Part II:
Preventive Health Services

Adolescent Pregnancy

After a steady increase in the 1970s and 1980s, the birth rate among U.S. teens aged 15-19 fell 20 percent between 1991 and 1999, according to the National Center for Health Statistics (NCHS).[1]

According to the NCHS, the birth rate for African-American teenagers saw the most dramatic decline, falling by 30 percent between 1991 and 1999. Hispanic teenagers saw the smallest decline at 13 percent.[2] The NCHS attributes the decline in teen pregnancies over the past decade to changing attitudes toward premarital sex, a leveling-off of teenage sexual activity, an increase in contraceptive use, and increasing economic opportunities for teenagers.[3] Additionally, the proportion of high school students reporting sexual experience decreased by 8 percent between 1991 and 1999.[4] Despite marked improvement, however, unintended pregnancy among teens remains a serious problem.

- Four in 10 young women become pregnant at least once before they reach the age of 20, resulting in nearly one million adolescent pregnancies each year. Eight in 10 of these pregnancies are unintended and 79 percent are to unmarried teens.[5]
- In 1999, 66 percent of female students and 64 percent of male students in the 12th grade reported ever having sexual intercourse, compared with 33 percent of female students and 45 percent of male students in the 9th grade.[6]
- An estimated 4 in 10 teen pregnancies are terminated by abortion, resulting in 274,000 abortions among teens in 1996, the most recent year for which data is available.[7]
- A sexually active teen who does not use contraception has a 90 percent chance of becoming pregnant within one year.[8]

Congressional Action

Congress first attempted to address the problem of teen pregnancy in 1978 with the passage of the Adolescent Health Services and Pregnancy Prevention and Care Act. While the law authorized the development of pregnancy prevention programs, funds were primarily used to provide services to pregnant and parenting teens.

In 1978, Congress sought to make contraceptive services more accessible to sexually active adolescents by amending the federal family planning program (Title X) to require that clinics serve teenagers.

In 1981, a number of health programs, including the Adolescent Pregnancy Prevention and Care Act, were folded into a new Maternal and Child Health Block Grant for states.

Currently, nearly one-third of Title X-funded clinics clients are teenagers and one-half are women in their twenties. Many clinics encourage their counselors to spend extra time with teenage clients and maintain education and outreach programs aimed at adolescents. According to the Alan Guttmacher Institute, federally funded family planning clinics have helped to prevent 5.5 million adolescent pregnancies. [9]

By law, Title X clinics must provide confidential services to minors, although they are required to encourage family participation in a minor's decision to seek family planning services. In 1996 and 1997, the House defeated attempts to require parental consent or notification for minors using Title X services. In 1998, during consideration of the FY1999 Labor, Health and Human Services, and Education appropriations bill (P.L. 105-277), the House approved a parental consent or notification requirement, but the language was dropped during a House-Senate conference. Similar amendments were not considered by the 106th Congress.

Abstinence Education

In an effort to focus more attention on promoting abstinence, in 1981, Congress created the Adolescent Family Life Act (AFLA). Demonstration projects funded under the AFLA are required to promote abstinence from premarital sexual activity by encouraging strong family values; grantees are prohibited from providing contraceptive services.

In FY2001, the AFLA received $24.3 million, a $5 million increase over FY2000. In addition to the $50 million mandated under the welfare reform law in each of FY1998 through FY2002, abstinence education programs received $20 million in FY2000 supplemental appropriations (P.L. 106-246). Abstinence education programs also received $30 million in advance FY2002 funding.

A recent survey found that abstinence-only sexual education courses were increasing in the United States. The survey found that in 1999, 23 percent of secondary school teachers surveyed taught abstinence-only courses compared with 2 percent in 1988. In contrast, the survey also found that 86 percent of teachers surveyed believed that students who received education on contraceptives would be more likely to use contraceptives when sexually active than students who did not receive contraceptive education.[10]

Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act, the welfare reform law (P.L. 104-193) enacted in 1996, has been a vehicle for congressional action on teen pregnancy. One of the stated purposes of the law's Temporary Aid to Needy Families block grant was to prevent and reduce the incidence of out-of-wedlock pregnancies. Before a state can receive block grant funds, it must submit a written plan outlining how it intends to establish and meet its goal for preventing and reducing out-of-wedlock pregnancies, with special emphasis on teen pregnancies. In addition, the Department of Health and Human Services (HHS) is required to establish national goals for preventing teen pregnancy and to ensure that at least 25 percent of U.S. communities have teen pregnancy prevention programs in place.

In an effort to further motivate states to make teen pregnancy prevention a priority, the welfare law provided for a $20 million bonus grant to each of the five states that demonstrate the greatest decrease in out-of-wedlock births and reduce their abortion rate below the 1995 level. Beginning in FY1999, the bonus is granted in each of FY1999 through FY2002.

The welfare measure also imposed restrictions on block grant assistance for teen parents. States have the option to deny benefits to unwed teen parents under the age of 18. In addition, states are prohibited from using federal grant funds to assist unmarried parents under age 18 who have not completed high school unless they are attending school or an alternative educational or training program. Unmarried teens must live with a parent or in an adult-supervised setting in order to receive federal assistance.

Finally, the welfare law authorized $50 million a year for five years beginning in FY1998 for abstinence education programs. Administered under the Maternal and Child Health Block Grant, programs eligible to receive abstinence education funds must meet eight criteria, including the requirement that their exclusive purpose is teaching the social, psychological, and health gains to be realized by abstaining from sexual activity. States are required to contribute $3 for every $4 provided by the federal government.

National Teen Pregnancy Campaign

In 1995, President Clinton announced the creation of a private, nonpartisan National Campaign to Prevent Teen Pregnancy with the goal of reducing the teen pregnancy rate by one-third by 2005. One of the first efforts of the National Campaign was to review evaluation data for a wide range of local teen pregnancy prevention initiatives. *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*, released in 1997, concluded that while abstinence-only programs may be appropriate for younger adolescents such as junior high students, no published scientific research existed to demonstrate that such programs have actually delayed the onset of sexual intercourse or reduced sexual activity.[11]

The report also noted that the overwhelming weight of evidence shows that sex education programs do not increase sexual activity among teens, a concern long raised by critics of sex education. Furthermore, it found that school and community programs that combine education, messages about avoiding pregnancy, and the provision of contraceptives may increase contraceptive use and decrease pregnancy rates.[12]

In 1999, the National Campaign, in conjunction with HHS, unveiled a comprehensive guide, *Get Organized: A Guide to Preventing Teen Pregnancy*, that provides a localized approach to preventing teen pregnancy.[13] Additionally, Advocates for Youth developed a guide to components of teen pregnancy prevention programs, which include setting clearly defined and realistic program goals and objectives; encouraging community collaboration; involving youth in needs assessment, program design, implementation, and evaluation; creating activities that are both age and developmentally appropriate; providing culturally appropriate program activities; coordinating messages to target both young women and men; offering long-term and consistent support; providing information on both abstinence and

contraception; and ensuring access to contraceptive services.[14]

A July 2000 study published in *Family Planning Perspectives* found an overall decline in sexual activity and an increase in condom use among adolescents aged 15-17. The study drew from data collected for the National Survey of Family Growth, the National Survey of Adolescent Males, the Youth Risk Behavior Survey, and the National Longitudinal Study of Adolescent Health.[17]

Additionally, a June 2000 survey by the National Campaign found that 63 percent of teenagers polled wished they had waited longer to have sex. Thirty-seven percent of teens also cited their parents as the greatest influence on their decisions about sex.[18]

Legislation

Teenage Pregnancy Reduction Act of 1999 (H.R. 1636/S. 1458)—Reps. Nita Lowey (D-NY) and Michael Castle (R-DE) and Sen. Harry Reid (D-NV)

H.R. 1636/S. 1458 would provide $3.5 million each year for three years for HHS to evaluate teen pregnancy prevention programs. The purpose of the evaluations would be to determine the effectiveness of such programs in reducing adolescent pregnancy, the factors contributing to the effectiveness of the programs, and the feasibility of replicating the programs in other locations. The bill also would authorize the Secretary of Health and Human Services to make one grant to a prevention program found to be effective under the evaluation. H.R. 1636/S. 1458 would provide $10 million for FY2004 through 2006.

Notes

1 Sally Curtin, M.A. and Joyce Martin, M.P.H., "Births: Preliminary Data 1999," *National Vital Statistics Reports* 48 (2000) 14: 1.
2 Ibid., p. 3.
3 Stephanie Ventura, M.A., et al., "Variations in Teenage Birth Rates, 1991-1998: National and State Trends," *National Vital Statistics Reports*, 48 (2000) 6: 4.
4 National Center for Health Statistics (NCHS), *Health, United States, 2000 With Adolescent Health Chartbook* (Hyattsville: NCHS, 2000), p. 110.
5 National Campaign to Prevent Teen Pregnancy, "Facts and Stats" <http://www.teenpregnancy.org/genlfact.htm> (6/2/00).
6 NCHS, *Health, United States, 2000 With Adolescent Health Chartbook*, p. 110.
7 The Alan Guttmacher Institute (AGI), "Teen Sex and Pregnancy," Sept. 1999 <http://www.agi-usa.org/pubs/fb_teen_sex.html> (8/22/00).
8 Ibid.
9 AGI, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* (New York: AGI, 2000), pp. 17, 24.
10 Jacqueline Darroch, et al., "Changing Emphases in Sexuality Education in U.S. Public Secondary Schools," *Family Planning Perspectives* 32 (2000) 5: 204-211.
11 National Campaign to Prevent Teen Pregnancy, *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington: National Campaign to Prevent Teen Pregnancy, 1997).
12 Ibid.
13 Department of Health and Human Services, "Preventing Teenage Pregnancy Fact Sheet," Oct. 25, 1999 <http://waisgate.hhs.gov/> (2/22/00).
14 Advocates for Youth, "Components of Promising Teen Pregnancy Prevention Programs" <http://www.advocatesforyouth.org/IAG/COMPNENT.HTM> (6/6/00).
15 National Campaign to Prevent Teen Pregnancy, "The Cautious Generation? Teens Tell Us About Sex, Virginity, and 'The Talk,'" Apr. 27, 2000 <http://www.teenpregnancy.org> (6/2/00).
16 National Campaign to Prevent Teen Pregnancy, "Risky Business: A 2000 Poll," Mar. 8, 2000 <http://www.teenpregnancy.org> (6/2/00).
17 John S. Santelli, et al., "Adolescent Behavior: Estimates and Trends From Four Nationally Representative Surveys," *Family Planning Perspectives* 32 (2000) 4: 156-165, 194.
18 National Campaign to Prevent Teen Pregnancy, "Not Just Another Thing to Do: Teens Talk About Sex, Regret, and the Influence of Their Parents," June 30, 2000 <http:www.teenpregnancy.org> (10/18/00).

Domestic Violence

A 1999 study by the Department of Justice's Bureau of Justice Statistics (BJS) found a 21 percent decline in intimate partner violence against women between 1993 and 1998.[1] Still, female victims of violence are more likely than male victims to identify intimates as offenders. A more recent study found that intimates were the offenders in 20 percent of the overall violence against women, compared to 3 percent of the violence against males.[2] According to the BJS:

- One million violent crimes were committed against persons by their current or former spouses, boyfriends, or girlfriends.[3]
- Eighty-five percent of the victims of intimate partner violence were women.[4]
- While there was an overall decline in domestic violence, African-American women experienced violence at a rate 35 percent higher than Caucasian women, and African-American women were more likely than Caucasian women to report abuse to the authorities.[5]
- Women aged 20-24 experienced the highest rates of intimate partner violence.[6]
- About 4 in 10 female victims of intimate partner violence lived in households with children under the age of 12.[7]

Congressional Action

In 1993, Congress gave new authority to the Centers for Disease Control and Prevention (CDC) to study domestic violence and develop effective strategies for its prevention, including training health care providers to be better able to recognize victims of domestic violence.

Additionally, the 1994 Violence Against Women Act (VAWA) (P.L. 103-22) established a number of programs aimed at combating violence against women. In addition to creating law enforcement grants to encourage arrests, providing judicial and court personnel training in domestic violence, and providing rape prevention programs, the law established the National Domestic Violence Hotline and expanded support for battered women's shelters.

Under the original law, VAWA programs were set to expire at the end of FY2000. However, prior to adjournment, the 106th Congress enacted legislation (P.L. 106-386) to reauthorize all original VAWA programs for five years, as well as create a number of new VAWA programs. The bill, sponsored by Rep. Connie Morella (R-MD) and Sens. Joseph Biden (D-DE) and Orrin Harch (R-UT), was included in the conference report accompanying the Victims of Trafficking and Violence Protection Act (H.R. 3244).

Health Care Providers Response

Several studies suggest that battering may be one of the leading causes of injury to women. The BJS estimates that 37 percent of women treated in hospital emergency rooms were treated for injuries or symptoms associated with physical abuse.[8] Another 1998 study by the National Institute of Justice and the CDC reported that each year women make 693,933 visits to the health care system as a result of injuries sustained from intimate partner violence.[9] Despite these statistics, a more recent study estimates that 6 in 10 women who were victims of intimate partner violence did not seek treatment for their injuries in 1998.[10]

A study published in the *Journal of the American Medical Association* found that while 79 percent of primary care physicians screened for partner abuse when a patient's visit involves physical injuries, only 10 percent of physicians routinely screened during new patient visits, and only 9 percent screened during periodic checkups. The study also found that patient-related factors were the most common barrier to identifying and referring individuals, with a patient's fear of retaliation by the partner cited as the most common barrier.[11]

While less than half of physicians cited lack of training, time, and information about local resources as major barriers to identifying and referring victims of intimate partner violence, the study suggested that physicians were not adhering to current screening guidelines and opportunities to identify abused women were being missed.[12]

In 1999, the Family Violence Prevention Fund, in conjunction with the Department of Health and Human Services, issued clinical guidelines on routine screening for domestic violence. The guidelines are supported by the American Medical Association and the Ameri-

can Nurses Association. The guidelines recommend:

- Routine screening for domestic violence for all female patients aged 14 and older in primary care, obgyn and family planning, emergency department, inpatient, pediatric, and mental health settings;
- Implementation of culturally competent programs to ensure routine screening of all female patients; and
- Confidential documentation of the screening outcomes.[13]

Discrimination

Unfortunately, until recently many women were forced to pay a stiff penalty for seeking medical assistance by being denied health insurance coverage. A 1995 survey by the Pennsylvania Insurance Commissioner found that one-third of the companies surveyed in that state admitted that they considered domestic violence as a factor in issuing insurance. In an effort to reverse that trend, Congress approved legislation barring group health plans from discriminating against victims of domestic abuse. Passed as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), the law makes it illegal for health insurers to deny coverage on the basis of medical conditions caused by domestic violence, a history of domestic violence, or current status as a victim of domestic violence.

Legislation

Domestic Violence Identification and Referral Act of 1999 (S. 198)—Sen. Barbara Boxer (D-CA)

S. 198 would give preferences in the granting of awards or contracts by the Public Health Service to those health profession entities that require students to complete coursework/training in the identification, treatment, and referral of victims of domestic violence.

Rx for Abuse Act (H.R. 3317)—Reps. Nita Lowey (D-NY) and Connie Morella (R-MD)

H.R. 3317 would authorize grants to state and local entities to strengthen the health care system's response to domestic violence. The bill would authorize $11 million for each of FY2001 through FY2003 and $10 million for FY2004.

