

The SPEAKER pro tempore (Mr. ROGERS). Under a previous order of the House, the gentlewoman from Connecticut [Ms. DELAURO] is recognized for 5 minutes.

[Ms. DELAURO, addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington [Mr. METCALF] is recognized for 5 minutes.

[Mr. METCALF addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from North Carolina [Mrs. CLAYTON] is recognized for 5 minutes.

[Mrs. CLAYTON addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana [Mr. ROEMER] is recognized for 5 minutes.

[Mr. ROEMER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

PROGRESS REPORT ON WOMEN'S HEALTH

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentlewoman from Maryland [Mrs. MORELLA] is recognized for 60 minutes as the designee of the majority leader.

Mrs. MORELLA. Mr. Speaker, I am really very pleased to sponsor tonight's special order on women's health with my colleagues NANCY JOHNSON, LOUISE SLAUGHTER, and ELEANOR HOLMES NORTON, and so many of our colleagues who are here this evening.

The Congressional Caucus for Women's Issues has spent a number of years attempting to address the neglected women's health research at the National Institutes of Health. The caucus asked the General Accounting Office in 1989 to investigate the NIH policy regarding the inclusion of women in clinical studies.

Women had been routinely excluded from many studies, such as the Physicians' Health Study which studied the effects of aspirin on heart disease of 22,000 male physicians. Another study, the Multiple Risk Factor Inventory Trial, a 15-year project studying the risk factors for cardiovascular disease, included 13,000 men and no women.

In 1990, the GAO reported that the NIH had made quote, little progress in implementing a 4-year-old policy to encourage the inclusion of women in research study populations. The caucus in 1990 introduced omnibus legislation, the Women's Health Equity Act, which included the establishment of an Office of Research on Women's Health and the

requirement that women and minorities be included wherever appropriate in research studies funded by NIH.

Well, in the fall of 1990, at a meeting with many caucus members, NIH announced the formation of the Office of Research on Women's Health, to ensure that greater resources were devoted to diseases primarily affecting women and to ensure that women were included in clinical trials. Since 1990, great progress has been made in funding for women's health concerns, particularly breast, ovarian, and cervical cancer, osteoporosis, and the women's health initiative.

While I focus my remarks tonight on HIV AIDS, osteoporosis, and domestic violence, there are so many issues critical to women's health that will not be mentioned tonight but are still high priorities for all of us.

Since 1990 I have been the sponsor of legislation to address women and AIDS issues. Women are the fastest growing group of people with HIV, and AIDS is the third leading cause of death in women ages 25 to 44. While the overall number of AIDS deaths declined last year, the death rate for women actually increased by 3 percent, resulting in a record 20 percent of reported AIDS cases in adults.

Low-income women and women of color are being hit the hardest by this epidemic. African-American and Latino women represent 75 percent of all U.S. women diagnosed with AIDS.

NIH is currently working to develop a microbicide. This is a chemical method of protection against HIV and STD infection, which is sexually transmitted disease infection, with an emphasis on methods that women can afford, control without the cooperation and knowledge of their male partners, and use without excessive difficulty.

We must acknowledge the issues of low self-esteem, economic dependency, fear of domestic violence, and other factors which are barriers to empowering women to negotiate safer sex practices. Research on a safe and effective microbicide must be a priority for our research and prevention agendas, and we must also work to answer the full range of questions important to understanding HIV in women, including adequate funding for the women's inter-agency HIV study, the natural history study of HIV in women.

In order to address these priorities for women, I will be introducing my women and AIDS research bill next week, and I hope my colleagues here tonight will join me as original cosponsors.

The gentlewoman from California [Ms. PELOSI] and I have also introduced H.R. 1219, a comprehensive HIV prevention bill which includes the provisions of my bill from the last Congress to address the need for more targeted prevention programs for women. Our bill authorizes funding for family planning providers, community health centers, substance abuse treatment programs, and other providers who already serve

low-income women to provide community-based HIV programs. Our bill also creates a new program to address concerns about HIV for rape victims.

