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Between reproductive rights and sex selection in New Zealand's abortion reforms: practitioner dilemma in institutionalising 'choice' and 'agency'

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ABSTRACT

In 2020, the New Zealand (NZ) Parliament voted to decriminalise abortion. Although NZ's abortion law formally opposes sex selective abortions, there is considerable complexity in the gender politics of 'choice' and 'agency' in multi-ethnic societies, and interpretations of reproductive rights for ethnic minority women and for the girl child, respectively. This paper explores these complexities through the perspectives of reproductive and maternity care practitioners who are situated at the interface of legal systems, health service provision, and delivery of culturally sensitive care. Thirteen practitioners were interviewed as part of this study. The analysis highlights strains in framings of 'reproductive choice' (underpinned by western liberal notions of rights) and 'gender equality' (abortion rights that acknowledge the complexity of cultural son-preference) for ethnic minority women. These tensions are played out in three aspects of the post-reform landscape: (a) everyday practice and accountability; (b) consumerism and choice; (c) custodianship and gender rights. The findings point to the limitations in operationalising choices for ethnic women in health systems wherein trust deficit prevails, and cultural dynamics render complex responses to abortion. They also highlight reconfigurations of client-expert relationships that may have implications for practitioners' abilities to advocate for ethnic women's rights against cultural influences.

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Aotearoa New Zealand; ethnic minorities; Asian; abortion; sex selection

Introduction

In March 2020, following an impassioned debate, the New Zealand (henceforth, NZ) Parliament voted in favour of the Abortion Legislation Act (2020, henceforth ALA20) making abortion a public health, rather than criminal, matter.[1] A key argument made during the parliamentary debates centred around sex selection. Members both in favour of, and opposed to, abortion law change used sex selection as a point of argument – the former to dissociate rights to abortion from an endorsement of sex selection and the latter to equate one with the other.[2] In its final summation, the law states that '[t]his Parliament opposes the performance of abortions being sought solely because of a preference for the foetus to be of a particular sex' (ALA20, Section 21 (1)).

The reference to sex selection in the abortion debate directly draws attention to New Zealand's ethnic minority and migrant communities from Asia, Africa, the Middle East, and Latin America,

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who comprise around 17% of the total population. Internationally, sex-selective abortion, particularly favouring boys, has been seen as inherent to Asian, particularly Indian, and Chinese societies, impacting sex ratio at birth profiles in these countries (Bongaarts & Guilmoto, 2015; Sen, 1990). In recent years, similar sex ratio patterns have been noted among Asian migrant populations residing in western countries like the UK, Canada, and the US, signalling the continuing practice of sex-selective abortions post-migration (e.g. Almond et al., 2013; Dubuc & Coleman, 2007; Srinivasan, 2018; Wanigaratne et al., 2018).

Abortion-related practices among Asians in NZ present an ambivalent picture. NZ-Asians have low numbers of abortion overall but their abortion *rates* (abortions per pregnancies) in comparison to all ethnicities are the highest (Ministry of Health, 2021; Simon-Kumar, 2009). Although abortion is legal in the origin countries of the two main migrant groups – India and China – research shows Asian-NZers to be generally less supportive of the recent abortion reforms compared to other ethnicities (Huang et al., 2019). Perhaps reflecting this position, at least two Asian women parliamentarians voted against the 2020 reform, with at least one noting the potential abuse for sex selection as a reason (MP Parmar, New Zealand Parliament, 2020), despite the data on sex-selective abortion to date belying this assertion. Recent work notes no male-favouring sex ratios among children born in NZ in ethnic communities noting that, compared to other western countries, NZ presents an 'anomaly' (Simon-Kumar et al., 2021). Despite this evidence, there is an entrenched popular association of sex selection with cultural diversity, as reflected in comments by parliamentarians during the debate '[t]hat (sex selection) is not part of New Zealand culture, and we never want it to be'.[3]

In all, the recent abortion law reforms raise concerns regarding gender politics of reproductive rights, for ethnic women, on the one hand, and the girl child, on the other. How are 'choice' and 'agency' to be understood in multi-ethnic societies? As part of a broader research project exploring the prevalence and values of son preference and sex selection among NZ's ethnic populations, this paper explores the contradictions of the abortion reform through the perspectives of health practitioners who are situated at the interface of legal systems, health service provision, cultural influences, and gender rights, and through whom these political tensions play out in practice.

