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"Combating Gender-Biased Sex Selection in Armenia"

Համառոտագիր
Policy Brief

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Legal Regulation of Sex Selection: Pros and Cons

ICHD Policy brief

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a Think Tank

Salient arguments against sex selection are numerous. These stress the harmful consequences of non-medical sex selection for the society, its controversiality for individuals and ambiguity in terms of professional ethics of service providers. Among the implications of sex selection are the harm to the offspring, as well as to women and men, misuse of medical resources for nonmedical purposes, and risks of discrimination and perpetuation of social injustice.

The weight of these arguments differs from country to country. Thus, in East Asia and the South Caucasus, sex selection leads to considerably skewed sex ratio at birth, whereas issues of medical ethics are voiced rarely. While sex selection has no significant impact on the demographic situation in the United States, the issues of medical ethics and the rights and freedoms of women and children are on the agenda there. As for Armenia, the public, including the authorities, are especially sensitive to severe demographic consequences and security challenges of sex selection practices and are mostly concerned about the issue of post-implantation method of sex selection, i.e. sex-selective abortions. Whereas sex selection through assisted reproductive technologies, though legally regulated (restricted), does not elicit public discussions on ethical issues. This may be accounted for by the fact that given the poverty of 1/3 of the population, the access to such services remains extremely limited for large groups of the society, and some technologies are even inaccessible at all. The significance of the arguments also depends on the size of the group of people in the country who wish to choose the sex of their child.

The most common measures to prevent non-medical sex selection practices are perhaps instruments of legal regulation: restrictions and bans. However, effectiveness of public policies and programs aimed at preventing gender-biased sex selection, particularly fetal sex selection and sex-selective abortions, has rarely been assessed anywhere in the world. While the final assessment of their impact is easily measureable by the sex ratio at birth, the role of regulation is not always clear in the end result, especially in cases when the country reasonably applies a comprehensive impact toolkit. Therefore, it is not surprising that analysts and groups protecting various interests often make substantially and sometimes even diametrically different assessments of the impact and effectiveness of a particular legal regulation.

Some people are enthusiastic about restrictions noting that they reflect the attitude of the authorities to the phenomenon and its dangers, while others argue that both restrictions and bans prove useless and unrealistic.

Arsenal of restrictions and bans

In *India,* since 1971 abortion has been legal up to 20 weeks of pregnancy for a broad range of indications: risk to the woman's life, threat to physical or mental health, contraceptive failure in married women, rape and fetal anomaly. Prenatal sex determination tests were banned in 1994 and the pre- and peri-conception techniques were prohibited in 2002. They were allowed in exclusive circumstances, including risk of chromosomal abnormalities in the case of women over 35 years, and genetic diseases evident in the family history of the married couple. However, before conducting any prenatal test or diagnostic procedure, the medical practitioner must obtain a written and informed consent from the pregnant woman. All the health facilities offering diagnostic and prenatal tests have compulsory visible warnings stating that sex detection tests are banned. The sale of ultrasonic machines is allowed only to registered health facilities. The penalties include seizure of machines, fines, different terms of imprisonment and revocation of medical license.

19 Sayat Nova
Yerevan 0001
Armenia

Tel.: +374 10 582638
Fax: +374 10 527082

mail@ichd.org
www.ichd.org

In *China,* abortion has been available and widely accessible since 1953, whereas sex selective abortion was prohibited in 1994. No criminal penalties are imposed for it. Prenatal sex determination tests were banned in 1989. Pre-implantation sex selection is also prohibited in case of in vitro fertilization. The marketing of ultrasonic B machines and other equipment used for prenatal diagnosis is limited and controlled. Medical and family planning organizations submit compulsory reports on the numbers of male and female newborns, and abortions and pregnancies, which have been subject to prenatal diagnosis of sex via various medical technologies. The penalties include fines and revocation of medical license. Fears of clandestine second trimester medical abortions for sex selection have resulted in banning the sale of medical abortion pills in several provinces in China.

In *Nepal,* abortion was legalized in 2002 and became available on request of a woman up to 12 weeks' gestation, up to 18 for limited conditions and at any time during pregnancy if her life is at risk or the fetus has congenital anomalies. Sex selective abortions are banned and penalties include up to 1-year imprisonment. Prenatal sex determination tests were banned in 2002. Penalties include 3-6 months imprisonment.

In *Vietnam,* abortion has been legal since 1960 and sex selective abortions were banned in 2003. Penalties include fines. Prenatal sex determination tests were banned in 2003. Offenders are fined; even disseminating materials on sex selection can incur a fine.

In *South Korea,* abortion was legalized in 1973 and allowed to save the life of the woman, for rape, incest and some birth defects, and medical conditions and is widely available in practice. While at the early stage of public policy implementation, the ultrasound technologies to determine the sex of the fetus for sex selection purposes were prohibited in 1987, but sex-selective abortions were never banned by law. Penalties increased in 1994 to include imprisonment, a fine up to 12,000 USD and revocation of the medical license. Currently, the restrictions on the fetal sex determination tests have been lifted.

