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# THE CLINTON ADMINISTRATION:
## STANDING UP FOR A WOMAN'S RIGHT TO CHOOSE

The new steps the Clinton Adminsistration took today build on the Administration's longstanding commitment to provide American women with safe, high quality family planning services and assure access to choice. This Administration has worked hard to protect a woman's right to choose and to promote safe reproductive health services for women.

- **Creating of the National Task Force on Violence Against Health Care Providers.** Last November, the Justice Department*'s* launched a National Task Force on Violence Against Health Care Providers to coordinate the investigation of violence against women's health care clinics nationwide. The Task Force works closely with local authorities and U.S. Attorneys investigating acts of violence against clinics by: coordinating national investigative efforts; creating an investigative clearinghouse for information related to clinic violence; and providing training to federal, state and local law enforcement personnel.

- **Provided Contraceptive Coverage to More than a Million Women.** The FY99 Omnibus Appropriations Act contains an important policy breakthrough on reproductive choice. The final bill requires the 300 Federal Employees Health Benefits Plans (FEHBP) to cover contraceptive drugs and devices, providing coverage to approximately 1.2 million women of childbearing age. Until now, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all. The Republican Leadership tried to remove this measure, but President Clinton and pro-choice members remained firm.

- **Providing family planning services to low income women.** The Administration has granted Medicaid waivers to expand access to family planning services in 11 states in order to reduce the number of women with mistimed or unwanted pregnancies. These waivers extend family planning services to low-income women of childbearing age who would not otherwise be eligible for Medicaid family planning services, including low-income women who are eligible for Medicaid while pregnant but who lose their eligibility at the end of pregnancy, and low-income women who would become eligible for Medicaid if pregnant, even if they've never been pregnant or Medicaid eligible.

- **Stopped the Coburn Amendment Prohibiting the FDA from Approving RU-486.** On January 22, 1993, President Clinton reversed the ban on the importation of Mifepristone or RU-486; RU-486 is currently under review by the Food and Drug Administration (FDA). Unfortunately, the FDA's scientific drug approval process became under assault in the 105th Congress. President Clinton threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion, including RU-486. Because of the President's veto threat, Republicans backed down and decided not to attach this provision to any funding bill.

- **Defeated Parental Consent Restrictions on Contraceptives for Minors.** The House voted to require minors to obtain parental consent prior to receiving any Title X family planning services (this has also been referred to as the Istook amendment). The President's veto threat helped to keep it out of the final bill.

- **Stopped the So-Called "Child Custody Protection" Act.** Senior Clinton Administration Advisers recommended a veto of this bill which would have made it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws. The Clinton Administration, as detailed in the Statement of Administration Policy, was very concerned that the bill did not protect close family members --including grandmothers, aunts and siblings --from criminal and civil liability. Family members could face criminal charges for aiding a relative in distress. The bill also did not protect persons that only provide information, counseling, referral or medical services to the minor from liability. Under a veto threat, the Senate failed to invoke cloture (or end debate) on the Child Custody Protection Act.

- **Upheld the Late Term Abortion Veto.** This year, the House of Representatives voted to override President Clinton's veto of a bill banning certain late-term abortions, known by proponents of the ban as "partial birth abortions." While the House voted to override the President's action, the Senate sustained the veto by a vote of 36-64 --just three votes short of the required two-thirds majority needed to override the veto. President Clinton vetoed the measure in October 1997 because it did not contain an exception that protected the health or life of the woman.

- **Continued to Fight Restrictions on International Family Planning**. The FY99 Omnibus Appropriations Act does not contain the so-called "Mexico City" policy, a provision that denies U.S. funds to international family planning organizations that use their own resources to perform abortions or lobby on abortion policy. The Mexico City restrictions were also included in the Foreign Affairs Reform and Restructuring Act. President Clinton vetoed this legislation because it contained these unacceptable restrictions.

**NARAL** ***Promoting Reproductive Choices***

TO: Agriculture Appropriations and Reproductive Health Staff
FROM: Allison Herwitt, Director of Government Relations
Terri McCullough, Legislative Representative
DATE: May 24, 1999
RE: ***FY 2000 Agriculture Appropriations Bill***

On Tuesday, May 25, the House is scheduled to consider the FY2000 Agriculture Appropriations bill. Last year, Representative Tom Coburn offered an amendment prohibiting the Food and Drug Administration (FDA) from using funds to test, develop, approve or manufacture drugs for early, medical abortion, including mifepristone (commonly known as RU-486). It is likely that there will be an attempt to offer a similar amendment when this bill is considered on the floor. ***NARAL urges you to oppose any amendment banning the FDA from approving drugs used for medical abortion.*** **NARAL will score this vote in our 1999 Congressional Record on Choice.**

Mifepristone is an effective and nonsurgical method of early abortion that has been in use since 1981. The drug was approved for use in France, Great Britain, and Sweden following extensive clinical trials that demonstrated its safety and effectiveness. In September 1996 the FDA issued an "approvable letter" for the use of mifepristone and misoprostol for early abortion, but the agency is awaiting more information about its manufacture and labeling before it gives mifepristone final approval and allows it to be prescribed to American women outside of clinical trials. It is possible that final approval of mifepristone could come as early as the end of this year.

Recognizing that mifepristone would expand women's choices and make it more difficult to target women seeking abortion for violence and harassment, anti-choice forces have worked to deny American women access to nonsurgical methods of abortion. Mifepristone offers the promise of very early abortion, and abortion that can be conducted in the privacy of a medical office and in the safety of a woman's home.

Bans such as this threaten to reduce women's options by precluding scientific developments, just as research that could lead to more contraceptive alternatives has been impeded. Other bans, such as on human embryo research, have stymied developments that could lead to cures and treatments for diseases such as Parkinson's, Alzheimer's and diabetes. ***Don't allow anti-choice politicians to halt beneficial scientific developments and efforts to broaden women's reproductive health options.***

Attached for your information are talking points on mifepristone and information about last year's Coburn amendment. If you have any questions, please contact Allison Herwitt at 973-3003 or Terri McCullough at 973-3047.

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**NARAL** ***Promoting Reproductive Choices***

TO: Defense and Reproductive Health Staff
FROM: Allison Herwitt, Director of Government Relations
Terri McCullough, Legislative Representative
DATE: May 24, 1999
RE: ***FY 2000/2001 Defense Department Authorization Act***

This week, the Senate is scheduled to consider the FY 2000/2001 Defense Department Authorization bill. The bill leaves in place current law, which bans privately-funded abortions for servicewomen and military dependents at overseas military hospitals. During floor consideration, Senators Patty Murray and Olympia Snowe plan to offer an amendment to repeal this ban. ***NARAL urges you to support the Murray-Snowe amendment.***

Without the repeal of this ban, women who have volunteered to serve their country will continue to be discriminated against by being prohibited from exercising their legally protected right to choose simply because they are stationed overseas.

- The Murray-Snowe amendment will restore the ability of our female service members and female dependents stationed overseas to exercise their constitutional right to choose safe abortion services.

- This amendment does not require the Department of Defense to pay for abortions -- it simply repeals the current ban on *privately*-funded abortions at U.S. military facilities overseas. No federal funds will be used for abortion services.

- Military women should be able to depend on their base hospitals for all their medical services. This amendment gives them access to the same range and quality of health care services that they could obtain in the U.S. In many countries where our forces serve, that quality of care is not available. Abortion is an extremely safe procedure when performed by trained medical professionals. However, in the hands of untrained medical professionals, or in unsterilized facilities, abortion can be dangerous and risky to a woman's health.

- No medical providers will be forced to perform abortions. All branches of the military have provisions that permit medical personnel who have moral, religious, or ethical objections to abortion not to participate in the procedure. The Murray-Snowe amendment preserves these provisions.

Attached is more information on this prohibition. If you have any questions, please call Allison Herwitt at 973-3003 or Terri McCullough at 973-3047.

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**U.S. Department of Justice**

Office of Legislative Affairs

Office of the Assistant Attorney General — Washington, D.C. 20530

605 333 2800
367 2800
Mike Bender
Scott Cross

# FAX COVER SHEET

*DATE:* 11/9/98

*TO:* Caroline Frederickson

PHONE NO.

FAX NO. 456-6468

Boxer
Shumer

*FROM:* Nancy Scott-Finan

PHONE NO. 514-3752

FAX NO. 305-2643

NO. OF PAGES: 4 (EXCLUDING COVER)

COMMENTS:

# Department of Justice

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MONDAY, NOVEMBER 9, 1998
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## ATTORNEY GENERAL RENO CREATES TASK FORCE TO COMBAT CLINIC VIOLENCE

### Reno Announces $500,000 Reward in Fatal Shooting of Dr. Slepian

WASHINGTON, D.C. -- Attorney General Janet Reno today established a national task force to coordinate the investigation of violence against women's health care clinics nationwide.

The National Clinic Violence Task Force will coordinate national investigative efforts, establish a central location for all information related to clinic violence, identify at-risk clinics and develop ways to make those clinics more secure, and enhance law enforcement training. It will also work closely with local authorities investigating acts of violence against clinics.

