MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1464

2007 HOUSE JUDICIARY

HB 1464

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1464

House Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 1/22/07

Recorder Job Number: 1573

Committee Clerk Signature D. Delmore

Minutes:

Chairman DeKrey: We will open the hearing on HB 1464.

Christopher Dodson, Executive Director, ND Catholic Conference: (see attached testimony).

Chairman DeKrey: Thank you. Further testimony in support.

Rep. James Kerzman: (see attached testimony).

Rep. Delmore: Is there a fiscal note for the cost of updating the videos and pamphlets.

Rep. James Kerzman: I don't know the cost of updating those materials.

Rep. Delmore: You say it needs to put a listing of assistance available in agencies that offer alternatives to abortion. Are the women required to speak to one of those, or just given the information.

Rep. James Kerzman: I think you are just required to give the information.

Rep. Delmore: In Section 5 that deals with the penalty. If the person intentionally causes the death of an infant born alive, is that the doctor for the AA felony, does it include the mother as well, because she had a part in it.

Rep. James Kerzman: I would be opposed to it if it includes the mother. I don't read that into the language.

Rep. Wolf: In Section 9, page 9, it talks about a person acting in an official capacity as an employee or agent of a school district, so as a high school teacher, I see lots of pregnant students. Now would this preclude me from talking to them when they come to me in tears and don't know what to do. I would be forbidden to mention the word abortion to them.

Rep. James Kerzman: I don't read it that way. I think you would, it doesn't extend to private communication between the employee or agent and a child of the employee or agent. Where are you reading this. Is that in existing language or new language.

Rep. Wolf: Subsection 2 of section 9, no public school in the state may endorse or support any program that does not give preference, encouragement and support to normal childbirth.

Rep. James Kerzman: It might.

Chairman DeKrey: Thank you. Further testimony in support.

Rep. Klemin: On page 3, lines 13-16, the new language "the physician has not received or obtained payment for a service provided to a patient who has inquired..." is part of the definition of informed consent. That's the way I understand it. I would like you to explain subsection 5e, what that means. And secondly, why should that be part of Informed Consent and not someplace else in this bill.

Christopher Dodson: The purpose is to prevent undue pressures during the reflection period. That she doesn't think that because she made a payment already, or scheduled an abortion, that she has to go through with it, to prevent undue pressure. It is in the informed consent statute because the requirements of what has to be done and the information that has to be provided to a woman appear in the definition of informed consent in the present code. It could be moved. That is an awfully long definition of informed consent, but that is a decision that the legislature made some time ago, so I tried to work with them.

Rep. Klemin: So if the physician has received payment for a service provided to a patient who has inquired about an abortion, then there is no informed consent.

Christopher Dodson: I believe that to be correct. In other words, they can't collect payment before there is a determination at the end of reflection period.

Rep. Klemin: Payment for any kind of service would fit into the abortion, it says "a" service, it doesn't specify.

Christopher Dodson: That's the way it was written, yes.

Rep. Klemin: On page 8, line 1, we're increasing the penalty from class C felony to a class AA felony, that seems to be more than a technical correction.

Christopher Dodson: Actually it is a technical correction for two reasons. First of all, definitions change because at one point the definition or the penalty provision was changed here and they don't match. That's why an infant born alive and the word fetus, we're simply synching them back together. An infant that's born alive, if we intentionally kill an infant born alive, it's under the homicide statute, as a AA felony. To be honest, you don't need this section, because it's already covered in the homicide statute. But if it's going to be in the abortion control act, the penalties should be consistent.

Rep. Klemin: Does the homicide statute say a person is guilty of a AA felony if he intentionally causes the death of an infant born alive.

Christopher Dodson: That's correct. Because an infant born alive is a human person in the homicide statute.

Rep. Klemin: But it doesn't use the term "infant born alive" in there.

Christopher Dodson: The homicide statute may not use that definition, but it's just a matter of common law. If they are born alive, or in the process of being born alive, and killed then it is a AA felony.

Rep. Delmore: I have another question on page 7, the abortion inducing drugs. Are you thinking about a specific drug, would you include birth control pills that might begin with conception.

Christopher Dodson: You're referring to page 7. This only deals with the timing of when the statute would go into effect. The actual language regarding to what types of drugs would be considered as an abortion inducing drug is in the definition section. If it's a drug that still produces an act which is an abortion under the definition section, then it is an abortion. Which would be found on page 1, lines 10-15. The act itself has not changed.

Rep. Koppelman: The language at the bottom of page 2, and on the top of page 3, why is that being removed.

Christopher Dodson: Part of this is moved to page 2, lines 20-22, and the change is also on page 3, lines 8-10. The rest of that section is no longer necessary. One of the questions raised earlier about the printed materials. The printed materials exist now, only a few things would have added to them; whether a list that is attached to it, or new printing, that would have to be decided. As far as the video goes, some states already require a video and they are already available and the state can purchase them. Changes in section 8, regarding schools, whether or not it precludes a teacher talking about abortion, in actuality, it does preclude discussing with that student about abortion, if you're an agent or employee of that school. This language simply clarifies that because that very question is asked. We added clarification, but it is our understanding that based on existing law, that would already be precluded.

Rep. Delmore: Are doctors required now to give out any specific information under current law.

Christopher Dodson: Yes, they are. Most of that is still here. The only two additionals would be the two I mentioned, that they are free to withdraw their consent and a catch all that there

should be full and reasonable information that would be material to her decision. Everything else is in existing law.

Rep. Klemin: On page 10, last line there is two "to"s on the line. What should be the correct wording.

Christopher Dodson: It should say "immediate live birth or to remove dead embryo or fetus."

Chairman DeKrey: Thank you. Further testimony in support.

Janne Myrdal, Director of Concerned Women for America, ND: Our organization has 1000+ members in ND and growing quite rapidly. I represent those people here today. We fully support this bill, because it clarifies quite well the existing statute. I would mention that I am also the co-director of a health center in Walsh County, ND and have been in the pro-life work for over 20 years. I can fully understand the concerns by Rep. Delmore about rape and incest and the rights of the mother. I always take the position, in my faith with God values, that the mother and child are equal. I am a woman and believe in women's rights. This particular bill, as a woman and as a pro-life movement, it covers in even more detailed information that a woman needs to have to make an informed decision, a life-long decision like this. I have never met a woman in a crisis that did not want all information. On page 6, it mentions that the juvenile court shall be in the county of the minor's residence. In my experience in Walsh County, that has not occurred and we have had many parents come to us and we are very confidential. We cannot tell you that your child has been to the Center for a pregnancy check or whatever. Under the law we can't divulge that information; unless it is a life threatening condition to the minor or woman.

Chairman DeKrey: Thank you. Further testimony in support of HB 1464.

Stacey Pfliiger, Legislative Director, for ND Right to Life: We stand in support HB 1464 (see attached testimony).

Rep. Klemin: On page 7, at the top on lines 3-4, where it states that the juvenile court or juvenile judge or referee shall find by clear and convincing evidence: a, b and c. I am wondering, it looks to me like we've increased the standard of proof there, from a preponderance to clear and convincing. Why did you want to do that.

Christopher Dodson: When reviewing other states, informed consent laws, I noticed that clear and convincing evidence again and again in other states. When I looked at ours, there wasn't any standard of proof. It just made sense that there should be some standard of proof. We don't want the proceedings to become rubber stamping. There has to be some showing and clear and convincing evidence standard is typical in most statutes in other states; and has been upheld by the US Supreme Courts.

Chairman DeKrey: Thank you. Further testimony in support. Testimony in opposition.

Tim Stanley, Planned Parenthood: (see attached testimony).

Rep. Koppelman: You mentioned in your testimony that your organization is opposed to ND's current law as well as this revision of it. Do you plan to propose amendments to change the current law or do you have a bill to attack the current statutes in the state.

Tim Stanley: No.

Chairman DeKrey: Thank you. Further testimony in opposition. All testimony that was submitted earlier will be recorded to the minutes of this hearing as well. Testimony in Neutral.

Kim Senn, Director of Division of Family Health for the ND Dept of Health: (see attached testimony). We did do some estimations for printing the pamphlets and video, and that came out to around $15,000 for the Department.

Rep. Koppelman: You spoke from this study, it says federal guidelines. What is the impact of that particular paragraph, what does the guideline do, if you don't follow the guideline.

Kim Senn: The guidelines are really set up and have some different definitions of words. Some guidelines say programs should do this and other times when it says the program must do. So when you see that word "must" it's telling us in order to receive the Title grant funds into the state, we must do that. So the part that I read to you, is a must. We must include that in order to receive the Title X funds.

Rep. Koppelman: Are you aware of any states that have done something similar to this or are not compliant with that must.

Kim Senn: I'm not aware of any states, no.

Rep. Griffin: Regarding section 9 of the bill, there was concerns brought up as to what would be a violation of Title X as well, lines 25-28 on that page. Do you have any thoughts regarding that.