Presently, eight states in the *US* have laws prohibiting sex-selective abortion at some point in pregnancy, including 1 state prohibiting abortions for reasons of race, 1 state prohibiting abortions when the fetus may have a genetic anomaly, 3 states requiring counseling on perinatal hospice services available before a woman may undergo an abortion if it may be due to a lethal fetal condition. Kansas requires counseling on such services before any abortion may be performed. The law in South Dakota requires physicians to "inquire into whether the pregnant mother knows the sex of her unborn child and if so, whether the mother is seeking an abortion due to the sex of the unborn child." Under the state laws banning sex-selective abortions, doctors who perform abortions based on a sex preference face various penalties: from jail time or fines, up to restrictions on practicing their professional activities and lawsuit for damages from a patient or her family. On the federal level, sex-selective abortion bans have been proposed four times in the House of Representatives; however, they were not passed.

In *Israel*, the pre-implantation genetic diagnosis (PGD) has been regulated by the Ministry of Health since 2005. In general, sex selective abortions are prohibited, but exceptions can be made for medical indications as well as by application for family balancing or emotional and religious reasons. Couples or single pregnant women can apply to the Committee of the Ministry for a permission for sex selective abortion if they feel that there would be significant damage to the family member's mental health if the procedure was not done. The applicants should be married and have four joint children of same sex and none of other. They must undergo genetic counseling about the pre-implantation genetic diagnosis, and give written consent.

In 36 countries, including *Armenia* and *25 European countries*, legislation bans or restricts to some extent sex selection using assisted reproductive technology. In Canada, assisted reproductive technology for sex selection for nonmedical purposes is prohibited as well. In Europe, the legislative regulation of the issue varies widely from country to country, which complicates its effective application given the possibility of free movement. In certain cases, the legislation of the countries is very liberal. Thus, Sweden has legalized abortions for all reasons up to the 18th week of pregnancy, even if the sex of the fetus is the basis for the request. As a result, the European families determined

to resort to sex selective abortions anyway, or to the use of assisted reproductive technology for sex selection, sometimes travel to special clinics or even abroad.

In *Great Britain*, any use of sex selection technology is subject to legal restrictions; only medical sex selection is currently legal. The Law of 2008 prohibits health facilities from selecting embryos of a particular sex, separating sperm samples or using separated sperm samples for the purpose of sex selection for social reasons or participating in any other practices designed to ensure that a resulting child will be of a particular sex.

In the *US*, there is no federal legislation preventing PGD for non-medical sex selection and it is regulated by state legislation. Despite the effective guidelines against such PGD, in practice such services are provided at many clinics.

Throwing out the baby, but not the bath water

Summing up the research and conclusions on the effectiveness of legislative bans and restrictions in various countries, it should be noted that the sex ratio at birth in many countries continued to worsen even after applying such restrictions. Despite the strict sanctions and restrictions introduced in some countries, sex-selective abortions remain common. Referring to the evidence, analysts argue that banning sex selective abortions has no effect on gender-biased sex selective practices.

The effectiveness of public policy based predominantly on legal restrictions does not seem sufficient; it is impossible to achieve social changes only by legal regulation and laws, and the methods based on fear and control cannot have a lasting effect. Even in case of imposing restrictions and sanctions on the services in demand by the society, families and individuals, these services are still provided driven by the very demand. Even with the best laws and legal systems, if people are convinced that the law is not for their welfare, they are likely to find ways to bypass them without much difficulty.

The expediency of legal regulation gets even more questionable given the insufficient efficienty of governance and high risks of corruption. Instead of promoting a favorable behavior among the citizens and the society for the solution of the problem, legal restrictions merely develop into a means to ensure an extra income for people responsible for the application of the restrictions. The interests of individual specialists as well as health facilities and their influential owners also have a significant role. The people responsible may turn a blind eye to the legality of the activity of particular health facilities or a specialist, and prosecute the other based on their personal or group interests. Issues of selective enforcement of legislation and corruption risks are of great concern.

Information about the sex of the fetus is mainly revealed to the pregnant woman or her family orally, or even through nonverbal communication. Therefore, there is either no evidence for such a practice, or even if there is, it is insubstantial. Physicians are part of the society and also carry in their system of values and approaches the roots of the son-preference culture; therefore, they often believe that by helping pregnant women and families in sex-selection they do a good job and in case of refusing to say the sex of the fetus, they would merely lose their patient who would get the same service from another doctor. Radiological services become more and more accessible and affordable. Moreover, radiological tests can be carried out at one health facility, and the abortion at another, where a woman can provide an absolutely different pretext for abortion; and given the ban of sex-selective abortions and restricted tests, the healthcare providers performing abortions mention totally legitimate reasons. Criminal prosecution appears extremely difficult, and investigations can take years before bringing charges. Under pressure to disclose offenders, authorities sometimes resort to unusual methods like monetary incentives to encourage informers, and a visit of a decoy patient to the health facilities with a hidden camera capturing their interaction with the medical personnel.