Sex selection and the Asian diaspora: Framing the debate

At immediate consideration, non-medical sex selection, especially in non-western contexts, connotes gender injustice; an expression of society's inherent devaluation of girls and women and preference for males and boys. Beyond this broad – and at times abstracted – refutation however, the ethics, legality, and political morality of sex selection, in *actual* context, is far more amorphous and contested. The parameters of its rights and wrongs are circumscribed by competing actors: medical professionals, pro-choice feminists in the global south and north, diaspora/minority feminist activists, anti-choice proponents, ethicists and philosophers, religious actors, academics and researchers, and official actors both international and domestic.

The ethics of non-medical sex selection, first and foremost, are defined by the stage in the birth cycle: pre-conception (including procedures such as sperm sorting); during pregnancy (sex-selective abortion), or after birth (infanticide). While the ethical, including feminist, arguments and potential regulations arising from the latter two stages are well developed, pre-implantation debates by and large are still shrouded in vagueness. Of the latter two, infanticide – regardless of context – is unambiguously criminal and is a domain where there is little divergence among actors.

Sex selection during pregnancy, materialised as sex-selective abortion, raises competing interpretations of choice and autonomy, including questions about whose autonomy is prioritised. Diverse interpretations have fragmented solidarity among feminists as well as between feminists and non-feminist perspectives. In the global south, especially in India, led by feminist agitation since the 1990s, the state has ruled sex-selective abortion, in all forms and at all stages, as illegal. Even the act of enquiring about the sex of the unborn child is seen as a transgression of legal norms. There are critiques of the

actual ability to surveil sex-selective abortions, especially in the face of rapidly emerging new reproductive and medical technologies (Unnithan & Dubuc, 2018); these limitations notwithstanding, the norm is to consider all sex-selective abortion a crime of violence against girls and women.

On the other hand, proponents of western liberal feminism fold all demands for abortions into notions of reproductive choice, individual rights and 'abstract' human rights centred on the woman who is pregnant (Cioffi et al., 2022; de Londras et al., 2021; Harris, 2005; Savulescu, 1999; Strange & CESAGEN, 2010), arguing against regulation of any abortion unless weighted unambiguously by evidence of 'serious' harm (Harutyunyan, 2019). In large part, this protects sex-selection for 'family balancing', where sex selection is purportedly not a reflection of systemic societal gender bias but rather a personal desire to parent children of both or some sexes (Strange & CESAGEN, 2010).

Diasporic and migrant, particularly South Asian feminists in the west, on the other hand, argue that western notions of individualism and choice are unrealistic for framing abortion decisions for minority, and especially Asian, women, given the significant influence of cultural norms in women's reproductive agency (Ganguli-Mitra, 2021; Moazam, 2004). There is a distinction in the discourse between 'gender equality' and 'reproductive choice' where the former, typically used by diasporic feminists and anti-abortion activists, is used as grounds against sex-selective abortion while the latter, led by liberal/European feminists, warn against quelling women's choices (Kasstan & Unnithan, 2020). In a qualitative research project conducted among first-generation Indian women living in the US, Puri et al. (2011; see also Gill & Mitra-Kahn, 2008; Purewal & Eklund, 2018) found extreme pressures to concede to family desires for sons. Research in Canada (Wanigaratne et al., 2018) found the practice of sex-selective abortion even among second-generation migrants; the argument was that it was not so much that girls were 'unwanted' but rather that the privileges accruing to women who bore sons influenced decisions to sex select, and in fact, could be considered a form of reproductive autonomy for them (Unnithan & Dubuc, 2018). Equally, it is not uncommon to find son preference alongside a relative absence of daughter aversion once born (Kohli, 2018; Unnithan & Kasstan, 2022) expressed as 'soft' sex selection practices, such as, for example, higher birth parity until the desired sons are achieved, avoiding morally fraught decisions around abortion.

To others (Puri et al., 2011), sex selection is an act of 'resistance against patriarchy', by refusing to contribute to the pool of women's discrimination, and a blessing in disguise for girls who are better unborn. Scholars (Ganguli-Mitra, 2021; Moazam, 2004) label liberal feminist framings of autonomy as 'meaningless' given that these are not real choices. Countering this argument, others (e.g. Macklin, 2010, july) argue against an idealised framing of autonomy but rather that everyday enactments of autonomy *in context* are relevant, even if imperfect, against universal standards. In the face of these complexities, calls to universalise abortion norms based on western liberal standards are themselves seen to be 'totalitarianism' (Moazam, 2004).

