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SELECTIVE ABORTIONS

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Why this Gazette

The Asia Safe Abortion Partnership is the only safe abortion rights advocacy network in Asia. Founded in 2008 it has members from over 20 countries across South Asia, South East Asia, South West Asia and the Oceania region.

As new members and partners join the safe abortion rights' movement we realized that there are hardly any collated or curated resources that they can engage with in order to gain a deeper understanding of some of the key issues or challenges in this work.

There are search engines and journals and many websites dedicated to safe abortion rights information and even services which people can access. However, there is no dedicated space where you can get a snapshot of a core topic within safe abortion rights that can offer someone the highlights of the scope of the issue and a range of perspectives that are relevant to us as a movement.

In order to address this gap, we have launched The Abortion Gazette.

This will be an immersive repository for a reader who would like to learn more on the landscape and depth of the issue in a relatable and practical way without having to search through pages and pages on the internet and sifting through multiple sources.

It will be a short quarterly publication and will include lead articles, clinical updates, thought pieces, interviews, statistics and of course links to other key articles, videos and other relevant material. It will be published on the ASAP website as a pdf that can be downloaded and printed for use by anyone in the safe abortion rights movement. For those who would like to engage in deeper learning and a structured program, stay tuned for more updates!

Editorial

By Suchitra Dalvie

Even within the sexual and reproductive health and rights movement, where the right to choice and systemic justice are the critical pillars to ensure autonomy, agency and self determination, one topic continues to be a grey zone, a landmine & a faultline. We stumble over this even as passionate defenders of the right to safe abortion or as liberal policymakers.

Do we believe that 'every pregnant person has the right to choose to terminate an unwanted pregnancy.'?

Is this a complete sentence? Or is it 'every pregnant person has the right to choose to terminate an unwanted pregnancy, unless/ except for/ within etc.'?

If we accept, believe and defend the position that every and any pregnant person has the right to choose to terminate an unwanted pregnancy, should there ever be any conditions set upon what is an agreeable reason for it to be unwanted?

Who decides which choices are ok or comfortable or acceptable?

You? Me? The service provider? The demographers? The marriage bureau? The government? The W.H.O ?

Once we start imposing our moral or demographic agenda onto the pregnant person's body, our political stance is only a few degrees of separation from that of the anti-choice folks!

Basically if you say "YES, every pregnant person has a right to choose to terminate an unwanted pregnancy..... unless it is because of ABC reasons (reasons which make me uncomfortable or upset or are not for the greater good etc etc)..... are you still truly pro- choice, pro- rights, pro- reproductive justice?

If abortion itself is a selection out of the assumed natural progression of a pregnancy towards a delivery, then why do we baulk at the idea of any further selection within this choice?

Selective abortion is an abortion carried out not just because the pregnancy was unwanted, but because it was unwanted for a very specific, subjective, personal reason. It could be that the woman or pregnant person does not want to have another daughter (or rarely, another son). Or the woman or pregnant person does not wish to have a baby born with disabilities.

While there are valid arguments that these choices represent discrimination, why are we unable to accept that the lived reality of the quality of life of the mother or parent is something only they have to face and therefore only they can make a reasonable choice?

As a safe abortion rights movement we need to be aware of these faultlines and zones of discomfort so that our agenda does not get hijacked and used against us by the anti-choice.

Another important angle in this discourse is that 'Sex selection' can happen post birth also and doing sex selection pre conception does not eliminate the discrimination –just the abortion!

Instead of asking ' How do we stop selective abortions?" we need to ask " Why are people making these choices?". Selective abortions will remain a crucible for us as a safe abortion rights movement in which we will need to burn away the judgment and prejudices until we are genuinely left with the clarity that yes, 'every pregnant person has the right to choose to terminate an unwanted pregnancy' is a complete sentence!!

A difficult conversation: Safe Abortion and Sex Selection in Nepal

By Shreejana Bajracharya,
YSERHA Nepal, Guest Editor

The termination of a pregnancy only because of the sex of the fetus is a strongly gendered and ethically controversial phenomenon. While the right to safe abortion is inherent in bodily autonomy and dignity, the way son preference and patriarchal norms intersect with this right renders the conversation difficult, especially in Nepal.

WHY DOES SEX SELECTION OCCUR?

Son preference in Nepal is of patriarchal origin. Sons are expected to perpetuate the family line, care for parents in old age, and perform death rituals— greatly esteemed roles for the majority of Nepali families. Daughters, however, are considered economic burdens due to dowry requirements, patrilocal marriage traditions, and social conventions limiting their independence.

This cultural bias leads to sex-selection. In 2016, a CREHPA study found abnormal sex ratios in districts like Arghakhanchi, Mahottari, and Kathmandu, where families having one or more daughters chose to terminate a pregnancy when they found out the sex of the fetus.

THE CONSEQUENCES FOR WOMEN

Although these practices have their roots in social pressure, women are the ones who bear the brunt of such decisions. A mother expecting a second or third child typically endures emotional, social, and economic consequences:

- Family pressure: Women are pressured by their husbands and in-laws to produce sons.
- Abuse and abandonment: In some cases, giving birth to daughters can lead to domestic violence or even expulsion from home.
- Autonomy loss: Women may want to proceed with the pregnancy but are forced into unwanted decisions.

Thus, in patriarchal societies, women are denied both the right to choose and blamed for decisions made under force.

SAFE ABORTION RIGHTS AND THE POLITICAL CLIMATE

Nepal decriminalized abortion in 2002 as part of the broader Safe Motherhood and Reproductive Health Rights program. Under the law, abortion is permissible up to 12 weeks into pregnancy, or 18 weeks in cases of rape or incest.

Abortion based on the sex of the fetus is prohibited to prevent gender discrimination and correct sex ratio imbalances. While this is important, it's equally essential to ensure that such laws do not become a barrier for women and girls seeking safe and legal abortion. Reproductive rights and choice must be protected alongside efforts to promote gender equality. Its application, nevertheless, has generated gray zones and perverse consequences. Safe abortion services are withheld by health providers for fear of being charged with complicity in sex selection. Women who seek abortion—regardless of the reason—are interrogated, delayed, or denied.

This undermines the whole purpose of legalizing abortion: for safety, dignity, and access. In this case, we must be absolute: if safe abortion is a legal right, its access may not be limited on the grounds of hypothetical grounds like potential sex selection. The woman's reason is her own, and her rights may not be contingent upon proving moral worthiness.

REVISITING THE ROLE OF THE LAW

Sex selection laws are meant to reduce discrimination but, paradoxically, end up reinforcing patriarchal control. If the underlying gender bias in society is not addressed, legal restrictions will ultimately police women rather than protect girls.

To ensure that legislation protects both reproductive rights and gender equality, we must:

- Enhance enforcement of gender equity laws—such as inheritance and property rights for daughters—so that families value girls as much as sons.
- Educate health providers to offer non-judgmental, rights-based abortion services.
- Raise awareness at the community level about the consequences of son preference and the value of daughters.

WHAT CAN BE DONE?

To prevent sex selection without banning safe abortion access, we need to tackle the underlying causes—gender inequality, not abortion. This includes:

- Shifting social norms: Programs like 'UNICEF's Rupantaran' in rural Nepal empower girls through education, mentoring, and life skills, and show concrete progress in shifting mindsets.
- Protecting and expanding access to abortion: Laws on **sex-selection and safe abortion** should not be invoked to restrict women's legal rights to access abortion for other indications.
- Prioritizing women's lived experience: Consider the real impact on women who are forced to carry pregnancies due to patriarchal pressure. Their voices must guide our policies and legislation.

IN CONCLUSION

Sex selection is a symptom—and not a cause—of patriarchy. Restricting it by limiting abortion only continues to propagate harm. The solution does not lie in controlling women's choices, but in uprooting the systems that limit them.

We must end gender discrimination, not women's reproductive freedom.

We can end the injustice of sex-selection and ensure access to safe, respectful, and rights-based reproductive healthcare only when our laws, healthcare systems, and societies value all genders equally and recognize the reproductive rights of everyone who can become pregnant.

Selective abortion: A choice? A right? A justice issue?

By Ayesha Bashir, Communications & Networking Manager, ASAP

Highlights of a conversation with **Manisha Gupte**, *PhD, who co-founded of MASUM, a rural feminist organization in 1987. She has participated in the campaign against sex determination tests in the 1980s and has been involved in policy making around the issue at state and national level. She has been active in intervention and advocacy around people's rights to safe abortion and is a globally respected leader and mentor in the gender and rights movement.*

To read the complete interview, visit this link.

"In the 1970s there were many progressive movements worldwide and in India. All movements, whether they were against racism, Dalit rights movements, the Black Panther movement, the Dalit Panther movement, peasant movements or the feminist movement—all of these supported each other.

I was part of a non-party political group where we also fought for land rights and women's equal access to land. So the women's question was taken up, economic questions were taken up, issues of violence—state violence, rape by the police, any kind of sexual assault by the police. So both state and family violence were taken up. While we had an understanding of class and caste consciousness, feminism gave us the lens to see patriarchy operating within all these structures—whether it's pluralism, capitalism, or imperialism. It allowed us to apply the lens of gender inequality inside and outside the house. That was the feminist movement of the 1970s: extremely rich, vibrant, and thrilling.

Now, about the connection with the abortion rights movement. Largely, that was my engagement with the global women's health movement. In India, we didn't really need to discuss abortion very much because in 1971–72, we got a fairly liberal Medical Termination of Pregnancy Act, which was before we had got our act together. We were organizing in the mid-to-late 70s.

So really, we didn't need to discuss abortion.

Things changed in the 1980s when we started consolidating the campaign against discriminatory sex determination tests in India, we were also campaigning against population control. We were also campaigning against dangerous and invasive contraceptives being used in the Indian family planning program.

We were also very upset about the fact that all of women's health was relegated just to maternity. Basically, after women had two children, they just dropped off the public health train. Nobody cared for them because the tubectomy was done.

We woke up to the sex determination issue from two or three different angles. One was hoardings coming up in Northern India: "Better 5,000 now than 50,000 later" or "five lakhs later." Spend this much money now so that you don't have to spend on dowry.

Son preference has always been there, right, in our cultures? It's been there all over the world. I mean, even the throne of England, right? It's the first-born son that would inherit the throne. Or princesses were married to princes of other countries to keep peace or expand empires.

But here the girls were seen as a burden, not just economically but also culturally. So you might have three sons, but the daughter brought "dishonor" (in quotes) to the family with her behavior—

if she decided to marry someone, if she got pregnant, if she was even sexually abused, or if she didn't stay in the house of a violent husband and came back to her natal family.

The whole issue—patriarchy's mystery lies in the womb. In which womb does whose seed go? That is the basic question. It's a question of the seed, right? Whose seed is there?