Notes

1 Callie Marie Rennison, Ph.D. and Sarah Welchans, "Intimate Partner Violence," *Bureau of Justice Statistics Special Report* (Washington: Department of Justice, 2000), p. 2.
2 Rennison, "Criminal Victimization 1999: Changes 1998-99 with Trends 1993-99," *National Crime Victimization Survey* (Washington: Department of Justice, 2000), p. 8.
3 Ibid., p. 1.
4 Ibid., p. 4.
5 Ibid., pp. 4, 7.
6 Ibid., p. 4.
7 Ibid., p. 1.
8 Michael R. Rand, "Violence-Related Injuries Treated in Hospital Emergency Departments," *Bureau of Justice Statistics Special Report* (Washington: Department of Justice, 1997).
9 National Institute of Justice and the Centers for Disease Control and Prevention, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* (Washington: National Institute of Justice and the Centers for Disease Control and Prevention, 1998).
10 Rennsion and Welchans, "Intimate Partner Violence."
11 Michael A. Rodriguez, et al., "Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians," *Journal of the American Medical Association* 282 (1999) 5: 468-474.
12 Ibid.
13 Family Violence Prevention Fund, *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* (San Francisco: Family Violence Prevention Fund, 1999) <http://www.fvpf.org> (6/6/00).

Eating Disorders

Eating disorders are long-term, complex illnesses with interacting physical, psychological, and social components. The eating patterns characteristic of these illnesses are often related to the individual's distorted body image and unrealistic societal ideals of thinness. Eating disorders can lead to lifelong psychological and physical problems and are destructive not only to a victim but to family and friends as well. However, the United States does not track epidemiological data on eating disorders, so all statistics are estimates and most research occurring in the field are patient studies.[1]

- More than 90 percent of those with eating disorders are female.[2]
- The number of American women affected by eating disorders has doubled to at least five million in the past three decades.[3]
- According to the Public Health Service's Office on Women's Health (PHS-OWH), 1 to 4 percent of all young women in the United States are affected by eating disorders, and anorexia nervosa ranks as the third most common chronic illness among adolescent females.[4]
- A 1997 survey by the Commonwealth Fund found that one in six girls in grades 5-12 said that she had binged and purged. Fifty-eight percent of girls in grades 9-12 said they had been on a diet and one in three thought she was overweight. Additionally, abused girls were nearly three times as likely to binge and purge as girls who had not been abused.[5]

Silence surrounds the issue of eating disorders. Many states and schools devote time and resources to very effective education programs aimed at preventing alcoholism, drug abuse, and HIV/AIDS. Very few schools and colleges have adequate eating disorder education programs.

Eating disorders include anorexia nervosa (characterized by self-starvation, an intense desire to be thin, repeated dieting attempts, and excessive weight loss), bulimia nervosa (characterized by binge eating followed by self-induced vomiting and/or the misuse of laxatives, diet pills, diuretics, excessive exercise, or fasting), binge-eating disorder (characterized by repeated episodes of uncontrolled eating), and disordered eating (characterized by atypical eating behaviors, such as restrictive dieting, binging, and purging).[6]

Approximately 1 in 10 women with anorexia nervosa will die of starvation, cardiac arrest, or other medical complications, making its death rate the highest for a psychiatric disease, according to the National Institutes of Health. Others suffer for years. In one study, 30 percent of eating disorder victims reported their illness lasting 1 to 5 years, 31 percent reported 6 to 10 years, and 16 percent reported 11 to 15 years. Only about half reported being completely cured.[7]

The physical effects of anorexia include amenorhhea, osteoporosis, hair loss, hypothermia, heart ailments, obstetric complications, and immune system suppression. One study found that anorexics who developed the disorder during their teenage years were at a greater risk of osteoporosis and that 50 percent of the studied anorexics had low bone density.[8] Additionally, vomiting associated with bulimia can cause damage to tooth enamel, the esophagus, and the salivary glands. The abuse of diuretics and laxatives can lead to chemical imbalances. Eating disorders are also associated with a variety of psychological conditions such as depression, anxiety, and substance abuse.[9] One study found that almost half of the eating disordered patients studied met the criteria for major depression.[10]

While there is no known cause of eating disorders, certain characteristics have been shown to influence the development of eating disorders, such as low self-esteem, poor family and peer influences, cultural and media influences that emphasize thinness, and clinical depression.

Silence surrounds the issue of eating disorders. Many states and schools devote time and resources to very effective education programs aimed at preventing alcoholism, drug abuse, and HIV/AIDS. Very few schools and colleges have adequate eating disorder education programs.[11] Prevention programs could help counter

the societal causes of eating disorders by educating young people about proper nutrition, normal body development and growth, and healthy self-esteem. Programs aimed at early detection and treatment of eating disorders are also necessary, according to advocates. Education programs are particularly important for adolescents and young adults, since 86 percent of eating disorder cases begin before age 20.[12]

Access to Health Care

Eating disorder advocates are pressing for increased access to health care not only by calling for mental health parity, but also by urging health insurance companies to include eating disorders among the list of covered mental illnesses. Often, health plans place limits on the treatment they cover for eating disorders or they exclude eating disorders from the list of mental illnesses covered by the plan altogether.[13]

Under a recent study, 1 in 10 patients received treatment for his or her eating disorder. Additionally, the study found that the intensity of treatment was less than what is recommended by clinical guidelines. The study examined a national database of health insurance claims to determine the number of claims for eating disorder treatment and the type and length of treatment received.[14]

Another 1999 survey of leading eating disorders experts in the United States found that 96.7 percent believed that their anorexia patients were put in life-threatening situations because health insurance policies mandated early discharge. Additionally, 18 percent believed that insurance companies indirectly caused at least one of their patients to die, and 100 percent believed that some of their patients suffered relapses as a result of health care coverage limits.[15]

Congressional Action

The House Appropriations Committee report accompanying the FY1998 Labor, Health and Human Services, and Education appropriations bill (P.L. 105-78) urged the PHS-OWH to establish a national media campaign to educate the public about eating disorders. The report also encouraged the establishment of a toll-free number and an information clearinghouse on eating disorders. The first phase of the "BodyWise Campaign" developed an eating disorders module aimed at middle-school educators, including teachers, coaches, principals, and school administrators. The "BodyWise Campaign" is featured on the National Women's Health Information Center website at *www.4woman.org*. The second phase, which will be launched in the near future, will target health officials. Additionally, the office is partnering with the National Osteoporosis Foundation and the Centers for Disease Control and Prevention to implement the National Bone Health Campaign, the first phase of which will target girls aged 9-18 with information about behaviors that lead to bone loss. That campaign is slated to begin in early 2001.[16]

In 1996, the office also helped launch the Girl Power! campaign, a national public health education campaign for girls aged 9-14. The goal of the campaign is to provide the support and encouragement needed to allow girls to make good health and lifestyle choices. The office also created a Get Real! Video Kit, which is aimed at educating college-age women about important health issues, including eating disorders.[17]

Legislation

Eating Disorders Awareness, Prevention, and Education Act of 2000 (H.R. 3928)—Reps. Judy Biggert (R-IL) and Carolyn Maloney (D-NY)

H.R. 3928 would amend the Elementary and Secondary Education Act to allow states and local school districts to use federal education funding for programs aimed at increasing the awareness of eating disorders among parents and students, and to train educators on effective eating disorder prevention and assistance methods. The bill also would require the Departments of Education and Health and Human Services to develop, distribute, and promote public service announcements on eating disorders. H.R. 3928 would require the National Center for Education Statistics and the National Center for Health Statistics to conduct a study on the impact eating disorders have on educational advancement and achievement.

Notes

1 Dr. Ruth Striegel-Moore, speech given at congressional briefing, Sept. 13, 2000.
2 National Association of Anorexia Nervosa and Associated Disorders (ANAD), "Facts About Eating Disorders" <http://www.anad.org/facts.htm> (2/23/00).
3 Ibid.
4 Public Health Service's Office on Women's Health (PHS-OWH), "Eating Disorders Information Sheet," Feb. 2000 <http://www.4woman.org/owh/pub/eatingdis.htm> (6/6/00).
5 The Commonwealth Fund, *The Commonwealth Fund Survey of the Health of Adolescent Girls* (New York: The Commonwealth Fund, 1997), p. 4.
6 PHS-OWH, "Eating Disorders."
7 ANAD, "Facts About Eating Disorders."
8 A.E. Becker, et al., "Eating Disorders," *New England Journal of Medicine* 340 (1999): 1092-1098.
9 PHS-OWH, "Eating Disorders."
10 A.E. Becker, et al., "Eating Disorders."
11 ANAD, "Facts About Eating Disorders."
12 Ibid.
13 ANAD, "Q&A: Parity Legislation" <http://www.anad.org/parity.htm> (10/19/00).
14 Ruth H. Striegel-Moore, et al., "One-year Use and Cost of Inpatient and Outpatient Services Among Female and Male Patients with an Eating Disorder: Evidence from a National Database of Health Insurance Claims," *International Journal of Eating Disorders* 27 (2000): 381-389.
15 David France, "Anorexics Sentenced to Death," *Glamour Magazine*, Aug. 1999.
16 PHS-OWH, "Programs and Activities, Girls and Adolescent Health" <http://www.4woman.org/owh/prog/girls.htm> (6/6/00).
17 Ibid.

Family Planning Informed Consent

The Title X family planning program was created in 1970 to provide voluntary family planning services to low-income individuals. Forty-nine percent of all pregnancies are unplanned, roughly half of which end in abortion.[1]

- Eighty-five percent of U.S. counties have at least one publicly funded family planning clinic. About one-quarter of women who obtain family planning services receive care at clinics funded in part by Title X.[2]
- Twenty-four percent of women who use reversible contraceptives obtain them from a family planning clinic or from a private doctor reimbursed by Medicaid. Family planning clinics are an especially important source of care for teenagers, women of color, and low-income women.[3]

Since its inception, the Title X statute has prohibited the use of federal funds in programs where "abortion is a method of family planning." Until 1987, that restriction had been interpreted by the Department of Health and Human Services (HHS) only to forbid the performance of abortion with federal funds. The program guidelines required health care providers to offer counseling on all legal options regarding a pregnancy, including abortion, and to refer patients requesting abortions.

Beginning in 1987, HHS sought to prohibit family planning clinics that received federal funds under the Title X program from providing abortion information or referrals to pregnant clients. The HHS regulations were tied up in legal challenges for several years. Finally in 1991, the U.S. Supreme Court voted 5-4 to uphold the policy, ruling that the government could prohibit federally funded clinics from providing patients with information about abortion.

In 1992, the Bush administration formally moved to implement the HHS regulations. On two separate occasions, Congress voted to overturn the controversial family planning policy. However, the House narrowly failed to override presidential vetoes of the legislation. While one of the vetoed bills simply blocked implementation of the regulations, the other would have put into federal statute the requirement that family planning providers inform pregnant women about all of their options for dealing with an unintended pregnancy, including abortion.

The Clinton administration formally lifted the restrictions in 1993, at which time HHS proposed new regulations on the issue. On July 3, 2000, HHS published its final interpretation of the statutory requirement that no federal funds be used for Title X programs in which "abortion is a method of family planning." Under the final rule, Title X clinics may provide counseling and referral services for abortions, but the information must be presented in a neutral manner. Additionally, Title X clinics are prohibited from promoting or encouraging abortion as a method of family planning. The rule also clarifies that financial separation of non-Title X abortion activities from Title X activities is sufficient to comply with the law.[4]

Congressional Action

The issue of "gag rules" in government health programs arose in a different context during the 105th Congress. As Congress moved to pass legislation to balance the federal budget, a number of provisions affecting managed care plans that participate in Medicare and Medicaid were considered.

One provision approved in the Balanced Budget Act (P.L. 105-33) bars managed care plans from restricting the information a health care provider can provide to a patient. The so-called "anti-gag rule" provision also included a "conscience clause," which allows a health plan to refuse to provide information on a service it finds objectionable on moral or religious grounds. The conference report accompanying the Balanced Budget Act made clear, however, that states are still obligated to ensure that covered services, such as nondirective counseling and referral for the full range of reproductive health care services, are available through another system or provider.

During the 106th Congress, the issue surfaced again during consideration of managed care reform legislation. Both the House-passed and Senate-passed bills (H.R. 2990/S. 1344) included an "anti-gag rule" provision that would have prohibited health plans from restricting the information a physician may provide a patient about a patient's illness and/or treatment; however, that legislation stalled in conference.

Legislation

Women's Right to Know Act of 1999 (H.R. 270)—Rep. Louise Slaughter (D-NY)

H.R. 270 would amend the Civil Rights Act of 1964 to prohibit any state or federal government authority from restricting a health professional's right to give, or a woman's right to receive, information about reproductive health options, including family planning, prenatal care, adoption, and abortion services.

Patient Right to Unrestricted Medical Advice Act of 1999 (H.R. 2043)—Rep. Sue Kelly (R-NY)

H.R. 2043 would prohibit health plans from restricting the information provided to a participant about the health status of the participant or the medical care or treatment for the condition of the participant, regardless of whether the plan covers such treatment.

Notes

1 The Alan Guttmacher Institute (AGI), *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* (New York: AGI, 2000) pp. 16, 17.

2 AGI, "Contraceptive Services" <http://www.agi-usa/pubs/fb_contr_serv.html> (8/8/00).

3 Ibid.

4 Department of Health and Human Services, "Provisions of Abortion-Related Services in Family Planning Services Projects," *Federal Register* 65 (July 3, 2000) 128: 41281-41282 <http://wais.access.gpo.gov> (8/3/00).

Health Status of Women of Color

The health status of women of color has come under scrutiny because many health indicators for minority women lag behind those of their Caucasian counterparts. Although there is now ample data to demonstrate discrepancies in the health status and outcomes between women of color and Caucasian women, few conclusive reasons for these differences have been established. This knowledge gap has made forging effective programs and policies a frustrating process of trial and error.

Although many generalized pronouncements have been made on the health status of women of color, these generally fail to capture the total picture of this population, made complex by diverse subsets. This diversity manifests itself in different languages, cultures, degrees of acculturation, and histories. These differences may account for some of the difficulty in accurately depicting the health status of this broad spectrum of women.

A 1997 report from the Centers for Disease Control and Prevention showed wide disparities in health-risk behaviors, even among members of the same racial and ethnic group living in different states. The report also found that African Americans and Hispanics engage in more health-risk behaviors and make less use of preventive services.[1]

The misclassification of race and ethnicity in data collection also contributes to the disparity. For example, it is not uncommon for some Hispanic, Asian/Pacific, and American Indian/Alaska Native women to be classified as Caucasian on hospital admission records or death certificates.

Another contributing factor is the generally sparse representation of women of color in research studies. This concern has prompted a call for greater outreach to these communities, as well as increased education for health care providers and researchers on the importance of including women of color in studies.

According to the Population Reference Bureau, women of color are more likely than Caucasian women to live in poverty. Of American women currently living below the federal poverty line, 28.5 percent are African American, 28 percent are Hispanic, 24.9 percent are Native American, 13.2 percent are Asian/Pacific Islander, and 9.4 percent are Caucasian.[2] The negative effect of poverty on health and on accompanying conditions such as housing and violence has been well-documented.

There also may be specific barriers within the health care system that limit the access of women of color to proper services. According to the Public Health Service's Office on Women's Health (PHS-OWH), many health care providers and facilities are not sensitive to the needs and preferences of women of color. The PHS-OWH cites inadequate communication resulting from stereotyping, language barriers, health information provided at an inappropriate literacy level, and a lack of culturally appropriate services and education material.[3]

Although specific rates of disease vary greatly by race and ethnicity, it is instructive to evaluate a few indicators to understand the depth of the gap between the health status of women of color and that of Caucasian women.

Health Indicators

Life expectancy for most women of color is lower than for Caucasian women. Current estimates of life expectancy for Caucasian women is 79.6 years; for Hispanic women, 77.1 years; for American Indian/Alaska Native women, 74.4 years; and for African-American women, 74.1 years.[4]

Heart disease is the leading killer of women of color, as it is for all women in the United States. African-American women and Hispanics, however, have higher death rates from heart disease than do Caucasian women. Mortality from coronary heart disease is 40 percent higher among African Americans than Caucasians, while the mortality rate for stroke is 80 percent higher among African Americans than Caucasians.[5] Although family history of heart disease and lifestyle are major risk factors for this disease, the wide gap has not been satisfactorily explained.

