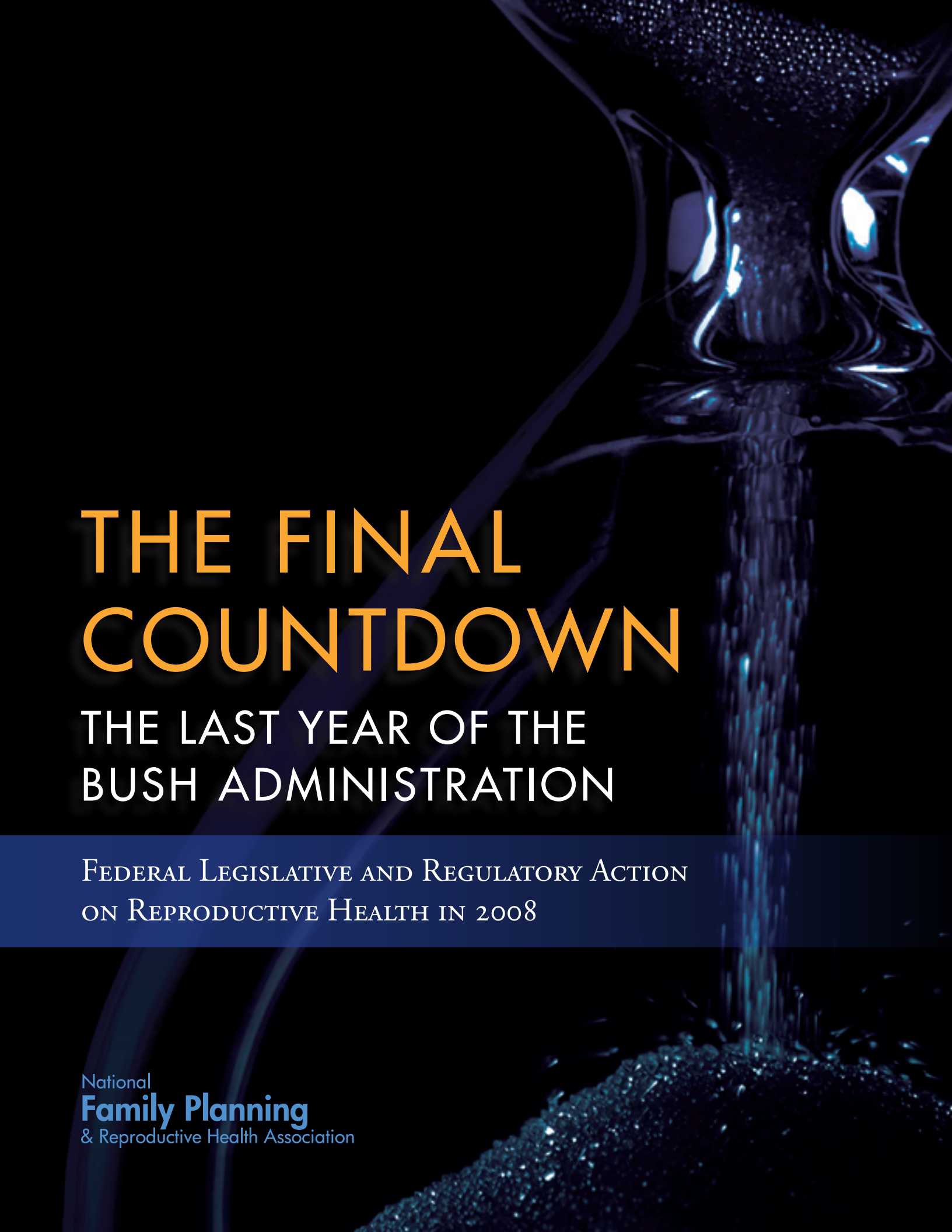

THE FINAL COUNTDOWN

THE LAST YEAR OF THE BUSH ADMINISTRATION

Federal Legislative and Regulatory Action on Reproductive Health in 2008

National
Family Planning
& Reproductive Health Association

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This publication is made possible with the generous support of the Robert Sterling Clark Foundation.

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Executive Summary

Making policy in an election year is never easy, and this year was no exception. With all eyes focused on the race for the White House, congressional action on major issues, including appropriations, largely ground to a halt. The pending end of the Bush Administration, however, did not mean an end to Executive Branch attacks on family planning – before year's end the outgoing Administration launched one final salvo in its War on Contraception with the issuance of new regulations designed to undermine access to contraception.

As anticipated, the appropriations process ended in a continuing resolution which funds the vast majority of non-security-related government programs at their Fiscal Year 2008 levels until March 6, 2009. Under the stopgap spending package, which passed in late September, Title X was flat-funded at $300 million, while the ineffective and dangerous Community-Based Abstinence Education (CBAE) program continues to receive critical tax dollars totaling $113 million.

The Bush Administration spent much of the year approving new rules from nearly twenty agencies on a range of topics largely favoring business and embodying conservative ideology. NFPRHA and our allies spent months fighting a dangerous rule allowing providers to refuse to provide basic health care services to patients at federally funded health care entities, which could jeopardize access to contraceptives for millions of men and women. When the Department of Health and Human Services announced the proposed provider refusal regulations in August, NFPRHA immediately moved to stop this assault on family planning. Despite intense opposition from states, organizations, individuals, and even the Equal Employment Opportunity Commission (EEOC), the Bush Administration published the final version of the HHS regulation in December.

The election of Senator Barack Obama as the 44th President of the United States, however, offers reproductive rights advocates hope that the new year will bring family planning and reproductive health to the forefront of federal policy and the nation's consciousness. During the campaign, President-elect Obama put the issue of unintended pregnancy center-stage, signaling an important shift in the debate over reproductive health, away from the rhetoric of abortion and toward the common-ground, common-sense solution that family planning represents. Obama said:

> "Surely there is some common ground when both those who believe in choice and those who are opposed to abortion can come together and say, we should try to prevent unintended pregnancies. . ."

As we continue to work along with our national partners in the reproductive health community and a broad-based coalition of groups to undo the damage done by the Bush Administration, we also look forward to moving forward a proactive family planning agenda with the help of the new Obama Administration and one of the largest pro-family planning congressional majorities in history. We are hopeful that the coming years will bring great gains in reproductive health, and that the goal of ensuring access to quality, comprehensive family planning services for all those who need them is not far from becoming a reality.

Title X Family Planning

Fiscal Year 2009 Appropriations

The President's Budget

President Bush set the tone for the budget battle by vowing to veto all appropriations bills not containing spending cuts. In his State of the Union address in January 2008 the President pledged "to veto any appropriations bill Congress sends him that does not cut the number and cost of earmarks in half."

President Bush then released his Fiscal Year 2009 budget which funded Title X at the FY 2008 level of $300 million. As predicted, the President's budget did not include increased funding for Title X, continuing to ignore the needs of millions of women and men without access to comprehensive family planning services.

Mary Jane Gallagher, President and CEO of NFPRHA, reminded budget negotiators about the dire need for additional Title X funding after decades of stagnant appropriations. NFPRHA urged a minimum $100 million increase in funds for Title X that would bring total funding to $400 million, still far short of the investment needed for this critical health program.

The Bush budget also proposed an increase in funds for the three federally funded abstinence-only programs by $28 million from $176 million to $204 million. In 2007, Members of Congress chose not to heed the President's call for increased funding, after the long-awaited Mathematica evaluation capped off the ever-growing mountain of evidence that abstinence-only education programs are ineffective. NFPRHA continues to oppose these ineffective, dangerous abstinence-only programs and urges lawmakers to invest in comprehensive sex education that works to keep our young people safe.

The Administration also included a legislative proposal in the budget that would align the reimbursement rate for family planning services and supplies with a state's regular Federal Medical Assistance Percentages (FMAP). By proposing to eliminate the current 90/10 family planning match rate, the Bush Administration estimated it could save approximately $570 million in federal dollars a year. Congress rejected this proposal, which would have significantly reduced federal funding for many states already struggling to serve those in need of family planning services.

Congressional Budget

On March 5, congressional leaders unveiled their own budget plans. The FY 2009 House budget resolution called for $57.559 billion for health-related discretionary spending, an increase of $4.438 billion (8.4 percent) over FY 2008. The Senate budget resolution called for an even larger increase - $58.908 billion for health spending, which is $5.27 billion (9.8 percent) over FY 2008. Any increase for health-related spending under the budget resolution translates to a higher allocation for the Labor, Health and Human Services and Education (Labor-HHS) appropriations subcommittee, a necessary ingredient for any increased appropriation for Title X.

Work on the twelve annual appropriations bills, including Labor-HHS, was delayed in light of controversy surrounding a supplemental spending package to fund military action in Iraq and Afghanistan. In June, the House and Senate Appropriations Committees finally approved what are known as the "302(b) allocations," which set the total amount of money that each subcommittee has to work with, and began marking up draft spending bills in Subcommittee.

The House Appropriations Subcommittee on Labor, Health and Human Services, and Education, which has jurisdiction over both the Title X and Community-Based Abstinence Education programs (CBAE), marked up their draft bill on June 19. The draft bill approved by the panel provided for a $15 million increase for Title X (for a total funding level of $315 million for FY 2009), and, once again, level-funded CBAE at $176 million.

The proposed Title X increase built upon 2007's $17 million increase, representing a small but important step towards rectifying years of stagnant funding. Legislators included language in the report reflecting the subcommittee's support for Title X as follows, "the President's fiscal year 2009 budget declines to increase the family planning program, despite significant unmet needs. The Committee strongly disagrees and provides $315,000,000, which is $15,019,000 above the fiscal year 2008 funding level and the budget request."

NFPRHA President & CEO Mary Jane Gallagher praised the Committee's work at the time, saying, "it is fantastic that Chairman Obey recognizes the importance of sustained investment in Title X, our nation's family planning program, in this tight budget year. Title X provides basic health care for millions of Americans, and we applaud the Chairman and subcommittee for their commitment to providing comprehensive, high-

quality family planning and reproductive health services that women and men need to act responsibly, stay healthy and plan their families."

The Senate Subcommittee on Labor, Health and Human Services, and Education then took up its draft bill on June 24, but flat-funded Title X at the FY 2008 level of $300 million. The bill, however, did cut funding for CBAE by a significant 25 percent ($28 million). The bill also included a provision to restore the ability of university-based and safety-net health centers to access nominally priced drugs as they did prior to the passage of the Deficit Reduction Act of 2005. This provision was modeled after a bill called the Prevention Through Affordable Access Act, introduced in November 2007 by Senator Barack Obama and Representative Joseph Crowley (S.2347, H. R. 4054). That provision passed the Senate as part of the war supplemental in May, but was later dropped from the bill.