Restrictions also have a negative impact on control of the situation; health facilities previously leading an otherwise lawful practice, in many cases slip underground. Given the bans, healthcare workers face the risk of administrative and criminal prosecution and raise the price for tests to determine the sex of the fetus. The tests are offered without written evidence to escape possible legal actions. This situation makes it difficult to establish and exercise consistent control over the minimum quality standards of the services. Day by day, more and more "mobile clinics" mushroom, which are run by unqualified personnel using cheap portable ultrasound machines and offering services of questionable quality. Bans on cheap and affordable fetal sex-determination technology and tests are ineffective, since many individuals can purchase, install and operate them without any

professional intervention. In some countries, the low salaries of public sector doctors, underfunding of public hospitals and the dependence on informal fees force numerous doctors into the private sector, where the control over provision of demanded shadow services is problematic.

Bans on sex-selective abortions place the burden on medical providers; they have to question every woman's reasons for seeking an abortion. The legal liability for violating the bans and the exact indications imposed on healthcare providers increase their exposure to liability, which can further encourage them to deny such services in certain cases. In this sense, ban on sex-selective abortions threatens women's lives and health by making abortions harder to obtain for women who need them.

Indeed, a woman when denied the service and still facing the pressure by the environment may seek unsafe, harmful and illegal abortions. Bans on sex-selective abortions undermine women's autonomy and shift the focus to less effective solutions. The criminalization of the services undermines women's human rights by restricting access to safe abortion. Societies must take responsibility for pervasive expressions of gender preferences and stereotypes, and for their transformation, rather than avoid them by criminalizing sex-selective abortion and placing all the burden of a much larger societal problem on women and abortion providers at a high cost to women's health and dignity.

In the West, it is widely believed that bans on sex-selective abortions are part of the campaign against limiting abortion rights. While disguised as a means to eliminate gender discrimination, these laws make abortion less accessible, do not prohibit other sex selection methods and entrench the gender inequality more deeply by eroding a woman's basic and legal rights to make decisions about her own reproductive health

New laws or new values?

Hence, the international experience shows that the rigid and coercive intervention of the state may well provide a solution that causes more trouble, than the problem. A more effective alternative to restricting abortions, sex-selection and prenatal sex determination and combating the manifestations of gender-biased sex selection is combating the root causes of such practices, including gradually improvement of the status and social role of women, which will lead to giving equal importance to girl and boy children. The Armenian authorities should develop and enforce predominantly human-centered measures to increase the role of women, contribute to the well-being of families and security of the society, which should be voluntary in nature. Such approaches require better knowledge, greater ethical insights, more effective pragmatic attitudes, adequate public debate and dialogue, and full social engagements at local and national levels.

Legal restrictions and bans must complement the awareness campaigns, reforms and programs aimed at ensuring legal equality of men and women, only the joint application of which can change the cultural and economic pressures causing son-preference and sex-selective abortion. Service providers, health facilities, doctors and law-enforcement officers cannot alone prevent this practice and achieve results that can be achieved only through social change.

Even if combating the consequence of such practices in short terms is extremely important for the country and there is an evidence-based conviction that legal changes in the cultural context of our country can help to drive social changes, it should be still borne in mind that legal changes alone in practice have not stopped sex selection or reduced it effectively in any country so far.

Balanced and consistent, or sectorial and inappropriate?

The number of issues and concerns mentioned above were voiced previously at various policy-making platforms in Armenia. At the same time, the RA Government has initiated a package of legislative changes primarily aimed at imposing legal restrictions to prevent gender-biased sex selection in Armenia and stipulating administrative sanctions for violations. Relevant amendments are proposed to be made to the RA Law on Human Reproductive Health and Reproductive Rights and RA Code on Administrative Offences.

Further legal regulation initiatives may also include stipulating in the RA Law on Medical Aid and Service to the Population (Article 9) a provision banning sex-selective abortions except for medical indications. The procedure for application of assisted reproductive technology, the types of methods and medical practices may also include a provision excluding non-medical gender-biased sex selection. A similar provision should also be stipulated in the instruments regulating the medical aid and services through the use of assisted reproductive technology guaranteed free by the state or on preferential basis, as well as in the procedures for state-guaranteed medical aid and services through assisted reproductive technology for the residents of rural communities bordering with Azerbaijain, and in the scope of free gynecological medical aid and service of the free state-guaranteed obstetric and gynecological inpatient care.

The current initiatives of the Government on introducing legislative restrictions and the above-mentioned proposals for legal regulation fortunately are complemented with the initiatives supported by the European Union and the RA authorities, which mostly aim at public awareness, appreciation of girl children, transformation of stereotypes feeding into discrimination, and development of the human capital and institutional capacities required to achieve such transformations.

Armenia ranges among the three worst countries in the world in terms of disproportionate sex ratio at birth. However, with comprehensive and thorough, sensible and balanced, consistent and relevant steps, in the near future Armenia can become the first country in the world to significantly overcome the disproportionate sex ratio at birth in the shortest terms.

The paper is elaborated based on the analysis of Armenian and international practices of sex selection and relevant policies to address the issue, and the opinions of independent analysts, government officials, and representatives of international organizations who participated in working meetings and round tables, organised in 2015 – 2016 within the framework of the project "Combating Gender-Biased Sex Selection in Armenia", funded by the European Union.