And that unwanted seed in the womb of your community, your family, or your religion brings dishonor not only to the person but also to the family, to the community, and to the entire caste and religion.

So patriarchy exists, and therefore it's son preference and daughter-unwantedness. Earlier, it was more mumbo-jumbo—say this prayer, give this offering to the god, all kinds of rituals. It was all mumbo-jumbo. But now these tests actually help you make it happen.

For the first time, there was a scientific way in which you could choose a son and not have a daughter. And that's what everybody was doing—and was proud of it. Everybody wanted to know about how those tests worked.

I've spoken—I can't even count—at least 200, 300 places during the sex determination campaign. We were booed many times—outside Churchgate railway station, in colleges, wherever. "You're anti-science. You're anti-development. You're anti-doctor. You're anti-woman. You're anti-national." So many things. "Anti-technology. Anti-science." All of those labels were put on us.

Similarly, selective abortion based on *disability* was seen as okay—because we weren't hearing from the disability rights movement in the 80s. They were not yet organized in the same way.

So that's the context we need. To keep abortion a right, while making space for more people to be part of the conversation. And when you open the door to more people, *some* politics will get diluted. That's the job of an astute campaigner—to be conscious of history, of broader socio-political systems, of cultural realities. We have to keep re-examining our positions—not get so attached to what *we* did, and yet not be ashamed of movements that took place in different contexts.

Can we ever expect a *feminist* state? Not really. The state itself is patriarchal. When conservatism becomes national policy—everything gets worse. So we ask: should reproductive rights be seen as *individual* rights? Or should we be talking about reproductive justice?

And everyone who's worked with marginalized or subordinated communities knows—the contradictions are real.

Because for many people, especially the poor, Dalit, Adivasi, Black, queer, disabled, immigrant, or stateless—having a right written on paper doesn't mean much if it doesn't show up in your material conditions. That's why reproductive justice goes beyond abortion or contraception—*it's about what kind of life you can live*.

The goal should never be just stability. It should be liberation.

And liberation means asking uncomfortable questions not just about how many people exist, but which people get to live with dignity, and who gets to decide."

Beyond Blame: Why safe abortion is essential to gender justice

By Nikki Agarwal, ISAY, India

In India, the conversation around sex-selection is loud and loaded—but too often, it drowns out a quieter crisis: the shrinking space for safe, stigma-free abortion care.

As a medical student and youth advocate, I've seen firsthand how societal judgment and legal suspicion bleed into public healthcare settings. In government hospitals, women,—especially those already parenting daughters,are treated less like patients and more like suspects.

The unspoken assumption? That they've broken the law, undergone illegal sex determination, and now seek to erase the evidence.

This assumption-based care is more than just disrespectful—it's dangerous.

It delays critical services and denies women their autonomy. Providers, unsure of where legality ends and moral judgment begins, err on the side of refusal. Even when abortion requests fall squarely within the scope of the MTP (Medical Termination of Pregnancy) Act, fear of legal backlash leads many providers to turn women away.

A LEGAL MAZE THAT EVEN MEDICS DON'T UNDERSTAND

Through our workshops based on *The Abortion Curriculum*, developed by *us*, we've worked with over 560 medical students across India to unpack the laws that govern abortion and prenatal diagnostics: the MTP Act and the PCPNDT (Pre-Conception and Pre-Natal Diagnostic Techniques) Act.

What we've found is troubling.

Even among future doctors, confusion runs deep. Many still believe that abortion is criminalized under the PCPNDT Act—a law that actually targets sex-determination practices, not abortion itself. This mix-up shows just how urgent it is to reform medical education.

If tomorrow's healthcare providers can't confidently navigate these laws, how can we expect today's patients to safely access their rights?

RECLAIMING THE NARRATIVE

There's no question that son preference and sex-based discrimination are deeply rooted in patriarchal values. But we can't ignore how the State's response—through restrictive policies and moral surveillance—has only added fuel to the fire. Instead of addressing discrimination at its source, the system has made vulnerable women bear the cost of reform.

When laws meant to protect become tools to police, women go quiet. And when safe abortion access is compromised, they don't stop needing it—they're simply pushed into riskier, hidden alternatives.

Our work isn't just about legal literacy. It's about building a culture of empathy and protection of rights. We don't see safe abortion as the enemy of gender justice—**we see it as a cornerstone of it.** Reproductive rights are not separate from the fight against patriarchy; they are central to it.

To truly combat sex selection, we must stop punishing women for choices they make under pressure—and start dismantling the pressures themselves.

Silence and fear upholds patriarchy. Safe abortions are the tools to dismantle it!

Youth voices for choice: Addressing Sex Selection and Safe Abortion in Nepal

By Asika Ghemosu, YSERHA Nepal

In Nepal, the issue of sex-selection and safe abortion is not just a reproductive health concern, it's a reflection of deeply entrenched gender inequality. While our abortion laws are among the most progressive in South Asia, permitting abortion up to 12 weeks on request and up to 28 weeks under specific conditions, legal provisions alone cannot dismantle the social norms that fuel gender-biased practices.

As young advocates in YSERHA, the youth-led advocacy network of the Asia Safe Abortion Partnership (ASAP), we recognize that sex-selection is rooted in patriarchal systems that undervalue daughters. Families often associate sons with financial security, family lineage, and social status, while daughters are seen as liabilities due to dowry, inheritance practices, and limited societal opportunities.

These discriminatory beliefs create impossible situations for women, particularly in rural or marginalized communities, who face pressure to bear sons, shame when they have daughters, and judgment if they seek abortion services, even where abortion is legal, stigma, misinformation, and fear of being accused of sex selection lead to denial of care or drive women toward unsafe alternatives.

WHAT WE'RE DOING AS YOUTH ADVOCATES

At YSERHA, we believe young people must be at the forefront of creating a future rooted in equality, dignity, and choice. Our advocacy efforts center around:

- Through community dialogues, school programs, and peer education, we engage young people to question harmful narratives that place greater value on sons than daughters.
- We raise awareness about Nepal's abortion laws and the rights they provide. Safe abortion is a *right*, and access to it should not be compromised by suspicion, shame, or fear.
- We advocate for solutions that target the root causes of son preference, not by restricting abortion services, but by promoting gender equity in education, property rights, and economic opportunity.
- Through social media campaigns, youth storytelling, and myth-busting infographics, we're working to normalize conversations about reproductive rights and reduce the stigma surrounding abortion.

WHAT NEEDS TO CHANGE

Even with progressive policies, the implementation gap is wide. To protect women's rights and ensure equitable access to reproductive healthcare, Nepal must:

- Invest in youth-friendly, stigma-free healthcare services.
- Train providers to offer non-judgmental care regardless of a woman's reproductive history.
- Address the underlying cultural and economic pressures that lead families to prefer sons.
- Strengthen gender-sensitive education at all levels.

OUR CALL TO ACTION

As the youth of Nepal, we are not only witnesses to this injustice, but we are agents of change. We call on our peers, policymakers, and communities to stand with us in demanding a future where all children are valued equally, and all women can access reproductive healthcare safely, legally, and without fear.

More laws = Less selective abortions? Analyzing the Vietnam story

By Thuy Mai and Shaun Kavanagh

The issue of selective abortion in Vietnam has been shaped by a complex interplay of legislative actions and societal attitudes towards reproductive healthcare and gender inequality.

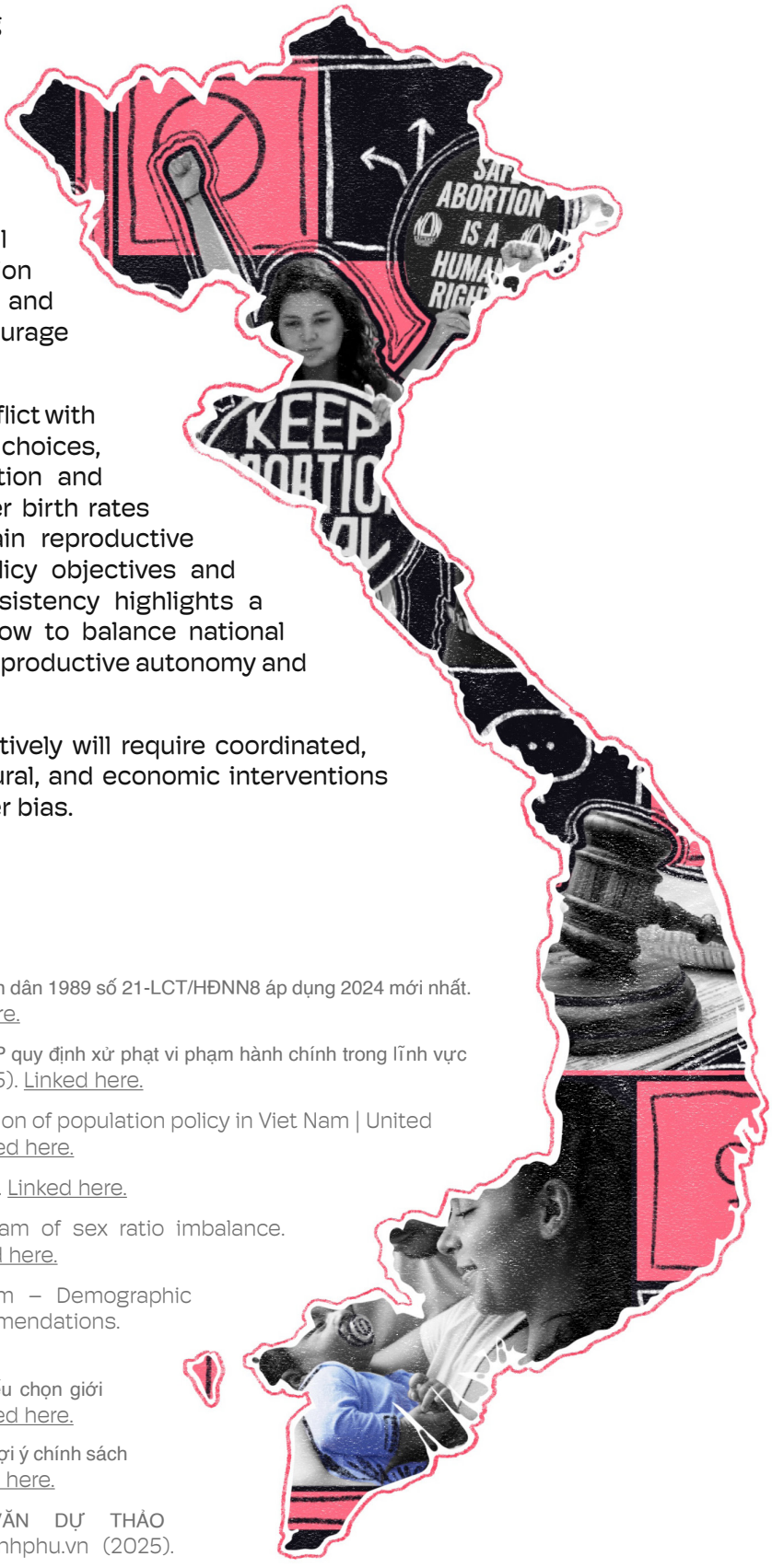
Since 1989, Vietnam has maintained relatively liberal abortion legislation, permitting terminations up to 22 weeks of gestation while specifically prohibiting sex-selective procedures. This legal framework operates within a broader population control architecture, including subsidized contraceptives and abortion services. Particularly, the Party's Resolution No. 4 on Population and Family Planning, established in 1993, marked the first formalization of the one-to-two child policy aimed at controlling population growth.

