by increasing muscle tone around areas of degeneration such as in the joints and spine. There are many people who suffer from the exact same type of chronic pain condition yet their ability to function and their activity levels can be completely different. The goal of physical therapy in the setting of chronic pain is to improve function and self-management of pain. In order to obtain optimal benefits from a physical therapy program, it is important for the patient to participate in its activities and exercises fully. Sometimes, it can be difficult to do this if one's pain is debilitating. In severe cases, it is recommended to see a pain physician first so that other treatment modalities to minimize pain are done and the

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(**UNDERSTANDING CHRONIC**....*from S11*)

patient with minimal pain then is able to fully participate in physical therapy and derive maximal benefits from it. it can be difficult to do this if one's pain is debilitating. In severe cases, it is recommended to see a pain physician first so that other treatment modalities to minimize pain are done and the patient with minimal pain then is able to fully participate in physical therapy and derive maximal benefits from it. it can be difficult to do this if one's pain is debilitating. In severe cases, it is recommended to see a pain physician first so that other treatment modalities to minimize pain are done and the patient with minimal pain then is able to fully participate in physical therapy and derive maximal benefits from it.

Psychological Therapy. Everyone experiences the same type of pain differently. For example, if two people accidentally stubbed their respective toes in the the exact same way, one may take the pain that ensues with minimal fuss while the other may wail incessantly. This difference in the pain experience is referred to as the "affective component" of pain. That is, we experience pain differently based on our previous personal experiences, our own memories of similar pain and the social support network that we have. Psychological therapy targets the affective component, also known as the "suffering aspect" of our pain experience. Examples of psychotherapy include cognitive behavioral therapy, biofeedback, relaxation and imagery.The goal of psychotherapy is to teach a patient coping skills and to minimize the biological stress response to pain and finally to decrease the emotional distress that naturally comes hand-in-hand with chronic pain. Research has shown that psychological therapy is effective but success widely depends on a patient's willingness to participate.

Injections. For those whose pain becomes too debilitating that they want a procedure done but something less invasive than surgery, injections may be a good alternative. Injections come in many forms, depending on the pain location and source. Physicians can target specific pain-causing nerves and inject medications to "quiet" them down or even perform a radiofrequency ablation to disrupt the transmission of pain signals. In certain areas of increased irritation and inflammation such as a degenerated spine or joint, steroids can be injected directly to the pain generator in order to to eliminate the pain caused by inflammation almost immediately. These injections are safer alternatives to surgery and in many instances are pre-requisites by many insurance carriers prior to the consideration of surgery. To know if you are a candidate for an injection,speak to your primary care provider.

Surgery. Not all chronic pain issues have surgical solutions. A migraine headache, for example, does not require surgery. However, some pain generators such as a herniated disc in the spinal cord that is impinging on a nerve root can be corrected surgically if the patient so wishes. In general, surgery is often seen as a last resort in the treatment of certain chronic pain conditions because of the inherent risks involved. However, it is also the most definitive means to treat specific pain conditions. The decision to undergo surgery to treat pain is made between the patient and his/her surgeon after weighing the risks, benefits and alternatives involved in taking such a step.

Implants. Because chronic pain is such a complex phenomenon, it is still poorly understood and difficult to treat. Scientists have employed other methods that can be considered "new technology" and "outside the box" if only to provide patients suffering from severe pain some improvement in their quality of life. Two examples of "new technology" techniques are spinal cord stimulators and intrathecal pain pumps. Spinal cord stimulators involve implanting electric leads and a battery source close to the spine in order to interfere with the transmission and therefore the experience of pain. This option is generally reserved for those who have tried and failed many other treatment modalities including surgery. The second type of "new technology"is an intrathecal pain pump wherein an implanted catheter and pump delivers miniscule doses of pain medicine directly into the spinal space. This decreased dosing reduces many of the common side effects of taking pain medicine by mouth. However, intrathecal pain pumps are not without risk and require close and frequent monitoring. Some pain physicians reserve these pumps for cancer-related pain.

