

[Prenatal Nondiscrimination Act \(PRENDA\) of 2017 \(HR 147, 115th Congress\)](#)

Imposes criminal penalties upon any person who performs a sex-selective or race-selective abortion, among other things.

Updated last **September 11, 2017**
for the 01/03/2017 version of HR 147.

WHAT IT DOES

[HR 147](#), also known as the Prenatal Nondiscrimination Act (PRENDA) of 2017, imposes criminal penalties, including fines and/or imprisonment for up to five years, upon any person who knowingly or knowingly attempts to:

1. Perform an abortion in which the choice to abort is based on the sex, gender, color, or race of the fetus;
2. Use or threaten force to coerce a person into undergoing a sex-selective or race-selective abortion;
3. Ask for or receive payment for performing a sex-selective or race-selective abortion; or
4. Transport a pregnant person into the the United States or across a state line in order for the person to obtain a sex-selective or race-selective abortion.

Pregnant persons who may undergo sex-selective or race-selective abortions cannot be held liable under PRENDA. A [civil action](#) can be sought by the father or maternal grandparents of the fetus if the affected pregnant person is a minor. A civil action can also be sought by the affected pregnant person if the person was the victim or attempted victim of force or intimidation in relation to the abortion procedure. [Injunctive relief](#) can be sought against an abortion provider considered in violation of HR 147 by the person upon whom the abortion was carried out or attempted, the father of the fetus, the Department of Justice, or if the affected pregnant person is a minor, the maternal grandparents of the fetus. Medical or mental health professionals must report known or suspected violations, or face fines and/or imprisonment up to one year.

RELEVANT SCIENCE

Sex-selective abortions are abortions that are performed because of the sex of the fetus. Sex is a [genetic trait](#) that is determined by the [X and Y sex chromosomes](#), with most human women having two X chromosomes and most human men having one X and one Y chromosome within their usual 46 total chromosomes. Some people have [sex chromosome abnormalities](#) in which they have either one sex chromosome or more than two, which can result in [intersexuality](#), also sometimes referred to medically as disorders or differences in sex development (DSDs). The sex of a fetus can be determined by [genetic testing](#) on [DNA](#) acquired through maternal-fetal bloodstream DNA sampling (prenatal cell-free DNA testing), amniocentesis, and chorionic villus sampling (CVS). Such genetic tests are primarily used to detect genetic abnormalities in the fetus, such as [Down Syndrome](#). However, they are also commonly used to scan the sex chromosomes, primarily looking for the presence or absence of the Y chromosome or secondarily counting the number of copies of the X chromosome.

Maternal-fetal bloodstream DNA sampling, more commonly known as prenatal [cell-free DNA \(cfDNA\) testing](#) (a type of noninvasive prenatal testing (NIPT)), is a genetic test performed using a blood sample from the pregnant person, which contains both maternal and placental [DNA](#). The [placenta](#) has a genetic makeup that is [largely identical](#) to the fetus, as both are derived from the [fertilized egg](#). This testing is conducted at around 9-10 weeks of gestation. Further advances in NIPT technologies could allow [earlier testing](#).

[Amniocentesis](#) is a medical procedure in which amniotic fluid, which surrounds the fetus *in utero*, is extracted. The [amniotic fluid](#) contains fetal cells that can be used for genetic testing. Amniocentesis is usually only performed after 15 weeks of gestation.

[Chorionic villus sampling](#) (CVS) involves the extraction of a sample of chorionic villi, which are finger-like tissue structures found in

the placenta. DNA is then extracted from the chorionic villi and used for genetic testing. The procedure is usually conducted between 10 and 13 weeks of gestation.

An alternative to genetic testing is a [sonogram](#), also known as a fetal ultrasound, which can visually identify the sex of a fetus based on the appearance of the genitals. Sonograms utilize sound waves that are projected into a pregnant person's abdomen to create a visual image. This method is the most common for determining fetal sex, but is only used for this purpose at around 18 to 20 weeks gestation during a [fetal anatomic survey](#).

