CLOSE HOLD file abortion

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

May 26, 1993

MEMORANDUM FOR CAROL RASCO

FROM: Nancy-Ann Min NAM
Associate Director for Health

SUBJECT: Family Planning/Abortion Q's and A's

I have attached a revised draft of Secretary Shalala's responses to the Q's and A's on family planning and abortion issues. This draft reflects comments I received from some of the members of our working group, as indicated in the margins.

I would appreciate it if everyone would give this one more careful look before we clear it for submission to the Congress.

Attachment

cc: Susan Brophy
Bill Galston
Steve Neuwirth
Melanne Verveer
Ricki Seidman
Charlotte Hayes

Revised Draft: 5-25-93

Family Planning

(1) It was recently announced that Baltimore City Schools are expected to be the first in the nation to offer Norplant, a surgically implanted contraceptive, to teenage girls. The drug is expected to be offered to students at Laurence Paquin Middle and High School, and will eventually be expanded to the six high schools that have school-based health clinics on campus.

a. Do you support the distribution of Norplant to this population?

Norplant, a new (FDA) implantable hormonal, long-term contraceptive, has been approved by the Food and Drug Administration as safe for use as a contraceptive method in the United States. Local community groups, including the Baltimore City Schools, may ~~have a right to~~ provide voluntary contraceptive services to sexually active individuals in compliance with any relevant Federal, State or local requirements, including informed consent requirements. However, I am not aware of any Federal restrictions on the provision of Norplant through the schools, nor would I support such restrictions ~~at the national level~~.

b. Given the drug's short history, do you believe these minor girls should have to obtain parental consent before implanted with Norplant?

Norplant has been approved by the FDA as a safe, that reversible family planning method. ~~These inserts can~~ be reversed ~~removed~~ through a simple, outpatient procedure. As with all other contraceptive services provided to adolescents through the Title X national family planning program, Norplant is available to adolescents who request such services on a confidential basis. I would however urge parents to become involved with their children's decisions whenever practicable. to remove the implant.

c. If you do not support parental consent before Norplant is distributed to minor girls, do you at least support parental notification before this new drug is distributed?

There are no Federal laws that require parental consent or notification for the provision of contraceptive services to minors. ~~I would~~ I recommend that Norplant would not be singled out for such a requirement.

d. Would you support using federal funds for this type of distribution?

Funding for the provision of Norplant is currently available through various Federal programs including Medicaid and the Title X national family planning program. Title X specifically requires that all family planning services to adolescents be provided in a confidential manner, and prohibits parental consent or notification requirements for the provision of such services. provided

e. What if any restrictions would you place before federal funds could be used to distribute Norplant to minors?

(See above response)

Family planning

(2) Section 1008 of the Public Health Service Act implementing the Title X Family Planning Act provides that: "None of the funds appropriated under this Title shall be used in programs where abortion is a method of family planning."

a. How do you interpret this section of the law, which has not been altered since 1970?

The previous Administration's interpretation of this section of the statute lead to the so-called "Gag Rule", which has been the focus of much litigation and controversy. ~~Because we believe the rule inappropriately restricted grantees, I suspended them and proposed that the program return to~~ and which (see insert 1 below) the compliance standards operative prior to the issuance of the "Gag Rule" in 1988. The Department is currently reviewing comments received in response to ~~the~~ its February, 1993 Federal Register notice and working on the development of a new rule in accordance with the notice and comment provisions of the Administrative Procedures Act. As the Department's February, 1993 interim rule notes, the original interpretation of section 1008 (from the program's inception in 1970 up until the 1988 "Gag Rule") did not include a prohibition on non-directive counseling on abortion.

b. Do you support regulations known as the "Gag Rule" which aim to separate abortion related activities from federally supported family planning activities? If not, do you support any limitations on the ability of clinics receiving federal funds to counsel and refer women for abortion in federally funded Title X clinics?

~~I support the President's efforts in which he directed the Department to publish~~ (see insert 2 below) in the Federal Register -- (1) a notice of proposed rulemaking (NPRM) proposing to return the program to the abortion policies and interpretations that were in effect prior to February 1988 and (2) an interim final rule suspending the "gag rule" and reinstating the pre-1988 policies pending the issuance of a final rule.

The Department has proposed that the compliance standards operative prior to 1988 be reinstated, including those set out in the Family Planning Program Guidelines which require that in the event of an unplanned pregnancy, ~~and where the patient requests such action, that~~ non-directive counseling be provided to a client that on all options relating to her pregnancy, including abortion, and to refer her for abortion, if that is the option she selects.

Insert 1: I therefore suspended the so-called "gag rule" and proposed that the program return to

Insert 2: See above response. The Department has published

c. Do you view the federal family planning program as preventive in nature?

The Department believes that the intended Federal family planning program is ~~meant~~ to provide a broad range of acceptable and effective medically approved family planning methods and services to persons desiring such services. ~~These~~ services must be provided in a manner that does not subject individuals to coercion, deception or withholding of complete and accurate medical information about their health condition and legal options. The Department's view is that these

d. Do you think it is important to separate abortion activities from legitimate family planning or preventive activities? How do you propose to separate abortion activities from legitimate family planning activities?

As the Department stated in the February, 1993 interim rule, we believe the 1988 "Gag Rule" would have required many grantees to make extensive, expensive and unnecessary alterations in their physical facilities and organizational structures. ~~We have proposed,~~ consistent with the longstanding Departmental interpretation and administration of the statute, that we have proposed Title X projects not be permitted to promote or encourage abortion as a method of family planning, and that they be required to maintain a separation (that is more than a mere exercise in bookkeeping) of their project activities from any activities that promote or encourage abortion as a method of family planning. The Department will consider this issue further ~~in response to the comment received~~ when promulgating a new final rule, in light of the comments received to its February, 1993 interim final rule.

e. Should Title X clinics be permitted to perform abortions on the same site as the federally funded Title X clinic?

(See above response)

f. Should personnel whose salaries are supported by federal funding be permitted to work in abortion related activities at the same site?

(See above response)

Family Planning

(3) Since its involvement in funding contraceptives and family planning, the Federal government has invested over $2 billion to curb teenage pregnancy. Yet the rate of teenage pregnancy and sexually transmitted diseases afflicting teenagers continues to grow. Many experts feel it is time for us to admit this approach has not yielded the returns we had hoped, and to recognize that we have focused on the symptom of teen pregnancy rather than the root, which is teen sexual activity.

a. What if anything will you direct the Department of Health and Human Services to do to curb the rate of teen sexual activity?

Adolescent pregnancy prevention is a priority within the Department in order to provide national leadership in ~~creating~~ developing a credible, reliable response to the problem. Toward this end, I have asked several experts in the Department to begin to design a strategy on teenage pregnancy in order to develop a strong adolescent pregnancy initiative.

b. What role, should abstinence education play in this effort?

Abstinence is a legitimate public health approach to ~~delaying or~~ preventing early adolescent sexual activity ~~in order to prevent pregnancy~~ and the transmission of sexually transmitted diseases, including HIV infection. However, a broader, more comprehensive range of public health and social service approaches is needed to target these dual problems. ~~The impact of the abstinence-only message of the last decade has been minimal because it is laden with heavy moralistic tones. We need a significantly revised approach which includes among other things age-appropriate comprehensive sexuality education, comprehensive reproductive health information and services, school-based services, family life and life skills training, and on-going parenting education and family support efforts.~~

Abortion

(1) What is your position on abortion?

~~Individuals have a right to complete and accurate medical information and unharassed access to safe, legal medical services.~~

See insert 3 attached

(2) Do you believe a woman should have a right to an abortion, for any or no reason, throughout the entire duration of pregnancy?

~~I support the right to privacy as articulated in the 1973 Supreme Court decision Roe v. Wade.~~

See insert 4 attached

(3) Do you support reasonable restrictions on abortion such as parental consent for minors? What about parental notification?

~~Ideally, parents should be involved in decisions affecting the health and well-being of their children. In real life, however, such matters are not clear-cut, and as with all such controversial matters, parental consent and notification requirements are a matter of continued policy debate both at the State and Federal level.~~

See insert 5 attached

(4) What is your position on the Freedom of Choice Act?

~~This bill codifies the tenets of the Roe v. Wade decision legalizing abortion and defers to States on matters of parental involvement and public funding. The Department is reviewing this legislation, however, to date, we have no formal position.~~

See insert 6 attached

(5) Do you support the 'Hyde' amendment which prohibits the expenditure of federal funds for abortion except in those cases where the mother's life would be endangered if the fetus was carried to term?

~~The Administration's FY 1994 budget request proposes repeal of the Hyde Amendment,~~ an annual HHS appropriations rider which has ~~prohibited~~ the use of ~~any~~ federal funds for abortions since the mid-70s. ~~The Administration will be working with the Congress to provide for an approach that is consistent with Federal and State laws.~~

so-called

does not

include

limited

Insert 3: The right of personal privacy is a fundamental liberty guaranteed and protected by our Constitution. The Government's role should be to reduce the need for abortion, not to interfere with the difficult and intensely personal decisions women must sometimes make with regard to abortion.

Insert 4: The application of the right to privacy in this content has been articulated by the Supreme Court in Roe v. Wade.

Insert 5: The Administration opposes any Federal attempt to limit access to abortion through mandatory waiting periods or parental or spousal consent requirements. The Administration supports State efforts to require some form of adult counseling or consultation for underage girls who choose to have an abortion -- as long as workable and effective bypass provisions are attached to such laws.

Insert 6: The Administration supports the Freedom of Choice Act, which codifies the tenets of Roe v. Wade.

(6) What is your position on RU-486?

~~I support the President's efforts in which~~ The President directed the Department to review the scientific basis for the import ban on RU-486 and to pursue initiatives that promote the testing, licensing, and manufacturing of RU-486 in the U.S. FDA has since lifted the ban and Roussel-Uclaf, the French manufacturer of RU-486, has agreed to license the drug to an American organization, the Population Council, to begin the process of clinical trials in the U.S.

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 27, 1995

Honorable Steny Hoyer
Subcommittee on Treasury, Postal Service
and General Government
Committee on Appropriations
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Hoyer:

I understand that your Subcommittee is considering including in the 1996 Treasury, Postal Service and General Government Appropriations Act a provision that would prohibit health plans that participate in the Federal Employees' Health Benefits Program (FEHBP) from providing coverage for abortions.

From the inception of FEHBP in 1959, the Office of Personnel Management has opposed statutory restrictions with respect to benefits coverage, on the grounds that the health care needs of Federal employees and their families can best be addressed through negotiations between OPM and the many health insurance carriers and plans that participate in FEHBP.

Currently, as you know, the decision to cover abortion is left up to each health plan participating in the FEHBP. At this time, approximately 178 of the 345 FEHBP plans have chosen to cover abortion, with some others covering it in certain circumstances. Federal employees who wish to purchase health coverage that does not include abortion services have that choice.

The Administration believes that employees should continue to have both options. Therefore, we oppose an amendment that would prohibit FEHBP health plans from covering abortion services. While the President believes that abortion should be safe, legal and rare, we do not believe that Federal employees and their dependents should be restricted from choosing to spend their premium dollars on a health plan that includes coverage for abortion services.

Sincerely,

Alice M. Rivlin

Alice M. Rivlin
Director

Identical letter sent to the Honorable Jim Lightfoot

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WASHINGTON, D.C. 20503

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Sincerely,

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Director

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Reproductive Health, Reproductive Rights and Family Planning

• Reproductive health is the condition in which the reproductive process is accomplished in a state of complete physical, emotional and social well-being. Reproductive rights provide the framework in which to achieve reproductive health. Such rights include an individual's and/or couple's right to determine the number and spacing of births. Comprehensive family planning services facilitate the securing of these rights.

Fertility

• Fertility is probably the single most important gauge of reproductive health. There are four key factors affecting fertility: 1) age at marriage; 2) contraceptive use rate; 3) number of months of post-partum sterility (approximated by the time spent breast-feeding); and, 4) rate of induced abortion. Contraceptive use rates have the strongest overall effect closely followed by the age at which a woman first marries. The influence of this factor is, however, being diminished by the worldwide increase in out-of wedlock births.

• Over 100 million acts of sexual intercourse occur daily resulting in approximately 910,000 conceptions. At least 50% of these are unplanned, and 25% are unwanted. Worldwide, approximately 390,000 infants are born every day. The total fertility rate (average number of children per woman) has fallen in developing countries from 6.1 in 1965-1970 to 3.6 in 1990-1995. For women in the developed world, the average is 1.9.

Reproductive Rights

• International guarantees of reproductive rights have evolved since the mid 1960's. In 1968, the UN International Conference on Human Rights (Teheran) granted "the basic human right to determine freely and responsibly the number and spacing of their children" to "parents" and the 1974 Population Conference at Bucharest affirmed the right for "all couples and individuals." In the 1978 Alma Alta Declaration, family planning and maternal and child health were included in the definition of "primary health care." Article 16 of the 1979 UN Convention on the Elimination of all forms of Discrimination against Women conferred "on a basis of equality of men and women...the same rights to decide freely and responsibly on the number and spacing of their children." The article went on to embrace the right to "access to information, counseling and services in family planning."

Adolescent Pregnancy

• Even though the fertility rate among adolescents has been declining on a global basis over the past decades, very high rates of adolescent pregnancy still exist in many countries of

Africa and Asia. From a social standpoint, concern rises from the limitation this childbearing places on educational and employment opportunities. In most countries, children of adolescents face greater-than-average health risks, particularly if the mother is very young (under 18 at the time she gives birth). There are significant barriers worldwide to providing sex education and family planning services to adolescents. Contraceptive use is low among adolescents and the risk of contracting STDs and HIV/AIDS remains high.

• Currently, almost 15 million births of the more than 140 million per year are births by adolescent women (90% in developing countries). A study of 38 countries found that the percentage of women bearing children before the age of 20 ranges from 50% in Africa to 38% in Asia and 36% in Latin America. In traditional societies, most of these births occur within marriage.

• With increasing urbanization, educational opportunity, and age at first marriage, the amount of time between the onset of menarche and marriage is increasing and the rate of out of wedlock pregnancy is rising globally. In Latin America, 30-50% of current births to teens were conceived out-of-wedlock.

Infertility in Sub-Saharan Africa

Data on childlessness in 49 developing countries reveals an infertility belt in Central Africa.

Region/country	Infertility Rate
Sub-Saharan Africa (22 countries)	3% - 32%
(weighted average - 10.1%)	
Other developing countries (27 countries)	1% - 7%
(average - 3.4%)	
Central Africa	
Gabon	32%
Congo	21%
Zaire (parts)	21%
CAR	17%
Cameroon	15%

Infertility

• An inclusive definition of reproductive health implies the ability to bear children that are wanted. While infertility generally poses no threat to physical health, there may be implications for mental and social well-being, particularly in instances of divorce and desertion for infertile women. WHO estimates that there are 60 to 80 million infertile couples worldwide. Most infertility is potentially preventable or treatable.

• Acquired infertility, the vast majority of cases, is most often caused by pelvic infection due to sexually transmitted diseases (STDs) and thus considered preventable. Infection-related infertility in men is relatively low. However, transmission of STDs by men to their female partners is often a root cause of female infertility.

Sexually Transmitted Diseases (STDs) and HIV/AIDS

• Approximately 356,000 sexually transmitted viral and bacterial infections occur daily (over 125 million new cases annually). These include gonorrhea, syphilis and chancroid, chlamydia trachomatis, human herpes and papillomavirus and human immunodeficiency virus (HIV).

• The consequences of STDs for women are generally worse than for men, in whom they are easier to detect and treat. In women, STDs often lead to pelvic inflammatory disease,

greater risk of ectopic pregnancy and permanent infertility. STD pathogens can also be transmitted to a fetus or newborn during pregnancy, birth or breastfeeding.