As part of the national effort, Reno also directed every U.S. Attorney to convene a meeting of their already-existing local working groups to discuss efforts that may need to be taken within their communities.

"The recent attacks on health care providers confirm the need for a coordinated investigative approach," said Reno, noting the recent violence directed at health care providers, including the fatal shooting of Dr. Barnett Slepian two weeks ago. "Every woman has the constitutional right to reproductive health care, and no one should ever be able to impede that right through violence."

The task force will investigate violence against health care providers, focusing on any connections that may exist between individuals engaged in criminal conduct.

The task force, which will report to Bill Lann Lee, the Acting Assistant Attorney General for Civil Rights, will be staffed by attorneys from the Civil Rights and Criminal Divisions. It will also be comprised of law enforcement personnel from the FBI, the Bureau of Alcohol, Tobacco, and Firearms (ATF), and the U.S. Marshals Service.

Today's announcement follows the October 23, murder of Dr. Slepian, who was fatally shot in the kitchen of his Amherst, New York home. The Dr. Slepian shooting followed four non-fatal shootings that took place in western New York and Canada over the last four years, including shootings in Vancouver, British Columbia in November 1994; Ancaster, Ontario (near Buffalo) in November 1995; Rochester, New York in October 1997; and, Winnipeg, Manitoba (near Rochester) in November 1997.

In each of the shootings, the victim was a physician who performed abortions, the assailant used a similar weapon, and the victim was shot through a window while at home. On Wednesday, a warrant was issued for the arrest of an individual whom the Justice Department considers a material witness in the case.

In addition, Reno today also announced that the Justice Department is offering up to $500,000 for information leading to the arrest and conviction of the person or persons responsible for the fatal shooting.

Since at least January 1998, a joint Canadian-American Task Force, named "Project Equality," has been investigating the four non-fatal shootings.

In addition to the shootings, between May and July of this year, about 20 health care clinics in three states were splattered with isobutyric acid, and two clinics in the Fayetteville, North Carolina area were the victims of arsons and attempted bombings. Just last weekend, clinics in Indiana, Tennessee and Kentucky received letters that falsely claimed to contain anthrax.

Investigations into these incidents are being conducted by the FBI, the ATF, and state and local law enforcement, either individually or by joint federal/state task forces.

In 1994, a similar task force was established to investigate whether a national conspiracy existed. While it developed several successful criminal cases, it did not develop sufficient evidence upon which to prosecute a national conspiracy. In 1996, the task force was phased out and the Civil Rights Division continued the work of prosecuting clinic violence cases. In addition, local working groups, that were created and lead by U.S. Attorneys, remained in tact.

Since 1994, when President Clinton signed the Freedom of Access to Clinic Entrances Act (FACE), the Justice Department has brought 27 criminal cases and 17 civil cases.

The new task force will establish a centralized clearinghouse of information pertaining to clinic violence and create a structure by which prosecutors can analyze and investigate nationwide trends in clinic violence.

In addition, today's task force will:

- assist local officials in the investigation and prosecution of clinic violence;
- coordinate our national investigative efforts, focusing on connections that may exist between individuals involved in criminal conduct;
- make security recommendations to enhance the safety and protection of providers;
- assist the work of the U.S. Attorneys' local working groups on clinic violence;
- coordinate the training of federal, state, and local law enforcement agencies on clinic-related violence; and,
- coordinate the federal civil investigation and litigation of abortion-related violence.

"No amount of effort could ever stop every individual intent on perpetrating violence," added Reno. "But this Administration will take all appropriate measures to reduce the risk and prosecute those who engage in violence."

Individuals who have information about the shooting of Dr. Slepian should call 1-800-281-1184.

# # #

98-

# Abortion Pill Inches Closer to Production

## *merican Marketer Hopeful That Drug Will Be Available by the End of the Year*


and has been used in Europe for more than a decade. Mifepristone makes it difficult for a fertilized egg to adhere to the uterus, and a second drug, misoprostol, administered two days later, triggers contractions.

Largely unnoticed by the public, some women are already using RU-486 in a special research program. Women early in their pregnancies can get the drug today at more than a dozen sites across the country, including the Johns Hopkins Bayview Medical Center in Baltimore.

In the past 18 months, more than 3,000 women in the United States have taken RU-486 under this program, sponsored by an advocacy group known as the Abortion Rights Mobilization (ARM). The group's efforts, funded by nonprofit organizations including the John Merck Family Foundation and the George Soros Foundation, have provided the drug to 15 centers from Seattle to Bellevue, Neb., to Cherry Hill, N.J.

"We're looking to increase the flexibility of the drug, make it more user-friendly and less expensive," said Eric Schaff of the University of Rochester, medical director for the project.

Schaff said women have been accepting mifepristone-induced abortions well in his research program, which was approved by the FDA in 1997. While the procedure can involve significant bleeding and pain—and has sent a limited number of women to the emergency —the complications are manageable, he said. A study published in the Archives of Medicine may have other uses—in the treatment, for instance, of menstrual cramps and fibroids, and to reduce the need for Caesarean sections. "We want to make this drug indispensable to doctors for a variety of reasons—to make it part of the medical mainstream," he said.

Johns Hopkins participated in the initial RU-486 clinical trials that led to the FDA's tentative approval and has been offering the drug as part of the Abortion Rights Mobilization effort since early last month.

The availability of RU-486 has not been advertised to the public, but Blumenthal said the Hopkins network of health providers was notified and news spread by word-of-mouth. Blumenthal said his clinic can treat 20 women a month, and the cost is equal to that of a surgical abortion.

"We know this method of medical abortion is acceptable to most women, but fine-tuning is necessary," Blumenthal said. "What we're doing now is familiarizing doctors with the procedure, providing a service and preparing for the day when, hopefully, this drug will be a lot more available."

The "abortion pill" was developed by the French firm Roussel-Uclaf in the late 1980s and is now commonly used in France, England, Sweden and China, according to the Alan Guttmachter Institute. The French company's corporate owner was so concerned about boycott threats from anti-abortion groups in the United States that in 1994 it donated RU-486's American patent rights to the Population C , a nonprofit planning group in York

Washington Post - March 23 1999


ILLUSTRATION BY JOEL BOWER FOR THE WASHINGTON POST

*By* MARC KAUFMAN
*Washington Post Staff Writer*

The American company licensed to market RU-486 says it has found manufacturers willing to produce the French "abortion pill" and is working with the U.S. Food and Drug Administration (FDA) for final approval.

"We expect to have the drug available by the end of the year," said spokeswoman Heather O'Neill of the Danco Group, a start-up pharmaceutical company in New York. She said her company is confident enough of its timetable that it has begun contacting doctors to discuss how best to prescribe and administer the drug, which won contingent FDA approval in 1996.

"It appears that everything is finally in order," said Eleanor Smeal of the Feminist Majority Foundation, which has been active in efforts to bring RU-486 to the United States for more than a decade.

Intense antiabortion opposition and business missteps by its nonprofit American sponsors have kept RU-486 off the market in this country and led many to believe that it would never be commercially available here.

While the drug's sponsors are still cautious because of the controversy surrounding the development of an abortion pill, Smeal said "there has been real progress."

Antiabortion groups, however, remain as opposed to drug-induced abortion as to the surgical procedure.

"Does it make any difference if an abortion is medical or surgical? No, it doesn't change a thing," said Randall O'Bannon, a spokesman for the National Right to Life Committee. "If this drug is approved, we may well see a short-term increase in abortions, and we think that would be very unfortunate."

The RU-486 pill, or mifepristone, is designed for women up to 49 days pregnant. Rights Mobilization (ARM). [illegible]s efforts, funded by nonprofit organizations including the John Merck Family Fo[illegible]tion and the George Soros Foundation, have provided the drug to 15 centers from Seattle to Bellevue, Neb., to Cherry Hill, N.J.

"We're looking to increase the flexibility of the drug, make it more user-friendly and less expensive," said Eric Schaff of the University of Rochester, medical director for the project.

Schaff said women have been accepting mifepristone-induced abortions well in his research program, which was approved by the FDA in 1997. While the procedure can involve significant bleeding and pain—and has sent a limited number of women to the emergency room—the complications are manageable, he said. A study published last year in the Archives of Family Medicine found that 95 percent of American women who used RU-486 for "medical abortions" would recommend it to others.

"The potential here is to make abortions more private and accessible, and to allow nonsurgeons to provide it," Schaff said.

What's more, researchers now are using lower doses of the drug and changing how they are administered to reduce side effects and cut costs.

When the FDA gave its initial tentative approval to RU-486, the agency addressed not only the safety and usefulness of the drug, but the whole process of administering the pills under a doctor's care. In the regimen approved by the FDA, the specific dosage of RU-486 was 600 milligrams, and women received a follow-up dose of the drug misoprostol. In clinical trials, this process required three trips to a doctor.

But doctors in the current RU-486 research program at Hopkins and elsewhere are using a lower dose (200 milligrams), and they now allow women to take the misoprostol vaginally at home, rather than by mouth in an office. According to Paul D. Blumenthal, a Hopkins gynecologist and professor, the new regimen requires only two trips to a doctor and gives women more control and privacy.

