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The Women's Health Activist®

FEATURE STORY: PAGE 4

The Path Forward is a Radical One

By Kira S. Jones

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NATIONAL WOMEN'S HEALTH NETWORK
A VOICE FOR WOMEN, A NETWORK FOR CHANGE

DIRECTOR'S MESSAGE

The Choices We Make: in Voting Booths & Medicine Cabinets

By Cynthia Pearson

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

For more information about menopause HT, visit *www.nwhn.org/menopause-hormone-therapy/.*

For more information about candidates' stands on women's health rights, visit the non-partisan League of Women Voters, at *www.lwv.org/other-issues/health-care-reform.*

How can I write about anything *but* the election? The NWHN is non-partisan: we never endorse or assist candidates in any way. We do, however, educate people about what's at stake for women's health rights in upcoming elections. You are likely doing the same thing: educating friends and families and encouraging them to look at candidates' positions on crucial health policy issues.

At the same time, the NWHN advocates for, and educates about, day-to-day health issues. We're advocating for policies and regulatory decisions that affect millions of women, like approval of a new low-dose contraceptive patch, or expansion of post-partum Medicaid coverage. We're educating through our advocacy campaigns, so women can make informed choices about their health. Our efforts often respond to external circumstances.

Lately, we're responding to a disturbing trend of pro-HT messages that requires correction. The NWHN is not anti-HT; we're opposed to messages that inaccurately promote menopause HT as necessary for all women, several of which have appeared in publications ranging from The *Los Angeles Times*[1] to *The Economist.*[2] The authors, and others like them, falsely claim that starting HT at exactly the right time will be life-enhancing, even life-extending. They use guilt-tripping language to convince a new generation of women that HT will help them stay "feminine forever"— an ageist, sexist phrase coined by Robert A. Wilson back in the 1960s.[3]

The NWHN is responding to these "HT will save your life" messages with the facts: HT is an effective treatment for vaginal dryness and troubling hot flashes; it's not risk-free, but can be a reasonable choice to manage symptoms. And, alternative treatments work for many people.

The evidence doesn't support claims that taking HT will extend your life. Our analysis is that the claim that HT is life-saving is based on a sub-set analysis of the Women's Health Initiative (WHI). The WHI is a huge (27,000 women participated) and long-lasting study in which volunteers were randomized to take menopause HT or placebo pills for roughly 5 to 9 years, and carefully followed for illnesses like cancer and heart disease. The most recent report included health information from the WHI's first 18 years.[4] The overall results are clear: menopause HT caused *more* health problems than it prevented, although those problems did not cause more women to die. In other words, HT neither increased nor decreased mortality.[5] We're encouraging our readers to educate themselves and share this information with family and friends.

So how can people claim that HT saves lives? They pick just **one** sub-set of WHI data (women who were in their 50s when they joined the WHI) and only look at deaths occurring in the study's first few years, while participants were taking study medications. Women assigned to take HT in their 50s were less likely to die *while* they were taking HT, but the apparent benefit of taking hormones soon after menopause disappeared as the women aged, regardless of whether they chose to continue taking HT or not.

The choice of whether to take menopause HT or not is yours...and the choice of who to vote for in November is also yours. An educated choice is a pro-women's health choice, both in the medicine cabinet and the voting booth! ✤ References are available from *info@nwhn.org.*

NWHN in Action

By Sarah Christopherson

Raising Women's Voices (RWV)

Just when you think the Trump administration has run out of terrible ways to sabotage women's health care, they come up with another. With the NWHN's assistance, Raising Women's Voices' (RWV) regional coordinators have helped the larger movement generate hundreds of thousands of public comments opposing Trump's attacks on abortion care coverage through the ACA, immigrant access to health care, red tape and illegal benefit cuts in Medicaid, and more. In many cases, we can't stop bad rules from being issued, but we can help the courts block them from going into effect for as long as possible.

We've also been hard at work ensuring the strongest possible ACA enrollment for 2020. From the very beginning of this administration, we've known that one of the best ways to protect the ACA is to make clear, through enrollment, that millions of Americans want and need the affordable and comprehensive coverage that the health law makes possible. Now, a conservative lawsuit backed by the Trump administration has made the link between enrollment and the health law's survival even more direct. In *California v Texas* (formerly *Texas v Azar*), red state attorneys general led by Texas are arguing that, because the 2017 GOP tax bill eliminated the tax associated with the individual mandate, the mandate is now unconstitutional. And, because the law wasn't originally designed to survive *without* the mandate, they contend, the courts must strike down the entire law. The only problem for Texas? The law is surviving, even in the face of GOP sabotage. Millions of people continue to enroll in ACA coverage and states continue to work to shore up their ACA implementation and expand Medicaid. With our help, and that of our allies, reality keeps getting in the way of conservatives' legal theory.

Challenging Dangerous Drugs and Devices (CDDD)

Toxic ingredients and contaminants in cosmetics and other personal care products — like shampoo and conditioner, deodorant, makeup, baby powder, vaginal douches, lotion, body sprays and perfumes, hair dyes and straighteners — have been linked to numerous health problems (see M. Isabelle Chaudry's federal update in this issue). But, with few exceptions, current federal law doesn't require cosmetics or other personal care products to be approved by the Food and Drug Administration (FDA) before going on the U.S. market.

NWHN Executive Director Cynthia Pearson, FDA Associate Commissioner for Women's Health Kaveeta Vasisht, and Women's Congressional Policy Institute President Cindy Hall.

With our help, that could be changing. In the last few months, we've testified in Congress about the dangers of toxic products and the way that some of the most dangerous products are aggressively marketed to Black and Latina women. We've testified in front of the FDA about the need for improved testing standards to ensure that cosmetic talc isn't contaminated with asbestos. We've called out a badly done study that was published in the *Journal of the American Medical Association* and gives women a false sense of security about using talc-based powder for feminine hygiene. We hosted a second webinar and social media campaign with leaders from industry and the environment, women's health, and reproductive justice communities to help consumers and advocates protect themselves and take action. Our work has been covered in Good Morning America, ABC News, and a number of other outlets.

If that wasn't enough, we were also at the FDA testifying in support of pulling an ineffective drug from the market. In 2011, the FDA approved 17-hydroxyprogesterone caproate (Makena) with incomplete trial data, because it was (and remains) the only drug of its kind on the market intended to prevent preterm birth in at-risk women. But, subsequent studies have made clear that Makena doesn't actually work, and may expose pregnant people to unknown side effects. CONTINUED ON PAGE 5

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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.

The Women's Health Activist® is a 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*.

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The Path Forward is a Radical One

By Kira S. Jones

"A leopard can't change its spots." This saying reminds us that, even if someone or something pretends otherwise, the chance that they've altered their true nature is pretty slim. It's a phrase that perfectly captures how I think about the breast cancer industry and the true nature of "pink ribbon culture."

