EC–1178. A communication from the Secretary of Housing and Urban Development, transmitting, a draft of proposed legislation to exempt HUD and Agriculture multifamily loan foreclosures and related actions from the bankruptcy code; to the Committee on the Judiciary.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. CHAFEE, from the Committee on Environment and Public Works, without amendment:

S. 1033. An original bill to amend the Federal Water Pollution Control Act to establish uniform national discharge standards for the control of water pollution from vessels of the Armed Forces, and for other purposes (Rept. No. 104–113).

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. KASSEBAUM (for herself, Mr. KENNEDY, Mr. FRIST, Mr. DODD, Mr. JEFFORDS, Ms. MIKULSKI, Mr. GREGG, Mr. WELLSTONE, Mr. GORTON, Mr. PELL, Mr. HATCH, Mr. SIMON, Mr. CHAFEE and Mr. LIEBERMAN):

S. 1028. A bill to provide increased access to health care benefits, to provide increased portability of health care benefits, to provide increased security of health care benefits, to increase the purchasing power of individuals and small employers, and for other purposes; to the Committee on Labor and Human Resources.

THE HEALTH INSURANCE REFORM ACT OF 1995

Mrs. KASSEBAUM. Mr. President, I rise today to introduce on behalf of myself, Senators KENNEDY, FRIST, GREGG, JEFFORDS, GORTON, HATCH, CHAFEE, PELL, DODD, SIMON, MIKULSKI, WELLSTONE, and LIEBERMAN, the Health Insurance Reform Act of 1995.

This legislation will make it easier for individuals and employers to buy and keep health insurance—even when a family member or employee becomes ill. And it will allow people to change jobs without fear of losing their health coverage.

Despite past State and Federal reform efforts, the lack of poor portability of health insurance remains a serious concern for many Americans, particularly those with preexisting health conditions. The General Accounting Office estimates that as many as 25 million Americans could benefit from this legislation.

The Health Insurance Reform Act builds upon and strengthens the current private insurance market by, one, guaranteeing that private health insurance coverage will be available, renewable and portable; two, limiting preexisting condition exclusions; and, three, increasing the purchasing clout of individuals and small employers by creating incentives to form private, voluntary coalitions to negotiate with the providers and health plans.

Mr. President, I believe that the American people want us to work together to fix what is broken in the current system without relying on big Government solutions.

The legislation we are introducing today does not impose new, expensive regulatory requirements on individuals, employers or States. It does not create new Federal bureaucracies. It does not create any new taxes, spending or price controls nor does it require employers to pay for health insurance coverage.

While this insurance reform legislation alone will not cure all the ills of the Nation's health care system, it will in some small and important ways, I believe, promote greater access and security for health coverage for all Americans by requiring private insurance carriers to compete based on quality, price, and service instead of by refusing to provide coverage to those who are in poor health and who need it the most.

Mr. President, I want to thank all of my cosponsors. Senators GREGG, FRIST, JEFFORDS, HATCH and GORTON have all contributed a great deal to this effort. Senator JEFFORDS has worked particularly hard on the group purchasing provisions of the legislation. But I want to especially recognize the contributions of the ranking member of the Labor and Human Resources Committee, Senator KENNEDY. He has worked, along with his staff, for many hours, in many ways, to help make this legislation a bipartisan effort. Senator KENNEDY has spent many years on the health care agenda working tirelessly to improve the health care delivery system. And I am particularly pleased that this is such a strong bipartisan bill that we are introducing today. It is not a major piece of legislation. As I said, it is not going to be the answer to all the ills in our health care system. But I think it is a very important step forward.

I am confident that with the support of the other original cosponsors and others, the Labor Committee we will be able to report this legislation favorably in the near future and we can begin to move forward, on a bipartisan basis, to make private health insurance more readily available, more secure and more affordable for all Americans. Mr. President, I intend to work with all of my colleagues to ensure that these reforms are enacted during the 104th Congress.

Mr. KENNEDY. Mr. President, first of all, I welcome the opportunity to join Senator KASSEBAUM in the introduction of the Health Insurance Reform Act of 1995. I would like to pay tribute to her leadership in this area which is of enormous concern to the American people—addressing the issue of access to health insurance in a way that is going to be reasonable for working families in this country.

Making health insurance available to working Americans means they will be able to receive the kind of high-quality health care that is possible in this country—and that care will be available in the inner cities and rural communities of this country. Improving access to health care is one more way of stressing the obvious importance of prevention and demonstrating our commitment to the American people, particularly our seniors, to provide them with the security of health benefits in this diverse and complex Nation.

Building on the current health care system is incredibly, incredibly difficult and complex. Many of us have been addressing this issue over a considerable period of time. I think comprehensive reform of the system is still a very, very worthy objective.

But what we have today is something which, I think, is extremely important. There will be those who say, ''Well, have we lost our goal of trying to deal in a comprehensive way? Should we just come back and try to reform the entire system? Let's just wait for the opportunity to do so.''

Senator KASSEBAUM has said, ''Let us try to find common ground and let us try to make progress in areas where progress can be made. And, at a time where we do have diversity on a great many issues that are of very great importance and where there is a difference in viewpoint by the American people, expressed by their representatives—let us put that aside and say that it is more important for families in this country to have access to health care; it is more important to make meaningful progress to try to address their central needs.'' I think she deserves great credit for these initiatives and for working in a very strong, bipartisan way to try to find common ground on an issue which is going to make a very important and significant difference in the lives of millions of Americans who have preexisting conditions. This bill will help respond to the real needs and anxieties of millions of people.

Often we debate and discuss the bottom line issues in terms of cost, and that is certainly important. But for those who have a disability, we forget that these people live with a sense of fear and anxiety about what their future holds and whether they will have coverage for their health needs, or whether they will be locked into a particular work situation. The reforms in this bill let people know that Congress believes our working Americans deserve opportunities for moving ahead in terms of their career and progress for their families—which have been limited. It also encourages small businesses to work together to try to leverage the system in a positive and constructive way by using their purchasing power in the economy to negotiate a more reasonable cost for health care.

So, even though some might consider this a modest step, I think it is an extremely important one. And it is one in which I welcome the opportunity to work with Senator KASSEBAUM and to work with Senator JEFFORDS, who, as Senator KASSEBAUM has mentioned, spends a great deal of time on this issue. Many others on our committee

do also. Senator KASSEBAUM has mentioned our Republican colleagues. I would like to mention our Democratic colleagues as well. Senator WELLSTONE has taken a particular interest and has made important contributions. And generally speaking, all of the members spend time and are interested in improving this Nation's health care system.

Having been honored with chairing the Labor and Human Resources Committee last year, I was enormously impressed with the commitment of the members on the committee when we did move towards a markup on health care. The markup lasted for a period of some 10 days, long days from 8 or 9 in the morning until 10 at night. We had virtually complete attendance of our committee, Republicans and Democrats, all really participating in that process, all who went through an extraordinary learning experience. And, as a result of that, there were broad areas of bipartisan agreement and there were important areas of difference.