• The WHO estimated that by 1991, there had occurred at least 2 million cases of AIDS and 10-12 million HIV infections. AIDS has been reported in 162 nations around the world. By the year 2000, the WHO estimates there will be 30-40 million HIV infections and 12-18 million AIDS cases globally, the majority resulting from transmission through sexual intercourse. Ninety percent of the infections will occur in developing countries and 5-10 million of them will be among children, mostly in sub-Saharan Africa.

Maternal Mortality

• Between 350,000 and half a million women die each year in the course of pregnancy and childbirth. Factors contributing to increased risks of death during pregnancy include poor nutrition, illiteracy, lack of income and employment opportunities, poor environmental conditions, inadequate health and family planning services and low social status.

Female Genital Mutilation

• Between 30 million and 80 million women in nearly 40 countries in east and west Africa and parts of the Arabian peninsula have been subjected to female genital mutilation. The procedure is usually performed outside the established medical system and can thus have grave physical and health consequences. The risk of death during childbirth doubles and the risk of stillbirth increases seven-fold for women who have undergone the procedure.

• Various religious and cultural rationales have been advanced to explain the origins and continuation of the practice. These include that female circumcision increases pleasure for husbands and reduces a woman's sexual desire, thus "saving" her from temptation and infidelity.

Family Planning

Three major rationales underlie fertility regulation through family planning. First, the ability of couples and individuals to choose the number and spacing of children is recognized as a basic right. The human rights rationale recognizes the equality of women and the role of fertility regulation in facilitating completion of education, maintenance of employment, and partnership in marital decision-making. The health rationale underscores improving maternal and infant health by reducing births too early and too late in a mother's life, increasing the intervals between births, diminishing high birth orders and addressing needs

In 1951, India adopted the first country-level population policy. The family planning program was not limited to regulating birth control or the spacing of children, but was designed to ultimately promote the family as a unit of society. By 1965, 10 countries, representing more than 50% of the developing world's population had adopted national programs to reduce population growth rates.

From approximately 1960 to the mid 1980's there was an explosion of activity, characterized by increasing support for family planning in the industrialized and developing worlds, the introduction of oral contraceptives and the plastic IUD, and the establishment of the United Nations Fund for Population Activities. By 1990, 82% of the people in the developing world were living in countries that had official policies to slow population growth.

in the post-partum and breast-feeding periods. The demographic rationale addresses the negative effects of rapid population growth on socio-economic development.

Contraceptive Access, Methods and Usage

• In developing countries, the use of contraceptives has increased dramatically over the quarter century. Contraceptive prevalence rates rose from 9% in 1960-65 to 51% in 1990. Regionally, increases varied significantly. In East Asia, contraceptive prevalence rates rose from 13% to 70%, in Latin America from 14% to 60%, in South Asia from 7% to 40%, and in Africa from 5% to 17% over the same time period.

Family Planning Programs

There are 5 types of family planning program activities which receive broad international support. They are:

1) demonstration projects;
2) provision of contraceptives;
3) support of advanced training in population and family planning;
4) assistance in gathering data; and,
5) other technical assistance including support of clinical services.

Furthermore, information, education and communication activities which seek to inform people about family planning methods and services and thus generate demand for family planning.

• Eighty-two percent of contraceptors in the developing world use one of three methods: the IUD, sterilization and the pill (oral contraceptives). The same methods are used by only 45% of contraceptors in industrialized countries where condom use is much higher (20% vs 5%). The pill is the most widely used contraceptive in terms of global accessibility but its use is relatively unimportant in China and India.

• Currently, UNFPA estimates that 60% of the population of developing countries have ready and easy access to at least one modern contraceptive method (individuals can obtain supplies using less than 2 hours per month and 1% of their wages). Studies show that on average slightly under two contraceptive methods are available per country and that countries with more methods available have substantially higher contraceptive prevalence rates (up to 12% per new method introduced). Approximately 300 million couples have no access to family planning methods and services.

• Unmet need for contraceptives can be defined as the number of women/couples who are not currently contracepting but who either want to delay their next birth or want no more children. A recent study in 25 countries in Latin America, Asia and sub-Saharan Africa of women who have given birth in the past two years, and who are exposed to pregnancy but not using contraceptives revealed that 33% to 70% wanted either to delay the next birth or stop having children. This indicates a high level of unmet need.

• Improvements in the quality of care within family planning services can increase effectiveness and better meet clients' individual needs. Numerous actors affect quality including: availability and choice of contraceptive methods; the amount and accuracy of information provided to users; the general competence of the provider; the nature of the client-provider relationship; the degree to which clients are recontacted and a follow up mechanism is in place; and, the availability of an appropriate mix of services.

• Reproductive rights and the extent of these rights has long been a bone of contention between various religious, socio-cultural, women's and human rights groups and governments. Recent efforts to broaden the definition are starting with the health, well-being and empowerment of women. This includes health considerations beyond family planning and covering the full range of health needs associated with reproductive and sexual health. Access to safe early abortion, as a means to reduce maternal mortality, issues of sexuality - granting women and men the right to lead self-determined sexual lives free form fear of pregnancy, cultural stigma and disease, as well as discussions of whether population programs should be neutral - neither pro nor anti-natalist in orientation, form part of the current debate.

• As a health issue, early research indicated that women under 20 have more pregnancy and delivery complications and die more often than those over 20. Furthermore, children born to younger mothers were shown to be at increased risk of mortality and morbidity. More recent research indicates that with proper nutrition and pre-natal care, women under 20 show no greater risk than those over 20 in terms of childbirth. However, those conditions are unlikely in developing countries whether due to poverty, lack of health facilities or social stigma and lack of familial support for pregnant teens.

• The determinants of an individual's reproductive health are varied. Socio-economic conditions, including economic status, nutrition and access to clean water and sanitation affect overall health concerns. Lifestyle choices such as smoking and sexual behavior can promote or diminish health. Access to appropriate health care services and the fruits of research in terms of expanded knowledge and technological innovation can also positively influence health outcomes.

Other issues

Community-based delivery systems
Social marketing of contraceptives
Cost of supplies/services

Family planning and health - health of children, mothers, STDs

Role of government, NGOs, private sector

Reproductive decision-making

(i.e., joint decision with partner and not subordinate to other family members, ethnic groups, religious institutions, health providers, policy-makers)

Notes

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Health and Mortality

• Death rates have fallen dramatically over last 40 years. Half of the reduction can be accredited to socio-economic development which includes rising standards of living, increased education, and improvements in the status of women, while the other 50 percent is due to public health technology. The eradication of disease carrying insects and rodents, chlorination of drinking water, establishment of good sewage systems, child vaccination programs, the introduction of dietary supplements, and education programs to support better personal hygiene have all played part in the public campaign to reduce deaths globally.

• From an economic standpoint, improvements in health increase growth in four ways by: 1) reducing production losses due to worker illness; 2) permitting the use of natural resources totally or nearly inaccessible due to disease; 3) increasing enrollment of children in school and making them better able to learn; and, 4) freeing resources for alternative uses that would have been spent on treating illness.

• In much of the developing world, high mortality rates persist. Nearly half of the annual deaths are among children under the age of five (largely due to infectious diseases) and less than five percent of total deaths occur among people over the age of 75. Health care is concentrated in maternal and infant care, and the treatment of infectious and parasitic diseases. There is limited need for long term hospitalization.

LIFE EXPECTANCY

Worldwide, life expectancy rose from 47.5 years in the early 1950's to nearly 64 years in the late 1980s.

Region	early 1950's	late 1980's
Latin America	52 years	64 years
East Asia	45	71
South Asia	38	58
Africa	36	54
Industrialized countries	65	70
Extremes		
Low: Sierre Leone	30	42
High: Norway	72	
Japan		78

Three hundred million people live in one of twenty countries where life expectancy is under 50 years.

• In the developed world, low mortality conditions exist. Less than two percent of deaths are among children under 5, while nearly two thirds of the deaths are among the elderly over 75 years of age. Health care for extended periods of sick care to increasingly elderly and disabled populations and the treatment of debilitating chronic diseases predominates.

• Differences in the nature of health care needs, the structure of the health care system and available resources are also reflected in differences in health expenditures. In the low and middle income countries of the developing world, as well as Eastern Europe and the former Soviet Union, approximately 2-7% of gross national product (GNP) is spent on health care. The developed world spends between 6-13% on health care. On a per capita basis, annual health care expenditures range from under $5 in certain countries in Africa and Asia to $2800 in the United States.

Some Key Milestones in Public Health

18th century:
- Jenner creates first vaccine
- Semelweiz introduces safer, cleaner childbirth techniques

19th century:
- Lister discovers germ theory
- 1864 - first sanitary system (NYC)
- 1871 - first drinking water filter
- 1895 - first septic tank

20th century
- 1900 - development of chlorine
- 1940 - development of penicillin
- 1967 - Intensified Smallpox Eradication Programme begins (WHO)
- 1977 - Smallpox eradicated

Adult Health

• For adults, aged 15 to 65, in the industrialized world, lifestyle is a significant determinant of health, most problems being preventable. Diet, exercise, and the use/abuse of alcohol, tobacco and drugs are key indicators.

• In the developing world, a dual pattern of health concerns exists. While infectious and parasitic diseases are fading as causes of death among children, for those over 30, the high prevalence of these diseases in their childhoods left residual effects. Many suffer permanent disabilities including lameness due to polio, blindness from trachoma, and hearing loss due to ear infections. Some of the diseases have progressive consequences such as rheumatic heart disease and liver cirrhosis due to schistosomiasis. Still others remain active throughout their lives, such as tuberculosis, hepatitis B and malaria.

• As societies industrialize, adult health is increasingly affected by substance abuse, increased dietary fat, injuries, pollutants and violence. Declines in adult mortality for industrializing countries will be associated with reductions in 1) infectious disease; 2) maternity-related conditions; 3) digestive diseases; and, 4) cardiovascular diseases.

Maternal and Child Health

• In 1950, 24 percent of children worldwide died before reaching their 5th birthday. By 1990, this figure had dropped to 10.5 percent. Children born in the industrialized world live on average 20 years longer than their counterparts in developing world, much of the difference due to deaths to children under 5. However, an 8 to 9 year difference persists beyond the age of five because children in the developing world are more likely to suffer from or be weakened by nonfatal diseases.

• Children born to woman under 20 are 35% more likely to die before age one than those born to women in their twenties and thirties while those born to woman over 40 are 47% more likely to die. Children born less than two years after a sibling are 80% more likely to die in their first year than those born more than two years later. Children seventh born or

higher are 50% more likely to die than the third or fourth born.

• Most deaths to children under five are caused by a few major diseases. Child survival programs focus on low cost technologies and education to promote the health of children. These programs include immunizations for diphtheria, whooping cough and tetanus (DPT vaccine), measles, polio, tuberculosis, and maternal tetanus toxoid (to prevent neo-natal tetanus); oral rehydration therapy to combat diarrheal diseases; vitamin A supplements and nutrition programs; the promotion of breastfeeding and birth spacing; and, malaria treatment and prevention. Due to improvements in the availability of clean water and sanitation combined with successful oral rehydration campaigns over the past ten years, diarrheal diseases are no longer the leading cause of child deaths.

• Mothers are the primary health providers for their children. A mother's level education is key. The more educated a woman, the better her knowledge of health, hygiene and nutrition, both for her children and herself (thus reducing the incidence of low birth-weight babies). An educated mother is more likely to seek pre- and post-natal care, see that her children are immunized, seek care when her child is ill and use family planning services. Studies in Africa in the late 1970s showed that a ten percent improvement in female literacy rates reduced child mortality by 10% while studies in Peru showed that mortality risks fell 75 percent when mothers had 7 or more years of schooling.

• The goal of family planning in health terms is to help couples and individuals delay pregnancy until the most appropriate time considering a woman's age, spacing and number of children, in order to prevent high-risk or unwanted pregnancies. To reduce risks to both mothers and children, pregnancies should be prevented from occurring too early (under 20), too late (over 40), too often (birth intervals less than two years) and too often (high birth orders).

• One contentious and often neglected health issue which greatly impacts maternal mortality is access to safe abortion. Nearly 30 percent of pregnancies end in abortion. There are approximately 55 million induced abortions annually with as many as 25 million of these performed under unsafe conditions. Estimates of maternal deaths due to unsafe abortions range from 60,000 to 200,000 per year.

Urbanization

• Urbanization, particularly in the developing world, has dual impacts on health. On the positive side, movement to urban areas often leads to better living conditions, transport, markets and health care. Public sanitation and water systems are more likely to be in place, reducing the incidence of communicable and infectious diseases. By 1990, 76 percent of urban dwellers had access to clean water and sanitation versus only 53 percent of the rural population. But new risks associated with accidents (motor vehicle deaths), pollution, increased alcohol and tobacco consumption, over consumption, sedentary lifestyles, and the exposure to sexually-transmitted diseases offset some of the gains.

Sexually Transmitted Diseases (STDs)

• Inability to control the spread of STDs is a major public health disappointment.

Approximately 356,000 sexually transmitted viral and bacterial infections occur daily (over 125 million new cases per year). Traditional venereal diseases like gonorrhea, syphilis and chancroid have declined, particularly in developed countries. However these STDs have been replaced by a second generation of diseases - chlamydia trachomatis, human herpes virus, human papillomavirus and human immunodeficiency virus (HIV), which are more difficult to identify, treat and control, often leading to chronic ill health, disability and death.

• The consequences of STDs for women are generally worse than men, in whom they are easier to detect and treat. In women, STDs often lead to pelvic inflammatory disease, greater risk of ectopic pregnancy and permanent infertility. STD pathogens can also be transmitted to a fetus or newborn during pregnancy, birth or breastfeeding.

• Widespread HIV infection and AIDS appeared in the late 1970's or early 1980s. By 1991, the WHO estimated that there were at least 2 million cases of AIDS and 10-12 million HIV infections in 162 nations around the world. While the rate of infection appears to be slowing in developed world, it is on the rise in the developing world.

• By the year 2000, the WHO estimates there will be 30-40 million HIV infections and 12-18 AIDS cases globally. Ninety percent of these will occur in developing countries and 5-10 million of the HIV infections will be among children, mostly in sub-Saharan Africa.

MORTALITY

• Biologically, the risk of death is greatest during the first year of life and post mid-life. These risks affect life expectancy or average length of life which is a measure of longevity.

Leading Causes of Death among Adults

Developed Countries	Developing Countries
Cancer	Cardiovascular disease
Heart disease	Cancer
Injuries	Respiratory diseases
Stroke	Tuberculosis
Suicide	Digestive tract diseases
Liver disease	Accidents
Chronic lung disease	Suicide/homicide/wars
Homicide	STDs/HIV/AIDS
HIV/AIDS	Diabetes
Diabetes	Maternal deaths

Causes of Death

• Degeneration or chronic disease leads to the gradual deterioration of the body. Chronic diseases are the major causes of death in the industrialized world (accounting for 75% of annual deaths in US). In order of annual deaths in the US, the major degenerative diseases are 1) cardiovascular disease; 2) cancer; 3) stroke; 4) arteriosclerosis; 5) diabetes; 6) cirrhosis of liver; 7) hypertension; and, 8) ulcers.

• Communicable or infectious diseases are generally transmitted from person to person. Tuberculosis accounts for approximately one death in five in the developing world, the most prevalent of infectious diseases globally. Hepatitis B is the leading cause of liver cancer, which is particularly prevalent in China, Southeast Asia and Africa. The advent and rapid spread of AIDS and the virus which causes it has focused attention on a new class of sexually-transmitted diseases which are more difficult to identify, treat and control than the first generation of such diseases. WHO predicts that there will be 30-40 million HIV

infections and 12-18 million AIDS cases globally by the year 2000.

• Accidents are among the top five causes of death in both the industrialized and the developing worlds. These deaths can be due to a variety of factors such as job-related injuries, environmental disasters (floods, earthquakes, hurricanes, etc.) and motor vehicle accidents. Homicide and suicide close out the list of major causes of death.

