



April 13, 2016

## Oppose the Prenatal Nondiscrimination Act of 2016

Dear Members of the House Judiciary Committee Subcommittee on the Constitution and Civil Justice:

On behalf of The Leadership Conference on Civil and Human Rights, a coalition charged by its diverse membership of more than 200 national organizations to promote and protect the civil and human rights of all persons in the United States, we urge you to oppose the “Prenatal Nondiscrimination Act of 2016” (PRENDA). We oppose this bill because it does not in any way address discrimination on the basis of sex. Rather, it is a veiled attempt to restrict health care for women of color under the guise of civil rights.

The problem of racial and sex disparities in health care is real. According to a report by the Kaiser Family Foundation, 16 percent of African-American women and 28 percent of Latina women are in fair or poor health.<sup>1</sup> Additionally, African-American women<sup>2</sup> and Latina women<sup>3</sup> have less access to contraception, prenatal care and other critical reproductive health services, resulting in stark disparities across a number of sexual and reproductive health indicators. Instead of addressing these critical issues, this bill exacerbates the disparities by further restricting certain women’s access to comprehensive reproductive health care services, scrutinizing the health care decisions of women of color, and penalizing health care providers who serve communities of color.

At a time when large numbers of women, particularly women of color, are concentrated in low wage jobs without access to most benefits and are struggling to support their families,

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<sup>1</sup> Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kurani, “Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women’s Health Survey,” Kaiser Family Foundation (May 2014), available at <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>.

<sup>2</sup> “Addressing Sexual and Reproductive Health Disparities among African Americans,” Planned Parenthood Federation of America (March 2015), available at [https://www.plannedparenthood.org/files/3614/2773/6927/AA\\_Disparities.pdf](https://www.plannedparenthood.org/files/3614/2773/6927/AA_Disparities.pdf) (stating that: African American women are 40% more likely to die of breast cancer than white women; African American women have more than double the unintended pregnancy rate of white women; and, African American men and women account for 44 percent of new HIV/AIDS cases).

<sup>3</sup> “Addressing Sexual and Reproductive Health Disparities among Latinos,” Planned Parenthood Federation of America (March 2015), available at [https://www.plannedparenthood.org/files/2814/2773/6927/Latino\\_Disparities.pdf](https://www.plannedparenthood.org/files/2814/2773/6927/Latino_Disparities.pdf) (stating that: Latina women are more likely to be diagnosed with cervical cancer than women of any other racial group, and have the third highest death rates from cervical cancer; 56 percent of pregnancies among Latina women are unintended; and that Latinos and Latinas contract HIV at more than three times the rate of non-Latino whites).

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Congress should take up legislation that would actually alleviate discrimination on the basis of gender and race. Unlike this bill, legislation such as the Paycheck Fairness Act, the Pregnant Workers Fairness Act, the Healthy Families Act, and the Family and Medical Insurance Leave (FAMILY) Act protect women from discrimination and empower women of color to make informed, personal health care decisions.

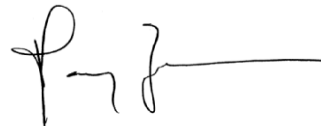
Women and their families continue to bear the negative consequences of persistent sex discrimination. Yet, despite its lofty title, PRENDA does nothing to address the causes or pernicious effects of such discrimination. As the nation's largest civil and human rights coalition, we have worked for decades to address the longstanding problems of sex discrimination in the United States. While we would welcome the opportunity to work with members of the Committee to advance meaningful civil rights legislation, we must oppose PRENDA, which does nothing to address ongoing discrimination.

Thank you for your consideration. If you have any questions, please contact June Zeitlin, Director of Human Rights Policy at [zeitlin@civilrights.org](mailto:zeitlin@civilrights.org) or (202) 263-2852.

Sincerely,



Wade Henderson  
President & CEO



Nancy Zirkin  
Executive Vice President



Prenatal Non-Discrimination Act of 2016

An Attack on the Reproductive Rights of Women of Color

Testimony Presented by

Ilyse Hogue  
President

U.S. House of Representatives  
Committee on the Judiciary  
Subcommittee on the Constitution and Civil Justice

April 14, 2016

Members of the House Judiciary Subcommittee on the Constitution: I am honored to submit this testimony.

Today you are considering the Prenatal Non-Discrimination Act (H.R.xxxx), introduced by Rep. Trent Franks (R-AZ). Despite sponsors' claims to the contrary, this bill does nothing to address our country's real problems of racism and sexism, but instead could subject a doctor to up to five years in prison for failing to determine if race or sex is a factor in a woman's decision to terminate a pregnancy. Ultimately, the legislation could erect new barriers to reproductive-health care for women and perpetuates stereotypes about immigrant communities and communities of color.

As a reproductive-rights organization committed to diversity, NARAL Pro-Choice America believes that all individuals—no matter their racial or ethnic background—have the right to make personal decisions regarding their reproductive lives. All women—including women of color—are the best decision-makers regarding their reproductive choices, and we support policies that address reproductive-health disparities. We condemn gender bias that contributes to pressures to have a child of a particular sex, but believe there are ways to combat gender inequity without threatening a woman's right to make the best decision for herself and her family.

For these reasons, we oppose the Franks legislation. It is an insincere attempt to help the communities with which it claims to be concerned, and is nothing more than a disingenuous attempt to make abortion out of reach.

### **The Franks Bill Could Block Women's Reproductive-Health Care and Harm the Very Communities It Purports to Protect**

The Franks bill imposes unprecedented restrictions on the constitutionally protected right to choose for targeted groups of women. No patient should ever be subjected to more scrutiny or control based on her racial or ethnic background, yet that is exactly what could happen if this bill becomes law. Thus rather than eliminate discrimination, this bill entrenches it even more deeply. The bill likely would restrict the ability of women of color to obtain abortion care, and ultimately could jeopardize the availability of abortion services for all women.

Given that the Franks bill subjects providers to fines and prison time for failing to detect that a woman is seeking abortion services for reasons of race or sex selection, the legislation essentially would encourage racial profiling in the doctor's office. The legislation's de facto requirement that abortion providers screen for race or sex selection means that a doctor would have to interrogate a woman about her racial and ethnic heritage and about the race and background of her partner in order to detect motivations related to the expected race or sex of the pregnancy. This demonstrates a clear intrusion into patient privacy and violates the all-important bond of trust between doctor and patient.

Moreover, this bill gives the federal government unprecedented authority to interfere with a woman's right to choose. Disturbingly, the legislation mandates that health-care providers report known or even suspected violations of the legislation to law-enforcement authorities and allows specific parties, including the attorney general, to sue to block a woman's access to abortion services based on the reason she is seeking such care. Every woman has unique considerations and circumstances that inform her decision-making process, and she is in the best position to make the right decision for herself and her family. For instance, the bill does not even include exceptions to protect a woman's life or health, not does it permit abortion care sought in cases where debilitating or even fatal sex-linked diseases are detected through genetic testing. By requiring that health-care providers report the details of a woman's private medical care to the government and by holding providers financially and criminally liable for the reasons a woman makes personal health decisions, the bill pits doctors against their patients.

Further, in order to protect themselves against the law's harsh penalties, some providers and reproductive-health centers may even cease providing abortion care to entire groups they perceive to be most "at risk" for such practices, thereby diminishing access to medical care for women of color and immigrant women. Despite a purported interest in assisting marginalized groups, the bill would serve only to isolate and stigmatize these women.

### **A Ban on Race-Selective Abortion**

It is clear that this bill is a thinly veiled attempt to block access to abortion for communities of color under the guise of anti-discrimination policy. The bill's sponsor has claimed that abortion has resulted in a form of genocide in the African-American community.<sup>i</sup> Further, the findings section of the bill opines that abortion rights have negatively affected communities of color. However, women of color themselves actually oppose this legislation.

Trust Black Women (TBW), a coalition of African-American women and women-of-color-led organizations, has strongly rejected the notion of "race-selective" abortion as nothing more than an attempt to undermine black women's autonomy and self-determination.<sup>ii</sup> Loretta Ross, a founding member of TBW and national coordinator of the SisterSong Women of Color Reproductive Justice Collective stated:

The Black anti-abortion movement doesn't represent our views and we are not fooled into thinking that they care about gender justice for women... They tell African American women that we are now responsible for the genocide of our own people. Talk about a "blame the victim" strategy! We are now accused of "lynching" our children in our wombs and practicing white supremacy on ourselves.<sup>iii</sup>

During a forum in which Black Lives Matter partnered with TBW, and New Voice for Reproductive Justice, to address the critical issues of intersectionality of race and reproductive justice, La'Tasha Mayes, founder of New Voices for Reproductive Justice, stated:

We look at Cleveland where we see the deaths of Tamir Rice and Tanisha Anderson, and then to co-opt our language in talking about access to abortion is absolutely insulting. And so when billboards [employing negative messaging about abortion] come up in our communities, in the past what we've been able to do is get those billboards taken down. But we believe it's necessary to take a proactive approach in changing the culture and stigma around Black woman and abortion...<sup>iv</sup>

In point of fact, proposals that claim to protect women of color by outlawing abortion based on race are insincere attempts to help this community. Instead, they deny women of color their reproductive freedom by imposing additional restrictions on abortion access, including subjecting them to invasive questioning about their intentions in seeking abortion care and threatening harsh penalties that may deter abortion providers from accepting women of color as patients. Moreover, proponents of this bill are members of the very same anti-choice majority which is attempting to dismantle the health-reform law, eliminate publicly funded family-planning services, and slash funding for social-welfare programs that have a disproportionate impact on communities of color.

NARAL Pro-Choice America has stood in solidarity with women-of-color-led groups in opposition to the legislation from the time it was first introduced. This bill could create a two-tiered system of access based on race and ethnicity and, therefore, is antithetical to our values.

### **A Ban on Sex-Selective Abortion**

Not only does the bill co-opt civil-rights rhetoric, it exploits the very real issue of sex discrimination to advance an anti-choice agenda. Sadly, there are women around the world and here at home who face pressure from family members or their community to have a child of a particular sex. However, the root causes of sexism and gender bias that drive son preference will not be addressed by limiting a woman's access to reproductive-health care. To the contrary, abortion bans, mandatory reporting requirements, and harsh penalties on providers only further marginalize women who are already disempowered. In fact, a 2011 report from the World Health Organization and other international-health groups on efforts to combat gender-biased sex selection indicates that restricting access to abortion services without addressing social norms and cultural factors is likely to result in a greater demand for unsafe, clandestine procedures that place women's health and lives at risk.<sup>v</sup>

Furthermore, community leaders like the National Asian Pacific American Women's Forum and Raksha, a South-Asian anti-domestic violence group, have rejected previous iterations of this legislation because banning sex-selective abortion does not address underlying cultural factors that contribute to son preference. Moreover, it does nothing to empower women to take control over their reproductive health.<sup>vi</sup> While the Franks bill states that sex selection undermines women's equality and erodes women's rights, the bill itself demands unequal treatment of

women by spurring racial and ethnic profiling and requiring invasive questioning about a woman's reasons for seeking abortion care.

While some lawmakers may genuinely be concerned about sex-selective practices, this legislation simply deploys issues of sex discrimination to thwart the advancement of reproductive rights. This legislation seems to be part of a larger strategy undertaken by the anti-choice movement to drive a wedge into the progressive community and chip away at the constitutionally protected right to choose.

Lawmakers with a true interest in addressing gender inequality should support policies and community programs that address its root causes. They should invest in policies that integrate public education with preventative-health programs, and promote fair pay and anti-discrimination policies in employment. The Franks legislation does nothing but promote an anti-choice agenda that will only serve to isolate and stigmatize women of color.

NARAL Pro-Choice America condemns gender bias that contributes to pressures to have a child of a particular sex, and we believe policies should be directed at combating gender inequity, rather than blocking access to reproductive care and privacy.

### Conclusion

The divisive provisions in the Prenatal Non-Discrimination Act serve no legitimate health-care purpose. Rather, the legislation cynically cloaks an anti-abortion proposal in the rhetoric of civil rights. NARAL Pro-Choice America opposes this legislation and urges lawmakers to respect the fundamental American values of fairness, freedom, and the right to privacy by opposing this bill.

