

# Center for American Progress



**SPECIAL PRESENTATION ON:**

**“WHAT’S THE PLAN B FOR PLAN B?”**

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JESSICA ARONS: Good morning. If everyone could please take their seats, we're about to get started. And, again, I'd like to remind everyone to turn off cell phone pagers – anything that might make noise during the program.

Good morning and welcome to the Center for American Progress. Thank you for joining us today. My name is Jessica Arons and I'm a legal policy associate here at the Center, and I'll be your moderator today.

The Center for American Progress was formed to find progressive and practical solutions to the significant problems of the day. One significant problem we are currently facing in the area of reproductive health policy is just what should be done about the emergency contraceptive pill known as Plan B. As you may know, Plan B has been available as a prescription drug for several years since 1999, but the application for its approval as an over-the-counter drug, which would make it available without a prescription, has encountered a number of what one might call unusual obstacles in the FDA's process.

The issue has deservedly received much attention because it implicates so many important issues, such as the perceived tension between science and ideology, the separation of powers, and the reliability of governmental decision-making. Should the FDA's decision regarding access to a drug be based purely on its safety and effectiveness or is it appropriate for the agency to consider behavioral and moral concerns as well? Under what circumstances and in what manner may Congress intervene in an agency's decision-making process? How can we ensure the integrity of governmental decisions in an increasingly polarized political climate?

Today we have gathered to address some of these questions and to discuss what happened with the Plan B application, how it could happen, and where should we go from here. Joining us for this conversation are Susan Wood; Silvia Henriquez, who is running just a few minutes late and should be with us shortly; Naina Dhingra; and Chris Mooney. Until recently, Dr. Wood was the assistant commissioner for women's health and the director of the Office of Women's Health with the FDA. As you probably know, she resigned in protest over the FDA's decision not to make a decision about the Plan B application.

Ms. Henriquez is the executive director for the National Latina Institute for Reproductive Health and has worked to increase access to and awareness of emergency contraception in the Latina community.

Ms. Dhingra is the director of public policy at Advocates for Youth and has fought to ensure that young women receive equal access to reproductive healthcare, including emergency contraception.

And last but not least, Mr. Mooney is a journalist who covers the intersection of science and politics. He is the Washington correspondent for *Seed* magazine, a senior correspondent for the *American Prospect*, and just published a book titled *The Republican War on Science*. Please join me in welcoming these panelists, who each bring a unique perspective to this issue.

(Applause.)

And to give you just a brief sketch of how we'll proceed: each of the panelists will speak for a few minutes and then I'll probably ask them a few follow-up questions, and at that point I'll open it up to a question and answer from the audience, but if we could save the questions until after all the panelists have spoken, I think that'll work better. And at that point, I would like to encourage an interactive conversation with all of you in the audience.

So with that, let's start with Susan Wood.

DR. SUSAN F. WOOD: Thank you and thank you for having me here. I think I'm here today because I did something rather unusual for a career federal employee, which was to publicly resign on principle or on disagreement with the agency. That's not to say that people don't move on or leave based on principle when they disagree with what they're doing, but I think because this was done publicly and on a topic that does draw attention, such as contraception, that that led to the attention on this issue. And it is so important to take that and say, "Well, what does that mean and why should people beyond those of us in federal government and beyond those who advocate for these issues care about them?"

I'd like to start by saying that women's health is so much more than reproductive health, and it's cardiovascular disease, it's AIDS, it's autoimmune disorders, it's epilepsy. It's so much more that women's health encompasses, and we have to keep that in mind. The problem is is that reproductive health is what gets the controversy attached with it and there are lots of reasons why that happens, but I think it to me is disappointing that we have to spend so much energy around reproductive health issues. It's so necessary that we do so. It's required. But we really have so much work to be done, and there's been so much progress made in the last 20 years in the area of women's health beyond reproductive health that it almost feels that we're stepping back if we have to then fight for something like contraception, which is what this is about.

When I resigned, I did so because the decision to once again delay approval of Plan B over-the-counter was clearly and most unusually disregarding normal agency processes. Again, I was five years at FDA, but 15 years in government, and had not seen anything quite like it. I will refer you to the timeline that the Center for American Progress has so nicely put together because it sort of lays it out for you so that I don't necessarily have to do it.

But during the course of the two decisions that occurred, one in the spring of 2004 and the one just recently in August of 2005, both of those were extraordinary in that they disregarded not just the advisory committee recommendations, which FDA often does, but it disregarded the professional staff recommendations at multiple levels within the agency, so that the reviewers who had spent months evaluating the data and pulling together all the information agreed with the advisory committee that it should be bought over the counter. The management levels above them at multiple levels also agreed, but at the top in both cases in May of 2004 and in August of 2005, it wasn't a tweaking of the decision or making a call when there are competing points of view inside the agency. This was simply overturning the consensus view of the professional staff as well as the advisory committee, and that to me was extraordinary.

At the first time of the first decision, I did not resign because I, too, was hopeful that going through a prescription status, nonprescription status based on age, although not necessary, was a way to getting it approved somehow. And that was what we thought what would happen six months or eight months later – that the process would work through and we would have an approved over-the-counter product, although limited.

But when that didn't happen and when what happened instead was that no one in the scientific or medical review staff had any idea of this idea to go into rulemaking until very, very late in the process, that was again extraordinary in terms of process, but also extraordinary in the nature of the decision. To say we're at the very end of a review cycle, we're going to open up a new regulatory process, which can take a minimum of months and more likely years. This was something that was untenable to me, again, as a career scientist at FDA. This was not how we should do business. This is not how we should make decisions that affect health policy. It should be made based on the science and independent of any other forces, and that was clearly what had not happened. So that was one of the reasons I resigned.

The second reason was this clearly was not benefiting women's health. By denying all women access to this product, you are restricting access to a very safe and effective method of contraception that should be available and is more effective the sooner you use it. It's been clear for a long time that this was a very appropriate and very suitable product for over the counter and would benefit women, would prevent unintended pregnancy, and if widely used and appropriately used would prevent the need for abortion. So this should be common ground, but it should also be something that promotes the health of women and families. Again, this is something I felt very strongly with my entire life, and this is something that was clearly not being promoted and in fact harmed by making decisions such as was made in August.

Just so you know, the Office of Women's Health is not in part of the review chain itself. I was not the one to make a decision or asked to review, but we stayed very closely apprised as to what was going on, and I did try and stay on top of how everything was moving along during the course of the approval. And what shocked me again was how cut out the professional staff was from the final decision in that no one knew what it was going to be at the very end.

I think the take-home thought that I have and the reason I resigned, the reason I'm talking to you, is that it's so important that we make our decisions based on the science. This is about contraception. This is about safe and effective contraception. This is about safe and effective contraception that needs to be available, and we really need to remember that. This is not about abortion politics. But even if so, this should not – our decision should be based on science and medical evidence and should be based on proper review process that ensures the independence of FDA so that you can count on the information you get from agencies like the FDA. It needs to have credibility. It needs to have independence. It needs to have a strong science base, and that's so important for this issue and it's so important for all of the health information and the health decisions and the health treatments that would be available for you if you – you must be able to count on it being made on the science and medical evidence and the best possible evaluation of that data.

