SUSAN B. ANTHONY AND FREDERICK DOUGLASS PRENATAL NONDISCRIMINATION ACT OF 2011

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

H.R. 3541

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APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

SUSAN B. ANTHONY AND FREDERICK DOUGLASS PRENATAL NONDISCRIMINATION ACT OF 2011

TUESDAY, DECEMBER 6, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CONSTITUTION,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:12 p.m., in room 2141, Rayburn House Office Building, the Honorable Trent Franks (Chairman of the Subcommittee) presiding.

Present: Representatives Franks, Pence, Chabot, Forbes, King, Jordan, Conyers, Scott, and Quigley.

Staff Present: (Majority) Paul Taylor, Subcommittee Chief Counsel; Jacki Pick, Counsel; Sarah Vance, Clerk; (Minority) David Lachmann, Subcommittee Staff Director; and Veronica Eligan, Professional Staff Member.

Mr. FRANKS. This meeting will come to order.

I want to welcome all of you here today. We are grateful for your attendance, grateful to the people of this panel for being here with us. And I am going to go ahead and recognize myself for 5 minutes for an opening statement.

Given the subject of this hearing, it seems appropriate to me that we all remind ourselves that the very bedrock foundation principle that gave birth to America in the first place was the conviction that all human beings are children of God and created equal in his sight.

Throughout America's history, we have struggled to fulfill that conviction in our national life. It took a civil war in this Nation to make the 7,000-year-old state-sanctioned practice of human slavery come to an end, and, ultimately, it did so across the world. American women overcame the mindless policy that deprived them of the right to vote in America. Then this Nation charged into Europe and arrested the hellish Nazi Holocaust. We crushed the Ku Klux Klan and prevailed in the dark days of our own civil rights struggle.

And, in so many ways, we have made great progress in the area of civil rights in this country. But there is one glaring exception. We have overlooked unborn children and that life itself is the most foundational of all civil rights.

The result is that today in America between 40 and 50 percent of all African American babies, virtually one in two, are killed be-

fore they are born, which is a greater cause of death for African Americans than heart disease, cancer, diabetes, AIDS, and violence combined. A Hispanic child is three times more likely to be aborted than a White child. A Black child is five times more likely to be aborted than a White child. Fourteen million Black babies have been aborted since *Roe v. Wade*. It translates to fully one-fourth of the African American population in America today.

Now, you add to that the thousands of little girls who have been aborted in America simply because they are little girls instead of little boys. And these are travesties that should assault the mind and conscience of every American.

The Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act heard today by this Committee will help prevent race and sex discrimination against the unborn by prohibiting anyone from subjecting them to an abortion based on their sex or race.

Now, there will be those who say that this bill has a much larger agenda, and let me respond simply by saying that I sincerely and passionately hope that they are right. I truly hope that the debate and passage of this bill will call all Americans, in and outside of Congress, to an inward and heartfelt reflection upon the humanity of unborn children and the inhumanity of what is being done to them in 2011 in the land of the free and the home of the brave.

But, until then, can we not, at the very least, agree that it is wrong to knowingly kill unborn children because they are the wrong color or because they are baby girls instead of baby boys?

You know, I have often asked myself what finally enlightened and changed the hearts of those across history who either perpetrated or supported or ignored the atrocities in human genocides of their day. And while I probably will never truly understand, I believe I caught a glimpse of that answer during the Thanksgiving recess from my 3-year-old little girl named Gracie.

As we were watching her favorite laughing baby videos on YouTube, I inadvertently clicked on a video that showed a young man from China playing poignant and beautiful music on the piano with his feet because he had no arms. They had been amputated when he was a child.

My little girl looked at me with wet little eyes and she said, "Daddy, he doesn't have any arms." I said, "Yes, baby, but look how well he plays the piano with his feet. Isn't that amazing?" And she said, "Yes, but, Daddy, we have to help him. We have to get some arms to give to him." And I said, "Baby, there aren't any extra arms. They are all attached to other people already." And she thought for a moment, and she held up her own little arm and she said, "Daddy, we can give him one of my arms if it will fit on him, can't we?"

I believe the key to answering some of these seemingly unanswerable questions facing the human family is in how we see each other. On that video I saw an amazing young man who played heart-stirring music with his feet, but my little girl saw a child of God who had no arms and wanted to give him one of hers. How very thankful I am that my little girl was not one of the hundreds of millions of little girls whose lives and hearts were taken from this world before they ever saw the light of sunrise simply because they were little girls.

Across human history, the greatest voices among us have always emphasized the critical responsibility of each us to recognize and cherish the divine light of eternity shining in the soul of every last one of our fellow human beings. In 1847, Frederick Douglass said, "Right is of no sex, truth is of no color. God is the father of us all, and all are brethren." In Matthew 25, Jesus said, "Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me." Thomas Jefferson said, "The care of human life and its happiness, and not its destruction, is the chief and only object of good government."

So, ladies and gentlemen, I know that when the subject is related in any way to abortion the doors of reason and human compassion in our minds and hearts often close and the humanity of the unborn can oftentimes no longer be seen. But this is the civil-rights struggle that will define our generation, and I hope this hearing today will begin to open those doors again.

The bill, H.R. 3541, follows:]

I

112TH CONGRESS
1ST SESSION

H. R. 3541

To prohibit discrimination against the unborn on the basis of sex or race, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 1, 2011

Mr. FRANKS of Arizona (for himself, Mr. COLE, Mr. HUELSKAMP, Mr. LANKFORD, Mr. FLEMING, Mr. BISHOP of Utah, Mr. PENCE, Mr. CHABOT, Mr. POSEY, Mr. GRAVES of Georgia, Mr. GOHMERT, Mr. HULTGREN, Mr. GARRETT, Mrs. SCHMIDT, Mr. BRADY of Texas, Mr. FORBES, Mr. WILSON of South Carolina, Mr. STUTZMAN, Mrs. LUMMIS, Mr. ROE of Tennessee, Mr. NEUGEBAUER, Mr. HARRIS, Mr. YODER, Mr. WALBERG, Mr. BOREN, Mr. BARTLETT, Mr. SMITH of Texas, Mr. LIPINSKI, Mrs. BLACK, Mr. BOUSTANY, Mr. WESTMORELAND, Mr. PEARCE, Mr. HUIZENGA of Michigan, Mr. ROSS of Florida, Mr. KINZINGER of Illinois, Mr. BURTON of Indiana, Mr. AKIN, Mr. FORTENBERRY, Mr. JONES, Mr. DUNCAN of Tennessee, Mrs. BLACKBURN, Mr. CRAWFORD, Mr. MCCAUL, Mr. BROUN of Georgia, Mr. MANZULLO, Mr. MCHENRY, Mr. LATTA, Mrs. ROBY, Mr. SCALISE, Mr. FARENTHOLD, Mr. MCCOTTER, Mr. COBLE, Mr. MILLER of Florida, Mr. PETERSON, and Mr. SMITH of New Jersey) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To prohibit discrimination against the unborn on the basis of sex or race, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011".

SEC. 2. FINDINGS AND CONSTITUTIONAL AUTHORITY.

(a) FINDINGS.—The Congress makes the following findings:

(1) SEX DISCRIMINATION FINDINGS.—

(A) Women are a vital part of American society and culture and possess the same fundamental human rights and civil rights as men.

(B) United States law prohibits the dissimilar treatment of males and females who are similarly situated and prohibits sex discrimination in various contexts, including the provision of employment, education, housing, health insurance coverage, and athletics.

(C) Sex is an immutable characteristic ascertainable at the earliest stages of human development through existing medical technology and procedures commonly in use, including maternal-fetal bloodstream DNA sampling, amniocentesis, chorionic villus sampling or "CVS", and obstetric ultrasound. In addition to medically assisted sex-determination, a growing sex-determination niche industry has developed

and is marketing low-cost commercial products, widely advertised and available, that aid in the sex determination of an unborn child without the aid of medical professionals. Experts have demonstrated that the sex-selection industry is on the rise and predict that it will continue to be a growing trend in the United States. Sex determination is always a necessary step to the procurement of a sex-selection abortion.

(D) A ''sex-selection abortion'' is an abortion undertaken for purposes of eliminating an unborn child of an undesired sex. Sex-selection abortion is barbaric, and described by scholars and civil rights advocates as an act of sex-based or gender-based violence, predicated on sex discrimination. Sex-selection abortions are typically late-term abortions performed in the 2nd or 3rd trimester of pregnancy, after the unborn child has developed sufficiently to feel pain. Substantial medical evidence proves that an unborn child can experience pain at 20 weeks after conception, and perhaps substantially earlier. By definition, sex-selection abortions do not implicate the health of the mother of the

unborn, but instead are elective procedures motivated by sex or gender bias.

(E) The targeted victims of sex-selection abortions performed in the United States and worldwide are overwhelmingly female. The selective abortion of females is female infanticide, the intentional killing of unborn females, due to the preference for male offspring or ''son preference''. Son preference is reinforced by the low value associated, by some segments of the world community, with female offspring. Those segments tend to regard female offspring as financial burdens to a family over their lifetime due to their perceived inability to earn or provide financially for the family unit as can a male. In addition, due to social and legal convention, female offspring are less likely to carry on the family name. ''Son preference'' is one of the most evident manifestations of sex or gender discrimination in any society, undermining female equality, and fueling the elimination of females' right to exist in instances of sex-selection abortion.

(F) Sex-selection abortions are not expressly prohibited by United States law or the

laws of 47 States. Sex-selection abortions are performed in the United States. In a March 2008 report published in the Proceedings of the National Academy of Sciences, Columbia University economists Douglas Almond and Lena Edlund examined the sex ratio of United States-born children and found "evidence of sex selection, most likely at the prenatal stage". The data revealed obvious "son preference" in the form of unnatural sex-ratio imbalances within certain segments of the United States population, primarily those segments tracing their ethnic or cultural origins to countries where sex-selection abortion is prevalent. The evidence strongly suggests that some Americans are exercising sex-selection abortion practices within the United States consistent with discriminatory practices common to their country of origin, or the country to which they trace their ancestry. While sex-selection abortions are more common outside the United States, the evidence reveals that female feticide is also occurring in the United States.

(G) The American public supports a prohibition of sex-selection abortion. In a March

2006 Zogby International poll, 86 percent of Americans agreed that sex-selection abortion should be illegal, yet only 3 States proscribe sex-selection abortion.

(H) Despite the failure of the United States to proscribe sex-selection abortion, the United States Congress has expressed repeatedly, through Congressional resolution, strong condemnation of policies promoting sex-selection abortion in the "Communist Government of China". Likewise, at the 2007 United Nation's Annual Meeting of the Commission on the Status of Women, 51st Session, the United States delegation spearheaded a resolution calling on countries to condemn sex-selective abortion, a policy directly contradictory to the permissiveness of current United States law, which places no restriction on the practice of sex-selection abortion. The United Nations Commission on the Status of Women has urged governments of all nations "to take necessary measures to prevent . . . prenatal sex selection".

(I) A 1990 report by Harvard University economist Amartya Sen, estimated that more than 100 million women were "demographically

missing'' from the world as early as 1990 due to sexist practices, including sex-selection abortion. Many experts believe sex-selection abortion is the primary cause. Current estimates of women missing from the world range in the hundreds of millions.

(J) Countries with longstanding experience with sex-selection abortion—such as the Republic of India, the United Kingdom, and the People's Republic of China—have enacted restrictions on sex-selection, and have steadily continued to strengthen prohibitions and penalties. The United States, by contrast, has no law in place to restrict sex-selection abortion, establishing the United States as affording less protection from sex-based feticide than the Republic of India or the People's Republic of China, whose recent practices of sex-selection abortion were vehemently and repeatedly condemned by United States congressional resolutions and by the United States Ambassador to the Commission on the Status of Women. Public statements from within the medical community reveal that citizens of other countries come to the United States for sex-selection procedures that

would be criminal in their country of origin. Because the United States permits abortion on the basis of sex, the United States may effectively function as a "safe haven" for those who seek to have American physicians do what would otherwise be criminal in their home countries—a sex-selection abortion, most likely late-term.

(K) The American medical community opposes sex-selection abortion. The American College of Obstetricians and Gynecologists, commonly known as "ACOG", stated in its February 2007 Ethics Committee Opinion, Number 360, that sex-selection is inappropriate for family planning purposes because sex-selection "ultimately supports sexist practices". Likewise, the American Society for Reproductive Medicine has opined that sex-selection for family planning purposes is ethically problematic, inappropriate, and should be discouraged.

(L) Sex-selection abortion results in an unnatural sex-ratio imbalance. An unnatural sex-ratio imbalance is undesirable, due to the inability of the numerically predominant sex to find mates. Experts worldwide document that a significant sex-ratio imbalance in which males

numerically predominate can be a cause of increased violence and militancy within a society. Likewise, an unnatural sex-ratio imbalance gives rise to the commoditization of humans in the form of human trafficking, and a consequent increase in kidnapping and other violent crime.

(M) Sex-selection abortions have the effect of diminishing the representation of women in the American population, and therefore, the American electorate.

(N) Sex-selection abortion reinforces sex discrimination and has no place in a civilized society.

(2) RACIAL DISCRIMINATION FINDINGS.—

(A) Minorities are a vital part of American society and culture and possess the same fundamental human rights and civil rights as the majority.

(B) United States law prohibits the dissimilar treatment of persons of different races who are similarly situated. United States law prohibits discrimination on the basis of race in various contexts, including the provision of em-

ployment, education, housing, health insurance coverage, and athletics.

(C) A "race-selection abortion" is an abortion performed for purposes of eliminating an unborn child because the child or a parent of the child is of an undesired race. Race-selection abortion is barbaric, and described by civil rights advocates as an act of race-based violence, predicated on race discrimination. By definition, race-selection abortions do not implicate the health of mother of the unborn, but instead are elective procedures motivated by race bias.

(D) Only one State, Arizona, has enacted law to proscribe the performance of race-selection abortions.

(E) Race-selection abortions have the effect of diminishing the number of minorities in the American population and therefore, the American electorate.

(F) Race-selection abortion reinforces racial discrimination and has no place in a civilized society.

(3) GENERAL FINDINGS.—

(A) The history of the United States includes examples of both sex discrimination and race discrimination. The people of the United States ultimately responded in the strongest possible legal terms by enacting constitutional amendments correcting elements of such discrimination. Women, once subjected to sex discrimination that denied them the right to vote, now have suffrage guaranteed by the 19th amendment. African-Americans, once subjected to race discrimination through slavery that denied them equal protection of the laws, now have that right guaranteed by the 14th amendment. The elimination of discriminatory practices has been and is among the highest priorities and greatest achievements of American history.

(B) Implicitly approving the discriminatory practices of sex-selection abortion and race-selection abortion by choosing not to prohibit them will reinforce these inherently discriminatory practices, and evidence a failure to protect a segment of certain unborn Americans because those unborn are of a sex or racial makeup that is disfavored. Sex-selection and race-selection

abortions trivialize the value of the unborn on the basis of sex or race, reinforcing sex and race discrimination, and coarsening society to the humanity of all vulnerable and innocent human life, making it increasingly difficult to protect such life. Thus, Congress has a compelling interest in acting—indeed it must act—to prohibit sex-selection abortion and race-selection abortion.

(b) CONSTITUTIONAL AUTHORITY.—In accordance with the above findings, Congress enacts the following pursuant to Congress' power under—

(1) the Commerce Clause;

(2) section 2 of the 13th amendment;

(3) section 5 of the 14th amendment, including the power to enforce the prohibition on government action denying equal protection of the laws; and

(4) section 8 of article I to make all laws necessary and proper for the carrying into execution of powers vested by the Constitution in the Government of the United States.

SEC. 3. DISCRIMINATION AGAINST THE UNBORN ON THE BASIS OF RACE OR SEX.

(a) IN GENERAL.—Chapter 13 of title 18, United States Code, is amended by adding at the end the following:

"§ 250. Discrimination against the unborn on the basis of race or sex

"(a) IN GENERAL.—Whoever knowingly—

"(1) performs an abortion knowing that such abortion is sought based on the sex, gender, color or race of the child, or the race of a parent of that child;

"(2) uses force or the threat of force to intentionally injure or intimidate any person for the purpose of coercing a sex-selection or race-selection abortion;

"(3) solicits or accepts funds for the performance of a sex-selection abortion or a race-selection abortion; or

"(4) transports a woman into the United States or across a State line for the purpose of obtaining a sex-selection abortion or race-selection abortion;

or attempts to do so, shall be fined under this title or imprisoned not more than 5 years, or both.

"(b) CIVIL REMEDIES.—

"(1) CIVIL ACTION BY WOMAN ON WHOM THE ABORTION IS PERFORMED.—A woman upon whom an abortion has been performed or attempted in violation of subsection (a)(2), may in a civil action against any person who engaged in the violation obtain appropriate relief.

"(2) CIVIL ACTION BY RELATIVES.—The father of an unborn child who is the subject of an abortion performed or attempted in violation of subsection (a), or a maternal grandparent of the unborn child if the pregnant woman is an unemancipated minor, may in a civil action against any person who engaged in the violation, obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

"(3) APPROPRIATE RELIEF.—Appropriate relief in a civil action under this subsection includes—

"(A) objectively verifiable money damages for all injuries, psychological and physical, including loss of companionship and support, occasioned by the violation of this section; and

"(B) punitive damages.

"(4) INJUNCTIVE RELIEF.—

"(A) IN GENERAL.—A qualified plaintiff may in a civil action obtain injunctive relief to prevent an abortion provider from performing or attempting further abortions in violation of this section.

"(B) DEFINITION.—In this paragraph the term 'qualified plaintiff' means—

"(i) a woman upon whom an abortion is performed or attempted in violation of this section;

"(ii) any person who is the spouse or parent of a woman upon whom an abortion is performed in violation of this section; or

"(iii) the Attorney General.

"(5) ATTORNEYS FEES FOR PLAINTIFF.—The court shall award a reasonable attorney's fee as part of the costs to a prevailing plaintiff in a civil action under this subsection.

"(c) LOSS OF FEDERAL FUNDING.—A violation of subsection (a) shall be deemed for the purposes of title VI of the Civil Rights Act of 1964 to be discrimination prohibited by section 601 of that Act.

"(d) REPORTING REQUIREMENT.—A physician, physician's assistant, nurse, counselor, or other medical or mental health professional shall report known or suspected

violations of any of this section to appropriate law enforcement authorities. Whoever violates this requirement shall be fined under this title or imprisoned not more than 1 year, or both.

"(e) EXPEDITED CONSIDERATION.—It shall be the duty of the United States district courts, United States courts of appeal, and the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of any matter brought under this section.

"(f) EXCEPTION.—A woman upon whom a sex-selection or race-selection abortion is performed may not be prosecuted or held civilly liable for any violation of this section, or for a conspiracy to violate this section.

"(g) DEFINITION.—The term 'abortion' means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child, unless the act is done with the intent to—

"(1) save the life or preserve the health of the unborn child;

"(2) remove a dead unborn child caused by spontaneous abortion; or

"(3) remove an ectopic pregnancy.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 13 of title 18, United States Code, is amended by adding after the item relating to section 249 the following new item:

"250. Discrimination against the unborn on the basis of race or sex.".

SEC. 4. SEVERABILITY.

If any portion of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the portions or applications of this Act which can be given effect without the invalid portion or application.

○

Mr. FRANKS. And, with that, I would like to yield to the distinguished former Chairman of the full Committee, Mr. Conyers, for an opening statement.

Mr. CONYERS. Thank you, Chairman. I am happy to join you today.

I begin with a question about the title of this bill. Is there anybody on this Committee that can explain to me why this is called the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act?

Mr. FRANKS. I will try to explain it as best I can, Mr. Chairman.

First of all, you know, Frederick Douglass fought for equal rights back in the days of slavery and was someone that had great ability to speak into the heart of Abraham Lincoln and probably made a profound difference today. And, secondly, Susan B. Anthony was a tremendous advocate for women's right.

And we are convinced that, at the very heart of this bill, that there is an effort here to try to carry on with those traditions and felt like this would be a good way to honor their service to mankind.

Mr. CONYERS. Well, I have studied Frederick Douglass more than you, and I have never heard or read about him saying anything about prenatal nondiscrimination in the course of it. And I would invite you to put into the record just exactly why you put his name to this bill.

Susan B. Anthony I know less about, but I can—I know she was a strong advocate for women's rights.

So I think this bill is a—the names are complete misnomers. And I think when we find out more about their careers, their speeches, their writings, their actions, I think that we will all find out that there is no relation whatsoever to the object of this measure and the two revered leaders whose names are on the title of this measure.

What does the bill do? Oh, well, it makes it more difficult for women of color to obtain basic reproductive health-care services that should be available to all women. By threatening health-care professionals with prison time—that is what the bill does—it is inevitable that they will be reluctant to treat some patients, namely people of color, including Asian and Pacific Islanders, African Americans, interracial couples.

Where someone might suspect that race or sex selection may have been a factor in the patient's decision, doctors will be reluctant to perform any tests that might reveal the sex of the fetus or to reveal that information to their patients—information to which every patient has a right.

Now, in my view, this measure would provide an opportunity for a conservative court to attack the very legal underpinning of *Roe v. Wade*. And I was hoping that the distinguished Chairman would suggest that that was one of the accusations that are being made about the objective of this bill. And if he had said this, he would be right, because I think that this is a way of chipping away at *Roe v. Wade*.

Not since that decision has government ever arrogated to itself the power to decide whether a woman's reason for a pre-viability abortion is satisfactory. This bill would be the first. And the rea-

sons women have for terminating pregnancy is something I am not able to, nor particularly care to, go into. Indeed, some have long opposed exceptions for preserving the life or health of women in legislation that otherwise restricts the rights to abortion.

Take Henry Hyde, the former Chairman of this Committee. If he didn't argue 100 times that health and safety of the woman should be no reason for them to be permitted an abortion, he didn't say it once. He said it all the time, from the first time I met him in this Committee until his last day of service, particularly when he was Chairman of the Committee. He was wrong then, and those that argue that health and safety of a woman would not be grounds for an abortion are still as erroneous as this argument has always been.

Now, just recently, some in this Committee have opposed requiring hospitals to perform emergency-room abortions even when a woman's life is at stake—if you don't believe me, ask them—in the "No Taxpayer Funding for Abortion Act." And after public outrage forced many of my colleagues to remove language in the text of that bill designed to eliminate statutory rape for existing exceptions that permit a woman raped to obtain an abortion, my colleagues tried to resurrect the effort through Committee report language.

The measure before us does absolutely nothing to previde women with the tools they need to get adequate prenatal care so that their babies—female, male, Black, White, Asian, Latin—can come into the world healthy, and so that both mother and child can thrive. That is what we are here, or supposed to be here, for.

The measure before us, that we will hear from our distinguished witnesses, doesn't do a thing to empower women to make these important life choices free from any family or community pressures that they may now face either to have an abortion or to carry the pregnancy to term, or to not have an abortion. Remember, the right to choose is not limited to the right to end the pregnancy but includes the right to become pregnant and the right to bring a healthy child into the world. And so we must support women regardless of their choices and give them the tools to exercise those choices.

I can't explain how the Chairman of this Committee feels about these real issues behind the bill, but I, as usual, always give him the benefit of the doubt. But the title really ought to be changed, and I will be talking with him about this after this hearing.

This bill will not liberate or empower women but will further shackle them. This bill will not provide women with the ability to have a healthy child or have the tools necessary to raise that healthy child, well-educated, a full citizen of society, but this bill will, however, deprive women of their fundamental constitutional rights to personal and bodily autonomy.

And so, we are all free to pursue our conscience, and I am sure we will seek clarity and understanding from the distinguished witnesses before us. And it is with that spirit and that openness of mind that I attend and join these hearings and welcome the witnesses.

Thank you, Mr. Chairman.

Mr. FRANKS. And I thank the gentlemen.

At this time, other Members of the Subcommittee can be recognized for opening statements. And I now recognize the distinguished gentleman from Virginia, Mr. Forbes, for an opening statement.

Mr. FORBES. Thank you.

Mr. Chairman, I want to thank you for having this hearing. And I want to thank you, also, for something else, and that is for focusing your introductory remarks on the issue at hand.

Over and over again, we hear our friends from the other side, when it benefits them, saying, why aren't we looking at the actual provisions of the law? But we always have the same type of comments that come out.

First of all, we see the comment about, we just don't like the name of the bill. Well, I remember when we passed the Patient Protection and Affordable Care Act, many of us felt that that had nothing to do with patient protection. In fact, we hear from our clients over and over again how they feel it is hurting them and it is costing them more money. But that was the name. We would rather focus and debate the matters at hand on the bill.

Then we talk about all the red herrings about what this bill does not do. Because if we can't deal with the subject matter here—which is, when you focus it down, how does anybody really justify the sex selection or race selection for doing an abortion? And you can't. So what you talk about is all the things that the bill won't do.

And then the third thing we see, Mr. Chairman, is we love to talk about, look at all the things that proponents or people who might have been proponents, like the former Chairman, might have done on something else, because it gets us away from the focus of this bill.

And then, after we have said that, despite the fact of just delineating all the atrocities that will occur if the bill becomes law, we say the bill really won't do anything anyway.

And, Mr. Chairman, what I appreciate you doing is bringing this hearing so we can actually focus on the provisions of the bill and we can argue one issue, which is what is this bill says: Is it permissible, should it be policy this of this country, that we allow for sex-selection or race-selection abortions? And that is what is before us today.

And, Mr. Chairman, thank you for having this hearing. And I hope that is what ultimately our focus will be on.

And, with that, I yield back.

Mr. FRANKS. And I certainly thank the gentleman. And that is, indeed, our hope.

I would like to recognize now Mr. Quigley for an opening statement.

Mr. QUIGLEY. Thank you, Mr. Chairman.

Before we begin today's discussion, I want to make sure we are clear on an important point: Race- and gender-based abortions are two distinct issues and should be addressed as such.

On the issue of the supposed race-based abortions, the entire premise of the bill is wrongheaded. I must assume that the writers of the bill don't mean to imply that women of color would choose abortion as some sort of self-afflicted genocide. Abortion rates are

higher among Black women because Black women face unintended pregnancies at a rate much higher than the general population. And the reasons for these unintended pregnancies that have led to abortions are a lack of contraception access and proper use, according to a 2008 Guttmacher Institute report.

So if the proponents of this bill truly want to help minority women, they would support Title X funding for family-planning clinics like Planned Parenthood, comprehensive sex education, and the myriad of preventive health benefits such as free birth control and health-care reform. But they don't, which should tell us something about their true motivations behind the bill.

As for sex-selective abortions, I agree with this bill's proponents that abortions based on gender are a problem around the world. I agree that we must take action to stop these abusive practices both at home and around the world.

But here is where my agreement with the proponents of the bill stops. I haartily disagree with this remedy for this serious problem.

First, criminalizing such practices simply will not work. Banning sex-selective abortions has already been tried in various countries around the world, and what expert agencies, such as the World Health Organization, which operate in these countries have found is that, rather than preventing such abortions, bans simply result, "in a greater demand for clandestine procedures, which fall outside regulations, protocols, monitoring, and basic safety." In other words, rather than preventing abortions, which is what you want to do, such restrictions serve only to drive them underground, making them less safe. Our own history shores up this point, as well.

Second, criminalization of sex-selective abortions would force physicians to question women about their reasons for seeking an abortion and would likely compel physicians to target certain groups of women from cultural groups where sex selection is more prevalent. To avoid liability, physicians may even cease providing such care to entire groups of women simply because of their race. This bill would promote the very racial discrimination it purports to combat.

Additionally, targeting such motivations in practice would be nearly impossible. According to an analysis by the World Health Organization and four other U.N. agencies, "Prosecuting offenders is practically impossible," and "Proving that a particular abortion was sex-selective is equally difficult."

These expert international organizations do, however, offer a viable solution to address sex-selection abortions, a solution unmentioned in H.R. 3541: Address the root causes of son preference.

The United Nations, through its work in nations where sex selection is prevalent, has stated that the most effective way to address son preference is by fighting the root economic, social, and cultural causes of sex inequality. For instance, South Korea successfully lowered its male-female ratio from 116 boys for every 100 girls in the 1990's to the 107 boys per 100 girls in 2007 by passing laws to improve the legal status of women and by implementing a public education campaign emphasizing the importance of women.

So if the supporters of this bill are truly interested in preventing sex-selective abortions, I would like to invite them to join us in

supporting measures that will address the root causes of such abortions and empower women. Such measures include, but are not limited to, the Global Sexual and Reproductive Health Act, the Paycheck Fairness Act, and the Violence Against Women Act.

Sadly, I fear that supporters of H.R. 3541 will not champion these bills, because their true motivation behind this bill is not equal rights but, rather, a restriction of women's rights. This bill is a wolf in sheep's clothing which distorts the language of civil rights in order to further an ongoing attack on women's rights.

So I urge my colleagues not to be fooled by the rhetoric of this bill and to instead work together to pass measures that will empower women both at home and around the world.

Thank you.

Mr. FRANKS. I thank the gentleman.

And I now recognize the distinguished gentleman from Indiana, Mr. Pence, for an opening statement.

Mr. PENCE. Thank you, Mr. Chairman. And I would ask unanimous consent to revise and extend my remarks.

Mr. FRANKS. Without objection.

Mr. PENCE. Thank you.

I want to thank the Chairman for calling this hearing and for his unwavering leadership on this issue broadly. Those of us who have had the privilege of serving for a number of years with Congressman Franks know that he has been an eloquent and persistent advocate of the sanctity of life. And that is evidenced very clearly by his authoring the bill that is before us today.

I believe that ending an innocent human life is morally wrong, an abortion. But I also believe it would be morally wrong for American law to remain silent when that act is motivated by discrimination based on race or gender. I am a strong supporter and cosponsor of H.R. 3541, the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011," authored by this Chairman. And let us be clear on this point: I believe that abortion is heartbreaking in any circumstance, but it is particularly so when a child is aborted on the basis of race or gender.

The legislation before us today, commonly referred to as "PRENDA," would explicitly prohibit the coercion of either a sex-selection or race-selection abortion, as well as the solicitation or acceptance of funds for performing either procedure. It would also prohibit the transportation of women into the country or across State lines for the purpose of obtaining a sex-selection or race-selection abortion.

Notably, the pregnant woman is explicitly protected in this legislation from any penalties. However, those who coerce or facilitate an abortion on the basis of race or gender would be subject to all penalties under the Civil Rights Act of 1964.

Now, having glanced a bit at summaries of the testimony we will hear today, I know that there will be arguments made from this side of the panel and that, that this legislation is unnecessary or even frivolous. But I have to say, Mr. Chairman, the facts suggest otherwise.

Today, an African American unborn baby is five times as likely to be aborted as a White baby. And abortion, according to the Guttmacher Institute, I say with a heavy heart, abortion is now the

leading cause of death in the Black community, with more than 450,000 Black abortions per year. More African Americans are lost to abortion annually than are lost to cancer, heart disease, diabetes, AIDS, and violence combined. According to a 2008 report by the Guttmacher Institute, a Black baby, as I mentioned, is five times as likely to be aborted, and at least 42 percent of Black babies are aborted in this country every year.

The facts cry out for action. And that is action that this Nation and this Congress take a step one more time toward a more perfect union.

And over the course of our history, America has had anything but a perfect record on protecting civil rights. But we have ever strived toward that more perfect Union, ending the injustice of slavery through war and national travail, granting civil rights to women and minorities. And now I believe it is time for us to take the next step and extend those protections against discrimination within the womb itself in our march toward a more perfect Union.

One last note, Mr. Chairman. Perhaps the most compelling fact before this Committee today should be the realization that, while the United States has been on the record for some time condemning sex-selection abortion around the planet, our own laws are silent on the issue of sex- and race-selection abortion. Thanks to your leadership, Mr. Chairman, and I hope with the bipartisan support of Members of Congress, we will change that and we will see the laws of this Nation reflect our Nation's deep commitment to civil rights for the born and the unborn.

And I yield back.

Mr. FRANKS. Mr. Scott, do you have an opening statement, sir?

Mr. SCOTT. Thank you, Mr. Chairman.

I would just briefly say that I would hope we would be looking at a number of initiatives that would actually reduce the need for abortions, including health care, education, job training, and adoptions.

And I yield back the balance of my time.

Mr. FRANKS. Thank you, sir.

I now recognize the distinguished gentleman from Iowa, Mr. King, for an opening statement.

Mr. KING. Thank you, Mr. Chairman. I thank you personally and professionally and from the bottom of the hearts of my constituents for holding this hearing today and bringing forward this piece of legislation.

I thank the witnesses in advance. I very much look forward to your testimony.

I hear that phrase, "women and minorities." It comes through this legislation over and over again. If I had thought ahead, I would have done a search through the Federal Code to see how many times women and minorities are specifically protected in Federal law. It is over and over again. Dozens and dozens of times, this Congress, the voice the American people, have specifically defined women and minorities as being the very categories worthy of special protection, because, throughout the history of civilization, women and minorities have found themselves at a disadvantage and found themselves often the targets of some type of annihilation.

And I find it ironic to hear the Ranking Member of the full Committee's opening statement on this. When I go back and look at the 14th Amendment of the Constitution, "nor deny to any person the equal protection of the laws." When this Congress goes to such great lengths to specifically protect women and minorities, and the bill that is named after Frederick Douglass and Susan B. Anthony, it is very clear. The two people that are icons, that have done a great deal, and perhaps the most in each of their categories, for the rights and protection of minorities—Frederick Douglass, completely eloquent, and Susan B. Anthony—I don't think there is any question about why their names are in the title of this bill.

And I sit here and I listen and I think, what if I had advocated for a policy that would put 80 percent of the abortion clinics in the inner city, in the heart of the minority areas in this country, that resulted in half of the African American pregnancies becoming aborted or a high percentage of Hispanic pregnancies becoming aborted, if I advocated for such a policy, let alone a publicly funded policy, you all know what I would be called for such a thing. I oppose those policies.

And this bill defines a way that we can protect the innocent, unborn human lives that are targeted because of a bias against race and a bias against—we are calling it "sex" now, aren't we, instead of "gender." Why is that? It is because the definition of "gender" is what you think you are, and the definition of "sex" is what anybody can observe, any physician can observe, any layperson can figure out you are. Do you know why we use the term "sex" instead of "gender" with an unborn baby? Because they haven't had a chance to have a voice. They haven't said, "Here is my gender." So we identify them by "sex." That is the only way I know in this public policy anymore that we discuss "sex" as opposed to "gender." They don't have a voice for themselves.

And so we would have a discussion here about how we are somehow biased bringing forward to protect unborn human lives that are targeted because of race and gender, and that we should instead address the root causes of this being in the culture rather than put in law. Well, some will say you can't legislate morality, but the law is a reflection of our morality. It is the defined moral code of the United States of America. And that morality that is defined here by this Congress is a reflection of the culture and the people. And it is a restraint, and it is a guideline. And it does put a stigma in place, and it does advise the American people, who don't agree, that there is a strong majority position that protects the innocent, unborn lives especially of women and minorities.

From my standpoint, I wanted to take a lot of that special protection language out of there for the born people, because I think, to a large degree, it has served a successful purpose, and most people now do have something much closer to equal opportunity today than existed when I was a young man growing up. But here is where I say we need to continue to make the case. They don't have a voice for themselves. They never had the opportunity to breathe free air, never had the opportunity to go out and be successful, never had the opportunity to love or live or laugh or study or work or play or contribute to this country.

And I think that positions taken on the other side that say, "We can't criminalize it because it will just drive it underground," is a modern version of the coat-hanger argument. Yes, we can. We protect innocent, unborn human lives.

We need to have this discussion and this debate. The 14th Amendment says, "nor deny to any person the equal protection of the laws." And we will get to the point of what a person is in this discussion, in this debate. We need to protect and define a person in law. That is a constitutional protection. The only reason we allow abortion in this country and the way that we do elective abortion is because we have not defined personhood.

I would point out also that there is an industry in this country that is establishing sex selection in industry and advertising now worldwide and taking the claim that they are 100 percent efficient in identifying the sex, not the gender, of the unborn baby. And that is bringing about some 37 million more boys in China than there are girls in China. That is just one country. This is global. This is America, with a moral standard.

I thank the Chairman. I yield back the balance of my time.

Mr. FRANKS. And I thank the gentleman.

And we will now hear the opening statement of Mr. Chabot.

Mr. CHABOT. I thank the gentleman for yielding. And I want to especially thank the Chairman for holding this hearing today and his leadership in pushing the passage of this much-needed legislation.

Throughout the past several decades, our country has struggled to eliminate gender discrimination in our schools, in the courtrooms, in the workplace. Today, we face these types of discrimination in abortion procedures. These abortions not only terminate life, they also yield irreparable harm on the future of our Nation's diversity.

The harm goes beyond the performance of the abortions themselves; many of the women who have these abortions are abused and coerced into the procedure. A 2011 study by the University California at San Francisco interviewed Indian American women in California, New York, and New Jersey who had sought sex-selection abortions between the years 2004 and 2009. Nearly half of the participants had already had a sex-selection abortion, with some having as many as four sex-selection abortions. The women in this study talk about the forms of abuse and coercion they faced during that time.

When these Indian American women were asked why they sought sex selections, they often described the suffering of female relatives who had not given birth to sons. The pressure takes the form of social stigma and a lack of economic support and respectability, stability, et cetera. These concerns were found to be consistent among all socioeconomic levels, even among the 23 percent that held advanced degrees in medicine and law and scientific research.

In this study, women also frequently discussed instances where their husbands were abusive because they were bearing a female baby. Some husbands even reportedly withheld food and water from their wives. Some hit, punched, choked, and kicked the

women in the abdomen, attempting to forcibly terminate the pregnancy.

A growing body of research now documents the relationship between intimate partner violence and reproductive coercion, sometimes resulting in forced sex and denial of health-care services if pregnant. One-third of the women in this study reported that family violence was exacerbated when they did not give birth to a son. As a result, many of these women tragically faced psychological and physical morbidity.

What I find most heartbreaking is that many of these women expressed guilt, shame, and sadness over their inability to save the daughters that had been aborted. These women should not have to stand alone to save their daughters. It is time that we stand alongside them to protect life. And that is exactly what this bill will do.

A courageous woman of her time, Susan B. Anthony, said, "It was we, the people, not we, the White male citizens, nor yet we, the male citizens, but we, the whole people, who formed the Union." I believe the sanctity of life, all life, is precious and should be protected. We must firmly challenge these new discriminatory practices and stand for children of all races and genders, for it is this very diversity of race and gender that makes America great.

And I yield back, Mr. Chairman.

Mr. FRANKS. Thank you, Mr. Chabot, especially for quoting Susan B. Anthony. That was very appropriate. Thank you, sir.

And we have no other opening statements on this side, so, Mr. Jordan, I will recognize you, sir, for an opening statement.

Mr. JORDAN. I thank the Chairman.

I will just be brief, with just a couple thank you's. I, too, want to thank the Chairman, not just for this legislation, but for your commitment to protecting the sanctity of human life and highlighting this issue throughout your career. We truly appreciate that leadership and that hard work that you have done so well on this most fundamental of issues.

And, secondly, I just want to take a moment to thank the millions of pro-life people who, every single day, do things that they never get credit for, who sit down and counsel a teenager, who take baby supplies, who take clothes to the local crisis pregnancy center, who will take in unwed mothers in a difficult time. I want to thank all those people. They are the ones who make such a difference in advancing and protecting life.

This issue is going to highlight something that is terrible that is going on, but it is those people across this country who truly make a difference day-in and day-out. And I want to take just a few minutes and thank them again for their tireless efforts to recognize what the Founders understood, that all life is precious and it truly is a gift from God.

So, Mr. Chairman, thank you again for this opportunity and for this hearing.

Mr. FRANKS. And I thank the gentleman.

And, without objection, other Members' opening statements will be made a part of the record.

[The prepared statement of Mr. Smith follows:]

Statement of Judiciary Committee Chairman Lamar Smith
Hearing on H.R. 3541, the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) of 2011"
Tuesday, December 6, 2011

I thank Chairman Franks for his pro-life leadership on the issue to be discussed today.

The Prenatal Nondiscrimination Act, also called PRENDA, prohibits the performance of an abortion with the knowledge it was sought based on the race or sex of the child.

The bill also prohibits the solicitation or acceptance of funds for such purposes, and prohibits the federal funding of abortions based on race or sex.

As the *New York Times* has reported, "There is evidence that some Americans want to choose their babies' sex" through abortions.

U.S. Census numbers and national vital statistics show that certain communities achieve unnatural sex ratios at birth that are statistically impossible without medically assisted sex-selection, with the cheapest option being abortion.

These sex-selection abortions discriminate strongly against females, and they are overwhelmingly opposed by the American people. According to the most recent Zogby poll on the subject, 86% of those surveyed thought sex-selection abortions should be illegal.

Regardless of one's views on abortion generally, everyone should object to its practice on the grounds of race or sex. PRENDA prohibits abortions based on race or sex and imposes the same penalties for a violation of its provisions that are provided in the Civil Rights Act of 1964, including a loss of federal funding for offenders.

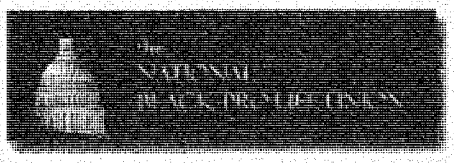
Arizona has already passed its own state-level version of PRENDA. The law passed both the Arizona House and Senate by over two-thirds margins. Similar bills have been introduced in seven other states.

It is time to end the practice of using race or sex as an excuse for abortion. And I thank Chairman Franks again for his leadership on this issue.

Mr. FRANKS. And, with unanimous consent, I would like to submit for the record the December 5, 2011, statement of Dr. Day Gardner on behalf of the National Black Pro-Life Union, addressed to the Chairman of the Subcommittee on the Constitution.

Without objection.

[The material referred to follows:]



December 5, 2011

To: Congressman Trent Franks, Chairman of the Subcommittee on the Constitution and Fellow Subcommittee Members:

Our nation is scarred by the battles of eradicating slavery and advancing civil rights for women and minorities. Though we have come a very long way toward achieving racial equality, instances of horrible discrimination are still tolerated.

In 1939, Margaret Sanger, founder of Planned Parenthood, the nation's largest abortion chain launched the Negro Project which was a program aimed specifically at limiting the growth of the black population in America by sterilization and abortion. The war against unborn black children started with the Sanger.

In 1971, Black Panther activist, Brenda Hyson realized there was a rising problem when she printed this statement in their New York newsletter: *"The abortion law, hides behind the guise of helping women, when in reality it will attempt to destroy our people."*

Then in 1977, the Reverend Jesse Jackson agreed. He stated: *"It is strange that they choose to start talking about population control at the same time that Black people in America and people of color around the world are demanding their rightful place as human citizens and their rightful share of the material wealth in the world."*

In 2006, Nicolas and Lola Kampf residents of Maine kidnapped their 19 year old daughter to force her to abort her baby because the father of the child was black.

Recently, Tom Metzger a former Klan leader who also founded White Aryan Resistance (WAR) promotes the placement of abortion clinics in Black Neighborhoods, he states: ***"...abortion and birth control should be promoted as a powerful weapon, in the limitation of non-White birth."***

In recent Live Action videos there were instances where Planned Parenthood representatives were willing to accept race-targeted donations, even to the point of being "excited" at the possibility of taking money specifically earmarked to kill a black baby.

Today, Planned Parenthood doesn't just operate an abortion program that disproportionately targets minorities—it operates such a program with tax dollars--your

money, my money. Planned Parenthood has received over three hundred million tax dollars each year.

Although U.S. law prohibits discrimination on the basis of race in various contexts, including the provision of employment, education and housing, African American babies are still openly targeted and discriminated against. Since 1973, Planned Parenthood has strategically planted its facilities throughout the United States, in areas heavily populated by Blacks and Hispanics. The Alan Guttmacher Institute, along with the Center for Disease Control and Prevention (CDC), show that the majority of abortion clinics are located in minority neighborhoods—experts estimate the number at higher than 75%. This is no accident.

Throughout our history, America has opened her arms to the masses. People from all over the world want to come here to experience for themselves what life and liberty and the pursuit of happiness really means. However, we are failing to protect our smallest Americans. America needs a law to prohibit the acceptance or solicitation of funds earmarked for aborting a child of a specific race. It is paramount that the federal government provides protection for these children. A person must not be denied life because of gender or the color of his or her skin. We must eliminate racism wherever it lives and the Pre-natal Nondiscrimination Act will do just that.

I strongly urge all members of Congress to support PreNDA.

Sincerely,

Dr. Day Gardner
President
National Black Pro-Life Union
P.O. Box 76452
Washington, DC 20013
202-834-0844
www.nationalblackprolifeunion.com

Mr. FRANKS. With unanimous consent, I would like to submit for the record the statement of Dr. Alveda King, director of African American outreach for Priests for Life, on the reintroduction of the Prenatal Nondiscrimination Act.

Without objection.

[The material referred to follows:]

STATEMENT OF DR. ALVEDA KING
on the Reintroduction of the
Prenatal Nondiscrimination Act

There's still a place in America where people can be killed because of their race or sex and the perpetrators go free. It's the abortion clinic.

The child whose father and mother are not of the same race; the baby girl whose parents come from a culture that devalues women; the minority baby whose mother listens to an abortionist who masks his racism in false "compassion;" all can be denied their lives and liberty today simply because of who they are.

There's no excuse why this should be tolerated.

The Prenatal Nondiscrimination Act would eliminate one of the last vestiges of government sanctioned bigotry. Abortionists would be placed on notice that they cannot take a baby's life simply because of that baby's race or sex. And women would be reminded that they cannot be coerced into ending their children's lives.

I want to thank Congressman Trent Franks for reintroducing this legislation and I want to encourage every Member of Congress to support it. A vote for PRENDA is a vote for equality and justice.

I also ask every citizen to call his or her congressional representative to urge cosponsorship of PRENDA.

Dr. Alveda King is the niece of Martin Luther King, Jr. and works fulltime for Priests for Life as Director of African-American Outreach. See www.AfricanAmericanOutreach.com.

Mr. FRANKS. Also, without objection, I would like to submit for the record the December 6, 2011, statement of Ms. Kristan Hawkins, executive director of Students for Life of America.

[The material referred to follows:]

STUDENTS FOR LIFE OF AMERICA

Equipping the Pro-Life Generation

December 6, 2011

Congressman Franks,

As one of the leading pro-life advocates in the House of Representatives during the 112th Congress, you have the praise and support of myself and the entire team at Students for Life of America for your tireless efforts in upholding the rights to life, liberty, and happiness for all citizens – born and pre-born - that are endowed to us through the promises of our Constitution.

As SFLA continues to expand our network of pro-life students across the nation and work to train, equip, and organize pro-life student leaders from coast-to-coast, we are in a unique position to witness and examine first-hand how the culture of death has indoctrinated our youth, our culture, and our media. Planned Parenthood targets college-aged women by promoting sexual promiscuity and is able to feed their multi-million dollar abortion industry by welcoming these young people back through their doors once faced with an unplanned pregnancy. As has been proven time and time again, Planned Parenthood also targets minorities. As the abortion giant touts the title for being the number one abortion provider in America, we also know that abortion is the number one cause of death for African Americans, slaying more every year than heart disease, cancer, strokes, accidents, diabetes, homicide, and chronic respiratory diseases combined.

Over 90% of pre-born children found to have a mental of physical disability in-utero will be aborted. Pre-born girls are also at risk of falling prey to abortion, with statistics showing that pre-born boys are far more likely to survive a pregnancy.

The Prenatal Nondiscrimination Act of 2011 is a giant leap forward for those seeking to squelch gender and racially-based abortions. Pre-born children who are susceptible to death based solely on their God-given identities are in greatest need of our protection and witness. Students for Life stands proudly next to you, Congressman Franks, in your attempt to silence the greatest social injustice our nation has ever faced. As fellow warriors on the front lines of the fight for Life, we recognize the two-fold need for the changing of hearts and minds of Americans in addition to promulgating pro-life legislation to continue to turn the tide in our nation and create an nation in which even the youngest and weakest among us can thrive.

Thank you.

For Life,

Kristan J. Hawkins

Kristan Hawkins
Executive Director, Students for Life of America

Mr. FRANKS. Also, the June 24, 2011, Wall Street Journal article, "The War Against Girls," by Mr. Jonathan Last.

[The material referred to follows:]

THE WALL STREET JOURNAL.
WSJ.com

BOOKSHELF | JUNE 24, 2011

The War Against Girls

Since the late 1970s, 163 million female babies have been aborted by parents seeking sons

By JONATHAN V. LAST

Mara Hvistendahl is worried about girls. Not in any political, moral or cultural sense but as an existential matter. She is right to be. In China, India and numerous other countries (both developing and developed), there are many more men than women, the result of systematic campaigns against baby girls. In "Unnatural Selection," Ms. Hvistendahl reports on this gender imbalance: what it is, how it came to be and what it means for the future.

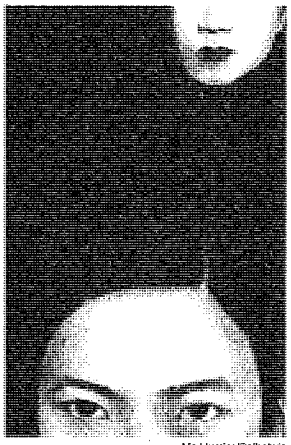
In nature, 105 boys are born for every 100 girls. This ratio is biologically ironclad. Between 104 and 106 is the normal range, and that's as far as the natural window goes. Any other number is the result of unnatural events.

Yet today in India there are 112 boys born for every 100 girls. In China, the number is 121—though plenty of Chinese towns are over the 150 mark. China's and India's populations are mammoth enough that their outlying sex ratios have skewed the global average to a biologically impossible 107. But the imbalance is not only in Asia. Azerbaijan stands at 115, Georgia at 118 and Armenia at 120.

What is causing the skewed ratio: abortion. If the male number in the sex ratio is above 106, it means that couples are having abortions when they find out the mother is carrying a girl. By Ms. Hvistendahl's counting, there have been so many sex-selective abortions in the past three decades that 163 million girls, who by biological averages should have been born, are missing from the world. Moral horror aside, this is likely to be of very large consequence.

In the mid-1970s, amniocentesis, which reveals the sex of a baby in utero, became available in developing countries. Originally meant to test for fetal abnormalities, by the 1980s it was known as the "sex test" in India and other places where parents put a premium on sons. When amnio was replaced by the cheaper and less invasive ultrasound, it meant that most couples who wanted a baby boy could know ahead of time if they were going to have one and, if they were not, do something about it. "Better 500 rupees now than 5,000 later," reads one ad put out by an Indian clinic, a reference to the price of a sex test versus the cost of a dowry.

But oddly enough, Ms. Hvistendahl notes, it is usually a country's rich, not its poor, who lead the way in choosing against girls. "Sex selection typically starts with the urban, well-educated stratum of society," she writes. "Elites are the first to gain access to a new technology, whether MRI scanners, smart phones—or ultrasound machines." The behavior of elites then filters down until it becomes part of the broader culture. Even more



Ma Liuming/Sotheby's

'No. 23' (2005-06), a painting by Ma Liuming.

Unnatural Selection: Choosing Boys Over Girls and the Consequences of a World Full of Men

By Mara Hvistendahl
PublicAffairs, 314 pages, $26.99

unexpectedly, the decision to abort baby girls is usually made by women—either by the mother or, sometimes, the mother-in-law.

If you peer hard enough at the data, you can actually see parents demanding boys. Take South Korea. In 1989, the sex ratio for first births there was 104 boys for every 100 girls—perfectly normal. But couples who had a girl became increasingly desperate to acquire a boy. For second births, the male number climbed to 113; for third, to 185. Among fourth-born children, it was a mind-boggling 209. Even more alarming is that people maintain their cultural assumptions even in the diaspora; research shows a similar birth-preference pattern among couples of Chinese, Indian and Korean descent right here in America.