In my work focusing on the needs of women in the HIV epidemic, the effectiveness of community-based prevention programs has been demonstrated time and time again. Providers with a history of service to women's communities understand that prevention efforts must acknowledge and respond to the issues of low self-esteem, economic dependency, fear of domestic violence, and other factors which are barriers to empowering women. I urge my colleagues to cosponsor this legislation.

Now on to osteoporosis. Mr. Speaker, it is a major public health threat for 28 million Americans who either have or are at risk for the disease. One out of every 2 women and 1 in 8 men over age 50 will have an osteoporosis-related fracture.

A woman's risk of hip fracture is equal to her combined risk of breast, uterine, and ovarian cancer. Often a hip fracture marks the end of independent living. Many enter nursing homes and a large percentage die within 1 year following the fracture. The costs incurred due to the 1.5 million annual fractures are staggering at \$13.8 billion, or \$38 million a day. Osteoporotic fractures cost the Medicare Program 3 percent of its overall cost.

I have reintroduced H.R. 1002 along with the gentlewoman from Connecticut, [Mrs. JOHNSON], the gentlewoman from New York, [Mrs. LOWEY] and the gentlewoman from Texas, [Ms. EDDIE BERNICE JOHNSON], to standardize Medicare coverage for bone mass measurement tests for the diagnosis of osteoporosis. Without bone density tests, up to 40 percent of women with low bone mass could be missed at a time when we now have drugs that promise to reduce fractures by 50 percent.

At this time, Medicare leaves the decision to cover bone density tests to local Medicare insurance carriers, and the definition of who is qualified to receive a bone mass measurement varies from carrier to carrier. H.R. 1002 would standardize Medicare coverage in order to avoid some of the 1.5 million fractures caused annually by osteoporosis. Since these tests are already covered by every carrier, the cost to the Medicare Program will not be substantial. As a matter of fact, with Congresswoman JOHNSON, we just met with representatives of the Congressional Budget Office to talk about that.

With regard to domestic violence, we have made great progress, yes, in training law enforcement personnel about domestic violence and funding battered women's shelters and starting up the national domestic violence hotline. I want to say that our speaker this evening has been certainly very cooperative and generous in the funding of the Violence Against Women Act.

But one area where we have room for improvement is in the training of our

health care professionals, doctors, dentists, nurses, and emergency personnel who are also in the frontlines in the fight against domestic violence. Many health professionals are unaware or unsure about the symptoms, treatment, and the means of preventing domestic violence, and many unknowingly send victims home with abusive husbands and boyfriends.

That is why I have introduced the Domestic Violence Identification and Referral Act, which is H.R. 884, which will amend the Public Health Service Act to give a preference in awarding Federal grants to those schools, medical, dental, nursing, and allied professionals that provide significant training in identifying, treating, and referring victims of domestic violence.

The gentleman from Vermont [Mr. SANDERS] and I have introduced the Victims of Abuse Insurance Protection Act, H.R. 1117, that would outlaw discrimination in all forms of insurance: Health, life, homeowners, auto, and liability. Although the Kennedy-Kassebaum health care reform bill included language prohibiting insurers from denying coverage to victims of domestic violence, companies can still charge domestic violence victims prohibitively higher rates; in effect, ban them from affordable health insurance coverage.

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H.R. 1117 would also protect the confidentiality of victims records. I urge my colleagues to join us in cosponsoring these bills.

There is more we could say, but I have many of my distinguished colleagues, and I appreciate their being here, who do also want to speak.

Mr. Speaker, I yield the balance of my time to the gentlewoman from Connecticut [Mrs. JOHNSON].

MORE ON WOMEN'S HEALTH

The SPEAKER pro tempore [Mr. ROGERS]. Under the Speaker's announced policy of January 7, 1997, the gentlewoman from Connecticut [Mrs. JOHNSON] is recognized for the balance of the time as the designee of the majority leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield to the gentlewoman from New York [Ms. SLAUGHTER], my colleague in this special order.

Ms. SLAUGHTER. Mr. Speaker, I thank the gentlewoman for yielding to me.

Mr. Speaker, there are a wide range of both triumphs and shortcomings in women's health that could be discussed this evening. On the one hand, a woman's life expectancy has increased from 48 years in 1900 to 79 years today. But on the other hand, many devastating women's health disorders still remain a mystery and research is desperately needed to find effective diagnostics, treatments, cures and preventive medicine.