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<sup>i</sup> Kathryn Joyce, *Is Abortion "Black Genocide"?*, COLLECTIVE VOICES, Summer 2011. On file at the NARAL offices.

<sup>ii</sup> Belle Taylor-McGhee, *Trust Black Women Talking Points*, COLLECTIVE VOICES, Summer 2011. On file at the NARAL offices.

<sup>iii</sup> Loretta Ross, *Re-enslaving African-American Women*, On the Issues, Fall 2008, at <http://www.trustblackwomen.org/2011-05-10-03-28-12/publications-a-articles/african-americans-and-abortion-articles/27-re-enslaving-african-american-women> (last visited April 8, 2016).

<sup>iv</sup> Kenrya Rankin, *Black Lives Matter Partners with Reproductive Justice Groups to Fight for Black Women*, COLORLINES, Feb. 9, 2016, at <https://www.colorlines.com/articles/black-lives-matter-partners-reproductive-justice-groups-fight-black-women> (last visited April 12, 2016).

<sup>v</sup> World Health Organization, *Preventing Gender-Biased Sex Selection: An Interagency Statement of OHCHR, UNFPA, UNICEF, UN Women and WHO*, at [http://whqlibdoc.who.int/publications/2011/9789241501460\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501460_eng.pdf) (last visited April 8, 2016).

<sup>vi</sup> SisterSong, *Race, Gender and Abortion: How Reproductive Activists Won in Georgia, Oct. 2010*, at [http://www.trustblackwomen.org/SisterSong\\_Policy\\_Report.pdf](http://www.trustblackwomen.org/SisterSong_Policy_Report.pdf) (last visited April 8, 2016).

April 14, 2016

Dear Members of the House Judiciary Subcommittee on the Constitution and Civil Justice:

We the undersigned organizations, members of the reproductive rights, justice, and health community, have a demonstrated commitment to gender and racial equality in the United States.

The Prenatal Nondiscrimination Act of 2016 (H.R. 4924) purports to address gender and racial inequality. In fact, this measure will have exactly the opposite effect—it will limit access to abortion care for some women. It is simply more of the same from anti-choice extremists in the House committed to undermining women's health.

Although its supporters will represent it as such, this proposed measure is not a legitimate effort to tackle the serious issues of racial and gender inequality. Rather, the bill will effectively exacerbate already existing disparities by limiting some women's access to comprehensive reproductive health care and penalizing health care providers. Instead of addressing health disparities and ensuring accessible and culturally competent medical care for all women, this abortion ban will further isolate and stigmatize some women—particularly those in the Asian American and Pacific Islander and African American communities—from exercising their fundamental human right to make and implement decisions about their reproductive lives.

Furthermore, bans like these open the door for politicians to further intrude into the personal health decisions of women and interfere with the provider-patient relationship. It sets us on a slippery slope, attempting to define what reasons are or are not acceptable for women seeking an abortion and could lead to even more restrictions on access to safe, legal reproductive health care for women. Patients must be able to trust their providers to keep their personal and private information confidential. These laws would interfere with open, honest communication between providers and patients by forcing providers to make assumptions about and report a patient's motivations for seeking care to authorities.

This bill is not the way to address discrimination against women and girls. You can't *give* women rights by *taking away* their rights. Banning certain abortions will not provide a real solution to gender discrimination and does nothing to address its root causes. We ask you not to be distracted by this kind of unfounded, misinformed, and thinly-veiled attempt to limit the decision-making authority of women, and urge you to oppose this legislation. Moreover, we invite you to partner with us to put forth real solutions in the 114<sup>th</sup> Congress that will eliminate racial, ethnic, and gender disparities in health care access and information.

Sincerely,

Advocates for Youth

American Civil Liberties Union

Center for Reproductive Rights

Feminist Women's Health Center

Hadassah, The Women's Zionist Organization of America, Inc.



Institute for Science and Human Values  
Legal Voice  
NARAL Pro-Choice America  
National Abortion Federation (NAF)  
National Center for Lesbian Rights  
National Council of Jewish Women  
National Family Planning & Reproductive Health Association  
National Health Law Program  
National Latina Institute for Reproductive Health  
National Network of Abortion Funds  
National Partnership for Women & Families  
National Women's Health Network  
National Women's Law Center  
New Voices for Reproductive Justice  
Physicians for Reproductive Health  
Planned Parenthood Federation of America  
Reproductive Health Technologies Project  
Sexuality Information and Education Council of the U.S. (SIECUS)  
SisterReach  
SisterSong Women of Color Reproductive Justice Collective  
South Carolina Coalition for Healthy Families  
Unitarian Universalist Association  
Unitarian Universalist Women's Federation  
URGE: Unite for Reproductive & Gender Equity  
Wisconsin Alliance for Women's Health  
Women's Law Project

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URGE: Unite for Reproductive & Gender Equity  
Wisconsin Alliance for Women's Health  
Women's Law Project



## **Testimony on Sex and Race Selective Abortion Bans**

*Prepared for the House Judiciary Committee  
Subcommittee on the Constitution and Civil Justice Hearing*

*April 14, 2016*

Dear Members of Congress:

We write to express our opposition to the *Prenatal Nondiscrimination Act of 2016*. The bill would criminalize the alleged practice of sex-selective and race-selective abortion. The National Abortion Federation (NAF) strongly opposes this bill because it is yet another thinly-veiled attempt to criminalize abortion providers and make abortion care less accessible.

NAF is the professional association of abortion providers. Our mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women. Our members include clinics, doctors' offices, and hospitals, which together care for more than half the women who choose abortion each year in the United States and Canada.

This bill contains civil and criminal penalties, including incarceration for up to 5 years, for abortion providers who knowingly provide abortion care to anyone who seeks abortion care based on the race or sex of the fetus. Additionally, it requires medical and mental health professionals to report known or suspected violations of this law to law enforcement authorities. The penalty for failure to report is a fine and/or incarceration for up to 1 year.

This bill creates significant obstacles to open, honest communications between health care providers and their patients, which is essential to quality health care. This is part of the code of conduct among medical professionals and is included in NAF's *Clinical Policy Guidelines* Standards 2.3 and 2.6. Our Guidelines state that a woman "must have a private opportunity to discuss issues and concerns about her abortion" and that "(A)ll reasonable precautions must be taken to ensure the patient's confidentiality." The requirement in this bill that medical professionals report "known or suspected violations" or face a fine and incarceration interferes with the trust between doctors and their patients and will only discourage dialogue, preventing doctors from fulfilling their duties to the best of their abilities. In fear of learning something that might trigger the reporting requirement, doctors may be reluctant to ask questions. In the same vein, women may withhold information in fear of having their motivations disclosed.

Furthermore, abortion providers know a patient's decisions must be voluntary and informed, and already screen for patients they suspect are being coerced to obtain abortion care. The

mandatory reporting requirement will prevent providers from establishing trusting relationships with patients because of the fear of criminal penalties if they even so much as suspect selective abortion.

At a time when women in the U.S. are experiencing a dramatic increase in restrictions on abortion access, this bill would open the door to even more abortion bans by setting a dangerous precedent for defining what reasons are or are not acceptable for women seeking an abortion. The long-term, insidious goal of this bill is to establish more abortion bans based on a woman's motivations for choosing abortion care. Instead of addressing the root causes of race and sex discrimination, this legislation is part of a hidden agenda by anti-abortion groups to reduce access to abortion care by weakening public support and criminalizing abortion providers.

There is no evidence that race selection is happening in the U.S. Instead, there is evidence that women in communities of color have a higher incidence of abortion due to having less financial means and thus limited access to contraception.<sup>1</sup> If enacted into law, this ban would do nothing to uplift communities of color, or address the real barriers women of color face in accessing reproductive health care. In fact, these types of bans could actually force providers to treat women of color seeking abortion care with suspicion solely because of this ban.

Similarly, this ban will do nothing to reduce gender discrimination, the root cause of sex-selective abortion. There are much better ways to combat gender discrimination than taking away a woman's ability to make personal medical decisions. Congress cannot improve the lives of women by taking away their rights. If lawmakers want to eliminate gender discrimination, they should support policies that are effective in decreasing discrimination and improving the lives of women and girls. For example, Congress could propose measures to help end sexual violence, improve health care access, ensure pay equity, require paid maternity leave, and ensure women can plan their own families.

Members of NAF provide compassionate care for women who choose abortion care. By threatening medical professionals with criminal penalties, this bill will only chill the ability of abortion providers like our members to provide safe, high-quality care.

We strongly urge you to oppose the *Prenatal Nondiscrimination Act of 2016*.

Thank you.

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<sup>1</sup> Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POLICY REV. 2, 3 (Summer 2008) available at <http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html> ("The disparities in unintended pregnancy rates result mainly from similar disparities in access to and effective use of contraceptives.").



**Written Testimony of Planned Parenthood Federation of America**

**Dana Singiser, Vice President, Public Policy and Government Affairs**

**Submitted to the House Judiciary Subcommittee on the Constitution and Civil Justice  
Hearing Testimony**

**Congressional Hearing on the "Prenatal Nondiscrimination Act" of 2016 (HR 4924)**

**April 14, 2016**

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") stand in strong opposition to are pleased to submit these comments regarding H.R. 4924, "Prenatal Nondiscrimination Act" of 2016, a bill introduced by Subcommittee Chairman Trent Franks which is an unconstitutional abortion ban being considered before the U. S. House Judiciary Subcommittee on the Constitution and Civil Justice.

Planned Parenthood is the nation's leading provider and advocate of high-quality, affordable health care for women, men, and young people, as well as the nation's largest provider of sex education. With over 650 health centers across the country, Planned Parenthood health centers provide affordable birth control, lifesaving cancer screenings, testing and treatments for STDs and other essential care to nearly three million patients every year. Nearly 78% of Planned Parenthood patients have incomes at or below 150 percent of the federal poverty level, and are among the most vulnerable, facing limited access to reliable and affordable health care.

Planned Parenthood strongly opposes the proposed race and sex selection abortion ban which is nothing more than an attack on the reproductive freedoms of all women. Under the guise of protecting women, this bill perpetuates stereotypes about Asian American women and other immigrant women from countries with sex-ratio imbalances, and more broadly racially profiles

women of color. These stereotypes are not only false, but dangerous. This legislation would impose strict criminal and civil penalties on abortion care providers who fail to determine the motives of their patients. The bill would obstruct women's ability to make their own health care decisions and places increased scrutiny on African American and Asian American women seeking abortion.

Further this legislation fails to address the real causes of inequality and health disparities, and instead takes aim at the very communities it purports to help. The solution to the serious issues of racism and discrimination is not to cast suspicion on doctors that serve communities facing the greatest health disparities, many of which are communities of color. Planned Parenthood opposes racism and sexism in all forms, and we are committed to advancing equity and human rights in the delivery of health care.

Planned Parenthood is a trusted health care provider, and more than one third of our patients are people of color and rely on for preventive services. We know that when people are truly cared for, they make their lives, their families, and their communities better and healthier. We are committed to helping everyone get the health care services and information they need to stay healthy.

The proposed legislation to limit women's ability to access the care they need is a misguided attempt to insert the government squarely between a woman, her family and her doctor. Patients must be able to trust their doctors to keep their personal and private information confidential. This legislation jeopardizes the doctor/patient relationship by requiring doctors to become investigators and patients their suspects. Leading medical associations including the American College of Obstetricians and Gynecologists and the National Family Planning and Reproductive Health Association oppose these bans because it interferes in the patient-physician relationship and allows the government to inappropriately interfere with the confidential communications between doctors and their patients. Communications between patients and providers free from government interference allow for patients and providers to openly discuss all medical issues and is vitally important to high quality health care.

These types of restrictions that exacerbate race-based health care inequities, have a long history of opposition by religious and faith based organizations, who share the core belief that everyone has an equal rights to health care, and are concerned about the disproportionate burden that women of color and immigrant women already face when it comes to accessing adequate and timely health care. Similarly, leading civil rights organizations such as the NAACP, an organization dedicated to ending discrimination, also oppose the Prenatal Nondiscrimination Act because it does not in any way address discrimination on the basis of race and sex. Rather, it is a veiled attempt to restrict health care for women of color under the guise of civil rights.