Blumenthal points out that mifepristone [illegible]ot-m[illegible]n. Blumenthal said his [illegible] can treat 20 [illegible] a [illegible] the [illegible] is equal to that of a surgical abortion.

"We know this method of medical abortion is acceptable to most women, but fine-tuning is necessary," Blumenthal said. "What we're doing now is familiarizing doctors with the procedure, providing a service and preparing for the day when, hopefully, this drug will be a lot more available."

The "abortion pill" was developed by the French firm Roussel-Uclaf in the late 1980s and is now commonly used in France, England, Sweden and China, according to the Alan Guttmachter Institute. The French company's corporate owner was so concerned about boycott threats from antiabortion groups in the United States that in 1994 it donated RU-486's American patent rights to the Population Council, a nonprofit family planning group based in New York. The council sought to make the drug available quickly, but no large manufacturer was interested and the council was overwhelmed by problems both internal and external.

Within one year of the FDA's tentative approval of RU-486, two important council business relationships collapsed. A lawyer selected to develop and market the drug turned out to have been disbarred and a manufacturer pulled out of the project.

Meanwhile, opposition from antiabortion groups intensified. Last year, the U.S. House of Representatives passed a bill that would deny money to the FDA for testing RU-486 or any drug like it—effectively blocking approval of medical abortion. The legislation, however, died later in the session. Antiabortion groups are expected to fight final approval by the FDA.

Because of the country's divisiveness over abortion, neither the Population Council nor the Danco Group will identify the companies now willing to manufacture mifepristone and make it into tablets. Those companies, and their manufacturing processes, have to be examined by the FDA before it can give final approval.

An FDA spokesman said he couldn't comment on the RU-486 application because it is still under review. ■

## HOUSE FLOOR

### MEASURES WOULD REAFFIRM U.S. SUPPORT FOR DEFENDING TAIWAN

Tensions over Chinese espionage and U.S. weapons technology could escalate Tuesday as the House considers a resolution designed to pressure the president to toughen his stance on China about its mounting military threats to Taiwan.

The measure (H Con Res 56) expresses "grave concerns" about recently reported Chinese military build-ups targeting Taiwan. It would call on the president and all U.S. officials to seek an official Chinese renunciation of force against Taiwan. It also would reaffirm the U.S. commitment to the 1979 Taiwan Relations Act (PL 96-9) that allows the United States to provide military supplies to ensure Taiwan's self-defense.

The measure also would call on U.S. leaders to support Taiwan's acceptance into the World Trade Organization (WTO).

The vote comes just weeks before Chinese Premier Zhu Rongji is scheduled to arrive in Washington for a much-anticipated round of talks. The discussions likely will touch on issues such as China's longstanding efforts to become a member of the WTO; the country's alleged attempts to steal nuclear weapons technologies from U.S. labs; and regional missile defense.

The resolution would refer to a classified Pentagon report that found in February that China plans in the next several years to raise the number of missiles it has pointed at Taiwan, possibly in response to anticipated U.S. plans to construct a missile defense system that could protect U.S. defense installations in the Pacific, as well as Japan and Taiwan.

Since former President Richard M. Nixon's historic trip to China in 1972, the United States has maintained its support for the idea of "one China," but recognizes Taiwan's distinct concerns and opposes a forceful reunification. But China has resolutely refused to renounce force against Taiwan, and expressed menacing opposition to a democratic Taiwan in 1996, when it fired missiles into the strait during the nation's elections.

• **Senate action.** The Senate Foreign Relations Committee Tuesday will mark up a nearly identical measure (S Con Res 17) Tuesday expressing support for Taiwan.

The panel also will consider another non-binding resolution (S Res 26) that would urge the administration to push for Taiwan's entry into the World Health Organization (WHO).

Bill sponsors say Taiwan has made great strides in the health care field since being removed from WHO in 1972, exemplified by repeatedly sending health experts to assist other East Asian and Pacific countries that belong to WHO. Taiwan's membership in WHO has been hampered by the implications that such membership would recognize independent statehood for Taiwan.

## HOUSE FLOOR

### RESOLUTION SETS IN MOTION CONDEMNATION OF CUBA

In the wake of the Cuban government's recent imprisonment of political dissidents, the House is expected to pass a resolution (H Res 99) Tuesday that would condemn President Fidel Castro's regime and call on the Clinton administration to use an upcoming U.N. human rights meeting as an opportunity to win passage of an international condemnation of Cuba's policies.

The measure would express support for internal political opposition and the independent press in Cuba, call for democratic elections in the communist country, demand the release of all political prisoners and support the legalization of all political parties, labor unions and the press.

"At this time of great repression, the internal opposition requires and deserves the firm and unwavering support and solidarity of the international community," the resolution states.

The measure would encourage U.S. officials to push for an official, multilateral condemnation of the Cuban government at the April meeting of the U.N. Human Rights Commission in Geneva, Switzerland, that would voice opposition to "its gross abuses of the rights of the Cuban people and for continued violations of all international human rights standards and legal principles."

Cuba critics have pushed several similar measures in recent years, relying on them and sanctions against Castro's regime to express vigorous opposition to his policies. The resolution would also call for the reinstatement of a special U.N. human rights monitor in Cuba.

The measure is scheduled for consideration under suspension of the rules procedures.

## HOUSE FLOOR

### FAMILY PLANNING SERVICES ISSUE MAKES INITIAL MARK THIS SESSION

In the first House action this session on the perennially thorny issue of international family planning, members are expected Tuesday to pass a resolution (H Res 118) that attempts to ensure that providers of such services overseas furnished with taxpayer dollars are truly "voluntary."

The measure is nearly identical to language the House attached with bipartisan support to the fiscal 1999 foreign operations spending bill, and later enacted into law as part of the omnibus appropriations measure (PL 105-277).

It would state the sense of Congress that all family planning programs should be completely voluntary; avoid numerical targets; provide recipients with complete information on methods; and be respectful of individual values and beliefs, as well as national laws.

In preparation for a late June meeting on U.N. population planning policy, officials will meet in New York this week to discuss progress since the policies were laid out in a 1994 agreement reached in Cairo, Egypt. Resolution sponsor Todd Tiahrt, R-Kan., told colleagues in a letter circulated Friday that the measure will "send an important message to the United Nations that all family planning programs should be voluntary."

A spokesman said Tiahrt first drafted the language in response to news reports that in some countries, family planning organizations charged with promoting voluntary programs were undertaking forced sterilizations for population control purposes.

Democrats worry the measure's language could allow individuals or entire organizations to opt out of family planning services on the basis of religion or conscience, leaving women in some countries with no alternative.

"There's nothing in the resolution that talks about the benefits of international family planning," said Peter Yo, deputy Minority Staff Director of the House International Relations Committee. Panel Democrats tried Monday to make minor modifications to the measure to address those issues, but a Tiahrt aide said any changes would have to be accepted by unanimous consent during floor debate.

The measure is scheduled for expedited consideration under suspension of the rules.

## HOUSE FLOOR

### CHAMBER CONSIDERS LEGISLATION RESTRICTING BURIAL IN ARLINGTON

The House will make a second attempt Tuesday to enact stricter guidelines for burial in Arlington National Cemetery, when members take up a bill (HR 70) that would limit eligibility to certain veterans and their families and U.S. presidents.

The legislation, which is scheduled for expedited consideration under suspension of the rules procedures, is similar to a measure that won easy passage in the House last year but died in the Senate.

Introduced in response to accusations that President Clinton was issuing burial

Bayh - loss on 6012
Lincoln - ? Okay w CC
Edwards - probably ok

THE WHITE HOUSE
WASHINGTON

Child Custody - introd
Clinic Violence hrg HELP ?
PBA 2 votes away / more # Budget
on Lott's pre-Mem Day recess

Bankruptcy → FACE Ds
declaring bkruptcy rather than paying NMH ILL etc.
fraudulent conveyance
* Non-dischargeability of debt

Incr. family planning

Cont. Cvrg

THE WHITE HOUSE

WASHINGTON

(1) Snowe dragging feet on intro
wants same # cosponsors
after Apr. 12

(2) EPICC as amdt to ngl care
Reid ok

(3) protecting FEHB
~~pvtg~~

March 22, 1999

Mr. John Podesta
Chief of Staff
The White House
1st Floor, West Wing
Washington, D.C. 20502

Dear Mr. Podesta:

As supporters of family planning and equity in women's health care, the undersigned organizations are writing to ask the Administration to continue its long-standing support for both domestic and international family planning by endorsing the "Equity in Prescription Insurance and Contraceptive Coverage Act" (EPICC), a bill to remedy an existing gender inequity in private insurance coverage of contraceptives. The Administration's endorsement of EPICC would be a strong statement in opposition to this discriminatory treatment. It also would build upon the Administration's support last year for this same coverage for federal employees participating in FEBHP – support which was key to its inclusion in the FY 1999 omnibus appropriations bill.