Ms. Hvistendahl argues that such imbalances are portents of Very Bad Things to come. "Historically, societies in which men substantially outnumber women are not nice places to live," she writes. "Often they are unstable. Sometimes they are violent." As examples she notes that high sex ratios were at play as far back as the fourth century B.C. in Athens—a particularly bloody time in Greek history—and during China's Taiping Rebellion in the mid-19th century. (Both eras featured widespread female infanticide.) She also notes that the dearth of women along the frontier in the American West probably had a lot to do with its being wild. In 1870, for instance, the sex ratio west of the Mississippi was 125 to 100. In California it was 166 to 100. In Nevada it was 320. In western Kansas, it was 768.

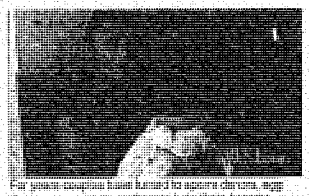
There is indeed compelling evidence of a link between sex ratios and violence. High sex ratios mean that a society is going to have "surplus men"—that is, men with no hope of marrying because there are not enough women. Such men accumulate in the lower classes, where risks of violence are already elevated. And unmarried men with limited incomes tend to make trouble. In Chinese provinces where the sex ratio has spiked, a crime wave has followed. Today in India, the best predictor of violence and crime for any given area is not income but sex ratio.

A high level of male births has other, far-reaching, effects. It becomes harder to secure a bride, and men can find themselves buying or bidding for them. This, Ms. Hvistendahl notes, contributes to China's astronomical household savings rate; parents know they must save up in order to secure brides for their sons. (An ironic reflection of the Indian ad campaigns suggesting parents save money by aborting girls.) This savings rate, in turn, drives the Chinese demand for U.S. Treasury bills.

And to beat the "marriage squeeze" caused by skewed sex ratios, men in wealthier imbalanced countries poach women from poorer ones. Ms. Hvistendahl reports from Vietnam, where the mail-order-bride business is booming thanks to the demand for women in China. Prostitution booms, too—and not the sex-positive kind that Western feminists are so fond of.

Related Video

The economist Gary Becker has noted that when women become scarce, their value increases, and he sees this as a positive development. But as Ms. Hvistendahl demonstrates, "this assessment is true only in the crudest sense." A 17-year-old girl in a developing country is in no position to capture her own value. Instead, a young woman may well become chattel, providing income either for their families or for pimps. As Columbia economics professor Lena Edlund observes: "The greatest danger associated with prenatal sex determination is the



For years couples have turned to sperm clinics, egg donors or surrogate mothers to bring them a baby that is stretching legal and ethical boundaries. WSJ's Linda Blake reports from India.

propagation of a female underclass," that a small but still significant group of the world's women will end up being stolen or sold from their homes and forced into prostitution or marriage.

All of this may sound dry, but Ms. Hvistendahl is a first-rate reporter and has filled "Unnatural Selection" with gripping details. She has interviewed demographers and doctors from Paris to Mumbai. She spends a devastating chapter talking with Paul Ehrlich, the man who mainstreamed overpopulation hysteria in 1968 with "The Population Bomb"—and who still seems to think that getting rid of girls is a capital idea (in part because it will keep families from having more and more children until they get a boy). In another chapter she speaks with Geert Jan Olsder, an obscure Dutch mathematician who, by an accident of history, contributed to the formation of China's "One Child" policy when he met a Chinese scientist in 1975. Later she visits the Nanjing headquarters of the "Patriot Club," an organization of Chinese surplus men who plot war games and play at mock combat.

Ms. Hvistendahl also dredges up plenty of unpleasant documents from Western actors like the Ford Foundation, the United Nations and Planned Parenthood, showing how they pushed sex-selective abortion as a means of controlling population growth. In 1976, for instance, the medical director of the International Planned Parenthood Federation, Malcom Potts, wrote that, when it came to developing nations, abortion was even better than birth control: "Early abortion is safe, effective, cheap and potentially the easiest method to administer."

Related Video

Jonathan Last describes the rising international trend of aborting females.

The following year another Planned Parenthood official celebrated China's coercive methods of family planning, noting that "persuasion and motivation [are] very effective in a society in which social sanctions can be applied against those who fail to cooperate in the construction of the socialist state." As early as 1969, the Population Council's Sheldon Segal was publicly proclaiming the benefits of sex-selective abortion as a means of combating the "population bomb" in the East. Overall Ms. Hvistendahl paints a detailed picture of Western Malthusians pushing a set of terrible policy prescriptions in an effort to road-test solutions to a problem that never actually manifested itself.

There is so much to recommend in "Unnatural Selection" that it's sad to report that Ms. Hvistendahl often displays an unbecoming political provincialism. She begins the book with an approving quote about gender equality from Mao Zedong and carries right along from there. Her desire to fault the West is so ingrained that she criticizes the British Empire's efforts to stamp out the practice of killing newborn girls in India because "they did so paternalistically, as tyrannical fathers." She says that the reason surplus men in the American West didn't take Native American women as brides was that "their particular Anglo-Saxon breed of racism precluded intermixing." (Through most of human history distinct racial and ethnic groups have only reluctantly intermarried; that she attributes this reluctance to a specific breed of "racism" says less about the American past than about her own biases.) When she writes that a certain idea dates "all the way back to the West's predominant creation myth," she means the Bible.

Ms. Hvistendahl is particularly worried that the "right wing" or the "Christian right"—as she labels those whose politics differ from her own—will use sex-selective abortion as part of a wider war on abortion itself. She believes that something must be done about the purposeful aborting of female babies or it could lead to "feminists' worst nightmare: a ban on all abortions."

It is telling that Ms. Hvistendahl identifies a ban on abortion—and not the killing of tens of millions of unborn girls—as the "worst nightmare" of feminism. Even though 163 million girls have been denied life solely because of their gender, she can't help seeing the problem through the lens of an American political issue. Yet, while she is

not willing to say that something has gone terribly wrong with the pro-abortion movement, she does recognize that two ideas are coming into conflict: "After decades of fighting for a woman's right to choose the outcome of her own pregnancy, it is difficult to turn around and point out that women are abusing that right."

Late in "Unnatural Selection," Ms. Hvistendahl makes some suggestions as to how such "abuse" might be curbed without infringing on a woman's right to have an abortion. In attempting to serve these two diametrically opposed ideas, she proposes banning the common practice of revealing the sex of a baby to parents during ultrasound testing. And not just ban it, but have rigorous government enforcement, which would include nationwide sting operations designed to send doctors and ultrasound techs and nurses who reveal the sex of babies to jail. Beyond the police surveillance of obstetrics facilities, doctors would be required to "investigate women carrying female fetuses more thoroughly" when they request abortions, in order to ensure that their motives are not illegal.

Such a regime borders on the absurd. It is neither feasible nor tolerable—nor efficacious: Sex determination has been against the law in both China and India for years, to no effect. I suspect that Ms. Hvistendahl's counter-argument would be that China and India do not enforce their laws rigorously enough.

Despite the author's intentions, "Unnatural Selection" might be one of the most consequential books ever written in the campaign against abortion. It is aimed, like a heat-seeking missile, against the entire intellectual framework of "choice." For if "choice" is the moral imperative guiding abortion, then there is no way to take a stand against "gendercide." Aborting a baby because she is a girl is no different from aborting a baby because she has Down syndrome or because the mother's "mental health" requires it. Choice is choice. One Indian abortionist tells Ms. Hvistendahl: "I have patients who come and say 'I want to abort because if this baby is born it will be a Gemini, but I want a Libra.' "

This is where choice leads. This is where choice has already led. Ms. Hvistendahl may wish the matter otherwise, but there are only two alternatives: Restrict abortion or accept the slaughter of millions of baby girls and the calamities that are likely to come with it.

—Mr. Last is a senior writer at the Weekly Standard.

Mr. FRANKS. And then, finally, I would like to submit for the record the June 26, 2011, New York Times article, "160 Million and Counting," by Mr. Ross Douthat.

Without objection.

[The material referred to follows:]

June 26, 2011

160 Million and Counting

By ROSS DOUTHAT

In 1990, the economist Amartya Sen published an essay in The New York Review of Books with a bombshell title: "More Than 100 Million Women Are Missing." His subject was the wildly off-kilter sex ratios in India, China and elsewhere in the developing world. To explain the numbers, Sen invoked the "neglect" of third-world women, citing disparities in health care, nutrition and education. He also noted that under China's one-child policy, "some evidence exists of female infanticide."

The essay did not mention abortion.

Twenty years later, the number of "missing" women has risen to more than 160 million, and a journalist named Mara Hvistendahl has given us a much more complete picture of what's happened. Her book is called "Unnatural Selection: Choosing Boys Over Girls, and the Consequences of a World Full of Men." As the title suggests, Hvistendahl argues that most of the missing females weren't victims of neglect. They were selected out of existence, by ultrasound technology and second-trimester abortion.

The spread of sex-selective abortion is often framed as a simple case of modern science being abused by patriarchal, misogynistic cultures. Patriarchy is certainly part of the story, but as Hvistendahl points out, the reality is more complicated — and more depressing.

Thus far, female empowerment often seems to have led to more sex selection, not less. In many communities, she writes, "women use their increased autonomy to select for sons," because male offspring bring higher social status. In countries like India, sex selection began in "the urban, well-educated stratum of society," before spreading down the income ladder.

Moreover, Western governments and philanthropic institutions have their fingerprints all over the story of the world's missing women.

From the 1950s onward, Asian countries that legalized and then promoted abortion did so with vocal, deep-pocketed American support. Digging into the archives of groups like the Rockefeller Foundation and the International Planned Parenthood Federation, Hvistendahl depicts an

unlikely alliance between Republican cold warriors worried that population growth would fuel the spread of Communism and left-wing scientists and activists who believed that abortion was necessary for both "the needs of women" and "the future prosperity — or maybe survival — of mankind," as the Planned Parenthood federation's medical director put it in 1976.

For many of these antipopulation campaigners, sex selection was a feature rather than a bug, since a society with fewer girls was guaranteed to reproduce itself at lower rates.

Hvistendahl's book is filled with unsettling scenes, from abandoned female fetuses littering an Indian hospital to the signs in Chinese villages at the height of the one-child policy's enforcement. ("You can beat it out! You can make it fall out! You can abort it! But you cannot give birth to it!") The most disturbing passages, though, are the ones that depict self-consciously progressive Westerners persuading themselves that fewer girls might be exactly what the teeming societies of the third world needed.

Over all, "Unnatural Selection" reads like a great historical detective story, and it's written with the sense of moral urgency that usually accompanies the revelation of some enormous crime.

But what kind of crime? This is the question that haunts Hvistendahl's book, and the broader debate over the vanished 160 million.

The scale of that number evokes the genocidal horrors of the 20th century. But notwithstanding the depredations of the Chinese politburo, most of the abortions were (and continue to be) uncoerced. The American establishment helped create the problem, but now it's metastasizing on its own: the population-control movement is a shadow of its former self, yet sex selection has spread inexorably with access to abortion, and sex ratios are out of balance from Central Asia to the Balkans to Asian-American communities in the United States.

This places many Western liberals, Hvistendahl included, in a distinctly uncomfortable position. Their own premises insist that the unborn aren't human beings yet, and that the right to an abortion is nearly absolute. A self-proclaimed agnostic about when life begins, Hvistendahl insists that she hasn't written "a book about death and killing." But this leaves her struggling to define a victim for the crime that she's uncovered.

It's society at large, she argues, citing evidence that gender-imbalanced countries tend to be violent and unstable. It's the women in those countries, she adds, pointing out that skewed sex ratios are associated with increased prostitution and sex trafficking.

These are important points. But the sense of outrage that pervades her story seems to have been inspired by the missing girls themselves, not the consequences of their absence.

Here the anti-abortion side has it easier. We can say outright what's implied on every page of "Unnatural Selection," even if the author can't quite bring herself around.

The tragedy of the world's 160 million missing girls isn't that they're "missing." The tragedy is that they're dead.

Paul Krugman is off today.

Mr. FRANKS. Our first witnesses—thank you all for being here today. I am going read a little bit about you, and then we will—our first witness is Steven Aden. He serves as senior legal counsel at the Alliance Defense Fund, home to the country's most successful constitutional lawyers litigating the most significant Federal cases that threaten America's religious freedom and the sanctity of human life, with a near-75-percent win rate.

I might need a lawyer here.

He is a member of the bars of the U.S. Supreme Court and numerous Federal courts. He has earned a J.D. From Georgetown University Law Center.

And thank you for being here with us, Mr. Aden.

Our second witness, Mr. Edwin Black, is a New York Times best-selling international investigative author of 80 award-winning editions in 14 languages, in 65 countries, with more than a million books in print. His book, "War Against the Weak: Eugenics and America's Campaign to Create a Master Race," met wide acclaim from Mother Jones, the National Review, and the New York Times Book Review, which described his book as, "chilling in its exposure of the shameless racism, class prejudice, and cruelty of eugenic attitudes and practices in the United States." Mr. Black is the child of Holocaust survivors.

Our third witness, Miriam Yeung, is executive director of the National Asian Pacific American Women's Forum, where she guides the country's only national multi-issue progressive organization dedicated to social justice and human rights for Asian and Pacific Islander women and girls in the United States. Current priorities include winning rights for immigrant women, organizing nail salon workers for safer working conditions, conducting community-based participatory research with young API women, and ending human trafficking.

Our fourth and final witness, Steven Mosher, is an internationally recognized authority on China and population issues as well as an acclaimed author and speaker. In 1979, Mr. Mosher became the first American social scientist to work in mainland China on invitation by the Chinese Government, where he had access to government documents and actually witnessed women being forced to have abortions under the then-new one-child policy. Mr. Mosher was a pro-choice atheist at the time, but witnessing these traumatic abortions led him to reconsider his convictions and eventually become a practicing pro-life Roman Catholic.

Each of the witnesses' statements will be entered into the record in its entirety, and I would ask each of the witnesses to summarize his or her testimony in 5 minutes or less.

And to help you stay within that time, there is a timing light on your table. When the light switches from green to yellow, you will have 1 minute to conclude your testimony. When the light turns red, it signals that the witness' 5 minutes have expired.

Now, before I recognize the witnesses, it is the tradition of this Subcommittee that they be sworn. So if you would please stand to be sworn.

[Witnesses sworn.]

Mr. FRANKS. Please be seated. Thank you.

I would now recognize our first witness, Mr. Aden, for 5 minutes.

TESTIMONY OF STEVEN H. ADEN, VICE PRESIDENT/SENIOR COUNSEL, HUMAN LIFE ISSUES, ALLIANCE DEFENSE FUND

Mr. ADEN. Thank you, Mr. Chairman, Mr. Conyers, Members of the Subcommittee. I am deeply privileged to have been asked by the Subcommittee to testify today regarding the constitutionality of this bill.

The bill would prohibit the practice of abortion committed by reason of the gender or race of the pre-born patient. Gender and the physical qualities that are construed as race are immutable human genetic qualities that exist at conception, like the innumerable characteristics that are woven together in the womb to create each unique member of the human species.

Federal and State laws prohibit discrimination on the basis of gender and race in housing, employment, education, lodging, commercial transactions, and a host of other contexts. Human life in the womb is recognized and protected by the laws of many, if not most, of the United States against crimes of violence.

In 2007, the U.S. delegation to the U.N. Commission on Status of Women advocated for a resolution condemning sex-selection abortion. The Secretary of State has also spoken out against the practice. The U.S. Congress has passed multiple resolutions condemning the People's Republic of China for its failure to end sex-selection abortion. The American College of Obstetricians and Gynecologists has likewise condemned the practice.

In the case of racial-selection abortion, it is no exaggeration to say that the African American population of the United States has been decimated by the widespread availability of abortion on demand in the last 40 years, and particularly by the placement of abortion providers in predominantly minority population centers. CDC data for 2007 shows that in the 25 reporting areas that reported cross-classified race and ethnicity data, non-Hispanic Black women had the highest abortion ratios, at 480 abortions per 1,000 live births. Non-Hispanic Black women accounted for nearly as many abortions proportionately, 34.4 percent, as non-Hispanic White women, at 37.1 percent.

Commenting on this trend, The Washington Post observed that, in the past 30 years, more mothers of color are opting to abort and that, in 2004, there were 50 abortions per 1,000 Black women, compared with 10.5 per 1,000 White women. In other words, African American infants were five times more likely to be aborted than White infants. These are grave statistics for the African American population. Tragically, the CDC observes that, "Abortion provides a proxy measure for the number of pregnancies that are unwanted."

Pursuant to Congress' authority to eradicate all badges of slavery and eliminate all barriers to gender equality based on invidious, archaic, and overbroad stereotypes, this bill would prohibit the knowing commitment of abortion based on the sex, gender, color, or race of the child or the child's parent. The bill also prohibits the use or threat of force to intentionally injure or intimidate any person for the purpose of coercing a sex-selection or race-selection abortion and the solicitation or acceptance of funds for the purpose of financing such an abortion.

Congress has broad powers under the Commerce Clause to enact the legislation at hand in furtherance of the rights of equality secured by the 14th Amendment. As the Supreme Court stated in the *United States v. Lopez*, "We have upheld a wide variety of congressional acts regulating intrastate economic activity where we have concluded that the activity substantially affected interstate commerce."

Nor does the Supreme Court's abortion jurisprudence require a different result. Although the Supreme Court in *Planned Parenthood v. Casey* recognized the essential holding of the Court in *Roe v. Wade*, that women possess the right to obtain an abortion without undue interference from the State before viability, that holding, *Casey* clarified, was based on the Court's perception that the State's interests weren't strong enough to support a prohibition at that stage.

However, the Supreme Court has made it clear in numerous cases that States have a compelling interest in eliminating discrimination against women and minorities. Moreover, the *Casey* Court also affirmed the principle that, "The State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus."

Nor is the absence of a medical necessity or health exception in this bill a constitutional infirmity. By definition, abortions conducted because of the sex or race of the infant are elective procedures that do not implicate the health of the maternal patient. The act clarifies that the mother may not be prosecuted or held civilly liable under the act. Thus, the private right of action provisions strike only at the commercial activity of providing abortion, which clearly substantially impacts interstate commerce. The debarment provision is to the same effect. As the Supreme Court has declared, "It is beyond dispute that any public entity, State or Federal, has a compelling interest in assuring that public dollars drawn from the tax contributions of all citizens do not serve to finance the evil of private prejudice."

In conclusion, H.R. 3541 is conceived and drafted pursuant to sound constitutional authority and the best tradition of this Nation's commitment to civil rights and equality for all of its citizens.

Thank you again for the privilege of appearing before this Committee.

[The prepared statement of Mr. Aden follows:]

Steven H. Aden
Vice President/Senior Counsel, Human Life Issues
Alliance Defense Fund

Hearing of the House Judiciary Committee, Subcommittee on the Constitution
Regarding H.R. 3541, the Prenatal Nondiscrimination Act

December 6, 2011
1:00 p.m.
2141 Rayburn Building

ALLIANCE DEFENSE FUND
Defending Our First Liberty
801 G St. N.W., Suite 509
Washington, DC 20001
Tel.: 202.393.8690

December 6, 2011

Hon. Lamar S. Smith, Chair
Hon. John Conyers, Jr., Ranking Member
Honorable Members
United States House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution
2138 Rayburn House Office Building
Washington, DC 20515-6216

Mr. Chairman, Mr. Conyers and Members of the Subcommittee:

I am deeply privileged to have been asked by the Subcommittee to testify today regarding the constitutionality of the Prenatal Nondiscrimination Act of 2011, H.R. 3541. This bill is appropriately named for two great champions of human equality, the suffragist Susan B. Anthony and the abolitionist Frederick Douglass. Susan B. Anthony was a moving force behind the extension of the voting franchise to women, for whom the right to life was an indispensable aspect of the right of equality. Anthony observed, "When a woman destroys the life of her unborn child, it is a sign that, by education or circumstances, she has been greatly wronged."[1] Frederick Douglass, born a slave, became perhaps the most influential black spokesman for emancipation and citizenship of the antebellum era through his newspaper, *The North Star*, founded in 1847. On the masthead of the newspaper was emblazoned the motto: "Right is of no sex; truth is of no color, God is the Father of us all - and all are brethren."

H.R. 3541 would prohibit the practice of abortion committed by reason of the gender or race of the preborn patient.[2] Gender, and the many physical qualities that are construed as "race," are immutable human genetic qualities that exist at conception, like a myriad characteristics that are woven together in the womb to create each unique member of the human

1 *See* http://womenshistory.about.com/od/anthonysusanb/a/anthony.htm.

2 A physician treating a pregnant mother has two patients, the maternal patient and the fetal patient and owes duties of care to each. L.B. MCCULLOUGH AND F.A. CHERVENAK, ETHICS IN OBSTETRICS AND GYNECOLOGY (Oxford University Press New York 1994); D.W. Bianchi, *et al.*, FETOLOGY: DIAGNOSIS AND MANAGEMENT OF THE FETAL PATIENT (McGraw Hill New York 2000).

species.[3] Federal and State laws prohibit discrimination on the basis of gender and race in housing, employment, education, lodging, commercial transactions and a host of other contexts. Human life in the womb is recognized and protected by the laws of many, if not most, of the United States, against crimes of violence.[4]

The targeted victims of sex-selection abortions committed in the United States and worldwide are overwhelmingly female. As early as twenty years ago, Harvard researcher Amartya Sen found that more than 100 million women were demographically missing from the world's population due to discriminatory practices and policies that in part reflected strong cultural preferences for male babies, so-called "son preference."[5] *The Economist* recently reported on that phenomenon, and particularly on the role that sex-selection abortion plays in son preference.[6] "It is no exaggeration to call this gendercide," *The Economist* declared. "[T]he cumulative consequence for societies of such individual actions is catastrophic."[7]

In 2007, the U.S. delegation to the United Nations Commission on the Status of Women advocated for a resolution condemning sex-selection abortion.[8] The U.S. Congress has passed multiple resolutions condemning the People's Republic of China for its failure to end sex-selection abortion.[9] The American College of Obstetricians and Gynecologists has likewise

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[3] Sex is determined even before fertilization. If a spermatozoon containing an x chromosome fertilizes an egg, the embryo will become a female; if the spermatozoon contains a y chromosome, the embryo will become a male. "Race" is a description of certain physical characteristics that are genetically determined; as discretely genetic characters, race and ethnicity do not exist, as the Human Genome Project explains:

> DNA studies do not indicate that separate classifiable subspecies (races) exist within modern humans. While different genes for physical traits such as skin and hair color can be identified between individuals, no consistent patterns of genes across the human genome exist to distinguish one race from another. There also is no genetic basis for divisions of human ethnicity.

The Human Genome Project, "Minorities, Race and Genomics," available at http://www.ornl.gov/sci/techresources/Human_Genome/elsi/minorities.shtml.

[4] *See, e.g.*, Unborn Victims of Violence Act of 2004 (PUBLIC LAW 108-212), at 18 U.S.C. 1841 and 22 U.S.C. § 919a (UNIFORM CODE OF MILITARY JUSTICE, Article 119a).

[5] Amartya Sen, "More Than 100 Million Women Are Missing," *The New York Review of Books*, Vol. 37, Number 20, Dec. 20, 1990, available at http://www.nybooks.com/articles/3408.

[6] "Gendercide: The War on Baby Girls," *The Economist*, Mar. 4, 2010, available at http://www.economist.com/node/15606229.

[7] *Id.*

[8] *Draft Agreed Conclusions on the Elimination of All forms of Discrimination and Violence Against the Girl Child*, Commission on the Status of Women, 51st Session (26 February - 9 March 2007); *see also* Janice Shaw Crouse, "United States Resolution Shanghaied by China and India," Concerned Women for America, at http://www.cwfa.org/articledisplay.asp?id=12532&department=BLI&categoryid=reports&subcategoryid=bliun. Crouse noted that United Nations documents condemn the practice of sex-selection abortion; the United Nations Development Fund for Women (UNIFEM) argues that violence against women begins "quite literally" in the womb, and other U.N. documents label sex selection abortions as "violence." *Id.*

[9] H. R. CON. RES. 83, 109th Cong. (2005); H. R. RES. 794, 109th Cong. (2006).

condemned the practice, stating, "[T]he committee opposes meeting requests for sex selection for personal and family reasons, including family balancing, because of the concern that such requests may ultimately support sexist practices."[10]

The United States is far from immune to this problem. In 2008, researchers Douglas Almond and Lena Edlund of Columbia University analyzed year-2000 census data to document male-biased sex ratios among U.S.-born children of certain Asian and South Asian populations.[11] These researchers concluded that the demonstrated deviation from the norm in favor of sons was "evidence of sex selection, most likely at the prenatal stage."[12] This "Son Preference" was true regardless of the absence in the United States of many factors used to rationalize son bias in other countries (*e.g.*, high dowry payments, patrilocal marriage patterns, and China's one-child policy) and was irrespective of the mother's citizenship status; "[i]f anything," they noted, "mothers with citizenship had more male-biased offspring sex ratios," although the difference was not considered statistically significant.[13] Almond and Edlund further observe, "Since 2005, sexing through a blood test as early as 5 weeks after conception has been marketed directly to consumers in the United States, raising the prospect of sex selection becoming more widely practiced in the near future."[14]

In the case of racial selection abortion, it is no exaggeration to say that the African-American population of the United States has been decimated by the widespread availability of abortion on demand in the last forty years, and particularly by the placement of abortion providers in majority-minority population centers. Nationally, for all racial groups, the abortion ratio[15] was 231 abortions for every 1,000 live births.[16] Among women from the 37 health agencies that reported results for race in 2007, "Black women had higher abortion rates and ratios than white women and women of other races."[17] In the 25 reporting areas that reported cross-classified race and ethnicity data for 2007, "non-Hispanic black women had the highest abortion rates (32.1 abortions per 1,000 women aged 15 – 44 years) and ratios (480 abortions per

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[10] American College of Obstetricians and Gynecologists, Committee on Ethics, Committee Opinion 2007, available at http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co360.ashx?dmc=1&ts=20111203T1536377176.

[11] D. Almond and L. Edlund, "Son-biased Sex Ratios in the 2000 United States Census," Jan. 24, 2008, available at www.pnas.org/cgi/doi/10.1073/pnas.0800703105.

[12] *Id.*

[13] *Id.* In fact, they concluded, "the magnitude of the deviations we find for second and third children is comparable to that documented for India, China and South Korea...." *Id.*

[14] For media reports on sex-selection advertisements, *see* Susan Sachs, "Clinics' Pitch to Indian Émigrés: It's a Boy," *The New York Times*, Aug. 15, 2001, available at http://www.geneticsandsociety.org/article.php?id=118; Rich Lowry, "The Backwardness of Abortion," *National Review*, Aug. 23, 2001, available at http://old.nationalreview.com/lowry/lowry082301.shtml.

[15] "Abortion ratios reflect the relative number of pregnancies in a population that end in abortion compared with live birth; abortion ratios change both according to the proportion of pregnancies in a population that are unintended and the proportion of unintended pregnancies that are continued." Centers for Disease Control Abortion Incidence Report 2007, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6001a1.htm?s_cid=ss6001a1_w.

[16] *Id.*; Table 1.

[17] *Id.*; Table 12.

1,000 live births)."[18] Non-Hispanic black women accounted for nearly as many abortions proportionately as non-Hispanic white women (34.4% for black women vs. 37.1% for whites).[19] In 15 out of 38 reporting areas for which the data was available, the percentage of African-American abortions was approximately forty percent or higher, ranging up to 59.1% in one area (Georgia).[20]

Thus, although African-Americans account for only 13.6% of the U.S. population,[21] they account for over one-third of all abortions nationally, and in many states, that percentage is much higher. Commenting on this trend, the *Washington Post* observed that in the past 30 years, more mothers of color are opting to abort, and that in 2004, there were 10.5 abortions per 1,000 white women, compared with 50 per 1,000 black women. [22] In other words, African-American infants were more than five times more likely to be aborted than white infants.[23] African-American women also obtained the highest percentage of later-term abortions,[24] in which risks to health are greater, and are more likely to suffer from preterm birth,[25] which has been linked to prior abortion of the maternal patient and is associated with a multiplicity of health problems for the neonatal patient.[26]

These are grave statistics for the African-American population. Tragically, the CDC observes that "abortion provides a proxy measure for the number of pregnancies that are unwanted."[27]

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18 *Id.*; Table 14.

19 *Id.*

20 *Id.*; Table 12.

21 2000 census data lists persons responding to the category of "Race" with "Black or African-American alone or in combination" at 12.9% of the U.S. population; that percentage rose to 13.6% in the 2010 census. *See* http://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf.

22 Rob Stein, "Study Finds Major Shift in Abortion Demographics," *Washington Post*, Sep. 23, 2008, available at http://pqasb.pqarchiver.com/washingtonpost/access/1559584011.html?FMT=ABS&FMTS=ABS:FT&date=Sep+23%2C+2008&author=Rob+Stein+-Washington+Post+Staff+Writer&pub=The+Washington+Post&edition=&startpage=A.3&desc=Study+Finds+Major+Shift+in+Abortion+Demographics (by subscription).

23 Notably, although the CDC attributes the comparatively high abortion rates and ratios among African-American women to higher unintended pregnancy rates and a higher percentage of unintended pregnancies ending in abortion, Hispanic women have a slightly higher percentage of pregnancies that are unintended but are no more likely than non-Hispanic white women to end unintended pregnancies by abortion. CDC, *supra*; Table 21.

24 *Id.*; Table 22.

25 African-American women have three times the risk of early preterm birth, defined as delivery at less than 32.0 weeks' gestation, and four times the risk of extremely preterm birth, defined as delivery at less than 28.0 weeks' gestation, compared with non-African-American women. G. Alexander et al., *U.S. Birth Weight/Gestational Age Specific Neonatal Mortality: 1995-1997 Rates for Whites, Hispanics and Blacks*, 111 PEDIATRICS 61 (2003), available at www.pediatrics.org/cgi/content/full/111/1/e61.

26 B. Rooney & B.C. Calhoun, *Induced Abortion and Risk of Later Preterm Birth*, 8 J. AM. PHYS. SURG. 6 (2003).

27 *Id.* "[I]ntended pregnancies are estimated to account for only 4% of all abortions." *Id.* These data do not appear to be changing over time. Three nationally representative surveys of women obtaining abortions in 1987, 1994-95 and 2001-02 have reported similar demographic results. *CDC, supra*, nn. 7-9.

The CDC notes that multiple factors can influence the incidence of abortion, "including the availability of abortion providers."[28] In this regard, it is important to note that 80% of all non-primary-care abortion providers are located in major metro U.S. regions, where the population of African-American citizens is concentrated.

Pursuant to Congress' authority to regulate interstate commerce and its power under section 2 of the Thirteenth Amendment and section 5 of the Fourteenth Amendment to "eradicate all badges of slavery"[29] and eliminate all barriers to gender equality based on "invidious, archaic and overbroad stereotypes,"[30] this bill would prohibit the knowing commitment of abortion based on the sex, gender, color or race of the child or the child's parent.[31] The bill also prohibits the use or threat of force to intentionally injure or intimidate any person for the purpose of coercing a sex-selection or race-selection abortion, and the solicitation or acceptance of funds for the purpose of financing such an abortion.[32] Civil remedies in the form of injunctive relief may be sought by the Attorney General in a civil action, and perpetrators may face loss of federal funding pursuant to Title VI of the 1964 Civil Rights Act.[33] A private cause of action is also provided for the father of the baby lost to a sex- or race-selection abortion or, in the case of an unemancipated minor, the maternal grandparents of the preborn child.[34]

Insofar as H.R. 3541 targets only persons who commit, finance or coerce a sex- or race-selection abortion, Congress has broad police powers under the Commerce Clause to enact this legislation in furtherance of the rights of equality secured by the Fourteenth Amendment.[35] As the Supreme Court stated in *United States v. Lopez*, "[W]e have upheld a wide variety of congressional Acts regulating intrastate economic activity where we have concluded that the activity substantially affected interstate commerce."[36]

Nor does the Supreme Court's abortion jurisprudence require a different result. Although the Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*[37] recognized the essential holding of the Court in *Roe v. Wade*[38] that women possess the right to obtain an abortion without undue interference from the State before viability, that holding, *Casey* clarified, was based on the Court's perception that the State's interests were not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure at that stage.[39] However, the Supreme Court has made it clear that States

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28 *Id.*; nn. 11, 68-70.

29 *Jones v. Alfred H. Mayer Co.*, 392 U.S. 409, 439 (1968).

30 *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 131 (1994).

31 Sec. 3(a), adding Sec. 249(a)(1) to Ch. 13, tit. 18 U.S.C.

32 Sec. 3(a), adding Sec. 249(a)(2), (3) of Ch. 13, tit. 18 U.S.C.

33 Sec. 3(a), adding Sec. 249(b)(1), (2) of Ch. 13, tit. 18 U.S.C. The operative provision of Sec. 601 prohibits discrimination on the ground of race, color or national origin, in any program or activity receiving federal financial assistance. 42 U.S.C. § 2000d.

34 Sec. 3(a), adding Sec. 249(b)(3) of Ch. 13, tit. 18 U.S.C.

35 *See Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964); *Katzenbach v. McClung*, 379 U.S. 294 (1964).

36 514 U.S. 549, 559 (1995).

37 505 U.S. 833 (1992).

38 410 U.S. 113 (1973).

39 *Casey*, 505 U.S. at 846.

have a compelling interest in eliminating discrimination against women and minorities.[40] Moreover, the *Casey* Court also affirmed the principle that "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus...."[41]

Nor can it be objected that no exception is made in H.R. 3541 for "medical necessity" or "health of the mother." By definition, abortions conducted because of the sex or race of the infant are elective procedures that do not implicate the health of the maternal patient. Consequently, the absence of a "medical necessity" or "health exception" in this bill is not a constitutional infirmity.[42]

The balance of H.R. 3541's operative provisions are likewise well-grounded in constitutional Fourteenth Amendment and Commerce Clause jurisprudence. The term "based on [sex or race]" used by H.R. 3541 is similar to the term "on the grounds of" employed by Title VI, 42 U.S.C. § 2000d, which is incorporated by reference in H.R. 3541. Both of these terms are functionally identical to the well-known and judicially developed term employed by Title VII of the 1964 Civil Rights Act, "because of... [*inter alia*] [race or sex]."[43] The Act clarifies that the mother may not be prosecuted or held civilly liable under the Act,[44] and thus the private right of action provisions[45] strike only at the commercial activity of providing abortion, which clearly substantially impacts interstate commerce.[46] The debarment provision is to the same effect. As the Supreme Court has declared, "It is beyond dispute that any public entity, state or federal, has a compelling interest in assuring that public dollars, drawn from the tax contributions of all citizens, do not serve to finance the evil of private prejudice."[47] The authority of Congress to direct the federal courts to expedite any matter[48] is conferred by Article III, Sec. 1 of the Constitution.

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[40] *See, e.g., Roberts v. United States Jaycees*, 468 U.S. 609 (1984); *Board of Directors of Rotary Intern. v. Rotary Club of Duarte*, 481 U.S. 537 (1987); *Miller v. Johnson*, 515 U.S. 900, 920 (1995) ("There is a 'significant state interest in eradicating the effects of past racial discrimination.'"), quoting *Shaw v. Reno*, 509 U.S. 630, 656 (1993).

[41] 505 U.S. at 846.

[42] The Supreme Court approved the constitutionality of the federal Partial-Birth Abortion Ban Act despite the absence of a health exception in that statute, based upon the existence of a "documented medical disagreement" whether such an exception was required. *Gonzales v. Carhart*, 550 U.S. 124, 163-64 (2007). In this case, although some authorities contend there is a basis for prenatal sex screening for the purpose of genetic counseling for certain diseases that are gender-determinant, there can be no substantial disagreement that such cases do not implicate the health of the maternal patient.

[43] *See Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75 (1998) (affirming that the Title VII rubric "because of sex" is a workable standard that may be applied in a variety of contexts).

[44] Sec. 3(a), adding Sec. 249(e).

[45] Sec. 3(a), adding Sec. 249(b).

[46] *United States v. Morrison*, 529 U.S. 598, 611 (2000) ("in those cases where we have sustained federal regulation of intrastate activity based upon the activity's substantial effects on interstate commerce, the activity in question has been some sort of economic endeavor.").

[47] *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 492 (1989).

[48] Sec. 3(a), adding Sec. 249(d).

In conclusion, H.R. 3541 is conceived and drafted pursuant to sound constitutional authority and the best tradition of this nation's commitment to civil rights and equality for all of its citizens. Thank you again for the privilege of appearing before this Honorable Committee.

Respectfully submitted this 6th day of December, 2011.

Steven H. Aden

/s/ Steven H. Aden

ALLIANCE DEFENSE FUND
Senior Counsel/Vice President
Human Life Issues

Mr. FRANKS. And thank you, Mr. Aden, very much.

Mr. Black, you are recognized for about 5 minutes. And thank you, sir, for being here.

TESTIMONY OF EDWIN BLACK, AUTHOR AND HISTORIAN, THE FEATURE GROUP

Mr. BLACK. Thank you very much for having me, Chairman Franks and the other distinguished Representatives. I was very moved by all these remarks, but I was especially moved by yours about the young child who was playing piano. I have had many similar feelings.

So my name is Edwin Black, and I am here not as a Democrat or a Republican or in favor of the bill or opposed to the bill, but to give historical context to the discussion you are having now. I am an expert on eugenics, and I have come here to explain how America began the concept of the White master race some 30 years before Adolf Hitler and, in doing so, institutionalized through the rule of law the concept of race selection and gender selection—in fact, these words were deliberately used by them—as a context to Darwin in natural selection.

So, basically, it all began, more or less—to condense this into the 3 minutes and 34 seconds I have left—it all began at the beginning of the 20th century, when millions of Jews and Eastern Europeans were coming in from the east coast, the Chinese laborers were coming in from the west coast. Mexicans were now abundantly in the United States in the Southwest as a result of the Treaty of Hidalgo, which means half of Mexico became the United States' property. The Blacks were off the plantation; the Indians were off the reservation. The agrarian society was moving to a cosmopolitan industrial society, and there was a huge dislocation in the United States in terms of socio-ethnic and economic texture.

The men in power at that time decided that they wanted to turn back the clock and they wanted to improve society. And they thought that you were not born into prostitution, they thought that prostitution was a genetic trait; that you were not born into poverty, that poverty was actually born into you. And so they decided to get rid of poverty and to get rid of the social problems by subtracting the very people who they assumed were responsible. These were the do-gooders, the liberals, the progressives, who decided to subtract 10 percent of the American population at a swipe. At that time, it was 14 million people.

And the methods that they proposed included gas chambers. The first euthanasia law was entered into Iowa in 1906. When these euthanasia laws were not put forward, they went to coercive sterilization, they went to marriage voiding, marriage prohibition. Marriage prohibition between the races was not decriminalized until the 1960's, *Loving v. Virginia*. And, ultimately, some 27,000 individuals in this country, under the rule of law sanctified by the Supreme Court, were coercively sterilized, mainly women, mainly without knowing what was happening.

And, therefore, when I speak to you, I speak to you about the never-born, about the millions of people who have been subtracted from our society. This always was genocide. It is genocide today, legally. And now there is a move—and I am only here for the eugenics side of this—to replicate this type of social engineering in the United States by using advanced medicine.

We all know that there are multi-millions of gendercide around the world, especially in certain cultures where son preference rules.

The statistics have been given by these individuals. The method of population and social engineering there was murder. They would take the kid, they would put him in a pail; they would take the kid, they would throw him in the river. In Chicago, they did it by leaving children unattended in the surgical suite. It was done time and time again.

Now we have the powers of observation, we have the powers of measurement, we have the power to foresee into the future. We don't have to wait for the first moments of life to murder an innocent. We can do it beforehand by techniques.

My interest is only in the effort to manipulate society in favor of one gender or one race or to de-emphasize the existence of these people. There is a huge move afoot in this country to design babies, to design societies, and to create a new master race. Everyone can see it on the Internet. It is the greatest minds and the greatest moneys that want to get this done.

So this is the context, the historical context.

I am out of time. Thanks.

[The prepared statement of Mr. Black follows:]

Edwin Black
Washington D.C.
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REMARKS RELATING TO MY SPONTANEOUS AND UNREHEARSED TESTIMONY BEFORE THE *HOUSE JUDICIARY COMMITTEE'S SUBCOMMITTEE ON THE CONSTITUION* ON THE HISTORICAL QUESTION OF EUGENICS AND RACISM DECEMBER 6, 2011, 1 PM.

INTRODUCTION: Preface: I come not as a Democrat or a Republican, nor as an advocate or adversary of the legislation now under consideration but rather as a historian who has chronicled the dark chapters of racist and genocidal eugenics in America and Nazi Germany. I will outline some historical points and answer questions.

My remarks will trace the early 20th Century collusion by government, academia, and tax exempt philanthropic organizations in a county-by-county and state-by-state crusade to eventually eliminate an estimated 90 percent of Americans. The population control and social engineering techniques debated and proffered to legislators included gas chambers, euthanasia, abortion, forced sterilization, confinement, and internal deportation. Many of these techniques were adopted into law, some were debated by legislatures, and some were adopted as *de facto* policy by governments. Targets were Blacks, Native Americans, Southern Italians, Eastern Europeans, Jews, Hispanics, the poor, criminals, the intellectually unaccepted, the so-called "shiftless," Appalachian whites with brown hair, and many others. Eventually, American eugenics proliferated its medicalized concept of racial supremacy into Nazi Germany which then emulated and expanded on what the U.S. had done. This was not less than a genocidal movement by the government against its own citizens, done in the name of progress. This movement did not end until the 1970s.

I attach some in-depth materials for the record to be considered in tandem with my testimony.

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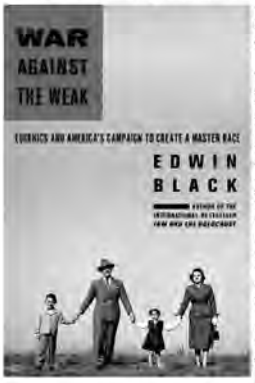
Eugenics in America Back

Government Death Panels and Mass Murder was Always an Option in 20th Century America's War Against the Weak

Edwin Black August 24th 2009



This article is based on the award-winning bestseller *War Against the Weak--Eugenics and America's Campaign to Create a Master Race* **(Dialog Press). Buy it here**

The summer of 2009 has been rife with misplaced fears about government death panels arising from proposed insurance reform. These fears are not based on anything in the proposed legislation. But government death panels and mass euthanasia were always a public option during the first decades of the twentieth century. This campaign to exterminate all those deemed socially or medically unworthy was not conducted by the worst segments of our society but by the elite of the American establishment. They saw themselves as liberals, progressive, do-gooders—and even utopians—trying to create a more perfect society.

The mission: eliminate the existence of the poor, immigrants, those of mixed parentage, and indeed anyone who did not approximate the blond-haired blue-eyed ideal they idealized. This racial type was termed Nordic, and it was socially deified by a broad movement of esteemed university professors, doctors, legislators, judges and writers. They called themselves eugenicists. This widely accepted extremist movement was virtually created and funded by millions in corporate philanthropy from the Carnegie Institution, the Rockefeller Foundation and the Harriman railroad fortune through a complex of pseudoscientific institutions and population tracking offices at Cold Spring Harbor, Long Island. From there, leading academics supported by big money lead a termite-like proliferation of eugenics into the laws, social policies and curricula of the nation. During these turbulent decades, eugenics enjoyed the active support of the government, especially the U.S. Department of Agriculture which wanted to breed men the way they bred cattle, and many state and county offices.

Indeed, Eugenics was enacted into law in some 27 states during the first decades of the twentieth century and then exalted as the law of the land by the U. S. Supreme Court. In a famous 1927 opinion, revered jurist Oliver Wendell Holmes compared social undesirables to bacteria to be wiped out. The sanctioned methods to be used were nothing less than a combination of pseudoscientific taxeology, social engineering, ethnic cleansing and abject race law, designed to eliminate millions in an organized fashion. More specifically, the American eugenics movement sought to continually subtract the so-called "bottom tenth" of America. These were to include Blacks, Native Americans, Southern Italians, East Europeans, Jews, Hispanics, the poor, criminals, the intellectually unaccepted, the so-called "shiftless," and many others. The drive for perfection even included excising the existence of Appalachians with brown hair, frequently rounded up by county officials for confinement. When this effort began in the early twentieth century, some fourteen million Americans were targeted for elimination.

Methods

To eliminate entire bloodlines of undesirables, American eugenics advocated marriage prohibition and marriage voiding for those deemed racially or socially undesirable. Such laws were enacted from coast to coast. These criminal sanctions for interracial marriage were not completely negated until 1960 when *Loving v Virginia* had such laws debunked.

Eugenics advocated detention or confinement camps—some would call them concentration camps. These were

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established throughout Connecticut, Massachusetts, New York, New Jersey and other states to quarantine those considered otherwise unsuited to exist in society, especially the so-called "feeble-minded," a never-defined and widely abused intelligence caste. Among the camps shrouded behind high-sounded names was The Vineland Training School in New Jersey and the Virginia Colony for the Epileptic and the Feebleminded. Forced surgical sterilization of the undesired was imposed in jurisdictions across American. Some 60,000 individuals in 27 states, mostly young women, were forcibly sterilized, many without their knowledge, often by the use of trickery using misidentified medical procedures. Untold additional thousands were coercively or stealthily sterilized by federal programs. California led the union in forced sterilizations. But marriage restriction, concentration, and forced sterilization were always the B Plan.

For American eugenics, mass murder was always a public option.

Eugenicide and Public Gas Chambers

In 1911, the leading pioneer eugenicists, supported by the U.S. Department of Agriculture, the American Breeders Association and the Carnegie Institution, met to propound a battle plan to create a master race of white, blond, blue-eyed Americans devoid of undesirables.

Point eight of the Preliminary Report of the Committee of the Eugenic Section of the American Breeders Association to Study and to Report on the Best Practical Means for Cutting Off the Defective Germ-Plasm in the Human Population specified euthanasia as a possibility to be considered. Of course, euthanasia was merely a euphemism—actually a misnomer. Eugenicists did not see euthanasia as a "merciful killing" of those in pain, but rather a "painless killing" of people deemed unworthy of life. The method most whispered about, and publicly denied, but never out of mind, was a "lethal chamber."
The lethal chamber first emerged in Britain during the Victorian era as a humane means of killing stray dogs and cats. Dr. Benjamin Ward Richardson patented a "Lethal Chamber for the Painless Extinction of Lower Animal Life" in the 1880s. Richardson's original blueprints showed a large wood- and glass-paneled chamber big enough for a Saint Bernard or several smaller dogs, serviced by a tall slender tank for carbonic acid gas, and a heating apparatus. In 1884 the Battersea Dogs Home in London became one of the first institutions to install the device, and used it continuously with "perfect success" according to a sales proposal at the time. By the turn of the century other charitable animal institutions in England and other European countries were also using the chamber.

This solution for unwanted pets was almost immediately contemplated as a solution for unwanted humans —criminals, the feebleminded and other misfits. The concept of "the lethal chamber" was in common vernacular by the turn of the century. When mentioned, it needed no explanation; everyone understood what it meant.

In 1895, the British novelist Robert Chambers penned his vision of a horrifying world twenty-five years into the future. He wrote of a New York where the elevated trains were dismantled and "the first Government Lethal Chamber was opened on Washington Square." No explanation of "Government Lethal Chamber" was offered—or necessary. Indeed, the idea of gassing the unwanted became a topic of contemporary chitchat. In 1901, the British author Arnold White, writing in *Efficiency and Empire*, chastised "flippant people of lazy mind [who] talk lightly of the 'lethal chamber'..."

In 1905, the British eugenicist and birth control advocate H. G. Wells published *A Modern Utopia*. "There would be no killing, no lethal chambers," he wrote. Another birth control advocate, the socialist writer Eden Paul, differed with Wells and declared that society must protect itself from "begetters of anti-social stocks which would injure generations to come. If it [society] reject the lethal chamber, what other alternative can the socialist state devise?"

The British eugenicist Robert Rentoul's 1906 book, *Race Culture; Or, Race Suicide?*, included a long section entitled "The Murder of Degenerates." In it, he routinely referred to Dr. D. F. Smith's earlier suggestion that these found guilty of homicide be executed in a "lethal chamber" rather than by hanging. He then cited a new novel whose character "advocate[d] the doctrine of 'euthanasia' for those suffering from incurable physical diseases." Rentoul admitted he had received many letters in support of killing the unfit, but he rejected them as too cruel, explaining, "These [suggestions] seem to fail to recognize that the killing off of few hundreds of lunatics, idiots, etc., would not tend to effect a cure."

The debate raged among British eugenicists, provoking damnation in the press. In 1910, the eugenic extremist George Bernard Shaw lectured at London's Eugenics Education Society about mass murder in lethal chambers. Shaw proclaimed, "A part of eugenic politics would finally land us in an extensive use of the lethal chamber. A great many people would have to be put out of existence, simply because it wastes other people's time to look after them." Several British newspapers excoriated Shaw and eugenics under such headlines as "Lethal Chamber Essential to Eugenics."

One opponent of eugenics condemned "much wild and absurd talk about lethal chambers..." But in another article, a eugenicist writing under the pseudonym of "Vanoc" argued that eugenics was needed precisely because systematic use of lethal chambers was unlikely. "I admit the word 'Eugenics' is repellent, but the thing is essential to our existence... It is also an error to believe that the plans and specifications for County Council lethal-chambers have yet been prepared."

The Eugenics Education Society in London tried to dispel all "dark mutterings regarding 'lethal chambers.'" Its key activist, Caleb Saleeby, insisted, "We need mention, only to condemn, suggestions for 'painless extinction.'

lethal chambers of carbonic acid, and so forth. As I incessantly have to repeat, eugenics has nothing to do with killing…" Saleeby returned to this theme time and again. When lecturing in Battle Creek, Michigan, at the First National Conference on Race Betterment in 1914, Saleeby emphasized a vigorous rejection of "the lethal chamber, the permission of infant mortality, interference with [pre]-natal life, and all other synonyms for murder."

But many British eugenicists clung to the idea. Arthur F. Tredgold was a leading expert on mental deficiency and one of the earliest members of the Eugenics Education Society. His academic credentials eventually won him a seat on the Brock Commission on Mental Deficiency. Tredgold's landmark *Textbook on Mental Deficiency*, first published in 1908, completely avoided discussion of the lethal chamber. But three subsequent editions published over the next fourteen years did discuss it, with each revision displaying greater acceptance of the idea. In those editions Tredgold equivocated: "We may dismiss the suggestion of a 'lethal chamber.' I do not say that society, in self-defense, would be unjustified in adopting such a method of ridding itself of its anti-social constituents. There is much to be said for and against the proposal…." By the sixth edition, Tredgold had modified the paragraph to read: "The suggestion [of the lethal chamber] is a logical one… It is probable that the community will eventually, in self-defense, have to consider this question seriously." The next two editions edged into outright, if limited, endorsement. While qualifying that motives need not be put to death, Tredgold concluded that for some 80,000 imbeciles and idiots in Britain, "it would be an economical and humane procedure were their existence to be painlessly terminated…The time has come when euthanasia should be permitted."

Leaders of the American eugenic establishment also debated lethal chambers and other means of euthanasia. But in America, while the debate began as an argument about death with dignity for the terminally ill or those in excruciating pain, it soon became a palatable eugenic solution. In 1900, the physician W. Duncan McKim published Heredity and Human Progress, asserting, "Heredity is the fundamental cause of human wretchedness… The surest, the simplest, the kindest, and most humane means for preventing reproduction among those whom we deem unworthy of this high privilege [reproduction], is a gentle, painless death." He added, "In carbonic acid gas, we have an agent which would instantaneously fulfill the need."

By 1903, a committee of the National Conference on Charities and Correction conceded that it was as yet undecided whether "science may conquer sentiment" and ultimately elect to systematically kill the unfit. In 1904, the superintendent of New Jersey's Vineland Training School, E. R. Johnstone, raised the issue during his presidential address to the Association of Medical Officers of American Institutions for Idiotic and Feebleminded Persons. "Many plans for the elimination [of the feebleminded] have been proposed," he said, referred to numerous recently published suggestions of a "painless death." That same year, the notion of executing habitual criminals and the incurably insane was offered to the National Prison Association.