This bill does nothing to reduce health disparities the proposed legislation would further stigmatize and restrict the comprehensive health care services available to women.

Further this bill is part of a deeply unpopular agenda and has long been a part of the strategy of anti-women's health elected officials and organizations to make abortion illegal by using inflammatory racial arguments and false claims to stigmatize abortion in communities of color and divide reproductive health care providers like Planned Parenthood from the communities they serve. In fact, according to recent polling 65% of Americans say that Congress should not be spending time debating and passing a ban on sex selective abortions. A sex-selective ban opens the doors for politicians to further intrude into the personal health decisions of a woman. A large majority of Americans support keeping abortion legal, and fully 68% say they oppose overturning *Roe v. Wade*.

True health equity includes access to the full range of reproductive and sexual health care. Even as our nation has made strides to expand health care access, communities of color continue to face significant disparities in their health care outcomes. A critical part of racial justice in the U.S. is access to high-quality, affordable, non-judgmental health care in order for people to build the futures and families they choose. There are significant gains to be made in increasing women's access to comprehensive health care. The Prenatal Nondiscrimination Act does nothing to address these needs, and instead creates additional obstacles for women, often in vulnerable situations, who are seeking safe and legal health care. We strongly urge Congress to increase access to preventive health services and protect women's access to safe and legal abortion.





April 14, 2016

The Honorable Trent Franks, Chairman  
Judiciary Subcommittee on the Constitution and Civil Justice  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Steve Cohen, Ranking Member  
Judiciary Subcommittee on the Constitution and Civil Justice  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Franks and Ranking Member Cohen:

Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in opposition to H.R. 4924, the Prenatal Nondiscrimination Act (PRENDA) of 2016, on which a hearing is being held before the Subcommittee on the Constitution and Civil Justice on April 14, 2016.

Through its work as an independent, not-for-profit organization focusing on reproductive health research, policy analysis and public education in the United States and internationally, the Guttmacher Institute has developed and analyzed a great deal of information on abortion, including the incidence of abortion, access to care and barriers to obtaining services, factors underlying women's decisions to terminate a pregnancy, characteristics of women who have abortions and the conditions under which women obtain them. Guttmacher also tracks abortion-related legislation and policies at the federal and state level, making an evidence-based case against restrictions that limit access.

Many of the Institute's research findings and policy analyses, along with key research findings of other experts in the field, are addressed in two articles from the *Guttmacher Policy Review*, directly relevant to PRENDA: "[A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans](#)" (2012) and "[Abortion and Women of Color: The Bigger Picture](#)" (2008), both attached for inclusion in the record. Although these articles pre-date recent legislative history and studies relevant to the issues at hand, the underlying arguments against PRENDA remain.

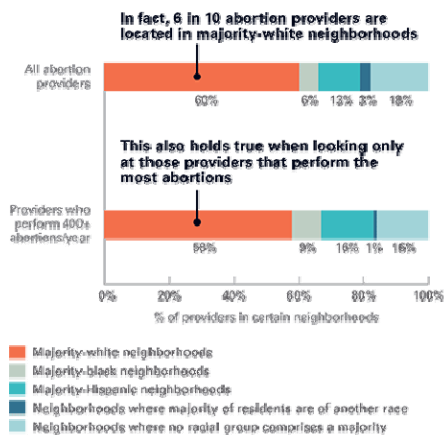
PRENDA purportedly addresses gender and race discrimination by outlawing abortions sought on the basis of sex, gender, color or race. In reality, PRENDA targets the very communities it ostensibly seeks to protect. This bill would only perpetuate further discrimination through stereotyping and racial profiling of women of color, whose motivations for an abortion would be suspect. As discussed in "[A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans](#)," the underlying cause of sex-selective abortions is son preference, itself a deeply seated and complex manifestation of gender inequality and discrimination. Although sex-selective abortions resulting in skewed sex ratios are a serious problem in certain countries around the world, they do not regularly occur in the United States. In fact, 90% of abortions in the United States take place in the first trimester—before fetal sex can be determined. History has proven that restrictions on sex determination tests and sex-selective abortion are ineffective and impossible to enforce. Moreover, they erode women's autonomy in reproductive decision-

making and erect barriers to accessing health care services. Instead, researchers and experts recommend tackling the bias of son preference by addressing the root problem of gender discrimination through social, economic and legal measures to raise women's status.

As discussed in "[Abortion and Women of Color: The Bigger Picture](#)," higher abortion rates among black and Hispanic women are directly related to their higher rates of unintended pregnancy, which in turn reflect pervasive health disparities more generally. The abortion rate among black women, for example, has decreased in recent years; nonetheless, it remains more than twice that of non-Hispanic white women. The high abortion rate is mainly because of their high rate of unintended pregnancy, which is more than double that of white women. This is likely because of a combination of factors, including a long history of discrimination, lack of access to high-quality, affordable health care and unstable life situations, in which consistent use of contraceptives may be more difficult. Narrowing the gaps in access to quality health care is a public health priority and requires an ongoing investment from multiple sectors.

Moreover, antiabortion legislators and activists have long argued that high abortion rates among women of color are the result of supposed aggressive marketing by abortion providers. In fact, six in 10 abortion providers are located in majority-white neighborhoods.

The claim that most abortion providers are located in black or Hispanic neighborhoods is **FALSE**



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In conclusion, rather than addressing serious underlying issues—including disparities in unintended pregnancy and other health outcomes, as well as broader social and economic inequities—PRENDA does nothing to help women, but is simply a subterfuge to ban access to safe and legal abortion.

Thank you for the opportunity to provide these comments.

Sincerely,

Susan Cohen  
Vice President for Public Policy

## A Problem-and-Solution Mismatch: Son Preference and Sex-Selective Abortion Bans

By Sneha Barot

**A**mong the widening panoply of strategies being deployed to restrict U.S. abortion rights—ostensibly in the interest of protecting women—is the relatively recent push to prohibit the performance of abortions for the purpose of sex selection. Sex-selective abortion is widespread in certain countries, especially those in East and South Asia, where an inordinately high social value is placed on having male over female children. There is some evidence—although limited and inconclusive—to suggest that the practice may also occur among Asian communities in the United States.

A broad spectrum of civil rights groups and reproductive rights and justice organizations stand united in opposition to these proposed abortion bans as both unenforceable and unwise. Advocates for the welfare of Asian American women are particularly adamant in protesting that such laws have the potential to do much harm and no good for their communities. Moreover, they argue that proposals to ban sex-selective abortion proffered by those who would ban all abortions are little more than a cynical political ploy and that the real problem that needs to be addressed is son preference—itsself a deeply seated and complex manifestation of entrenched gender discrimination and inequity.

### Understanding the Root Problem...

Son preference is a global phenomenon that has existed throughout history. Today, in some societies, son preference is so strong and sex-selective practices so common that, at the population level, the number of boys being born is much

greater than the number of girls. This is notably the case in a number of South and East Asian countries, primarily India, China, Singapore, Taiwan, Hong Kong and South Korea, as well as in such former Soviet Bloc countries in the Caucasus and Balkans as Armenia, Azerbaijan, Georgia and Serbia.

Particularly in India and China, a deep-seated preference for having sons over daughters is due to a variety of factors that continue to make males more socially and economically valuable than females. Inheritance and land rights pass through male heirs, aging parents depend on support from men in the absence of national security schemes and greater male participation in the workforce allows them to contribute more to family income. Women, on the other hand, require dowries and leave the natal family upon marriage, which make them an unproductive investment. Moreover, only sons carry out certain functions under religious and cultural traditions, such as death rituals for parents.

At the individual and family level, the primary consequence of son preference is the intense—and intensely internalized—pressure placed on women to produce male children. In the past, when having a large number of children was desirable and the norm, one option was to simply allow a family to grow until a son—or the requisite number of sons—was born; even so, female infanticide—the most drastic possible expression of son preference—was not uncommon. Today, son preference is jutting up against widespread desires for smaller families and, at least in China,

strict population policies that limit family size to one or two children. And, of course, new technologies such as ultrasound imaging to determine fetal sex, together with sex-selective abortion, have facilitated the preference for and practice of choosing boys without having to resort to infanticide.

At the macro level, the results of entrenched son preference are highly skewed national sex ratios, which in turn can have decidedly negative social consequences—again, largely for women and girls. Societies with heavily lopsided sex ratios may face a dearth of women for marriage, which could increase the likelihood of coerced marriages or bride abduction, trafficking of women and girls, and rape and other violence against women and girls. A large cohort of young, single men may lead to more crime-ridden, violent communities and general societal insecurity, especially in cultures where social standing is closely connected with marital status and fatherhood.

Under normal circumstances, the sex ratio at birth usually ranges from 102–106 live male births per 100 live female births.<sup>1</sup> (Boys are biologically more likely to suffer child mortality, so sex ratios at birth are naturally higher.) The sex ratio at birth in China has been growing at an alarming rate over the last three decades. The ratio of boys per 100 girls jumped between 1982 and 2005, from 107 to 120.<sup>2</sup> At the regional level, the disparity is even sharper, as the ratio in some provinces is higher than 130.<sup>3</sup> The Chinese Academy of Social Sciences predicts that by 2020, China will have 30–40 million more boys and young men under age 20 than females of the same age.<sup>4</sup> India, too, is facing a national crisis with its sex ratios. The Indian census does not publish sex ratios at birth, but rather child sex ratios, expressed as the number of females below age seven for every 1,000 males. The last four census surveys point to rapidly increasing disparities: The child sex ratio dropped from 962 (girls to 1,000 boys) in 1981 to 945 in 1991 to 927 in 2001,<sup>5</sup> and according to the latest census, in 2011, the ratio decreased further, to 914.<sup>6</sup>

As in China, India has considerable fluctuations across different regions and localities. For example, the northern Indian states of Haryana and

Punjab are notorious for their exceedingly disparate ratios, at 830 and 846, respectively, with some districts dipping into the 770s.<sup>6</sup> In contrast, south India has normal sex ratios. In this regard, it is worth noting that the status of women in parts of south India is higher than in the rest of the subcontinent; gender discrimination—and thereby son preference—apparently is not motivating women and their families to use the same accessible technology for sex-selection purposes in these regions.

Finally, a discernible pattern among most countries with skewed sex ratios is that disparities increase with birth order. In other words, even in China, the sex ratio is near normal for first-order births;<sup>3</sup> however, it increases dramatically for second-order births and sky-rockets for third-order or later births.<sup>1</sup> This evidence shows that families will accept a daughter if she is a first-born child, but then will take inordinate steps to guarantee that the second one is a son. For example, in certain provinces in China, the sex ratio for third-order births exceeds a whopping 200 (boys per 100 girls).<sup>3</sup>

### ...And Effectively Addressing It

Women's rights advocates, researchers, multilateral agencies and affected governments have been working on the problem of son preference and the outcome of imbalanced sex ratios for many years; however, with the limited exception of South Korea (see box, page 21), relatively little headway has been made. That said, recent international agreements provide insights into how—and how not—to move forward.

The consensus documents brokered by more than 180 United Nations (UN) member states at the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing represent seminal agreements on women's health and rights. Both the ICPD Programme of Action and the Beijing Declaration squarely identify sex selection as a manifestation of son preference and frame the problem of son preference as a form of gender discrimination and a violation of women's human rights.<sup>8,9</sup> And the ICPD Programme of Action urges governments to

“eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection”<sup>8</sup>—a recommendation also echoed in the Beijing Declaration.<sup>9</sup>

The most authoritative and instructive roadmap on how to understand and counter the problems of sex selection is a statement released last year by five UN agencies—the Office of the High Commissioner for Human Rights, the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), UN Women and the World Health Organization. This joint interagency statement outlines the lessons experienced by different governments in addressing sex selection and lists five categories of recommendations for action, including the need for more data on the magnitude of the problem and its consequences; guidelines on the use of technology in obstetric care that do not reinforce inequities in access; supportive measures for girls and women, such as education and health services; laws and policies to strengthen gender equality and equity in areas such as inheritance and economic security; and advocacy and communication activities to stimulate behavior change regarding the value of girls. Notably, the statement includes this caution: “Experience also indicates that broad, integrated and systematic approaches need to be taken if efforts to eliminate son preference are to succeed...[and] to ensure that the social norms and structural issues underlying gender discrimination are addressed. Within this framework, legal action is an important and necessary element but is not sufficient on its own.”<sup>11</sup>

On that note, three dozen countries have enacted laws or policies on sex selection.<sup>10</sup> Both India and China outlaw prenatal testing—particularly ultrasound—to detect the sex of the fetus (except for medical reasons), and China additionally bans sex-selective abortions. Neither country’s laws, however, have been effective in stopping sex-selective abortions,<sup>11</sup> likely because enforcement is extremely difficult, affordable ultrasound services are widely available and fetal sex information can be relayed to potential parents without

even saying a word. Moreover, an ultrasound may be performed in one location and an abortion obtained in another, where a woman can provide alternative reasons for the procedure.