And finally, all of the – the reason we do all these things is because we have hope for the future. We want to have things that can treat diseases, prevent health problems, promote good health. These are all things that we seek when we fund our scientific research, when we look to the health system to take care of us and to give us appropriate care. And we need to reach for that hope and count on it and say “This is what we want. This is a proactive step.” We need to move forward and insist from our health agencies, from the medical community, from the research community that we want to move forward and we want to promote the health of people and not limit it. And I'll stop there.

MS. ARONS: Thank you very much. Since we're still waiting on Silvia, I'll turn to Naina Dhingra now.

NAINA DHINGRA: Good morning, everyone. I'm amazed to see so many of you here at 9:00 a.m. on Monday morning. I typically don't do very well at 9:00 a.m. on any day, so thank you all so much for coming here. I'm so honored to be on this panel with – particularly with these two people who I respect so much. And if you haven't read Chris's book, I highly recommend it.

I also want to take the opportunity to – I don't know if they're here – but to thank the Reproductive Health Technologies Project. There. Right there. I think throughout all of this, you guys have been amazing in keeping the community informed. Getting the regular updates, getting the talking points has been amazing and I think that all of us in the community with so many issues to monitor really appreciate your work, and so I just – I wanted to take that opportunity to thank you.

For those of you not familiar with Advocates, Advocates for Youth is an organization that works in adolescent sexual and reproductive health. And for public policy what that means over the last two years is promoting science-based public health interventions. Who knew that promoting science would become so controversial? So that's what we focus on.

Our primary policy agency has been promoting comprehensive sexuality education; of course, lobbying against abstinence-only-until-marriage programs, so we see EC as crucial to this, crucial to our agenda of promoting science and really taking a hard look at where's ideology – where's ideology taking – overruling science.

Additionally, we have an emergency contraceptive initiative that I want to share with you because with this initiative, we're working intensively in ten states on a variety of different levels doing public education campaigns, working to change state and local policies to increase access, and also working with healthcare providers and hospitals, and Title X clinics and rape crisis centers to ensure that those who provide emergency contraception and who have the ability to have the resources and have the skills to do that.

And I mention that because I think what's important is to realize that in building our base for this, we have to really think about ensuring that all those who can provide EC are really being educated and trained so that they have the tools to provide EC while we're trying to get it federally so that any young woman can receive it. We need to ensure that places where these young women go, the Planned Parenthood Clinics, the Title X clinics, sexual assault centers, that the people working in those places understand how to distribute EC effectively to a young woman.

I want to look at three things today and discuss with you. First, that EC is the classic example of scapegoating of young people. The second, the concern that I and advocates have about the precedence that this will – that this is going to set for young people in the future. And the third is to look at the opportunity here. We have to find a silver lining, and what is the opportunity in this in messaging this piece to build our base, messaging this to young women and to the general public. How are we talking about this issue to move it forward?

So starting with the first one, the scapegoating of youth, former Commissioner Crawford – I'm happy to say the "former" piece now – Crawford has claimed that he needed to consider this process for implementing age restrictions for OTC because of his belief that all of a sudden millions of young women across America would become highly promiscuous and start engaging in risky behaviors. Young women everywhere should be outraged and they should feel that their intelligence has been insulted by this.

Prevention does not cause pregnancy. We know that. Umbrellas are not causing rain. (Laughter.) I mean, I don't understand if this man honestly believes that, but the fact is I don't genuinely think he does or if he does, he's not really thinking about it. But we have to stop thinking about the outrage of it and instead think about it to what he's doing by doing that. What he did and what the right did in change – in making that the message was they shifted the frame of the discussion. Instead of it being a discussion about – a national discussion of shouldn't women, regardless of age, have access to progress – have access to progress in reproductive health technologies, the issue became – it became a debate of how young is too young for women to be engaged in sex, and that's what they made our side start discussing and debating. It's not an issue of how

young is too young. It's that women – all women – have the right to progress in technology, and so we need to again take the debate back. The issue is not how young is too young, and we cannot get caught up in that.

Crawford and others who believe that the FDA's decision citing fraudulent health concerns due to the fact that they believe that, well, we just don't know enough about this drug safety in young people and young women in particular, that's just false. I mean, for those of you who haven't read the *New England Journal of Medicine* article, it's fantastic. You should read it. The research is there. The doctors are there. We have research and we have science on our side and we have to remember to use that.

We know his own advisory committee found that there was no evidence of this and declared EC completely safe. Unfortunately, though, when I've come into discussions about this with people who don't work in the community, just people I've met through different social events or that sort of thing, it's unbelievable that people genuinely believe this. They have been successful. Those two pieces – “Well, EC is going to cause more young people to be promiscuous and have unsafe sex because they have a backup plan,” and that “We just don't really know if EC is safe for young women,” – they did a really good job of getting that message across so we need to be aware of that, particularly those of us who are, I think, sometimes – our social circles, we like to surround ourselves with people who think like us. I know I do, and so once in awhile you kind of realize that, oh, I'm really in the minority of people here.

So moving on, I think we really need to think about the dangerous precedent that this could set. If young people don't have the right to access new technology for their sexual and reproductive health, the advent of any new further technology – what's going to happen with microbicides? That's not immediately down the road, a couple years down the road – five, ten years down the road. What is happening right now is the HPV vaccine. That is happening right now. It's the same thing.

And if we start to get into this discussion of limiting technologies to young women, then we are furthering the social mythology that these young women can't make decisions for themselves; that they are – instead of being their own people that they are sexually promiscuous, they will engage in risky behavior, and we're taking the trust out of them. It's saying that society is smarter than young women. That's a very dangerous road to go down. We don't want to allow a two-tiered structure of healthcare to exist in this country because what will happen is it won't be a two-tiered structure of age. It will be an increased – and we already have this – it will be increasing the class structure in this country. And I'm sure that maybe Silvia will add to this about the fact that who this will really hurt – it will never hurt young women 25 and under, people who would be sitting in this room, people who have – right now can get Plan B, they can go to the web site, they can fill out a prescription and call your doctor, and within a couple hours go to a CVS, go down the street and pay the \$30 to get Plan B. It's not going to hurt us.

It's going to hurt the young women who don't have IDs. It's not just young women 16 and 17 who don't have – I'll share something, actually. I actually don't drive,

so I don't have a driver's license and never had one and haven't had a passport. Who carries around their passport with them all over the place at 16 years old? You don't.

Young women – 15, 16, 17 – they don't have IDs. They have a high school ID. Do you honestly think they're going to show a high school ID at the pharmacy? No. That's not going to happen. So we need to look at the fact that who is dual status helping and hurting. Well, it's helping no one. In fact, it would increase barriers to young women who are over 16, over 15, over eight, whatever age they would make it, particularly young women of color, particularly immigrant communities.

The last point that I want to talk about is how do we learn from this and how do we move past the outrage strategically to build our base. That's something I think we all need to think about. I was actually at a presentation here a couple – I think last month or two months ago where we were discussing new messaging and frames. And I know we're all concerned about thinking about it, particularly looking at, well, why isn't the choice community – the reproductive health community, attracting young women? Why aren't more young women – why aren't women of color interested in this movement? You know, we know that young women shut off when they think – when they start talking about abortion politics. We know that issue isn't appealing right now to a lot of young women.

And so I want to stress that we really use this issue and highlight this issue to be talking to young women, to build our base, to get young women outraged, and go beyond the usual suspects because what you'll find is that building on this issue with young women will really get them involved and activated. This is an issue that is very easy to understand.