While these policies aimed to address demographic pressures and promote gender equality, they inadvertently created conditions that exacerbated selective abortion practices driven by societal son preference. For example, despite national prohibitions, such procedures account for an estimated 11.8% of total terminations, averaging 21,790 cases annually between 1999 and 2009. As of 2025, approximately 112 boys are born per 100 girls, significantly exceeding the natural range of 104–106.4,5 This sex ratio at birth leads to a shift in the adult sex ratio, which is being projected as affecting individuals' relationships, broader societal stability, and heightened social tensions.

Recognizing that current regulations have not sufficiently curbed these practices, policymakers are now considering significantly harsher penalties as part of an evolving, enforcement-driven policy response without looking deeper into the root cause of such choices. Under existing law, Vietnam prohibits fetal sex disclosure and imposes financial penalties of up to USD 800 for medical providers, along with possible license suspensions. To strengthen deterrence, the Ministry of Health has proposed increasing the maximum fine to approximately USD 3,800, a huge increase.

However, this enforcement strategy has raised questions about effectiveness and potential adverse consequences. For instance, increased penalties could drive demand toward unregulated providers, elevating health risks and associated costs. Additionally, substantial fines may disproportionately impact lower-income populations while allowing wealthy families to continue discriminatory practices, thereby exacerbating rather than addressing underlying inequalities.

At the same time, Vietnam's declining fertility rate has introduced a new layer of policy tension that intersects with the issue. As the country's total fertility rate fell from 2.11 children per woman in 2021 to 1.91 in 2024, the government has proposed several measures under the draft Population Law, including financial incentives and extended parental leave to encourage larger families.



However, these efforts appear to conflict with ongoing restrictions on reproductive choices, particularly those related to abortion and sex determination. Promoting higher birth rates while continuing to penalize certain reproductive decisions creates confusion in policy objectives and undermines coherence. This inconsistency highlights a broader governance dilemma on how to balance national demographic goals with individual reproductive autonomy and gender equity.

Addressing selective abortion effectively will require coordinated, multifaceted, sustained social, cultural, and economic interventions that target the root causes of gender bias.

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Selective abortion in China: From gender and fetal health preference to survival rationality

By Yu Yang, ASAP Steering Committee member, China

In 2023, China's newborn sex ratio dropped to 108.3 males per 100 females, a significant decline from its 2004 peak of 121.2.

While this statistic is often celebrated as a victory against gender-based selective abortion, a deeper structural shift is also underway.

As traditional son preference fades, economic pressures, soaring marriage costs, and generational conflicts are reshaping reproductive choices, transforming selective abortion from a gender-driven decision to one rooted in survival rationality.

POLICY, ECONOMICS AND CULTURAL ENTRENCHMENT

The prevalence of gender-selective abortion in China's early days was the result of the interweaving of multiple factors. The one-child policy (1980–2015) strengthened families' pursuit of "quality" through restrictions on the number of children born. With limited resources, boys were favored due to their traditional ethical and economic values. In rural areas, men were regarded as the core for the continuation of family labor and old-age security. Systems such as land distribution and clan inheritance further consolidated this concept.

At the same time, the popularization of ultrasound (B-ultrasound) technology made it possible to identify the gender of a fetus, giving rise to a gray industrial chain of "selective abortion."

Although the state explicitly prohibited gender identification and abortion without medical necessity in 2002, loopholes in law enforcement and ineffective supervision of primary healthcare led to limited policy effectiveness.

THE RESULT OF TRADITIONAL POLICY AND MODERN REALITIES

The one-child policy resulted in a 'surplus' of approximately 34 million men. Today, these men face intense competition in the marriage market. In rural areas, "sky-high bride prices" now exceed 300,000 yuan, prompting some counties (e.g., in Henan Province) to cap dowries at 50,000 yuan through official regulations. Meanwhile, the proportion of urban women actively choosing singlehood has risen from 6% in 2015 to 17% in 2023 (Fudan University survey), dismantling traditional marriage dynamics.

Paradoxically, the easing gender imbalance has not reversed China's fertility crisis. In 2022, births fell below 10 million, with a total fertility rate of just 1.09. A 2023 National Health Commission report revealed that 43% of abortions are now driven by financial stress—surpassing those due to fetal health concerns (37%) for the first time.

This marks a pivotal shift: selective abortion is no longer primarily about gender preference but about economic survival.

MARRIAGE AND PARENTHOOD AS LUXURY

As marriage transitions from a "necessity" to a "luxury," young Chinese are applying economic logic to family planning. A viral social media post titled Cost-Benefit Analysis of Marriage and

Childbearing calculates the net present value (NPV) of raising a child at -820,000 yuan. Behind this cold math lies the crushing weight of modern China's "three new mountains": housing, education, and healthcare.

- Raising a child in cities like Beijing or Shanghai costs over 1 million yuan by age 18 (Yuwa Population Research Institute, 2023).
- School district housing near top-tier elementary schools carries a 57% price premium, fueling cutthroat competition among middle-class families.
- Under the 996 work schedule (9 a.m.–9 p.m., six days a week), 70% of dual-income households rely on grandparents for childcare—a support system collapsing under rapid aging.

For many, selective abortion has become a pragmatic "stop-loss strategy" to avoid downward social mobility. A stark divide separates older and younger generations. While parents cling to the belief that "more children mean more blessings," young adults voice resistance on social media platforms like Douban's "Anti-Marriage, Anti-Parenthood" group: "We don't hate children—we refuse to pass on systemic struggles in a high-risk society."

DISABILITY SELECTIVE ABORTION

Currently, China allows the termination of pregnancy for fetuses with severe congenital defects for medical reasons. According to the Maternal and Child Health Care Law and local regulations, after a group of experts diagnose and confirm that a fetus has "major genetic diseases or severe physical defects," families can legally choose to have an abortion.

Although there are no national statistical data, the popularization of prenatal screening technology has significantly increased the termination rate of fetuses with defects. In 2023, China's birth defect rate has dropped to 2.5%-3%.

However, this "preventive abortion" has sparked ethical controversies: On the one hand, it is regarded by the official as a necessary means to "reduce congenital disabilities and alleviate the burden on families and society." On the other hand, disability rights groups criticize its implicit "eugenics" tendency, which devalues the lives of the disabled.

Social surveys show that Chinese families' choices regarding fetuses with defects highly rely on economic rationality. The average annual treatment cost for a child with hemophilia in a family is 100,000-150,000 yuan (equivalent to about $13,600-$20,400), far exceeding the affordability of rural families, forcing parents to choose to terminate the pregnancy to avoid "falling into poverty due to illness."

This "survival rationality" is consistent with the logic of gender-selective abortion—when childbearing is regarded as a high-risk investment, any factor that may reduce the "rate of return" (including fetal health) may be eliminated.

CONCLUSION

China's selective abortion debate now reflects broader societal transformation. Addressing it requires more than condemning gender bias or discrimination against people living with disabilities. Instead, the focus must shift to systemic reforms: affordable housing and healthcare system, equitable workplaces, and robust social safety nets.

Only by reducing the existential risks of parenthood can China rebuild a society where ordinary people feel empowered to embrace life's uncertainties.

The History of Sex-Selective Abortion in South Korea and the Importance of the Reproductive Justice Movement

By Na Young, Steering Committee Member of ASAP; SHARE, center for Sexual rigHts And Reproductive justicE

In South Korea, it is believed that when a woman is pregnant, she, her family, or acquaintances dream of her pregnancy. One day, my mother told me about a dream she had when she was pregnant with my younger sibling.

She went out to hang laundry in front of the house, and grapes were on the wall. All the other grapes were purple, but one was black, so my mother picked that grape. But then her father-in-law came and said, "You always pick such ugly things." Yes. That grape was my younger sister.

My mother had always been under pressure from her family-in-law members that she must not let the family's lineage end. I was the first granddaughter, so it was okay. However, it was not okay for the second granddaughter. My in-laws and sisters-in-law often harassed my mother. Deprived of her freedom and suffering from depression, my mother confirmed that her third pregnancy was a female fetus and had an abortion.

And a few years later, she got pregnant again. She couldn't get an abortion again, so she gave birth to a girl again. Under pressure to have a boy, my mother got pregnant again after her third baby, and it seemed to be a girl again. One day, while she was crying in frustration, a neighbor who went to the same church came to visit her and said she knew a hospital and would go with her. My mother asked her sister-in-law to take care of me and my siblings for a while, and went to the hospital and had an abortion without telling anyone. When she returned home with the anesthesia still in effect, her sister-in-law got angry that she had a hard time taking care of us, and for a month after that, she didn't say anything and tormented my mother.

Sadly, the story didn't end there. When I was twelve, my mother found out that my father had been seeing another woman for seven years. What was even more shocking was that my father-in-law also knew about it, but he tolerated their relationship because he wanted a son.

This story is not unique to my mother. Many women in Korea experienced this until the 1980s. The pressure to continue the family lineage forced them to have sons, and if they failed to have sons, they were ignored and abused. Many of my friends were the fifth or even the eighth daughter, because their mother kept getting pregnant until they had a son.

Many of those women lived in poor families, so having daughters and adding a financial burden to the family was an even heavier burden. Since the conditions for success in society were all favorable for men, if they had sons,they would send them to college at great expense because the family would succeed through their sons.

But they did not expect educational achievement or success from daughters. Rather, they thought that marriage meant becoming someone else's family, so they hoped that their daughters would earn money for a short time before marriage to help the family's finances, and that they would help the family through marriage afterward. In many families, most daughters did not receive education beyond middle school or high school, and they had to start working early and use the money they earned to pay for their brothers' tuition.

In this context of this strong and violent patriarchal system, many women who became pregnant

with their daughters went to the hospital alone to have an abortion.

Meanwhile, the Korean government implemented a birth control policy starting in the 1970s. The logic was that if the population increased, the country would become poorer, and if it became poorer, more people would sympathize with communism, making it vulnerable to attacks from North Korea and communist countries.

In return for reducing the population, Korea received aid from first-world countries such as the United States. The more successfully the population was reduced, the more aid it could receive from the United States, and this was closely related to Korea's economic growth project in the 1970s and 1980s.