An even more compelling argument against sex-selective abortion bans is that restrictions on access to prenatal technologies and to abortions can create barriers to health care for women with legitimate medical needs; scare health care providers from providing safe, otherwise legal abortion services; and force women who want to terminate their pregnancies into sidestepping the regulated health care system and undergoing unsafe procedures. Accordingly, the joint UN statement stresses that “States have an obligation to ensure that these injustices are addressed without exposing women to the risk of death or serious injury by denying them access to needed services such as safe abortion to the full extent of the law. Such an outcome would represent a further violation of their rights to life and health.”<sup>11</sup>

### Enter U.S. Abortion Politics

While governments in Asia grapple with the serious consequences of entrenched son preference and lopsided sex ratios, antiabortion lawmakers in the United States are working overtime to capitalize on the issue for their own ends. In February, the House Judiciary Committee approved legislation to ban sex-selective abortions. Among other actions, the bill would allow criminal prosecution of health care providers who perform such abortions, and of medical and mental health professionals who do not report suspected violations of the law. It would make no exceptions to save the life or health of the mother, or to allow for medical, sex-linked reasons for an abortion. (The bill also bans so-called race-selective abortions, citing disproportionately high abortion rates among communities of color as evidence that abortion providers are “targeting” them, while ignoring the underlying racial disparities in unintended pregnancy rates; see “Abortion and Women of Color: The Bigger Picture,” Summer 2008.)

Rep. Trent Franks (R-AZ) originally introduced the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) in 2008, and reintroduced it in 2011, as chairman of

## Multiprong Measures

*South Korea stands as a useful example of a country that has made real progress in improving a highly imbalanced sex ratio. The country's already elevated sex ratio at birth climbed even higher during the 1980s, when sex detection—and therefore sex-selective abortions—became commonplace. The ratio peaked at almost 116 in the mid-1990s, but declined to 107 by 2007.<sup>1</sup> (Nonetheless, the ratio remains outside*

*the normal biological range, and even greater imbalances persist among later order births.) Korea's approach to its sex ratio problem is instructive because the government espoused a multitude of economic, social and legal avenues. Although the government pursued concerted attempts to enforce its laws against prenatal sex detection, researchers give much of the credit for the turnaround to the country's in-*

*dustrialization, urbanization and rapid economic development, which together played a major role in fundamentally altering underlying social norms.<sup>17</sup> Other trends that increased the status of women included more female employment in the labor market, new laws and policies to improve gender equality and awareness-raising campaigns through the media.*

the Judiciary Committee's Subcommittee on the Constitution. In the interim, bills to outlaw sex-selective abortion were introduced in 13 states and enacted in two: Oklahoma and Arizona.

The "findings" included by Rep. Franks in the preamble of his bill rely on international evidence of sex selection because U.S. data on the subject are both limited and inconclusive. What is conclusively known is that the U.S. sex ratio at birth in 2005 stood at 105 boys to 100 girls, squarely within biologically normal parameters.<sup>12</sup> Beyond that salient fact, two studies using 2000 U.S. census data to examine sex ratios among Chinese-, Indian- and Korean-American families found that although the ratio for first-born children in such families was normal, there was evidence of son preference in second- and third-order births, if the older children were daughters.<sup>13,14</sup> Notably, the authors do not pinpoint the cause of the disparate ratios—whether prepregnancy techniques involving fertility treatments or sex-selective abortions. In addition, they comment that these three ethnic communities constitute a very small proportion—less than 2%—of the U.S. population.<sup>13</sup> A third analysis that supporters of PRENDA rely on is a small-scale qualitative study involving interviews with 65 immigrant Indian women who practiced sex selection, either before pregnancy or during pregnancy through an abortion.<sup>15</sup> Many of these women spoke of the social and cultural basis for son preference and the intense pressure faced by women in their communities to produce sons.

Advocacy organizations, such as the National Asian Pacific American Women's Forum (NAPAWF), that work in these communities readily acknowledge that son preference is an important global concern that needs attention wherever it continues to exist. But they also emphasize that "son preference is a symptom of deeply rooted social biases and stereotypes about gender" and that "gender inequity cannot be solved by banning abortion. The real solution is to change the values that create the preference for sons."<sup>16</sup>

Reproductive justice and Asian women's rights groups, in fact, cite myriad problems that sex-selective abortion bans could create. At the most practical level, such restrictions are neither enforceable nor effective, as already demonstrated internationally. And various attempts to enforce them, they stress, would only perpetuate further discrimination in their communities through stereotyping and racial profiling of Asian women whose motivations for an abortion would be under suspicion. In a recent op-ed explaining their opposition to PRENDA, the executive directors of NAPAWF and the National Latina Institute for Reproductive Health wrote: "Immigrant women already face numerous barriers to accessing health care of any kind, including reproductive health care and abortion, and this ban would make an already difficult situation far worse."<sup>17</sup>

At the end of the day, these advocates are fiercely denouncing PRENDA and its copycats because of



their deep-seated conviction that the true motivations of the measures' proponents have everything to do with undermining abortion rights and nothing to do with fighting gender discrimination—and that, in fact, the measures themselves threaten only to exacerbate that very problem. In written testimony opposing PRENDA, 24 organizations from the reproductive justice community had this to say: “This anti-choice measure dressed as an anti-discrimination bill...further exacerbates inequities and diminishes the health, well-being, and dignity of women and girls by restricting their access to reproductive health care. We represent the women and people of color this bill purports to protect, and we are announcing our unequivocal condemnation of it.”<sup>18</sup> [www.gutmacher.org](http://www.gutmacher.org)

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## Abortion and Women of Color: The Bigger Picture

By Susan A. Cohen

**T**his much is true: In the United States, the abortion rate for black women is almost five times that for white women.

Antiabortion activists, including some African-American pastors, have been waging a campaign around this fact, falsely asserting that the disparity is the result of aggressive marketing by abortion providers to minority communities.

The Issues4Life Foundation, for example, is a faith-based organization that targets and works with African-American leaders toward achieving the goal of “zero African-American lives lost to abortion or biotechnology.” In April, Issues4Life wrote to the Congressional Black Caucus to denounce Planned Parenthood Federation of America (PPFA) and its “racist and eugenic goals.” The group blamed PPFA and abortion providers in general for the high abortion rate in the African-American community—deeming the situation the “Da[r]fur of America”—and called on Congress to withdraw federal family planning funds from all PPFA affiliates.

These activists are exploiting and distorting the facts to serve their antiabortion agenda. They ignore the fundamental reason women have abortions and the underlying problem of racial and ethnic disparities across an array of health indicators. The truth is that behind virtually every abortion is an unintended pregnancy. This applies to all women—black, white, Hispanic, Asian and Native American alike. Not surprisingly, the variation in abortion rates across racial and ethnic groups relates directly to the variation in the unintended pregnancy rates across those same groups.

Black women are not alone in having disproportionately high unintended pregnancy and abortion rates. The abortion rate among Hispanic women, for example, although not as high as the rate among black women, is double the rate among whites. Hispanics also have a higher level of unintended pregnancy than white women. Black women’s unintended pregnancy rates are the highest of all. These higher unintended pregnancy rates reflect the particular difficulties that many women in minority communities face in accessing high-quality contraceptive services and in using their chosen method of birth control consistently and effectively over long periods of time. Moreover, these realities must be seen in a larger context in which significant racial and ethnic disparities persist for a wide range of health outcomes, from diabetes to heart disease to breast and cervical cancer to sexually transmitted infections (STI), including HIV.

### Behind the Numbers

Abortion rates have been declining in the United States for a quarter of a century, from a high of 29.3 per 1,000 women aged 15–44 in 1981 to an historic low (post-*Roe v. Wade*) of 19.4 in 2005. The overall number of abortions has been falling too, dropping to 1.2 million in 2005. Currently, about one-third of all abortions are obtained by white women, and 37% are obtained by black women. Latinas comprise a smaller proportion of the women who have abortions, and the rest are obtained by Asians, Pacific Islanders, Native Americans and women of mixed race (see chart).

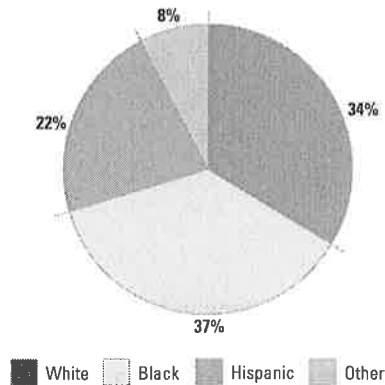
The abortion rates among women in minority communities have followed the overall downward trend over the three decades of legal abor-



## WHO HAS ABORTIONS

Most abortions in the United States are obtained by minority women.

PROPORTION OF U.S. ABORTIONS, 2004



Notes: "Other" includes Asians, Pacific Islanders, Native Americans and those of mixed race. These numbers add to 101% because of a small overlap among the Hispanic, black and other categories.  
Source: Guttmacher Institute, 2008.

tion. At the same time, however, black women consistently have had the highest abortion rates, followed by Hispanic women (see chart). This holds true even when controlling for income: At every income level, black women have higher abortion rates than whites or Hispanics, except for women below the poverty line, where Hispanic women have slightly higher rates than black women.

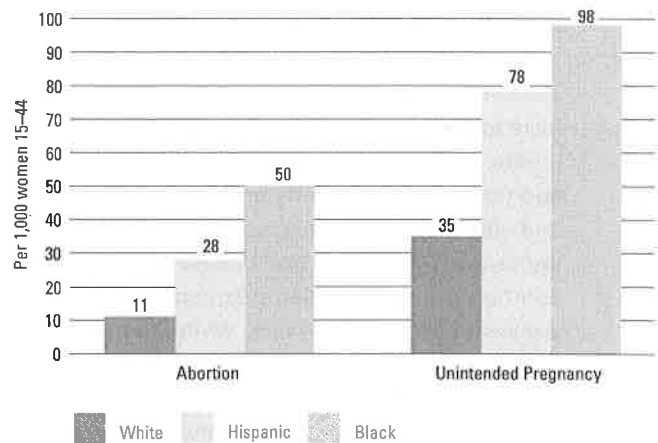
These patterns of abortion rates mirror the levels of unintended pregnancy seen across these same groups. Among the poorest women, Hispanics are the most likely to experience an unintended pregnancy. Overall, however, black women are three times as likely as white women to experience an unintended pregnancy; Hispanic women are twice as likely. Because black women experience so many more unintended pregnancies than any other group—sharply disproportionate to their numbers in the general population—they are more likely to seek out and obtain abortion services than any other group. In addition, because black women as a group want the same number of children as white women, but have so many more unintended pregnancies, they are more likely than white women to terminate an unintended pregnancy by abortion to avoid an unwanted birth.

The disparities in unintended pregnancy rates result mainly from similar disparities in access to and effective use of contraceptives. As of 2002, 15% of black women at risk of unintended pregnancy (i.e., those who are sexually active, fertile and not wanting to be pregnant) were not practicing contraception, compared with 12% and 9% of their Hispanic and white counterparts, respectively. These figures—and the disparities among them—are significant given that, nationally, half of all unintended pregnancies result from the small proportion of women who are at risk but not using contraceptives.