These fractured perspectives are reflected in legislative frameworks leading to a panoply of interpretations among legal practitioners. Strange and CESAGEN (2010) note that the International Human Rights framework, under its enshrined reproductive rights, allows for 'two opposite positions': the right to reproductive choice, in principle, permits parents to determine the sex of their children while the principle of non-discrimination disallows this. Toebes (2008), on the other hand, categorically points out that international frameworks allow for reproductive decision making around 'when and how many, not which sex' (p. 217). Others (see Dickens et al., 2005) recommend differential application of sex selection prohibition in different countries; in the west where there is no widespread evidence of son preference, couples should not be prohibited from sex selection for family balancing, whereas prohibitions are appropriate in Asian countries widely known for discrimination against girls, a stance that poses more confusion than clarity for Asians who migrate and are resident in the west. Western countries – including the US, UK, western Europe and Canada – in general, have tended towards stringency rather than flexibility of interpretation (see Table 1), leading some liberal scholars to draw attention to the dangers of greater state intervention in reproductive decision-making (Harris, 2005); at a time when there is a resurgence of moral panic around reproductive rights (Parker, 2020), sex selection stands as another ground to

Table 1. Sex Selection in abortion and assisted technology: comparative legislation in select multi-ethnic societies.

Abortion Legality and Sex Selection

New Zealand	***United States of America***	***Great Britain and Northern Ireland (United Kingdom)***	***Canada***	***Australia***
Abortion Legislation 2020 Legal: Up to 20 weeks. *Sex Selection*: Legislation states government 'opposes' abortion 'solely' for sex preference. S21(1).	Roe vs Wade 410 U.S 113 (1973), overturned in June 2022. Illegal: 14 states, (as at March 2023) Illegal with gestational limits: 4 states Ban blocked: 8 states Legal with limits: 10 states Legal: 15 states *Sex Selection*: 8 states have enacted laws prohibiting sex selective abortion. 21 states have considered such laws since 2009[a]	Great Britain: Abortion Act 1967 Legal: Up to 23 weeks and 6 days. *Sex Selection:* Although not specifically mentioned in Abortion Act, it is illegal. Sex selection also assessed under the Serious Crimes Act (2015). Northern Ireland: The Abortion (Northern Ireland) Regulations 2020 Legal: Up to 12 weeks *Sex Selection*: Not specifically mentioned in legislation.	Canada Health Act 1985 Legal, but gestational limits different in each province; typically ranges from 12 weeks to 24 weeks and 6 days *Sex Selection*: Not specifically mentioned in legislation.	Legislation titles differ per state and territory. Legal in all states and territories: Gestational limits differ, ranging from 16–22 weeks. *Sex Selection:* Not specifically mentioned in legislation, however it has been banned by the National Health and Medical Research Council.

Sex Selection via Assisted Reproductive Technologies

New Zealand	***United States of America***	***United Kingdom***	***Canada***	***Australia***
Illegal: 2004 Human Assisted Reproductive Technologies Act. Section 11 (1) (2) (3)	The Fertility Clinic Success Rate and Certification Act Legal: No current laws banning sex selection for social reasons such as 'family balancing'.	Illegal: Human Fertilisation and Embryology Act 2008 (HFEA), except for: sex selection in families where the risk of a genetic disorder is greater in one sex than the other.	Illegal: Assisted Human Reproduction Act 2004 (AHRA) Gender selection procedures illegal 'except to prevent, diagnose or treat a sex-linked disorder or disease.' (AHRA 5(1)e).	Illegal: Assisted Reproductive Treatment Act 2008, except in two situations (section 28): (1) to avoid the transmission of a genetic abnormality or genetic disease. (2) The Patient Review Panel has otherwise approved the use of the gametes or embryo … for purpose of producing … a child of a particular sex.

Source: various; [a]Citro, B., Gilson, J., Kalantry, S., & Stricker, K. (2014). Replacing myths with facts: sex-selective abortion laws in the United States.

reintroduce conservative laws on abortion, so that in the end, everyone stands to lose. Yet others (Ganguli-Mitra, 2021; Moazam, 2004) argue that the complexities in the interstices between cultural values and women's rights call for precisely greater state intervention (or 'the power of the state', Moazam, 2004) as long as it passes the 'lens of gender justice' to avoid new conservatist politics over women's bodies (Ganguli-Mitra, 2021, p. 9).