Stem Cells. As of this writing, scientists from all over the world are actively trying to gain a better understanding of chronic pain and seeking new ways to treat it. A promising area is stem cell therapy wherein young, baby cells are injected or placed in areas of pain caused by ageing and degenerative cells and tissues. For example, in arthritic knees and shoulders. More research and understanding need to be done before stem cells can become a part of the mainstream chronic pain treatment modality. There are certain institutions that are already employing this strategy but they are generally not covered by medical insurance and require out of pocket expenditure on the part of the patient.

To summarize, chronic pain is a type of pain that does not resolve or go away for several months or even years. If you suspect that you are suffering from a chronic pain condition, it is important that you speak to your primary care doctor in order to determine the many treatment options you have at your disposal. The longer your pain persists, the more difficult it becomes to treat. Pain specialists usually employ a multidisciplinary approach in treating chronic pain and this usually combines different methods including medication, physical therapy, psychological therapy and interventional therapy such as injections or surgery. Patients need to understand that there is no "magic pill" that will miraculously take away all of their chronic pain overnight. To get the best possible outcome,patients usually have to undergo a lengthy treatment process requiring some time and patience.

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Amazing Outcome from TAILORx Study for Breast Cancer

By Melvin Palalay, M.D.

Breast cancer is the most commonly diagnosed cancer in women nationwide. In Hawaii, it's estimated that there will be 1,150 new female breast cancers diagnosed and 160 deaths attributed to breast cancer in 2018.[1] As a practicing medical oncologist in Honolulu, I am well aware of the clinical/societal impact the disease has in the community. Breast cancer mortality rates have steadily declined based on national data aggregates, suggesting improved detection modalities and more effective treatments. National movements that increase breast cancer awareness contribute to these better patient outcomes. We now associate October as Breast Cancer Awareness Month, and I commend the Filipino Chronicle for participating in this effort to inform and educate. With this in mind, I wanted to discuss findings from a recent large, multi-institutional study, conducted in the United States, the long-awaited TAILORx study.

The use of chemotherapy in breast cancer therapy is universally acknowledged. Using chemotherapy following an operation that has removed all evidence of disease is called "adjuvant" chemotherapy. There have long been efforts in clinical oncology to select out patients who may benefit from chemotherapy. The toxicities of treatment are well known. Hair loss, fatigue, nausea and vomiting are just some of the common side effects. There are scary, long-term complications such as heart failure, bone marrow effects, and second cancers. Oncologists have resorted to different resources to make important decisions on treatment. One of the most widely used tools was a database that looked at all patient outcome results from early stage breast cancer treatment. Using this database as a reference was a primary tool in counseling patients on treatement.[2] Progress in the understanding of tumor biology has changed this platform. Oncology has evolved to "looking inwards" at tumor DNA. Terms such as "molecular profiling" or "targeted therapy" are routinely used at medical meetings, reflecting the increased sophistication and complexity of the approach to cancer.

The OncotypeDX test is a 21-gene assay that can determine how aggressive one's breast cancer is.[3] Oncologists use this study to determine whether patients will benefit from adding chemotherapy to the treatment plan. This study has been used in breast tumors that express estrogen or progesterone receptors, negative for the Her-2/neu antigen, and who have no disease in the axillary lymph nodes (removed at time of surgery). The result of an analysis will yield three possibilities, based on a scoring system encompassing the 21-gene assay. Low risk indicates a good prognosis and chemotherapy is not recommended. A high risk score means a less favorable prognosis and patients are uniformly offered chemotherapy . All patients receive anti-hormonal therapy, regardless of score. An "intermediate score" is less clear. These patients could receive either hormone therapy alone, or some would also receive chemotherapy.

The TAILORx study was devised to address the question of what to do with the "intermediate score" patients.[4] This was a randomized trial, involving multiple institutions, including the University of Hawaii Cancer Center, and results of this important study have recently been presented and published in a major peer-reviewed journal (New England Journal of Medicine). The defined primary end-point was something called invasive disease free survival (freedom from recurrence of another invasive breast cancer, second primary, or death). The key finding from this study was that outcomes were the same, regardless of whether patients received chemotherapy or not. In other words, the addition of chemotherapy did not seem to incur any benefit. One observation, however, was that for patients who were less than 50 years of age, there may be some benefit with the addition of chemotherapy. The major outcome from this study may lead to fewer women having to go through chemotherapy as they recover from curative breast surgery. They would still be required to take 5-10 years of anti-hormonal therapy, however. We would have to individualize the decision making with patients less than 50 years of age, as there may be a benefit to adding chemotherapy in this specific sub-group.