For a number of reasons, we were unable to reach final legislation in the U.S. Senate. But nonetheless, I think all of us, as legislators, try and learn from past experiences.

One that certainly continues to ring in my mind is the real desire in this body by Republicans and Democrats alike to see progress in this area. It is enormously obvious the reason why, and that is because this is a matter of ongoing central concern to families in this country. We all have seen the results of various polls about the budget, about deficits, about taxes, about priorities, about Medicare and Medicaid cuts. A variety of opinions are illustrated in newspapers and on radio and television across the country.

But one element that shows up in all kinds of studies and reviews is the real desire of the American people for Congress to try and find common ground; to try and make progress; to try and move this process forward. We have a very, very important responsibility to try and do so.

There are naysayers. There are those who will find reasons to criticize this approach. There will be those who say it goes too far in some areas—and there will be those who say it does not go far enough. I want to be one of those to say—I think this is an enormously important and constructive effort and I am very hopeful that we can build broad support in the Senate with the introduction of this bill as we move through the hearing process and through the markup.

I invite all of the Members on this side, as Senator KASSEBAUM has done on her side, to join with us to make suggestions and recommendations. The issue of health care is a constantly changing landscape. It is dramatically different from where it was 2 or 4 years ago. But despite this, there continue to be issues of great concern for which we all agree something must be done—and those include the issues of access, affordability and coverage.

What we have tried to do in this bill is to respond in a way, under the leadership of Senator KASSEBAUM, that we could find the areas of common stream. We have tried to review what we debated last year and take what was central to the different approaches that were put forward in the Senate by Republicans as well as Democrats. Then we have tried to take those recommendations and shape them in ways which would be more adaptive to the kind of conditions that we find today—advancing those ideas in a way that really can make an important difference.

Mr. President, I welcome the chance of joining today with my colleagues in introducing the Health Insurance Reform Act of 1995. To review, I will now summarize and highlight the specifics of the bill.

Mr. President, it is a pleasure to join Senator KASSEBAUM in introducing the Health Insurance Reform Act of 1995. This bipartisan proposal was developed in close cooperation between our two offices, and I commend her for her leadership.

The private health insurance market in the United States is deeply flawed, and with each passing year, the flaws become more serious. This legislation is designed to remedy some of the worst abuses of the current system, and provides protection to large number of families victimized by such abuses.

Today, insurers often impose exclusion for preexisting conditions. As a result, insurance is often denied for the very illnesses most likely to require medical care.

The valid purpose of such exclusions is to prevent people from gaming the system by purchasing coverage only when they get sick. But too often today, the exclusions go too far. No matter how faithfully people pay their premiums, they may have to start again with a new exclusion period if they change jobs or lose their coverage.

Eighty-one million Americans have conditions that could subject them to such exclusions if they lose their current coverage. Sometimes, the exclusions make them completely uninsurable.

Many employers do not provide health insurance to their workers at all, but too often, even those who want to do the right thing can't find an insurer to write the coverage. Sometimes entire categories of businesses, with millions of employees, are redlined out of coverage. Even if a firm is in an acceptable category, coverage may be denied if someone in the firm—or a member of their family—is in poor health. People who have paid insurance premiums for years can be canceled because they have the misfortune to get sick, just when they need coverage the most.

One consequence of the current system is job lock. Workers who want to change jobs to improve their careers or provide more efficiently for their families must give up the opportunity because it means losing their health insurance. A quarter of all American workers say they have been forced to stay in a job they otherwise would have left, because they were afraid of losing their health insurance.

This legislation addresses these problems. Exclusions for preexisting condition will be limited. They cannot be reimposed on those with current coverage who change jobs or whose employer changes insurance companies. Cancellation of policies will be prohibited for those who continue to pay their premiums. No employers who want to buy a policy can be turned down because of the health of their employees. No employees can be excluded from an employer's policy because they have higher than average health costs. Any employee losing group coverage because they leave their job or for any other reason would be guaranteed the right to buy an individual policy.

Small businesses and individuals are particularly victimized under the current system, because they lack the bargaining power of larger corporations. The legislation addresses this problem by encouraging the development of purchasing cooperatives that will have the same kind of clout enjoyed by large corporations.

Because of concerns about the impact on overall premiums, this legislation does not provide for guaranteed availability of coverage for those who have not been part of an employment group. The bill requires the Secretary of HHS to conduct a study of current State practices in this area, to consult with the National Association of Insurance Commissioners and other appropriate sources of expertise, and to provide recommendations for solving this serious problem.

I continue to support the goal of comprehensive health reform. I am confident we will find a way to provide health security for all citizens, stop the ominous rise in the number of uninsured, and the ridiculous soaring cost of health care. This bill is not a comprehensive reform, but it will eliminate some of the worst abuses of the private insurance market and provide greater protection for millions of our fellow citizens.

Mr. FRIST. Mr. President, I rise today to join the distinguished chair of the Committee on Labor and Human Resources, Mrs. KASSEBAUM, in introducing the bipartisan ''Health Insurance Reform Act of 1995''.

This bill provides long awaited reforms for this country's health insurance market. I say long awaited because the Senate passed similar insurance reforms a few years ago, but regrettably they failed to become law. This legislation, with its bipartisan support, reflects essential market-based reforms.

One of the important things I have witnessed, from my perspective as a

physician and now as a member of the Senate Committee on Labor and Human Resources, is the absolutely critical role that both employers and employees play in the current health care system, and the critical role they must play as we struggle to reform the system to deliver higher quality health care at lower costs.

Over the years, employers have directed much of the change in the health care system. Many employers have been a creative force in containing health care costs. In fact, as a result of innovative and aggressive management of health care costs, employers actually saw their health care costs for 1994 decline 1.1 percent for the first time in a decade.

However, this success does not mean that the current system is free from problems. It is not.

It is the large employers which have the greatest influence in the market. Small employers lack the same bargaining power. For example, the large employers reported health care cost decreases averaging 1.9 percent, while small employers experienced an average cost increase of 6.5 percent. Moreover, uninsured rates continue to climb in many States and many families are finding it more difficult to obtain health coverage.

The system needs to be reformed so that health care is available to all Americans.

Last year, many of these same insurance reforms became entangled with President Clinton's heavy-handed approach to health care reform. As a result, Congress again failed to pass these provisions which are necessary to increase access to insurance. Even so, many States moved forward with their own reforms. Forty-four States, including my State of Tennessee, have passed some type of small group insurance market reform. In addition, 27 States have set up high-risk insurance pools to increase access to insurance for individuals.

There should be no bar to insurance based on preexisting conditions, and no one should have to face the fear that they will lose their health insurance when they lose their job, change jobs, divorce, or become sick. Mr. President, this is the focus of this legislation.

As a transplant surgeon, I have personally witnessed the obstacles my patients face after they have received a new heart and are ready to return to the work force and productive lives. These reforms go to the heart of the problem for families that feel locked into their jobs because an illness makes it difficult to obtain health insurance. If I give someone a new heart today, they cannot hope to look for a new job tomorrow. Rather, they desperately hope to keep their current job to maintain their health insurance coverage. They are trapped. The costs of their care prohibit the freedom of movement. Therefore, Mr. President, this bill ensures portability from one group health plan to another.