While nominally protective, criminalisation of sex-selective abortion legislation can have other ramifications for Asian minority/diaspora populations. Often these laws are based on an essentialised, backward, and simplified notions of 'culture', the oppression of minority women, and their lack of agency, eliding what is, in reality, a set of complex relationships and values (Ganguli-Mitra, 2021; Unnithan & Dubuc, 2018). For instance, Unnithan and Kasstan (2022) show that 'culture' and

'religion' are constructed very differently by minority girls – the latter, central to their identities as minorities, is constructed as progressive while culture is framed as retrograde. These distinctions are lost in sweeping criminalisation of the act of sex-selection. Thus, the cost of protecting the unborn girl child has unwittingly or otherwise been pitted against other democratic entitlements of minority populations deepening their 'othering' and limiting their freedoms. A 2012 editorial for the *Canadian Medical Association Journal (CMAJ)* entitled 'Sex selection migrates to Canada' typifies this construction of 'us v. them'; a quote by a medical practitioner in the article notes that sex selection 'works against everything *we* believe in Canada in terms of equality' (Vogel, 2012, p. E163, italics added). Lee (2017) notes the racial profiling of ethnic minority women where every request for a non-medical abortion is carefully scrutinised. Similarly, Unnithan and colleagues (Kasstan & Unnithan, 2020; Unnithan & Dubuc, 2018; Unnithan & Kasstan, 2022) point to the emergence of new 'reproductive governance' arising from contemporary sex-selection debates in the west that complicate politics and players: these include the greater surveillance of abortion providers and the minority community; new mobilisations of activist groups; starker polarisations among diverse positions held on abortion, and alliances between ideologically incompatible partners such as anti-abortion activists and South Asian progressive feminists. Furthermore, abortion-permissive frameworks are not necessarily an indication of abortion-supportive care (Romanis, 2023).

In contrast to intense debates and regulation of sex selection during pregnancy, there are comparatively fewer lines of clarity in relation to pre-implantation sex selection (Van Balen & Inhorn, 2003). Medically, some small-scale studies show that pre-implantation births tend to be male dominant, although there is no clear evidence as to whether this is socially designed or merely an outcome of natural processes (Maalouf et al., 2014). As of the present, it is not seen as an act of criminality to determine the sex of the child prior to implantation on the grounds that pre-fertilisation sorting does not constitute foetal harm, which is the main grounds for prohibiting reproductive choice. There are challenges to this liberal view of absence of harm, but these are largely appeals to societal morals at this stage – Sandel (2004), for instance, claims that sex selection is an example of the misplaced quest for human perfection and efforts to gain mastery over nature and are to be resisted, while McDougall (2005) argues for parental virtues of 'acceptance' over perfection. Scully et al.'s (2006) empirical research demonstrates that everyday parenting reflects these values – that, by and large, parents believe that good parenting requires them to, at best, protect their children from harm, rather than intervene to produce the perfect child. Despite these calls for caution, in the sphere of pre-implantation sex selection there is greater dominance of market rules: the rights of paying customers and pricing of technology are among them (see Table 1).

It is against this wider canvas of moral persuasions that health professionals make every day medical decisions for their patients. As practitioners, they are caught between forces that impel them to progress women's and minority rights (some of them identify personally with both) but are limited by feminist and market forces that emphasise freedom and choice. Although they are required to act in accordance with their professional ethics of no-harm, there is ambivalence around who that is intended to cover. In actuality, the ambivalence in legislation means additional burdens on practitioners to make ethical decisions (Kasstan & Unnithan, 2020). Berkowitz and Snyder (1998) charge practitioners for furthering racism and sexism when they facilitate sex selection, while Lee (2017) constructs them as victims of social vilification. In the impossible intersections between multiple understandings of agency, freedom, and harm, the impact of decriminalisation in New Zealand is at an especially important crossroads for practice.