Breast cancer provides another example of differences in the health status of women of color as compared to Caucasian women. Although they develop breast cancer less frequently than Caucasian women, African-

American and Hispanic women have a higher rate of mortality, due most likely to later diagnosis and treatment.[6]

Screening for early diagnosis continues to be a key factor in breast cancer survival. All groups of women of color are less likely to receive routine mammograms after the age of 40 than are Caucasian women. Fifty-four percent of Asian-American women over the age of 40, 52 percent of African-American women over the age of 40, and 51 percent of Hispanic women over the age of 40 have not had a mammogram within the past two years. Forty-four percent of Caucasian woman over the age of 40 have not had a mammogram in the past two years. [7]

A recent statistic may indicate that awareness about breast cancer screening in the African-American community is beginning to have a beneficial impact. From 1990 to 1998, the death rate from breast cancer among African-American women decreased by 8 percent. This is a dramatic change from 1980 to 1990, during which time the death rate for African-American women increased 18 percent. Although this trend is encouraging, it should be noted that from 1990 to 1998, the death rate for Caucasian women from breast cancer decreased by 20 percent.[8]

Infant mortality rates are frequently viewed by public health specialists as primary indicators of the health of a population as a whole. A recent study by the National Center for Health Statistics found that the infant mortality rate for infants born to African-American women was more than twice as high as those born to Caucasian women at 13.8 deaths per 1,000 live births.[9] Native American women followed with a rate of 9.3, while the rate for Caucasian women was 6.0, just below the national average of 7.2.[10] According to the report, infants of mothers who began prenatal care after the first trimester or not at all had an infant mortality rate of 9.4, which was 49 percent higher than the rate for those who began care in the first trimester.[11]

HIV/AIDS is a pressing health issue for women of color. African-American and Hispanic women constitute 77 percent of women with HIV/AIDS.[12] Asian/Pacific and American Indian/Alaska Native women make up less than 1 percent of the total HIV/AIDS cases among women.[13] In 1999, HIV/AIDS was the fifth leading cause of death for women aged 25-44. It was the third leading cause of death for African-American women and the fourth leading cause of death for Hispanic women in the same age group.[14]

In addition to HIV/AIDS, racial and ethnic minorities are disproportionately affected by other STDs. For some STDs, the reported rate can be as much as 40 times higher for African Americans than for Caucasians.[15] In 1999, African Americans represented 77 percent of all reported gonorrhea cases.[17]

Other diseases that are more prevalent among women of color include diabetes, rheumatoid arthritis, and lupus, the latter afflicting African-American women three times more often than Caucasian women.[18]

In some instances, women of color may have a lower incidence of illness, but because they are more likely to lack access to adequate health care they are diagnosed at later stages when the health consequences may be more severe. This phenomenon seems to be the case with mental illness. Women of color utilize outpatient services far less often than Caucasian women, yet their rate of inpatient treatment is much higher.[19] Additionally, Hispanic women have the highest lifetime prevalence of depression among all women at a rate of 24 percent.[20] According to the American Psychological Association, women of color are more likely than Caucasian women to share a number of socioeconomic risk factors for depression.[21]

It also is important to note that violence constitutes a more significant health risk for women of color than for Caucasian women. According to the Bureau of Justice Statistics at the Department of Justice, African-American women experienced a 35 percent higher rate of intimate partner violence than Caucasian women.[22] Additionally, 40 percent of African-American women reported coercive contact of a sexual nature before the age of 18.[23] More research is needed to establish the causes of these troubling discrepancies. Also, increased outreach and education to communities of color regarding prevention and screening may help reduce the gap in health outcomes.

Need for Culturally Competent Providers

Women's health advocates point to a lack of culturally and linguistically competent health care providers as a primary contributor to the poor health status of women of color. According to the American Medical Association (AMA), roughly 12 percent of practicing physicians are African American, Hispanic, Asian Ameri-

can or American Indian/Alaska Native. However, the AMA believes that many minority groups are underreported because the organization has data on only 60 percent of all U.S. physicians. Nearly 23 percent of practicing physicians are female. Of the total number of female physicians, roughly 14 percent represent minority groups; however, the race/ethnicity for 49 percent of female physicians is not known to the AMA.[24]

The AMA recently established a cultural competence initiative aimed at establishing cultural competence as the "Fifth Physician Competence." Currently, there are four competence standards to which physicians are held: cognitive knowledge, technical skill, behavior, and managerial competence.[25] A recently published *Cultural Competence Compendium* provides a list of resources for medical schools, residency program directors, and physicians to assist medical professionals in providing culturally competent health care.[26]

According to the PHS-OWH, cultural competence—more than gender, race, or ethnicity—is the attribute that best fosters an environment in which patients of diverse backgrounds will be understood, appropriately diagnosed, and treated.[27]

Within federal agencies, several programs have been established to specifically address the health of women of color. These include initiatives at the Food and Drug Administration, Centers for Disease Control and Prevention, National Institutes of Health, Indian Health Service, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality. In addition, the Public Health Service has both an Office on Minority Health and an Office on Women's Health, and the Department of Health and Human Services has implemented a department-wide Initiative to Eliminate Racial and Ethnic Disparities in Health.

Congressional Action

The 106th Congress enacted legislation (P.L. 106-525) designed to address racial and ethnic minorities. The law establishes a National Center for Research on Minority Health and Health Disparities at the National Institutes of Health (NIH), as well as Centers of Excellence for Research Education and Training at the NIH. Additionally, the new law requires the Agency for Healthcare Research and Quality to conduct research on how to improve the quality and outcomes of health care services for minority populations and the causes of health disparities. The law also provides for grants for health professional education curriculum development, as well as development of a continuing medical education incentive program.

Under the new law, the National Academy of Sciences is required to study the data collection of the Department of Health and Human Services (HHS) with respect to race and ethnicity. HHS also is allowed to aid in the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes, including cultural competency as a method of eliminating health disparities. The law also establishes a national public awareness campaign to inform the public and health care professionals about health disparities in minority and underserved populations.

Additionally, Congress enacted legislation (P.L. 106-554) to provide additional Medicare payments to health care providers. Provisions pertaining to racial and ethnic minorities were included in the new law. P.L. 106-554 establishes cancer prevention and treatment demonstration projects for racial and ethnic minorities. Additionally, the law will expand the Medicare+Choice quality assurance program to include a separate focus on racial and ethnic minorities, and the Secretary of Health and Human Services will be required to report to Congress on how the Medicare+Choice quality assurance program is focusing on racial and ethnic disparities. The provisions were included in the FY2001 Consolidated Appropriations Act (P.L. 106-554).

Notes

1 Julie C. Boehn, Ph.D., "State-Specific Prevalence of Selected Health Behaviors, by Race and Ethnicity: Behavioral Risk Factor Surveillance System, 1997," *Morbidity and Mortality Weekly Report* 49: 1-60 <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/ss4902a1.htm> (5/31/00).

2 Population Reference Bureau, *PRB Analysis of Data from the U.S. Census Bureau Current Population Survey* (Washington: PRB, March 1999 supplement).

3 Public Health Service's Office on Women's Health (PHS-OWH), "The Health of Minority Women," May 2000 <http://www.4woman.gov/owh/pub/minority> (8/7/00).

4 Ibid.

5 Ruth Kirschstein, M.D. of the National Institutes of Health, testimony before the Senate Health, Education, Labor, and Pensions Subcommittee on Public Health, July 26, 2000, p. 2.

6 Alexis Jetter, "Breast Cancer in Blacks Spurs Hunt for Answers," *New York Times*, Feb. 2, 2000, D5; Elena Rios, M.D. of the National Hispanic Medical Association, testimony before

the Senate Health, Education, Labor, and Pensions Subcommittee on Public Health, July 26, 2000, p. 3.
7 PHS-OWH, "The Health of Minority Women."
8 National Center for Health Statistics (NCHS), *Health, United States, 2000 With Adolescent Health Chartbook* (Hyattsville: NCHS, 2000), p. 198.
9 NCHS, "Infant Morality Data from the 1998 Period: Linked Birth/Infant Death Data Set," *National Vital Statistics Report* 48 (2000) 2.
10 Ibid.
11 Ibid.
12 CDC, *HIV/AIDS Surveillance Report*, 11 (1999) 2: 5 <http://www.cdc.gov/hiv/stats/hasr1102/commentary.htm> (8/1/00).
13 Ibid.
14 Ibid.
15 Deborah McNeal Arrindell, American Social Health Association, "Eliminating Racial Disparties: Sexually Transmitted Diseases and African-Americans" (fact sheet, 2000).
16 CDC, "HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk" <http://www.cdc.gov/hiv/pubs/facts/women.htm> (11/27/00).
17 CDC, "Sexually Transmitted Diseases Surveillance 1999," p. 59 <http://www.cdc.gov/nchstp/dstd/Stats_Trends/1999SurvRpt.htm> (11/6/00).
18 National Institute of Arthritis and Musculoskeletal and Skin Diseases <http://www.nih.gov/niams/healthinfo/lupus/> (8/1/00).
19 Department of Health and Human Services (HHS), *Mental Health: A Report of the Surgeon General* (Washington: HHS, 1999).
20 PHS-OWH, "The Health of Minority Women."
21 American Psychological Association (APA), "Women and Depression" (fact sheet, 2000).
22 Department of Justice (DOJ), Bureau of Justice Statistics, *Intimate Partner Violence* (Washington: DOJ, 2000), p. 4.
23 APA, "Intimate Violence and Black Women's Health" (fact sheet, 1997).
24 American Medical Association (AMA), "Women in Medicine Data Source" <http://www.ama-assn.org/ama/pub/article/171-195.html>; AMA, "Minority Physicians Data Source" <http://www.ama-assn.org/ama/pub/article/168-187.html> (8/28/00).
25 AMA, "Cultural Competence Initiative" <http://www.AmericanMedicalAssociation.org/ethic/diversity/index.htm> (8/28/00).
26 AMA, *Cultural Competence Compendium* (Chicago: AMA, 1999), p. viii.
27 PHS-OWH, "The Health of Minority Women."

HIV/AIDS Prevention

As has been the case for the past several years, women are the fastest-growing population group with HIV/AIDS. While treatment advancements have led to a reduction in AIDS deaths in recent years, the growing incidence of HIV infection among women seems to indicate that prevention programs have not effectively reached many young women or women of color.

In 1999, HIV/AIDS was the fifth leading cause of death in women aged 25-44, the third leading cause of death for African-American women in this age group, and the fourth leading cause of death for Hispanic women in the same age group.[1] The number of AIDS cases among female adults and adolescents has more than tripled over the past 14 years, from 7 percent in 1985 to 23 percent in 1999.[2]

As of December 1999, women accounted for 32 percent of HIV cases. African-American and Hispanic women accounted for 77 percent of AIDS cases, while representing less than one-fourth of women in the United States.[3] Among women aged 13-24, women account for 49 percent of HIV cases. Given that risk behaviors are most likely to begin during the teenage years, individuals who are diagnosed before the age of 25 are more likely to represent newer infections, a fact that can be useful in targeting prevention efforts.[4]

Women with STDs are three to five times more likely to become HIV-infected.

Sexual Transmission

Since 1994, heterosexual contact has been the leading source of HIV infection among women, followed by injection drug use.[5] In addition to the direct risk of injection drug use through the sharing of needles, heterosexual transmission also is growing as a result of drug use. Many women are infected through partners who are injection drug users. Thus, effective substance abuse prevention and treatment must be a critical component of HIV/AIDS prevention efforts targeted to women.[6] Among women reported with AIDS in 1999, 40 percent acquired the virus through heterosexual contact; intravenous drug use accounted for 27 percent.[7]

Many women who were newly identified as HIV-infected reported no known risk factor for infection, possibly either indicating a lack of knowledge of their partners' risk factors or that their health care providers did not document the information. According to the Centers for Disease Control and Prevention (CDC), more than two-thirds of AIDS cases in women that are initially reported with no known risk factor are reclassified as contracted through heterosexual contact and one-fourth are attributed to injection drug use.[8]

There also is a strong correlation between infection with HIV and with other sexually transmitted diseases (STDs). The presence of STDs increases a woman's likelihood of both acquiring and transmitting HIV. Women with STDs are three to five times more likely to become HIV-infected.[9] The importance of prompt detection and treatment is paramount; all sexually active women should be screened regularly for STDs.

Prevention Messages

Although in the early 1990s, HIV prevention programs targeted specifically to women tended to focus on relatively narrow groups, these programs are expanding to meet the needs of all women, particularly minority women.

A substantial effort has targeted pregnant women for HIV counseling and testing. According to the CDC, rates of perinatal HIV transmission decreased by 75 percent between 1992 and 1998.[10] The CDC attributes the decrease to recommendations by the Public Health Service to routinely counsel and voluntarily test pregnant women, as well as offer HIV-positive women AZT during their pregnancy.[11] The CDC estimates that without current perinatal prevention efforts, an additional 656 infants would be born with HIV, costing roughly $105.6 million in medical care expenses.[12]

Additionally, in 1999, the Institute of Medicine (IOM) issued a report recommending that the United States adopt a national policy of universal voluntary HIV testing, with patient notification, as a routine component of prenatal care.[13] The recommendations are supported

by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. However, despite the decline in perinatal transmission, infection rates for women continue to rise. As a result, women's health advocates argue that the best way to prevent HIV infection in babies is to prevent HIV infection in all women.

Several studies indicate that STD/HIV prevention programs for women are most effective when they occur at a place where women go for their health and social services, including family planning and women's health clinics, application sites for public assistance and food stamps, and migrant worker camp kitchens. Most recently, the CDC published a compendium of HIV prevention interventions, which detailed effective intervention programs. Recognizing that many women are at risk due to the behavior of their male partners, behavior about which they may or may not have knowledge, many of the programs targeting women focused on risk-reduction skills, such as negotiation, assertiveness, and communication.[14]

Microbicides

Prevention messages that primarily emphasize abstinence, partner reduction, and condom use may fail to recognize that women are not always in control of when, with whom, and on what terms they have sexual relations. Many women's health advocates continue to press for the development of microbicides—a female-controlled method of preventing HIV and other STDs. A woman could use a microbicide without her partner's knowledge to protect herself from HIV, other STDs, and pregnancy. Researchers are also working to develop a microbicide that could protect against HIV, while still allowing women to become pregnant.[15] Scientists are currently pursuing over 50 different product leads and advocates believe that with sufficient resources a microbicide may be available in five years.[16]

In July 2000, researchers announced the results of a study to determine whether nonoxynol-9, a spermicide, would be effective in preventing the transmission of HIV. The study enrolled 1,000 HIV-negative sex workers in Africa. Half of the women received the spermicide, while the other half received a placebo. The study found that women who used nonoxynol-9 became infected with HIV at a 50 percent higher rate than women who used the placebo. Additionally, the more frequently women used the spermicide, the higher their infection risk. As a result of the study, the CDC recommended that HIV prevention messages be changed to reflect that the use of spermicides alone does not prevent HIV transmission.[17] The results of the study further highlight the need to pursue expanded research for HIV prevention.[18]

The CDC has primary responsibility within the federal agencies for HIV education, prevention, surveillance, and population-based research activities. It conducts prevention programs through community-based organizations, schools, and public information campaigns. A relatively small portion of the CDC's HIV prevention budget for FY1999 and FY2000 was specifically targeted to women. In FY1999, $111.6 million of the $656.6 million appropriated was spent on women's programs. In FY2000, 17 percent ($118 million) of the $694 million appropriated for HIV prevention was estimated to have been spent on programs targeted to women.[19]

After passage of the Comprehensive HIV Prevention Act in 1993, CDC created the HIV Prevention Community Planning Initiative, designed to give local communities input into prevention programs and to ensure the development of culturally competent programs that best meet the needs of the community. More recently, the 106th Congress reauthorized (P.L. 106-345) the Ryan White CARE Act with language to ensure that populations most affected by HIV/AIDS are represented in the CARE Act's HIV Health Planning Councils.