It's been more than 30 years since the multinational pharmaceutical corporation AstraZeneca established National Breast Cancer Awareness Month and nearly as long since the pink ribbon burst onto the scene. Susan G. Komen was technically the first to start pushing pink ribbons,[1] but it was Self Magazine and Estée Lauder that launched the ribbon as an icon of breast cancer awareness and a marketing tool.[2]

And whenever I think about the history of the breast cancer movement and the machine that is the breast cancer industry, I get angry.

I'm not angry because over the years people have banded together with the hope of figuring out how to end an epidemic or find a "cure." I'm angry because so little has really changed over the past three decades, especially when it comes to breast cancer treatment, metastatic breast cancer, mortality rates, the language we're conditioned to use when we talk about breast cancer and...that damned color pink.

We just entered a new decade — we're literally living in the future — isn't it about time we started talking about breast cancer in a way that reflects that? We live in the era of #MeToo and #TimesUp, and we can't continue to deny that the winds of change need to rattle the breast cancer movement, too. It's time for a *real* shakeup. It's time for us to finally peel every shred of that sickly-sweet pink ribbon off and shed all the ideological trappings of gender, female sexuality, and female sexual identity that have come to be associated with it. It's time to tear out the patriarchal belief system that's woven into the fabric of the pink ribbon, and set both it and the ribbon aside.

The color pink has hijacked the way we think about and talk about breast cancer for decades, which has set the disease up, disingenuously, as a palatable women's issue — one without teeth, without politics. But this is all a big fat hegemonic lie. Breast cancer isn't palatable. It's a devastating disease with harsh realities and treating it can be a significant financial burden and take a lasting physical, sexual, and emotional toll.

And it's political. It's political because breast cancer still kills female-identifying humans (approximately 40,000 every year, for more than 30 years)[3] more than male-identifying humans, which means that it is primarily a *women's* health issue. Women's health has always been political, and is especially so right now.

I'm angry because so little has really changed over the past three decades, especially when it comes to breast cancer treatment, metastatic breast cancer, mortality rates, the language we're conditioned to use when we talk about breast cancer and...that damned color pink.

But, here's the thing: as a disease, breast cancer doesn't really care about gender identity or gender expression. It kills humans regardless of where they sit on the gender spectrum. Covering that fact up with a pink ribbon hides the truth of individual lived experiences and the need for important changes that can improve our health care experiences and health outcomes.[4]

The pink ribbon, the color pink, even the word "pink," have narrowly defined and shaped conversations about breast cancer until now because, as scholar Veronika Koller explains, "People are culturally socialized into colour meaning." In other words, the association that stems from a particular color or shade isn't indicative of the color or shade itself, "but of the cultural and historical formation in which it is constructed as having particular characteristics and being suitable for particular social groups."[5]

We know the cultural association of pink with femininity *very* well: the color is a marker of stereotypically feminine traits and has historically been linked to restrictive and ideological definitions of female sexuality and female bodies. When we swaddle baby girls in pink blankets we cloak them not only in that color, but also in deep-seated, typically white, patriarchal beliefs and ideas about female passivity, helplessness, and dependence — ideals that are often proclaimed as biologically predetermined. As such, it's impossible to fully disentangle ourselves from the color pink's problematic and gendered cultural meaning. In turn, this stunts conversations about breast cancer before they even start, and constrains how we then think about someone living with or dying from the disease, awareness, activism, and what the path to preventing breast cancer and ending the epidemic looks like.[6]

The pink ribbon doesn't serve the breast cancer community, and it never really has. It serves the companies and organizations that make billions of dollars off breast cancer every year, by slapping a pink ribbon on their products; or running a pink ribbon campaign while also making or selling products linked to breast

We need change. Real, and meaningful change. Not the tiny incremental change that white patriarchy tells us is the only thing possible. It's not good enough.

cancer (Breast Cancer Action calls this "pinkwashing");[7] or coming up with "edgy" new campaigns that do little more than reinforce gender stereotypes and toxic ideological assumptions and expectations about female-presenting and -identifying humans, like Walgreens' 2018 campaign, "Battle Beautifully."[8]

We need change. Real, and meaningful change. Not the tiny incremental change that white patriarchy tells us is the only thing possible. It's not good enough.

We talk about breast cancer publicly more than we did a century ago, and that's reduced some of the stigma and taboo surrounding the disease. But, we need a more radical, nuanced, and intersectional discourse that's not constrained or stunted. We need a discussion that doesn't sexualize the disease or objectify female-presenting and -identifying humans. Slogans like "Save the Tatas," "Save Second Base," "Check Your Headlights," or "Keep the Lumps Out of Your Cups" are not cute, funny, or witty. They're demeaning and miss the mark of what's truly at stake. Not our breasts, but our *lives.*

We have to talk about breast cancer as a public health crisis, while making clear that it disproportionately affects female-identifying and -presenting humans. We have to talk (*a lot more*) about how race, class, gender identity, and our environment (the toxic chemicals in the air we breathe, the food we eat, and the water we drink) impact our risk of developing breast cancer, the quality of health care we receive, and whether we will die from the disease. We have to *stop* talking about mammograms as the solution, and instead figure out how to prevent the disease from developing in the first place. And, we have to talk *a lot more* about how the metastatic community needs more effective, more affordable, and less toxic treatments.

Then we have to do more than walk, run, or buy something pink for "the cure." And that's hard. I know. Especially when someone we love is dying from this damned disease and we feel helpless and hopeless. But, reaching for a pink ribbon to wrap around us in these fragile moments isn't going to get the job done — because it hasn't up to this point. We need to act, to agitate, to take political action, and to work for systematic change.

I know there are people who find comfort in, or identify with, the pink ribbon, but I'm not alone in pointing out that *pink ribbon culture* is doing more harm than good. Political breast cancer activists — like Barbara Brenner,[9] Karuna Jaggar,[10] Barbara Ehrenreich,[11] Ellen Leopold,[12] and Sharon Batt,[13] as well as corporate breast cancer movement scholar and the author of Pink Ribbons, Inc., Samantha King,[14] — have blazed a path forward by calling out the hypocrisy of the breast cancer industry and pink ribbon culture. And we must follow, channeling the spirit of Barbara Brenner, as "hell-raisers, question-askers, agents of change, and dogged and courageous pursuers of truth."[15]

Addressing and ending the breast cancer epidemic can't be done by continuing to think that if we could just figure out the right *shade* of pink or if we launch campaigns called "*More* than Pink," (like Komen did in 2018[16]) that we'll someday, somehow, arrive at the destination we all hope for — a world where fewer people die from breast cancer. The leopard can't change its spots, so it's high time we find a new leopard.✤

References are available from *info@nwhn.org.*

Kira S. Jones, M.A., is a NWHN Board Member. She was previously Breast Cancer Action's Communications Manager, and has been writing about and working in women's health for over 10 years. Her master's thesis on the breast cancer movement is titled, In The Pink: The (Un) Healthy Complexion Of National <Breast Cancer Awareness> Month.

NWHN in Action

FROM PAGE 3

Following our recommendation, an FDA advisory committee recommended withdrawing the drug from the market.