As you are well aware, family planning is basic, preventive health care for American women, and most American women use family planning at some point in their reproductive years. However, many private insurance policies either exclude coverage for prescription contraceptives and related services *entirely* or single out these services for limited coverage. At the same time, almost all of these same policies offer coverage for prescription drugs and devices.

The exclusion of prescription contraceptive coverage makes little sense when the benefits of such services are examined. Timing and spacing births is critical in improving women's and children's health and avoiding unintended pregnancies. Pregnancies that are unintended, spaced too closely together, or occur very early or very late in a woman's reproductive years often have adverse health, social, or economic consequences for both women and children – consequences which can include lower levels of educational and job attainment as well as a greater risk for these families of living in poverty. The use of family planning also increases the likelihood that the estimated 15 million Americans who contract a sexually transmitted disease each year will be diagnosed and treated, and reduces the incidence of unintended pregnancy and abortion. The United States has an extremely high rate of unintended pregnancy compared with other developed countries – approximately half of all pregnancies in our country are unintended and half of these end in abortion. By improving and increasing access to a full range of contraceptive services, women's risk of unintended pregnancy is reduced, as is the rate of abortion.

Despite the myriad health and social benefits associated with contraception, it is the only non-experimental prescription drug benefit that is regularly excluded by insurers. Almost half of all fee-for-service plans and Preferred Provider Organizations (PPOs), 20 percent of Point-of-Service plans (POS), and seven percent of Health Maintenance Organizations (HMOs) **do not offer *any* coverage for reversible contraception**. Of those plans that do offer some coverage for contraception, many

do not cover all five major methods of reversible contraception. Fewer than 20 percent of fee-for-service plans or PPOs and fewer than 40 percent of POS networks and HMOs routinely cover all five major methods – oral contraceptives (OCs), diaphragms, intrauterine devices (IUDs), Norplant, and Depo Provera.

In an important step toward remedying this inequity, family planning advocates in Congress, along with the Administration, succeeded in providing contraceptive coverage to the 1.2 million women of reproductive age participating in the Federal Employees Health Benefits Program, the largest employer sponsored health insurance plan in the world. It is now time to expand this common sense provision to the rest of privately insured Americans – of whom more than eight in ten support contraceptive coverage.

Bipartisan legislation was introduced in 1997 and is about to be reintroduced in the 106th Congress to help remedy this fundamental inequity in health care coverage and to create a level playing field for American women and their families. The Senate bill will be sponsored by Senators Olympia Snowe (R-ME) and Harry Reid (D-NV), while the House bill will be sponsored by Representatives Jim Greenwood (R-PA) and Nita Lowey (D-NY). EPICC would require insurance plans that offer prescription drug coverage to cover prescription contraceptive drugs and devices. Similarly, the measure would require that health plans offering coverage for outpatient medical services also provide coverage for outpatient contraceptive services. The bill defines contraception as "consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy." Moreover, research indicates that the cost of such coverage would be minimal.

We would like to meet with you at your earliest convenience to discuss the Administration's endorsement of EPICC. Judith DeSarno, the President of NFPRHA, will be happy to serve as the contact point with the groups to set up the meeting. She can be reached at 293-3114.

Thank you for your consideration.

The Alan Guttmacher Institute
American College of Obstetricians and Gynecologists
American Association of University Women
American Nurses Association
Center for Reproductive Law and Policy
National Abortion and Reproductive Rights Action League
National Family Planning and Reproductive Health Association
National Partnership for Women and Families
National Women's Law Center
Planned Parenthood Federation of America

cc:

Monica Dixon, Deputy Chief of Staff, Office of the Vice President
Maria Echaveste, Assistant to the President and Deputy Chief of Staff
Pat Ewing, Deputy Chief of Staff for Communications, Office of the Vice President
Audrey Tayse Haynes, Chief of Staff to Mrs. Gore
Christopher Jennings, Deputy Assistant to the President for Health Policy Development
Elena Kagen, Deputy Assistant to the President for Domestic Policy
Ron Klain, Assistant to the President and Chief of Staff and Counselor to the Vice President
Jenny Luray, Deputy Assistant to the President and Director of Women's Initiatives and Outreach
Bruce Reed, Assistant to the President for Domestic Policy
Melanne Verveer, Assistant to the President and Chief of Staff to the First Lady

# FIRST LADY HILLARY CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INVESTMENT IN SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN

**January 22, 1999**

Today, in honor of the 26th anniversary of Roe vs Wade, First Lady Hillary Rodham Clinton and Vice President Gore met with representatives from the reproductive health community to unveil a series of new steps to prevent unintended pregnancy, including a new multi million dollar initiative to ensure access to safe, high quality family planning services for American women.

**MILLIONS OF AMERICAN WOMEN NEED FAMILY PLANNING SERVICES**

More than 3 million unintended pregnancies occur every year in the United States. Women who use no contraceptives account for almost half of these pregnancies (47%), while the 39 million method users account for 53%. Unintended pregnancies among women who do not use contraception are almost as likely to end in abortion as they are in a birth.

**NEW STEPS TOWARDS PROVIDING SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN.** This initiative reaffirms the Clinton-Gore Administration's committment to expanding and enhancing the quality of reproductive health services for all American women. Today, the First Lady and Vice President announced that the Administration is:

- **Unveiling the Largest Increase in Family Planning Services in 15 Years.** The Clinton/Gore Adminstration's FY 2000 budget includes $240 million for family planning, a $25 million increase, and the largest increase in 15 years. These grants fund family planning clinics providing reproductive health services and clinical care to over 5 million low income women. These new funds will be used to prevent over a million unintended pregnancies year by improving the delivery of comprehensive reproductive health services, including STD and cancer screening and prevention, and HIV prevention, education and counseling; providing educational programs that encourage adolescents to postpone of sexual activity; increase the accessibility of contraceptive counseling and services; increasing efforts to provide effective contraceptives to those in need; and developing partnerships with other community based providers to conduct outreach to adolescents at risk.

- **Preventing violence at women's health clinics.** In the wake of escalating violence against women's health clinics that provide abortions, the First Lady and the Vice President will announce the the FY 2000 budget includes $4.5 million for support additional security enhancements, such as including closed circuit camera systems, improved lighting, motion detectors, alarm systems and bullet-resistant windows for these clinics in order to protect their doctors and nurses. Under this proposal, the Department of Justice would make security assessments and enhancements available to clinics deemed to be at high risk of violence. This Administration is committed to fighting this form of domestic terrorism that has threatened so many clinics and providers. While emphasizing the importance of family planning services to prevent unintended pregnancies, the First Lady and Vice President also emphasized that those women who choose to have an abortion do not have to fear violence.

- **Contributing $25 million to the UNFPA.** Today, the First Lady and Vice President will announce that the President's FY 2000 budget proposes a $25 million voluntary contribution to the UNFPA, $5 million more than the President's FY 1999 budget proposal. The UN Population Fund is the largest multilateral donor organization in the population sector and concentrates its assistance to countries in the areas of reproductive health and voluntary family planning, population policy and advocacy.

- **Ensuring that Federal employees have access to comprehensive family planning services.** The FY 2000 budget also continues to ensure that the Federal government leads the way as a model health plan by assuring that Federal employees and their families participating in the 300 Federal Employees Health Benefit Program (FEHBP) have access to contraceptive coverage. This policy provides coverage to approximately 1.2 million women of childbearing age and reduces unwanted pregnancies and the need for abortions by requiring most FEHB plans to offer the full range of contraceptive services. Before this requirement, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all.

30TH ANNIVERSARY YEAR
THE ALAN GUTTMACHER INSTITUTE
NEW YORK & WASHINGTON

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# UNPLANNED PREGNANCY COMMON WORLDWIDE
## Neither Legal Status of Abortion nor Health Risk Deters Women from Terminating Pregnancies

## Four in 10 Pregnancies Unplanned—Half of Which End in Abortion

Each year, about 35 of every 1,000 women of childbearing age in the world have an induced abortion. Despite variations in the legal status of abortion, when women living in more and in less developed regions are compared, their overall abortion rates are strikingly similar (39 abortions per 1,000 and 34 abortions per 1,000 women of reproductive age, respectively). The slightly higher level in the *developed* than in the *developing* world largely reflects that the *developed* world includes Eastern Europe, the area with the highest rate of abortion (90 per 1,000 women).

Of the estimated 210 million pregnancies that occur throughout the world each year, about 38% are unplanned, and 22% end in abortion, according to a new report by The Alan Guttmacher Institute (AGI)

- In *developed* countries (where average desired family size is small), of the 28 million pregnancies occurring every year, an estimated 49% are unplanned, and 36% end in abortion.
- In *developing* countries (where average desired family size is still relatively large), of the 182 million pregnancies occurring every year, an estimated 36% are unplanned, and 20% end in abortion.

"It is clear that women the world over go to great lengths to terminate an unplanned pregnancy. It is not only our responsibility but our duty to respect that decision. We must do our best to ensure that abortion takes place only under safe conditions and to see that women

have the means to prevent pregnancy in the first place," comments Jeannie I. Rosoff, AGI's president.