Even though Korea already had a "crime of abortion" clause in its Criminal Act, to make this plan successful, the Korean government created a legal justification by inserting a very restrictive and discriminatory clause for abortion into the "Mother and Child Health Act" in the 1970s. Then, it placed family planning agents throughout the country and performed sterilization and unofficial abortion procedures using "health vehicles."

Most obstetrics and gynecology hospitals performed unofficial abortion procedures, taking advantage of the situation where it was officially illegal, but the government did not necessarily crack down on it. There was no guarantee of health issues or safety related to the procedure or its aftereffects.

'Sex-selective abortion' carries a great ethical stigma among abortions.

Sometimes, abortion is understood as an 'inevitable' choice due to socioeconomic circumstances or health issues, but abortion simply because the fetus is not the desired sex is considered an even more unethical and selfish choice. However, we must remember that the context of 'sex-selective abortion' is already intricately linked to the patriarchal structure in which the woman is.

No abortion is done separately from the social structure.

That is why we need a perspective and movement of 'reproductive justice' that goes beyond the 'life versus choice' framework.

In February 2024, the Constitutional Court of Korea ruled unconstitutional the 'Fetal Sex Selection Prohibition Act', which was enacted in 1987 to prevent sex-selective abortion. The Constitutional Court ruled that the provision of the Medical Act that prohibited medical professionals from informing pregnant women or their families of the sex of the fetus before 32 weeks of pregnancy is unconstitutional. The Constitutional Court stated the reason for its decision as follows: "With the improvement of women's socioeconomic status, awareness of gender equality is becoming more established, and due to changes in the values and consciousness of the people, the preference for male children, which is an influence of traditional Confucian society, is declining."

The sex ratio at birth, which means the ratio of male children per 100 female children, reached 116.5 in 1990, and soared to 193.7 for third children or more, but in 2014, the sex ratio for third children also fell to 106.7. In effect, the tendency to prefer male children has disappeared.

The historical context related to sex-selective abortion in Korea shows the importance of the direction of the reproductive justice movement that confronts injustice together against the stigma that places abortion solely on the ethical responsibility of women's choice.

I hope that we can uncover more of the structure of injustice in this society and confront it together through the stories of more women that we have not been able to reveal so far.

Compilation of quotes from the assignments for the ASAP Academy Selective Abortion module in the Advanced Course

Sign up for the Academy from here:

Amalia Puri Handayani, Indonesia:

> Women and pregnant people have rights to know what happens in their bodies, including if they want to determine the sex of the fetus for whatever reason. We must trust women and pregnant people's decision if they want to have safe abortion whether it's female or male fetus because they know what could have happened if they continue with the pregnancy. They might experience violence and it might be part of protecting themselves. Anyway, for whatever reason, if they want to have an abortion, then it needs to be supported. We trust their decision.

Some people would argue that women and pregnant people who want to terminate the pregnancy because of sex selection is internalized the patriarchy norms and continuing the pregnancy is part of being resistance. But, it's their body, they have agency towards their body. Women and pregnant people know the struggles that they might carry. It is not internalized the patriarchy norms, having abortion of sex selection is part of being resistance and survival in this patriarchy world.

It is the same with banning access to safe abortion if it is for disability reasons. It is not addressing the root cause, which is that we live in an ableist system.

When Suchitra mentioned that there is no infrastructure and facilities ready in many countries for people who live with disability, I remember about techno justice. I first learned about this from Nissi, my dear feminist deaf friend from FeminisThemis Indonesia. Many technology tools, such as hearing aids, are made to force people to be able to hear. They do not facilitate the people with disability needs, but what ableist's needs. It makes it harder to have a quality of life for people who live with disability. It gives me more confidence that women and pregnant people must have access to safe abortion in order to protect their quality of life as well.

Even if the State has fulfilled their responsibility to provide inclusive infrastructure, but there is still more emotional labour to be a caregiver.

Ignatia Rosari, Indonesia:

> The real focus should be on transforming the conditions that make daughters unwanted—not merely banning sex-selective abortion.

In conclusion, we should be concerned about sex selection because it often reflects systemic gender inequality. However, we must avoid restricted women's choices for these reasons:

- We have no authority to judge which reasons for abortion are 'good' or 'bad'.
- Respecting women's decisions includes recognizing that, for some, it may be a way to resist or survive within a patriarchal society that punishes them for raising girls.
- The root problem is structural. Banning sex-selective abortion often leads to greater control over women's bodies, without addressing the social norms and systems that created son preference in the first place.

Nishadi Gunatilake, Sri Lanka:

“I think we should be bothered not by the practice of sex determination, but of sex selection. If people are getting to know the sex of the child they are expecting and not taking any action based on it, it’s not something that we should be concerned about, I feel. But sex selection at all stages, including postnatal, is an issue to be worried about. It provides a shortcut to deal with the larger problems of patriarchy: “You think girls suffer under patriarchy? Let’s keep the patriarchy but not bring forth girl children to suffer under that. Problem solved!” This kind of attitude demotivates people from advocating against oppressive instruments and norms of patriarchy.

Sangeetha Permalsamy, Malaysia:

“One reason why we should not be overly bothered is to embrace scientific advances that allow people to know the sex of the embryo way in advance, and for some, this helps them plan the kind of family they want. It gives people more autonomy over their life plans. So in that sense, being able to determine and select the sex of their child should be embraced as part of reproductive autonomy. The only thing we should be bothered by in this framing is how we can make this knowledge and option more accessible and available in a dignified manner.

I also think we should not be caught up in why people choose sex determination and selections or try to stop these people from doing this. It is still a personal decision. What is key is to why someone chooses to do it; their pathway to sex determination and selections. Is it because of pressure? Or because they feel they have no other choice? If it’s rooted in patriarchy, then that’s what we should be addressing, not just the act itself. The focus should be on making sure choices are really choices, not shaped by discrimination or inequality.

Isabelle Tan, Malaysia:

“Abortion and raising a child are both deeply personal choices that are influenced by the larger social, political and economical environments. Caregiving work within the family is done mostly by women and goes unpaid, and there is often little governmental support for disabled children. There is an added vulnerability if the woman is going through a divorce or faces domestic abuse and could completely lose spousal support. With these factors in mind, if a woman does not have the capacity to raise a disabled child (for any reason) and give them a life and loving family that the child fully deserves, then they have every right to non-judgemental access to terminate the pregnancy. As with any other type of abortion, it is the needs of the pregnant woman that should come first.

Mukta Kamble, India:

“A woman’s autonomy and agency must always be valued, especially because, as mentioned, it’s the government and systems that make already vulnerable people even more vulnerable, by not providing enough support to raise a child born with a disability.

This kind of discrimination also falls under the broader conversation around inclusivity and equality; the effort to create a world where everyone can exist with dignity and choice.

What makes the situation harder is the unequal distribution of resources. PWDs are often born into poorer families due to multiple factors. Denying access to abortion only adds more weight to this existing vulnerability, reinforcing the cycle of discrimination.

My thoughts are that women (inclusive of all) must always have the right to choose, under any and all circumstances. A woman’s decision must be upheld. And as rightly mentioned, disability is a social construct. It’s the government and systems that need to be designed in a way that doesn’t turn disability into a discrimination.

Tamara File, New Zealand:

> This segment sets out to challenge my beliefs, in fact this entire module has me examining and question what my personal morals and ethics are.

On the one hand the idea of a disability being a deciding factor for abortion seems discriminatory and unfair to people living with disability but on the other hand it is still an issue of the person's right to choose what is right for them.

I particularly resonated with the point about how our countries are not built for the differently abled and that our society doesn't provide assistance so the full care will fall to the mother and that alone is enough for me to cement in my mind that pro choice is pro choice no matter what the reason is.

I do not believe we make these decisions on a whim, it's not a matter of just popping out for a coffee and an abortion. I've seen enough women cry when finding out they are pregnant when they don't want to be, enough women stress about what they are going to do, enough people agonizing over if they can afford it, what they will have to give up to know that for me being pro choice is the only choice.

Selective abortions in India and the second trimester: What is the connection?

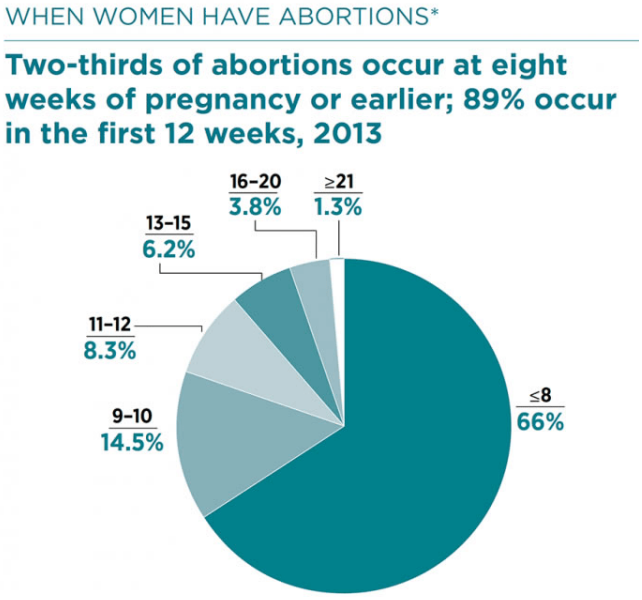
By Dr. Kalpana Apte, Director General, Family Planning Association of India; and Dr. Suchitra Dalvie, Coordinator ASAP & Consultant Gynaecologist

INTRODUCTION:

The literature on second trimester abortion in India is scanty, with accurate and disaggregated data difficult to obtain. Estimates of the number of abortions in India have always varied. The Shantilal Shah Committee, which reviewed abortion law and practice in the 1960s before the law was revised in India, estimated in 1964 that for every 73 live births, there were 15 induced abortions. In the mid-1990s, it was estimated that there were 6.7 million induced abortions per year in India.

The latest assessment conducted in 2015 jointly by the Guttmacher Institute and Population Council indicates 15.6 million abortions take place each year.

However, these estimates usually do not distinguish between first and second trimester abortions.



At the FPAI clinics across the country we have 36 facilities and on an average 320 women seeking abortions in the second trimester. Also, only 9 clinics are registered for and are providing second trimester services

While some second trimester abortions may have been preceded by sex determination, a 2006 study suggests that unintended pregnancy rather than the sex of the child underlies the demand for most of these abortions in India.

In one hospital in rural Maharashtra, 72.2% of induced abortions in unmarried women took place in the second trimester, as compared to 42.6% among married women. A similar observation was made in a case–control study in Chandigarh, in which 60% of unmarried women were second trimester abortion seekers, as compared to only 7% of married women.

For a woman the divide between trimesters is artificial. She has a pregnancy that she does not wish to continue to term.