Securing Sexual and Reproductive Health and Autonomy (SRH)

In partnership with the National Institute for Reproductive Health (NIRH), we introduced a *Toolkit* for reproductive health activists in 2019 to help them respond to contraceptive policy initiatives. The *Toolkit* builds on our 2016 *Statement of Principles,* which we co-led with SisterSong, about coercion in the provision of long-acting reversible contraceptives (LARCs). Over the last few months we've been finding ways to help spread the word, joining NIRH at the American Public Health Association's annual conference to talk about the *Toolkit,* and presenting at the annual Med Students for Choice conference. All of our LARC materials, including the *Statement* and the *Toolkit,* are at *nwhn.org/larcs.*

Finally, the day after the FDA met to consider withdrawing Makena from the market, we were back to testify before a different FDA advisory committee — this time in support of the low-dose contraceptive patch, Twirla. If approved, Twirla would be a significantly lower-dose product than the only other contraceptive patch currently on the market. This would give women a safer choice if they want a user-controlled method that doesn't have to be taken daily, taken orally, or inserted into the vagina. By a vote of 14 to 1, the committee agreed with our recommendations, with members echoing many of our arguments. By a vote of 14 to 1, the committee agreed with our recommendations, with members echoing many of our arguments. On February 14, the FDA released the agency's final decision, approving Twirla and giving us all a nice Valentine's Day gift. You can find all of our public testimony at *nwhn.org/testimony.*✤

Sarah Christopherson is the NWHN's Policy Advocacy Director

Improving Black Maternal Health

By Kalena Murphy

Black women in the U.S. have among the world's highest maternal mortality rates: they're three to four times more likely to die from pregnancy-related complications than white women. The numbers are getting worse and, in some states (like New York and Illinois), the rates are higher, with Black women dying *six to eight times* more often than white women during pregnancy, childbirth, or post-partum period.

Raising Women's Voices (RWV) hosted a webinar to raise awareness specifically about Black maternal health. Our guest speaker was Dr. Joia Crear-Perry, Founder and President of the National Birth Equity Collaborative, and member of Black Mamas Matter Alliance's Advisory Committee. She shared updates on federal responses to this health crisis, 2020 advocacy plans, and strategies activists can use in their states.

The Roots of Inequities

People often think maternal mortality is related to poverty but, while socio-economic status can affect maternal health, the problem is much deeper. So, we provided an overview of both social determinants of health (economic and social conditions that influence both individual and group differences in health status) and inequalities' contribution to negative health outcomes, including Black maternal mortality.

Although Black women do what's considered best to ensure positive childbirth and health outcomes, they are more likely to have a preterm birth or to die during, or right after, pregnancy:

- Black college-educated mothers have worse maternal health outcomes than women of all other races who haven't finished high school.
- Normal weight Black women have worse birth outcomes than obese women of all other races.
- Black women who initiate prenatal care in their first trimester have higher rates of infant mortality than non-Hispanic white women who received no prenatal care or prenatal care that starts later in pregnancy.

The Black maternal mortality crisis is driven by social determinants of health, which are intensified by deeper problems, including institutional racism, gender oppression, gender discrimination and exploitation. "If we don't actually fix these root causes, we are just going to create new programs looking at social determinants of health," said Dr. Crear-Perry.

Federal & State-Level Efforts

There are many federal efforts to combat this issue, including investing in maternal health through Healthy Start's grant program in cities nationwide. The NWHN was pleased by passage of the 2018 "Preventing Maternal Deaths Act," which establishes and supports state Maternal Mortality Review Committees that review pregnancy-related and -associated deaths and develop recommendations to prevent maternal mortality. Last year, Representatives Lauren Underwood (D-IL) and Alma Adams (D-NC) launched the Black Maternal Health Caucus, a bi-partisan effort to expand access to infertility treatment, high-quality hospital care, and abortion care services — all of which can improve Black maternal health outcomes.

Dr. Crear-Perry highlighted state efforts to address Black maternal mortality, including implementing Maternal Mortality Review Committees on both local and state levels; supporting Perinatal and Maternal Care Quality Collaboratives to provide system-wide education and trainings for health providers; and adopting racial and health equity frameworks in state Health Department and local hospitals' strategic planning efforts.

RWV mini-grants are helping our Regional Coordinators (RCs) address this issue in their states. Kavelle Christie, Associate Director for Community Catalyst Women's Health Program, and a member of RWV's national coordinating team, described her work on Black maternal health at her previous position at Planned Parenthood of Southern New England (PPSNE). PPSNE is our Rhode Island RC and we were proud to support its "Healthy Neighborhood Canvass Initiative." Through the Initiative, PPSNE went into communities to educate the public and collect stories about Black maternal mortality. Ms. Christie also discussed PPSNE's work to help draft a bill on doula reimbursement, which passed the RI Senate in 2019 (but didn't advance in the House).

RWV also supports our Dallas-based RC, The Afiya Center, to address Texas' maternal mortality. The Center's efforts include training doulas and launching a doula collective that provides full-spectrum doula care to Black women, other women of color, and low-income women. D'Andra Willis, Lead Doula for the Southern Roots Doula Collective, discussed the Collective's work and opportunities for 2020, including collecting data on birth work and fund-raising for a birthing center.

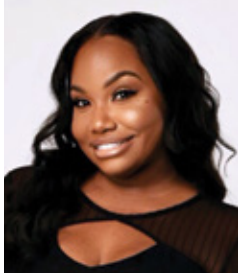
We will continue supporting our RCs to advance Black maternal health priorities through efforts including doula training, insurance reimbursement for doulas, and expansion of Medicaid coverage for a full 12 months post-partum. We'll keep you updated on our efforts!

2020 Black Maternal Health Week

One important effort is Black Maternal Health Week (BMHW), founded by the Black Mamas Matter Alliance to occur during National Minority Health Month. The third annual Black Maternal Health Week Campaign occurs April 11–17, 2020, and will include awareness-raising, activism, and community-building for Black mamas! These activities will amplify the voices of Black mamas and center the values and traditions of the human rights, reproductive justice, and birth justice movements.

Join Us

Sign up for RWV's weekly newsletter at *http://raisingwomensvoices.net/*, and get instant updates on our work via Facebook and Twitter (@RWV4HealthCare).✤



Kalena Murphy is the NWHN's Senior State Advocacy Manager for RWV.

2020 Board Election

Dear NWHN Members,

An important aspect of the NWHN's membership is your role in choosing the leaders of the organization. The NWHN is governed by a 14-person Board of Directors. Every two years, approximately half of the 14 seats are up for election. NWHN's bylaws require that members always have more choices than open seats. This means that you actually choose our Board of Directors, not merely ratify the recommendations of the Election Committee.