When insurers are allowed to discriminate based on a preexisting condition, a heart transplant recipient becomes a liability to the rest of a company's employees. It can even result in an insurer dropping the entire employer group altogether. Mr. President, this legislation prohibits insurance carriers from refusing to issue a policy or refusing to renew an existing policy. It is my hope that this bill will help return my patients to work and back to their pretransplant lives.

This bill reflects a desire to build a partnership between business and Government, not an adversarial relationship. Instead of mandating and controlling the health care market, Government should ensure that the market operates efficiently to deliver value to all consumers regardless of their health status.

Mr. JEFFORDS. Mr. President, I rise today in support of the Health Insurance Reform Act of 1995, which is being introduced today by Senators KASSEBAUM, KENNEDY, FRIST, DODD, GORTON, MIKULSKI, GREGG, PELL, SIMON, WELLSTONE, CHAFEE, HATCH, LIEBERMAN, and myself. I applaud Senator KASSEBAUM and Senator KENNEDY for their commitment in developing, what I believe to be the first truly bipartisan insurance reform bill introduced this Congress. As I have stated many times in the past few years, health care reform cannot be successful unless Republicans and Democrats work together.

I am proud to be an original cosponsor of a piece of legislation that has been developed in one of the most inclusive processes that I have been privileged to be a part. This legislation makes great strides in laying a foundation for a well functioning private market, which is critical if we are to be successful in creating a solid health care system for all Americans.

This bill puts into place minimum national insurance reform standards, which transforms the current exclusionary insurance system into one which moves closer to accepting all comers, yet the bill allows States a great amount of flexibility to move ahead at a faster pace if they choose.

This bill, assures that if any individual has insurance today even if they get sick, or change or lose their job, they will be able to purchase insurance tomorrow.

This bill encourages a variety of health plans to compete in the marketplace. Individuals will have choices between managed care plans which focus on preventative care, as well as, catastrophic plans with medical savings accounts.

This bill fixes certain glitches in COBRA so that individuals with disabilities will no longer have to experience a gap in health insurance between the transition from employer to Medicare coverage.

Mr. President, I am most grateful for the inclusion of the health plan purchasing coalition section of this legislation. I will be introducing legislation next week called the Employer Group Purchasing Reform Act of 1995, in which health plan purchasing coalitions are the center piece. I believe very strongly that voluntary private market group purchasing arrangements, for employers and individuals, is the key to making health insurance not only more accessible but also more affordable for all Americans.

My legislation will also address the fraud and abuse in employer group purchasing arrangements called multiple employer welfare arrangements [MEWA's] under the Employee Retirement Income Security Act of 1974 [ERISA]. Senators NUNN and COHEN have both held hearings over the past few years which have uncovered ponzi schemes that have left millions of small business owners and their employees sick and without insurance. The legislation will give clear authority to the States to shut down group purchasing arrangements that are fraudulent and clear authority to certify health plan purchasing coalitions. In addition, the legislation also begins to level the playing field between insured and self-funded health plans in the market by amending ERISA. I look forward to the same bipartisan support of this bill as has been achieved by Senators KASSEBAUM and KENNEDY.

Mr. President, I am very eager to work with Senator KASSEBAUM, chairman of the Labor and Human Resources Committee, in the next couple of months, to report a market reform bill out of committee that can be brought to the Senate floor this session. We must begin to address Americans concern about portability and affordability of health insurance this year and I believe that the Health Insurance Reform Act of 1995 is an excellent place to start.

Mr. HATCH. Mr. President, I am delighted to join with the distinguished chairman and ranking minority member of the Committee on Labor and Human Resources in cosponsoring today S. 1028, the Health Insurance Reform Act of 1995.

This important piece of legislation is designed not only to increase access to health care benefits, but also to provide portability of those benefits and to increase the purchasing power of individuals and small employers who wish to seek insurance.

As my colleagues know, the issue of health care coverage for millions of Americans remains a critical concern for this Congress and for the American people.

The bill which we introduce today represents a reasonable and significant step in extending health insurance to a larger segment of the American population.

As my colleagues are aware, for 18 years, I had the privilege of serving on the Labor and Human Resources Committee, including 6 years as chairman and 6 years as ranking minority member.

We have spent innumerable hours pondering how to improve our Nation's health care delivery system. There were times when we thought we had the answer, but we could never manage to develop exactly the right bill.

More recently, last year in the Labor Committee we spent innumerable hours considering President Clinton's Health Security Act. Although my esteemed colleague and close friend, Senator KENNEDY, fought long and hard for the President's proposal, that legislation was ultimately rejected by the American people and by the Congress.

If we learned any lesson from that experience, it was that Americans do not want the Federal Government to have a larger role in shaping America's health care system.

However, that does not lessen the need for some health care reform, and it is clear that insurance market reform is one area in which we have had, and continue to have, a good deal of consensus. We should not let the need for other reforms hold up passage of this much needed measure.

Chairman KASSEBAUM and her staff are to be congratulated for developing the Health Insurance Reform Act based on the lessons we learned last year. It is a narrowly tailored bill which addresses very real problems in the marketplace.

This bill will achieve many of the objectives we sought in the areas of insurance portability as well as correcting problems with respect to those individuals with preexisting health conditions.

I am particularly pleased that the measure is receiving wide bipartisan support among the members of the Labor Committee. This is a very good signal that shows we have a viable bill which represents a consensus approach to a difficult and complicated problem.

I strongly believe this bill represents the first meaningful and generally acceptable bipartisan insurance reform proposal in either house of Congress and I hope it will be enacted swiftly.

Mr. WELLSTONE. Mr. President, I am pleased to join Senators KENNEDY and KASSEBAUM, as well as many of my colleagues on the Labor and Human Resources Committee, in introducing the Health Insurance Reform Act of 1995. The reforms included in this legislation would make it illegal for insurers to drop people when they become sick and to discriminate against individuals with preexisting conditions. While I wish that we were doing much more in Congress to ensure that all Americans have access to affordable, comprehensive health insurance coverage, I view the insurance reforms contained in this legislation as a serious step in the right direction. There is no excuse for not doing what we can to make coverage more accessible—especially for people with preexisting conditions and disabilities. It is a disgrace that our private insurance system continues to discriminate against precisely the individuals who most need coverage.

All working Americans face a growing threat from the uncertainties created by the health insurance system. Even people with good health insurance coverage cannot count on protection if they lose or change jobs, especially if someone in their family has a preexisting condition. Our current health care system allows insurers to collect premiums for years and then suddenly refuse to renew coverage if individuals or employees get sick. It also allows insurers to routinely deny coverage to different types of businesses from auto dealers to restaurants.

The GAO has estimated that as many as 25 million Americans could potentially benefit from the insurance reforms included in this bipartisan bill. Most of the people who would be helped by this legislation are people who change jobs and currently face preexisting conditions or waiting periods with their new health coverage.

