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ROLL NUMBER

DESCRIPTION

1494

2007 HOUSE JUDICIARY

HB 1494

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1494

House Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 1/22/07

Recorder Job Number: 1527

Committee Clerk Signature D Delmore

Minutes:

Chairman DeKrey: We will open the hearing on HB 1494.

Rep. Dan Ruby: Sponsor of the bill. This bill does two things. First of all, it requires no public funding to go for prenatal genetic testing, unless the testing is a precursor to treatment for the woman or unborn child. The other thing is it restricts an insurance company, it says no insurance company, non-profit health services corp., or health services organization may require, as a condition of coverage, prenatal genetic testing without the pregnant woman's consent or use genetic information to coerce or compel a pregnant woman to have an abortion. I think that she should be able to make a decision to keep her child, without the penalty of losing her insurance coverage. I know there is a lot of testing being done on women who are pregnant. I am opposed to just testing for medical conditions that have no cure. There are false positives and false negatives all the time. I am not an expert in this field.

Rep. Delmore: Are you aware of any insurance company or health organization that has ever coerced or compelled a pregnancy woman to have an abortion in this state.

Rep. Dan Ruby: I have not, at this time. I don't know of any problem right now that this may be addressing. I was asked to introduce this and so it's not my language. I believe it is a good thing to have in our law, in the case that it would happen.

Chairman DeKrey: Thank you. Further testimony in support.

Christopher Dodson, Exec. Dir., ND Catholic Conference: (see attached testimony). Perhaps the language isn't the best, but I think it is workable. We can also look at the state of TN, which funds prenatal genetic testing for its citizens, but expressly excludes prenatal testing for diseases for which there is no treatment in utero. They have language on the statute that has been working for years. There are ways to determine what you are testing for and whether or not the state should be covering it. You will hear about protocols and standards that this type of testing should be done. Behind all those protocols, is one basic fact that they serve no other legitimate purpose, other than to give information in regards to whether or not to abort. Those are the only tests that this bill covers. This is no different than restricting funding for sex determination. It serves no legitimate medical purpose, it can only be used to determine whether to perform an abortion or not. The state doesn't fund, nor does insurance companies, to perform tests to determine the sex of the child. Nor do they scientifically do ultrasounds that serve no medical purpose.

Rep. Delmore: How often are you aware of these tests being performed, and do you have specific tests that would be denied where the problem could be fixed and become a viable pregnancy. Are you ruling some of that out by saying none of these allowed.

Christopher Dodson: It is not our intention to rule those out. One, it doesn't prohibit the testing. Second, the determination of payment would follow, and they could look at the test under reasons given for a test, to determine if it should be paid.

Rep. Delmore: So if a test were given to see whether there were genetic problems that would affect the viability, you're saying that those tests couldn't be given even though perhaps that woman could find out that there is something that could be done, we've come a long way with medical research.

Christopher Dodson: First of all, the tests could be given. We're only dealing with the funding issue here and second, in a situation like you've described, I think it would be funded, because the purpose for the test being given would be determined if there is a condition there which we can treat.

Rep. Koppelman: Are state funds currently used to perform prenatal genetic testing.

Christopher Dodson: I haven't been able to ascertain that. It has become a more standard protocol, especially with a pregnancy woman over 35, to do these tests. We know that the number of children with Down's Syndrome that are born, has dramatically been reduced. That means that they have been aborted because there is no cure for that condition.

Rep. Klemin: Could you define prenatal genetic testing, tell me what's included within the scope of that term.

Christopher Dodson: I looked to see if there was any reason for a definition of prenatal genetic testing. I assume there wasn't, because I never found one. I assumed that in usage, regarding payments, they know what that means. It could be described also as those tests to determine the existence of conditions for which there is no treatment. That is all that is going to be excluded from funding.

Rep. Klemin: You mentioned ultrasound. Is that included within the scope of prenatal genetic testing.