Kim Senn: Part of what they do, is go into the schools and provide education. They go in to a school only at the request of the school, and provide the information that the school's request. So if they go into a school and the school doesn't want them to provide that information, or only provide a very specific part, that's what they will do. I am not as concerned about that part as I am about the part that has the referral language.

Chairman DeKrey: Thank you. Further testimony in opposition or neutral to HB 1464. Seeing none, we will close the hearing on HB 1464.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1464

House Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 1/24/07

Recorder Job Number: 1849

Committee Clerk Signature Maun P. Penrose

Minutes:

Chairman DeKrey: We will take a look at HB 1464. Does anyone have any amendments.

Rep. Koppelman: I think that this was to clean up the law and restate what the Dept. sends out in literature and calls for a video to be produced.

Rep. Klemin: There were some amendments that were offered.

Rep. Koppelman: I would move the Dept. of Health's amendments.

Rep. Kretschmar: Seconded.

Chairman DeKrey: Any discussion on the amendments.

Rep. Kretschmar: The first amendment is an "either or", you have to choose which one you want.

Rep. Koppelman: I move that we go with the second one. On page 8, section 6, #3, line 27-28 change it to "or referral for except upon request"; page 5, section 2, #1(c), line 22 to read "that paternity may be established by the father's signature on an acknowledgement of paternity or by court action."; and on page 10, clean up the typo on page 10, remove the first "to" and replace with "or".

Chairman DeKrey: We will take a voice vote. Motion carried. We now have the bill before us as amended.

Rep. Wolf: I move a Do Not Pass as amended.

Rep. Delmore: Seconded.

Rep. Koppelman: Just a point of clarification, I'm not sure, I think the only substantive change here is that the video that we are talking about. I don't think there is anything else to this.

Rep. Delmore: That first change certainly affects anybody who would have in vitro and the doctor may decide that for the pregnancy to be viable, if there are six and it's not going to happen, or it threatens the life of the mother, this is what they would need to do.

Rep. Koppelman: What are we regulating there, that is a definition, right, is that what you are referring to.

Rep. Delmore: Including the elimination of one or more fetuses or embryos in a multifetal pregnancy. The most common use of this would be with the use of fertility drugs.

Rep. Koppelman: So it's including that under the definition of abortion. Then what effect does that have. This bill does not do anything, does it.

Rep. Delmore: On page 10, it clarifies exactly what it is, yes that is a change.

Rep. Koppelman: As I look at this, I think the intent of those who brought this forward, was that the class AA felony in the current statute is for the current penalty for murder and it looks to me, in reading this, that this is talking about a viable fetus and it changed back to infant born alive, so that makes it clear that a baby has been born alive, so it makes it clear that a baby has been born, not abortion situation; and the change "knowingly or negligently with an intention" so it raises the standard there. I didn't draft the bill, but I assume the intent was to be consistent.

Rep. Wolf: On page 10, section 10 it talks about participation is not mandatory, and it says no hospital, physician, nurse, etc. Then it goes on to say that for purposes of this section,

"abortion" means the termination of a pregnancy, including the elimination of one or more fetuses or embryos in a multifetal pregnancy. It says it right there. So if you have a lab technician, where they've grown 10 embryos in a Petri dish, and they decide to impregnate two of those viable fetuses in a woman, and the lab tech throws out the other eight, is he then in violation of this statute.

Rep. Klemin: I don't think something in a Petri dish is a pregnancy.

Rep. Koppelman: It says one or more fetuses or embryos in a multifetal pregnancy. It doesn't appear to draw any, this is not a criminal statute, and this has to do with being forced to participate in something that they have a conscientious objection to. It is a conscientious objection protection. It says that if you have an opposition to this, you can't be forced to do it.

Rep. Klemin: So this doesn't say you can't do this, it says that you don't have to participate.

Chairman DeKrey: Further discussion? The clerk will call the roll.

7 YES 6 NO 1 ABSENT DO NOT PASS AS AMENDED CARRIER: Rep. Delmore

Date: 1-24-07
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1464

House JUDICIARY Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass as Amended

Motion Made By Rep. Wolf Seconded By Rep. Delmore

Representatives	Yes	No	Representatives	Yes	No
Ch. DeKrey		✓	Rep. Delmore	✓	
Rep. Klemin		✓	Rep. Griffin	✓	
Rep. Boehning		✓	Rep. Meyer	✓	
Rep. Charging			Rep. Onstad	✓	
Rep. Dahl	✓		Rep. Wolf	✓	
Rep. Heller		✓			
Rep. Kingsbury	✓				
Rep. Koppelman		✓			
Rep. Kretschmar		✓			

Total (Yes) 7 No 6

Absent 1

Floor Assignment Rep. Delmore

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1464: Judiciary Committee (Rep. DeKrey, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (7 YEAS, 6 NAYS, 1 ABSENT AND NOT VOTING). HB 1464 was placed on the Sixth order on the calendar.

Page 5, line 22, replace "a birth" with "an acknowledgement"

Page 5, line 23, remove "certificate or statement"

Page 8, line 27, after "or" insert ", except upon request,"

Page 10, line 10, replace the first "to" with "or"

Renumber accordingly

2007 TESTIMONY

HB 1464

Chairman Rep. DeKrey

Members of House Judiciary

Rep. James Kerzman, District 31

HB 1464 was brought to the Pro-Life Caucus as suggested update of ND's existing code relating to life issues. Several themes or thoughts going into this proposed legislation were to clarify the material given to a woman, to include modern technology like video, that she can use to make an informed decision. The inclusion of drugs that induce abortion, and language that directs the State and any agency of the State to encourage and give preference to normal childbirth.

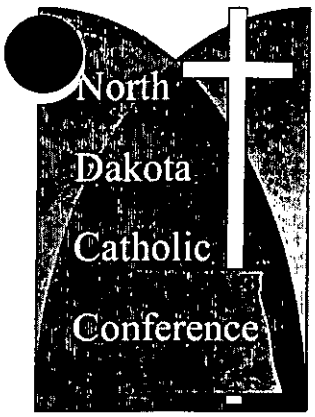
As we go through the bill, on page one language is added to clarify multifetal pregnancy and the elimination of one or more fetuses or embryos. Page two directs material to be given to a woman to include listings of assistance available and listings of agencies that offer alternatives to abortion. Page three deals with a woman's consent to abortion and twenty-four-hour waiting period. Page four and five and six deal with updating materials given a woman to help her make a informed decision and to include a video. Bottom of page six and part of page seven update language dealing with a minor. Section 4 is a new section relating to abortion-inducing drugs. Section 5 changes fetus to infant and penalty to AA felony for person who intentionally causes the death of a infant born alive. Section 6 and 9 ask State agencies and the State to give preference to live birth. Section 7 disallows insurance paying for elimination of fetuses or embryos in a multifetal pregnancy. And lastly section 10 also deals with multifetal pregnancy.

I feel these changes in code will go a long ways to enhance our existing laws without changing the existing intent. I feel we need to provide as much information and assistance as possible so that a woman can make an informed decision.

I'll try and answer any questions.

Respectfully Submitted.

Rep. James Kerzman



Representing the Diocese of Fargo and the Diocese of Bismarck

Christopher T. Dodson
Executive Director and
General Counsel

To: House Judiciary Committee
From: Christopher T. Dodson, Executive Director
Subject: House Bill 1464 (Revisions to Abortion Laws)
Date: January 22, 2007

The North Dakota Catholic Conference supports House Bill 1464.

North Dakota has long embraced reasonable regulations on the practice of abortion in order to protect women, foster parental involvement, respect the deeply-held views of taxpayers, ensure the collection of important public data, and foster, to the extent possible under law, a culture of life.

House Bill 1464 helps us continue those tasks by updating and improving the state's existing laws related to abortion. It addresses changes in abortion practices, clarifies some statutory language, "cleans-up" some contradictory provisions, and makes improvements to some of the current policies.

It does not change the structure or underlying policies of the current law. It does not place new restrictions on abortion except to the extent it closes unintended gaps in the existing law. Although there is never a guarantee that opponents of such laws will not pursue litigation, there is nothing in HB 1464 that can reasonably said to be contrary to existing constitutional jurisprudence.

Finally, it does not, as some have already claimed, place a bunch of new requirements on what the abortionist must tell the woman considering an abortion. It adds only two reasonable pieces of information that must be provided to the woman. The first says that a woman must be informed about "any information that a reasonable patient would consider material to the decision of whether to undergo abortion." The second states that the woman be told that she is "free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally funded benefits to which she might otherwise be entitled." Everything else required exists in the current law.

What HB 1464 *does* do is enhance and strengthen the type of reasonable regulations on abortion that are supported by a majority of citizens and have been shown to reduce the incidence of and the demand for abortion.

The bill makes revisions to four parts of the Century Code. The changes to Chapter 14-02.1, which is called the Abortion Control Act, address definitions, the informed consent/Woman's Right to Know provisions, the procedures for a judicial bypass in the case of a minor seeking an abortion, and the crime of causing the death of an infant born alive.