Race-selective abortions are abortions that are performed because of the race of the fetus. The biological significance of the concept of "race" is [disputed](#), especially as it pertains to genetics. It is unclear from the language of HR 147 how "race" would be defined.

RELEVANT EXPERTS

[Sital Kalantry](#), Clinical Professor of Law at Cornell Law School. Kalantry also serves as the Director of the [International Human Rights Policy Advocacy Clinic](#) and Co-Director of the [Migration and Human Rights Program](#) of Cornell Law School. Her research focuses upon discourse and legislative processes in the United States as they pertain to sex-selective abortion bans.

Relevant publications:

- Kalantry, S. 2017. *Women's Human Rights and Migration: Sex-Selective Abortion Laws in the United States and India*. Philadelphia, PA: University of Pennsylvania Press.
- Kalantry, S. 2015. "Sex-Selective Abortion Bans: Anti-Immigration or Anti-Abortion?" *Georgetown Journal of International Affairs* 16: 140-158.
- Kalantry, S. 2013. "Sex Selection in the United States and India: A Contextualist Feminist Approach." *UCLA Journal of International Law and Foreign Affairs* 18: 61-85.

BACKGROUND

The Centers for Disease Control [found](#) that, in 2009, 91.7% of legally performed abortions in the United States occurred during the first thirteen weeks of gestation. Only 3.1% of abortions were performed at or after 18 weeks of gestation, when ultrasound is typically used for a fetal anatomic survey.

[No studies have shown conclusive evidence](#) that sex-selective abortions are a large problem in the United States, but [some research](#) has identified limited sex-selection in Korean, Chinese, and Indian immigrant communities. These findings of sex-selection are based on an observed male-favored increase in the biologically normal [sex ratio](#), which is typically 105 males to 100 females at birth. This increase in males to females is primarily true for third children born after two female siblings. It's unclear what role, if any, abortion plays in the limited sex-selection trends that have been found to occur. Sex-selection does sometimes occur through [in vitro fertilization](#), where couples can select an embryo with a particular sex before implantation. Despite the potential for sex-selection, both the [United States sex ratio](#) as a whole and the [Asian-American sex ratio](#) are within the normal biological range.

In countries like China and India, where male-preferred, sex-selective abortions are a [documented problem](#), sex-selective abortion bans have [failed to address the problem](#). Experts at the United Nations [recommend](#) that promoting responsible use of prenatal screening technologies and addressing the underlying issues that lead to cultural preferences for male infants is more productive. The Republic of Korea (i.e., South Korea) is [held up as an example](#) of the success of such measures, and some similar measures are now [being implemented](#) in China, India, and other countries. Additional studies conducted in the United States, where states like Pennsylvania and Illinois have passed laws prohibiting sex-selective abortions, found that the laws [did not affect](#) sex ratios at birth.

Currently, [no studies show conclusive evidence](#) that Americans are choosing to have race-selective abortions. The text of the [Prenatal Nondiscrimination Act of 2017](#) states that race-selective abortions are a growing problem and links this to the fact that

women of color undergo abortion procedures at a greater rate than white women. A [2011 study](#) found the rates of abortion in the United States were as follows: 40.2 abortions per 1000 black women, 28.7 abortions per 1000 Hispanic women, and 11.5 abortions per non-Hispanic white women. Other studies have provided evidence that increased abortion rates in black and Hispanic communities are likely due to [a lack of contraception access in these populations](#) and an associated, increased rate of unintended pregnancies. [Research conducted in 2011](#) found that 42% of all unintended pregnancies ended in abortion. The same study showed that unintended pregnancy rates per 1000 women aged 15-44 were as follows: 79 for Black women, 58 for Hispanic women, and 33 for non-Hispanic white women. [Racial disparities in reproductive health care access](#) are believed to account for a significant portion of these differences.