Now, the key word here that resonates with young people – young women on this is not rights, and that was sort of hard for me to learn. And this is – and I'm sorry: I'm basing this purely anecdotally from talking to a lot of my own friends, who are actually on the other side of the aisle who may not be pro-choice. They are anti-choice, but they understand contraception. And so the key issue that is resonating here is respect. Our side – we are the ones who respect young women, and that's what we have to make it about: who respects young women and who does not? And when you put it in those terms, it's very easy to understand. It's about who is going to respect young women and believe that giving them information and increasing access to all types of technology and services will allow them to make healthy decisions versus the idea of those who inherently distrust young women, who do not believe that they can make healthy and responsible decisions for themselves, thereby censoring information and denying healthcare.

Now, I found in conversations that this is actually very helpful. I know that other people advocate that this message works quite a bit with the audience that we are trying to reach, particularly nonprogressive, non – women who do not consider themselves progressive because it's a concept of – you know, they don't want the government making decisions for them. Well, this is the government making a decision for them.

Going broader than that, how do we – actually, I just want to share one other thing. To build youth activism on this issue, in five of the states we're working in we have young women acting as secret shoppers and trying to figure out where they can access emergency contraception. And that in itself has really helped to pull them into wanting to work on this issue at a federal and on a policy level. So I think thinking innovatively about how do you engage young women to become involved in policy issues by seeing how it affects them really personally is important.

The last point that I'll just make before I wrap up is messaging this to the broader public, and I really want to stress the Lakoff theme here of prevention versus punishment, because I think that theme and that frame is what really works when talking to the general public. This clearly reveals the ideological right would rather punish young people and rather punish young women for having sex outside of marriage, and that's just it. And once you put it like that, I think people kind of go, whoa. I mean, EC is safer – much safer option for young women than pregnancy.

And so I'll stop there. I'm looking forward to continuing this discussion further with all of you. I know there are so many amazing advocates here in the office – in the room.

MS. ARONS: Thanks so much, Naina.

With that, we'll turn to Silvia. Thank you for getting here.

SILVIA HENRIQUEZ: Sorry. I apologize for being late. Okay. Well, I'm Silvia Henriquez and I'm with National Latina Institute for Reproductive Health, and thank you very much for the Center for American Progress for putting this panel together and for all the advocates in the room who've been leading the effort around Plan B, RHDP in particular and others.

I'd like to start by talking about why emergency contraception is an important option for Latinas. And I'd also like to emphasize that while I'm going to focus on Latinas, a lot of the information specifically surrounding immigrant women and low-income women really crosses different races and ethnicities. So I think that there's a lot of opportunity here to think about engaging other communities of color as well.

So specifically what are – why EC is an important option for Latinas. The basic most fundamental reason is lack of access to healthcare and insurance and lack of opportunities to be able to see a provider who can provide information on contraception and who will be able to – and the lack of access to the full range of reproductive healthcare services.

Specifically, why emergency contraception is important is because we know that Latinas are much less likely to use contraception during the first intercourse experience. Sixteen percent of Latinas experience contraceptive failure during their first two years of

use, which is a much higher rate than it is for white women. Low-income Latinas have a harder time accessing and using regular contraceptives and the number for this is about 13 percent of Latinas use the pill followed by 11 percent, and sterilization continues to be the most popular form of contraception for Latinas.

So in addition to that, that leads to high rates of unintended pregnancy. Specifically, Latina teens have the highest teen birth rate of any racial and ethnic group and Advocates for Youth does a lot of work on that. Specifically around immigrant Latinas, the difference with immigrant Latinas is that they tend to be less sexually active than acculturated Latinas, but they use contraception even less and they have even less access to family planning options.

So that leads us to specifically some of the barriers facing Latinas. I've mentioned lack of health insurance. There's also lack of access to providers. There's also cultural and language barriers and differences. And finally, lack of information continues to be a huge, huge barrier.

For the Latina Institute why this is such an important issue for us, in addition to the statistics and everything that I've mentioned, is that we do believe it's an entry point for many Latinas in our community to start talking about reproductive healthcare. Women are outraged when we tell them they can't access emergency contraception in a timely manner. This issue has really, really galvanized a number of different Latinas who may not have necessarily become involved with reproductive health and rights issues.

And for us, in addition to the basic fundamental need and bringing dignity to the community to be able to access this such basic, basic reproductive health service, the concept behind politics trumping science and all of the issues and the long history of what's been going on with access to emergency contraception has really, really increased the number of people that want to hear about it, that are surprised and angry that they didn't know about emergency contraception before and want to do something about it.

So I think that this shows that at least for us when we're working with a community who – you know, some people may look at abortion is not necessarily the issue we lead with, contraception, family planning, and emergency contraception has been a really, really great opportunity for us to be able to introduce this. And now we're stuck with the issue of, well, it's a really great option, but you can't access it as easily as you should.

So specifically, some of the reasons why lack of access is particularly important and not apparent in the Latino community is Latinas have the highest uninsured rate among other racial and ethnic groups. Right now, it's about 41 percent. And when you take into consideration low income, Latina immigrants, the rate goes up to 60 percent. Twenty-five percent of Latinas have not visited a physician in the last year, approximately, and one-third of Latinas do not have a regular healthcare provider.

Additionally, because a lot of new immigrants are migrating to places that are more rural, lack of transportation and geographic isolation continue to affect access, so clearly when you're looking at emergency contraception, you can see how this is even more of a challenge.

So some of the linguistic and cultural differences: only 4 percent of physicians and 3 percent of nurses nationwide are Latino. And while it's important to have Latino nurses and physicians, I also want to emphasize that the cultural piece – just because you're a Latino physician does not necessarily mean that you're going to have the cultural piece. And so the cultural competency part is a little bit harder to quantify or look at, but that's a huge, huge issue primarily because of the high rates of unintended pregnancy, and the reasons behind the unintended pregnancy is an important component when you want to talk to the Latino community about why emergency contraception is important.

There's not enough well-trained medical interpreters on this issue. And particularly in reproductive healthcare, at Latina Institute when we talk about culturally competent medical interpreters, we have to look at interpreters who are not biased to the issue and who are not going to bring – maybe they don't bring a completely anti-choice perspective, but they may not necessarily be pro-choice and that's a huge issue as well. And in terms of foreign-born Latinos, almost 70 percent prefer to speak Spanish or speak Spanish only, so that gives you sort of a sense of why linguistic competence and cultural competency is so important, and that's a lack of information.

With emergency contraception, 50 – this was a couple – a few years ago, 51 percent of Latinas nationwide did not know what emergency contraception was compared to 71 percent of white women, as opposed to other forms of birth control, which were a little bit higher in the area of knowledge. And in a recent study in California, only an estimated 29 percent of Latina immigrants new about EC.

So at Latina Institute, one of the campaigns or one of the main areas of our focus around EC is public education. And what we have found to be extremely successful is doing public education in more intimate settings with – in conjunction with community-based organizations. And when I was talking about entry points earlier – when bringing a community-based organization who is not providing, necessarily, abortion access in that community and who may have some issues with reproductive healthcare, when it comes to emergency contraception we found really great partners with community-based organizations. And they've been able to work with us and sent people over to be trained on how to talk about emergency contraception, what is it, and why it's an important option for Latinas.