Whether an at-risk woman practices contraception, however, does not in itself tell the whole story. For an individual woman who is attempting to avoid a pregnancy, the particular method she chooses and the way she uses it over time also matter. In fact, all of the major contraceptive methods are extremely effective if used "perfectly." In actual practice, however, there are significant variations in a method's effectiveness in "typical use" (i.e., for the average person who may not always use the method correctly or consistently). The IUD has a very low failure rate because it is long-acting and requires little intervention by the user. Coitus-related methods such as condoms are at the other end of the typical-use effectiveness scale, because they depend on

## STARK CONTRASTS

Black and Hispanic women have much higher abortion rates than white women—because they have much higher rates of unintended pregnancy.



Notes: Abortion data, 2004; unintended pregnancy data, 2001. Sources: Guttmacher Institute, 2008 and 2006.

proper use at every act of intercourse. The pill, which is not coitus-related but must be taken every day, is usually more effective than the condom, but less effective than an IUD (see table). Factoring together the method choices and the real-life challenges to effective use over long periods of time, women of color as well as those who are young, unmarried or poor have a lower level of contraceptive protection than their counterparts.

### Widespread Disparities

Fundamentally, the question at hand is less why women of color have higher abortion rates than white women than it is what can be done to help them have fewer unintended pregnancies. Obviously, facilitating better access to contraceptive services is key. Beyond access, however, dissatisfaction with the quality of services and the methods themselves may be as much or sometimes more of an impediment to effective use of contraceptives.

Studies by Guttmacher Institute researchers, published in *Perspectives on Sexual and Reproductive Health* in 2007 and in *Contraception* in 2008, sought to shed some light on the reasons women at risk of unintended pregnancy do

not use contraceptives at all or use them only sporadically. Geographic access to services is a factor for some women; however, for many, it is more a matter of being able to afford the more effective—usually more expensive—prescription methods.

Beyond geographic and financial access, life events such as relationship changes, moving or personal crises can have a direct impact on method continuation. Such events are more common for low-income and minority women than for others, and may contribute to unstable life situations where consistent use of contraceptives is lower priority than simply getting by. In addition, a woman's frustration with a birth control method can result in her skipping pills or not using condoms every time. Minority women, women who are poor and women with little education are more likely than women overall to report dissatisfaction with either their contraceptive method or provider. Cultural and linguistic barriers also can contribute to difficulties in method continuation.

These themes resonate beyond the domains of contraceptive use, unintended pregnancy and abortion. Indeed, they probably underlie many of the stark racial and ethnic disparities that exist across a broad range of health indicators. For example, the Centers for Disease Control and Prevention presented data in March 2008 indicating that black teens were more than twice as likely as their white or Mexican-American counterparts to have one or more of the four STIs studied (chlamydia, trichomoniasis, genital herpes and human papillomavirus), independent of income and number of sexual partners. Reported cases of syphilis are triple the rate for Hispanics than for whites, according to the American Social Health Association. According to the Department of Health and Human Services Office of Minority Health, the AIDS case rate for African-American men is more than eight times that for whites; the rate for Latinos is more than three times that for whites. Hispanic women are more than twice as likely as whites to be diagnosed with cervical cancer; black women are less likely to be diagnosed with breast cancer than white women, but 30% more likely to die from it.

### CONTRACEPTION WORKS

The most commonly used contraceptive methods vary widely in their theoretical and real-world effectiveness, but all are far more effective than not using a method at all.

Method	First year failure rate*	
	Perfect use	Typical use
Oral contraceptives	0.3	8.7
Tubal sterilization	0.5	0.7
Male condom	2.0	17.4
Vasectomy	0.1	0.2
3-month injectable	0.3	6.7
Withdrawal	4.0	18.4
Copper IUD	0.6	1.0
Hormonal IUD	0.1	0.1
Periodic abstinence	1	25.3
Implant	0.05	1.0
Patch	0.3	8.0
No method	85.0	85.0

\*Percentage of women experiencing an unintended pregnancy during first year of use. †Failure rate varies by specific method of periodic abstinence, from 9% for calendar method to 1% for post-ovulation. Source: Guttmacher Institute, 2008.

Beyond sexual and reproductive health, African-Americans and Hispanics bear a greater disease burden than whites across a range of important health indicators. Blacks, for example, are almost twice as likely as whites to have diabetes. New cases of colorectal, pancreatic and lung cancer occur more often in African-American women than in any other group. There is a higher incidence of stomach and liver cancer among Hispanics, male and female, than among whites and a higher mortality rate from these cancers as well.

Access to health care, including financial access, remains a significant issue that particularly affects minority communities; however, there is increasing recognition of the critical importance of quality of care as it affects health-seeking behavior and outcomes. In 2002, the Institute of Medicine (IOM) reported that “minorities are less likely than whites to receive needed services, including clinically necessary procedures.” The IOM offered a number of explanations for this finding, including linguistic and cultural barriers that interfere with effective communication between a patient and a provider. The IOM also noted a level of mistrust for the health system in general that exists in minority communities. Mistrust can cause a patient to refuse treatment or comply poorly with medical advice, which in turn can cause providers to become less engaged—leading to a vicious cycle. These obstacles are difficult enough to surmount in cases where a patient is ill and presumably motivated to receive some kind of treatment. In the case of a prevention intervention such as birth control, however, where the need for “treatment” may seem less pressing, the cumulative effect of these obstacles could be daunting.

Ironically, treating all patients the same, regardless of race or ethnicity, may not be the answer to the problem of health disparities. Harvard Medical School professor Thomas Sequist published the results of his research in a June 2008 issue of the *Archives of Internal Medicine* in which he and his colleagues found that a physician’s failure to match a treatment regimen with a patient’s cultural norms could contribute significantly to the poor compliance and worse health outcomes manifest in minority communities. “It isn’t that

providers are doing different things for different patients,” he explained to the *New York Times*. “It’s that we’re doing the same thing for every patient and not accounting for individual needs. Our one-size-fits-all approach may leave minority patients with needs that aren’t being met.”

### **Speaking for Themselves**

Perhaps all that is certain about racial and ethnic health disparities is that there are too many, they are too great and the reasons for and solutions to them are complex. Narrowing the gaps in access, quality and health outcomes is essential and a priority in the public health community. It is also a priority among key members of Congress, led by Rep. Hilda L. Solis (D-CA), chair of the Congressional Hispanic Caucus Task Force on Health and the Environment, along with Del. Donna M. Christensen (D-VI), chair of the Congressional Black Caucus Braintrust, and Del. Madeleine Z. Bordallo (D-GU), chair of the health care task force of the Congressional Asian Pacific American Caucus. Under Solis’ leadership, these three caucuses have been advocating for passage of the Health Equity and Accountability Act of 2007, legislation designed to address some of the known impediments to quality health care, including some aspects of reproductive health care, for minority populations.

Perhaps it is because they are more acutely aware of the larger societal issues surrounding health disparities, members of the Black, Hispanic and Asian Pacific American caucuses in Congress, overwhelmingly, are strong and reliable advocates of reproductive health and rights, including abortion rights. So, too, is an array of organizations representing women of color, including African American Women Evolving (AAWE), the National Asian Pacific American Women’s Forum, the National Latina Institute for Reproductive Health and Sistersong, among others.

To be sure, the leaders of these organizations have on occasion voiced their own frustrations with what they consider the “mainstream” reproductive rights movement, contending that the movement has been too narrowly focused on

*Continued on page 12*

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The root causes of these disparities are manifold: a long history of discrimination, too few educational and professional opportunities for disadvantaged groups and unequal access to safe, clean neighborhoods, just to name a few. There are no easy solutions to these complex challenges. Innovative strategies—looking at empowering individuals, ongoing cross-cultural education of providers, access to and quality of care, and efforts to reduce entrenched poverty and improve education—will all have to be part of the longer-term approach.

The bottom line is that even as advocates press for targeted initiatives to reduce sexual and reproductive health disparities, they need to give greater attention to the larger forces that drive disparities. Addressing social and economic disparities is critical to reproductive health. At the same time, empowering women and couples to decide if and when to have a child and enabling them to have a healthy pregnancy and baby are critical to achieving social justice. [www.guttmacher.org](http://www.guttmacher.org)

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### Abortion and Women of Color

continued from page 5

protecting and promoting family planning and abortion rights. They argue that these rights, although critical, must be lodged in the broader health, social and economic context of women's lives—especially the lives of poor and low-income women who are disproportionately minority—and interconnected with other critical life needs and aspirations. AAWE's mission, for example, states forthrightly that "a woman's ability to lead [a] reproductive healthy li[fe] is closely connected to her ability to overcome other social and economic barriers." AAWE advocates for reproductive health in a broad way that includes addressing issues surrounding infertility and menopause, reducing infant and maternal mortality, and promoting breast care and prenatal care, as well as promoting access to quality contraceptive services, safe abortion services and services to prevent STIs, including HIV.

The fact that AAWE and other minority-focused groups argue as passionately for alleviating poverty, promoting access to health care more broadly and advancing women's equality more generally as they do for family planning or abortion rights in no way diminishes their commitment to those rights. To the contrary. In stark contrast to the antiabortion pastors who appear intent on trying to protect minority women from themselves, it is these groups and their advocates in Congress who are working to advance the real interest of women of color, by advocating for all women's meaningful access to the range of health information, services and rights they need to live and improve their own lives.

[www.guttmacher.org](http://www.guttmacher.org)

*This article was made possible by a grant from the Robert Sterling Clark Foundation. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.*



# AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

## Administrative Office

1209 Montgomery Highway  
Birmingham, Alabama 35216-2809  
Tel 205/978-5000 • Fax 205/978-5005  
Email: [asrm@asrm.org](mailto:asrm@asrm.org) • Web Sites: [www.asrm.org](http://www.asrm.org)  
[www.reproductivefacts.org](http://www.reproductivefacts.org)  
[www.asrmanualmeeting.org](http://www.asrmanualmeeting.org)

## J. Benjamin Younger

Office of Public Affairs  
409 12th Street S.W., Suite 602  
Washington, D.C. 20024-2155  
Tel 202/863-4985 • Fax 202/484-4039

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*Editor, Journal of Assisted Reproduction and Genetics*

April 12, 2016

The Honorable Trent Franks  
Chair, Subcommittee on the Constitution and Civil Justice  
Judiciary Committee  
2435 Rayburn House Office Building  
Washington, DC 20515

The Honorable Steve Cohen  
Ranking Member, Subcommittee on the Constitution and Civil Justice  
Judiciary Committee  
2404 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Franks and Ranking Member Cohen:

I am writing on behalf of the American Society for Reproductive Medicine (ASRM) with regard to the Prenatal Nondiscrimination Act of 2016 that will be heard in committee this week. ASRM is a multidisciplinary organization of nearly 8,000 professionals dedicated to the advancement of the science and practice of reproductive medicine. Our members include obstetricians and gynecologists, urologists, reproductive endocrinologists, embryologists, mental health and allied professionals.

This bill references an Ethics Committee Opinion issued by our medical society. While ASRM is generally pleased to have the reports of our Ethics and Practice Committees used to help inform policy makers, I feel compelled to point out that the Ethics Committee Report referenced in the bill is an outdated version. Secondly, our Ethics Committee Report is misrepresented in this bill.

The bill would make illegal the use of elective pregnancy termination in certain circumstances. Our report, however, is limited to a specific family building treatment modality, and does not address pregnancy termination. ASRM's Ethics Committee has not reached consensus on

whether it is ethical for providers to offer assisted reproductive technologies for sex selection for nonmedical purposes. We feel it is inappropriate to use the conclusions about sex selection during a family building process in the context of a discussion about pregnancy termination.

Sincerely,

A handwritten signature in black ink, appearing to read "Owen K. Davis, MD". The signature is written in a cursive style with a large initial "O" and a long horizontal stroke extending to the right.

Owen K. Davis, MD  
President, ASRM



The Honorable Trent Franks  
Chairman, Subcommittee on the  
Constitution and Civil Justice  
Judiciary Committee  
2138 Rayburn HOB  
Washington, DC 20515

The Honorable Steve Cohen  
Ranking Member, Subcommittee on  
the Constitution and Civil Justice  
Judiciary Committee  
2138 Rayburn HOB  
Washington, DC 20515

April 14, 2016

**Statement for the Record in Hearing on H.R. 4924, the Prenatal  
Nondiscrimination Act (PRENDA) of 2016**

Dear Members of the Subcommittee:|

On behalf of the American Civil Liberties Union (ACLU), a non-partisan organization with more than a half million members, countless additional activists and supporters, and 53 affiliates nationwide, dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws, we submit this statement in opposition to the Prenatal Nondiscrimination Act (PRENDA) of 2016.