103 S. 3rd St., Suite 10 • Bismarck, ND 58501
(701) 223-2519 • 1-888-419-1237 • FAX# (701) 223-6075
http://ndcatholic.org • ndcatholic@btinet.net

The changes to Chapter 14-02.3, which is commonly called "Limitations on Abortion," clarify state policy favoring childbirth.

North Dakota Century Code sections 15.1-19-05 and –06 address birth control devices and abortion in public schools. The changes to those sections in HB 1464 provide clarifications.

North Dakota Century Code section 23-16-14 protects a person from being compelled to participate in an abortion. The changes to this section add an up-to-date definition of "abortion."

Those are the parts of the Code revised by HB 1464. In some cases, the changes occur in more than one part of the Code. Overall, the revisions in HB 1464 would:

- Clarifies that abortion statutes apply to the elimination of one or more fetuses in a multiple fetal pregnancy;
- Clarifies that performance of abortion includes prescribing an abortion-inducing drug;
- Improves the content of printed materials needed for informed consent;
- Assures that the woman receives the printed materials;
- Directs the Department of Health to produce a video format to complement the printed materials;
- Clarifies that proceedings for a judicial by-pass for a minor seeking an abortion must occur in the county of the juvenile's residence;
- Sets a standard of proof for bypass proceedings;
- Clarifies that the confidentiality provisions for the judicial bypass proceedings do not preclude release of information that does not identify the minor;
- Makes causing the death of an infant born alive a AA felony, consistent with homicide statute;
- Clarifies state policy in favor of childbirth; and
- Clarifies policy on birth control and abortion in public schools.

Mr. Chairman, I have included with my testimony an explanation of the changes, by page and line number. I am willing to explain the changes section by section or answer questions the committee may have on specific sections.

Thank you for this opportunity, we ask the committee to give a **Do Pass** recommendation to House Bill 1464.

House Bill 1464
Explanations of Changes to Current Law, by Page and Line Number

Page 1, lines 10-11	This change clarifies that a reduction in the number of fetuses in a multifetal pregnancy is an abortion for purposes of this statute. The change is needed because the current definition states that an abortion is the "termination of a human pregnancy." The elimination of one or more fetuses in a multifetal pregnancy does not necessarily end the pregnancy.
Page 1, line 12	Part of the clarification that a reduction in the number of fetuses in a multifetal pregnancy is an abortion for purposes of this statute. In a fetal reduction the killed fetus is sometimes absorbed into the body and is not removed. Also, the intention is to eventually produce a live birth, albeit later with a different fetus.
Page 1, line 14	Reflects current availability of abortions by prescription.
Page 1, line 22	Reflects current availability of abortions by prescription.
Page 2, lines 12-13	A sensible catch-all, allowing for the law to reasonably respond to changes in medical, scientific, and social data.
Page 2, lines 17-19	Assures that the woman knows that the information is available and that it includes information related to health care needs.
Page 2, lines 20 –22	This is not new law. It is just moved.
Page 2, line 25 – page 3, line 2	Part of this is moved to page 2, lines 20 –22. With the changes on page 3, lines 8-10, the rest is no longer necessary.
Page 3, lines 3-6	Ensures that the woman knows she can withdraw her consent without affecting her rights. Note: This and the change on page 2, lines 12-13 are the **only** additions to the information the physician must provide the woman.
Page 3, lines 8-10	This ensures that the woman receives the information.
Page 3, lines 14-16	Prevents additional pressure on the woman during the reflection period
Page 4, lines 4-5	References informational video described on page 6, lines 6-15.
Page 4, line 15 – Page 5, line 2	Adds information a woman should be expected to have in order to make an informed decision. (1) Cannot be coerced; (2) Financial help available, even if woman is minor; (3) informed consent required; (4) adoptive parents can pay for some costs; (5) agencies available to help
Page 5, lines 7 –15	Ensures that fetal development information is accurate and not out-dated in information or presentation
Page 5, lines 19 –26	Ensures that the woman knows about the father's legal obligations before she makes a decision

Page 5, line 27 – page 6, line2	Provides that the materials – which can be viewed outside the presence of the abortionist – provide important medical information. (Note: at least 5 states already require a warning on abortion-breast cancer link.)
Page 6, lines 3-5	A uniform method of ensuring compliance
Page 6, lines 6-15	Adds informational video. We live in a video age, and using an informational video makes sense. Other states already produce videos.
Page 6, line 31, page 7, line 1	Clarifies requirement that proceedings be held in the county of the minor's residence, as is already in existing law in 14.02.1-03.1.
Page 7, lines 3-4	Curiously, our existing law does not provide a standard of proof for the judicial bypass proceedings. This would provide that standard of proof. "Clear and convincing" is a standard used in other states and was upheld in *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502 (1990).
Page 7, lines 21-23	The confidentiality provisions and the requirement in 14-02.1-03.1(4) that the proceedings be sealed serve a good purpose, but should not prevent the release of data, without names, regarding number and frequency of judicial bypasses.
Page 7, lines 26-28	The development of abortion inducing drugs has created a need to determine when an abortion is deemed to occur for purposes of the Abortion Control Act – necessary because of the Act's timing requirements. This new language addresses that issue.
Page 7, line 31 – page 8, lines 1-2, and 9.	These changes correct two inconsistencies in the existing law. (1) The Act has a definition for "infant born alive," not "viable fetus born alive." Somewhere in the Act's history, this provision or the definition was changed, but not the other. This change corrects that problem. (2) Under the homicide statute, Chapter 12.1 – 16, the act described in this provision is a class AA felony. This change would make the required mental state and penalty match the homicide statute.
Page 8, lines 19-24, 28	Strengthens existing state policy that, between normal childbirth and abortion, the state gives preference, encouragement, and support to normal childbirth. Gives notice to all state and local entities that when it comes to abortion, the state is not neutral. Some opponents of the state's policy may argue that this provision is unconstitutional. It is not. *Webster v. Reproductive Health Services*, 492 U. S., at 511; reaffirmed in *Planned Parenthood of Southeastern Pa. v. Casey*, 505

	U.S. 833 (1992). The restrictions on funding are only unconstitutional to the extent they conflict with specific federal program requirements, such as Medicaid and Title X, where the preemption clause is at issue.
Page 9, lines 3-4	This change would make clear that a reduction in the number of fetuses in a multi-fetal pregnancy is an abortion for purposes of this statute, which is a different chapter from the one addressed in the page 1 of the bill.
Page 9, lines 13 –14	This change addresses a question that has periodically arisen during the history of this statute.
Page 9, lines 22 –29	Restates the state's policy as it applies to public schools.
Page 9, lines 29 – 31	Like the provision on birth control, this language should eliminate questions that have periodically arisen.
Page 10, lines 7-10	The state law protecting a person from being required to participate in an abortion is another section of the Code. This change applies the definition used in the Abortion Control Act to this section.

Prepared by the North Dakota Catholic Conference

NDRL

North Dakota Right to Life Association

Testimony before the HOUSE JUDICIARY COMMITTEE
House Bill 1464
January 22, 2007 8:00 am

Chairman DeKrey, members of the committee, I am Stacey Pfliiger, Legislative Director of the North Dakota Right to Life Association. I am here today in support of HB 1464 relating to limitations on abortion; and to provide a penalty.

HB 1464 reaffirms the tradition of the state of North Dakota by updating our existing statutes concerning abortion provisions. As you can see by reading through HB 1464, the bill does the following:

*Updates the definitions found in North Dakota's Abortion Control Act;
*Enhances the language of our informed consent and woman's right to know laws;
*Clarifies the judicial bypass provision stating that hearings must be heard in the juvenile court of the county of the minor's residence;
*Updates the penalty for an infant born alive to a class AA felony; and
*Clarifies that the state of North Dakota's policy is that normal childbirth is to be given preference by law and by state action.

The North Dakota Right to Life Association urges a **DO PASS** recommendation on HB 1464.

Thank you. I would be happy to address any questions the committee may have.

P.O. Box 551 • Bismarck, North Dakota 58502 • (701) 258-3811 • Fax (701) 224-1963 • 1-800-247-0343

Planned Parenthood®

Serving Minnesota • North Dakota • South Dakota

Testimony to the North Dakota House Judiciary Committee
January 22, 2007

Chairman DeKrey, members of the Judiciary committee, thank you for the opportunity to present testimony in opposition of House Bill 1464.

For more than 75 years, Planned Parenthood has worked in our region to make sure all people have the information and the means to decide freely and responsibly whether and when to have children. Planned Parenthood also believes that women should have access to medically accurate and objective information about their reproductive health and that biased counseling measures such as House Bill 1464 are an example of the government forcing political ideology into the doctor/patient relationship.

Planned Parenthood believes strongly that decisions surrounding reproductive health care are best left to women, families and their doctors, and we oppose the existing anti-choice laws set forth in Section 14-02.1-02 and I am here today to oppose the new restrictions being proposed in House Bill 1464.

..

I sincerely appreciate this opportunity to be heard on this very important issue. My testimony will be categorized in the order that our concerns arise in the bill.