Women are now regularly included in clinical studies after having been ex-

cluded for decades. There is now an Office of Women's Health at the Public Health Service with corresponding offices at other agencies like NIH, the CDC, FDA, and the Health Resources and Services Administration and the Agency for Health Care Policy and Research.

Breast cancer survival rates are up for women for the first time ever. And genes have been identified that are linked to early onset breast and cervical cancers as well as a number of other disorders that affect women like Alzheimer's disease. Estrogen replacement therapy has provided relief for millions of women from the harsher symptoms of menopause as well as osteoporosis and other age-related disorders.

The NIH is conducting major women's health initiative designed to study and to track women health in a large population over decades. This research will yield invaluable information about the normal aging process and its pitfalls for women. All of those things have happened since 1990, as my colleague, the gentlewoman from Maryland [Mrs. MORELLA] pointed out, when we first set up the Office of Women's Health.

But there are some shortcomings still in the health of women in the country. They suffer from a variety of gender-specific disorders that we do not really understand yet and which, in many cases, are receiving insufficient attention from the medical and research establishments.

Each year breast cancer strikes 182,000 American women and kills 44,000. We still do not know why breast cancer occurs, how to cure it or how to prevent it. We do not even know whether it is for different ages and groups of cancer types and the mammography machine which we have had for the past number of years is all we still have. We need to do more.

About 12,000 babies are born each year with fetal alcohol syndrome, a disorder that is completely preventable if women just abstain from alcohol during pregnancy, and yet we have just learned that the rate of pregnant women drinking alcohol is on the increase, showing a great need for education. About 4,000 pregnancies are affected by disorders like spina bifida or hydrocephalus, which are almost totally preventable if the woman consumes adequate levels of folic acid. Again, another need for education.

One-quarter million women die each year of heart attacks and strokes. Many of them could have reduced their risk by making dietary changes, quitting smoking, getting more exercise and, I might add, getting the kind of medical care that they need. Some of the bills that the gentlewoman from Maryland [Mrs. MORELLA] mentioned are very important, and I am sure all of us will sponsor and work for them very hard, because there are a number of things that we need to do to move along the issue of women's health.

One bill that I have introduced is the genetic information nondiscrimination bill, because I want to make sure that as the human genome mapping continues that no one man, woman or child in America is discriminated against when it comes to health insurance. Our bill just says that the insurance company cannot cancel, deny, refuse to renew or change the terms or the premiums or the condition of health insurance coverage based on genetic information.

And most importantly, it says that your genetic information belongs to you. And without your specific written concept, no one may use it.

H.R. 306, the bill number, has 96 cosponsors and has been endorsed by over 60 respected health organizations, included the American Cancer Society, the American Heart Association, the National Breast Cancer Coalition, and the Jewish Women's Community.

Congress should not be forcing women into making the Hobson's choice between learning valuable genetic information that they must have and their risk of losing their insurance or remaining ignorant and keeping the coverage.

We will also be introducing information on education efforts for DES or diethylstilbestrol, which was given to pregnant women during the 1970's so that they could have a healthy, bouncing baby. DES was given to pregnant women in the United States long after the Department of Agriculture had denied its use for cattle because they knew that it caused reproductive damage. Yet women in the country continued to be damaged.

We are seeing that their children and again into a second generation now have often been damaged by DES, and we need to have more of an understanding about DES and similar synthetic estrogens because amazing impacts and discoveries are being made on the effects of estrogen on women's health. It also authorizes a national education effort to identify DES-exposed women and their children and their grandchildren and educate them about the continuing health needs and the risks.

I have also introduced an Eating Disorders Prevention and Education Act, which I think is terribly important. We are very concerned about young women who are very unlikely to have a good diet because of their concern about their weight. Girls as young as 8 are dieting. This is a national disgrace that interferes with their normal development and their continued health. We have to make sure that young women understand that milk and dairy products will not make them fat but will indeed help to give them the calcium to lay down a good bone mass.

In conclusion, women's health should not be taking a back seat anymore. We compose over half the Nation's population and a large number of us are workers and taxpayers. And we want some of our taxpayer dollars to be used in the health of women in the country.