Christopher Dodson: I do not think it is, because it doesn't identify a genetic condition.

Rep. Delmore: Are the tests labeled to see if I want an abortion or not. Secondly, what if I want to know, say I'm 43 years old, it's my first pregnancy, and I really want to have children. Don't I have a right to know that there might be something wrong, to give me time to adjust to the fact that I may have a child with special needs.

Christopher Dodson: You have the right to know, but you may not have the right to state funding or to have insurance premium dollars paying for it, because it doesn't serve a medical purpose. It's no different than if somebody wants to know whether it is a boy or a girl.

Rep. Delmore: It might be for my mental or emotional health. Are the tests labeled.

Christopher Dodson: They do have testing for certain purposes, to identify whether or not a certain condition or genetic condition exists. Of course, what could be treated, can change. If it becomes a treatment that you can provide, there would be a legitimate reason for this genetic test.

Rep. Delmore: Under provisions of this law; however, if I wanted to know for legitimate reasons, but not for an abortion, I would not be able to do it.

Christopher Dodson: You'd be able to find that out, but if you were on medical assistance paid for by the State, it would not be covered by the State. If you were under a group health insurance plan, you would have to pay for it yourself or minor.

Rep. Wolf: Who would make the determination whether this service is going to be covered or not.

Christopher Dodson: Medical assistance, such as Medicaid and health insurers do that all the time, as to whether or not a particular procedure or test is for a legitimate medical purpose and they would make that determination based on the data they have at that time.

Rep. Wolf: How do they know if it is legitimate or not. They won't know what's in my head.

Christopher Dodson: What is at issue isn't your intent, the issue is whether or not that particular test will be covered by insurance or state medical assistance. That's an objective standard. That doesn't depend on what the intent is for giving the test.

Chairman DeKrey: You stated that the number of births for Down Syndrome children is down and the use of abortions, is that a scientific fact or that just conjecture because the number is down.

Christopher Dodson: It is due to abortion. In fact, there was a recent Washington Post column about this matter last week or the week before. Because there is nothing to prevent the conception of a child with Down's Syndrome, the only explanation for the decrease would be a change in age patterns with regard to conception or abortion.

Rep. Dahl: Would genetic tests be included with paternity tests.

Christopher Dodson: Paternity tests aren't. That is a separate part of the code.

Rep. Klemin: In your written testimony, this only restricts funding for prenatal testing for conditions for which there is no treatment. I don't see that it actually says that in this bill, but assuming that it could be read into that, where do we get lists of diseases for which there is no treatment that you can test for.

Christopher Dodson: I assume that there could be a list and it changes because health insurers and Medicaid do have a system of determining what is the purpose of the test and whether it is a legitimate medical procedure that should be reimbursed. This would fall into that same category.

Rep. Klemin: Since there is nothing here that says that, how is somebody who is going to do this test, going to know what to test for and can't test for.

Christopher Dodson: I think that is something that can be worked out; TN has done it for at least a decade. We can make some calls and find out.

Chairman DeKrey: Thank you.

Rep. James Kerzman: I am a sponsor of this bill, and support this.

Chairman DeKrey: Thank you. Further testimony in support of HB 1494.

Stacey Pfliiger, ND Right to Life: (see attached testimony).

Chairman DeKrey: Thank you. Further testimony in support. Testimony in opposition. All testimony previously given in HB 1464, 1466 and 1489 will be included with the record of this bill.

