Chairman Burke, Vice-Chairman Huffman, Ranking Member Antonio, and members of this committee, I thank you for the opportunity to provide testimony in opposition to SB23. This is the sound of my son Ezra's heartbeat. This is the only way I'll ever hear it. I had an abortion at 17 weeks and 3 days after learning Ezra had died in utero sometime around 16 weeks gestation due to cord entanglement. When I share that with people, it causes confusion because people don't tend to recognize that after a fetal death, many women require a procedure to remove the fetal tissue and placenta and that procedure is an abortion. I am so grateful that I had multiple options that were compassionately explained to me and that I was able to choose a medication abortion. Misoprostol allowed me to deliver my son intact and I was able to hold him as was my husband and our three other children. We were able to cremate his remains. SB 23 does specify that physicians are not in violation of the law if a fetal heartbeat is not detected so in theory, women who suffer losses like mine would still legally be able to have an abortion to remove the remains. But, this assumes that any physician would still be willing to perform the procedure at all with the strict regulations regarding documentation and high stakes risks of felony charges and loss of medical licensure. Women like myself losing access to medical care and returning to a time when women were forced to carry their dead babies to term is just one of my concerns with SB23.

I have some additional technical concerns with the bill as I find it poorly written, vague, and based on an uninformed interpretation of an outdated study that is not generalizable. I also have concerns about abortion bans in general to share. Finally, as a Registered Nurse and a graduate student of public health policy, I have some suggestions for effective evidence-based policy that this committee might consider if a reduction in abortion rates is truly the intended purpose of SB23.

SB23 defines conception and the beginning of pregnancy as fertilization, which I understand aligns with current law but it does not align with medical practice which defines it as implantation. With contraceptive methods constantly under attack, I fear the implications this bill might have on access to both emergency contraceptives as well as hormonal birth control. These medications have the potential secondary mechanism of uterine wall changes. Some may argue this is equivalent to preventing implantation and is therefore an abortifacient.

The sponsor testimony and the bill itself reference a statistic from a "recent medical study" that providers will be mandated to share with women seeking abortions. That study is not at all recent by the standards of medicine as it was published in 1999 and the interpretation of that study demonstrates, with all due respect, why individuals who lack medical and research design knowledge should not be drafting legislation that dictates the practice of either. The study statistic calculated the percentage of women who carried to term after detection of the fetal heartbeat at either 8 or 10 weeks gestation which reflects the technology at the time. The study sample actually suffered miscarriage rates of 25% which is more consistent with CDC estimates, with most happening prior to 8 weeks. Today's ultrasound capabilities are more sophisticated and considering that the majority of abortions occur prior to 8 weeks anyway, the true estimation of carrying to term is closer to 75%. The results from this study are also not

generalizable as the sample was specifically looking at women who had suffered previous miscarriage and excluded women with various medical conditions and genetics. If we are going to force providers to “counsel” patients, we should at least provide true and accurate information. We should probably also include the statistics for maternal and infant death which are abysmal in Ohio at 42.3 and 720 per 100,000 respectively. To be thorough, we should include that the risks for women of color are 3 times that of white women, another disparity that Ohio has failed to address.

The sponsor testimony also attempts to assert that viability has no clear definition and that the fetal heartbeat is an acceptable one. I am disheartened to learn that a State Senator would use various dictionary definitions as the defense for this when the Supreme Court has given a clear definition of viability as “potentially able to live outside the mother’s womb, albeit with aide.” The sponsor testimony also describes the moving target that is viability in regards to medical advancement, but that was also already addressed by the Supreme Court in Casey.

My concerns with abortion bans in general, and SB 23 in particular, are that bans have a long history of helping no one while hurting many. Abortion bans simply do not lower abortion rates, this we know from decades of research from across the globe. Today’s home abortions are not being performed with hangers, but with readily available, inexpensive misoprostol that can be shipped to one’s door as easily as the fentanyl that Ohio has failed to prevent from entering via the mail. How does the state plan to enforce the ban? While the sponsor testimony focused on prosecution of physicians, the bill itself does not limit the felony charge to physicians but states any “person” or “individual” who performs an abortion which leads me to believe this is applicable to pregnant women themselves. The bill states no private identifiable information will be included in the investigation of abortions, but can we be certain this will not be disregarded if the state believes a woman has attempted an abortion herself? Will we begin investigating women who present to the hospital with hemorrhaging from the cervix? Perhaps this will become another crime of privilege where white women in suburban hospitals are admitted with “miscarriage” while impoverished women of color are handcuffed and charged with a felony while a nurse tries to pack her vagina with gauze. I am concerned about no exceptions for rape or incest which should require no explanation. I have an issue with no exceptions for fetal anomalies not compatible with life. While I’ve read proponent testimony that carrying to term and delivering to watch your child die in your arms was cathartic for some parents, I personally would choose a more humane option as I have seen firsthand what it looks like when a human gasps for air as their lungs fill with fluid at the end of their life and I would never torture my newborn that way. The difference is that I respect the autonomy of a parent enough to never dream of imposing my personal view of morality and values on another person via the law. The exception for saving the life of the mother in a medical emergency is appreciated, but too ambiguous to practically enforce. Who will be responsible for determining if the physician’s judgement indeed justifies an abortion?

What of a woman carrying twins who learns one baby is dying and jeopardizing the life of her healthy twin? We do nothing and allow them both to die? Now who is playing god with someone's life?

What of a woman with severe mental illness who takes medication not compatible with pregnancy? Do we force her to carry and accept that the baby will be severely injured or die due to her medication regimen? Can the law force her to stop taking her teratogenic medications? Will we just institutionalize her and restrain her until she can deliver?

What of a woman who has cancer? Is that enough of an emergency to justify abortion or is the increased risk of waiting 9 more months for treatment not enough of a threat to her life?

I could describe to you many situations too nuanced to be addressed by a ban such as SB 23 and while the illusion of physician discretion exists, we need to be honest that physicians will be unwilling to risk a felony charge and loss of their license for any of these ambiguous cases. Women and their unborn babies will be hurt by this poorly designed legislation.

I choose to believe that most individuals who support abortion bans do so with good intentions and desires to protect the potential of life. As a student of public health, I share the desire to reduce abortion rates and I support evidence-based policy that achieves that goal. SB 23 is not evidence-based. One specific example comes from South Carolina where abortion rates in one cohort where reduced by full 50% by a simple change in Medicaid reimbursement law that allowed an IUD to be placed during an inpatient stay. This meant postpartum mothers could receive long-acting birth control immediately, rather than waiting for a follow up appointment. Universal healthcare, access and affordability of birth control, particularly long-term birth control, investment in development of non-hormonal birth control and male birth control, comprehensive sex education, livable wages and equal pay, paid maternity and paternity leave, affordable housing and childcare, etc have been proven to lower abortion rates and support families. If those are truly the goals of this committee, I would urge you to oppose SB 23 and instead draft legislation that has a sound evidence-base, is constitutional, and will not hurt families like mine with the unintended consequences of a poorly drafted bill.