A 1999 IOM report found that the United States did not have a "comprehensive, effective, and efficient strategy for preventing the spread of HIV." Moreover, the report found that current prevention programs are not effectively reaching women, youth, and racial and ethnic minorities. The report recommends a national prevention goal to avert as many new infections as possible.[20] This would be accomplished through a six-element program, which would include:

- Development of an accurate HIV surveillance system;
- Allocation of prevention resources to prevent as many new infections as possible;
- Direction of prevention activities to HIV-infected individuals;
- Translation of prevention research findings into action;

- Investment in the development of new tools and technologies to expand HIV prevention efforts; and
- Increased efforts to overcome social barriers and to remove policy barriers that impede HIV prevention.[21]

In response to the report, the CDC released a draft "HIV Prevention Strategic Plan Through 2005." The draft plans highlights four goals for HIV prevention in the United States:

- Reduce the number of new HIV infections per year from an estimated 40,000 to 20,000 by 2005;
- Through voluntary counseling and testing, increase the proportion of HIV-infected people who know they are infected from the current 70 percent to 95 percent by 2005;
- Increase the proportion of HIV-infected people who are linked to appropriate care, prevention services and treatment services from the current 50 percent to 80 percent by 2005; and
- Reduce HIV transmission and improve HIV/AIDS care and support through partnership with resource-constrained countries.[22]

After public comments are considered, the CDC hopes to begin implementing the plan by the end of 2000.

Targeted Prevention Services

Because of the connection between heterosexual activity and HIV transmission to women, family planning clinics are a particularly promising site for HIV education and prevention. An estimated 33 million U.S. women are in need of contraceptives services and roughly half of them will receive those services from a publicly funded clinic.[23]

Family planning clinics routinely provide a broad range of health services including gynecological and breast examinations, Pap tests, STD and urinary tract infection testing and treatment, pregnancy testing, diabetes and high blood pressure screening, prenatal and well-baby care, and HIV testing. A majority of clinics also provide services to men including condom distribution, STD testing and treatment, and HIV testing—making these clinics promising sites for educating men about the importance of using condoms to prevent HIV transmission. Additionally, 7 out of 10 clinics provide outreach and education programs designed to target adolescents.[24]

A number of family planning clinics provide HIV education and testing services, as well as outreach and education programs. Publicly funded family planning clinics account for one in four HIV tests; one in three clinic visits are for other STD services.[25] After adjusting for inflation, total public funding for family planning services decreased by 60 percent between 1980 and 1999.[26] While Title X received a $24 million increase to $239 million in FY2000, the program received a $15 million increase to $253.9 million in FY2001.

Legislation

Comprehensive HIV Prevention Act of 1999 (H.R. 2405)—Reps. Nancy Pelosi (D-CA) and Connie Morella (R-MD)

H.R. 2405 would direct the Secretary of Health and Human Services (HHS) to plan, coordinate, and evaluate HIV infection prevention with the CDC, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Indian Health Service, the NIH, the Public Health Service, and the Substance Abuse and Mental Health Services Administration. The bill would require each agency to establish and implement a comprehensive HIV prevention plan, as well as an office within the agency to carry out the plan.

H.R. 2405 also includes a section specific to women. The bill would authorize grants to provide HIV prevention education to women, substance abuse treatment for women, HIV prevention counseling for women who engage in substance abuse, HIV prevention counseling for women whose partners are substance abusers, and early intervention services for women.

Notes

1 Centers for Disease Control and Prevention (CDC), *HIV/AIDS Surveillance Report* 11 (1999) 2 <http://www.cdc.gov/hiv/stats/hasr1102/commentary.htm> (8/1/00).

2 CDC, "HIV/AIDS Among US Women: Minority and Young Women at Continuing Risk" <http://www.cdc.gov/hiv/pubs/facts/women.htm> (11/27/00); CDC, *HIV/AIDS Surveillance Report* 11 (1999) 2 <http://www.cdc.gov/hiv/stats/hasr1102/commentary.htm> (8/1/00).

3 CDC, "HIV/AIDS Among U.S. Women: Minority and Young

Women at Continuing Risk."
4 CDC, *HIV/AIDS Surveillance Report*.
5 Ibid.
6 CDC, "HIV/AIDS Among U.S Women: Minority and Young Women at Continuing Risk."
7 Ibid.
8 Ibid.
9 Judy Wasserheit, M.D., M.P.H., "Epidemiological Synergy: Interrelationships between Human Immunodeficiency Virus Infection and other Sexually Transmitted Diseases," *Sexually Transmitted Diseases* 19 (1992): 61-77.
10 CDC, "HIV Prevention Strategic Plan Through 2005" <http://www.cdc.gov/nchstp/od/news/draft.plan.pdf> (10/18/00).
11 CDC, "Status of Perinatal HIV Prevention: U.S. Declines Continue" <http://www.cdc.gov/hiv/pubs/facts/perinatl.htm> (5/31/00).
12 Ibid.
13 Institute of Medicine, *Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States* (Washington: National Academy Press, 1999).
14 CDC, *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (Atlanta: CDC, Nov. 1999).
15 Lori Heise, "Topical Microbicides: New Hope for STI/HIV Prevention" <http://www.genderhealth.org/pubs/publications.htm#TopicalMicrobicides> (8/10/00).
16 Alliance for Microbicide Development, 2000. *Microbicides: Research and Development Status*, February 2000.
17 CDC, "Nonoxynol-9 Trial—The Implications," August 4, 2000 <http://www.cdc.gov/hiv/pubs/mmwr/mmwr11aug00.htm> (8/10/00).
18 Susan Okie, "AIDS Study Prompts New Look at Prevention," *New York Times*, Aug. 14, 2000, A3.
19 Eva Margolies-Seiler of the CDC's National Center for HIV, STD, and TB Prevention, email communication with Women's Policy, Inc., Aug. 21, 2000.
20 Institute of Medicine, *No Time to Lose: Getting More from HIV Prevention* (Washington: National Academy Press, 2000).
21 Ibid.
22 CDC, "HIV Prevention Strategic Plan Through 2005."
23 AGI, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* (New York: AGI, 2000), p. 16.
24 Ibid., p. 19.
25 Ibid., p. 20.
26 Ibid., p. 27.

International Women's Health

Every year, 585,000 women die from pregnancy-related causes; 99 percent of these deaths occur in developing countries.[1] Over the past decade, congressional action on international women's health has focused primarily on access to family planning services and the practice of female genital mutilation. More recently, action has focused on the global HIV/AIDS epidemic, particularly in Africa. While funding for international family planning programs has proven to be a major point of contention in both the House and Senate, legislation to authorize additional funding for HIV/AIDS education, prevention, and treatment was enacted by the 106th Congress.

HIV/AIDS

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 9 million women worldwide have died from AIDS. In 2000, 2.2 million women worldwide were newly infected with HIV, and 16.4 million women were living with HIV worldwide. There were 1.4 million children under the age of 15 living with HIV.[2]

Infection rates in young African women are three to five times higher than the infection rates in young African men.[3] High infection rates in young women can be attributed to cultural taboos that prevent people from talking about sex, as well as a myth that sexual intercourse with a virgin will cure AIDS. One study found that nearly 75 percent of Mozambican girls aged 15-19 did not know how to protect themselves from HIV.[4]

Sub-Saharan Africa bears the brunt of the HIV/AIDS epidemic, accounting for 71 percent of the global total of HIV infections.[5] In 2000, an estimated 600,000 children aged 15 and younger became infected with HIV.[6] UNAIDS and the World Health Organization (WHO) estimate that over 90 percent of these new infections were in babies born to HIV-positive women and almost nine-tenths of HIV-infected babies were born in sub-Saharan Africa.[7]

Life expectancy in Africa has dramatically dropped because of HIV/AIDS. Fewer than 50 percent of sub-Saharan Africans are expected to reach the age of 60, compared with 90 percent of individuals in industrialized countries.[8] African economies and infrastructure are not prepared to deal with the vastness of the epidemic. Recently, UNAIDS announced that gender inequality was a driving force behind the HIV/AIDS epidemic, saying that the issue has to be addressed as agencies, governments, and service organizations respond to the problem.[9]

The 106th Congress most recently addressed the global HIV/AIDS epidemic when it enacted the Global AIDS and Tuberculosis Relief Act (P.L. 106-264). The new law authorizes $150 million in each of FY2001 and FY2002 to create a trust fund under the auspices of the World Bank to address the global HIV/AIDS epidemic. The trust fund will make grants, rather than loans, to countries with the highest HIV-infection rates and countries at risk for high HIV-infection rates. Activities supported by the fund will include prevention, education, treatment and care services, and research and development activities. The new law also authorizes $60 million for tuberculosis prevention and treatment, $50 million for the Global Alliance for Vaccines Initiative (GAVI), $10 million for the International AIDS Vaccine Initiative (IAVI), and $300 million for HIV/AIDS prevention activities at USAID.

The FY2001 foreign operations appropriations bill (P.L. 106-429) included $315 million for global HIV/AIDS prevention and treatment activities, including $15 million for microbicides research, up to $50 million for GAVI, up to $10 million for IAVI, and up to $20 million for an HIV/AIDS program under the auspices of the World Bank.

A number of legislative proposals aimed at addressing the global HIV/AIDS epidemic were introduced during the 106th Congress. For a listing, see Appendix II.

International Family Planning

International family planning plays a significant role in stabilizing population growth and safeguarding reproductive health. In addition to contraceptive care, population assistance programs provide quality health care services and public health information.

- In October 1999, the world's population reached 6 billion, with an expected increase of 78 million people each year. The United Nations projects that the world's population could reach between 7.3 billion and 10.7 billion by the mid-21st century.[10]

- One-half of the world's women are in their childbearing years—and this number increases by about 24 million each year. More than 95 percent of population growth occurs in developing countries.[11]
- Around the globe, it is estimated that more than 150 million men and women want to space or limit their families but lack access to family planning services.
- Seventy million abortions occur each year and about 20 million are performed illegally or in unsafe conditions, resulting in 76,000 maternal deaths.[12]
- The odds of a woman dying from maternity-related causes ranges from 1 in 10,000 in Northern Europe to 1 in 23 in Africa.[13]

The United States began to emerge as an important contributor to international family planning more than three decades ago. In 1967, Congress amended the Foreign Assistance Act to include family planning activities overseas. Most U.S. population assistance is distributed in one of two ways. The first is through the U. S. Agency for International Development (USAID), a federal agency that provides funds to developing countries for economic and humanitarian purposes. A primary USAID goal is protecting the United States against global threats such as destabilizing population growth and environmental degradation. A second channel for U.S. funds is through contributions to the United Nations Population Fund (UNFPA), the largest multilateral family planning organization.

However, for more than a decade congressional debate around international family planning policy has been dominated by the issue of abortion. During the last two decades, Congress has voted to withhold funds from UNFPA because it is active in China, where a one-child population policy promoted coercive abortions. Funding for international family planning was further restricted by the "Mexico City policy." Announced by the United States in 1984 at the U.N. International Conference on Population in Mexico City, the restrictions prohibited the United States from giving international family planning funds to private organizations that also provide abortion services. This policy was in place until 1993, when the President reversed the restriction by executive order.

U.S. international family planning received a 35 percent funding cut from $547 million in FY1995 to $365 million in FY1996. Although supporters of the family planning program were successful at fending off efforts to restore the "Mexico City policy," opponents of the program were able to impose new restrictions, including a 9-month freeze in funding after which time funds were allowed to trickle out over a 15-month period, with no more than 6.67 percent available in any one month.

During the next several years, abortion opponents sought to prohibit funding of organizations that use their own funds to conduct abortion-related activities. With strong support from the Senate and the White House, the "Mexico City policy" was dropped in conference in FY1997, FY1998, and FY1999. Although international family planning programs received a modest increase from $365 million in FY1996 to $385 million in FY1997, funding restrictions were imposed and the programs remained level-funded through FY1999.

In FY1999, Congress eliminated the U.S. voluntary contribution to UNFPA due to controversy surrounding UNFPA's program in China. In past years, Congress approved the $25 million contribution but placed restrictions on the money: no funds could be spent in China; U.S. funds had to be kept in a separate account; and the U.S. contribution would be reduced dollar-for-dollar by the amount spent in China. In FY2000 and FY2001, Congress reinstated the $25 million contribution to UNFPA with the funding restrictions. In FY2000, U.S. funding was reduced by $5 million and it is estimated that U.S. funding will be reduced by the same amount in FY2001.

With the cooperation of the Clinton administration, Congress enacted a version of the "Mexico City policy" in FY2000. The restriction was written into both the FY2000 Commerce, Justice, State, and Related Agencies appropriations bill (P.L. 106-113) and the FY2000 foreign operations appropriations bill (P.L. 106-113), which were included in an omnibus appropriations measure. Under the restriction, organizations that use their own money to perform abortions abroad or to lobby foreign governments on abortion policy were denied U.S. aid. Lobbying was broadly defined to include "any activity or effort to alter the laws or governmental policies of any country."

The President was allowed to waive the restriction, but by doing so, the total funds available for international family planning were reduced by 3 percent. Upon en-

actment, the President immediately exercised the waiver, reducing funding from $385 million to $372.5 million in FY2000. Additionally, the total funding made available to groups using their own funds to perform abortions abroad or to lobby on abortion policy was capped at $15 million.

The House-passed FY2001 foreign operations appropriations bill (H.R. 4811) included the restriction enacted last year, while the Senate-passed measure (S. 2522) did not. The final measure (P.L. 106-429) does not include the restriction and provides for a $40 million increase for international family planning programs to $425 million. However, the funding will be delayed until February 15, 2001, allowing the next President the opportunity to decide whether restrictions should be imposed on the money.

Legislation

United Nations Population Fund (UNFPA) Funding Act of 1999 (H.R. 895/S. 965)—Reps. Carolyn Maloney (D-NY) and Connie Morella (R-MD) and Sens. James Jeffords (R-VT) and Olympia Snowe (R-ME)

H.R. 895/S. 965 would authorize the U.S. $25 million voluntary contribution to the UNFPA with certain limitations. The President would be required to certify that the UNFPA program in China focuses on improving the delivery of voluntary family planning information; is designed in conformity with the International Conference on Population and Development; is implemented only in areas of China where all quotas and targets for the recruitment of program participants have been abolished; is carried out in consultation with UNFPA; is subject to regular, independent monitoring; and suspends operations in areas where the program is found to be in violation of the guidelines. The U.S. contribution to the UNFPA would be reduced dollar-for-dollar by any amount the UNFPA spends in China unless the President can certify the conditions outlined in the bill.

Saving Women's Lives Through International Family Planning of 2000(H.R. 3634/S. 2380)—Reps. Carolyn Maloney (D-NY) and James Greenwood (R-PA) and Sens. Frank Lautenberg (D-NJ) and Olympia Snowe (R-ME)

H.R. 3634/S. 2380 would authorize $541.6 million for international family planning programs in FY2001, $366 million for foreign assistance and environment programs dealing with health and population, and $35 million for the U.S. contribution to the UNFPA.

