

exist for human utilisation and mechanises the animal, inter alia through repeated references to the ‘destruction’ of the animal (see ss 3(1)(a), 4(3)(b) and 5(1) of the AP Act). With this, the animal is deprived of the dignity of being able to ‘die’ and relegated to the status of an object that can only be destroyed. The apposite questions, then, are to what degree will the court’s pronouncement on the shift in the law’s view of animals be transposed into the new legislation, and how will animal liberation advocates utilise this judgment going forward?

Whilst I remain cautious and sceptical of a resort to (existing) legal constructs in service of animal liberation, I locate the primary significance of this judgment at the level of potentially facilitating a shift towards the extension of legal rights to animals, rather than mere increased (private) prosecution of animal cruelty cases. This opinion inevitably raises several important questions regarding law’s limits, whether or not law can be reflexive and ethically consistent. The task of *thinking* becomes increasingly essential and with that, the ethical imperative to place the animal at the centre of enquiry and to challenge the institution of law itself as a mechanism of social change.

IS IT TIME TO RECONSIDER THE BAN ON NON-THERAPEUTIC PRE-IMPLANTATION SEX SELECTION?

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INTRODUCTION

Parents who use in vitro fertilisation (‘IVF’) can have their in vitro embryos tested for several genetic characteristics. This is referred to as pre-implantation genetic testing (‘PGT’). The word ‘pre-implantation’ means ‘occurring or existing between the fertilization of an ovum and its implantation in the wall of the uterus’ (*Oxford English Dictionary* (on-line edition) s v ‘pre-implantation’, accessed on 14 October 2018). Based on the results of PGT, in vitro embryos with the desired genetic characteristics can be selected for transfer to the prospective mother’s uterus. PGT currently takes the following forms (regarding terminology, see F Zegers-Hochschild, G D Adamson, S Dyer et al ‘The international glossary on infertility and fertility care, 2017’ (2017) 108 *Fertility and Sterility* 393 at 404):

- Testing for aneuploidy (‘PGT-A’). Aneuploidy means an abnormal number of chromosomes. Chromosomes are the structures in a cell that contain the genetic material. A normal human cell contains 46 chromosomes grouped in 23 pairs. The 23rd pair are the sex chromosomes — biological females have two X chromosomes, and biological males have one X and one Y chromosome at pair 23. The chromosomes in pairs 1 to 22 — the non-sex-chromosomes — are also referred to as autosomes.

Embryos with a missing or extra autosome generally cannot survive, and this results in miscarriage. However, embryos with some forms of aneuploidy can survive, the most common example being Down's syndrome.

- Testing for structural rearrangements ('PGT-SR'). While aneuploidy refers to an abnormal *number* of chromosomes, structural rearrangements pertain to changes in the normal *size* or *arrangement* of chromosomes, which typically also compromise the chances of a successful pregnancy.
- Testing for monogenetic disorders ('PGT-M'). A monogenetic disorder (or single-gene disorder) is a disorder that results from a single mutated gene. PGT-M is typically used by parents who wish to avoid transmitting a known inherited monogenetic disorder. With current PGT-M technology, more than two dozen single-gene disorders, including cystic fibrosis and Huntington's disease, can be detected in an embryo.