And in New York we've had a number of different workshops. That was where we piloted this idea of partnering with a CBO or a different kind of organization like an organization that works against violence against women. And then now we've taken it to Chicago as well and had some success there. And this model that we've been partnering, we partnered with other organizations, like mainly around New York and other

reproductive health organizations to make sure that we can have a really great model on talking about emergency contraception in an intimate and familiar setting for many women.

So that's – I mean, at least these are small, small steps and there's other groups that are working really hard on sort of more national, median advertising campaigns around emergency contraception. So in terms of strategies for increasing access to EC, obviously over-the-counter access is what – one of the strategies that Latina Institute is pushing for, but we're also at the same time looking at Medicaid coverage.

We know that, again, Medicaid is a huge safety net and an important basic form of health insurance for many, many, many Latinas. But we also know that the Latinas who do not qualify for Medicaid, growing numbers of Latinas who do not qualify for Medicaid are going to rely on over-the-counter access. So when we look at over-the-counter, one of the issues that we're still confronted with is that people ask us is how much is it going to cost, and do I have to show identification, and who am I going to speak with, and is the pharmacist going to speak Spanish. I mean, these are all the issues that we still need to hammer out and I think where we're focusing on is obviously continuing the fight with over-the-counter access. And what we see our role is as this – hopefully this happens, Latina Institute can begin looking at all of these other issues such as how women who don't have identification or who are not citizens of this country going to feel about going to get access emergency contraception, whether it's in a pharmacy or not.

The other issue that we look at is HIV/AIDS and STIs are prevalent among Latinas, and we need to make sure that there's also information included about screening and testing. This is another issue that's come up from women that come to these trainings and when we talk about emergency contraception is the need to have that information easily accessible as well.

And going back to sort of the Medicaid issue, we – one of the strategies is we want to – as we continue looking towards over-the-counter access, we're simultaneously researching and working with advocates who are specifically focused around Medicaid access to look at, well, what would it look like to have emergency contraception on Medicaid formularies? What does it take? And this has been an issue that again has really galvanized a lot of Latinas across the country and hopefully we can target a couple states and look at what is the possibility of doing that.

And again, for us we're also looking at pharmacy access. We know eight states have pharmacy access right now, and this is a viable option. There are still some challenges for many Latinas, particularly the ones that don't speak English, and concerns about being treated unequally or feeling that they're going to their pharmacy and that's the only pharmacy in their neighborhood and they also know that their mom goes there, and their neighbors, et cetera.

So I think that as a community we – this is really our opportunity to continue looking at all strategies. And over-the-counter access would be a huge, huge success for us. And I think as Latina Institute continues to be involved with this, we're going to always be looking at, well, what about immigrant women and what about low-income women? And sometimes people think, well, we just have to get over-the-counter access. We just have to get there and then we'll figure it out. But it's really important for us, since we're using this as an entry point into the Latina community, to make sure that we can be held – that we're held accountable and that we can say to women, "Well, now you've all been doing these community workshops and here's this information about this great, great reproductive health option." We need to be able to ensure that they can actually access it.

So, again, I think public education is the key. We're happy to work with people on giving you our materials that are culturally and linguistically competent. If people are interested in hearing more about the workshops, I'm happy to talk about that. And as we continue the work around Medicaid, I'm also happy to work on that, so I'll leave it at that. And I'll look forward to questions, conversation, and dialogue. Thank you.

MS. ARONS: Thanks very much, Silvia.

And Chris?

CHRIS MOONEY: Thanks. I want to thank the Center for American Progress for having this great event. I thank all the panelists for your great work on this issue, and I particularly as a journalist would like to really thank Susan Wood for coming out, being a whistleblower, and telling everybody what happened behind the scenes at the FDA on this issue. I can't tell you how important it is that we have voices like that: people who are willing and courageous enough to let us see behind the curtain. And I think that the reason we know so much about the misuse of science under the Bush administration is because we have had so many people like this, so I really appreciate that.

We've heard a lot from previous panelists about the problems that the lack of access that Plan B is creating and also the corruption of the process at the FDA before deciding whether or not to approve this drug over the counter. I'm going to specifically focus on the role that science plays in all of this because – and at the background – in the background of this whole issue is the misuse of science. And of course, this is something that I do talk about in the Republican war on science. I talk about the Plan B issue. And it turns out that it has a lot of similarities with a lot of other issues where science is being misused and abused under the Bush administration. And in fact, the undermining of the credibility of the FDA on the Plan B issue is really quite analogous to the undermining of the credibility of the Fish & Wildlife Service when it comes to using science to make endangered species decisions or even the credibility of FEMA when it comes to using emergency management expertise to address catastrophes.

So the essence – as I see it, the essence of how science was misused in the Plan B case was that the FDA decided to cherry-pick a minority scientific opinion and it

apparently relied upon an outlier scientist as well, and then it also misused the concept of scientific uncertainty. And these are things that we see across a lot of issues. Let's first elaborate on how that happened with Plan B.

The joint advisory committee for the FDA ruled 23 to four that Plan B was safe, effective, and should be available over the counter, and the FDA's experts agreed. That's a pretty strong mainstream consensus opinion. The FDA ignored this and it went with an argument that was most prominently articulated by W. David Hager, who's a very controversial and obviously, I think, quite ideological member of the committee. He's the author of *As Jesus Cared for Women*, and in essence, I think he's sort of the religious right's favorite gynecologist.

And the role of religion in this for him was, I think, made clear when he explained how he had submitted a minority report to the FDA over this issue in a public speech that he gave in October of 2004. And he said, "The opinion I wrote was not from an evangelical Christian perspective. I argued it from a scientific perspective and God took that information and He used it through this minority report to influence the decision. You don't have to wave your Bible to have an affect as a Christian in the public arena. We serve the greatest scientist. We serve the Creator of all life. We serve the author of all truth. All we're required to do is proclaim that truth." So more than science was going on here and at least Hager is humble and he credits God, and not himself, for having such a huge influence.

So the FDA went with this minority opinion from Hager about the lack of data about how Plan B would affect young adolescent women. And argument about lack of data, it's quite an unreasonable request because, of course, first of all, there's no evidence to suggest that young adolescent women will use the drug any differently. And of course, it would also be extremely problematic to target them specifically with emergency contraception.

I just want to read you a quote from one of the scientists on the FDA advisory committee who was in favor of Plan B and who was explaining to me why you can't just set up a study to determine how young adolescent women are going to use this drug. This is Alistair Wood. He told me, "Visualize the consent form for a study in which you're going to study 14 to 16-year-olds with emergency contraception specifically." There's reasons that you can't do that and I think good ethical reasons.

So a minority scientific argument – the argument about lack of data – was cherry-picked and the mainstream of scientific advisory committee's opinion was ignored and scientific uncertainty was selectively cited. And of course, uncertainty is the strength of science. You can never completely dispel uncertainty, but to say, "Oh, we don't know something," can be very, very misleading when you ignore what we do know, which is often a lot.

And this is just the same sort of behavior – these kinds of misuses of science. We see very similar things on, for example, global warming, so let me just show the parallels

there. We have someone like Senator Inhofe, who cherry picks his own selected experts to support – and even he cherry picks his own favorite novelist like Michael Creighton – to support what is essentially an outlier position that humans aren't causing global warming. It's all just natural variability. And he ignores the National Academy of Sciences and basically all of the expert scientific bodies that work on this area and he's gone so far to suggest that global warming is a hoax, so he's cherry picking outlier experts.