Female Genital Mutilation

Female genital mutilation (FGM)—sometimes called "female circumcision"—is the cutting of a female's genitals. FGM encompasses practices from the partial removal of the clitoris to infibulation, which involves the removal of all external genitalia and the stitching together of the vulva. It is estimated that between 100 and 140 million women worldwide have undergone some form of FGM and 2 million girls are at risk each year.[14]

FGM is usually performed with razor blades, scissors, or other crude tools—often without anesthetics, antiseptics, or antibiotics. Immediate complications of FGM include severe bleeding, shock, and infections (such as tetanus and septicemia) transmitted through the unsterilized instruments used. Long-term effects of FGM include chronic pelvic infections, infertility, anemia, incontinence, and severe pain during urination, menstruation, sexual intercourse, and childbirth.[15]

The age at which FGM is performed varies among different ethnic groups and may be as early as infancy or as late as the time of a woman's first pregnancy. However, it is usually done between the ages of 4 and 10 as part of a coming-of-age ceremony. The reasons cited to justify FGM include purification, personal hygiene, protection of family honor, and prevention of promiscuity. Religion is another reason often given for the practice, but according to the WHO, no religious tradition requires FGM. Girls are taught that FGM makes them marriageable, will increase the sexual pleasure of their future husbands, and is required for their acceptance into the community.[16]

FGM is most common in a band of 28 countries stretching across Africa, including Egypt, and in several Middle Eastern and Asian countries.[17] As immigration from FGM-practicing countries to the West grows, the practice has been seen in Europe, Canada, Australia, and the United States.

Legislation aimed at criminalizing FGM in the United States became law on September 30, 1996. The criminalization provision was included in the Illegal Immigration Reform and Immigration Responsibility Act of 1996, which became law as part of the FY1997 omnibus appropriations bill (P.L. 104-208). The provision criminalizes FGM in the United States and imposes fines and up to five years' imprisonment for individuals found guilty of performing FGM on girls under the age of 18. The law also directs the Immigration and Naturalization Service (INS) to educate all immigrants who are issued visas on the health hazards of FGM and the legal consequences of performing the procedure in the United States. The Secretary of the Treasury is also required to identify countries that have traditionally practiced FGM and require the U.S. directors of international financial institutions to actively oppose nonhumanitarian loans to those countries.

In a separate piece of legislation approved in April 1996 (P.L. 104-134), Congress directed the Secretary of Health and Human Services to conduct a study documenting the incidence of FGM in the United States and to engage in outreach and education efforts. Working from 1990 Census data, the Centers for Disease Control and Prevention determined that as of 1990 there were approximately 168,000 women and girls living in the United States who had either undergone the procedure or were at risk. Acknowledging that the study had several limitations, such as the inability to quantify the degree of acculturation, researchers conducting the study said that their numbers probably underrepresented the actual incidence of FGM in the United States.[18]

Although FGM was criminalized during the 104th Congress, the United States does not officially consider FGM a form of persecution and therefore it is not considered a sufficient reason to grant asylum. In light of several highly publicized cases involving African women who sought, or are seeking, asylum here rather than be subjected to FGM in their home countries, legislation is pending to include FGM among those forms of persecution for which asylum may be granted.

Congressional Action

The FY2001 foreign operations appropriations bill (P.L. 106-429) requires the Secretary of State to determine the prevalence of the practice of FGM and the existence and enforcement of laws prohibiting this practice. Additionally, the Secretary is required to make recommendations on how the United States can work to eliminate FGM. Report language accompanying the final bill directs the USAID to allocate $1.5 million to develop and integrate educational programs aimed at eliminating FGM.

Legislation

Female Genital Mutilation Asylum Protection Act (H.R. 1849)—Reps. Carolyn Maloney (D-NY) and Sue Kelly (R-NY)

H.R. 1849 would require the Attorney General to issue regulations that set new standards for asylum seekers. The bill would expand the definition of "persecution" in the determination of an alien's eligibility for asylum to include gender-related persecution, such as female genital mutilation.

Notes

1 The Alan Guttmacher Institute (AGI), "Support for Family Planning Improves Women's Lives" (issue brief, 1998) <http://www.agi-usa.org/pubsib23.html> (6/12/00).
2 Joint United Nations Programme on HIV/AIDS (UNAIDS), *AIDS Epidemic Update: December 2000* <http://www.unaids.org> (11/30/00).
3 UNAIDS, *Report on the Global HIV/AIDS Epidemic*, June 2000 <http://www.unaids.org> (6/12/00).
4 The Washington Post Online <http://www.washingtonpost.com/world/daily/july00/aidsgraphic3.htm> (7/12/00).
5 Karl Vick, "Disease Spreads Faster Than the Word," *Washington Post*, Juy. 7, 2000, A1.
6 UNAIDS, *AIDS Epidemic Update: December 2000*.
7 UNAIDS, *Report on the Global HIV/AIDS Epidemic*.
8 The Washington Post Online.
9 UNAIDS, "Gender is Crucial Issue in Fight Against AIDS, Says Head of UNAIDS" (press release, June 5, 2000).
10 Population Action International, "Why Population Matters," 1999 <http://www.populationaction.org/why-pop/birthdearthfs.htm> (6/12/00).
11 Ibid.
12 AGI, "Support for Family Planning."
13 United Nations Population Fund, "Population Issues Briefing Kit," 2000 <http://www.unfpa.org/modules/briefkit/English/ch01.html> (6/12/00).
14 World Health Organization (WHO), "Female Genital Mutilation Fact Sheet," June 2000 <http://www.who.int/inf-fs/en/fact241.html> (6/12/00).
15 Ibid.
16 Ibid.
17 Ibid.
18 Wanda Jones, Dr.P.H., et al., "Female Genital Mutilation/Female Circumcision: Who is at Risk in the U.S.?" *Public Health Report* 368, 372 (1997).

Mid-life and Older Women

Today, more than 40 million American women are over the age of 50.[1] Based on current life expectancies, women spend one-third of their lives in post-reproductive menopausal years. The health concerns of older women are different from those of younger women and older men.

- Breast cancer risk increases with age, with women aged 50 and older accounting for 77 percent of newly diagnosed cases and 84 percent of deaths.[2]
- About 70 percent of all cervical cancer deaths occur among women aged 50 and older.[3]
- Half of the women over 50 will have an osteoporosis-related fracture in their lifetimes.[4]
- Two to three times more women than men suffer from arthritis. By age 65, about 80 percent of women report arthritic conditions.[5]
- One in nine women aged 45-64 has some form of heart disease; one in three women aged 65 and older has heart disease.[6]

Although prevention programs and early detection screenings are available for a number of these health conditions, many women do not take advantage of them. The Public Health Service's Office on Women's Health estimates that only half the women with diabetes are diagnosed, largely due to a lack of testing.[7] The proportion of women who receive mammograms and Pap tests declines with increasing age.[8]

Cost is often cited as a barrier to health care, particularly preventive care, for women of all ages. Low-income older women are less likely to receive preventive care. The effect of income on access to preventive care is of particular concern because so many older women have low incomes. In 1998, about 13 percent of women aged 65 and over had incomes below the poverty level, compared with 7 percent of men the same age.[9] The poverty rate is higher for several groups of elderly women—18 percent for widows, 20 percent for never-married women, and 22 percent for divorced women.[10]

Researchers predict that poverty among elderly women will not decline in the near future with rates predicted to be the same in 2020. Partly, this is because more women in the future are likely to be divorced, separated, or single as they age.[11]

In addition, women usually rely on Social Security for a longer time period, as their average life expectancy is seven years longer than that of men.[12] Even when income is adjusted for smaller households, the income of older women tends to fall when they are widowed. In addition, single older women are most likely to incur high medical expenses.[13]

Most efforts to increase access to care for poor women have focused on women of reproductive age. Care provided at most women's clinics primarily consists of family planning and prenatal care. As a result, large numbers of post-reproductive-aged women have fallen outside of the health care system.

In recent years, a growing awareness of mid-life and older women's health issues, and the fact that a disproportionate number of breast and cervical cancer deaths occur among low-income older women, has led to some progress. Since 1991, more than 2.5 million cancer screening tests have been provided by the Centers for Disease Control and Prevention (CDC) through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which targets free screening services to underserved populations including low-income, minority, and older women.[14]

Additionally, as part of the NBCCEDP, the CDC operates the WISEWOMAN program to provide screening for cardiovascular diseases, as well as dietary and physical activity interventions for women with abnormal test results. These services are currently provided to some low-income and uninsured women aged 50 and older in three states.[15] The CDC hopes to expand the program to provide screening and follow-up to the approximately 25,000 women aged 50 and older who participate in the NBCCEDP in those states. Additionally, the CDC hopes to expand the program to include additional states.[16]

However, even when cost barriers to preventive services are removed, lack of education about the benefits of these services remains a significant hurdle. Many older women believe that preventive services such as mammography and Pap tests are no longer needed. Many physicians stop recommending Pap tests for women over 65 who have a history of normal results, based on the false assumption that older women

do not require testing because they are not sexually active. However, recent evidence indicates that one-fourth of new cervical cancer cases occur in women over 65.[17] Further, older women lack knowledge about where to go for quality health care facilities in their community or lack transportation to reach facilities outside the community.

Access to screening for conditions such as breast and cervical cancer does not satisfy women's need for comprehensive care. Women of post-reproductive age need access to quality information, prevention, and treatment for conditions ranging from heart disease to osteoporosis. Mid-life and older women require information on how lifestyle choices can affect a variety of health conditions, as well as access to providers who will respond to their unique health concerns.

In addition, conditions related to menopause can occur for up to ten years and women whose daily activities are interrupted by these conditions should be informed about hormone replacement therapy (HRT) and other coping strategies. As they enter their post-reproductive years, 75 percent of midlife women report some menopausal symptoms, which can include irregular menstrual bleeding, hot flashes, night sweats, mood swings, depression, sleeplessness, vaginal dryness, and urinary tract infections.[18] These symptoms result from a natural decrease in the hormones estrogen and progesterone, which regulate the menstrual cycle. In many cases, doctors prescribe HRT—either as estrogen alone or as estrogen in combination with progesterone—in an effort to ease symptoms by restoring hormones to their premenopausal levels.

Some controversy surrounds HRT because studies show that it helps to address some health concerns for midlife and older women while contributing to the development of others. Research has indicated that HRT is likely to help prevent osteoporosis.[19] In addition, it may help delay the onset of Alzheimer's disease.[20]

A number of studies, however, have shown a link between HRT and breast cancer risk.[21] One study indicated that HRT combining estrogen and progestin (a synthetic form of progesterone) may increase this risk more than estrogen-only therapy.[22] Another recent study found that women who used estrogen replacement therapy between the ages of 50 and 60 increased their risk of breast cancer over time by 23 percent. For women who used HRT combining estrogen and progestin for ten years, the risk increased by 67 percent.[23]

Other studies are mixed as to whether the short-term use of estrogen replacement therapy (ERT) and HRT in postmenopausal women reduces the risk of heart disease. In 1995, the Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial found that both ERT and HRT increased the level of HDL cholesterol, the "good" cholesterol.[24] Additionally, the Nurses' Health Study found that ERT and HRT reduced the risk of death from heart disease and stroke.[25] However, results from the Heart and Estrogen/Progestin Replacement Study (HERS), published in August 1998, found that the use of estrogen plus progestin in postmenopausal women with heart disease did not prevent further heart attacks or death from coronary disease.[26] Additionally, there are other health risks associated with ERT, such as an increased risk of endometrial or uterine cancer and an increased risk of blood clots and gall bladder disease.

In fact, in April 2000, researchers involved with the HERS trial announced that women who had been taking estrogen as part of the study were at a slightly higher risk for heart attacks and strokes. However, officials at the National Heart, Lung, and Blood Institute (NHLBI) at the National Institutes of Health (NIH) cautioned that the results did not address the long-term benefits and risks of HRT and should not influence current medical practice.[27]

An August 2000 study published in the *New England Journal of Medicine* found that the use of estrogen alone or estrogen plus progestin did not affect the progression of heart disease in women whose already had the disease. The study suggests that "women should not use estrogen replacement with an expectation of cardiovascular benefit."[28]

There are various non-hormonal strategies recommended to many women by their doctors as an alternative or as a supplement to HRT. Some of those strategies include the consumption of soy products, which are high in phytoestrogens; the use of herbs and vitamin supplements to help balance mood and body temperature; and the consumption of yogurt and/or cranberry juice to stabilize the urinary tract.[29] Exercise is also known to be helpful for mood regulation and increased bone strength.

Congressional Action

Committee report language accompanying the Senate-

passed FY2001 Labor, Health and Human Services, and Education appropriations bill (S. 2553) urged the National Institute of Neurological Disorders and Stroke (NINDS) at the National Institutes of Health to expand research on possible connections between HRT and stroke in women. The NINDS also was encouraged to study strategies to help women prevent and recover from stroke.

Additionally, committee report language accompanying the final FY2001 Labor, Health and Human Services, and Education spending bill (P.L. 106-554) stated that adequate funding was provided to allow the CDC to expand its WISEWOMAN programs to not more than 15 states.

Legislation

WISEWOMAN Expansion Act of 2000 (S. 2635/ H.R. 4606)— Sens. Bill Frist (R-TN) and Tom Harkin (D-IA) and Reps. Rosa DeLauro (D-CT) and Jim Leach (R-IA)

S. 2635/H.R. 4606 would expand the WISEWOMAN program through the CDC. The program would provide preventive health services to low-income women for heart disease, osteoporosis, and obesity. S. 2635 would authorize $15 million in FY2001, $20 million in FY2002, and $25 million in FY2003. H.R. 4606 would authorize $20 million in FY2001, $25 million in FY2002, and $30 million in FY2003. Both bills would limit additional funding for the WISEWOMAN program for a fiscal year, unless at least $158 million is spent on the National Breast and Cervical Cancer Early Detection Program in that fiscal year.

Notes

1 U.S. Census Bureau, "Resident Population Estimates," May 24, 2000 <http://www.census.gov> (6/26/00).

2 American Cancer Society, "Who Gets Breast Cancer?" <http://www.cancer.org/99bcff/index.html> (6/26/00).

3 The National Women's Health Information Center (NWHIC), "Older Women's Health Priorities" <http://www.4woman.gov/owh/pub/older%20wh/oldpriorities.htm> (6/26/00).

4 Older Women's League (OWL), "Osteoporosis: A Challenge for Midlife and Older Women" <http://www.owl-national.org> (6/26/00).

5 NWHIC, "Older Women's Health Priorities."

6 OWL, "Women and Heart Disease: A Neglected Epidemic" <http://www.owl-national.org> (6/26/00).

7 NWHIC, "Older Women's Health Priorities."

8 Centers for Disease Control and Prevention (CDC), "The National Breast and Cervical Cancer Early Detection Program At-A-Glance 2000" <http://www.cdc.gov/cancer/nbccedp/about.htm> (6/26/00).

9 Federal Interagency Forum on Aging Related Statistics, *Older Americans 2000: Key Indicators of Well-Being* (Hyattsville: Federal Interagency Forum on Aging Related Statistics, 2000) <http://www.agingstats.gov/chartbook2000/economics.html> (9/11/00).

10 Lois Shaw and Catherine Hill, *How Economically Secure are Older Women*? (Ann Arbor: University of Michigan Press, forthcoming).

11 Ibid.

12 OWL, "Older Women and Poverty."

13 Shaw and Hill, *How Economically Secure are Older Women?*

14 CDC, "Ten Years of Progress: The National Breast and Cervical Cancer Early Detection Program" <http://www.cdc.gov/cancer/nbccedp/anniversary.htm> (8/28/00).

15 CDC, "Preventing Cardiovascular Disease: Addressing the Nation's Leading Killer At-a-Glance 1999" (fact sheet, 1999), p. 5.

16 CDC, "The WISEWOMAN Program: Capitalizing on Opportunities to Improve the Health of Women," Nov. 16, 1999 <http://www.cdc.gov/nccdphp/dnpa/wisewoma.htm> (8/28/00).

17 American Cancer Society, "Cervical Cancer Overview" <http://www3.cancer.org/cancerinfo/load_cont.asp?ct=8&doc=25&Language=English> (6/26/00).

18 Women's Health Advocate Research Group (WHARG), "Easing Your Menopausal Symptoms," 1999.

19 OWL, "Osteoporosis: A Challenge for Midlife and Older Women."

20 National Cancer Institute (NCI), "Questions and Answers About Hormone Replacement Therapy," Apr. 12, 2000 <http://www.nci.nih.gov> (6/26/00).