Many States, including Minnesota, have already enacted standards for insurance carriers, but because ERISA preemption prevents States from regulating self-funded health plans, only Federal standards can apply to all health plans. More and more employers in Minnesota have been choosing to offer self-funded plans to employees. Such plans now enroll about 1.5 million people, up from 890,000 in 1992, and about 50 percent of all privately insured residents. Current estimates also show that more than 400,000 Minnesotans—including 91,000 children—are uninsured.

I am under no delusions that these insurance reforms will fix our broken health care system. They will not result in universal coverage—or anywhere near it—and they will not solve the problem of rising costs. After all, only comprehensive reform will make health care affordable for many of the uninsured who simply cannot afford the high cost of coverage.

While I am committed to fighting for comprehensive reforms that would include everyone and enable working families to afford health care coverage as good as Members of Congress have, I recognize that this may not happen this year. At the very least, however, we should act on reforms that would address some of the most egregious inequities in our current system, as well as those that would allow States to expand access and contain costs.

By Mr. SIMPSON (for himself and Mr. BINGAMAN):

S. 1029. A bill to amend the Foreign Assistance Act of 1961 to establish and strengthen policies and programs for the early stabilization of world population through the global expansion of reproductive choice, and for other purposes; to the Committee on Foreign Relations.

THE INTERNATIONAL POPULATION STABILIZATION AND REPRODUCTIVE HEALTH ACT

Mr. SIMPSON. Mr. President I rise to join my good friend and able colleague from New Mexico, Senator JEFF BINGAMAN. The two of us are reintroducing the very important legislation called the International Population Stabilization and Reproductive Health Act.

During the last congressional session, Senator BINGAMAN and I introduced this bill to call attention to some very vital issues in this country and in the world. Our former colleague, Tim Wirth, championed these issues while he was in the Senate and, together, he and I laid the foundation upon which this bill is built, and then came my colleague from New Mexico, JEFF BINGAMAN—Senator BINGAMAN, who I thoroughly enjoy, and enjoy working with, his word is his bond. We work well together. He shares the same concerns and commitment to this crucial global issue as I do.

I am pleased to be working in a bipartisan fashion with him so we can move forward with an effective public policy on an issue that affects everyone in some way, worldwide.

The legislation we introduce today builds upon the Programme of Action Document adopted by acclamation by 180 nation states in September of 1994 at the International Conference on Population and Development in Cairo.

At the conference, the United States was seen, as always, as the world's leader on population and development assistance. I was a congressional delegate at the conference. There were not a lot of colleagues seeking to go. Senator JOHN KERRY was there and represented our country well.

I came away much impressed with the leadership and direction displayed by our Vice President, AL GORE. Then, of course, assistance given to him by the now Under Secretary of State, former Senator Wirth, in guiding the conference and its delegates in developing a consensus document of a broad range of short- and long-range recommendations concerning maternal and child health care, strengthening family planning programs, the promotion of educational opportunities for girls and women, and improving the status and rights of women across the world.

We surely do not want to lose our moral leadership role and relinquish any momentum by abandoning or severely weakening our financial commitment to population and development assistance. The United States needs to continue its global efforts to achieve responsible and sustainable population levels, and to back up that leadership with specific commitments to population planning activities.

In my mind, of all the challenges facing this country—and there are plenty of them—and around the world—and there are plenty of them—none compares to that of the increasing of the population growth of the world. All of our efforts to protect the environment, I have heard all of that in the last few days—protecting the environment, protecting this, protecting the aged, protecting the young—all the things to protect the environment and promote

economic development around the world are compromised and severely injured by the staggering growth in the world's population.

I hope my colleagues realize, of course, that there are currently 5.7 billion people on the Earth. In 1950, when I was a freshman at the University of Wyoming, not that long ago, there were 2.5 billion people on the face of the Earth. Mr. President, 2.5 billion in 1950, 5.7 billion today.

If current birth and death rates continue, the world's population will double again in just 40 years. Despite some progress in reducing fertility rates, birth rates in developing countries are declining too slowly to prevent a cataclysmic near tripling of the human race before stabilization can occur.

The bill as Senator BINGAMAN and I propose focuses on a coordinated strategy that will help to achieve world population stabilization, encourage global economic development and self-determination, and improve the health and well-being of women and their children.

Fundamental to this legislation is a recognition of the fact that worldwide efforts to alleviate poverty, stabilize populations, and secure the environment have been undermined by a total lack of attention to women's reproductive health and the role of women in the economic development of their families, their communities, and their countries.

Under the legislation, global and U.S. expenditure targets will be set for overall population assistance, with specific programs to help achieve universal access to culturally competent family planning services and reproductive health care; expand programs for treatment and prevention of HIV and AIDS and other sexually transmitted diseases; close the gender gap in literacy and primary and secondary education; and increase economic opportunities for women so they can realize their full productivity potential.

Other initiatives authorized under this legislation will help to reduce global maternal and infant mortality rates, and improve the overall health status of women and their children by addressing problems such as unsafe abortion. This is not about abortion. I have been here a long time. Every time we bring up something that has to do with stabilization of the Earth's population, somebody throws in the issue of abortion. That is not what this is about.

It is also about harmful practices such as female genital mutilation, along with malnutrition, low immunization rates, and the spread of contagious diseases.

There is a real need throughout much of the developing world for access to family planning services, especially as to safe abortion. Women in these countries are desperately seeking ways to take control of their reproductive lives and cannot do so because there is a severe lack of access to such services.

Worldwide, estimates are that 350 million couples want to space or prevent another pregnancy but lack the access to a full range of modern family planning.

In addition, any comprehensive family planning initiative must include access to primary health care with an emphasis on child survival to reduce infant mortality. In many developing countries, parents have a perception that many of their children will not survive beyond their first birthdays. If these parent's fears are allayed, they will not feel much pressure to have more children than they actually desire in order to insure against the possible loss of one or more of their children before adulthood.

This is why for all of these pressing reasons, I join today with my friend and colleague from New Mexico, Senator BINGAMAN in introducing this legislation. It is our aim to call attention to global population stabilization, to give it focus, and to make it a vital part of U.S. foreign aid and development assistance programs. We need to begin to make much-needed policy changes in international population stabilization, and the United States needs to take this lead to ensure that these new policy developments are recognized worldwide. This one is long overdue.

Mr. President, I ask unanimous consent to have printed in the RECORD a summary of the bill.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SUMMARY: INTERNATIONAL POPULATION STABILIZATION AND REPRODUCTIVE HEALTH ACT

The International Population Stabilization and Reproductive Health Act lays the foundation for a coordinated U.S. foreign aid strategy, consistent with the Programme of Action endorsed at the 1994 International Conference on Population and Development. This strategy will: help achieve world population stabilization; encourage global economic development and self-determination; and improve the health and well-being of women and their children.

The Act recognizes that worldwide efforts to alleviate poverty, stabilize population, and secure the environment have been significantly undermined by the lack of attention to women's reproductive health and the role of women in the economic development of their families, their communities, and their countries.