In the United States, over 20 per cent of IVF cycles include PGT-A (E Fragouli 'Next generation sequencing for preimplantation genetic testing for aneuploidy: Friend or foe?' (2018) 109 *Fertility and Sterility* 606). PGT-A is typically used to improve IVF outcomes, and has even been reported to reduce overall IVF healthcare costs (S A Neal, S J Morin, J M Franasiak et al 'Preimplantation genetic testing for aneuploidy is cost-effective, shortens treatment time, and reduces the risk of failed embryo transfer and clinical miscarriage' (2018) 110 *Fertility and Sterility* 896 at 896). Given that contemporary PGT-A entails a comprehensive screening of all the chromosomes — including the sex chromosomes — it reveals whether the embryo has XX or XY chromosomes. As such, PGT-A can be used to select the sex of the embryo to be transferred to the mother's uterus. Given that PGT-A using next-generation sequencing offers high accuracy (A Penzias, K Bendikson, S Butts et al 'The use of preimplantation genetic testing for aneuploidy (PGT-A): A committee opinion' (2018) 109 *Fertility and Sterility* 429 at 433), this technology offers a reliable way for prospective parents to determine the sex of their future child. Sex selection can be the primary reason for using PGT-A, but it can also be incidental to PGT-A for improving IVF outcomes. Sex selection may not even be contemplated at the stage when parents decide to do PGT-A for improving IVF outcomes, as it can be introduced as an option when the parents receive the PGT-A results. Ethics guidelines for this latter possibility were developed and published by the American Society for Reproductive Medicine ('ASRM') in 2018 (J Daar, J Benward, L R Collins et al 'Disclosure of sex when incidentally revealed as part of preimplantation genetic testing (PGT): An ethics committee opinion' (2018) 110 *Fertility and Sterility* 625). Alternatively, parents may simply want to know their embryos' sex, without intending to select any embryo based on such knowledge, which is similar to finding out the sex of a foetus during an ultrasound scan.

Prior to 2012, pre-implantation sex selection was unregulated in South Africa, and was offered as a service by some fertility clinics. However, on 2 March 2012, the Minister of Health promulgated several sets of regulations

in terms of the National Health Act 61 of 2003. Two of these sets of regulations, namely the Regulations Relating to the Artificial Fertilisation of Persons (GN R175 GG 35099 of 2 March 2012) and the Regulations Relating to the Use of Human Biological Material (GN R177 GG 35099 of 2 March 2012), include identical provisions that read: 'Pre-implantation and pre-natal testing for selecting the sex of a child is prohibited except in the case of a [*sic*] serious sex linked or sex limited genetic conditions.' This provision clearly bans the use of PGT-A for sex selection. In other words, although the testing laboratory will inevitably screen all the chromosomes as part of the PGT-A protocol, and can include the XX/XY result in its report to the fertility clinic, the fertility clinic should not use this information to make a *selection* based on the fertility clinic's own policies or based on the patient's sex selection wishes, if expressed. The fertility clinic is supposed to use the PGT-A results purely to select against aneuploid embryos, in order to improve IVF outcomes and to avoid having a child with a genetic disorder such as Down's syndrome.

I must immediately observe that the enforceability of the ban on non-therapeutic pre-implantation sex selection is likely to be close to zero, rendering it largely a symbolic gesture. Contravention of the ban will be difficult, if not impossible, to prove. For instance, if a fertility patient who uses PGT-A to improve her IVF outcomes expresses the desire to have a child of a certain sex to her fertility specialist, and she then falls pregnant with an embryo of the desired sex, was this by chance, or was there intentional selection by a human actor? When a fertility specialist decides to transfer embryo A, B, or C — all of them euploid — who will ever know how the decision was made in the specialist's mind? The ban is therefore unlikely to be effective in stopping fertility clinics that feel compelled, on ethical grounds, to assist patients who seek sex selection from ceasing such informal assistance. However, breaching this ban carries a criminal sanction. Should a person be found guilty of breaching the ban, or being an accomplice, such a person may face a criminal record, a fine, and/or imprisonment of up to 10 years (see Regulations Relating to the Artificial Fertilisation of Persons, and Regulations Relating to the Use of Human Biological Material *op cit*).