On June 26, the full Appropriations Committees in both the House and Senate met to markup their respective bills. The House markup, however, ended abruptly after committee Republicans tried to force the committee to take up the long-stalled Fiscal Year 2009 Interior and Environment Appropriations bill. A heated exchange took place between Committee Chairman David Obey (D-Wis.) and Ranking Member Jerry Lewis (R-Calif.) as to whether Chairman Obey would bring up the Interior bill before the July 4 recess. Lewis then announced that he would offer a "highly unusual" amendment to the Labor-HHS Appropriations bill that would strip the text from the Labor-HHS bill and replace it with the Interior spending bill, where they hoped to attach controversial provisions such as allowing additional oil and natural gas exploration, including drilling in the Alaska National Wildlife Refuge.

Chairman Obey adjourned the committee shortly thereafter and halted action on all twelve regular appropriations bills in the Appropriations Committee. He was quoted at the time in a number of Capitol Hill publications saying that "there [would] be no more markups" by his panel in 2008, setting the stage for passage of a continuing resolution to fund the government until after the November election.

The Senate Appropriations Committee's hour-long markup passed largely without incident, although Title X, CBAE, and the nominal drug pricing provision were not mentioned. Three policy-related amendments were offered, including one by Senator Patrick Leahy (D-Vt.) directing the Administration to release the emergency funds recently provided for the Low-Income Home Energy Assistance Program (LIHEAP) in the war supplemental. By a vote of 26-3, the Committee approved the draft bill, which flat-funded Title X and included a 25 percent cut for the CBAE program.

As expected, Congress passed a continuing resolution in late September to fund the government for the first part of Fiscal Year 2009. The stopgap measure funded all programs at FY 2008 levels through March 6, 2009, preventing the need for Congress to return for a "lame-duck" budget session after the elections. Title X will continue to be funded at $300 million, and Community-Based Abstinence Education (CBAE) will receive $113 million (see table p. 9).

New Research on the Impact of Family Planning

Study Shows Family Planning Programs Increase Federal Savings

In October, researchers at the Guttmacher Institute released a study on the cost-effectiveness of services provided at publicly funded family planning health centers.[i] They found that in 2004, publicly supported family planning centers prevented 1.4 million unplanned pregnancies with total state and federal spending at $1.4 billion. Researchers found that these programs saved states and the federal government $5.7 billion dollars in Medicaid expenses that year. In total, for every dollar the U.S. spends on family planning, it saves $4.02 — building our case that the cost-benefit analysis for family planning is compelling.

An Investment in Family Planning Eases Environmental Strain

NFPRHA board member J. Joseph Speidel, Adjunct Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California at San Francisco and Director for Communication, Development and External Relations at the Bixby Center for Global Reproductive Health, co-authored a study on the environmental impact of family planning and reproductive health care. Speidel's January study, entitled "Family Planning and Reproductive Health: The Link to Environmental Preservation," cites rapid birth rates and human consumption in both developing and industrialized nations as key contributing factors in the global environmental crisis. Family planning, according to Speidel, can greatly mitigate the harmful environmental effects of worldwide sky-rocketing birth rates, especially in the United States, and it can serve as a new front on which the environmental and reproductive health rights movements join forces. He cited programs in places as diverse as Iran and California, which have both implemented programs that have resulted in fewer births in a relatively short amount of time.

i Frost, Jennifer J. (2008). "The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings." *Journal of Health Care for the Poor and Underserved* 19.

Fiscal Year 2009 Funding for Selected Public Health Programs ($ in millions)

Program	FY 2009 House Subcommittee Approved	FY 2009 Senate Committee Approved	FY 2009 President's Budget Request	FY 2008 Final	FY 2007 Final
Title X Family Planning	$315	$300	$300	$300[1]	$283
Adoption Awareness Training	$13	$13	$13	$13	$13
Social Services Block Grant	$1,700	$1,700	$1,200	$1,700	$1,700
MCH Block Grant	$675	$664	$666	$666	$693
Abstinence-Only Programs (total)	$176	$143	$204	$176	$176
1. Community-Based Abstinence Programs (ACF)[2]	$113	$80	$141	$113[3]	$113
2. State Abstinence Grants (ACF)	$50	$50	$50	$50	$50
3. Adolescent Family Life Act Abstinence Earmark (OPA)	$13	$13	$13	$13	$13
CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention (total)[4]	$1,010	$1,002	$1,000	$1,002	$1,002
HIV/AIDS			$691	$692	$695
Viral Hepatitis			$18	$18	$17
STD			$152	$152	$155
TB			$140	$140	$135
Ryan White	$2,241	$2,148	$2,143	$2,142	$2,112
Community Health Centers	$2,165	$2,215	$2,048	$2,022	$1,943

1 The FY '08 Title X funding level reflects a 1.747% across-the-board rescission.

2 Includes $4.5 million for evaluation. Up to $10 million of total can be spent on a national abstinence education campaign.

3 The FY '08 CBAE funding level reflects a 1.747% across-the-board rescission.

4 Individual program numbers for CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention are rounded up to nearest million, and may not reflect the total funding. The total funding level provided reflects the amount detailed in the budget.

The study was later updated with new figures for family planning costs, showing estimates that the annual cost of family planning services per client ranges from $124-$487, with a mid-range of $236. Speidel's research showed that annual public expenditures for family planning must be approximately $3.5 billion to serve the 17 million women who rely on publicly subsidized care to access contraceptive services. In 2006, public expenditures totaled $1.85 billion for family planning, or just over half of the required need.[ii]

Speidel's research also demonstrated that Medicaid pays about 90 percent of states' family planning program costs, yet strict income and eligibility requirements have the adverse effect of excluding a large number of low-income women and men in need. Without a substantial increase in Title X funding and without an expansion of Medicaid coverage of family planning services, most of this country's family planning programs will continue to be seriously underfunded.

DASPA Resignation

On May 21st, Dr. Susan Orr resigned from her post as Deputy Assistant Secretary for Population Affairs, also known as DASPA. In this position Orr oversaw the only dedicated federal program for family planning services, Title X. Prior to joining the Bush Administration, Dr. Orr was the Senior Director for Marriage and Family Care at the Family Research Council, an organization well known for its efforts to limit access to contraception.

NFPRHA President & CEO Mary Jane Gallagher expressed relief at the resignation, but continued to express concerns about efforts by the Bush Administration to restrict family planning programs.

In the waning months of the Bush presidency, the administration failed to fill this position. NFPRHA continues to monitor this and other appointments of key officials who are responsible for implementing family planning policy, and at the end of the year, sent recommendations to the presidential transition team regarding qualified candidates.

ii This figure includes spending at the federal and state level for Medicaid, Title X, and state family planning programs.

Preventing Unintended Pregnancy

NFPRHA continues to work with congressional leaders to pursue a broad agenda to reduce unintended pregnancy, particularly among those who are low-income or uninsured, by expanding Title X funding, providing greater access to contraception and comprehensive sex education programs.

The Prevention First Act

In 2007, NFPRHA assisted with the reintroduction of the Prevention First Act (S. 21) - a comprehensive bill intended to reduce unintended pregnancy by expanding access to contraception, sponsored by Majority Leader Harry Reid (D-Nev.). Representative Louise Slaughter (D-N.Y.) introduced the companion bill in the House (H.R. 819). In 2008, the bill reached 164 co-sponsors in the House and 34 in the Senate, more than similar bills in previous sessions.

Prevention First would increase funding for Title X to $700 million, expand eligibility for family planning services under Medicaid, require private health plans to cover prescription contraceptives to the same extent they cover other prescription drugs, provide funding for an emergency contraception (EC) education campaign, require emergency rooms to provide EC access to victims of sexual assault, and provide funding for comprehensive sex education. NFPRHA will build upon the strong working relationships we have with congressional leaders and coalition partners to advance this important legislation in 2009.

Other Federal Legislation

Reducing the Need for Abortion and Supporting Parents Act

Reps. Rosa DeLauro (D-Conn.) and Tim Ryan (D-Ohio) sponsored the Reducing the Need for Abortion and Supporting Parents Act, H.R. 1074 to reduce the number of unplanned pregnancies by helping women bear healthy children and supporting new parents with daycare and education.

A section of the bill to provide information to parents of babies with Down syndrome passed as a free-standing measure. The Prenatally and Postnatally Diagnosed Conditions Awareness Act, S. 1810, sponsored by Senators Sam Brownback (R-Kan.) and Edward Kennedy (D-Mass.) requires that families who receive a diagnosis of Down syndrome or any other condition will be given information about the nature of the condition and connection with support services and networks that could offer assistance.

Drug Pricing Fix Dropped After Passing in the Senate

On May 22, the Senate passed the supplemental war funding bill, which included a provision to address contraceptive drug pricing for university-based and safety-net health centers, but was later dropped from the bill. The provision is modeled after legislation introduced in 2007 by Representative Joe Crowley (D-N.Y.) and Senator Barack Obama (D-Ill.), called the Prevention Through Affordable Access Act (H.R. 4054/S. 2347), which would restore the ability of university-based and safety-net health centers to access nominally priced drugs as they did prior to the passage of the Deficit Reduction Act of 2005. The provision was part of a domestic spending amendment (S.Amdt. 4803) to the war supplemental, and the amendment was agreed to by an overwhelming 75-22 vote. The war supplemental, which had passed the House without the drug pricing measure, was then sent back to the House, and was ultimately dropped.

The War on Contraception

In the last several years, conservative extremists have found a new target in their war on reproductive health: contraception. In 2008, the War on Contraception reached new levels, forcing reproductive rights advocates to defend even the most basic freedoms.

HHS Provider Refusal Regulations

While previous Presidents have issued "midnight regulations" — the practice of approving numerous rules in the final months of office to ensure an administrative legacy — the Bush Administration has taken the practice to a new level by offering sweeping industry-friendly rules on the environment and worker safety, as well as rules on high-profile health, social and civil rights issues which advance conservative ideology.

According to the Office of Management and Budget, their Office of Information and Regulatory Affairs (OIRA) reviewed 83 final rules from nearly 20 agencies from September 1 to October 31. Some of the rules benefit special interests such as oil and gas companies, banks and farms. Proposed rules would lower air pollution standards, weaken the Endangered Species Act, ease rules on dumping of mining debris, lessen worker rights and protections, require groups who help persons with HIV/AIDS to renounce prostitution to get federal funding, pave the way for allowing guns in national parks and give more surveillance power to law enforcement.

After the rules take effect, they are difficult to reverse. Options include congressional action through the regular legislative process or a new time-consuming regulatory rulemaking that could take months or years. Congress could also use a rarely-used maneuver to take quick action to pass special, fast-track resolutions of disapproval.