PRENDA is yet another attempt to restrict access to safe, legal abortion, falsely characterized by its proponents as an effort to address discrimination. Far from advancing equality, this bill perpetuates harmful and discriminatory stereotypes about why women of color choose abortion care and would only worsen the health care disparities they experience.

The bill is premised entirely on harmful stereotypes about immigrants and communities of color. Specifically, the bill bans race-selective abortions, citing the disproportionately high number of abortions among Black women. It assumes that Black women who choose abortion care do so because of racial animus—seeking to eliminate fetuses “of an undesired race.” It suggests that, unlike White women or women of any other race, Black women alone are incapable of making personal decisions about whether and when to start a family.

The bill's ban on sex-selective abortion is similarly based on unfounded and offensive stereotypes about immigrants, particularly Asian and Pacific Islander (API) communities. PRENDA cites a preference for male children in other parts of the world as the reason why a ban on sex-selective abortion is needed in the U.S. Even if there were evidence that sex-selective abortion

AMERICAN CIVIL  
LIBERTIES UNION  
WASHINGTON  
LEGISLATIVE OFFICE  
915 15th STREET, NW, 6<sup>TH</sup> FL  
WASHINGTON, DC 20005  
T/202.544.1681  
F/202.546.0738  
[WWW.ACLU.ORG](http://WWW.ACLU.ORG)

KARIN JOHANSON  
DIRECTOR

NATIONAL OFFICE  
125 BROAD STREET, 18<sup>TH</sup> FL.  
NEW YORK, NY 10004-2400  
T/212.549.2500

OFFICERS AND DIRECTORS  
SUSAN N. HERMAN  
PRESIDENT

ANTHONY D. ROMERO  
EXECUTIVE DIRECTOR

ROBERT REMAR  
TREASURER

is prevalent in the U.S., which there is not,<sup>1</sup> PRENDA would do nothing to address the underlying problem of gender inequality that leads to the preference for sons in some places. PRENDA instead singles out API women for greater scrutiny at the doctor's office solely because of their ethnicity, suggesting that some Americans exercise sex-selection abortion consistent with practices in "the country to which they trace their ancestry" and specifically targeting people "tracing their origins to countries where sex-selection abortion is prevalent."

PRENDA's requirement that doctors profile their patients based on their race or immigration status is not only offensive, it's also unconstitutional. It demeans, humiliates, and discriminates against women who choose abortion care by treating their personal, private, and constitutionally protected decisions to end a pregnancy as automatically suspect solely because of their race, in violation of the Fourteenth Amendment's Equal Protection Clause.

Furthermore, the bill would make it even harder for women in communities of color to access care, leading to even greater health care disparities. It would force doctors and other medical professionals to report a patient's motivations for seeking care to authorities under threat of harsh criminal penalties, including up to five years in prison. This would destroy doctor-patient confidentiality, chilling open, honest communication between doctors and patients and pushing providers out of already-underserved communities of color. This does nothing to help women and girls—it only creates additional and detrimental obstacles to accessing health care.

The ACLU opposes PRENDA. This bill does nothing to address discrimination against women and people of color, and would restrict the rights of the communities it purports to protect. It is a thinly veiled attack on access to safe, legal abortion and must be rejected. Should you have any questions, please contact Legislative Counsel Georgeanne Usova at (202) 675-2338 or [gusova@aclu.org](mailto:gusova@aclu.org).

Sincerely,



Karin Johanson  
Director, Washington Legislative Office



Georgeanne M. Usova  
Legislative Counsel

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<sup>1</sup> National Asian Pacific American Women's Forum, Univ. of Chicago Law School Int'l Human Rights Clinic, and ANSIRH, *Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States*, June 2014, <https://napawf.org/wp-content/uploads/2014/06/Replacing-Myths-with-Facts-final.pdf>.



**More than 20 Faith-based Organizations and Communities  
Oppose the Prenatal Nondiscrimination Act (HR 4924)**

April 19, 2016

US House of Representatives  
Committee on the Judiciary  
Subcommittee on the Constitution and Civil Justice  
Washington, DC 20515

RE: Subcommittee Hearing on the Prenatal Nondiscrimination Act of 2016, held April 14, 2016

Dear Representative,

As religious and faith based organizations and communities, we are writing in opposition to the Prenatal Nondiscrimination Act of 2016 (PRENDA). **We urge you to reject this bill because it would harm women's health, interfere in women's personal decision making, and erode women's basic rights — most jeopardizing women of color and immigrant women.**

While we come from a variety of faith traditions, we share a core belief that everyone has an equal right to health care. We are concerned about the disproportionate barriers that women of color and immigrant women already face when it comes to accessing care. Rather than seeking to reduce health disparities, PRENDA would erode trust in the doctor-patient relationship. It would interfere in open and honest communication between a woman and her doctor, forcing doctors to police their patients and threatening doctors with criminal penalties.

Additionally, by proposing to ban abortion for certain reasons, this bill would push safe care out of reach. Our diverse traditions are united in the moral obligation to protect every woman's life and health; we believe in ensuring women have access to safe, comprehensive medical care. By further stigmatizing and restricting comprehensive health care services available to women, this legislation would only make it more difficult for a woman to obtain safe care. It would fall hardest on women of color and immigrant women, who already face systemic inequities and entrenched barriers to health information and services. Bans on abortion harm women, with far-reaching consequences on women and their families.

We also jointly affirm that all women have the right to make personal health care decisions in keeping with their own faith and values, personal circumstances, and health needs. PRENDA would dangerously erode this right. This legislation is offensive to women, and to women of color and immigrant women in particular; it presumes they are unable to make health care decisions for themselves and their families. And, though it purports to be a civil rights bill to address sexism and racism, in reality, this legislation would discriminate against women of color. It would scrutinize their health care decisions more intensely and invasively than the healthcare decisions of women in other communities. In so doing, PRENDA undermines the dignity and equal rights of women of color and immigrant women, and would violate their basic right to personal moral autonomy.

As communities of faith, we are committed to ensuring that every woman can exercise her constitutional right to make private decisions and follow her own conscience. Established law protects a woman's right to seek abortion *for any reason* prior to fetal viability, a right which PRENDA would eliminate. This measure would dangerously open the door to further restrictions based on a woman's personal reasons to seek care. Discrimination against women and people of color are critical problems in our society, but eliminating a woman's ability to make personal, moral health care decisions is not the way to address them. We believe effective ways to address such discrimination is through proactive policies that, for example, change the way women, girls, and people of color are treated; improve economic security and access to comprehensive health care for all; and reduce violence against women.

**More than 20 Faith-based Organizations and Communities  
Oppose the Prenatal Nondiscrimination Act (HR 4924)**

Policies that undermine women's dignity, violate their privacy, and deny them the basic human right to self-determination are not the answer.

**As faith based and religious organizations and communities, we strongly urge you to oppose the Prenatal Non-discrimination Act of 2016, as it will unjustly harm the health, erode the moral agency, and violate the dignity and constitutional rights of women of color and immigrant women.**

Thank you for considering our perspective. Should you have any questions, please contact Amy Cotton at the National Council of Jewish Women, 202 375 5067 or [amy@ncjwdc.org](mailto:amy@ncjwdc.org).

Sincerely,

Bend the Arc Jewish Action

Catholics for Choice

Concerned Clergy for Choice

Disciples for Choice

Disciples Justice Action Network

Equal Partners in Faith

Hadassah, The Women's Zionist Organization of America, Inc.

Jewish Women International

Keshet

Methodist Federation for Social Action

Muslims for Progressive Values

NA'AMAT USA

National Council of Jewish Women

Planned Parenthood Clergy Advisory Board

Presbyterian Voices for Justice

Rabbinical Assembly

Reconstructionist Rabbinical College/Jewish Reconstructionist Communities

Religious Coalition for Reproductive Choice

Religious Institute

Union for Reform Judaism

Unitarian Universalist Association

Unitarian Universalist Women's Federation

United Church of Christ, Justice and Witness Ministries

Women's Alliance for Theology, Ethics and Ritual (WATER)

Women's League for Conservative Judaism

April 21, 2016

Rep. Trent Franks  
Chairman, Subcommittee on the Constitution  
House Judiciary Committee  
2435 Rayburn HOB  
Washington, DC 20515

Rep. Steve Cohen  
Ranking Member, Subcommittee on the Constitution  
House Judiciary Committee  
2404 Rayburn HOB  
Washington, DC 20515

Dear Chairman Franks, Ranking Member Cohen, and Members of the Subcommittee:

We, the undersigned 56 people of color, write to you with concerns as to the future of access to safe abortion care and the needs of people seeking abortions. We are appalled at the introduction of H.R. 4924, the *Prenatal Nondiscrimination Act* (PRENDA), which is yet another attempt to deny abortion care to people of color, in particular, Asian American and Pacific Islanders (AAPI), Black people, and Latin@s. As people of color who have had abortions, we are vehemently opposed to this legislation.

H.R. 4924 seeks to codify pernicious racist and sexist stereotypes about women of color into law, while denying us our Constitutional right to abortion. There is no basis for this bill and it seeks only to erect a political divide between us and the compassionate clinicians who provide our abortion care. In reality, this bill would force abortion providers to interrogate our reasons for having an abortion, rather than supporting us in accessing the health care that's safe and best for our lives. We are people of color who have had abortions. We made the best decisions for us and our circumstances. We should be trusted to make decisions for ourselves, free from political interference, stigma, paternalism, and racism. Racial profiling is not an American value, and this bill would legitimize and set a dangerous standard in the practice in health care.

The decision to become a parent is a deeply personal one, one that politicians have no business inserting themselves in. We all deserve basic human rights, which include the right to be able to decide if, when, where, and how to build our families, and to raise our families with dignity, respect, in healthy communities, and free from violence. *We* should be trusted, not politicians or ideologues. *We* knew abortion was best for us.

The rhetoric around this bill is offensive and seeks to shame people of color for choosing abortion. Data from Centers for Disease Control shows that no racial or ethnic group makes up the majority of those who have abortions<sup>1</sup>, and yet this committee seeks to push the myth that when we have abortions it is somehow more egregious or different than our White counterparts.

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<sup>1</sup> *Abortion Surveillance - United States, 2012*, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) (Nov. 26, 2015), [http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s\\_cid=ss6410a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s_cid=ss6410a1_e) (last visited April 20, 2016).

The racist stereotype that Asian American and Pacific Islander communities prefer male children over female children is a gross mischaracterization, and posits politicians to be experts in health care over clinicians and patients themselves. Indeed, Aruna Papp MA, ADR, one of the researchers cited in the bill itself, submitted testimony that her work is being mischaracterized by the majority<sup>2</sup>. The most recent research on AAPI sex ratios at birth in the U.S. shows that people in this community are actually having *more* girls on average than white Americans are<sup>3</sup>, and opinion polling of AAPIs shows no preference for sons or daughters<sup>4</sup>. This bill would turn us into suspects in the exam room. Moreover, it is not a solution to gender inequality. If lawmakers truly want to prevent sex selection, they would pass legislation that creates an environment in which girls and women are valued in the first place -- like equal pay and parental leave. In the hearing, the sponsors of PRENDA claimed to care about women and girls, yet didn't ask Asian American and Pacific Islander women what support is needed for full gender equality in their own community. Instead, they spoke over Miriam Yeung, Executive Director of National Asian Pacific Women's Forum, as she attempted to make final remarks.