This year, there are 10 candidates running for 7 seats on the Board. The candidates include 2 incumbents running for re-election, and 8 others who are interested in serving for the first time. These candidates reflect a broad spectrum of the people who belong to the NWHN and are impacted by our work. We encourage you to vote for candidates who are diverse in many ways: race/ethnicity, geography, age, professional and experiential background, varying lengths of experience with the NWHN, sexual identity, and issues of interest.

Each candidate has written a short statement explaining why she wants to serve on the Board and what she feels she can offer to the NWHN. We are sharing these statements with you here, and they will also be available on-line, on the NWHN's secure voting site. To encourage turn-out, the NWHN makes it possible for members to vote either on-line or through the mail. Please see the box below for detailed instructions on how to vote.

Sincerely,

Anu Manchikanti Gómez, Chair
NWHN Nominations & Elections Committee

NWHN BOARD ELECTIONS

Following the passage of the revised bylaws in 2013, the NWHN instituted "hybrid voting," which allows members to vote either by paper or on-line. To help administer the process, the NWHN contracts with a third party, Intelliscan.

Intelliscan will mail all qualified voters (i.e., members) a postcard with a unique voter ID PIN number (*please see sample below*). The postcard will have all information you need about how to vote either via a secure on-line ballot or by paper ballot. You may vote using either method, **but not both!** Multiple ballots from the same person will be disqualified.

Each member will receive her or his own postcard from Intelliscan. (If there is more than one NWHN member in your household, each person will receive her/his own postcard and voter ID PIN number).

The election closes on April 28. On-line voting will end on that day at 11:59 pm EDT; ballots returned by mail must be received by Intelliscan by April 28 as well.

If you have questions about either the election process or the ballot, please contact Intelliscan between 9:00 am–5:00 pm (Eastern) via email: *aarbitell@intelliscaninc.com* or phone: 610.935.6172.

If you have a question about your membership, please contact our Membership Department between 9:00 am–5:00 pm (Eastern) via email: *membership@nwhn.org* or phone: 202.682.2640.

Election results will be announced on the NWHN website in mid-May and in the Summer edition of the *Women's Health Activist.* You can meet the new Board of Directors at the NWHN's June Board meeting, to be held in Washington, DC on June 13–14, 2020 or at the 13th Annual Barbara Seaman Awards for Activism in Women's Health on June 15 at the Whittemore House in Washington, DC. For more information, contact the NWHN office.

Candidate Statements

Lacey Alexander

I was a teen mother and then a single mother for almost a decade. Navigating teen pregnancy and postpartum care in rural Wisconsin's healthcare systems provided me insight into disparities in public health and healthcare. I decided to become a nurse while I was pregnant in high school for the purpose of financial stability, but shortly after starting college I knew I wanted to dedicate my career to improving the healthcare of vulnerable populations through nursing education and research. I earned degrees with honors in Nursing and Gender and Women's Studies (GWS). I completed a PhD in Nursing at the University of Wisconsin-Madison. As a graduate student, I published research about an intervention to reduce implicit gender and race biases among internal medicine residents. My dissertation focused on how implicit weight and sexual identity biases can influence clinical decision-making. I am currently an Advanced Fellow in Women's Health at William S. Middleton Memorial Veterans Hospital and an honorary fellow at the University of Wisconsin-Madison Department of Medicine. I co-authored studies about patients' gender and race biases aimed at physicians. My current research is focused on examining weight bias in primary care interactions. I have been teaching a feminist biology course in GWS about gender and health since 2014. I have worked as a staff nurse since 2012 and hold hospital leadership positions, including LGBTQ+ Care Coordinator and LGBTQ+ Program Manager. Serving NWHN would allow me to continue to fulfill my career aspirations of promoting social justice in healthcare.

Abigail Arons

Since my undergraduate history research on Planned Parenthood's efforts to challenge state laws prohibiting contraception during the 1950s, I have been fascinated by the social, political, and financial contexts of reproductive health specifically, and women's health more broadly. For nearly two decades, I have conducted research in reproductive health at the University of California, San Francisco, including studies on long-acting contraception, teen pregnancy prevention, sexual health education, and access to care. Currently, I direct a national, NIH-funded clinical trial looking at prevention of HPV-related anal cancer among adults living with HIV. While this study sounds very specific in scope, our goal is to change the standard of care for anal cancer prevention, following in the footsteps of researchers who determined how to screen, treat, and prevent cervical cancer. My interest in cancer prevention stemmed from my own diagnosis with an aggressive form of breast cancer at age 31. Despite my public health training and my family history of breast cancer, I was unprepared to identify as a cancer patient and unfamiliar with the myriad difficult and confusing choices I would face throughout my treatment. Since completing active treatment, I remain focused on advocating for and contributing to evidence-based policies that support all women to make informed decisions for their own health, regardless of age, race, ethnicity, religion, geography, insurance, ability, and income. Serving on the National Women's Health Network Board will allow me to contribute my personal and professional experiences toward this goal.

Sequoia Ayala

Given the opportunity, I would be an asset to the National Women's Health Network, primarily because of my various experiences advocating on behalf of women and communities of color at the state, national, and international level. As a multilingual and multicultural individual, I have worked extensively on various human rights campaigns centered on and for adolescent girls and women, LGBTQ folks, and others who face considerable barriers to family planning, sexual and reproductive healthcare. I began my career working with women refugees fleeing civil war and interpersonal violence. As a trained advocate for individuals who have been subjected to gender-based violence, I have a unique perspective on the various mechanisms women of diverse backgrounds utilize to navigate trauma and the unique health needs they have. Understanding and implementing culturally responsive mechanisms that addressed the intersectional struggles many women from these communities faced was and remains central to my work. If elected as a Board Member it would be an honor to continue supporting the leadership and staff of an organization dedicating to exposing conditions and environments that pose a risk to the safety, health, and well-being of women. I bring both lived experience and program management and operations experience that will surely prove useful in improving internal and external communication.

Leslie Diaz

Growing up in a low income traditional latinx household, politics and social issues were never pertinent in my life. I grew up surrounded by cousins and friends that were teenage mothers and I never gave it a second thought. It wasn't until I became more involved with reproductive justice and sexual education that I realized that the normalization of teenage pregnancy was due to the lack of proper education in my community. As a sexually active freshman with a boyfriend, sex ed taught me nothing about where to go or who to go to if I was having sex. It seemed as if everyone was having sex but no one knew about safety, access, or getting tested. Through trials and tribulations, I realized that if I wanted to learn about sex, I had to do it on my own accord, which is something, I believe, students shouldn't have to go through. My junior year of high school I started to become involved

in women's issues and reproductive justice. As a result of my personal experiences, I have devoted my work to women's health and policy. Although I am only a junior in college who is still learning, I have gathered extensive experience in sexual health, organizing, reproductive justice, leadership, community building, and legislative advocacy. I continuously advocate for women's health through outreach, local activism, research, and volunteering. As a NWHN board member, I hope to be a voice for young women in America and represent those who are overlooked.