On August 26, the Department of Health and Human Services (HHS) proposed regulations permitting institutions and individuals employed at federally funded health care entities to refuse to provide a variety of basic health care services, including information, counseling and referrals, without any mention of the existing legal framework which protects patient needs. These extreme new regulations could be used to deny millions of women and men access to contraceptive services.

The rule purports to interpret and educate recipients of HHS funds about existing law that gives individuals and institutions the ability to refuse to participate in certain health services or research activities in certain circumstances. The regulations, however, dramatically expand the scope and reach of these laws.

Federal law already protects individuals working for certain federally funded health care entities from being discriminated against for refusing to perform or assist in the performance of sterilization or abortion services to which they object based on their religious or moral beliefs.

However, statements by HHS Secretary Michael Leavitt and an earlier leaked draft of the rule suggested that HHS intends for the regulations to provide a new, potentially unlimited right for institutions and individuals to refuse to provide contraceptive services. For example, HHS cited several "problems" the regulations were intended to address, including state laws requiring employers to provide contraceptive coverage on an equal basis with all other prescriptions in their insurance plans, requiring emergency rooms to offer rape survivors medication to prevent pregnancy (emergency contraception) and requiring pharmacies to provide women with oral contraceptives and emergency contraception.

If HHS allows health care entities to use the rule to refuse to provide contraceptives, the proposed rule could undermine a state's ability to enforce its own laws protecting contraceptive access. This could severely undermine women's access to contraceptives.

The earlier draft also included a redefinition of abortion, which extended the reach of the existing refusal laws – laws that were intended by Congress to cover only abortion and, in some instances, sterilization – to cover some of the most widely used forms of contraception. Such an unwarranted and unauthorized expansion of the definition of abortion to include contraception would threaten the ability of the Title X program to continue to provide comprehensive, quality family planning services.

The regulation also opens the door to undermining access to a broad spectrum of health care services and the ability of federally funded institutions and individuals to conduct research. The proposed rule prohibits any entity that receives HHS funding to carry out any part of any health service program or to conduct research from requiring any individual to participate in any activity with a reasonable connection to any HHS-funded health service or research activity to which the individual objects on religious or moral grounds. The breadth of the rule has implications for those providing or doing research in a wide range of

areas including, HIV, drug addiction, infertility, vaccinations, psychology, sexually transmitted infections and end-of-life care.

Further ignoring the needs and rights of patients, the rule fails to provide guidance in the case of medical emergencies. For example, under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to at least stabilize a patient who comes into an emergency room in a medical emergency. The regulation is at best unclear about whether a provider's ability to refuse to perform a procedure would be allowed to trump a patient's need to be treated in a medical emergency, including life-threatening emergencies.

Regrettably, HHS allowed just 30 days for public comments on these sweeping new regulations. In addition to encouraging our members to submit comments on behalf of their own organizations expressing concerns about the significant impact these rules could have on their patients' access to family planning services, NFPRHA submitted comments on behalf of our membership, expressing similar concerns.

NFPRHA worked with a broad range of organizations, both within and outside the reproductive health community, including Planned Parenthood Federation of America, NARAL Pro-Choice America, the National Women's Law Center and members of the Family Planning Councils of America, to encourage groups to submit comments opposing the rules. For example, we worked closely with both the Association of Maternal and Child Health Programs and the Association of State and Territorial Health Officials to help them develop and submit their comments.

The response in opposition to the regulations has been overwhelming. Thanks in part to the tremendous efforts of all NFPRHA members at the state and local levels, more than 200,000 comments were submitted. Attorneys General and Governors from at least 15 states submitted comments opposing the regulations. More than 100 national organizations signed on to comments spearheaded by the reproductive health community, and medical groups such as Physicians for Reproductive Choice and Health, the American Academy of Pediatrics, the American Nurses Association, the American Psychiatric Association, the Association of Women's Health, Obstetric and Neonatal Nurses and the Society for Adolescent Medicine.

NFPRHA continues to work with our allies in Congress to fight these rules. In the House, more than 100 Representatives, led by Representatives Slaughter (D-N.Y.), Lowey (D-N.Y.), DeGette (D-Colo.), and Waxman (D-Calif.), signed onto comments opposing the regulations. In the Senate, 28 Senators signed onto an effort led by Senators Clinton (D-N.Y.) and Murray (D-Wash.). Numerous other Members of Congress have voiced their opposition to the regulations as well.

On September 23, Senators Clinton and Murray met with HHS Secretary Mike Leavitt to discuss the proposed regulations. Both Senators expressed concerns to the Secretary regarding the proposed rules' silence regarding patient protections. In a follow-up statement, Senator Clinton said that she "urged Secretary Leavitt to ensure explicit protection of patients' rights to have full access to health care, and he assured [her] he would take these concerns into consideration."

Chairman Henry Waxman contended that HHS and the Office of Management and Budget (OMB) may have violated an executive order that mandates interagency consultation prior to issuing any proposed regulations. In the letter from his Oversight and Government Reform Committee, Waxman stated that the failure of HHS and OMB to consult with, or even notify, the Equal Employment Opportunity Commission (EEOC) about the rule violated the 1993 Executive Order 12866. The EEOC later opposed the rule in comments to HHS, citing Title VII of the 1964 Civil Rights Act, which expressly prohibits employment discrimination based on religion.

Waxman wrote, "because the HHS rule deals in large part with the rights of health care employees to make certain refusals on the basis of religious or moral beliefs, there is a clear and substantial overlap between its scope and that of EEOC's religious discrimination work." Waxman said that had the proper consultation between the agencies taken place, as the Executive Order requires, the proposed rule might have been written differently or not issued at all. Waxman demanded that HHS and OMB document its consultation process with other agencies.

NFPRHA, in partnership with other national organizations and our members, advocated for a "fix" that would have prevented the regulations from being included in the FY 2009 continuing resolution. Unfortunately, despite significant support in the Senate, the resolution failed to include our requested language. Congress adjourned at the end of the year without further action on this issue.

HHS officials at the Health and Human Services Department issued a final version of the rule in December. NFPRHA will continue its fight against this rule into the new year.

Pharmacy Refusals

Refusals by pharmacists to provide contraception severely threaten women's health and are an insidious form of sex discrimination, as refusals in almost all cases pertain to medications exclusively taken by women. According to the Pharmacy Refusals Project at the National Women's Law Center, there have been complaints of chain and local pharmacies refusing to fill prescriptions for contraceptives (including emergency contraception) in twenty-one states.

For example, a Chantilly, Virginia "pro-life" pharmacy refuses to provide emergency contraception, and even denies women and men access to oral contraceptives and condoms. Divine Mercy Care, or DMC, a Catholic nonprofit organization, runs the pharmacy as well as Tepeyac Family Center in Fairfax, Virginia, an obstetrics-gynecology practice that does not prescribe any contraceptives, nor perform abortions or sterilizations. Virginia does not have any laws or regulations that would prohibit a pro-life pharmacy, and is not considering adopting any, according to the Virginia Board of Pharmacy.

Far right groups are engaged in a national campaign to expand harmful pharmacy refusal laws to other states. On June 7, the American Life League, Pharmacists for Life International and Pro-Life Wisconsin held a series of protests on "The Pill Kills Day," a day an American Life League spokesman described as dedicated to "raising awareness about the abortifacient nature of the pill, which is responsible for killing preborn children in their earliest days." Protests were held in eighteen states and the District of Columbia, including one at a Planned Parenthood of Metropolitan Washington health center.

Only seven states currently have laws protecting patients' rights by prohibiting refusals by pharmacists or pharmacies to dispense a particular medication. In fact, four states (Arkansas, Georgia, Mississippi, and South Dakota) have laws that explicitly allow pharmacists to refuse to dispense a prescription on the basis of their personal beliefs, with no patient protections whatsoever.

The time-sensitive nature of emergency contraception, of course, further complicates and intensifies the threat to women's health posed by pharmacy refusals. Although women in large metropolitan areas have many pharmacies at their disposal, and may not feel the impact of a handful of pharmacies in their area that refuse to provide contraception, women in more isolated areas risk losing access to contraception entirely.

In Wisconsin, an appeals court held in March that pharmacists who refuse to fill prescriptions for contraceptive pills may be subject to punishment. According to state law, health care providers may refuse to provide treatment based on religious or moral beliefs, but that privilege does not extend to pharmacists.

The 3rd District Court of Appeals upheld the Wisconsin Pharmacy Examining Board's reprimand of Neil Noesen, a pharmacist who refused to fill a prescription for contraception. He had the right to refuse, the court found, but he erred by refusing to offer any recourse for rejecting a legal prescription. Therefore, wrote Judge Michael Hoover, "The Board could... properly conclude that he violated a standard of care applicable to pharmacists." The court also noted that the U.S. Supreme Court has held that individual religious beliefs do not excuse compliance with otherwise valid laws. The pharmacist was expected to appeal the decision. The state legislature passed two bills that would change the law, but Governor Jim Doyle (D) has vetoed both.

Family planning advocates suffered a setback in Washington state. In February, U.S. District Judge Ronald Leighton ruled that pharmacists in Washington may refuse to provide customers with emergency contraception, overturning a state regulation. In 2007, the state Pharmacy Board had issued a rule that pharmacies have a duty to fill lawful prescriptions, even if individual pharmacists object to the medication. Under the rule, pharmacists with objections to a drug could opt out of providing it by getting a co-worker to fill the order, but the opt-out provision would only apply if the customer is able to get the prescription filled in the same pharmacy visit. The court blocked the rule after two pharmacists and a pharmacy owner filed suit, claiming it was unconstitutional. The case is under appeal. However, for now, Washington pharmacists may still refuse to provide emergency contraception to patients.

A statewide survey of pharmacies in Washington released in February revealed that ten percent either will not stock Plan B emergency contraception or will employ pharmacists who are unwilling to provide it. NARAL Pro-Choice Washington conducted the survey.

Although federal activity on the issue of pharmacy refusal has been limited, at least one bill to ensure access to contraception is pending. In June 2007, two champions of family planning, Congresswoman Carolyn Maloney (D-N.Y.) and Senator Frank Lautenberg (D-N.J.), introduced a bill to prohibit pharmacists from refusing to fill any legal prescription for a federally approved drug stocked by the pharmacy. The Access to Birth Control Act, which has 57 co-sponsors in the House and 9 in the Senate, has been referred to committee.

Contraceptive Use and Access

States Take Action on Contraceptive Access

A measure that would have required parental consent for dispensing oral contraceptives in Maine was blocked by the state legislature in January. Republican State Senator Doug Smith introduced the bill that would have applied to all students under the age of 14 after Maine's Portland School Committee decision to offer contraception at King Middle School. The school will continue to require parental permission to use the health center, and treatment will continue to be confidential.

