

The Women's Health Activist.®

FEATURE STORY: PAGE 4
**The FDA's Hesitation to Approve
'Female Sexual Dysfunction'
Drugs Isn't About Sexism**

by Coco Jervis, JD

IN THIS ISSUE

Director's Message 2

The Network
in Action..... 3

Maternal Mortality
Review 6

Is a Lower Number
Worth a Higher
Risk? 7

Young Feminist 8

The Great Diabetes
Epidemic..... 9

Language Matters.... 10

Snapshots 12



6



7



9



NATIONAL WOMEN'S
HEALTH NETWORK

A Voice for Women, a Network for Change

DIRECTOR'S MESSAGE

The Women's Health Activist: A Reliable Source for Information in a Changing World

By Cynthia Pearson



Cindy Pearson is the Executive Director of the National Women's Health Network.

...one thing hasn't changed: you can count on the Network. We will always bring you reliable information and challenging perspectives on important topics.

During the last few weeks, I've had a chance to talk to several members about the Network's newsletter. Some wanted to tell me that they liked the new look. (We do, too!) Others had compliments or criticisms about a specific article that ran in a recent issue. Mostly, though, people had suggestions about topics they'd like us to cover in the newsletter. I always enjoy hearing feedback about the newsletter — even if the feedback is critical — because it's such an important communication tool for us, and I'm impressed by how attached Network members are to this publication.

Over the years, readers have told me that they look to the newsletter to learn about cutting-edge issues and to get an alternative perspective on heavily promoted tests and treatments. Members tell me that they count on the newsletter's reliable information and often put it to use in their own lives. I often hear "I took your newsletter to the doctor's office with me!"

The first issue of the *Network News* appeared in October 1976, less than a year after the Network was publicly launched. The women who came together to found the Network knew women's health information was badly needed. Back then, there weren't many female physicians, and even fewer nurse practitioners. There was one great book about women's health (you know the name!) and several wonderful feminist clinics. But, there were *no* reliable periodicals providing accurate and up-to-date information about women's health. The Network made a commitment back in 1976 to address this need — and we've done so ever since.

Thirty-nine years later, the landscape of women's health information is very different. Information is everywhere — mainstream media frequently cover women's health topics; there are lots of great books about women's health; special health magazines aimed at teens, moms, and women of all ages are on display in waiting rooms; and the Internet makes it easy to get questions answered 24/7. Nowadays, the problem isn't finding information, it's sorting out the truly independent and reliable information from advertisements that masquerade as information. But, one thing hasn't changed: you can count on the Network. We will always bring you reliable information and challenging perspectives on important topics.

This issue of the *Women's Health Activist* is a good example of our approach. It includes articles that span the gamut from drug safety to diabetes, and from childbirth to abortion. Christina ChereL takes an in-depth look at the newest weight loss drug; Coco Jervis debunks false claims that the FDA is biased against sex drugs for women; Dr. Victoria Kavanaugh shares an insider's view about using a "federal safety board" approach to investigating women who died during or after childbirth to save other women from the same fate; and Dr. Gilbert Friedell and J. Isaac Joyner call for applying community solutions to the Type 2 Diabetes epidemic. We also welcome a new contributor in this issue: Laura Kaplan has written a thought-provoking essay about the unintended consequences of de-politicizing the language we use to talk about women's health.

We're already at work on upcoming newsletter issues and plan to publish articles on some of the issues members have suggested to us. We rely on your support and appreciate your feedback. Let us hear from you! ❁



Participate in our Member Survey!

The Network wants to hear from you, our valued supporters! Please engage with us and give us your feedback in our short member survey on *Women's Health Empowerment*. Our mission is to provide women with the information and facts they need to make their own health decisions — help us improve how we do this, and better serve all woman!

Complete the survey at: www.surveymonkey.com/s/3LQZCRH

40 for 40 Anniversary Events

As the Network launches our 40th anniversary, we celebrate our advocacy and organizing work on behalf of all women. We are honoring the milestone by hosting a series of 40 events, in 40 cities, to promote our mission and grow our network of supporters.

The *40 for 40* events present an opportunity to share the Network's important programmatic agenda with your friends, family, and colleagues. Help us build the Network's visibility, and increase membership in your region by hosting an event!

Board member and former Network intern, Kira Jones, hosted a *40 for 40* party in Salt Lake City, UT. The Halloween-themed "Spooktacular" brunch was a creative approach to present the very serious battles women's health activists fight every day. The event was a success — not only as a fundraiser, but also in recruiting new members.

There is no limit to the type of event you can host — ideas include house parties, barbecues, cocktail brunches, etc. The Network provides a tool kit to help hosts plan their events, and assistance from our development team. A staff member may also be available to attend, if we're going to be in your city. Kira noted, "The Network team was excellent at assisting every step of the way." (The event is the fiscal responsibility of the host, as this is a Network fundraiser.)

Interested in hosting a 40 for 40 event? Want to find out if there are other Network members in your area with whom you can collaborate on an event?

Start by visiting the interactive map at our website, nwhn.org/40for40, to see if any local events are already being planned. Then contact us for help in with the event: Heidi Gider, Director of Advancement, 202.682.2640 or hgider@nwhn.org.



Board Member and former intern Kira Jones hosted a house party in November in Salt Lake City, Utah. She was joined by long time member Tessa Epstein, and other guests.