He is also – the right generally, not just Inhofe, has set up a number of think tanks that are explicitly devoted to providing contrary “expertise on global warming,” so again they are finding a way to have their own selected experts they can then go to to ignore what is a mainstream consensus position, very similar to what happened on Plan B.

And the president is somewhat more subtle, but his administration likes to highlight uncertainty about global warming while ignoring the things that we do know, so there's some uncertainty about global warming, just as there's some uncertainty when it comes to perhaps how adolescent women will use Plan B, at least in the sense that we don't have a lot of data. But it's really misleading to cite uncertainty selectively when you ignore what the scientific community does know and has established, and that's how uncertainty is misused.

Frankly, the same strategies again appear on the evolution issue, which is a very hot-button one right now. Once again, the Christian right claims to have its own science on this issue. They're not arguing just from a moral perspective. They're saying that intelligent design is science – a scientific rival to evolution, just as David Hager is suggesting that he has a scientific alternative position for why Plan B should not be approved, even though the committee was so powerfully in favor. And of course, the FDA cherry-picked the minority outlier scientific position, which is just what religious conservatives who are advocates of intelligent design would like to see happen in high school classes with regard to the teaching of evolution; the only difference being intelligent design isn't science at all and Hager's position is simply bad science.

And furthermore, the attack on evolution is once again an end run around the mainstream scientific process. It's being set up at think tanks and it's occurring politically at the local level, rather than in scientific journals. So again, we have a way – a very reliable way of assessing what is the state of mainstream scientific understanding on all of these issues. We have processes set up in order to do that – scientific publication, scientific advisory committees and so forth – and there is a strategic attempt to get around these because people don't like the results that are coming out of the regular scientific processes.

So the question then becomes, what can we do about these sorts of abuses, whether on Plan B, on global warming, on evolution or anything else? And I have some suggestions here. Congressman Waxman is actually – for the Plan B issue in particular has proposed legislation, actually, that would shore up advisory committees and try to ensure that expertise is the criterion for judging members who are on these committees,

not ideology. And so this is one sort of step that you might think about because there have been a lot of allegations, not just with respect to Plan B, not just with respect to the FDA's reproductive health drugs advisory committee where advisory committees have either been slanted or there have been political litmus tests applied, so if someone who's an expert on drug use is being asked whether they voted for the president or what their views are on abortion and things like that. So we can reform, to some extent at least, the scientific advisory committee process.

Another issue you might not think is connected here, but I actually think that it is, 49 pro-life members of Congress wrote to the Food and Drug Administration echoing David Hager's questionable argument about lack of data on how Plan B is going to be used by young adolescent women. And I think that if Congress still had a credible Congressional Science Advisory Office, it might be at least a little bit harder for – and it had studied this topic, it might be a little bit harder for members to sign on to these statements that really misrepresent what's known or the state of scientific understanding on key issues.

The Gingrich Republicans got rid of the Congressional Office of Technology Assessment. It was a globally renowned, extremely credible, scientific advisory body. Bringing something like that back would at least make it harder for some members – some members of Congress will say anything, no matter what, but at least put them in the position where they have to contradict the Congress's own advisors on some of these issues, which might be a little bit difficult for them to do.

There's a role for the media here. You talked a little bit about how the right has created a debate over whether there's enough data and so forth. Journalists need to stop treating some of these discussions as if there's arguments – as if it's an argument where there are two equally valid opinions that need to be "balanced." Sometimes balance is a good thing in journalistic coverage, but sometimes it just misrepresents what's known because there isn't really a real debate. And in the Plan B case, where you have the scientific experts 23 to four, it's not – it's clearly not a debate in which both sides have an equally valid perspective, at least within the world of science.

Finally, though, it is clear that on the Plan B issue the FDA got good scientific advice. It did get good scientific advice, so there were a couple of people on the advisory committee who may have been outliers, but they were not the majority. And then the higher-ups just chose to ignore the good scientific advice. In that situation, in the end probably the option is you have to speak out and you have to challenge the administration directly, which is just what we're doing here.

And here I want to suggest something very paradoxical, which is the misuse of science has to be exposed and the political interference with science is quite an outrage, but when we are critiquing what the FDA has done or what the administration has done, it's best not to limit ourselves just to arguing over science because the debate quickly gets technical and we get lost down in the weeds and you can lose people.

I think that a better talking point along – you have to make the point about science, but perhaps a better talking point to access everybody is to speak out about how the alleged pro-life side of the debate is blocking wider availability for a drug that could reduce abortions. How is that pro-life? That mystifies me. And so that might be a better way of talking about this because I think sometimes what they want is actually to get you into a scientific debate, which is very technical, full of details, and hard for ordinary people to access.

And what's really going on behind all of these case studies of the misuse or abuse of science is that there are real world consequences, and that's true on Plan B. That's true on global warming. That's true in evolution. It's true on every one of these issues, and that's why it matters.

MR. ARONS: Thank you to all the panelists for their excellent comments. I really do want to hear from the audience, but I'm going to exercise the moderator's prerogative and start off the questioning.

For particularly Chris and Susan, if you could speak to whether you think any kind of additional regulations can prevent this kind of abuse in the future or is this emblematic of a larger cultural trend that needs to be embattled in a different arena.

DR. WOOD: I'm not quite sure about in terms of additional laws or regulations. I think what – except to something that could perhaps guarantee the independence in the scientific decision-making of the agency from some sort of outside pressure. This is not to say the agency shouldn't take comments, shouldn't have – be transparent, shouldn't have input from all over, be that from political entities as well as the general public and people who care about their health or care about science. Input is always welcome, but it's how that then translates into decision-making. The FDA has to be able to maintain its independence in terms of its decision-making; that it can take all the information and all the ideas and all the concerns and then know what it is that it needs to base its decisions on, and then do it independently.

So, for example, this question about whether moral or societal decisions should influence how FDA makes its decisions, FDA is making its decisions in terms of the larger public health, but it has restricted legal jurisdiction, which is appropriate in that it is supposed to make decisions based on scientific evidence on safety and efficacy of a product; and in the case of over-the-counter, whether or not you can understand it and use it appropriately and you don't need a physician intermediary. And that is what it bases its decision on.

I don't think the American public wants FDA being the one to make societal decisions on who can access safe and effective medications. Those are decisions they made in healthcare settings, made in families, made by individuals. It's not made by government, and I think having a government agency be the one who decides who has access to a product, which is determined scientifically and medically to be safe and effective and appropriate for use over the counter – that's not FDA's job and so I

wouldn't want to – I would say that part of it needs to be left to, again, families and individuals in healthcare settings that are – where you get your medical advice, not government. So no additional – other than whatever it would take to give FDA that independence.

MS. ARONS: Thank you. And Chris, do you have any thoughts to add?

MR. MOONEY: Well, yeah. I've pointed out that there have been suggestions about reforms to ensure that the scientific advisory committees are balanced and the members are chosen on the basis of expertise and not ideology. I think that's important. And speaking more generally, these kinds of good government, scientific integrity sorts of reforms include other things like whistleblower protection for people who blow the whistle on specifically – (laughter) – yeah, specifically scientific matters and making sure that there's no interference with scientific documents by the White House – things like that. We don't have any evidence of that happening in the Plan B case, although we do have it on other issues.