So, what are the reasons for delay in seeking abortion that results in women coming to the facilities in the second trimester?

1. The woman's or girl's failure to recognise the pregnancy. This may occur when pregnancy follows sterilisation failure or during lactational amenorrhoea, when many women believe they cannot get pregnant or if there is rape or incest where the young girl does not understand what has happened.
2. Many women, even urban women, are unaware of the legal status of abortion and will often go to one or more unqualified providers first, and look for a doctor or hospital only when that fails or complications ensue.
3. Public sector hospital staff are insensitive and do not offer respectful care or privacy. To avoid these situations often women seek care in the private sector but need time to collect the money needed and also to negotiate the time and opportunity to travel to the clinic.
4. Women who are mentally challenged, institutionalised in remand homes or in prisons are in a vulnerable situation and may be victims of sexual abuse. A pregnancy may become obvious to them only in the second trimester. Migrant workers and housebound domestic servants may also find themselves in this situation.
5. Often, women or girls in these situations attempt to conceal the pregnancy until it becomes evident. This is most common in adolescents who are likely to be in denial or concerned about confidentiality issues, and unwilling to face the unsupportive attitudes and behaviour of providers until the pregnancy can no longer be hidden. This is also seen in women who are unmarried, widowed and separated, i.e. not in a socially accepted relationship.
6. If there is a relationship breakdown then women may seek abortion services at the time, which could be at any time during the pregnancy..
7. Many fetal anomalies are detected by ultrasound only in the second trimester and beyond.
8. As many as 41% of the women in the Southampton study said that they were unsure about having an abortion and therefore it took some time to make up their minds.
9. Over half the teenage women said they were worried how their parents would react, while 23 per cent overall said that their relationship with their partners had broken down or changed.

The Turnaway study found that those who had a first trimester abortion found out that they were pregnant at an average of five weeks after their last menstrual period, while those who had abortions at 20 weeks or later found out that they were pregnant at an average of 12 weeks after their last menstrual period. Both sets of individuals reported delays in finding out that they were

pregnant. They also found that those seeking a first trimester abortion and those seeking an abortion after 20 weeks both reported delays due to trouble deciding to end the pregnancy and disagreements with partners.

A 2008 study found several risk factors for delayed pregnancy testing, including obesity, substance abuse, previous second trimester abortion, and uncertainty about the date of a woman's last menstrual period.

Another very important reason why pregnancies need to be terminated in the second trimester or even beyond is maternal health issues.

Conditions that may threaten the life of the pregnant woman include (Source linked here):

- Severe preeclampsia
- Serious heart conditions.
- Cancer or other conditions requiring treatment that cannot be administered if the woman is pregnant.

Certain maternal health conditions, physical and mental, may also be identified in later pregnancy. Where universal HIV testing is carried out in antenatal clinics, often without pre-test counselling, many women who test positive receive the results in the early second trimester. These women are often abandoned by their husband and in-laws, as well as ostracised by the community. Under these circumstances they often choose to terminate the pregnancy.

A very important cause for a late decision is a change in circumstances. This may happen when the pregnancy may be wanted or not entirely unwanted, but where the ability to have the child depends on external factors such as continuing employment, financial stability and/ or partner support. Adolescents are unlikely to have access to enough money if costs are high. The public sector may not offer them the confidentiality, even secrecy, that they desire so highly, and which they may value even more than safety. In India, many adult women do not have money at their disposal to be used at their own discretion either. Incest and rape victims are likely to want to shut out the episode, and it may only be the growing pregnancy that brings to light the events.

CHALLENGES IN INDIA:

In India the Medical Termination of Pregnancy (MTP) Act, 2021 was a landmark amendment to the earlier Act (1971 and Amendments in 2002) which ensured legal access to an extended gestation till 24 weeks from the existing 20 weeks limit. It further expanded access to late terminations, even beyond 24 weeks, in cases of foetal malformations.

Unfortunately, this legal access has not become a reality for majority of women and pregnant persons. Second-trimester abortions account for 13% of all terminations in India, with regional variations influenced by healthcare access and socioeconomic factors.

Ironically the delays are often caused by reduced access to first trimester abortion and then second trimester abortions are even more difficult to obtain.

Almost all these access related challenges and barriers emerge from a single source – the quest to eliminate gender biased sex selection and balance the sex ratio (0- 6). This has resulted in stringent and overreaching implementation of other Acts like the 'Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 2003' and 'The Drugs and Cosmetics Act, 1940'; prosecution and stigmatization of Abortion Providers leading to a negative and fearful mindset amongst providers; and creating misunderstanding amongst communities that all abortions are illegal.

It is mistakenly assumed by different stakeholders, people responsible for implementation of the that all abortions, and especially second trimester abortions are sought for gender biased sex selection.

This impacts access to second trimester abortions in a wide variety of ways:

- **Increased documentation and oversight:** There are multiple instances where providers have been penalised and jailed for incomplete documents, registers or errors in filling up forms etc, increasing administrative burdens on providers. There are situations where some local authorities have insisted on prior permission to be taken before providing second trimester abortion. Some providers have stopped providing a second trimester services as they have been 'warned' and feel intimidated.
- **Reduced availability of the appropriate drugs:** In the recent past the FDA has attempted to restrict and penalise the storage, prescription and access to Medication Abortion combipack on the assumption that somehow this will reduce the 'sex selection' related abortions. In addition to this the availability of Ethacridine Lactate has also reduced drastically. This compound has been used for decades in India for second trimester abortions.
- **Provider Reluctance:** Both public and private healthcare providers have become increasingly hesitant to perform second trimester abortions due to the legal risks and the fear of being accused of facilitating 'sex-selection'.
- **Administrative Barriers:** The recent Amendments have expanded the gestational age to 24 weeks and there is no gestation limit in cases of foetal anomaly. However, the need to obtain approval of a Medical Board (and hence a court case) results in delays, confusion and the mistaken notion that all second trimester abortions need this level of approval from authorities.

CONCLUSION

Even though the vast majority of abortions are sought in the first trimester, those in the second trimester continue to be a significant public health issue, with access constrained by legal, infrastructural, and social barriers.

Addressing these challenges requires a wider understanding of reproductive Justice issues at policy and programmatic levels as well as through medical and nursing education.

Second trimester abortions will always be needed in cases of delayed detection of fetal anomaly and for maternal health reasons. We have to ensure that they remain available, accessible, safe and of a good quality.

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Why do women need later abortion care? | Later Abortion Initiative. Linked here.

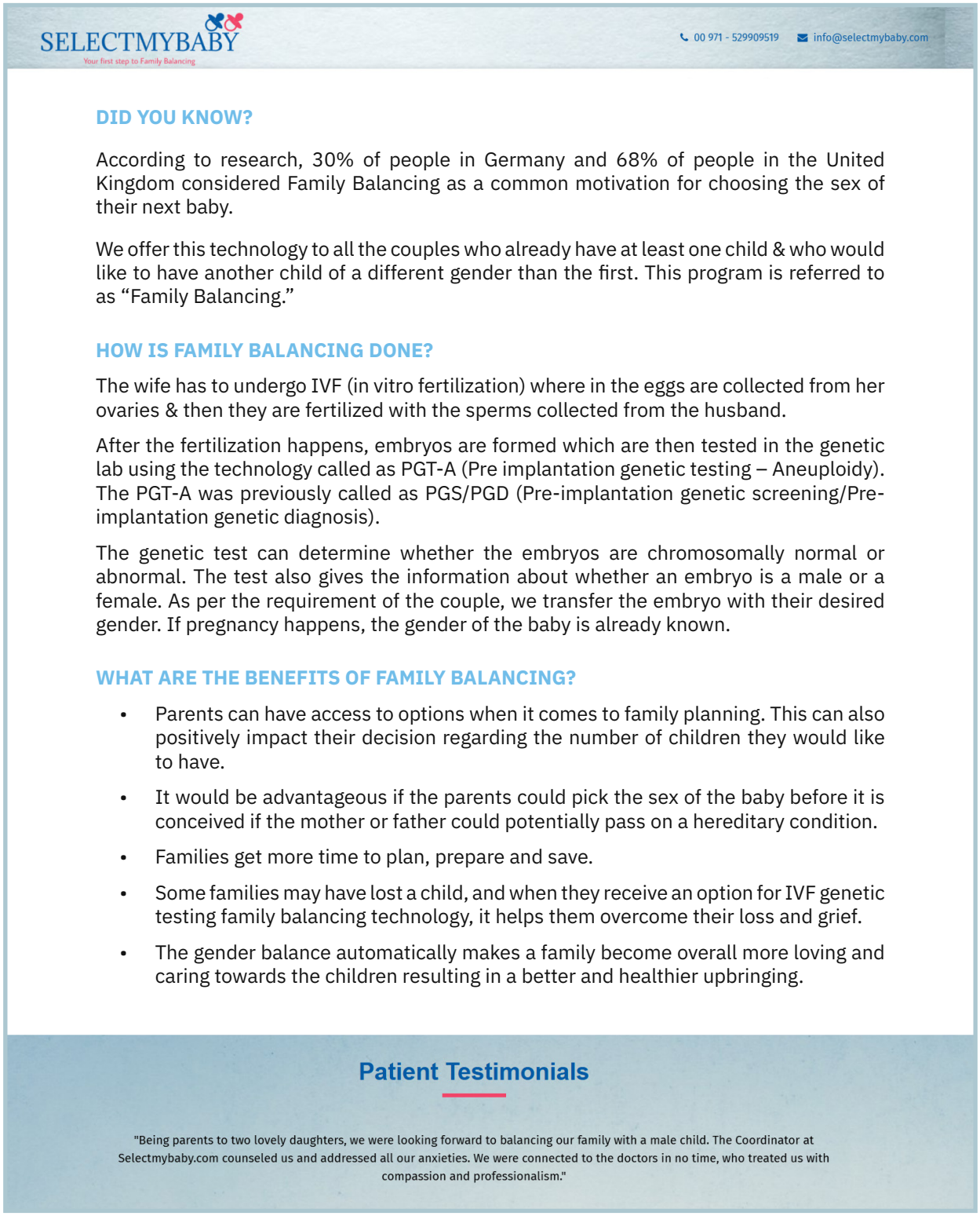
Late-termination of pregnancy for medical reasons: when abortion isn't really by choice. Linked here.

Detection of fetal abnormalities by second-trimester ultrasound screening in a non-selected population. Linked here.

What is Family Balancing?

Family Balancing is done through sex selection but is presented as a way to 'balance the genders of the children'. The underlying assumption is that as many couples will choose to have a girl as will want a boy and there will be no large scale imbalance of choices.

Here is an excerpt from a website that promotes family balancing:



SELECTMYBABY
Your first step to Family Balancing

00 971 - 529909519 info@selectmybaby.com

DID YOU KNOW?