National Women's Health Network

1413 K Street NW, Suite 400
Washington, DC 20005-3459
202.682.2640 phone
202.682.2648 fax
www.nwhn.org

The Women's Health Voice: 202.682.2646

Facebook: facebook.com/TheNWHN

Instagram: [thenwhn](https://instagram.com/thenwhn)

Twitter: [@theNWHN](https://twitter.com/theNWHN), [@RWV4HealthCare](https://twitter.com/RWV4HealthCare)

Pinterest: pinterest.com/nwhn

YouTube: www.youtube.com/user/TheNWHN

Our Mission

The National Women's Health Network improves the health of all women by developing and promoting a critical analysis of health issues to influence public policy and support consumer decision-making. The Network aspires to a health care system that is guided by social justice and reflects the needs of diverse women.

Board of Directors

Dara Mendez, *Chairperson*
Anu Manchikanti Gomez, *Action Vice Chair*
Zipatly Mendoza, *Administrative Vice Chair*
Ninia Baehr, *Treasurer*
Charlea Massion, *Secretary*
Dazon Dixon Diallo
Emma Duer
Shalini Eddens
Andrea Friedman
Kira Jones
Kara Loewentheil
Tiffany Reed
Dipti Singh
Mia Kim Sullivan

NWHN Staff

Cynthia Pearson, *Executive Director*
Pat Antonisse, *Finance Manager*
Frances Ampah, *Office Coordinator*
Cecelia Saenz Becerra, *Field Organizer*
Christina Cherel, *Program Coordinator*
Susan K. Flinn, *Newsletter Editor*
Heidi Gider, *Director of Advancement*
Coco Jervis, *Program Director*
Shaniqua Seth, *Health Communications Manager*
Ariel Tazkargy, *Program Coordinator*
Amirah Tyler, *Membership Coordinator*
INTERNS: Jenny Li, Amanda Lynen

The Women's Health Activist® is a bimonthly publication of the National Women's Health Network. We'd like to hear from you. Please email questions or comments to editor@nwhn.org. Please send change of address notices to membership@nwhn.org.

Volume 40, Issue 2

March/April 2015

ISSN no. 1547-8823

©2015 National Women's Health Network



Facebook, Twitter and YouTube: TheNWHN



Pinterest: NWHN



The FDA's Hesitation to Approve 'Female Sexual Dysfunction' Drugs Isn't About Sexism

by Coco Jervis, JD

The cultural impact and huge profitability of male-targeted impotence drugs has prompted a rapidly accelerating race to create similar drug treatments for women. Despite more than a decade of research and millions of dollars spent on development, the Food and Drug Administration (FDA) has yet to approve a single drug treatment for cis women dealing with so-called female sexual dysfunction (FSD). In response, the pharmaceutical industry has launched a campaign to persuade the FDA to approve such medications in the name of equality — a campaign that ignores the fact that most of the drugs under consideration simply don't work. ("Cis" refers to "individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity."¹ To date, clinical trials for FSD drugs have *only* enrolled cis women who are in heterosexual relationships. The drug manufacturers' and FDA's limited concept of female sexuality is the subject of another article, however!)

This industry campaign, Even the Score (<http://eventhescore.org>), relies on the fact that drugs to treat FSD are less available than drugs for erectile dysfunction. Therefore, the campaign

claims, the FDA is holding drugs for women's sexual problems to a higher standard than men's, and preventing women from making informed choices about their sexual health. (FSD is an umbrella term for a number of disorders, such as hypoactive sexual arousal disorder, female sexual arousal

No amount of slick marketing can get around the fact that the FSD drugs just don't work. Nevertheless, pharmaceutical executives hype the possibility of a "pink Viagra," because the potential market is estimated to exceed \$2 billion annually.

disorder, orgasm disorder, and sexual pain disorder.)

These tactics are working: Even the Score's backers include FSD manufacturers as well as prominent women's rights groups, reproductive justice groups, and many legislators, too.

No amount of slick marketing, however, can get around the fact that the FSD drugs *just don't work*. There are many reasons why they may not effectively increase women's sexual enjoyment — chief among them is the heterogeneity of female sexuality and the fact that sexual problems are mostly shaped by interpersonal, psychological, and social factors. Nevertheless, pharmaceutical executives continue to hype the possibility of a "pink Viagra"... because the potential market is estimated to exceed \$2 billion annually.² As this push continues, it's vital to consider how much of the discussion around female sexuality is fact — and how much is fiction.

Fact: FSD is much less prevalent than FSD proponents like Even the Score claim it is.

Proponents who hope the FDA will to lower its drug approval standards are overstating the number of women suffering from FSD, putting it at 43 percent of all women. They believe that by making the "problem" seem widespread, the FDA can be encouraged to relax its standards. This claim first appeared in a 1999 *Journal of the American Medical Association* article and was based on an analysis of 1,749 women and 1,410 men's answers to questions about their sex lives.³ Women who reported lack of sexual desire, difficulty in becoming aroused, inability to achieve orgasm, or anxiety about sexual performance within the last two months were deemed to have a sexual dysfunction. The researchers also noted that women were more likely to suffer from sexual dysfunction if they were single, had less education, had physical or mental health problems, had undergone recent social or economic setbacks, or were dissatisfied with their relationship with a sexual partner. In fact, these reasons that someone might be less inclined to become aroused have little to do with *physiology*. Since the report's publication, scientists have rightly challenged its problematic conclusions.

Fact: There is no norm for female sexual function.

The implied parallel between female sexual dysfunction and male impotence is inaccurate and problematic. “Dysfunction” is just medical jargon for “something that doesn’t work the way it should;” it suggests that there is an acknowledged norm for female sexual function. But, this norm has never been established and probably doesn’t exist. Although male sexuality is more complex than sheer physical arousal, erections are quantifiable events that can be measured objectively. By contrast, cis women’s sexual responses are, by and large, qualitative, and difficult to analyze in clinical trials. And, as we know, sexual desire differs over time and between people for a range of reasons largely related to relationships, life situations, past experiences, and individual and social expectations. What is “normal” varies widely from person to person. Without downplaying the significance of any woman’s pain or distress, there is real danger in defining *different* as “dysfunctional.”

