pects of reproductive freedom if elected, especially if he chooses not to seek a second presidential term? It would appear that McCain is at odds with the Republican party's platform not only in his support of limited human embryonic stem-cell research but also in his leaning toward exceptions to abortion restrictions in cases of rape, incest, or a threat to the life of the mother.

In Obama's 8 years in the Illinois State Senate and 4 in the U.S. Senate, he has had more limited opportunities to vote on these issues, and his positions have had less time to evolve. His future actions may therefore be less predictable than those of many past nominees. Would Obama issue an executive order, as expected, rescinding the Mexico City Policy, which currently prohibits foreign recipients of U.S. family-planning funding from providing, or even counseling clients about, abortions (except in cases of rape, incest, or a threat to the life of the mother)? Would he restore U.S. funding to the United Nations Population Fund, and would he work with Congress to ensure the federal funding of human embryonic stem-cell research? We don't know for certain.

Even if we were guaranteed full knowledge of a candidate's position on past and current controversies, the way in which a new president will handle issues that arise in the future is a matter of pure conjecture. As the life sciences continue to advance, new light is shed on early human development and the thorny question of when life begins. Insofar as the scientific horizons are unknowable, the questions of which programs or research the federal government should fund and what restrictions, if any, should be placed on emerging areas of research remain unanswerable. Practitioners of the life and health sciences who are concerned about these issues, like all Americans, will have to vote their consciences while relying on the voting records and public statements of the candidates — and, as is often the case, a hefty dose of imprecise extrapolation.

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ELECTION 2008: OPINION AND ANALYSIS

Moving Forward on Reproductive Health

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Reproductive health policy has been mired in debates over abortion and sexuality, leaving unresolved a cluster of reproductive health problems. For a country of such wealth and technical prowess, the United States has long fared poorly in this key public health domain. The litany of grave public health problems is as familiar as it is long: elevated rates of pregnancy-associated deaths, infant deaths, low-birth-weight newborns and preterm births, adolescent pregnancies, sexually transmitted infections, and unintended pregnancies.[1] Some of these rates have actually increased in recent years, and all are far higher than those in other developed countries. Moreover, these problems are concentrated among disadvantaged groups, and the disparities have persisted or worsened in the past three decades.

How, then, might a new presidential administration move forward? Reframing this cluster of issues in terms of public health — a field that favors pragmatic, evidence-based approaches over ideology — might lead to real progress toward improving women's health. When these issues are viewed from such a perspective, certain themes emerge.

First, reproductive health requires the availability of scientifically accurate information regarding all stages of life. The recent debate over a proposed federal regulation that would redefine common contraceptives as forms of abortion highlights but one example of the current administration's damaging distortion of science. Other examples have involved persistent governmental publication of false or misleading information suggesting that contraception or abortion is associated with breast cancer and mandates that health care professionals provide women with misleading or inaccurate information concerning fetal development before delivering abortion services.[2] Government at

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all levels must be a source of dispassionate, accurate information that reflects the best judgment of scientific professionals and medical experts.

Providing accurate information also requires comprehensive education, covering all means of avoiding sexually transmitted infections and unintended pregnancy as well as ways of ensuring that desired pregnancies are as healthy as possible. Such education must include accurate information not only about the efficacy of abstinence but also about the efficacy and safety of condoms, birth-control pills, emergency contraception, and sterilization. The past 8 years have seen a marked decline in the accuracy and completeness of the information made available in U.S. public schools. Despite compelling evidence that abstinence-only programs do not stop — or even significantly delay — sexual activity among teenagers, these programs are currently funded at a level of $176 million annually; unfortunately, one in three teens currently gets no education about birth control at all.[3] Good health begins with good facts.

Second, even if Americans elect an administration committed to nominating Supreme Court justices who support a constitutionally protected right to privacy encompassing reproductive choice, reproductive health services must still be legally, financially, and practically accessible. State and federal restrictions on the funding of reproductive health services reduce the number of facilities and providers offering such care. Insurance coverage for the full range of reproductive health services and products is uneven, with many public and private insurers omitting contraceptive, abortion, or infertility coverage, which is particularly unfair to lower-income populations. A variety of parental notice and consent rules and criminal investigations when adolescents present for contraceptive, abortion, or sexually transmitted infection services deter girls from seeking timely medical assistance to protect themselves from pregnancy or disease. And an increasing number of health care professionals are claiming the right to abandon their patients — particularly those who have to make reproductive choices — in the name of "conscience." The well-being of patients should be the first priority of both medicine and public health policy; it is the responsibility of the health care system to ensure that patients are fully informed about all their legally available medical options and that they receive referrals if an individual clinician opts out of providing a specific service. A new administration embarking on a national health care plan will have the opportunity to establish the system's obligation to provide care and to ensure a full range of reproductive health services.[4]

Third, such services should encompass not only efforts to avoid pregnancy but also efforts to achieve pregnancy. The typical American woman wants to have two children. To do so, she will spend roughly 5 years trying to become pregnant, being pregnant, or in the immediate postpartum period. She will also spend 30 years trying to avoid pregnancy. In other words, a woman needs care for wanted pregnancies at certain times and to prevent unwanted pregnancies at other times. These services should be integrated and viewed as components of a seamless whole.[1]

Fourth, pregnancy and childbirth can and should be made safer. We still do not fully understand why maternal death rates in the United States are so much higher than those elsewhere in the developed world or why, in the United States, black women die at 3.5 times the rate of white women from pregnancy-associated causes. But we do know that certain problems could be tackled now. Obviously, we need to improve medical treatment for obesity and addiction, both of which can contribute to complications of pregnancy. But we also need to explore social policies that go toward preventing these problems, whether by making healthy foods more affordable, protecting children from the onslaught of advertising, planning cities and buildings to promote walking, or other approaches. We also need to enhance research on the effects of medications on pregnant women and fetuses. At present, few clinical trials generate such data, and far too few data are gathered after a drug has been approved for marketing, which leaves physicians and pregnant women unable to make informed decisions about the use of certain medications. The next administration's health plan should include research and postmarketing surveillance.

Fifth, a public health approach places medical problems in the context of social forces such as poverty, environmental pollution, poor education, and domestic violence. Through such a multifaceted lens, it becomes clear that the domain of work and family

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will be a critical focus for the next administration. The U.S. government has done little to address the difficulties of balancing work and family, despite the striking increase in the number of mothers of young children who work outside the home. This neglect has led many U.S. women to delay having their first child, and the trend toward later pregnancies is associated with increased morbidity and mortality among mothers and infants. Benefits such as paid parental leave, paid sick days for caring for sick children, available and affordable high-quality child care, breastfeeding support for working women, and flexible work schedules all help to make pregnancy, childbirth, and motherhood physically and economically safer. The difference between families who can afford to pay for these services on their own and those who simply go without contributes to the persistent health disparities between white, middle-income families and poor and minority women and children.[5]

The data are compelling. We know how to improve the reproductive health of Americans: base policies on evidence, not ideology; improve clinical research and postmarketing drug-safety studies; make accurate, comprehensive information about sexual health and family planning available to everyone, regardless of age; protect the privacy of patients; ensure access to reproductive health products and services; and adopt social policies that promote good health and facilitate individual choice about when to have children. As noted in the consensus documents from the 1994 International Conference on Population and Development, care that promotes all these aspects of reproductive health is not just good policy, it is a human right.

Ms. Charo reports serving as an expert witness for Planned Parenthood of Western Washington in a case concerning pharmacists' refusal to fill prescriptions for emergency contraception. No other potential conflict of interest relevant to this article was reported.

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