International Mortality Targets

The World Plan of Action, initiated at the 1974 Population Conference at Bucharest, set targets for reducing mortality. By 1985 countries with the highest mortality levels should reach life expectancy at birth of at least 50 years and infant mortality rates (IMR) under 120 deaths per 1000 children under one year old. The 1984 Mexico City Conference updated these to the year 2000, setting life expectancy targets of 60 years and IMRs under 50 (for intermediate countries, 70 years and IMR under 35).

Results: In 1988, evaluations were made of progress toward the goals. Half of African countries did not reach the targets for 1985 and fewer were expected to reach the targets for 2000. All of Latin America (except Haiti) reached the 1985 targets and more than half are expected to reach the goals for 2000. In Asia, three quarters of the countries reached the 1985 goals and slightly fewer than half should reach the targets for 2000. In Oceania, only Papua New Guinea is expected to reach the goals.

Mortality Differentials

• Gender plays a significant part in mortality differentials. Women in the industrialized world live an average of 7 years longer than their male counterparts while women in the developing world live from 2 to 7 years longer than do males.

• Individual socio-economic status affects risk of death. Skills and education affect occupation and income. These in turn dictate the occupational and environmental hazards to which one is exposed. Also, marital status affects risk factors as the unmarried typically have higher suicide rate and higher substance use/abuse rates.

Smoking

Smoking is an international health problem. Globally, nearly 50 percent of males and 10 percent of females smoke, and the rate is rising by 2 percent annually. WHO estimates that nearly 2.5 million deaths due to tobacco occur annually. This figure is expected to rise five fold over next 50 years, with most of the increase in the developing world. Chronic diseases associated with smoking are manifested on average 20 years after the start of smoking and occur at about ten times the rate of tobacco deaths.

• Risk of death varies significantly by age group. Though infant mortality rates have been falling, the highest risk of death is in the first year of life. In 1960, IMRs for low middle and upper income countries were 165, 126 and 29 deaths per 1000 births respectively. Today, only 85 of every 1000 infants in the developing world and 14 per 1000 in the industrialized world die before their first birthday.

• For youth the risk of death is low and most often due to injuries and violence. However, many lifestyle choices that affect health and mortality in later life are made at an early age, such as tobacco, alcohol and substance use. Post mid-life the risk of death begins to rise again due to communicable, infectious and chronic diseases.

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WHO estimates (new cases annually - bacterial - G 25 mil, genital chlymidial infections 50 mil, infectious syphilis 3.5 mil, chancroid 2 mil - viral - genital herpes 20 mil, genital h.p. 30 mill

- For the public at large, good health can be achieved in poor countries if political commitment to equity which assures wide access to basic health services, education and food such as in China, the Indian State of Kerala, Sri Lanka and Costa Rica.

- Numerous factors interplay to affect the health of individuals, including economic status, the environment and individual knowledge. An individual's ability to purchase or procure adequate food, housing, fuel, water and medical services has a direct bearing on individual and family health status.
- The physical environment in which one lives and works also impacts health status through factors such as climate, the prevalence of communicable or infectious diseases and the state of public sanitation and water services. Individual knowledge of nutrition, hygiene and health issues directly affects health outcomes.

Crude Death Rates by Region 1950-1980

region	1950	1965	1980
SSA	29.3	22.8	17.7
ME and NAf	24.0	18.1	12.6
SAsia	28.9	20.6	14.5
EAsia (no China)	27.1	16.3	10.5
China	27.3	16.0	7.9
LA and Carib	16.6	11.7	8.5
Indust. countries	10.5	9.6	9.1

Crude Death Rate - Age/Sex Specific Death Rates
CDR - total deaths/ave total pop x 1000
Age sex specific - 5 year increments

At risk - infants born to mothers under 20, over 40 or had 7+ births or under two year interval between births. Diarrheal diseases and immunizible diseases - 50% of deaths

Urban/Rural - sanitation and water, spread of infectious disease. in west - higher life expectancy on cities due to public health/access to care - not necessarily true in third world

since ww2 - developing world - average real incomes up 2x
IMR and CMR halved
life exp up 1/3
children in school up from <1/2 to >3/4
rural access to safe drinking water - up to 60% form 10%
8 of 10 immunized fr polio nad measles

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GENDER EQUALITY AND WOMEN'S EMPOWERMENT

In 1946, although the world's 1.2 billion women accounted for half of the population they had a meager claim on opportunities and resources. Beginning with the 1946 Commission on the Status of Women, several United Nations efforts were launched to monitor and improve their condition. Many of today's 2.74 billion women have benefitted from gains in health, education, work and legal status, but **nowhere** has gender equality been reached.

The 'typical' woman: then and now

There has been rapid population growth in the developing world and slow population growth in the developed world. The proportion of women who live in the developing world has risen from 66 to 76 percent. The median age of women has dropped during this period.

	Developed		Developing	
	1950	Today	1950	Today
Demographics				
population (billions)	0.43	0.62	0.82	2.00
median age	—	—	—	—
Health				
life expectancy (years)	68.7	77.9	41.9	64.2
total fertility rate 2.8	1.8	6.1	3.7	
maternal mortality (per 100,000 live births)	—	26	—	420
Education				
% primary school aged girls enrolled	100	100+	—	96
% adult women literate	<92	96	<50	55
Employment				
% share economically active	36	42	33	34
% share of labor force	—	42	—	32

Compared to her counterpart of forty years ago, the average woman can expect to live longer and in better health. Because of developments in family planning and maternal health care she will have fewer children and be at less risk during pregnancy. The children she bears will be more likely to survive infancy. She is more likely to be able to read and write and her daughters are more likely go to school. Like her predecessors, she is likely to be economically active -- today 828 million women over the age of 15 are working for a wage, for profit or producing goods for the home-- but, she is more likely to be earning an income.

Her political and legal rights have greater recognition. To date, over 100 nations have signed the 1979 U.N. Convention on the Elimination of Discrimination Against Women, endorsing rights to: vote; hold political office; institute legal action; file for separation and divorce; receive alimony and the custody of children; and others. Meanwhile, with more national and international statistics are available that describe women's status.

Gender Disparities Remain
With the exception of life expectancy, many women lag behind men on social and economic indicators.

	Developed		Developing	
	Female	Male	Female	Male
Health				
Life expectancy(years)	78	71	64	61
Education				
Girls per 100 boys in primary school	95	—	91	—
Girls per 100 boys in secondary school	100	—	73	—
% adults literate	100?	100?	55	75
Employment				
Women per 100 men in labor force	77	—	77	—
Leadership				
% parliamentary seats	9	91	12	88

Health: Women's longer life expectancy and health advantage over men narrows as social inequity rises. Generally girls aged 2-5 years have lower mortality rates than boys, but in 17 developing countries the reverse is true. In China, India and Korea, 'son preference' promotes selective abortion and reports of female infanticide: there are usually 105-108 boys born per 100 girls but in the China there are 118. Women outlive men by seven years in the developed world but only three in the developing world. In Bhutan, the Maldives and Nepal, men live longer.

In several regions, women lack adequate food. An estimated 438 million adult women world-wide are anaemic, almost double the number of anaemic men. Women are also less likely to have access to health care, especially where tradition bars them from seeing a male doctor. In particular, women are more vulnerable to the effects of sexually transmitted diseases as these are less readily diagnosed in females.

Childbearing is an added health risk for women in the developing world, where 99 percent of the annual 500,000 maternal deaths occur. Of pregnant women there, 65 percent are anaemic, 40 percent lack prenatal care and 80 percent give birth without a medical attendant.

Education: The developing world's parents still send more sons than daughters to school and boys stay in school longer. Where women are seen only as housekeepers and childbearers, parents see no need to educate girls and remove them from school to help with household work or to marry early. Where women have less chance of securing jobs, parents are more willing to pay to educate sons. And, where tradition requires seclusion and segregation, parents are unwilling to send girls to coeducational schools. Women account for two-thirds of the developing world's 920,000 adult illiterates.

Work: In both the developed ad developing world, women are traditionally responsible for the household. Their 'unpaid work', which includes care of children and the elderly, feeding the family, fetching water and firewood, is equal to about 30 percent of global output. When this is counted, women in the developing world work more than men, up to 15 hours longer each week in parts of Africa and Asia.

Women are still outnumbered by men in the paid labor force. Employers are reluctant to hire women and provide for maternal leave; work outside the home conflicts with caring for the family; and, lesser education puts women at a disadvantage in the job market.

Women who work have lower paying and less prestigious jobs. In Asia and Africa most women work in agriculture while in Latin America and the developed world they predominate in the service sector. Opportunities in management and industry are limited in all countries.

Women's earnings do not equal men's -- on average they are paid 20 to 50 percent less. Large numbers of women work in the 'informal sector', for example, subsistence farming, tailoring or making handicrafts. Such work requires little capital or tools and can be carried out from the home with little assistance, but it is less profitable.

Legal Status and Decision-making: Despite gains, women in some countries do not enjoy the legal and political rights of men. In Kuwait? and the United Arab Emirates? women do not have suffrage. In some Islamic countries they do not have rights to own property or inheritance. In many countries women still do not have a say in when and to whom they will marry.

Wives who are younger than their husbands also have less decision-making power in the home. The average age of a bride at first marriage is 23 in the developed world, 17 in Africa and Asia, and 19 in Latin America. Meanwhile, grooms are often four years older or more. Young wives often have less control over their fertility, income, and other aspects of their lives. These choices may be left to husbands or mother-in-laws. Women are also under-represented in national decision-making as they hold only a small fraction of parliamentary seats and policy-making or leadership positions.

Key issues

By 2025, there will be 4.3 billion women in the world. Their well-being will depend on building on the progress of the past forty years to further empower women.

Large numbers of women live in regions where human development is low. Given gender inequalities, they fare even more poorly than men and their status is below that of the 'typical' woman. Efforts will be needed to both redress regional disparities and gender disparities.

	LA	EA	SEA	ME	SA	SSA
% of female population	9	22	3	3	22	10
Status						
life expectancy	70	72	65	64	59	54
total fertility rate	3.2	1.8	3.4	5.5	4.4	6.1
maternal mortality	210	130	340	320	570	690
% primary school girls enrolled	106	123	—	90	75	61
% adult women literate	83	66	—	38	32	36
Gender gaps						
female - male life expectancy	6	4	4	3	0	3
Girls/100 boys primary schl.	99	100	96	81	90	85
Girls/100 boys secondary schl.	99	99	91	71	59	64
male - female literacy rates	4	22	10	24	26	12
female as % of male labor force	48	75	70	16	29	55

LA = Latin America EA = East Asia SEA = South East Asia
ME = Middle East SA = South Asia SSA = Sub-Saharan Africa

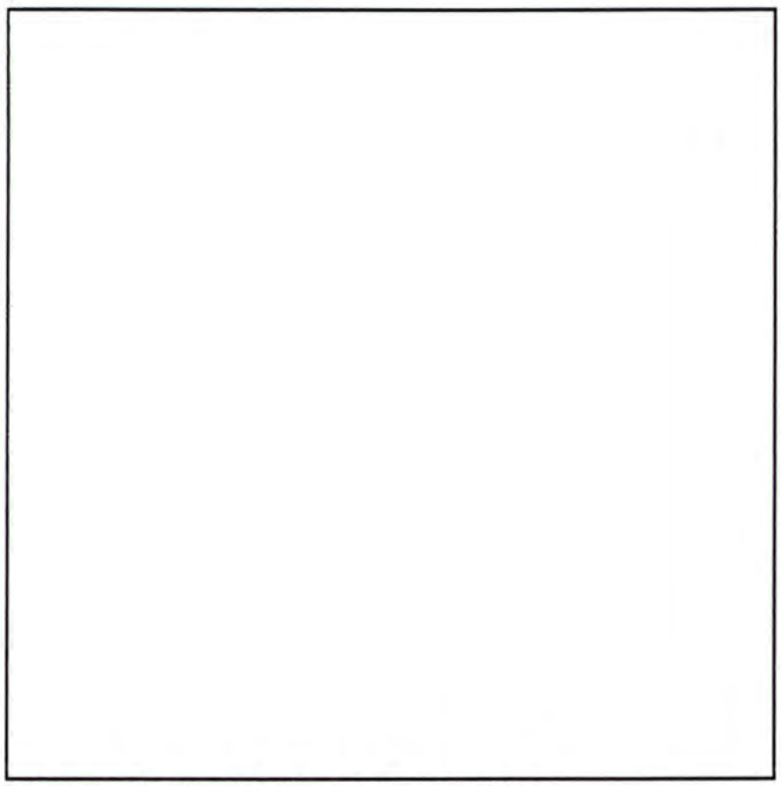
Of particular concern is the status of the "girl child." Given their inability to fend for themselves, young girls are perhaps most vulnerable to gender equality. Special attention needs to be paid to issues of son preference; inequalities in health, nutrition and education; and, early marriage and childbearing.

The role of men in supporting and achieving gender equality will be paramount. Men too will need to shed the attitudes and norms that keep women as undervalued members of society and must take on the responsibility of changing their roles in the home and at work.

Women, Population and Development: Interlinkages

Improving women's status is important in and of itself. But, it is intertwined with issues of population growth and development.

Studies suggest that improving women's status will enable them to be active partners in reducing population growth. Education makes women aware of options for family planning. Employment is an incentive to delay childbearing and have smaller families. Better health allows women to pursue education and employment and with reduced child mortality, couples are less likely to want large families. With decision-making power in the home, women are more likely to have control over their fertility.



Women's education is related to lower fertility

Similarly, improving women's status allows them to be active partners in national development. Until recently, the many of the benefits of development have not reached women or have been achieved been at their expense. In the developing world, for example, most rural credit programmes have not served women and agricultural development has affected women subsistence farming. "Gender equitable development" is needed. For example, development that invests in education and health, that supports the informal sector where women predominate, that safeguards the environment, that brings women into positions of leadership in development.

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release April 10, 1996

REMARKS BY THE PRESIDENT
ON HOUSE RESOLUTION 1833

The Roosevelt Room

5:22 P.M. EDT

THE PRESIDENT: Good afternoon. I have just met with five courageous women and their families, and I want to thank the Lines, the Stellas, the Watts, the Costellos, and the Ades all for meeting with me. They had to make a potentially life-saving, certainly health-saving, but still tragic decision to have the kind of abortion procedure that would be banned by HR 1833.

They represent a small, but extremely vulnerable group of women and families in this country, just a few hundred a year. Believe it or not, they represent different religious faiths, different political parties, different views on the question of abortion. They just have one thing in common: They all desperately wanted their children. They didn't want abortions. They made agonizing decisions only when it became clear that their babies would not survive, their own lives, their health, and in some cases, their capacity to have children in the future were in danger.

No one can tell the story better than them, and I want to call on one of them. But before I do, I want to say that this country is deeply indebted to them for being willing to speak out and to talk about the real facts, not the emotional arguments that, unfortunately, carried the day on this case.

So I'd like to ask Mary Dorothy Line to come up here and introduce herself and say whatever she'd like to say about why we're all here today.

MRS. LINE: My name is Mary Dorothy Line. My husband, Bill, and I are honored to be here today to speak for the many women and families who have also come forward to tell their stories in opposition to this terrible legislation.

Last April we were overjoyed to find out that I was pregnant with our first child. Nineteen weeks into my pregnancy, an ultrasound indicated that there was something wrong with our baby. The doctor diagnosed a condition called hydrocephalus. Every person's head contains fluid to protect and cushion the brain. But if there is too much fluid, the brain cannot develop.

As practicing Catholics, when we have problems and worries, we turn to prayer. As we waited to find our more from the doctors, our whole family prayed together. My husband and I were very scared, but we are strong people and believe that God would not give us a problem if we couldn't handle it. This was our baby. Everything would be fine. We never thought about abortion.