1. POLICY AND PURPOSE

A. Key Objectives: To help stabilize the world's population, improve the health and well-being of families, provide greater self-determination for women and ensure the role of women in the development process, and protect the environment, key objectives of U.S. foreign policy will be to:

Assist in the worldwide effort to achieve universal access to safe, effective, and voluntary family planning services;

Promote access to quality reproductive health care for women and primary health care for their children; and

Support the global expansion of basic literacy, education, and economic development opportunities for women.

B. Expenditure Targets: To promote the objectives, expenditure targets for population assistance are:

Global Target: $17 billion by 2000 (total domestic and international)

U.S. Target: $1.85 billion by 2000.

2. U.S. POPULATION ASSISTANCE PROGRAMS

U.S. population assistance will be available to international governments; multilateral organizations, including the United Nations and the UN Population Fund; and nongovernmental organizations.

A. Authorized Activities include:

Affordable, culturally-competent, and voluntary family planning and reproductive health services and educational outreach efforts particularly those designed, monitored, and evaluated by women and men from the local community;

Research on safer, easier to use, and lower-cost fertility regulation options and related disease control for women and men that: are controlled by women; are effective in preventing the spread of sexually transmitted diseases (STDs); and encourage men to take greater responsibility for their own fertility;

Efforts to prevent and manage complications of unsafe abortions, including research and public information dissemination;

Adolescent programs to prevent teen pregnancy, prevent the spread of STDs, and promote responsible parenting; and

Prenatal and postnatal programs that include breastfeeding as a child survival strategy and means for enhancing birth spacing.

B. Conditions on Eligibility for Support:

Largest share of U.S. population assistance will be made available through nongovernmental organizations;

Assistance priority to countries that account for a significant portion of the world's population growth; have significant unmet needs in the delivery of family planning services; or are committed to population stabilization through the expansion of reproductive choice;

Programs receiving support must maintain privacy and confidentiality standards; must support HIV–AIDS prevention; promote responsible sexual behavior; and may not deny services based on ability to pay;

No U.S. funds may be used to coerce any person to accept any method of fertility regulation or undergo contraceptive sterilization or involuntary abortion.

3. Economic and Social Development Assistance: U.S. development assistance will be available to help improve educational and economic opportunities for girls and women and improve the health status of women and their children.

Education: Priority assistance to countries that have adopted strategies to help ensure achievement of the goal of universal primary education of girls and boys before 2015.

Economic Productivity: Priority assistance to governments and nongovernmental organizations for programs that help women increase their productivity through vocational training and access to new technologies, extension services, credit programs, child care, and through equal participation of women and men in all areas of family and household responsibilities.

Women's Health: Priority assistance to governmental and nongovernmental programs that increase the access of girls and women to comprehensive reproductive health care services, including HIV–AIDS prevention and the prevention of other STDs.

Children's Health: Priority assistance to governmental and nongovernmental programs that are aimed at reducing malnutrition; increasing immunization rates; reducing the number of childhood deaths resulting from diarrheal diseases and respiratory infections; and increasing life expectancy at birth to greater than 70 years of age by 2005.

Violence Prevention: Priority assistance to governmental and nongovernmental programs which are aimed at eliminating all

forms of exploitation, abuse, and violence against women and children.

4. Safe Motherhood Initiative: The Act authorizes the ''Safe Motherhood Initiative,'' which helps girls and women world-wide gain access to comprehensive reproductive health care, including:

fertility regulation services;

prenatal care and high-risk screening;

supplemental food programs for pregnant and nursing women;

child survival and other programs that promote breastfeeding;

prevention and treatment of STDs, including HIV–AIDS;

programs aimed at eliminating traditional practices injurious to women's health, including female genital mutilation; and

programs promoting midwifery and traditional birth attendants.

5. Reports:

A. Annual Report: To assess progress toward the Act's objectives and expenditure targets, the President will submit an annual report to the Congress which:

estimates international population assistance by government, donor agencies, and private sector entities;

analyzes population trends by country and region; and

assesses by country availability and use of fertility regulation and abortion.

B. Expenditure Target Report: To determine expenditure targets for economic and social development activities, the President will prepare a report which:

estimates the resources needed, in total and by entity, to achieve the education, productivity, and health initiatives in the Act;

identifies legal, social, and economic barriers to women's self-determination and to improvements in the economic productivity of women;

describes existing initiatives aimed at increasing the women's access to education, credit, and child care and new technologies for development; and

describes causes of mortality and morbidity among women of childbearing age around the world and identifies actions and resources needed to address them.

C. Report on Discrimination: Each annual country human rights report will include information on patterns within a country of discrimination against women in inheritance laws, property rights, family law, and access to credit, technology, employment, education, and vocational training.

6. Authorization of Appropriations:

A. Section 104(g)(1): $635 million is authorized for Fiscal Year 1996, $695 million for FY95, for section 104(g)(1) of the Foreign Assistance Act of 1961.

B. Development and Economic Assistance Activities: Authorized levels are:

$165 million in FY96 and $200 million in FY97 to increase primary and secondary school enrollment and equalize levels of male and female enrollment;

$330 million for FY96 and $380 million for FY97 through the Child Survival Fund for child survival activities, including immunization and vaccines initiatives;

$100 million for FY96 and FY97 for the Safe Motherhood Initiative.

C. AIDS Prevention and Control Fund: $125 million is authorized for FY96, $145 million for FY97, for research, treatment, and prevention of HIV–AIDS.

Mr. SIMPSON. Mr. President, we are going to hold hearings on this. Those hearings will be held in my Subcommittee on Social Security and Family Policy. We are going to take this one very seriously. There is no need to talk about what is going to happen to the environment because of methane gas in cows, and how much propellant is in the bottom of the shaving cream can, when the population of the Earth will double in the next 40 years, and how many footprints will the Earth hold. It is very simple.

Mr. BINGAMAN. Mr. President, I want to compliment my colleague who is the prime sponsor of this bill in this Congress, and I am pleased to cosponsor the bill with him. I want to compliment him for his leadership on this very important issue. He has been a leader in trying to deal with the problem of how to stabilize population growth in the world for a very long period of time.

Today, we are reintroducing the International Population Stabilization and Reproductive Health Act. I also believe that this is a very important piece of legislation and has the potential of providing substantial benefits to this country over the coming decades.

I think we have already benefited greatly from the very modest investment we have made in sustainable development and in population efforts.

From my perspective, just as the Senator from Wyoming was saying, the attention to global population issues and support for worldwide development is critical to our future success here in this country.

We have joined, Senator SIMPSON and I, with Congressman BEILENSON and Congresswoman MORELLA, to introduce an earlier version of this in the last Congress, the 103d Congress.

The bill we are introducing today, like the previous bill, will focus U.S. foreign policy on a coordinated strategy to accomplish three things. No. 1, to achieve world population stabilization; No. 2, to encourage global economic development and self-determination for all women; No. 3, to improve the health and well-being of women and their children.

These three objectives are inseparable. To be successful, U.S. foreign policy needs to integrate population strategies and programs into our broader economic and development agenda. The way I see it, the U.S. efforts to help develop economies around the world, to promote democracy around the world, all of those efforts will be futile if we do not first address this issue of the staggering rate of global population growth.