According to research, 30% of people in Germany and 68% of people in the United Kingdom considered Family Balancing as a common motivation for choosing the sex of their next baby.

We offer this technology to all the couples who already have at least one child & who would like to have another child of a different gender than the first. This program is referred to as "Family Balancing."

HOW IS FAMILY BALANCING DONE?

The wife has to undergo IVF (in vitro fertilization) where in the eggs are collected from her ovaries & then they are fertilized with the sperms collected from the husband.

After the fertilization happens, embryos are formed which are then tested in the genetic lab using the technology called as PGT-A (Pre implantation genetic testing – Aneuploidy). The PGT-A was previously called as PGS/PGD (Pre-implantation genetic screening/Pre-implantation genetic diagnosis).

The genetic test can determine whether the embryos are chromosomally normal or abnormal. The test also gives the information about whether an embryo is a male or a female. As per the requirement of the couple, we transfer the embryo with their desired gender. If pregnancy happens, the gender of the baby is already known.

WHAT ARE THE BENEFITS OF FAMILY BALANCING?

- Parents can have access to options when it comes to family planning. This can also positively impact their decision regarding the number of children they would like to have.
- It would be advantageous if the parents could pick the sex of the baby before it is conceived if the mother or father could potentially pass on a hereditary condition.
- Families get more time to plan, prepare and save.
- Some families may have lost a child, and when they receive an option for IVF genetic testing family balancing technology, it helps them overcome their loss and grief.
- The gender balance automatically makes a family become overall more loving and caring towards the children resulting in a better and healthier upbringing.

Patient Testimonials

"Being parents to two lovely daughters, we were looking forward to balancing our family with a male child. The Coordinator at Selectmybaby.com counseled us and addressed all our anxieties. We were connected to the doctors in no time, who treated us with compassion and professionalism."

Fetal reduction and implications

This is a topic that may be unknown to many of the readers and holds an unusual space in the ethical domain of abortion rights. These articles have been collated by the Editors to offer a range of perspectives on the procedure.

No. 1. Voluntary multifetal pregnancy reduction: who should decide and select, and why?

Sara Patuzzo Manzatia et al. European Journal of Obstetrics and Gynecology and Reproductive Biology (2025). Linked here.

"Multifetal Pregnancy Reduction (MFPR) is a term for a procedure in which one or more fetuses in multiple pregnancies are terminated to "improve the chances of healthy survival in the remaining conceptuses and to reduce the hazards to the mother" [10].

The risks of MFPR include loss of the entire pregnancy [11], making this a difficult decision for both providers and patients as risks and benefits compete, including the potential harms (to mother and child) of twins versus the dangers of reduction (to the mother through surgery and to the future child if the pregnancy is lost).

According to the ethical principle of beneficence, the physician has a duty to protect the health and life of both the woman and the fetus, which may be considered as a patient [24]. However, this does not imply that the woman is ethically (or legally) obligated to continue the pregnancy if it poses a risk to her physical or psychological health within the first three months or a serious threat to her life thereafter. In this context, the physician must prioritize the woman's right to life by providing clear and comprehensive information regarding the risks associated with pregnancy. If clinically indicated, the physician should propose the option of pregnancy termination while respecting the woman's autonomy to decide whether to terminate the pregnancy or continue it at personal sacrifice.

Ultimately, the decision regarding pregnancy termination belongs to the woman, even if her choice does not align with the physician's personal beliefs or professional duties. Similarly, the principle of informed consent does not require the physician to personally or professionally agree with the patient's decision but rather to present a medically appropriate recommendation in accordance with the principle of beneficence. In summary, there is a hierarchy between the principle of beneficence and the principle of autonomy, in which the latter prevails in cases of conflict."

No. 2. Abortion and multifetal pregnancy reduction: An ethical comparison.

Silje Langseth Dahl et al. Etikk i praksis, Nordic Journal of Applied Ethics (2021), 15 (1). Linked here.

In recent years, multifetal pregnancy reduction (MFPR) has increasingly been a subject of debate in Norway. The intensity of this debate reached a tentative maximum when the Legislation Department delivered their interpretative statement, Section 2 – Interpretation of the Abortion Act, in 2016 in response to a request from the Ministry of Health (2014) that the Legislation Department consider whether the Abortion Act allows for MFPR of healthy fetuses in multiple pregnancies.

Many of the arguments in the MFPR debate are seemingly similar to arguments put forward in the general abortion debate, and an analysis to ascertain what distinguishes MFPR from other abortions has yet to be conducted. The aim of this article is, therefore, to examine

whether there is a moral distinction between abortion and MFPR of healthy fetuses.

We have dubbed the most important arguments against MFPR that we have identified: the harm argument, the slippery-slope argument, the intention argument, the grief argument, the long-term psychological effects for the woman argument, and the sorting argument. We conclude that these arguments do not measure up in terms of demonstrating a morally relevant difference between MFPR of healthy fetuses and other abortions. Our conclusion is, therefore — despite what several discussants seem to think — that there is no morally relevant difference between the two. Therefore, on the same conditions as we allow for abortions, we should also allow MFPR.

No. 3. Multifetal pregnancy reduction and selective termination

Sridevi Beriwal MRCOG, Lawrence Impey FRCOG, Christos Ioannou DPhil MRCOG (2020). Linked here.

Ever since the introduction of assisted reproduction technology (ART) in the early 1980s, the rate of twins and high-order multifetal pregnancies has increased from 10.1 to 15.8 per 1000 maternities for England and Wales. In 2017, this translated to 10 621 women, of whom 10 462 had twins, 154 had triplets and five had four or more babies.

It is well known that ART – in particular, the number of transferred embryos during in vitro fertilisation (IVF) – is the single biggest contributor to multiple pregnancy. Following IVF conception, one in five births results in multiple pregnancy. Approximately half of twin pregnancies, and virtually all higher-order multifetal pregnancies, are delivered before 37 weeks of gestation.7 Preterm birth is the single biggest cause of lifelong neurodevelopmental morbidity. Cerebral palsy affects approximately 1 in 400 singleton births, 1 in 100 twin births, and a markedly increasing proportion for higher-order pregnancies. For triplet births, cerebral palsy affects approximately 1 fetus in 30 (1 in 12 pregnancies), 1 fetus in 10 quadruplet births (4 in 10 pregnancies) and for quintuplets and above, the rate is probably over one in two per pregnancy.

Around the world there is variation in the legality of, gestational age limits for and access to safe termination services. Under ground E of the 1967 Abortion Act, termination in England, Wales and Scotland is legal at any gestational age if two registered doctors are satisfied that "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped". Following the amendment introduced by the 1990 Human Fertilisation and Embryology Act, it was made clear that selective termination (ST) is also covered by the same legislation.

Although several different terms are often used, the current consensus on terminology is that termination of an abnormal fetus should be described as ST, whereas termination of one or more normal embryos in a higher-order multifetal pregnancy should be termed multifetal pregnancy reduction (MFPR).

ST of pregnancy and MFPR are, by the nature of the pregnancy involved, fraught with emotional, ethical and practical difficulties. Attitudes vary widely. Considerable clinical skill is required and the procedures should not be performed outside of an FM unit. Accurate determination of chorionicity is an absolute prerequisite and will determine the type of procedure, its risks and its benefits.

The intended benefit in MFPR is the considerable reduction in preterm birth and consequent risk of disability; with ST it is to prevent the birth of an abnormal baby. With TRAP or other complicated monochorionic pregnancies, termination seeks to minimise risk to the healthy fetus from the shared placentation. Women struggle with decision-making, particularly with fetal reduction, and should be supported with frank discussion of the risks, but also emotionally: the need for emotional and psychological support may long outlast the pregnancy.

Sex Selection and Safe Abortion: Unravelling the Gordian Knot

By Suchitra Dalvie and Manisha Gupte, The Journal of Family Welfare, Volume 65-2021.

Full article available here.

EXCERPTS:

The conversation and rhetoric around sex ratio in India became more visible and mainstreamed in the 1990s. Unfortunately, this resulted in making the sex ratio a priority as a number to be 'fixed' and deflected attention from the core issue of gender-based discrimination which is the reason why daughters are unwanted and sons are desired in India. It ignored the centuries of oppression and inequality that has led to girls being seen as a social and economic liability to their natal families. It also encouraged quick fixes which did little to acknowledge or change the skewed power dynamics and injustices done to girls and women within the patriarchal socio-cultural context.

Thus, the scramble to equalise the sex-ratio has not been accompanied by any significant measures to enhance gender equality and women's economic and political empowerment. As a result, women are still shamed and made to feel guilty after giving birth to a girl child, and often subjected to violence and/or abandonment. Neglect and discrimination of girl children continues as well resulting in a higher death rate for the girl children below six years of age, even as the policy and programme efforts are on to ensure that more of them are being born.

Women's status (or lack of thereof) within a patriarchal society depends on their reproductive capacities. Motherhood, involving child bearing as well as child rearing, firmly situates the woman as an ever-loving, ever-ready altruistic individual within the cis-heteronormative family unit. Failure to perform sexual or reproductive 'duties' (both biological and social) can result in neglect, violence, exclusion or desertion, because women can be rendered dispensable at any time by their natal or marital families.