Fact: Female sexual dysfunction is not a defined disease category.

Without empirical standards by which to assess female sexual function, it is extremely difficult to generate effective treatment criteria for FSD. That hasn’t stopped drug manufacturers from trying, however. In fact, each time a drug sponsor claims to have a new solution for women’s sexual concerns, the “reason” for the dysfunction changes. Over the past 15 years, drugs affecting vaginal blood flow have been tested on women deemed to be suffering from FSD due to “insufficient vaginal engorgement.” Then, corporations and the media hailed testosterone patches as a magic bullet, because FSD allegedly resulted from hormone deficiencies. Most recently, re-purposed antidepressants have gained scientific currency, as women are being told that their low libido is due to a chemical problem in their brains.

Fact: Drug developers are not searching for a solution for women’s sexual concerns.

The pharmaceutical industry is driven by profits made from drugs. If a solution isn’t found in a pill, the industry is simply not interested. If product development-driven research

occurred in a balanced context — with proportionate attention being paid to *all* causes of women’s sexual concerns — the focus on *only* biomedical causes and solutions would be less damaging. The focus on pharmaceutical over emotional solutions has serious limitations, and is unlikely to be effective. And, the industry’s presentation of FSD threatens to make women’s sexual experience a “performance” issue, much like it has with men’s.

Fact: There are 6, not 26, drugs approved for men.

Even the Score inaccurately claims there are 26 drugs approved for men, and none for women. But this claim is generated from counting *every* brand-name drug, and many of their identical counterparts, as unique treatment options, and artificially inflates the number of drugs available for men. Actually, there are *six* different FDA-approved drugs available for male sexual dysfunction.⁴



Fact: The standard for FDA review of male impotence drugs should not be the same for FSD drugs.

Even the Score’s gender equity argument is catchy, but ignores the real safety differences between the drugs tested for FSD and those already approved for men, including different dosages and administration. All but one of the drugs approved for men are taken on an as-needed basis, while the latest drug being tested for women, flibasterin, is used like an anti-depressant and taken daily. Sponsored by Sprout Pharmaceuticals, flibanserin is a central nervous system

serotonergic agent with effects on adrenaline and dopamine in the brain; it requires daily, long-term administration. This raises toxicological concerns, and it is entirely appropriate for the FDA to subject this drug to elevated safety scrutiny. Substantial adverse events reports and dropout rates in the latest flibanserin trial also must be taken seriously.⁵

Conclusion

Women have answers to the age-old question, “What do women want?” We want, and demand, products that are rigorously evaluated, safe, effective, and meet our real needs. The Even the Score campaign’s effort to make this a conversation about gender equality is misleading and dangerous; although the FDA should be held accountable for gender equality, doing so should not compromise women’s safety by approving drugs that are neither effective nor safe. The FDA should continue to balance a serious and respectful incorporation of patient input while maintaining a rigorous, science-based review standard for drugs and devices it approves. ❖

REFERENCES

1. Schilt K, and L Westbrook, Doing Gender, Doing Heteronormativity: ‘Gender Normals,’ Transgender People, and the Social Maintenance of Heterosexuality,” Gender & Society 2009; 23(4):440-464, doi: 10.1177/0891243209340034
2. Clarke S, “Pink Viagra?” Drug Promises to Boost Female Sex Drive,” ABC News, Good Morning America, May 25, 2010. Available on-line at: <http://abcnews.go.com/GMA/OnCall/female-viagra-pill-promises-enhance-female-libido/story?id=10731882>
3. Laumann EO, Paik A, Rosen RC, “Sexual Dysfunction in the United States: Prevalence and Predictors, JAMA 1999; 281(6):537-544. doi:10.1001/jama.281.6.537. Available on-line at: <http://jama.jamanetwork.com/article.aspx?articleid=188762>
4. Bloom J, “Is The FDA Really Sexist?” Science 2.0, February 27, 2014. Available on-line at: www.science20.com/pfired_still_kicking/fda_really_sexist-130694
5. Food and Drug Administration, Summary Minutes of the Advisory Committee for Reproductive Health Drugs Meeting, June 18, 2010. Silver Spring, MD: Center for Drug Evaluation and Research, 2010. Available on-line at: www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/ReproductiveHealthDrugsAdvisoryCommittee/UCM248751.pdf



Coco Jervis is the NWHN Program Director

Maternal Mortality Review — Each Death Matters

By Victoria Kavanaugh, RN, PhD

The United States is one of few industrialized countries where maternal death rates are rising.¹ Rates of maternal mortality in the United States are also higher among certain groups than others, including African-American women, who are three to four times more likely to die during pregnancy or childbirth than are White women.² Sadly, the vast majority of these deaths are preventable.

Efforts to reduce stagnant maternal death rates and to address racial disparities began in the mid-1980s, when the Centers for Disease Control and Prevention (CDC) formed the Maternal Mortality Study Group in collaboration with the American Congress of Obstetricians and Gynecologists (ACOG). The Study Group called for state-based maternal mortality review teams to identify and review *all* pregnancy-associated deaths in order to identify problems and possible solutions.³

in the U.S. maternal mortality rates.

Teams composed of experts from a variety of disciplines work together to identify what happened, and why. Strengths, gaps, and the need for additional resources can be identified by those most knowledgeable about policies and practices associated with their specific discipline. State-based maternal death reviews are anonymous, confidential, and nonjudgmental. Team members do not know the names of decedents, health care providers, or the facilities where care was received.