1. Lines 1.10-1.11-12

"including the elimination of one or more fetuses or embryos in a multifetal pregnancy,"

Adding this line to the definition of abortion is problematic as it would mean that women choosing to selectively reduce the number of viable embryos in their womb – whether for medical, ethical or health reasons and for the purpose of increasing the chances of fetal survival - would be subjected to the recitation of the state scripted language meant to deter and delay their decision. Often times these are difficult decisions made between a woman and her doctor and the government has no place forcing a woman to listen to biased anti-choice rhetoric, while facing these hard decisions.

2. Lines 2.11-13

"and any other information that a reasonable patient would consider material to the decision of whether to undergo the abortion"

This phrase is extremely vague and would put a distinct chilling effect on the doctor patient relationship, instigate inevitable second guessing by the patient and, perhaps most importantly, leave far too much room for gratuitous litigation against the physician and/or their agent.

3. Lines 2.30 – 3.2

"The physician and the physician's agent may disassociate themselves from"

Similar to the insertion above, eliminating the ability of physicians to disassociate themselves from the state supplied materials not only unwisely imposes governmental mandates that gag physicians and inherently interferes with the doctor-patient relationship but also eliminates the individual care so important in health care provision. Forcing doctor's to give their patient information they disagree with jeopardizes the doctor patient relationship and is another example of the government becoming too involved in the private lives of its citizens.

4. Lines 3.14 – 3.16

"The physician has not received or obtained payment for a service provided to a patient who has inquired about an abortion or has scheduled an abortion before the twenty-four-hour period required by this section."

This insertion is vague and interferes with the physicians' right to collect a fee for their services. What if a physician, who was in complete adherence to all of the requirements found in HB 1464, had a patient who required complicated lab work and a ultrasound prior to their termination but then was delayed in having her abortion scheduled such that she decided to have her case transferred to another physician or changed her mind? Based on the language in this section if the doctor accepted payment for these services he or she would be in violation of this provision. Similarly, it would also mean that the physician could not do the abortion if the patient came back a week later because they had charged her for the services provided the week before? This provision is an attack on doctors and their business practices.

5. Line 5.19.26

"Materials that include information on the support obligations of the father of a child who is born alive, including the father's legal duty to support his child, which may include child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate or statement of paternity or by court action. The printed material must also state that more information concerning paternity establishment and child support services and enforcement may be obtained by calling state or county public assistance agencies."

Insertion of this paragraph once again ignores the complex realities women can face when seeing their physician. This language could force a doctor to inflict additional pain and suffering on their patients; the very people they have sworn to protect and serve. Being forced to spell out to their patient, the possible victim of a crime, that they have the right to be financially tied to the perpetrator for the next 18 years is unnecessarily cruel. What if the woman fears disclosing who the father is? Who pays for or forces paternity testing? This measure is an example of the need for a physician to individualize the informed consent process.

6. Line 5.31 – 6.2

"danger to subsequent pregnancies, increased risk of breast cancer, the possible adverse psychological effects associated with an abortion, and the medical risks associated with carrying a child to term."

The purpose of this insertion into the process of informed consent is a political effort to frighten women from choosing abortion by falsely invoking the specter of a medically inaccurate and unfounded connection between abortion and breast cancer and to expand the foundation for further governmental restrictions on the right to a legal abortion. The National Cancer Institute (NCI), the American Cancer Society (ACS), and The American College of Obstetricians and Gynecologists (ACOG) have all refuted the reliability of such an association (ACOG, 2003; ACS, 2003; NCI, 2003). If this legislature cares about women it seems counterintuitive to scare them with false claims about abortion or breast cancer. Abortion is a legitimate area for public policymaking and for moral debate, but it is wrong to harm the credibility of the State of North Dakota by knowingly advancing an anti-abortion agenda founded on medically inaccurate information.

7. Lines 6.24 – 7.4

"All applications in accordance with this section must be heard by a juvenile judge or referee in the juvenile court of the county of the minor's residence"

While we all would want our children to be able to come to us and discuss their life choices not all young women live in a safe and loving environment, so it is imperative that we give these young women the opportunity for judicial bypass when seeking an abortion. In order for this process to work the judicial bypass must actually function as a safe haven for teens. This insertion goes way beyond what is necessary to ensure that judges, clinics and young women are obeying the requirements of North Dakota's rigid two-parent consent law. The U.S. Supreme Court has firmly established that minors must be given a confidential, fair and expeditious alternative to parental notification for abortion. In North Dakota, that alternative is a judicial bypass.

Forcing a young woman to seek a bypass from a judge in their county of residence would unduly burden young women seeking to avail themselves of their constitutional right to choose. It is obvious that the authors of this language do not care about teens obtaining the help they need, but instead want to make it harder for them to obtain a safe and legal abortion.

8. Line 9.3-9.4

Adding a prohibition on the ability of health insurance plans in North Dakota to pay for any abortion "including the elimination of one or more fetuses or embryos in a multifetal pregnancy,

This restriction on insurance funding once again would mean that women choosing to selectively reduce the number of viable embryos in their womb – whether for medical, ethical or health reasons and for purpose of increasing the chances of fetal survival - would be burdened with high financial costs. Often times these are difficult decisions made between a woman and her doctor and the government has no place denying women this right by limiting their ability to pay for the procedure.

9. Insert (Line 9.22 – 9.31)

"Between normal childbirth and abortion, it is the policy of the state of North Dakota that normal childbirth is to be given preference, encouragement, and support by law and by state action. A person acting in an official capacity as an employee or agent of a school district, between normal childbirth and abortion, shall give preference, encouragement, and support to normal childbirth. No public school in the state may endorse or support any program that, between normal childbirth and abortion, does not give preference, encouragement, and support to normal childbirth. No public school of the state may authorize a presentation to students that, between normal childbirth and abortion, does not give preference, encouragement, and support to normal childbirth."

Women need access to complete, nonbiased information and counseling about all the available options in order to make responsible decisions about their reproductive health. By limiting the provision of abortion information, HB 1464 inappropriately censors health care professionals, impermissibly interferes with the doctor/patient relationship, undermines women's health, and, as previous testifiers have cited, this paragraph puts the State of North Dakota in violation of Title X.

HB 1464 is anti-free speech, overbroad in its scope and strikes the hardest at the women in North Dakota who can least afford the delay and distraction this bill imposes. Additionally, this bill is an ill-advised attempt to insert the government between health care professionals and their patients, and it should be defeated by this committee.

January 22, 2007

Chairman DeKrey and members of the House Judiciary Committee:

My name is Vicky Altringer and I am a member of the League of Women Voters, North Dakota. We speak in opposition to House Bills HB 1464, HB 1466, HB 1489, and HB 1494.

The League of Women Voters Public Policy Position on Reproductive Choice, as announced by our national board in January, 1983 is as follows:

The League of Women Voters of the United States believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices.

A copy of the League's study, review and updates on our position is attached for your examination.

Based on our support of the LWVUS pro-choice public policy position and a twenty-four year history of re-affirmation of this policy by our members at our biennial conventions, we request a committee vote of DNP on HB 1464, HB 1466, HB 1489, and HB 1494.

Thank you for this opportunity to testify against these bills.

PUBLIC POLICY ON REPRODUCTIVE CHOICES **

The League's History

The 1982 convention voted to develop a League position on Public Policy on Reproductive Choices through concurrence. During fall 1982, League members studied the issue and agreed to concur with a statement derived from positions reached by the New Jersey and Massachusetts LWV's. The LWVUS announced the position in January 1983.

In spring 1983, the LWVUS successfully pressed for the defeat of S.J. Res. 3, a proposed constitutional amendment that would have overturned *Roe v. Wade*, the landmark Supreme Court decision that the right of privacy includes the right of a woman, in consultation with her doctor, to decide to terminate a pregnancy. Also in 1983, the League joined as an *amicus* in two successful lawsuits to challenge proposed regulations by the federal Department of Health and Human Services (HHS). Favorable court decisions thwarted attempts by HHS to implement regulations requiring parental notification by federally funded family planning centers that provide prescription contraceptives to teenagers.

The League has joined with other pro-choice organizations in continuous opposition to restrictions on the right of privacy in reproductive choices that have appeared in Congress as legislative riders to funding measures. In 1985, the League joined as an *amicus* in a lawsuit challenging a Pennsylvania law intended to deter women from having abortions. In 1986, the Supreme Court found the law unconstitutional, upholding a woman's right to make reproductive choices.

In 1986, the League opposed congressional provisions to revoke the tax-exempt status of any organization that performs, finances or provides facilities for any abortion not necessary to save the life of a pregnant woman. In 1987, the League unsuccessfully opposed regulations governing Title X of the Public Health Service Act. The League reaffirmed that individuals have the right to make their own reproductive choices, consistent with the constitutional right of privacy, stating that the proposed rule violated this right by prohibiting counseling and referral for abortion services by clinics receiving Title X funds.

In 1988 and 1990, the League urged congressional committees to report an appropriations bill for the District of Columbia without amendments limiting abortion funding. The League also urged support of 1988 legislation that would have restored Medicaid funding for abortions in cases of rape or incest.