Some U.S. lawmakers considered similar ideas. Two years later in 1906, the Ohio legislature considered a bill empowering physicians to chloroform permanently diseased and mentally incapacitated persons. In reporting this, Rentoul told his British colleagues that it was Ohio's attempt to "murder certain persons suffering from incurable disease." Iowa considered a similar measure.

By 1910, the idea of sending the unfit into lethal chambers was regularly bandied about in American sociological and eugenic circles, causing a debate no less strident than the one in England. In 1911, E. B. Starlock's book, *The Feebleminded: a guide to study and practice*, acknowledged that "glib suggestions of the erection of lethal chambers are common enough…." Like others, he rejected execution in favor of eugenic termination of bloodlines. "Apart from the difficulty that the provision of lethal chambers is impracticable in the existing state law…," he continued, "the removal of them [the feebleminded] would do practically nothing toward solving the chief problem with the mentally defective set… , the persistence of the obnoxious stock."

But other eugenicists were more amenable to the idea. The psychologist and eugenicist Henry H. Goddard seemed to almost express regret that such proposals had not already been implemented. In his infamous study, *The Kallikak Family*, Goddard commented, "For the low-grade idiot, the loathsome unfortunate that may be seen in our institutions, some have proposed the lethal chamber. But humanity is steadily tending away from the possibility of that method, and there is no probability that it will ever be practiced." Goddard pointed to family-wide castration, sterilization and segregation as better solutions because they would more broadly address the genetic source.

In 1912, Carnegie-financed eugenicist Harry Laughlin and others at the Eugenics Section of the American Breeders Association considered euthanasia as the eighth of nine options. Their final report, published by the Carnegie Institution as a two-volume bulletin, enumerated the "Suggested Remedies" and equivocated on euthanasia. Point eight cited the example of ancient Sparta, fabled for drowning its weak young boys in a river or letting them die of exposure to ensure a race of warriors. Mixing condemnation with admiration, the Carnegie report declared, "However much we deprecate Spartan ideals and her means of advancing them, we must admire her courage in so rigorously applying so practical a system of selection…Sparta left but little besides tales of personal valor to enhance the world's culture. With euthanasia, as in the case of polygamy, an effective eugenical agency would be purchased at altogether too dear a moral price."

William Robinson, a New York urologist, published widely on the topic of birth control and eugenics. In Robinson's book, *Eugenics, Marriage and Birth Control (Practical Eugenics)*, he advocated gassing the children of the unfit. In plain words, Robinson insisted: "The best thing would be to gently chloroform these children or to give them a dose of potassium cyanide." Margaret Sanger was well aware that her fellow birth

control advocates were promoting lethal chambers, but she herself rejected the idea completely. "Nor do we believe," wrote Sanger in Pivot of Civilization, "that the community could or should send to the lethal chamber the defective progeny resulting from irresponsible and unintelligent breeding."

Still, American eugenicists never relinquished the notion that America could bring itself to mass murder. At the First National Conference on Race Betterment, University of Wisconsin eugenicist Leon J. Cole lectured on the "dysgenic" effects of charity and medicine on eugenic progress. He made a clear distinction between Darwin's concept of natural selection and the newer idea of simple "selection." The difference, Cole explained, "is that instead of being natural selection it is now conscious selection on the part of the breeder: ...Death is the normal process of elimination in the social organism, and we might carry the figure a step further and say that in prolonging the lives of defectives we are tampering with the functioning of the social kidneys!"

Paul Popenoe, leader of California's eugenics movement and coauthor of the widely-used textbook *Applied Eugenics*, agreed that the easiest way to counteract feeblemindedness was simple execution. "From an historical point of view," he wrote, "the first method which presents itself is execution. ...Its value in keeping up the standard of the race should not be underestimated."

Madison Grant, who functioned as president of the Eugenics Research Association and the American Eugenics Society, made the point clear in *The Passing of the Great Race*. "Mistaken regard for what are believed to be divine laws and a sentimental belief in the sanctity of human life tend to prevent both the elimination of defective infants and the sterilization of such adults as are themselves of no value to the community. The laws of nature require the obliteration of the unfit and human life is valuable only when it is of use to the community or race."

The Black Stork

On November 12, 1915, the issue of eugenic euthanasia sprang out of the shadows and into the national headlines. It began as an unrelated medical decision on Chicago's Near North Side. At 4 A.M. that day, a woman named Anna Bollinger gave birth at German-American Hospital. The baby was somewhat deformed and suffered from extreme intestinal and rectal abnormalities, as well as other complications. The delivering physicians awakened Dr. Harry Haiselden, the hospital's chief of staff. Haiselden came in at once. He consulted with colleagues. There was great disagreement over whether the child could be saved. But Haiselden decided the baby was too afflicted and fundamentally not worth saving. It would be killed. The method: denial of treatment.

Catherine Walsh, probably a friend of Anna Bollinger's, heard the news and sped to the hospital to help. She found the baby, already named Allan, naked and alone in a bare room. He had clearly been laying in one position for a long time. Walsh urgently called for Haiselden, "to beg that the child be taken to its mother," and dramatically recalled, "It was condemned to death, and I knew its mother would be its most merciful judge."

Walsh pleaded with Haiselden not to kill the baby by withholding treatment. "It was not a monster—that child," Walsh later told an inquest. "It was a beautiful baby. I saw no deformities." Walsh had putted the infant lightly. Allan's eyes were open, and he waved his tiny fists at her. She kissed his forehead. "I knew," she recalled, "if its mother got her eyes on it she would love it and never permit it to be left to die." Begging the doctor once more, Walsh tried an appeal to his humanity. "If the poor little darling has one chance in a thousand," she pleaded, "won't you operate and save it?"

Haiselden laughed at Walsh, retorting, "I'm afraid it might get well." He was a skilled and experienced surgeon, trained by the best doctors in Chicago, and now chief of the hospital's medical staff. He was also an ardent eugenicist.

Chicago's health commissioner, Dr. John Dill Robertson, learned of the deliberate euthanasia. He went to the hospital and told Haiselden he did not agree that "the child would grow up a mental defective." He later recollected, "I thought the child was in a dying condition, and I had doubts that an operation then would save it. Yet I believed it had one chance in 100,000, and I advised Dr. Haiselden to give it this one chance." But Haiselden refused.

Quiet euthanasia of newborns was not uncommon in Chicago. Haiselden, however, publicly defended his decision to withhold treatment as a kind of eugenic expedient, throwing the city and the nation into moral turmoil amid blaring newspaper headlines. An inquest was convened a few days later. Some of Haiselden's most trusted colleagues were impaneled on the coroner's jury. Health Commissioner Robertson testified, "I think it very wrong not to save life, let that life be what it may. That is the function of a physician. I believe this baby might have grown up to be an average man....I would have operated and saved this baby's life..."

At one point Haiselden angrily interrupted the health commissioner's testimony to question why he was being singled out when doctors throughout Chicago were routinely killing, on average, one baby every day, under similar circumstances. Haiselden defiantly declared, "I should have been guilty of a graver crime if I had saved this child's life. My crime would have been keeping in existence one of nature's cruelest blunders." A juror shot back, "What do you mean by that?" Haiselden responded, "Exactly that. I do not think this child would have grown up to be a mental defective, I know it."

After tempestuous proceedings, the inquest ruled, "We believe that a prompt operation would have prolonged and perhaps saved the life of the child. We find no evidence from the physical defects that the child would have become mentally or morally defective." The jurors concluded that the child had at least a one-in-three

chance—some thought an "even chance"—of surviving. But they also decided that Haiselden was within his professional rights to decline treatment. No law compelled him to operate on the child. The doctor was released unpunished, and efforts by the Illinois attorney general to indict him for murder were blocked by the local prosecutor.

The medical establishment in Chicago and throughout the nation was rocked. The *Chicago Tribune* ran a giant banner headline across the width of its front page: "Baby Dies; Physician Upheld." One reader in Washington, D.C., wrote a letter to the editor asking "Is it not strange that the whole country should be so shaken, almost hysterical, over the death of a babe never consciously alive?" But the nation was momentarily transfixed.

Haiselden considered his legal vindication a powerful victory for eugenics. "Eugenics? Of course it's eugenics," he told one reporter. On another occasion he remarked, "Which do you prefer—six days of Baby Bollinger or seventy years of Jukes?"—referring to a mythical family of degenerates fabricated by academicians to justify ethnic cleansing.

Emboldened, Haiselden proudly revealed that he had euthanized other such newborns in the past. He began granting high-profile media interviews to advertise his determination to continue passively euthanizing infants. Within two weeks, he had ordered his staff to withhold treatment from several more deformed or birth-defected infants. Haiselden would sometimes send instructions via cross-country telegraph while on the lecture tour that arose from his eugenic celebrity. Other times he would handle it personally, like the time he left a newly delivered infant's umbilical cord untied and let it bleed to death. Sometimes he took a more direct approach and simply injected newborns with opiates.

The euthanasia of Allan Bollinger may have begun as one doctor's controversial professional decision, but it immediately swirled into a national eugenic spectacle. Days after the inquest ruling, *The Independent*, a Hearst weekly devoted to pressing issues of the day, ran an editorial asking "Was the Doctor Right?" *The Independent* invited readers to send off. In a special section, *The Independent* published supportive letters from prominent eugenicists, including Carnegie-funded eugenic kingpin Charles Davenport himself. "If the progress of surgery," wrote Davenport, "is to be used to the detriment of the race…it may conceivably destroy the race. Shortsighted they who would unduly restrict the operation of what is one of Nature's greatest racial blessings —death."

Slaughterhouse in Lincoln Illinois

Haiselden continued to rally for eugenic euthanasia with a six-week series in the *Chicago American*. He justified his killings by claiming that public institutions for the feebleminded, epileptic and tubercular were functioning as lethal chambers of a sort. After clandestinely visiting the Illinois Institution for the Feebleminded at Lincoln, Illinois, Haiselden claimed that windows were deliberately left open and unscreened, allowing drafts and infecting flies to swarm over patients. He charged that Lincoln consciously permitted "flies from the toilets, garbage and from the eruptions of patients suffering from acute and chronic troubles to go at will over the entire institution. Worse still," he proclaimed, "I found that inmates were fed with the milk from a herd of cattle reeking with tuberculosis."

At the time, milk from cattle with tuberculosis was a well-known cause of infection and death from the disease. Lincoln maintained its own herd of seventy-two cows, which produced about 50,000 gallons of milk a year for its own consumption. Ten diseased cows had died within the previous two years. State officials admitted that their own examinations had determined that as many as half of the cows were tubercular, but there was no way to know which ones were infected because "a tubercular cow may be the fattest cow in the herd." Lincoln officials claimed that their normal pasteurization "by an experienced employee" killed the tuberculosis bacteria. They were silent on the continuous handling of the milk by infected residents.

Medical watchdogs had often speculated that institutions for the feebleminded were really nothing more than slow-acting lethal chambers. But Haiselden never resorted to the term lethal chamber. He called such institutions "slaughterhouses."

In tuberculosis colonies, residents continuously infected and reinfected each other, often receiving minimal or no treatment. At Lincoln, the recently established tuberculosis unit housed just forty beds for an estimated tubercular population of hundreds. Lincoln officials asserted that only the most severely infected children were placed in that ward. They stressed that other institutions for the feebleminded recorded much higher mortality rates, some as high as 40 percent.

Eugenicists believed that when tuberculosis was fatal, the real culprit was not bacteria, but defective genes. The Carnegie and Rockefeller-financed Eugenics Record Office, headquartered at Cold Spring Harbor, Long Island, kept special files on mortality rates resulting from hereditary tuberculosis. The data was compiled by the Belgian eugenicist Albert Govaerts, among others.

Tuberculosis was an omnipresent topic in textbooks on eugenics. Typical was a chapter in Davenport's *Heredity in Relation to Eugenics* (1911). He claimed that only the "submerged tenth" was vulnerable. "The germs are ubiquitous," he wrote. "Why do only 10 percent die from the attacks of this parasite? …It seems perfectly plain that death from tuberculosis is the result of infection added to natural and acquired non-resistance. It is then highly undesirable that two persons with weak resistance should marry…." Popenoe and Johnson's textbook, *Applied Eugenics*, devoted a chapter to "Lethal Selection," which operated "through the destruction of the individual by some adverse feature of the environment, such as excessive cold, or bacteria, or by bodily deficiency."

Some years earlier, the president of the National Conference on Charities and Correction had told his institutional superintendents caring for the feebleminded, "We wish the parasitic strain... to die out." Even an article in *Institution Quarterly*, Illinois's own journal, admitted, "It would be an act of kindness to them, and a protection to the state, if they could be killed."

No wonder that at one international conference on eugenics, Davenport proclaimed without explanation from the podium, "One may even view with satisfaction the high death rate in an institution for low grade feebleminded, while one regards as a national disaster the loss of... the infant child of exceptional parents."

Haiselden himself quipped, "Death is the Great and Lasting Disinfectant."

Haiselden's accusations of deliberate passive euthanasia by neglect and abuse could neither be verified nor dismissed. Lincoln's understaffed, overcrowded and decrepit facility consistently reported staggering death rates, often as high as 12 percent per year. In 1904, for example, 109 of its epileptic children died, constituting at least 10 percent and probably far more of its youth population; cause of death was usually listed as "exhaustion due to epileptic seizures." Between 1914 and 1915, a bout of dysentery claimed eight patients; "heat exhaustion" was listed as the cause. During the same period, four individuals died shortly after admission before any preliminary examination at all: their deaths were categorized as "undetermined."

For some of its most vulnerable groups, Lincoln's death rate was particularly high. As many as 30 percent of newly admitted epileptic children died within eighteen months of admission. Moreover, in 1915, the overall death rate among patients in their first two years of residence jumped from 4.2 percent to 10 percent.

Tuberculosis was a major factor. In 1915, Lincoln reported that nearly all of its incoming patients were designated feebleminded; roughly 20 percent were classified as epileptics, and some 27 percent of its overall population was "in various stages of tubercular involvement." No isolation was provided for infected patients until the forty-bed tuberculosis unit opened. Lincoln officials worried that the statistics were "likely to leave the impression that the institution is a 'hot-bed' for the spread of tuberculosis." Officials denied this, explaining that many of the children came from filthy environments, and "the fact that feebleminded children have less resistance, account[s] for the high percentage of tuberculosis found among them."

Lincoln officials clearly accepted the eugenic approach to feeblemindedness as gospel. Their reports and explanations were laced with scientific quotations on mental deficiency from Tredgold, who advocated euthanasia for severe cases, and others doctors who extolled the wisdom of castrations performed in Kansas. Lincoln officials also made clear that they received many of their patients as court-ordered institutionalizations from the Municipal Court of Chicago; as such, they received regular guidance from the court's supervising judge, Harry Olson. *Eugenical News* praised Olson for operating the court's psychopathic laboratory, which employed Laughlin as a special consultant on sterilization. Olson was vital to the movement and hailed by Eugenical News as "one of its most advanced representatives." In 1922, Olson became president of the Eugenics Research Association.

Moreover, staff members at Lincoln were some of the leading eugenicists in Illinois. Lincoln psychologist Clara Town chaired the Eugenics Committee of the Illinois State Commission of Charities and Corrections. Town had helped compile a series of articles on eugenics and feeblemindedness, including one by her friend, Henry H. Goddard, who had invented the original classifications of feeblemindedness. One reviewer described Town's articles as arguments that there was little use in caring for the institutionalized feebleminded, who would die anyway if left in the community, caring for them was little more than "unnatural selection."

For decades, medical investigators would question how the death rates at asylums, including the one in Lincoln, Illinois, could be so high. In the 1990s, the average life expectancy for individuals with mental retardation was 66.2 years. In the 1930s, the average life expectancy for those classified as feebleminded was approximately 18.5 years. Records suggest that a disproportionate percentage of the feebleminded at Lincoln died before the age of ten.

Haiselden became an overnight eugenic celebrity, known to the average person because of his many newspaper articles, speaking tours, and his outrageous diatribes. In 1917, the film industry came calling. The film was called *The Black Stork*. Written by *Chicago American* reporter Jack Lait, it was given a massive national distribution and promotion campaign. Haiselden played himself in a fictionalized account of a eugenically mismatched couple who are counseled by Haiselden against having children because they are likely to be defective. Eventually the woman does give birth to a defective child, whom she then allows to die. The dead child levitates into the waiting arms of Jesus Christ. It was unbridled cinematic propaganda for the eugenics movement.

In many theaters, such as the LaSalle in Chicago, the movie played continuously from 9 A.M. until 11 P.M. National publicity advertised it as a "eugenic love story." Sensational movie posters called it a "eugenic photoplay." One advertisement quoted Swiss eugenicist Auguste Forel's warning: "The law of heredity winds like a red thread through the family history of every criminal, of every epileptic, eccentric and insane person. Shall we sit still... without applying the remedy?" Another poster depicted Haiselden's office door with a notice: "BABIES NOT TREATED." In 1917, a display advertisement for the film encouraged: "Kill Defectives, Save the Nation and See *The Black Stork*."

The *Black Stork* played at movie theaters around the nation for more than a decade.

Gassing the unwanted, the lethal chamber and other methods of euthanasia became a part of everyday

American parlance and ethical debate some two decades before President Woodrow Wilson, in General Order 62, directed that the "Gas Service" become the "Chemical Warfare Service," instructing them to develop toxic gas weapons for world war. The lethal chamber was a eugenic concept more than two decades before Nevada approved the first such chamber for criminal executions in 1921, and then gassed with cyanide a Chinese-born murderer, the first such execution in the world. Davenport declared that capital punishment was a eugenic necessity. Popenoe's textbook, Applied Eugenics, listed execution as one of nine suggested remedies for defectives—without specifying criminals.

In the first decades of the twentieth century, America's eugenics movement inspired and spawned a world of look-alikes, act-alikes and think-alikes. The U.S. movement also rendered scientific aid and legitimacy to undisguised racists everywhere, from race-tracking bureaucrat Walter Plecker in Virginia right across Europe. American theory, practice and legislation, were the models. In France, Belgium, Sweden, England and elsewhere in Europe, each clique of racecological eugenicists did their best to introduce eugenic principles into their national life, perhaps more importantly, they could always point to the recent precedents established in the United States.

Germany was no exception. German eugenicists had formed academic and personal relationships with Davenport and the American eugenic establishment from the turn of the century. Even after World War I, when Germany would not cooperate with the International Federation of Eugenic Organizations because of French, English and Belgian involvement, its bonds with Davenport and the rest of the U.S. movement remained strong. American foundations such as the Carnegie Institution and the Rockefeller Foundation generously funded German race biology with hundreds of thousands of dollars, even as Americans stood in breadlines.

Germany had certainly developed its own body of eugenic knowledge and library of publications. Yet German readers still closely followed American eugenic accomplishments as the model: a biological court, forcible sterilizations, detention for the socially inadequate, euthanasia debates. As America's elite were describing the socially worthless and the ancestrally unfit as "bacteria," "vermin," "mongrels," and "subhuman," a superior race of Nordics was increasingly seen as the final solution to the globe's eugenic problems.

Fan Mail from Germany

America had established the value of race and blood. In Germany, the concept was known as Rasse und Blut. Yet the catch phrase was developed by David Starr Jordan, the racist president of Stanford University. U.S. proposals, laws, eugenic investigations and ideology were not undertaken quietly out of sight of German activists. They became inspirational blueprints for Germany's rising tide of race biologists and race-based hatemongers, be they white-coated doctors studying *Eugenical News* and attending congresses in New York, or brown-shirted agitators waving banners and screaming for social upheaval in the streets of Munich.

One such agitator was a disgruntled corporal in the German army. He was an extreme nationalist who also considered himself a race biologist and an advocate of a master race. He was willing to use force to achieve his nationalist racial goals. His inner circle included Germany's most prominent eugenic publisher. In 1924, he was serving time in prison for meth action. While in prison, he spent his time poring over eugenic textbooks, which extensively quoted Davenport, Popenoe and other American racecological stalwarts. Moreover, he closely followed the writings of Leon Whitney, president of the American Eugenics Society, and Madison Grant, who extolled the Nordic race and bemoaned its corruption by Jews, Negroes, Slavs and others who did not possess blond hair and blue eyes. The young German corporal even wrote one of them a fan letter.

In *The Passing of the Great Race*, Madison Grant wrote: "Mistaken regard for what are believed to be divine laws and a sentimental belief in the sanctity of human life tend to prevent both the elimination of defective infants and the sterilization of such adults as are themselves of no value to the community. The laws of nature require the obliteration of the unfit and human life is valuable only when it is of use to the community or race."

One day in the early 1930s, AES president Whitney visited the home of Grant, who was at the time chairing a eugenic immigration committee. Whitney wanted to show off a letter he had just received from Germany, written by the corporal, now out of prison and rising in the German political scene. Grant could only smile. He pulled out his own letter. It was from the same German, thanking Grant for writing *The Passing of the Great Race*. The fan letter stated that Grant's book was "his Bible."

The man writing both letters to the American eugenic leaders would soon burn and gas his name into the blackest corner of history. He would duplicate the American eugenic program—both that which was legislated and that which was only brashly advocated—and his group would consistently point to the United States as setting the precedents for Germany's actions. And then this man would go further than any American eugenicist ever dreamed, further than the world would ever tolerate, further than humanity will ever forget.

The man who sent those fan letters to America was Adolf Hitler.

Edwin Black is the New York Times *bestselling and award-winning author of* IBM and the Holocaust. *This article is adapted from War Against the Weak--Eugenics and America's Campaign to Create a Master Race (Dialog Press).*

Back

Mr. FRANKS. Thank you, Mr. Black. Thank you very much, sir. And, Mrs. Yeung, you are now recognized for 5 minutes.

TESTIMONY OF MIRIAM W. YEUNG, EXECUTIVE DIRECTOR, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM

Ms. YEUNG. Thank you all for having me here today.

My name is Miriam Yeung, and I am the executive director of the National Asian Pacific American Women's Forum. We are the country's only multi-issue organization dedicated to building a movement for social justice and human rights for Asian and Pacific

Islander women and girls in the United States. I am also a Chinese immigrant from Hong Kong and the proud mother of two wonderful daughters, who are doing a very good job of staying quiet.

On behalf of NAPAWF and the dozen of women's rights, Asian American and Pacific Islander, human rights, civil rights, and reproductive groups that stand with me, I strongly urge the Members of this Congress to oppose H.R. 3541, otherwise as known as "PRENDA."

Forgive ME for allowing my Brooklyn roots to show just a little bit when I say, "PRENDA is nothing but a pretenda." PRENDA pretends to fight against racial discrimination by actually perpetuating discrimination against women of color. This bill undermines and calls into question our ability as women of color to make decisions about our own bodies.

The truth is, most Americans believe that a woman knows what is best for her and her family. But this bill places unfair scrutiny on African American and Asian American women around our motives for seeking abortion care. This scrutiny promotes racial profiling by pushing doctors to assume African American and Asian American women are seeking abortions because of the race or sex of their fetus.

Women of color already face difficulty accessing health care and have poorer health outcomes. African American women are three to four times more likely to die from pregnancy-related causes than White women, and their unintended pregnancy rate is almost twice that of White women. Vietnamese women are more than five times as likely to die from cervical cancer, and Korean women have the highest uninsurance rates of any ethnic or racial group. Unfortunately, this measure would make health-care outcomes for women of color even worse. Making abortion harder to obtain exacerbates racial disparities in health care.

PRENDA pretends to speak the language of women's equality, but, unfortunately, the voting records of its supporters do not strengthen civil rights, women's rights, or the rights of Asian Americans and Pacific Islanders. For example, this year alone, sponsors voted to de-fund family planning, eliminate funding for the United Nations Population Fund, ban abortion coverage in State health insurance exchanges, and allow providers to refuse abortion care even when a woman's life is in danger. Sponsors of this bill did not support the Children's Health Insurance Program Reauthorization Act. And some would even require hospitals to report possible undocumented persons that seek treatment, thus preventing immigrants from seeking emergency health care.

PRENDA pretends to address the issue of sex selection but does nothing to address the root causes of son preference or gender inequity. Son preference is a symptom of deeply rooted social biases and stereotypes about gender. Gender inequity cannot be solved by banning abortion. In fact, the United Nations Population Fund, the World Health Organization, the Office of the High Commissioner for Human Rights, UNICEF, and U.N. Women have issued a clear joint statement that countries have an obligation to ensure that these injustices, meaning son preference, are addressed without exposing women to the risk of death or serious injury by denying them access to needed services such as safe abortion.

Asian American and Pacific Islander women know that gender inequities do exist and are working in culturally competent ways to provide long-term, sustainable solutions. We are working with members of our own community to empower women and girls, thereby challenging norms and transforming values. For example, we are carrying out programs that build the leadership of women, improve our economic standing, create better access to health care, and end gender-based violence against us.

We need your support to put Asian Americans and Pacific Islanders back to work, since our community experiences the longest duration of unemployment of all races and ethnicities. We need your support on current bills such as the reauthorization of the Violence Against Woman Act, the Lilly Ledbetter Fair Pay Act, and the Health Equity and Accountability Act. We need humane immigration reform and many other policy efforts which would help my community.

In summary, PRENDA pretends to eliminate racial and gender discrimination but is a thinly veiled attempt to limit abortion access for women of color. Instead of curbing women's rights and exacerbating racial discrimination, I welcome all Members of Congress to work with NAPAWF and all other organizations that stand with me to pass legislation that truly results in racial justice and gender equality. Let's really work together to improve the lives of women of color and to make this country a better place for daughters like mine. But let's not continue to pretend that this bill does that.

Thank you.

[The prepared statement of Ms. Yeung follows:]

Hearing on H.R. 3541,
The Susan B. Anthony and Frederick Douglass
Prenatal Nondiscrimination Act (PRENDA) of 2011
Subcommittee on the Constitution

Testimony of the Miriam W. Yeung, MPA
National Asian Pacific American Women's Forum (NAPAWF)

December 6, 2011

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

The National Asian Pacific American Women's Forum (NAPAWF) joins numerous women's rights, civil rights, racial justice, Asian and Pacific Islander (API), and human rights leaders in calling on Congress to oppose the "Prenatal Nondiscrimination Act," which is a thinly veiled attempt to limit abortion access for women of color.

NAPAWF is the only national, multi-issue API women's organization in the country. Our mission is to build a movement to advance social justice and human rights for API women and girls. Since 1996, we have represented API women, who are overwhelmingly pro-choice,[1] in pushing back against abortion bans that disproportionately impact women of color. Therefore, we are compelled to express concern over this dangerous and duplicitous legislation.

This bill is a wolf in sheep's clothing. Its proponents co-opt the language of equality and human rights to be purposely misleading in an effort to pass an anti-choice measure without a fight. We see clearly that this bill is an attack on our right to self-determine whether and when to have children.

Although this bill purports to support gender equity and civil rights, it does neither. It is regrettable that in the past, sponsors of this bill have not demonstrated similar concerns for civil rights, women's rights or the rights of Asian and Pacific Islanders. For example, this year alone, sponsors voted to defund family planning, eliminate funding for the United Nations Population Fund (UNFPA), reinstate the global gag rule, reinstate the D.C. abortion funding ban, ban abortion coverage in state health insurance exchanges, and allow providers to refuse abortion care even when a woman's life is in danger. And, as evidence of their anti-immigrant stance, sponsors of this bill cosponsored H.R. 997, a xenophobic measure that would declare English the official language of the United States. In addition, another sponsor supported H.R. 1868, which would end birthright citizenship for children of undocumented immigrants—in violation of the Fourteenth Amendment which this bill purports to enforce—and voted for H.R. 3722, which would require hospitals to report possible undocumented persons that seek treatment, thus preventing immigrants from seeking healthcare.

[1] Nearly 70% of APA women support a woman's decision to have an abortion. Another 20% stated that they would support a woman's decision to have an abortion in certain cases such as rape or incest. National Asian Women's Health Organization, Expanding Options: A Reproductive and Sexual Health Survey of Asian American Women (Jan. 1997).

Put simply, the legislative priority of the committee members who dreamed up this legislation is to take away the rights of women and communities of color, not to help us.

Moreover, consider the media campaign related to this bill, the billboards that read, "Black children are an endangered species," and "The most dangerous place for an African American is in the womb." It is easy to follow the money behind these billboards campaigns straight to anti-choice organizations such as Georgia Right to Life[2] and Heroic Media[3]. This effort is about attacking women of color's reproductive autonomy and our access to abortion services.

This bill discriminates against women of color. It undermines and calls into question our ability to make decisions about our own bodies. The truth is most Americans believe that a woman knows what is best for her and her family. Further, this bill places an unfair burden on African American and Asian American women that other women do not have to face—increased scrutiny around their motives for seeking abortion care. This scrutiny promotes racial profiling by pushing doctors to assume African American and Asian American women are seeking abortions because of the race or sex of the fetus.

Disturbingly, this measure would make healthcare outcomes for women of color *even worse* than they already are. African American women are already three to four times more likely to die from pregnancy related causes than white women,[4] and their unintended pregnancy rate is 67% compared to 40% for white women.[5] Making abortion harder to obtain will cause women to seek unsafe illegal abortions and exacerbate racial disparities in healthcare.

This bill correctly states that the United Nations Commission on the Status of Women urges governments to prevent selective abortions.[6] However, it omits that the international community, including the UNFPA, the Office of the United Nations High Commissioner for Human Rights (OHCHR), the United Nations Children's Fund (UNICEF), United Nations Women, and the World Health Organization (WHO), believes that abortion restrictions are not the solution because they put women's health and lives in jeopardy and violate women's human and reproductive rights.[7]

Family planning programs allow women of color to access contraceptives, prevent unplanned pregnancies, and improve healthcare outcomes for themselves and their children. Yet, the proponents of this bill, espousing concern for women of color, have repeatedly proposed legislation to cut funding for family planning and women's healthcare, creating more barriers to access.

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[2] Shaila Dewan. "To Court Blacks, Foes of Abortion Make Racial Case." *The New York Times*. 26 Feb. 2010. Retrieved December 2, 2011, from http://www.nytimes.com/2010/02/27/us/27race.html?pagewanted=all

[3] Titania Kumeh. "Mother Sues Anti-Choice Groups Behind Billboards." *Mother Jones*. 29 Apr. 2011. Retrieved December 2, 2011, from http://motherjones.com/mixed-media/2011/04/mother-sues-anti-abortion-groups-billboards

[4] U.S. Department of Health and Human Services Office on Women's Health, "Pregnancy Related Death." Last modified 18 May 2010. http://www.womenshealth.gov/minority-health/african-americans/pregnancy.cfm

[5] Guttmacher Institute, "Facts on Induced Abortion in the United States." Last modified Aug. 2011. http://www.guttmacher.org/pubs/fb_induced_abortion.html

[6] Section 2. Findings and Constitutional Authority. (a)(1)(II).

[7] OCHR, UNFPA, UNICEF, UN Women, and WHO. "Preventing Gender-Biased Sex Selection: An Interagency Statement." World Health Organization, 2011, 7.

As an organization that represents Asian American and Pacific Islander women, NAPAWF is extremely concerned that the anti-choice movement is exploiting the issue of son preference in some Asian cultures while doing nothing to support efforts that truly address the issue. It is true that a few studies[8] point to the practice of son preference among Chinese-, Indian-, and Korean-American families with more than one child, with results most pronounced for families with two or more children. Researchers are quick to note that this problem is far from widespread. Because of the low fertility rate in the United States, and because those API ethnicities make up less than two percent of the total US population, this phenomenon would in no way result in the skewed sex ratios that cause concern in Asia.[9]

Son preference is a symptom of deeply rooted social biases and stereotypes about gender. Gender inequity cannot be solved by banning abortion. The real solution is to change the values that create the preference for sons. Asian American and Pacific Islander women's organizations know this and are working on this problem in culturally competent ways that provide long-term, sustainable solutions. We are working with members of our own community to empower women and girls, thereby challenging norms and transforming values. For example, we are carrying out programs that build the leadership capacity of women, improve their economic standing, create better access to healthcare for them, and lower the rates of gender-based violence against them. Instead of supporting us in this work, proponents of this bill ignore what Asian American and Pacific Islander women know is best for our own community and undermine our agency by trying to curb our rights.

Anti-choice activists are using the language of gender and racial inequality in the service of efforts to incrementally dissolve abortion rights, which is more politically efficient for them than a flat-out ban. In 2008, Steven Mosher, who is testifying before you today, suggested that, "we—the pro-life movement—adopt as our next goal the banning of sex-selective abortion."[10] For him, sex-selection is the next logical battleground in the abortion wars; not because it discriminates or hurts women, but because it is a cloak to hide under that might gain sympathy and support from individuals who are uninformed on this topic.

In closing, we encourage you to find the right solutions to the right problem. This bill will exacerbate inequities and diminish the health, well-being, and dignity of women and girls by restricting their access to reproductive health care. If members of Congress want to support women and communities of color, we look forward to your swift support of such pending legislative items that address pay equity, access to healthcare, freedom from violence, fair and humane immigration policies, and the ability to control our bodies and our futures. Abortion bans do nothing of the sort.

Thank you for your time and attention to this important issue.

[8] See Abrevaya, J., 2008. Are there missing girls in the United States? Evidence from birth data. And Almond, D. & Edlund E. 2008. Son-biased sex rations in the 2000 United States Census.
[9] Almond, D. & Edlund, E.
[10] Hvistendahl, Mara. *Unnatural Selection: Choosing Boys Over Girls and the Consequences of a World Full of Men.* (New York: Public Affairs, 2011), 240.

Mr. FRANKS. Thank you, Ms. Yeung.
Mr. Mosher, you are recognized, sir, for 5 minutes.

TESTIMONY OF STEVEN W. MOSHER, PRESIDENT, POPULATION RESEARCH INSTITUTE

Mr. MOSHER. Thank you, Mr. Chairman, Members of the Subcommittee.

Nearly 9 out of 10 Americans oppose abortion for reasons of sex selection, but such acts of gender violence are neither illegal nor uncommon in our country. Permissive abortion laws and high resolution ultrasounds make it easier than ever for parents to target and eliminate unwanted daughters before birth.

Now, I have followed the issue of sex-selective abortion for a long time. I was the first American social scientist in China in 1979-1980 during the beginning of the one child policy. I documented sex-selective infanticide in the Pearl River Delta, the killing of little girls after birth by their parents, who were under terrible pressure by the government to end over-quota pregnancies.

I also testified before the Australian Senate in 1986 against shipping ultrasound machines to China because I argued they would be used overwhelmingly to detect the sex of unborn children and that girls would be targeted for elimination; 37 million baby girls in China have perished in this way. So this is an issue of concern to me for a long time.

You know, until the recent spate of negative publicity focused public attention on these crimes, it was not unusual to find abortionists advertising the availability of sex-selective abortions in newspapers like The New York Times. Now, anyone who has lived in the Asian American community, as I have, is aware that the practice of selectively aborting female fetuses is disturbingly common. Women, as well as their daughters, are both victimized.

Now, Congressman Chabot has already mentioned the study, the very gripping and disturbing study by Sunita Puri, an Asian American physician, but it is worth mentioning again because she actually interviewed 65 immigrant Indian women who had pursued fetal sex selection. She found that 89 percent of the women carrying girls aborted during the study. That is to say almost all of the women when they found out they were carrying girls went in and ended the lives of their unborn baby girls. She found that nearly half had previously aborted girls.

And she found something else. She found evidence of gender violence. These women told Dr. Puri that they had been, by their husbands or in-laws, they had been shoved around, kicked in the abdomen, denied food, water and rest in an attempt to make them miscarry the girls they were carrying. Even the women who were carrying boys told of their guilt over past sex-selection abortions, the feeling of being unable to save their daughters.

So these episodes are not isolated tragedies. These are common occurrences in some American communities. We have two studies now by economists which document son-biased sex ratios. I don't have time to go into the details.

But the one point that jumped out at me was this: Whether a mother in some of these communities gave birth to a boy could not be predicted by her immigration status alone. In fact, mothers who are U.S. citizens were slightly more likely to have sons than those who were immigrants. This means that sex selection is not a tradition from the old country that easily dies out. The enduring nature

of sex-selection abortion further underlines the need for the kind of legislative remedy that PRENDA offers.

Those who argue against sex and race selective abortions do so on the grounds that sex-selective abortion is not really a problem here. In fact, Maria Hvistendahl, who wrote a book about this, writes, "the Prenatal Nondiscrimination Act is not such a bad law were it to be enacted in the countries that actually need it."

The implication here is that the United States doesn't need it. I disagree. While it is difficult to say with any exactitude how many sex-selection abortions take place in the U.S. Each year, the number is not trivial. Consider that we are talking about communities consisting of 3.9 million Chinese Americans, 2.8 million Indian Asians—Asian Indians, 1.6 million Korean Americans, the highly skewed sex ratios found in census surveys suggest among these groups alone, that tens of thousands of unborn girls have been eliminated, for no other reason than they are considered by some to be the wrong sex.

I disagree with Hvistendahl that the death of tens of thousands of American baby girls does not constitute a problem significant enough to be combated with legislation. Even one death is too many.

Finally, this reasonable effort to rein in discriminatory abortions has been mischaracterized by some as "an attempt to restrict health care for women of color." What this bill is really talking about is allowing Indian, Chinese, Korean American and other women the freedom to have babies of their own choosing. Isn't that what reproductive choice is supposed to be all about: allowing women the freedom to have the babies of their own choosing.

Thank you very much.

[The prepared statement of Mr. Mosher follows:]

Ban Sex Selective Abortions in the U.S.

Steven W. Mosher
President
Population Research Institute

Nearly nine out of ten Americans oppose abortion for reasons of sex selection, but such acts of gender violence are neither illegal nor uncommon in our country. Permissive abortion laws and high-resolution ultrasounds make it easier than ever for parents to target and eliminate unwanted daughters (or sons) before birth.

Are Sex- and Race-Selective Abortions Occurring Here?

Until the recent spate of negative publicity focused public attention on such crimes, it was not unusual to find abortionists advertising the availability of sex-selective abortions in newspapers such as the *New York Times*.

Anyone who has lived in and worked with the Asian-American community, as I have, is aware that the practice of selectively aborting female fetuses is disturbingly common.[i] Women and their daughters are both victimized.

Sunita Puri, an Asian-Indian physician, interviewed 65 immigrant Indian women in the United States who had pursued fetal sex selection. She found that a shocking 89% of the women carrying girls aborted during the study, and that nearly half had previously aborted girls.

These women told Puri of how they were the victims of family violence; how their husbands or in-laws had shoved them around, kicked them in the abdomen, or denied them food, water, rest in an attempt to make them miscarry the girls they were carrying. Even the women who were carrying boys told of their guilt over past sex-selection abortions, and the feeling of being unable to "save" their daughters.[ii]

Such episodes are not isolated tragedies, but are common occurrences in some American communities. An analysis of 2000 Census data found clear evidence of sex-selective abortions in what the authors called "son-biased sex ratios," that is, a higher ratio of boys to girls than would occur in nature.[iii]

The 2008 study, by Columbia University economists Douglas Almond and Lena Edlund, examined the sex ratio at birth among U.S.-born children of Chinese, Korean and Asian-Indian parents. They found that the first-born children of Asians showed normal sex ratios at birth, roughly 106 girls for every 100 boys. If the first child was a son, the sex ratio of the second-born children was also

normal.

But what happened if the first child was a girl? In that case, they found, the sex ratio for second births was 117, meaning that the second child tended to be a boy. To put it another way, roughly 10 percent of girls had been eliminated.

"This male bias is particularly evident for third children," they reported. "If there was no previous son, sons outnumbered daughters by 50%." Their raw numbers showed that, for every 151 boys, there were only 100 hundred surviving girls. The rest had been eliminated.

The authors quite rightly interpret this "deviation in favor of sons" the only way they possibly could, namely, as "evidence of sex selection, most likely at the prenatal stage." In other words, as early as a decade ago, Asian-American communities in the U.S. were already practicing sex-selective abortion.

Moreover, they went on to note, whether a mother gave birth to a boy could not be predicted by her immigration status. Indeed, mothers who were U.S. citizens were slightly more likely to have sons.

This means, as Mara Hvistendahl, the author of *Unnatural Selection*, notes, that *"Sex selection ... is not a tradition from the old country that easily dies out."* [iv] (italics added) The enduring nature of sex selective abortion further underlines the need for the kind of legislative remedy that PRENDA offers.

An even earlier study, by Jason Abrevaya of the University of Texas, also confirmed that that is empirical evidence of gender selection within the United States. Abrevaya analyzed birth data and showed unusually high boy-birth percentages after 1980 among later children (most notably third and fourth children) born to Chinese and Asian Indian mothers. Moreover, using maternally linked data from California, he found that Asian-Indian mothers are significantly more likely both to have a terminated pregnancy and to give birth to a son when they have previously only given birth to girls.

It is worth noting that similar sex imbalances have also been documented among Canada's Asian immigrant communities. Quoting the *Toronto Globe and Mail*, Joseph D'Agostino has written, "Figures from the 2001 census supplied by Statistics Canada suggest a slight skew in the usual gender ratio among people with South Asian backgrounds.... According to the 2001 census data, the proportion of girls under 15 in the South Asian communities of Mississauga and Brampton is two percentage points below the ratio for the rest of the population in those municipalities."[v]

In Great Britain skewed sex ratios have been documented among South Asian immigrants by Oxford University human geographer and population expert Sylvie

Dubuc. She concluded that the most probable explanation was sex selective abortion by a certain percentage of mothers born in India.[vi]

Such numbers do not mean that most Asians living abroad practice sex selection, of course. There is no evidence of sex selection among Japanese-Americans or Filipino-Americans. Even among those immigrant populations that do practice sex selective to some degree, the majority does not.

Finally, it is worth noting that there is probably no segment of the U.S. population that has perfectly clean hands. The difference is that, absent a strong preference for one sex over the other, no sex disparity is likely to show up statistically. But were unborn boys and girls eliminated for reason of their sex? Undoubtedly yes.

What the numbers do suggest is that this ultimate form of misogyny is happening in the United States, and that it is ethically an excellent idea to say that we are not going to tolerate sex-selective abortion in our country, that we are going to defend the intrinsic dignity of unborn girls.

Objections to Banning Sex- and Race-Selective Abortions

Those who argue against restrictions on sex- and race- selective abortions do so on the grounds that sex selective abortion is not really a problem here. Mara Hvistendahl, for example, writes that "the Prenatal Nondiscrimination Act is not such a bad law—were it to be enacted in the countries that actually need it."

The implication here is that the U.S. doesn't "need it."

I disagree. While it is difficult to say with any exactitude how many sex-selection abortions take place in the U.S. each year, the number is not trivial.

Consider that among the populations demonstrated to practice sex-selective abortion there are 3.9 million Chinese-Americans, 2.8 million Asian-Indians, and 1.6 million Korean-Americans living in the United States. The numbers of Asian-Indians, in particular, has doubled over the last two decades. The highly skewed sex ratios found by both Abrevaya and Almond et al suggest that, among these groups alone, tens of thousands of unborn girls have been eliminated for no other reason than they are considered by some to be the wrong sex.

I disagree with Hvistendahl that the death of tens of thousands of American baby girls does not constitute a problem significant enough to be combated with legislation.

Even one death is too many.

The International Situation and the United States

Consider the situation in India, which has a *de facto* two-child policy. A national survey published in *The Lancet* revealed that as many as half a million female fetuses are aborted there each year because of their gender.[vii] The worst performing Indian state was Punjab, which saw only 775 births per 1,000 males births in 1999-2001. This works out to a sex ratio at birth of 129 males to 100 females that is the highest known sex ratio in the world.[viii]

Since the mid-1980s, when ultrasound technology began allowing parents to learn the sex of their children before birth, the number of Indian girls per 1,000 boys has declined from 962 in 1981 to 927 in 2001. Given the large size of the Indian population, with annual birth cohorts in the tens of millions, this is statistically a very significant decline.

The disparity is even more lopsided among middle-class urban families, reportedly because of their greater access to ultrasounds and their greater ability to pay for them. Here the number of girls per 1,000 boys drops into the 800s, or even lower. The lowest recorded number of girls is found in some high-caste urban areas of Punjab, where only 300 girls per 1,000 boys survive gestation.[ix]

The problem extends far beyond India, of course. A recent United Nations Population Fund report says at least 60 million girls are "missing" throughout Asia because of sex-selective abortion, infanticide and neglect.

The most egregious example is China, where a brutally enforced one-child policy has produced a national ratio of 121 boys born for every 100 girls, with some provinces posting ratios of more than 150 boys per 100 girls.[x] The shortage of girl children is obvious to anyone who visits rural China, as I have recently. One can visit elementary schools classrooms where, out of a total of 30 students, 20 or so are boys. On a national level, demographers predict that there will be 30 million more Chinese men than women of marriageable age by 2020.[xi]

The practice of female feticide, as it is sometimes called, is also found in other "Confucian" cultures, such as South Korea, Taiwan, Hong Kong, Singapore and Vietnam. Vietnam, for example, has in recent years seen a spike in the number of male births compared with female births.[xii]

The South and Southeast Asian countries of Pakistan, Bangladesh and Indonesia also show unbalanced sex ratios.[xiii] Even more lopsided ratios are found in the Caucasus countries of Azerbaijan, Georgia, and Armenia.[xiv] Less pronounced but still evident biases in the sex ratio also emerged in southern Europe after the wars of the Yugoslav succession, affecting the countries of Serbia, Macedonia and Bosnia and, further north, Belarus.[xv]

The selective abortion of unborn girls is a serious international problem, which to date has cost the lives of 160 million females.

Hvistendahl and others ignore another consequence of allowing sex-selective abortions to continue unabated in the U.S.

The fact is, many other countries, including India and China, have already begun to place restrictions on identifying the sex of unborn children precisely to create an obstacle to sex selective abortion. Hvistendahl maintains that banning sex selective abortion in places like India and China is not only not only necessary, but also that such laws should be vigorously enforced.

But if other countries have bans in place and the U.S. doesn't, then our country runs the risk of becoming a magnet for those who wish to procure sex- and race-selective abortions.

For such bans to be effective abroad we need to criminalize sex selective abortion at home.

What is to be Done?

Sex-selective abortion is rightly seen by many as the ultimate form of discrimination against women. As investigative journalist Gita Aravamudan argues in her 2007 book, *Disappearing Daughters: The Tragedy of Female Feticide*, "Female infanticide is akin to serial killing. But female feticide is more like a holocaust. A whole gender is getting exterminated."[xvi] Sex selective abortion is increasingly being called "gendercide," especially in countries where it has reached massive proportions.

Sex-selective abortion is illegal under Indian and Chinese law. India has in fact gone even further, requiring all ultrasound machines to be registered with the authorities.[xvii] These laws are not rigorously enforced and, as a result, have scarcely curbed the practice.

Sex Selection is generally prohibited in Europe. In the UK, as in most European countries, abortion can be carried out for medical reasons but is not permitted on the grounds of sex alone.[xviii] Health authorities in Sweden, however, recently ruled that it is not illegal to kill a healthy unborn child based simply on its gender. There is, reportedly, abortion tourism from Great Britain to the U.S., and from other Scandinavian countries to Sweden, for the purpose of aborting unwanted girls.[xix]

Still, a logical first step in curbing any heinous practice is to ban it. Such a measure would enjoy widespread public support, even in countries like the U.S. where it is currently legal to abort a child for any and all reasons. Fully 86 percent of those Americans surveyed in a 2006 Zogby/USA Today poll would like to see sex-selective abortion banned.

Former U.S. Senator Jesse Helms, each year that he was in the U.S. Senate, introduced legislation to ban sex-selective abortion. The language was simple, yet powerful: "It shall be illegal to perform an abortion for the sole purpose of sex selection."

It is a commonplace to say that the law is a teacher. Nowhere is this more true than in democratic countries whose citizenries understand that their elected legislators speak for them. Banning the practice of sex selective abortion in China and India has had a limited effect. For the parliaments of Canada and Europe, or the Congress of the United States, to legislate against it would undoubtedly have a much greater impact, at least among those people who are cognizant of the new law.

I congratulate Congressman Trent Franks and his co-sponsors of the Prenatal Nondiscrimination Act. It is a necessary corrective to a real and continuing problem.

Mara Hvistendahl, who has studied the problem of sex-selective abortion extensively, has expressed disappointment "at the degree to which domestic American politics prevents action on a problem of great importance." (p. xviii)

With Prenatal Nondiscrimination Act we now have an opportunity for take action, passing legislation that would not only accord with the wishes of the vast majority of the American people, but would conform U.S. laws to those of much of the rest of the world, and reduce the number of sex- (and race-) selective abortions in the U.S.

We have a chance to end the ugliest form of misogyny imaginable, a misogyny that kills.[xx]

I strongly endorse its passage.

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[i] I was for 10 years (1986-1995), the Director of the Asian Studies Center at the Claremont Institute in Southern California.

[ii] Sunita Puri et al, "*There is such a thing as too many daughters, but not too many sons*": A qualitative study of son preference and fetal sex selection among Indian immigrants in the United States. Social Science & Medicine, Volume 72, Issue 7, April 2011, Pages 1169-1176.

[iii] Douglas Almond and Lena Edlund, "Son-biased sex ratios in the 2000 United States Census," Published online before print March 31, 2008, doi: 10.1073/pnas.0800703105; *Proceedings of the National Academy of Sciences, April 15, 2008 vol. 105 no. 15 5681-5682.*

[iv] Mara Hvistendahl, *Unnatural Selection: Choosing boys over Girls, and the Consequences of a World Full of Men*, Public Affairs, 2011, p. 43.

[vi] Syvie Dubuc and David Coleman, "An Increase in the Sex Ratio of Births to India-born Mothers in England and Wales: Evidence for Sex-Selective Abortion," *Population And Development Review* 33(2) 383-400 June 2007.

[vii] Prabhat Jha et al, "Low male-to-female sex ratio of children born in India: national survey of 1.1 million households," *The Lancet* (Jan 21, 2006) Vol. 3367 No 9511 pp 679-688.

[viii] Carl Haub, "Future Fertility Prospects for India," paper presented to the United Nations Expert Group Meeting on Recent and Future Trends in Fertility, Population Division, United Nations Department of Social and Economic Affairs, New York 2-4 December 2009. Available at www.un.org/esa/population/meetings/EGM-Fertility2009/P12_Haub.pdf

[ix] Sahana Charan, "Female feticide prevalent in urban areas," *The Hindu*, November 20, 2002.

[x] ShuZhou Li, "Imbalanced Sex Ratio at Birth and comprehensive Intervention in China" (paper presented at the Fourth Asia pacific Conference on Reproductive and Sexual Health and Rights, 2007), 7.

[xi] National Population and Family Planning Commission of China, "Thirty million men face bleak future as singles," January 12, 2007. Accessed at http://www.npfpc.gov.cn/en/detail.aspx?articleid=090609161817184239.

[xii] Patralekha Chatterjee, "Sex ratio imbalance worsens in Vietnam," *The Lancet* (October 24, 2009) Vol. 374 No 9699 p. 1410.

[xiii] Isabelle Attarie, *Une China sans Femmes?* (Perrin, Paris 2005). As Attarie notes, in 2005, for every 100 girls born, 115 boys were born in Azerbaijan, 118 in Georgia and 120 in Armenia. Give that in 1995 the birth ratios in these countries were normal, this suggests a rapid increase in sex selective abortion over the past few years.

[xiv] France Mesle et al, "A sharp increase in sex ratio at birth in the Caucasus. Why? How?," CEPED-CICRED-INED Seminar on Female Deficit in Asia: Trends and Perspectives, Singapore, 5-7 December 2005. Accessed at www.cicred.org/Eng/Seminars/Details/.../64_Badurashvili.pdf.