21 Ibid.

22 NCI, "Study Shows Greater Risk of Breast Cancer with Estrogen-Progestin Therapy Compared to Estrogen Alone," (press release, Jan. 28, 2000) <http://www.nci.nih.gov> (6/26/00).

23 Graham A. Colditz and Bernard Rosner, "Cumulative Risk of Breast Cancer to Age 70 Years According to Risk Factor Status: Data From the Nurses' Health Study," *American Journal of Epidemiology* 152 (2000) 10: 950-964; Reuters News Service, "Estrogen therapy may increase breast cancer risk," Nov. 24, 2000 <http://www.4woman.gov/nwhic/News/Nov00/27Nov00.htm> (11/17/00).

24 National Heart, Lung, and Blood Institute, "Hormone Replacement Therapy and Heart Disease: The PEPI Trial," August 1995.

25 AHA, "Estrogen and Cardiovascular Diseases in Women" <http://www.americanheart.org> (1/11/00).

26 National Institutes of Health, "The HERS Study Results and Ongoing Studies of Women and Heart Disease" (press release, Aug. 18, 1998).

27 Gina Kolata, "Estrogen Use Tied to Slight Increase in Risks to Heart," *New York Times*, Apr. 5, 2000, A1.

28 David Harrington, et al., "Effects of Estrogen Replacement on the Progression of Coronary-Artery Atherosclerosis," *New England Journal of Medicine* 343 (2000) 8: 522-529.

29 WHARG, "Easing Your Menopausal Symptoms."

Osteoporosis

Over the course of a lifetime, bone is constantly being broken down and rebuilt in a process called bone remodeling. Until around age 30, more bone is created than is reabsorbed, and bone mass increases. As people get older, the balance shifts and more bone is broken down than is replaced. This happens to both men and women, but because women have less bone mass to start, the consequences for them tend to be more severe. In addition, the decline in estrogen levels at menopause causes bone to be lost at an accelerated rate, up to 20 percent a year in the five to seven years after menopause.[1]

A leading cause of injury and disability among elderly women, osteoporosis is characterized by a thinning of the bones which makes them brittle and prone to fracture.

- Twenty-eight million Americans are at risk of osteoporosis due to low bone mass and eight million women have osteoporosis.[2]
- Of those who have osteoporosis or are at risk to contract it, 80 percent are women.[3]
- One in two women aged 50 and over will have an osteoporosis-related fracture in her lifetime.[4]
- By the age of 20, the average woman has acquired 98 percent of her skeletal mass.[5]

Osteoporosis causes 1.5 million fractures per year, mostly of the wrist, spine, ribs, and hip. Fractures can result from everyday activities such as bending to pick up a newspaper or lifting a bag of groceries. Spine fractures can lead to a loss of height, curvature of the spine, and chronic back pain. The rate of hip fractures is two to three times greater in women than in men, and a woman's risk of hip fracture is equal to her combined risk of breast, uterine, and ovarian cancer. Caucasian women aged 65 and older have twice as many fractures as African-American women in the same age group.[6]

According to the National Osteoporosis Foundation (NOF), the direct medical costs resulting from osteoporosis total $14 billion per year and constitute 3 percent of all Medicare costs. Without greater prevention efforts, the NOF warns, the cost of osteoporosis could reach a total of $62 billion by the year 2020.[7]

Osteoporosis is a "silent" disease; most women do not know they are at risk until bone loss is quite advanced and a fracture occurs. Many women also are unaware that osteoporosis is largely preventable and can often be treated through a combination of lifestyle, dietary, and medical approaches. Participating in regular weight-bearing exercise such as walking or jogging, and eating a diet high in calcium and vitamin D (which helps the body absorb calcium) throughout life can help prevent osteoporosis, although some bone loss will still occur. In menopausal years, this may not be enough.[8]

New Therapies

Several technologies exist for measuring bone density, which allow doctors to diagnose osteoporosis and determine treatment strategies. If osteoporosis is diagnosed, a number of treatments have been approved by the Food and Drug Administration (FDA) for both the prevention and treatment of osteoporosis. Such treatments include calcitonin, a naturally occurring hormone that slows bone loss in women five years beyond menopause; estrogen replacement therapy, which has been found to reduce bone loss and increase bone density; alendronate, a drug that has been shown to reduce bone loss and increase bone density in postmenopausal women; fosomax, a nonhormonal drug that prevents bone loss; and raloxifene, a Selective Estrogen Receptor Modulator (SERM) that acts like estrogen in the bones and cardiovascular system but blocks estrogen's effects in the breasts and uterus.[9]

Congressional Action

Despite the recent approval of new drugs for the treatment and prevention of osteoporosis, more research is needed to expand the range of treatment options available to patients. Federal funding for osteoporosis research has more than doubled since 1991 from $60 million to roughly $140 million in 1999.

Congress established the Department of Defense (DoD) Osteoporosis and Related Bone Disease Research Program in 1994 with a $5 million earmark. In FY2001, Congress appropriated $6 million. The program is designed to foster innovative research on prevention, early detection, and treatment of osteoporosis. In conjunction with the DoD program, a 1998 Institute of Medicine report, *Reducing Stress Fracture in Physically*

Active Military Women, found that 10-20 percent of female recruits experienced a stress fracture during basic training compared to 5-10 percent of the male recruits.[10]

In addition to funding through the National Institutes of Health (NIH) and the DoD, in FY2000, the Veterans Administration (VA) was appropriated $13 million to research osteoporosis. However, no money was earmarked for osteoporosis research at the VA in FY2001.

Research directed at developing low-cost screening and treatment options is particularly important. The relatively high cost of bone mass measurement (ranging from $50 to $350 depending on the test) may be an obstacle to wider use. In an attempt to provide greater access to bone mass measurement, Congress mandated Medicare coverage of the test under the Balanced Budget Act of 1997 (P.L. 105-33). Under the law, Medicare is required to cover bone density testing every two years for high-risk women.

Education

The NIH Osteoporosis and Related Bone Diseases National Resource Center was established in 1994 with a grant from the National Institute of Arthritis and Musculoskeletal and Skin Diseases at the NIH. The resource center was created to provide patients, health professionals, and the public with access to resources and information on metabolic bone diseases. The original four-year grant was renewed in 1998 and extended through the year 2003. In the next several years, the resource center will seek to increase awareness, knowledge, and understanding of prevention, early detection, and treatment of osteoporosis.

A recent study published in the *Journal of Bone and Joint Surgery* highlights the need for increased education for physicians and patients about osteoporosis. The study found that of 1,200 older women with fractured wrists, only one-quarter of the women were screened or treated for osteoporosis.[11]

In FY1999, Congress earmarked $3 million through the Public Health Service's Office on Women's Health (PHS-OWH) for a National Bone Health Campaign. The PHS-OWH is partnering with the NOF and the Centers for Disease Control and Prevention to implement the campaign. The first component of that campaign, expected to be launched in early 2001, will target adolescent girls. Statistics show that more than 70 percent of girls aged 6-18 do not meet national guidelines for calcium intake, greatly increasing their risk for osteoporosis later in life.[12]

Legislation

Osteoporosis Education and Prevention Act of 1999 (H.R. 2294)—Reps. Shelley Berkley (D-NV) and Marge Roukem (R-NJ)

H.R. 2294 would amend the Older Americans Act of 1965 to require agencies on aging to coordinate education relating to osteoporosis prevention, diagnosis, and treatment and to cooperate with states or localities that have implemented such programs.

Public Health Osteoporosis Screening, Diagnosis, and Treatment Act of 1999 (H.R. 2471)—Reps. Eddie Bernice Johnson (D-TX) and Sue Kelly (R-NY)

H.R. 2471 would make osteoporosis screening a required primary health service for federal health centers, and would authorize the Secretary of Health and Human Services to make grants to states and local governments for the establishment and operation of programs for screening, referrals, and education.

Notes

1 National Osteoporosis Foundation, "Fast Facts," Feb. 2000 <http://www.nof.org> (8/9/00).
2 Ibid.
3 Ibid.
4 Ibid.
5 Ibid.
6 Ibid.
7 Ibid.
8 Ibid.
9 Ibid.; National Women's Health Network, "Osteoporosis" <http://www.womenshealthnetwork.org/advocacy/factsheets/osetoper.htm> (5/31/00).
10 Institute of Medicine, *Reducing Stress Fracture in Physically Active Military Women* (Washington: National Academy Press, 1998).
11 Reuters News Service, "Fracture Often a Sign of Osteoporosis in Older Women," Aug. 9, 2000 <http://news.lycos.com/docid=RTHEALTH-BONES&date=20000809> (8/9/00).
12 National Institutes of Health Osteoporosis and Related Bone Diseases National Resource Center <http://www.osteo.org> (8/23/00).

Reproductive Health

The majority of Americans believe that unplanned pregnancy is a serious problem. When compared with other Western countries, the United States has one of the highest rates of unintended pregnancy. While abortion is one of this country's most divisive political issues, most people also agree that the number of abortions should be reduced.

- Nearly 49 percent of all pregnancies in the United States are unplanned, including 8 in 10 pregnancies among adolescent women.[1] Of the 39 million women at risk of unplanned pregnancy, 9 out of 10 are using a contraceptive method. Forty-seven percent of unplanned pregnancies occur among the three million women who do not use contraception.[2]
- Half of all unplanned pregnancies in this country end in abortion. Abortion rates are highest among women under age 25, unmarried women, poor women, and women of color. About 14,000 women have abortions each year as a result of rape or incest.[3]
- A woman who wants only two children will need to use contraception for at least 20 years of her life.[4]

Congressional Action

Congress cast 120 votes on reproductive rights issues between 1995 and 1999.[5] Although most votes cast during this period sought to deny the use of government funds to pay for abortion, Congress also voted to criminalize a specific method of abortion and, in the House, to deny international family planning funds to organizations that use their own funds for abortion-related services, to prohibit the transportation of a minor across state lines to obtain an abortion, and to make it a federal crime to injure or kill an "unborn child."

The 106th Congress adopted riders to the FY2001 appropriations bills that restricted access to abortion for federal workers and their dependents, women in the military and the Peace Corps, women in federal prison, low-income women in the District of Columbia, disabled women on Medicare, and low-income women on Medicaid.

In 1997, Congress voted to revise the existing Hyde amendment, which bars the use of federal Medicaid funds to pay for abortions for low-income women. The revised language seeks to make clear that the Hyde restriction also applies to Medicaid recipients who participate in managed care plans. The 105th Congress also wrote the Hyde amendment into permanent law for the first time as part of the State Children's Health Insurance Program (P.L 105-33). In both cases, exceptions are made in cases of rape, incest, or life endangerment.

Since the 104th Congress, lawmakers have voted to outlaw "partial-birth" abortions. The measure was vetoed by the President in 1996 and 1997 because it lacked an exception to protect the health of the woman. Additionally, on June 28, 2000, the U.S. Supreme Court struck down a Nebraska law that was modeled after the bills vetoed by President Clinton.

The 105th Congress successfully implemented contraceptive coverage for federal employees under the Federal Employees Health Benefits Program as part of the FY1999 Treasury, Postal Service, and General Government appropriations bill (P.L. 105-277). The provision was renewed by the 106th Congress in the FY2000 and FY2001 Treasury-Postal Service spending bills (P.L. 106-58/P.L. 106-554).

Additionally, Title X, the federal family planning program, received a $24 million increase to $238.9 million in FY2000. The program received $253.9 million in FY2001.

Since 1973, more than 1,000 bills dealing with reproductive choice have been introduced in Congress.[6] For a listing of selected bills introduced in the 106th Congress, see Appendix II.

Notes

1 The Alan Guttmacher Institute (AGI), "Induced Abortion," Feb. 2000 <http://www.agi-usa.org> (8/22/00).
2 AGI, "Contraceptive Use" <http://www.agi-usa.org> (8/22/00).
3 AGI, "Induced Abortion."
4 AGI, "Contraceptive Use."
5 The National Abortion and Reproductive Rights Action League, *Congressional Record on Choice 106th Congress, 1st Session*, 1999 <http://www.naral.org> (8/22/00).
6 Mark Eddy of the Congressional Research Service, telephone communication with Women's Policy, Inc., Nov. 24, 2000.

Sexually Transmitted Diseases

While the rates of infection for some sexually transmitted diseases (STDs) have dramatically declined in recent years, other diseases continue to spread unabated.

- An estimated 15 million new STD infections occur each year, with about one quarter of new infections occurring in teens.[1]
- A teenage woman with a single exposure to an infected partner has a 1 percent risk of contracting HIV, a 30 percent risk of acquiring genital herpes, and a 50 percent risk of contracting gonorrhea.[2]
- The highest rates of both chlamydia and gonorrhea in women are among adolescents aged 15-19.[3]
- Women with STDs have a three- to five-fold increased risk of contracting HIV/AIDS (see HIV/AIDS Research, p. 23, HIV/AIDS Prevention, p. 47).[4]
- The annual direct medical costs of STD treatment are estimated to total at least $8.4 billion.[5]

A teenage woman with a single exposure to an infected partner has a 1 percent risk of contracting HIV, a 30 percent risk of acquiring genital herpes, and a 50 percent risk of contracting gonorrhea.

The long-term effects of STDs fall disproportionately on women and infants. If untreated, 20-40 percent of women infected with chlamydia and 10-40 percent of women infected with gonorrhea will develop pelvic inflammatory disease (PID). Among those women who develop PID, 20 percent will become infertile, 9 percent will have a potentially fatal ectopic pregnancy, and 18 percent will experience chronic pelvic pain.[6] Women infected with some types of human papillomavirus (HPV) will develop cervical cancer (see Cervical Cancer/HPV, p. 16).