Similar bans in other jurisdictions have remained controversial (AM Long 'Why criminalizing sex selection techniques is unjust: An argument challenging conventional wisdom' (2006) 14 *Health LJ* 69). In 2005, the United Kingdom's Human Fertilisation and Embryology Authority ('HFEA') suggested that the existing ban in that country should remain in force — eliciting fierce criticism from influential UK-based bioethicist John Harris (J Harris 'No sex selection please, we're British' (2005) 31 *Journal of Medical Ethics* 286; T Baldwin 'Reproductive liberty and elitist contempt: Reply to John Harris' (2005) 31 *Journal of Medical Ethics* 288; J Harris 'Sex selection and regulated hatred' (2005) 31 *Journal of Medical Ethics* 291). More recently, in 2013, the European Society of Human Reproduction and Embryology ('ESHRE') suggested a relaxation of the European ban on non-therapeutic pre-implantation sex selection, to allow for family balancing (W Dondorp,

G De Wert, G Pennings et al 'ESHRE task force on ethics and law 20: Sex selection for non-medical reasons' (2013) 28 *Human Reproduction* 1448 at 1453). In the United States, where non-therapeutic pre-implantation sex selection is not regulated by law at national level, the ASRM updated its ethics guidelines for non-therapeutic pre-implantation sex selection in 2015 (P Amato, R Brzyski, J Benward et al 'Use of reproductive technology for sex selection for nonmedical reasons' (2015) 103 *Fertility and Sterility* 1418). In essence, the 2015 ASRM ethics guidelines state that non-therapeutic pre-implantation sex selection by intended parents is permissible, but fertility clinics are not obliged to provide such a service; each fertility clinic can decide on its own policy in this regard, and must clearly communicate its policy to its patients.

In the remainder of this note, I reconsider the well-known arguments for and against non-therapeutic pre-implantation sex selection, with reference to the most recent case law dealing with artificial reproductive technologies. I also introduce some new arguments that are specific to the South African context.

SEX DISCRIMINATION

The Constitution of the Republic of South Africa, 1996, clearly prohibits unfair sex discrimination (s 9(3)). Is this not a decisive argument against non-therapeutic pre-implantation sex selection? I suggest not. The object of the 'discrimination' in non-therapeutic pre-implantation sex selection is an *in vitro* embryo, and not a person.

The South Gauteng High Court, Johannesburg recently said something interesting about *in vitro* embryos (*Ex Parte KAF* [2018] ZAGPJHC 529). The context was a surrogacy agreement confirmation hearing. Surrogacy agreements must be approved by the high court before the parties can proceed with the execution of the surrogacy agreement. Therefore, the *in vitro* embryos may usually only be created after the agreement is approved by the court. However, in this case, there were already *in vitro* embryos that would be used for the surrogate pregnancy. The reason for this was that the commissioning mother had unsuccessfully undergone IVF, and some of the *in vitro* embryos that were created for her IVF were not used. The surrogacy legislation further provides that the court must consider the best interests of the child that is to be born, when considering a proposed surrogacy agreement. The question then arose: how do the best interests of the child relate to the embryos that are already in existence? Are these embryos all future children whose best interests must be considered? The court held that 'not one of these embryos can be legally equated with the child that is to be born' (*ibid* para 14). In a footnote to this statement, the court elaborated as follows: 'the embryos are merely the human biological material that may [...] give rise to the child that is to be born.' The position in the law is thus settled: the *in vitro* embryo has no interests or rights. Accordingly, one cannot discriminate against an *in vitro* embryo.

SEXISM

Even though non-therapeutic pre-implantation sex selection does not infringe on a specific person's rights, it can be argued that it is evidence of a sexist attitude — an attitude that a child of the selected sex is worth more than a child of the unselected sex. The problem with this argument, however, is that it presumes to know parents' personal motivations. Consider the following: parents use PGT-A and instruct their fertility clinic to select against embryos with Down's syndrome. Does this parental choice signal an attitude that a chromosomally normal child is worth more than a child with Down's syndrome? The Constitutional Court was confronted with this argument in its first wrongful life case, *H v Fetal Assessment Centre* 2015 (2) SA 193 (CC). In a unanimous judgment, the Constitutional Court rejected this argument. The court held as follows (para 72):

'Lastly [...] is the argument that recognition of the child's claim [for wrongful life] would somehow infringe upon his dignity because recognising a claim for damages would imply that life with a disability is worth less than life without one. This is not necessarily the case.'