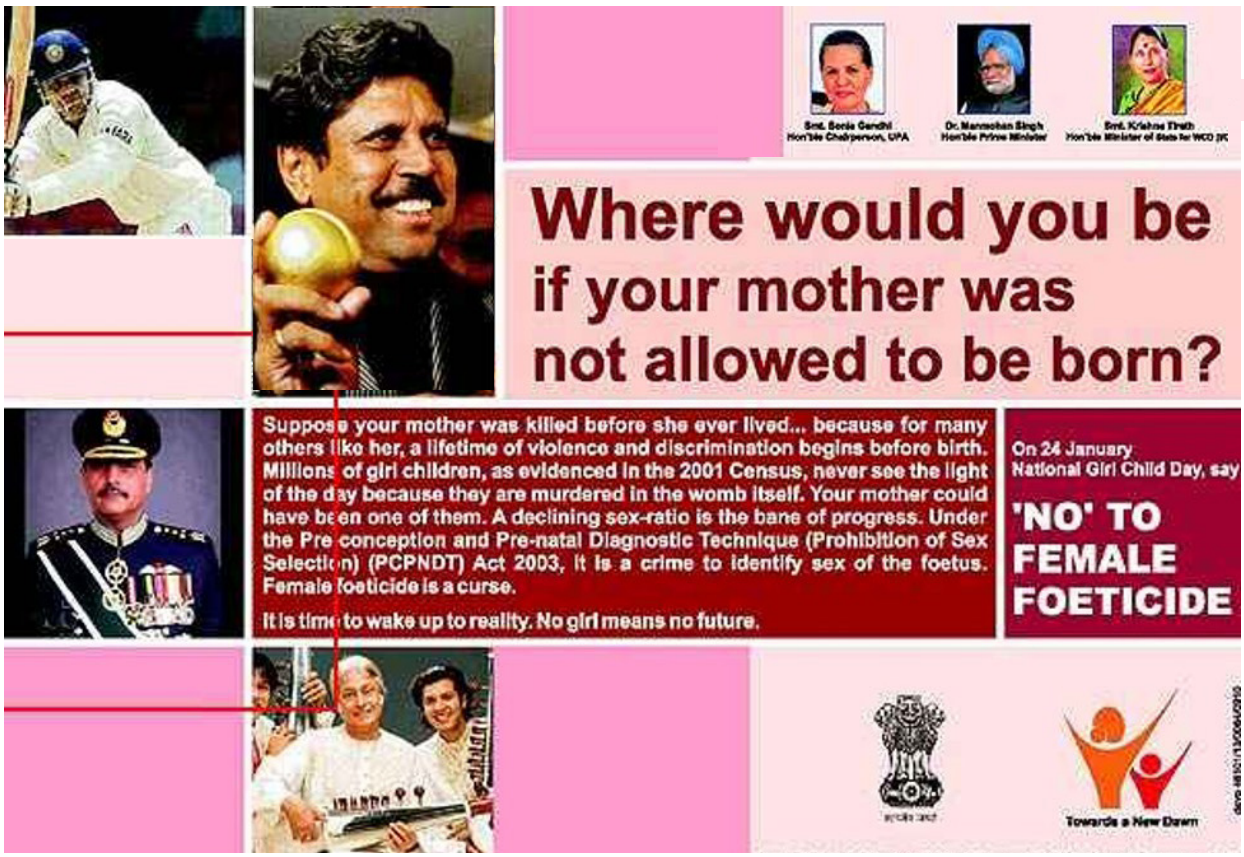
Factors beyond the 'economic burden' argument, such as fear of losing family 'honour' due to the sexual conduct of a daughter, patrilocality (whereby the daughter leaves her natal home and joins the affinal household after marriage), socio-cultural restrictions on her being allowed

to support her parents, and the family's economic dependence on a son in the absence of any State supported pension or social security schemes are also considered reasons for daughter unwantedness.

It is important to make a distinction between sex selection and sex determination. While the former includes diverse steps to fight the son-preference-daughter-unwanted-ness continuum, the latter specifically concentrates on medical advancements and their misuse to further patriarchal concerns. Although the campaigns concentrated on sex determination and sex-selection as distinct categories (during pregnancy and pre-conception), the terms sex-selection and sex-determination have come to be used interchangeably, blurring the distinction between the act of determining the sex of the foetus or embryo, and the act of selecting a foetus or embryo of a certain sex for survival or elimination. Sex 'selection' can also be practised post-birth either through infanticide or pernicious neglect of the girl child.

BBBP CAMPAIGN INDIA

Despite the BBBP scheme accomplishing the major task of bringing the issue of son preference to the forefront, the scheme in its present form is at risk of failing its central task due to poor implementation and monitoring. The lack of frequent meetings at the district and state levels can lead to the scheme losing the momentum it has created in the past few years. It is, hence, imperative for the district- and state-level action committees to have representation from community-level workers, cognisance of the challenges faced by the female students such as unavailability of toilets and adept monitoring and evaluation mechanisms in place to have measurable outcomes indicative of the progress made on the objectives of the schemes (Source linked here).



Highlight Articles

EDITOR'S NOTE: Here are some articles collated to offer the readers a range of perspectives on the way the politics of sex selection and safe abortion has been navigated and negotiated over the last five decades.

Unlike the article "Unravelling the Gordian Knot" these following articles do not all represent the perspective of the Editors. They have been included here to offer an understanding of the ways in which the nuances and the politics of the issue have been articulated, defended and justified, so that we can learn from it to inform our advocacy.

Please note that the use of the phrase 'sex-selective abortion' is inaccurate since sex selection can take place prior to conception and also after birth (through infanticide, neglect and starvation of the unwanted girl child). Hence using the phrase 'sex selective abortion' only adds to the stigma against abortion while misdirecting away from the systems of patriarchal oppression and lack of public welfare funding that creates the discrimination.

They have been listed chronologically to also help see the pattern of the concerns which started off as a clear issue of gender discrimination and women's status in society and slowly morphed into a concern for unmarried men.

No. 1. Getting rid of girls

> Getting rid of girls - PubMed. Asiaweek. 1987 Aug 2:25-9. *No authors listed*
>
> In many Asian countries with patriarchal traditions and social stigmas, the birth of a girl is an occasion for gloom and bitterness. Prenatal testing--amniocentesis, chorion villus biopsy, and ultrasonography--is used by more and more women to discover the sex of the child in their womb. For many, if it proves to be female, the next step will be an abortion. In India, such gender testing is a lucrative business. Over 50,000 amniocentesis tests are carried out every year in Bombay alone. The population balance in South Korea and China has shown an alarming swing towards males in recent years.

No. 2. Women - an endangered species

> PubMed. World Dev Forum (1987) 30;5(21):1-2. *No authors listed.* Linked here.
>
> Throughout India and China, South Korea and Taiwan, Pakistan and Malaysia, the same sentiment recurs: "The birth of a girl is an occasion for gloom, not cheer, for bitterness, not pleasure." In all these countries "patriarchal traditions and social stigmas" make females the unwanted sex, reports Asiaweek. The tragic result: prenatal gender tests are flourishing. And for many women, if the test indicates a female, they abort. In India, sex tests and abortions are legal, cheap and readily available. Some 1500 sex-tested girls are aborted annually in Bombay alone. In China, abortions are legal, but gender tests strictly forbidden. Says one official: We cannot afford to let people know what sex the fetus is because all the girls would be aborted."
>
> Can laws and education change the social attitudes against girls in these Asian countries? Indian activist Vibhuti Patel, a lobbyist for stronger controls over sex-testing, hopes so. She urges a "continuous campaign" to fight the "centuries-old values" that encourages gender tests. Says Patel: Nothing less than the very survival of women is at stake."

No. 3. Where are the missing Chinese girls?

L Keysers. PubMed. Newsl Womens Glob Netw Reprod Rights 1991 Jul-Sep:(36):15. Linked here.

Commentary focuses on the 1990 China Census data on births by sex and the sex ratio differences which suggest that 5% of all infant girls are unaccounted for. A combination of factors may account for this pattern: infanticide, adoption, or hidden births. Parents traditionally prefer sons and the 1 child policy acts as a disincentive to raise a girl child. The May 1990 census results indicate that for every 100 girls 1 year old there were 111.3 boys.

A recent study by 2 Swedish experts and a Chinese demographer found that up to 50% of the 500,000 girls missing each year are adopted informally. The 2nd explanation offered is that daughters are raised by relatives in order to avoid having to pay fines. Infanticide as an option is considered possible and may account for a large number of killings in spite of the small proportion.

No. 4. Will sex selection reduce fertility?

S F Leung. PubMed. J Popul Econ. 1994;7(4):379-92. Linked here.

Population control is one of the primary policies applied against poverty in many low income countries. The widespread prevalence of son preference in some countries such as China and India, however, works against any reduction of fertility. This is so because parents often continue to have children until they obtain the number of sons which they desire. The bias against girls has also led to higher abortion and mortality rates of female children. It is frequently argued that if sex selection methods are made available to parents so that they can control the gender of their children, population growth would be lowered and women's welfare improved.

No. 5. When daughters are unwanted. Sex determination tests in India

M Kishwar PubMed. Manushi. 1995 Jan-Feb:(86):15-22. Linked here.

Amniocentesis and ultrasound have been used for detecting fetal abnormalities, but in India they have been used for sex determination, leading to the abortion of hundreds of thousands of female fetuses. As a result, by 1991 the sex ratio had declined to 929 females per 1000 males from 972 females per 1000 males in 1901. This amounts to a deficit of almost 30 million females in the whole population. A ban on such prenatal diagnosis was passed in several states, but it proved to be ineffective and unenforceable. The result was only that the fees charged soared.

Finally, in August 1994 the Indian Parliament enacted the Prenatal Diagnostics Techniques Act that prohibited genetic counseling centers to perform such procedures unless strict criteria were observed (age over 35 years, two or more previous abortions, exposure to drugs, infections, and mental or physical retardation). However, the emergence of a police-doctor nexus is dangerous for the well-being of any society and could lead to criminalization of the medical profession.

Women themselves perpetuate the dread because of their own misery, low status, abuse, and the burden of the dowry. The devaluation of women is rooted in history, particularly in the northwest where constant wars favored a martial society for males (with strict purdah for females), and in addition British colonialism perpetuated land rights giving preference to property ownership over the value of labor.

No. 6. Dr. Gu Baochang speaks out on son preference in China

F Bair. Dr. Gu Baochang speaks out on son preference in China - PubMed. China Popul Today. 1995 Aug;12(3-4):27-8. Linked here.

In an interview, Dr. Gu Baochang of China discussed the topics of son preference and the increasing male-to-female sex ratio at birth in China. The preference for sons which persists in China, Taiwan, and the Republic of Korea is determined by the issues of family labor, elderly support, women's status, and carrying on the family line. The Chinese government is trying to curb son preference by making efforts to improve the status of women and girls and by banning the illegal use of the sonogram.

No. 7. Is sex-selective abortion morally justified and should it be prohibited?

Wendy Rogers , Angela Ballantyne, Heather Draper. Bioethics. 2007 Nov;21(9):520-4. Linked here.

In this paper we argue that sex-selective abortion (SSA) cannot be morally justified and that it should be prohibited. We present two main arguments against SSA.

First, we present reasons why the decision for a woman to seek SSA in cultures with strong son-preference cannot be regarded as autonomous on either a narrow or a broad account of autonomy.

Second, we identify serious harms associated with SSA including perpetuation of discrimination against women, disruption to social and familial networks, and increased violence against women. For these reasons, SSA should be prohibited by law, and such laws should be enforced.

Finally, we describe additional strategies for decreasing son-preference.

No. 8. Sex selection and restricting abortion and sex determination

Julie Zilberberg. Bioethics. 2007 Nov;21(9):517-9. Linked here.

Sex selection reinforces oppression of women and girls. Sex selection is best addressed by ameliorating the situations of women and girls, increasing their autonomy, and elevating their status in society. One might argue that restricting or prohibiting abortion, prohibiting sex selection, and prohibiting sex determination would eliminate sex selective abortion. But this decreases women's autonomy rather than increases it. Sex selective infanticide, and slower death by long term neglect, could increase. But, if a ban on sex selective abortion or a ban on sex determination is indeed instituted, then wider social change promoting women's status in society should be instituted simultaneously.