How can we expect underdeveloped countries to pull themselves up when the world's population is growing at a rate of over 10,000 people per hour? When the women and men who make up a nation's work force pool do not even have the right to plan their families? And when millions of women around the world do not have access to basic and lifesaving reproductive health care or educational opportunities?

The 1994 U.N. International Conference on Population Development, which Senator SIMPSON attended and Senator KERRY attended, from this body, focused the world's attention on these issues and began a new era in population and development. At that Cairo conference, Senator SIMPSON indicated there was a program of action that was adopted as a consensus document. That program of action is the foundation for the legislation that we are introducing today. It clearly puts human beings at the center of development activities and encourages the international community to address global problems by meeting individual needs. It calls for gender equity and equality, for women to have and exercise choices in their economic and public and family lives, and for making reproductive health care available throughout the world.

The program of action which was adopted in Cairo recognizes that some significant worldwide progress has already been made in the last few decades, including lower birth and death rates in most parts of the world, reduced infant mortality, increased life expectancy, a slight rise in educational attainment, and a slight narrowing in the gap between the educational levels of men and women.

However, the Cairo Programme of Action, along with the State of Population Report, which was released just 2 days ago by the U.N. Population Fund, also recognized that a tremendous additional amount needs to be done. At the core of both the International Programme of Action and the United Nations report are two fundamental concepts. They are, first of all, that population, poverty, patterns of production and consumption, and the environment are so closely interconnected that none can be considered in isolation. And, second, that sustained economic growth, sustainable development in population, are fundamentally dependent upon investing in people; more specifically, on making advances in education and in economic status and in the empowerment of women.

This legislation, which I am very proud to cosponsor with Senator SIMPSON in this Congress, represents a significant step forward. I sincerely hope our colleagues in the Senate will give it a careful look. I commend him for scheduling a hearing this next week, at which we can explore the issues in more depth, and I look forward to working with him throughout the rest of this Congress in trying to see this legislation enacted into law.

Mr. SIMPSON. Mr. President, I certainly concur. I look forward to working with my friend from New Mexico. Hearings will start next week, and we will be about our business. That is something that is very clear.

By Mr. REID (for himself, Mr. SIMPSON, Mr. WELLSTONE, and Ms. MOSELEY-BRAUN):

S. 1030. A bill entitled the ''Federal Prohibition of Female Genital Mutilation Act of 1995''; to the Committee on the Judiciary.

THE FEDERAL PROHIBITION OF FEMALE GENITAL MUTILATION ACT OF 1995

● Mr. REID. Mr. President, last September I introduced a sense-of-the-Senate resolution condemning the practice of female genital mutilation [FGM]. I was compelled to react after I read an article in the newspaper reporting the arrest of two men in Egypt who arranged for the filming of this appalling ritual procedure being performed on a 10-year-old girl for the Cable News Network [CNN]. Last October, Senators WELLSTONE, MOSELEY-BRAUN, and myself introduced legislation that would ban this practice and today, along with Senator SIMPSON, we again introduce such legislation.

I realize the significance of the ritual in the culture and social system of the communities in Africa, Asia, and the Middle East. However, I cannot ignore the cruel and torturous nature of this procedure which is generally performed on very young girls who do not have a choice in what is about to happen to them. The immediate effects of the procedure are bleeding, shock, infections, emotional trauma, and even death because of hemorrhage and unhygienic conditions. As adults, complications during pregnancy and labor can occur.

Although FGM is most prevalent in Africa, Asia, and the Middle East, it is not confined to these areas. It is estimated that over 80 million young girls and women have been mutilated in this ritual. Excision and infibulation are the most common practices. Infibulation, which is practiced in many countries, entails the excision of all of the female genitalia. The remaining tissue is stitched together leaving only a small opening for urine and menstrual flow. FGM has no medical justification for being performed on healthy young girls and women. In Egypt, mothers perpetuate the tradition to shield their girls from lust and to make sure they will be accepted in marriage. They believe an uncircumcised women cannot control her sexual appetite, or if married, likely to commit adultery.

Although I believe this practice is a torturous act when performed on any woman, I am most concerned about it being performed on children and young girls under the age 18—in other words, below the age at which a child can give consent. A child does not have the ability to consent or understand the significance and the consequence this ritual will have on her life, on her health, or on her dignity. Young girls are tied and held down, they scream in pain and are not only physically scarred, but they are emotionally scarred for life.

Many nations have made efforts to deter the practice of FGM with legislation against its execution as well as creating educational programs for women. The United Kingdom outlawed FGM in 1985 after a BBC documentary revealed that British doctors were performing the procedure on children whose families had immigrated. Unfortunately, despite these initiatives, the societal pressures are too much to overcome. Sudan is a prime example of the failure of honest efforts to deter the practice. Sudan has the longest record of efforts to combat the practice of FGM and has legislated against the procedure. Yet, according to the 1992 Minority Rights Group report, 80 percent of Sudanese women continue to be infibulated. Nevertheless, as stated in my sense-of-the-Senate resolution, it is important that any effort by a nation to curb FGM be recognized and commended.

The most successful endeavors to prevent FGM has been at the grassroots level led by women, many of whom have undergone this excruciating operation, with support from the World Health Organization, UNICEF, and other international human rights groups. African and Arab women have begun to speak out and we must do all we can to support their efforts. They are working under difficult circumstances and often in hostile social environments for the preservation of a woman's health, dignity, and human rights. We must work to support and encourage their efforts to end this violent degradation of female children throughout the world.

Primarily, we must join other countries in legally banning FGM. As immigrants from Africa and the Middle East travel to other nations, the practice of FGM travels with them. The United Kingdom, Sweden, and Switzerland have all passed legislation prohibiting FGM in their countries. France and Canada maintain that FGM violates already established statutes prohibiting bodily mutilation and have taken action against its practice. The United States is also faced with the responsibility of abolishing this specific practice within its borders. Traditional child abuse interventions do not sufficiently address the problem.

FGM is difficult to talk about, but ignoring this issue because of the discomfort it causes us does nothing but perpetuate the silent acquiescence to its practice. The women of Africa and the Middle East are standing up against tremendous pressure and defiance to fight for the health and dignity of their sisters, friends, mothers, and daughters. The least we can do is support and encourage their struggle and to continue to talk about FGM and to condemn its practice. Education will be our most important and effective tool against FGM, and I intend to do my part to educate my colleagues, my constituents, and my friends to the horrors of this ritual practice.

In hopes to educate the public, our legislation provides for research on the prevalence of FGM in the United States. Furthermore, our bill provides that medical studies be aware of the ritual and be trained in how to treat effected women, and it will make illegal the denial of medical services to any woman who has undergone FGM procedures in the past.