Similarly, non-therapeutic pre-implantation sex selection is not necessarily motivated by sexism. People may use non-therapeutic pre-implantation sex selection for a whole *variety* of reasons other than *sexism*. Studies on parents who used non-therapeutic pre-implantation sex selection identified the following motivations, among others: (a) the belief that a child of a certain sex is more likely to share common interests with a parent of the same sex, and will hence be more likely to have a strong bond with such a parent; (b) the belief that it is good for a parent to experience rearing not only children of one sex, but children of both sexes; and (c) the belief that it is good for children to have siblings of the opposite sex (R R Sharp, M L McGowan, J A Verma et al 'Moral attitudes and beliefs among couples pursuing PGD for sex selection' (2010) 21 *Reproductive Biomedicine Online* 838 at 841–2; M L McGowan & R R Sharp 'Justice in the context of family balancing' (2013) 38 *Science, Technology, & Human Values* 271 at 282–3; T Hendl *Ethical Aspects of Gender Selection for Non-Medical Reasons* (unpublished PhD thesis, Macquarie University, 2015) 209–20). It is therefore evident that non-therapeutic pre-implantation sex selection is not necessarily motivated by sexism. Accordingly, given the Constitutional Court's judgment in *H v Fetal Assessment Centre* (supra), it will be difficult to argue that the values of dignity and equality are infringed by non-therapeutic pre-implantation sex selection.

However, the possible motivations for using non-therapeutic pre-implantation sex selection highlighted above may lay the foundation for another argument against non-therapeutic pre-implantation sex selection, which I discuss next.

ASSUMPTIONS ABOUT GENDER IDENTITY

From the motivations listed above, the inference can be made that parents who use non-therapeutic pre-implantation sex selection do not only want a

child with a certain biological *sex*, but actually want a child with a certain *gender-typical identity*. However, biological sex is not the same as gender-typical identity. As such, it can be argued that parents who use non-therapeutic pre-implantation sex selection are misguided — they select something that will not give them what they actually want. (See: T K Browne ‘Why parents should not be told the sex of their fetus’ (2017) 43 *Journal of Medical Ethics* 5.)

The obvious counter-argument is that in current developmental environments children are *likely* to have gender identities that are typical of their biological sex, although this is not *necessarily* the case. As such, parents who use non-therapeutic pre-implantation sex selection are not misguided, as selecting the biological sex of a child does affect the *probability* of getting a child with the desired gender identity. (See I Mikhalevich & R Powell ‘Sex, lies and gender’ (2017) 43 *Journal of Medical Ethics* 14.) Furthermore, even if some parents are misguided, being misguided is not a ground for justifying a legal prohibition.

What about the possibility that parents who use non-therapeutic pre-implantation sex selection would try to steer their child toward having a gender-typical identity? This might offend certain people’s sense of morality, but it will not be illegal. Our law allows parents wide discretion on how to socialise their children. Parents can, if they want to, go to great lengths to get their children to participate in certain gender-typical activities, and to behave in gender-typical ways.

DESIGNER CHILDREN

It can, however, be argued that the way in which we *socialise* our children is one thing, but to attempt to determine the *genetic* characteristics of our children is something different — determining the genetic characteristics of a child would be to attempt to create a ‘designer child’. Paradoxically, the Regulations Relating to the Artificial Fertilisation of Persons (op cit) that currently outlaw non-therapeutic pre-implantation sex selection, provide that a woman who uses artificial fertilisation has the right to *choose* to use male and/or female donor gametes, and the right to *choose* the gametes of a specific donor based on the donor’s characteristics — such as race, height, hair colour, eye colour, and complexion (see regulations 10(2)(a), 11(c)(ii) and 14(1)(a)(iii)). As such, as the law presently stands in South Africa, a woman can use existing reproductive technologies in an attempt to design her child’s race, height, and many more traits, *genetically*, but not the child’s sex.