The League joined in an *amicus* brief to uphold a woman's right of privacy to make reproductive choices in the case of *Webster v. Reproductive Health Services*. In July 1989, a sharply divided Supreme Court issued a decision that severely eroded a woman's right of privacy to choose abortion. Although *Webster* did not deny the constitutional right to choose abortion, it effectively overruled a significant portion of the 1973 *Roe* decision. The *Webster* decision upheld a Missouri statute that prohibited the use of public facilities, employees

** *Impact on Issues*: A Guide to Public Policy Positions, 2004-06, LWVUS, Washington, DC

r funds for counseling, advising or performing abortions and that required doctors to conduct viability tests on tuses 20 weeks or older before aborting them.

The League supported the "Mobilization for Women's Lives" in fall 1989. Also in fall 1989, the League joined an *amicus* brief in *Turnock v. Ragsdale*, challenging an Illinois statute that would have effectively restricted access to abortions, including those in the first trimester, by providing strict requirements for abortion clinics. In November 1989, a settlement in the case allowed abortion clinics to be defined as "special surgical centers," and to continue to perform abortions through the 18th week of pregnancy without having to meet the rigorous equipment and construction requirements for hospitals.

In 1990 the LWVUS joined the national Pro-Choice Coalition and began work in support of the Freedom of Choice Act, designed to place into federal law the principles of *Roe v. Wade*.

In 1990-91, the League, in *New York v. Sullivan*, joined in opposition to the "gag rule" regulations of the Department of Health and Human Services that prohibit abortion information, services or referrals by family-planning programs receiving Title X public health funds. In June 1991 the Supreme Court upheld the regulations, and Leagues across the country responded in opposition. The LWVUS urged Congress to overturn the gag rule imposed by the decision.

The 1990 League convention voted to work on issues dealing with the right of privacy in reproductive choices, domestic and international family planning and reproductive health care, and initiatives to decrease teen pregnancy and infant mortality (based on the International Relations and Social Policy positions). The LWVUS quickly acted on a series of pro-choice legislative initiatives. The League supported the International Family Planning Act, which would have reversed U.S. policy denying family planning funds to foreign organizations that provide abortion services or information. The LWVUS opposed the Department of Defense Policy prohibiting military personnel from obtaining abortions at military hospitals overseas and supported the right of the District of Columbia to use its own revenues to provide Medicaid abortions for poor women.

Throughout 1991 and 1992, the League continued to fight efforts to erode the constitutional right of reproductive choice by supporting the Freedom of Choice Act and attempts to overturn the gag rule. In coalition with 178 other organizations, the League also filed an *amicus* brief in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, arguing that constitutional rights, once recognized, should not be snatched away. In June 1992, the Court decision in Casey partially upheld the Pennsylvania regulations, seriously undermining the principles of *Roe*. In response, Leagues stepped up lobbying efforts in support of the Freedom of Choice Act. The 1992 LWVUS convention voted to continue work on all domestic and international aspects of reproductive choice.

During 1993, the League continued to support legislative attempts to overturn the gag rule. Late in 1993, President Clinton signed an executive order overturning it and other restrictive anti-choice policies. The LWVUS continued to work for passage of the Freedom of Choice Act and against the Hyde Amendment. The LWVUS supported the Freedom of Access to Clinic Entrances (FACE) Act, a response to escalating violence at abortion clinics. The FACE bill passed and was signed by the President in 1993.

Throughout the health care debate of 1993-94, the League pressed for inclusion of reproductive services, including abortion, in any health care reform package. In 1995, the League joined with other organizations to oppose amendments denying Medicaid funding for abortions for victims of rape and incest.

** *Impact on Issues*: A Guide to Public Policy Positions, 2004-06, LWVUS, Washington, DC

In 1998, the LWVUS also opposed the "Child Custody Protection Act," federal legislation designed to make it illegal for an adult other than a parent to assist a minor in obtaining an out-of-state abortion. The League also worked against proposals that would ban late-term abortions as interfering with a women's right of privacy to make reproductive choices.

In spring 2000, the LWVUS joined an *amicus curiae* brief in *Stenberg v. Carhart*. The brief urged the Supreme Court to affirm a U.S. Court of Appeals ruling that a Nebraska law criminalizing commonly used abortion procedures was unconstitutional. The Court's affirmation of the ruling in June 2000 was pivotal in further defining a woman's right to reproductive freedom.

As Congress continued to threaten reproductive rights with legislative riders to appropriations bills, the League contacted congressional offices in opposition to these back door attempts to limit reproductive choice. Throughout the 107th Congress, the League signed on to group letters opposing these riders and supporting the right to reproductive choices.

In 2002, the LWVUS lobbied extensively against attempts to limit funding for family planning and, in 2003, the League lobbied the House to support funding for the United Nations Population Fund, which lost by just one vote. The League strongly opposed the passage of the so-called Partial-Birth Abortion Act in 2003, but it was passed by Congress and signed into law by President Bush.

In March 2004, the LWVUS lobbied in opposition to the Unborn Victims of Violence Act (UVVA), which conveys legal status under the Federal Criminal code to an embryo and fetus, but Congress passed the bill and the president signed it. The law was challenged and is currently in the courts.

The League was a cosponsor of the March for Women's Lives held in Washington, D.C. on April 25, 2004. The March demonstrated widespread support for the right to make reproductive choices and included many delegations of state and local Leagues.

THE LEAGUE'S POSITION

Statement of Position on Public Policy on Reproductive Choices
Announced by National Board, January 1983

The League of Women Voters of the United States believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices.

** *Impact on Issues*: A Guide to Public Policy Positions, 2004-06, LWVUS, Washington, DC

NASW

NATIONAL ASSOCIATION OF SOCIAL WORKERS
NORTH DAKOTA CHAPTER

January 22, 2007

Testimony on House Bills (HB 1464, HB 1466, HB 1489 and HB 1494)
North Dakota House Judiciary Committee

Chairman DeKrey and members of the House Judiciary Committee:

My name is John E. Aikens, Minot resident and Past President of the ND Chapter of the National Association of Social Workers. We speak in opposition to House Bills HB 1464, HB 1466, HB 1489, and HB 1494.

The National Association of Social Workers Policy Position on Family Planning and Reproductive Choice, as approved by our national Assembly in 1975 and reconfirmed by the Assembly in 1990 is as follows:

The social work profession's position concerning abortion, family planning, and other reproductive health services is based on the principle of self-determination. The profession supports the fundamental right of each individual throughout the world to manage his or her fertility and to have access to a full range of safe and legal family planning services regardless of the individual's income, marital status, race, ethnicity, sexual orientation, age, national origin or residence.

A copy of NASW's background information, issue statement, policy statement and education and research references is attached for your review.

For thirty-two years NASW has supported choice in family planning and reproductive health. Our members continue to voice support for public policy based on self-determination at our triennial NASW Assembly's.

We request a committee vote of DNP on HB 1464, HB 1466, HB 1489, and HB 1494.

Thank you for this opportunity to testify against these bills

Family Planning and Reproductive Choice

BACKGROUND

Women and men have attempted to practice family planning since the beginning of human history. The modern history of family planning in the United States began in 1916 when Margaret Sanger, a public health nurse in New York City, opened the first birth control clinic. She and two of her associates were arrested and sent to jail for violating New York's obscenity laws by discussing contraception and distributing contraceptives. Ms. Sanger argued "that birth control had to be legalized to free women from poverty, dependence and inequality" (Planned Parenthood Federation of America, 1998b, p. 2). Many social workers have participated in the birth control movement in the United States.

Government support of family planning in the United States began in the 1960s when President Kennedy endorsed contraceptive research and the use of modern birth control methods as a way to address the world's population growth. It was under President Johnson and the War on Poverty that family planning services became more widely available. At that time, studies showed that the rate of unwanted childbearing among poor people was twice as high as it was among the more affluent population. This difference was attributed to the lack of available family planning services for poor women. By 1965, with bipartisan support, federal funds were made available to support family planning services for low-income women as a way of alleviating poverty, expanding economic independence, and decreasing dependency on welfare (Planned Parenthood Federation of America, 1998b).

Title X of the Public Health Service Act of 1970 provided the majority of public funding for family planning services until 1985. Because of political factors, such as the right wing and religious assaults on women's reproductive rights, and fiscal pressures, Congress has not formally reauthorized Title X since 1985. Appropriations have continued, but without congressional support funding has been lower (Planned Parenthood Federation of America, 1998b). Government funding has been significantly reduced for family planning services in general in the United States and internationally, resulting in a two-tiered system of reproductive health care.

A vocal and well-organized minority of the population has been able to wield undue influence in the area of reproductive choice. However, public opinion polls continue to show that a large majority of Americans support a woman's decision in seeking contraception, abortion, and other reproductive health services. The public also supports sex education and continued government funding for research and development of birth control methods (Planned Parenthood Federation of America, 1998a).