Seble Dawit and Salem Mekuria, two African women who are working to end FGM, described the challenges to abolishing FGM. ''We do not believe that force changes traditional habits and practices. Genital mutilation does not exist in a vacuum but as part of the social fabric, stemming from the power imbalance in relations between the sexes, from levels of education and the low economic and social status of most women. All eradication efforts must begin and proceed from these basic premises.''●

● Mr. WELLSTONE. Mr. President, the issue of female genital mutilation [FGM] was first brought before the Senate last September when Senator REID introduced a sense-of-the-Senate resolution condemning this cruel ritual practice and commending the Government of Egypt for taking quick action against two men who performed this deed on a 10-year-old girl in front of CNN television cameras. Last October, Senators REID and MOSELEY-BRAUN and I introduced a bill entitled Federal Prohibition of Female Genital Mutilation Act of 1994. At that time we committed ourselves to working on this issue until legislation passes that bans the practice of female genital mutilation in the United States.

The bill we are introducing today would accomplish this goal by making it illegal to perform the procedures of FGM on girls younger than 18. In addition, this legislation proscribes the following measures as necessary to the eradication of this procedure: compiling data on the number of females in the U.S. who have been subjected to FGM, identifying communities in the United States in which it is practiced, designing and implementing outreach activities to inform people of its physical and psychological effects, and developing recommendations for educating students in medical schools on treating women and girls who have undergone mutilations. I am proud to be a cosponsor of an act that addresses an issue so crucial to the mental and physical health of women and girls.

The ritual practice of female genital mutilation currently affects an estimated 80 million women in over 30 countries. Although FGM is most widespread in parts of Africa, the Middle East, and the Far East, immigrants from practicing groups have brought the custom to wherever they have settled, including the American cities of New York, Seattle, Portland, San Francisco, and Washington, DC. This tradition is sometimes euphemistically referred to as ''female circumcision,'' a dangerously misleading label which encourages us to think of the procedure as nothing more significant than the culturally required removal of a piece of skin.

A closer examination of the issue makes it clear that female genital mutilation is in fact the ritual torture of

young girls. In her Washington Post article, Judy Mann describes female genital mutilation as ''the ritualized removal of the clitoris and labia in girls—from newborns to late adolescents. In its most extreme form, a girl's external sexual organs are scraped away entirely and the vulva is sewn together with catgut, leaving a hole the size of a pencil for urine and menses to pass through. Her legs are bound together for several weeks while a permanent scar forms.''

In the countries and cultures of its origin, FGM is most commonly performed with crude instruments such as dull razor blades, glass, and kitchen knives while the girl is tied or held down by other women. In most cases, anesthesia is not used. Afterwards, herb mixtures, cow dung, or ashes are often rubbed on the wound to stop the bleeding.

Aside from the obvious emotional and physical trauma which are caused by this procedure, it has been estimated that 15 percent of all circumcised females die as a result of the ritual. The long term effects dealt with by American doctors who treat mutilated women and girls are listed by the New England Journal of Medicine as including chronic pelvic infections, infertility, chronic urinary tract infections, dermoid cysts (which may grow to the size of a grapefruit), and chronic anxiety or depression.

Although female genital mutilation has sometimes been viewed as a purely cultural phenomena, it is clear that no ethical justification can be made for this inhumane practice in any country.

The unacceptable nature of FGM by international human rights standards was underscored by the World Health Organization on May 12, 1993, when it adopted a resolution which highlighted the importance of eliminating harmful traditional practices affecting the health of women, children and adolescents. This resolution explicitly cited female genital mutilation as a practice which restricts ''the attainment of the goals of health, development, and human rights for all members of society.'' In 1993, the Vienna Declaration of the World Conference on Human Rights also held that FGM is an international human rights violation.

Additionally, FGM has already been banned in many Western nations. In 1982, Sweden passed a law making all forms of female circumcision illegal, and the United Kingdom passed a similar law in 1985. France, the Netherlands, Canada, and Belgium have each set a precedent for the illegality of female circumcision by holding that it violates laws prohibiting bodily mutilation and child abuse. Action has been taken to enforce the statutes banning this practice in all the countries I've just mentioned.

However, due to complex cultural factors, dealing with this issue in the United States require more than making the ritual practice of FGM illegal. Immigrant parents in the United States who import a circumciser from their home country or find an American doctor willing to perform the procedure claim to do so out of a desire to do the best thing for their daughters. In the societies and cultures that practice it, FGM is said to be an integral part of the socialization of girls into acceptable womanhood. Often, the mutilations are perceived by a girl's parents as her passport to social acceptance or the required physical marking of her marriageability. In spite of its obvious cruelty therefore, FGM is a part of cultural identity. Clearly, female genital mutilation must be dealt with in a manner which takes into account its complex causes and meanings.

Because of the complexity of this issue and the lack of available information regarding FGM in the United States, this bill includes a provision ensuring that research be carried out to determine the number of females in the U.S. who have undergone mutilations. This research would also document the types of physical and psychological damage dealth with by American medical professionals who treat mutilated women.

The bill also requires that we investigate approaches such as the one used in Great Britain where child protection networks are used to identify at risk girls and trained professionals are assigned to work with their families.

Finally, the legislation would ensure that medical students are educated in how to treat women and girls who have undergone FGM. In 1994, the New England Journal of Medicine reported that pregnant women who have undergone infibulation—in which the labia majora are stitched to cover the urethra and entrance to the vagina—are at serious risk, as are their unborn babies, if treated by physicians who have not been trained in dealing with infibulated women. In fact, untreated infibulated women have double the risk of maternal death and several times increased risk of stillbirth when compared with women who have not undergone mutilation.

The education of medical students regarding FGM is especially essential as under this bill it would be considered illegal to discriminate or deny medical services to any woman who has undergone FGM procedures.

Passage of a bill banning FGM would have helped Lydia Oluloro who fought her deportation and that of her two daughters on the grounds that her sister had threatened to kidnap the girls and have the mutilations performed on them if they were forced to return to their native Nigeria.

Passage of this bill would also send a clear message to American medical professionals, some of whom reportedly have been offered as much as $3,000 to perform mutilations on young girls. It would see to it that the names of Western doctors who mutilate girls would no longer be passed around in immigrant communities. It would help in prosecuting cases resembling the one faced by the Atlanta district attorney in 1986 in which an African-born nurse was charged with child abuse after botching a clitoridectomy on her 3-year-old niece, and it would ensure that immigrants are educated as they enter the country regarding the operations's illegality and its dangers.

Female genital mutilation is the world's most widespread form of torture, yet no other mass dilation of humanity has received so comparatively little journalistic or governmental attention. We in the United States should make it clear that it is a serious crime if it occurs here. I urge my colleagues to support this legislation as an essential tool in the struggle against the perpetuation of this heinous practice.●

● Ms. MOSELEY-BRAUN. Mr. President, I am very pleased to join Senator REID, Senator WELLSTONE and Senator SIMPSON as an original cosponsor to the Federal Prohibition of Female Genital Mutilation Act of 1995.

Male circumcision is a procedure with a long history. It is a common, accepted practice in the United States for male babies to be circumcised. In the Jewish religion, tradition dictates that a baby boy be circumcised when he is 8 days old in a special ceremony to symbolize the covenant between God and the children of Israel. It is quick, relatively painless, and without long-term consequences—for men.