The new report, ***Sharing Responsibility: Women, Society and Abortion Worldwide***, examines the major factors that contribute to unplanned pregnancy and the reasons women give for choosing to terminate pregnancies. It provides the most up-to-date information on abortion in both legal and illegal circumstances around the world.

About 26 million women have legal abortions each year, and an estimated 20 million have illegal abortions. The conditions women face when they choose to have an abortion differ enormously from one part of the world to another:

- 25% of the world's women live in parts of the world where abortion is permitted only to save a woman's life or is prohibited altogether.
- 10% reside in countries where abortion is allowed when it is necessary to protect a woman's physical health or her life.
- 4% live in places where abortion is permitted for these reasons or to protect a woman's mental health.
- 61% of women live under more liberal laws: 20% in countries that permit abortion for socioeconomic reasons, as well as for the narrower grounds described above, and 41% in countries where women may obtain the procedure without being required to give a specific reason (at least in the early months of pregnancy).

Millions of women who live in countries that place severe restrictions on abortion nevertheless attempt to end their pregnancies by unauthorized and often unsafe means. The World Health Organization defines an unsafe abortion as a "procedure for terminating an unwanted pregnancy [carried out] either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."

Abortions carried out under such conditions place women's health and lives at risk. For example, of the estimated 600,000 annual pregnancy-related deaths worldwide, about 13% (or 78,000) are related to complications of unsafe abortion. In *developing* regions (excluding China), where abortion is often illegal or highly restricted, abortion mortality is hundreds of times higher than in *developed* countries (330 deaths per 100,000 abortions compared with 0.2-1.2 per 100,000). Mortality due to abortion is highest in Africa—an estimated 680 deaths per 100,000 procedures.

Based on analyses of government data and other research, the information in the Institute's new comprehensive study on abortion worldwide comes mainly from countries in

which pregnancy termination is legal and the number of abortions is collected by the government. However, some regional estimates and some estimates for countries in which abortion is illegal are also included.

Jeannie Rosoff comments further, "In the poorest countries, women are exposed to the highest risks of death and disability from unsafe, usually illegal abortion—often leaving whole families bereft of mothers and wives. The major victims are women living on the edges of survival, with few prospects that their governments can or will do much to improve their lot."

The findings from ***Sharing Responsibility: Women, Society and Abortion Worldwide*** point to several possible policy responses to reproductive health and social problems faced by individual countries or regions. In addition to providing sexuality and family life education, introducing contraceptive services where these are nonexistent, and expanding and improving them where they are inadequate, the report suggests that

- where abortion services are of high quality and easily accessible, governments need to give priority to maintaining them; and
- where abortion is provided predominantly in unsafe conditions, governments must try to create a consensus in favor of addressing the harmful social and health consequences of this situation.

###

**For a full copy of the report, contact Christiane Kirchgaessner at**:
*Telephone:* 212/248-1111 ext. 2203
*E-mail:* ckirchgaessner@agi-usa.org
*Fax:* 212/248-1952

***The Alan Guttmacher Institute is a not-for-profit organization focused on reproductive health research, policy analysis and public education, with offices in New York City and Washington, D.C.***

# Their religion, your rights

## You could lose access to:

- Contraception
- Getting your tubes tied to prevent pregnancy
- Emergency contraception after rape
- Pregnancy termination when your health is at risk
- Fertility treatments

If your hospital merges with a Catholic hospital, you may be denied basic health services.

BY JUDITH MANDELBAUM-SCHMID

It has already happened: Women in dozens of communities in the United States have been unable to get the medical care they want and need. Financially strapped nonsectarian hospitals and managed-care plans are merging with Catholic-owned health care groups, which operate under Catholic beliefs—that birth control and other reproductive services are morally wrong—and will not provide them to their patients.

Catholic health care is a powerful and economically robust force on the American medical scene. It is the nation's largest not-for-profit provider of health care and handles approximately 15 percent of our nation's hospital needs. Its importance only stands to increase. Like other health care providers, Catholic groups are looking to broaden their economic base and consolidate their position. During the past decade, the majority of hospital mergers were between Catholic and non-Catholic institutions. From 1990 to 1998 there were 127 such pairings. Significantly, in half of those hospitals the new unions resulted in elimination of some or all reproductive services.

Catholic health care organizations are required to follow the guidelines established by the National Conference of Catholic Bishops as spelled out in a publication called *Ethical and Religious Directives for Catholic Health Care Facilities*. Expressly forbidden are contraception, abortion, in vitro fertilization (and most other forms of assisted fertility), tubal ligation and vasectomy. The *Ethical and Religious Directives* also dictates the stance doctors who provide obstetric care must take in life-and-death situations.

Other religiously affiliated health care organizations and hospitals also limit certain reproductive services, but they are less aggressive players on the merger scene. Generally, Adventist hospitals ban elective abortion (making some exceptions for medical neces- *Continued on page 146*

*Continued from page 144* say with approval from a hospital ethics committee), but permit birth-control services, sterilization and infertility treatments. At Baptist hospitals, policies vary. Florida's South Miami Hospital, part of Baptist Health Systems of South Florida, has almost no restrictions, while Memphis' Baptist Memorial Health Care Corporation, the largest Baptist health care network in the United States, permits termination of pregnancy only when a woman's life is immediately threatened. The Memphis-based group allows contraception and sterilization, but is considering limiting fertility treatments at a planned new women's hospital to married couples only. Single women and lesbian couples may be turned away.

In a number of areas, a Catholic hospital is a woman's only choice. In 1994 there were 46 communities where a Catholic hospital was the sole hospital provider. Five years later, this number has nearly doubled—to 91.

What's more, many women who are cared for in a Catholic hospital are unaware of its religious affiliation. "They find that out the hard way when they discover there's a service they can't get," says Frances Kissling, president of Catholics for a Free Choice, a nonprofit group promoting reproductive freedom. "It's much harder to tell whether or not a hospital is Catholic these days. There aren't nuns in habits walking around. In addition, today's Catholic hospitals—especially those that have recently merged into a Catholic system—don't always have names that evoke their religious affiliation." For example, Community Health Partners in Lorain, Ohio, is a Catholic facility, so is Northridge Hospital Medical Center in Los Angeles.

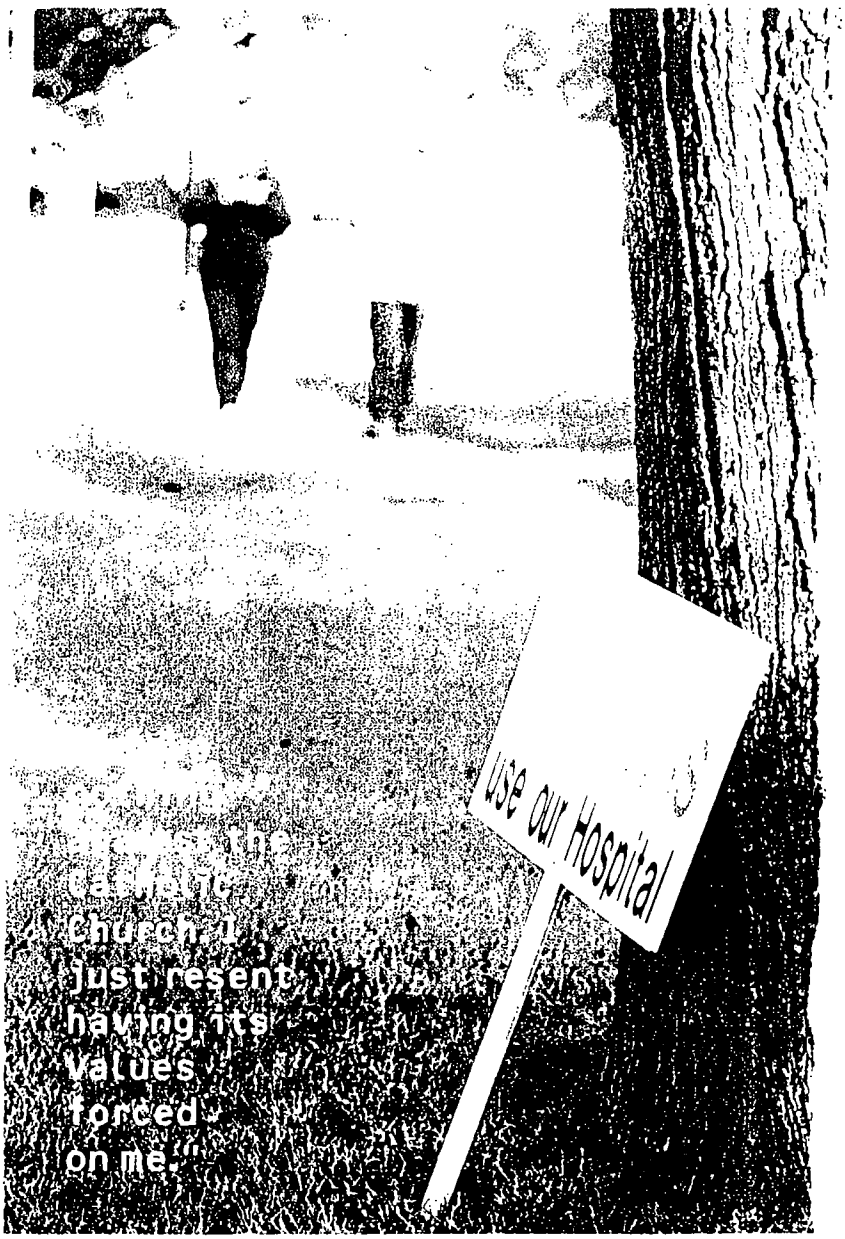
A proposed merger between a Catholic and non-Catholic health care organization can come as a surprise to a community because negotiations may be private and swift. This is what happened in 1994 in Manchester, New Hampshire. The nonsectarian Elliot Hospital entered into a merger agreement with Catholic Medical Center, the only other hospital in town, to form Optima Healthcare.