It is an exciting time to be a cancer doctor! It is with great optimism and confidence that we move forward to a day when cancer can be cured. My colleagues and I are indebted to the scientists, researchers, and patients who are involved in clinical trials such as these.

Reference:

1 *Siegel RL, et al. Cancer Statistics, 2018. CA: A Cancer Journal for Clinicians 2018;68(Issue 1): 7-30.*

2 *Early Breast Cancer Trialists' Collaborative Group: Effects of chemotherapy and hormonal therapy for early breast cancer recurrence and 15-year survival: An overview of the randomised trials. Lancet 2005; 365:1687-1717.*

3 *Paik S, Shak S, Tang G, et al. A multigene assay to predict recurrence of tamoxifen-treated, node-negative breast cancer. N Engl J Med 2004;351:2817-2826.*

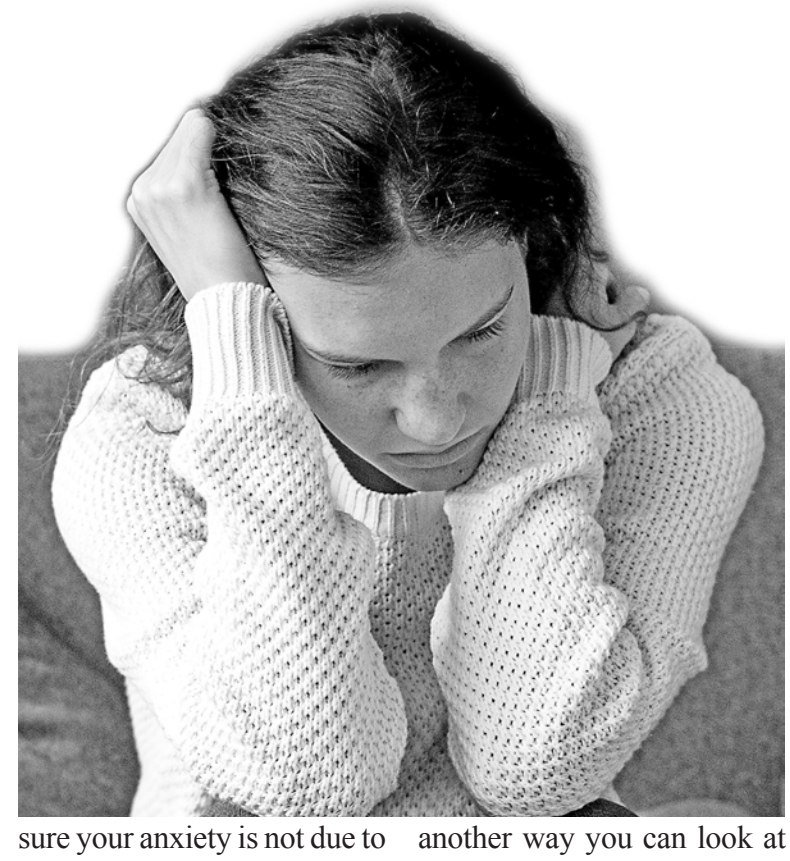
4 *Sparano JA, et al. Adjuvant Chemotherapy Guided by a 21-Gene Expression Assay in Breast Cancer. N Engl J Medicine 2018; 379:111-121.*

Anxiety, The Double Edged Sword

By Jay D. Valdez, Psy. D.

Anxiety is a common emotion that everyone experiences. However, women tend to experience anxiety earlier than men. Women deal with stress differently and are twice as likely to have an anxiety disorder. They tend to think and dwell on their stressors. As women's role in society changes, women are experiencing more stress and anxiety. There are more working women than ever before. Their role as "the stay at home mom" has changed. They are becoming the family's main source of income and with divorce on the rise, there is increasingly more single working mothers. Women also experience hormonal changes that make them more prone to anxiety disorders. But what is anxiety and when does it become a problem.