But the diagnosis was as bad as it could be. Our little boy had a very advanced textbook case of hydrocephaly. All the doctors told us there was no hope. We asked about in utero surgery, about shunts to remove the fluid, but there was absolutely nothing we could do. I cannot express the pain we still feel. This was our precious little baby, and he was being taken from us before we even had him.

This was not our choice, for not only was our son going to die, but the complications of the pregnancy put my health in danger, as well. If I carried to term, he might die in utero, and the resulting toxins could cause a hemorrhage and possibly a hysterectomy. The hydrocephaly also meant that a natural labor risked rupturing my cervix and my uterus.

Several specialists recommended that we terminate the pregnancy. I thank God every day that I had this safe medical option available to me, especially now that I am pregnant again and expecting a baby in September.

I pray every day, I really do, that this will never happen to anyone else. But it will. Those of us unfortunate enough to have to live this nightmare need a procedure that will give us hope for the future.

And I thank God for President Clinton; we all do here. the people who promoted this bill do not understand the real issues, but he does. It is about women's health, it's not about abortion, and certainly not choice. These decisions belong to families and their doctors, not the government. President Clinton listened to us and protected families like ours by vetoing legislation that would hurt so many people.

Thank you, Mr. President.

THE PRESIDENT: Thank you.

I'd like to ask Coreen Costello to come up and speak a little bit about her experience.

MRS. COSTELLO: My name is Coreen Costello, as you heard. I found out when I was seven months pregnant that my daughter was dying. She was dying inside my womb. The complications that she had posed severe health risks to me. One of the conditions she had was polyhydramnia, where the amniotic fluid puddles into the uterus.

I had over nine pounds of excess amniotic fluid. My daughter's body was rigid and it was stuck in a position that was as if she was doing a swan dive inside my womb. Her head and -- the back of her feet were touching the back of her head at the top my uterus. There was no way to deliver her.

My husband and I have always been extremely opposed to abortion. We consider ourselves very, very much pro-life, conservative Republicans. For us, terminating this pregnancy was not an option. For three weeks we attempted to turn my daughter so that I could deliver her vaginally and naturally. We had one hope, and that was that we would be able to hold our daughter alive for possibly an hour, maybe two.

Over the three weeks that we carried her we realized that that was not a possibility. She was dying and she would likely not survive any labor and there was no way I could deliver her. We had her baptized in utero. We named her Katherine Grace. We then realized that our only safe option was the procedure that is being outlawed -- is being attempted to be outlawed.

I am so grateful because today I am standing here before you pregnant again with a healthy child. I have two children. I have my health. I don't know how to tell you how important that is. This was such a tragedy, such a personal family tragedy. Our daughter will always be a part of our lives. There will always be someone missing in our family, and that's Katherine Grace. But I am so grateful for the ability to be able to go on and enjoy the two children that I do have, to be with my husband, to be with my family, and to be here today.

And that's what this is about. This is not about choice. We made a very different choice than what we ended up having to have. This is not about abortion, and it's not about choice. It's a medical issue. And I am so grateful for President Clinton and his ability to hear our stories, because we have been telling them for a long time and a lot of people haven't listened. But this is the truth, and this is what happened to us. And as painful as it is, we are all here to share that with you.

Thank you.

THE PRESIDENT: Thank you.

I would also like to thank Jim and their children, and William.

Would you tell them what you told me in the office? Can you do it? This is Tammy Watts.

MRS. WATTS: Hi, my name is Tammy Watts. I live in Tempe, Arizona. I simply told our dear President that my story is not so different from everyone else's. I have the heartache, I have the same tragic story. I have the loss in my heart, as does my husband and the rest of my family and friends.

The fact is this: I would have given my life and traded placed with my daughter, Mackenzie. And in fact, with my pastor, that is exactly what I prayed for for the three days we tried desperately to find something that could cure her. You simply look for a magic wand and it's not there.

I am so thankful to our doctors, who were able to perform this very safe medical procedure, save our health, save our families. And I am particularly thankful to our President, without whom we would not be here. And he is a true blessing in all of our lives.

Thank you.

THE PRESIDENT: Thank you, Mitchell -- and those are the prints of your baby, right?

MS. WATTS: Yes, this is my daughter Mackenzie's handprints and footprints. This is something that is very special to us, and is something that we would not have if we did not have this very safe procedure.

THE PRESIDENT: Vikki, do you want to say anything?

MRS. STELLA: My name is Vikki Stella, and I'm from Chicago, Illinois. My story is basically the same thing. We're like a family now. And at 32 weeks I found out that my son wasn't growing properly, and when everything was all done and said and the ultrasounds were in and I had the answer, I found out my son had nine major anomalies, one including no brain. It did not show up on the amnio because it was a closed neural tube defect, so those things don't show up. That's for genetic research.

And I miss my son. But the one part I want to stress is I needed this for health reasons. I'm a diabetic. Other procedures would not have been what I needed. I don't heal as well as other people, so other procedures just were not the answer. I could have gone on and maybe tried to give birth to a child that would not live.

I didn't make the decision for my child to die; God made the decision for my child to die. I had to make the decision to take him off life support.

THE PRESIDENT: Thank you. And you have a baby here.

MRS. STELLA: Yes, I have a little boy here.

THE PRESIDENT: You have a three-month-old little boy here.

MRS. STELLA: Nicholas.

THE PRESIDENT: Claudia, would you like to talk?

MRS. ADES: Much like everyone else -- we've all had similar circumstances -- I was six months pregnant, 26 weeks into my pregnancy and happier than I had ever been in my entire life when, in a routine ultrasound, we found out that there was something terribly wrong with our son. He had fluid in his brain that was keeping his brain from developing. He had a hole in his heart, a hole between the chambers of his heart so that there was no normal blood flow.

He had -- I won't go on with the details, but horrible, horrible anomalies, and he stood no chance of survival. It was something -- it was a chromosomal abnormality, called Trisomy-13. It was actually the same condition that Tammy Watts's baby had.

Again, like everyone else, we begged for a cardiologist or a neurosurgeon or someone that could fix my baby's brain or the hole in his heart. And when we got the news -- I say this for the people that say that we don't care and for the people who say we don't want our children, and for the people that say we have no spirit or no soul or no religion.

My husband and I are Jewish and we got the news on Rosh Hashana. And when we finally had the procedure, the third day of this grueling procedure, it was Yom Kippur, the holiest day of the Jewish year. And Yom Kippur is the day that you mourn those that have passed, and it's the day that you pray that God will inscribe them in the Book of Life.

We'll forever, and for the past four years and forever we will mourn our son. We are very -- since that pregnancy, unfortunately lost five more, but we are very blessed that in July we're going to adopt a baby and we're going to be parents, and we're going to have the child we so desperately wanted.

And we are all here, my husband, myself and all of the other people standing behind me, we are all here as we have been for months, fighting in Congress. I just actually came back with Mary Dorothy from Sacramento, where we were testifying, where it is now in the State of California. And we are all here for the women that follow us, because all women deserve the finest medical care that exists. And we are the blessed ones and we want that for them.

And like everyone else, I just want to thank the President, because it's an enormous, enormous responsibility that he's taken. And we're all here to back him up -- it's so, so important what he's doing.

Thank you.

THE PRESIDENT: Thank you very much.

Thank you. Thank you, Richard. Thank you, Mitchell.

Ladies and gentlemen, I asked these families to come here today to make a point that I think every American needs to understand about this bill. This is not about the pro-choice/pro-life debate. This is not a bill that ever should have been injected into that.

This terrible problem affects a few hundred Americans every year who desperately want their children, are trying to build families, and are trying to strengthen their families. And they should not become pawns in a larger debate, even though it is a serious and legitimate debate of profound significance.

I hope that we can continue to reduce the number of abortions in America. When I was governor I signed a bill to restrict late-term abortions, consistent with the Supreme Court decision of Roe v. Wade, only cases where the life or health of the mother is at risk. When I asked the supporters of the bill here to try to take account of this, they said, well, if we have a health exception you know you could -- the doctor and the mother could say anything -- they can't fit in their prom dress, that's a health exception -- some terrible things like that.

And I said, no, no, no, I will accept language that says serious, adverse health consequences to the mother. Those three words. Everyone in the world will know what we're talking about. We're talking about these families. I implored them. I said, if you want to pass something on this procedure, let's make an exception for life and serious adverse health consequences so that we don't put these women in a position and these families in a position where they will lose all possibility of future child-bearing, or where the doctor can't say that they might die, but they could clearly be substantially injured forever.

And my pleas fell on deaf ears. The emotional power of the description of the procedure -- which I might add did not cover the procedure these women had and did not cover all the procedures banned by the law -- but the emotional power was so great that my plea just to take a decent account of these hundreds of families every year that are in this position fell on deaf ears. And, therefore, I had no choice but to veto the bill. I vetoed it just a few minutes ago before I met with these families.

I will say again, if the Congress really wants to act out of a sincere concern that some of these things are done, which are wrong, in casual ways, then if they will meet my standards to protect these families, they could pass a bill that I would sign tomorrow. But these people have no business being made into political pawns.

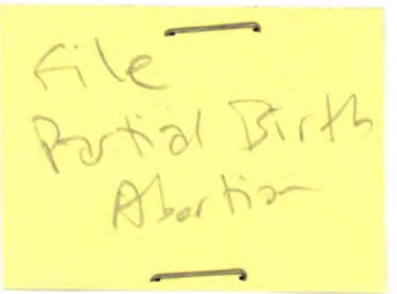
As I said, and as they said, they never had a choice. This affects staunchly pro-life families as well as people that are pro-choice. They never had a choice. And I cannot in good conscience see their lives damaged and their potential to build good, strong families damaged.

We need more families in America like these folks. We need more parents in America like these folks. They are what America needs more of. And just because they happen to be in a tiny minority to bear a unique burden that God imposes on just a few people every year, we can't forget our obligation to protect their lives, their children, and their families' future.

That is what this veto is all about. And let me say again how profoundly grateful I am to them for coming here today and having the courage to tell their stories to the American people.

Thank you. Thank you all very much.

END 5:40 P.M. EDT


File
Partial Birth
Abortion

Late-term abortion veto merits analysis

Bill would ban single method; others bring higher risk to mother

Those opposed to abortion have the right and duty to urge public officials to work diligently to make abortion "rare." President Clinton in his campaign promised that he would work to make abortions "legal, safe and rare." But opponents of abortion cannot reasonably or responsibly fault Clinton for his April 10 veto of a bill that would have criminalized certain late abortions.

This issue will be used and abused by the Christian Coalition and the Republican Party during the presidential cam-

ROBERT F. DRINAN

paign. Consequently, comprehensive information and careful analysis are in order.

The number of U.S. abortions has edged downward in recent months. In 1993, the last year for which we have adequate statistics, there were about 1.3 million abortions, down 2.1 percent from the 1992 figure. Of these, 1.3 percent — or about 17,000 — were performed on women whose pregnancies had gone more than 20 weeks.

One of the late-term abortion techniques is "dilatation and extraction." It was this technique that alone would have been forbidden in the bill Clinton vetoed.

Jesuit Fr. Robert Drinan is a professor at Georgetown University Law Center.

There are no reliable statistics as to how often this technique is used or how often the aborted fetus is normal. Other methods for late-term abortions include inducing labor to deliver a fetus whose life has been extinguished by chemical means and a surgical procedure removing the fetus from the abdomen.

Although these techniques would not have been outlawed by the bill vetoed by Clinton, they pose higher risks for the mother than dilatation and extraction. A survey of deaths from legal abortions between 1972 and 1981 found mortality in second-trimester abortions done by dilatation and extraction to be 4.9 cases out of 100,000. It was 9.6 per 100,000 for the induced-labor method and 60 per 100,000 for the abdominal surgery method.

The measure vetoed by the president therefore was not a bill that would have outlawed all or even most of the abortions done after 20 weeks of pregnancy. It was a proposal that was aimed at one technique, which was portrayed as particularly inhuman and brutal.

Clinton strenuously urged Congress to broaden the bill to include the health of the mother rather than only a threat of death. As governor of Arkansas he signed a bill that outlawed late-term abortion unless there was a serious threat to the health of the mother or a likelihood of death. But the Republican majority in the House and Senate sent the president a bill that he announced early on he would veto. The Republicans will now use the veto to allege that the president is an "extremist" and that he has reneged on his promise to try to make abortion "rare."

Whether Clinton has done all he could to make abortion "rare" is a fair question. It should be discussed. But his veto cannot fairly be put down as a refusal to fulfill his pledge.

Had the measure he vetoed become law, it would have meant that obstetricians could be charged with a federal crime if they performed a late abortion by the one legally forbidden technique and, if convicted, could go to jail. As a result, the small number of abortions done after 20 weeks of a pregnancy would be done by other methods that are statistically less safe.

Some antiabortion critics of Clinton's veto seem to assume that any measure, however poorly drafted, should be advocated if it would prevent even one abortion. But this attitude misses the point that virtually all women who have carried their child for five months or more do not want an abortion but rather are compelled to take medical action when informed that the fetus will almost certainly die in the womb or shortly after birth. These women almost always want their pregnancies to go to term but unusual medical difficulties make that difficult or impossible.

Even if one assumes that some of the 17,000 women who each year request an abortion after 20 weeks of childbearing are seeking a termination of their pregnancy for personal reasons rather than a compelling medical reason, it does not make sense for a federal law, for the first time in history, to enter into such a complicated arena of specialized professional and ethical issues. If members of Congress still desire to get involved in this complex area of medical practice, they can do it by simply adding "health of the mother" to reasons permitting late abortions.

The Clinton administration, meanwhile, asserts the following activities in its promise to make abortion "rare":

1. The administration challenges the private sector to form the National Campaign to Reduce Teen Pregnancy. This effort seeks to coordinate resources so that teen pregnancy can be reduced by one-third in 10 years.

2. The president has taken creative steps to encourage adoption and to support families that choose to open their homes to waiting children. The Multi-Ethnic Placement Act, which the president signed into law in October 1994, removes barriers to adoption based on race or ethnic origin.

3. The president signed the Family Medical Leave Act allowing workers to take up to 12 weeks of unpaid leave to care for an infant while retaining the right to return to their jobs.