Dan Ulmer, Blue Cross/Blue Shield: We are not really opposed to this matter, you need to understand that you are entering into a field that you may not want to go. You have a lot of grayness here. We don't make a requirement for genetic testing. When you get to the point that you use the genetic information to coerce or compel a pregnancy woman to have an abortion, the question is what is coerce or compel mean. If you take a test and you have a child who has a problem, you may have a woman wondering what to do with this particular child. So do we just stop giving these tests to parents who may have a Down Syndrome child, age 35 which is standard protocol at this juncture. Mom gets tested if she is over 35. Under this, we wouldn't be able to give this test. Basically this morning, BC/BS tried to stay out of this particular issue, it is a perennial issue that has gone on for a long time. We don't set policy statements, but we do need to tell you that there are issues that you need to look closely at in terms of the advancement in prenatal care as well as delivery. There are decisions that are very difficult for parents to make. Our medical staff called me this morning to tell me to come up here to oppose this particular bill. There is a list of prenatal diseases that can be treated or not, but the list has gotten longer with what diseases can be treated as a result of genetic testing and the future is bright in this regard to making it better for moms and kids.

Rep. Koppelman: I'm not familiar with the specifics on how insurance coverage works in these areas. Does a company like BC/BS, or health insurer currently require tests as a condition of coverage that would be for the specific purpose, without the pregnant woman's

consent as the bill says, or that it would be used to coerce or compel someone to have an abortion.

Dan Ulmer: No, we would not compel to do that, any of those particular tests. Now, we hope that no coercion would happen in that regard. However, we do determine what tests are available to people is done on what's called medical efficacy; whether or not there is an effect, whether or not there's some treatment that can take place. I think it's important to understand that as well, as we look forward to particular advancements in genetic testing in our lifetime and in these children's lifetime, they will be phenomenal in terms of what we would be able to do in the field of genetics.

Rep. Koppelman: Would the insurance company require that kind of test under current practices.

Dan Ulmer: Protocol probably would. Women who are over the age of 35 and are pregnant, the medical protocol is that they should have this particular tests so they are aware of potential for Down's Syndrome.

Rep. Koppelman: The insurance company pays for that.

Dan Ulmer: Yes.

Rep. Koppelman: The purpose for that test would be information, but not treatment of this condition.

Dan Ulmer: Yes, the treatment would then be up to the physician and patient.

Rep. Koppelman: The test would be a cost to the insurance company, if the child were born and you had a condition like that, it would be more expensive to the insurance company.

Dan Ulmer: Yes, complications are massive and we cover those.

Chairman DeKrey: Thank you. Further testimony in opposition to HB 1494. We will close the hearing.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1494

House Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 1/24/07

Recorder Job Number: 1848

Committee Clerk Signature Shawn Penrose

Minutes:

Chairman DeKrey: We will take a look at HB 1494.

Rep. Klemin: I move a Do Not Pass.

Rep. Wolf: Seconded.

Rep. Delmore: I think this bill is restricting testing for perhaps unborn children that could be fixed. Why would we want to pass that kind of legislation, I have no idea. There is no laundry list here, no list attached, we are not in a position, that is determination that needs to be made by the woman and doctor.

Rep. Klemin: There is no description of the scope of what is included, and the sponsor couldn't tell us what would be. Also, it talks about the insurance on the second part, what does it mean? I think that the list of what diseases can be treated is getting longer, so this talks about diseases that can't be treated. I don't know what that means either. I think there is a lot of vagueness in here, there are a lot of things that aren't defined. I don't think it would stand up in court either.

Chairman DeKrey: We have a motion before us. Further debate? Clerk will call the roll.

11YES 2 NO 1 ABSENT DO NOT PASS CARRIER: Rep. Klemin

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

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1494

House JUDICIARY Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Rep. Klemin Seconded By Rep. Wolf

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) 11 No 2

Absent 1

Floor Assignment Rep. Klemin

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

REPORT OF STANDING COMMITTEE

HB 1494: Judiciary Committee (Rep. DeKrey, Chairman) recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). HB 1494 was placed on the Eleventh order on the calendar.

2007 TESTIMONY

HB 1494

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 1494 (Funding for Prenatal Genetic Testing)
Date: January 22, 2007

The North Dakota Catholic Conference supports House Bill 1494.