Anxiety is our body's reaction to any threat or stressor in the environment. The "fight or flight" response is triggered and a series of physiological changes occur that prepares our body to deal with the threat. Our heart beats harder and faster, we breathe more shallow and rapid, muscles tense, pupil and blood vessels constrict to draw the blood into our vital organs, and appetite and digestive processes decrease. However, in our modern age, the threats that trigger our anxiety are stress and other pressures from life including family, work, social situations, finances, and health among other things. Anxiety becomes a problem when it is triggered by illogical fears, uncontrollable worry and nervousness that prevent a person from enjoying and functioning fully in life. Common situations include fear about being in social situations, being judged, disliked, or not measuring up to expectations. Another situation is worrying that the worse is always going to happen despite knowledge that everything will be okay. Sometimes a panic attack may occur. Panic attacks are more common in woman and can happen suddenly or unexpected. Panic attacks does not necessarily have a trigger. A person could wake up in the middle of night due to a panic attack or could be in the middle of doing some mundane activity. Some unhealthy coping behaviors are social avoidance, hair pulling until there is a bald spot on the scalp, eyebrow or eyelids, uncontrollable behavioral compulsions such as cleaning, and/or use of drugs and alcohol. A common symptom of anxiety that affects the Asian population is physical sickness. Untreated or undetected anxiety disorders could lead to stomach ulcers, gastrointestinal problems, headaches, insomnia, high blood pressure, depression and unexplained pain or physical symptoms.



If you think you have a problem with anxiety. It is a good idea to make sure your anxiety is not due to an underlying medical condition, such as hyperthyroidism and menopause, which are common in woman. Also look at your lifestyle. Are you eating healthy, exercising, and practicing good stress and time management. There are many excellent apps geared toward meditation and relaxation. Learning to do deep breathing exercises is also very powerful and effective for anxiety. Think about your worry. Examine it, does it make sense and is there another way you can look at a problem or situation. Are you overly too negative and not considering the positive and realistic. Journaling and talking to others also helps. Medications are also very effective but some of them can be addictive and lead to dependence. It would be wise to discuss this approach with both your doctor and a mental health professional about this option. Psychotherapy is another excellent and effective treatment for anxiety, worry, and panic attacks.

September Is National Suicide Prevention Awareness Month

September is National Suicide Prevention Awareness Month and the Hawai'i Department of Health (DOH) Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) in partnership with the Prevent Suicide Hawai'i Task Force hosted a series of community events across the state.

Events aimed to raise public awareness about the topic of suicide and the impact of suicides in Hawai'i as well as to connect survivors with postvention services.

Suicide is the leading cause of fatal injuries in Hawai'i for people ages 15 to 44 and is the ninth leading cause of all deaths in the state. From 2013 to 2017, 926 Hawai'i residents died from suicide. On average, one person dies by suicide every two days in the state.

"Our goal is to educate the public about the warning signs of suicide and encourage individuals to address these warning signs with family members, friends and colleagues," said Nancy Deeley, DOH EMSIPSB's suicide prevention coordinator. "These annual events help to strengthen our efforts by allowing us to build stronger community support systems for those who most need them and to identify effective strategies to reduce the risk factors for suicide."

For anyone experiencing difficult or suicidal thoughts, or anyone who knows someone who is, call the Crisis Line of Hawai'i at 832-3100 (Oahu), 1-800-753-6879 (Neighbor Islands), the National Suicide Hotline at 1-800-273-TALK (8255), and message the Crisis Text Line at 741741. Resources are available 24 hours every day.

Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X

By Kinsey Hasstedt | Guttmacher Institute

In recent months, social conservatives have doubled down on various long-standing proposals to deny public funding to Planned Parenthood and other providers focused on reproductive health. This includes efforts by Congress and the Trump administration to bar Planned Parenthood from receiving funding through federal programs—including Medicaid and the Title X national family planning program—as well as attempts to eliminate or reshape Title X, based on the premise that the program indirectly subsidizes abortion. Proponents of such restrictions are ultimately seeking to make abortion inaccessible for U.S. women, and so are seeking to shutter Planned Parenthood health centers and any safety-net health center providing publicly funded family planning services that additionally offers abortions (using other funds), or is affiliated with an abortion provider.