ENDORSEMENTS & OPPOSITION

Endorsements:

- Anna Higgins, associate scholar at the [Charlotte Lozier Institute](#), [testified](#) before the House Judiciary Committee on April 14, 2016 regarding a previous version of the Prenatal Nondiscrimination Act ([HR 4924](#)): “The practice of sex-selective abortion implies a right to choose not just whether or not to have a child, but the right to choose the characteristics of a child. The ethical implications of such a practice are numerous and unacceptable. The result of continuing to allow this practice is an implicit approval of the practice of assigning value to a person based on his or her sex alone.”
- Dr. Alveda King, Pastoral Associate for [Priests for Life](#), said in a [statement](#): “The Prenatal Nondiscrimination Act authored by Congressman Trent Franks and other distinguished members of Congress is a brave and honest approach to the solutions to the violations of the civil rights of America’s weakest population, the pre-born.”

Opposition:

- Miriam Yeung, Director of the [National Asian Pacific Women’s Forum](#) stated in a [press release](#): “PRENDA threatens women’s health and perpetuates the racist myth that Asian American Pacific Islander (AAPI) families do not value girls. Even though it is cloaked in the language of civil and women’s rights, this bill is antithetical to gender and racial equality. Rather than protect baby girls, this bill will endanger women’s health and restrict women’s rights.”
- Wade Henderson, President and CEO of [The Leadership Conference on Civil and Human Rights](#) and Nancy Zirkin, Executive Vice President of The Leadership Conference on Civil and Human Rights stated in a joint [letter to Congress](#): “The problem of racial and sex disparities in health care is real. According to a report by the Kaiser Family Foundation, 16 percent of African-American women and 28 percent of Latina women are in fair or poor health. Additionally, African-American women and Latina women have less access to contraception, prenatal care and other critical reproductive health services, resulting in stark disparities across a number of sexual and reproductive health indicators. Instead of addressing these critical issues, this bill exacerbates the disparities by further restricting certain women’s access to comprehensive reproductive health care services, scrutinizing the health care decisions of women of color, and penalizing health care providers who serve communities of color.”
- Marcela Howell, founder of the [National Black Women’s Reproductive Justice Agenda](#) stated in an [interview](#) that the bill “perpetuates hurtful racial stereotypes about Black women. The implication is that we are incapable of making ‘right’ and ‘sound moral’ reproductive health decisions. Unlike the conservative GOP, we TRUST Black women to make the important personal decisions about abortion that are right for themselves and their families.”

STATUS

HR 147 was introduced in the House of Representatives on January 3, 2017, where it was referred to the [House of Representatives Judiciary Committee](#). On January 23, 2017 the Judiciary Committee referred HR 147 to the [House Subcommittee on the Constitution and Civil Justice](#).

POLICY HISTORY

Representative Trent Franks (R-AZ-8) first introduced a version ([HR 7016](#)) of the Prenatal Nondiscrimination Act in 2008 in the 110th Congress. Other versions were introduced in the 111th, 112th, 113th, and 114th Congresses. Senate versions were also introduced by Senator David Vitter [R-LA] in the 112th, 113th, and 114th Congresses. [HR 3541](#) of the 112th Congress made it the furthest of all these bills in the legislative process. It was introduced on January 1, 2011, amended by the [House of Representatives Judiciary Committee](#) on May 29, 2012, and failed in a vote by the House of Representatives on May 31, 2012.

SPONSORS

Sponsor: [Representative Trent Franks](#) (R-AZ-8)

Cosponsors: No original cosponsors.

PRIMARY AUTHOR

Hayley Farless

EDITOR(S)

Rachel Fox; Alex Robeson, PhD

RECOMMENDED CITATION

Duke SciPol, "Prenatal Nondiscrimination Act (PRENDA) of 2017 (HR 147, 115th Congress)" available at <http://scipol.duke.edu/content/prenatal-nondiscrimination-act-prenda-2017-hr-147-115th-congress> (09/11/2017).

LICENSE

This work is licensed under a [Creative Commons Attribution-ShareAlike 4.0 International License](#). Please distribute widely but give credit to Duke SciPol, linking back to this page if possible.