While banning elective abortion, Optima assured doctors at Elliot that it would not interfere with other reproductive-health services. Medically necessary abortions would be allowed. Three years later, when an anti-choice group leaked a hospital surgery schedule showing that such abortions were taking place at Elliot, the Church threatened to tear up the merger unless all abortion services ended. Optima banned all terminations of pregnancy at both hospitals.

That policy was in effect when, in May 1998, Kathleen Hutchins, a 30-year-old restaurant worker who was 14 weeks pregnant, felt a sudden stream of warm fluid run down her legs. Her heart sank: this was very much a wanted pregnancy. She rushed to see Wayne Goldner, M.D., her obstetrician. Dr. Goldner told her that the amniotic sac had ruptured. Because she was only in the early part of her second trimester, the fetus had at best a 2 percent chance of surviving. If she tried to continue the pregnancy, he cautioned her, she would be putting at risk her future fertility and possibly even her life because of the high likelihood of uterine infection. He asked her what she wanted to do. Hutchins reluctantly chose to end her pregnancy.

When a staff member in Goldner's office tried to schedule the procedure at Elliot Hospital, she was told it would not be allowed. Because Hutchins wasn't showing signs of illness now, Goldner would not be permitted to end her pregnancy. (Vatican directives state that treatments that could result in the death of the unborn child are only allowed when they cannot be safely postponed until after the child is viable.) "I told them, 'The whole point is, we don't want to wait until she gets sick. I want to prevent that,'" says Goldner. Such arguments were useless. Goldner and other health care workers were threatened with having their privileges at the hospital revoked if they tried to proceed.

The only other hospital in New Hampshire where Hutchins could obtain the medically necessary abortion was at Dartmouth-Hitchcock Medical Center 80 miles away. "I really didn't know what to do," recalls Hutchins. She turned to Goldner for advice. He offered her his back-up plan, handing her $300. *Continued on page 148*



# How to fight a merger

Here's what communities facing a merger can do to block religious restrictions on reproductive services.

Gather a group of concerned people willing to take an active role in fighting the merger.

Get in touch with the board of directors of the hospital and try to see a copy of the "memorandum of understanding" or "statement of intent" your hospital has signed with the Catholic one. (It's not a public document, and the hospital is not required to provide it to you.) Terms such as *canon laws, health care philosophy* and *ethical and religious directives* are a likely indication of plans to restrict reproductive services.

Ask a lawyer to read the agreement to determine how much control the religious hospital will have over the affairs of its merging partner.

Find out all you can about your hospital's board of directors, which has the power to stop the merger.

Find out how many of your community's doctors are on your side. If a majority of local physicians actively resists a hospital merger, it is generally difficult for a hospital to go through with a deal.

Groups representing seniors and the terminally ill are concerned about Catholic mergers because Vatican directives affect end-of-life care. Organizations working with people who have HIV/AIDS also may have compelling reasons to join in a protest. Sympathetic clergy are often the most effective spokespeople against restrictive religious rules.

Even if you lose your fight against a merger, you may be able to retain some reproductive services. When consumers aggressively and publicly demand specific services, Catholic health care organizations can sometimes develop solutions to satisfy them.

For research materials and advice, contact:
MergerWatch, c/o Family Planning Advocates of New York State, 17 Elk St., Albany, NY 12207; 518-436-8408; www.mergerwatch.org
Catholics for a Free Choice, 1436 U St. NW, Suite 301, Washington, DC 20009-3997; 202-986-6093; www.cath4choice.org; cffc@lgc.apc.org

For information on fighting mergers through antitrust laws:
American Civil Liberties Union, 125 Broad St., 18th floor, New York, NY 10004; 212-549-2500; www.aclu.org
National Women's Law Center, 11 Dupont Circle NW, Suite 800, Washington, DC 20036; 202-588-5180 —*J. M. S.*

Source: MergerWatch

*Continued from page 146* out of his own pocket and putting her in a cab to Dartmouth where he'd made arrangements for her to have the procedure done.

Medical abortion was not the only casualty after Elliot Hospital's merger. "After removing all of the information about reliable forms of birth control," Goldner says, "the Catholic nurses started distributing pamphlets about 'natural' birth control—better known as the rhythm method—which is what the Catholic Church advocates."

Doctors at Elliot were no longer permitted to give rape victims the morning-after pill, which almost always prevents pregnancy from occurring. Although postcoital contraception is considered a standard emergency medical treatment after rape and is recommended by the U.S. Centers for Disease Control and Prevention, few Catholic hospitals permit doctors to offer it.

Whether or not reproductive services are retained after a merger depends on many variables: the attitudes of the local Catholic authorities (some are more liberal than others), how resourceful and forward-thinking the merging parties are, and how much information the community has about the merger and its willingness to undertake tough negotiations. In some cases, hospitals have adopted a "don't ask, don't tell" policy, in which reproductive services are provided on the sly, in the hopes that the local Catholic order and the local Bishop will look the other way. "This approach is usually doomed to failure. Eventually the local Catholic authorities find out or change their minds, and access is lost," says Lois Uttley, director of MergerWatch, a project of Family Planning Advocates of New York State.

In other cases, the merging parties make formal arrangements that are likely to remain acceptable to the local Catholic authorities, including provisions for an independently operated reproductive-health service on its own floor. In other cases, hospitals have achieved "virtual" mergers, in which they share business operations while maintaining separate identities and philosophies.

Still another option is to remove reproductive services from the hospital and relocate them to another building. While this may sound like a reasonable compromise, it has tremendous disadvantages. First, freestanding clinics are often a target of protests by antiabortion groups. Second, these clinics force women to have reproductive services performed in a facility that isn't thoroughly prepared for a medical emergency, a place that's unable to cope with medical conditions not related to reproductive health. In a town where the only place you can get a tubal ligation is at a reproductive clinic, what happens when a woman goes into cardiac arrest during the procedure? Or what about the woman who wants to have a tubal ligation in the hospital immediately after delivering a baby, which is the most sensible and convenient time?

Losing access to tubal ligation after delivery can be the "hot button" that ignites protests against Catholic mergers. In Batavia, New York, the prospect of losing this service provoked residents to fight a proposed merger between the region's only two hospitals: the Catholic St. Jerome and the nonsectarian Genesee Memorial.

Many women could identify with the plight of Susan Pangrazio, a 34-year-old stay-at-home *Continued on page 214*

## THEIR RELIGION, YOUR RIGHTS

*Continued from page 151*

mother who was expecting her fourth child when the prospective merger between the two hospitals was being negotiated. For medical reasons, Pangrazio's physician had decided that she should deliver by cesarean section. She had arranged to have a tubal ligation at the same time.

At her five-month checkup in March 1998, her obstetrician told her that if the merger was completed before her delivery, he wouldn't be able to do the tubal ligation at Genesee Memorial when she delivered. Pangrazio would be obliged to wait until she recovered from the C-section and undergo a second surgery not in the hospital, but at a separate women's reproductive-health center the two hospitals were planning to open. If she wanted to have her tubes tied when she delivered, her only alternative would be to deliver at another hospital; the nearest one was 40 miles away.

Pangrazio was profoundly upset. "I have nothing against the Catholic Church," she says. "I just resent having its values forced on me."

Luckily for Pangrazio, public outcry against the merger resulted in delays, and she was able to get the tubal ligation when she delivered at Genesee. At this writing, the merger is off. Because New York law requires that a hospital merger be approved by the state public health department, merger opponents have an opportunity to present their case. "Fortunately for us, the New York State health department weighs public sentiment heavily in its decision-making," says the Reverend Martha Munson, a Unitarian minister living in Elba who is active in People Against Lost Services (PALS).

Protesters in other states have had a tougher battle. In Oklahoma, the state government has no authority to stop or even influence the terms of hospital mergers. There, in rural Garfield County, the two sole hospitals—St. Mary's Mercy and Integris Bass Baptist hospitals—were collaborating to create a new "women's plaza," which would have consolidated all reproductive and obstetric services. Because the Baptist hospital agreed that the center would abide by Vatican directives, women would have had to travel 80 miles to Oklahoma City to obtain tubal ligation, fertility treatments and the other reproductive services prohibited by the Catholic Church. As of mid-March, however, the merger was called off, due largely to the efforts of community activists.