These teams review psychosocial, clinical, and medical factors associated with each case. For each case, the team answers several questions: Which agencies met this woman in the days or years before her pregnancy? Which agencies or providers might have gathered more information, provided additional resources, and/or sought alternatives to address an identified

need? Had someone known of an existing condition, might they have referred her for additional evaluations or treatment? Were appropriate services available and accessible to the woman who died? How and where could changes be made to reduce the likelihood of a similar death occurring in the future?

Review teams then make recommendations for interventions and prevention strategies to prevent future deaths. These recommendations apply to a wide array of fields, including prenatal health care, social work, psychiatry, emergency care, dietary services, health care, and advocacy.

Virginia's multidisciplinary Maternal Mortality Review Team has reviewed nearly 400 cases of pregnancy-associated death occurring between 1999 and 2007. The Team has identified several risk factors, including substance abuse, obesity, heart disease, and other chronic conditions, which are major



Victoria Kavanaugh, RN, PhD, is the Coordinator of the Virginia Maternal Mortality Review in the Virginia Department of Health's Office of the Chief Medical Examiner.

contributors to these deaths. These women often had chronic conditions such as hypertension and obesity, highlighting the need to improve women's overall health before they reach childbearing age. Virginia's findings mirror national reports of disparity, which show that African-American women are more likely to die during or near pregnancy when compared to White women. For example, African-American women died from heart disease and related conditions within one year of pregnancy at a rate more than three times that of White women. As a result of its reviews, the Team developed recommendations to address these risk factors throughout the state.

Currently, about two-thirds of states have maternal mortality review teams either in operation or development.⁵ Several national initiatives are also attempting to increase the number of state maternal mortality reviews, including efforts by ACOG and the Association of Maternal and Child Health Programs.^{6, 7} In 2012, the CDC launched the Maternal Mortality Initiative, through which 15 active review teams and multiple national partners are assessing capacities for conducting maternal death reviews. As a result, national guidelines and standardized methods for data collection are being developed. On the Federal level, the Maternal Health Accountability Act was introduced in both 2011 and 2014, but was not passed by the House of Representatives. The Act would provide grants to states for mandatory reporting of pregnancy-related deaths; establish state maternal mortality review committees; and organize the study of maternal morbidity.⁸

Maternal mortality and morbidity reviews offer our best opportunity for reversing our dismal trend and improving maternal outcomes in the United States. We encourage you to find out what is being done in your state and/or facility! If your state lacks a review committee, propose that one be formed; if it has one, consider participating as a member of the established team. ❀

References are available online or from editor@nwhn.org.

Trends in pregnancy-related mortality in the United States: 1987–2011



*Note: Number of pregnancy-related deaths per 100,000 live births per year.

“Pregnancy-associated” deaths are deaths that occurred either during pregnancy or within one year of pregnancy — regardless of the cause of death or the pregnancy outcome (i.e., abortion, miscarriage, still birth, birth). The Study Group used this broad definition in order to better identify deaths not due to the specific reasons reflected in the “cause of death” codes. These case reviews are more critical today than ever before to improve our understanding of the events leading to maternal deaths and the formulation of corrective strategies.⁴ Hopefully, these reviews can help accelerate reductions

Is a Lower Number Worth a Higher Risk?

By Christina ChereI

Imagine taking a pill, stepping on your scale, and seeing a lower number — just like that, and just in time for Spring’s warmer weather. Now, imagine that lower number coming at a heavy price — and not just the money you’ll spend on your weight loss drug’s prescription. Would you be willing to take the risk?

Quick-fix weight loss remedies have always been popular, but they have gained even more momentum in recent years due to increased attention to the rising rates of obesity. In 2012, 69 percent of U.S. adults over age 20 were overweight, and 35 percent were obese.¹ Internationally, in 2008, 35 percent of people over 20 were overweight and 11 percent were obese; obesity affects almost 1.5 billion adults worldwide, making prevention and treatment efforts a global public health concern.²

Anti-obesity drugs are often touted as “miracle products” that yield results with minimal effort. Misleading ads for these products appear everywhere from magazines to public buses to interstate billboards, and promote the idea that being thin is more important than being at a healthy weight. They portray heavily airbrushed and largely unattainable body parts like six-pack abs and long, lean legs. The ads are not only deceptive, but also encourage weight loss for the sole purpose to improve sex appeal rather than short- and long-term health.

Now there’s another drug on the market. Last September, the Food & Drug Administration (FDA) approved a controversial anti-obesity drug (after previously rejecting it), even though, during clinical trials, it was only minimally effective compared to placebo when combined with diet and exercise. The drug, Contrave, is a reformulation of an anti-depressant (bupropion) and a substance abuse treatment drug (naltrexone). People who took it lost a meager 4.1 percent more weight than those in the placebo group.