The World Health Organization (WHO) has four program goals in the area of reproductive health. WHO (1999) holds that people should exercise their fundamental "sexual and reproductive rights" in order to:

> (1) experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfillment

(2) achieve their desired number of children, safely and healthily, when and if they decide to have them

(3) avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed

(4) be free from violence and other harmful practices related to sexuality and reproduction. (p. 1)

These areas of concern make clear how comprehensive services must be in order to achieve sexual and reproductive health for all.

There are numerous economic and social benefits to good public family planning policies. Public funding for family planning prevents 1.2 million pregnancies in the United States each year. Of that number, 509,000 are prevented unintended births and 516,000 are prevented abortions. Each dollar spent on prevention saves more than four dollars in other medical costs and welfare. Women who use family planning services are more likely to use prenatal services and thus have reduced infant mortality, have fewer low-birthweight babies, have reduced mortality, and have decreased health problems for themselves (Alan Guttmacher Institute, 1998a, 1998b). The infant mortality rate is two times higher for a sibling born within two years of another child, a rate that is constant throughout the world (Planned Parenthood Federation of America, 1998c).

Maternal Death

Effective family planning policies prevent maternal mortality and morbidity. Mortality declines significantly with better and safer contraceptives. For example, "maternal mortality fell by one-third in a rural area of Bangladesh following a community project that increased contraceptive use prevalence to 50 percent" (Keller, 1995, p. 4). Worldwide there are approximately 585,000 pregnancy-related deaths each year. Ninety-nine percent of these deaths have occurred in developing countries (Alan Guttmacher Institute, 1998c). According to UNICEF, "no public health problem shows greater disparity between rich and poor countries than maternal mortality" (UNICEF, 1998). Adolescents and older women are at the greatest risk of maternal death. In the United Sates between 1987 and 1990, there were 1,459 deaths that were pregnancy related, representing 9.2 deaths per 100,000 live births. The death rate for African American women was three to four times higher than for white women. The pregnancy-related death rate for women with no prenatal care was 7.7 times higher than for the group who had "adequate" prenatal care (Koonin, MacKay, Berg, Atrash, & Smith, 1998). Overall, the health and well-being of all family members improve when women are able to control the number and spacing of their children.

Abortion Rates and Unintended Pregnancies

Among the 190 million women who conceive each year in the world, there are 20 million abortions. These abortions usually occur under unsafe conditions, increasing the mortality rate and subsequent health problems (UNICEF, 1998). In 1996 there were 1.37 million abortions performed in the United States, according to the Centers for Disease Control and Prevention. This represented a decrease of 4.5 percent over the preceding year ("Morbidity and Mortality Weekly Report," as cited in American Medical Association, 1998). Women who have access to contraceptives are less likely to be faced with unwanted pregnancy and to face the decision to have an abortion or carry to term. What common sense and research show, however, is that the most effective means of reducing abortion is preventing unintended pregnancies in the first place (Alan Guttmacher Institute, 1998b). In fact, the use of contraceptives reduces the incidence of abortions by 85 percent (Alan Guttmacher Institute, 1998b). The average heterosexual woman must practice contraception for approximately 27 years of her life to protect against unwanted pregnancies (Monson, 1998). However, contraception, even under the best circumstances, cannot end the need for abortion entirely. Contraceptive methods will never be perfect, and women and men will never be perfect users of them. For example, about 1 in 10 women in the United States using contraception experiences an accidental preg-

nancy within 12 months of beginning to use a specific contraceptive method (Alan Guttmacher Institute 1998). Thus, the use of contraception reduces but will never eliminate the need for access to emergency contraception and to abortion services. Therefore women must have the right to decide for themselves, with the advice of qualified medical service providers, to determine whether or not to carry a pregnancy to term.

Since 1973 and the landmark *Roe v. Wade* U.S. Supreme Court decision granting women in the United States the right to an abortion, access to safe and legal abortion services has been gradually restricted. Some of this erosion has been in the form of discontinuing government funding for abortions for poor women and of allowing states to bar use of public facilities for abortion. Some of it has taken the form of imposing restrictions and conditions on abortion services—such as requiring counseling, waiting periods, and/or notification and consent procedures, restrictions related to the circumstances of the pregnancy, or restrictions on the specific surgical or medical procedures that can be employed.

Men and Contraception

Prior to the advent of oral contraception for women, men had a greater part in taking responsibility for birth control. The primary methods of birth control at that time were abstinence, withdrawal, and condoms, methods that depended on the cooperation of men. After the pill, men have been largely left out of the area of reproductive choices (Ndong & Finger, 1998). Men are important to reproductive health because they benefit from limits in family size, are intimately involved in child rearing, are concerned with the spread of sexually transmitted diseases (STDs), and are interested in the health and welfare of their partners and children (Population Reports, 1998). The only effective way to prevent STDs is abstinence or condom use, which involves the cooperation of men.

More research on methods of birth control that involve men is being done (Ndong & Finger, 1998). Contraceptive use needs to be seen in the larger context of gender equality and the involvement of men and women in roles and responsibilities that serve both sexes, not sex at the expense of one over another. One gender should not have the ultimate responsibility for contraception, procreation, and childbearing.

Violence and Reproductive Health

The World Health Organization (1996) stated that "the most pervasive form of gender violence is violence against women by their intimate partners or ex-partners, including the physical, mental, and sexual abuse of women and sexual abuse of children and adolescents" (p. 1). In addition, violence has been associated with greater sexual risk taking among adolescents and the development of sexual problems in adulthood. Studies conducted in a range of countries suggest that from 20 percent to 50 percent of women experience being victims of physical abuse by their partners at some time in their lives and that on average from 50 percent to 60 percent of women abused by their partners are raped by them as well. The reproductive health consequences of gender-based violence include unprotected sex, STDs including acquired immune deficiency syndrome and human immunodeficiency virus, unwanted pregnancy, miscarriage, sexual dysfunction, and gynecological problems (WHO, 1998).

In the United States in recent years increasing incidents of violence, intimidation, and harassment of providers and users of legal abortion services have been curtailing the availability of abortion services (National Abortion and Reproductive Rights Action League [NARAL], 1999a). Since 1991, a number of physicians and other clinic staff have been murdered, and there have been over 200 reported acts of violence, including bombings, arsons, and assault, and 28,000 reported acts of disruption directed against abortion providers. The 1994 Freedom of Access to Clinics Entrances was passed but has not eliminated acts of violence of this kind. Unfortunately, "physicians and other clinic workers daily face the possibility of anti-choice terrorism and violence in order to provide women with essential reproductive health services" (NARAL, 1999a,

p. 4). These are health care professionals and their support staff engaged in providing legal medical services to clients who choose to receive them. This situation has contributed to the growing shortage of abortion providers in the United States: in 1999, 86 percent of counties in the United States had no abortion providers. When abortion services are safe and legal, the risk of complication and harm to women from the procedure is much lower than that of childbirth (Allan Guttmacher Institute, 1998c). The statements made by opponents of abortion that abortion leads to later problems with infertility, infant problems at birth, or breast cancer are not supported by any scientific evidence (NARAL, 1997).

ISSUE STATEMENT

The NASW Code of Ethics (NASW, 1999) states that "social workers promote clients' socially responsible self-determination" (p. 5). Self-determination means that without government interference, people can make their own decisions about sexuality and reproduction. It requires working toward safe, legal, and accessible reproductive health care services, including abortion services, for everyone.

As social workers, we believe that potential parents should be free to decide for themselves, without duress and according to their personal beliefs and convictions, whether they want to become parents, how many children they are willing and able to nurture, and the opportune time for them to have children. For the parents, unwanted children may present economic, social, physical, or emotional problems. These decisions are crucial for parents and their children, the community, the nation, and the world. These decisions cannot be made without unimpeded access to high-quality, safe, and effective health care services, including reproductive health services.

Reproductive choice speaks to the larger issue of quality of life for our clients. It "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so" (Hardee & Yount, 1998, p. 4). As social workers, we cannot address reproductive choice without addressing the larger issue of discrimination and the empowerment of women. "How, when and whether to have a child involve different issues for women than for men; yet they do so in ways that vary depending on a woman's class, age, and occupation, as well as the time and culture in which she lives. . . . Unequal access to abortion and birth control perpetuates existing systems of discrimination" (Rudy, 1996, p. 92). The lack of funding for abortion for poor women, decreased availability of family planning services, and our current system of welfare reform with financial disincentives to pregnancy and childbearing with no mention of family planning or abortion services or the responsibilities of men in contraception and child rearing clearly work to the disadvantage of women.

The United Nations' Fourth World Conference on Women adopted a platform statement in 1995 recognizing the importance of women's sexual and reproductive health (along with physical, social, and mental health) (United Nations, 1995). The International Federation of Social Workers (IFSW) has adopted a policy statement on women endorsing the platform statement and identifying women's health issues, including sexual and reproductive health, as an area of critical concern to social work (IFSW, 1999).