[xv] Christophe Z. Guilmoto, "Sex-ratio imbalance in Asia:
Trends, consequences and policy responses," Paper submitted to the 4th Asia Pacific Conference on Reproductive and Sexual Health and Rights, October 29-31, 2007, accessed at www.unfpa.org/gender/docs/studies/.../regional_analysis.pdf.

[xvi] Gita Aravamudan, *Disappearing Daughters: The Tragedy of Female Feticide* (Penguin *Books*, New Delhi, 2007).

[xvii] "Stricter law to check female feticide," *The Hindu*, June 1, 2002.

[xviii] Parliamentary Office of Science and Technology, "Sex Selection," *Postnote*, July 2003, No. 198. 198 198. 198. Accessed at www.parliament.uk/post/pn198.pdf.

[xix] Kathleen Gilbert, "Sweden rules gender-selective abortions legal," LifeSite News, May 12, 2009. Accessed at http://www.lifesitenews.com/ldn/2009/may/09051201.html.

[xx] See Colin Mason, "Drive to ban sex-selective abortion gaining momentum," 20 July 2009. Accessed at http://pop.org/20090720975/july-20-drive-to-ban-sex-selective-abortion-gaining-momentum.

Mr. FRANKS. Well, thank you, Mr. Mosher.

We will now begin the questions. I will recognize myself for 5 minutes for questions, and I will direct my first question to you, Mr. Black.

I keep trying to call you Dr. Black. I apologize, but you talk like an Ph.D. here, better than most of them, I will tell you.

Mr. Black, your testimony for me was so very compelling because you seemed to restate one of humanity's oldest and perhaps most evil practices in ways that help us understand the consequences in real terms. I was particularly struck in your comments about the early eugenicists' philosophy that it wasn't advocated so much by the "activists of the day" that you might consider the uneducated masses, but these were the elite, the—I won't say do-gooders of society—but the ones that considered themselves smarter than everybody else. And it frightens me a little bit, because I think we think that they weren't very bright back then and how could they have fallen into that trap, but I wonder if sometimes today that we don't do the same thing.

So my question to you, at the risk of sounding redundant, would you capsulize again the eugenicist practices in this country in the 20th century and what it led to in our country and outside our country and who were the primary movers and shakers behind it?

Mr. BLACK. Well, it is important to understand that the genocidal actions of the American eugenicists were not conducted by men in white sheets burning crosses at midnight, but by men in white lab coats and in three-piece suits in the fine corridors of our great universities, in the State House, in the court house and in the medical society. This was all subject to the rule of law, and the law was put into place by the men in power to eliminate the existence of those they believed had no right to exist.

You asked about the do-gooders. These were actually Utopians, and they believed that they could form a Utopia by cutting off 14 million Americans at a time, at a slice, and eventually, there would be no one left except those who resembled themselves. Unfortunately, as I am sure the Members of the Committee know, the word "Utopia" in Greek means nowhere, and even the ancient Greeks knew that Utopia was unattainable.

But in their effort to create a Utopia, they decided to corral and sterilize and stop the reproductive rights and incarcerate White people with brown hair from Appalachia, Hispanics, Jews coming in from the East, the Asians who had come in to work on the railroads. These people were turned into untermenschen, meaning subhumans, and this was pursuant to law in 27 States, and was upheld by the Supreme Court no less than Oliver Wendell Holmes, when he said three generations of imbeciles are enough. Now, the kids up there think that the words "imbecile," "moron" and "idiot" are insults, but the adults up there, the older ones, know that these were scientific terms that were designed to measure intelligence and to stigmatize.

What is important to understand is that while we invented this race policy and eugenics, we empowered it into Nazi Germany. It was decades of our funding of Nazi eugenics that caused Adolph Hitler to praise the United States eugenics policy in Mein Kampf, to write fan mail to the chair, to the board members of Margaret Sanger, to say, your work is my Bible, and to pursue American principles, laws, statutes, with tremendous ferocity and velocity.

In fact, we are all in horror about what happened at Auschwitz with Mengele. What most people don't understand is that Mengele's twin research was in fact funded by the Rockefeller Foundation when they made his boss, Otmar Verschuer, their chief

researcher on the Rockefeller twin project. It was Adolf Hitler who said that national socialism is just biology in action.

So we must understand that World War II was more than a war of economic plunder and territorial conquest. World War II was actually a genetic war backed up by a merciless military that sought to eliminate the existence of all those deemed to be socially unfit.

Mr. FRANKS. I am going to ask unanimous consent for one more minute to just throw one quick other question at you. Can you explain how the American eugenics movement influenced the efforts of American population control or family planning movement so that the racial minorities were targeted for birth control, sterilizations and abortion?

Mr. BLACK. During what period?

Mr. FRANKS. It would be the——

Mr. BLACK. After the war or before the war?

Mr. FRANKS. Before the war.

Mr. BLACK. Oh, okay. Well, basically, they turned welfare upside down. They turned education upside down. The best way to give educational services was to train one of these social misfits to care for themselves and then spend their resources elsewhere.

The welfare departments thought the best thing you could do for a socially unfit person was to deny their existence on the planet. And remember this, please: It was never about your education or your money, because these people, the American eugenicists, the great legislators, the great judges, the university presidents, the doctors, the scientists, from Alexander Graham Bell all the way to Oliver Wendell Holmes to the Chief Justice of the Chicago Municipal Court, they all felt that they were doing something good for the country. What they didn't realize was that they were in fact committing genocide under Article II, Sub D, which specifically says in the Genocide Treaty that organized efforts to restrict births within a group constitutes genocide.

Mr. FRANKS. Thank you, Mr. Black.

I now recognize Mr. Conyers for 5 minutes for questioning.

Mr. CONYERS. Thank you, Chairman.

Mr. Aden, do you believe *Roe v. Wade* should be overturned?

Mr. ADEN. Emphatically, yes, Mr. Conyers.

Mr. CONYERS. I heard you. I said thank you.

Mr. ADEN. Yes, sir. I think that is a civil rights struggle of this generation.

Mr. CONYERS. Hold it just a minute. You answered the question.

Now, Mr. Mosher, do you believe *Roe v. Wade* should be overturned?

Mr. MOSHER. Yes, I do.

Mr. CONYERS. Thank you.

You ask Mr. Black. I am not going to ask him anything.

Mr. BLACK. Go ahead. What is your question?

Mr. CONYERS. Ms. Yeung, I would like to talk with you for a minute about what I consider the most critical part of *Roe v. Wade*, and that is with respect to the State's important and legitimate interest in life, the compelling point is viability, because the fetus then presumably has the capability of meaningful life outside the mother's womb, when you reach viability. So that means to me that

the Supreme Court has made clear in this case from 1973 that the government may not prohibit abortion prior to fetal viability.

Would you comment on that part of the case for me, please?

Ms. YEUNG. Thank you, Mr. Conyers, for the question.

I will admit, firstly, that I am no legal scholar by any means, but I do know that there are many of my colleagues in the room who are from the Center for Reproductive Rights or the ACLU that have submitted comments and testimony, who can talk about the legal standing.

I was actually more of a science person in my upbringing, and that may be a stereotype, but I actually was pretty good at math and science, and what I do know scientifically is that a fetus cannot live outside of a woman's body before 24 weeks.

Mr. CONYERS. That is not bad for a person without medical training or legal training.

Let me ask you this, Ms. Yeung. In the communities where you work, what are some of the actual barriers to women's comprehensive health care?

Ms. YEUNG. Yes. I am really pleased that there is this hearing which focuses on the needs of Asian Americans and Pacific Islanders. We have always wanted this sort of support and attention, particularly, as many of us know, Asian Americans and Pacific islanders make up only 6 percent of the U.S. population, we often have to fight for our air time. And there is a huge need, of course, for disaggregated information about our community, so information that treats the different ethnicities as separate.

So I am also pleased that this issue allows us to look at how—to look at different ethnic communities, particularly Chinese, Korean and Indian communities in this case. But we have really serious issues that the Asian Pacific Islander community have identified. As I mentioned in my testimony, we know that Asian American women, particularly Vietnamese women, suffer from cervical cancer at extraordinarily high rates. We have disproportionate rates of hepatitis B infection, which would require more attention. We know that Filipino women are at higher risk for breast cancer than Black or White women.

We know also that Asian American and Pacific Islander young people are targets for school bullying at disproportionate rates and higher rates than other races and ethnicities. And when do you do look at disaggregated Asian Pacific Islander data, we see in many places that young API women and girls have lower self-esteem than their counterparts. And, as I mentioned before, we also have long-term unemployment to face.

These are all issues that are real issues that I would submit and ask that the Congress really do help us address.

Mr. CONYERS. Thank you very much.

Do you believe that this bill would help women, would liberate them? I mean, after all, where we got the names of two great civil rights people I will never know, but do you think that this is going to help liberate women in their struggle?

Ms. YEUNG. On the contrary, I believe that this bill would hurt women, and women of color in particular.

Mr. CONYERS. Thank you so much.

Thank you, Mr. Chairman.

Mr. FRANKS. I thank the gentleman.

I now recognize Mr. Chabot for 5 minutes.

Mr. CHABOT. I thank the Chairman for his recognition.

Ms. Yeung, it was mentioned—well, let me just make a couple of comments.

First of all, I think Mr. Conyers, who I consider to be a friend, even though we don't agree on a whole lot of issues, I still think he is a gentleman and a scholar, I just think he is very wrong on this particular issue.

But I think asking some of the panel members relative to their position on *Roe v. Wade*, I think the implication is that they are somehow biased because they do believe that *Roe v. Wade* ought to be overturned.

I strongly believe it ought to be overturned as well, particularly when you consider that there is about 50 million or so Americans who aren't here because of that decision that happened on the day—my birthday actually is on January 22nd, 1973, and every day on my birthday, I think about how many—and we have nice thoughts, other than getting older, which isn't necessarily all that great, but I think of all those who never experienced life, the opportunities that I have had and our kids have had and many other people have had because of that decision. Fifty million Americans aren't here, don't exist, because of that decision. So there is an awful lot of us that think that that was a horrific decision.

And I happen to be the principal sponsor of the ban on partial birth abortion, which was originally *Stenberg v. Carhart* and then *Gonzales v. Carhart*, which was upheld by a 5-4 decision in the U.S. Supreme Court.

I guess, Mr. Aden, I would like to ask you that question if I could to begin with.

In the light of that particular decision, are you confident that this legislation, should we be able to pass it in the House and the Senate and get it beyond this President's veto, because I am sure—well, I can't say I am sure he would veto it, but assuming he would veto it, we probably wouldn't have the two-thirds to override the veto.

But if we got it there to the Supreme Court, do you feel confident on a legal basis that this would be upheld?

Mr. ADEN. Yes, I am confident of that.

Mr. Conyers asked about *Roe v. Wade*. As I quoted earlier, the Supreme Court in *Roe* affirmed the principle that the State has legitimate interests from the outset of the pregnancy in protecting the life the fetus. It reaffirmed that principle recently in *Gonzales v. Carhart*.

In point of fact, the partial birth abortion procedure, as you probably know, was not restricted to post-viability abortions. It was also performed before viability. But that was of no moment to the Supreme Court in determining that the Partial Birth Abortion Ban Act was constitutional, despite the absence of a health exception.

Mr. CHABOT. Thank you.

Ms. Yeung, you had mentioned—well, let me just comment. You had mentioned that, you know, a fetus or a baby or unborn child, whatever terminology one prefers, can't survive outside the womb, the womb beyond—before 24 weeks. That is why I believe that we

shouldn't remove those babies from the womb before 24 weeks. In fact, we ought to let them go to term and then be delivered naturally and enjoy the same life that we all have.

Let me ask you this: Do you think it is okay to determine the sex of the child and you find out it is a girl and then to terminate that life? Do you think that should be the law?

Ms. YEUNG. Thank you for the question.

And thank you also for inviting Mr. Black to be part of the panel. As a reproductive——

Mr. CHABOT. I have got a limited amount of time, if you could get to my question. Do you believe it is okay to terminate the life of that child simply because you found out that it is a little girl? Yes or no?

Ms. YEUNG. Because eugenics is an issue that reproductive justice organizations have really cared about, and coercive actions on the part of any person to make or force a woman to make a decision that she cannot—or that she is not asked about making——

Mr. CHABOT. Yes or no, that is what I am asking. Do you think it should be okay?

Ms. YEUNG. I believe is just as bad. So I would believe that coercing or a woman to become a parent when she knows it is not the best thing for her——

Mr. CHABOT. Let's talk about coercion. I think you heard this study about Indian American women that showed that a significant proportion of those women were coerced, either beaten, or even food and water oftentimes withheld from them because they wanted to continue to proceed to have their daughter, but they were forced, there was coercion there. Do you think that that coercion should affect the decision as to whether one should have that abortion or not?

Ms. YEUNG. This bill does not address anything on coercion, and I would submit that we have the support of many South Asian organizations, including the South Asian Americans Leading Together——

Mr. CHABOT. I think my time has expired, Mr. Chairman. And I would just note that the witness still hasn't the question yes or no.

Mr. FRANKS. Well, the coercion statement is in the first and second section of the criminal part of the bill, so coercion is definitely addressed in the bill.

I now recognize Mr. Quigley for 5 minutes.

Mr. QUIGLEY. Thank you, Mr. Chairman.

Mr. Aden, I respect your viewpoints. I just want to ask you about the racial aspect of this. The study I saw with Guttmacher is that only 1 in 10 abortion clinics in the United States are in predominantly Black neighborhoods. African American women have less access to sex education and contraception. Isn't it more likely that that is the reason there are more unwanted pregnancies and abortions among the Black community than among the White community?

Mr. ADEN. Actually, Mr. Quigley, I am not sure I agree with the statement. That is not in the record. Planned Parent and other organizations have poured millions and millions into predominately minority neighborhoods in the last 40 years.

Mr. QUIGLEY. That is a 2008 Guttmacher study, 1 in 10.

Mr. ADEN. Well, sir, there are a couple of studies that indicate that predominately abortion clinics are located in disproportionately minority neighborhoods, somewhere between 70 and 80 percent. A lot of us believe that has been intentional; that has been a policy on the part of Planned Parenthood and other abortion providers.

What this bill does, sir, is not target the mere placement of an abortion clinic in a predominantly minority neighborhood. It targets the purposeful termination of a baby's life because that baby is of a disfavored race.

Mr. QUIGLEY. It is the fundamental premise of the legislation, as we are reading this, is we are concerned with African Americans having more abortions and that somehow it is a race-based decision. There is a deliberate attempt out there to have more Blacks have abortions.

When you mention Planned Parenthood, if that is their grand plan, why would they offer contraception? Why would they promote sex education, which you have to believe reduces the number of unwanted pregnancies? You have to agree. I don't know of any studies that show that African American women have more access to these things and have fewer unintended pregnancies as a result.

Mr. ADEN. Well, I think that shows the failure of those family planning policies, that so many millions have been poured into contraceptives for minority populations and yet they still have abortions at a much higher rate.

Mr. QUIGLEY. And I am not trying to rush you, talk as long as you need to on that point, but you don't believe in a woman's right to choose. That is your point. Do you believe a woman should have access to contraception on an equal basis?

Mr. ADEN. I am sorry, would you repeat the question, please?

Mr. QUIGLEY. Should women have a right to contraception on an equal basis?

Mr. ADEN. I don't think my opinion on that subject is part of this hearing or one of the issues.

Mr. QUIGLEY. It helps me understand——

Mr. ADEN. It is not about family planning, Mr. Quigley.

It has nothing to do with clinics that provide contraception, chemical or otherwise, or family planning. It has to do with clinics that provide abortion. Family planning doesn't reduce the numbers of, for example, African Americans by 14 million over the last 40 years.

Mr. QUIGLEY. Do you believe that contraception, if available, reduces unintended pregnancies? I guess it is the other way——

Mr. ADEN. I think the jury is out on that question, Mr. Quigley. I don't think that has been proven. I think that is the Guttmacher Institute's position, but as you know, Guttmacher is financed by and was started by Planned Parenthood and recites the party line. So I don't think it can be trusted.

Mr. QUIGLEY. You don't believe Black women want to have abortions because they don't like having Black babies.

Mr. ADEN. No, sir.

Mr. QUIGLEY. So they have abortions because they have unintended pregnancies disproportionate to the White population.

Mr. ADEN. That is not what this bill targets, sir. This bill targets providers who provide abortions based on race, just as it targets abortionists that provide abortions based on sex. If the abortionist knows that the mother desires to abort the baby because of the sex or because of the race, for example in a case in Maine, where the parents of a minor girl tried to force her to have an abortion because the father was African American. A perfect example.

Mr. QUIGLEY. So the physician would say to an African American woman, to follow a process that you are thinking here, are you having this abortion because your child is Black? That is what they would have to ask?

Mr. ADEN. That would be an example of private racial discrimination that would be the subject of this legislation, yes, sir, if that were the case.

Mr. QUIGLEY. So you would have a physician ask a woman of color if she is having this abortion because her child is minority?

Mr. ADEN. There is nothing in the bill, sir, that requires the abortionist to go into a lengthy inquiry about the patient's state of mind.

Mr. QUIGLEY. How will they make the decision then?

Mr. ADEN. If the patient made that statement to them, "Doctor, I can't have this baby because it's Black or because this baby is my third daughter."

Mr. QUIGLEY. Thank you, Mr. Chairman.

Mr. FRANKS. I now recognize the gentleman from Ohio, Mr. King—I am sorry, Mr. Iowa.

Mr. KING. Thank you, Mr. Chairman.

I thank the witnesses for your testimony.

I listen to this discussion and the disproportionate number of female babies that are aborted, I think of a story that I recall hearing some years ago, and it referenced some of the British occupation of India 200 years ago, when a British general found himself on a location where there was an Indian man who had died and they were getting ready to build the funeral pyre to force the widow to die on the funeral pyre, because that was what they did. And the British general began building a gallows. And they said, what are you doing? He said, I am building a gallows. They said, why? He said because you are about to burn this widow on the funeral pyre. And they said that is our custom. And the British general said to them, that is your custom. When you burn the widow on this funeral pyre, I will follow our custom, and I will hang you all. That was 200 years ago.

During World War II, I had a friend, who has since passed away, his name is Gill Copper, Fort Dodge, Iowa. He went down under the bridge in the Ganges River in India, and when he had any leave time during the Second World War, just stood there or sat and listened and waited for the splash, for the splash of a little girl baby being thrown off the bridge into the Ganges River, because it was still their custom to disrespect the little female lives in their culture.

So here we are, the modern version of this, the modern version of this that is identified by what we call science, and a way to bypass the guilt of listening to that widow scream or that baby gurgle

in the river, and now it is a science-selected death of an innocent little baby.

I just saw the little children in the back, and it warms me to see them.

And I hear your testimony, Ms. Yeung. But I just ask you, you testified that you did well in science, and I accept that. You said that a fetus can't live outside the womb short of 24 weeks. But I don't think that has been upheld by science. I think there are hundreds of little babies that have survived outside the womb before 24 weeks.

So I would just ask you, you know, when did those little girls' lives begin? At what instant was it? And could you actually take their life the minute before they were born or the day or the week or the month? Could you really take them back and say viability, and if you don't know that moment of viability, doesn't it have to be an instant, an instant that life begins? Because if not, aren't we playing guessing games with innocent unborn human lives? How can you be a mother and not think about those things as learned as you are in science?

Ms. YEUNG. Respectfully, I am a very good mother.

I think, you know, this bill purports to address gender inequity and gender discrimination, which is a driver of your preference, and we have been on record very concerned about gender inequities. And all of the international agencies that I have mentioned before have all talked about——

Mr. KING. Ms. Yeung, I apologize for having to interrupt you, but I do recall that you didn't answer the question from the gentleman from Ohio, so I don't think I want to let the clock tick down on this.

I will just ask you, have you contemplated the instant that your child's life began? Do you think of that in the terms of a instant in the way I framed the question to you?

Ms. YEUNG. I think that is a question of a very personal nature.

Mr. KING. You are here to testify though as an expert witness and as a mother and you identified that in your testimony.

Ms. YEUNG. Sure.

Mr. KING. So are you here now saying that you would advocate that we not limit the abortion of little baby girls based on your testimony that I shouldn't ask you personal questions? Isn't it personal to those little unborn babies?

Ms. YEUNG. I am here to testify for—against racial discrimination and against gender discrimination. I will not submit myself to personal questions of that nature and insinuations that I am not a perfectly fine mother.

Mr. KING. Then I would say that you are disqualified here as a witness, and I am done with my questions of you.

And I would turn to the gentleman Mr. Black, and I ask you, Mr. Black, you have done some research or written a book, and I am interested in the genesis of the Planned Parenthood. Who were the people that formed it, the years prior to World War II, the first half of 20th Century, what were the names of the organizations that emerged from those leaders, the names of the leaders, the names of the organizations that emerged from those leaders and how that morphed into Planned Parenthood?

Mr. BLACK. You want the history of Margaret—Planned Parenthood and Margaret Sanger before Hitler, before the Third Reich?

Mr. KING. Yes, the names of the American players in particular.

Mr. BLACK. Well, this is a very, very sensitive matter, so it is important to put the truth in context, and I am not seeking to judge modern day organizations by what happened 60, 70, 80 years ago. But since you have asked me the history, I should tell you that Margaret Sanger was one of the leading eugenicists in the United States. She was a racist. She believed in saving humanity, the historical record and her own writings show, and saving it by eliminating two-thirds of it.

She referred to the people she wanted to get rid of as human weeds. She was never, contrary to some suggestion that she was a good face for eugenics, he was never accepted in the eugenics circles by the American Eugenics Society, et cetera, because she was a woman. And she was trying to find a humane alternative to gas chambers, coercive sterilization, confinement, et cetera, et cetera.

She did have midnight meetings with the Ku Klux Klan. Adolf Hitler did write fan mail to her colleague Lothrop Stoddard, who wrote "The Passing of the Great White Race," and Adolph Hitler wrote to him, your book is my Bible. And she maintained her identity as a eugenicist long after World War II finished and long after eugenics was codified into international law, the Genocide Treaty, as a crime against humanity and as a violation under Article II, Sub D, of the Genocide Treaty as genocide because a particular group was being identified. That's the facts of the history.

I can give you lots of facts about this institution, which also enabled these very same people, such as Harry Laughlin during the National Origins Act created the Federal Eugenics Officer who then devised the formula that Hitler employed to have the Nuremberg laws, for which Harry Laughlin from the Carnegie Institution received an award from the Hitler regime in 1937.

Where did they get this idea of a half Jew and a quarter Jew and a 16th of a Jew? That all came from the Congress of the United States. That all came from Harry Laughlin, Federal Eugenics Officer. That all came from the Carnegie Institution. That is who invented this stuff.

So the short answer to your question, was Margaret Sanger a racist with an organic connection to Nazism, the short answer is yes. The long answer is, the short answer isn't as good as the long answer.

Mr. KING. Thank you, Mr. Black.

I appreciate it and I yield back.

Mr. FRANKS. Thank you, Mr. King.

And I recognize Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Aden, is it legal in America to force someone to have an abortion?

Mr. ADEN. No, sir.

Mr. SCOTT. Is it legal to force someone to have an abortion?

Mr. ADEN. To the best of my knowledge, there is no Federal law that prohibits it. A number of States have passed laws that do. Of course, the Supreme Court in *Roe v. Wade* said something about it being a woman's choice and actually upheld in *Roe v. Wade*, af-

firmed the right of pro-life doctors and nurses not to participate in abortions. So, from the beginning, it was intended that it be a woman's choice, which is why it is so important for this legislation to target coerced abortion. To my knowledge, this will be the first time that it is addressed in Federal legislation.

Mr. SCOTT. So if you forced a woman to undergo an abortion, that would not be a crime in the United States?

Mr. ADEN. It might be kid—I am not an expert on criminal law, sir, but I do believe it would be kidnapping. It would be battery.

Mr. SCOTT. You can't imagine that forcing someone to have an abortion and not looking at civil—criminal liability?

Mr. ADEN. Yes, sir. It would also be battery on the part of the doctor if he knew that the woman was not giving her consent.

Mr. SCOTT. Okay, that would be forced and coercion. If you forced someone to have abortion, would that be a crime in the United States?

Mr. ADEN. If it took those forms that fall under those criminal statutes, yes.

Mr. SCOTT. Because in your perfect example, you had parents who forced their daughter to have an abortion because of the race of the father. If the parents forced their daughter to have an abortion for any other reason, wouldn't that be a crime?

Mr. ADEN. It could be.

Mr. SCOTT. It could be.

Mr. ADEN. It could be. And, again, on the part of the doctor if he knew the minor didn't give her full informed consent, it would be battery.

Mr. SCOTT. So the situation that you—perfect example you gave where they forced her to have an abortion because of the race of the father, that has already got to be a crime?

Mr. ADEN. Depending on the circumstances, yes, sir, it would be. But civil rights legislation has not waited for all of the particulars of private action to add up to a Federal offense in order to prophylactically address activity, like excluding African Americans from lodging, lunch counters, education and other places like that.

There is a place appropriately for broad prophylactic measures that the Congress has said many times and the Supreme Court has affirmed in addressing——

Mr. SCOTT. In those cases, it was not illegal to decide—you could decide who you wanted in your hotel and who you didn't want in your hotel, and what the civil rights laws did was to establish protective classes, where you could not exclude certain people because of those characteristics.

Mr. ADEN. That is right, sir.

Mr. SCOTT. And we made something that was legal illegal. And the question was whether or not forcing someone or coercing someone to have an abortion is already illegal, whatever the purpose. How would you ascertain what the purpose was if there was no comment made as to the purpose of the abortion?

Mr. ADEN. The same way that the Justice Department's Civil Rights Division ascertains that fact in enforcing a variety of civil rights legislation; the statements of the perpetrator, the circumstances of the action, the usual tools that a prosecutor has in proving the elements of a crime or offense.

Mr. SCOTT. Well, if a doctor is performing abortions, and someone comes in for a sex-selected abortion and nothing is said one way or the other—I mean, we have heard a lot about the numbers of abortions and the race and location. How would you—if a lot of abortions are going on, in an individual abortion, how would you prosecute a doctor for performing abortions that had the effect of being racially biased?

Mr. ADEN. Well, in the case of a sex-selection abortion, for example, there is a requirement that a doctor ascertain that he or she has obtained full informed consent from the patient. It is under common law. It is under State statute. If a woman comes in and she has had, for example, two abortions in a row of a female baby, that might raise an inference in the mind of the doctor and might impose on the doctor an obligation to inquire about the circumstances to ensure that the patient has not been coerced into this abortion, particularly if she comes from one of the populations, subpopulations, that has a proclivity toward this kind of coerced abortion for gender.

Mr. SCOTT. If he doesn't do that due diligence, he is guilty of a criminal offense?

Mr. ADEN. I am sorry, sir?

Mr. SCOTT. If he does not do the due diligence to ascertain why the woman is having an abortion, he would be exposed to criminal prosecution?

Mr. ADEN. If the circumstances are patent to the average reasonable doctor, it might be a matter for an inquiry by the Justice Department, yes, sir. That is the seriousness with which we take racial and gender discrimination in this country.

Ms. YEUNG. Mr. Scott?

Mr. FRANKS. In the interest of not having to come back here after votes, we are going to have a second round here. I think there are only three of us left and maybe we can do this without having could to come back after votes. So I am going to go ahead and recognize myself for 5 minutes for questions.

You know, I think it is important to remind ourselves here that we have talked about a lot of different things here, but this bill essentially says that you can't discriminate against the unborn by subjecting them to an abortion based on their race or sex.

Ms. Yeung, you testified that you were here to address racial or discrimination inequities against women or different races. And I would just suggest to you that being aborted because you are a little girl is a gender inequity. And I know you are having a hard time with that. It is unfortunate. It doesn't seem like you have read the bill, because you didn't know there was a section in there on coercion, and it was one of the main parts of the bill.

Be that as it may, to address Mr. Mosher's concern or question here earlier that was asked, Mr. Mosher, isn't it true that on the State level, that battery like that would be like a State misdemeanor, and this would make coercing a woman to abort her child because the child is a little girl then would become a felony? That is one of the distinctions in the bill, is that correct?

Mr. MOSHER. Yes, I would agree with that.

Mr. FRANKS. Thank you, sir.

Let me, if I could, return to you, Mr. Black. You know, when I look back at the effect of eugenicist ideas, sometimes ideas have pretty profound implications. From your testimony today, I am sensing that—and you can correct me if I am wrong when you respond—that the abortion-birth control establishment early on in this country had roots in eugenics, and it appears that those eugenic goals were tantamount to genocide. And it appears that they achieved those goals, if you look at some of the numbers today. Also it is clear to me that some of these eugenicist ideas were part of the tragedy that took place in Europe, that catalyzed the genocide in Europe and the ultimate ensuing war that took place because of it. And if I remember right, about 50 million people died in that war.

So these ideas are not trivial ideas. Fifty million unborn children have died since 1973 in this country. And when they talk about has it liberated women, I am not sure we have liberated women by killing 50 million children. It seems like there's better ways to help mothers than killing their children for them.

But my question is this: We are never quite so eloquent as when we decry the crimes of a past generation, and we are never quite so blind as when we assess genocide in our own time, and sometimes we don't know what present policies like a eugenicist attitude portend for future generations.

So, can you tell us in your mind if we don't draw a line here at sex selection and race selection, what does the future portend? What are the policies going forward? What are the possibilities? Where are we going as a people if we allow this to be sewn into our policies regarding some of these new technologies and some of these new ways that we are delving into the very deepest elements of life?

Mr. BLACK. Thank you for the question. First of all, I should mention that I had unrestricted access to all the files of Planned Parenthood and Margaret Sanger, published and unpublished, to a large extent when I did my research, as well as all of her writings.

Planned Parenthood at that time, not now, but at that time was not rooted in eugenics. It was eugenics. It was open eugenics. The cause and effect of what the United States race policy did here and what we did in—what we funded in Germany, what we inspired in Germany, with Nazi Germany, we know exactly what books Hitler was reading in his prison cell when he was writing Mein Kampf and which editions they were and which eugenics books and which publishers and translations. I have all of that down.

Now, we are moving, and let me just bring out the Genocide Treaty here. I always carry it with me. The reason that Article II, Sub D, imposing measures intended to prevent birth within the group, and the group here being women or any race or any gender, the reason that is important is because eugenics is an attempt to affect bloodlines.

You know, they used to say that you can take a Negro and you could dress him up in a toga and teach him Latin and that would not make him a Roman. It was the descendants of this society that they were always worried about based on Mendel's principles of heredity with the striped pea and the smooth pea. And right now, today, this minute, the transhumanist movement, which is well-

funded and well-established, and corporations who have run afoul of the genetic anti-discrimination statutes both in the U.K. and the U.S. are trying to manipulate and create a society.

I would defer to Mr. Mosher, who knows more than I about this, but if I am not mistaken, in approximately 8 years, as a result of son preference and this subtraction of women, in approximately 8 years, some 40 to 45 million Chinese young men under the age of 20 will not have brides because of the gender imbalance. He can correct me.

Mr. FRANKS. Would you like it address that, Mr. Mosher?

Mr. BLACK. And just one other thing; 40 to 45 million, it is in 8 years. It just two more terms, that 40-45 million is approximately the same size of the male population in the United States of America at that particular age, 18, 19 and 20. And this data comes from the Chinese Academy of Social Sciences, to which Mr. Mosher is far more qualified to talk than I do.

So the reason I am here is because you are attempting to address a doorway that our society is going into because we are moving from organized and systemic, and that is the key word, systemized, organized and systemized subtraction of a group, in this case women or Black people or whatever gender it is, to create, to socially engineer. If we just let it keep going this way, there is reason to believe that we won't really have a society because we will have gone against the biological imperatives and the biological opportunities that are a balance between the genders provide in a natural society. So, actually, you are slightly ahead of the game, because, I assure you, it is coming.

Mr. FRANKS. Mr. Mosher, did you want to follow up? More.

Mr. MOSHER. Yes, thank you, Mr. Chairman. I would say that those numbers are approximately right. The selective elimination of little girls in China continues apace, more so by sex-selective abortion now than by female infanticide, and that is going to cause huge social problems in China in the future. And you can already see those problems arising now with tens of millions of young men not being able to find brides.

But I must say that I think that the insouciance of some of the people on the other side of this issue who are not enthusiastic about the PRENDA bill must derive from the fact that they think these are transitory phenomena, that, yes, these immigrant populations will practice this now, but the problem will disappear over time. And I would remind people here that the study that looked into that question by Almond and Edmond pointed out that women in those minority populations who were born here actually had higher rates, not lower rates, but higher rates of sex-selective abortion.

So this is not a problem that is likely to simply disappear over time. And indeed, with our reckless genetic engineering, as in the future, we start selecting for hair color, height, IQ, eye color and everything else, and against eye colors and skin colors that we don't like, that sex-selective abortion and race-selective abortion is probably going to become more common rather than less common as the technology becomes available. Violence against women will become more common in this regard rather than less common. So the time, I believe, to legislate against this is now.

Mr. FRANKS. Thank you. I now recognize Mr. King.

Mr. KING. Thank you, Mr. Chairman.

I would like to inquire of Mr. Mosher, you went to study in China in the late 1970's. Was it right before the beginning of the one child policy that you arrived there or right after?

Mr. MOSHER. Well, I arrived in China in March 1980, about 2 months after we normalized diplomatic relations with the People's Republic of China. I was teaching at the University of California at Berkeley at the time. And the program descended upon the area that I was in, in the spring of 1980, in March 1980.

Quotas went out from the provincial government reflecting new directives from the Central Committee of the Chinese Communist Party, directing that the population of Canton Province not increase by more than 1 percent in 1980, and they carried out that dictate by arresting women for the crime of being pregnant. These were women who in many cases were 7, 8, and 9 months pregnant, who had gotten pregnant when it was legal to have a second or a third or fourth order child, and now all of a sudden, the state was declaring their pregnancies illegal. And then I went with them as they were taken in for forced abortions.

Obviously, you will understand that I am very sensitive to issues of coercion because I am an eyewitness to coercion in China. I saw women taken in by force and given cesarean section abortions in the third trimester of pregnancy, which is not a pretty sight.

But there are levels of coercion and there are levels of abuse, and, unfortunately, we see elements of the coercion that takes place in China, not just on a cultural level or a social level, but actually on a physical level, in some populations, some communities in the United States. So there is coercion involved in sex-selective abortion in the United States.

Mr. KING. Mr. Mosher, I am just very curious. It is a gruesome story, and I understand that, but how you transpose that into the United States, I can't imagine this public accepting something like that. What goes on in the culture or the minds of the Chinese to allow something like that to happen, forced abortions and cesarian-section abortions in the 7th, 8th and 9th month. How did the public react to that? What existed within their culture that allowed that to happen?

Mr. MOSHER. That is a very interesting question which would probably take—the answer to which would take more time than we have at our disposal. But I can say that the brunt of the one child policy has fallen on girls. It is girls who are discriminated against in the womb. It is girls who are discriminated against after birth. It is girls who fill the orphanages of China, being abandoned by their parents in the hope that they can then go to the officials and say, my daughter is no longer here; may I have permission to have another child?

Mr. KING. Do you accept the number of 35,000 forced abortions a day in China?

Mr. MOSHER. Absolutely. The number of abortions in China ranges from 7 to 15 million each year. Many of those abortions involve elements of coercion. Some of them, not an insignificant number, involve out and out coercion, out and out physical force.

Mr. KING. And that number is probably reduced over years because they have been adapting to the policy of one child in different ways to avoid the gruesomeness of the way it abruptly entered upon the society that you were in?

Mr. MOSHER. Well, there are two factors. One is that subsequent to a forced abortion, the women in question are generally sterilized, so they will not be back illegally pregnant in years to come. That has reduced gradually over time the number of abortions. China's economic development with urbanization and modernization has reduced the desire of young people in China who live in cities for children. So that has lowered the level of abortions and coercion in China.

But the policy still continues. We have been in China. We at The Population Research Institute carry out periodic investigations in China. We do work in China. And there are still high levels of coercion in that country.

Mr. KING. Thank you, Mr. Mosher.

I would like to turn to Mr. Aden, who hasn't had a lot of action here today and ask you this question—I posed it a little bit in the earlier round. But this practice that exists in this country with regard to sex-selected abortions and race-selected abortions, if this Congress were to advocate for such a policy in the affirmative, if we passed a law in this Congress that brought about sex-selected abortions, race-selected abortions, and promoted them, as was the law in China, what do you think the results would be in the streets of America and how would you respond to that?

Mr. ADEN. Well, as a lawyer, I would have to say that in the corridors of the Supreme Court it would not fly, because it would be racial and gender discrimination. And I cannot imagine the Congress passing such a policy like China's.

Mr. KING. But can only government discriminate by race and gender, or can individuals do that? Doesn't the 14th Amendment protect all by the same standard?

Mr. ADEN. Well, sir, the Constitution applies directly, of course, to government officials—Federal, State, and local public officials. It does not directly apply to the acts of private individuals.

But the Supreme Court has affirmed in cases like Heart of Atlanta Motel and *Katzenbach v. McClung* that the Commerce Clause is an appropriate authority for eradicating badges of slavery. And in other cases involving gender discrimination, the Court has applied that rule to gender discrimination based on outmoded, archaic stereotypes.

So what the Supreme Court has said is that it is not—Congress is not bound to sit and wait until racially discriminatory and gender discriminatory policies make themselves manifest. They can act—the Congress can act proactively in addressing them, as it has many times.

Mr. KING. And haven't we also acted, at least by resolution, to reject the genocide in China that Mr. Mosher talked about, as an act of Congress?

Mr. ADEN. Oh, certainly, yes. The resolutions there, the words of the Secretary of State condemning China's sex-selection policy, and the efforts of our delegation to the United Nations Committee on the Status of Women would point to that.

Mr. KING. Then would it be consistent of Congress to pass this legislation that is the subject of this hearing today consistent with the previous acts of Congress that have condemned the genocide in the other countries?

Mr. ADEN. Yes, sir, it would be quite consistent with Congress' previous statements on these issues.

Mr. KING. All right. I thank you, Mr. Aden.

And I thank all the witnesses for your testimony and the Chairman for the hearing.

And I yield back the balance of my time.

Mr. FRANKS. Mr. Black, you have heard a lot of numbers here today. And I hear you talking about the never-born. Do you believe that the numbers here related to up to 200 million baby girls worldwide, do you believe that the numbers are overstated as to the impact of the policies that we have discussed this morning, or this afternoon?

Mr. BLACK. From the historical perspective, I think that these numbers are not overstated; they might be understated.

You know, when you attempt to wipe away the stars and there are no stars left and you say, "Now I have counted all the stars, I will wipe them away," what about the stars you cannot see that are beyond your plane of sight? I believe that we can't fathom or measure what has been lost from any genocide. We cannot fathom or measure what is lost from any society by subtracting the young man that you spoke of playing piano with his feet, a Stephen Hawking, a bad mathematician like Albert Einstein, a guy with a bad back like me, and lots of other people. For heaven's sake, there was a guy on one of these TV shows; he was competing for the best singer. And he was found in a shoebox in an orphanage in Iraq.

None of us may judge the value of a human being. We don't have the measuring sticks, and we don't have the right, historically speaking, to do this to another person. And that is why the genocide laws indicate the group, any group, whether it is Biafrans; whether it is American Indians, who were imposed upon by the BIA, Bureau of Indian Affairs, to get abortions and to get forcibly sterilized. None of us can decide what is best for humanity. That is what nature is about. That is what the Almighty is about, if I can use the historical term, okay?

Mr. FRANKS. Well, I don't know how to add a great deal to that or what other questions I could ask that would bring more relevance to the central point here.

The fact is that when we consider historically some of the great struggles of our past, whether it is World War II that cost us 50 million people or whether it is 50 million abortions since 1973 or whether it is 200 million little baby girls that have been aborted because they are little girls—I think someone would say the civil war in our country had something to do with racial inequity—it does call out to each of us that this notion that we can just have ideas that suggest that another group or another person is less than we are or that somehow they can be discarded and that it not have a tremendous impact on the greater whole of humanity is a failed notion.

And the implications are pretty profound. I heard a gentleman earlier today say, you know, the most dangerous three words in the world now are, "It's a girl."

And I just want to thank all of you for being here.

I believe, Mr. Black, your comments about some of the challenges that we face are so very relevant.

And I hope that somehow we can end this hearing where we began, and that is the notion that, in America, everyone is created equal and endowed by their creator with certain unalienable rights, and among these are life, liberty, and the pursuit of happiness. And that pretty much covers all of us. And if we can hold on to that, I think there is hope for humanity.

And, with that, I would just say, without objection, all Members will have 5 legislative days to submit to the Chair additional written questions for the witnesses, which we will forward to the witnesses and ask them to respond as promptly as they can so their answers may be part of the record.

Without objection, all Members will have 5 legislative days in which to submit any additional materials for inclusion in the record.

And, with that, again, I thank all the witnesses.

And I thank all of the people that have joined us here today in the audience. There wasn't any fighting or cussing or throwing bricks or anything. It was wonderful. I appreciate you all being here.

And this hearing is now adjourned.

[Whereupon, at 3:20 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Material Submitted by the Honorable Trent Franks, a Representative in Congress from the State of Arizona, and Chairman, Subcommittee on the Constitution

THE ETHICS & RELIGIOUS LIBERTY COMMISSION
OF THE SOUTHERN BAPTIST CONVENTION

Richard Land, D.Phil. (Oxon.), President

December 6, 2011

The Honorable Trent Franks
United States House of Representatives
2435 Rayburn Office Building
Washington, D.C. 20515

Dear Congressman Franks:

We write to express our sincere appreciation to you for your leadership demonstrated by introducing the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011, or PRENDA (H.R. 3541), which would prohibit abortion on the basis of sex or race. The Southern Baptist Ethics & Religious Liberty Commission strongly supports this legislation.

As you well know, protecting the sanctity of every human life is a fundamental concern of the overwhelming majority of Southern Baptists. Ending an unborn human life through abortion is tragic. Yet when an abortion is tied to selective processes that discriminate based on gender or race—sometimes a result of coercing the mother—it becomes all the more deplorable.

It is unconscionable that our nation has not already enacted a ban on this heinous practice. Appallingly, our government has called for laws against this crime in foreign lands but has yet to take any action at home. Congress has an obligation to cease its silent approval of these practices through its inaction.

As PRENDA notes in its findings, an overwhelmingly majority of the public agrees. According to a 2006 Zogby poll, 86 percent of Americans support a full ban on gender-based abortions. Regrettably, studies suggest that sex-selection abortion, once considered a practice isolated abroad, is happening here in the United States. Further, the prevalence of race-based abortion is evidenced by, for example, exposés showing Planned Parenthood, the nation's largest abortion provider, agreeing to accept financial donations designated for the express purpose of aborting black babies. These barbarisms must be addressed swiftly with the force of law.

Again, thank you for your commitment to end the scourge of sex-based and race-based abortions. We wholeheartedly support your efforts to stop these reprehensible acts and to bring justice to the abortion providers who engage in such practices. We hope your colleagues will likewise lend their full support to the Prenatal Nondiscrimination Act. Please know that we stand with you in seeking to enact this legislation into law this Congress.

Sincerely,

Richard D. Land

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Are there missing girls in the United States? Evidence from birth data

by Jason Abrevaya*

ABSTRACT

We offer evidence of gender selection within the United States. Analysis of comprehensive birth data shows unusually high boy-birth percentages after 1980 among later children (most notably third and fourth children) born to Chinese and Asian Indian mothers. Based upon linked data from California, Asian Indian mothers are found to be significantly more likely to have a terminated pregnancy and to give birth to a boy when they have previously only given birth to girls. The observed boy-birth percentages are consistent with over 2,000 "missing" Chinese and Indian girls in the United States between 1991 and 2004.

It is not possible to assess how popular sex-determination tests and gender-selection techniques might be among Indian-Americans or any other group. There are no official statistics, and people who wish to choose the sex of their child do not wish to discuss it publicly...
(*New York Times* article, Aug. 15, 2001)

Amartya Sen (1990, 1992) coined the term "missing women" to illustrate differential mortality rates experienced by women in several Asian countries. Sen (1990, 1992) has estimated 80-100 "missing women" in Asia[1] and has pointed to gender selection as one contributing factor:

> *Given a preference for boys over girls that many male-dominated societies have, gender inequality can manifest itself in the form of the parents' wanting the new born to be a boy rather than a girl. There was a time when this could be no more than a wish (a daydream or a nightmare, depending on one's perspective), but with the availability of modern techniques to determine the gender of the fetus, sex-selective abortion has become common*

* Address: Department of Economics, University of Texas at Austin, Austin, TX 78712; e-mail: abrevaya@eco.utexas.edu. The author is grateful to Jan Christensen, Karl Halfinan, and Roxana Killian of the CDHS for their assistance during the data-acquisition process. The California birth data used in this paper can not be released due to a confidentiality agreement with the California Department of Health Services (CDHS). The federal birth data and Census data used in this paper were obtained from the Inter-University Consortium for Political and Social Research (ICPSR) and the National Bureau of Economic Research (NBER). The Editor, Esther Duflo, and two anonymous referees provided comments that greatly improved the exposition of this paper. Ken Chay, David Hummels, Jeffrey Kubik, Steve Levitt, and seminar participants at Georgia, Purdue, Oklahoma, and Syracuse also provided helpful comments. Jack Barron provided invaluable computer assistance. Dudley Poston, Jr. kindly provided data on Chinese and South Korean sex ratios at birth. An earlier version of this paper (Abrevaya (2005)) was based on fewer years of birth data and inadvertently included multiple births (e.g., twins) in some of the empirical analysis.
[1] Several studies (e.g., Stephan Klasen and Claudia Wink (2002, 2003)) re-examined the level and trend of "missing women" in Asia.

> *in many countries. It is particularly prevalent in East Asia, in China and South Korea in particular, but also in Singapore and Taiwan, and it is beginning to emerge as a statistically significant phenomenon in India and South Asia as well.* (Amartya Sen 2001)

The existing evidence on gender-selective abortion in Asia is primarily indirect, based upon unusually high percentages of boys being born.[2] In particular, several Asian countries, including China, India, South Korea, and Taiwan, have seen significant increases in the percentages of boys at birth since the 1970's and 1980's, when ultrasound technology (and to a lesser extent amniocentesis technology) became available and affordable to women (see, for example, Dudley L. Poston, Jr., Julie Luan Wu, and Han Gon Kim 2003, Robert D. Retherford and T. K. Roy 2003, and Dudley L. Poston, Jr. and Karen S. Glover 2006). To illustrate these trends, Figure 1 provides a plot of boy-percentages-at-birth for China, India, South Korea, and the United States.[3] Whereas the likelihood of a male birth has remained at just above 51 percent in the United States, the percentage of male births rose above 53 percent in China, India, and South Korea in the late 1980's and early 1990's.

Recent research has pointed to more subtle forms of gender bias (specifically, bias favoring sons) in the United States. Shelly Lundberg and Elaina Rose (2003) find that single mothers are more likely to marry a child's biological father if the child is a boy. Gordon B. Dahl and Enrico Moretti (forthcoming) find that parents with sons are less likely to be divorced and that divorced fathers are more likely to have custody of their sons. One previous study that considers the effect of gender bias on prenatal (rather than postnatal) outcomes is Aparna Lhila and Kosali Simon (forthcoming), who find no evidence from federal birth data that gender is related to quality of prenatal care (e.g., prenatal visits, smoking, etc.).

While the boy-percentage trend for the United States in Figure 1 certainly doesn't provide evidence of gender-selective practices in the aggregate, evidence for gender selection may exist at a more disaggregated level.[4] One might suspect, for instance, that those races associated with the

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[2] An exception is Baochang Gu and Yongping Li (1994), who examine the sex ratio of aborted fetuses in southern Zhejiang province. They find a significantly larger proportion of female fetuses aborted after daughters are born.

[3] Three-year moving averages are plotted at each year. Sources: China and South Korea, Poston and Glover (2006); India, Office of the Registrar General of India (2001); United States, federal birth data (see Section I).

[4] The slow decline in boy-birth percentages within the United States over the last three decades has been noted in previous research (Devra Lee Davis, Michelle B. Gottlieb, and Julie R. Stampnitzky 1998; Michele Marcus et al. 1998). This decrease has also been observed in other countries, including Canada (Bruce B. Allan et al. 1997), Denmark (Henrik Moller 1996), and the Netherlands (K. M. van der Pal-de Bruin, S. P. Verloove-Vanhorick, and N. Roeleveld 1997).

Asian countries in Figure 1 (Chinese, Indian, Korean) would be more likely to practice gender selection due to cultural biases.[5] This idea has been suggested by others, including John A. Robertson (2001): "Until they are more fully assimilated, immigrant groups in Western countries may retain the same gender preferences that they would have held in their homelands." As anecdotal evidence to this point, a recent *New York Times* article (Susan Sachs 2001) described efforts by several companies to directly market gender identification and pre-conceptive selection products to Indian expatriates in North America:

> *"Desire a Son?" asked an advertisement in recent editions of* India Abroad, *a weekly newspaper for Indian expatriates in the United States and Canada. "Choosing the sex of your baby: new scientific reality," declared another in the same publication. A third ad ran in both* India Abroad *and the North American edition of* The Indian Express. *"Pregnant?" it said. "Wanna know the gender of your baby right now?"*

The incentives for gender selection depend not only on gender preferences but also upon family size (i.e., number of children already born). Even in the absence of exogenous family-size limits (such as the Chinese "One Child Policy"), gender-selection incentives (in the presence of gender bias) become stronger as a family approaches its own size limit. For instance, consider a family that has a strong preference for having at least one son and is willing to have at most two children. If the first child is a boy, this family might stop having children; if the first child is a girl, the family would have another child and a greater incentive (than in the first pregnancy) to determine gender and, perhaps, undertake a gender-selective procedure. If there were many such families, the data in the aggregate would indicate a higher percentage of boys among second births (as compared to first births) due to the combination of fertility stopping (by families with first-born sons) and gender determination/selection (by families with first-born daughters).[6] More generally, as a family has more children, the incentives for gender selection increase as the opportunity cost of having a child of the less-preferred gender increases.[7]

The foregoing argument suggests that son-biased gender selection is most likely to manifest itself through (1) unusually high boy-birth rates at later births and (2) unusually high boy-birth rates following daughters. As such, this paper will investigate whether these two irregularities in boy

[5] The term "Indian" will be used to mean "Asian Indian" (rather than "American Indian") throughout this paper.
[6] Fertility stopping by itself has no impact on boy-birth percentages, but the sample of families having second children are over-represented by those families with first-born daughters. As such, the second-born boy-birth percentage would be even higher than it would have been if all families with first-born sons had also had a second child.
[7] Jinyojng Kim (2005), Jason Abrevaya (2005), and Ebenstein (2007) develop dynamic models of gender selection.

births are present among specific races within the United States. Moreover, if gender selection is arising from cultural biases, we would expect the timing of these irregularities to mirror those in the parents' home countries. The use of higher-parity and conditional-upon-previous-gender boy-birth percentages has been considered in several previous studies of Asian countries (see, for example, Chai Bin Park and Nam Hoon Cho 1995, Retherford and Roy 2003, Prabhat Jha et al. 2006, and Avraham Y. Ebenstein 2007). The recent study by Sylvie Dubuc and David Coleman (2007) found that the likelihood of male births to India-born mothers in the United Kingdom (i) had an overall upward trend since the 1980's and (ii) is significantly higher at third and later births after 1990.[8]

If parents wish to select their baby's gender, there currently exist three options in the United States: gender-selective abortion, gender-selective in vitro fertilization (IVF), or sperm sorting. The latter two options are performed *prior* to pregnancy. Gender-selective IVF is a modified version of the traditional IVF procedure, in which fertilized embryos are transferred into the mother's uterus. For gender-selective IVF, however, embryos are genetically tested ("preimplantation genetic diagnosis") to determine gender and chosen accordingly. Such testing is nearly 100 percent accurate for gender determination and, when done for gender reasons only (rather than avoiding a genetic disease), has been banned in many countries. Although a very effective means of gender selection, the IVF procedure is expensive ($10,000-$20,000 per implantation cycle).[9] Sperm sorting, on the other hand, is less expensive (costing a few thousand dollars) but also less effective. The procedure involves selecting sperm from a given sperm sample in order to increase the probability of the desired gender when the egg is fertilized.[10] Although both gender-selective IVF and sperm sorting may be options for gender selection, these two procedures would likely only account for a very small proportion of the gender-selective procedures that might have occurred in the United States in the past few decades. The reasons for this include their recent introduction, their high expense, and the limited number of doctors willing to perform such procedures. As such, this study will focus primarily on abortion as the means for

[8] Dubuc and Coleman (2007) did not control for potential confounders (maternal characteristics, prenatal variables) that might affect the likelihood of a male birth.