Untreated syphilis during pregnancy results in infant deaths in up to 40 percent of cases.[7] In a pregnant woman, gonorrhea can result in premature delivery, spontaneous abortion, blindness, joint infection, or a life-threatening blood infection in the baby.[8] Infants born to women infected with chlamydia may suffer from neonatal ophthalmia and pneumonia, and infants born to women with HPV can have recurrent respiratory papillomatosis.[9]

In addition, racial and ethnic minorities are disproportionately affected by STDs. For some STDs, the reported rate can be as much as 40 times higher for African Americans than for Caucasians.[10] In 1999, African-American and Hispanic women accounted for 77 percent of reported AIDS cases, while representing less than one-fourth of U.S. women.[11] Additionally, African Americans represented 77 percent of all reported gonorrhea cases in 1999.[12]

Syphilis

The incidence of syphilis declined 88 percent from 1990 to 1999 to its lowest level since reporting began in 1941. Syphilis is concentrated primarily in nine states in the South, with 25 counties accounting for 50 percent of all primary and secondary syphilis cases in 1999. Syphilis rates for African Americans were 30.4 percent higher than the rate reported for Caucasians but still represented a decline from the ratio of 56 in 1995. High syphilis rates have been associated with poverty and lack of access to adequate health care.[13] Individuals with syphilis have a two- to five-fold increased risk of contracting HIV infection: the areas of the United States with the highest rates of syphilis are the same areas with the highest rates of HIV/AIDS in women.[14]

Chlamydia

Since 1994, chlamydial infections have represented the largest proportion of STDs reported to the Centers for Disease Control and Prevention (CDC). Women with chlamydial infections often do not have any noticeable symptoms; chlamydia can cause pelvic inflammatory disease—a major cause of infertility—ectopic pregnancy, and chronic pelvic pain. In addition, chlamydial infection increases the risk of HIV infection.[15]

Gonorrhea

Like chlamydial infection, gonorrhea is a major cause of PID. After a 72 percent reduction in the rate of reported cases of gonorrhea from 1975 to 1997, the CDC reported the second consecutive year of increased gon-

orrhea rates in 1999. While some of the increase could be explained by expanded and improved screening, the increase also reflected a higher rate of new infections. Rates were highest in adolescents aged 15-19.[16]

Genital Herpes

Over the last two decades, the number of Americans infected with genital herpes has increased 30 percent. Herpes simplex virus (HSV) causes herpes; HSV-type 2 (HSV-2) usually affects the genital area and is more common in women than men. Women can experience painful genital lesions and increased risk for HIV transmission and infection. If infected during pregnancy, their infants can acquire potentially fatal neonatal infections. As is the case with many STDs, African Americans are disproportionately affected; however, the rate of new infections is increasing most among young Caucasian teens.[17]

Prevention and Screening

Because many infections have no noticeable symptoms and because there is such a stigma attached to STDs, most Americans underestimate their risk and often forgo testing.[18] Approximately 70 percent of women with chlamydial infections and 50 percent with gonococcal infections experience no symptoms, and are diagnosed primarily through screening programs. In fact, many STDs can be effectively treated with antibiotics.[19]

A 1997 Institute of Medicine report concluded that an effective national STD prevention system does not exist. The report recommended the development of a national STD prevention system, employing four major strategies at the national, state, and local levels:

- addressing barriers to the adoption of healthy sexual behaviors;
- developing expanded investment, leadership, and information systems for STD prevention;
- establishing innovative STD-related services for adolescents and underserved populations; and
- providing high quality, accessible clinical services for STDs.[20]

Since the report, a collaborative effort led by the CDC has been launched to improve national STD prevention and treatment efforts, with a particular focus on eliminating syphilis from the United States.[21]

The geographic concentration and low rate of infection led to the development of the National Plan to Eliminate Syphilis from the United States, announced by U.S. Surgeon General David Satcher in October 1999. The syphilis elimination plan includes five strategies:

- strengthen community involvement and partnerships;
- institute rapid outbreak response;
- enhance surveillance;
- expand clinical and laboratory services; and
- enhance health promotion.[22]

Begun in 1988 as a demonstration project, the CDC's chlamydia screening and prevalence monitoring effort has been steadily expanded. In locations where large screening programs have been in place for a number of years, their effectiveness has been demonstrated clearly. From 1988 to 1999, the screening programs in Pacific Northwest family planning clinics resulted in a decline in chlamydia rates of 62 percent among women aged 15-44.[23] Publicly funded family planning clinics have become an important resource in STD screening. Sixty-four percent of Title X clinics routinely screen for chlamydia, while 54 percent routinely screen for gonorrhea.[24]

Despite the effectiveness of such interventions, the chlamydia screening program continues on a limited basis in most states. In addition, most men with chlamydia are not diagnosed and treated, since these programs have served only women. However, the expanded availability of a more sensitive urine test is resulting in greater testing rates among men. The CDC also expects that the inclusion of chlamydia screening as a Health Plan Employer Data and Information Set (HEDIS) 2000 measure, used by managed care plans, will expand screening efforts for women covered by those plans.[25]

In the late 1970s a large-scale screening program for gonorrhea in women was implemented, which led to a steady decrease in gonorrhea rates for women and men during the 1980s and early 1990s. However, the gonorrhea rate for women remained steady between 1998 and 1999, while the rate for men increased by 2.5 percent.[26]

The National Institute of Allergy and Infectious Diseases at the National Institutes of Health (NIH) announced in 1999 the development of a behavioral in-

tervention that was effective in reducing new cases of chlamydia and gonorrhea among African-American and Mexican-American women who were being treated for an STD in San Antonio, Texas. About half the participants received in-depth group counseling to commit to behavior change and to learn the skills necessary to do so, including negotiating safer sex practices. The other women received standard individual counseling, usually for a one-time 15-minute session. The women who were part of the intervention had a 34 percent lower rate of chlamydia or gonorrhea than the control group at six months; a 49 percent lower rate between 6 and 12 months, and a 38 percent lower rate during the entire study.[27]

While there is no cure for genital herpes, scientists recently announced the development of a vaccine to help prevent the infection in some women. According to scientists in Belgium, the vaccine was about 73 percent effective in preventing genital herpes sores in women who never had either form of the virus. It did nothing to protect men or women who already were infected with HSV-1. The lead investigator who tested the vaccine suggested that the vaccine would be most effective for adolescent girls and could indicate that gender-specific differences will be found in other STD vaccines.[28]

A heightened effort also has been underway to increase research on the development of gels, foams, creams, or films, known as topical microbicides, that women could apply intravaginally before sex to prevent STD transmission.[29] As a woman-controlled method, microbicides would fill a gap in prevention strategies. The NIH funds topical microbicide research; however, many advocates believe the funding should be expanded.[30] Legislation (H.R. 3891) has been introduced to expand resources committed to microbicide research (see HIV/AIDS Prevention, p. 47).

Congressional Action

The final FY2001 Labor, Health and Human Services, and Education appropriations bill (P.L. 106-554) included a $26 million increase to $148.26 million for STD prevention and control activities at the CDC. According to the final conference report, a $6 million increase was provided for chlamydia screening, and a $14.93 million increase was provided for syphilis prevention.

The Senate committee report included language directing the CDC to use half of the increased funding provided in the bill to implement the National Plan to Eliminate Syphilis. It further directed the agency to expand chlamydia screening and services and to implement pilot projects to begin screening and treatment for men. The Senate committee also urged that the rest of the increase be used for infertility prevention programs.

The House committee report included language urging the CDC to expand its efforts to educate providers and the public about human papillomavirus.

Both bills included report language related to microbicide research (see HIV/AIDS Research, p. 23). The final bill concurred with the Senate language urging the establishment of a five-year implementation plan for microbicide research at the NIH.

Notes

1 American Social Health Association (ASHA) for the Kaiser Family Foundation, "Sexually Transmitted Diseases in America: How Many Cases and at What Cost" <http://www.kff.org/content/archive/1445/std_rep.htm_> (9/22/00).

2 The Alan Guttmacher Institute, "Facts in Brief: Teen Sex and Pregnancy, 1999" <http://www.agi-usa.org/pubs/fb_teen_sex.html> (9/22/00).

3 Centers for Disease Control and Prevention (CDC), "Sexually Transmitted Disease Surveillance 1999," p. 2 <http://www.cdc.gov/nchstp/dstd/Stats_Trends/1999SurvRpt.htm> (11/6/00).

4 Judy Wasserheit, M.D., Ph.D., "Epidemiological Synergy: Interrelationships Between Human Immunodeficiency Virus Infection and other Sexually Transmitted Diseases," *Sexually Transmitted Diseases* 19 (1992): 61-77.

5 ASHA, "Sexually Transmitted Diseases in America," p. 5.

6 CDC, "Sexually Transmitted Disease Surveillance 1999," p. 41.

7 Ibid., p. 25.

8 CDC, "Gonorrhea" <http:www.cdc.gov/nchstp/dstd/Fact_Sheets/gonorrhea_facts.htm> (9/22/00).

9 CDC, "Sexually Transmitted Disease Surveillance 1999," pp. 7, 41.

10 Deborah McNeal Arrindell, ASHA, "Eliminating Racial Disparties: Sexually Transmitted Diseases and African-Americans" (fact sheet, 2000).

11 CDC, "HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk" <http://www.cdc.gov/hiv/pubs/facts/women.htm> (11/27/00).

12 CDC, "Sexually Transmitted Diseases Surveillance 1999," p. 59.

13 Ibid., pp. 3, 4, 27.

14 CDC, "Some Facts about Syphilis," p. 3; CDC, "The

National Plan to Eliminate Syphilis from the United States," (Executive Summary, June 1999), p. 1 <http://www.cdc.gov/stopsyphilis/ExecSumPlan.htm> (9/22/00).

15 CDC, "Sexually Transmitted Disease Surveillance 1999," p. 7; ASHA, "Untreated, Chlamydia Can Lead to Infertility; Routine Testing is Critical, Especially for Young Women" (press release, Apr. 2000) <http://www.ashastd.org/press/040100.html> (9/22/00).

16 CDC, "Sexually Transmitted Disease Surveillance 1999," p. 15.

17 CDC, "Some Facts About Genital Herpes," pp. 1, 2 <http://www.cdc.gov/nchstp/dstd/Fact_Sheets/facts_Genital_Herpes.htm> (10/3/00); CDC, "Sexually Transmitted Disease Surveillance 1999," p. 35.

18 ASHA, "Sexually Transmitted Diseases in America," p. 7.

19 CDC, "Sexually Transmitted Disease Surveillance 1999," p. 41.

20 Institute of Medicine, *The Hidden Epidemic* (Washington: National Academy Press, 1997), p. 27.

21 CDC, "CDC Issues National Report Card on STDs" (press release, Dec. 7, 1998) <http://www.cdc.gov/nchstp/dstd/Press_Releases/National_Report_Card_STDs.htm> (9/22/00).

22 CDC, "Some Facts about Syphilis," pp. 2, 3; CDC, "Sexually Transmitted Disease Surveillance 1999," p. 25.

23 CDC, "Sexually Transmitted Disease Surveillance 1999," pp. 2, 8.

24 The Alan Guttmacher Institute, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics* (New York: Alan Guttmacher Institute, 2000), p. 19.

25 CDC, "Some Facts About Chlamydia," p. 3; CDC, "Sexually Transmitted Disease Surveillance 1999," pp. 1, 7, 8.

26 CDC, "Sexually Transmitted Disease Surveillance 1999," p. 42.

27 National Institute of Allergy and Infectious Diseases (NIAID), "Culturally Relevant Behavioral Intervention Dramatically Reduces STDs" (press release, Jan. 13, 1999) <http://www.niaid.nih.gov/newsroom/std.htm> (9/22/00); Rochelle Shain, et al., "A Randomized, Controlled Trial of a Behavioral Intervention to Prevent Sexually Transmitted Disease among Minority Women," *The New England Journal of Medicine* 340 (Jan. 14, 1999) 2: 1 (abstract) <http://www.nejm.org/content/1999/0340/0002/0093.asp> (10/3/00).

28 Keith Mulvihill, "First Herpes Vaccine Developed; Works only in Women," Reuters News Service, Sept. 18, 2000 <http://www.4woman.gov/nwhic.news/Sep00/19sep00.htm> (9/22/00).

29 NIAID, "NIAID Topical Microbicide Research: Developing New Tools to Protect Women from HIV/AIDS and Other STDs" <http://www.niaid.nih.gov/factsheets/topmicro.htm> (9/22/00).

30 Lori Heise, *Topical Microbicides: New Hope for STI/HIV Prevention* (Takoma Park: Center for Health and Gender Equity, 1999).

Smoking

Tobacco use is a public health threat to all Americans, but women may be at greatest risk. Smoking-related illnesses and deaths among women continue to rise, and because of gender differences in reaction to nicotine, it may actually be more difficult for women to quit smoking than for men.[1] In addition, much tobacco industry marketing has targeted women and, increasingly, girls.

Tobacco use is the leading preventable cause of death among women in the United States, accounting for more than 140,000 deaths per year.[2] Lung cancer mortality rates for women who smoke are 13 times higher than for women who have never smoked.[3] Approximately 22 million adult women smoke.[4] According to the National Center for Health Statistics, 22.1 percent of women aged 18 and over smoked cigarettes in 1998.[5]

The linkage between smoking, heart disease, and cancer applies to both women and men, but there are other health risks from smoking that are unique to women. These include increased risks of cervical cancer, infertility, and osteoporosis.[6] A recent study determined that women smokers were diagnosed with lung cancer, cervical cancer, cardiovascular diseases, mouth diseases, and infertility at higher rates than women nonsmokers.[7]

Maternal smoking also has been associated with multiple health problems in infants and children, including low birthweight, mental retardation, respiratory problems, and Sudden Infant Death Syndrome. In 1996, 400,000 women reported smoking during pregnancy, a decline of 26 percent from 1990. The highest rates of smoking during pregnancy were reported by teens aged 15-19 (17.2 percent).[8]

Most alarming to health experts is the sharp rise in smoking among teenage girls. It is estimated that each day, another 1,500 girls under the age of 18 will smoke their first cigarette.[9] The younger the individual when she starts smoking, the more likely it is that she will be a long-term smoker. Currently, 1.5 million adolescent girls smoke cigarettes.[10] Throughout the 1980s, smoking increased among girls under the age of 18, with the current rate equal to that of boys in the same age group.[11] The smoking rate is higher among Caucasian and Native American girls and lowest among African-American and Asian American girls. A recent study found that 15.6 percent of high school girls in grades 9-12 were frequent smokers.[12]

Socioeconomic factors and educational goals seem to be related to smoking among girls.[13] Adolescents from low-income homes, particularly those headed by single parents, are more likely to begin smoking.

Media images publicized by the tobacco industry are thought to have a subtle yet pervasive effect on women's and girls' attitudes toward smoking. Tobacco advertising and promotion have specifically targeted women with appeals to beauty, glamour, independence, defiance, and weight control. This has been true throughout the 20th century and into the 21st century.

As early as 1920, a cigarette company urged women to reach for one of their cigarettes "rather than a sweet" in its advertisements. In the 1960s and 1970s, at a time when women's political power was beginning to grow, tobacco ads featured women suffragists lighting up cigarettes. Currently, many cigarettes specifically geared toward women are marketed under names such as "slim" and "lite."[14] Additionally, according to a tobacco company's internal memo, in the early 1990s, a new cigarette was launched and was marketed toward females aged 18-24 who have "no education, watch soap operas and attend tractor pulls." At a subsequent meeting of the Interagency Committee on Smoking and Health chaired by the U.S. Surgeon General, this marketing plan was called a "deliberate focus on young women of low socioeconomic status who are at high risk of pregnancy."[15]

According to a recent study, the tobacco industry has increased its media advertisements in an effort to recruit new customers, mainly teenagers.[16] In late 1999, Philip Morris launched a new $40 million "Find Your Voice" advertising campaign aimed specifically at minority women.[17] As a result, the National Coalition FOR Women AGAINST Tobacco launched a counter campaign, "Our Voices are Loud and Clear Without Tobacco." The campaign designs stickers for individuals to place across cigarette ads in magazines. Individuals can return the magazines to the publisher or to the tobacco company.[18]

Policymakers have taken a range of actions to halt the growth in smoking and limit its devastating impact on public health.

In 1999, the Centers for Disease Control and Prevention (CDC) launched the National Tobacco Control Program, which distributed $59 million in FY2000 for comprehensive tobacco control efforts around the country. The CDC recommends four program goals: prevention of tobacco use in adolescents, promotion of cessation among adults and adolescent smokers, elimination of exposure to second-hand smoke, and identification and elimination of health disparities.[19]

In FY2000, the National Institutes of Health (NIH) spent $392.5 million in smoking and health research and $529 million on tobacco research. The NIH is estimated to spend $414.23 million on smoking research in FY2001 and $557.8 million on tobacco research in FY2001.[20]

Legislation

Medicare, Medicaid, and MCH Smoking Cessation Promotion Act of 2000 (H.R. 5208)—Reps. Diana DeGette (D-CO) and Connie Morella

H.R. 5208 would provide for coverage of smoking cessation programs under Medicare, Medicaid, and the Maternal and Child Health Block Grant.

Congressional Action

The Food and Drug Administration (FDA) issued regulations in August 1996 aimed at reducing easy access to tobacco by children. The regulations included requirements of age verification for over-the-counter sales, prohibitions on free sample cigarette distribution, and several restrictions on the format and placement of cigarette advertising that might be seen by children.[21] While Congress appropriated funding to the FDA for this program, in early 2000, the U.S. Supreme Court ruled that the FDA did not have the legal authority to regulate tobacco. Therefore, no money was appropriated for the FDA program in FY2001. However, there has been discussion in Congress that action may be forthcoming to approve legislation providing such authority to the FDA.

Notes

1 American Cancer Society (ACS), "Women and Smoking," March 30, 1998 <http://www.cancer.org/tobacco/women.html> (6/6/00).