The FDA’s current efficacy standard requires weight management products to meet one of two criteria that focus *solely* on weight loss as an endpoint

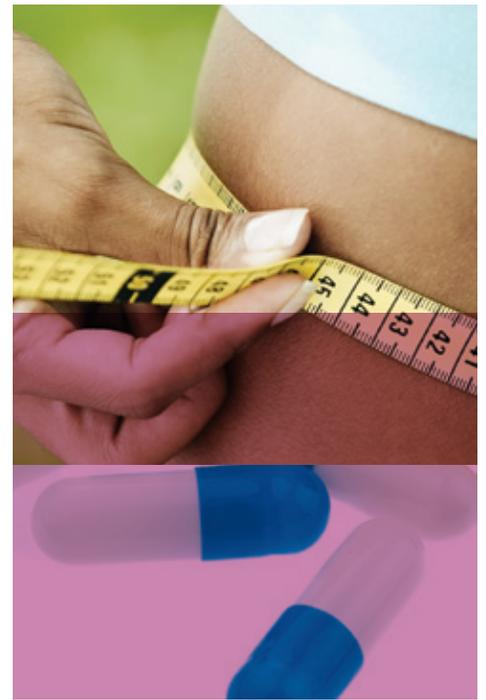
without regard to drug-specific health benefits. So, we know nothing about whether Contrave’s modest-at-best weight loss results are indicative of long-term health promotion.

Alarminglly, in addition to demonstrating only modest effectiveness, Contrave also proved to be unsafe during its clinical trials. People who took it reported having increased heart and blood pressure rates, and were more likely to experience seizures, compared to those taking the placebo. Serious psychiatric events were also more common in the treatment group — including depression, anxiety, sleep disorders, and psychosis. In fact, people taking Contrave were twice as likely to withdraw from the trial due to adverse events, compared to the placebo group.

Contrave and other minimally effective and unsafe anti-obesity drugs not only *don’t* work that well, but also may actually *worsen* health issues faced by overweight and obese individuals. Reducing an arbitrary number on a scale while simultaneously increasing blood pressure and risk of serious neuropsychiatric events, does not improve *anyone’s* health or well-being.

Another concerning aspect of the FDA’s approval of Contrave’s was the brevity of the clinical trials, which only lasted a year. This means we lack information about the complications that may arise from its long-term use. The National Women’s Health Network (NWHN) is adamant about the need for adequate pre- and post-market surveillance of *all* new drugs and medical devices. That’s why we asked the FDA to insist on three year-long trials before approving any new weight loss drugs. This would provide regulators and consumers with more information on the risks and benefits of long-term use of these obesity drugs. Consumers may be willing to risk rebound weight gain after using a safe weight-loss product, but obesity drugs like Contrave must deliver on their promise of safety first and foremost.

Contrave, like many of the obesity



drugs on the market, lacks sufficient data to assess its long-term safety with any confidence. The National Women’s Health Network has long advocated that clinical trials include diverse groups of populations (including women, the elderly, and people of color) and last long enough to identify any long-term complications. When a clinical trial lasts only a matter of months — like Contrave’s did — consumers are forced to rely on adverse event reports after the drugs are on the market (this is called “post-market surveillance”) in order to identify possible side effects. This process allows pharmaceutical companies to maximize their profits and places the burden of risk on consumers.

Women may be interested in losing weight, but at what cost to their health? A “miracle drug” like Contrave, which claims to help people achieve a slim physique, jeopardizes their health to do so, is far more of a curse than a blessing. ❁

References are available online or from editor@nwhn.org.



Christina ChereI is the NWHN Program Coordinator

YOUNG FEMINIST

The Inevitable Feminist

By Jennifer Choi

I recently made a profile for an on-line dating website. I still feel iffy about relegating my dating life to computer algorithms, but as my parents' "jokes" about bringing me a nice boy from Korea increase in frequency, I figured it was time to take matters into my own hands. My friends helped me answer the profile questions, which included a "self-summary." The first phrase that popped into my head was, "I am an unrepentant feminist who rants a lot about social justice issues." My friends and I laughed, then one commented, "I wonder how many guys you'll scare away with *that* description?" I responded, "Do I *really* want to date a guy who is scared away by that?"

I am an unrepentant feminist who rants a lot about social justice issues.

But, the truth is, I haven't always been so at ease with calling myself a feminist. When I look back, I can't really pinpoint an "a-ha" moment when I had my feminist awakening; my path to feminism was both surprising and inevitable. As an Asian-American, I was teased for the way I looked, the food I ate, and the "odd" customs of my cultural heritage. I've also encountered my fair share of misguided pre-conceptions about my race, but the one that's always perplexed me is that Asian women are meek, subservient, and quiet; the reality of how I was raised could not have been more different.

I pride myself on the fact that I come from a family of strong women. My grandmother moved to Germany by herself in the 1970s to build a career, knowing just three German words. My mother worked my whole life and is a successful business owner. I was raised with parents who are very much partners, in the truest sense of the word. My mom doesn't know how to sew, and I can't say I've ever seen her iron clothes, either. My brother and I were not delegated chores based on



Jennifer Choi is a graduate student at Johns Hopkins Bloomberg School of Public Health's Population, Family, and Reproductive Health Department. She is a member of the School's Sexual Violence Advisory Council and will present at the National Conference on Health and Domestic Violence in March. She is interested in effective health communication for changing behaviors and bridging the gap between academia and policy work.

our gender: I was out shoveling snow as often as he was doing the dishes.

In fact, the expectation for unwavering excellence in all academic and extra-curricular pursuits often pushed me to defy many of the gender norms that are prevalent in our society. If I received a poor grade in math or science, the only thing that was blamed was my work ethic. Many of my Asian-American high school friends who went on to study advanced science and mathematics are females. This is unusual among American students. There is *no* evidence that men are better than women at math or science, but if you look at the small number of women who pursue science, or who are even *encouraged* to pursue science, it's both alarming and shameful.

The same thing goes for sports. My dad made many unsuccessful attempts to mold me into a successful tennis player, but he never once blamed my lack of tennis coordination on my gender. I eventually found my athletic glory in martial arts (in this case, the Asian stereotype does hold true). If you look at the research literature, you find that girls and boys don't differ in physical ability as children. Yet, society designates labels, stereotypes, and different expectations for boys and girls before they're even old enough to crawl, and many girls drop out of sports as a result.