This point about independence is so crucial. Russell Train was the former – he was the former administrator of EPA under Nixon and Ford, and he's pointed out that – he's a Republican. He's pointed out that the agency was just so much more independent then. The White House would never have tried to change the content of a scientific report discussing global warming back then. We've lost that sense of independence. Who enforces that? Well, that's Congress. They need to ask tougher questions, clearly, when you're going through the nomination process for the administrator of an agency like FDA or EPA, and if they find that this person is not capable of being sufficiently independent, then they need to do something about it then.

And of course, they also have to hold investigations when we have scandals on the scale that we have with Plan B, so in some sense Congress is not really getting that involved here. And of course, it's in part because the Republican-controlled Congress maybe doesn't want to make the Republican administration look bad, so that's another factor as well.

MS. ARONS: Thank you.

Well, and for Silvia and Naina, given limited resources, do you think that – where should our energy and resources be focused? Should it be at the federal level trying to accomplish over-the-counter status or are these resources better used at the state level with some of these alternative programs that you're pursuing and also perhaps trying to get increased pharmacy access?

MS. HENRIQUEZ: Good question and something that we think about at Latina Institute all the time. I don't think we can afford to just choose one strategy at this point. I think that there's so many things at stake when it comes to our federal – on a federal level over-the-counter access. And unfortunately, we're starting to see a lot of

restrictions on pharmacy access on a state-by-state level as well, and that's not necessarily a perfect solution.

I think that because there are a number of advocacy organizations working on this issue, we have the opportunity to simultaneously look at all three different strategies – at least the way we see it – and complement each other's efforts through that. I think, as I mentioned earlier, for us looking at Medicaid coverage is a huge priority, and that's something that we're working with people that are working on Medicaid coverage in general with. And there are people that – there are advocates that are working specifically on pharmacy access and obviously once we get over-the-counter access, and hopefully we will, then obviously some of these issues will change.

So I don't think we can afford to just pick one strategy at this point. And what I do think we need to focus more on are public education efforts that do reach diverse communities, that do reach young women, women of color, and immigrant women. And that, I think, is something that we should probably think about more of how we can step up some of those efforts.

MS. DHINGRA: I very much echo what Silvia is saying. As they're focusing on Medicaid coverage, I think what we at Advocates will continue to focus on is at the state level as well as the federal level. But at the state level we believe very strongly in trying to get collaborative practice because training of pharmacists is crucial. If we tomorrow got nonprescription status, we are not guaranteed that pharmacists are going to dispense that. We've already seen issues with birth control with EC in this, so we need to ensure that pharmacists are trained on that issue. And so it's – and we have to build the groundwork for having nonprescription status.

At the same time, I think on the federal level what's important is for us to have a solid message and have a solid communications strategy on this that is linking this to, I think, the ideological attack on prevention, linking EC to HPV, to the denigration of condoms, to use a general attack on preventative services for reproductive health. We can't look at any of these issues in isolation. And I think Chris has done a great job of even (tracking?) it far, far beyond our issues, and so I would really urge us to think about how are we looking at all of these together.

MS. ARONS: Okay, thank you.

Well, now I'd like to turn it over to you, the audience. If we have any members of the press here, I'd like to invite you to ask the first questions. And also to anyone who asks a question, please state your name and your affiliation for transcription purposes. Over on the –

Q: My name is Megan Colon. Oh, sorry. My name is Megan Colon and I work for Senator Tim Johnson out of South Dakota. Just wondering – for Ms. Dhingra, you said you have a campaign going for ten states. What states are they and how did you target them?

MS. DHINGRA: Sure. Just one second. I don't have all – Minnesota, Arizona, Pennsylvania, Hawaii, Colorado, South Carolina, D.C., and I thought I saw somebody here from our EC initiative, who has left now, and I actually will have to get back to you on the other states.

The original states – how they were picked were based on our providers, based on our local partners there who wanted to work very strongly on this. One of the first states we started working in was Hawaii, and you can bet I was definitely very jealous of the staffers who got to work on that, but it was because they had – they were just about – they were just starting their collaborative practice campaign, and they had a very strong group there and it was clear that with us investing a limited amount of resources that we could really make a difference there.

What's happened now is that we're adding states based on state-specific funders who are – who have been very excited by some of the work that we've been able to do at the state level who want to see that work continue in their state, so we just added South Carolina because a South Carolina funder is very excited about working on this issue and has invested a lot just specifically to that state. So it's been funding based on the partner, how strong a partner, and also doing an assessment of can we change anything here.

MS. ARONS: Again, if there are any members of the press with questions, I just want to make sure we get to you.

Q: Thanks. My name is Susan Heavy. I'm a reporter with Reuters and I just had a question for Dr. Wood. Since you've stepped down, a member of the advisory committee has also stepped down. I wanted to get your thoughts on that. And also just to ask you what impact you see the resignation is having, if any, at the agency on wider –

DR. WOOD: Yes, I became aware only a few weeks ago that Dr. Davidoff had resigned. He was a member of the over-the-counter advisory committee. I think he was in a consultant status, but had been previously a member for a number of years and is a very senior academician and clinician, and so I was impressed that he took the step. I thought his letter of resignation to the committee had very similar themes to the reasons I left – had the same sort of evolving thinking about how you can work inside and make a difference, but with this decision realizing that being inside no longer could make a difference and it was important not to be placed in the position of having to explain the decision to the public.

So I don't know whether it's having an impact on any other advisory committee members or any other staff within the agency. My concern within the agency – it's not necessarily the impact of my resignation except to say that I got a lot of incredibly supportive and very personally helpful emails from people inside the agency from all levels from in the trenches to quite senior, being very supportive and encouraging and congratulatory when I resigned. But I think the larger concern is that the people behind – left behind who are dedicated to good science, dedicated to the public health, dedicated to

the mission of FDA are feeling quite – many of them are feeling quite angry, quite disappointed, quite demoralized, and in feeling that if they can do all the good work and have it completely lifted out of their hands on this one thing, it can happen on anything. And this really has left the agency at risk both in terms of its public credibility, but also in terms of its internal morale and stability.

MS. ARONS: In the middle.

Q: I'm Amy Alena from the National Women's Health Network and I wanted to ask Susan a question.

You know, we share your concern about what's going on at the FDA right now and we really – well, we're very supportive of what you're doing. We regret that you felt you had to leave. And I wanted to ask about a point that Chris made about whistleblower protection and to ask you, do you think that stronger protections for people inside the agency might not just provide them protection to do what's right and stay in their jobs, but also help fight back against the shift that we're seeing in terms of the culture – the culture at the FDA?

DR. WOOD: I mean, I don't know what's technically necessary. I think the concept – because I didn't actually investigate whistleblower protection at – my decision stage was to come or to go, so it didn't really need to investigate what would happen if I stayed and talked publicly. I think there are a lot of whistleblower protections in place, but there may well need to be some sort of strengthening or some sort of method that would improve the ability of people to communicate concerns to appropriate oversight bodies. Sometimes that's Congress, but perhaps there could be some other method where, again, that concerns could be arbitrated not in a political setting, because I think the people inside the agency who have concerns – oftentimes the last place they want to go is into the political realm because that's a very – it's a legalistic realm. It's a very public realm. It's one that's fraught with fears of being grilled by Congress by people who have no intention of putting themselves in that circumstance.

So perhaps there's some other method of having a good-faith arbitration or a reevaluation when concerns are raised about the science or about the proper evaluation. Again, going back to your mention of OTA or something like that where you can have a good scientific discussion where people at least feel their views are aired and heard. Certainly that's – when I was inside, we lost fights, but you feel like you're playing a role and engaging and in keeping the transparency and keeping the debate going, and better ways to do that may well help.