It is the long-standing policy of North Dakota not to compel its citizens to fund abortion through taxpayer or insurance premium dollars. House Bill 1494 would extend that policy to prenatal genetic tests which serve no purpose other than provide information to be used for deciding whether or not to abort an unborn child.

The bill does not prohibit prenatal genetic testing. Nor does it prohibit state or insurance coverage for prenatal genetic tests that are used as a precursor to treating the woman or the unborn child. It only restricts funding for prenatal testing for diseases for which there is no treatment.

Like abortion itself, prenatal genetic testing for conditions that cannot be treated is highly controversial. In addition to implicitly encouraging abortion, the practice raises serious moral and social issues concerning eugenics, discrimination against the disabled, cultural attitudes towards parents who chose not to abort, and society's commitment to those who are different.

As it has with abortion, the state should ensure that people are not forced to financially support this practice with tax or insurance premium dollars.

We ask for a **Do Pass** recommendation on House Bill 1494.

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North Dakota Right to Life Association

Testimony before the HOUSE JUDICIARY COMMITTEE
House Bill 1494
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 1494 relating to limitations on abortion.

HB 1494 reaffirms the tradition of the state of North Dakota prohibiting state funding for abortion and abortion counseling. In addition, no health insurance contracts, plans or policies delivered in North Dakota may provide coverage for abortions except by an optional rider for which an additional premium is paid. [The only exception to these limitations is if an abortion is necessary to prevent the death of the woman.]

The North Dakota Right to Life Association believes that a human being once conceived has the innate right to life regardless of disabilities. HB 1494 limits the funding that may be used to pay for prenatal genetic testing UNLESS the testing is a precursor to treatment for the woman or unborn child. In addition, HB 1494 requires that the testing cannot be done without the woman's consent nor can the test results be used to coerce a woman into having an abortion.

The North Dakota Right to Life Association urges a **DO PASS** recommendation on HB 1494.

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TESTIMONY IN OPPOSITION TO H.B. 1494

Chairman DeKrey, members of the Judiciary committee, my name is Tim Stanley and I am the Senior Director of Government and Public Affairs for Planned Parenthood Minnesota, North Dakota and South Dakota. Thank you for this opportunity to present testimony regarding H.B. 1494, a bill which would prohibit any public funds from being used to pay for genetic testing unless that testing is a precursor to treatment for the woman or the fetus.

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 believes strongly that decisions surrounding reproductive health care are best left to women, families and their doctors, and that is why we oppose H.B. 1494. H.B. 1494 is an unconstitutional measure that would curtail women from exercising their reproductive health options. As an advocate for women's health and on behalf of the women and men we serve, I am here today to implore the committee to recommend this bill does not pass.

H.B. 1494 would deny some pregnant women and their families the ability to choose how to proceed with a pregnancy. In order to be eligible for publicly-funded genetic testing, a woman might have to agree beforehand that she would seek "treatment" for herself or her fetus. The word "treatment" goes undefined in H.B. 1494 and can be interpreted in numerous ways leaving the language of this bill vague and open for interpretation. For example, this legislation could require a woman to seek "treatment" prior to getting genetic testing despite what the results of the test show. Therefore, if a woman receives testing and the results show no fetal anomaly she would still be required to seek treatment. On a similar note, if it was determined through genetic testing that there was a fetal anomaly, but a woman decided to carry her pregnancy and not seek "treatment", for personal reasons, this too would be in violation of the law. In other words, for a woman to receive genetic testing she would be forced to agree to seek "treatment," despite the results of the testing or her own moral beliefs.