In any event, whether there is an *ethically relevant* difference between genetic and social designing attempts is debatable. Can it really be said that genetically determined characteristics like race and sex are somehow more fundamental to a person’s personality and wellbeing than socially determined characteristics like culture and religion? Also, many characteristics such as intelligence and probably sexual orientation are the results of an interplay between genes and environment, therefore blurring the line between genetic

design and social design. Attempting to design a child genetically therefore does not appear to be unethical per se. However, if the *outcome* of the design attempt is likely to harm the child, it would be unethical. In the absence of evidence of such harm, the concept ‘designer child’ does not seem to have much ethical sway.

The concern about the creation of ‘designer children’ was recently raised in *AB v Minister of Social Development* 2016 (2) SA 27 (GP) and 2017 (3) SA 570 (CC) (‘*AB*’), a case dealing with gamete donor selection by a surrogacy commissioning mother. The Minister of Social Development adopted a critical stance toward gamete donor selection even though it is a legal right in terms of the Regulations Relating to the Artificial Fertilisation of Persons (op cit) made by the Minister of Health — and referred to gamete donor selection as ‘shopping around’ to create children with particular characteristics (answering affidavit to the first applicant’s founding affidavit, para 5.1, record at 1398). The expert opinion filed by the Minister of Social Development disapprovingly referred to gamete donor selection as creating ‘designer babies’ (Van Bogaert opinion, s 3, para 2, record at 1764; para 8, record at 1767; para 10, record at 1769; para 13, record at 1770; para 14, record at 1770). However, this argument did not make much of an impression on the Constitutional Court: the majority judgment ignored the ‘designer children’ argument altogether, and the minority judgment remarked that the concept ‘designer child’ or ‘designer baby’ is confounding and unhelpful (*AB* (CC) paras 149–52).

COMMERCIALISATION OF PROCREATION

Related to the designer child objection to non-therapeutic pre-implantation sex selection is the objection that non-therapeutic pre-implantation sex selection will commercialise human procreation, causing the child to be perceived as a mere commodity or commercial object, rather than a subject with dignity. In other words, the commercialisation of human procreation is equated with child trafficking — a practice that is self-evidently ethically wrong. This equation is however unjustified. For instance, when parents use PGT-A to select against aneuploid embryos, are they *buying* a healthy baby without disabilities? Is this baby now a mere commodity whose dignity has been sacrificed? Quite the opposite, I would suggest. Paying for a service that is likely to affect the characteristics of a person now or in the future, cannot be equated with paying for the person or kind of person that the service is likely to produce. When one sends one’s child to soccer practice and pays the soccer coach, one may hope to *produce* a young soccer star, but one is not *buying* a young soccer star in the sense of child trafficking. The commercialisation objection does not make much sense.

A similar argument based on the commercialisation of procreation was also raised by the Minister of Social Development in the *AB* case, and was argued at length in the papers (see answering affidavit to the first applicant’s founding affidavit, para 8.27, record at 1431 and para 24.1, record at 1540; Van Bogaert

opinion, s 3, paras 18–29, record at 1772–79; second applicant’s replying affidavit paras 166–79, record at 1601–6). However, neither the majority nor minority of the Constitutional Court felt it necessary to deal with this argument.