Jennifer Miller

When I was fifteen years old, I watched my sixteen year old sister experience both teen pregnancy and pregnancy loss. I heard her recount the story of her ob/gyn suggesting it wasn't such a bad thing that she loss the baby since she was so young and the relief experienced by some of my family members. However, I was devastated and felt the pain of losing my first nephew and witness the struggle my sister endured. It was not until I was in my early 20's that I realized how much of an impact that experience had on me. I went on to pursue my doctor of public health with a specific interest in all things women's health. Through that hard experience, I found a passion to fight for women to be able to have babies when they want, if they want, and to have healthy pregnancies and healthy birth outcomes. My life's mission has become the promotion of women's health and the protection of women's choices around their bodies. Also, I have used my education and the experiences I have had to reach out to physicians, nurses, etc. to help them understand the experience of pregnancy loss and to create greater sensitive around this topic. I would love the opportunity to serve on the Board of Directors to help further this organization's goal of protecting the rights of women across the Nation. I believe my experience, education, and passion would bring new ideas and perspectives to the Board.

Nadiah Mohajir

I am a lifelong Chicagoan, Pakistani-American-Muslim, mother of three, public health professional, reproductive justice activist, and anti-sexual assault advocate. I discovered my interest in health disparities as a young girl, when I would visit my grandparents in Pakistan and was surrounded by poverty, health disparities, and the intersectionality of class, race, gender that widened the gap between the rich and poor. As I grew older and pursued my academic and professional career, I was dismayed to see that such disparities weren't that far from my own home in Chicago. I began exploring ways to work to help reduce disparities in vulnerable populations — particularly in Maternal and Child health and I have worked in many settings — policy, research, programmatic, and advocacy. Each of these experiences have allowed me to appreciate the intersectionality of race, gender, class, and other determinants to population health as well as the need to bring an interdisciplinary approach by working with different perspectives in order to develop a sustainable strategic response to a specific problem. Currently, I am Founder & Executive Director of HEART Women & Girls, a national nonprofit that provides sexual health education and sexual violence prevention programming in Muslim communities. I have been serving on the board of NWHN for the last four years and it has been such an honor. I look forward to bringing my life experiences, nonprofit and MCH expertise to the table for a second term.

Jaime Natelson

I am not alone. Like countless other women, I worry about my health, where I can find accurate information, will my privacy and rights be honored, and how do I support other women and families who fight for access. This is essential to how I approach this in my daily life… how I think, how I interact and engage with others in the world. As health care access has become a growing movement in the United States, the National Health Network has been on the forefront. Not just advocating for access for all, but refocusing health care to distinguish and support women and their individual needs. I learned about the National Women's Health Network as their direct marketing fundraising at Avalon. There I got to know about the importance of the Networks mission and the difference it was making women's lives as well as helping them to raise critical funding. Even when I left Avalon, I wanted to continue my relationship with Cindy and her team. From there I volunteered to work with the board to expand their engagement with one another and the work that they represent as leaders of the organization. This is why I would like to serve on the board of the National Women's Health Network. In this age of uncertainty and discord, it is time to step up and give back to my community, to the spectrum of women who have supported me and to the countless others who need their voices raised and rights protected.

Yamini Oseguera-Bhatnagar

I moved to south-east San Francisco (Frisco) from Dilli, India with my whole family in 9th grade. The cultural shift was massive, the struggle was real. I found my home among the community organizers and Hip-Hop heads in my inner-city environment. I became active in the brewing movement and revolutionization of Bay Area young folks to fight against criminalization and for ethnic studies in our schools. In 2007, I came upon public health via youth case management position at Oakland's largest HIV clinic. I spent many years building with and serving patients, partners and

Candidate Statements

families. In 2015, I connected with HIVE at San Francisco General hospital — a program dedicated to reproductive health needs of people affected by HIV. There, I created programming on a national level and a wide breadth of online content aimed at engaging women of reproductive age around HIV prevention as well as their providers on issues of health equity and reproductive justice. My independent projects have included: documenting HIV prevention programs in the Netherlands, South Africa and Mozambique serving women and children; examining the role of hospital-based staff in referring women to Child Protective Services interventions in clinical settings; creating sexual health content for community colleges and family planning websites. My personal lens is rooted in racial and gender justice focused on resilience and a strengths-based perspective. I look forward to the opportunity to strengthen my leadership, share diverse expertise, develop advocacy strategies, and collaborate with others in ongoing efforts to activate our communities towards change.

Kim Robinson

My passion for women's health combined with my strong leadership qualities led me into an executive management position at Women's Health Specialists. Working at WHS helped me grow and develop into the woman I am today. I've facilitated training programs for Doctors/Residents to learn how to preform abortion procedures, I've lobbied at the California and Washington DC Capitols' to fight for reproductive rights, I've taught women how to do self-cervical exams, and I've held the hands of many women during their abortion procedures. After 14 years of training, lobbying, and fighting for reproductive rights the place where I got my start was suddenly closed due to reproductive health restrictions and funding cuts. As devastating as that was, I didn't let that stop me. I was more determined than ever to create an environment where women could be heard and had a safe space to gather. For the past 4 years I've served on the board and currently I'm the Board Chair for NWHN. In my professional career I oversee four Federally Qualified Health Centers, and I'm a Community Liaison with Black Women for Wellness. As a women's health activist, I work with colleagues', communities and allies to build constituencies that demand reproductive justice for all women. These positions keep me connected by providing a vehicle to stay involved and informed. I'm motivated by the idea of keeping women's health in women's hands and include all women in the dialogue and give them the tools to have complete autonomy over their bodies.

Nekose Wills

Since I was an undergraduate student in the late 90s, I have been a dedicated women's health and wellness advocate. I am committed to reproductive justice and ensuring women, particularly women of color and marginalized women, have access to their full range of health care options. I have a plethora of experience in many facets of health, including a master's degree in women's health, and I enjoy helping women address the real-life nuances that exist in their lives. Over the last twenty years, I have worked or volunteered for a number of women's health organizations, including the National Women's Health Network (NWHN), Our Bodies Ourselves, Planned Parenthood Federation of America, Maryland NARAL, INCITE! Women of Color Against Violence, and the National Abortion Federation. Unfortunately, women's health continues to function under a persistent, institutionalized, gendered, and racial oppression that is embedded in the health care system, health policies, and too many health organizations. We are at a critical moment in time where it is extremely for women to make fully informed decisions and have complete access care. By joining the NWHN board, I know I will be able continue to help women prosper.

The election closes on Tuesday, April 28, 2020.

If you have questions about either the election process or the ballot, please contact Intelliscan between 9:00 am–5:00 pm (Eastern)

- **Email: *aarbitell@intelliscaninc.com***
- **Phone: 610.935.6172**

If you have a question about your membership, please contact our Membership Department between 9:00 am–5:00 pm (Eastern)

- **Email: *membership@nwhn.org***
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Board Meeting

The NWHN Board of Directors will meet next in Washington, DC, on June 13–14, 2020. NWHN members are welcome to join us for parts of the weekend. If you are interested in attending, please contact the office for more information at 202.682.2640.