In January, Christie Vilsack, wife of former Governor Vilsack launched the Iowa Initiative to Reduce Unintended Pregnancies. Funded by the Susan Thompson Buffett Foundation, the program will educate women on contraception options and raise awareness about family planning. In Iowa, half of all pregnancies are unplanned; among women ages 18 and 19, that figure jumps to 72 percent. To reach young people between 18 and 30 who are most at risk for unplanned pregnancy, the initiative will use "cutting edge social marketing techniques."

Court Upholds Emergency Contraceptive OTC Sales

In March, a federal court upheld the Food and Drug Administration's (FDA) policy that allows Barr Pharmaceuticals to sell the emergency contraception Plan B pill over-the-counter (OTC). Plan B, available since 1999, is currently the only such contraceptive available without a prescription, but is only available to women over the age of 18. In 2006, the FDA allowed its sale without a prescription. If taken within three days of sexual intercourse, the drug can reduce the chances of pregnancy by 90 percent.

The Association of American Physicians and Surgeons, joined by anti-choice groups such as the Family Research Council, sued federal regulators and Barr citing claims that it had not proven to be safe. The U.S. District Court for the District of Columbia approved the FDA and Barr's motion to dismiss the lawsuit because the groups failed "to identify a single individual who has been harmed by Plan B's current availability."

Generic Oral Contraceptive

In June, Barr Pharmaceuticals Inc. announced an agreement with the German drug company Bayer AG to sell a generic version of the oral contraceptive Yasmin. Barr will hold the exclusive license to sell the drug in the U.S. Barr also announced that it will be selling a generic version of Yaz, another oral contraceptive, starting July 1, 2011.

In September, Bayer announced a limited distribution of Yasmin beginning in the fourth quarter of 2008 because anticipated demand could result in a shortage of the drug for millions of women. Bayer said that it anticipated a higher than usual number of orders because of the 340B program's "penny price" policy for Yasmin. Yasmin was being offered at a penny price as a penalty assessed against Bayer related to new CMS regulations.

In October, the Food and Drug Administration (FDA) issued a warning to Bayer regarding its "misleading" ads for Yaz. Aside from the contraceptive benefits, the ads claim to mitigate ailments such as irritability, moodiness and bloating, conditions associated with premenstrual syndrome (PMS). The FDA noted that while Yaz has been approved for treating a far more serious condition, premenstrual dysphoric disorder, or PMDD, Yaz has not been approved for the treatment of PMS or any of the conditions indicated in the ads. The FDA also determined that the ads fail to clearly distinguish PMS from PMDD and minimize the risks associated with the drug. Bayer agreed to stop running one of the ads.

New Research on Contraceptive Use and Access

Emergency Contraception Study

A study found that increased access to emergency contraceptive (EC) substantially increased use and had no adverse impact on risk of sexually transmitted infections. However, increased access to EC did not decrease unintended pregnancy. The authors concluded that instead of solely focusing on EC, health care workers should encourage women who use EC to begin to use or improve their use of effective and ongoing contraception. (Source: "Effect of an Emergency Contraceptive Pill Intervention on Pregnancy Risk Behavior," Doctors Elizabeth Raymond and Mark Weaver, *Contraception*, May 2008)

Increasing Access to Long-Acting Reversible Contraceptives

In another 2008 study, a team of researchers found that increasing access to long-acting reversible contraceptives (LARCs), such as intrauterine contraceptives (IUCs) and implants, would be the best way to reduce unintended pregnancies.

Researchers including NFPRHA board member J. Joseph Spiedel, Adjunct Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California at San Francisco and Director for Communication, Development and External Relations at the Bixby Center for Global Reproductive Health, found that in the U.S., half of the 6.1 million pregnancies in 2001 were unintended, resulting in 1.3 million abortions, and that leading causes of unintended pregnancy are closely related to contraceptive method choice.

By contrast to other methods, the LARC methods have a very high rate of effectiveness and are also more convenient, cost-effective and generally result in higher user satisfaction. However, LARC use is low in the U.S., accounting for about two percent of contraceptive use. Barriers include outdated perceptions of those who might benefit, provider misinformation, lack of adequate provider training in IUC and implant insertion, patient fears and cost. To increase the accessibility and use of LARC, the researchers recommend more research and training, as well as fully-funded government family planning programs. (Source: "The Potential of Long-acting Reversible Contraception to Decrease Unintended Pregnancy," by J. Joseph Spiedel, Cynthia Harper, & Wayne C. Shields, *Contraception*, September 2008)

Women With Access to Contraception Still Susceptible to Unplanned Pregnancies

New research from the Guttmacher Institute shows that, despite having access to contraception, more than half of women at risk are not fully protected from unplanned pregnancies. Of the women surveyed, 8 percent used no contraception, 15 percent had gaps in use and 27 percent used their method inconsistently or incorrectly. The researchers, led by Jennifer J. Frost, PhD, found that gaps in contraception use in more than 50 percent of the women coincided with "important life events," such as the beginning or end of a relationship, a move, a new job or a personal crisis. Other contributing factors include dissatisfaction with a specific contraceptive, as women who are unhappy with their drugs are less likely to use them. Guttmacher also cited ambivalence as another factor. Other factors included lack of access and disparities, such as racial and economic barriers.

Continuation Rates for the Pill

A study released in the November Journal of Adolescent Health addressed methods of taking oral contraceptives and the impact on teen pregnancy rates. Researchers found that women who used a Quick Start method had fewer pregnancies than those who used the conventional start method. Because conventional start times for oral contraceptives occur after the next menstrual cycle, there has been some concern that many women get confused about when to actually start taking their pills. This could in turn lead to forgetting to take the pill or losing the motivation to follow through with it altogether.

One possible solution to that problem is the Quick Start method whereby women take the pill after a negative pregnancy test regardless of the timing of their menstrual cycle. Researchers examined continuation rates of 539 adolescents ages 12 to 17. The study showed that 45 pregnancies occurred among those women who stopped using the pill for more than a week. Of 272 women who used the Quick Start method, 17 pregnancies occurred, compared with 28 pregnancies in the group of women who were assigned to the conventional start group.

Teen Relationship Factors Affect Rate of Contraceptive Use

A February survey of high school students performed by ChildTrends reveals that the strength of a teen sexual relationship has a strong impact on contraceptive use. The age of the teens, relationship status, types of contraceptives, similarities between partners and openness of communication in the relationship are important factors that influence how often and how consistently sexually active teens use contraceptives. Those who described themselves as being in strong, romantic and positive relationships with people similar to them were more likely to use contraception. Fifty-nine percent of teens surveyed reported using contraceptives all the time and 17 percent of teens reported inconsistent use.

Researchers found that teens who discussed contraceptives before sex and participated in dating activities were also more likely to use contraception. The study also revealed that the contraceptive habits teens develop in one relationship carry over into future relationships. Researchers concluded that relationship types between teens are important to consider when developing pregnancy prevention programs.

Study Links Family Religion, Teen Sexual Behavior

Another study from ChildTrends found that teens from more religious households delay becoming sexually active and have fewer sexual partners than their less-religious peers. The study, published in the June issue of *Perspectives on Sexual and Reproductive Health*, is based on a 1997 study of adolescent and teen sexual behavior. The results stress the benefits of strong family monitoring and cohesion, which are often linked to a family's religiosity. The study demonstrates that routine parenting behavior, such as eating dinner with children or asking where a child is going when they leave the house, can significantly impact teen sexual behavior.

The study's author emphasizes that such domestic habits are not limited to religious families. "This study shows the importance of parents who are involved in their children's lives and know who their children's friends are," said Jennifer Manlove, Ph.D., lead author of the study. "Parents who monitor their children's activities and peer environments, who engage their families in regular activities, and who foster strong parent-child relationships can help reduce risky sexual behaviors, regardless of family religiosity."

Improving Contraceptive Use

In May, the Guttmacher Institute released an issue brief entitled "Improving Contraceptive Use in the U.S.," which showed that half of women at risk for unintended pregnancy are not fully protected because they do not consistently or correctly use contraception. The issue brief explains how to help sexually active women who do not want to become pregnant make better use of contraception.

Medicaid-Funded Family Planning Services

Preserving and expanding Medicaid, which provides the main source of funding for family planning services, is essential to the health of low-income women and their families. Currently, Medicaid provides the overwhelming majority of funding for family planning services for low-income and uninsured men and women in the United States, and NFPRHA continues to work with our members and allies to expand Medicaid coverage of family planning services, through both legislative advocacy and technical assistance. Studies show that increasing numbers of women of reproductive age are eligible for Medicaid and that many of their family planning needs are still unmet.

Expanding Eligibility for Family Planning Services Under Medicaid

NFPRHA continues to push for federal legislation to expand Medicaid funding for family planning. In 2007, Senator Hillary Rodham Clinton (D-N.Y.) introduced the Unintended Pregnancy Reduction Act (S. 1075) to require states to cover family planning services through Medicaid for all women who would be entitled to Medicaid-funded pregnancy-related care if they became pregnant. The measure would also clarify that family planning services are mandatory benefits under Medicaid, an entitlement called into question by the Deficit Reduction Act (DRA).

The Senate bill has ten cosponsors and the companion bill (H.R. 2523), introduced in the House by Representative Nita Lowey (D-N.Y.), also has ten cosponsors. Unfortunately, this bill remained in committee this year.

Bush Administration Issues Harmful Medicaid Rules

There were seven Medicaid rules of concern to the health care community that were blocked by a moratorium package, "Protecting the Medicaid Safety Net Act of 2008," (H.R. 5613), eventually included in the Supplemental Appropriations Act, 2008 (the war supplemental). The regulations would have restricted how Medicaid pays for hospital services, graduate medical education, outpatient services, school-based health services, services for individuals with disabilities, and case management services. The regulations would have a substantial impact on vulnerable clients such as low-income children and low-income people with disabilities by cutting funds to hospitals and other health care providers.

The rule concerning hospital outpatient clinics, the only one of the seven regulations that was not blocked by congressional action, was substantially modified in the final rule, addressing many of the concerns of family planning providers.

CMS Cost Sharing Rule

On November 19th, the Centers for Medicare and Medicaid Services (CMS) published the final rule implementing the Medicaid cost sharing provisions of the Deficit Reduction Act of 2005. The final rule allows states to charge beneficiaries a premium as a condition of Medicaid enrollment and creates special cost-sharing rules for prescription drugs. States have been charged with developing a list of preferred drugs, including contraceptives, and Medicaid beneficiaries may be charged a nominal co-payment for purchasing non-preferred contraceptives. Providers may waive the cost sharing on a case-by-case basis, but states must reduce provider payments by the cost-sharing amount, regardless of whether the provider successfully collects it.