One can argue that this is not enough. Those who want to decrease the number of abortions should continue to propose legal and educational measures by which this objective can be advanced. ■

file abortion

National Catholic Reporter®

NCR

Islam

Extremism and violence not the whole Muslim story

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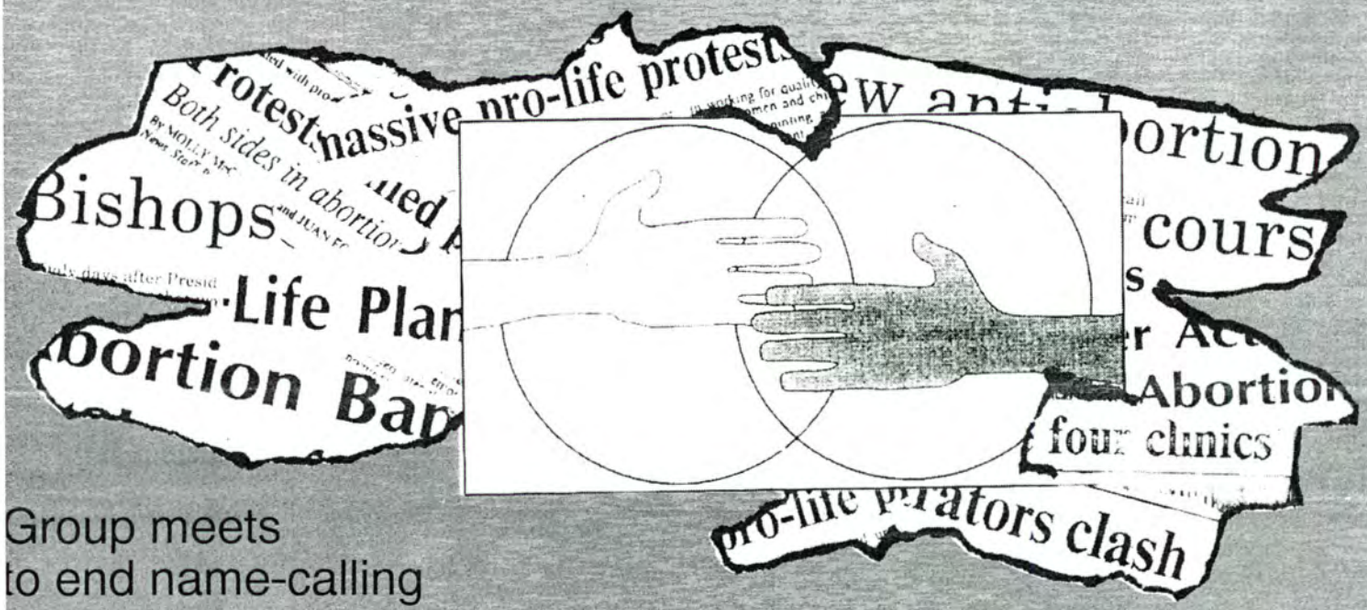
HE INDEPENDENT CATHOLIC NEWSWEEKLY VOL. 32, NO. 32 JUNE 14, 1996 $1.50

Reaching for common ground



Group meets to end name-calling and search for unity in coping with abortion issues

By LESLIE WIRPSA
NCR Staff

MADISON, Wis. — Five years ago in St. Louis, Jean Cavender and B.J. Isaacson made an urgent appeal to their friend Loretto Wagner. Could Our Lady's Inn, the home Wagner ran for single pregnant women, receive a 9-year-old girl who had been raped by her stepfather and who was more than seven months' pregnant?

Could Wagner help them find someone to take full-time care of the girl, whose age made her pregnancy one of high medical risk? The girl, they said, had wanted an abortion but had waited too long. Adoption was an option.

Cavender and Isaacson rallied medical care for the girl, who lived in poverty with her working mother. Wagner gave the child a temporary home and raised funds to pay a daytime caretaker. The baby was born healthy and lives today with its birth mother and grandmother.

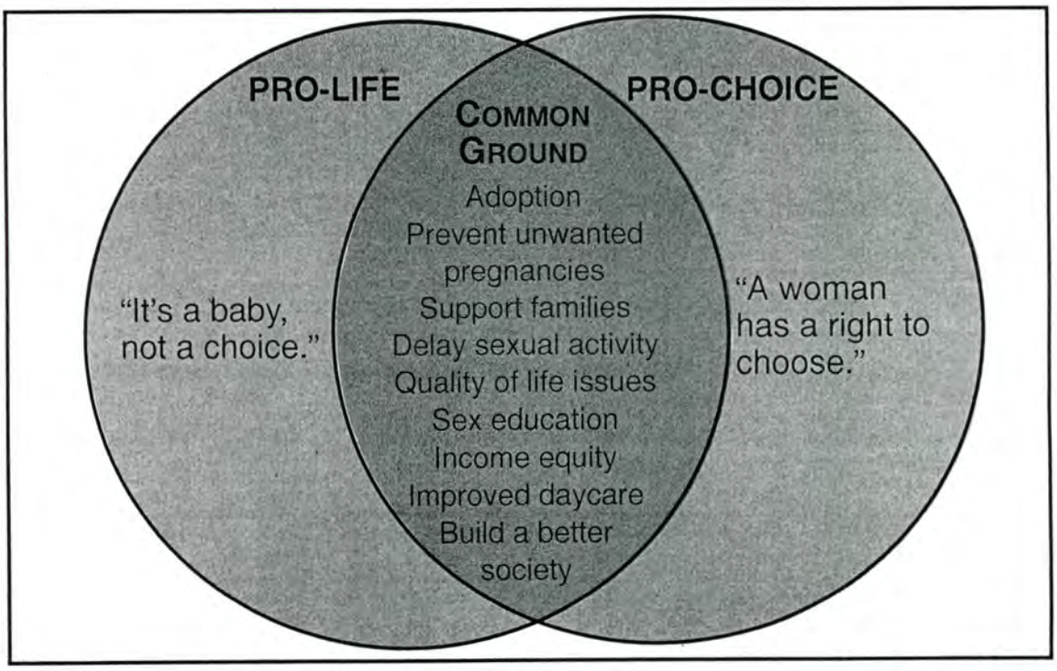
Cavender, Isaacson and Wagner were not always open to this kind of collaboration. In fact, they were, and in some ways still are, high-profile opponents in one of the most acerbic debates in the United States — the debate over abortion.

Wagner, 62, a self-described pro-life activist for more than two decades and former president of the Missouri Right to Life chapter, has joined numerous protests outside of the St. Louis Reproductive Health Services. The facility is one of the largest ambulatory surgical centers providing abortion in the United States and was the site of a 1987 firebombing. Isaacson, 45, helped direct the clinic for 17 years; Cavender, 45, worked there for six years in public affairs.

Today these women, along with St. Louis antiabortion

See reaching on page 14

Reaching



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lawyer Andrew Puzder, are not only "unconditional friends," but they rank among the founders of the Common Ground Network for Life and Choice, a growing initiative that aims to bring "light rather than heat" to the abortion conflict.

More than 100 people from all sides of the abortion picket lines and legislative debates gathered here for the first national Common Ground conference May 30-June 2. Transcending the political rhetoric framing the issue, conference participants sought ways to "reduce the need for abortion and the emotional pain and devastation of unwanted pregnancies," in Isaacson's words.

The Common Ground Network for Life and Choice is supported by the Washington-based Search for Common Ground, a nonprofit organization founded in 1982. Headed by journalist John Marks, a former Vietnam activist and U.S. foreign service officer, Search for Common Ground has played an instrumental mediating role in conflicts in Russia, South Africa, Burundi, the Middle East and Macedonia.

Marks said he realized the abortion conflict was ripe for Common Ground methodology after he filmed an aggressive conversation between two prominent figures on either side of the issue. The speakers identified eight points of commonality to stop unwanted pregnancies and do more for women and children. But they were so irate with each other after the debate that they refused to share a taxi to catch the same flight home.

Marks thought, "What would happen if we could get them together in a cab to talk?" He said social and political conditions were "throwing up" people across the United States who were already taking this approach — the St. Louis four, for example.

Despite the polarity highlighted by the media, Marks said a huge constituency in the United States "doesn't like the national debate (on abortion), the violence and adversarial behavior, the way conflict has become entertainment." More than any other issue, he said, people are fed up with the way the abortion conflict has been framed, and they want it "dealt with in a way that will make the country move forward."

So under the guidance of Common Ground Network for Life and Choice codirectors Benedictine Sr. Adrienne Kaufmann and labor lawyer Mary Jacksteit, techniques used in South Africa to rebuild after apartheid and methods used to help curb ethnic warfare between Hutus and Tutsis in Burundi were brought to the abortion battleground in the United States.

At the Madison conference, funding from the Kellogg Foundation and support from the University of Wisconsin-Madison helped bring together people involved in Common Ground activities at the grassroots level. Participants took a cue during the opening plenary from South African conflict resolution consultant Susan Collin-Marks. In South Africa, Collin-Marks said, "We learned to face the common problems of society instead of facing each other. We learned to bring the strength and wisdom of both sides, the stability of the conservatives and the vision of the progressives, to our society to create a new 'how' in how to do conflict."

Symbolically, this new "how" was illustrated in Madison through blue and green dots. "Pro-choice" activists could choose to identify their position by wearing a green dot on their nametags; "pro-lifers" were given blue dots. Many people wore no dot.

By the end of the conference, one woman had painted a marble blur of blue and green on her tag; others placed intersecting blue and green dots on theirs. That intersection, according to network codirector Kaufmann, was exactly the common ground the conference aimed to identify. "Common Ground rolls the circles together to focus not on areas of difference, not on the area that doesn't interlock, but it invites all of you standing in the shared space to look outward at the differences," Kaufmann said. "This is not a compromise. It is not fitting one circle artificially into the other, but it is getting close enough to share the interlocking area."

Catherine Coy had initial difficulty when asked to define her position on the conference registration form. Her solution reveals the complex continuum of positions on abortion that is often absent from political and media presentations of the issue. "I wrote 'politically prochoice, religiously pro-life and currently five months pregnant,' " said Coy, 32, coordinator of the Wisconsin Council of Churches Ecumenical Partnership for Peace and Justice. "I have a strong belief that extremism on both ends doesn't contribute to anything at all." She said abortion is the "grayest issue there is ... the harder choice is to look not at the black or white."

By the end of the conference, Coy adopted the symbol of the two dots intersecting.

Fordham University sociology Professor James Kelly faced a similar dilemma. He said his first thought during his first workshop was, "I am with very deep people, indeed." That was when he decided to wear a blue dot. But, he admitted, "deep people take you to deep depths." He revealed those depths during the closing plenary by telling a story of how his dot went from dark blue to light blue.

Pivotal in Kelly's color change, he said, was a story told during a workshop by a man who turned "pro-choice" after getting to know a woman who was "mostly a victim of hard circumstances all her life" and who "had no sense of self." Faced with an unwanted pregnancy, the woman chose abortion.

"Abortion gave her a chance to take control of her life and act as a moral agent instead of just being a victim," Kelly said. He said the story brought to light the "complexity of moral agency." Common Ground, he said, "means trying to get as much complexity as possible and look at it."

One participant described the majority of conference attendees as "professional enemies, people who usually write and say scathing things about each other."

Present were dozens of representatives of movements whose members commonly view their opponents as killers of

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A selection of new books, plus *NCR* readers' favorites

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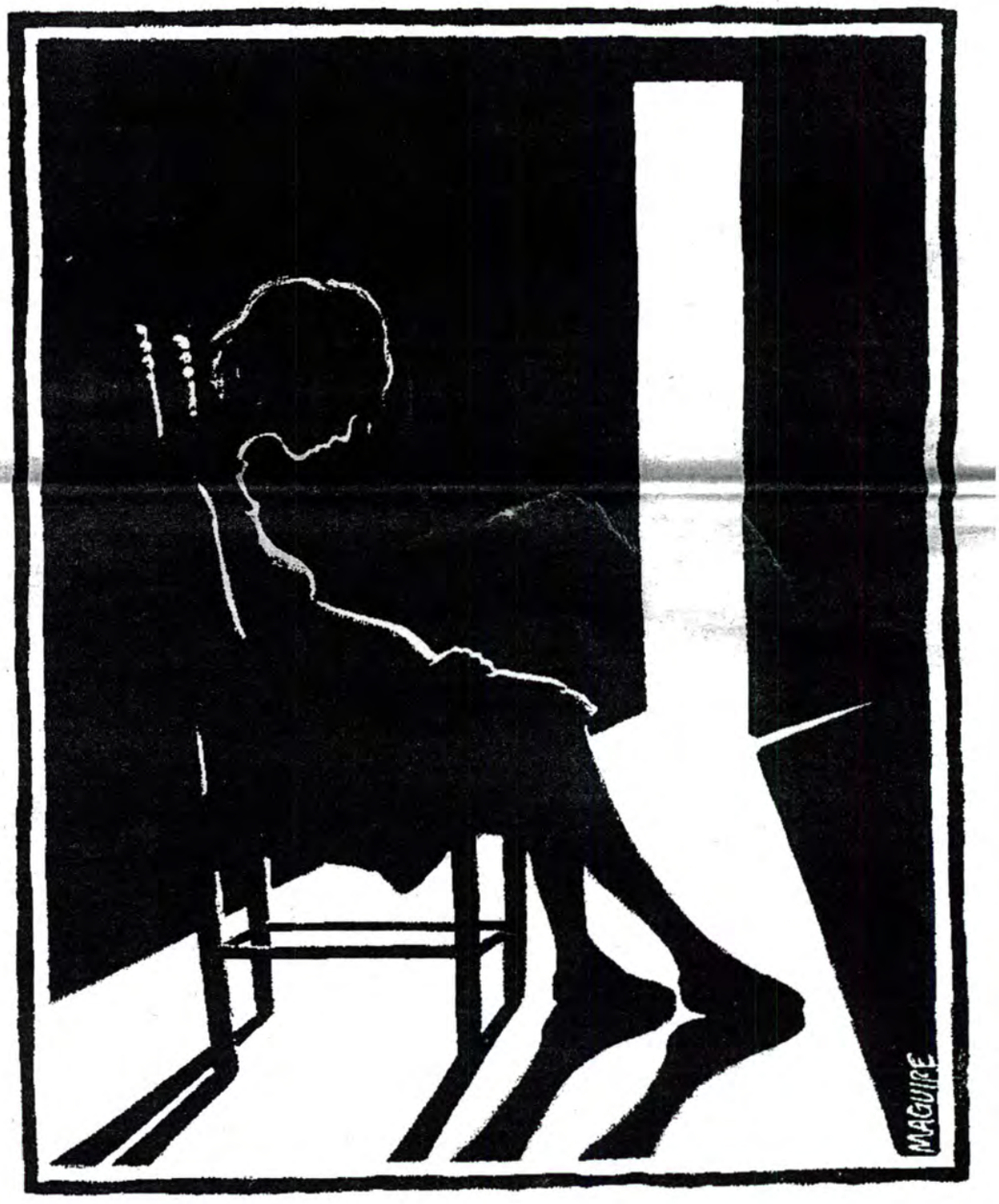
THE INDEPENDENT CATHOLIC NEWSWEEKLY VOL. 33, NO. 3 NOVEMBER 8, 1996 $1.50

The tangled abortion debate



Rigid rules meet real life

Page 6

Slogans rarely fit real life complexities

By PAMELA SCHAEFFER
NCR Staff

Neither Sophie Horak nor Albert Brooks, both active Catholics, expected to become public figures characterized as opposing church leaders in the highly polarized abortion battle. But life often fails to produce the expected.

The medical decisions of these two people, whose stories are reported in these pages, have put them at the center of current, bitter controversies involving religion and politics, theology and ethics, law and medicine. These controversies often pit slogans against sad realities and are more often noted for producing distortion, demonization and rhetoric than compassion, civility and honest, useful information.

In both cases, their choices conflict with official church teaching, which opposes direct abortion for any reason and also forbids fetal tissue research. But their decisions do not necessarily violate the reasoning of many Catholic ethicists and theologians. Many Catholic thinkers point out that the church's official positions on abortion and other questions of sexuality are likely to be more rigid than positions on other ethical matters.

Horak, late in a pregnancy her entire family had rejoiced over, felt she had no option but to undergo a procedure that goes by various names. Her physician called it "intact D and E" (dilation and evacuation). Abortion foes prefer to call it partial-birth abortion. (According to Richard Doerflinger, associate director of the Office of Prolife Activities for the National Conference of Catholic Bishops, the procedure is called "intact D and E" to distinguish it from another procedure, labeled just "D and E," which involves dismembering the fetus.)

Whatever it's called, the procedure Horak underwent involves removing a child from the womb by artificially dilating the cervix, pulling the fetus into the birth canal with forceps and then reducing the size of the head to allow it to pass through the cervix. This is done by making a hole in the baby's head and extracting fluid and tissue with a catheter. The child, if living, dies in the process.

Dr. James McMahon, the physician who performed Horak's intact D & E, told her, as well as a congressional subcommittee, that the fetus feels no pain because a narcotic analgesia given to the mother induces a medical coma in the fetus. McMahon has written, "There is a neurological fetal demise. There is never a live birth."

That claim has been denounced. Dr. Norig Ellison, president of the American Society of Anesthesiologists, told the same subcommittee that he believed McMahon's claim to be "entirely inaccurate." He noted that many surgical procedures requiring anesthesia are performed on pregnant women "with absolutely no adverse effect on the fetus, let alone brain death."