Population development, the environment, and social and economic stability are integrally linked. Worldwide, women who defer childbearing have the chance to further their education, develop work skills, acquire broader life experiences, have fewer children, provide better for the children they do have, and improve the well-being of their families. Unimpeded access to family planning and reproductive health services, including abortion services, is a fundamental human right that contributes to the advancement of women worldwide (United Nations Commission for Human Rights, 1979). A total approach to population policy must include not only family planning and reproductive health care services but improvement of socioeconomic conditions, including the provision of income, food, and other essential goods and services that are basic to meeting family needs. Without such planning and development, individual self-determination in reproduction and sexuality

cannot be realized and the full benefits resulting from family planning and reproductive health services cannot be achieved.

A continuing partnership between the private and the public sectors is necessary to assist families to plan for children. Adequate financing is necessary to make family planning programs and professional services available to all, regardless of the ability to pay. Government policies and medical programs, as well as medical programs under private auspices, should ensure that potential parents have full access to the technical knowledge and resources that will enable them to exercise their right of choice about whether and when to have children. As part of the professional team operating these programs, social workers, with their underlying emphasis on and particular methods for enhancing self-determination, have a special responsibility.

Social workers should take professional responsibility to assist clients in obtaining whatever help and information they need for effective family planning and for safeguarding their reproductive health. Because social workers are knowledgeable about family and community resources, they have many opportunities to help clients obtain desired services. Social workers also have a professional obligation to work on local, state, national, and international levels to establish, secure funding for, and safeguard family planning and reproductive health programs, including abortion providers, to ensure that these services remain safe, legal, and available to all who want them.

POLICY STATEMENT

The social work profession's position concerning abortion, family planning, and other reproductive health services is based on the principle of self-determination:

- Every individual (within the context of her or his value system) must be free to participate or not participate in abortion, family planning, and other reproductive health services.

- The use of all reproductive health care services, including abortion and sterilization services, must be voluntary and preserve the individual's right to privacy.

- Women of color, women in institutions, and women from other vulnerable groups should not be used in the testing and development of new reproductive techniques and technologies.

- The nature of the reproductive health care services that a client receives should be a matter of client self-determination in consultation with the qualified health care provider furnishing them.

- Current inequities in access to and funding for reproductive health services, including abortion services, must be eliminated to ensure that such self-determination is a reality for all.

- We believe that client self-determination and access to a full range of safe and legal reproductive health care services without discrimination will contribute to an enhancement of the individual and collective quality of life, strong family relationships, and population stability.

Although men also have an important stake in access to family planning and reproductive health services (Ndong & Finger, 1998; Population Reports, 1998), because women bear and nurse children their right to these services has been recognized internationally. The Convention to Eliminate All Forms of Discrimination Against Women asserts that women internationally have the right to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (United Nations Commission for human Rights, 1979, p. 8).

If an individual social worker chooses not to participate in the provision of abortion or other specific reproductive health services, it is his or her responsibility to provide appropriate referral services to ensure that this option is available to all clients.

Availability of and Access to Services

In addition, the profession supports:

The fundamental right of each individual throughout the world to manage his or her fertility and to have access to a full range of safe

and legal family planning services regardless of the individual's income, marital status, race, ethnicity, sexual orientation, age, national origin, or residence

- Access to the full range of safe and legal reproductive health services for women and men including (and not limited to) contraception, fertility enhancement, treatment of sexually transmitted diseases, and emergency contraception, prenatal, birthing, postpartum, sterilization, and abortion services

- The provision of reproductive health services including abortion services that are legal, safe, and free from duress for both patients and providers

- The provision of reproductive health services, including abortion services, that are confidential, comprehensive, available at reasonable cost, and covered in public and private health insurance plans on a par with other kinds of health services (contraceptive equity)

- Improvement in access to the full range of reproductive health services, including abortion services, for groups currently underserved in the United States, including the poor and those who rely on Medicaid to pay for their health care; adolescents; sex workers; single people; lesbians; people of color and those from nondominant ethnic and cultural groups; those in rural areas; and those in the many counties and municipalities that currently do not have providers of such services as abortion (NARAL, 1999b)

- Empower women through public policies that incorporate women's rights, reproductive health, and reproductive choices; condemn all forms of discrimination; and increase the economic and social supports for women and families who choose to have children

- The provision of reproductive health services to include access, protection, and supportive services to people with special challenges and needs.

Only by eliminating barriers to services based on finances, geography, age, or other personal characteristics will self-determination for all be achieved.

Legislation

Recent years have seen many initiatives at the state and federal level to erode the privacy and reduce the freedom granted by the Supreme Court to women seeking abortion, contraceptive, and other reproductive health services. In particular, national and state legislative bodies have acted to restrict funding, even internationally, to family planning and other health care programs that include abortion among the services they offer. Therefore, NASW:

- supports a woman's right to seek and obtain a medically safe abortion under dignified circumstances

- opposes government restrictions on access to reproductive health services, including abortion services, or on financing for them in health insurance and foreign aid programs

- opposes any special conditions and requirements, such as mandatory counseling or waiting periods, attached to the receipt of any type of reproductive health care

- opposes legislative or funding restrictions on medically approved forms of birth control, including emergency contraception

- opposes limits and restrictions on adolescents' access to confidential reproductive health services, including birth control and abortion services, and the imposition of parental notification and consent procedures on them

- supports legislative measures, including buffer zone bills, to protect clients and providers seeking and delivering reproductive health services, including abortion services, from harassment and violence.

Education and Research

In order for people to exercise their right to freedom in making sexual and reproductive choices for themselves and their families and to choose their own reproductive health care services, NASW supports:

- funding for research into medically safe and effective methods of birth and fertility control for women and men that includes attention to the needs of minority women.

- inclusion of content on the provision of effective, safe, and high-quality family planning and reproductive health services, including abortion services, in the training of physicians and other relevant medical professionals.

- comprehensive, age-appropriate, culturally competent sex education programs that include information about sexuality and reproduction; the role of personal attitudes, beliefs, and values in individual and family decision making on these issues; how gender roles and stereotypes can harm the reproductive health of women and men; the prevention of sexually transmitted diseases; the range of reproductive health services and technologies available; and the development of skills to make healthy personal choices about sexuality, reproduction, and reproductive health care.

- funding for sex education programs without restriction on the content of the information provided.

- development and funding of programs to prevent the spread of sexually transmitted diseases, to prevent unwanted pregnancies, and to reduce all forms of sexual violence and coercion from which many unwanted pregnancies result.

- education of social workers, in degree-granting programs and through continuing education, about human sexuality, emerging reproductive technologies, and effective practice with people making choices about their reproductive behavior and reproductive health care services.

Support, including governmental support, should be available to develop and disseminate improved methods of preventing, postponing, or promoting conception.

REFERENCES

Alan Guttmacher Institute. (1998a). *Facts in brief: Induced abortion.* New York: Author. Available [6/15/99]: http://www.agi-usa.org/pubs/fb_induced_abort.html

Alan Guttmacher Institute. (1998b, September 3). *The role of contraception in reducing abortion.* New York: Author. Available: http://www.agi-usa.org/pubs/ib19.html

Alan Guttmacher Institute. (1998c, September 3). *Support for family planning improves women's lives.* New York: Author. Available: http://www.agi-usa.org/new/ib23.html

Alan Guttmacher Institute. (1998d, September 3). *The U.S. family planning program: faces challenges and change.* New York: Author. Available: http://www.agi-usa.org/pubs/ib3.html

Alan Guttmacher Institute. (1999, April 20). *About one in 10 women using contraceptives experience an accidental pregnancy.* New York: Author. Available: http://www.agi-org./pubs/archives/newrelease3102.html

American Medical Association. (1998, October 12). Morbidity and mortality weekly report: Abortion surveillance—Preliminary analysis. United States, 1995. *Journal of the American Medical Association, Women's health contraception information center.* Available: http://www.ama-assn.org/special/contra/newsline/special/mm4648.html

Hardee, K., & Yount, K. M. (1998, October 21). *From rhetoric to reality: Delivering reproductive health promises through integrated services.* Available: http://reservoir.fhi.org/wsp/wspubs/rhetor.html

International Federation of Social Workers. (1999). *International policy on women.* Oslo, Norway: Author.

Keller, S. (1995, September). Good reproductive health involves many services. *Network, 16* (1), 4. Available [10/7/98]: http://reservoir.fhi.org/fp/fppubs/network/v-16-1/nt1619.html

Koonin, L. M., MacKay, A. P., Berg, C. J., Atrash, H. K., & Smith, J. C. (1998, September 26). Prenancy-related mortality surveillance: United States, 1987–1990. *Journal of the American Medical Association, Women's health contraception center.* Available: http://www.ama-ssn.org/special/conta/treatmnt/guide/mmwr0897/preg/preg.html

Monson, N. (1998, May 6). *Contraception at 20, 30, 40.* Available: http://www.choice.org/2,monson.1.html

National Abortion and Reproductive Rights Action League. (1997). *Abortion, breast cancer, and the misuse of science*. Washington, DC: Author. Available [6/16/99]: http://www.naral.org/publications/facts/breast.html

National Abortion and Reproductive Rights Action League. (1999a, January 8). *Clinic violence, intimidation and terrorism* [Fact-sheet]. Washington, DC: Author. Available [6/16/99]: http://www.naral.org/publications/facts/clinic.html

National Abortion and Reproductive Rights Action League. (1999b). *Who decides? A state-by-state review of abortion and reproductive rights* (8th ed.). Washington, DC: Author.