[9] Insurance coverage for IVF is currently mandated in only a handful of states (Connecticut, Illinois, Massachusetts, New Jersey, and Rhode Island). See http://www.asrm.org/patients/insur.html.

[10] One company that offers sperm sorting in the United States (Microsort) claims a success rate of 92 percent (668 out of 726) for couples who desired a girl and 81 percent (172 out of 211) for couples who desired a boy. These success rates were reported on the company's website (http://www.microsort.com) for pregnancies through January 1, 2007. Scientific evidence of the technology's effectiveness has existed for more than a decade (e.g., L. A. Johnson et al. 1993).

gender selection. On the other hand, when thinking about the future of gender selection, these more advanced technologies will play an increasingly important role.

Turning to gender-selective abortion, the introduction of ultrasound and amniocentesis in the 1970's made such a procedure a possibility. Although neither technology was introduced for the explicit purpose of determining the gender of a fetus, both technologies are capable of this determination during the first half of pregnancy. Amniocentesis, generally performed between the 14th and 18th weeks of pregnancy, is nearly 100 percent accurate in determining gender but has a small risk (0.5-1.0 percent) of miscarriage associated with it. Ultrasound, which can usually be used to detect gender between the 16th and 20th weeks of pregnancy, is safer than amniocentesis but is somewhat less accurate in gender determination.[11] If either ultrasound or amniocentesis is used as a precursor to gender-selective abortion, the abortion would most likely occur during the second trimester of pregnancy. Although most abortions in the United States occur prior to the second trimester, there are a large number of abortions that do occur during the second trimester and later. Table 1 provides some summary statistics on abortions in the United States in 1980, 1990, and 2000, as reported by the Centers for Disease Control and Prevention (CDC) (2003). Since 1980, roughly 5 percent of abortions have occurred at 16 weeks or later. These numbers, of course, do not imply gender selection; they merely indicate that a non-negligible fraction of abortions do occur after the point that gender determination is possible. Another interesting fact from Table 1 is that a large percentage of abortions are associated with women who have previously had live births (41.6 percent in 1980, 54.8 percent in 1990, and 60.0 percent in 2000). According to Stanley K. Henshaw and Lawrence B. Finer (2003), the average cost of an abortion at 20 weeks of gestation was just over $1,000 in 2001; for abortions that are not "medically necessary," this cost is most likely paid out-of-pocket.

The outline of the paper is as follows. Section I describes the different data sources (federal birth data, California birth data, and Census data) used in the empirical analysis. Section II reports the empirical results. Wherever possible, results are reported separately for the following racial groups: whites (specifically, non-Hispanic whites), Chinese, Indian, Japanese, and Korean.[12] The

[11] Chorionic villus sampling (CVS) can also be used for gender determination. CVS is performed at 10-13 weeks and is nearly 100 percent accurate. However, CVS carries a greater risk of fetal loss than amniocentesis and is rarely performed. For example, use of CVS during pregnancy was reported for only 0.1 percent of births in California between 2000 and 2003.

[12] Results for other racial groups (the largest being black, Hispanic, Vietnamese, and Filipino) are available from the author. We find no convincing evidence consistent with gender selection among other racial groups. Although

sample of white births is extremely large and therefore allows very precise estimates of boy-birth percentages and their determinants. We view the white sample as a "control" for comparison with the Chinese, Indian, and Korean samples since there is likely to be minimal gender selection among whites. The Japanese sample serves as another "control" for comparison since Japan has not exhibited the gender-selective trend observed in other Asian countries. First, we analyze the federal and California birth data to determine the factors associated with a baby's gender. The statistical analysis on births after 1980, both with and without controls, indicates that Chinese and Indian mothers are significantly more likely to have sons at higher birth parities (third and fourth children) than for their first child. Second, we analyze a maternally linked version of the California data. This version allows us to condition upon gender of previous children and to determine whether current baby's gender and terminated pregnancies are systematically related to previous children's gender. We find that Indian mothers are significantly more likely to have a terminated pregnancy and to give birth to a boy when they have previously only given birth to girls. Third, we use a simple framework to infer the degree of gender selection that would explain the unusual boy-birth percentages observed in the data. Finally, we briefly consider evidence from Census data on race-specific gender preferences (specifically, the decision to have a second or third child based upon the gender of previous children) and also the likelihood of sons conditional upon previous children's gender. Section III concludes.

I. Data sources

Unfortunately, existing abortion data in the United States are inadequate for analyzing evidence of gender-selective practices. First, gender is not recorded in the two primary abortion surveys in the United States, conducted by the CDC and the Alan Guttmacher Institute. Second, although information on the number of previous live births is available in these surveys, there is no information on the gender of a mother's existing children. Third, not all states have abortion data available. Ted Joyce et al. (2005), who have compiled the most comprehensive data on abortions to date, indicate that 19 states (including populous states such as California, Florida, and Illinois) had data unavailable "due to statutory restrictions or inadequate data collection and/or storage."

Vietnam has seen a recent increase in its boy-birth percentage (Institute for Social Development Studies 2007), this increase has been far less dramatic (and occurred later) than the increase in China, India, and South Korea. The black and Hispanic samples, like the white sample, are extremely large and offer precise estimates. Qualitatively, these estimates are extremely similar to those for white mothers, with the overall percentage of male births slightly lower than within the white sample; for instance, see the results for black mothers in Figure 2.

Fourth, when women are asked about the reason(s) for having an abortion, gender preference is rarely mentioned (see, for example, Torres and Forrest (1998)).

Therefore, rather than using abortion data, we consider three different comprehensive data sources that allow us to analyze trends and potential irregularities in male births: (1) federal birth data (annual files from 1971 to 2004) from the National Center for Health Statistics (NCHS); (2) California birth data (annual files from 1970 to 2005) from the California Department of Health Services (CDHS); and, (3) the 5-percent public-use microdata samples (PUMS) of the United States Census (1980, 1990, and 2000);. The federal birth data and Census data are publicly available, whereas the California birth data contain personal identifiers and are subject to confidentiality restrictions. As discussed in more detail below, the personal identifiers were used to maternally link births and identify siblings.

Table 2 provides a summary of the three data sources to clarify the advantages and disadvantages of each. Further details for each of the three data sources are given below:

(1) Federal birth data: These annual data files contain information on births occurring within the United States, obtained from birth certificates filed in individual states. Since 1985, a 100-percent sample of birth certificates has been used to compile these data. In 1971, a 50-percent sample of birth certificates was used. From 1972 to 1984, a 100-percent sample was used for states participating in the Vital Statistics Cooperative Program (with the number of such states increasing from 6 to 46 during the period) and a 50-percent sample for other states. Each record in the federal birth data contains detailed information about the birth (including gender and parity), maternal characteristics (including age, education, and race), and prenatal care (including month of first prenatal visit). Each birth record also indicates the number of previous terminated pregnancies a mother has experienced and, from 1989 on, whether ultrasound and/or amniocentesis were used during pregnancy. The number of terminated pregnancies includes both voluntary and involuntary terminations but does not specify the type(s) of termination(s). The federal data has two important limitations. First, detailed Asian races (including Indian and Korean) were only recorded in the data starting in 1992; prior to that, the only specific Asian races recorded were Chinese and Japanese.[13] Second, due to lack of personal identifiers, there is no way to reliably link siblings

[13] Depending on the year, other Asian races are categorized as "Other" or "Other Asian or Pacific Islander."

together. Therefore, although the birth-order and gender of a given child are observed, one can not relate birth outcomes to the gender of a mother's previous children.

(2) California birth data: The California birth data contain information on all births in California between 1970 and 2005 (a total of over 16.9 million births, accounting for roughly 10 percent of all births in the United States). The California data overcome the two limitations of the federal data mentioned above. First, detailed Asian races are available starting in 1982. Second, personal identifiers (specifically, mother's maiden name and mother's birthdate) enable accurate matching of a given mother's births. This paper will use both an *unlinked* version and a *linked* version of the data. The unlinked version, which makes no use of the personal identifiers, serves as a useful complement to the federal data since the Indian and Korean identifiers are absent from the federal data between 1982 and 1991. The linked version is used in order to analyze birth and pregnancy outcomes for a mother's second and/or third child, conditioning on gender of previous children. Additional details on the linking algorithm are provided in Appendix A.

(3) Census data: While birth data are ideal for examining prenatal gender selection, the Census data will also be considered for complementary evidence. Despite allowing sibling linkages, the Census data has several drawbacks relative to the linked California birth data: (i) smaller sample sizes for the Asian races, (ii) lack of prenatal data, and (iii) observation of household's gender composition after births (which may be affected by childhood deaths, household dissolution, etc.). Since all family members (with age and gender) in a household are observed, the Census data are suitable for examining how fertility decisions depend on the gender mix of previous children. This idea has been pursued by others (e.g., Dahl and Moretti (forthcoming)) but not at the detailed racial level considered here. Details on construction of the Census samples are provided in Appendix B.

For an overview of the birth data and a comparison of their sample sizes, Table 3 reports sample averages of the variables that will be used in the analysis of the next section. Results are broken down by mother's race and reported for 1992-2004, the years for which information is available in both datasets for the five races considered. The last row reports the percentage of U.S. births that occurred in California for each of the racial categories. For the purposes of this study, an appealing feature of the California data is the disproportionately large number of Asian births. The

percentages of births occurring in California for the four Asian racial categories range from 27.9 percent for Indian mothers to 44.7 percent for Korean mothers, which are far greater than the 10 percent overall percentage of the country's births.

The percentage of foreign-born mothers among Chinese, Indian, and Korean births is extremely high---about 90 percent for Chinese mothers and 95 percent for both Indian and Korean mothers. The percentage of births to fathers of the same race is also very high for these races---between 70 and 80 percent for Chinese and Korean births and nearly 90 percent for Indian births. As a comparison, for the Japanese sample, the percentage of foreign-born Japanese mothers (57.5 percent) and same-race fathers (39.8 percent) are significantly lower. The high percentage of foreign-born Asian mothers and same-race fathers suggests that cultural influences could play a role in fertility decisions. Table 3 also indicates several differences between the Asian mothers and non-Asian mothers. Compared to white mothers, Asian mothers are, on average, older when they give birth, more educated, more likely to have first-trimester prenatal care, less likely to have had a previous termination, and more likely to have a boy.

II. Empirical results

A. Boy-birth percentages at later births

In this section, we analyze the trends in boy-birth percentages at later births. First, time-series plots from the California birth data are provided. Then, we document boy-birth percentages by birth parity in both the California and federal data. Finally, to establish a more convincing link between birth parity and male births, we use regression analysis to control for observable maternal characteristics and prenatal care variables that might influence the likelihood of a male birth. Most of the results will be described in terms of boy-birth percentages. At times, however, we will also mention the associated sex ratio at birth (SRB) (defined as the number of boys born per 100 girls) since this measure is commonly used in the demographic literature.

Figure 2, based upon the California birth data, plots the time series of boy-birth percentages within California broken down by birth parity (two categories: first/second births and third/fourth births) and mother's race.[14] Results for black mothers are also included for comparison. For black and white mothers, the third/fourth birth boy percentages track the first/second birth boy percentages very closely. For white mothers, the third/fourth birth boy percentages are slightly

[14] Each point represents a seven-year moving average.

lower (0.1-0.2 percentage points) than the first/second birth percentages. For the four Asian categories, the first/second birth boy percentages remain stable over the time period shown on the graphs. Looking at third/fourth birth boy percentages, however, the pattern observed for Indian mothers is striking. During the 1980's, the boy percentage among third/fourth births was 1-2 percentage points higher than among first/second births. Starting around 1990, this difference rose dramatically, with the level of boy-birth percentages among third/fourth births reaching around 58 percent (SRB of 138) in the mid-1990's; during this same time period, the level of boy-birth percentages among first/second births to Indian mothers remained stable and consistently under 52 percent. The time-series pattern at third/fourth births roughly coincides with the overall boy-birth pattern seen in India at the same time (see Figure 1).

For Chinese and Korean mothers, there is some evidence of a difference in boy-birth percentages at later births. Among Korean mothers, the third/fourth birth boy percentage was mostly 1-2 percentage points higher since the mid-1980's, although the difference disappears in the last several years of the time series plot. Among Chinese mothers, the difference appears primarily between the late 1980's and the mid 1990's, with essentially no difference before or afterwards.[15] The pattern for births to Japanese mothers is a bit more erratic, with the boy-birth percentages at later births moving both above and below the boy-birth percentages at earlier births.

To provide a more detailed look at the trends among Chinese, Indian, and Korean mothers, Figure 3 plots the time series at first, second, third, and fourth births (rather than combining first/second and third/fourth as in Figure 2). White mothers are included as a comparison; as before, the boy-birth percentages for white mothers have little relation to birth parity and exhibit no visible trends (with "normal" SRB levels of 105-106). For the Asian races, however, the fourth-birth percentages are higher than the lower-parity percentages. The fourth-birth percentage for Chinese mothers peaked around 56 percent (SRB of 127) in 1996, whereas the fourth-birth percentage for Indian mothers reached a level near 60 percent (SRB of 150) in the early 1990's and continued near this level beyond 2000. For Indian mothers, there is also a noticeable difference between first-birth and second-birth percentages during the 1990's. We note, however, that the Indian second-birth percentages are quite similar to those of Chinese and Korean mothers, while the Indian first-birth percentages dipped below its usual level during this period.

[15] Strangely, there is a very low boy-birth likelihood among third/fourth Chinese births in the early and mid 1970's. Although we do not have a good explanation for this occurrence, this period pre-dates the availability of ultrasound technology and, therefore, is likely not related to gender selection.

Table 4 provides a breakdown of boy-birth likelihoods by time period (1970-1980, 1981-1990, 1991-2005), by race, and by parity of the child. Results for both the federal birth data (Panel A) and California birth data (Panel B) are reported. Each cell has a boy-birth percentage with its associated standard error. The total number of births (parity one through four) is reported in the last column. The pattern among white births is that higher-parity births are slightly less likely to be boys, which (as discussed below) would be expected if later births are more common among women with lower socioeconomic status and lower-quality prenatal care.

The first-child boy percentages among the Asian races are roughly the same as those for whites. For later children in later time periods (since 1980), higher boy percentages among Chinese, Indian, and Korean births begin to emerge. In the latest time period for the U.S. data, the boy-birth percentages for Chinese mothers is 53.0 percent (SRB of 113) and 54.0 percent (SRB of 118) at third and fourth births, respectively; both of these percentages are significantly different from the first-birth boy percentage (at a 5 percent level). For Indian mothers in the U.S. between 1992 and 2004, we observe similar boy-birth percentages at third and fourth births (54.4 and 53.5 percent, respectively) that are also significantly different from the first-birth boy percentage. The higher percentages for Korean mothers at later births are not statistically different within the U.S. sample, although there is evidence of a statistically significant difference at fourth births within the California sample. The higher boy-birth percentages among Indian mothers at higher parity are more dramatic in the California sample than the U.S. sample. For the 1991-2005 period, where there are significant differences at higher parity, the boy-birth likelihood is 57.5 percent (SRB of 135) and 59.0 percent (SRB of 144) for third and fourth births, respectively.

To control for other factors (such as mother's age, prenatal care, etc.) that might affect the likelihood of having a boy, Table 5 reports regression results using these same data sources and time periods. The reported results are from linear probability models, where the dependent variable is an indicator variable equal to one for boy births. Heteroskedasticity-robust standard errors are reported. The linear probability model is particularly appropriate for this application since the fitted probabilities are very close to 50 percent; probit estimation yields nearly identical results in all cases. To make this table (and also Tables 6-8) easier to read, all estimates have been scaled up by a factor of 100, so that they can be interpreted as percentage-point effects; for instance, an estimate of 1 would correspond to an increase of one percentage point in the boy-birth probability.

For each time period and race considered in Table 5, results are reported for a regression specification that includes parent-related and pregnancy-related control variables. The covariates are birthyear, a full set of mother's age dummies, and indicators for foreign-born mothers, same-race father, father's race missing, no prenatal care, initial prenatal visit in 2nd trimester, initial prenatal visit in 3rd trimester, and previous terminated pregnancy. For the most recent time period (1991-2004 U.S.; 1991-2005 California), the covariates also include mother's education and indicators for ultrasound and amniocentesis usage during pregnancy. The indicator variable for first-child births is the "omitted category," so that the estimates for the three birth-parity indicators ("2nd child," "3rd child," and "4th child") should be interpreted as a difference in boy likelihood from first-child births. For instance, in the U.S. sample of Chinese births for 1991-2004, the regression indicates that, holding parental and prenatal characteristics fixed, the fourth child is 2.250 percentage points more likely to be male than the first child.

For white births, the likelihood of a boy becomes slightly lower at higher parity, even when other variables are included as controls. This finding holds during the 1970's, the period in which gender determination would have been either impossible or very unlikely, and then continues in the later periods. Note that the magnitudes of the birth-parity effects are quite low for white births (for example, between 0.067 and 0.407 percentage points in the federal-data regressions with control variables), but the huge sample sizes allow these effects to be precisely estimated.

For Chinese births, statistical evidence of higher boy percentages for third and fourth children is seen in the 1991-2004 federal sample and the 1991-2005 California sample (just over 2 percentage points more likely to have a fourth-child boy than a first-child boy). The evidence of higher boy percentages at later births is even stronger among Indian parents, with larger effects seen for the third child (3.6 percentage points in the federal sample and 6.7 percentage points in the California sample) and the fourth child (roughly 8 percentage points in the California sample). For Indian parents, even the second-child boy percentage is significantly higher than the first-child boy percentage (at a 5 percent level), with a magnitude of around one percentage point. For Korean parents, nearly all of the estimates on the third- and fourth-order births are positive but only a few are statistically significant at a 5 percent level. For Japanese births, there is no significant effect from birth parity found in any of the results after 1980.

We stress the importance of controlling for observable differences in parents' characteristics and prenatal behavior as these factors can affect the likelihood of a male birth. Male fetuses have a

more difficult time surviving pregnancy (e.g., Thomas T. Perls and Ruth C. Fretts 1998 and Reiko Mizuno 2000).[16] Since the birth data contain only live births, a "survival bias" could contaminate the estimated birth-parity effects if other biological factors are not considered. All things being equal, one would expect that male births are more likely in the presence of favorable demographics (younger mothers, higher education) and quality prenatal care (earlier prenatal visits, ultrasound usage). Although it is tempting to infer gender-selective practices from the estimates on the ultrasound, amniocentesis, and previous-termination indicator variables, we strongly caution against doing so. Ultrasound is primarily a proxy for quality prenatal care, whereas both amniocentesis and previous termination are both primarily proxies for pregnancy complications. As such, even in the absence of gender selection, ultrasound usage would be expected to be positively associated with male births and amniocentesis and previous termination to be negatively associated with male births. In the interest of space, we do not report the full set of estimates for the control variables. Appendix C reports results for the sample of white mothers, where significant effects are found for several control variables. However, as seen above, these effects have no important impact on the conclusions regarding the birth-parity estimates (and their magnitudes are very small in comparison to the size of the birth-parity differences found among Chinese and Indian mothers).

B. California birth outcomes conditional upon previous gender

This section utilizes the maternally linked California birth data to analyze the relationship between previous gender(s) of a mother's child(ren) and subsequent birth outcomes. The analysis focuses upon second- and third-birth outcomes, as the number of births for the Asian races becomes too small at higher birth parities. In addition, we focus upon the time period (1982-2005) for which information is available on all races.

Table 6 reports the boy-birth regression results for the samples of second- and third-child births. The second-child regressions includes an indicator variable for a firstborn-girl child and the set of control variables considered in the regressions of Section II.A. Only the coefficient estimate

[16] Although the data on fetal deaths in the United States are limited, the existing information indicates that the percentage of male fetal births is significantly higher than the percentage of male live births. For instance, according to data from the NCHS, 53.3 percent of the 214,043 fetal deaths that occurred after 20 weeks of gestation between 1995 and 2002 were male. Gender is usually not recorded for fetal deaths prior to 20 weeks of gestation. Of the 21,399 fetal deaths where gender was recorded between 1995 and 2002, 66.9 percent were identified as male. Source: National Center for Health Statistics, Perinatal Mortality Data, 1995-2002. Data was obtained from the National Bureau of Economic Research.

of the firstborn-girl indicator variable is reported. For the third-child regressions, the same control variables are included and coefficient estimates are reported for a no-sons indicator variable and a one-son indicator variable (relative to the omitted category of two sons).

For both Chinese and Indian mothers, there is a significantly positive effect of first-child gender on second-child gender. Chinese and Indian mothers were, respectively, 0.9 and 2.8 percentage points more likely to have a second-child boy if their first child was a girl. The associated *z*-statistics are 2.20 and 3.63, respectively. The positive effects of previous female births among Chinese and Indian mothers are also seen in the third-child regression results. While the estimates for Chinese mothers are not statistically significant, the estimate of the effect of the no-sons indicator variable (relative to two sons) for Indian mothers is extremely large and statistically significant (11.3 percentage points, with a *z*-statistic of 3.68). This estimate implies that Indian mothers with no previous sons are roughly 20 percent more likely to have a third-child son than Indian mothers with two previous sons.

No significant effects of previous gender are found for Japanese or Korean mothers. White mothers, however, are slightly more likely to give birth to sons after daughters are born. The magnitudes of these effects are of an order of magnitude different from that found for Indian mothers. While it is conceivable that these effects are the result of gender selection, the lack of other systematic evidence for white mothers would make such a conclusion unwarranted; moreover, the largest effect on white male-birth likelihood is found after a gender mix (one son, one daughter), which is unlikely to be driven by gender selection. The most plausible explanation for this association is biological in nature; for instance, recent research (Henriette Savarre Nielsen et al. 2008) suggests that male births have small (but significant) negative effects upon future birth outcomes.

To focus upon the previous-gender effects found for Indian mothers, Figures 4 and 5 provide time-series plots of the boy-birth likelihoods for second and third births, respectively, conditional upon gender(s) of previous child(ren).[17] Figure 4 shows a consistently higher likelihood (since the late 1980's) of a second-birth boy when there is a firstborn girl, although the time series shows evidence that this difference has narrowed since the mid-1990's. Throughout the time period shown, the percentage of sons born after firstborn daughters averaged around 54 percent (SRB of 117). In Figure 5, the association of third-child boy births with previous gender

[17] Each point represents a seven-year moving average.

mix is quite dramatic. The boy-birth percentage among Indian mothers with no boys (first two children were female) began to increase sharply after 1990, reaching a peak of around 68 percent (SRB of 213) in 1995 and 1996, and thereafter decreased to a level of about 58 percent (SRB of 138). Also, note that the boy-birth percentages for one previous boy and two previous boys track each other fairly closely until 2000, where an increase in third-child boy-birth percentages is observed among Indian mothers with a boy-girl mix.

Using the linked nature of the California data, we are also able to construct a "termination-since-last-birth" indicator variable by comparing the number of previously terminated pregnancies reported in two successive pregnancies. Specifically, the variable was defined to be equal to one if the number reported at the later pregnancy was larger than the number reported at the previous pregnancy, and zero otherwise. Although clearly still imperfect as an indicator of gender-selective practices (due to termination proxying for a difficult pregnancy), this variable is a better proxy for gender-selective practices since it focuses upon the time period just before the birth in question.

With the constructed termination-since-last-pregnancy indicator as the dependent variable, Table 7 reports the conditional-upon-previous-gender regression results. We caution that these estimates are not direct evidence of gender-selective behavior since we have no measure of intent. For white births, there is a small positive association (0.14 percentage points) between a firstborn girl and a terminated pregnancy between the first and second birth. The overall percentage of white mothers that have a termination between their first and second pregnancy is just over 14 percent, so the 0.14 percentage-point difference represents only about a 1 percent difference relative to the baseline. For Indian second births, the estimated positive association is larger (0.97 percentage points (p-value = 0.04)). Based upon the overall percentage (11.3 percent) of Indian mothers having a termination between their first and second pregnancies, this effect means that Indian mothers with a firstborn daughter are nearly 10 percent more likely to have a terminated pregnancy prior to their second birth than Indian mothers with a firstborn son.

For Indian third births, the estimated difference in the likelihood of a termination between the second and third births is 5.56 percentage points (s.e. 1.86) higher for mothers with no sons as compared to mothers with two sons. The magnitude of this difference is extremely large, relative to the overall likelihood (11.6 percent) of a terminated pregnancy between second and third births among Indian mothers. The unconditional (without control variables) percentages for Indian mothers with two previous daughters and two previous sons are 14.2 percent and 8.3 percent,

respectively. This difference implies that Indian mothers with two previous daughters are 71 percent more likely to have a termination prior to their third birth than Indian mothers with two previous sons.

As a reality check on the results for Indian mothers, an anonymous referee suggested the following falsification exercise. For the third-birth results, if the dependent variable (an indicator of termination between second and third births) is replaced by an indicator of termination between first and second births, we should see no effect of gender. Indeed, this is what happens; a regression with the alternative termination indicator yields an estimate on the no-sons indicator of 2.94 (s.e. 1.86). Similarly, for the second-birth results, we replaced the dependent variable (an indicator of termination between first and second births) by an indicator of termination prior to the first birth. In this case, the regression coefficient on the first-born-daughter indicator variable was negative (-0.27) and insignificant (s.e. 0.47).

C. A more detailed look at Chinese and Indian subsamples

The results of the previous sections are based upon samples that pool together all mothers of a given race. In this section, we consider finer subsamples of the data for Chinese and Indian mothers. Specifically, we are interested in examining whether the birth-parity and conditional-upon-previous-gender effects are more prevalent among those with stronger cultural ties (specifically, births to parents of the same race) or depend upon age or education.

Table 8 summarizes the results. The regression specifications are identical to those used in Tables 5 and 6. The first column of the table reports the original estimate (for the full sample). The remaining columns consider five different subsamples of births: (i) same-race fathers, (ii) mothers younger than 30, (iii) mothers age 30 or older, (iv) mothers with high school education or below, and (v) mothers with more than high school education.

For the same-race father subsamples, every estimate indicates a stronger effect of birth parity upon boy-birth likelihood. The fourth-child effect becomes around 3 percentage points for both Chinese and Indian same-race parents in the federal data. The previously large birth-parity effects for Indian mothers in California become even larger when looking only at births to Indian fathers (from 6.7 to 7.3 at third births and from 7.9 to 9.4 at fourth births). The effect of previous daughters upon boy-birth likelihood is also stronger for same-race Chinese and Indian parents. Among Chinese third births, the coefficient estimate on the no-sons indicator becomes significant

at a 10 percent level (with a magnitude of 2.6 percentage points). For Indian third births, the magnitudes on both the no-sons and one-son indicator estimates increase, and the one-son estimate is now significant at a 5 percent level (relative to the two-sons category).

With respect to age, the birth-parity effects in the U.S. and California data are evident for both younger (age less than 30) and older (age 30 or greater) mothers. The biggest distinction between younger and older mothers appears in the third-child conditional-upon-previous-gender California results (bottom panel of Table 8). Specifically, the no-sons indicator estimates are statistically significant for older Chinese and Indian mothers but insignificant for younger mothers. While this difference is consistent with higher opportunity costs later in a mother's fertility years, the difference in statistical significance may be instead driven by the relatively smaller sample size of young mothers (1306 younger Chinese mothers and 582 younger Indian mothers, as compared with 7971 and 1383 older mothers, respectively).

Finally, the breakdown by education level yields mixed conclusions. The birth-parity effects for Chinese mothers are larger and more significant among mothers with 12 years or less of education. For Indian mothers, however, both education categories exhibit similar birth-parity effects, although the second-child effect seems to be more pronounced (and significant) among less-educated Indian mothers (2.5 percentage points in the California sample, relative to the overall estimate of 1.0 percentage points). The conditional-upon-previous-gender estimates for Indian mothers are quite similar in magnitude for less-educated and more-educated mothers. These results strongly suggest that the unusual boy-birth pattern for Indian mothers is not a phenomenon isolated among women with less education.

D. Inferring the prevalence of gender selection from boy-birth percentages

In this section, the following question is considered: If unusual boy-birth percentages are the result of gender-selective abortions, what does the observed boy-birth percentage imply about the prevalence of both gender determination and gender selection? We consider the case where the gender bias favors sons and gender-selective abortion is only chosen when the female gender is revealed.[18] Let p denote the "natural" probability of a boy birth. Let g denote the probability that a woman has a gender-determinative procedure (meaning that gender-selective abortion would be

[18] To the extent that the reverse is true for a subgroup of the population (daughter bias and gender-selective abortion only for males), the prevalence of gender determination/selection discussed below would be a lower bound on the actual prevalence.

chosen if female gender is revealed).[19] Finally, let $\tilde{p}$ denote the boy-birth probability in the presence of gender selection. The probability $\tilde{p}$ is the quantity corresponding to the boy-birth percentage *observed* in the data. Note that $\tilde{p}$ is related to p and g as follows:

$$\tilde{p} = \frac{\Pr(\text{boy birth})}{\Pr(\text{live birth})} = \frac{p}{1-g(1-p)}. \quad (1)$$

Equivalently, g can be written in terms of the probabilities p and $\tilde{p}$ as follows:

$$g = \frac{\tilde{p}-p}{\tilde{p}(1-p)}. \quad (2)$$

To infer anything about the prevalence of gender determination/selection, a value for the "natural" boy-birth probability (p) is needed. A very conservative choice of p, based upon the first-birth boy percentages reported in Table 4, is $p=0.52$. For this value of p and realized boy-birth probabilities ($\tilde{p}$) ranging from 0.52 to 0.65, Figure 6 shows the implied probabilities of gender determination and gender-selective abortion. As an illustration, consider the boy-birth percentages for Indian births reported in Table 4. In the federal birth data, the fraction of boy births among third and fourth children is approximately 0.54. If this higher percentage is the result of gender selection, Figure 6 indicates that the probability of gender determination is approximately 8 percent.[20] For the 1991-2005 California estimates (57.5 percent boy-birth percentage for third children and 59.0 percent for fourth children), the implied gender-determination probabilities are much higher --- about 18 percent for third births and 24 percent for fourth births.

How do these implied gender-selection probabilities relate to the number of implied abortions? As an example, again consider the 1991-2005 sample of California births to Indian women, for which there were a total of 7,102 third births and 1,428 fourth births. The implied gender-selection probabilities (18 percent and 24 percent) from above would correspond to roughly 850 abortions during this time period. If the unusual boy-birth percentages among Indian births are truly the result of gender-selective abortion, this represents a crude estimate of the number of "missing girls" within California between 1991 and 2005. Table 9 provides similar estimates of nationwide abortion numbers for third and fourth births to Chinese (1991-2004) and Indian (1992-2004) mothers. The table reports results for natural boy-birth probabilities (p) of 0.52 and 0.515.

[19] If *all* pregnant women had a gender-revealing ultrasound performed, g would represent the fraction of women who *would* have a gender-selective abortion if a female is revealed.

[20] If p is taken to be 0.51, which is closer to the observed percentage of first-birth boys for Indian parents in the federal and California samples, the implied probability of gender determination would of course be higher.

For the conservative $p=0.52$ choice, the number of implied "missing girls" among 1991-2004 Chinese third and fourth births is just over 900; the estimate for 1992-2004 Indian third and fourth births is nearly 1300. Overall, then, the boy-birth percentages at higher parity are consistent with more than 2,000 "missing" Chinese and Indian girls in the U.S. between 1991 and 2004..

E. Census data: gender preferences and boy births

In this section, we briefly consider an analysis of the Census PUMS data as a complement to our birth-data analysis. First, we consider the decision of families to have either a second or third child based on the gender(s) of their previous child(ren) and how this decision has changed over time. This fertility-stopping analysis is similar to that undertaken by Dahl and Moretti (forthcoming), although they pool Asian races together in their results. Second, analogous to the analysis of the linked California birth data, we consider the likelihood of having a son conditional on the gender(s) of previous child(ren).[21]

Table 10 summarizes fertility-stopping behavior by race. Among families with at least one child, the table reports the percentage of families that had a second child within 5 years of the birth of the first child. Similarly, for every family with at least two children, the table reports the percentage of families that had a third child within 5 years of the birth of their second child. Results are provided for two time periods (1966-1979 and 1980-1994), with observations categorized by first- (or second-) child birthyear and previous gender mix ("girl"/"boy" for second births and "0 boys"/"1 boy"/"2 boys" for third births). In addition, the table reports the change in these percentages over the two time periods.

Overall, gender of the first child does not appear to play an important role in determining whether a family has a second child. There is slight evidence of son preference among Indian families (more likely to have a second child if the first was a girl) and daughter preference among Japanese families in 1980-1994. A significant son preference in Chinese families is observed in the earlier 1966-1979 period. Across all races, there is a decrease in the likelihood of having a second child from the earlier to the later time period. The largest decreases are observed among Chinese and Korean families.

[21] This analysis is a revised version of my 2005 working paper (Abrevaya 2005). Almond and Edlund (2008) also show male biased sex ratios following girls among Chinese, Koreans, and Asian Indians in the 2000 Census data.

The third-child results highlight much larger gender-preference differences between races. For white and Japanese families, the overall preference is for a gender mix: families are most likely to have a third child if the gender of the previous two was the same (either two sons or two daughters) and least likely to have a third child if they have had a son and a daughter. For Chinese, Indian, and Korean families, there is a definite bias toward having a son: (i) families with two daughters are far more likely (about 10-16 percentage points) to have a third child than families with one or two sons; and, (ii) families with two sons are about equally likely to have a third child as families with a son and a daughter. Although the overall likelihood of having a third child drops in the later time period across all races, the pattern of gender-mix preferences remains fairly similar across the two time periods for each race. The drop in fertility (with respect to third children) is far more pronounced among the Asian races than whites. As discussed in the Introduction, smaller family sizes lead to increased opportunity costs of having a child of the less-preferred gender and, thus, to greater incentives for gender determination.

Table 11 provides a breakdown of boy-birth percentages from the Census PUMS data based upon race, time period, and previous gender. The only statistically significant difference (at a 5 percent level) among second births is for Chinese families in 1980-1994 (53.4 percent chance of a son following a daughter versus 49.1 percent chance of a son following a son). Similar differences are found for Indian and Korean families in this later time period, but neither is significant at a 5 percent level due to the relatively small sample sizes. For third births in 1980-1994, the boy-birth percentages for Chinese, Indian, and Korean families are highest after two previous daughters (57.1 percent, 57.4 percent, and 57.1 percent, respectively). Statistically speaking, however, there is no compelling evidence that these percentages are significantly larger than the 1-previous-son and 2-previous-son percentages for any of these individual races. Pooling the three races together, as in Almond and Edlund (2008), would yield statistical significance. Given the small-sample size issue, future research might focus upon the 100 percent Census sample in order to investigate child gender sequences within families. While these data would still be subject to the drawbacks (relative to birth data) discussed in Section I, such research would complement the analysis of the California linked data since the Census data covers all states.

III. Conclusion and discussion

This study has offered evidence consistent with gender selection at later births within the United States. For Chinese and Indian parents, the likelihood of having a son is significantly higher for third-born and fourth-born children as compared to first-born children.[22] Controlling for maternal characteristics, prenatal-care variables, and time trends, the increase in boy-birth likelihood explained by birth parity is extremely significant and of an order of magnitude larger than other determinants. On the other hand, slight evidence of birth-parity effects is found among Korean births (specifically, fourth births within California) and no evidence is found among Japanese births.

The evidence from the California birth data is particularly striking for Indian births between 1991 and 2005: third and fourth children are 6.7 and 7.9 percentage points more likely to be sons, respectively. Moreover, Indian mothers were significantly more likely to have a son and a terminated pregnancy since last birth if they had only daughters previously. For third births, Indian mothers with two daughters were roughly 20 percent more likely to have a son than Indian mothers with two sons and 70 percent more likely to have a terminated pregnancy (in between the second and third birth).

The use of an extensive set of control variables in the boy-birth regression analyses rules out any simple biological explanations for the observed irregularities in boy-birth percentages. As such, gender selection stands out as the most logical explanation of the observed irregularities. This conclusion is further supported by the observed timing of the irregularities, concurrent with the increased availability of ultrasound and amniocentesis technologies. The third-birth and fourth-birth trends among Chinese and Indian mothers (Figure 3) match closely with the corresponding trends seen in China and India (Figure 1). Moreover, the trend among Indian mothers is extremely similar to that found by Dubuc and Coleman (2007) in the United Kingdom.

The simple framework of Section II.D suggests that the unusually high boy percentages among third- and fourth-born Indian children in California would be consistent with gender-determination rates of around 20 percent (i.e., 20 percent of female fetuses being aborted at these higher parities). Combined, the estimates for Chinese and Indian births (Table 9) are consistent with over 2,000 "missing girls" in the United States between 1991 and 2004.

[22] Although it is also possible that gender selection occurs among first-born children, the existing data do not support this conclusion. For Chinese births (see Table 7), there has been almost no change since 1971 in the boy-birth percentage among first-born and second-born children. Unfortunately, such a time-series comparison is infeasible for Indian and Korean births since data is not available prior to 1992 at the federal level and 1982 at the California level.

Future research might focus upon the underlying motives for gender selection within the United States. Common explanations for the trends in Asian countries, such as exogenously imposed child limits or extensive dowry systems, should not be relevant.[23] For Indian mothers, we found no evidence that the observed boy-birth irregularities were isolated among less-educated (or more-educated) mothers. Gender-selection motives may simply stem from overriding cultural son biases that remain with immigrants to the United States. Since such son bias has been previously documented to vary over different regions in China and India, it would be interesting to relate the likelihood of male births within the United States to the specific regions from which Chinese and Indian mothers immigrated.

Overall, the empirical findings are in line with the gender preferences seen in the Census data and the stronger incentives for gender selection that arise at later births. For Chinese, Indian, and Korean families, the Census data indicate a strong son bias in the decision to have a third child, with a much higher likelihood of having a third child among families with two daughters. In contrast, the third-child outcomes from the Census data indicate a preference for a gender mix among white and Japanese families. Despite the gender-mix preference that appears in the fertility decisions for these races, the empirical results do not suggest that gender selection is being used to achieve a gender mix. For example, the aggregate birth-parity effects for white parents (estimated in Section II.A) do not change much from the 1971-1980 time period to later time periods.

Several factors could lead to an increase in the prevalence of gender selection within the United States. First, if the declining trend in family size continues, there would be increased incentives (holding gender preferences fixed) for gender selection. Second, introduction of technologies that can reliably and safely detect gender at an earlier stage in pregnancy (than amniocentesis or ultrasound) would reduce the "cost" of abortion by allowing women to have early-term rather than late-term abortions. Third, the availability of improved preconceptive gender-selective technologies at lower costs will tend to increase the prevalence of gender selection.[24] Most importantly, a preconceptive gender selection method would entirely eliminate the need for a gender-based abortion, which involves prohibitive costs (including moral and ethical costs) for most parents.

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[23] It is unclear how prevalent dowries are within the United States, as we could not find any evidence on this point.
[24] The CDC (2004) documented the increased use of "assisted reproductive technology" (defined as fertility treatments involving both sperm and eggs, predominantly IVF). The number of live-birth deliveries using this technology increased steadily from 14,507 in 1996 to 33,141 in 2002 (roughly 1 percent of live births in the United States).

Although the predominant gender-mix preference in the United States is not likely to change much in the near future, it is possible that the son bias observed among some of the Asian races (Chinese, Indian, and Korean) could diminish. Such a change could occur for a variety of reasons, including reduced cultural bias toward sons and increasing proportions of second- and third-generation Asian mothers in the United States.

Given that the predominant preference within the United States is for a gender mix, an increase in gender selection would not lead to a gender-imbalance problem in the aggregate. Such a gender imbalance could, however, arise among subpopulations with a bias toward sons or daughters. The effect on family size would be ambiguous: although families could achieve gender mix with fewer children, some families would be willing to have additional children if they could choose gender. Given that gender-selective procedures are not currently banned in the United States, the most predictable effect of increased gender selection would be the ensuing debate on the surrounding moral and ethical issues and potentially the fight over regulation.[25]

Appendix

Appendix A: Construction of the maternally linked California birth data

The CDHS provided data for every birth that occurred in California between 1970 and 2005. The total number of birth records during the 36-year period was 16,932,031. In addition to the publicly available data, the author was provided with data on mother's first name, mother's maiden name (surname), and mother's date of birth. The first name and birthdate items were available for all births after 1981 and 1988, respectively. A full name for each mother was created by concatenating the first name and maiden name together (with a space in between). Any records that had missing values for mother's name, mother's age, mother's birthdate (for births after 1988), or total number of previous live births were dropped, leaving 16,799,227 observations.

For any two births in the sample, the pair of births is considered a *potential match* if all of the following conditions are met:

- An exact match on mother's full name (or mother's maiden name if one of the births occurred before 1982).
- An exact match between the month and year of the earlier birth and the month-of-last-birth and year-of-last-birth reported at the later birth.
- Consistency of the total-previous-live-births variable (meaning an increase of one from the earlier birth to the later birth).
- Consistency of mother's age information, meaning:
    - if both births occurred after 1988, an exact match on mother's birthdate.
    - if at least one birth occurred between 1970 and 1988, the reported difference between the mother's age at the earlier birth and her age/birthdate at the later birth was possible given the number of months between the two births.

[25] The President's Council on Bioethics considered some of these issues at its October 2002 meeting. Full transcripts are available at http://www.bioethics.gov/transcripts/oct02/index.html.

After all potential matches are recorded, a pair of births is then considered an *actual match* if (i) the earlier birth is not a potential match with any other later births and (ii) the later birth is not a potential match with any other earlier births.

To link more than two births for a given mother together, additional linkages are made based upon the actual matches of the birth pairs. For instance, suppose that three births are denoted A, B, and C, in chronological order. If both pairs A-B and B-C represent actual matches, then the birth sequence A-B-C would be linked together. Additional births could be added to this sequence if A is an actual match with an earlier birth or if C is an actual match with a later birth. This process is continued until all matched birth sequences are constructed.

The matching algorithm resulted in a total of 9,821,455 births (58.0 percent of the total) being part of a matched birth sequence. The remainder of the births consisted of (i) only children, (ii) births that could not be uniquely matched together, (iii) births that could not be matched due to the mother's other births not being in the sample (e.g., because they occurred before 1970 or outside of California), or (iv) births that could not be matched due to coding errors (e.g., misspelled name or incorrect age). Table A1 provides a racial breakdown of the birth sequences used in the analysis, reporting the number of mothers for whom the first two (three) births are observed and the second (third) birth occurs between 1982 and 2005. The first column corresponds to the sample sizes for analysis that conditions on gender of the first child, whereas the second column corresponds to the sample sizes for analysis that conditions on the gender mix of the first two children. Since race itself is not used to maternally link the data, we were able to link post-1982 births of Indian and Korean mothers to pre-1982 births of these same mothers. The linked-data regressions (Tables 6 and 7) use only observations from 1982-2005 to avoid under-representation of those mothers who stopped having children before 1982 (when their race would have been identified).

Appendix B: Details on 5 percent PUMS Census data analysis

The 1980, 1990, and 2000 editions of the 5 percent PUMS Census data were used. The racial category was determined by the reported race of the mother. In 2000, the Census questionnaire allowed respondents to also indicate "secondary" racial categories. For the 2000 sample, the categorization was based upon the primary racial category reported for the mother.

In order to condition upon gender of first child or first two children, it is necessary to identify mothers for whom first-child information is available. Although the 1980 and 1990 data contain an item related to a mother's fertility (specifically, the "number of children ever born"), we decided to use the same method for family construction for each of the three samples. Specifically, a family was only retained in the sample if the oldest child in the household was 13 years of age or younger. This choice would misclassify birth order for families with older children that have left the household, but the cutoff of 13 was chosen to minimize this possibility. Other cutoff choices yielded extremely similar results, although choosing a lower cutoff reduces the sample size available for analysis. We dropped any families for which the sex or age of any child was "allocated" in the data.

Each child's age (in years) is reported in the Census data, taking on values between 0 and 17. The birthyear of a child was calculated by subtracting the reported age (plus one) from the Census year. This birthyear is used to categorize families into the time periods in Tables 10 and 11 (based on first child's birthyear and second child's birthyear, respectively). Table 10 reports the likelihood of having an additional (second or third) child within five years of the previous child. For the second-child outcomes, the families considered are those whose oldest child is at least five years of age. Similarly, for the third-child outcomes, the families considered are those whose second-oldest child is at least five years of age. A family is recorded as "having an additional child" if the difference in ages between the previous child and the "additional child" is less than or equal to five years. Finally, the earliest birthyear considered is 1966, which corresponds to 13-year-old children from the 1980 sample, and the latest birthyear considered is 1994, which corresponds to 5-year-old children from the 2000 sample.

Appendix C: Detailed boy-birth regression results for white mothers

In the interest of space, coefficient estimates for the boy-birth regressions in Table 5 were reported only for the birth-parity indicator variables. To show the association of male births with other observable maternal and pregnancy-related variables, we provide the complete set of estimates (Table A2) for white mothers in the federal data between 1991 and 2004. The sample size is huge (over 30 million births), which allows for precise estimation of the effects. Mother's education has a positive association with male births (0.03 percentage points per year of education). Mothers with first-trimester initial prenatal visits are least likely to have sons, holding all else fixed, which indicates that the other prenatal visit categories largely proxy for problem-free pregnancies. Finally, the previous-termination, ultrasound, and amniocentesis indicator variables all have the expected signs. Mothers with a previous terminated pregnancy or an amniocentesis are less likely to have boys (0.16 percentage points for termination, 0.50 percentage point for amniocentesis), as these indicators proxy for pregnancy problems. In contrast, mothers who have an ultrasound are 0.07 percentage points more likely to have a boy.

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Table 1: Summary statistics on abortion in the United States

	1980	1990	2000
Reported # of legal abortions	1,297,606	1,429,247	857,475
Weeks of gestation:			
8 weeks or less	51.7%	51.6%	58.1%
9-10	26.2%	25.3%	19.8%
11-12	12.2%	11.7%	10.2%
13-15	5.1%	6.4%	6.2%
16-20	3.9%	4.0%	4.3%
21 weeks or more	0.9%	1.0%	1.4%
Previous live births:			
Zero	58.4%	46.2%	40.0%
One	19.4%	25.9%	27.7%
Two or more	22.2%	27.9%	32.3%

Source: Centers for Disease Control and Prevention (2003)

Table 2: Summary of data sources

Dataset	Federal birth data	California birth data	Census (5% PUMS) data
Years	1971-2004	1970-2005	1980, 1990, 2000
Sample	1971-1984: 50-100% of births 1985-2004: 100% of births	All California births	5% of U.S. population
Asian race information	Chinese and Japanese in all years; detailed races available from 1992 on	Chinese and Japanese in all years; detailed races available from 1982 on	Detailed races available
Able to link siblings	No	Yes, using maternal identifiers	Yes, using household identifiers
Prenatal-care data	Yes, with ultrasound and amniocentesis usage available from 1989 on	Yes, with ultrasound and amniocentesis usage available from 1989 on	No
Data on previous terminated pregnancies	Yes, all years	Yes, all years	No

Table 3: Descriptive statistics for federal birth data, 1992-2004

	Chinese	Indian	Japanese	Korean	White
Boy birth	0.519	0.516	0.514	0.520	0.513
Birth parity	1.92	2.01	1.96	2.12	2.27
Mother's age	30.21	27.35	30.60	29.16	26.78
Mother's education	14.20	14.62	14.67	14.72	13.45
Foreign-born mother	0.904	0.950	0.575	0.945	0.055
Same-race father	0.772	0.886	0.398	0.719	0.875
Father's race missing	0.037	0.042	0.035	0.031	0.095
No prenatal care	0.003	0.009	0.005	0.005	0.007
1st-trimester initial visit	0.845	0.809	0.873	0.818	0.858
2nd-trimester initial visit	0.106	0.121	0.080	0.116	0.102
3rd-trimester initial visit	0.021	0.030	0.018	0.032	0.018
Prior terminated pregnancy	0.228	0.202	0.254	0.229	0.258
Ultrasound during pregnancy	0.636	0.660	0.664	0.576	0.687
Amniocentesis during pregnancy	0.057	0.029	0.079	0.035	0.032
# of U.S. births	381,034	258,871	112,448	122,169	30,706,760
# of California births	152,435	72,088	39,239	54,601	2,308,550
Percentage of U.S. births occurring in California	40.0%	27.8%	34.9%	44.7%	7.5%

Notes: Sample averages are reported. "Birth parity" is number of previous births plus one. "Same-race father" is 1 if mother and father have same reported race. The "initial visit" indicator variables are based upon the timing of first prenatal-care visit (1-3 months, 4-6 months, and 7+ months, respectively).

Table 4: Boy-birth likelihoods, U.S. and California birth data

Panel A: Federal natality data						
		1st birth	2nd birth	3rd birth	4th birth	Sample size
Chinese	1971-1980	0.519	0.513	0.513	**0.478**	53,879
		(0.003)	(0.004)	(0.006)	(0.011)	
	1981-1990	0.517	0.517	**0.526**	0.525	151,925
		(0.002)	(0.002)	(0.004)	(0.008)	
	1991-2004	0.518	0.518	**0.530**	**0.540**	399,820
		(0.001)	(0.001)	(0.003)	(0.006)	
Indian	1992-2004	0.510	**0.516**	**0.544**	**0.535**	255,610
		(0.001)	(0.002)	(0.003)	(0.007)	
Japanese	1971-1980	**0.507**	**0.520**	0.519	0.517	42,997
		(0.004)	(0.004)	(0.007)	(0.014)	
	1981-1990	0.513	0.514	0.512	0.517	72,201
		(0.003)	(0.003)	(0.005)	(0.011)	
	1991-2004	0.513	0.514	**0.519**	0.521	119,267
		(0.002)	(0.002)	(0.004)	(0.009)	
Korean	1992-2004	0.519	0.519	0.527	0.529	121,021
		(0.002)	(0.002)	(0.004)	(0.011)	
White	1971-1980	0.515	**0.514**	0.513	**0.512**	17,519,422
		(0.000)	(0.000)	(0.000)	(0.001)	
	1981-1990	0.514	**0.514**	**0.513**	**0.513**	24,497,438
		(0.000)	(0.000)	(0.000)	(0.000)	
	1991-2004	0.514	**0.513**	**0.512**	**0.511**	32,250,458
		(0.000)	(0.000)	(0.000)	(0.000)	
Panel B: California natality data						
		1st birth	2nd birth	3rd birth	4th birth	Sample size
Chinese	1970-1980	0.520	0.516	0.516	**0.497**	33,416
		(0.004)	(0.005)	(0.008)	(0.013)	
	1981-1990	0.516	0.516	0.517	0.524	78,792
		(0.003)	(0.003)	(0.005)	(0.010)	
	1991-2005	0.519	0.517	0.525	**0.539**	174,772
		(0.002)	(0.002)	(0.004)	(0.009)	
Indian	1982-1990	0.515	0.512	0.530	0.543	17,026
		(0.006)	(0.006)	(0.011)	(0.023)	
	1991-2005	0.509	**0.518**	**0.575**	**0.590**	82,999
		(0.002)	(0.003)	(0.006)	(0.013)	
Japanese	1970-1980	0.518	0.512	0.512	0.517	25,478
		(0.005)	(0.005)	(0.009)	(0.017)	
	1981-1990	0.512	0.520	0.513	0.531	30,834
		(0.004)	(0.005)	(0.009)	(0.018)	
	1991-2005	0.516	0.512	0.511	0.496	45,017
		(0.003)	(0.004)	(0.007)	(0.015)	
Korean	1982-1990	0.511	0.514	0.530	**0.559**	33,670
		(0.004)	(0.004)	(0.009)	(0.022)	
	1991-2005	0.517	0.517	0.520	**0.550**	63,726
		(0.003)	(0.003)	(0.006)	(0.016)	
White	1970-1980	0.515	0.513	**0.512**	0.513	2,426,607
		(0.000)	(0.001)	(0.001)	(0.001)	
	1981-1990	0.514	0.513	0.513	0.512	2,260,572
		(0.000)	(0.001)	(0.001)	(0.002)	
	1991-2005	0.515	**0.513**	**0.513**	0.511	2,613,136
		(0.000)	(0.001)	(0.001)	(0.001)	

Note: Each race/time-period cell reports the fraction of male births, with standard error in parentheses. Bold indicates a significant difference (at the 5-percent level) from the first-birth boy likelihood.