"In my medical judgment, it would be necessary, in order to achieve the neurologic demise of the fetus in a partial-birth abortion, to anesthetize the mother to such a degree as to place her own health in serious jeopardy," Ellison said.

Willing to risk surgery

In Horak's case, she was willing even to undergo high-risk fetal surgery if it could have saved her child. But she thought then and still thinks three years later that intact D and E surgery was the best option available in her situation, though one she hated to choose. She considers it important to keep the procedure legal for others like herself. She has engaged in public speaking and writing, putting herself at odds with leaders of her parish.

Horak resigned as a volunteer catechist at her parish, Holy Cross Catholic Church in Batavia, Ill., after leaders, including her parish priest, questioned her suitability for the job. She and her husband, Bob Horak, had taught religion to school-age Catholics in their home. Now Horak, who said she had been an active member of her parish, wonders, "How can someone else decide what's right for me and my family and my medical situation? I do understand the church's position, but they have to understand mine. The church has guidelines, but sometimes in tragic situations the guidelines can't be followed."

Horak and her husband are lifelong Catholics who attended Catholic schools. Sophie attended Catholic grade school, then public high school and community college. Her husband attended Catholic school and then Notre Dame High School, a Catholic school for boys in Niles, Ill., before going on to the University of Illinois.

According to advocates for keeping intact D and E legal, it is rarely used in the third trimester except in difficult medical circumstances where physicians determine that carrying a malformed fetus to term will risk a woman's life or health. Opponents, however, say that the procedure is often used electively in second-trimester abortions and sometimes even in the third trimester.

The procedure has become the subject of recent vociferous legislative battles. Opponents paint it as cruel and macabre, a form of euthanasia or even infanticide, often used to deny life to deformed human beings. Proponents of keeping it legal, who include Jesuit Fr. Robert Drinan, professor at Georgetown University Law Center, note that some physicians say the procedure may pose the least risk to women caught in a medical corner. The matter of least risk is disputed. Nevertheless, Drinan notes that other methods of performing late-term abortions remain legal, and it makes no sense to single out one for extinction.

Drinan is persuaded by medical views like one expressed to *NCR* by Dr. David Grimes, an obstetrician-gynecologist at San Francisco General Hospital. Grimes is also former chief of the abortion surveillance branch at the U.S. Centers for Disease Control in Atlanta. In a telephone interview, he said, "There are a number of ways one can empty the uterus," including inducing labor and performing a cesarean section. "Once you make the decision that it is in the best interest of the woman to have the uterus emptied, the decision boils down to which is the best method.

"In some cases, the intact D and E method may be considerably less dangerous" for the woman, he said. "To foreclose options is medically inappropriate."

As with many medical procedures, that argument is disputed. Some obstetricians disagree that the procedure is the safest method of late-term abortion. Among those, some still favor keeping the procedure legal and some do not, saying it is rarely, if ever, a medical necessity.

Earlier this year Congress passed a bill that would have outlawed intact D and E, but the bill was vetoed by President Clinton. Despite a campaign by U.S. Catholic bishops that resulted in 10 million postcards sent to legislators, Congress did not override the president's veto.

Using fetal tissue

In the other story reported in this issue, Albert Brooks, suffering from Huntington's disease, will benefit from abortion when he receives a fetal tissue transplant later this month at Good Samaritan Hospital in Los Angeles. His story was reported by the *Kansas City Star* and NBC news.

Brooks, whose condition is debilitating and fatal, does not see his decision as supporting abortion. Some ethicists would agree, arguing, for example, that putting fetal tissue to good medical use, even where abortion is considered wrong, brings good out of evil. Others strongly reject such arguments, contending that research and surgery using fetal tissue inevitably uphold and may well even advance abortion.

Members of Brooks' former parish in Kansas City are helping to raise the

Catholic and antiabortion, he needs fetal tissue operation

By ALAN BAVLEY
Special to the National Catholic Reporter

Albert Brooks is staunchly antiabortion. He opposes abortion for any reason. Yet Brooks, a Catholic, is hoping that tissue from aborted 8- to 10-week-old fetuses will save his life.

Brooks, 57, of Centerview, Mo., has Huntington's disease, a fatal degenerative brain disorder. He is losing control over the movement of his body and is slowly being robbed of his intellect.

Physicians offer Brooks little hope. There has been no cure for this fatal disorder or even any treatment to slow its progression. But earlier this year, researchers at a Los Angeles hospital reported they had transplanted tissue from human fetuses into the brains of several Huntington's patients with incredible results.

Patients quickly regained the ability to walk unassisted and to speak intelligibly and they have maintained that improvement, researchers said.

Brooks will have the experimental surgery in mid-November, as soon as fetal tissue is available, according to his son Steve of Kansas City, Mo.

Huntington's disease usually strikes in midlife, between the ages of 30 and 45. Early symptoms include depression, emotional outbursts, fidgeting or clumsiness. As it progresses, sufferers become confused and forgetful. They lose control of their body. Walking becomes difficult. Their arms and legs move ceaselessly. Treatment has been limited to drugs that relieve symptoms.

Friends have been helping to raise the $50,000 cost. Steve Brooks said about $16,000 has come in from donors, and an equity loan on his father's house would pay the rest.

Albert Brooks, a member of Catholics for Justice, an organization devoted to promoting peace and justice in society, doesn't see a contradiction between his faith and antiabortion stance and medical research that depends on abortions. Brooks said he would not wish any woman to have an abortion. But, he reasons, if an abortion occurs, why waste human tissue that can benefit others?

—David Pulliam/*The Kansas City Star*

Albert Brooks, left, and son, Steve: exploitation or doing something good?

Steve Brooks said his father had long opposed abortion "as a personal belief" but had never participated in marches or rallies. He said his father's belief had not changed.

In a voice made slow and halting by his illness, Albert Brooks said, "I certainly do not believe the abortion issue is relevant to this particular operation. I look at this on the same basis as a heart transplant or liver transplant. It's making tissue available from other donors."

Still, experimentation with human fetal tissue, typically obtained from abortions, has become a significant factor in the nation's acrimonious abortion debate.

Douglas Johnson, legislative director of the National Right to Life Committee, calls research that uses tissue from aborted fetuses exploitation of human victims.

"To the degree that society depends on unborn human beings for spare parts,

Continued on page 8

Alan Bavley is the medical writer for the Kansas City Star. *A version of this story appeared in the* Star *on Sept. 7.*

$50,000 he needs for his surgery. But members of his family have been distressed by some news reports about the decision. For example, Brooks' son Todd of Kansas City worries that his 57-year-old father has been characterized as a hypocrite rather than as a man watching his life drain away and reaching for a procedure that could help him.

Albert Brooks, who now lives in Centerview, Mo., said in an interview, "I certainly do not believe the abortion issue is relevant to this particular operation. I look at this on the same basis as a heart transplant or liver transplant. It's making tissue available from other donors."

But it is different, simply because the abortion issue is involved and, as in all debates involving abortion, emotions run high on both sides. The politicized atmosphere extends into the Catholic church, with the unfortunate result, many theologians say, of closing off reasoned discussion and obscuring the traditionally nuanced arguments of moral theologians and ethicists.

Lisa Sowle Cahill, Catholic moral theologian from Boston College, wrote in the May 22, 1993, issue of *America*: "Aggressive, competitive and ultimately destructive polemics and tactics are especially inappropriate for a movement claiming to derive its mandate from compassion for the most vulnerable." Cahill thinks the church has done far too little to discourage abortion, relying instead on efforts to change the law. "Misgivings about abortion should be the basis for an alliance in favor of social measures that will reduce abortion, even if not outlawing it entirely," she wrote.

Philip Boyle, senior vice president of the Park Ridge Center in Chicago, a center for research on health care, faith and ethics, said, "The agenda of both those who are for and against is so political that any moderate or nuanced voice is edged out. That's a loss for civic discussion."

Nuances ignored

Even the most conservative Catholic views on abortion — the official church teaching coming from Rome — contains nuances that are often ignored. For example, official teaching holds that abortions may be done in certain cases as long as they are indirect abortions, such as removal of a cancerous uterus from a pregnant woman or of a fallopian tube in danger of infection from an ectopic pregnancy in the tube. Further, the church has taken no definitive position on the question of when an embryo becomes a human life. The ambiguity on that issue was acknowledged in "Instruction on Human Life," published by the Vatican's Congregation for the Doctrine of the Faith in 1987. Nevertheless, official teaching holds that abortion performed even very early in a pregnancy is wrong, based on the theory that the embryo is at least potentially human and therefore has a right to life.

James F. Drane, author of *Clinical Bioethics: Theory and Practice in Medical-Ethical Decision Making*, and an active Catholic, is among those who think official church teaching is overly strict when it comes to abortion.

"In traditional moral theology you listen to the story before you decide what's right or wrong," Drane said. In terms of the Catholic church's natural law tradition, based on reason informed by faith, Sophie and Bob Horak's decision "is reasonable," he said. "She did the best she could. She chose the lesser of two evils and she certainly doesn't deserve public recrimination."

"Ethics, like poetry and history, tries to bring critical reflection, organization and deepened meaning to human experience," Drane wrote. "The alternative to ethics is to decide complex and difficult questions by slogans, rhetoric or preformed opinions couched in 'ethically loaded' ordinary language."

Drane, who teaches clinical medical ethics at Edinboro University of Pennsylvania, considers it "very difficult" to construct public policy, or even policies for Catholic or Protestant hospitals, on sensitive ethical issues. In a telephone interview, he told *NCR*, "An important underlying assumption is that when no clear conclusions can be drawn from ethical principles about a particular problem, the best policy is one of flexibility."

"The late-term abortion issue is one instance of the complexities that develop around childbearing and fetal development, and the idea that one can articulate a public policy, either pro-choice or pro-life, that would be adequate to all these complexities is simply naive," he said.

Politics, not theology

"What Horak is now fighting — the result more of her speaking engagements than of her medical decision — is not the church's theological tradition," Drane said, "but a relatively new political dimension. We are under a pope who believes we are struggling against a culture of death ... leadership formed in the solidarity experience in Poland.

"In that experience, you are in a death struggle with this evil empire and the only condition for surviving the struggle is to never deviate publicly from the standards," Drane said. "And so the Catholic church today is under the leadership of bishops who are in turn trying to please and imitate the pope, and we have a type of political policy in place that does not reflect any sympathy for persons caught in dilemmas and does not have much place for nuances in its political program."

Catholic moral theologians and even many bishops oppose "putting into place a public policy that would proscribe all abortion," Drane said. "Law has to address the reality in which we live, and nobody who knows anything about good law thinks you could legislate a complete pro-life policy." There is a need, he said, to "move toward the center" in the abortion debate, away from abortion on demand, yet allowing for exceptions. The protests that surround abortion, whether pro-choice or pro-life, "are more slogans than possibilities for public policy."

Jesuit Fr. Drinan, a former U.S. congressman, has incurred the wrath of abortion foes by his support of President Clinton's April 10 veto of the bill intended to ban partial-birth abortion. He expressed his support in opinion pieces published in the *New York Times* and in *NCR*. In a column appearing in *NCR* May 31, Drinan called for "comprehensive information and careful analysis" along with diligent efforts to make abortion rare. But it needs to be recognized both in ethics and law, he said, that when a woman's health requires that a fetus be removed late in pregnancy, the intact D and E procedure poses fewer risks to the woman than either inducing labor or performing a cesarean section.

Drinan cited a survey of legal abortions between 1972 and 1981 that found mortality in second-trimester abortions done by D and E to be 4.9 per 100,000. That compared to 9.6 per 100,000 for an induced-labor method, in which fetal life is first extinguished by chemical means, and 60 per 100,000 for abdominal surgery (cesarean section). The finding that intact D and E is the safest procedure is disputed by some medical professionals.

Nevertheless, Drinan said the procedure should remain legal. In a telephone interview he said, "We're all against late abortion, but once in a while it's needed for therapeutic reasons. When it happens, it's always gruesome, and the way it's done is really immaterial." He added, "A woman should not be censured for her decision."

The attitude that a law should be written, however poorly, to stop even one abortion "is ridiculous," Drinan said. It "misses the point," he said in his column, "that virtually all women who have carried their child for five months or more do not want an abortion but rather are compelled to take medical action when informed that the fetus will almost certainly die in the womb or shortly after birth.

"Even if one assumes that some of the 17,000 women who each year request an abortion after 20 weeks of childbearing are seeking a termination of their pregnancy for personal reasons rather than a compelling medical reason, it does not make sense for a federal law, for the first time in history, to enter into such a complicated arena of specialized professional and ethical issues," he wrote. "If members of Congress still desire to get involved in this complex area of medical practice,

Continued on page 9

A decision she hated to make but has never since doubted

By PAMELA SCHAEFFER
NCR Staff

When Sophie Horak learned she was pregnant in October of 1992, she and her husband, Bob, were elated.

The Horaks had one child, 7-year-old Steven Andrew Horak, and had long wished for another. They announced the good news to their extended families at Thanksgiving.

The following spring, the couple, both active Catholics, made a painful decision to end the pregnancy. Sophie Horak has spoken publicly about their loss, supporting the legality of the controversial procedure known as intact dilation and evacuation or partial-birth abortion. The developments she relates illustrate the complexities of medical situations removed from the sloganeering that so often marks the public abortion debate.

Sophie, Bob and Joey Horak: "Would he ever know how much I wanted to hold and touch him?"

Horak's public discussion of her situation has brought her into conflict with her parish. Recently, she and Bob were asked to discontinue teaching in the parish School of Religion at Holy Cross Catholic Church in Batavia, Ill. — a volunteer job she had accepted for the second year.

Here is her story, as she told it in an interview with *NCR*:

When Horak was four months into her pregnancy, her physicians recommended a routine ultrasound, partly because of her age. She was 35. The ultrasound produced two findings: that their second child would also be a boy and that there were potential complications with the fetus.

The couple had already picked a name: Joseph Peter Horak — Joey. "In my heart I was really hoping for another boy," Sophie Horak said.

But the technician's sudden silence as he scanned her womb worried her. The problem, she later learned was the position of the baby's heart. It appeared to be on the right side of the chest cavity. More tests followed. The problem was a diaphragmatic hernia, a hole that allowed abdominal organs to push against the heart.

Horak's physician sent her to a specialist, an obstetrician specializing in high-risk pregnancies. She made an appointment with Dr. James Keller at Lutheran General Perinatal Center in Park Ridge, Ill., not far from Batavia, the Chicago suburb where the Horaks live.

Keller ordered further tests. Horak said he told her that, barring problems with the baby's liver (extremely fragile and hard to deal with in neonatal surgery), the hernia might be repairable in surgery after birth. She could deliver Joey around her due date, in June or July. As she recalls it, his chances for survival were estimated at 25-30 percent.

Horak had already been warned that delivery would be by cesarean section. A previous emergency C-section when Steven was born had left her unable to deliver vaginally, she said.

Keller mentioned other options, Horak said, including fetal surgery at the University of California at San Francisco, where Dr. Michael Harrison has pioneered the procedure. The fetus would be removed from her womb while remaining connected through the umbilical cord. An operation would be performed, and the fetus would be put back in the womb. Horak would then remain at the medical center until delivery, many weeks away, receiving medication to prevent premature labor.

The Horaks were interested and agreed to more tests. "I was very frightened at this point, for Joey, Bob, our son Steven and finally for myself. I would have done anything to save our

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Fetal tissue

Continued from page 6

abortion is more firmly entrenched and respect for human life is eroded," he said.

Johnson said scientists should limit their research to fetuses obtained from pregnancies that end unintentionally, with miscarriages, for example.

The Reagan and Bush administrations prohibited federal funding of human fetal tissue research that involved transplants. As one of his first official acts, President Clinton rescinded the ban.