NFPRHA does not expect any immediate changes as a result of this rule. The majority of provisions of this rule were already in effect, and the rule gives states the option to impose premiums and co-payments, but does not require that they do so. Any changes to current state Medicaid policies will have to go through the normal CMS approval process for Medicaid state plan amendments. NFPRHA members will have the opportunity to weigh in with states as they examine these options.

State Action on Medicaid-Funded Family Planning Services

Pennsylvania was one of two new states to expand access to family planning services under Medicaid, when it was approved for an income-based waiver program (called SelectPlan for Women) in 2007 and began enrolling patients in January 2008. Wyoming was also approved for a waiver expanding coverage

to women following a Medicaid-funded birth (a postpartum waiver) in October 2008. The waiver will expire five years after the implementation date.

California could lose hundreds of millions of dollars in federal funding for the state's Medicaid family planning waiver program, the *Los Angeles Times* reported in October. The California Department of Public Health Family PACT program provides comprehensive family planning services for almost 1.7 million low-income people. The federal government pays $315 million of the program's $432 million annual cost. Federal funds can only be used for legal residents, so the state covers the costs for services to undocumented immigrants.

The dispute is over the statistical method California uses to count how many undocumented immigrants use Family PACT services. The Bush administration has reportedly objected to the statistical method since 2004 and in September informed California it had 30 days to begin vetting every participant to determine if each is in the country legally, or else lose their federal funding.

California estimates that complying with this requirement would cost almost twice as much per patient per year as the current average cost of providing services to a Family PACT patient. The federal government has given the state 30 days to change the way it counts undocumented immigrants who receive services through the program.

Governor Arnold Schwarzenegger (R) and state legislators have started an intense lobbying effort to get the President to overturn the ruling or to delay it until after a new administration takes office.

The Mississippi House passed legislation in February that would allow physician assistants to provide family planning services under Medicaid and would include drugs and supplies as long as the services are provided under the supervision of a doctor or a nurse practitioner. (House Bill 1013) Providers in Mississippi would also be reimbursed for administering "preterm labor management" services to women who are considered at risk for preterm delivery, including home infusion therapy, tocolytic infusion therapy, pharmacy services and nursing visits. After passage in the House, the bill was sent to the Senate, but no further action was taken.

The Education Fund of Family Planning Associates (FPA) of New York State released a policy brief on New York's decision to cover Plan B emergency contraception over-the-counter (OTC) through Medicaid. Federal law made Plan B available OTC to women 18 and older in August 2006. This expanded access to emergency contraception, but high costs remained a barrier for low-income women. Federal Medicaid law allows states to cover OTC drugs as prescriptions, but it stipulates that a health care provider must provide a written order for the drug to the pharmacist. For many women, getting this written order can be as difficult as getting a prescription for Plan B.

In 2007, FPA began working with the New York State Department of Health to address this barrier, and on July 23, 2008, a final rule was issued allowing the state to bypass the federal requirement in exchange for assuming 100 percent of the cost of Plan B for its eligible residents. The brief examines what these costs have meant for the state and how effective the decision has been in preventing unintended pregnancies.

Research on Medicaid Family Planning Waivers

In July, the Brookings Institute released a research brief that focuses on states that have received Medicaid waivers to provide coverage of family planning services to women who earn up to 200 percent of the poverty line. The report found that these waivers had a significant impact on reducing unplanned births and, in some cases, tripled the utilization of family planning services by women under 200 percent of poverty. The report states, "The effect on birth rates was largest for women ages 18 to 24. Data on individual behavior confirms that this reduction in births was achieved through increased use of contraception among sexually-active women." The report describes Medicaid family planning waivers as a cost-effective policy intervention.

A Guttmacher Institute study, released in March of 2008, highlighted innovations by state officials in creating, executing and improving upon earlier expansions. The report highlights promising practices in simplifying the application and enrollment process, utilizing community-based tactics to expand outreach, working with professional organizations to recruit a large network of providers, ensuring adequate provider reimbursement, identifying innovations for future expansions, and taking steps to ensure confidentiality, particularly for teens and patients who are victims of intimate partner violence. These developments are beneficial to reproductive health and to health care as a whole, and are helping states with Medicaid family planning waivers better meet the needs of women in need of publicly supported contraceptive care – three-quarters of whom live in waiver states.

Abstinence-Only Programs

Since 1982, over $1.5 billion in federal funds has been spent on abstinence-only education programs that often teach false, misleading and inaccurate information. Despite mounting evidence as to the ineffectiveness of these programs, which promote abstinence from sexual activity without teaching basic facts about contraception and disease prevention, federal funding for abstinence-only programs remains strong. NFPRHA continues to work to end funding for these harmful, ineffective programs, and to advocate for new funds for comprehensive sex education programs that keep teens safe by providing them with the information and resources they need to make healthy choices.

Historic Hearing on Abstinence Programs

On April 23, the U.S. House Committee on Oversight and Government Reform held the first-ever congressional oversight hearing focused on the public health and ethical concerns about domestic abstinence-only sex education programs. The hearing, convened by Committee Chairman Henry Waxman (D-Calif.), examined the evidence on the ineffectiveness of abstinence-only programs, how such programs cause harm to public health, and why these programs are out of touch with the views of American parents.

In a statement submitted for the Congressional Record, NFPRHA President and CEO Mary Jane Gallagher said, "Young people deserve straight talk about sex so they can make smart, informed decisions about their sexual behavior and its outcomes. If Congress is serious about providing our youth with real solutions to help them delay sexual activity and prevent unintended pregnancies and sexually transmitted diseases, they will de-fund abstinence-only programs."

As noted in the Appropriations section, Community-Based Abstinence Education (CBAE) and other federal abstinence programs were continued at FY 2008 levels and will receive $176 million in FY 2009.

In light of the House hearing and a Senate committee vote to cut funding by 25 percent, not to mention the end of the Bush Administration, the next congressional session may provide the opportunity to shift funds from abstinence programs to comprehensive sex education.

State Refusal of Federal Funds

Iowa joined sixteen other states by publicly rejecting approximately $319,000 in Title V federal funding for abstinence-only education because Title V prohibits states receiving such funds from providing complete and accurate information about contraception and sexually transmitted diseases. At a statewide briefing in March, Gov. Chet Culver (D) announced the rejection of federal funds and said the policy will remain in place until the federal government makes changes to the program.

A leading proponent of the move, State Rep. Mary Mascher, said that abstinence-only education is dishonest and inaccurate for teens. "If we expect credibility, I think it is extremely important that information we give them be scientifically and medically accurate," Mascher said. Rep. Mascher sponsored the 2007 law that required sex education in the state to be medically and scientifically based.

Every year, Title V provides $50 million to recipients and it requires states to match $3 for every $4 that the federal government provides. Iowa now joins other states, such as Arizona, California, Maine, New York, Ohio, Virginia, Washington, and Wisconsin that have opted out of the program.

Studies on Abstinence-Only Programs and Teen Sexuality

Review Finds No Evidence to Support Funding of Abstinence-Only Programs

A September review of sexuality education program evaluations by Dr. Douglas B. Kirby affirms that most abstinence-only programs, such as those that have received more than a billion federal dollars, do not effectively help teens delay the initiation of sex. The new review is part of a series published in a special edition of *Sexuality Research and Social Policy*, guest edited by Dr. John S. Santelli and Dr. Leslie M. Kantor, both of the Mailman School of Public Health at Columbia University.

Abstinence-Only Programs Challenged on Constitutionality

The American Constitution Society released an Issue Brief in September that challenges the legality of teaching gender stereotypes in the context of abstinence-only programs. Lesson One: Your Gender is Your Destiny - The Constitutionality of Teaching Sex Stereotypes in Abstinence-Only Programs, by Bonnie Scott Jones and Michelle Movahed, reviewed two of the most widely taught curricula and concluded that the teaching of such stereotypes as facts by public schools violates the Equal Protection Clause of the Fourteenth Amendment. One of the leading curricula, "WAIT" (Why Am I Tempted?) explains that each gender has a set of five major needs in a romantic relationship. For boys, the program teaches, these include "sexual fulfillment, recreational companionship, physical attractiveness, admiration, and domestic support." For girls, however, they include "affection, conversation, honesty and openness, financial support, and family commitment."

Study on Teen Sexual Behavior Debated

Abstinence-only advocates, who deny criticism that their programs lead to more teens engaging in oral sex in order to preserve their virginity, pointed to a study which seemed to support their contention. However, proponents of comprehensive sex education still insisted that such behavior puts teens at risk for infections which are not addressed by abstinence-only programs.

The long-held belief that teenagers are increasingly engaging in oral sex in order to maintain a "second virginity" is simply untrue, according to a study conducted by the federal government and the Guttmacher Institute. The survey of more than 2,200 males and females aged 15-19 revealed that more than half of them, 55 percent, have engaged in heterosexual oral sex. Fifty percent have had vaginal sex and 11 percent of them have had anal sex. Oral sex and anal sex, however, is much more common among those teens who have already had vaginal sex than it is for those who haven't, the study showed. "There is a widespread belief that teens engage in non-vaginal forms of sex, especially oral sex, as a way to be sexually active while still claiming that technically they are virgins," said the study's author Laura Lindberg. The research suggests that this is a myth.

Abstinence-only advocates say these results are a vindication for their brand of sex education, according to the *Washington Post*. This study debunks the criticism that abstinence-only sex education only encourages more teens to have oral sex in order to preserve virginity, the paper reports. "This study...invalidates the suggestion that 'technical virgins' account for the rise in oral and anal sex," says Valerie Huber of the National Abstinence Education Association. "Sexually experienced teens were almost four times more likely to engage in oral sex and 20 times more likely to engage in anal sex than their peers who were virgins. Only abstinence education adequately addresses this problem."

Lindberg sees the results differently, citing concerns for an increase in sexually transmitted infections (STIs). "The study has clear policy implications," she says. "While oral and anal sex carries no risk of pregnancy, engaging in these behaviors can nevertheless put teens at risk of STIs. The federal government's exclusive emphasis on abstinence-only-until-marriage programs does not give teens the skills and information they need to be safe."

Report Reveals Rise in Teens' Sexual Activity

In September, the Kaiser Family Foundation released a report titled, "Sexual Health of Adolescents and Young Adults in the United States." According to the report, sexually transmitted infections (STIs) and teen pregnancy rates are trending up after a decade of decline. Overall teen sexual activity, however, appears to have "leveled off." The report also examines some of the policies that affect access to reproductive health care services for youth.

The report provides data in the following four categories: Sexual Activity, Pregnancy, Contraceptive Use and Services and HIV/AIDS. One statistic documented that a number of youth consider oral sex to be less risky than other forms of activity, with respect to the health, social and emotional consequences that may come with vaginal sex. Fifty-five percent of males and 54 percent of females aged 15-19 say they have engaged in oral sex at least once with someone of the opposite sex.