This legislation is not only an affront to women and families – especially those who hear difficult news as a result of genetic testing, it is also likely unconstitutional. While the State can determine how its funds are spent, it cannot tell a recipient of those funds that she cannot engage in constitutionally protected conduct with separate funds. H.B. 1494 seems to prohibit just that – a woman who received publicly-funded genetic testing would be prohibited from later, with her own funds, exercising her constitutional right to choose to have an abortion. This, the State cannot do. *See Rust v. Sullivan*, 500 U.S. 173, 196 (1991) (explaining that the Supreme Court has held laws unconstitutional when "the Government has placed a condition on the recipient of the subsidy rather than on a particular program or service, thus effectively prohibiting the recipient from engaging in the protected conduct outside the scope of the federally funded

program"); *Perry v. Sinderman*, 408 U.S. 593, 597 (1972) ("[I]f the government could deny a benefit to a person because of his constitutionally protected [conduct], his exercise of those freedoms would in effect be penalized and inhibited. . . . allow[ing] the government to 'produce a result which [it] could not command directly.'") (quoting *Speiser v. Randall*, 357 U.S. 513, 526 (1958)); *see also Regan v. Taxation With Representation*, 461 U.S. 540, 545 (1983); *Harris v. McRae*, 448 U.S. 297, 317 n.19 (1980); *Planned Parenthood of Mid-Missouri v. Dempsey*, 167 F.3d 458, 461 (8th Cir. 1999).

In addition, H.B. 1494 is hopelessly vague. What is "treatment"? If genetic testing revealed no problems and a woman chose to continue the pregnancy to term (and therefore, do nothing), was the testing a "precursor to treatment"? And how could a provider of genetic testing be assured in advance that the woman will seek "treatment"? If the provider was not sure, she could not go forward with the testing because she could find herself criminally liable and subject to jail time. *See* N.D. Cent. Code §§ 12.1-32-01; 14-02.3-05 (violation is a class B misdemeanor).

In order to pass constitutional muster, a law must provide those affected with "a reasonable opportunity to know what [conduct] is prohibited, so that [they] may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). H.B. 1494 does not do that. A vague law is especially problematic where, as here, "the uncertainty induced by the statute threatens to inhibit the exercise of constitutionally protected rights." *Colautti v. Franklin*, 439 U.S. 379, 391 (1979). In addition, where, as here, "a statute imposes criminal penalties, the standard of certainty is higher." *Kolender v. Lawson*, 461 U.S. 352, 358 n.8 (1983).

H.B. 1494 fails this test and would deny women and their families the ability to make fully informed decisions about their pregnancies. Therefore, on behalf of the nearly 5 million men, women and teens that Planned Parenthood serves across the country each year, I urge you to recommend that H.B. 1494 does not pass.

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.

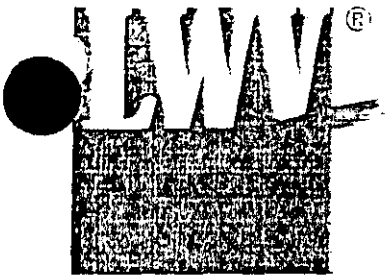
The League of Women Voters Public Policy Position on Reproductive Choice, as announced by our national board in January, 1983 is as follows:

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

or funds for counseling, advising or performing abortions and that required doctors to conduct viability tests on uses 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 uickly acted on a series of pro-choice legislative initiatives. The League supported the International Family lanning 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 ppose 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

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 [AGI], 1996). 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.

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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

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.

AMERICAN
ASSOCIATION OF
UNIVERSITY
WOMEN

TESTIMONY ON HB1494
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 testimony in opposition to HB 1494.

AAUW believes that individuals should be given complete and accurate information about their reproductive health and family planning options. Women need reliable and complete information about their reproductive health, including genetic information.

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 opposes any effort by the North Dakota legislature to intrude in the delivery of reproductive health care. North Dakota cannot predetermine the "best interest" of a patient. AAUW is not interested in "coercing or compelling" any woman in her reproductive health decisions. We only wish to preserve her right to choose for herself, with full and complete information. Only then can anyone make informed and appropriate decisions

Thanks, for the opportunity to provide testimony in opposition to HB 1494 on behalf of North Dakota's 300 members and 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.