2 National Coalition FOR Women AGAINST Tobacco, "Our History" <http://www.womenagainst.org/ourHistory.htm> (8/28/00).

3 ACS, "Cancer Facts and Figures 2000: Tobacco Use" <http://www.cancer.org/statistsics/cff2000/tobaccouse.html> (6/6/00).

4 ACS, "Women and Smoking."

5 National Center for Health Statistics (NCHS), *Health United States, 2000 With Adolescent Chartbook* (Hyattsville: NCHS, 2000), p. 234.

6 National Coalition FOR Women AGAINST Tobacco, "Our History."

7 Reuters News Service, "Smoking Particularly Dangerous for Women," Nov. 13, 2000 <http://www.4woman.org/nwhic/news/Nov00/14Nov001.htm> (11/27/00).

8 NCHS, "Smoking During Pregnancy, 1990-1996," *National Vital Statistics Reports* 47 (Nov. 19, 1998) 10: 1.

9 ACS, "Women and Smoking."

10 Ibid.

11 Cheryl Healton, Dr.P.H., "Women and Tobacco: With the Master Settlement Agreement, We've Come a Lon Way, Baby!" *Journal of the American Medical Women's Association* 55 (2000) 5: 303.

12 NCHS, *Health United States, 2000 With Adolescent Chartbook*, p. 110.

13 Ibid., p. 235.

14 Anne Marie O'Keefe, J.D., Ph.D. and Richard W. Pollay, Ph.D., "Deadly Targeting of Women in Promoting Cigarettes," *Journal of the American Medical Women's Association* 51 (1996) 1 and 2: 67-69.

15 American Heart Association, "Tobacco Industry's Targeting of Youth, Minorities and Women" <http://www.americanheart.org/Heart_and_Stroke_A_Z_Guide/tobta.html> (8/28/00).

16 National Coalition FOR Women AGAINST Tobacco, "The Rise in Tobacco Ads in Magazines is a Call to Action" (press release, May 2000) <http://www.womenagainst.org/pressrelease.htm> (6/6/00).

17 Department of Health and Human Services, *Reducing Tobacco Use: A Report of the Surgeon General*, (Atlanta: Centers for Disease Control and Prevention, 2000).

18 National Coalition FOR Women AGAINST Tobacco Use, "The Rise in Tobacco Ads in Magazines is a Call to Action."

19 Department of Health and Human Services, "Tobacco Advertising and Promotion Fact Sheet" <http://www.cdc.gov/tobacco/sgr_tobacco_facts.htm> (8/28/00).

20 National Institutes of Health, Office of the Director, Office of Financial Management funding chart <http://www4.od.nih.gov/ofm/diseases/index.htm> (8/28/00).

21 The White House, "Remarks by the President During the Announcement of the Food and Drug Administration Rule on Children and Tobacco" (press release, Aug. 23, 1996) <http://www.pub.whitehouse.gov/uri-res/I2R?urn:pdi://oma.eop.gov.us/1996/8/23/1.text.1> (8/28/00).

Veteran Women's Health

Women represent the fastest-growing group of new veterans, a trend that is expected to escalate as the presence of women in the military increases. According to the Department of Veterans Affairs (VA), there are more than 1.2 million women veterans, making up approximately 4.8 percent of the veteran population. In addition, women currently represent roughly 15 percent of active duty military personnel. By the year 2010, women will constitute 10 percent of all veterans.[1]

With this growth has come increased attention to the unique health care needs of women veterans. The VA has long been criticized for its treatment of women veterans, particularly in its response to their health care needs. In 1982, the General Accounting Office (GAO) reported that VA facilities were not meeting the health care needs of women veterans.[2] Many women veterans did not even know they were eligible for VA medical services. In addition, the GAO found that many VA medical centers did not provide basic gynecological care like breast exams and Pap tests. The lack of privacy for women veterans also ranked as a major concern, with many hospitals lacking private toilet and bath facilities for women.

A decade later, the GAO conducted a second assessment, concluding that although progress had been made, a number of problems remained. Two problems identified by the GAO in its 1992 report were the sporadic availability of gender-specific cancer screening services for women at VA medical facilities and the failure to adequately monitor in-house mammography programs.[3] These findings were particularly troublesome in light of a 1985 VA survey that found that the lifetime prevalence of cancer in women veterans was nearly twice that of the general adult female population, a trend that has held constant over the past decade.[4]

The mental health needs of women veterans also have been long overlooked. In fact, until recently, women were not considered to be at risk for post-traumatic stress disorder because they were not involved in combat. This misconception has been refuted by several studies of Vietnam-era women, which documented serious mental health problems related to their wartime experiences.[5] Experts also believe the Persian Gulf War experience may have presented some unique mental health issues for women. It was the first time in history that women with small children were deployed for wartime service.

Despite the passage of a 1992 law aimed at improving health care services for women veterans, problems in VA medical facilities were still reported. Specifically, women veterans reported a lack of patient privacy, a shortage of gynecologists that caused long waiting lists, a failure to provide routine cancer and osteoporosis screening, undertrained staff who were insensitive and inattentive to women's health needs, and limited outreach to women. In 1993, the VA Inspector General surveyed medical centers to determine how effectively they were meeting the needs of women veterans and to evaluate the scope of gender-specific services. Only one in eight of the health care facilities evaluated by the Inspector General met the VA's definition of comprehensive services for women veterans.[6] A separate survey of all VA medical facilities found that nearly half of the sites (75 of 166) had no women's health clinic of any type.[7]

More recently, the VA Advisory Committee on Women Veterans issued a 1998 report with 42 recommendations dealing with a range of issues, including outreach, health care, benefits entitlement, homeless veterans, and Women Veteran Coordinators.[8]

Although the VA has attempted to respond to women veterans' needs with women's clinics and other gender-specific services at each VA facility, it is currently considering whether to continue these services.[9]

Congressional Action

Congress attempted to address some of these issues in 1992 with the passage of the Veterans Health Care Act (P.L. 102-585). In response to the increasing number of servicewomen reporting widespread sexual assault and harassment in the military, the bill authorized counseling services for women veterans who were sexually assaulted during active duty. The bill also authorized the VA to provide general reproductive health care, including Pap tests, breast exams, and mammography.

An ambitious effort to provide a broad package of primary and preventive health care services for women

veterans died in the final days of the 103rd Congress after House and Senate conferees failed to resolve an abortion dispute. In the end, the only provisions to become law narrowly expanded counseling and treatment services for sexual trauma and required the VA to include women and minorities in clinical research and testing where possible.

During the 104th Congress, however, legislation was passed that required the VA to take three actions to improve the health of women veterans. First, the VA must implement mammography standards consistent with the Mammography Quality Standards Act of 1992 (P.L. 102-539) by accrediting and inspecting VA facilities that perform mammographies. Second, each VA medical facility must be surveyed to identify deficiencies relating to the personal privacy of women patients and to develop plans to correct those deficiencies. Finally, the Center for Women Veterans must assess the use of VA health services by women veterans (including counseling for sexual trauma and mental health services) and identify barriers faced by women veterans seeking health services.

The 105th Congress reauthorized the sexual trauma counseling program through the year 2001 and made several minor changes to the program. According to the VA, in 1999, 50 percent of all women assaulted in the military developed signs of post-traumatic stress disorder, and 60 percent of all women in the military have experienced at least one instance of sexual harassment or assault while on active duty.[10]

Despite Congress' commitment to continuing the sexual trauma counseling programs, women veterans and their advocates pressed the 106th Congress to make the program permanent. Additionally, women veterans sought to change the requirements for program eligibility. Under current law, women who are sexually assaulted or harassed while on active duty are eligible to receive counseling services; however, women serving in the Reserves or National Guard are not eligible for counseling if the incident occurs while they are on "active duty for training." While the House Veterans Affairs Subcommittee on Oversight and Investigations held a hearing on women veterans, there was no congressional effort to make the sexual trauma counseling program permanent.

The 106th Congress enacted legislation (P.L. 106-413) to make women veterans eligible for a special monthly compensation award for the service-connected loss of one or both breasts, including a loss due to a modified mastectomy. The language is similar to a bill (H.R. 3998) sponsored by Rep. Lane Evans.

Legislation

Veterans Sexual Trauma Treatment Act (H.R. 1799/S. 1579)—Rep. Luis Gutierrez (D-IL) and Sen. Olympia Snowe (R-ME)

H.R. 1799/S. 1579 would make the VA sexual trauma counseling program a permanent program. The bill also would expand the program to provide treatment to women veterans seeking counseling services and would make all women veterans eligible for the program regardless of their military status or duty. The bill would require the VA to provide outreach to promote the program, as well as report to Congress on the implementation of the program.

Notes

1 Joan Furey of the VA's Center for Women Veterans, testimony before the House Veterans Affairs Subcommittee on Oversight and Investigations, June 8, 2000.

2 General Accounting Office (GAO), *Actions Needed to Ensure That Female Veterans Have Equal Access to VA Benefits* (Washington: Government Printing Office, 1982).

3 GAO, *Despite Progress, Improvements Needed* (Washington: Government Printing Office, 1992).

4 VA, "The Department of Veterans Affairs Advisory Committee on Women Veterans 1998 Report" <http://www.va.gov/womenvet/advisorycommitteereport.htm> (8/28/00).

5 Linda Spoonster Schwartz, "Women and the Vietnam Experience," *Image: Journal of Nursing Scholarship* 19 (1987) 4: 168-173.

6 VA, *Report of the Inspection of Women Veteran's Health Care Programs* (Washington: VA Office of Inspector General, 1993).

7 Ibid.

8 Furey, congressional testimony.

9 Ibid.

10 Marsha Tansey Four, R.N. of the Vietnam Veterans of America, testimony before the House Veterans Affairs Subcommittee on Oversight and Investigations, June 8, 2000.

Women's Health Offices

The first office on women's health was established at the National Institutes of Health (NIH) in 1990. The Public Health Service (PHS) established an Office on Women's Health (OWH) the next year.

Today, each of the agencies that make up the PHS have either established an office on women's health, designated a women's health coordinator, or designated a women's health liaison. In addition to the NIH and the PHS, offices on women's health currently exist within the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) have women's health coordinators. The Indian Health Service and the Health Care Financing Administration have designated women's health liaisons. The only offices established by statute, however, are those at the NIH and SAMHSA.[1]

Women's Health Offices

CDC-OWH: The CDC Office of Women's Health works to ensure that women's health needs are reflected in the agency's work and was funded at $1.3 million in FY2000.[2] Priority issues include violence and injury, sexually transmitted diseases, including HIV/AIDS, tobacco use, older women's health, reproductive health, and breast and cervical cancer.[3] The office also developed and distributed state-specific information on risk and prevention of cardiovascular diseases, violence against women, and sexually transmitted diseases.[4]

FDA-OWH: The FDA Office of Women's Health works to ensure that the FDA is responsive to the needs of women in its regulatory and oversight functions and was funded at $1.7 million in FY2000.[5] The Office also "promotes an integrative and interactive approach" to women's health issues within the FDA and works with partners outside the agency to further its objectives. The Office spearheaded "Women's Health: Take Time to Care," a three-year public awareness campaign about the safe use of medicines; the FDA-OWH and its partners distributed six million copies of the brochure, "My Medicines."[6]

NIH-ORWH: The NIH Office of Research on Women's Health works both within the NIH and throughout the scientific community to accomplish its mandate to "strengthen, develop, and increase research into diseases, disorders, and conditions that affect women, determine gaps in knowledge about such conditions and diseases, and establish a research agenda for the NIH for the future directions in women's health research; ensure that women are included as participants in NIH-supported research; and develop opportunities and support for recruitment, retention, reentry, and advancement of women in biomedical careers."[7] The office was funded at $20.4 million in FY2000.[8]

The NIH-ORWH held a series of four meetings across the country in 1997 and 1998 to update the women's health research agenda at the NIH; this effort culminated in a 1999 report, "Agenda for Research on Women's Health for the 21st Century."[9] In FY2000, the NIH-ORWH established the Building Interdisciplinary Research Careers in Women's Health program, which trains researchers studying women's health.[10]

PHS-OWH: Through its collaborations with private organizations and public agencies, the PHS-OWH coordinates women's health initiatives across the federal agencies and within HHS. Some of its partnerships include: the PHS Coordinating Committee on Women's Health, the Collaborative Group on Women and HIV/AIDS, the Federal Interagency Working Group on Women's Health and the Environment, and the National Advisory Council on Violence Against Women. The PHS-OWH also created and maintains the National Women's Health Information Center, the gateway to information from the federal government on women's health (1-800-994-woman or www.4woman.gov).[11] The office was funded at $15 million in FY2000.[12]

SAMHSA-OWH: The SAMHSA Associate Administrator for Women's Services leads the Women, Children, and Families Team (WCF) for the agency, which was funded at $500,000 in FY2000.[13] The WCF provides leadership in developing and implementing the agency's plans in regard to women's priorities, including early intervention and treatment for women with addictive and mental health disorders, violence against women, HIV/AIDS and other STDs, and community-

based integrated services for children and families affected by substance abuse and mental illness.[14] Additionally, the WCF developed training for gender-specific substance abuse and mental health prevention and treatment programs.[15]

Women's Health Coordinators

AHRQ: The Agency's focus on the quality and outcomes of health care services is reflected in the women's health programs priorities. These include development of research examining male-female differences in the aggressiveness of treatment for women with cardiovascular disease, assessing the impact of race and age on access to treatments for breast cancer, and evaluating the costs and effectiveness of health care interventions for victims of domestic violence and sexual assault. AHRQ also reviews new screening technologies for cervical cancer and other preventive care services.[16] AHRQ's women's health program is legislatively established under the Office of Priority Populations Research and was funded at $315,000 in FY2000.[17]

HRSA: In keeping with its mission to expand primary and preventive health care services to underserved populations, the HRSA Senior Advisor for Women's Health works to ensure that the agency's programs adequately serve women and girls, particularly women of color. Some of the agency's priorities include health education and training projects to improve the delivery of "culturally competent" quality health services to women; community-based health services, such as Girl Power!, a program targeted to girls aged 9-14; the promotion of disease prevention and healthy living through the assistance of the Maternal and Child Health Services Block Grants; and expanded access to prenatal care and other preventive health care through its Health Centers Program.[18] In FY2000, $354,000 was allocated to address women's health at HRSA under the Senior Advisor.[19]

Legislation

Women's Health Office Act of 2000 (H.R. 4483/ S. 2675)—Reps. Connie Morella (R-MD) and Carolyn Maloney (D-NY) and Sens. Olympia Snowe (R-ME) and Barbara Mikulski (D-MD)

H.R. 4483/S. 2675 would provide statutory authorization for women's health offices at the CDC, FDA, HRSA, AHRQ, and HHS.

Notes

1 Department of Health and Human Services, "Report to Congress on Women's Health Programs and Offices of the U.S. Department of Health and Human Services (HHS)" (Executive Summary, 2000).
2 Ibid.
3 CDC-OWH <http://www.cdc.gov/od/owh> (8/28/00).
4 HHS, "Report to Congress."
5 Ibid.
6 FDA-OWH <http://www.fda.gov/womens/> (8/28/00).
7 NIH-ORWH <http://www4.od.nih.gov/orwh/> (8/28/00).
8 HHS, "Report to Congress."
9 NIH-ORWH.
10 HHS, "Report to Congress."
11 National Women's Health Information Center, "OWH: Federal Women's Programs" <http://www.4woman.gov> (8/28/00).
12 HHS, "Report to Congress."
13 Ibid.
14 SAMHSA, Office of Policy and Program Coordination, Women, Children and Families Team, mission statement.
15 HHS, "Report to Congress."
16 Marcy Gross of AHRQ, email communication with Women's Policy, Inc., Dec. 1, 2000.
17 HHS, "Report to Congress."
18 HRSA, "HRSA Women's Health—Who We Are" <http://www.hrsa.gov/WomensHealth/> (8/28/00).
19 HHS, "Report to Congress."