Access to Abortion Care

While NFPRHA's family planning agenda places a strong emphasis on preventing unwanted pregnancies and reducing the need for abortion, the issue of choice remains an important aspect of our reproductive rights agenda. Although no major federal legislation on abortion passed this year, opponents continued to tack harmful amendments to various bills.

Federal Action

Regulating Fake Abortion Clinics

In April, Senator Robert Menendez introduced the "Stop the Deceptive Advertising in Women's Services Act" (S. 2793), the companion bill to Representative Carolyn Maloney's bill (H.R. 2478) to prohibit Crisis Pregnancy Centers (CPCs) from intentionally misleading women to prevent them from accessing abortion care. The bill authorizes the Federal Trade Commission to regulate the deceptive advertising practices of CPCs, which regularly advertise that they provide abortion care when they in fact do not provide such care. Upon introduction, the bill was referred to committee, and no further action has taken place.

Harmful Amendments Defeated

During the Senate's consideration of the budget resolution, two anti-choice amendments were defeated. Senator John Ensign (R-Nev.) introduced an amendment that would have provided funding for the Department of Justice to enforce the Child Custody Protection Act (CCPA) in the event it became federal law. CCPA would prohibit the transportation of minors across state lines in order to circumvent parental consent laws with respect to abortion services for minors. The amendment was defeated on a tie vote, 49-49 (S.Amdt. 4355).

A second amendment by Senator Wayne Allard (R-Colo.) would have codified the "unborn children" regulations under the Children's Health Insurance Program by establishing a reserve fund in the event that the CHIP program is reauthorized in the future. The amendment was defeated, 46-52 (S.Amdt. 4233). On March 14, the Senate approved its version of the FY 2009 budget (S. Con. Res. 70) by a vote of 51-44.

Amendment to Limit Abortion Funding Passed

In February, Senator David Vitter (R-La.) offered an amendment to S. 1200, the Indian Health Improvement Act, that would prohibit the use of Indian Health Service (IHS) funds for abortion services except in cases of rape, incest or life endangerment. The amendment (S.Amdt. 3896) passed the Senate by a vote of 52-42, much to the disappointment of reproductive health and family planning supporters.

IHS is already prohibited from using federal funds to pay for abortions as dictated by the Hyde Amendment, originally passed more than thirty years ago. Vitter's stated intent in offering the amendment was to ensure that future presidential administrations are barred from providing federal funds for abortion. The bill passed the Senate, but it appears that it died in the House.

Challenge to Weldon Law Dismissed

On March 18, a federal judge dismissed California's challenge to the federal refusal law, also referred to as the Weldon law that precludes all federal funding through the Labor, Health and Human Services, and Education Appropriations to state or local governments if funding provides coverage or referrals for abortion. It became law as part of the federal FY 2005 omnibus spending bill approved in December 2004.

In 2005, California's then-State Attorney General Bill Lockyer sued to overturn the law, arguing that it could cost California $37 billion because it conflicted with a state law requiring any hospital or clinic to perform an abortion in an emergency, such as when childbirth would threaten a woman's life or health. U.S. District Judge Jeffrey White stated that the court could not address California's legal claims because they were based on events that may never occur, and that the state's legal arguments would remain premature until a woman is denied an emergency abortion, the state attempts to enforce its law and the federal government threatens to withhold funding.

The dismissal of the California suit is similar to the rejection of NFPRHA's own lawsuit challenging the federal refusal law. NFPRHA filed suit in 2006 on behalf of more than 4,400 family planning centers around the country receiving Title X funds that could be impacted under the refusal law. The U.S. Court of Appeals for the District of Columbia dismissed the case.

State Legislation and Ballot Initiatives

Illinois Parental Notification Law to Remain on Hold

In March, a federal judge ruled that a 1995 state law prohibiting minors from acquiring an abortion without parental consent remains unconstitutional. In 1996, the law was permanently enjoined because although it allows a judge to waive the notification requirement in the "best interest" of the minor, it lacks clear rules governing that procedure and specifying how the minor could then attain the abortion. In 2006, the Illinois Supreme Court unanimously adopted judicial bypass rules. However, in 2008, U.S District Judge David Coar refused to lift the federal order citing that it was "contradictory and incomplete" and that doing so would put some minors in "legal limbo."

Attorney General Lisa Madigan (D), who generally supports abortion, issued a statement asking the court to lift the permanent injunction to allow parental involvement.

Virginia Votes to Cut Funding for Planned Parenthood

For the first time in over a decade, the Virginia State Senate voted in March to cut funding to Planned Parenthood of Virginia because the organization offers abortion services. Planned Parenthood receives funds to support a range of reproductive health and family planning services throughout the state, including programs operated at juvenile correction facilities to teach pregnancy prevention, programs to prevent HIV, programs providing health care services to low-income women and teen pregnancy prevention. The amendment was stricken from the budget during House and Senate negotiations.

Medical Records of Abortion Patients Protected

In September 2007, the anti-abortion group Kansans for Life delivered a petition urging an investigation of late-term abortion provider Dr. George Tiller. However, in February 2008, the Kansas Supreme Court blocked enforcement of a Sedgwick County grand jury subpoena for medical records of 60 women who obtained abortions after their 21st week of pregnancy. This was the second time in two weeks that the Kansas Supreme Court intervened to delay a subpoena for the health records of women who sought abortions, citing concerns for patient privacy and the authority of the grand jury to issue subpoenas in the matter.

Ballot Initiatives

Voters in California, Colorado, and South Dakota defeated ballot initiatives in November that would have significantly restricted reproductive health. For a third time, California defeated an initiative requiring a waiting period and parental notification before a minor could obtain an abortion. Colorado's initiative to legally define a fertilized egg as a person failed in landslide. And South Dakota's residents voiced their opposition to an abortion ban with unclear exceptions for health of the mother, rape and incest.

Product Safety

The sole U.S. supplier of mifepristone, an abortion medication, stood by its claims of drug safety after published reports linked a Chinese drug-maker to tainted products. According to the New York Times, the Shanghai Pharmaceutical Group, which produces mifepristone, also manufactured a tainted leukemia drug sold in China. Danco Laboratories issued a statement that mifespristone is made at a separate plant, and that the cross-contamination that caused the problem with the leukemia drug could not occur at the plant where mifepristone is produced.

The FDA confirmed that the plant that manufactures mifepristone is not linked to the problems at the plant that makes the leukemia drug. The mifespristone plant passed FDA inspections in May of 2007.

"Abortion" Barred in Public Health Database

In April, the reproductive health community denounced a Johns Hopkins University decision to bar the term "abortion" from searches on the publicly financed reproductive health database POPLINE. JHU manages POPLINE, the world's largest reproductive health database with more than 300,000 records and articles on issues such as family planning, fertility and sexually transmitted infections. It operates with funds from the U.S. Agency for International Development.

According to the *New York Times*, a POPLINE manager, Debra L. Dickson, responded to the inquiry of two medical librarians from San Francisco saying, "We recently made all abortion terms stop words. As a federally funded project, we decided this was best for now." Dickson suggested using other terms such as "postconception" or "pregnancy, unwanted." Upon learning of the decision, the dean of the Public Health School, Dr. Michael J. Klag, scrapped the policy which had been enforced since February and promised to investigate the issue.

Reproductive Health: Breast and Cervical Cancer

NFPRHA strongly supports preventative health measures, such as screenings for breast cancer, cervical cancer and sexually transmitted diseases, which save lives and lower social costs. No significant action took place on reproductive health at the federal level this year, however, numerous studies of interest to the family planning community were released.

State Action

In 2007, Virginia was the only state to mandate that girls receive the human papillomavirus (HPV) vaccine which protects girls from some types of cervical cancer, although the law included a parental opt-out provision. In January 2008, the state House passed a bill that would delay implementation of the law from October 2008 until fall of 2010. The reported reasons for the delay include more time to study the vaccine and waiting for competing vaccines to reach the market. The bill then passed a Senate committee, but no further action took place.

New Studies on Breast and Cervical Cancer

Oral Contraceptives May Reduce Ovarian Cancer

British researchers found that women who have taken the pill for fifteen years cut their chances of developing ovarian cancer in half and that protection against the cancer lasts long after women have stopped taking the pill. The study, funded by Cancer Research UK and the British Medical Research Council, was published in *The Lancet* medical journal.

Researchers divided women in two groups: those on the pill who had ovarian cancer and those on the pill who had not been diagnosed with ovarian cancer. Without the pill, researchers say, about 12 women per 1,000 can expect to develop ovarian cancer before age 75. That figure is reduced to 8 per 1,000 for those on the pill. Researchers estimated that so far the pill has prevented 200,000 cases of ovarian cancer and 100,000 deaths. The number of potential cases that are avoided each year could top 30,000.

Breast Cancer Rates Falling in White Women

Breast cancer rates in women have been falling, but the decline has been largely limited to white women, according to a study released in April. Researchers say the falling rate is probably related to the relatively large numbers of white women who have abandoned hormone replacement therapy. Hormone therapy fell out of favor in 2002 when a study was published suggesting a link between the therapy and the increased risk of breast cancer and heart disease. The increased risk is the result of combining estrogen and progestin, the study reported. While white women shifted away from hormone therapy, minority women continue to use it.

Researchers used data from 2001 to 2004 from the National Cancer Institute to calculate whether the rates were falling across other racial and ethnic lines. By the end of 2003, breast cancer rates among white women started falling by as much as 2.4 percent per quarter while the rates continued to rise by .7 percent per quarter among African-American women. The American Cancer Society reported that overall, breast cancer rates in women fell 3.9 percent per year from 2001 through 2004.

Mothers More Likely to Have Older Daughters Vaccinated Against HPV

Research released in May showed that mothers are more likely to have their daughters vaccinated against HPV if they are over the age of thirteen. Only 49 percent of mothers of daughters ages 9 to 12 intend to have them vaccinated, compared to the 86 percent who said they would be likely to vaccinate if their daughters were 16 to 18 years of age. Mothers who believed the vaccine would lessen their child's risk of contracting cervical cancer were more likely to embrace the vaccine. Some mothers voiced concerns that the vaccine would cause their daughters to engage in "risky sexual behavior." Jessica Kahn, a physician in adolescent medicine at Cincinnati Children's Hospital Medical Center, conducted the study, which surveyed more than 10,000 mothers as part of a Growing Up Today study.