For women, however, circumcision is another matter altogether. The procedure known as female circumcision is not at all benign. It is mutilation.

Eighty million women worldwide have been mutilated by female circumcision. The procedure is most widely seen in eastern and western Africa, and a number of Middle Eastern countries. And as communities from African countries immigrate to the United States, we are tragically seeing more and more cases of genital mutilation in this country. That is why this legislation is so important.

I am concerned that in this country there are misperceptions that this procedure is part of African and Islamic culture and tradition, and that the Government should not interfere. Nowhere in Muslim scripture is female circumcision required. It is not practiced in Saudi Arabia, the cradle of Islam. Historically, the procedure dates back before the rise of the Moslem religion to the times of the Pharaoh in Egypt.

In countries where the practice is not universal, female genital mutilation is more common among poor, uneducated women, and it is inextricably tied to the status of women in the community. In these societies, women who have not been circumcised are considered unclean, and unmarriageable. In communities where the only role for a women is to be married and have children, the fear of being labeled unmarriageable is enormous and real.

Ironically, that is why women are the strongest supporters of this practice. It is the older women who know best about how an uncircumcised woman in a traditional village will be treated. Girls are taught that with circumcision, they enter womanhood. Mothers encourage the mutilation because they want their daughters to marry—because marriage is the only access to a meal ticket. And men support the custom because a woman who is circumcised is considered chaste. In short, circumcision is a passport into the only role that some societies give women.

As a woman and a mother, I can't imagine leading a child to this kind of torture.

I want to raise awareness of this practice. This is mutilation of otherwise healthy women, pure and simple. We must work together to stop teaching girls that undergoing this kind of butchery is essential to their future.

Mr. President, there are very serious health risks associated with the practice of female genital mutilation that do not exist with male circumcision. This practice is most often performed by midwives or other women elders with little or no medical training. It is performed without anesthetic or sanitary tools. Often, the cut is made with a razor blade or a piece of glass.

The New England Journal of Medicine has examined female genital mutilation as a public health issue. They report that women often hemorrhage after the cutting. Prolonged bleeding may lead to severe anemia. Urinary tract infections and pelvic infections are common. Sometimes, cysts form in the scar tissue. The mutilation can also lead to infertility.

At childbirth, circumcised women have double the risk of maternal death, and the risk of a stillbirth increases several fold. And because the cutting is performed without sanitary tools, female genital mutilation has become a means of spreading the HIV virus. There are no records of how many girls die as a result of this practice.

Mr. President, Sweden, Britain, The Netherlands, and Belgium have outlawed this practice. In France, it is considered child abuse. The United States has an important role to play as well. Two years ago, the world health organization adopted a resolution on maternal child health and family planning for health sponsored by Guinea, Kenya, Nigeria, Togo, Zambia and Lebanon that highlights the importance of eliminating harmful traditional practices, includings female genital mutilation, affecting the health of women, children and adolescents.

Banning this practice in the United States is just the first step toward eradicating it. Girls must be taught that they will have opportunities, both in marriage and outside the home, if they are not mutilated. Mothers must believe that their daughters will have a place in the community if they are not circumcised. And men must be taught that the terrible health risks involved with the procedure far outweigh their belief that a circumcised woman is a more suitable bride.

I want to commend the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, for their work in Africa over the last 10 years to educate women so that this practice can be abolished. It will take much more than Government statements against the procedure to eradicate the tradition.

Mr. President, no woman, anywhere, should have to undergo this kind of mutilation, not to get a husband, not to put food on the table, not for any reason. Female circumcision is, in the final analysis, about treating women as something less than people. It must be stopped. It has no place in today's world.●

By Mr. THOMAS (for himself, Mr. SIMPSON, Mr. BURNS, Mr. CRAIG, Mr. STEVENS, Mr. KEMPTHORNE and Mr. HELMS):

S. 1031. A bill to transfer the lands administered by the Bureau of Land Management to the State in which the lands are located; to the Committee on Energy and Natural Resources.

BLM LEGISLATION

Mr. THOMAS. Mr. President, I rise to introduce legislation that would transfer the lands managed by the BLM in the various States to State control. This bill is not a new one. We have had it in last year. But it is a commonsense approach that supports the goal of good government, supports the goal of bringing government closer to the people, and a necessary reform in the way that public lands are managed.

Currently, the BLM, the Bureau of Land Management, manages nearly 270 million acres of land in the United States, most of it, of course, in the West. Wyoming, for example—nearly 50 percent of Wyoming is owned by the Federal Government, much of it managed by the BLM. In some other States, it is more—86 percent in Nevada. So when half of your State is managed by the Federal Government, it has a great deal to do with your future. It has a great deal to do with the economy and growth, because these are multiple use lands.

Let me make a point originally that is very important to this bill. We are talking about Bureau of Land Management lands. We are not talking about Forest Service. We are not talking about wilderness. We are not talking about parks—lands that are set aside with particular purpose, lands that had a particular character. BLM lands are residual lands that were left when the homesteaders came in the West and took the land that is along the river and took the winter feed and took the best land. That land that was left was managed by the Federal Government.

Indeed, in the early acts that had to do with managing that land, it said ''manage it pending disposal.'' The notion was never to maintain them. So we are talking about a fundamental change and that is sort of what we are doing in this Congress, looking at some fundamental changes in the way we operate Government. It moves Government closer to the people, and that is what it is all about. It helps to reduce the size and cost of the Federal Government and transfers this function to the State as we are talking about transferring others.

It would have to do with the budget. It would, indeed, save money for the budget of the United States. There will be less money going to the Department of Interior. That is just the way it is. So the priorities will have to be established. We heard a lot about not being able to finance national parks, and that is actually going to be the case. So what it does is set some priorities as to where that money ought to be.

There is a fairness doctrine here. The States east of the Missouri River do not have half of their lands belong to the Federal Government. So there is a fairness question. Why should the State not have these lands? There is a question of States rights. Many maintain the Constitution does not provide the authority for the Federal Government to maintain those lands that have no specific use. I do not argue that. Others say we ought to get control by having the counties do zoning. They do that some in Arizona. That is an idea. I say, let us move them back to the States and let the States manage them as public lands. These will be multiple use lands, for hunting, for fishing, for grazing, for mineral development.

If you have ever seen a map of the West, you will see a strange ownership pattern. There are lands spread around over the whole State. One of the most unusual is the checkerboard, what we call the checkerboard, that runs all the way through Wyoming and through much of the West, when every other section was given to the railroads early on, 20 miles on either side of the railroad. So those checkerboards still belong to the Federal Government with deeded lands in between.

These are low production lands. These are not national parks. These are very low rainfall, low moisture content areas, so they are very unproductive. It takes a great deal of land to support one cow-calf unit.

Along with the House—there will be an identical bill in the House that will be introduced to transfer these lands to the State. Actually, in order to have time to accommodate that, in order to do something with the budgeting, that would be a 10-year period before they would be transferred. But we almost constantly have a conflict between the States, between the users —whatever they are, whether they are commodity users or recreational users—and the Federal land managers. And these folks do a good job. I have no quarrel with the managers. I just think, as many