Table 5: Boy-birth regressions

Race	Parity	Federal data			California data		
		1971-1980	1981-1990	1991-2004	1970-1980	1981-1990	1991-2005
Chinese	2nd child	-0.395	-0.068	0.002	-0.533	-0.092	-0.139
		(0.532)	(0.295)	(0.180)	(0.642)	(0.410)	(0.268)
	3rd child	-0.758	0.923**	1.176**	-0.592	0.150	0.750*
		(0.779)	(0.452)	(0.304)	(0.925)	(0.614)	(0.445)
	4th child	-3.422**	0.742	2.250**	-2.966**	0.593	2.058**
		(1.358)	(0.830)	(0.644)	(1.479)	(1.072)	(0.923)
Indian	2nd child			0.791**		0.025	0.990**
				(0.233)		(0.898)	(0.403)
	3rd child			3.575**		2.076	6.658**
				(0.380)		(1.309)	(0.693)
	4th child			2.481**		3.227	7.942**
				(0.722)		(2.502)	(1.390)
Japanese	2nd child	1.432**	0.020	0.143	-0.849	0.648	-0.525
		(0.591)	(0.423)	(0.332)	(0.724)	(0.647)	(0.531)
	3rd child	1.629*	-0.371	0.581	-1.081	0.082	-0.712
		(0.852)	(0.616)	(0.504)	(1.060)	(0.979)	(0.824)
	4th child	1.378	0.106	0.527	-0.971	1.465	-2.627
		(1.607)	(1.180)	(0.950)	(1.890)	(1.937)	(1.622)
Korean	2nd child			0.326		0.277	-0.174
				(0.333)		(0.628)	(0.451)
	3rd child			1.254**		1.712	-0.027
				(0.526)		(1.063)	(0.717)
	4th child			1.154		4.360*	3.011*
				(1.168)		(2.369)	(1.632)
White	2nd child	-0.114**	-0.131**	-0.067**	-0.141*	-0.138*	-0.185**
		(0.031)	(0.024)	(0.021)	(0.077)	(0.078)	(0.073)
	3rd child	-0.232**	-0.183**	-0.144**	-0.269**	-0.161	-0.194**
		(0.043)	(0.032)	(0.028)	(0.106)	(0.105)	(0.097)
	4th child	-0.407**	-0.215**	-0.204**	-0.285*	-0.259	-0.320**
		(0.064)	(0.051)	(0.043)	(0.156)	(0.166)	(0.147)

Notes: Each estimate is from a linear regression with boy birth as the dependent variable where the sample consists of singleton births (first through fourth children) to mothers of a given race. Heteroskedasticity-robust standard errors are reported in parentheses. Estimates and standard errors have been multiplied by 100 and should be interpreted as differences in boy-birth percentage from first-child births. The specification includes birthyear, a full set of mother's age dummies, and indicator variables for foreign-born mother, same-race father, father's race missing, no prenatal care, 2nd-trimester initial visit, 3rd-trimester initial visit, and previous terminated pregnancy. The 1991-2004/5 regressions also include mother's education and indicators for ultrasound and amniocentesis use during pregnancy. Significance at the 5-percent and 10-percent level is denoted by ** and *, respectively.

Table 6: Boy-birth regressions, conditional on previous gender(s), California birth data

	2nd-child regression	3rd-child regression	
	Coefficient on firstborn-girl indicator variable	Coefficient on no-sons indicator Variable	Coefficient on one-son indicator variable
Chinese	0.932**	2.165	0.807
	(0.424)	(1.354)	(1.287)
Indian	2.766**	11.256**	5.486*
	(0.761)	(3.059)	(3.002)
Japanese	0.215	-0.272	2.981
	(0.758)	(2.221)	(1.945)
Korean	0.887	0.115	-0.439
	(0.736)	(2.537)	(2.360)
White	0.187**	0.394*	0.532**
	(0.091)	(0.218)	(0.191)

Notes: Estimates are from linear regression models with boy birth as the dependent variable. The 2nd-child (3rd-child) regressions are for the sample of second (third) births to mothers of a given race between 1982 and 2005. Heteroskedasticity-robust standard errors are reported in parentheses. Estimates and standard errors have been multiplied by 100. The other regression covariates are mother's age, mother's age squared, birthyear, and indicators for foreign-born mother, same-race father, and father race missing. Significance at the 5-percent and 10-percent level is denoted by ** and *, respectively.

Table 7: Termination-since-last-pregnancy regressions, conditional on previous gender(s), California birth data

	2nd child regression	3rd child regression	
	Coefficient on firstborn-girl indicator variable	Coefficient on no-sons indicator variable	Coefficient on one-son indicator variable
Chinese	-0.121	0.923	0.374
	(0.262)	(0.836)	(0.784)
Indian	0.972**	5.559**	2.672
	(0.479)	(1.864)	(1.731)
Japanese	0.112	-2.464	-2.441*
	(0.516)	(1.564)	(1.392)
Korean	0.027	-0.858	-0.197
	(0.477)	(1.686)	(1.591)
White	0.140**	-0.136	0.196
	(0.064)	(0.155)	(0.136)

Notes: Estimates are from linear regression models with termination-since-last-pregnancy as the dependent variable. The 2nd-child (3rd-child) regressions are for the sample of second (third) births to mothers of a given race between 1982 and 2005. Heteroskedasticity-robust standard errors are reported in parentheses. Estimates and standard errors have been multiplied by 100. The other regression covariates are mother's age, mother's age squared, birthyear, and indicators for foreign-born mother, same-race father, and father race missing. Significance at the 5-percent and 10-percent level is denoted by ** and *, respectively.

Table 8: Breakdown of samples for Chinese and Indian mothers

		Original Sample	Subsample with: Same-Race Fathers	Mother's Age < 30	Mother's Age >= 30	Mother HS educ or less	Mother Beyond HS educ
Federal data (1991-2004 results, Table 5)							
Chinese	2nd-child indicator	0.002	0.103	0.095	-0.146	0.090	-0.074
	3rd-child indicator	1.176**	1.476**	2.596**	0.596*	1.591**	0.805**
	4th-child indicator	2.250**	3.065**	1.526	2.338**	3.205**	1.148
Indian	2nd-child indicator	0.791**	0.927**	0.808**	0.723*	1.322**	0.497*
	3rd-child indicator	3.575**	4.068**	2.894**	3.896**	3.406**	3.468**
	4th-child indicator	2.481**	3.094**	2.236*	2.459**	3.503**	0.967
California data (1991-2005 results, Table 5)							
Chinese	2nd-child indicator	-0.139	0.038	0.170	-0.316	-0.199	-0.157
	3rd-child indicator	0.750*	1.035**	1.225	0.573	0.479	0.875
	4th-child indicator	2.058**	2.753**	1.502	2.187**	3.887**	0.647
Indian	2nd-child indicator	0.990**	1.103**	1.217**	0.862	2.520**	0.665
	3rd-child indicator	6.658**	7.279**	4.742**	7.465**	5.459**	7.505**
	4th-child indicator	7.942**	9.387**	9.001**	7.596**	8.713**	7.013**
California data (2nd child results, Table 6)							
Chinese	Firstborn-girl indicator	0.943**	1.162**	1.462*	0.772	1.610*	0.751
Indian	Firstborn-girl indicator	2.766**	3.113**	2.417**	2.848**	2.836	2.714**
California (3rd child results, Table 6)							
Chinese	No-sons indicator	2.165	2.638*	-4.735	3.195**	-1.195	3.142**
	One-son indicator	0.807	0.056	-4.763	1.661	-6.488**	2.980**
Indian	No-sons indicator	11.256**	13.659**	1.214	14.925**	15.927**	10.230**
	One-son indicator	5.486*	7.584**	-6.168	9.749**	4.579	6.187*

Notes: Significance at the 5-percent and 10-percent level is denoted by ** and *, respectively. Aside from choice of subsamples, the regression specifications are identical to those used in Tables 6 and 7.

Table 9: Number of abortions consistent with high boy-birth percentages

Sample	Fraction of boy births	Number of births	If natural boy-birth probability = 52.0 percent: Implied probability of female-fetus abortion	If natural boy-birth probability = 52.0 percent: Implied number of abortions	If natural boy-birth probability = 51.5 percent: Implied probability of female-fetus abortion	If natural boy-birth probability = 51.5 percent: Implied Number of abortions
Chinese 3rd children (1991-2004, U.S.)	0.530	36,018	3.8%	680	5.6%	1,019
Chinese 4th children (1991-2004, U.S.)	0.540	6,802	7.4%	252	9.2%	315
Indian 3rd children (1992-2004, U.S.)	0.544	25,172	8.8%	1,111	10.6%	1,342
Indian 4th children (1992-2004, U.S.)	0.535	5,815	5.6%	163	7.4%	217
Indian 3rd children (1991-2005, California)	0.575	7,102	19.2%	679	20.8%	741
Indian 4th children (1991-2005, California)	0.590	1,428	23.8%	169	25.4%	182

Table 10: Fertility-stopping for second and third children, Census data

Race	Time Period	Fraction of families having a 2nd child if first child is a:		Fraction of families having a 3rd child given number of previous boys:			# families with at least 1 child	# families with at least 2 children
		Girl	Boy	0 boys	1 boy	2 boys		
Chinese	1966-1979	**0.664**	**0.622**	**0.383**	**0.296**	**0.261**	3,791	1,345
		(0.011)	(0.011)	(0.021)	(0.014)	(0.018)		
	1980-1994	0.544	0.537	**0.315**	0.173	0.201	8,265	3,698
		(0.008)	(0.008)	(0.018)	(0.010)	(0.014)		
Indian	1966-1979	0.649	0.627	0.382	0.219	0.272	2,548	816
		(0.014)	(0.013)	(0.026)	(0.015)	(0.025)		
	1980-1994	**0.626**	**0.587**	**0.333**	0.200	0.209	5,543	2,750
		(0.009)	(0.009)	(0.020)	(0.012)	(0.017)		
Japanese	1966-1979	0.630	0.625	0.312	**0.221**	0.332	2,869	1,056
		(0.013)	(0.013)	(0.024)	(0.015)	(0.024)		
	1980-1994	**0.604**	**0.639**	0.264	0.226	0.275	2,965	1,538
		(0.013)	(0.012)	(0.028)	(0.017)	(0.026)		
Korean	1966-1979	0.682	0.666	**0.346**	0.220	0.208	2,685	1,041
		(0.013)	(0.013)	(0.024)	(0.015)	(0.020)		
	1980-1994	0.624	0.598	**0.276**	**0.122**	**0.178**	4,585	2,438
		(0.010)	(0.010)	(0.021)	(0.011)	(0.017)		
White	1966-1979	**0.631**	**0.634**	**0.407**	**0.327**	**0.389**	659,456	254,305
		(0.001)	(0.001)	(0.002)	(0.001)	(0.002)		
	1980-1994	**0.616**	**0.621**	**0.371**	**0.294**	**0.363**	752,237	399,923
		(0.001)	(0.001)	(0.002)	(0.001)	(0.002)		

Notes: "Having a 2nd (3rd) child" means that the 2nd (3rd) child is born within five years of the 1st (2nd) child. Standard errors are reported in parentheses. Bold indicates an estimate is significantly different (at a 5-percent level) from the other category in the 2nd-child results or *both* of the other two categories in the 3rd-child results.

Table 11: Boy-birth likelihoods conditional on previous gender, Census data

Race	Time Period	Fraction of families having a second-born son if first child is a:		Fraction of families having a third-born son given number of previous boys:		
		Girl	Boy	0 boys	1 boy	2 boys
Chinese	1966-1979	0.526	0.521	0.522	0.511	0.510
		(0.014)	(0.014)	(0.043)	(0.033)	(0.050)
	1980-1994	**0.534**	**0.491**	0.571	**0.483**	0.560
		(0.011)	(0.010)	(0.030)	(0.027)	(0.035)
Indian	1966-1979	0.499	0.472	0.506	0.607	0.517
		(0.018)	(0.018)	(0.055)	(0.047)	(0.066)
	1980-1994	0.532	0.502	0.574	0.558	**0.457**
		(0.012)	(0.012)	(0.032)	(0.030)	(0.042)
Japanese	1966-1979	0.502	0.492	0.478	0.468	0.479
		(0.017)	(0.017)	(0.052)	(0.045)	(0.052)
	1980-1994	0.527	0.502	0.528	0.533	0.473
		(0.017)	(0.016)	(0.053)	(0.039)	(0.048)
Korean	1966-1979	0.526	0.516	0.460	0.441	0.521
		(0.017)	(0.017)	(0.050)	(0.041)	(0.060)
	1980-1994	0.526	0.500	0.571	**0.462**	0.563
		(0.013)	(0.013)	(0.040)	(0.042)	(0.049)
White	1966-1979	0.513	0.512	0.514	0.518	0.512
		(0.001)	(0.001)	(0.003)	(0.002)	(0.003)
	1980-1994	0.511	0.513	**0.504**	0.515	0.518
		(0.001)	(0.001)	(0.003)	(0.002)	(0.003)

Notes: Standard errors are reported in parentheses. Bold indicates an estimate is significantly different (at a 5-percent level) from the other category in the 2nd-child results or *both* of the other two categories in the 3rd-child results. Sample sizes are reported in Table 10.

Table A1: Sample sizes by race, California data

Race	# of mothers with first two births observed	# of mothers with first three births observed
Chinese	60,391	10,888
Indian	20,886	3,107
Japanese	19,690	4,585
Korean	20,174	3,257
White	1,277,114	421,561

Table A2: Boy-birth regression for white mothers, U.S. data, 1991-2004

	Coeff. estimate (s.e.)
2nd child	-0.0666**
	(0.0212)
3rd child	-0.1444**
	(0.0278)
4th child	-0.2037**
	(0.0432)
Birthyear	-0.0034
	(0.0024)
Foreign-born mother	0.0809**
	(0.0406)
Same-race father	0.4128**
	(0.0538)
Father's race missing	0.0363
	(0.0610)
Mother's education	0.0303**
	(0.0047)
No prenatal care	0.2381**
	(0.1209)
2nd-trimester initial visit	0.5172**
	(0.0310)
3rd-trimester initial visit	0.3574**
	(0.0706)
Previous terminated pregnancy	-0.1642**
	(0.0211)
Ultrasound during pregnancy	0.0704**
	(0.0196)
Amniocentesis during pregnancy	-0.5046**
	(0.0529)
Age dummies?	Yes
Number of observations	30,723,930

Notes: Significance at the 5-percent and 10-percent level is denoted by ** and *, respectively.

Figure 1: Likelihood of a male birth, by country

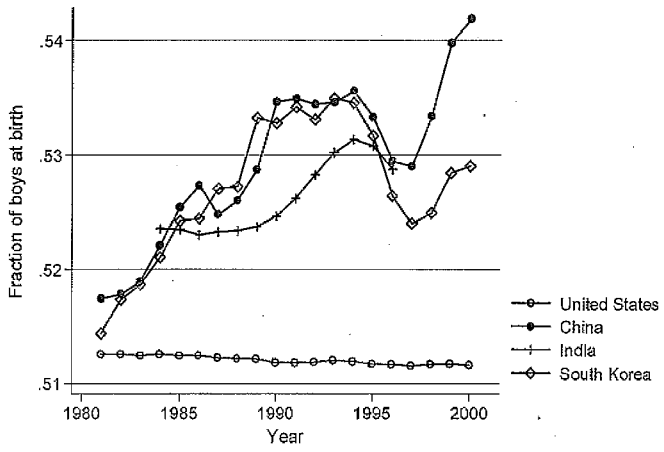


Figure 2: Boy-birth likelihoods by birth parity and race, California

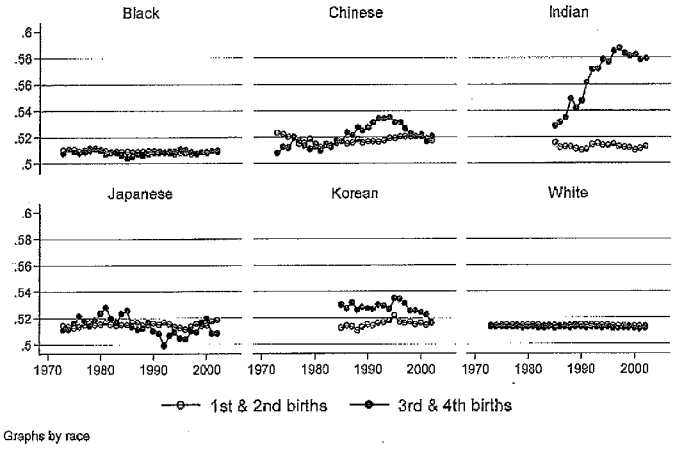


Figure 3: Boy-birth likelihoods by birth parity and race, California

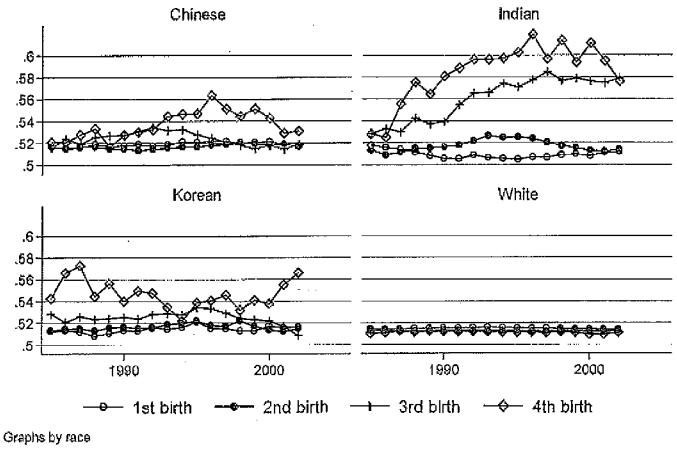


Figure 4: Boy-birth likelihoods for second children of Indian mothers in California

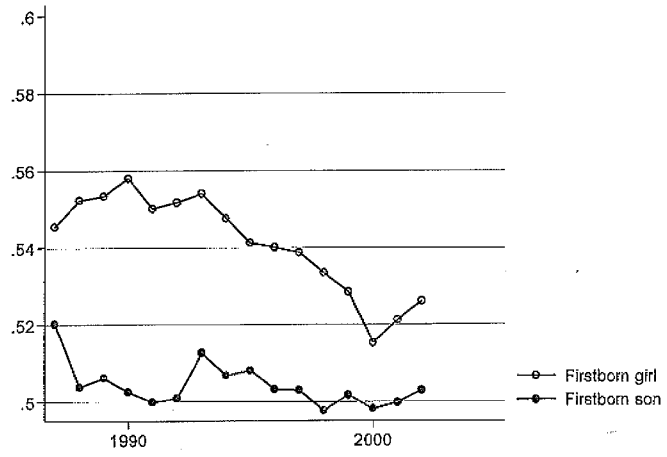


Figure 5: Boy-birth likelihoods for third children of Indian mothers in California

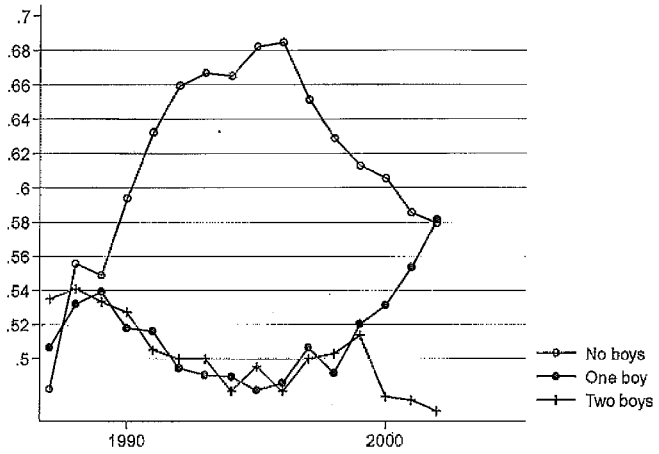
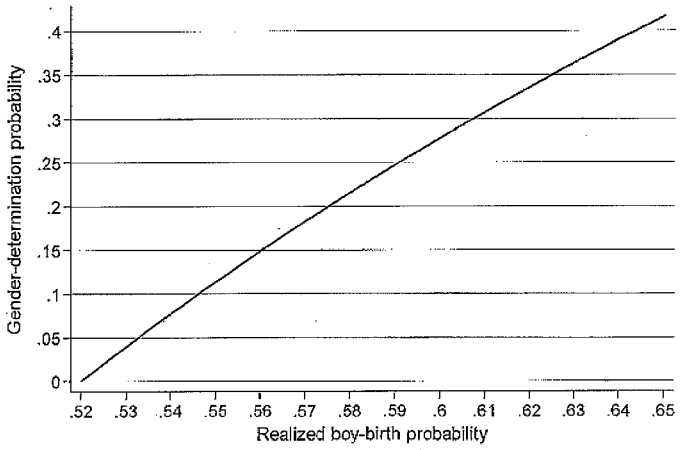


Figure 6: Implied prevalence of gender determination (for $p = 0.52$)



June 15, 2009

U.S. Births Hint at Bias for Boys in Some Asians

By SAM ROBERTS

The trend is buried deep in United States census data: seemingly minute deviations in the proportion of boys and girls born to Americans of Chinese, Indian and Korean descent.

In those families, if the first child was a girl, it was more likely that a second child would be a boy, according to recent studies of census data. If the first two children were girls, it was even more likely that a third child would be male.

Demographers say the statistical deviation among Asian-American families is significant, and they believe it reflects not only a preference for male children, but a growing tendency for these families to embrace sex-selection techniques, like in vitro fertilization and sperm sorting, or abortion.

New immigrants typically transplant some of their customs and culture to the United States — from tastes in food and child-rearing practices to their emphasis on education and the elevated social and economic status of males. The appeal to immigrants by clinics specializing in sex selection caused some controversy a decade ago.

But a number of experts expressed surprise to see evidence that the preference for sons among Asian-Americans has been so significantly carried over to this country. "That this is going on in the United States — people were blown away by this," said Prof. Lena Edlund of Columbia University.

She and her colleague Prof. Douglas Almond studied 2000 census data and published their results last year in the Proceedings of the National Academy of Sciences.

In general, more boys than girls are born in the United States, by a ratio of 1.05 to 1. But among American families of Chinese, Korean and Indian descent, the likelihood of having a boy increased to 1.17 to 1 if the first child was a girl, according to the Columbia economists. If the first two children were girls, the ratio for a third child was 1.51 to 1 — or about 50 percent greater — in favor of boys.

Studies have not detected a similar preference for males among Japanese-Americans.

The findings published by Professors Almond and Edlund were bolstered this year by the work of a University of Texas economist, Prof. Jason Abrevaya. He found that on the basis of census and birth records through 2004, the incidence of boys among immigrant Chinese parents in New York was higher than the national average for Chinese families. Boys typically account for about 515 of every 1,000 births. But he found that among Chinese New Yorkers having a third child, the number of boys was about 558.

Joyce Moy, executive director of the Asian American/Asian Research Institute of the City University of

New York, said that family values prevalent in China, including the tradition of elder parents depending on their sons for support, have seeped into American culture even among younger immigrants, and even when some of the historic underlying reasons for the preference are less relevant here than in China, Korea and India.

"Inheritance in the old country is carried through the male line," she said. "Families depend on the male child for support."

Dr. Norbert Gleicher, medical director of the Center for Human Reproduction, a fertility and sex-selection clinic in New York and Chicago, said that from his experience, people were more inclined to want female children, except for Asians and Middle Easterners.

The preference for males among some immigrant Asians may fade with assimilation, experts said. And no one expects it to result in the lopsided male majorities like those in China, where, according to a study published this year in the British Medical Journal, the government's one-child policy has resulted in the world's highest sex disparity among newborns — about 120 boys for every 100 girls.

"The patients come in and they all think they owe me an excuse, but the bottom line is it's cultural," said Dr. Jeffrey Steinberg, medical director of the Fertility Institutes, a California clinic that began sex-selection procedures in New York in March.

The Fertility Institutes, which does not offer abortions, has unabashedly advertised its services in Indian- and Chinese-langnage newspapers in the United States.

"Culturally, there are a lot of strange things that go on in the world," Dr. Steinberg said. "Whether we agree with it, it's not harming anyone."

Efforts by clinics to appeal to Indian families in the United States provoked criticism and some community introspection in 2001. Some newspapers and magazines that ran advertisements promoting the clinics, which offered sex-selection procedures, expressed regret at the perpetuation of what critics regard as a misogynistic practice.

In this country, some Asian families are having more than the two children they had planned for if the first two are girls. "I do have girlfriends who have had multiple children in anticipation there will ultimately be a boy," Ms. Moy said.

Experts say that Asian-American families are using sex-selection techniques, also called family balancing.

In China, sex selection is usually achieved by aborting female fetuses, which doctors say also occurs in this country, although few parents were willing to be interviewed about it.

"It's a real touchy thing," Dr. Steinberg said. "It's illegal in Asia, and culturally, it's private."

One New York couple, Angie and Rick, Chinese immigrants who were brought here by their parents as young children and now own several food markets in the city, agreed to be interviewed only if their last name was not used.

The first time Angie became pregnant and learned that the baby was a girl, she and her husband were merely disappointed. They had planned on having a second child anyway. When she learned she was pregnant with a girl again, though, the couple considered an abortion.

Their doctor argued against terminating the second pregnancy, they said. The couple reluctantly agreed to try for a third child.

"Our theory was that to raise kids, it's tough already, so we didn't want too many," Rick recalled.

They explored various forms of sex selection, which could cost $15,000 or more, but they feared that because Angie was so fertile, the process would result in multiple births. She became pregnant a third time naturally. The couple were delighted to learn they were finally having a boy.

"If the third one was going to be a girl, then I would say probably I would have terminated," Angie said.

A 1989 study of sex selection in New York City, conducted by Dr. Masood Khatamee, a clinical professor at N.Y.U. Langone Medical Center, found that all the foreign-born couples — mostly from Asia and the Middle East — preferred boys, predominantly for cultural and economic reasons. Often, the pressure comes from the husband's parents.

"I have two daughters and am married to an only child," said a Chinese-American professional woman who is married to an engineer. "Early on, after the two girls were born and another two years went by and there was not a third, I found myself in the living room with four or five older relatives in a discussion of 'Wouldn't it be lovely for you to have a boy?' It's extremely uncomfortable."

Dr. Lisa Eng, a Hong Kong-born gynecologist who practices in Chinatown and Sunset Park, Brooklyn, said she tried to discourage couples who prefer boys from having abortions.

But, she said, "If it's going to be a third, they're pretty determined to have a boy. If it's a boy, they keep it. If it's a girl, they'll abort."

Male Birth Rate Among Asian Americans Studied

April 1, 2008 text size A A A

An analysis of the 2000 census suggests that some Asian-American parents of girls may be using advances in prenatal technology to ensure they get a boy the next time around.

MICHELE NORRIS, host:

The preference for sons, particularly first-born sons, has long been deeply rooted in some Asian societies. A new study using census data finds that a growing number of Asian-American families may be asserting that same preference here in the U.S., and they're doing it with the help of medical technology.

The findings focus on children born in the U.S. to Chinese, Korean, and Asian Indian parents. The findings appear in today's edition of Proceedings of the National Academy of Sciences. The study was co-authored by Douglas Almond and Lena Edlund, a team from Columbia University.

And Dr. Almond joins us now from New York.

Welcome to the program, doctor.

Dr. DOUGLAS ALMOND (Economist, Columbia University): Thank you very much for having me.

NORRIS: Now, using the census data, could you briefly describe what you set out to find in the study?

Dr. ALMOND: Sure. What we set out to find was basically, do we observe in the United States the same thing that we observe in certain Asian countries? And that is, following the birth of a daughter, are subsequent children more likely to be sons than is the biological norm, which is about 1.05 or 1.06 sons per one daughter.

NORRIS: And what did you find?

Dr. ALMOND: When there's a third child following two daughters, it's 50 percent more likely that a son is born if the parents are Chinese, Korean or Asian Indian. And we see no difference for whites if the first two children were girls.

NORRIS: Fifty percent more likely. That's a much higher ratio than you would normally see.

Dr. ALMOND: That's right. The ratio is usually about 5 percent more likely to have a son.

NORRIS: What does this suggest? Why is this happening?

Dr. ALMOND: I think we should say we don't really know. We're documenting this empirical finding.

To us, given the context that in certain Asian countries there's a traditional preference for sons, that desire of sons is being exercised not only in Asia but in the United States, and that the technologies for prenatal sex determination, there's now evidence that those are being used to generate male birth.

NORRIS: It sounds like you're saying that these findings suggest that some Asian families are practicing a form of sex selection, gender selection.

Dr. ALMOND: Yes. That's what we think is going on. The results that we find in the census are confirmed when looking at linked natality data, so we can I think safely conclude that this is not something that's happening following birth. It's something that's happening prenatally or around conception. And speaking as an economist, I guess, the cheapest way to achieve that is through a prenatal ultrasound and sex-selective abortion.

NORRIS: Again, we should emphasize that you're not entirely sure why this is happening. But in terms of the medical technologies that families might be using, you mentioned ultrasound and then abortion. Are there other things that families would do before conception?

Dr. ALMOND: There are other technologies. There's in vitro technologies and there's sperm-sorting technologies that can be used, and those are substantially more expensive.

NORRIS: When these medical technologies first became available, whether you're talking about amniocentesis or ultrasound or in vitro fertilization, there was a debate that still continues today about this concern that parents might participate in gender selection. What are the implications, potential implications of this finding?

Dr. ALMOND: Right. Well, one implication is that we should have more of that debate again. There are countries that customarily do not reveal the sex of the baby with a customary prenatal ultrasound. Sweden is one such country.

NORRIS: Dr. Almond, were you surprised by these findings?

Dr. ALMOND: We really were. And the reason why we're so surprised is, though the high sex ratios following female births have been noted in certain Asian countries, it has not been noted in the United States. Furthermore, the explanations that are often given for the high sex ratios in Asian countries are things that do not exist in the United States, things like the one-child policy or widespread dowry payments in the case of India. So the expectation was, absent those things, we would observe similar sex ratios to the population norm.

NORRIS: Dr. Almond, thank you very much for speaking with us.

Dr. ALMOND: Thank you for having me.

NORRIS: Dr. Almond is the co-author of a study, along with his colleague Lena Edlund from Columbia University, of findings that are released today in the Proceedings of the National Academy of Sciences.

TIMES NATION

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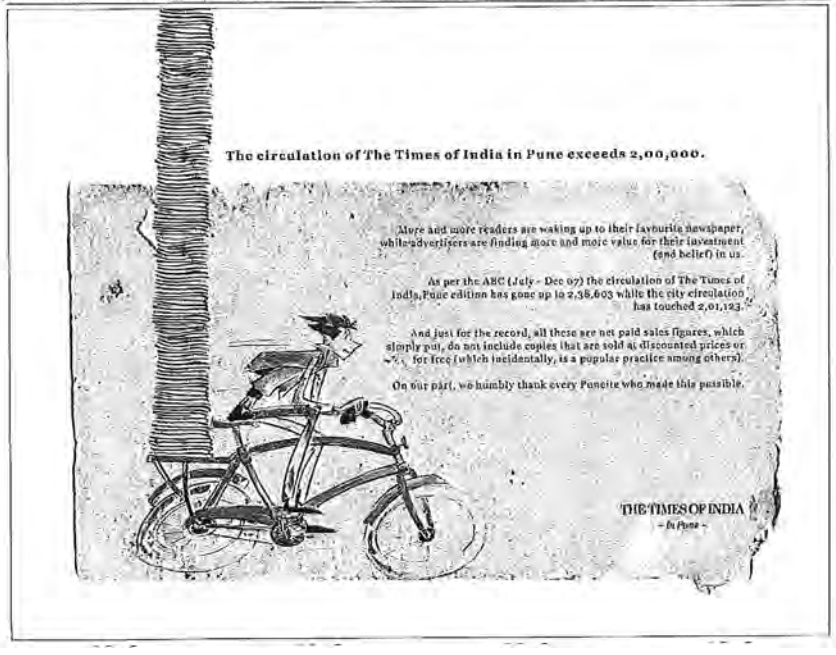
JUST LIKE THAT

Thanks to Asians, even US has got a skewed sex ratio

GENDER BENDER



PNAS

Son-biased sex ratios in the 2000 United States Census

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Edited by Ronald Lee, University of California, Berkeley, CA, and approved March 3, 2008 (received for review January 24, 2008)

We document male-biased sex ratios among U.S.-born children of Chinese, Korean, and Asian Indian parents in the 2000 U.S. Census. This male bias is particularly evident for third children: If there was no previous son, sons outnumbered daughters by 50%. By contrast, the sex ratios of eldest and younger children with an older brother were both within the range of the biologically normal, as were White offspring sex ratios (irrespective of the elder siblings' sex). We interpret the found deviation in favor of sons to be evidence of sex selection, most likely at the prenatal stage.

sex-selective abortion | son preference

The ratio of male to female births exceeds the biological norm of 1.05 (1) in a number of Asian countries, notably India (2, 3), China (4, 5), and South Korea (6, 7). Availability of prenatal sex determination and induced abortion have been identified as important factors (3, 8), to the point of the former being (ineffectively) banned in India and China. Sex selection is no less controversial outside Asian countries, but so far there has been little evidence of prenatal diagnostics being used to that end (an exception being ref. 9).

We document male-biased sex ratios among U.S.-born children to Chinese, Koreans, and Asian Indians in the U.S. The male bias is particularly evident for higher parities, echoing patterns in the corresponding Asian countries (4, 6, 10). At third parity, sons outnumbered daughters 1.51:1 if there was no previous son. As a comparison, for India, the corresponding figure was found to be 1.39:1 in a recent large-scale survey (2) and 2.25:1 for China in the 1990 Census (3).

Results

Using the 2000 U.S. Census, we find that the sex ratio of the oldest child to be normal, but that of subsequent children to be heavily male if there was no previous son. The sex ratio of the second child was 1.17 if the first child was a girl. At third parity, boys outnumbered girls by 1.51:1 if the two previous children were girls (Fig. 1 *Lower*).

By comparison, White offspring sex ratios varied only slightly with parity and sex composition of previous children, and the tendency was for repetition of the previous sex (Fig. 1 *Upper*).

Robustness. Similar results were obtained if we linked children to only mothers or only fathers. The found male bias at higher parity was true irrespective of the mother's citizenship status (a possible marker of cultural assimilation and expectations regarding future dependence on children for old age support). If anything, mothers with citizenship had more male-biased offspring sex ratios, but the difference was not statistically significant.

Discussion

We document son-biased sex ratios at higher parities in a contemporary Western society. We interpret the found deviation in favor of sons to be evidence of sex selection, most likely at the prenatal stage. Since 2005, sexing through a blood test as early as 5 weeks after conception has been marketed directly to consumers in the U.S., raising the prospect of sex selection becoming more widely practiced in the near future.

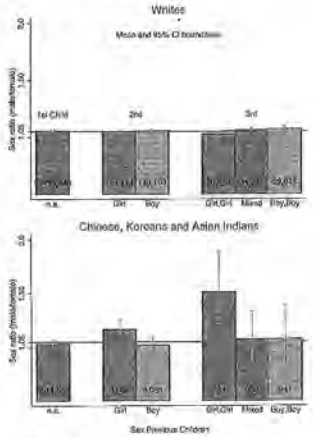

Fig. 1. Sex ratio by parity and sex of previous child(ren).

Son-biased sex ratios were found despite the absence of many of the factors advanced to rationalize son bias in India, China, and Korea, such as China's one-child policy, high dowry payments (India), patrilocal marriage patterns (all three countries) (11), or reliance on children for old age support and physical security.

Although the magnitude of the deviations we find for second and third children is comparable to that documented for India, China, and South Korea, the marriage market consequences for the U.S. are likely limited. Low fertility in the U.S. means that births are concentrated at lower parities, where sex ratios are closer to the biological norm. In addition, because Indians,

Author contributions: D.A. and L.E. designed research, performed research, contributed new reagents/analytic tools, analyzed data, and wrote the paper.

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Chinese, and Koreans make up <2% of the U.S. population, the effect on the breeding population sex ratio is small.

Finally, the male bias we find in the U.S. appears to be recent. In the 1990 U.S. Census, the tendency for males to follow females among Indians, Chinese, and Koreans is substantially muted.

Materials and Methods

We used the 2000 U.S. Census, 5% public use sample. We restricted the sample to families where both the mother's and the father's race was given as Chinese, Korean, or Indian, where either parent headed the household, and where all children were born in the United States (to ensure that the offspring sex composition was not the result of, for example, China's one-child policy). We excluded families with adopted or step-children. To reduce the probability that there was an eldest child not in the household, we also restricted our sample to families where the oldest child was 12 years or younger. Focusing on parity one through three yielded an analysis sample of 18,557 children in 11,553 families.

We investigated the sex ratio of children by parity (as calculated by the age of children reported in the household) and sex of previous children. In the absence of manipulation, we expected the sex ratio at each parity and sex composition of older siblings to be random, with a mean of 1.05 at birth. Lower parity children were older, but were born to younger mothers, two factors known to exert small and roughly offsetting effects on the sex ratio. As for sex of previous children, there may have been a small tendency toward repeating the same sex (1, 12).

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Pressure to Bear Sons Leads Some Immigrant Indian Women to Sex Selection, Abortion, Study Finds

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By Karin Brulliard-Monroe on May 20, 2011

Cultural pressure to bear male offspring leads some immigrant Indian women in the United States to use readily available reproductive technology in an effort to select sons or abort female fetuses, steps that are legal in this country but illegal in India, according to a University of California, San Francisco (UCSF) study.

Sunita Puri, MD, MS

Researchers interviewed 65 immigrant Indian women in California, New Jersey and New York who pursued fetal sex selection between September 2004 and December 2009. This qualitative study found not only that 40 percent of the women terminated prior pregnancies when they found the fetus was female, but that, of the women who discovered they were pregnant with a girl during the interview period, 69 percent underwent an abortion. These results were consistent among all education levels; approximately half the women interviewed held jobs outside the home.

In addition, women who carried a female fetus to term said they were subject to varying degrees of verbal and physical abuse.

The women came from various religious and educational backgrounds. Thirty-eight had finished high school, 12 had graduated from college and 15 held advanced degrees in medicine, law, business, nursing and scientific research.

"Health care providers often are well-positioned to intervene or suggest options, but may be hesitant to approach issues perceived as 'cultural'," said lead author Sunita Puri, MD, MS, a medical resident in the UCSF Department of Internal Medicine.

"Reproductive technological advances are extremely valuable, but it is important to understand the varied impact they may have on women from different sociological backgrounds," she said.

The study is available online in the journal *Social Science and Medicine*.

Cultural Pressures to Have Males

The researchers sought to understand how women exposed to cultural pressures to have male children react in an environment where reproductive choice is allowed and sex selection technologies are openly marketed and available.

The Indian government prohibits using ultrasound and sperm-sorting technologies explicitly for sex selection. In contrast, choosing an abortion for whatever reason, as well as selecting the sex of a child through various medical techniques, are legal in the United States.

Of the participants, 10 women used sperm-sorting technology and four underwent *in vitro* fertilization with pre-implantation genetic diagnosis to determine the sex of their fetuses. Of the 51 women using ultrasound to identify the baby's gender, 24 of their fetuses were male and 27 were female. All carried male offspring to term. All but three of the women carrying a female fetus terminated their pregnancies.

Sunita Puri, a UCSF medical resident, works at San Francisco General Hospital.

Women identified female in-laws

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and husbands as sources of significant pressure to have male children. This was especially true when in-laws lived nearby, but also occurred if they remained in India.

"When my second child was also a girl, she [mother-in-law] did not want to hold her after the birth," one woman commented. Another spoke of going for testing to find out if the baby she was carrying was male. "If not, I will have to get an abortion because he [husband] does not want another daughter," she said.

The study participants immigrated after age 16 from the Indian states and territories of Punjab, Haryana, New Delhi, Gujarat, Andhra Pradesh and Tamil Nadu.

"While higher education is often thought to translate into enhanced female empowerment, our data suggest a distinction between financial and educational empowerment and empowerment within marital relationships," said senior author Robert D. Nachtigall, MD, a clinical professor in the UCSF Department of Obstetrics, Gynecology, and Reproductive Sciences.

Puri conducted the interviews in English, Punjabi and Hindi.

"I was interested in employing an in-depth qualitative approach since there has been little research exploring immigrant Indian women's narratives about the pressure they face to have sons, the process of deciding to use sex selection technologies, and the physical and emotional health implications of son preference and sex selection," she said.

Co-authors are Vaccanne Adams of the Department of Anthropology, History, and Social Medicine, University of California, San Francisco and Susan Ivey, Department of Community Health and Human Development, University of California, Berkeley.

This research was supported by the UCB-UCSF Joint Medical Program Research Fund, the Berkeley Human Rights Fellowship, and the UCSF Pathways to Careers in Clinical and Translational Research Fellowship, a program of the Clinical and Translational Science Institute.

Photos by Susan Merrell

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"There is such a thing as too many daughters, but not too many sons": A qualitative study of son preference and fetal sex selection among Indian immigrants in the United States

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Abstract

In response to concerns from feminists, demographers, bioethicists, journalists, and health care professionals, the Indian government passed legislation in 1994 and 2003 prohibiting the use of sex selection technology and sex-selective abortion. In contrast, South Asian families immigrating to the United States find themselves in an environment where reproductive choice is protected by law and technologies enabling sex selection are readily available. Yet there has been little research exploring immigrant Indian women's narratives about the pressure they face to have sons, the process of deciding to utilize sex selection technologies, and the physical and emotional health implications of both son preference and sex selection. We undertook semi-structured, in-depth interviews with 85 immigrant Indian women in the United States who had pursued fetal sex selection on the East and West coasts of the United States between September 2004 and December 2009. Women spoke of son preference and sex selection as separate though intimately related phenomena, and the major themes that arose during interviews included the sociocultural roots of son preference; women's early socialization around the importance of sons; the different forms of pressure to have sons that women experienced from female in-laws and husbands; the spectrum of verbal and physical abuse that women faced when they did not have male children and/or when they found out they were carrying a female fetus; and the ambivalence with which women regarded their own experience of reproductive "choice." We found that 40% of the women interviewed had terminated prior pregnancies with female fetuses and that 89% of women carrying female fetuses in their current pregnancy pursued an abortion. These narratives highlight the interaction between medical technology and the perpetuation of this specific form of violence

against women in an immigrant context where women are both the assumed beneficiaries of reproductive choice while remaining highly vulnerable to family violence and reproductive coercion.

Highlights

► Although sex selection has been prohibited in India, it is available to South Asian families who have emigrated to the U.S. ► The cultural roots of son preference include the socioeconomic value of sons and the fear of raising daughters in the U.S. ► Eighty-nine percent of sex-selecting women terminated their pregnancy after discovering they were carrying a female fetus. ► Son preference was at times accompanied by verbal and physical abuse toward women who carried a female fetus to term. ► The proliferation of reproductive technology frequently has unanticipated cultural and gender-based ethical implications.

Keywords: USA; Gender; Reproductive technology; Sex selection; Son preference; South Asian women; Immigration and health; Reproductive decision making; Family violence; Reproductive coercion

Article Outline

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Distortions of sex ratios at birth in the United States; evidence for prenatal gender selection†

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Objective The normal male to female livebirth sex ratio ranges from 1.03 to 1.07. Higher ratios in China, India and Korea reflect prenatal sex selection. We reviewed sex ratios for US births to investigate potential prenatal sex selection.

Methods We reviewed all US livebirths from 1975 to 2002 using National Center for Health Statistics birth certificates in 4-year intervals. We compared the sex ratios of Blacks, Chinese, Filipinos, Asian Indians and Koreans relative to Whites. We also compared the sex ratios by birth order for first, second and third and more births (third+) from 1991 to 2002.

Results The male to female sex ratio from 1975 to 2002 was 1.053 for Whites, 1.030 ($p < 0.01$) for Blacks, 1.074 ($p < 0.01$) for Chinese and 1.073 ($p < 0.01$) for Filipinos. From 1991 to 2002, the sex ratio increased from 1.071 to 1.086 for Chinese, 1.060 to 1.074 for Filipinos, 1.043 to 1.087 for Asian Indians and 1.069 to 1.088 for Koreans. The highest sex ratios were seen for third+ births to Asian Indians (1.126), Chinese (1.111) and Koreans (1.109).

Conclusion The male to female livebirth sex ratio in the United States exceeded expected biological variation for third+ births to Chinese, Asian Indians and Koreans strongly suggesting prenatal sex selection. Copyright © 2011 John Wiley & Sons, Ltd.

KEY WORDS: male sex selection; prenatal diagnosis; ultrasound

INTRODUCTION

Male sex selection at birth has been well-documented in China, India, Korea and some other countries (Hesketh and Xing, 2006). The cultural basis for this in China and Korea is rooted in the tenets of Confucianism, which mandate a strict patrilineal inheritance (Chung and Das Gupta, 2007; Das Gupta, 2009) Sons were also traditionally responsible for the care of elders in the family and daughters were effectively lost to their parents after they married. This social structure made producing and raising male children the most important role for women in the family. The explanation for India may be more complex but probably also reflects similar patrilineal values (Das Gupta, 1987) Although these cultural preferences for male children existed for centuries, it was not until the 1980s that the technology for prenatal sex selection, i.e. second trimester ultrasound to determine fetal sex and thereby provide the choice for the termination of a female fetus, was widely available.

Although contemporary laws in these countries have made discrimination against women illegal, there is still evidence for continuing prenatal sex selection in areas of China and India (Park and Cho, 1995; George, 2006; Zhu *et al.*, 2009). A distortion in the sex ratio for a country or a population has many social and ethical implications. The potential consequences of a surplus of males include fewer women to marry, long-term economic stresses associated with declining population numbers, more mental health problems, increased mobility and violence in young men devoid of family responsibilities and a growing sex industry with coercion and trafficking of women.(Hesketh *et al.*, 2005; Hesketh and Xing, 2006)

The sex ratio is defined as the ratio of male births to female births. The sex ratio at birth ranges from 1.03 to 1.07 in most western industrialized countries with a median of 1.059 (Parazzini *et al.*, 1998; United Nations, Department of Economic and Social Affairs, 2008). Sex ratios generally decline with increasing parity and increasing age (Mathews and Hamilton, 2005). A reversal of this normal trend in the sex ratio with increasing parity might be indicative of prenatal sex selection because it may be motivated by parents wishing to be assured that there is a male heir.

Mathews and Hamilton(2005) analyzed trends in the sex ratios for US births from 1910 to 2002. They noted

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† An abstract with some of the data contained in this article was presented as a poster at the 31st Annual Meeting of the Society of Maternal–Fetal Medicine, February 11, 2011 in San Francisco, CA, USA.

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a high sex ratio for births to Chinese mothers (1.074) and Filipino mothers (1.072) but did not separately analyze other Asian minorities where gender selection is common or consider patterns associated with birth order in these populations. We reanalyzed the sex ratios in US births from 1975 to 2002 for various populations and sex ratios by birth order to determine if there were patterns consistent with prenatal sex selection.

METHODS

Various definitions of the sex ratio at birth are available (male to female, males per 100 females, males per 1000 females and female to male). We defined the sex ratio as the number of male births divided by the number of female births (Davis *et al.*, 1998).

Using data from the US National Center for Health Statistics (NCHS) from 1975 to 2002, we recorded the birth sex ratios by maternal race and nationality and birth order and grouped them into 4-year intervals (Centers for Disease Control and Prevention, National Center for Health Statistics, 1975–1990; Centers for Disease Control and Prevention, National Center for Health Statistics, 1990–2006). We included singleton and multiple births and also tracked maternal place of birth. Maternal race and nationality was based on birth certificate data and may include individuals of mixed race. Through 2002, NCHS classified mothers by a discrete race and/or nationality category, i.e. there was no overlap in the groups reported. For example, 'White' excludes all Asian and Pacific Islanders. Some race/nationality classifications changed during the study, so certain categories were only available for limited time periods. We confined our analysis to those Asian populations residing in the United States with the highest numbers of births. We assumed that the reporting of gender at birth was equally accurate for all populations and all time intervals included in this study.

Ratios for Black, Chinese, Filipino, Asian Indian and Korean were compared to those reported for White births. We also determined sex ratios by birth order for first, second and third or more children (third+), the mother's place of birth (i.e. in the 50 United States and the District of Columbia, or elsewhere) and singleton and multiple births from 1991 to 2002 by race and nationality. The quadrennial data for 1975–2002 allowed the analysis of race/nationality for many groups, but 1991–2002 was the only time period where data for parity was available for these specific Asian and Pacific Island populations in the United States.

Because the data is an entire population, statistical sampling errors are not present and the results can be interpreted directly. However, we also used the statistical test of proportions suggested by Mathews and Hamilton (2005) where the data is considered to be one possible set of outcomes that could have arisen in similar circumstances. This provided a measure of the strength of the observed patterns given the size of the populations. For the large number of comparisons involving differences in the sex ratio for populations relative to White, we used a two-tailed test with $p < 0.01$ considered significant. For the more limited analyses that evaluated whether there was an excess of males with higher parity, we compared the ratios using a one-tailed test with $p < 0.05$ considered significant.

This data is publicly available, de-identified data so our institutional human subject review board approval was not required.

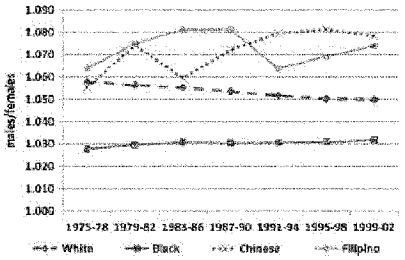

Figure 1—Male to female sex ratios at birth in the United States in 4-year intervals from 1975 to 2002 by selected races

RESULTS

The male/female sex ratio for all 105 939 732 US births from 1975 to 2002 was 1.050. The ratio declined from 1.053 in 1975–1978 to 1.048 in 1995–1998 before returning to 1.053 in 1999–2002. For White births, the ratio declined from 1.058 in 1975–1978 to 1.050 in 1999–2002 (Figure 1). At the same time, the ratio for Black births increased from 1.028 in 1975–1978 to 1.032 in 1999–2002 and this was significantly different from White births for all quadrennials (Table 1). The highest ratios were seen in several Asian-American populations. Ratios exceeded 1.08 for Filipinos from 1983 to 1990 and Chinese from 1995 to 1998. Chinese had significantly higher sex ratios when compared to White births for quadrennial intervals from 1991 to 2002 but there was no significant difference for 1975–1990. Filipino populations also showed significantly elevated ratios for the time periods of 1983–1990 and 1995–2002 (Table 1).

From 1991 to 2002, NCHS provided additional nationality sub-categories allowing the analyses to include Asian Indians and Koreans (Figure 2). Throughout this time period, both Asian Indian and Korean births showed higher sex ratios relative to Whites, but these differences only reached statistical significance for the 1991–1994 quadrennial (Table 1).