Breast Cancer Treatment Study

Another study released in March found that the breast cancer treatment Femara can greatly reduce the chances of cancer returning, even if women start the drug treatment long after they stop taking the estrogen blocker Tamoxifen (Nolvadex). Researchers noted that post-menopausal women who took Femara one to seven years after a five-year regimen of Tamoxifen reduced their risk of recurrence by 63 percent. Further, this drug, which is generically known as Letrozole, appears to cut the risk of cancer spreading to other parts of the body by 61 percent. Letrozole is part of a new class of breast cancer drugs known as aromatase inhibitors. They block the production of estrogen that can lead to cancer and researchers recommend them for use in women who are post-menopause. Tamoxifen is still the most widely-used estrogen blocker and has been shown to cut cancer recurrence by close to 50 percent. Its benefits, however, decrease dramatically after five years. More than half of breast cancer recurrences and deaths happen five or more years after women have stopped taking Tamoxifen.

Food and Drug Administration (FDA) Actions

No major policy directives were issued this year by the U.S. Food and Drug Administration (FDA), but NFPRHA continues to actively follow FDA efforts to monitor drugs crucial to women's reproductive health.

HPV Vaccines

Merck's Gardasil is currently the only cervical cancer vaccine on the market. An application for GlaxoSmithKline's vaccine, Cervarix is pending with the FDA, but many analysts believe Cervarix is now unlikely to be launched in the U.S until 2009.

Merck Applications to Expand Gardasil Use

In June, the FDA informed Merck that it cannot approve an application to expand marketing of Gardasil to older women, ages 27-45. Currently, Gardasil is approved for use in girls and women ages 9-26. Merck continued to address the FDA's concerns in further discussions.

There are several types of human papillomavirus (HPV), which can cause cervical cancer, and Gardasil currently blocks four: 6, 11, 16 and 18. These four types of HPV account for more than 70 percent of all cervical cancer cases.

Merck failed to win FDA approval to expand the use of Gardasil to protect against additional strains of HPV, and it has dropped plans to pursue that expansion.

However, Merck will be pursuing an expansion of Gardasil for use in males ages 9-26. Merck issued a report in November showing that Gardasil is highly effective in men and boys. The study involved 4,000 men from 20 different countries (1,000 of whom were American) ages 16-26. Gardasil proved to be 90 percent effective at preventing lesions, most of which were sexually transmitted warts. Researchers also tracked the rate of HPV infection and discovered 15 cases in the vaccinated group and 101 in the placebo group.

Merck said it plans to submit its application for approval for Gardasil for men to the FDA by the end of this year.

Claims Against Merck for Adverse Effects

In June, *The New York Post* reported that Gardasil is under federal investigation for possible links to paralysis, seizures and 18 deaths. Since Gardasil's approval in February 2007, the federal government has logged 8,000 "adverse events" in patients who were injected. Lawyers have filed claims in New York for two girls who both developed serious illnesses shortly after receiving Gardasil. Jessalee Parsons, 15, of Oklahoma, says she started vomiting the day she received her shot and then developed pancreatitis thereafter. Jessica Vega, 14, of Nevada, developed an immune disorder known as Guillain-Barre Syndrome only one week after receiving her shot. Gardasil, however, is one of many vaccines protected by federal law. So, lawyers for the two girls plan to file their claims under the Vaccine Injury Compensation Program, a federal program which compensates people who can prove that a vaccine caused an illness or a death.

Merck and Doctors Stand By Gardasil's Effectiveness

In the two years since its approval, Merck says that Gardasil has been administered to more than 8 million girls and women from the ages of 9 to 26. In clinical trials, it has been shown to prevent infection of HPV strains 16 and 18, which cause about 70 percent of cervical cancer cases. ABCNews.com reported that doctors are strongly supportive of Gardasil, and see it as an important and necessary vaccine. Many doctors say that they routinely give their patients the vaccine and that the adverse effects have been mostly minimal and confined to symptoms such as sore arms. Vaccines are a complex issue, medical experts say, but most seem to agree that the reported side effects cannot outweigh the benefits of reduced cancer rates since Gardasil's emergence on the market.

CDC Says Gardasil is Safe

In October, the Centers for Disease Control and Prevention (CDC) said Gardasil was not related to the reports of serious adverse effects and deaths in young girls and women. The CDC conducted a post-marketing safety study of Gardasil and data from that report, which also included a list of reports filed with the vaccine adverse reporting system (run by the FDA and the CDC) was presented to a CDC vaccine panel. The study analyzed 375,000 doses of Gardasil from August 20, 2006 to

July 20, 2008 administered to girls and women aged 9-26. The panel said that based on its study, both the FDA and the CDC "…determined that the HPV vaccine is safe to use and effective in preventing 4 types of HPV."

More than 10,000 reports of adverse events, including 27 deaths, were filed with the CDC by August 31, 2008. Of those reports, 94 percent were considered to be non-serious and 6 percent were considered to be serious. The CDC says most vaccines have a serious adverse event rate of between 10-15 percent.

Critics, however, say that there was not enough transparency in the government's internal decision-making process and requested that the FDA and the CDC release the study design, data and the names of the investigators involved in making the decision. The chief critic, the National Vaccine Information Center, (NVIC), also plans to call on the President and the new Congress to move the vaccine monitoring system from the Department of Health and Human Services to an entity monitored by Congress. "Until there is an independent confirmation of these unverified findings by individuals and companies without financial ties to the government or industry, it is not credible," said NVIC Co-founder and President Barbara Loe Fisher.

Continued Controversy on Safety of the Contraceptive Patch

In January, the FDA approved a change to the Ortho-EVRA Contraceptive Transdermal Patch label to warn consumers that those who use the patch may be at a higher risk of developing serious blood clots than women using birth control pills. The label change was implemented following the release of a study that found that women between the ages of 15 and 44 who used the patch were at a higher risk of developing serious clots that could lead to lung embolisms. Janet Woodcock, MD, the FDA's Acting Director of the Center for Drug Evaluation and Research, said, "This is an example of [the] FDA working in tandem with the drug manufacturer to keep the public informed of new safety data and epidemiological studies that may impact health decisions about the use of FDA approved products."

However, some consumer groups believe that the labeling change is not enough and that the patch should be pulled. In May, Public Citizen petitioned the federal government to remove the patch from the market. The FDA updated the patch label in 2005, 2006 and 2008 with warnings about the potential clotting. According to the *New York Times*, blood clots are a rare side effect for estrogen-related products. Some published studies have shown that blood clots are higher in patch users because 60 percent more estrogen is absorbed than with the pill. Public Citizen asked that the FDA slowly phase out the patch instead of a swift recall in order to avoid an increase in unwanted pregnancies.

Ortho Women's Health & Urology, the makers of the patch, responded by saying, "Ortho-EVRA is a safe and effective hormonal birth control option when used according to the labeling."

Rule on Condom Labeling in Line with Scientific Evidence on STIs

In November, the FDA published a final rule which recognizes that condom use reduces the risk of transmission of sexually transmitted infections (STIs). The rule establishes a "special control" for male condoms made of latex. The special control is an FDA guidance document that identifies minimum performance standards, continued testing, and labeling recommendations for a device.

The FDA concluded that the scientific evidence "continues to fully support the overall effectiveness of latex condoms in reducing the risk of transmission of common STIs. That evidence supports the conclusions that correct and consistent use of latex condoms reduces the risk of transmission of HIV/AIDS and other STIs such as gonorrhea that are sexually transmitted solely by contact with the head of the penis (via genital fluids)." The FDA also found that evidence shows "that latex condoms are effective in reducing the risk of transmission of other STIs, such as genital herpes and HPV, that can be transmitted not only by contact with the head of the penis, the area covered by a latex condom, but also by contact with infected skin outside the area covered by the latex condom."

According to the Reproductive Health Technologies Project, "the new rule is consistent with available scientific evidence and does not undermine current efforts to promote condoms as a means to reduce STIs and unintended pregnancy rates."

Marketing Issues

FDA in Compliance with Condom Labeling Provisions

The Government Accountability Office (GAO) found that the FDA complied with a provision in a law directing the FDA to "re-examine existing condom labels to determine whether they are medically accurate regarding the effectiveness of condoms in preventing STDs." Senator Tom Coburn, (R-Okla.), who authored the provision requiring FDA to examine condom labels in an attempt to disparage condom effectiveness, requested the GAO report. Coburn has remained a vocal critic of the FDA, first for what he deemed FDA's failure to take prominent action on condom labels, and later, for FDA's failure to mandate that new condom warning labels state that they do not protect against the human papillomavirus (HPV).

According to the GAO, which conducted its review from September 2007-March 2008, the FDA determined that existing labels fell short regarding, among other things, the protection against HPV. The FDA concluded that while condoms offer less protection against HPV than other sexually transmitted diseases, the correct and consistent use of condoms does decrease the risk of transmission of HPV. The agency, as a result of its review, identified several areas in which condom labels could be improved upon and, though not required to, even initiated regulatory action in 2005 under the Federal Food, Drug and Cosmetic Act to improve the labeling.

Claims About a Menopause Treatment Found to be False and Misleading

In January, the FDA took action against seven pharmacy operations that have made questionable claims about the effectiveness of "bio-identical hormone replacement therapy" or BHRT, used to treat symptoms of menopause. These products are marketed as natural and safe, but they are not FDA-approved, so that the claims are considered false and misleading. The FDA is asking patients who use compounded hormone therapy drugs to discuss treatment with their health care provider.

FDA Warnings on STD Marketing

The FDA issued warnings to six U.S. companies and one foreign individual in March after the companies marketed unapproved and misbranded drugs for the prevention and treatment of sexually transmitted diseases. The products were marketed under the names Tetrasil, Genisil, Aviralex, OXi-MED, Imulux, Beta-mannan, Micronutrient, Qina and SlicPlus. Manufacturers claimed that these drugs prevent or treat herpes, chlamydia, HPV, cervical dysplasia and HIV/AIDS and were approved by the FDA.

Centers for Disease Control and Prevention (CDC)

NFPRHA continues to monitor important studies by Center for Disease Control and Prevention (CDC) and joins family planning advocates in supporting a range of preventive health measures recommended by the CDC, such as screenings for cervical cancer, HIV and sexually transmitted diseases.

Note that the CDC did not move forward with any major new recommendations on these issues this year, however, CDC findings on increased HIV rates and high rates of sexually transmitted diseases among teens are alarming trends which further demonstrate the need for fully funded family planning programs that include comprehensive sexual education, counseling and preventive health testing.

CDC Data Highlights Changes in STIs, HIV and Teen Pregnancy

CDC's HIV/AIDS Tracking Shows Increase in Diagnoses

The annual HIV/AIDS surveillance report by the CDC found that 52,878 people were diagnosed with HIV in 2006, up from 35,537 in 2005. Although the report shows what could be considered a significant increase in reported cases of HIV, this growth reflects changes the CDC has made in tracking diagnoses rather than an increase in the epidemic.