YOUNG FEMINIST

Do We Really Have Reproductive Freedom?

By Shakun Kaushal

As I get older, my lifestyle continues to evolve. That includes important factors about what keeps me on track for where I want my life to go. One of these factors is being on birth control. I'm starting my career and am by no means able to mentally or financially care for a child. With that being said, I have been on the Pill, which requires daily consumption, since I was about 15 years old. In the following eight-ish years, I have forgotten to take countless numbers of birth control pills. While there are numerous reasons that I forget to take the Pill, I'm almost always nervous that I may become pregnant due to these slip-ups. Now, as a college-graduated, slightly more responsible 22-year-old, I want to be in better control of preventing pregnancy. This meant that I had to change my contraceptive method to one that I could rely on.

The OB/GYN handed me a pamphlet with brief explanations and pictures of contraceptives and described each one. After I explained that I wanted to switch from the Pill to something more long-lasting, she prompted me to tell her which method I wanted to use, and reminded me to make my next appointment at the reception desk.

What I thought would be a simple visit to my gynecologist resulted in a whole lot of confusion, and a whirlwind of emotions. Although I'm normally decisive in everything I do, I felt incapable of knowing which birth control method would work best for my body and my lifestyle. I made a follow-up appointment, determined to tell my gynecologist exactly what I wanted next time I came in.

The next day I Googled numerous reviews and testimonials about each birth control method. I decided I wanted a method that offered a long-term solution, so I didn't have to think twice about it. This lead me to consider the intrauterine device (IUD) and the implant that's inserted into your arm as the most compatible options.

The next thing I did was to ask the people in my life about their personal experiences with these specific birth control methods. My best friend had recently switched from the Pill to the implant. Not even two months later, she ended up going back to her OB/GYN to get the implant removed. At the time, she'd told me that she felt like the implant's hormones were messing with her body, I asked her to give me more details, and she confided that, when on the implant, she experienced depression and anxiety like she'd never done before. She wholeheartedly felt the implant caused side effects that negatively affected her mental health.

My best friend is normally a very stable person so, when she told me this, I decided not to take the risk of harming my mental health because I suffer from some anxiety already. I also realized my gynecologist hadn't informed me about side effects from the birth control methods we had discussed during my appointment. I wanted to be informed about the various side effects of the birth control methods I was considering — I felt that my mental health depended on it!

I had heard a lot about the IUD. I heard that it lasted for several years. I heard that it could be reversed. But most prominently, I heard that it hurt like hell going in. When I went to the initial appointment with my gynecologist she said she would insert the IUD in the office; that the insertion pain is tolerable; and so were the cramps that might occur for a little while afterwards. Back at home, I begin searching for IUD testimonials and quickly realized there is an wealth of horror stories.[1] So, now I had to be concerned not only about the birth control method's effects on my mental health, but also about the potentially very scary physical repercussions.

One story in particular caught my attention. Covered by *Cosmopolitan,*[2] a single mother in Baltimore, MD, endured horrific effects that may have been caused by her IUD, which pierced and wedged itself in the wall of her stomach. Due to infections from the stress of surgeries she lost her toes, uterus, and ovaries and would be unable to ever carry a pregnancy again. What alarmed me the most was what she said at the end of the article, "Although what happened to me won't happen to everyone, I hope other women will be careful when deciding how to prevent pregnancy. I don't regret getting the IUD in the first place — I did my research — I just never heard of complications as severe as what I've experienced."[2]

What she says is my biggest fear realized — all the research in the world could not prepare me for what may happen because of the contraceptive I choose.

What she says is my biggest fear realized — all the research in the world could not prepare me for what may happen because of the contraceptive I choose. I realized that, in fact, the whole foundation of my confusion and anxiety over choosing a birth control method stemmed from the possibility of harmful side effects. I now know that each birth control method has its own list of side effects, some more dangerous than others. And, choosing any method would feel like choosing the lesser evil. Unfortunately, that's the perception that I and many women share about the types of birth control that are currently available.

Feeling defeated, I went in for my next gynecologist appointment and simply asked for a prescription refill for my birth control pills. Hopefully, in the future, there will be a safe, highly effective birth control without side effects — until that day, I can't help but wonder, do we really have reproductive freedom?✤

References are available from *info@nwhn.org.*

Shakun Kaushal was the NWHN's communications intern in the Fall of 2019. She graduated from the University of Maryland, College Park and continues to write about diverse women's issues.

Cosmetic Legislation: Time for a Federal Fix

By M. Isabelle Chaudry

Many people assume that cosmetics and other personal care products marketed and sold in the U.S. are reviewed for their safety and regulated by the Food and Drug Administration (FDA). In fact, the Federal Cosmetics Act — last updated in 1938 — does not prohibit manufacturers from using dangerous ingredients in their products; failing to provide full disclosure about the chemicals contained in those products; and then selling those products, without FDA oversight, to the American public.

In December, I testified on behalf of the NWHN before the House Energy and Commerce Subcommittee on Health. My testimony addressed the dangers posed by unregulated products to the long-term health of women and girls and, specifically, to our reproductive health. (Watch my testimony at *nwhn.org/unsafe-cosmetics.*)

Cosmetics and personal care products — like moisturizer, soap, perfume, fingernail polish, makeup (including lipstick), hair products, and deodorant — are a disproportionately large source of chemical exposure for women and girls. On average, women in the U.S. use 12 products containing 168 unique ingredients every day,[1] while men use an average of 6 products daily, with 85 unique ingredients.[2]

Ingredients and contaminants found in these products have been linked to an increased risk of negative health outcomes for women, including ovarian and breast cancer, early onset of puberty, fibroids, endometriosis, miscarriage, infertility, pregnancy complications, endocrine disruption, changes in hormone levels, diabetes, obesity, and more. Practicing good hygiene and self-care should not create a risk for health problems like these.

In my testimony, I urged the Subcommittee members to protect women's health by including the strongest possible safeguards in cosmetics legislation. Current federal

law includes only lax regulations, and dangerous chemicals used in personal care products are not banned or restricted, nor is their safety even required to be studied. The FDA is not required to review any of the ingredients in personal care products that are sold over-the-counter, and the agency has not done so to date.