THE BEST INTERESTS OF THE FUTURE CHILD

As the court found in *Ex Parte KAF* (supra), a conceptual distinction must be drawn between the in vitro embryo and the future child. While the in vitro embryo has no interests, it is incumbent upon us to consider the best interests of the future child, even if he or she currently only exists as an idea in our minds. Throughout their judgments, the majority and minority in *AB* applied the constitutional protection of the best interests of the child to the *future* child, and considered how our present actions may affect the future child in *future*. In this light, the question can be posed: what about the best interests of the *future* child whose sex is selected at pre-implantation stage — can such a child perhaps suffer psychologically? No such evidence exists. Given that non-therapeutic pre-implantation sex selection was legal and practised in South Africa until 2012, anyone who takes the possibility of psychological harm seriously could undertake empirical studies on the psychological wellbeing of these children. However, common sense suggests that from a child’s perspective it is always better to be wanted than unwanted. If this commonsense principle is accepted, the question about psychological harm should be reformulated. If parents desired a child of a certain sex, but were prohibited from using non-therapeutic pre-implantation sex selection, and the child who is born is not of the desired sex, is such a child likely to suffer psychologically — or physically? Accordingly, common sense dictates that the onus should be on opponents of non-therapeutic pre-implantation sex selection to show that the prohibition on non-therapeutic pre-implantation sex selection is not harming children.

FAMILY BALANCING OR GENDER DIVERSITY

A popular ethical position is that non-therapeutic sex selection should be allowed for the purposes of ‘family balancing’ or ‘gender diversity’. This entails that when parents already have a child of one sex, they should be entitled to select a child of a different sex. Although I do not fault family balancing or gender diversity as a *personal motivation* for seeking non-therapeutic pre-implantation sex selection, it cannot be a foundation for *public policy*. The idea of family balancing or gender diversity privileges one conception of the ideal family — namely a family that contains children of both sexes. In a pluralist society, the law cannot privilege one conception of the family to the exclusion of others. In *Minister of Home Affairs v Fourie* 2006 (1) SA 524 (CC) para 59, the Constitutional Court held that ‘South Africa has a multitude of family formations that are evolving rapidly as our society develops, so that it is inappropriate to entrench any particular form as the only socially and legally acceptable one’. Research on the preferences

expressed by intended adoptive parents regarding the sex of the child they wish to adopt shows that, *inter alia*, gay men often prefer to adopt boys because they believe they are better prepared or experienced to socialise boys (A E Goldberg ‘Heterosexual, lesbian, and gay pre-adoptive parents’ preferences about child gender’ (2009) 61 *Sex Roles* 55 at 65–6). What makes the all-male family less valuable from a public policy perspective than a heterosexual couple with a boy and a girl? The answer from the platform of the *Fourie* judgment must be: nothing. Accordingly, family balancing or gender diversity cannot serve as a principle for regulating non-therapeutic pre-implantation sex selection.

PRIVACY

Privacy, or the right to be left alone, is recognised in what the Constitutional Court termed ‘the truly personal realm’ (*Bernstein v Bester* 1996 (2) SA 751 (CC) para 67), and this truly personal realm includes, according to the Constitutional Court, a person’s family life. Does family life include the decision regarding the *kinds* of persons that one wants to build one’s family with? I would suggest so. The law does not force one to accept any child into one’s family. Typically, parents decide to build their families with a very specific *kind* of child — a child that was conceived using their own genetic material. The law allows this very specific choice. Accordingly, in principle, the law allows parents to decide the *kind* of child with whom they want to build their families. It is simply an application of this principle to allow parents to decide the sex of their offspring. The current prohibition is therefore an infringement of the right to privacy.

REPRODUCTIVE AUTONOMY AND THE *AB* JUDGMENT

The Constitution provides in s 12(2)(a) that ‘[e]veryone has the right to bodily and psychological integrity, which includes the right [...] to make decisions concerning reproduction’. The majority of the Constitutional Court held in the *AB* case that this right does not include a surrogacy commissioning mother, reasoning that such a mother’s own body is not used for reproduction (para 313). However, while the majority was silent on other assisted reproductive technologies, the minority of the Court embraced these technologies — such as gamete donor selection and IVF — as being within the ambit of the right to reproductive autonomy (*ibid* paras 113–14). This established a binding precedent for all other courts in South Africa. By analogy, if gamete donor selection is included within the ambit of the right to reproductive autonomy, so should non-therapeutic pre-implantation sex selection be included. Stated differently, given that intended parents have the *right* to decide to use the gametes from donors who have specified genetic traits, hence determining various aspects of the genetic make-up of their children, such as their race, then, by analogy, intended parents should also have the *right* to decide to use non-therapeutic pre-implantation sex selection.