Methodology

Population background

New Zealand's demographic profile has seen dramatic transformations since the 1990s. Although small numbers of Indian and Chinese populations have resided in NZ since the eighteenth century,

significant immigration reforms in the 1980s aimed at attracting skilled labour resulted in the rapid growth of migrants in the following decades. In 1991, the proportion of the population group labelled 'ethnic' – comprising populations from Asia, Latin America, the Middle East, and Africa – was recorded as 3.1%, but this grew to 11.6% in 2006, and 17% in 2018. Nearly 27% of NZ's population today is born overseas (Stats, 2019a). Today, New Zealand is a multi-ethnic society; the 2018 Census recorded 180 ethnicities, 176 languages and 157 religions (Stats, 2019b, 2020) The largest and most rapidly growing of the diverse ethnic communities is Asian (particularly, Indian and Chinese), and is expected to comprise 26% of the total NZ population by 2043. Aside from ethno-cultural diversities, the Asian population is economically and income-stratified and heterogenous with respect to visa status (including citizens, permanent residents, and those on a range of temporary visas), length of time in NZ (generations to newcomers), and migration generation (viz., first- or second-generation migrant). These diversities manifest in varying degrees of continuity of cultural identities and practices which have beneficial and detrimental implications for gender equality. Culture, for instance, is a strong – although not sole – factor in family violence (Somasekharan, 2016; Simon-Kumar, 2019). Its effect on son preference and gender bias is less clear. Internationally, stronger son preference values are found among first-generation Indian and Chinese migrants, although the evidence for NZ appears to be weak (Simon-Kumar et al., 2021).

Study particulars

This study was approved by the University of Auckland on 1 July 2019 (Reference no. 023303). This paper presents analysis from a broader mixed-methods study – including quantitative analysis using Census data (Phase 1) and qualitative interviews with practitioners (Phase 2) and parents (Phase 3) – that examined sex-selection among ethnic minorities in New Zealand. For this paper, we draw on data from Phase 2, i.e. in-depth interviews with medical and health practitioners (midwives, gynaecologists and obstetricians, fertility, and abortion specialists). A total of 13 practitioners were interviewed to understand emergent challenges, dilemmas, and ethical and professional conflicts post-reform, although the analysis is informed by the other phases as well. Practitioners included both minority (South Asian and Middle Eastern) and majority ethnicities (Pākehā/European), recent migrants, established settlers and born New Zealanders. Table 2 provides an overview of the profile of practitioners who participated in our study.

Data collection included both in-person and online methods due to Covid-19 lockdown restrictions. Interviews, conducted in English, were completed between September 2020 and July 2021, each lasting between 60 and 75 min. Participants provided written informed consent at the beginning of the interview. Data were transcribed initially using the software Transcribe *Wreally* ™, followed by a manual clean for accuracy by a research team member. The interviews were conducted using a semi-structured interview guide which featured a range of topics including experience of providing maternal care for ethnic pregnant women, their understanding of gender bias and its manifestations within the ethnic communities, uptake of abortion services among ethnic women and whether the recent abortion reform will have an impact on it.

Given the sensitivity of the subject and size of the population, special care has been taken to ensure confidentiality, including the use of alpha-numeric identifiers throughout this paper.

Table 2. Ethnicity and place of birth of participants.

Ethnic Identity	Personal Biography	Participants
Ethnic minority	born and raised in NZ	GYN2, MW1, OS2
Ethnic minority	migrated to NZ	GYN4, GYN5, MW2, MW4, OS1
Majority group (European/Pākehā)	migrated to NZ	MW3
Majority group (European/Pākehā)	born in NZ	GYN1, GYN3, OB1, OS3

Acronym key: GYN-Gynaecologist; MW-Midwife; OB-Obstetrician; OS-Other Services.
Note: in the interest of confidentiality, we have not disaggregated identity by specific ethnicity or nationality of origin.

Themes were isolated from the data following processes outlined in Braun and Clarke (2006) and Joffe and Yardley (2003). During data collection, interview transcripts and field notes were reviewed and analysed. This interim analysis helped monitor data saturation and pursue emerging avenues of enquiry in further depth. Codes were analysed and collated to identify overarching themes and sub-themes, and the coded text was verified across authors. Theme identification was largely inductive, but where applicable these were compared against key strands from abortion and sex-selection debates present in other countries. We often returned to the interview transcripts during writing of the analysis to make sure we did not deviate from the data. We also consulted the broader literature to contextualise our study methods and findings in existing knowledge. In July 2022, themes from the analysis were presented to a multi-disciplinary and multi-cultural stakeholder consultation workshop comprising 35 practitioners including some study participants; their feedback enabled deeper reflections on the findings.

As authors, we acknowledge our own positionalities as significant in informing our interpretations of practitioners' views regarding gender bias and potentially sex-selection among ethnic communities in NZ. The members of the wider research team are non-clinical researchers, female, belonging to diverse ethnicities (Indian, Fiji Indian, Pākehā European, Taiwanese) with different migration (born in NZ/arrived as a migrant) and cultural histories. One of the researchers recently accessed maternal health services in NZ, while two others had used child health services in the late 1990s. Our diversities encouraged reflexivity throughout the planning and conduct of this study.