All of this isn't to say my parents weren't held down by societal expectations. I had my fair share of fights with my mom at Toys R' Us as a kid. She wanted to buy me Barbies; I wanted to get the toy guns. I won most of those fights. We also battled every Sunday morning. She wanted me to wear a dress to church, and I wanted to wear pants and sneakers

because wearing a dress wasn't conducive to running around outside with the other children after service. We usually compromised, with me putting on the dress but packing an extra set of clothes.

Yet, despite this background (what my mom calls as my "spunk"), I didn't become comfortable calling myself a feminist until my later college years. Growing up, feminism was treated like a dirty word. I remember once, after a female trumpet soloist delivered an intensely powerful and moving performance at a high school performance, somebody remarked, "It was good, but it just looks better if a guy is playing brass." When I asked this person for an explanation for such a sexist statement, I was bombarded with accusations of being a 'one of those crazy feminists.'

In college, however, as I sought to understand my place in the world, an Asian-American female Millennial, becoming a feminist was almost inevitable. In the last couple of years, I've seen my generation come together to claim our role in the on-going feminist movement (thanks, Internet!). Finally, I no longer feel like a lone leaf floating around in the air; now, I am anchored to a tree with all of the other budding leaves. I've seen women of my generation be inspired by those who have already paved so much of the way for us, and it gives me hope for the future. Perhaps I will scare away a decent number of guys on dating websites by stating my feminism so openly, but I say good riddance. If I've learned anything on my journey as a feminist, it's that there is no real dating potential with someone who doesn't believe that men and women deserve to be treated equally. ❀

The Great Diabetes Epidemic

By Gilbert H. Friedell, MD and J. Isaac Joyner, MPH

In the past few months, there have been two deaths from Ebola in the United States, and half a dozen patients with the disease have been transferred from West Africa to specialized U.S. facilities for treatment. Americans are panicking about a U.S. Ebola epidemic, which has evoked a loud call for public health action — and generated efforts focused on prevention and vaccine development. Now compare that response to the lack of public outcry about the 281,400 deaths in 2010 from a different epidemic: Diabetes mellitus! That number is about the population of Toledo, Ohio, but the nation has not yet truly mobilized to address this very real threat.

In 1994, the head of the Centers for Disease Control and Prevention's (CDC) diabetes program declared that diabetes had reached epidemic proportions and should be considered as a major public health problem. Yet, in the last 20 years, we have failed to apply a dedicated and focused public health approach to diabetes; as a result, Type 2 Diabetes' incidence has tripled, and deaths and serious complications have skyrocketed.

As of 2012, almost 30 million people in the U.S. were thought to have Type 2 Diabetes — more than 9 percent of the population.¹ Over one-quarter (27 percent) of those individuals have not been diagnosed and are not in treatment.² An additional 86 million have pre-diabetes and are at-risk for developing diabetes (up from 79 million in 2010); of these, 90 percent are unaware of their condition, and 5 to 10 percent will progress to full diabetes annually.³

Diabetes occurs when the body either does not make enough insulin or cannot use it effectively. Type 2 Diabetes is the gateway to many serious complications, as the excess blood sugar (hyperglycemia) results in progressive damage to large and small blood vessels. The resulting common and debilitating complications include heart disease, stroke, and the "BAD Complications" (**B**lindness, **A**mputations of lower extremities, and **D**ialysis due to kidney failure). Diabetes is responsible for about half of all new U.S. cases of BAD complications. The economic burden of diabetes and

pre-diabetes is huge: an estimated \$322 billion.⁴

That's the bad news. The good news is that we can fight this epidemic and prevent or delay Type 2 Diabetes; with early diagnosis and optimal treatment, diabetic complications can also be delayed and prevented. The personal and economic costs of Type 2 Diabetes highlight the need to commit the public and political will — and resources — to deal with the burden and address both social and individual risk factors. We know what to do; we just haven't done it yet. We can reverse the epidemic's tide, but, to do so, we must change our approach. As four distinguished endocrinologists noted recently, "As diabetes develops, we are currently wasting about the first 10 years of the [disease's] natural history. If we found pre-diabetes and early diabetes [by screening] and treated it more effectively, we could prevent or delay the progression of hyperglycemia and the development of complications."⁵

Type 2 Diabetes is a non-contagious epidemic and a societal problem — not just an individual health condition. As with most U.S. health problems, it disproportionately impacts those who are disenfranchised. While diabetes can strike anyone, some are at greater risk: people of color; low-income individuals; and those who lack access to information, support, and health care. People are most at-risk when they lack access to healthy foods, recreational opportunities, and health care information and services.

For that reason, a successful approach to eradicating Type 2 Diabetes includes:

1. Screening all adults, starting with seniors and then focusing on those over age 45;
2. Developing state population-based diabetes registries and reporting all new cases to those databases;
3. Raising awareness about diabetes in pre-school, schools, and throughout the community;
4. Implementing broad-based community diabetes prevention and control programs to identify and help treat Type 2 Diabetes in the community;

5. Offering accessible, affordable prevention activities in every community (e.g. the "Diabetes Prevention Program");
6. Establishing "Community Diabetes Care and Self-Management Centers" to help individuals and health care providers address all aspects of diabetes, and prevent its complications.

Here are some actions you can take:

1. Learn what diabetes' impact is on your state and county at the CDC's website (<http://www.cdc.gov/diabetes/data>); share this information with your elected officials and local public health officials, and ask them what their current and future plans are to address the epidemic.
2. Advocate for your community to address the problems that increase risk — lack of access to health information and services, healthy food, and physical activity — by implementing effective prevention efforts.
3. Support programs that screen community members for diabetes and connect them to health care to reduce their risk and access needed medical services.