REPRODUCTIVE AUTONOMY AND THE CHOICE ACT

The Regulations Relating to the Artificial Fertilisation of Persons and the Regulations Relating to the Use of Human Biological Material do not only prohibit non-therapeutic pre-implantation sex selection, but also non-therapeutic *pre-natal* sex selection. This deserves some consideration. In contrast to this prohibition in the regulations, the Choice on Termination of Pregnancy Act 92 of 1996 provides that a woman can have her pregnancy terminated without having to provide any reasons, up until the twelfth week of pregnancy. Non-invasive pre-natal testing ('NIPT') can, at seven weeks of pregnancy, already identify the pre-nate's sex (S S Ormstad, A Stoinska-Schneider, B Solberg et al 'Non-Invasive Prenatal Testing (NIPT) for fetal sex determination. Health technology assessment', Report from the Norwegian Institute of Public Health (NIPH) No 2016-03, available at <http://www.ncbi.nlm.nih.gov/books/NBK482070/>, accessed on 14 October 2018) — well within the twelve-week-long first trimester. Should NIPT be refused to women, because they can use such test results to practise pre-natal sex selection? Clearly there is conflict between the regulations and the Choice Act. If a woman does not need to provide reasons, it means that any reason is acceptable. However, the regulations provide that one reason, sex selection, is not acceptable. Given that the Choice Act must take precedence over the regulations, the prohibition on non-therapeutic *pre-natal* sex selection in the regulations is invalid.

This conclusion raises an obvious consistency issue: if non-therapeutic *pre-natal* sex selection is legal, how can non-therapeutic *pre-implantation* sex selection be illegal? It would be a clear violation of the health and physical integrity of a woman to compel her to first have the embryo transferred to her body before she can have the embryo's sex tested and, if not the preferred sex, undergo an abortion. Accordingly, given the current wording of the Choice Act, the regulatory ban on non-therapeutic pre-natal sex selection and consequently non-therapeutic pre-implantation sex selection is not tenable.

EQUALITY, CULTURE, AND BELIEF

Consider two groups of people. The first group contains prospective parents who believe in Western science-based medicine. The second group contains prospective parents who believe in African traditional medicine. If members of the first group wish to have a child of a particular sex, the apparent choice would be to use IVF combined with PGT to identify the embryos that have XY and XX chromosomes. However, this would be illegal under the aforementioned sets of regulations. In contrast, if members of the second group wish to have a child of a particular sex, they would approach a traditional healer for assistance. The traditional healer can prepare a traditional herbal medicine, with or without a combination of other spiritual remedies. This is completely legal in our law, because if it happens *prior* to fertilisation of an egg by a sperm, it does not involve the pre-implantation or pre-natal stages, and if it happens *after* fertilisation of an egg by a sperm, there

is in any event no ‘testing’ involved, hence never triggering the non-therapeutic pre-implantation sex selection ban in the regulations. As such, the ban on non-therapeutic pre-implantation sex selection in its current form can be argued to constitute discrimination based on culture and belief. While persons in the second group (who believe in African traditional medicine) are allowed to practise sex selection using the technologies and customs of their culture or belief system, persons in the first group (who believe in Western science-based medicine) are *not* allowed to practise sex selection using the technologies and customs of *their* culture or belief system.