Finally, it is worth noting at the outset that our interviews with practitioners revealed no concrete evidence of sex-selective abortion among ethnic communities in New Zealand. Many emphatically ruled out its prevalence: 'I can't remember one case in all those thousands where a woman has actually said "I know it's a girl and I want to abort it" Never' (OS3) and 'I'm not personally aware of anyone, travelling [overseas] to have a termination based on gender' (GYN5). Others were more reserved and, although they did not rule out its possibility, noted that 'if it does happen it'd be very hush-hush' (GYN2*)*. Practitioners who assumed the prevalence of sex selection often did so by reading between-the-lines of client enquiries or through third-party comments ('It was just a colleague saying "oh they were very particular. They wanted to know if it was a boy, or a girl" … ' (OS1)). Direct references to sex selection by clients tended to be noted by midwives, often as broadly worded enquiries rather than specific requests for themselves.

Beyond these generalised attributions, the data in this regard is ambiguous. Consequently, proof of prevalence of sex selection is not the focus of the current analysis. Rather, it examines the complex articulations of 'choice', 'rights' and 'agency' following reform, and the implications for abortion practice. Specifically, the analysis highlights the framings of 'reproductive choice' (a liberal notion of women's rights) and 'gender equality' (the exercise of abortion rights against the complexity of culturally defined son-preferences) (Kasstan & Unnithan, 2020). These tensions are played out in three aspects of the post-reform landscape: (a) everyday practice and accountability; (b) consumerism and choice; (c) custodianship and gender rights.

Everyday practice and accountability

Accountability to women clients by service providers is considered integral to reproductive rights (George, 2003; Schaaf et al., 2022). In the wake of NZ's abortion reform, new architectures of women-centred accountabilities were being constituted but, from the accounts of practitioners, these had complex ramifications for choice and agency. Practitioners in our study were widely supportive of the abortion law and recognised its many benefits for women (the reform 'improves access' for women: GYN3). The law change brought benefits also for practitioners; the previous law made consultations on abortion a 'nervous place to be' and always opened the possibility of being 'criminally prosecuted', but with the reform there was clarity of practice 'it's just part of medicine' (GYN3) without fear of punitive consequence. Another physician noted a specific instance of a woman who had ordered misoprostol online for an unplanned pregnancy. The very knowledge of

her act ('it's not really legitimate') placed the physician in a criminally compromising position ('a little bit confronting') but with the change of law, there was more freedom to address abortion as a health issue: 'And now it's not illegal, so like I guess it's less of an issue' (GYN2).

While recognising the benefits and the necessity for reforms in the abortion law, practitioners in our study were also quick to point to its limitations in everyday practice. Specifically, participants reflected on three key areas where the law was lacking. The first of these centred around the cessation of mandatory counselling. According to the Abortion Reform 2020, while practitioners 'must advise' a woman of counselling services they 'may not, as a condition of providing abortion services to a woman, require the woman to attend counselling before or after the provision of those services' (ALA20, Section 12). The lack of mandatory counselling was a point of concern for practitioners. GYN4 asserted: 'to put a termination into place there has to be robust counselling and that is missing with the new change in the law'. The removal of mandatory counselling has been a core claim for pro-abortion feminists, largely led by NZ Pākehā/European feminists (see, for example, http://alranz.org/alranz-analysis-of-the-abortion-law-reform-bill/). Placed within the context of ethnic minority communities, providers expressed apprehension that any coercion placed on women would not be detected at various stages of the termination process and if anything, the absence of mandatory counselling is tantamount to 'taking power away' from the woman.

> After that, even if [there's] family pressure, a woman goes and says I want a termination, I cannot afford it financially. She doesn't need to see a psychologist. She doesn't need to see a social worker. She can just have a termination .... It could be pressure from the family ... I will say that it's taking power away from such a big decision. (GYN4)

A second concern related to the lack of clear, step-by-step, official, and documented processes post-reform is as follows. In overseas studies, 'pre-signing' of documentation by doctors following phone consultations, without seeing actual patients and hence leaving abortion procedures to nursing staff, has been highlighted as a key point where sex-selection abuse is allowed to occur (Lee, 2017). In NZ, prior to the reform, practitioners signed off on every stage of the termination process, an assurance that official and due diligence had been done. As the extended excerpt below notes, after the reform and in cognisance of women's reproductive choice and privacy, there is a minimisation of steps involved for the termination and attendant official paperwork.