Despite spending a third of a trillion dollars on diabetes treatment annually, our current approach is not working. We need to take an aggressive public health approach, with universal screening to find pre-diabetes and early diabetes, provision of optimal care for patients; and addressing the social and community factors that increase people's risk for the disease. Working together we can make diabetes a preventable disease!✿

References are available online or from editor@nwhn.org.



Dr. Friedell is an Emeritus Professor of Behavioral Science at the University of Kentucky; Mr. Joyner has been an active member of health departments in South Carolina, Texas, and Kentucky. They are the co-authors of "The Great Diabetes Epidemic: A Manifesto for Control and Prevention", Butler Books, October, 2014

Language Matters, Especially When Talking About Root Causes

By Laura Kaplan

For my 67th birthday this year, my dear friend Peaches — with whom I shared those heady years in Jane, the underground, feminist abortion service — sent me a card. On the front was a picture of an elderly woman (much older than me) carrying a placard that said, “I Cannot Believe I Still Have To Protest This Shit.” Amen, sister, I thought as I read it and laughed.

But, really, it’s no laughing matter. I’m irked by the responses to the Ray Rice domestic violence episode, about rape charges being ignored on college campuses, and that birth control is still controversial. And don’t get me started about abortion. Why does it feel like we have to fight the same battles that we’ve fought for almost 50 years? Have our successes as a movement also harbored the seeds that limited that success? I’d like to share with you my thoughts on this question, based on my own very personal experiences.

From its earliest days, the women’s movement fought for social change. We sought an end to women’s second-class status. Individual women’s problems were the way to express our critique of a society that limited women’s lives and opportunities. Our work on particular issues like abortion, women’s health, domestic violence, sexual assault, etc., was the vehicle to deliver a larger message about women in society.

In the late 1970s, I was living in rural Wisconsin. When a nurse friend asked if I wanted to meet with a few other women to discuss what we could do about domestic violence, I jumped in. Before we actually did anything, the five of us (a social worker, a nurse, two mental health workers, and me) met and shared our experiences.

We talked about individual cases of domestic violence and quickly recognized that there were larger forces at work. It wasn’t just the intransigence of the local police, the District Attorneys making fun of battered women, or the doctors who reported they’d never seen a woman who had been physically abused by her partner. What we realized was that women’s safety took a back seat to their caretaking role within their families. To confront the problem of domestic violence, we had to talk

about women’s value as individuals (without, of course, given our conservative, Right Wing community, ever using the words “sexism” or “feminism”).

When we take the politics out of our work — either consciously or unconsciously, whether by choice or to gain funding or credibility — we undermine our efforts to effect social change, and to create a society where women are valued, and their decisions are valued.

On my frequent interviews with the local radio station, I said that domestic violence wasn’t an individual problem, but a community problem, and one that the community had to address. Boy, did that remark generate a backlash. One evangelical minister even preached against the shelter, saying we were out to destroy families. But, in time, the larger culture began to take domestic violence seriously. States, including Wisconsin, established funding for programs to remedy the problem.

It took a lot of money for us to accomplish our goals. We wanted to pay our bills and provide shelter to desperate women, but we also wanted to change society’s attitude about domestic violence. It wasn’t, we believed, just a problem of a few dysfunctional families. Our communities had to recognize that domestic violence was a pervasive problem and understand their role in perpetuating it. In order to get the funds we needed, we framed our work in language that would be acceptable



to state agencies — so we focused on the services we provided: shelter, counseling, and advocacy.

For those of us who ran these programs, and for the women we served, funding we received through the state Department of Social Services (DSS) was a lifesaver (sometimes literally). But, changing our language and the way we talked about issues changed our work. Our grassroots social change programs subtly became more like social service agencies, tallying up services provided, and working in tandem with law enforcement and community professionals to assist women in need. On the plus side, domestic violence became a recognized problem and women in danger had safe places to go.

But some things didn’t change. We still blame the victims; 40 years later, we’re still asking, why does she stay, or what did she do? We continue to accept excuses from perpetrators, in some cases even protecting them.

When we take the politics out of our work — either consciously or unconsciously, whether by choice or to gain funding or credibility — we undermine our efforts to effect social change, and to create a society where women are valued, and their decisions are valued. That was what originally motivated the women’s movement — a movement that we hoped would transform society. We did not want to be answering the same questions, justifying women’s lives, in the same way we had to half a century ago.

These are just my musings. I hope we can start a dialogue about these issues; I invite your thoughts, comments, and criticisms on what I have written here. You can reach me through editor@nwhn.org. ❁



Laura Kaplan is a life-long women’s health activist and the author of *The Story of Jane*. She is a former NWHN board member.

In Honor Of & Memorial Donor List

TRIBUTE GIFTS

The National Women's Health Network wishes to thank everyone for their generous donations.

Annie Ballard

In Honor of Amy Allina

Miriam Breyer (Gramma Mir & Grandpa Jack)

In Honor of Emma Mary Seaborn

Marlene Drescher

In Honor of Sheila Burns

Julie Fiandt

In Honor of Stella & Odette Klein

Susan Flinn

In Honor of Cindy Pearson

Adriane Fugh-Berman MD

In Honor of Phil Corfman

Lisa Handwerker, PhD, MPH

In Honor of Minnie Handwerker

Barbara Jones

In Honor of All Women

Laura Kaplan

In Honor of Amy Allina

Clare Kirby

In Honor of My Sisters & Their Families

Freda Kleinburd

In Honor of Charlotte Kleinburd (Happy Birthday!)