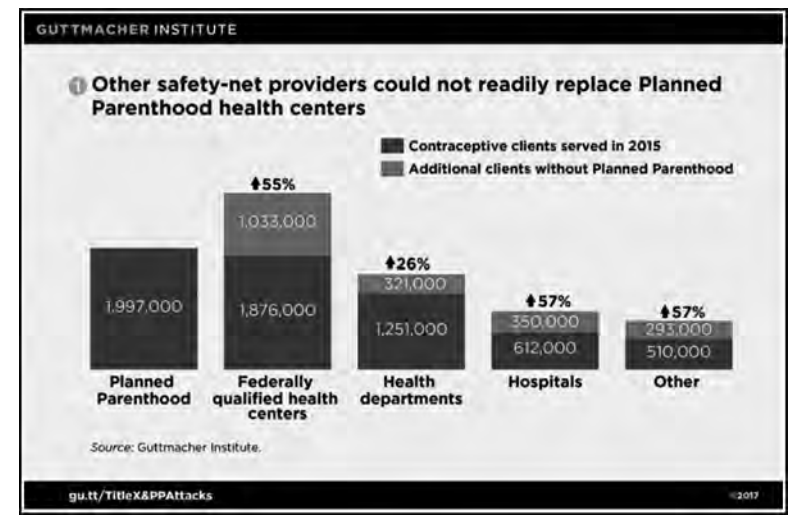


Chart 1

Map 2

However, the consequences of these proposals reach far beyond abortion. Nationwide, Planned Parenthood health centers serve two million (32%) of the 6.2 million women who obtain contraceptive care from some type of safety-net family planning center.1 And 1.6 million (41%) of the 3.8 million contraceptive clients served by Title X–funded providers are served at Planned Parenthood health centers.

Recent analyses conducted by the Guttmacher Institute have looked at the impact of four different scenarios that align with many of the specific antiabortion policy attacks that have been proposed at the federal and state levels. Each scenario would radically undermine the nation's family planning safety net and blatantly jeopardize women's access to family planning care.

Scenario 1: Exclude Planned Parenthood from all publicly funded programs.

For many years, social conservatives have sought to exclude Planned Parenthood health centers from receiving any type of public funding—whether in the form of grants specifically for the provision of reduced-cost or free family planning and other services, as under the Title X program, or in the form of reimbursement for services provided, as through Medicaid. President Trump's fiscal year 2018 budget proposal takes this broad approach, cutting Planned Parenthood off from all federal programs—including Title X, Medicaid and many others—that its health centers rely upon to deliver affordable health care services. In this scenario, women who currently depend on Planned Parenthood would be left to seek care elsewhere.

Guttmacher's analysis shows that if all other types of safety-net family planning centers had to fill the gap by serving all those currently obtaining contraceptive services from Planned Parenthood, women would find it considerably more difficult to obtain care. This is unsurprising, since Planned Parenthood serves two million contraceptive clients each year nationwide, and the average Planned Parenthood health center serves far more contraceptive clients than all other types of safety-net health centers.

In order to serve all the women currently obtaining contraceptive services at Planned Parenthood health centers nationwide, other types of safety-net family planning providers would have to increase their client caseloads by 47%, on average. Federally qualified health center (FQHC) sites offering contraceptive care, hospital sites and others would have to increase their capacity by more than half *(see chart 1)*. Sites operated by public health departments nationwide would have to increase their contraceptive client caseloads by a lesser proportion. Nevertheless, they still would have to take on hundreds of thousands of additional clients. Health departments have long been under-resourced and are often already stretched thin when it comes to maintaining the public funding and capacity necessary to meet the needs of their communities.