In the hearing, witnesses used our nation's horrific history of eugenics as a reason for this bill, ignoring the reality that Black women have the agency to make their own pregnancy decisions. Furthermore, it is offensive that politicians and the hearing witnesses used this bill as a vehicle to make derogatory claims that Black women would intentionally harm our families based on race, and allowed witnesses to equate us to slave owners and White supremacists. We were floored to hear a witness make claims that Civil Rights elders like Reverend Dr. Martin Luther King, Jr. and United States Representative John Lewis (GA-5) 'did not march across the Edmund Pettus Bridge and experience brutal attacks on Bloody Sunday so that Black women could have abortions.' Not only was this comment disrespectful in nature, it is inaccurate. Dr. King believed access to family planning was key to the success of Black families<sup>5</sup>. An outspoken voice in support of abortion rights and the fight for reproductive justice, Representative Lewis is a co-sponsor of both the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act (H.R. 2972) and the Women's Health Protection Act (S.R. 217, H.R. 448), a bill that would make legislation such as H.R. 4924 unlawful. To not trust Black women with their own bodies is racist and a reflection of how little the sponsors of this bill value Black people's autonomy, intelligence, and dignity. We rebuke these assumptions and this attack on Black people by Congress. As Yeung said in the hearing, "Black women are not the genocidal actors."<sup>6</sup> In fact, the overwhelming majority (80 percent) of Black people support access to abortion care and

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<sup>2</sup> *H.R. 4924 the Prenatal Nondiscrimination Act (PRENDA) of 2016 Before the Subcomm. On the Constitution and Civil Justice of the H. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Aruna Papp MA, ADR).

<sup>3</sup> NAPAWF, et al., *Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States* (June 2014), <https://napawf.org/wp-content/uploads/2014/06/Replacing-Myths-with-Facts-final.pdf>.

<sup>4</sup> *Id.* at 20

<sup>5</sup> *Family Planning – A Special and Urgent Concern*, PLANNED PARENTHOOD GULF COAST, INC., <https://www.plannedparenthood.org/planned-parenthood-gulf-coast/mlk-acceptance-speech> (last visited April 20, 2016) (providing the remarks delivered by Mrs. Coretta Scott King on behalf of her husband, Reverend Dr. Martin Luther King, Jr., on May 5, 1966).

<sup>6</sup> Christine Grimaldi, *House Hearing Becomes Forum for Anti-Choice Misinformation Campaign*, REWIRE (Apr. 15, 2016), <https://rewire.news/article/2016/04/15/house-hearing-forum-anti-choice-misinformation-campaign/> (last visited April 20, 2016).

access to contraception<sup>7</sup>. Congress, a body that has historically dehumanized Black bodies, may not accuse Black people of murdering their own families.

This rhetoric casting Black women as ‘dangerous’ towards their children has been helicoptered into our communities for years through anti-abortion billboards<sup>8</sup> claiming a Black woman’s womb to be a harmful place. Similarly, racially-charged tactics have been deployed in Latin@ communities proclaiming, “El lugar mas peligroso para un Latino es el vientre de su madre,” translated to mean “The most dangerous place for a Latino is in the womb.” This is not a value that reflects our culture. Polling has showed that 78 percent<sup>9</sup> of Latin@s believe that a person has the right to make their own decisions about abortion, even if they disagree with their reasons. Latin@ communities value family, culture, support and love. We trust one another to make the best decisions for ourselves. When will Congress trust us?

Our decisions to have abortions have nothing to do with racism or sexism, but all to do with a need for health care, ending cycles of poverty, and a desire to raise our families as we see fit. We do not need politicians to enact additional restrictions on abortion. What we need is for Congress to introduce legislation addressing unemployment, health care disparities such as the high rates of maternal health and infant mortality, and to ensure that public assistance programs are fully funded to nourish the families we are raising.

States continue to defund family planning clinics which are an important source of access to healthcare for communities of color. We are left without basic access to contraception, and studies have shown this is having a detrimental impact on our health<sup>10</sup> and economic opportunity. If Congress cared about our health and wellbeing they’d stop this charade immediately.

This bill is an injustice to people of color. If the sponsors of this bill truly sought to empower people of color, they would ask us what our communities need, not silence our voices. Research has demonstrated that women of color experience disproportionately high rates of unintended pregnancy<sup>11</sup> and are more likely to live in poverty<sup>12</sup>. Additionally, women of color are more

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<sup>7</sup> BELDEN RUSSONELLO STRATEGISTS, LLC, *African-American Attitudes on Abortion, Contraception and Teen Sexual Health* (Feb. 2013), <http://www.brspoll.com/uploads/files/African-American%20Attitudes%20on%20Abortion%20Contraception%20and%20Teen%20Sexual%20Health.pdf>.

<sup>8</sup> Titania Kumeh, *Mother Sues Anti-Choice Groups Behind Billboards*, MOTHER JONES (Apr. 20, 2011), <http://motherjones.com/mixed-media/2011/04/mother-sues-anti-abortion-groups-billboards> (last visited April 20, 2016).

<sup>9</sup> PERRYUNDEM RESEARCH/COMMUNICATION, *Latino/a Voters’ Views on Abortion: Findings from a National Survey* (Feb. 29, 2016), [http://latinainstitute.org/sites/default/files/NLIRH%20Public%20Survey%20Report\\_Final.pdf](http://latinainstitute.org/sites/default/files/NLIRH%20Public%20Survey%20Report_Final.pdf).

<sup>10</sup> Amanda J. Stevenson, M.A., et al., *Effect of Removal of Planned Parenthood From the Texas Women’s Health Program*, 374 N. ENG. J. MED. 853, 853-860 (March 3, 2016), <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1511902>.

<sup>11</sup> GUTTMACHER INSTITUTE, *Despite recent declines, unintended pregnancy rates in the U.S. remain high among women of color* (2015), [https://www.guttmacher.org/sites/default/files/infographic\\_attachment/unintendedpregnancy-declines.pdf](https://www.guttmacher.org/sites/default/files/infographic_attachment/unintendedpregnancy-declines.pdf) (showing a rate of 79 per 1,000 Black women and 58 per 1,000 Hispanic women aged 15-44 in 2011, compared to a rate of 33 per 1,000 among white women).

likely to be uninsured<sup>13</sup>, thus are often unable to afford the out-of-pocket costs associated with health care, including abortion<sup>14</sup>. We know those who are unable to access the abortion they seek are more likely to live in poverty<sup>15</sup> two years later. Congress *must* trust us to make decisions about our own lives and pregnancies.

Our rights should never be limited by those who are not from our communities and refuse to give us a seat at the table. Politicians continue to deny us a voice as they spoke over the women of color present at the hearing, many of whom have had abortions. We write to you to testify about what our communities need. These laws have nothing to do with protecting anyone, but everything to do with controlling our bodies and denying us the rights, autonomy, and full protections afforded to us by the United States Constitution.

As Black people, Latin@s, and Asian American and Pacific Islanders, we testify that we are autonomous and we decided to have abortions of our own volition. There was no wool pulled over our eyes by abortion providers -- we are capable of making our own choices and any questioning of that fact demeans our humanity. We will not sit silently while we are exploited for the passage of yet another abortion restriction. We testify we will not stand for the continued Congressional attacks on access to abortion care. We testify in support of the abortion providers who care for us, and denounce any attempts to criminalize their work. We testify that we deserve dignity and respect.

We testify that we had abortions and we will never be silenced.

Sincerely,<sup>16</sup>

The undersigned 56 people of color who had abortions.

Dian Alarcon, Cali, Colombia, 1990

“Fue una experiencia traumatica, pasar por un aborto clandestino donde nadie se preocupa de ti y donde es un procedimiento inseguro y sin los controles de higiene necesarios. solo una mujer sabe lo dificil que es tomar esta decision y solo puede jugarse en el context de tu historia en ese momento de tu vida, la falta de educación sexual que nos dan a los adolescentes en las escuelas y los tabues que tienen nuestras familias con la religion hace que seamos mas vulnerables, no tenemos acceso a los metodos de planificación todo esta mal si tiene que ver con la salud

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<sup>12</sup> Alana Eichner & Katherine Gallagher Robbins, *National Snapshot: Poverty Among Women & Families, 2014*, NATIONAL WOMEN'S LAW CENTER (Sept. 2015), <http://nwlc.org/wp-content/uploads/2015/08/povertysnapshot2014.pdf>.

<sup>13</sup> THE HENRY J. KAISER FAMILY FOUNDATION, *Women's Health Insurance Coverage* (Feb. 2, 2016), [https://www.guttmacher.org/sites/default/files/state\\_policy\\_overview\\_files/spib\\_oal.pdf](https://www.guttmacher.org/sites/default/files/state_policy_overview_files/spib_oal.pdf).

<sup>14</sup> Rachel K. Jones, PhD, et al., *At What Cost? Payment for Abortion Care by U.S Women*, 23 WOMEN'S HEALTH ISSUES e173, e175 (2013), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf>.

<sup>15</sup> Joshua Lang, *What Happens to Women Who Are Denied Abortions?*, NEW YORK TIMES MAGAZINE (June 12, 2013), <http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html> (last visited April 20, 2016).

<sup>16</sup> Signatories have listed the location and year of their abortion(s) and any additional comments.

reproductiva y solo nos exponen como jovenes a pasar historias dificiles que la sociedad hace aun más dificiles al no tener acceso a lugares seguros donde una mujer pueda practicarse un aborto seguro y donde ella pueda retomar su vida hacia el futuro tal vez en otro momento seas madre y una Buena madre pero preparada para serlo.

Aimee Arrambide, Laredo, Texas; San Antonio, Texas, 1993; 2005

“This bill perpetuates and codifies racial inequality and injustice. The individuals affected by this bill vote and will work to ensure that those of you that support it will no longer be able to dictate any part of our lives.”

Maura Bairley, San Francisco, California, 1990

“I have never regretted this abortion. 20 years later, I look back at this as one of the most clear decisions of my life.”

Orisha Bowers, Memphis, Tennessee, 1998

Shanel Boyce, New York City, New York, 2012

Renee Bracey Sherman, Chicago, Illinois, 2005

“I had an abortion. It was the best decision of my life. You will hear my voice. You will hear that this legislation is racist and misogynistic. You will let us testify.”

Jasmine Burnett, Indianapolis, Indiana, 1998

“This legislation is racist and disrespectful to women of color and in particular Black women. I sign this letter as a woman who knew she wanted an abortion as soon as I saw the outcome of my pregnancy test. I do not regret it and I believe it was one of the best decisions I had made for me at 19 years old and now at 37 years old I still believe it to be one of the best decisions I made for my life. Stay out of my choices and stop shaming Black women!”

Christine Carcano, Washington, District of Columbia, 2012

Nancy Cruz-Morning, Brooklyn, New York, 2015

Kersha Deibel, Cincinnati, Ohio, 2009

Sheila Desai, New York City, New York, 2009

Andrea Diaz, Oakland, California, 2012

Kimberly Espinosa, Albuquerque, New Mexico, 2007

Elizabeth Estrada, Atlanta, Georgia; New York City, New York, 2006; 2016

Etan Fraser, San Rafael, California

Liza Fuentes, Washington, District of Columbia, 2001

Misty Garcia, San Antonio, Texas, 2009

Melanie Garza, San Francisco, California, 2013

Victoria Gomez Betancourt, Denver, Colorado, 2011

“I had a safe and legal abortion. As a woman of color, an immigrant, and a Latina, I urge Congress to stop interfering with the decisions people in my community make about our bodies and our futures. Respect our human rights and protect abortion access.”

Shailey Gupta, College Station, Texas; Houston, Texas, 2001; 2006

“I’ve had two abortions, and they are the reason that I am a successful attorney. I would not have accomplished or achieved as much in my life if I had not had the ability to choose to have both abortions.”

Jack Gutierrez, Orlando, Florida, 2011

Damaris Henderson, Atlanta; Chicago; Alabama, 1990; 1992; 2005

Yamani Hernandez, Chicago, Illinois, 1997

Priscilla Huang, San Francisco, California, 2003

“I’m an Asian American woman currently pregnant with my second child. My first was born in 2012, nearly 10 years after my abortion. It’s not easy to parent or be pregnant, and each pregnancy reaffirms the decision I made many years ago. I’m appalled that some members of Congress continue to make racist and sexist assumptions about the reproductive decision-making of women of color. The decision to terminate a pregnancy or carry one to term is a difficult and personal one based on every woman and her family’s circumstances. This legislation is discriminatory, misguided and completely unnecessary. “

Sarina Irizarry, San Francisco, California, 2014

Maryam Janani, San Antonio, Texas, 2011

Ruth Jeannoel, Boston, Massachusetts, 2004

Aziza Jones, Chicago, Illinois, 2012

Shivana Jorawar, New York City, New York, 2002

Kristine A. Kippins, New York City, New York, 1999



Sharon Lagos, Albuquerque, New Mexico, 2016  
“Abortion is our desition, nobody can decide for our body.”