Mary Lou Leonard

In Honor of Gulielma Leonard Fager

Victoria Leonard

In Honor of Amy Allina

Holly Logan

In Honor of Linda Ayers

Judy Norsigian

In Honor of Vilunya Diskin

Cheri Pies

In Honor of Cindy Pearson & Amy Allina

Wendy Price

In Honor of Dr. John P. Craddock

Lisa Rose

In Honor of Dr. Charlea Massion

Ellen Schwartz

In Honor of Amy Saldinger

Rosalye Schwartz

In Honor of Kim Nolz

Janey Skinner

In Honor of Sonja Herbert

Sterling Sperin

In Honor of Dr. Charlea Massion

Susan Wind

In Honor of Anna Wind

Gary Woodard

In Honor of Jan Robbins

Lise Vogel

In Honor of Susan Reverby

Sue Davis

In Memory of June O'Hanlon Eagle

Estelle Disch

In Memory of Rita Arditti

Susan Elkins

In Memory of Dorothy Elkins

Stacie Geller

In Memory of Dennie Nadeau

Barbara Gold

In Memory of Leonard & Yetta Gold

Laura Helfman

In Memory of Frances Helfman

Benita Hirsch

In Memory of Joyce Amit

Nettie Kravitz

In Memory of Jessie Glaberman

Madelyn Levy

In Memory of Maxine Meyers Arendt

Sandra Epstein Mager

In Memory of Reba Epstein & Eda Rae Lasky

Charlotte Maloney

In Memory of Jude Campbell

Carol Mukhopadhyay

In Memory of Rose Z. Chapnick

Ann Norman

In Memory of Eleanor Walter

Ellen Novack

In Memory of Janice Novack

Susan and Gerald Post

In Memory of Marlene Kevy

Jo Reichler

In Memory of my grandmother, Rae Weiss

Susan Ritchie-Ahrens

In Memory of Joan Patrick

Robin Roth

In Memory of Judith Knoop

Carol Sakala

In Memory of Doris Haire

Marian Sandmaier

In Memory of Toni Sandmaier

Barbara Sarah

In Memory of Carol Dwyer

Carol Schelling

In Memory of Susan Marsland

Shana Singerman

In Memory of Barbara Seaman

Patricia Walker

In Memory of Phyllis Lane Walker

Muriel D. Wolf

In Memory of Richard N. Wolf

Alice Wolfson

In Memory of Noah Wolfson & Barbara Seaman

Sally Zierler

In Memory of Margie Shapiro

This list reflects gifts received through January 15, 2015.
If your name is missing, incorrectly listed, or misspelled, please accept our sincere apology,
and contact our Membership Department at 202.682.2640.



NATIONAL WOMEN'S HEALTH NETWORK

A Voice for Women, a Network for Change

Nonprofit Org
U.S. Postage
PAID
Permit #1400
Suburban, MD

1413 K Street NW, Suite 400
Washington, DC 20005-3459

www.nwhn.org

Address Service Requested



Printed on 100% postconsumer waste paper. Minimally bleached and printed using soybean ink.

SNAP SHOTS

Talking about gay marriage can improve people's perceptions of the issue, but may not create permanent attitude changes. A recent study, which followed 972 voters' views on gay marriage for 9 months, found the messenger matters as much as the message. Lesbian, gay, bisexual, and transgender (LGBT) people who canvassed voters to support same-sex marriage caused lasting shifts in voters' attitudes after a 20-minute conversation. Voters approached by LGBT canvassers improved their support for same-sex marriage by about 20 percent (as measured on a 5-point scale). This attitude change also spread to other household members, leading to a 3 percentage-point increase in support of marriage equality. Straight canvassers were able to shift voters' opinions in the short-term, but voters' opinions reverted to their original views by follow-up. Only voters who spoke to LGBT canvassers maintained their favorable views about marriage equality 9 months later.

Science, December 2014

There are currently three treatment options for endometriosis (hormonal treatment, surgery, or a combination of the two), but treatment is only successful around 70% of the time. A new study analyzed pain, fertility, and obstetrical outcomes such as pregnancy for 450 women with endometriosis who were assigned to one of these treatment options. Treatment success was evaluated using four criteria: cure rate, endometriosis stage before and after treatment, recurrence rate, and pregnancy rate. All three treatment options had an overall cure rate of more than 50 percent; combined treatment had the highest cure rate, at 60 percent. Combined treatment also showed the best reduction in endometriosis symptoms. The study highlights the limited treatment options for women with endometriosis, and indicates a benefit from combined therapy.

BioMed Research International,
December 2014

Thyroid disease is the most common endocrine condition affecting women of reproductive age and is associated with infertility and miscarriages. About 2.3% of women who have problems conceiving have high thyroid levels (hyperthyroidism), compared to 1.5% of women in the general population. Graves' disease, the most common form of hyperthyroidism in pregnancy, affects 1% of pregnancies and leads to adverse pregnancy outcomes, including preterm delivery, pre-eclampsia, growth restriction, heart failure, and stillbirth. Autoimmune thyroid disease (AITD) is the most common cause of low thyroid levels (hypothyroidism), and is consistently linked to poor fertility. Women who test positive for thyroid autoantibodies have a three-fold higher risk of miscarriage compared to women with normal thyroid functioning. The review concludes that screening and prompt treatment for thyroid disease can greatly reduce women's reproductive health risks (including infertility and miscarriage). Asymptomatic women who experience recurrent miscarriages should be screened for thyroid function.

The Obstetrician & Gynaecologist,
January 2015