Since then, the National Institutes of Health has awarded millions of dollars in grants to study fetal tissue transplants as a treatment for Parkinson's disease. These transplants already have shown promise.

Albert Brooks reasons that medical use of fetal tissue isn't going to promote abortion. Physicians don't approach women to donate fetal tissue until after they have had an abortion, so the possibility of a transplant never influences their decision.

Brooks, a former budget officer for the Federal Aviation Administration in Kansas City, Mo., has been dealing with the question for a couple of years. In his job, he distributed $100 million each year, but he noticed a few years ago that his mind was beginning to lose its edge. "I knew I was having memory loss problems," Brooks said. "They were substantial. And I couldn't ... do even routine mathematics."

Brooks went to a doctor for a physical examination in September 1994. The physician noticed Brooks' right arm was trembling. That led to months of tests. In December of that year, Brooks received the diagnosis.

Brooks' diagnosis stunned his family. People with Huntington's have a 50 percent chance of passing it to their children.

"We went about researching like crazy. We hit the libraries," said Steve, 29. He said he sought genetic testing immediately. He needed to know not just for himself, but for his 3-1/2-year-old son, Alexander. Steve came up negative.

"At first I felt elation, mostly for my child," Steve said. "Then guilt set in," he said, because he could not help his father.

About 30,000 people in the United States have Huntington's disease. Another 150,000 have a parent with the disease, which puts them at risk of developing the disorder.

So far, researchers at Good Samaritan Hospital in Los Angeles have given transplants to six Huntington's disease patients.

> 'You rewire the brain with these transplants. That tissue grows and re-establishes electrical connections and makes hormones.'

Pieces of fetal brain tissue, each about one cubic millimeter, are implanted into portions of the basal ganglia. This region of the brain, which is responsible for coordinating muscle activity, is damaged by the disease.

"The effects have been almost immediate, in hours or days," said Deane B. Jacques, one of the Good Samaritan researchers. "You rewire the brain with these transplants. That tissue grows and re-establishes electrical connections and makes hormones."

Brooks has the unreserved support of his longtime friend, Calvin Fields, a retired Church of Christ minister from Easton, Kan. Fields described himself as "very much an antiabortion advocate, a fundamentalist minister." But he said he saw no conflict in using fetal tissue for lifesaving purposes.

"The basic reason I'm antiabortion is I'm pro-life," he said. "If you're pro-life, how could you object to giving the infant tissue for someone's life?"

Opposing this use of fetal tissue because the fetus was obtained by abortion would be a dogmatic position, Fields said. "I'm scared to death by absolutists. They are so focused. But life is not that simple."

Todd Brooks, Steve's brother, agrees. "We have an opportunity right now to take what I think a lot of people are seeing as medical waste and do something good with it. We have a chance to save our father's life and at the same time bring a lot of attention to Huntington's disease and help others that have it. I do not believe this is promoting abortion."

Myra Christopher, president of the Midwest Bioethics Center in Kansas City, described Brooks' situation as "the classic ethical dilemma."

"I'm surprised he raised the issue, but frankly I respect him for it," she said. "I would not presume to pass judgment on him." ■

Decision

Continued from page 7

child, even if it meant giving my own life," Horak said.

When test results showed that Joey appeared otherwise healthy, the Horaks prepared to travel to San Francisco. Friends were recruited to care for Steven during their long stay. "Once people heard the news of Joey's troubles, they came from everywhere to help us," Sophie Horak said.

At that point, "Bob and I were all smiles," she said. "We were going to San Francisco to save Joey. I called everyone I knew."

But the surgery was not to be. In San Francisco, there were more tests, and the results were not good. Joey's stomach, his intestines and his entire liver were in his chest, smashing his tiny heart and lungs, Horak said. Further, she said, doctors had detected a ventricular septal defect, a tiny hole in Joey's heart. Harrison told her the baby was very weak and she would probably lose him soon. Surgery was out of the question.

Horak said she felt "alone, completely alone. I wanted to be so close to Joey, but I couldn't," she said. "Would he ever know how much I wanted to hold and touch him?"

Based on medical advice she had received up to that point, Horak, now in her 28th week, decided she had little choice but to terminate her pregnancy. She had been warned of possible serious medical complications at delivery, now exacerbated because of Joey's deteriorating condition. While Horak had been willing to go to any length to save her child, she didn't want to risk her life or health for a child who could not be saved.

The couple went to Los Angeles to have the fetus removed by intact dilation and evacuation. It was performed by Dr. James McMahon, a man Horak said they immediately trusted. They asked him some pressing emotional questions: Would it be possible to see Joey after the procedure, and would Dr. McMahon, a Catholic, agree to baptize their child. The answers were affirmative.

Not only could they see Joey, McMahon said. They could hold him and bathe him, and the staff would take pictures. McMahon said he would be honored to baptize their child, giving him the name they had chosen.

The first stage of the procedure is dilation of the uterus, a process that takes several days. Meanwhile, the Horaks went shopping. They bought a baby blue sleeper embroidered with a small Peter Rabbit. They bought a small stuffed Peter Rabbit to match.

"We knew these would be little Joey's only possessions," Sophie Horak said. "We were preparing for his funeral."

McMahon met the couple at the clinic, Eve Surgical Center in Los Angeles, on May 1, shortly after her water broke, and Joey was removed from the womb.

> 'We knew these would be little Joey's only possessions. We were preparing for his funeral.'

But first, as is usual with the intact D and E procedure, a catheter was inserted into his head through a hole the size of a drinking straw, Horak said, and fluid and tissue were extracted to reduce the size of his head. Horak said McMahon told her that Joey was in an anesthesia-induced coma when the catheter was inserted, so that he felt no pain.

When the procedure was over, Horak said both she and McMahon were crying. Nevertheless, she said, she has never doubted that she made the right decision.

Soon the staff brought Joey, swaddled in a blanket, to the recovery room. The Horaks bathed him, dressed him in his little blue outfit and took turns holding and rocking him. Except for a small hole, his head appeared normal, Sophie Horak said.

The Horaks and the center's staff took pictures — "pictures of proud daddy and mommy holding their baby boy," Horak said. The next day, the couple took their son home, holding him close in a small box. Back in Illinois they chose a white casket lined in satin. Next they selected a headstone, one engraved with a tiny lamb.

Joey was buried in a Catholic cemetery near Sophie's father's grave following a graveside service conducted by their pastor, Fr. Stephen St. Jules of Holy Cross Catholic Church. Two weeks later, scores of family and friends attended a memorial service at the church for Joey, Horak said. At that service, "we celebrated his life," Horak said. "Though it was short, Joey's life had meaning."

When it was all over, like many who mourn, Horak wanted to tell her story. She wanted to tell it for herself, to aid her grieving process, but also for McMahon, who died of a brain tumor months after Joey's death. Her story was published in November 1994 as an op-ed piece she submitted to the *Chicago Tribune*.

Horak was asked by Planned Parenthood and by the National Abortion Federation if she would talk publicly about her experience. She did. She addressed legislators in Maryland and Washington, did a cable television program and gave a series of talks in Illinois.

Her appearances generated news reports, which were faxed to Fr. St. Jules. A few days before classes were to begin this fall in the parish School of Religion, a conversation with the priest and a youth minister at the parish prompted her decision to resign.

Horak said she was made to feel unwelcome, and St. Jules, in a telephone interview said that, although he had asked for time to reflect on the situation, he probably would have asked her to resign.

"She told me she wouldn't defend the church's position on abortion," he said — although both he and Horak noted that abortion was not part of the curriculum for her class. "She would be a catechist, speaking publicly for Planned Parenthood. And she would be speaking in favor of upholding the availability of late-term abortion. I saw a conflict there. I really didn't think she could do both."

"I certainly feel compassion for her," St. Jules added. "I do not condemn her personally."

Nevertheless, Horak said she feels excluded, compounding the pain she feels. "We don't think that what we did was morally wrong," she said. And she feels her public appearances — which have been unpaid, except for expenses — are important to keep a procedure legal that physicians had recommended in her case.

As she looks back on it, Horak wonders how it all happened. "We are just simple people from a small town in Illinois," she said. "How we were able to get the best care in the world to try to save our son? I don't know how all that happened. Now, after so many years, to have somebody tell me I'm morally unfit to teach children ... I don't think so.

"There was an outpouring of love when all this happened and now suddenly I feel that I'm being attacked." ■

Slogans

Continued from page 7

they can do it by simply adding 'health of the mother' in legislation citing reasons for permitting abortion."

Dominican Fr. Patrick Norris of St. Louis University's Center for Health Care Ethics, thinks that wider dissemination of Catholic teaching in medical ethics is needed. He said women are often pushed into abortion when a fetus is deformed because they don't realize that they aren't obligated under Catholic teaching to use extraordinary means to keep a child alive.

"The principle I use is that you can't act against an innocent life in order to save another," he said. However, in many cases if the mother's life is in danger, the fetus' life is also in danger, so it may be justifiable to induce labor. Then, "if the child has severe multiple congenital abnormalities, it may not be appropriate to treat aggressively," he said.

"In medicine, one of two things often happen," he said. Abortion is advocated "because of underlying pathology," or if a severely deformed child is born, "they treat overly aggressively. I would say at times there's a middle ground. Allow the child to be born, but realize that it's inappropriate to use aggressive measures" to treat the child. It's acceptable in such cases "to provide appropriate palliative care."

Proportionalism

Fr. Charles Curran, a Catholic priest who teaches at Southern Methodist University in Dallas, considers Horak's choice to be reasonable. Curran noted the church's official way of doing moral theology is under attack by "virtually everyone" doing moral theology today. Curran said revisionists in Catholic moral theology "have trouble with the principle of double effect." The principle, which undergirds official church teaching, has as one of its tenets "that you can never use a bad means to achieve a good effect."

The contemporary method preferred by many moral theologians is "proportionalism," which teaches that an act can't be declared a moral evil until all the circumstances surrounding the act are fully spelled out.

In Horak's case, Curran said he regarded her decision as morally justifiable even in the absence of an "ultimate risk of her death. Is it morally better to bring the child to term if it is going to die? I would say she is perfectly justified in doing what she did," he said.

The principle of double effect was heavily used in late 19th century conflicts over abortion — an era in which the pope was declared infallible and when Roman documents were being used to solve problems in church life more than at any time previously in the church, Curran said.

"The trouble with people who adopt the slogan as the whole theology is that they eliminate moral theology by eliminating what has been essential to moral theology: consideration of all the details of the case before you articulate a particular response, one informed by reason and faith," Drane said.

He added; "Abortion properly understood has to do with the taking of a life that has potential for developing into a full human person. Where you have fetuses so essentially damaged that they could never survive perhaps even the fetal stage, the removal of that fetus is not like killing something that has potential

> 'I do understand the church's position, but they have to understand mine. The church has guidelines, but sometimes in tragic situations the guidelines can't be followed.'
>
> — Sophie Horak

Catholic tradition had always held that a person can kill an unjust aggressor in self-defense, Curran said. The question was posed in the late 19th century, "Can a fetus in the womb be considered an unjust aggressor" in certain cases, when it threatens a woman's life or health? The answer from Rome was no. The effect, Curran said, is that official church teaching today contains more exceptions allowing for killing outside the womb than inside.

Even so, he said, "official teaching on abortion is much more nuanced than it often comes across. There's lot of discussion going on today about the moment of conception." A number of theologians would argue "that you don't have a truly individual human being in the first three weeks. Others would go further."

Drane said he had spoken with "high level ecclesiastics" who, despite U.S. bishops' seemingly solid support for outlawing abortion, have admitted privately that such an absolute law would be a mistake. "But their reason for pushing as hard as they can toward an absolute pro-life stand is to get as much as they can in ultimate negotiation," he said.

for full human development. We have to be more careful about lumping all sorts of things under tags." Of Horak's decision, he said, "To call what she did an abortion, that's wrong."

As for Albert Brooks' decision to have a fetal tissue transplant, Drane said it's common for a person, when personally confronted "with the complexities of a particular situation," to "move to the center" on an emotionally-charged issue. Brooks' decision to have the surgery is unacceptable according to "the strictest interpretation of the pro-life stance," he said, but noted that the question of fetal tissue transplants is still being argued in Catholic theology.

Fetal tissue transplants — an experimental procedure that consists of surgically grafting fetal brain cells to replace a degenerating part of the brain — were first performed in Sweden in the mid-1980s. The procedure has been offered on a limited basis at a few U.S. hospitals, including Good Samaritan in Los Angeles, the only one to use it in treating Huntington's. As of late October, only seven such operations had been performed. The procedure is more common in treating Parkinson's disease, and researchers say it offers hope for people with Alzheimer's, spinal cord injuries and diabetes.

One of President Clinton's first acts after taking office in 1993 was to lift a federal ban on medical research using fetal tissue. The ban was in effect during the Reagan and Bush administrations. Since the ban was lifted, scientists and ethicists have questioned whether the effectiveness of fetal tissue transplants has been exaggerated.

Drane said, "Some people in the Catholic tradition, with reason informed by faith, come out and say on this (fetal tissue transplants) we draw the line and we are never going to publicly or privately accept this because we see it as the beginning of a slippery slope in which human life becomes an experimental subject." Others, he said, "would say that it's okay to use fetal tissue — but only that derived from miscarriages."

Medical researchers, however, say that fetal tissue from miscarriages is often unusable because of deformities that caused the miscarriage in the first place.

Fr. Richard McCormick, professor of moral theology at the University of Notre Dame, is among those opposed. He strongly objects to fetal tissue transplants because he believes the American public is already so "desensitized" to abortion, he said in a telephone interview. To allow fetal tissue to be used for good would only advance that desensitization, he said.

Drane thinks that extremes on issues related to abortion do not merit "any sort of public commitment" from the church at this point. "It's not Catholic tradition to hold and embrace a particular view while something is still being thought through," he said. "The Catholic tradition attempts to use careful analysis of situations in order to come to responses that are human and at the same time reflective of our basic commitments. On issues that are not yet clearly articulated, that are still in some developmental stage, then the proper Catholic response is to be in dialogue, to reason together and to respect and embrace those who differ." ■

Abortion vote not a defeat for pope but for conservative Polish bishops

By ARTHUR JONES
NCR Staff

The Polish parliamentary vote Oct. 24 that liberalized abortion was less a defeat for Pope John Paul II — who had appealed to Poles not to approve the bill — than it was partisan Polish politics amid the increasing secularization of Polish society, according to one seasoned observer.

Life issues to one side, the political loser in the confrontation was not the pope but the Polish "church," meaning the Polish bishops as centralized in their episcopal conference, said commentator Jonathan Luxmoore in a telephone interview from Warsaw, Poland.

Luxmoore, who is completing a book on the pope's role in the end of Polish communist rule, said "the conference is where the real antagonism toward the government rests, and from where the church issues the fighting statements that have come out repeatedly over the last few years — particularly since the election of an ex-communist-dominated government in September 1993."

The vote overturned a 1993 law — put into effect by a pro-Catholic government — that permitted abortion only to preserve the mother's life or when the pregnancy resulted from rape or incest or when the fetus was nonviable. The vote in the Parliament's lower house was to override senate blockage of the legislation. Catholics — and 90 percent of Poles are nominally Catholic — bombarded their representatives with letters and staged a massive silent march to no avail.

But the problem — for the church — is greater than the presence of former communist President Aleksander Kwasniewski, who promised to immediately sign the new abortion bill into law. It has to do with the growth of democracy.

Luxmoore, a British journalist living in Warsaw, said, "Broadly speaking the period since 1989 (when the communist regime fell) has been one of adjustment for the church, almost of failed adjustment. Under communist rule the situation was, paradoxically, at least in some respects a rather favorable one for the church."

The 1980s, the latter communist period, witnessed the great age of church-building in Poland, Luxmoore said, and the statistics reflected it: church attendance and vocations were at record levels.