Stephanie, Laster, Pensacola, Florida, 1978; 1980

Melissa Madera, New York City, New York, 1997

Phyllis Malone, Decatur, Georgia, 1977

Nia Martin-Robinson, Detroit, Michigan, 1999

Samantha Master

“PRENDA seeks to criminalize abortion, and is an affront to freedom, liberty and justice as articulated by the US constitution. This ploy to vilify women of color and roll back abortion rights must stop immediately.”

Shanelle Matthews, Pasadena, CA, 2002

La'Tasha Mayes, Philadelphia, Pennsylvania, 1996  
“#TrustBlackWomen”

Ileana Mendez-Penate, New York City, New York, 2010

Donna Morris, Pittsburgh, Pennsylvania, 1964

Jill Morrison, Cherry Hill, New Jersey, 1989

Brittany Mostiller-Keith, Chicago, Illinois, 2014

Daniela Ochoa Diaz, Washington, District of Columbia, 2015

Sofia Pena, McAllen, Texas, 2009

Imi Rashid, Dhaka, Bangladesh, 1993

Samantha Romero, El Paso, Texas, 2013

Elizabeth San Martin, Miami, Florida, 1999

“Fue una difcíl situación que marco mi vida y que gracias a que no tuve soporte calificado me sentí estigmatizada y dañada sicologicamente por los que no están de acuerdo con mi decision.”

Anise Simon, Chapel Hill, North Carolina, 2012

“My ex boyfriend was very educated and an accomplished leader in our community. I decided to get an abortion because we had only been dating for 10 months and I wasn't ready for kids. A couple of months after I had my abortion procedure, he became abusive. It took me two more

years to leave him. After we broke up, I found out that he owed thousands in back child support for children he hadn't seen in years. I was 23 at the time and making less per year than I owed in student loan debt. I'm 27 now and with someone who is very kind. I have a stable career now and I look forward to having children who will be very much wanted and brought into a safe and loving home.”

Valencia Smith, Atlanta, Georgia, 1985; 1986

Sonya Taylor, Hampton, Virginia, 1998

Rochelle Taylor, Atlanta, Georgia, 1981

Anne Timmons-Harris, Chicago, Illinois, 1973

Amanda Williams, Houston, Texas, 2009

Caitlin Williams, Elizabeth, New Jersey, 2009

“As a mixed-race Asian-American woman, I'm appalled to see members of Congress who have not and do not stand with communities of color insisting that PRENDA has our best interests at heart. How dare you use us as an excuse for this racist and sexist bill. Come to our communities and learn the issues that actually matter to us.”

Son Ah Yun, Atlanta, Georgia, 1993

Jennifer, New Orleans, Louisiana, 2012

Hearing on H.R. 4924,  
Prenatal Nondiscrimination Act (PRENDA) of 2016

**Letter from Asian American and Pacific Islander Community Organizations and Individuals  
April 21, 2016**

Chairman Franks, Ranking Member Cohen, and Members of the Subcommittee:

We are individuals and organizations that represent the Asian American and Pacific Islander community (AAPI), and we write today to register our opposition to H.R. 4924, the “Prenatal Nondiscrimination Act.” As organizations and members of the community, we want to improve the lives of Asian Americans and Pacific Islanders and welcome continued efforts to work with you on the issues that affect our community. However, this bill does nothing of the sort. Instead, this bill exploits our community in an attempt to limit abortion access for women of color, including AAPI women, and we stand firmly against it.

We are concerned this bill will perpetuate the dangerous stereotype that the AAPI community does not value the lives of girl children. By accusing AAPIs of choosing to have abortions because of a preference for sons to daughters, H.R 4924, accuses us of devaluing the lives of the women and girls in our families.

We condemn son preference in all its forms, if passed, this legislation will do nothing to address that issue. A real response to son preference would be to address social norms that devalue women and girls, and lead to son preference, not placing additional hurdles between women and their healthcare providers. This bill does nothing to address prevalent gender discrimination issues such as pay equity, gender-based violence or intimate partner violence.

By focusing on the AAPI community, this bill singles out the motivations behind our community’s need to access healthcare, a scrutiny that would not apply to others. A patient’s race or ethnicity should have no bearing on their ability to access healthcare.

AAPI women already face numerous hurdles to accessing healthcare, and if passed this bill would just exacerbate health disparities and put additional stigma on women of color. The existence of racial disparities in healthcare is a real problem. Nearly 9.3% of Asian Americans are uninsured while only 7.6% of the non-Hispanic, White population is without insurance.<sup>1</sup> Over 30% of Asian American women have not had a mammogram for the past two years, and 29.4% have not had a Pap-Test in three years.<sup>2</sup> In certain segments of the AAPI community, such as the Vietnamese-American community,

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<sup>1</sup> Jessica C. Smith & Carla Medalia, U.S. Census Bureau, *Health Ins. Coverage in the U.S.: 2014*, at 4 (Sept. 2015) <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf> .

<sup>2</sup> Am. Cancer Soc’y, *Cancer prevention and early detection facts and figures* at 42, 45 (2015-2016) <http://www.cancer.org/acs/groups/content/@research/documents/webcontent/acspc-045101.pdf> .

instances of cervical cancer are some of the highest in the country.<sup>3</sup> Additionally, women of color are diagnosed with HPV related cancer at higher rates than non-Hispanic White women.<sup>4</sup> Instead of addressing these critical issues, this bill exacerbates the disparities by further restricting certain women's access to comprehensive reproductive healthcare services, scrutinizing the health decisions of women of color, and penalizing healthcare providers who serve communities of color. Instead of empowering AAPI women, this bill implies that our community cannot make its own healthcare decisions.

We commend the goal of confronting race and sex discrimination. However, we strongly oppose H.R. 4924, as a wrong and deceptive approach to this important issue. We believe there are effective ways to take on the complex problems of racial and sex discrimination and we would welcome the opportunity to work with members of the subcommittee to advance legislation that would end discrimination in the United States.

Sincerely,

Organizations:

1. 18MillionRising.org
2. Asian American Psychological Association
3. Asian Pacific American Labor Alliance
4. Asian Pacific American Network of Oregon
5. Asian & Pacific Islander American Health Forum
6. Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
7. Collective Action for Safe Spaces
8. Hmong National Development
9. Jahajee Sisters
10. Lehmann Norman & Marcus
11. Medical Students for Choice
12. National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
13. National Asian Pacific American Women's Forum (NAPAWF)
14. National Council of Asian Pacific Americans (NCAPA)
15. National Council of Jewish Women Greater New Orleans Section
16. OCA - Asian Pacific Americans Advocates
17. Philadelphia South Asian Collective
18. Surge Reproductive Justice
19. Washington State Senator, 37th Legislative District

Individuals:

1. Aimee Thorne-Thomsen
2. Alice Polesky

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<sup>3</sup> Grace X. Ma et al., *Increasing Cervical Cancer Screening Among Viet. Am.: A Cmty-Based Intervention Trial*, 26 J. Health Care for the Poor and Underserved 2, 37 (May 2015).

<sup>4</sup> Ctr. for Disease Control and Prevention, *HPV in Cmty. of Color* (May 2015) <http://www.cdc.gov/features/preventhpv/>.

3. Alexandra DeMucha
4. Aleyne Larner
5. Amy Cross
6. Amy Tran
7. Anirvan Chatterjee
8. Anita Dharapuram
9. Arie Kroeger
10. Arpita Appannagari
11. Ashley Chan
12. A. Talbott
13. Aya Laurel Iwai-Folk
14. Barnali Ghosh
15. Benjamin De Guzman
16. Bianetth Valdez
17. Branan Edgens
18. Brooke McGee
19. Caitlin Ho
20. Carol Cantwell
21. Casey Sweeney
22. Chi Nguyen
23. Chitra Panjabi
24. Christine Ma
25. Christopher Kang
26. Chris Neff
27. Claudia Leung
28. Cole Parke
29. Cyndy Yu-Robinson
30. Cynthia Harbottle
31. Daniel Weeks
32. Dawn Albanese
33. Deepa Iyer
34. Denise Heitzenroder
35. Denise Tomasini
36. Devan Shea
37. Dinh Tran-Phuong
38. Dolly John
39. Elizabeth Adams
40. Elizabeth Watts White
41. Elsa Batica
42. Elyse Tuennerman
43. Emily Godfrey
44. Erika Walker
45. Eunice How
46. Eve Lo
47. Florence Chien
48. Gay Watmore
49. Gina Charusombat
50. Gladys Nubla

51. Gregory Cendana
52. Harmony Glenn
53. Hedy Tripp
54. Helen Babb
55. Henry Weinberg
56. Hoi-Fei Mok
57. Hye-Kyung Kang
58. IP Reid-Eaton
59. Irini Neofotistos
60. Ivy Yan
61. Jamie Lau
62. Janet Chung
63. Janice Craft
64. Janie Anderson
65. Jennifer Chin
66. Jennifer Chou
67. Jennifer Woodruff
68. Jessica Cendana
69. Jessica Rooks
70. Jessica Scruggs
71. Jnana Hand
72. Joanne Huff
73. Joanne Rondilla
74. John Blocher
75. Jon Longsworth
76. Joyce Flight
77. Joyce Follet
78. Judy Tan
79. Judy Yu
80. Julie Burton
81. Julie Guzman
82. Julie Vang
83. Kalpana Ramakrishna
84. Kao Ly Her
85. Karen Shimamoto
86. Kathleen Bartolomei
87. Kathy Nakagawa
88. Kaylie Tram
89. Kellie Smith
90. Kelly Baden
91. Kelly Hill
92. Kelly Gilmore
93. Kimberly Moen
94. Kristine Egerman
95. Lan Nguyen
96. Laura Jimenez
97. Leah Bonnema
98. Leslie Wolfe

99. Li-hsia Wang
100. Linda Eales
101. Lindsay Imai Hong
102. Linda Yang
103. Lisa Ikemoto
104. Lisa Xiong
105. Lloyd Y. Asato
106. Maia Cole
107. Mai Yang
108. Mandy Clinton
109. Mansi Shah
110. Maren McConnell-Collins
111. Marilyn Keo
112. Mario Penalver
113. Marita Etcubanez
114. Maryellen Armour
115. Mary Tablante
116. Mary Williams
117. Mayra Roos
118. Meghan Faulkner
119. Melissa Mikesell
120. Melissa Kwon
121. Michelle Chen
122. Michelle Erenberg
123. Monica Lee
124. Nalini Velayudhan
125. Nga Bui
126. Nhia Lee
127. Nimra Chowdhry
128. Oanh-Nhi Nguyen
129. Payal Sharmacharya
130. Phiengtavanh Savatdy
131. Pia Cortez
132. Pooja Ghosh
133. Pramila Jayapal
134. Prashant Inamti
135. Pratima Gupta
136. Priya Murthy
137. Radhika Rajan
138. Rajani Bhatia
139. Ravina Daphtary
140. Rebecca Chan
141. Regina Ledesma
142. Ritu Tripathi
143. R. Sugawa
144. Ronald Tam
145. Sadia Arshad
146. Samina Jain

147. Sarah Felts
148. Saurav Sarkar
149. Shan Lin
150. Sharon Her
151. Sharon Maeda
152. Sheila Desai
153. Smita Nadia Hussain
154. SooJi Maranda
155. Sophia Ng
156. Soya Jung
157. Stanley Thangaraj
158. Stephanie Anderson
159. Stephanie Zhou
160. Sunanda Kishore
161. Susannah Baruch
162. Susie Han
163. Symone Ma
164. Tai-An Miao
165. Tallah Temple
166. Theresa Dinh
167. Tiffany Tai
168. Venus Thomas
169. Veronica Salcedo
170. Vicki Hurst
171. Viraj Patel
172. Ying Zhang
173. Yong Chan Miller
174. Zabrina Collazo