Across the country, eliminating Planned Parenthood would affect different types of safety-net family planning providers to varying degrees, depending on the make-up of a given state's safety net. In 33 states, other providers would have to increase their contraceptive client caseloads by at least 20%, and in some cases, would have to at least double or triple their capacity.

Scenario 2: Bar federal funding to Planned Parenthood, with the expectation that FQHCs can fill the gap.

In justifying their efforts to exclude Planned Parenthood health centers from participating in public programs, many social conservatives have argued that Planned Parenthood health centers are not necessary because FQHCs are ubiquitous and could readily meet the demand for family planning services. Such claims often come with promises of additional funding for FQHCs. Most recently—and visibly—social conservatives in Congress have included such proposals in their efforts to repeal the Affordable Care Act (ACA), pairing a provision that bars Planned Parenthood from Medicaid with another that allocates new money for FQHCs.

In reality, although they have become increasingly important sources of publicly funded contraceptive care, FQHCs could not readily serve all the women who rely on Planned Parenthood (see "Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net," 2017). First, while there are indeed more FQHC sites than Planned Parenthood health centers across the country, not all of them offer contraceptive care. Guttmacher found that in 2015, only six in 10 FQHC sites reported serving at least 10 contraceptive clients in a year; this subset of sites are then counted among the nation's safety-net family planning centers. Second, client volume must also be taken into account: On average, a Planned Parenthood health center serves 2,950 contraceptive clients in a year, while an FQHC site providing contraceptive

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(**BEYOND THE RHETORIC**...*from page S15)*

care serves 320.

This adds up to unrealistic expectations for FQHCs if Planned Parenthood were cut out of the family planning safety net. In 27 states, FQHC sites that offer contraceptive care would have to at least double their contraceptive client caseloads, and in nine of those states, they would have to at least triple their caseloads *(see map 2)*. Nationwide, this would mean taking on an additional two million contraceptive clients.

The challenges are also clear at the local level. In 80% of the 415 U.S. counties with Planned Parenthood health centers, either existing FQHC sites offering contraceptive care would have to at least double their capacity, or there simply is no FQHC site providing these services. This scheme stands to have the largest negative impact on the 1.7 million (85%) of Planned Parenthood's contraceptive clients served in those counties.

Scenario 3: Exclude Planned Parenthood from Title X.

The federal Title X program is the backbone of the nation's publicly funded family planning effort. Despite a prohibition on the use of Title X funds for abortion services that has been in place since the program's inception, antiabortion policymakers have targeted the program as indirectly supporting abortion; they have repeatedly sought to restrict Title X funds from going to entities associated with abortion, often specifically Planned Parenthood. This tactic, which has been replicated in many states, prompted the Obama administration to issue regulations that clarified states cannot exclude otherwise qualified abortion providers from the Title X program (see "Recent Funding Restrictions on the U.S. Family Planning Safety Net May Foreshadow What Is to Come," 2016). Congress and President Trump have since overturned those regulations.

Excluding Planned Parenthood from Title X nationwide would pose massive challenges to the rest of the safety-net family planning provider network. Guttmacher's analysis shows that in order to serve all the women who currently obtain contraceptive care at Title X–supported Planned Parenthood health centers in the 50 states and the District of Columbia, other types of Title X sites would need to increase their client caseloads by 70%, on average.

This translates into Title X–funded FQHC sites having to more than double their contraceptive client caseloads, while Title X sites operated by hospitals would have to increase their caseloads by about three-quarters *(see chart 3)*. Title X–funded health department sites would need to expand their capacity to deliver contraceptive services by about one-third. Collectively, these additions represent hundreds of thousands of women who currently obtain care at Title X–funded Planned Parenthood health centers—most of whom are low-income and uninsured, relying on Title X for reduced-cost or free care.

Again, how this change would impact other Title X providers varies by state. Without Title X–supported Planned Parenthood sites, other Title X providers in 27 states would have to increase their contraceptive client caseloads by at least 20%. In 13 of those states, other Title X providers would have to at least double their capacity—and in many, to an even greater degree—to maintain the current reach of their states' Title X networks.

Scenario 4: Eliminate or restructure Title X to shift funding to FQHCs.