"It was almost a Golden Age for the church," said the commentator. "Since then," he continued, "the church has had to compete with a great many other attractions, a great many other expressions of civic, official, social and moral loyalty that have come into Polish society since the end of communist rule."

> 'The period since 1989 has been one of adjustment for the church, almost of failed adjustment. Under communist rule the situation was, paradoxically, at least in some respects a rather favorable one for the church.'

The Polish institutional church is not dealing easily with what Luxmoore — a specialist on Eastern European affairs — calls Poland's "chaotic democracy" and was in some ways content with the earlier, "tidier way of dealing with things behind the scenes with the government, operating with a certain balance of power even though it knew those people were hostile to it," he said.

"It was," said Luxmoore, "a carefully worked out system of checks and balances and privileges. Negotiations happened behind the scenes without any scrutiny by the press or public."

With the end of communism and the liberalizing of the media and civic organizations "the situation is entirely different," he said, "and the church has to deal in the full glare of television cameras with hostile parliamentarians. The church is not happy with the situation and has had a lot of trouble adjusting to it," he said.

Essentially the church, if forced to choose, he said, "would probably opt for a democratic system, but a democracy that preserves the kind of institutional values the church wants to see preserved." As this latest vote illustrates, that is not happening in Poland.

The center of Catholic authority in Poland is the episcopal conference of 112 bishops. Even so, Luxmoore said, "there is often a big difference between what the conference says and what the local priests — or even the occasional bishop — is saying."

There is a group of about 7 to 10 bishops who "appear to be very reasonable people, younger and rather ostentatiously approachable, with good media presence and so forth," he said, "but that still leaves well over a hundred" who are much more traditional — and confrontational.

The pope, Luxmoore said, is outside the political equation. "His name and authority are used to support the position of the bishops' conference on particular issues, the constitution, the concordat, abortion and so forth, yet his position in Poland remains somewhat fascinating.

"The knowledge of the pope's teaching among Poles is at a very low level, lower than among American Catholics, for example," said Luxmoore, "because, I think, the Polish bishops' conference wants to keep actual public knowledge of the pope at that low level."

The bishops prefer to have the pope as a lofty figure, he said, and the bishops do not want Poles and Polish Catholics debating what the pope says and does.

"It isn't necessary from the bishops' conference point of view to disseminate what the pope is saying, or allow any critical awareness — how does the pope compare with his predecessors, why do Catholics in the West so often disagree with what the pope says, and so on — for Poles might start questioning," he said.

"Paradoxically, that is why there's a very undeveloped knowledge of the pope, his system, his anthropology, his moral theology. Very undeveloped," said Luxmoore.

With or without the pope, the Polish Catholic decline continues. Church attendance (Mass two or three times a month), is at 35 per cent, down from the high 50s in 1989, Luxmoore said, while vocations — particularly to the women's orders — have dropped precipitously.

The church, Luxmoore said, counters that the mid-1980s figures were artificially high due to the dramatic circumstances — "martial law and such, and that the current ones are more typical, which may be true or not," he said. Poles, when surveyed on, "which institution you most trust or respect or feel most represents the interests of Poland," have seen the church tumble from top spot to sixth or seventh behind the Polish Army, Polish TV, Polish radio, the Polish police, and Polish civil rights spokesmen, he said.

"It must be emphasized," Luxmoore said, "that these polls are specifically dealing with questions of representing the public interest." Even so, he said, "where the Polish parliament, president and government were below the church until about a year ago, now the president — this ex-communist — has overtaken church in most opinion poll ratings."

And abortion, the most common form of birth control during communist rule, is now legal up to the 12th week of pregnancy — for financial or personal reasons — following counseling and three days of reflection. ■

No easy, quick-fix solutions to abortion issues

The stories of Sophie Horak and Albert Brooks (pages 6-9) are agonizing, haunting tales that refute the suggestion that there is an easy solution, a quick fix, to the complex biomedical ethical questions of the day.

Is there any point, then, in wrestling once more with such intractable questions? Why trudge again through this awful, divisive abortion terrain? Catholics have earned credentials in confronting this issue. And Catholics, whatever their stance, have paid a price for their convictions — in the divisions that have rent our community and even in the derision often experienced in the public square.

Abortion offends our deepest Catholic instincts. We have a sacramental view of the world, of life. We are pro-life. Increasingly, Catholics have a special credibility in speaking out on abortion because we have not made an easy accommodation with the culture on this issue.

Differ as we might on how to deal with the issue, there is something deep in us that says abortion has both private and communal dimensions. Whatever our positions on the legal and political battles surrounding abortion, few would disagree that the sheer number of procedures is troubling. If we stop for a moment's contemplation in the heat of the political battle, the nagging suspicion lurks that an industry has grown up to satisfy a carefree, no ill-effects demand that has a coarsening effect on our lives and culture.

Despite these complex feelings about abortion — an unease shared by the general populace — Horak and Brooks painfully remind us why we, as a church, have been unable to come to any solid agreement on how to deal with these matters in law.

A point we have made numerous times before in this space bears repeating: The more church officials insist on dealing in absolutes, whether in the moral or political arena, and in linking up with specific political agendas, the faster their credibility and moral authority gets eroded.

The U.S. bishops, for more than 23 years, have insisted on joining forces with whatever political party or candidate has promised them a vote against abortion. In doing so, in many cases, they have had to abandon much of the rest of the church's moral and social agenda. The bishops, meanwhile, have gained next to nothing for their expenditures of political capital. Their strategy, unproductive and isolating, has backed the church into a corner.

The political hard-liners are bolstered these days by the seemingly constant drumming by Cardinal Joseph Ratzinger, most recently warning of the threat of growing "relativism" in moral decision-making. Ratzinger would have us believe the only Christian choice available is between a host of moral absolutes on the one hand and complete moral relativism on the other. His position would have ill-served the bishops in other circumstances.

When the U.S. bishops wrote their peace pastoral, they were knee-deep in relativism as they deployed the most subtly nuanced moral categories in dealing with the reality of nuclear brinkmanship — a reality that held the possibility of destroying life as we know it. Likewise, the bishops went to incredible lengths to squeeze themselves far enough beyond any obstacles put up by the just war concept — the last instance being the Persian Gulf War — to give civic leaders a green light in their military pursuits.

They spoke forcefully to those in power, but they were unwilling to hold either the state or individuals to an absolute standard. If our religious leaders can jump through such a variety of hoops to mollify the demons of war, certainly they can grant women caught in extreme circumstances equal access to nuanced moral argument.

The tragedy of the current church position on abortion is that it not only is politically self-defeating, but it has also stripped Catholic theology of nuance, virtually disallowing the use of human reason.

The tragedy of the current church position on abortion is that it not only is politically self-defeating and uncompromising, but it has also stripped Catholic theology of nuance, virtually disallowing the use of human reason, if the theologians and ethicists quoted in our account are to be believed (page 6).

Said ethicist James F. Drane: "Law has to address the reality in which we live, and nobody who knows anything about good law thinks you could legislate a complete pro-life policy." People perceive a need to move toward the center. At the same time, Horak, he said, is up against a new church politics, not an old church theology. On either side of the abortion issue, the public debate consists of "more slogans than possibilities for public policy."

It is the limitations of law as a means of dealing with these matters — and the concurrent stripping of complexity from our theological thinking — that may well be adding to the paralysis in the public policy arena.

Legally driven absolutes have failed to sway the moral debate. Catholics remain deeply divided, with surveys showing Catholics seeking abortions in the same percentage as women of other faiths and denominations.

The paralysis might explain why some well-intentioned people on both sides of the issue are working against the odds to seek common ground. Even as staunch an abortion opponent as William Bennet, former official with the Bush and Reagan administrations, has counseled that the antiabortion movement, while not abandoning principle, should be willing to accommodate a wider range of views. "I do believe," he told a meeting of the Catholic Campaign for America last November, "that reasonable people of goodwill can and do disagree on the means to that end" of working to cut the number of abortions performed.

The two cases cited could be viewed as extreme cases, exceptions to the usual reasons for opposing abortion. But it is the exeptions so many of us are personally acquainted with that militate against the consensus needed for law.

As Bennett and others contend, much more could be done to diminish the number of abortions in this country, but it would mean backing away from the slogans and quick absolutes. It would require making room for dialogue and imaginative responses. An enormous task remains ahead for each of us and collectively for our churches if we are to wear a worthy pro-life mantle. ■

UNCLASSIFIED
NSC/RMO PROFILE

file asylum

RECORD ID: 9601305
RECEIVED: 27 FEB 96 20

TO: PRESIDENT

CHRON FILE

FROM: STERN, T

DOC DATE: 06 MAR 96
SOURCE REF:

KEYWORDS: HUMAN RIGHTS

PERSONS:

SUBJECT: COERCIVE FAMILY PLANNING & ASYLUM

ACTION: PRESIDENT APPROVED RECOM 3 DUE DATE: 01 MAR 96 STATUS: C

STAFF OFFICER: SCHWARTZ LOGREF:

FILES: WH NSCP: CODES:

D O C U M E N T D I S T R I B U T I O N

FOR ACTION	FOR CONCURRENCE	FOR INFO
		BASS
		BERGER
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		DANVERS
		KRECZKO
		LAKE
		NSC CHRON
		SCHWARTZ
		SODERBERG

COMMENTS: _____

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UNCLASSIFIED

ACTION DATA SUMMARY REPORT

DOC	ACTION OFFICER		CAO ASSIGNED ACTION REQUIRED
001	LAKE	Z	96022807 FWD TO PRESIDENT FOR INFORMATION
002	PRESIDENT	Z	96022818 FOR DECISION
003		X	96031318 PRESIDENT APPROVED RECOM 3

DISPATCH DATA SUMMARY REPORT

DOC	DATE	DISPATCH FOR ACTION	DISPATCH FOR INFO
002	960228		VICE PRESIDENT
002	960228		WH CHIEF OF STAFF

National Security Council
The White House

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Harmon			
Dohse	1	D	
Sens			
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Berger			
Lake			
Situation Room			
West Wing Desk	2	3/8	N
Records Mgt.			

A = Action I = Information D = Dispatch R = Retain N = No Further Act

cc: EPS, TL, NES, PEB, SKB 3/5

COMMENTS: File for the record and inform staff of POTUS decision.

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National Security Council
The White House

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Dohse	1	D	
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Lake	3		
Situation Room			
West Wing Desk	4	2/28	D RASC
Records Mgt.	5	2/28	D STERN

A = Action I = Information D = Dispatch R = Retain N = No Further Actio

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COMMENTS:

Exec Sec Office has diskette YES

THE PRESIDENT HAS SEEN

THE WHITE HOUSE
WASHINGTON

March 6, 1996

MR. PRESIDENT:

The attached Lake/Rasco memo concerns an amendment Rep. Chris Smith has offered to the State Department Authorization bill on coercive family planning practices. Smith would amend asylum law to make victims of coercive family planning practices eligible for asylum. (Hyde has a similar amendment on the immigration bill.) Under current law, such people are not eligible. For that reason, in 1994 you directed that executive action be taken to prevent the return of those who were victims of coercive practices in the past or had a credible fear of such abuse if returned.

The decision for you is whether (1) to oppose Smith as unnecessary in light of our current procedures; (2) indicate no objection to Smith; (3) support Smith.

State and Justice strongly favor Option (1), arguing that enactment of Smith would spur a large increase in the smuggling of illegal aliens and that Smith is unnecessary given your 1994 directive. NSC favors Option (3), arguing that (i) this would represent a strong affirmation of our opposition to coercive family planning, echoing the First Lady's statement in Beijing, and (ii) it isn't clear that Smith would trigger a big increase in smuggling. George, Jack and John Hilley agree with NSC.

Option 1 (oppose Smith)___ Option 2 (no objection)___ Option 3 (support)___

Todd Stern

THE WHITE HOUSE

WASHINGTON

ACTION

February 28, 1996 96 FEB 28 P6:29

MEMORANDUM FOR THE PRESIDENT

FROM: ANTHONY LAKE
CAROL RASCO

SUBJECT: Coercive Family Planning and Asylum

Purpose

To obtain an Administration position on proposed legislation relating to coercive family planning and asylum.

Background

Current situation: Under current asylum law, which Justice has defended, victims of abusive family planning practices in China do not generally qualify for asylum. For this reason, and at your direction, we instituted in 1994 an administrative regime that provides protection from return for claimants who were victims of coercive family planning practices in the past or have a credible fear that they would suffer severe mistreatment if returned.

Smith Amendment and State Authorization Bill: The House version of the State Department Authorization Bill contains an amendment offered by Representative Chris Smith that makes victims of coercive family planning eligible for asylum. The bill is in conference, and we may be asked for our view.

We have three options:

First, we could oppose the Smith Amendment but indicate that our current procedures provide adequate protection and make Smith unnecessary.

Second, we could indicate that we have no objection to the Smith Amendment.

Third, we could indicate that we support Smith.

cc: Vice President
Chief of Staff

Discussion of the Options

State and Justice strongly support maintaining the current administrative regime and opposing Smith. They argue that enactment of Smith would send a signal to would-be smugglers and spur a large increase in smuggling, severely taxing INS, Coast Guard and local law enforcement resources in California and other coastal and border states. Moreover, they argue that the availability of judicial review under a statutory regime would permit claimants to delay repatriation as their cases wend their way through the courts.

State and Justice also believe that the legislation is unnecessary and redundant given the current administrative regime we have implemented, which provides roughly the same level of protection from return that the Smith Amendment would provide.

Proponents of the Smith Amendment argue that it would represent a strong affirmation of the Administration's opposition to coercive family planning, an issue that the First Lady raised prominently in Beijing. It would also provide successful claimants with the opportunity to become permanent residents in the United States. (We have asked the Congress to empower the Attorney General to provide permanent resident status to those who are granted protection under our administrative regime, and we expect that Congress will provide such authority shortly.)

It is not clear that enacting Smith would cause a large increase in smuggling, as both State and Justice predicted that the administrative protections we are now providing would spur such an increase, which does not appear to have happened. (On the other hand, legislation would be far more publicly visible and thus could prompt a greater response from the smugglers.) It is also unclear that the availability of judicial review will create additional incentives for the smugglers. Even without the Smith Amendment, asylum-seekers from China already seek judicial review and have been successful in delaying their repatriations.

RECOMMENDATION

We believe that our position against coercive family planning weighs heavily in favor of our supporting the Smith Amendment and justifies the risk of some increase in smuggling activity (which we would seek to monitor and address through continued efforts to break up the smuggling rings). For this reason, we recommend you approve option 3, support of the Smith Amendment.

Approve _____

Disapprove _____

NATIONAL SECURITY COUNCIL
WASHINGTON, D.C. 20504

February 27, 1996

ACTION

MEMORANDUM FOR ANTHONY LAKE

FROM: ERIC SCHWARTZ ES

SUBJECT: The Smith Amendment on Coercive Family Planning and Asylum

I have attached a memorandum to the President on the Smith Amendment regarding coercive family planning and asylum. The Amendment may be considered at the House-Senate conference on the State Authorization Bill, which is scheduled to begin tomorrow.

The memorandum presents three options to the President: 1) oppose Smith, but indicate that the current administrative regime provides adequate protection; 2) do not oppose Smith; and 3) support Smith.

Per my conversation with Sandy, the memorandum recommends option 3: support the Smith amendment.

For your information, NSC staff views on the recommendation are split.

Alan Kreczko supports option 3: support Smith.

Eric Schwartz and Peter Boynton (for Dick Clarke) support option 1: maintain the current administrative protection regime but oppose Smith.

I have discussed the issue with Carol Rasco, who is prepared to concur in the memo as written.

Concurrence by: Peter Boynton, Alan Kreczko (not available), Bill Danvers/WD for SS for

RECOMMENDATION

That you sign the attached memorandum to the President at Tab I.

Attachment
Tab I Memorandum to the President