Reproductive-rights advocates are also concerned about the emergence of Catholic HMOs, which could be as restrictive as mergers. In New York State, thousands of low-income Medicaid recipients have signed up with Fidelis Care, a Catholic-owned managed-care plan, only to discover that it won't cover birth control, sterilizations, the morning-after pill, abortion or HIV safer-sex counseling services.

Reproductive-rights groups say that the emergence of Catholic HMOs is so new that they're just beginning to track them. In late January, MergerWatch convened what it believes was the first national meeting to discuss religiously affiliated managed-care hospital mergers and its implications for women's health.

The rise of the Catholic health business is more than just another example of how the economic pressures of managed care affect women. It raises troubling issues about how our legal system allows religious institutions to impinge on individual rights.

"When Catholic organizations remove women's access to reproductive services, they create a situation in which a corporate entity is imposing its religious views on people who may not agree with them," says Catherine Weiss, director of the American Civil Liberties Union's Reproductive Freedom Project. "This raises serious constitutional issues. The body of federal law that protects religious freedom doesn't provide a clear answer in cases where individual conscience conflicts with institutional conscience." This is not to say, however, that women have no recourse when a Catholic health care group attempts to set up shop. "Grassroots movements are often very effective," Uttley says. "Smart negotiations, political pressures and even antitrust strategies can be used to fight unwanted mergers and takeovers." The key, she says, is knowing who your health care provider is and being alert to changes. "Women should stay on top of these issues. Your community or place of work could be next."

*Judith Mandelbaum-Schmid is a contributing editor at* SELF.

## ABORTION ROADBLOCKS

*Continued from page 152*

possible is a 1992 Supreme Court decision—*Planned Parenthood of Southeastern Pennsylvania* v. *Casey*—which ruled that a state can create obstacles to abortion, so long as these obstacles don't present an "undue burden."

During the past three years, the number of new anti-choice laws has more than tripled, according to Elizabeth Cavendish, legal director of the National Abortion and Reproductive Rights Action League.

Fourteen states are also severely limiting a woman's access to abortion by requiring a mandatory delay called a "waiting period." In order to have an abortion, a woman—after undergoing the informed-consent counseling—must "consider" her decision before she can return to the clinic for the procedure. Typically, this wait is 24 hours.

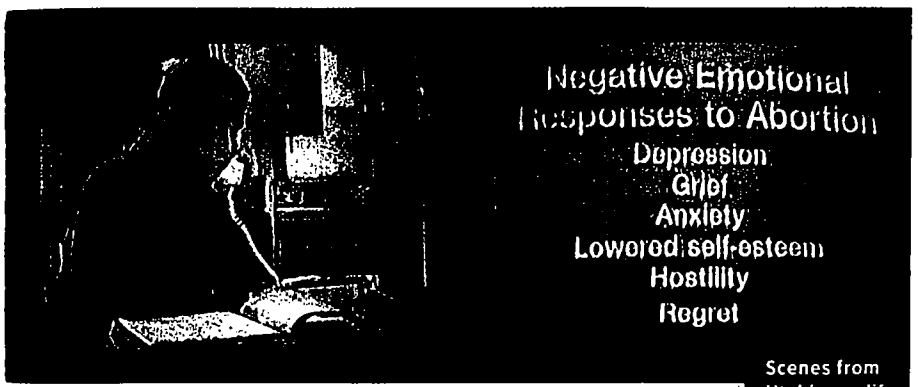
Abortion-rights advocates argue that the waiting period is nothing but a roadblock in disguise, "a way to force women to make two trips to the abortion provider instead of just one," says Klassel. In big states such as Wisconsin and Montana, this means making a second trip to a clinic that may be hundreds of miles away. "It is a hardship, especially for poorer women. It often requires an extra night away from home, which means a big expense, the burden of making child-care arrangements, plus missing an extra day's work," says Cavendish.

Waiting-period requirements result in far more than inconvenience. Research has shown that these laws result in an increased number of later-term abortions, which are medically riskier. After Mississippi enacted a waiting-period law, the number of abortions performed after 12 weeks—the first trimester—increased by 17 percent, according to a study published in 1997 in *The Journal of the American Medical Association*.

No one is saying that the decision to have an abortion is an easy one, but by the time a woman comes to a clinic, research shows, she has already made up her mind. "She's been thinking—even agonizing—over her decision for days or weeks," says Gloria Feldt, president of Planned Parenthood, and "once a woman's mind is made up, she very rarely changes it." The counseling and waiting period, she says, are nothing more than punitive.

Know Your Options

# Your State, Your Rights




Scenes from Utah's pro-life videotape.

## How mandatory counseling and waiting periods limit your access to abortion.

BY MARIA RUSSO

Since the *Roe* v. *Wade* Supreme Court decision in 1973, a woman has had a constitutional right to have an abortion. During the past 26 years, however, states have enacted laws that are making it increasingly harder for a woman to exercise this right.

Purportedly to protect women from "post-abortion trauma," 22 states have passed laws requiring a woman seeking an abortion to receive so-called informed-consent counseling. In Utah, for example, a woman who wants an abortion must first undergo a "counseling session" with a clinic worker. She is given a 53-page booklet that she must take home. She then must certify in writing that she has read it during a mandatory 24-hour waiting period. This booklet includes a 20-page listing of adoption services and agencies and a 15-page section of color photographs of fetal monthly development. It also includes warnings of the possible psychological and physical dangers of having an abortion. Examples:

- **"You need to know that serious emotional problems have been attributed by women to their abortion. Possible negative emotional responses to having an abortion include: depression, grief, anxiety, lowered self-esteem, hostility toward self and others, regret, difficulty sleeping, suicidal thoughts and behavior, sexual dysfunction, relationship disruption, flashbacks and a sense of loss or emptiness."**
- **"Serious medical complications can occur from legal abortion. They potentially include infection, bleeding, blood clots and puncturing of the uterus. Each woman reacts differently to abortion. Nearly all women undergoing abortion have some pain or discomfort, ranging in intensity from mild to very severe."**

While these warnings may seem reasonable to some, abortion-rights activists argue that Utah is twisting the medical notion of "informed consent" (telling a patient facing a treatment or procedure about any risks involved so she can make an "informed" decision about going ahead with it) in order to deliver thinly disguised propaganda. "The state is using informed consent to blatantly encourage women not to choose abortion," says Dara Klassel, director of legal affairs for the Planned Parenthood Federation of America.

What's worse, Utah's warnings about psychological trauma fly in the face of established research on the long-term effects of abortion. A study of 4,300 women ages 14 to 21 funded by the National Institutes of Health found that "the major predictor of a woman's well-being after an abortion is her well-being before the abortion occurred," says lead researcher Nancy Felipe Russo, now with Arizona State University. This study, published in 1997 in the American Psychological Association journal *Professional Psychology: Research and Practice*, found that "the risk for severe psychological problems after abortion is low and comparable to that of giving birth."

A woman in Utah is also offered a videotape, a professionally produced "docudrama" of a woman considering an abortion, to take home and view. In addition to providing a month-by-month description of fetal development and clinical diagrams of various abortion procedures, the tape explicitly states that "The State of Utah prefers adoption and childbirth to abortion."

What makes restrictions like Utah's *Continued on page 214*

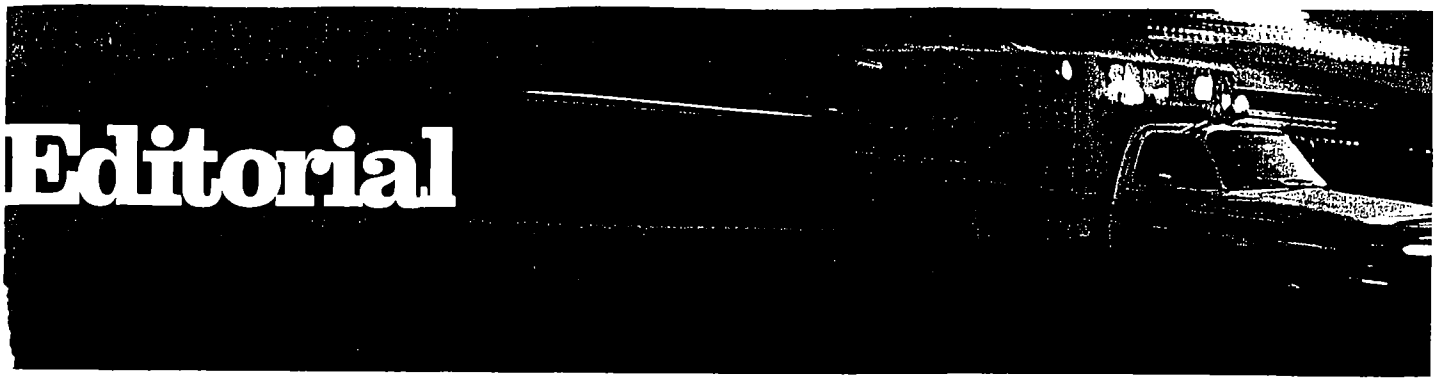
**In these states, a woman must undergo state-directed counseling before having an abortion:**

| | | |
|---|---|---|
| Alaska | Maine | Rhode Island |
| California | Minnesota | Virginia |
| Connecticut | Missouri * | |
| Florida * | Nevada | |

**In these states, women are required to undergo state-directed counseling, followed by a mandatory "waiting period" before having the procedure:**

| One hour | | |
|---|---|---|
| South Carolina | | |
| **18 hours** | | |
| Indiana | | |
| **24 hours or more** | | |
| Delaware* | Michigan* | Pennsylvania |
| Idaho | Mississippi | South Dakota |
| Kansas | Montana* | Tennessee* |
| Kentucky | Nebraska | Utah |
| Louisiana | North Dakota | Wisconsin |
| Massachusetts* | Ohio | |

* Laws are not yet in effect because they are being challenged in court.
Source: The Alan Guttmacher Institute



# Editorial

*Are Catholic hospitals playing God with women's lives?*

# Women's Health 911

In a Manchester, New Hampshire, hospital, a 35-year-old pregnant woman's doctor is refused access to perform an emergency abortion when the woman's water breaks after only 14 weeks, even though the fetus is unlikely to live. Fearing an infection that could cost the woman her fertility, and possibly even her life, the doctor must send her 80 miles away by taxi to get the procedure done.