MS. ARONS: The gentleman up front.

Q: My name is Peter Cohen from Georgetown University Law Center. I agree with everything that's been said. There's been an allusion to pharmacy access and I'm very concerned with this because if the FDA tomorrow passed what – allowed to go through – I think if I were on the religious right, I would say, fine. Now let's have the

real battle, and the real battle is going to be in those states with conscience clauses that permit pharmacists to simply say, “I don’t believe in it and I won’t do it.” There’s questions of boycotting pharmacies. There’s a whole host of major political pressure, and I – the question is, do you think we’re going to need federal legislation that will preempt the states, that would impose on the pharmacists the obligation to do their duty since they alone right now have a monopoly; and even if it went over the counter to impose the duty that at least the pharmacies should sell it irrespective (the way?) Giant or Safeway does. That’s one question.

And the other, do you think it has a chance in hell of passing? (Laughter.) Because if it doesn’t – I think these are important questions, but I think if it were put to a vote of all the people where there’s a question of parental notification for abortion, there’s a question of prayer in the school, I think it would be a mixed bag. And I have a feeling that it would be quite possible that the people would say “No, adolescent girls don’t need this stuff.” So I really think legislation really will be necessary.

MS. ARONS: Well, I have my own response, but if there are members of the panel who would like to speak to that.

DR. WOOD(?): I’ll just speak briefly. I can’t answer all your questions. I mean I think though the – I mean agree with some of your concerns. The issue of federal legislation engaging in pharmacy practice, just as in the practice of medicine, has always been less for the states. I think it would be extraordinarily difficult on a broader issue of who regulates the practice of pharmacy and who regulates the practice of medicine, and so in that sense federal legislation may not be the strategy to go. But the issue of having to take it state by state on the issues of conscience clauses and access, I don’t have any direct information on that. There may be others on the panel or actually in the audience who can address that.

MS. ARONS: Well, first of all, as some may be aware, legislation known as the Weldon amendment was folded into the omnibus bill at the end of last year’s budget reconciliation process, and that was on the abortion issue, but it went the other way in terms of allowing healthcare providers to refuse to provide abortion services or even referrals for abortion. And so I think in the current political makeup of Congress it’s probably very unlikely that we would get anywhere in terms of some sort of federal mandate requiring pharmacies to dispense emergency contraception regardless of individual pharmacist conscience.

But you wanted to speak to this? Okay.

Wait for a microphone.

RACHEL LASER: Hi. My name is Rachel Laser and I work at the National Women’s Law Center and I’m director of pharmacy refusal project there and so we’ve been looking very closely at these bills across the states and also working with federal policymakers. So there are three existing bills right now in Congress that you may be

aware of that would require a pharmacy to ensure dispensation of a prescription drug where the prescription is valid and doesn't conflict with other drug therapy uses, et cetera. And those bills aren't moving anywhere – nowhere. Zero movement. There's one – one of them is Senator Boxer's bill and another is Senator Lautenberg with Representative Maloney and then there's another one on the House side.

But it is true that – and what Jessica just spoke to is a conscience clause with respect to abortion, and so what we try and always distinguish at the law center is the conscience clauses that are being introduced and that exist with respect to abortion, and those that are being introduced and exist with respect to family planning. And what's interesting is that there are so many that are new that are being introduced with respect to family planning. And so right now in the past year what we've seen is 15 new ones that have been introduced with respect – that would include pharmacists and dispensation of birth control including emergency contraception. Some of them are limited to emergency contraception birth control; others aren't. Some of them are broader. Twenty-six have been introduced over time with respect to this issue.

So I think it's a very real issue and I think that what we've seen from the one concrete poll that's available which is the *New York Times*/CBS poll is that 80 percent of the American public, including over 70 percent of Republicans in this poll, are reported to have a strong aversion to permitting pharmacists to refuse to dispense birth control based on their personal beliefs, so I just wanted to add that for the record.

MS. ARONS: Thanks, Rachel.

Do we have other questions? Shira?

Q: Hi. I'm Shira Saperstein from the Moriah Fund. I have a question for Dr. Wood, but also for anyone else who wants to address it, which has to do with the new or coming HPV vaccine and whether there are lessons from the Plan B process for how to avoid a similar result and whether there are risks of a similar result given that the vaccine should be provided to younger adolescents.

DR. WOOD: I live in constant amazement that anyone would suggest that you should restrict access to a vaccine that could prevent cancer to anyone for whom it would be safe and effective. Having heard that suggestion now and been amazed, I'll think about it. Because I think it just – it goes beyond the pale. But I recognize the concern, and therefore I would hope that – I think you're right: the parallels that occurred – what happened with Plan B could happen, you know, and should not happen. And I think we need to make that connection because the American people and all those who work in trying to promote health need to insist that something like this, or whether we would get an AIDS vaccine or a microbicide or anything else – when we're talking prevention of pregnancy, prevention of cancer, prevention of AIDS, these are all things that are for the public good and are serious health and life-threatening issues, and we should in no way – I mean, this is just my personal reaction – we should in no way allow that to happen in those situations, just as we in no way should have allowed it to have happened in the area

of Plan B.

Now, in terms of structural ways to prevent it from happening – you know, what happened in FDA needs to be investigated, but there was nothing technically that was perhaps illegal. There were things that were wrong. There are things that should not have happened. But I don't – I mean it's that independence, again, I come back to that, that we must ensure the independence of the agency because I do not believe that if a product is safe and effective and can prevent cancer for all women who would use it, that the scientific and medical staff at FDA wouldn't treat it appropriately as it should be treated, and abiding by all the rules and regulations, et cetera, et cetera. So we must insist that FDA remain independent so that nothing like that could occur.

MR. MOONEY: I'll just add one brief thing. I don't know a lot about the specifics of this issue, but I do know that if there's a strong movement to attack this vaccine that part of the attack will come on scientific grounds and they'll claim that it's not – you know, it's not safe or that – part of the attack will definitely play out in the scientific area because that's how all of these issues now play out and that's what we have to prepare ourselves for.

Q: Sorry. Just so that I don't seem that I'm completely paranoid, but there are already statements from pro-life leaders asserting that this drug will increase promiscuity among young women.

MR. MOONEY: Exactly, yeah.

DR. WOOD: No, I have seen them and it's –

MS. DHINGRA(?): I think what – just to add, I think in coming out on top – I come from a grassroots organizing background, so I always think in, well, how are you using this to build your base? And I think that the key group that we really need to be targeting and working with is parents' groups on this. And make it about parents fighting parents saying, "Well, I want to protect my kid from cancer;" "Well, I think that's going to make my kid have more sex," and have that be the issue. And so, you know, when it comes to EC as far as – I agree with, you know, your point. We have to (build?) the pharmacists so it's pharmacists battling each other instead of us battling the pharmacists. So I think that we really – we need to think about that as well: in each of our issues, how are we building a broader cadre of supporters that go beyond our immediate community, particularly those of us who just work in D.C., because we really – we're spending too much time talking to each other and we need to be talking to a broader support base.

MS. ARONS: All the way in the back.