And, manufacturers are not required to disclose many cosmetic ingredients; instead, the chemicals are masked by descriptors like "fragrance," which do not need to be further specified. The term "fragrance" can be used to describe any one (or more) of about 3,000 chemicals. Consumers remain unaware of the actual chemicals contained in the products they purchase and use. As noted, studies show that the ingredients that are often used to formulate "fragrance" are linked to cancer, reproductive and developmental health effects, birth defects, and other problems.[3]

Other countries have far surpassed the U.S. in ensuring cosmetic safety. Both the European Union[4] (EU) and Canada[5] require cosmetic manufacturers to list, on the package, *any* fragrance substance that causes an allergic reaction (an allergen). The EU has also banned or restricted more than 1,300 toxic ingredients from use in cosmetics.[6]

In the U.S., only 14 states have introduced and/or adopted safe personal care products legislation: California,[7] Connecticut,[8] Maine,[9] Maryland,[10] Massachusetts,[11] Minnesota,[12] Mississippi,[13] New Jersey,[14] New York,[15] North Carolina,[16] Rhode Island,[17] Texas, [18] Vermont,[19] and Washington.[20]

Of these states, California is leading the way, having introduced and/or passed seven bills directly related to cosmetic regulation. The 2005 California Safe Cosmetics Act requires manufacturers to disclose any product ingredient that is on state or federal lists of chemicals that are known to cause cancer or birth defects, and created the California Safe Cosmetics Program Product Database. Three bills passed in 2017 and 2018: requiring cosmetic manufacturers to disclose ingredients on their product labels; prohibiting the sale of cosmetic products or ingredients that involve animal testing; and requiring companies to provide a list of ingredients in labels of hair, nail, and beauty salon products sold in the state.

Operating in such a piecemeal manner is not enough, however. Federal legislation is badly needed to provide meaningful protections for consumers. The NWHN endorses federal proposals including the Safe Cosmetics and Personal Care Products Act of 2019, which would mandate full fragrance ingredient disclosure by manufacturers, manufacturers' suppliers, and the FDA. The Act would require that dangerous fragrance ingredients — including allergens and chemicals linked to cancer and reproductive harm — to be disclosed so consumers can avoid these substances if they want to.

The NWHN has also worked directly with the House Energy and Commerce Committee and, more recently, with the FDA, to shape Committee-led legislation to address cosmetic safety and empower the FDA to review cosmetic ingredients and recall products that pose a health risk. On February 4, 2020, the FDA held a public meeting on methods to test for asbestos in talc and talc-containing cosmetic products.[21] Talc is found in many cosmetic products women use, including baby powder, lipstick, blush, eye shadow, foundation, and face powders. Independent labs have long documented asbestos' presence in consumer talcum products, including Johnson's Baby Powder. Given new research suggesting that cosmetic products can contribute to women's and girls' health problems, finding ways to effectively test cosmetic products for asbestos is of the utmost importance. Yet, although the FDA considers asbestos-contaminated talc unacceptable for use in cosmetics, no current U.S. laws prohibit the use of talc in cosmetics. The FDA can only act if a product is scientifically proven to cause harm (i.e., contains asbestos-contaminated talc), which requires specialized testing. CONTINUED ON PAGE 15

Rx for Change: Skin Lightening

By Nitika Gupta

Nitika Gupta is currently pursuing an M.S. in Health and the Public Interest at Georgetown University.

Skin lightening — also called skin whitening or skin bleaching — is the practice of using cosmetics to either reduce the appearance of age spots and/or discoloration or to change one's natural complexion.[1] Skin lightening cosmetics include bleaching creams, soaps, and pills that contain compounds designed to inhibit melanin production and thereby lighten skin.[2] Melanin, a pigment found in most organisms, is the main determinant of human skin color (it is also found in hair and specific eye tissues). Melanin has two primary forms: red- or yellow-colored pheomelanin and brown- or black-colored eumelanin.[3] People with dark skin have a larger percentage of eumelanin than those with fair skin.

Skin lighteners include compounds like hydroquinone, corticosteroids, and mercury,[2] which can cause severe complications.

- **Hydroquinone** is a skin-lighting agent that is associated with numerous harmful side effects, the most common of which is a skin rash (irritant contact dermatitis). Other side effects include allergic contact dermatitis and patchy skin lightening (hypopigmentation).[4] Prolonged exposure to hydroquinone may cause nail discoloration, damage to the cornea, impaired healing of wounds, and reopening of surgical incisions (wound dehiscence). The most severe side effect of continued hydroquinone use is a disorder characterized by blue-black pigmentation of the skin (exogenous ochronosis); to date, almost 800 cases have been reported.[4]
- **Corticosteroids** are a form of steroid hormones that can cause skin lightening. Side effects include allergic contact dermatitis, a skin rash near the mouth (perioral dermatitis), thinning of the skin (skin atrophy), excessive hair growth (hypertrichosis), redness and visible blood vessels (rosacea), and stretch marks (striae atrophicae). If used for several months or years, corticosteroids may cause multi-system consequences including: cataracts, glaucoma, increased infection risk, fragile bones (osteoporosis), high blood sugar (hyperglycemia), diabetes, and hypertension.[2]
- **Mercury** is a chemical element that blocks melanin production, is extremely toxic, and can trigger both acute and chronic side effects.[4] Acute side effects include inflammation of lung tissue (pneumonitis) and gastric distress. Chronic use of mercury-containing skin lighteners can cause neurological complications including tremors, memory loss, anxiety, depression, and psychosis; toxicity of the kidneys (nephrotoxicity); and — ironically — hyper-pigmentation.

Given the numerous dangers associated with skin-lightening products, many countries have restricted their importation and sale,[2] including Australia, Côte d'Ivoire, Ghana, Japan, Rwanda and South Africa.[5]

Since 1973, the U.S. Food and Drug Administration (FDA) has banned the use of mercury in cosmetics at levels exceeding one part per million (1 ppm). In 2019, the agency discovered a skin cream (Manning Beauty Cream) composed of approximately eight percent mercury by weight, and issued an import alert for mercury-containing bleaching creams.[6] While this alert enables FDA agents to seize these products, the agency's ability to monitor and manage cosmetic imports is limited. In 2006, the FDA proposed a ban on all over-the-counter skin lighteners containing hydroquinone (excluding products that were approved through the agency's New Drug Application review system).[2] The ban — which has not been implemented — was developed in response to a growing number of exogenous ochronosis cases.

Despite the clear, documented side effects of skin lightening products, and the growing number of national bans, these cosmetics continue to be frequently used, particularly in African and Asian nations. According to the World Health Organization (WHO), 77% of women in Nigeria report frequent use of these bleaching products, as do 59% of women in Togo, 35% of women in South Africa, and 27% of women in Senegal.[7] A 2004 study found that 40% of female respondents in China, Malaysia, the Philippines, and the Republic of Korea reported using skin lighteners.[7] Skin lighteners comprise 61% of India's skin care market.[7]

Why are such damaging products still being used, by so many women?

While individual incentives differ, many women bleach because of the prospect of gaining higher status — and, with the privileges afforded to those with lighter skin, who can blame them? Among Black women in the U.S., lighter skin predicts higher educational achievement and earnings.[8] Complexion affects employment opportunities, too; when

evaluated by white interviewers, light-skinned Black and Hispanic job applicants were perceived as being more intelligent compared to darker-skinned applicants with the same qualifications.[9]

The practice of bleaching may also be driven by the desire to attract a partner (possibly because many societies perpetuate the idea that a woman's worth is demonstrated by her ability to find a man). In one study of 600 Nigerian adolescent students, the top three reasons for skin bleaching were to "gain the attention of male folk," "get desired marriage partners," and "successfully maintain premarital relationships."[10]

Skin lightening is hardly a new practice: the first documented treatment dates back to 4,000 BC, in ancient Egypt.[11] At the height of slave trading in North Africa, slave owners used bleaching to lighten enslaved peopes' skin after extended sun exposure. The practice has persisted and even flourished, due to a global culture of "colorism," discrimination against people with dark complexions. For centuries, Black and Brown women have had to conform to Eurocentric beauty standards. Today, these damaging ideals are perpetuated throughout mass media; more music videos and cosmetic advertisements feature white women than women of color.[11] Meanwhile, celebrities like Blac Chyna and Azealia Banks tout skin lighteners, pressuring women to question the skin they're in.