No. 9. Second Trimester Abortions in India

Suchitra Dalvie. Reproductive Health Matters 16, no. 31 (2008). Linked here.
(email drsuchitra@asap-asia.org for the full article)

This article gives an overview of what is known about second trimester abortions in India, including the reasons why women seek abortions in the second trimester, the influence of abortion law and policy, surgical and medical methods used, both safe and unsafe, availability of services, requirements for second trimester service delivery, and barriers women experience in accessing second trimester services. Based on personal experiences

and personal communications from other doctors since 1993, when I began working as an abortion provider, the practical realities of second trimester abortion and case histories of women seeking second trimester abortion are also described.

Recommendations include expanding the cadre of service providers to non-allopathic clinicians and trained nurses, introducing second trimester medical abortion into the public health system, replacing ethacridine lactate with mifepristone-misoprostol, values clarification among providers to challenge stigma and poor treatment of women seeking second trimester abortion, and raising awareness that abortion is legal in the second trimester and is mostly not requested for reasons of sex selection.

No. 10. Non-medical sex-selective abortion in China: ethical and public policy issues in the context of 40 million missing females

Jing-Bao Nie. British Medical Bulletin. 2011:98:7-20. Linked here.

The rapidly growing imbalance of the sex ratio at birth (SRB) in China since the late 1980s demonstrates that, despite an extensive official prohibition, sex-selective abortion has been widely practised there in the past two or three decades. Given the reality of 30-40 million missing females, China has a more challenging set of ethical and social policy issues to be addressed regarding sex-selective abortion than is the case in Western and many other countries.

The current female deficit is a real and serious problem in China-not a 'false alarm' as earlier alleged. Chinese academics-demographers and medical ethicists-in general agree with the official position that sex-selective abortion is morally wrong and should be legally prohibited.

Some critical voices, mainly in the English-language literature, have asked whether coercive state intervention in this area is ethically justifiable. Another controversial question is whether and to what degree China's ambitious and rigorous population control programme, widely known as the 'one child' policy, is a contributing factor to the phenomenon of millions of missing females.

No. 11. Save the Baby Girl & Active tracker

Full article linked here.

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Save The Baby Girl & Active Tracker is a system and method using information technology to effectively implement the PCPNDT Act and saving the girl child. Magnum Opus invented this at Kolhapur district of Maharashtra and the first version was called as Silent Observer. Over the period of 6 years, the system has corrected all its errors and silent observer was upgraded to Active Tracker and now launching "Active Tracker+". The project is implemented in more than 60 districts across India with over 5000 centers made online and 2000 Active Trackers were installed. The project has shown tremendous results by controlling the under reporting and false reporting and increase in the sex ratio.

No. 12. Selecting sex: the effect of preferring sons

Therese Hesketh. Early Human Development. 2011 Nov;87(11):759–61. Linked here.

Son preference remains common in countries from East Asia through South Asia to the Middle East and North Africa. Worst excesses are seen in parts of rural China where there are 140 male births for every 100 female. This leads to large numbers of unmarriageable men.

Concerns about the consequences centre around the propensity to aggression and violence of these men with increased levels of crime and antisocial behaviour, threatening societal stability and security. But recent studies do not support these assumptions, but rather suggest that these men are marginalised, lonely, withdrawn and prone to psychological problems.

No. 13. "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

Sunita Puri, Vincanne Adams, Susan Ivey, Robert D Nachtigall. Soc Sci Med (2011). Apr;72(7):1169–76. Linked here.

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.

No. 14. Saving the girl child or destroying women's rights?

Brendan O'Neill. Spiked (2014). Linked here.

'The restriction on so-called sex-selective abortion is damaging women's right to choice more broadly', says Suchitra Dalvie, one of India's most outspoken pro-choice campaigners. Coordinator of the Asia Safe Abortion Partnership, Dalvie has watched as over the past decade and more both Western NGOs, campaigning under heartstring-tugging banners such as 'Save the Girl Child', and India-based women's groups have rallied against sex-selective abortion on the basis that it is misogynistic and is depleting womankind's numbers. Yet far from improving the lot of the female sex in India, or anywhere else, such campaigns are 'actually damaging the rights of women who already exist, and who want to terminate their pregnancies', Dalvie tells me.

No. 15. Sex ratios and Gender Biased Sex Selection

UNFPA India. UN WOMEN (2014). Linked here.

This publication maps existing evidence on gender biased sex selection in the Indian context, weaving in significant social debates and policy developments that have influenced perceptions, and pathways to action. It offers practical suggestions to advance the path of critical inquiry by focusing on different domains such as family and household, education, labour and employment, and on institutions that directly or indirectly aid or combat the practice of sex selection.

No. 16. Arbitrating Abortion: Sex-selection and Care Work among Abortion Providers in England

Kasstan B, Unnithan M. Med Anthropol. 2020 Aug-Sep;39(6):491-505. Linked here.

The UK's on-going sex-selective abortion (SSA) controversy remains a major obstacle to the liberalization of national abortion governance, and is an issue broadly attributed to a "cultural" preference for sons among South Asian women. We conceptualize how healthcare professionals "arbitrate" requests for SSA by exploring the tension between its legal status and how requests are encountered by abortion providers. SSA is framed in this article as a legitimate care service that can support providers to meet the diverse reproductive health needs of women to the full extent of the law.

No. 17. The bio-politics of population control and sex-selective abortion in China and India

Lisa Eklund and Navtej Purewa. Feminism & Psychology (2017), 27(1), 34–55. Linked here.

China and India, two countries with skewed sex ratios in favor of males, have introduced a wide range of policies over the past few decades to prevent couples from deselecting daughters, including criminalizing sex-selective abortion through legal jurisdiction. This article aims to analyze how such policies are situated within the bio-politics of population control and how some of the outcomes reflect each government's inadequacy in addressing the social dynamics around abortion decision making and the social, physical, and psychological effects on women's wellbeing in the face of criminalization of sex-selective abortion.

No. 17. The Gendered Biopolitics of Sex Selection in India

Ravinder Kaur, Taanya Kapoor, Asian Bioeth Rev. 2021 Jan 4;13(1):111–127. Linked here.

After China, India has the most skewed sex ratio at birth. These two Asian countries account for about 90 to 95% of the estimated 1.2 to 1.5 million missing female births annually, worldwide, due to gender-biased (prenatal) sex selection. The ethical consequences of advanced reproductive technologies, which remove the moral turpitude around gender-based sex selection by reformulating it into a "modern", "scientific" endeavour, facilitating the rise of "missing girls", make this an issue of gender justice, as noted by the World Population Report 2020.

This article argues that unpacking gendered biopolitics within the household is crucial to understanding the reproduction of son preference and daughter aversion since it is here that reproduction and parenthood are subjected to biopolitical governance.

No. 18. The slaughter of our daughters

Shristi Karki. Nepali Times (2025). Linked here.

"Nepal's sex ratio at birth shines a light on the deeply-entrenched patriarchy in our country," says demographer Gurung. "And it also clarifies the misconception that traditional and conservative mindsets and discriminatory practices exist exclusively in rural communities, because the data points to educated, economically well off people engaging in practices like GBSS."

> Historically, agrarian societies like Nepal preferred to have many sons because men were considered better suited to physical work. Today, many Nepalis hope to have male children so that they can migrate overseas, earn livelihoods, and support their families.

No. 19. A critical analysis of *Beti Bachao Beti Padhao* Scheme

See here.

Choosing 'normal': The overlooked conversation on Disability and Abortion

By Zargoona Wadood, Disability Rights Activist, ASAP Steering Committee Member, Pakistan

In all the discussions around abortion rights, a critical issue that often gets left out is the role of ableism.

Ableism is the discrimination against people with disabilities. This has been so normalized in all our societies, especially in the post- colonial, capitalist and urban settings, where people living with disabilities are often invisible because it is impossible for them to navigate public spaces which do not take into account their different needs. This is also seen in the simple assumption that if a fetus is diagnosed with a disability, the 'normal' option offered would be to terminate the pregnancy.

Here are two key concerns with this choice:

1. **It is a marker of the deep-rooted prejudices in society against people living with disabilities.**

   Ableism assumes that lives with disabilities are less valuable or simply even not worth living. This belief influences not just public opinion, but also the medical field, families, and even policy. In the larger context it simply disregards the rights of people to live with dignity and equality. Instead of being eliminated. We must challenge the idea that disabled lives are less worthy. True reproductive justice means supporting all women including those with disabilities to make informed, free, and supported choices about their own bodies.

   In Pakistan, 15% of the population lives with some form of disability, and half of them are women and girls. Yet, there's very little awareness about their sexual and reproductive health rights (SRHR).

2. **The right of a pregnant person to choose to continue or terminate a pregnancy gets influenced by external factors.**

   While it is true that no choices are really made in a vacuum and there are always economic,

social, political or legal issues to consider, it is also true that women living disabilities are often expected to have an abortion because they are seen as being incapable of being good mothers.

There is a deeply rooted belief that if a woman has a disability, she will give birth to a child with a disability. This misconception fuels stigma and societal bias, leading many women with disabilities to question their right and ability to become mothers. As a result, they may face intense emotional pressure worrying not only about their own well-being but also about the burden of raising a child who is expected to be disabled. These harmful narratives have a deep impact on the mental health of women with disabilities.

Many women with disabilities are not only excluded from the conversation but also excluded from healthcare services due to inaccessibility, lack of information, and biased attitudes from doctors and family members. Some are even subjected to forced sterilization or abortions without their consent—acts that are prohibited under international human rights laws like the Convention on the Rights of Persons with Disabilities (CRPD).

I would like to remind us that the fight for abortion rights is not just about **having the right to terminate** a pregnancy, but also about **having the right *not* to**—especially when the decision is being influenced by societal fear or shame about disability.

And I would also like to confirm that yes, any pregnant person who finds out that the fetus has a disability and chooses NOT to continue that pregnancy does also have the right to make that choice. Unless the public sector facilities become inclusive and supportive, with free and easy access to schools, employment, free access to medical care and facilities, it may truly not be possible for a woman or a couple to manage raising a child with disabilities. This too is an important right to choose.

In conclusion: To build an inclusive abortion rights movement, we need to work at many levels. As a movement we need to include more voices from women living with disabilities, many of whom, like those engaged by PAN in Pakistan, have been leading efforts to bring this issue to light.

We need to advocate for accessible services: sign language interpreters, ramps and respectful, informed healthcare providers. We must also listen to the voices of women with disabilities.

Abortion rights and disability rights are deeply connected. To ignore this link is to continue discrimination in the name of choice. Let's ensure that every woman's decision is truly her own, no matter what her identity.

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Selective abortions in India and the second trimester: What is the connection?

By Dr. Kalpana Apte, Director General, Family Planning Association of In

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QUEERING THE SAFE ABORTION RIGHTS MOVEMENT

Guest Editor: Sylvester Merchant, Regional Community Engagement and Networks Lead, IPPF South Asia Regional Office