Q: Thank you very much. I'm Margaret Vanderhye and I'm a Democratic Party activist the Commonwealth of Virginia, which is possibly more conservative than the federal government. And I believe it is – at least the leadership is. The issues that we grapple with in dealing with this issue with the legislators are basically, one, that life

begins at conception and therefore for people who are pro-life the emergency contraception violates that; and, two, the issues – as a gentleman spoke about – about parental notification. These seem to be barriers that we're having an insurmountable problem with in terms of lobbying to the point that we couldn't even get the legislature to approve university – if the were Virginia University health centers, to allow the prescription version of Plan B to be distributed through prescriptions at public universities because it would be encouraging promiscuity. If you have any thoughts or any advice on arguments or lobbying techniques that would address particularly the issues of the conception issue, which is false, and the parental notification issue for adolescents, that would be very helpful.

DR. WOOD: I'll tackle the first one if someone else will tackle the second one. The first one of is this an (abortive agent?). It is false. It's not an (abortive agent?), it's contraception, and I think you would just – I think we really have to hit home on the message that this has the potential to prevent abortions; that the only connection this has with abortion is that it can help prevent the need for them. And that in terms of the mechanism of action, to focus on the fact that it acts in a similar way to many other birth control pills and that, you know, you'd have to tackle all oral contraception, you know. And I think that helps people's comfort level in the general public if you talk about it acting similar to other birth control pills and just needing to be taken after the fact, that it's – and again, not getting caught in the weeds. Because the real abortions we're talking about preventing are ones that we agree are all abortions, and that there is a medical abortion pill and it is different. And you can have separate fights around that, but in terms of this one, I think the hitting home this is contraception and it has a potential to prevent the need for abortions, and this should be common ground.

Parental notification goes way beyond FDA, so I'll let perhaps someone who works with youth and state laws –

MS. ARONS: Naina, do you want to take a swing at the second part?

MS. DHINGRA: Well, actually, let me ask you a question. Did you have – how were you lobbying on this? Did you have students at these universities seeking this?

Q: Students and legislators – Democratic legislators who lobbying on behalf –

(Cross talk.)

MS. DHINGRA: We actually don't do a whole lot of work on parental notification on abortion issues, so I'm not – I'm really not an expert on issues on parental notification, so I don't know if there's somebody else in the audience that is. However, what I will say is that – you know, we work actually in Virginia on sex ed so I would like to talk afterwards about connecting up those efforts because I think that there are a lot of young people there who don't know that or are really unaware who would really start demanding this.

And getting caught in the weeds on this issue, it doesn't matter. They're never going to listen to the science and I think that we have to accept that and use that to say – to publicly shame these legislators and demand in writing that they state why they won't support these things, then have people writing in op-eds and letters to the editors about that and just make it a lot more public. But if we believe that we can change anyone's minds, then we're just fooling ourselves.

MS. ARONS(?): I would add to that that – and I'm sure this is an approach you've tried, but that these are university women we are talking about. We are not talking about minors, with possibly the exception of a few 17-year-olds who are, you know, freshmen. But for the majority – for the most part you are talking about women, adults under the law. And this again, as Susan said, is contraception. It's an emergency contraception, but it is contraception. And where do you – this is a slippery slope they are embarking upon. What is the difference between them preventing access to even prescription emergency contraception and the birth control pill? You know, if they – so I think if you make a clear connection with the pill, which I think they will find themselves very uncomfortable arguing against access for university women getting prescription birth control pills, I think that puts them on the defensive hopefully.

DR. WOOD: I'd also refer you to the article from the *Journal of Science*, which is in the packets, which talks about – again, perhaps the science will make no difference, but there's been a lot of evidence about how this does not change access to emergency contraception, does not change behavior, does not increase or change sexual activity. It does not change normal – you know, whatever the contraceptive behavior was. So there's a fair amount of evidence on that now, particularly with the college-age women, and, again, that article and others, but it's a nice summary and reasonably short that goes through those – the fact that you sort of if you do start getting caught in the weeds, or getting around questions about, “Well, this will change – this will promote promiscuity.”

MS. ARONS: Unfortunately this is all the time we have for questions. I'd like to give our panelists an opportunity to make any closing statements. Silvia?

MS. HENRIQUEZ: Sure. You know, after hearing all the panelists, and I'm sorry I missed Susan Wood, but I think that one of the themes that comes out of this is an opportunity to bring in new supporters and advocates into the reproductive health and rights movements, opportunity to build new coalitions and new partners on the grounds, and to focus that we need to continue on a state level. Many of us are national organizations, and we really need to continue our efforts on the state because at least what we've learned at Latina Institute is that our support on the state really has sort of fueled our ability to advocate on a national level on this particular issue. And with legislative education, you have this part of the grassroots and you have people on the ground that are demanding this product, then that really gives you the credibility and the ability to be able to advocate on much more solid ground.

DR. WOOD: I'll say thank you to the Center for American Progress and thank

you to all the people here for your interest and commitment to these issues. You know, again, my concern is that we make our decisions based on good medical evidence and good science, and this is what will help promote the health of women and families and the entire public health.

And we have to bring that out to beyond the beltway and beyond the usual suspects because I think people will begin to recognize that this type of thing destroys the credibility of our health agency and has the potential to affect the health of all of us at all stages of our lives, and that this, again, as we're talking about contraception and prevention of unintended pregnancies, should be something we should all agree about, should be something we should work together on.

And I think hopefully that as people become aware of that, they'll insist on better, because I think the American people do insist on having high standards and expect quality decision-making, and we have to insist on that across the board. And we start by talking about emergency contraception because it's so important for women's health, it's so important for families' health, and it's such a terrible precedent in how we move forward, and we have to insist on better.

MS. ARONS: Naina?

MS. DHINGRA: Thanks again to everybody who's here and to Jessica for trying so hard to organize this panel and really being dedicated to it. I think that a number of people would have given up, but she's been trying to do this panel for about a month now and all of our schedules were quite difficult. We at Advocates are always looking for new partners to do this work, and so if there are those of you in the audience from organizations who have not been working on this or are at the state and local level and want to work more, I'd love to talk with you afterwards.

MR. MOONEY: Well, again, I'd like to thank the Center for American Progress, this panel, and of course the great audience – everyone who came out. If I could just make two final big-picture kinds of comments. First, when you have something like this, the FDA's misuse of science and misuse of the process in order to block wider availability of Plan B contraception, what you really have is a case in which the credibility of our government is at stake, and more specifically the credibility of a government agency, the FDA, whose job is to use science to serve and protect the public interest, and that is what's being sacrificed here. And that is true of a wide variety of agencies now, and that is how we should think about these things. We are paying, as taxpayers, for these agencies and we can no longer rely upon them to use science to serve our interests.

The second point is let's remember again why all this matters. It's not just the misuse of science. It's the fact that bad science and bad information actually hurt people, and that is a clear on a wide variety of issues. It's clear on global warming. You know, if you sew doubt it helps creates an action and then sure enough you don't want to have beachfront property. And, you know, it's also true in the attack on condoms. You know,

this can lead to a situation in which people aren't using them as much and that can expose them to diseases that can kill them.

With Plan B, again, the misuse of science has a real-world consequence. This drug could be used to prevent abortions, could be used to prevent unintended pregnancies, and that's what we're losing. It's not just a technical matter about the misuse of science. This really hurts people, and let's not forget that.

MS. ARONS: Well, I want to thank everyone for coming out this morning, and I want to thank our panelists for all the work they're doing and for their thoughtful insights and comments today.

Thank you. Have a good day.

(Applause.)

(END)