Antiabortion policymakers have also suggested drastically undermining or outright eliminating the Title X program by directing all current funding to FQHC sites. This comes at the expense of not just Planned Parenthood, but all providers focused on reproductive health. State policymakers have been pursuing this goal for years, and socially conservative members of Congress may well carry their current rhetoric through to the illogical conclusion that Title X funds should go only to entities offering primary care, excluding the very providers often best able to provide high-quality family planning and related services to large numbers of people.

Guttmacher's research shows that FQHC sites alone could not sustain the current reach of Title X. If asked to serve all of the women who rely on many different types of providers for Title X–supported services, FQHC sites providing contraceptive care would have to at least double their contraceptive client caseloads in 41 states *(see map 4)*. In 27 of those states, these FQHC sites would have to at least triple their capacity. Nationwide, this adds up to an additional 3.1 million clients.

At the local level, there are Title X–funded providers in about 2,000 U.S. counties. In one-third of those counties, there is no FQHC site providing contraceptive care, and in about half of them, FQHC sites that offer contraceptive care would have to at least double their contraceptive client caseloads. Collectively, 2.8 million (91%) of the contraceptive clients currently served at Title X sites other than FQHCs are in one of those two categories of counties and would face the most considerable burdens in obtaining Title X–supported care.

Policymakers should put sound policy decisions above political expediency. Despite social conservatives' ploys to make Planned Parenthood and even Title X appear expendable, the facts prove otherwise. An abundance of evidence demonstrates how important Planned Parenthood health centers are for a large proportion of women who need publicly funded family planning services (see "Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net," 2017). Moreover, the health and economic benefits made possible by a robust Title X network have been well documented (see "Why We Cannot Afford to Undercut the Title X National Family Planning Program," 2017).

It is high time that congressional leaders, President Trump and his administration stop pushing ideologically motivated policies and misleading talking points, and instead focus on implementing policies that will advance access to high-quality reproductive health care. This means investing in proven public health programs and providers, by adequately funding Title X and abandoning the shortsighted campaign to cut Planned Parenthood off from participation in publicly funded programs. Doing so would be a step toward the types of investments and policies that the millions of women who rely on a diverse, robust network of safety-net family planning providers need and deserve.

(www.guttmacher.org)

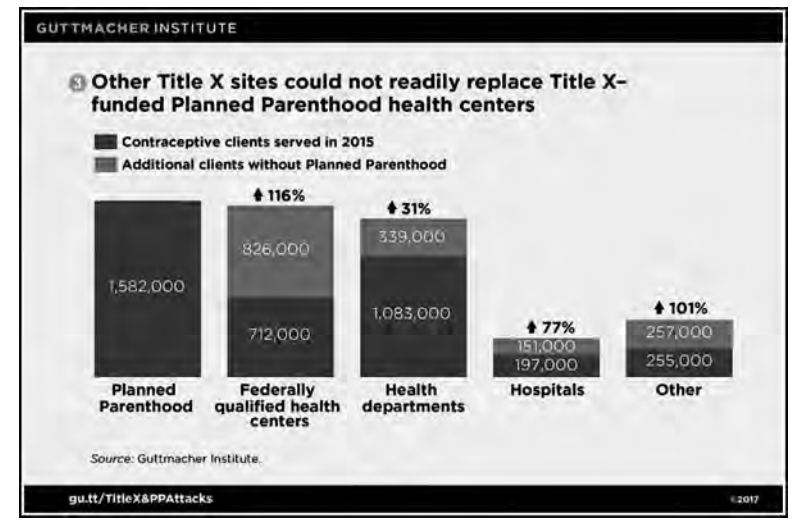

Chart 3

Map 4

REFERENCES

1. Frost JJ et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

2. Frost JJ and Zolna MR, Response to inquiry concerning the impact on other safety-net family planning providers of "defunding" Planned Parenthood, memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, June 15, 2017, https://www.guttmacher.org/article/2017/06/guttmacher-murray-memo-june-2017.

3. Frost JJ and Zolna MR, Response to inquiry concerning the availability of publicly funded contraceptive care to U.S. women, memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, May 3, 2017, https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.