Ndong, I., & Finger, W. R. (1998, October 7). Introduction: Male responsibility for reproductive health. *Network, 18*. Available: http://reservoir.fhi.fp/fppubs/network/v18-3/nt1831.html

Planned Parenthood Federation of American. (1998a, October 12). *Mission and policy statement*. Available: http://www.plannedparenthood.org/aboutthisispp/Mission.html

Planned Parenthood Federation of America. (1998b, October 12). *Narrative history*. Available: http://www.plannedparenthood.org/about/narrhistory/fpamnar.html

Planned Parenthood Federation of America. (1998c, July 19). *Pro-choice debate handbook*. Available:http://www.plannedparenthood.org/politicalarena/pro-choice_debate_handbook.html

Population Reports. (1998). *Reproductive health: New perspectives on men's participation*. Baltimore: Johns Hopkins School of Public Health, Population Information Program.

Rudy, K. (1996). *Beyond pro-life and pro-choice: Moral diversity in the abortion debate*. Boston: Beacon Press.

United Nations. (1995). *Platform for action summary: Obstacles, strategies, actions*. New York: Author.

United Nations International Children's Education Fund (UNICEF). (1998). *The role of contraception in reducing abortion*. New York: Author.

United Nations Commission for Human Rights. (1979). *Convention on the elimination of all forms of discrimination against women*. New York: Author.

World Health Organization. (1998, November 18). *Gender and health: Technical paper*. Geneva: Author. Available [6/16/99]: http://www.who.int/frh-whd/GandH/Ghreport/gendertech.html

World Health Organization. (1999, July 22). *Department of Reproductive Health and Research: Overall aim and goals*. Available [7/22/99]: http://www.who.int/rht/

Policy statement approved by the NASW Delegate Assembly, August 1999. This policy statement supersedes the policy statement on Family Planning approved by the Assembly in 1967 and reconfirmed in August 1990, and the policy statement on Abortion approved by the Assembly in 1975 and reconfirmed by the Assembly in 1990. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@naswdc.org

NORTH DAKOTA WOMEN'S NETWORK

House Judiciary Committee
HB 1464; HB 1466; HB 1489
January 22, 2007

Chairman DeKrey and members of the committee, my name is Renee Stromme. I am Executive Director of the North Dakota Women's Network. We are a membership organization working to improve the lives of North Dakota women. It is the position of the North Dakota Women's Network that reproductive choices for women must be ensured.

In the interest of time, I will use this testimony to express opposition to three bills that you will be discussing today: House Bills 1464, 1466, and 1489.

- In 2005, the Institute for Women's Policy Research released a report on the status of women in North Dakota – I have provided the clerk with a copy for each of you. It discusses many issues related to women. However, on the issue of reproductive rights, North Dakota received an F in the report because our laws do not provide the level of support which are most beneficial to respecting women's reproductive choices, including coverage for contraceptives and access to reproductive health services. Each of these three bills will be a step backward for the rights of women.
- North Dakota has long been a state that respects choice and independence. As well, we are a state with a long history of respecting women – we were among the first to create policies allowing for property ownership by women and were one of the first states to extend the right to vote to women. We respect the right to choose a profession, choose to work outside the home, or choose to start a business. It is a North Dakota tradition. I urge you to maintain that tradition with a do-not-pass recommendation on all of the aforementioned bills.

Thank you and I stand for any questions.

AMERICAN
ASSOCIATION OF
UNIVERSITY
WOMEN

NORTH DAKOTA

January 22, 2007

Chairman DeKrey and Members of the House Judiciary Committee:

My name is Muriel Peterson, President of the Bismarck-Mandan branch of the American Association of University Women. I am providing this testimony in opposition to HB 1464, HB 1466, HB 1489, and HB 1494.

The American Association of University Women's public policy position on Reproductive Rights, available through our Public Policy and Governmental Relations Department, and dated 12/18/06 reads as follows:

> *The U.S. Supreme Court's ruling in Roe v. Wade legalized abortion for all women and found it to be a constitutionally protected "fundamental right." The Court determined that the right to privacy extends to a woman's right to choose. AAUW stands behind a woman's right to choose as articulated in the Roe decision.*
>
> *AAUW supports the right of every woman to safe, accessible, and comprehensive reproductive health care and believes that decisions concerning reproductive health are personal and should be made without governmental interference. AAUW trusts that every woman has the ability to make her own choices concerning her reproductive life within the dictates of her own moral and religious beliefs. AAUW members have made this position an action priority since 1971.*
>
> *AAUW believes that individuals should be given complete and accurate information about their reproductive health and family planning options, including but not limited to, the option of abstinence, pregnancy prevention, and sexually transmitted disease prevention. Only with reliable and complete information about their reproductive health can people make informed and appropriate decisions.*

Based on our support of AAUW's pro-choice public policy position and a thirty-six year history of re-affirmation of this policy by our members at our biennial conventions, we request a committee vote of DNP on HB 1464, HB 1466, HB 1489, and HB 1494.

Thank you for the opportunity to provide testimony in opposition to these bills on behalf of North Dakota's 300 members and the 100,000 national members of the American Association of University Women.

Testimony by Elizabeth M.K.A. Sund
In Opposition to HB 1466

Chairman DeKrey and members of the House Committee, for the record my name is Elizabeth M.K.A. Sund. I am from Dickinson and am currently a student at the University of North Dakota. I am testifying in opposition to HB 1466, as well as HB 1489, HB 1494, and HB 1464.

These bills contain philosophical issues which are much deeper than the common debate over abortion. Outlawing abortion and restricting forms of birth control affect not only a woman's ability to make choices in her life, but also affects her humanity in general. Without the capability to control our own fertility, women will never have the opportunity to be the equals of men economically or socially.

It is unacceptable to pass legislation which diminishes one sector of society's life choices simply because of their sex. Laws of this nature could never affect the lives of men in the way they would forever change the lives of unwilling women. To force a woman to carry a child against her will is to force her to give up the life she chooses willingly. A woman is physically connected to a growing fetus while an unwilling man may choose to come and go as he pleases. Although this biologically will never change, outlawing abortion will deny women the equal opportunity to live the lives they choose everyday.

Women must fight hard enough as it is to be taken seriously the workplace, classroom, and at home. Approving these resolutions would only show that the State of North Dakota views women as second class citizens. I ask that the women of North Dakota be allowed to continue living fully human lives, which means taking part in society as the equals of men.

I encourage the committee to reject HB 1466 and all other related bills and approve a "do not pass" recommendation.

Testimony

House Bill 1464

House Judiciary Committee

Monday, January 22, 2007; 8 a.m.

North Dakota Department of Health

Good morning, Chairman DeKrey and members of the House Judiciary Committee. My name is Kim Senn, and I am director of the Division of Family Health for the North Dakota Department of Health. I am here today to provide information on House Bill 1464 and to offer amendments.

The Department of Health receives a federal grant for the North Dakota Family Planning Program. The mission of the Family Planning Program is to assist women and men to understand and take responsibility for their reproductive health through education, counseling and medical services. The program does not provide abortions as a method of family planning, nor does it engage in activities that promote or encourage the use of abortion as a method of family planning. Family Planning services are designed to be a significant contributor to the following health goals:

- Assist women and men in having the number of children they desire so that every child is intended.
- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Improve pregnancy outcome by identifying and addressing health problems before or between pregnancies and encouraging proper spacing and timing of pregnancy.
- Assure that more children are "wellborn" by decreasing the incidence of pre-maturity and birth defects.
- Improve and maintain the emotional and physical health of women and men particularly through the detection and prevention of cancer and sexually transmitted diseases.

In short, family planning clinics prevent and reduce the number of sexually transmitted infections, unintended pregnancies and abortions by providing birth control information, counseling, medical examinations and supplies.

House Bill 1464 restricts "federal funds passing through the state to be used for the *referral for* an abortion unless the abortion is necessary to prevent the death of the woman." However, federal guidelines for the Family Planning Program require the following:

> Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If requested to provide such information and counseling, the project must provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

In order to ensure that North Dakota continues to comply with and receive federal funding to provide services through the Family Planning Program, we request the following: In Section 6., #3, lines 27-28, either remove "or referral for" or change it to "or referral for except upon request." pg 8

The department also requests an amendment to Section 2., #1.c., line 22 to read "that paternity may be established by the father's signature on *an acknowledgement* of paternity or by court action." This is needed to provide language consistent with other laws regarding establishment of paternity. pg 5

Based on printing and video projects similar to those required in House Bill 1464, we estimate the fiscal impact to the department to be about $15,000.

This concludes my testimony. I am happy to answer any questions you may have.