EQUALITY AND SEX RATIO

One might attempt to counter the equality argument by pointing out the lack of evidence for the efficacy of African traditional medicine in ensuring the birth of a child of a particular chosen sex. This counter-argument implies that the current sex selection ban is based on some undesirable *outcome* of *efficient* sex selection, rather than the perceived inherently undesirable nature of selecting the sex of one’s child, or the perceived undesirable attitudes associated with such selection — arguments like the ones based on discrimination and sexism discussed above clearly apply, irrespective of the efficacy of the method involved. The typical *outcome*-based argument in support of the ban on pre-implantation and pre-natal sex selection is that allowing efficient technology like PGT to be used for sex selection would result in a skewed sex ratio. However, the sex-ratio argument assumes far too much. First, on a legal level, it assumes that managing the population’s sex ratio is a legitimate government purpose. The state has as much a legitimate role to play in managing the population’s sex ratio as it does in managing the number of people in the population with particular sexual orientations. Secondly, on a factual level, the question must be posed: where is the evidence that non-therapeutic pre-implantation sex selection is likely to lead to any discernible population-scale difference in the sex ratio in South Africa? There simply is no such evidence. And the constitutional right to equality cannot be limited based on conjecture.

Accordingly, pointing out the *lack of evidence* for the efficacy of African traditional medicine in ensuring the birth of a child of a particular chosen sex, is a double-edged sword. As a counter-argument to the equality argument, it ends exactly where it started: in an evidential desert.

CONCLUSION

Sexism is a social evil, and one can understand the sentiments underlying the position against non-therapeutic pre-implantation sex selection. However, non-therapeutic pre-implantation sex selection is not necessarily motivated by sexism, and even where it is, non-therapeutic pre-implantation sex selection is the symptom and not the cause. Fighting the symptom will not cure the underlying societal ill. Moreover, fighting the purported symptom clearly causes other social harms, namely an infringement of persons’ privacy

and reproductive autonomy, and unequal treatment of persons based on their culture or belief system. We do not want to live in a sexist society, but we also do not want to live in a society that assumes a sexist motivation where it is not necessarily the case. Furthermore, we certainly do not want to live in a society where the state can interfere in a person's reproductive decisions, and where this is done only to persons who are of a certain culture or belief. The ban on non-therapeutic pre-implantation sex selection could have been well intentioned, but it is ethically and legally untenable. It is indeed time to reconsider the ban on non-therapeutic pre-implantation sex selection.

WHERE MUST WITNESSES SIGN A WILL?

KARANI v KARANI NO (GJ)

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INTRODUCTION

The formalities required for the execution of a valid will are set out in s 2(1)(a) of the Wills Act 7 of 1953 (as amended). Compliance with these formalities is the only way in which a testator can execute a valid will. (The section states that 'no will ... shall be valid unless' the formalities are complied with.) In certain circumstances, however, it is possible for a court to issue an order in terms of s 2(3) of the Act directing the Master to accept a document as a will for the purposes of the Administration of Estates Act 66 of 1965 even though it does not comply with the will-making formalities, but this requires a court order and proof of the various requirements of s 2(3). (For general discussion of the will-making formalities see The Hon M M Corbett, Gys Hofmeyr & Ellison Kahn *The Law of Succession in South Africa* 2 ed (2001) 51–7 ('Corbett et al (2nd edition)'); M J de Waal & M C Schoeman-Malan *Law of Succession* 5 ed (2015) 53–67; and Juanita Jamneck (ed), Christa Rautenbach (ed), Mohamed Paleker, Anton van der Linde & Michael Wood-Bodley *The Law of Succession in South Africa* 3 ed (2017) 65–78; for general discussion of the requirements of s 2(3) see Corbett et al (2nd edition) op cit at 57–66; De Waal & Schoeman-Malan op cit at 67–79; and Jamneck et al op cit at 78–86.)

One of the requirements to execute a will validly is that it must be witnessed. In this regard the Act requires, inter alia, that:

- the testator sign the will (or acknowledge an existing signature) in the presence of two or more competent witnesses (s 2(1)(a)(ii); see also s 1 s v 'competent witness');
- all the witnesses be present at the same time (s 2(1)(a)(ii)); and
- the witnesses 'attest and sign the will' in the presence of the testator and each other (s 2(1)(a)(iii)).

The focus of this note is on the last of these requirements — that the witnesses 'attest and sign the will' in the presence of the testator and each