For 1991–2002, information was also available for sex ratios by birth order. Figure 3 compares the sex ratio in first versus second and subsequent births. For both White and Black populations, there was a statistically significant decrease in sex ratio for second

Table 1—Sex ratios at birth in 4-year groups by maternal race/ethnicity in the United States from 1975 to 2002

Year	White		Black		Chinese		Filipino		Indian Asian		Korean	
	Total	Ratio m/f	Total	Ratio m/f	Total	Ratio m/f	Total	Ratio m/f	Total	Ratio m/f	Total	Ratio m/f
1975–1978	10 491 596	1.058	2 121 821	1.028[b]	39 605	1.055	50 572	1.064				
1979–1982	11 557 875	1.056	2 347 909	1.030[b]	52 138	1.074	61 792	1.075				
1983–1986	11 789 564	1.055	2 408 164	1.031[b]	66 704	1.060	81 512	1.081[b]				
1987–1990	12 521 278	1.054	2 671 401	1.030[b]	85 916	1.072	98 603	1.081[b]				
1991–1994	12 713 788	1.052	2 651 501	1.031[b]	99 667	1.080[b]	113 324	1.064	32 673	1.069[b]	24 329	1.093[b]
1995–1998	12 383 309	1.050	2 407 735	1.031[b]	112 372	1.081[b]	124 328	1.069[b]	65 097	1.072	33 269	1.080
1999–2002	12 678 892	1.050	2 428 415	1.032[b]	128 198	1.078[b]	128 268	1.074[b]	102 328	1.066	40 132	1.071
Total	84 136 302	1.053	17 036 546	1.030[b]	584 600	1.074[b]	660 399	1.073[b]	200 098	1.068[b]	97 730	1.080[b]

Racial/ethnic data was not available for Indian Asians and Koreans from 1975 to 1990.
m/f, male/female.
[b] $p < 0.01$, for two-tailed test.

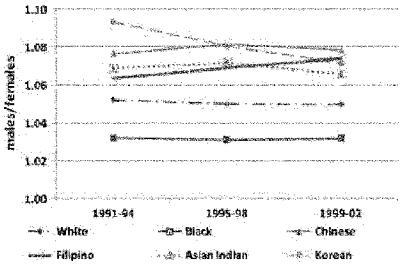

Figure 2—Male to female sex ratios at birth in the United States in 4-year intervals from 1991 to 2002 by maternal race with a focus on mothers of Asian or Pacific Island origin

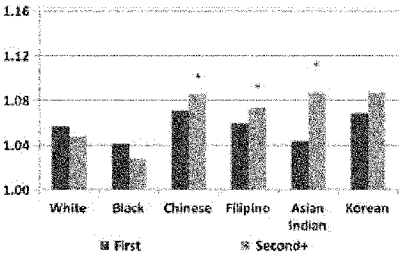

Figure 3—Male to female sex ratio by birth order (first and second+) in the United States by maternal race with a focus on mothers of Asian or Pacific Island origin from 1991 to 2002. [1] Significantly different when compared to White

and subsequent births, relative to that seen for first births. In contrast to this decrease, the male/female sex ratio for second and subsequent births increased relative to first births for Chinese, Filipino, Asian Indian and Korean populations. For Asian Indians, the sex ratio in second and more births was 1.087 ($p < 0.01$) and for Chinese was 1.086 ($p < 0.05$) and for Filipino, it was 1.073 ($p < 0.05$) (Table 2).

Figure 4 shows a further division of the sex ratios by birth order comparing first, second and third or higher livebirths. The highest ratios were seen for third+ births to Asian Indians (1.147), Chinese (1.101) and Koreans (1.140) for 1991–1994. These data show considerable differences between race/nationality in the sex ratios for first, second and third+ births. For Asian Indians, the very high rate for third+ births declined in each successive quadrennial although the ratio for first pregnancies increased. For Koreans, there also appeared to be a trend toward more normal sex ratios over time (Table 2).

The mother's place of birth from 1991 to 2002 was in the 50 states or the District of Columbia for 82.1% of Whites, 89.7% of Blacks, 9.6% of Chinese, 17.9% of Filipinos, 5.2% of Asian Indians and 5.3%

Table 2—Male to female (m/f) ratio at birth of first births, second, third + (i.e. third or more) and all births subsequent to first births (i.e. second +) in the United States by selected races from 1991 to 2002

Year	Total	Ratio m/f	Total	Ratio m/f	Total	Ratio m/f	total	ratio m/f
White	*First*		*Second*		*Third+*		*All subsequent to First*	
1991–1994	4 093 864	1.059	3 716 627	1.052	4 486 387	1.046	8 203 014	1.049
1995–1998	4 130 400	1.056	3 679 125	1.051	4 471 840	1.044	8 150 965	1.047
1999–2002	4 186 856	1.056	3 779 526	1.051	4 657 455	1.043	8 436 981	1.046
1991–2002	12 411 120	1.057	11 175 278	1.051	13 615 682	1.044	24 790 960	1.047
Black								
1991–1994	693 374	1.043	622 637	1.030	1 063 065	1.026	1 685 702	1.028
1995–1998	728 003	1.042	616 486	1.031	1 039 877	1.023	1 656 363	1.026
1999–2002	719 449	1.038	624 424	1.036	1 073 512	1.025	1 697 936	1.029
1991–2002	2 140 826	1.041	1 863 547	1.032	3 176 454	1.025	5 040 001	1.028
Chinese								
1991–1994	34 346	1.082	28 761	1.055	20 305	1.101	49 066	1.074
1995–1998	44 585	1.069	39 510	1.084	27 542	1.103[a]	67 052	1.092[a]
1999–2002	51 873	1.065	44 401	1.086	31 659	1.089	76 060	1.087[a]
1991–2002	130 804	1.071	112 672	1.077	79 506	1.097	192 178	1.086[a]
Filipino								
1991–1994	59 126	1.060	48 733	1.062	54 557	1.069	103 290	1.066
1995–1998	47 219	1.054	38 239	1.089[a]	38 295	1.068	76 534	1.079
1999–2002	47 027	1.066	40 063	1.084	40 744	1.072	80 807	1.078
1991–2002	153 372	1.060	127 035	1.077[a]	133 596	1.070	260 631	1.073[a]
Asian Indian								
1991–1994	13 297	1.026	10 752	1.063	8 370	1.147[a]	19 122	1.099[a]
1995–1998	26 170	1.024	21 609	1.086[a]	16 970	1.128[a]	38 579	1.105[a]
1999–2002	44 186	1.060	33 354	1.059	24 472	1.089[a]	57 826	1.071
1991–2002	83 653	1.043	65 715	1.068[a]	49 812	1.112[a]	115 527	1.087[a]
Korean								
1991–1994	9 516	1.085	8 686	1.071	5 942	1.140	14 628	1.098
1995–1998	12 630	1.045	11 579	1.095[a]	8 822	1.119[a]	20 401	1.105[a]
1999–2002	16 096	1.077	13 412	1.077	10 484	1.052	23 896	1.066
1991–2002	38 242	1.069	33 677	1.082	25 248	1.095	58 925	1.088

[a] We compared the first to each of the other groups.
[a] $p \leq 0.05$ for one-tailed test.

of Koreans. The percentages of all livebirths that were twins or higher order multiples from 1991 to 2002 were 2.8% for Whites, 3.1% for Blacks, 2.2% for Chinese, 1.9% for Filipinos, 2.6% for Asian Indians and 1.8% for Koreans. In all the above categories, the male to female sex ratio was lower for multiples than singletons, specifically Whites 1.013 to 1.052, Blacks 0.990 to 1.032, Chinese 1.077 to 1.080, Filipinos 1.022 to 1.070, Asian Indians 0.994 to 1.071 and Koreans 1.038 to 1.082 for multiples and singletons, respectively. Although there were differences in sex ratios for multiples, the inclusion of multiple births was insufficient to explain the overall distortions in sex ratios for the total population.

DISCUSSION

In the absence of extrinsic factors, the sex ratio at birth is widely considered to be consistent across human populations with values of 1.03 to 1.07 (Coale, 1991). In China, India, Korea and some other countries rates in excess of 1.08 have been found and these have been interpreted as having arisen through prenatal gender selection (Park and Cho, 1995; George, 2006; Hesketh and Xing, 2006; Sahni *et al.*, 2008; Zhu *et al.*, 2009). Our analyses show that there are also significant differences in the male to female sex ratio at birth for different populations in the United States. For some populations, notably, Chinese, Filipino, Asian Indian and Korean, the ratios did at times exceed that historically encountered as a consequence of normal variation. However, these ratios were lower than some of the values reported for the same populations in their native countries.

Differences in the sex ratios may be attributable to maternal age, parity, prenatal healthcare, stress and other environmental factors as well as prenatal sex selection (Davis *et al.*, 1998). It is well established that fetal loss rates are higher when the fetal gender is male (Catalano *et al.*, 2009) and it is reasonable to think that a broad spectrum of additional environmental challenges or sub-optimal healthcare will potentially have a greater toll on male fetuses. Our data for White and Black births indicate that such factors do not have an acute

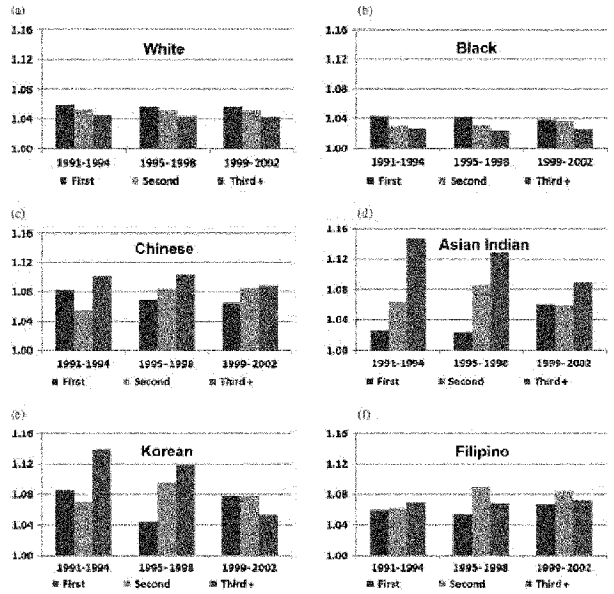

Figure 4—Sex ratios for first, second and third or more births for six races. Data for each quadrennial, 1991–1994, 1995–1998 and 1999–2002 is shown separately

impact on sex ratios; the observed rates show consistency over time with only very minor changes in the ratios over from 1975 to 2002. However, maternal demographics, environmental factors and healthcare could still account, at least in part, for observed race and nationality differences. Therefore, even though we observed statistically significant elevations in overall sex ratios for Chinese Filipino, Asian Indian and Koreans, the component attributable to prenatal sex selection cannot be easily established from these data.

Analyzing the data from the perspective of differences in the sex ratio across birth order for each race/nationality has the advantage of substantially controlling for the confounding environmental and healthcare differences. For each population group, the sex ratios for first, second and third+ births should be comparable with a slightly lower ratio for higher order births reflecting advancing maternal age (Mathews and Hamilton, 2005). Consistent with this, we did indeed see the expected slight decline in sex ratios with increasing parity for White and Black women (Figure 4). For Chinese, Filipino, Asian Indian and Korean populations, we observed the opposite, i.e. increases in sex ratios with higher parity with some of the ratios substantially higher than that expected for normal biological variation. Limited data from the U.S. year 2000 census provides independent evidence for an excess of males in second and third births to Chinese, Korean and Asian Indian parents (Almond and Edlund, 2008). This same trend of increased sex ratio with higher parity has also been reported in China, India and Korea and it is consistent with prenatal sex selection (Park and Cho, 1995; George, 2006; Zhu *et al.*, 2009)

The data shown in Figure 4 indicate that the greatest departure from the normal sex ratio occurred in the 1991–1994 quadrennial for third+ pregnancies. In the two subsequent quadrennials, there were lower sex ratios for the Chinese, Korean and Asian Indian populations. Possible explanations for the peak in the early 1990s include greater demand for sex selection at the time when the ultrasound technology was first being introduced in the 1980s, differences in education and acceptance or rejection of gender selection by different immigrant populations, assimilation and changes in laws in Korea, China, India and elsewhere that have reduced discrimination and increased societal opportunities for women(Park and Cho, 1995; Hesketh *et al.*, 2005; Lai-wan *et al.*, 2006; Zhu *et al.*, 2009). Our data on the maternal birthplace documents that over 90% of the Chinese, Asian Indian and Korean mothers and 82% of Filipino mothers were born outside of the 50 United States and District of Columbia. Those women

who came to the United States more recently were less likely to have had acculturation. Declining use of gender selection has been reported for native Koreans (Chung and Das Gupta, 2007). More data are needed to evaluate these temporal trends.

Limitations of our analyses include inaccurate or incomplete reporting, inability to separately take into consideration mixed parentage and the limited numbers of births in some subgroups. Although sex selection has not been identified as an issue in Whites, we assumed that if there were any gender selection in the control White population it was minimal or was minimal or neutral, in its effect on sex ratios. In evaluating sex ratio differences with increasing parity, it should be recognized that birth certificates do not provide data for the sex of previous children and slightly more than one half of first births are male. Therefore, many parents may not consider intervention in a subsequent pregnancy because their goal of having a male has already been met. There is also presumably a countering component of preferential selection for females to be considered; either because of X-linked genetic conditions, for family balancing, or other personal preferences.

It is not possible from our analyses to reliably estimate the overall deficit in the number of female infants for each year. However, from Figure 1, it would appear that at least for Chinese and Filipino, the ratios are very similar to White for the earliest (1975–1978) quadrennial when any gender selection would have been minimal. Applying the White sex ratio, to all Asian or Pacific Islanders, we can very crudely estimate that that there were approximately 20 000 (1.25%) missing females in this subset of US births from 1983 to 2002 or an average of 1000 per year. This 20-year interval was chosen as ultrasound identification of fetal sex became generally available in the early 1980s. The American College of Obstetrics and Gynecology (ACOG) opposes prenatal gender selection when it is motivated by, and reinforces, the devaluation of women (Committee on Ethics, 2007). However, ACOG acknowledges that 'it will sometimes be impossible for health care professionals to avoid unwitting participation'. George (2006) notes that it is not appropriate for dominant communities in Western societies to accept sex selection for Asian minorities and that the problem requires global responsibility. Indeed, the long-term consequences of sex ratio distortions (Hesketh *et al.*, 2005; Hesketh and Xing, 2006) will not necessarily be confined to the societies where gender selection is currently the most common.

CONCLUSION

We report evidence which strongly suggests that male sex selection occurs in some populations of Asian and Pacific Island origin/culture who deliver in the United States. Although the magnitude of prenatal sex selection in the United States is not on the scale of that seen in China and other Asian countries where it results in major sex ratio imbalances, the practice does raise serious ethical issues in the United States. Future monitoring of sex ratios will be especially important because inexpensive and non-invasive prenatal sex identification tests in the first trimester are becoming increasingly available (Benn and Chapman, 2010).

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Aruna Paap

"It Is Very Common"

Interviewer: Matt Galloway
CBC Toronto
January 17, 2012
http://www.cbc.ca/metromorning/episodes/2012/01/17/it-is-very-common/

Transcript

Matt Galloway: There are a lot of people commenting on a just published editorial in Canadian Medical Association Journal. It came out yesterday, this editorial, and it tackles a controversial practice that is deeply rooted in certain Asian and South Asian cultures. The practice is the deliberate abortion of female fetuses. According to this article, millions of girls are simply not allowed to be born in countries such as China and India. And it turns out the GTA is not immune to female feticide.
My next guest knows this subject well. Aruna Papp is a counselor and therapist with Family Services York Region and in private practice. And she is on the line with us now.
Aruna, good morning.

Aruna Papp: Good Morning

MG: According to this editorial in Canadian Medical Association Journal, preference for sons over daughters is common in some cultures. Now for people who are not familiar with this, explain why that is the case.

AP: It is very prominent in South Asian cultures, certainly in India, and that is because it is a patriarchal system. And the preference for sons is that if you don't have a son, then your family name is going to die. And sons also bring in a large dowry when they get married. When women-- when you have too many girls then you have to give a dowry to get those girls married. Then you have to give a lot of money to get them through education and university. And then they get married and belong to someone else, a different family. So--

MG: Mmmm

AP: it is very expensive. But also if you have girls, then there is the potential that they will bring disgrace, dishonor, and shame to the family because they might have boyfriends, they might start wearing short skirts, they might start wearing makeup. And the family will not be able to control these girls and that leads us into honor-based violence as well.

MG: You yourself grew up in a family with several girls before your brother was born. What was that-- what was that like for you?

AP: That was six girls. We had six girls and I--. My earliest memories is from when I was five years old, my grandmother saying, you know, there are so many girls in this family now and I'm going to have to drop some of you in the well. So I grew up wondering which one of us was going to be dropped in the well that day. So that kind of fear is very common.
But also in new brides. Even the first and second generation girls who are born here [Canada] and brought up here *are* under pressure to produce boys. For many of them, they do not want to have two-- more than two or three children. And one of them, especially the first one, should be a boy. And by the time they come to us-- by the time to the medical doctors, they are suffering from depression. They are suffering from many other physical ailments that are related to two, three, or four abortions.

MG: In the wake of this editorial being published yesterday, there has been some dispute as to how common this issue is in Canada.

AP: It is *very common*! It is *very common*!

MG: What then--.

AP: And nobody is keeping data because the doctors can't keep data. It is so easy to have that kind of ultrasound here in Canada, fly down to India, have an abortion. Go down to Buffalo. Go down to Michigan. Have your abortion and come back.

MG: How often is something like this happening? I mean again that-- I think that it strikes a lot of people or it would strike a lot of people very strongly wondering how this-- this could exist in Canada now. That perhaps there are other regions of the world where this does happen. But people would say "no, this simply is not happening."

AP: It *is* happening *here*! We are not allowed to keep data. We don't know how many are happening. I can say that in six months *so* many women have come. We have agency Punjabi Health Services in Peel region. It is *the top problem* there related to mental illness. In South Asian Settlement Services in Scarborough, for example, the top problem there is … (may be "this problem" - 4:20) related to mental illness, depression, and attempted suicide.

MG: If it is an issue that is prevalent but also taboo because you can't keep statistics and people don't like talking about it, how do you through your agency actually reach out and deal with this issue on the level that people are willing to talk about it?

AP: We can't reach out because we have to wait until they come to us. There is such a backlash from the community and everyone denies it. But it's only the service providers, *the doctors*, who send the clients to us, who can tell you that this is going on. Women can't talk about it publicly. If they do, then there is no place for them to go. They can't go back to their husbands and in-laws and talking about it. But also because they are women who don't want to have more than two or three children themselves, but the pressure comes from the family.

MG: What can you do to tell those women that girls are valued in our society?

AP: We have been working at the last 30 years. I believe that the community-- the leaders from the community, the religious leaders, the financial leaders, the people from within the community have to stand up and take responsibility and talk about it and say "this is not acceptable." Just service providers like myself talking about it, makes-- is not enough.

MG: Mmmm

AP: They make-- the backlash is you're perpetuating racism, you're perpetuating stereotype, negative things about the community. If we own the problem, then *as a community* we can start making the changes from inside. And outside service providers are doing their best. But it needs to be pr-- stopped from the inside. For example, on January eighteenth is a pr-- a celebration called Lohri and this is the-- in South Asian community. A special celebration is happening beca-- for those families-- within the families where the son was born or a newlywed has come-- has-- is there. So the family-- the community is invited to visit this house where the newlyweds are and they--

MG: Right

AP: They say "god bless you with 7 sons." No such celebration happens for the daughters. First daughter? Maybe. Second? Third? *No*. It is a curse, if you have that—so many daughters. The right now--

MG: Mmmm

AP: The television, radio programs in the South Asian communities are having special sales for Lohri. "If you're blessed with a son, jewelry is--" You know? They are perpetuating the importance of the son. On the eighteenth you can listen to all this media. Right now, the sales are going crazy. "If you're the mother of a son, we have special this for you, special that for you."

MG: Right

AP: So that's within the community. What happens to woman who has just given birth to a girl?

MG: As you say it is about owning that problem. Aruna, we'll talk more about this. It is an important subject. Thank you so much.

AP: You're welcome.

ACOG COMMITTEE OPINION

Number 360 • February 2007

Sex Selection*

Committee on Ethics

ABSTRACT: In this Committee Opinion, the American College of Obstetricians and Gynecologists' Committee on Ethics presents various ethical considerations and arguments relevant to both prefertilization and postfertilization techniques for sex selection. The principal medical indication for sex selection is known or suspected risk of sex-linked genetic disorders. Other reasons sex selection is requested are personal, social, or cultural in nature. The Committee on Ethics supports the practice of offering patients procedures for the purpose of preventing serious sex-linked genetic diseases. However, the committee opposes meeting requests for sex selection for personal and family reasons, including family balancing, because of the concern that such requests may ultimately support sexist practices. Because a patient is entitled to obtain personal medical information, including information about the sex of her fetus, it will sometimes be impossible for health care professionals to avoid unwitting participation in sex selection.

Sex selection is the practice of using medical techniques to choose the sex of offspring. Patients may request sex selection for a number of reasons. Medical indications include the prevention of sex-linked genetic disorders. In addition, there are a variety of social, economic, cultural, and personal reasons for selecting the sex of children. In cultures in which males are more highly valued than females, sex selection has been practiced to ensure that offspring will be male. A couple who has one or more children of one sex may request sex selection for "family balancing," that is, to have a child of the other sex.

Currently, reliable techniques for selecting sex are limited to postfertilization methods. Postfertilization methods include techniques used during pregnancy as well as techniques used in assisted reproduction before the transfer of embryos created in vitro. Attention also has focused on preconception techniques, particularly flow cytometry separation of X-bearing and Y-bearing spermatozoa before intrauterine insemination or in vitro fertilization (IVF).

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

*Update of "Sex Selection," in *Ethics in Obstetrics and Gynecology*, Second Edition, 2004.

In this Committee Opinion, the American College of Obstetricians and Gynecologists' Committee on Ethics presents various ethical considerations and arguments relevant to both prefertilization and postfertilization techniques for sex selection. It also provides recommendations for health care professionals who may be asked to participate in sex selection.

Indications

The principal medical indication for sex selection is known or suspected risk of sex-linked genetic disorders. For example, 50% of males born to women who carry the gene for hemophilia will have this condition. By identifying the sex of the preimplantation embryo or fetus, a woman can learn whether or not the 50% risk of hemophilia applies, and she can receive appropriate prenatal counseling. To ensure that surviving offspring will not have this condition, some women at risk for transmitting hemophilia choose to abort male fetuses or choose not to transfer male embryos. Where the marker or gene for a sex-linked genetic disorder is known, selection on the basis of direct identification of affected embryos or fetuses,

rather than on the basis of sex, is possible. Direct identification has the advantage of avoiding the possibility of aborting an unaffected fetus or deciding not to transfer unaffected embryos. Despite the increased ability to identify genes and markers, in certain situations, sex determination is the only current method of identifying embryos or fetuses potentially affected with sex-linked disorders.

Inevitably, identification of sex occurs whenever karyotyping is performed. When medical indications for genetic karyotyping do not require information about sex chromosomes, the prospective parent(s) may elect not to be told the sex of the fetus.

Other reasons sex selection is requested are personal, social, or cultural in nature. For example, the prospective parent(s) may prefer that an only or first-born child be of a certain sex or may desire a balance of sexes in the completed family.

Methods

A variety of techniques are available for sex identification and selection. These include techniques used before fertilization, after fertilization but before embryo transfer and, most frequently, after implantation.

Prefertilization

Techniques for sex selection before fertilization include timing sexual intercourse and using various methods for separating X-bearing and Y-bearing sperm (1–5). No current technique for prefertilization sex selection has been shown to be reliable. Recent attention, however, has focused on flow cytometry separation of X-bearing and Y-bearing spermatozoa as a method of enriching sperm populations for insemination. This technique allows heavier X-bearing sperm to be separated; therefore, selection of females alone may be achieved with increased probability (3). More research is needed to determine whether any of these techniques can be endorsed in terms of reliability or safety.

Postfertilization and Pretransfer

Assisted reproductive technologies, such as IVF, make possible biopsy of one or more cells from a developing embryo at the cleavage or blastocyst stage (6). Fluorescence in situ hybridization can be used for analysis of chromosomes and sex selection. Embryos of the undesired sex can be discarded or frozen.

Postimplantation

After implantation of a fertilized egg, karyotyping of fetal cells will provide information about fetal sex. This presents patients with the option of terminating pregnancies for the purpose of sex selection.

Ethical Positions of Other Organizations

Many organizations have issued statements concerning the ethics of health care provider participation in sex selection. The ethics committee of the American Society for Reproductive Medicine maintains that the use of preconception sex selection by preimplantation genetic diagnosis for nonmedical reasons is ethically problematic and "should be discouraged" (7). However, it issued a statement in 2001 that if prefertilization techniques, particularly flow cytometry for sperm sorting, were demonstrated to be safe and efficacious, these techniques would be ethically permissible for family balancing (8). Because a preimplantation genetic diagnosis is physically more burdensome and necessarily involves the destruction and discarding of embryos, it was not considered similarly permissible for family balancing (9).

The Programme of Action adopted by the United Nations International Conference on Population and Development opposed the use of sex selection techniques for any nonmedical reason (10). The United Nations urges governments of all nations "to take necessary measures to prevent . . . prenatal sex selection."

The International Federation of Gynecology and Obstetrics rejects sex selection when it is used as a tool for sex discrimination. It supports preconception sex selection when it is used to avoid sex-linked genetic disorders (11).

The United Kingdom's Human Fertilisation and Embryology Authority Code of Practice on preimplantation genetic diagnosis states that "centres may not use any information derived from tests on an embryo, or any material removed from it or from the gametes that produced it, to select embryos of a particular sex for nonmedical reasons" (12).

Discussion

Medical Testing Not Expressly for the Purpose of Sex Selection

Health care providers may participate unknowingly in sex selection when information about the sex of a fetus results from a medical procedure performed for some other purpose. For example, when a procedure is done to rule out medical disorders in the fetus, the sex of a fetus may become known and may be used for sex selection without the health care provider's knowledge.

The American College of Obstetricians and Gynecologists' Committee on Ethics maintains that when a medical procedure is done for a purpose other than obtaining information about the sex of a fetus but will reveal the fetus's sex, this information should not be withheld from the pregnant woman who requests it. This is because this information legally and ethically belongs to the patient. As a consequence, it might be difficult for health care providers to avoid the possibility of unwittingly participating in sex selection. To minimize the possibility that they will unknowingly participate in sex selection, physicians should foster open communication with patients aimed at clarifying patients' goals. Although

health care providers may not ethically withhold medical information from patients who request it, they are not obligated to perform an abortion, or other medical procedure, to select fetal sex.

Medical Testing Expressly for the Purpose of Sex Selection

With regard to medical procedures performed for the express purpose of selecting the sex of a fetus, the following four potential ethical positions are outlined to facilitate discussion:

Position 1: Never participate in sex selection. Health care providers may never choose to perform medical procedures with the intended purpose of sex selection.

Position 2: Participate in sex selection when medically indicated. Health care providers may choose to perform medical procedures with the intended purpose of preventing sex-linked genetic disorders.

Position 3: Participate in sex selection for medical indications and for the purpose of family balancing. Health care providers may choose to perform medical procedures for sex selection when the patient has at least one child and desires a child of the other sex.

Position 4: Participate in sex selection whenever requested. Health care providers may choose to perform medical procedures for the purpose of sex selection whenever the patient requests such procedures.

The committee shares the concern expressed by the United Nations and the International Federation of Gynecology and Obstetrics that sex selection can be motivated by and reinforce the devaluation of women. The committee supports the ethical principle of equality between the sexes.

The committee rejects, as too restrictive, the position that sex selection techniques are always unethical (position 1). The committee supports, as ethically permissible, the practice of sex selection to prevent serious sex-linked genetic disorders (position 2). However, the increasing availability of testing for specific gene mutations is likely to make selection based on sex alone unnecessary in many of these cases. For example, it supports offering patients using assisted reproductive techniques the option of preimplantation genetic diagnosis for identification of male sex chromosomes if patients are at risk for transmitting Duchenne's muscular dystrophy. This position is consistent with the stance of equality between the sexes because it does not imply that the sex of a child itself makes that child more or less valuable.

Some argue that sex selection techniques can be ethically justified when used to achieve a "balance" in a family in which all current children are the same sex and a child of the opposite sex is desired (position 3). To achieve this goal, couples may request 1) sperm sorting by flow cytometry to enhance the probability of achieving a pregnancy of a particular sex, although these techniques are considered experimental; 2) transferring only embryos of one sex in assisted reproduction after embryo biopsy and preimplantation genetic diagnosis; 3) reducing, on the basis of sex, the number of fetuses in a multifetal pregnancy; or 4) aborting fetuses that are not of the desired sex. In these situations, individual parents may consistently judge sex selection to be an important personal or family goal and, at the same time, reject the idea that children of one sex are inherently more valuable than children of another sex.

Although this stance is, in principle, consistent with the principle of equality between the sexes, it nonetheless raises ethical concerns. First, it often is impossible to ascertain patients' true motives for requesting sex selection procedures. For example, patients who want to abort female fetuses because they value male offspring more than female offspring would be unlikely to espouse such beliefs openly if they thought this would lead physicians to deny their requests. Second, even when sex selection is requested for nonsexist reasons, the very idea of preferring a child of a particular sex may be interpreted as condoning sexist values and, hence, create a climate in which sex discrimination can more easily flourish. Even preconception techniques of sex selection may encourage such a climate. The use of flow cytometry is experimental, and preliminary reports indicate that achievement of a female fetus is not guaranteed. Misconception about the accuracy of this evolving technology coupled with a strong preference for a child of a particular sex may lead couples to terminate a pregnancy of the "undesired" sex.

The committee concludes that use of sex selection techniques for family balancing violates the norm of equality between the sexes; moreover, this ethical objection arises regardless of the timing of selection (ie, preconception or postconception) or the stage of development of the embryo or fetus.

The committee rejects the position that sex selection should be performed on demand (position 4) because this position may reflect and encourage sex discrimination. In most societies where sex selection is widely practiced, families prefer male offspring. Although this preference sometimes has an economic rationale, such as the financial support or physical labor male offspring traditionally provide or the financial liability associated with female offspring, it also reflects the belief that males are inherently more valuable than females. Where systematic preferences for a particular sex dominate (13, 14), there is a need to address underlying inequalities between the sexes.

Summary

The committee has sought to assist physicians and other health care providers facing requests from patients for sex

selection by calling attention to relevant ethical considerations, affirming the value of equality between the sexes, and emphasizing that individual health care providers are never ethically required to participate in sex selection. The committee accepts, as ethically permissible, the practice of sex selection to prevent sex-linked genetic disorders. The committee opposes meeting other requests for sex selection, such as the belief that offspring of a certain sex are inherently more valuable. The committee opposes meeting requests for sex selection for personal and family reasons, including family balancing, because of the concern that such requests may ultimately support sexist practices.

Medical techniques intended for other purposes have the potential for being used by patients for sex selection without the health care provider's knowledge or consent. Because a patient is entitled to obtain personal medical information, including information about the sex of her fetus, it will sometimes be impossible for health care professionals to avoid unwitting participation in sex selection.

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ACOG NEWS RELEASE

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Contact: ACOG Office of Communications
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ACOG Opposes Sex Selection for Family Planning Purposes

Washington, DC -- Helping patients to choose the sex of their offspring to avoid serious sex-linked genetic disorders is considered ethical for doctors, but participating in sex selection for personal and family reasons, such as family balancing, is not, according to an opinion issued today by the Committee on Ethics of The American College of Obstetricians and Gynecologists (ACOG). The Committee concludes that the ethical objection to sex selection based solely on family balancing or personal preference holds, regardless of the timing of the selection (ie, preconception or postconception) or the stage of development of the embryo or fetus, because such requests may ultimately support sexist practices.

Sex selection is the practice of using medical techniques to choose the sex of offspring. In some cultures, males are more highly valued than females, and sex selection has been practiced to ensure that offspring will be male. However, there are medical indications for sex selection that are considered ethical, including the prevention of serious sex-linked genetic disorders such as hemophilia or Duchenne's muscular dystrophy. The term 'sex-linked' means a gene is carried on a sex chromosome (either the X or Y chromosome), but only X linkage has clinical significance since no genetic disorders have yet been associated with the Y chromosome. Therefore, X-linked diseases are usually recessive, and primarily affect males since they have only one copy of the X chromosome.

Prefertilization techniques for sex selection, including timing sexual intercourse and separating X-bearing and Y-bearing spermatozoa with flow cytometry are considered experimental and cannot be endorsed in terms of reliability or safety until more research is completed. The only reliable methods for selecting sex are limited to postfertilization methods. The sex can be determined for embryos created through *in vitro* fertilization, and the transfer of embryos of the undesired sex can be avoided. After implantation, fetal sex can be determined through testing of fetal cells (obtained through amniocentesis or chorionic villus sampling), and patients can opt for termination, if desired. In some cases, tests are available for the sex-linked disorder itself, making sex selection unnecessary.

ACOG acknowledges that it sometimes will be impossible for physicians to avoid unwitting participation in sex selection because patients are entitled to obtain personal medical information, including information on the sex of their fetus during pregnancy. Although physicians may not ethically withhold medical information from patients who request it, they are not obligated to perform an abortion, or other medical procedure, to select fetal sex.

Committee Opinion #360, "Sex Selection," is published in the February 2007 issue of *Obstetrics*

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Sex selection and preimplantation genetic diagnosis

The Ethics Committee of the American Society of Reproductive Medicine

American Society for Reproductive Medicine, Birmingham, Alabama

In 1994, the Ethics Committee of the American Society of Reproductive Medicine concluded, although not unanimously, that whereas preimplantation sex selection is appropriate to avoid the birth of children with genetic disorders, it is not acceptable when used solely for nonmedical reasons. Since 1994, the further development of less burdensome and invasive medical technologies for sex selection suggests a need to revisit the complex ethical questions involved.

BACKGROUND

Interest in sex selection has a long history dating to ancient cultures. Methods have varied from special modes and timing of coitus to the practice of infanticide. Only recently have medical technologies made it possible to attempt sex selection of children before their conception or birth. For example, screening for carriers of X-linked genetic diseases allows potential parents not only to decide whether to have children but also to select the sex of their offspring before pregnancy or before birth.

Among the methods now available for prepregnancy and prebirth sex selection are [1] prefertilization separation of X-bearing from Y-bearing spermatozoa (through a technique that is now available although still investigational for humans), with subsequent selection for artificial insemination or for IVF; [2] preimplantation genetic diagnosis (PGD), followed by the sex selection of embryos for transfer; and [3] prenatal genetic diagnosis, followed by sex-selective abortion. The primary focus of this document is on the second method, sex selection through PGD, although the issues particular to this method overlap with the issues relevant to the others. Preimplantation genetic diagnosis is used with assisted reproductive technologies such as IVF to identify genetic disorders, but it also can provide information regarding the sex of embryos either as a by-product of testing for genetic disorders or when it is done purely for sex selection (Table 1).

As the methods of sex selection have varied throughout history, so have the motivations for it. Among the most prominent of motivations historically have been simple desires to bear and raise children of the culturally preferred gender, to ensure the economic usefulness of offspring within a family, to achieve gender balance among children in a given family, and to determine a gendered birth order. New technologies also have served these aims, but they have raised to prominence the goal of avoiding the birth of children with sex-related genetic disorders.

Whatever its methods or its reasons, sex selection has encountered significant ethical objections throughout its history. Religious traditions and societies in general have responded with concerns varying from moral outrage at infanticide to moral reservations regarding the use of some prebirth methods of diagnosis for the sole purpose of sex selection. More recently, concerns have focused on the dangers of gender discrimination and the perpetuation of gender oppression in contemporary societies.

This document's focus on PGD for sex selection is prompted by the increasing attractiveness of prepregnancy sex selection over prenatal diagnosis and sex-selective abortion, and by the current limited availability of methods of prefertilization sex selection techniques that are both reliable and safe. Although the actual use of PGD for sex selection is still

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TABLE 1

Embryo sex identification by preimplantation genetic diagnosis for nonmedical reasons.

(a) Patient is undergoing IVF and PGD.
Patient learns sex identification of embryo as *part of*, or as *a by-product of*, PGD done for other medical reasons.

(b) Patient is undergoing IVF and PGD.
Patient requests that sex identification be *added to* PGD being done for other medical reasons.

(c) Patient is undergoing IVF, but PGD is not necessary to treatment.
Patient *requests PGD* solely for the purpose of sex identification.

(d) Patient is not undergoing either IVF or PGD (for the treatment of infertility or any other medical reason).
Patient *requests IVF and PGD* solely for the purpose of sex identification.

infrequent, its potential use continues to raise important ethical questions.

Central to the controversies over the use of PGD for sex selection, particularly for nonmedical reasons, are issues of gender discrimination, the appropriateness of expanding control over nonessential characteristics of offspring, and the relative importance of sex selection when weighed against medical and financial burdens to parents and against multiple demands for limited medical resources. In western societies, these concerns inevitably encounter what has become a strong presumption in favor of reproductive choice.

THE GENERAL ETHICAL DEBATE

Arguments for PGD and sex selection make two primary appeals. The first is to the right to reproductive choice on the part of the person or persons who seek to bear a child. Sex selection, it is argued, is a logical extension of this right. The second is an appeal to the important goods to be achieved through this technique and the choices it allows—above all, the medical good of preventing the transmission of sex-linked genetic disorders such as hemophilia A and B, Lesch-Nyhan syndrome, Duchenne-Becker muscular dystrophy, and Hunter syndrome. There also are perceived individual and social goods such as gender balance or distribution in a family with more than one child, parental companionship with a child of one's own gender, and a preferred gender order among one's children. More remotely, it sometimes is argued that PGD and sex selection of embryos for transfer is a lesser evil (medically and ethically) than the alternative of prenatal diagnosis and sex-selected abortion, and even that PGD and sex selection can contribute indirectly to population limitation (i.e., with this technique, parents no longer are compelled to continue to reproduce until they achieve a child of the preferred gender).

Arguments against PGD used for sex selection appeal either to what is considered inherently wrong with sex selection or to the bad consequences that are likely to outweigh the good consequences of its use. Suspicion of sex selection as wrong is lodged in the concerns identified earlier: the potential for inherent gender discrimination, inappropriate control over nonessential characteristics of children, unnecessary medical burdens and costs for parents, and inappropriate and potentially unfair use of limited medical resources for sex selection rather than for more genuine and urgent medical needs. These concerns are closely connected with predictions of negative consequences, such as risk of psychological harm to sex-selected offspring (i.e., by placing on them too high expectations), increased marital conflict over sex-selective decisions, and reinforcement of gender bias in society as a whole. Sometimes the predictions reach to dire consequences such as an overall change in the human sex ratio detrimental to the future of a particular society.

PREIMPLANTATION GENETIC DIAGNOSIS AND SEX SELECTION: JOINING THE PARTICULAR ISSUES

The right to reproductive freedom has never been considered an absolute right, certainly not if it is extended to include every sort of decision about reproduction or every demand for positive support in individuals' reproductive decisions. Still, serious reasons (e.g., the likelihood of seriously harmful consequences or the presence of a competing stronger right) must be provided if a limitation on reproductive freedom is to be justified. Hence, the weighing of opposing positions regarding PGD and sex selection depends on an assessment of the strength of the reasons given for and against it.

Preimplantation genetic diagnosis has the potential for serving sex selection in varying categories of cases, each of which raises different medical and ethical questions. Preimplantation genetic diagnosis may be done for disease prevention, or it may be done for any of the other motivations individuals have for determining the sex of their offspring. Moreover, information about the sex of an embryo may be obtained (a) as an essential part of or by-product of PGD performed for other (medical) reasons or (b) through a test for sex identification that is added to PGD performed for medical reasons. Further, (c) a patient who is undergoing IVF procedures as part of fertility treatment (but whose treatment does not require PGD for medical reasons) may request PGD solely for the purpose of sex selection, and (d) a patient who is fertile (hence, not undergoing IVF as part of treatment) may request IVF and PGD, both solely for the purpose of sex selection. Each of these situations calls for a distinct medical and ethical assessment (Table 1).

There presently is little debate over the ethical validity of PGD for sex selection when its aim is to prevent the transmission of sex-linked genetic disease. In this case, sex selection does not prefer one sex over the other for its own supposed value; it does not, therefore, have the potential to

contribute as such to gender bias. And when the genetic disorder is severe, efforts to prevent it can hardly be placed in a category of trivializing or instrumentalizing human reproduction. Moreover, prepregnancy sex-selective techniques used for this purpose appear to have a clear claim on limited resources along with other medical procedures that are performed with the goal of eliminating disease and suffering.

It is less easy to eliminate concerns regarding PGD and sex selection when it is aimed at serving social and psychological goals not related to the prevention of disease. It must be recognized, of course, that individuals and couples have wide discretion and liberty in making reproductive choices, even if others object. Yet ethical arguments against sex selection appear to gain strength as the categories of potential cases descend from (a) to (d). For example, desires for family gender balance or birth order, companionship, family economic welfare, and the ready acceptance of offspring who are more "wanted" because their gender is selected may not in every case deserve the charge of unjustified gender bias, but they are vulnerable to it.

Whatever they may mean for an individual or family choice, they also, if fulfilled on a large scale through PGD for sex selection, may contribute to a society's gender stereotyping and overall gender discrimination. On the other hand, if they are expressed and fulfilled only on a small scale and sporadically (as is presently the case), their social implications will be correspondingly limited. Still, they remain vulnerable to the judgment that no matter what their basis, they identify gender as a reason to value one person over another, and they support socially constructed stereotypes of what gender means. In doing so, they not only reinforce possibilities of unfair discrimination, but they may trivialize human reproduction by making it depend on the selection of nonessential features of offspring.

Desired potential social benefits of sex selection also may appear insufficiently significant when weighed against unnecessary bodily burdens and risks for women, and when contrasted with other needs for and claims on medical resources. In particular, many would judge it unreasonable for individuals who do not otherwise need IVF (for the treatment of infertility or prevention of genetic disease) to undertake its burdens and expense solely to select the gender of their offspring. Although individuals may be free to accept such burdens, and although costs may be borne in a way that does not directly violate the rights of others, to encourage PGD for sex selection when it is not medically indicated presents ethical problems.

More remote sorts of consequences of PGD and sex selection, both good and bad, remain too speculative to place seriously in the balance of ethical assessments of the techniques. That is, potential good consequences such as population control, and potential bad consequences such as imbalance in a society's sex ratio, seem too uncertain in their prediction to be determinative of the issues of sex selection. Even if, for example, the current rise in sex selection of offspring in a few countries suggests a correlation between the availability of sex selection methods and the concrete expression of son-preference, there can be no easy transfer of these data to other societies. This does not mean, however, that all concerns for the general social consequences of sex selection techniques regarding general gender discrimination can be dismissed.

The United States is not likely to connect sex selection practices with severe needs to limit population (as may be the case in other countries). Moreover, gender discrimination is not as deeply intertwined with economic structures in the United States as it may be elsewhere. Nonetheless, ongoing problems with the status of women in the United States make it necessary to take account of concerns for the impact of sex selection on goals of gender equality.

Moreover, the issue of controlling offspring characteristics that are perceived as nonessential cannot be summarily dismissed. Those who argue that offering parental choices of sex selection is taking a major step toward "designing" offspring present concerns that are not unreasonable in a highly technologic culture. Yet it appears precipitous to assume that the possibility of gender choices will lead to a feared radical transformation of the meaning of human reproduction. A "slippery slope" argument seems overdrawn when it is used here. The desire to have some control over the gender of offspring is older than the new technologies that make this possible. This, however, suggests that should otherwise permissible technologies for sex selection be actively promoted for nonmedical reasons—as in (b), (c), and (d) above—their threat to widely valued meanings of human reproduction may call for more serious concern than other speculative and remote negative consequences of PGD and sex selection.

Objections to PGD and sex selection on the grounds of misallocation of resources are more difficult to sustain. Questions of this sort are not so obviously relevant to systems of medical care like the one in the United States. If an individual is able and willing to pay for desired (and medically reasonable) services, there is no direct, easy way to show how any particular set of choices takes away from the right of others to basic care. Yet even here, individual and group decisions do have an impact on the overall deployment of resources for medical care and on the availability of reproductive services.

Although, as already noted, there is little controversy about the seriousness of the need to prevent genetic diseases, it is doubtful that gender preference on the basis of other social and psychological desires should be given as high a priority. The distinction between medical needs and nonmedical desires is particularly relevant if PGD is done solely for sex selection based on nonmedical preferences. The greater the demand on medical resources to achieve PGD for

no other reason than sex selection, as in descending order in (b) through (d) above, the more questions surround it regarding its appropriateness for medical practice. If, on the other hand, PGD is done as part of infertility treatment, and the information that allows sex selection is not gained through the additional use of medical resources, it presumably is free of more serious problems of fairness in the allocation of scarce resources and appropriateness to the practice of medicine.

The ethical issues that have emerged in this document's concern for PGD and sex selection are in some ways particular to the uses and consequences of a specific reproductive technology. Their general significance is broader than this, however. For example, the concerns raised here provide at least a framework for an ethical assessment of new techniques for selecting X-bearing or Y-bearing sperm for IUI or IVF (ongoing clinical trial reports of which appeared while this document was being developed). Here, too, sex selection for the purposes of preventing the transmission of genetic diseases does not appear to present ethical problems. However, here also, sex selection for nonmedical reasons, especially if facilitated on a large scale, has the potential to reinforce gender bias in a society, and it may constitute inappropriate use and allocation of medical resources. Finally, although sperm sorting and IUI can entail less burden for parents, questions of the risk to offspring from techniques that involve staining and the use of a laser on sperm DNA remain under investigation.

RECOMMENDATIONS

Of the arguments in favor of PGD and sex selection, only the one based on the prevention of transmittable genetic diseases is strong enough to clearly avoid or override concerns regarding gender equality, acceptance of offspring for themselves and not their inessential characteristics, health risks and burdens for individuals attempting to achieve pregnancy, and equitable use and distribution of medical resources. These concerns remain for PGD and sex selection when it is used to fulfill nonmedical preferences or social and psychological needs. However, because it is not clear in every case that the use of PGD and sex selection for nonmedical reasons entails certainly grave wrongs or sufficiently predictable grave negative consequences, the Committee does not favor its legal prohibition. Nonetheless, the cumulative weight of the arguments against nonmedically motivated sex selection gives cause for serious ethical caution. The Committee's recommendations therefore follow from an effort to respect and to weigh ethical concerns that are sometimes in conflict—namely, the right to reproductive freedom, genuine medical needs and goals, gender equality, and justice in the distribution of medical resources. On the basis of its foregoing ethical analysis, the Committee recommends the following:

1. Preimplantation genetic diagnosis used for sex selection to prevent the transmission of serious genetic disease is ethically acceptable. It is not inherently gender biased, bears little risk of consequences detrimental to individuals or to society, and represents a use of medical resources for reasons of human health.
2. In patients undergoing IVF, PGD used for sex selection for nonmedical reasons—as in (a) through (c) above—holds some risk of gender bias, harm to individuals and society, and inappropriateness in the use and allocation of limited medical resources. Although these risks are lower when sex identification is already part of a by-product of PGD being done for medical reasons (a), they increase when sex identification is added to PGD solely for purposes of sex selection (b) and when PGD is itself initiated solely for sex selection (c). They remain a concern whenever sex selection is done for nonmedical reasons. Such use of PGD therefore should not be encouraged.
3. The initiation of IVF with PGD solely for sex selection (d) holds even greater risk of unwarranted gender bias, social harm, and the diversion of medical resources from genuine medical need. It therefore should be discouraged.
4. Ethical caution regarding PGD for sex selection calls for study of the consequences of this practice. Such study should include cross-cultural as well as intracultural patterns, ongoing assessment of competing claims for medical resources, and reasonable efforts to discern changes in the level of social responsibility and respect for future generations.

New Abortion Center in New York Targets Brits Who Want Sex-Selection Abortions
by Steven Ertelt
LifeNews.com Editor
August 24, 2009

Washington, DC (LifeNews.com) -- A new abortion business in Manhattan is appealing to residents of Britain who want a sex-selection abortion. The abortion center uses pre-implantation genetic diagnosis (PGD), which is banned in England, to determine the sex of the unborn baby and allows couples to have an abortion if they want a child of another gender.

The PGD process is normally used to screen for genetic diseases but it can also reveal the sex of a baby during pregnancy.

Jeffrey Steinberg opened his New York clinic in January and he tells the London Times that half of the people who go there for a potential sex-selection abortion are from the UK.
In an interview he expressed some reservations about his practice but appeared more interested in the financial windfall it presents him.

"Britain is far more conservative than it used to be. They were the innovators but now they've got handcuffs on," he told the newspaper. "From a business standpoint, it's the best thing going. From a medical standpoint, it's a travesty."

The paper says the abortion facility isn't the only one in the United States to use PGD to determine the sex of the baby that could result in an abortion afterwards.

The Genetics and IVF Institute in Virginia was one of the first in the United States to use the PGD for such purposes and officials there say between 10 and 15 percent of the tests it does are for couples who live abroad.

Gary Harton, its PGD scientific director, told the Times, "The people that want to do it will come and find you."

Although sex-selection abortions were thought to be confined to Asian nations like China and Vietnam, where a strong cultural preference for boys exists, the phenomenon is spreading.

Last year, a national study showed the possibility that the practice of sex-selection abortions has made its way from Asia to the United States.

Researchers Douglas Almond and Lena Edlund of the National Academy of Sciences say their analysis of the 2000 Census shows the odds prematurely increasing for Asian-American families from China, Korea and India to have a boy if they already have a girl child.

The data "suggest that in a sub-population with a traditional son preference, the technologies are being used to generate male births when preceding births are female," they wrote in the paper. "Based on the most recent census, sex-selection abortion is also taking place in the United States," Frank says.

That has prompted Franks, an Arizona Republican congressman who is a member of the House Judiciary Committee, to introduce a new bill that would ban sex-selection or race-based abortions.

Franks has introduced the Prenatal Nondiscrimination Act, which would prohibit knowingly performing or financing sex-selection or race-based abortions.

Franks says the bill is needed because abortions on black babies are done at much higher rates than abortions on babies of other races.

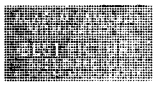
"It is estimated that as many as 50% of African-American babies conceived in the U.S. each year" become abortion victims, he said.

Franks also noted that abortion centers are disproportionately placed in African-American communities and he pointed out that Planned Parenthood has come under fire for accepting donations from people claiming to want the abortion business to target blacks.

"Following the unearthing of the nation-wide race-targeted abortion donations, civil rights activists and African-American pastors from across the country protested government acquiescence in race-targeted abortion and the government funding of clinics that they believe are purposefully placed in the inner city and targeted to minority women," he said.

Franks also says the bill is needed to target sex-selection abortions.

Franks indicated a majority of Americans would likely support the bill and noted a 2006 Zogby International poll shows that 86% of the American public desires a law to ban sex selection abortion. The poll surveyed a whopping 30,117 respondents in 48 states.



August 20, 2011

If You Really, Really Wanted a Girl ...

By PAM BELLUCK

Pam Belluck is a science reporter for The New York Times.

THIS month brought news that could alter the landscape of American pregnancy.

Tests using DNA to determine a fetus's sex were shown to be remarkably accurate, able to tell with 95 percent certainty as early as seven weeks into pregnancy, if a woman is carrying a boy or girl. The tests, which detect the fetus's DNA in a mother's blood or urine, are available in drugstores and online, and reports about their accuracy are likely to increase their popularity.

But the tests also raise ethical questions: whether couples will abort fetuses of an unwanted sex — as has happened in China and India, where boys now outnumber girls. The possibility discomfits many, and is also providing fuel for anti-abortion politics.