It's time that we condemn not only the producers and vendors of these unsafe products but also the misogynistic, racist culture that allows them to prosper. It's time we addressed bleaching cosmetics for what they are: an attack on dark-skinned women.❖

References are available from *info@nwhn.org.*

Since You Asked!

Question: I was on Depo-Provera birth control for years; what can I do to help prevent osteoporosis now?

Answer: Depo-Provera is a progesterone-based contraceptive shot injected into the arm, upper thigh, or abdomen. It is 97-99.7% effective in preventing pregnancy, and each shot lasts for about 13 weeks.[1] While the method is effective, it has significant side effects that are important to keep in mind if you used, are using, or were thinking about using this method of birth control.

When Depo-Provera was approved for use in the U.S. in 1992, preliminary research indicated that women who used the method experienced a loss of bone mineral density (BMD), putting them at higher risk of developing osteoporosis and experiencing bone fractures later on.[2] As a result, the Food and Drug Administration (FDA) required Depo-Provera's manufacturer to conduct post-approval studies to examine the drug's effect on BMD. In 2004, data submitted to the FDA by Pfizer (which now owns Depo) showed that the drug did, in fact, have a harmful effect on BMD for some women, and the FDA required changes to the drug label to reflect these risks. The Depo label now includes a Black Box warning (indicating severe risk) stating that:

> Women who use Depo-Provera Contraceptive Injection may lose significant bone mineral density. Bone loss is greater with increasing duration of use and may not be completely reversible. It is unknown if use of the Depo-Provera Contraceptive Injection during adolescence or early adulthood, a critical period of bone accretion, will reduce peak bone mass and increase the risk for osteoporotic fracture in later life. The Depo-Provera Contraceptive Injection should be used as a long-term birth control method (e.g. longer than 2 years) only if other birth control methods are inadequate.

There are a number of things women can do to strengthen and protect their bones throughout their lifetime.[3, 4] First, make sure you are getting enough calcium and Vitamin D in your diet, such as by eating a well-balanced diet, incorporating fruits and vegetables. Second, limit your alcohol consumption. Third, stop smoking. Fourth, strengthen your bones through exercise; the best workouts to build bone strength are weight-bearing and muscle-strengthening exercises.

As a long-acting, hormonal contraceptive method, Depo-Provera has advantages and disadvantages that each woman must assess with respect to her own life circumstances and health status. Depo-Provera's effect on BMD increases the need for women to receive thorough counseling and comprehensive education in order to make a fully informed decision about whether or not to use the method, and for how long. More research is needed to assess which women, if any, are most likely to experience irreversible BMD loss, and the full impact of adolescent BMD loss on future fractures and/or osteoporosis.❖

References are available from *info@nwhn.org.*

Online women's health column: *www.nwhn.org/since-you-asked*

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Cosmetics

FROM PAGE 13

I provided oral statements at the February meeting, urging the FDA to ensure the most sensitive methods are used to test for asbestos in products marketed to consumers. My statement was accompanied by a petition and supported by many of our women's health colleagues. For the first time in decades, Congress is working on a bipartisan effort to update the Cosmetic Act and provide more protections for consumers and the FDA is taking steps to ensure cosmetic products are adequately tested for their safety. You can help by calling your member of Congress and urging them to pass safe cosmetics regulation. Safer products can be found in the Environmental Working Group's *Skin Deep Database,* at: *www.ewg.org/skindeep/.*❖

References are available from *info@nwhn.org.*

M. Isabelle Chaudry is the NWHN Senior Policy Manager

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SNAP SHOTS

A new, long-term study indicates that a **shorter course of high-dose radiation is as effective** in treating breast cancer as a longer course, lower-dose treatment. The randomized controlled trial occurred from 2006 to 2011 among 2,135 women in Canada, New Zealand, and Australia. Participants were at least 40 years old, had ductal carcinoma or node-negative breast cancer, and had been treated by breast conserving surgery (avoiding a mastectomy). Half the participants received the standard treatment: whole breast radiation delivered once daily for three to five weeks. The other half received external beam Accelerated Partial Breast Irradiation (APBI), the least invasive approach to partial breast radiation, delivered twice daily for five to eight days. Median follow-up was 8.6 years. Results indicate the risk of cancer recurrence was very low and similar in both groups. Sixty percent of women experienced adverse effects from radiation, with this being more likely after treatment ended for those using the twice-daily approach. While not yet advisable, further refinements (i.e., lengthening time between treatments) may yield a shorter treatment option with manageable results.

The Lancet, December 2019

What price beauty? A new study suggests that **using permanent hair dye and chemical hair straighteners increase the risk of developing breast cancer.** Researchers analyzed data from 46,709 35–74-year-old women who participated in the Sister Study breast cancer research project, which collected data between 2003–2009 from women whose sisters had breast cancer. Women who reported regularly using permanent hair dye in the year before enrolling in the study were 9% more likely to develop breast cancer vs. women who did not. Black women who used permanent hair dye more often (i.e., at least every 5–8 weeks) had a 60% increased risk of breast cancer vs. an 8% increased risk for white women. Chemical hair straighteners were also associated with increased breast cancer risk: women who used hair straighteners at least every 5–8 weeks were about 30% more likely to develop breast cancer, vs. women with less-frequent use. Black women are at higher risk due to their more-frequent use of straighteners. More research is needed on the effects of these personal care products.

International Journal of Cancer, December 2019

We all know that diet is important; new research suggests **there may be a direct correlation between diet and depression.** A new study suggests that lower intake of two fatty acids — oleic acids (OA) and linoleic acids (LA) — helps improve mental health and **decrease depression in perimenopausal women.** These fatty acids are found in many foods: OA is in pecan, peanut, and canola oil, as well as in many animal fats. LA is found in many oils, including sunflower, grape seed, and corn oils. The researchers used data from 2,793 42-to-52-year-old perimenopausal participants in the Study of Women's Health Across the Nation (SWAN) to assess correlations between OA and LA intake and depression. Findings suggest a positive association between OA and LA intake with depressive symptoms, using the Center for Epidemiologic Studies (CES) Depression Scale. This is a counter-intuitive finding about OA and LA, which have been promoted as healthier dietary options than saturated fats. While it's a high-quality study, SWAN is observational and can't prove cause and effect. More research is definitely needed!

Nutrition, October 2019