The report was based on data from 45 states and 5 dependent territories. Seven states — California, Delaware, Illinois, Maine, Oregon, Rhode Island and Washington — were included for the first time. The report did not include data from Hawaii, Maryland, Massachusetts, Montana or Vermont. The 2005 report was based upon data from 38 states and 5 territories. The report indicates that between 2003 and 2006 the number of new HIV/AIDS diagnoses across 33 states and the 5 territories has remained fairly consistent.

CDC Study on Teen Sexual Health Raises Alarm on High Infection Rate

Researchers at the CDC completed a first of its kind study of teenage girls and sexually transmitted diseases (STDs), revealing a staggering statistic: nearly 1 in 4 teen girls has at least one STD. The study, released March 11, consisted of 838 girls ages 14-19 who were surveyed about sexual practices and tested for HPV, Chlamydia, trichomoniasis and genital herpes. The CDC found that:

- Almost half of the study participants acknowledged having sex.
- 26 percent of study participants, or 3 million girls nationwide, had at least one STD.
- 40 percent of those that acknowledged having sex had at least one STD.
- Nearly half of the black participants had an STD compared to 20 percent of white and Mexican-American participants.
- 18 percent had HPV — the most out of the four diseases tested.
- 4 percent had chlamydia.
- 2.5 percent had trichomoniasis.
- 2 percent has genital herpes.

Inadequate sex education, lack of testing, feelings of invulnerability, and an inconsistent definition of sex (ranging from intercourse only to including oral sex, anal sex and other intimate acts), have been identified as factors. CDC researchers urge that doctors talk to their teen patients about STDs and offer screenings. They also urge a dual message of condom use and abstinence for the prevention of STDs.

CDC Finds Teen Pregnancy Rates Dropping

In April, the CDC released a report that showed that pregnancy rates for females under age 25 are declining. According to the study, "Estimated Pregnancy Rates by Outcome for the United States, 1990-2004," nearly 38 percent of pregnancies in 2004 were to women under age 25, down from nearly 43 percent in 1990. Furthermore, in 2004 there were 4.11 million live births, 1.22 million induced abortions and 1.06 million fetal losses. During the studied time period abortions fell by 24 percent. The study also found that more than two-thirds of pregnancies for non-Hispanic white (67 Percent) and Hispanic women (69 percent) and just half of pregnancies to non-Hispanic black women ended in live birth.

International Family Planning

It was a relatively quiet year on the international front. Worth noting are the PEPFAR Reauthorization and the Bush Administration's continued enforcement of right-wing ideology through restrictive policies on international family planning providers.

PEPFAR Reauthorization

In July, the President's Emergency Plan for AIDS Relief (PEPFAR) reauthorization bill became law. The new law allocates $48 million for prevention and treatment of HIV/AIDS, tuberculosis, and malaria in poor countries. It also lifts a long-standing ban on HIV positive travelers and immigrants to the U.S.

The reauthorization overturns a previous requirement that one-third of all prevention funding must go to abstinence and fidelity programs. However, it now requires a report to Congress if countries spend less than half their prevention funding on such programs.

The new law continues the Bush Administration policy requiring recipients of federal funds to pledge their opposition to prostitution and sex-trafficking.

USAID Bars a Family Planning Organization from Getting Contraceptives

In fall of 2008, the U.S. Agency for International Development (USAID) ordered six African countries to ensure that no U.S.-financed condoms, birth control pills, I.U.D.'s or other contraceptives are furnished to Marie Stopes International (MSI), a British-based family planning organization that operates health clinics in the United Kingdom and worldwide.

The Bush administration said it took this action because MSI works with the U.N. Population Fund in China. Therefore, according to the Administration, MSI supports the one-child China policy, including forced abortions.

In response, MSI stated that it does not support forced abortions nor coercive sterilization in China or anywhere else in the world. MSI also said that cutting their access to contraceptives will result in more abortions in Africa, as women will be unable to get contraceptives and will end up with unwanted pregnancies.

New Research in HIV/AIDS

In February, researchers announced that late-stage trials of the drug Carraguard, an anti-AIDS vaginal gel, show the drug may not be successful at stopping sexually transmitted HIV infections. The double-blind study, funded by the Bill and Melinda Gates Foundation and the U.S Agency for International Development (USAID), involved more than 6,000 South African women over the course of three years.

The data shows statistically insignificant differences in the rate of HIV transmission between the test and control groups. Despite the disappointing outcome, researchers were optimistic about future studies into anti-AIDS vaginal creams or gels. One positive outcome is that Carraguard, developed by New York based non-profit Population Council, proved safe, in contrast to trials stopped last year when data indicated the products might have increased the risk of HIV transmission. Researchers are looking into the possibility that the participants' inconsistent use of the gel could have skewed the results. On average, participants used it only 44 percent of the time, though participants reported using condoms more than twice as much as they had at the beginning of the study.

Legislative Outlook for 2009 and Beyond

Election Analysis

The 2008 election provided voters with an opportunity to send a clear message of change to the political establishment. With an enthusiastic turnout, Senator Barack Obama (D-Ill.) won a solid victory over Senator John McCain (R-Ariz.), and Democrats expanded their majorities in both the House and Senate. Although gains for Congressional Democrats did not match the most optimistic predictions, results for both congressional and presidential elections suggest a convincing vote to take the country in a new direction.

The 111th Congress appears to have the largest pro-family planning majority in history. In the Senate, pro-family planning Democrats Jeanne Shaheen (N.H.) and Kay Hagan (N.C.) unseated anti-family planning Republican incumbents, while Tom Udall (N.M.), Mark Udall (Co.) and Mark Warner (Va.) captured open seats previously held by Republicans. Substantial gains in the House suggest that family planning advocates have much to celebrate in the 2008 results.

As of today, with one special election still to be held, NFPRHA classifies 209 Members of the House as pro-family-planning, meaning they have supported family planning all or almost all the time. An additional 22 Members lean pro-family-planning, supporting family planning most of the time, and 20 are mixed. Seven Members still lean anti, voting against family planning most of the time, and 176 are classified as anti-family planning, consistently failing to support these common sense, common ground policies. All told, the 2008 election produced a net gain of 12 pro-family planning seats and 1 mixed seat, and fourteen fewer anti-family planning seats in the House.

In the Senate, gains for family planning were comparatively even larger. Whereas the 110th Congress had 46 pro-family planning Senators, along with eight who leaned pro, there will be 53 strong pro-family planning Senators in the 111th Congress, along with seven who lean pro, giving family planning its first ever filibuster-proof majority. With the race between Minnesota Senator Norm Coleman, one of the Senate's most profoundly anti-family planning members, and pro-family planning challenger Al Franken still too close to call, the 2008 elections produced a net gain of six pro-family planning seats in the Senate, five fewer anti-family planning seats, and two fewer truly mixed seats.

For family planning providers and advocates around the country, Obama's election represents an enormous victory, and we are hopeful that the coming months and years will provide numerous opportunities to work with the new administration to increase access to family planning services for low-income and uninsured women and men. President Obama has spoken out repeatedly on the importance of access to family planning services and comprehensive sex education, and is a co-sponsor of key legislation such as the Prevention First Act (S. 21), and is the lead sponsor of the Prevention Through Affordable Access Act (S. 2347), a bill to restore access to nominally-priced drugs to certain college and university health centers and safety-net family planning providers. In addition, he joined Senators Hillary Clinton (D-N.Y.) and Patty Murray (D-Wash.) on comments submitted to the Department of Health and Human Services in opposition to the provider refusal regulations proposed on August 26, 2008.

NFPRHA continues to track appointments of key officials who will be responsible for implementing family planning policy. In addition to agency appointments, it is widely expected that the next President will have the opportunity to nominate several new Associate Justices to the Supreme Court.

NFPRHA looks forward to working with the largest Congressional pro-family planning majority in history, and hope that a substantial investment in women's reproductive health will be a reality in the early part of 2009. At the same time, we recognize the enormous number of issues that the incoming administration and congress must deal with, including the financial crisis, the wars in Afghanistan and Iraq, and any number of Bush administration misdeeds. With a deficit set to approach one trillion dollars in fiscal year 2009, new spending, even for the most worthy programs, will be difficult to come by, and the list of urgent needs, both in the progressive community and, indeed, the country, is almost incomprehensibly long.

All the while, we look forward to helping the incoming administration and the 111th Congress make their stated commitment to expanded access to family planning and reproductive health care a reality. We hope that they will immediately take the steps that we and other women's health advocates have recommended, steps that will provide fiscal relief and ease administrative burdens on states, provide millions of low-income and uninsured women access to health care, and save taxpayer dollars.

We believe the outlook for change is good, but are realistic that it will not happen overnight, and that this election is only the beginning. The President-elect and the leadership of this Congress have been longtime friends of women's health, and we look forward to working with them for many years to come.

NFPRHA's national staff has been hard at work making sure that the Obama-Biden transition team is aware of the critical needs of family planning providers. Family planning providers and others in the women's health care community have a long to-do list, and the list of priorities we have communicated to the transition team represent a first set of goals, each of which is achievable, urgent and would represent a meaningful step towards addressing the serious neglect, and even harm, done to women's health in the last eight years. These recommendations include: increased funding for Title X, expanded eligibility for Medicaid-funded family planning services, reversing the HHS provider refusal regulation, passing health care reform that includes comprehensive family planning, restoring access to nominally priced drugs and de-funding harmful abstinence-only programs and funding comprehensive sex education. Reports suggest that a Fiscal Year 2009 omnibus will pass as part of an economic recovery package early 2009, and NFPRHA is working to achieve some of these goals in that context.

About NFPRHA

The National Family Planning & Reproductive Health Association (NFPRHA) is a vital membership organization of dedicated family planning service providers – public health departments, hospitals, general health providers and community based reproductive health caregivers.

Our goal is to prevent unwanted pregnancies and reduce the need for abortion by providing the education, contraception, counseling and preventive health services low-income and uninsured people need to act responsibly, stay healthy and plan their families.

NFPRHA represents the full spectrum of the domestic family planning field, including clinicians, administrators, researchers, educators, advocates and consumers. NFPRHA represents our members' interests on the national stage and informs the public on family planning's non-controversial, common sense social and fiscal value. Together the voices of the family planning field has more influence on Capitol Hill as we work to protect and increase public funding for family planning and reproductive health services.

NFPRHA rapidly updates our members on relevant family planning policy and service delivery issues affecting through our publications, reports, white papers and website. NFPRHA links member health care providers and administrators with experts in the field and serves as the conduit for information exchange.

This publication is made possible with the generous support of the Robert Sterling Clark Foundation. It was prepared by the NFPRHA Public Policy Department, under the leadership of Sloane Rosenthal, Acting Director, and in consultation with Eleanor Allen, Editor.

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