The test is the first of an expected raft of DNA tests likely to detect disorders like Down syndrome and other genetic traits early enough in pregnancy that more women may consider abortion.

"I think over the long run this has the potential of changing attitudes toward pregnancy and to family," said Audrey R. Chapman, a bioethicist at the University of Connecticut Health Center. "Women may be less invested in their pregnancies earlier than they are later, and the question has been raised whether women will look at their pregnancies increasingly as being conditional: 'I will keep this pregnancy only if.' "

Fetal sex tests have a few medical applications, allowing couples with histories of rare sex-linked disorders to avoid costly and invasive genetic testing if they learn they are expecting the other sex. But for most couples, the tests, which are unregulated, simply answer the boy-or-girl question weeks earlier than ultrasound, and in a less invasive and safer way than amniocentesis.

"Seven weeks is a different time in pregnancy," said Dr. James Egan, a professor of obstetrics and gynecology at the University of Connecticut Health Center who was a co-author of a

study on sex selection with Dr. Chapman and others. "Women haven't had the ultrasound where you see the fetus that looks like a baby. Many people don't even know that a woman is pregnant. And you can have a medical termination," using pills like RU-486, which can be used at home discreetly before 10 weeks of pregnancy.

There is evidence that some Americans want to choose their babies' sex. At the Fertility Institutes, a set of clinics in Los Angeles, New York and Guadalajara, Mexico, 85 percent of roughly 500 couples each year seek sex selection, although three-quarters of them come from overseas, said Dr. Jeffrey Steinberg, the medical director.

"It's jumped over the past four years," said Dr. Steinberg, whose clinics determine sex through pre-implantation genetic diagnosis, an embryo screening that also detects genetic disorders. He said that "if a woman calls to make the appointment, the couple almost always wants a female. If a man calls, they almost always want a male."

But clinics and some ethicists say this type of sex selection is more acceptable because it occurs before embryos are implanted, before pregnancy.

"We're trying to prevent the abortion," said Dr. Jamie Grifo, program director for New York University's Fertility Center. His and other clinics typically allow sex selection for couples with two or more children, parents interested in "family balancing," adding a child of the opposite sex.

"For someone who has two girls and wants to have a boy, so each sibling can grow up with brother and sister, what's wrong with that?" Dr. Grifo said.

Still, the cost and commitment of the fertility process makes such sex selection cases relatively unusual. Fetal DNA tests, costing between $250 and $350, are more affordable.

Anti-abortion groups are incorporating sex selection in legislative agendas. Arizona and Oklahoma recently passed laws banning sex-selected abortion; a similar bill was just introduced in New York. "I think you will see more states introducing it," said Mary Spaulding Balch, director of state legislation for the National Right to Life Committee.

The laws would probably not survive court challenges, said John Robertson, a professor of law and bioethics at the University of Texas. But while abortion rights groups, like NARAL Pro-Choice America, oppose such bans, they may be less eager to fight them politically or in court because sex selection is not the most socially sympathetic motivation for abortion.

After all, one concern is whether immigrants from countries like India and China would use sex tests to abort female fetuses here. Dr. Egan and Dr. Chapman's study found that Asian-

American mothers, especially with third pregnancies, had more boys than girls in ratios strongly suggesting sex selection.

Some fetal DNA test-makers are trying to discourage sex selection by not selling in China and India, and requiring customers to sign waivers saying that is not their motivation.

Most mothers in Dr. Egan's data were born overseas, suggesting the possibility that American-born generations might become less concerned about having male heirs.

Still, fetal DNA tests for sex determination and other traits present "issues that I don't think many general obstetricians are ready to deal with," Dr. Egan said. "It's a brave new world."

Material Submitted by the Honorable Jerrold Nadler, a Representative in Congress from the State of New York, and Ranking Member, Subcommittee on the Constitution

December 6, 2011

Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011 (H.R. 3541)

Testimony submitted by Sujatha Jesudason, Executive Director

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

Members of the Judiciary Subcommittee on the Constitution:

Generations Ahead is unique among pro-choice and reproductive health organizations in working to *discourage* son preference and sex selective practices while *protecting* reproductive autonomy, including access to comprehensive health care and abortion. We are strongly opposed to H.R. 3541, the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011, or "PRENDA."

Generations Ahead works with reproductive health, rights and justice organizations to ensure women's reproductive health care access, particularly for low-income women and women of color. In addition, we work to discourage son preference norms that lead to sex selective practices, through partnerships and engagement with South Asian American and Asian American community groups as well as health care providers, including fertility doctors.

Many people are uncomfortable with the idea of abortion for sex selection, and the underlying assumptions that might lead to valuing a child more because of his or her sex. But current cynical and hypocritical efforts by anti- choice forces to ban abortions create insidious new obstacles to reproductive healthcare. Bills like "PRENDA" do not in any way address the serious and complex concerns raised by the practice of sex selection or racial health disparities.

Instead, anti-choice groups are just trying a new ploy -- one that uses the rhetoric of equality and rights, -- to promote their agenda. This bill means just one thing for every woman: the highest and most intrusive of scrutiny of the reason she seeks an abortion. It is clear that African- American and Asian American women in particular will face intrusive questions from providers if this proposal becomes law.

Restricting women's rights and questioning their decision-making is an utterly misguided approach to promoting gender equality. Our real challenge is to change the context in which sex selection occurs, and address gender and racial equality issues while protecting the right of all women to make the best reproductive decisions for themselves and their families.

Recent Generations Ahead research with South Asian American community members in the San Francisco Bay area found that participants are concerned about the social and cultural practices of son preference and norms regarding gender inequality in their community, but were opposed to legal restrictions as a solution. As one woman succinctly put it: "You cannot restrict women's autonomy – dealing with sex selection issues is through community education not legal restraint."

The research found that preference for sons is not the same as actually pursuing sex selection, and few research participants reported knowing of cases of sex selection using

abortion or other reproductive technology. Nor did most of the research participants want to see legal restrictions. They firmly believed that the way to address the problem was to change social and cultural norms through community education and discussions. Restricting access to the different sex selective practices would not resolve the social and cultural roots of the practice.

In conclusion, Generations Ahead believes the use of sex selective technologies reflects stereotypes that limit human potential, reinforcing unfortunate social and cultural norms. Changing attitudes and behaviors related to sex selection begins with encouraging prospective parents to question their own expectations of boys and girls.

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Statement of Solidarity

We, stand in solidarity with and support of SisterSong Women of Color Reproductive Justice Collective, SPARK Reproductive Justice NOW!, SisterLove, Planned Parenthood of Georgia, and Feminist Women's Health Center to affirm our belief that every woman has the human right to decide if and when she will have a baby, and the right to parent the children she already has with the social supports necessary. In our struggle for reproductive justice, African American women have a unique history that we must remember in order to ensure bodily sovereignty, dignity, and collective uplift of our community. The choices that women of color make are based on their lived experiences in this country and reflect multiple oppressions, including race, class, and gender, and their efforts to resist them. It is unacceptable to speak to the needs of any woman, or her children without taking into consideration the realities that exist in her home and local community.

We affirm that an African American woman's ability to determine if and when she will have children demands that she control the conditions under which she will give birth and have the power to decide the spacing of her children. These freedoms speak to the power and necessity of the preventive care of women *before* they become pregnant and the importance of comprehensive sex education for all of our children to understand their human right to sexuality in an empowering and responsible way. It means fully funding public education, protecting the environment in all communities, and eliminating sexual violence for all women.

We affirm that an African American woman's ability to determine if and when she does not have children must include a full range of options including the right to have an abortion. For women of color the privilege to exercise this right all too often hinges on other factors in her home and community. Abortion must be approached in the context of the individual woman and the circumstances surrounding her, such as poverty, sexual abuse, lack of health care. To extract a woman from the context of her life dishonors her lived experiences and the plight of a broader community of people.

We affirm that African American women have the human right to parent the children they already have. To ensure the full enjoyment of this right, they must also have access to the social supports necessary to raise their children in safe environments and healthy communities, without fear of violence from individuals or intervention by the government. A continuum of care is essential to protect the lives of women and children. And we must prioritize the needs of children *after* birth. This includes funding education, investing in health care reform for all, ensuring food security and prioritizing the unification of our families through the provision of social supports to protect the most vulnerable.

Protecting women and children requires a commitment to these principles. It is a matter of reproductive health, reproductive rights, and ultimately Reproductive Justice.

Signed during 2010 Georgia Campaign by the following:

Marcia Ann Gillespie, Writer, Editor Emerita Ms. and Essence Magazines
Eleanor Hinton Hoytt, Black Women's Health Imperative
Jewell Jackson McCabe, President Emeritus of National Coalition of 100 Black Women
Dorothy Roberts, Law Professor of Northwestern University, author of Killing the Black Body
Toni Bond Leonard, Black Women for Reproductive Justice
Rev. Carlton Veazey, President/CEO, Religious Coalition for Reproductive Choice
Faye Wattleton, Center for the Advancement of Women
Janice Mathis, Rainbow PUSH
Rev. Penny Willis, Black Church Initiative, Religious Coalition for Reproductive Choice
Gloria Steinem, Activist
Alice Walker, Pulitzer Prize Winner and Activist
Beverly Guy-Sheftall, Women's Research and Resource Center, Spelman College
Angela Davis, Scholar & Activist
Women's Media Center
Julian Bond, Board Chair, NAACP
The Honorable Barbara Smith, Albany, NY
Byllye Avery and Ngina Lythcott, The Avery Institute of Social Change
Dazon Dixon Diallo, SisterLove, Inc.
Rev. Susan Newman, Religious Coalition for Reproductive Choice
Paris Hatcher, SPARK Reproductive Justice NOW!
Reverend Antionette Kemp, Associate Minister, United Ghana Christian Church, Atlanta
Rev. Margaret E. Howland, Presbytery of Hudson River, Yonkers, New York
Paul D. Simmons, PhD, Th.M., Louisville
Rev. Laura Loving
Colleen Bowers, Presbyterians Affirming Reproductive Options, PCUSA
Rev. Elizabeth Griswold
Rabbi Andrew Bossov, Cherry Hill, NJ
Rev. Dottie Mathews, Associate Minister, Fox Valley Unitarian Universalist Fellowship, Appleton, WI
Rabbi Steven B. Jacobs, Founder Progressive Faith Foundation
Rev. Cynthia S. Bumb, Pastor, Pilgrim Congregational United Church of Christ, St. Louis, MO
Rev. Jack Zylman, Birmingham, AL
Rabbi Shelley Kovar Becker
Rev. Thomas A. Haller
Janet A. Holden, Unity Temple Unitarian Universalist Congregation, Oak Park, IL
The Rev. Dr. Jean Rodenbough, Greensboro, NC
Rev. Brenda Fletchall, Oklahoma
Patricia Relf Hanavan, Richland, MI
Barbara Harrison Condon, Idaho
Rev. Janet Schlenker, Aurora, Colorado
Rev. Steve Clapp, Christian Community, Inc.
Rev. Karen Lipinczyk, Pastor, St. Peter's UCC, Wadesville, IN
Bani Hines Hudson, Activist, Louisville, KY
Diane Griffin, Founder/CEO, Mercedes Parra Foundation
Lois "Toni" McClendon, Pittsburgh, PA
Joanne Smith, Girls for Gender Equity
Lynn Roberts, PhD, Hunter College Urban Public Health Program & SisterSong: Women of Color Reproductive Justice Collective
Barbara Berney, PhD, MPH, Associate Professor, Health Policy and Management, Hunter College
Sikivu Hutchinson, editor, blackfemlens.org
Loretta Ross, Heidi Williamson, Serena Garcia, Monica Simpson, Corean Elam, and Laura Jimenez, Staff of SisterSong Women of Color Reproductive Justice Collective

Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011 (H.R.3541)
An Attack on the Reproductive Rights of Women of Color

Testimony Presented by

Nancy Keenan
President

On Behalf of

NARAL Pro-Choice Arizona
NARAL Pro-Choice California
NARAL Pro-Choice Colorado
NARAL Pro-Choice Connecticut
NARAL Pro-Choice Maryland
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice Minnesota
NARAL Pro-Choice Missouri
NARAL Pro-Choice Montana
NARAL Pro-Choice New Hampshire
NARAL Pro-Choice New York
NARAL Pro-Choice North Carolina
NARAL Pro-Choice Ohio
NARAL Pro-Choice Oregon
NARAL Pro-Choice South Dakota
NARAL Pro-Choice Texas
NARAL Pro-Choice Virginia
NARAL Pro-Choice Washington
NARAL Pro-Choice Wisconsin
NARAL Pro-Choice Wyoming
Illinois Choice Action Team

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

December 6, 2011

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

Today you are considering the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011 (H.R.3541), introduced by Rep. Trent Franks (R-AZ). Contrary to its title, the 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. We affirm that 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 block access to abortion.

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

The Franks bill could lead to 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 or a prison sentence for failure 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 question 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 fetus. This demonstrates a clear intrusion into patient privacy and does nothing to facilitate trust between doctor and patient.

Further, in order to protect themselves against the law's harsh penalties, including jail time and loss of all federal funds, the bill could compel providers to single out women of color for greater scrutiny. To avoid increased legal and financial liability, 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 for women of color and immigrant women to necessary medical care. This would further exacerbate existing health disparities. Despite a purported interest in assisting marginalized groups, the bill would serve only to isolate and stigmatize these women.

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 diseased 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 law intrudes into the doctor-patient relationship and represents an initial step towards eroding the right to privacy, which includes the right to choose.

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.[1] Further, the findings section of the bill reinforces the belief that abortion rights have negatively affected communities of color. However, we believe that the true aim of the bill is to restrict the pregnancy decisions of black women rather than protect them from alleged coercion.

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.[2] Loretta Ross, a founding member of TBW and national coordinator of the SisterSong Women of Color Reproductive Justice Collective noted:

> 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.[3]

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 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. But while sex-selective abortion may be an issue in various parts of the world, there are no data that demonstrate it is a prevalent practice in the U.S. What is clear, however, is that 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.[4]

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.[5] 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 Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011 serve no legitimate health-care purpose. Rather, the legislation uses the issues of sex and race in an attempt to erode women's reproductive rights. Ultimately, the legislation wrongly would subject women of color to additional scrutiny when they access reproductive care. NARAL Pro-Choice America opposes this legislation and urges lawmakers to respect the fundamental American values of freedom and the right to privacy by opposing this bill.

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[1] Kathryn Joyce, *Is Abortion "Black Genocide"?*, COLLECTIVE VOICES, Summer 2011, *at* http://www.sistersong.net/documents/CollectiveVoices_Summer2011_rf2.pdf (last visited Dec. 4, 2011)

[2] Belle Taylor-McGhee, *Trust Black Women Talking Points*, COLLECTIVE VOICES, Summer 2011, *at* http://www.sistersong.net/documents/CollectiveVoices_Summer2011_rf2.pdf (last visited Dec. 4, 2011)

[3] Loretta Ross, *Re-enslaving African-American Women*, On the Issues, Fall 2008, *at* http://www.ontheissuesmagazine.com/2008fall/cafe2/article/22 (last visited Dec. 4, 2011)

[4] 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 (last visited Dec. 4, 2011)

[5] SisterSong, *Race, Gender and Abortion: How Reproductive Activists Won in Georgia, Oct. 2010, at* http://www.scribd.com/doc/52934613/SisterSong-Race-Gender-Policy-Report (last visited Dec. 4, 2011)

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Testimony of Douglas W. Laube, MD, MEd
Board Chair, Physicians for Reproductive Choice and Health
House Judiciary Committee
Subcommittee on the Constitution
December 6, 2011

Physicians for Reproductive Choice and Health (PRCH) is a doctor-led national advocacy organization that relies upon evidence-based medicine to promote sound reproductive health policies. PRCH stands against gender- and race-based discrimination. Our physicians provide comprehensive reproductive health care every day that helps women of all races, ethnicities, economic levels, and religious backgrounds achieve their education and life goals, plan their pregnancies, and become parents when they are ready. The "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) of 2011" (H.R. 3541) shows how out of touch our lawmakers are with the realities of women's lives.

The decision to have an abortion is complex and H.R. 3541 goes against everything my colleagues and I know about women's motivations for seeking abortion care in the United States. As physicians, we talk with our pregnant patients about all of their pregnancy options and make sure that their decision to have an abortion is informed and not coerced. In the countless conversations I and fellow physicians have with women seeking abortion care, we hear a resounding theme: responsibility. Our patients understand fully what it means to be a mother; many of them already have children. They cannot imagine bringing a child into the world whom they are not prepared to raise. We aid women suffering from serious health conditions and for whom pregnancy can be deadly—they have abortions not only to stay alive but also to remain healthy for the families who depend on them. We help women find the contraceptive best suited to them so that they can avoid unintended pregnancy (and abortion) altogether.

H.R. 3541 distorts the concepts of equality and rights by requiring providers to scrutinize the decision-making of certain populations[i] or risk serious, criminal penalties. As physicians, we find this attack on women seeking abortion and those of us who provide abortion care unconscionable. The bill does nothing to address the critical issues of gender inequality or racial disparities in access to high-quality reproductive healthcare,[ii] showing the sponsors' true intent, which is to decrease access to legal abortion. PRCH asks Congress to act responsibly; to trust women's decision-making about their health and well-being and that of their families, and to stop creating barriers to safe, legal abortion care.

[i] The bill cites research by economists to justify the legislation. This research describes a gender disparity in birth ratios in certain Asian communities for second and third children relying upon U.S. Census Data. The research does not study abortion rates or survey women who have had abortions. Douglas Almond and Lena Edlund. 2008. "Son-biased Sex Ratios in the 2000 United States Census." *Proceedings of the National Academy of Sciences*. 105(15): 5681–82.

[ii] For example, African-American women's unintended pregnancy rates are the highest [of all racial groups]. 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 also persist for a wide range of health outcomes, from diabetes to heart disease to breast and cervical cancer to sexually transmitted infections (STI), including Human Immunodeficiency Virus (HIV). Susan A. Cohen. Abortion and Women of Color: The Bigger Picture. 11 *Guttmacher Policy Review* 3 (Summer 2008) (available online at http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.pdf).

national partnership
for women & families
Because actions speak louder than words.

"Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011" (H.R. 3541)

Testimony submitted by
Debra Ness, President
Andrea D. Friedman, Director of Reproductive Health Programs

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

December 6, 2011

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Members of the Judiciary Subcommittee on the Constitution: we are honored to submit this testimony on behalf of the National Partnership for Women & Families and the women and families we represent.

The National Partnership is dedicated to promoting public policies and business practices that expand opportunities for women and improve the well-being of our nation's families. Through education, outreach, and legislative action, the National Partnership is an effective advocate for millions of women and families.

We believe that actions speak louder than words, and for 40 years we have played a critical role in enacting landmark policy from prohibiting pregnancy discrimination to giving more than 100 million Americans family and medical leave. Today, we promote fairness in the workplace, reproductive health and rights, access to quality and affordable health care, and policies that help women and men meet the dual demands of work and family.

Founded in 1971, the National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C.

Undermining Access to Abortion is *Not* the Way to Address Discrimination

This bill is a thinly veiled attempt to undermine women's constitutional right to abortion. At a time when a record number of women are living in extreme poverty[i] and the need to expand access to health care is more critical than ever, Congress is once again using its limited time and resources to discuss yet another bill to undermine women's comprehensive reproductive health services.

Far from addressing the real problems of race and sex discrimination, this bill would exacerbate already existing health disparities in communities of color and penalize health providers that offer services in those communities. This legislation undermines the rights of individual women to make their own personal and private health decisions, in particular whether and when to bear a child. Even worse, it particularly harms women in those communities the bill is purportedly aimed at helping. Congress can play an important role in addressing health disparities and discrimination and a number of bills have been introduced that would do so. Unfortunately, this bill does not support those efforts and instead is another attempt undermine women's access to reproductive health care.

Addressing Health Disparities

There are significant and serious disparities in health care. According to a 2009 report by the Kaiser Family Foundation, 17% of black women, 27% of Latinas, and 22% of Native American women are in fair or poor health, compared to 9.5% of white women. More than 22% of black women have no health coverage,[ii] which means less access to contraception, prenatal care and other critical reproductive health services.

There are significant disparities in reproductive health. African American women are three to four times more likely to die from pregnancy-related causes than white women.[iii] The unintended pregnancy rate for African American women is 67% and for Latinas it is 53%, compared to 44% for white women.[iv] In 2007, African Americans represented 48% of HIV/AIDS cases despite the fact that they are only 13% of the U.S. population. African Americans are nine times more likely to be

diagnosed with HIV than whites, and African American women are 20 times more likely than white women to die from the disease.[v] In 2008, African American teens were more than twice as likely as their white or Mexican-American counterparts to have chlamydia, trichomoniasis, genital herpes, or human papillomavirus. Latinos have three times the syphilis cases of whites. Latinas are more than twice as likely as white women to be diagnosed with cervical cancer. And while African American women are less likely to be diagnosed with breast cancer than white women, they are 30% more likely to die from it.[vi] These disparities are a result of pervasive sex and race discrimination in American society – discrimination that Congress can and shonld address. But H.R. 3541, rather than addressing these persistent and widespread problems, exacerbates them by singling out women of color and further restricting their access to comprehensive reproductive health services.

H.R. 3541 is Another Attack on Women's Reproductive Health

Unfortunately, H.R. 3541 is one more in a long line of attempts by this body to take away women's access to basic health services. In the 112th Congress, the House of Representatives has already voted more than six times to restrict women's access to abortion and family planning services, inclnding:

- The Full Year Continuing Appropriations Act (H.R. 1), which would eliminate fundiug for the Title X Family Planning Program, Planned Parenthood, and the Teen Pregnancy Prevention Initiative, reinstate the Global Gag Rule, and cut funding for the Title V Maternal and Child Health Program.
- The Pence Amendment (H. AMDT. 95 to H.R. 1), which would eliminate all federal funds for Plauned Parenthood.
- The No Taxpayer Funding for Abortion Act (H.R. 3), which would take away women's right to use their own funds for abortion care or insurance plans that provide abortion coverage.
- The Protect Life Act (H.R. 358), which would limit women's access to private insurance that covers abortion as well as allow hospitals to deny women abortion services even in emergency situations.
- The Foxx Amendment (H. AMDT.298 to H.R. 1216), which would undermine medical schools' ability to train their students in abortion care.
- The King Telemedicine Amendment (H. AMDT. 463 to H.R 2112), which would potentially limit access to telemedicine for women in rural and other underserved communities.

These cuts and restrictions would disproportionately negatively impact women and children of color, the communities this bill's supporters claim to want to help, by limiting access to comprehensive health care. Instead of empowering women of color to make informed personal health care decisions, H.R. 3541 and all the similar efforts that preceded it would prevent them from doing so.

Congress Needs to Advance Real Solutions to Discrimination and Health Disparities

Despite their claims of concern about race and sex discrimination, supporters of this bill have not supported measures in Congress that address ongoing legal and constitutional discrimination and related health disparities. For example, the vast majority of the sponsors of this bill who were members in the last Congress voted against the passage in the *Lilly Ledbetter Fair Pay Act*, signed into law January 2009, which will help to ensure that women are paid the same as their male counterparts. In addition, as part of H.R. 1, the Full Year Continuing Appropriations Act mentioned above, supporters of this bill voted to eliminate funding for the Teen Pregnancy Prevention Initiative and to cut funding for the Title V Maternal and Child Health Program, programs that help to address underlying health disparities in low-income communities.

We welcome this opportunity to highlight some of the important legislation proposed in this Congress that would take concrete steps to address real discrimination and health disparities. We urge the members of this committee who are concerned about the impact of discrimination to co-sponsor and support passage of these bills:

- *The Paycheck Fairness Act (H.R. 1519),* which would address the persistent pay gap between men and women.

- *The Healthy Families Act (H.R. 1876),* which would allow workers to take time off to care for themselves or their families and would allow individuals who are victims of domestic violence, stalking or sexual assault to take time off to recover and seek assistance.

- *The Health Equity and Accountability Act (H.R. 2954),* which aims to eliminate racial and ethnic health disparities by calling for culturally and linguistically appropriate health care; health workforce diversity; and improvement of health outcomes for women, children and families; among other things.

- *The Real Education for Healthy Youth Act (H.R. 3324),* which would provide funding for comprehensive sex education programs in a variety of communities throughout the United States.

- *Arbitration Fairness Act (H.R.1873),* which would limit corporations' ability to deny individual rights and allow victims to have their day in court when they are injured by employment discrimination or other unlawful conduct.

Congress also has a critical role to play in responding to an extremely serious and pervasive form of discrimination purportedly addressed in this bill, violence against women. We welcome this opportunity to highlight some of the important legislation that would provide needed resources and support for victims of sexual and other types of violence and we urge the members of this committee to use their valuable and limited time to pass this legislation.

- *Violence Against Women Health Initiative Act (H.R.1578),* which would ensure that victims of gender-based violence have access to important health services.

- *Compassionate Assistance for Rape Emergencies Act of 2011 (H.R.1724),* which would ensure that rape survivors have access to Emergency Contraception at any hospital.

- *MARCH for Military Women – Military Access to Reproductive Care and Health for Military Women (H.R. 2085)*, which would ensure that members of military and their dependents who become pregnant as the result of rape or incest would have access to safe abortion services through their federal health insurance.

Conclusion

The National Partnership urges Congress to reject the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) of 2011" (H.R. 3541). Instead of focusing on yet another bill to undermine women's comprehensive reproductive health services, Congress should be advancing bills that truly address discrimination. This piece of legislation is a thinly veiled attempt to undermine women's constitutional rights and eliminate women's access to abortion and only serves to deny women adequate and comprehensive health care and exacerbate health disparities. The National Partnership would welcome the opportunity to work with Congress to advance measures that truly address the pernicious issues of race and sex-based discrimination and expand, not restrict, women's access to reproductive health and we look forward to the opportunity to do so.

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[i] National Women's Law Center, Poverty Among Women and Families, 2000-2010, September 2011 "The rate of extreme poverty among women rose from 5.9 percent in 2009 to 6.3 percent in 2010, the highest rate since the Census Bureau began recording this figure 22 years ago. Black and Hispanic women experienced even greater increases in poverty between 2009 and 2010 than women overall, as did single mothers. Poverty rates for all groups of women in 2010 were substantially higher than poverty rates for their male counterparts." *Available at http://www.nwlc.org/sites/default/files/povertyamongwomenandfamilies2010final.pdf*

[ii] Kaiser Family Foundation, Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level (June 2009), available at http://www.statehealthfacts.org/downloads/womens-health-disparities/Putting%20Womens%20Healthcare%20Disparities%20On%20the%20Map.pdf.

[iii] Amnesty International, U.S. Maternal Health Crisis, http://www.amnestyusa.org/about-us/amnesty-50-years/50-years-of-human-rights/us-maternal-health-crisis-facts

[iv] Guttmacher Institute, Facts on Induced Abortion in the United States (August 2011), *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[v] United States Department of Health and Human Service.s Office of Minority Health, HIV/AIDS and African Americans, *available at* http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlID=51&ID=3019

[vi] Susan A. Cohen, Abortion and Women of Color: The Bigger Picture, Guttmacher Policy Review (Summer 2008), *available at* http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html.

Hearing on H.R. 3541,
The Susan B. Anthony and Frederick Douglass
Prenatal Nondiscrimination Act (PRENDA) of 2011

Letter from Asian American and Pacific Islander Community Organizations
December 6, 2011

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

We are organizations that represent the Asian American and Pacific Islander community (API), and we write today to register our opposition to H.R. 3541, the "Prenatal Nondiscrimination Act." We have worked for years 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 API women, and we stand firmly against it.

If passed, the Franks bill would exacerbate health disparities and put additional stigma on women of color. The existence of racial disparities in health care is a real problem. Nearly 18% of Asian Americans and 24% of Native Hawaiians are uninsured while only 12% of the non-Hispanic, non-elderly white population is without insurance. Over 29% of API women have not had a mammogram for the past two years, and 24.1% have not had a Pap Test in three years. Additionally, women of color are diagnosed for diabetes and cardiovascular diseases at a higher rate than Caucasians, with coronary disease a leading cause of death among API women, responsible for more than a quarter of all deaths. 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 decisions of women of color, and penalizing health care providers who serve communities of color. Instead of empowering API women, this bill implies that they cannot make their own health care decisions.

Similarly, this bill does nothing to address prevalent gender discrimination issues such as pay equity, gender-based violence or intimate partner violence. Nor does this bill address the underlying societal attitudes that may lead to the devaluation of women or girls. A real response would address social norms that devalue women and lead to son preference, not place additional hurdles between women and their health care.

We commend the goal of combatting race and sex discrimination. However, we strongly oppose HR 3541 as a wrongheaded 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,
Asian & Pacific Islander American Health Forum (APIAHF)
Asian Communities for Reproductive Justice (ACRJ)
Asian Pacific American Labor Alliance (APALA)
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Association of Asian Pacific Community Health Organizations (AAPCHO)
Hmong National Development
Jahajee Sisters
Manavi
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum (NAPAWF)
National Queer Asian Pacific Islander Alliance (NQAPIA)
OCA
Sakhi for South Asian Women
South Asian Americans Leading Together (SAALT)

Testimony of the Center for Reproductive Rights

Testimony on H.R. 3541:
Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011

Submitted December 6, 2011

The Center for Reproductive Rights respectfully submits the following testimony regarding H.R. 3541, the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act of 2011." Since 1992, the Center for Reproductive Rights has worked toward the time when the promise of reproductive freedom is enshrined in law in the United States and throughout the world. We envision a world in which every woman is free to decide whether and when to have children; every woman has access to the best reproductive healthcare available; and every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world in which every woman participates with full dignity as an equal member of society.

The Center for Reproductive Rights has worked tirelessly in Africa, Asia, Europe, and Latin America – as well as in the United States – to promote reproductive rights and eliminate the underlying sex discrimination that leads to son preference. For example, our lawsuits around the world have challenged inequalities and injustices related to comprehensive sexuality education, contraception, female genital mutilation, child marriage, sexual violence, and maternal mortality.

In light of our experience and long track record in working on behalf of women's rights, we support tools that have demonstrated effectiveness in remedying discrimination against women and improving the social standing of girls. Yet the evidence on one particular set of policies – criminal bans on sex-selective abortions – shows that these bans are both inappropriate and ineffective. They do not remedy the core problem of discrimination against women and girls, and they threaten the health and human rights of women by creating additional barriers to obtaining legal abortions.

Our conclusion, which is a shared global consensus, is that efforts should focus on eradicating the underlying causes of sex discrimination, and on educating populations where son preference exists, to promote and reinforce the inherent value and dignity of women and girls.

Summary: H.R. 3541 is a Dangerous and Unconstitutional Attack on Access to Health Services

The misleadingly titled "Prenatal Nondiscrimination Act" (H.R. 3541) would ban all abortions undertaken for "the purpose of" gender or race. This harsh legislation would impose criminal penalties on health care providers who perform certain abortions, allow suits for damages following such abortions, and require health care providers to report suspected violations to law enforcement. It also provides a vague authority regarding injunctive relief to stop an abortion altogether.

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The bill purports to combat race and sex discrimination. In reality, it is nothing more than a cynical exploitation of these serious societal problems to mask attempts to diminish the rights of women to control their reproductive lives. In sum, H.R. 3541 is a misguided and inappropriate response to the problem of race and sex discrimination. The bill is also unconstitutional.

I. The Prenatal Non Discrimination Act is a Cynical and Thinly Veiled Attempt to Ban Abortion

A. H.R. 3541 is an Anti-Choice Attack on Access to Reproductive Healthcare

The bill is not motivated by a concern for the wellbeing of women or minorities; instead, it is a cynical attack on access to reproductive healthcare. As noted above, sex selection is not a significant problem in the United States. And moreover, the bill's supporters have not co-sponsored – much less supported – the numerous legislative efforts that have been made to forthrightly remedy the embedded racial and sex discrimination, such as the Paycheck Fairness Act, the Lilly Ledbetter Fair Pay Act, or the Violence Against Women Act.

On the other hand, those who support this bill have consistently backed extreme anti-reproductive-choice bills, such as H.R. 3 and H.R. 358 (the so-called "Let Women Die Act"). Bill backers have also tried to strip Title X family planning funding and international family planning funding, both of which would help reduce the need for abortion. Even now, these attempts to roll back the clock on women's health continue, including an unprincipled attempt to override the locally stated preferences of the people of the District of Columbia to fund abortion care for low-income women using their own local dollars in the context of the Financial Services budget bill for FY2012.

This focus on "prenatal discrimination" is merely the latest in a string of ultra-conservative bills aimed at dismantling reproductive rights in America. As in the states where we have seen similar attempts, this kind of bill is part of the agenda by anti-choice groups to reduce access. As anti-choice legal strategists have explained, these bans constitute one piece of the anti-choice movement's long-term strategy of chipping away at women's ability to decide whether and when to have children: "The key to eroding *Roe v. Wade*, then, is to pass a number of state or federal laws that restrict abortion rights in ways approved of by at least fifty percent of the public . . . I would recommend passing laws like . . . a ban on abortion for sex selection…"[1]

The real problem in America is not that abortion services are too widespread, but that they are not sufficiently accessible for those who seek them. A full 88% of U.S. counties have no abortion provider; in non-metropolitan areas, the figure is 97%. Women who seek abortions are often forced to travel substantial distances in order to access them. And abortions are only available at about 1 in 10 hospitals nationwide.[2] This bill would only further impede women's already-limited access to abortion services.

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[1] *See, e.g.*, Steven G. Calabrasi, *How to Reverse Government Imposition of Immorality: A Strategy for Eroding Roe v. Wade*, 31 HARV. J. L. & PUB. POL'Y 85 (2008).

[2] According to a 2001-2002 Guttmacher Institute study, abortions were only available at 603 of the nation's 5,801 hospitals.

B. H.R. 3541 is a Cynical Pretext to Limit Abortion Access Because Sex and Race Selection are not Problems in the United States

i. Sex Selection Is not a Significant Problem in the United States

In the United States as a whole, son preference is not a problem, and the data on the general population reflect this reality. To the extent that it exists in a few communities, the best approach, as discussed in detail below, is to focus on efforts to address the root causes of sex discrimination, and to educate parents about the value of girls. In addition, this bill will have a host of unintended consequences – most notably, stigmatizing Asian-American and African-American women and reducing their access to healthcare.

The natural sex ratio is not naturally 50 percent for boys and girls. Instead, under natural circumstances, 102 to 106 boys are born for every 100 girls.[3] While some countries do have skewed birth ratios– China and India's ratios are 113 and 112 boys for every 100 girls, respectively – the United States is not one of them.[4] The birth ratio in the United States is 105 – squarely within the natural range of 102 to 106 – and slightly lower than the European Union's ratio of 106.[5]

To the extent that son preference exists in the United States, it is not a general problem, but exists instead in only a few communities. Although one recent study (Almond & Edlund) found skewed gender ratios among second and third births for U.S. born Chinese, Korean and Asian Indian parents, the study does not provide any evidence regarding what has caused the ratios.[6] In other words, the main study cited by the bill's sponsors does not conclude that sex-selective abortion is the reason for the male-skewed sex ratio (as opposed to, for example, natural methods or pre-conception sperm sorting).

Moreover, the impact of this limited son preference is negligible on the country as a whole due to the low fertility in the United States overall (meaning that most families only have one or two children), and the fact that the predominant preference in the United States is for a gender mix. In addition, while the issue is also rare within these communities, even those populations highlighted by the research (namely, Chinese, East Indian, and Korean communities) are a small percentage – less than 2% – of the U.S. population.[7]

Moreover, in other instances in the United States, the sex preference is for daughters, not sons. The World Health Organization reports that, among couples who used sex selection via sperm sorting

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[3] *See, e.g.*, United Kingdom Parliamentary Office of Science and Technology, *Postnote: Sex Selection*, July 2003. The publication notes that "The reason why slightly greater numbers of boys than girls are born is not known."
[4] *See* CIA World Factbook, *available at* https://www.cia.gov/library/publications/the-world-factbook/index.html.
[5] *Id.*
[6] Douglas Almond and Lena Edlund, *Son-biased sex ratios in the 2000 United States Census*, PNAS, Apr.15, 2008 vol. 105 no. 15 5681-5682, *available at* http://www.pnas.org/content/105/15/5681.full (Based on 2000 census data, the study cites ratios of 1.17:1 for the second child if the first child is a girl and 1.51:1 for third children if the two previous children were girls).
[7] Almond and Edlund, Abrevaya, at 28.

prior to implantation, 90% of couples reported engaging the service for family balancing and 80% of these couples desired girls.[8]

ii. Race Selection Is a Myth

The very notion of race selection or "race-selective" abortion is a myth. The higher abortion rate among African-American women is not the result of so-called "race selection" or a pro-choice conspiracy. Instead, African-American women face unintended pregnancies at a much higher rate than the general population (67% for African-American women versus 40% for white women), and as a result, African-American women seek out abortion services in greater numbers than do other women.

Women of color make their own decisions about whether to abort pregnancies. The claim that they are somehow coerced by the placement of women's health clinics is entirely fabricated and patently offensive. A 2008 Guttmacher Institute study found nationally only 1 in 10 abortion clinics are in predominantly black neighborhoods, refuting the claims of anti-choice organizations and politicians.[9]

In addition, the Guttmacher Institute attributed the high unintended pregnancy rate among black women to the lack of contraceptive access and proper use.[10] In 2002, Guttmacher found that 15% of black women at risk of intended pregnancy were not using contraception, compared with 9% of white women. These numbers align with the significant pattern of racial disparities in access to needed health care:

- African American women are 3 to 4 times more likely to die from pregnancy-related causes.
- Black people make up 13 percent of the population in the United States, yet account for more than 49 percent of AIDS cases. AIDS is the leading cause of death for black women between the ages 25 to 34, and the second leading cause of death for black men between the ages 35 to 44.[11]
- Black and Hispanic women have the highest teen pregnancy rates.[12]
- Forty percent of black Americans report being uninsured at some point from 2007 through 2008.[13]

Rather than deal with the root causes of this public health crisis, this bill would exacerbate the problem by further isolating black women from health care providers, placing black women and other

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[8] World Health Organization. *Genomic Resource Centre, Gender and Genetics.* http://www.who.int/genomics/gender/en/index4.html, accessed on Dec 2, 2011.
[9] Susan Cohen, *Abortion and Women of Color: The Bigger Picture,* Guttmacher Policy Review Summer 2008.Vol 11, No 3, http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html.
[10] *Id.*
[11] Centers for Disease Control. *30 years of HIV in the African American Communities: A Timeline.* http://www.cdc.gov/nchhstp/newsroom/docs/Timeline-30years-HIV-African-American-Community-508.pdf, accessed on Dec 5, 2011.
[12] Guttmacher Institute. *Facts on American Teens' Sexual and Reproductive Health.* http://www.guttmacher.org/pubs/FB-ATSRH.html Aug 2011, accessed on Dec, 2, 2011.
[13] Kai Wright. *10 Reasons African Americans Should Match on Washington About Health Care.* The Root, Sep 16, 2009. http://www.theroot.com/views/10-reasons-african-americans-should-march-washington-about-health-care, accessed on Dec 2, 2011.

women of color who seek reproductive health services under a cloud of suspicion, and penalizing providers who serve communities of color.

II. The Prenatal Nondiscrimination Act Is Unconstitutional

A. A Ban on Abortion Throughout Pregnancy Is Unconstitutional Because it Conflicts With Established Law Holding that Women Have the Right to Choose to Terminate a Pregnancy Prior to Viability

In *Roe v. Wade*, the Supreme Court held that a woman has the constitutional right to choose to terminate her pregnancy until the fetus reaches viability. Prior to viability, states cannot prohibit a woman's abortion due to the reason why she is seeking the procedure. *Roe v. Wade*, 410 U.S. 113, 164-5 (1973).

In 1992, the Court reaffirmed the constitutional protection for women's rights to choose abortion in *Planned Parenthood v. Casey*. Under *Casey*, states can regulate abortion throughout pregnancy, but cannot prohibit abortion or impose an undue burden on a woman's ability to choose abortion until viability. *Planned Parenthood v. Casey*, 505 U.S. 855, 869-71, 876-79 (1992). As the Court noted in a subsequent case in summarizing the law, "Before viability, a State 'may not prohibit any woman from making the ultimate decision to terminate her pregnancy.'" *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007). Even after viability, the state may not prohibit abortions necessary to preserve a woman's health or life. *Casey* at 879.

The *Casey* Court held that: "viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." *Casey*, 505 U.S. at 860. Moreover, the Court explained that the drawing of a clear line at viability is required to guarantee "the urgent claims of the woman to retain the ultimate control over her destiny and her body, claims implicit in the meaning of liberty." *Id.* at 869. Because H.R. 3541 would ban certain abortions at any point during pregnancy, including prior to viability, it runs directly afoul of the core protections articulated in *Roe* and *Casey*.

B. Before Viability, There Is No State Interest Compelling Enough to Justify Banning Abortion, Regardless of Whether the State or Others Disapprove of a Woman's Reason for Seeking an Abortion

This bill is based on a premise that the state has an interest in banning certain abortions throughout pregnancy, and that interest is strong enough to outweigh a woman's constitutional right to terminate a pregnancy before viability. But the Supreme Court has explained that until viability, *no* State interest is compelling enough to override the woman's right: "[A] statute which, while furthering the interest in potential life *or some other valid state interest*, has the effect of placing a substantial obstacle in the path of a woman's choice" to obtain an abortion must be considered invalid and unconstitutional. *Id.* at 877 (emphasis added).

Prior to viability, states may *regulate* the provision of abortion to protect women's health and to express their interest in potential life; however, that regulation must not impose an undue burden on

women seeking abortion. *Id.* at 872, 874-78. A outright ban on abortion prior to viability, as here, cannot be constitutionally justified by any state interest.

C. The Legislation is Unconstitutional Because it Contains No Exception for the Health or Life of the Pregnant Woman

Under the bill, if a woman sought an abortion for a fetal anomaly linked to gender (such as hemophilia or Duchenne's muscular dystrophy) or race (such as sickle-cell anemia), the physician could be prohibited from performing the abortion under this law because of the link to gender or race.[14]

The Supreme Court has repeatedly held that though a state may regulate or even proscribe abortion subsequent to viability, it may not do so "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *See Casey*, 505 U.S. at 879 (quoting *Roe v. Wade*, 410 U.S. 113, 164-65 (1973)); *Stenberg v. Carhart*, 530 U.S. 914, 930.

The Court has also noted in its analysis that the constitutional violation here can be further "aggravated" by the fact that legislation applies a ban both pre- and post-viability, as H.R. 3541 does. *See Stenberg*, 530 U.S. at 930 (stating that "the fact that Nebraska's law applies both pre-viability and post-viability aggravates the constitutional problem presented").

D. The Bill is Unconstitutionally Vague

H.R. 3541 also is unconstitutionally vague. It bans "solicitation" of funding for an abortion, but does not adequately define "solicit" for purposes of Sec. 250 (a)(3); nor does it define what is meant by "consent[]" to an abortion in the exceptions in Sec. 250 ((b)(2). It also fails to define what it means to seek an abortion "based on" gender or race – a key point that would mean the criminal ban could be read to bar abortions due to gender or race-related birth defects.

The Due Process Clause of the Fourteenth Amendment prohibits the States from enacting vague laws. *See, e.g., Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). A law is unconstitutionally vague if it fails to provide those targeted by the statute a reasonable opportunity to know what conduct is prohibited, or is so indefinite that it allows arbitrary and discriminatory enforcement. *See, e.g., Colautti v. Franklin*, 439 U.S. 379, 390 (1979); *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411, 421 (5th Cir. 2001).

Laws imposing criminal sanctions, as this bill does, must survive greater scrutiny than civil statutes. *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 498-99 (1982). The most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of a constitutionally protected right, and this bill undoubtedly does so. *Id.* at 499; *Colautti*, 439 U.S. at 391.

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[14] We note that some state-level bills, such as the one in Oklahoma, have had a considerably more limited (albeit still unconstitutional) approach. In that state, the law prohibited abortions performed "solely" on account of sex, and also included a provision that stated: "Nothing in this section shall be construed to proscribe the performance of an abortion because the unborn child has a genetic disorder that is sex-linked." Okla. Stat. tit. 63, §731.1 (A).

III. The Bill Jeopardizes Women's Health and Lives by Tnrning Virtually Any Abortion into the Grounds for a Criminal Charge

A. All Doctors and Medical Personnel Who Provide Abortions Wonld Become *De Facto* Criminal Suspects Under this Bill

The bill criminalizes abortions "based on" the sex, gender, color, or race of the fetus. But the bill provides no guidance as to what the term, "based on" means. Additionally, by its very nature, the bill specifically requires medical providers to scrutinize – far more than most women – Asian Americans, African Americans, and women in a couple or family with someone of a different race. The bill's findings are a recitation of the grounds for suspicion of women of Asian descent and African-American women. Also singled out for particular scrutiny are women with a different-race partner, as their abortions would ostensibly be more likely to be based on the fetus's race than abortions undertaken by women with a same-race partner.

In the real world, there is rarely, if ever, direct evidence that an abortion was based on sex (or race). The World Health Organization and four other leading United Nations agencies, in analyzing laws worldwide criminalizing sex-selective abortion, found that "prosecuting offenders is…practically impossible," and that "proving that a particular abortion was sex-selective is equally difficult."

In light of the non-existence of direct evidence, there is real concern that a prosecutor might try to "prove" the existence of a sex-selective abortion by relying solely on racial profiling. This could effectively make nearly any woman who underwent an abortion pose a risk of criminal sanction for providers – despite the fact that a woman's right to an abortion is a constitutionally protected right. The legislation also, in the civil context, authorizes punitive damages, threatening to put providers out of business.

For example, under the bill, the fact that a woman underwent an ultrasound and subsequently had an abortion could be the grounds for suspicion that the statute had been violated, because the woman could have learned of the sex of the fetus during the ultrasound. But of course, pregnant women *routinely* undergo ultrasounds to monitor the health and progression of their pregnancies. Indeed, the United Nations report noted that "it is difficult to prove that any particular ultrasound examination was used to determine sex rather than for other appropriate and legitimate reasons." But H.R. 3541 would potentially make a criminal accessory out of any doctor who performed an ultrasound on a woman who subsequently decided to have an abortion.

In addition, at-home kits are now available to determine the fetus's sex as early as 10 weeks. These kits, which cost less than thirty dollars, are available over-the-counter at pharmacies like Walgreens, CVS, and Rite-Aid. The bill would also conceivably mean that any woman who had an abortion after 10 weeks could be the basis for claims against the medical provider, because she might have used an at-home-sex-determination kit. The bill would thus make nearly every abortion a potentially suspect one.

B. By Turning Basic Prenatal Care an Element of a Crime, the Bill Jeopardizes the Health of Women and Their Pregnancies

Because, as noted above, the likelihood of finding direct evidence of sex or race selection is negligible, prosecutors will no doubt rely on insubstantial evidence, such as having had an ultrasound or utilized a home sex-testing kit. The danger inherent in turning an ultrasound into a potential element of a criminal act is obvious – some women may forego ultrasounds and other medical care, some legal providers may no longer feel safe in offering care, and thus women may have to increasingly rely on underground, unsafe abortions, rather than safe and reputable clinics.

In light of the draconian penalties providers can face, and the complete uncertainty about what an abortion "based on" sex or race actually means, medical providers of all sorts, ranging from abortion providers to prenatal-care specialists, will be wary of performing any prenatal medical procedure that could reveal the sex or race of the fetus, jeopardizing the health of women and their pregnancies. And the reporting requirement, which forces all medical staff to report "suspected" violations of the act under penalty of imprisonment, will only feed the environment of distrust and suspicion between not only doctors and their patients, but also among medical providers. In short, the bill makes all legal and safe abortions fraught with potential peril for both women and their providers – the result of which would be diminished health services for women and their pregnancies.

The World Health Organization and other U.N. agencies studying the issue of sex-selection concluded that reducing and restricting access to technologies that, among other things, allow for sex determination, are "likely to result in a greater demand for clandestine procedures which fall outside regulations, protocols and monitoring. Discouraging health care providers from conducting safe abortions for fear of prosecution thus potentially places women in greater danger than they would otherwise face."[15]

Particularly galling is the impact that the bill would have on women of Asian descent and African-American women. As noted above, both of these groups already face significant challenges to accessing healthcare; it is unconscionable for Congress to consider a bill that would present a further obstacle.

Finally, the bill threatens women's health and lives – at the expense of the health of a fetus. Incredibly, the bill permits sex-selective abortions when necessary to safeguard the life or health of the "unborn child," – but contains no such exception to safeguard the life or health of the woman. This is not only patently unconstitutional, as noted above, but is also morally reprehensible.

IV. International Experience Demonstrates that the Best Way to Address Sex Selection is by Remedying the Underlying Discrimination that Leads to Son Preference

A. There Is an International Consensus Against Criminal Bans on Sex Selection

The United Nations has a tremendous amount of experience addressing sex selection through its work in countries where sex selection is far more common than in the United States, such as India, China, and South Korea. The international consensus, based on years of study, is that the most effective way to address son preference is by fighting the root economic, social, and cultural causes of sex inequality.

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[15] World Health Organization, *Preventing Gender-Biased Sex Selection* (2011), at 6, *available at* http://whqlibdoc.who.int/publications/2011/9789241501460_eng.pdf.

The bill misleadingly states that the UN Commission on the Status of Women has urged governments "to take necessary measures to prevent…prenatal sex selection." In fact, the Commission's Agreed Conclusions call on States to "[e]liminate all forms of discrimination against the girl child *and the root causes of son preference*..." In 2007, the U.S. delegation even withdrew its own resolution proposing a criminal ban on sex selection after realizing that other countries' experiences demonstrated that such bans were counter-productive.

B. International Experience Demonstrates that the Best Approach Is to Address the Social and Economic Factors that Lead to Son Preference

Earlier this year, the leading United Nations agencies working to address gender-based sex selection – the World Health Organization, UN Women, UNICEF, the UN Population Fund, and the Office of the High Commissioner for Human Rights – released a joint statement, "Preventing Gender-Biased Sex Selection." These five UN agencies all agreed that laws seeking to prohibit sex-based abortion – like the proposed Prenatal Nondiscrimination Act – are counter-productive because, as noted earlier, they jeopardize women's health.

Rather than focus on a prohibition, nations around the world are realizing that an effective response should focus on the root causes that lead women and men to value sons over daughters: "there is wide agreement that the causes of biased sex selection lie in gender-based discrimination, and that combating such discrimination requires changing social norms and empowering girls and women."[16]

Efforts to eliminate sex and race discrimination, alongside educational efforts, have been shown to be effective. For example, in South Korea, the government successfully lowered the male/female ratio from a whopping 116 in the 1990s (a more unbalanced ratio than China has today) to 107 in 2007 by passing laws that made fundamental improvements to women's legal status and by launching a "Love Your Daughter" media campaign.

V. Conclusion: Lawmakers Should Address Discrimination Through Passage of Civil Rights Legislation, Not by Hampering Access to Needed Health Services

The Prenatal Nondiscrimination Act is, in reality, a cynical and disingenuous ploy by anti-choice lawmakers to hijack the language of sex and race discrimination to advance an extreme bill that aims at reducing women's rights, rather than empowering them to address the inequities in their lives.

Lawmakers should reject this bill, which will only jeopardize women's health, and instead embrace real efforts to eliminate sex and race discrimination and address disparities in access to health services.

[16] *Id.* At 7.

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December 20, 2011

Honorable Trent Franks
U.S. House of Representatives
Washington, DC 20515

Dear Representative Franks:

While we generally are pleased to have the reports of our Ethics and Practice Committees used to help inform policy makers, we feel we must correct the record as to how our Ethics Committee Report on Gender Selection (Sex Selection and Preimplantation Genetic Diagnosis) is misrepresented in HR 3541.

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. 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.

We would ask you to correct this misrepresentation of our report in the bill.

Sincerely,

Robert W. Rebar

Robert W. Rebar, MD
Executive Director

cc: Rep. John Conyers, Jr.