• In Ardmore, Oklahoma, women can't get their tubes tied at the local hospital—even though it's the only facility in town.

• And in dozens of hospitals across the country, patients have been barred from receiving birth control, STD-prevention counseling and in vitro fertilization. Victims of rape are denied emergency contraception to prevent pregnancy; most aren't even told that it's an option.

Why are these perfectly legal medical services becoming so difficult—in some cases, even impossible—to obtain?

In every instance, the hospitals involved had merged (or were attempting to merge) with Catholic hospitals, and were sacrificing women's most basic reproductive health services to appease the religious beliefs of the new partner.

What does this mean to you? Well, if your gynecologist's hospital merges with a Catholic hospital, she can still do what she likes in her off-site office. But as soon as your needs stretch over the hospital's threshold, you are subject to *its* policies, which in most cases means harsh restrictions on reproductive services.

"This practice directly interferes with my ability to treat patients," explains an East Coast ob-gyn who performs abortions and asked, for her safety, that her name not be published. When the hospital with which she was affiliated was preparing to merge with a Catholic hospital, it placed severe restrictions on doing abortions—meaning she could no longer treat most women who needed a hospital abortion (and many do). "My hospital always presented itself as one that cared about women, but they pulled the rug out from under them," she says. The merger was halted, but the abortion policy stuck.

Many cash-poor hospitals are turning to mergers to solve their financial woes, and the number of Catholic hospitals entering into such deals tripled last year. There have been 127 Catholic hospital mergers since 1990, and in nearly half of those cases, the joint venture adopted the policies of the Catholic partner, often eliminating not just abortion but also most of the fertility treatments (because they separate conception from the "marriage act").

**Health outrage: Even rape victims are turned away from many ERs without the morning-after pill.**

Rape victims are among the hardest hit: Eighty-two percent of America's Catholic hospitals (many of which are the only health-care provider in their area) don't offer emergency contraception, ever—not even to rape victims seeking the morning-after pill, according to a recent study of virtually all of the Catholic hospitals in the country by Catholics for a Free Choice, a Washington, D.C.–based advocacy group. This means that some rape victims literally have nowhere else to go. For them, the hideous trauma of rape is compounded by the fear of an unwanted pregnancy.

Forcing a rape victim to bear her assailant's child is beyond religious devotion—it's sadism. Catholic hospitals claim that their right to "exercise conscience" by refusing to provide "morally and religiously objectionable" services exempts them from antidiscrimination laws. But these same institutions receive money from federal sources, such as Medicare and Medicaid, and use government bonds to finance their expansion—all money that comes from *us*, the taxpayers. What's more, doesn't our constitutional right to freedom of worship also protect us from the imposition of the religious beliefs of others?

Fortunately, activists are going to the media (and to court) to stop the practice. In New Hampshire, for example, the attorney general took apart the Manchester hospital merger that prevented the 14-week emergency abortion mentioned earlier. (If you suspect a merger in your area, the advocacy group MergerWatch, www.mergerwatch.org, has been successfully organizing deal-blocking efforts nationwide.) In California and other states, activists have proposed legislation calling for the attorney general or health commissioner to have the authority to prevent any merger that denies patients access to the full range of health services.

It's time we all put pressure on our state legislatures and Congress to stop these injustices. "What if Jehovah's Witnesses ran much of this country's health care, and they tried to force their religious values on the communities they served?" asks Karen A. Raschke, a staff attorney for The Center for Reproductive Law and Policy in Richmond, Virginia. "They probably wouldn't allow blood transfusions—imagine the hue and cry over that." ⊙

# women

Female Forces to Reckon With

## Thoroughly Modern Monarch

A new young queen dons her crown.

Rania al-Abdullah rules.

At first glance, 28-year-old Rania al-Abdullah, the newly crowned queen of Jordan, may seem pretty young—and unbuttoned—to be top royal in a socially conservative nation. The Palestinian former bank teller and her husband, King Abdullah, enjoy cruising on the royal Harley, and she's been known to frequent chic American cafés. But Rania, who became queen in March after the death of her father-in-law King Hussein, also knows how to use her royal clout to bring formerly taboo issues to the public's attention. For example, she's capitalized on her reputation as a good mother to her two children, Hussein, four, and Iman, two, by establishing a support network for abused and battered children, and by speaking out for children's rights. "She is very intelligent," says an admittedly biased source, Rania's aunt Fadwa Yassin. "As far as I am concerned, she could be queen of the world, not just Jordan."

LAILA ALI: FOLLOWING IN HER FATHER'S FOOTSTEPS.

## Is she fighting the good fight?

Muhammad Ali's daughter plans to be a pro boxer. Is she inspiring or insane?

"Look at me! I'm so pretty!" Muhammad Ali proclaimed during his reign as heavyweight champion. Well, maybe not as pretty as his 21-year-old daughter, Laila, who recently announced her intention to follow her dad's fancy footwork by joining the ranks of female professional boxers. Laila's father, whose Parkinson's disease is believed to have been partially caused by the blows he's received, has not commented publicly on his daughter's decision. As Laila aims for her first professional match this summer (she's been training intensely over the past year), *Glamour* asked two groundbreaking sportswomen what they think of women in the ring.

*Robin Roberts, ESPN commentator and former college basketball star:* "My main concern is safety. There is definitely a correlation between Laila's father's condition and boxing. She needs to train properly; I have seen women seriously injured because they weren't ready. It's not that I don't want to see women in the boxing ring, but some of these women were not suited for the sport."

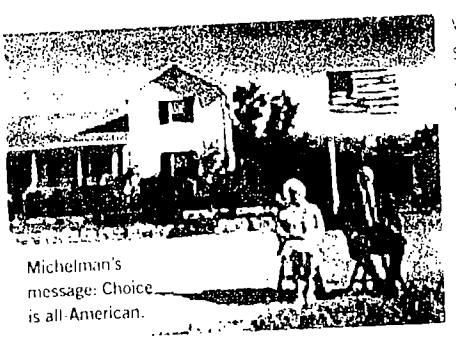
*Billie Jean King, tennis trailblazer:* "Why not have women's boxing? Ladies are fortunate that pioneers such as Jackie Joyner-Kersee have gone before her and opened doors. She'll be ahead of the game because of her name, but she'll have to prove herself in the ring. Yes, boxing is a high-risk profession, but Laila must know what she's getting into. I don't think she would be pursuing this if she didn't think she had what it takes to be a champion."

## GLAMOUR FORCE

We salute **Kate Michelman**, the wow woman of the month.

"I believe in my right to choose" without interrogations, without indignities, without violence," a woman's warm, firm voice asserts in an arresting new TV ad. As the scene shows a grandparently couple sitting on their suburban front yard, an American flag proudly waving behind them, the narrator continues: "I believe that's one of the founding principles of our country."

Anti-choice activists have paid for plenty of airtime over the years. So the [illegible] National Abortion and Reproductive Rights Action League (NARAL) Kate Michelman, 56, decided to fight back with a powerful, new, pull-no-punches campaign that presents the right to choose about as it's a fundamental American value. NARAL's new Choice for All America campaign includes both the first national TV spots [illegible] ads scheduled for [illegible] Ohio, Wisconsin, Pennsylvania, [illegible] New York [illegible]



Michelman's message: Choice is all-American.

women's heartfelt true stories and feelings about abortion [illegible] www.naralorg).

"Abortion has been demonized by the right wing," states Michelman, explaining the idea behind the ads. "We need to help people understand the underlying values and principles at stake." At the heart of those values is the message. The freedom to decide, whether to have a baby isn't just about that decision. It's about the right to make all [illegible] decisions—and you can't get any more American than that.

JUL 1 1999

(Date)

# Roll Call Vote

7:18 p.m.

Legislative

NO. 197

SUBJECT MOTION TO TABLE DeWine AMDT. NO. 1200

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