> For the under 20 [weeks], in the olden days, before it changed, you had this piece of paper where two people had signed, everything was official ... And the midwives or the nurses knew that it was all signed off. They'd had the conversation. They'd had the options. Adoption had been discussed, you know, all that sort of stuff. Currently there is no such documentation required. It's not mandatory. (OS1)

The reduced paperwork has left practitioners – particularly those on the hospital floor such as nurses – unclear about their accountability within the new architecture of decision-making. Practitioners perceived that elimination of clearly defined stages had reduced, rather than expanded, choices for women, revealing an underlying lack of trust in the system to enable authentic reproductive agency.

> So, the nurses started feeling, well, how do we know she wasn't forced into it? Because she can have bad interaction, let's say, with a GP and the GP sends her in for a termination, right? How do you know that that's not happened? These were the questions. (OS1)

In the end, to manage the uncertainty posed under the new system, providers constituted new documentation that clarified the client's choices of, but more importantly their own liabilities within, this process.

> So, we said, the best way to deal with this is that the woman signed a consent form just like for an operation to say, "I would like termination of pregnancy and the risks and things have been discussed with me" (OS1)

A third concern raised by several practitioners, particularly midwives, related to late-stage terminations, which had particularly been an issue during COVID-19 when delays in care were not

uncommon. Late-term abortion typically refers to termination after 20 weeks; in 2020, this category constituted approximately 0.77% of all terminations in NZ (Ministry of Health, 2021; Table 7.1). Under the new legislation, abortions after 20 weeks are legal 'if the health practitioner reasonably believes that the abortion is clinically *appropriate* in the circumstances' (ALA20, Section 11, italics added). Clinically 'appropriate' is defined as consultation with one other practitioner, and with 'regard' for the woman's health, gestational age of the foetus and professional, ethical, and legal considerations (Section 11 (2)). In practice, however, these guidelines do not appear to provide clear criteria regarding when termination is illegal, and the right to request abortion is understood as an unconditional entitlement at all stages of the pregnancy. As one physician noted: 'We're just sort of working our way around how to support women who come late and just think they can ask for an abortion and have it and not worry about it' (GYN3). Late terminations were highlighted as a particularly distressing aspect of the abortion reform and as seen in the following excerpt, the physician's comment juxtaposes 'people's choices' with that of 'baby's rights,' noting that the decisions around discerning the blurred lines between these falls on their judgement.

> People want that choice, I think, yeah, so they can. The difficulty is, is that if you have an abortion after 22 weeks, the baby does have a chance of being born alive. And the baby has rights. The foetus does not have rights … . So, we then have to do a foeticide. To kill the child before the child is born, which is not something we want to be doing. Which the government has not even thought of. (OS1)

Accountabilities in everyday practice post-reform are especially fraught with respect to sex selection as there was less of an obligation to provide a reason for a termination.

> … the sex-selection stuff is hard because … they might not even say that's the reason why they're having their termination and there's no obligation for them to give a reason … . So, I don't know how the law reform is going to impact on that .. (GYN2)

In contrast, practitioners specialising in in-vitro fertilisation, portrayed greater confidence in dealing with questions on sex selection. The Human Assisted Reproductive Technology (HART) legislation (2004) clearly forbids anyone to 'perform any procedure, or provide, prescribe, or administer anything in order to ensure, or in order to increase the probability, that a human embryo will be of a particular sex' (HART, 2004, Section 11). The legislation goes on to explicitly note that such action is an 'offence' liable to imprisonment and a fine (Section 11 (2)). The unambiguous directives around assisted reproduction in NZ translate into clear limits of reproductive choice allowed to clients: 'The IVF guys work under a very close ethical framework and so there's no way they would ever select an embryo to transfer based on gender' (GYN2). Consequently, when confronted with requests to select male embryos over female, these specialists carried an authoritativeness based on medical evidence and backed by law, bypassing individual preferences and choice.

> And I said "no, I'm deciding based on which ones are carrying a higher risk of genetic problems based on assessments on scan and which ones are the easiest access so less likely to have a miscarriage as a result" … . And I knew that was about gender selection and a request for boys … (GYN3)

By comparison, the abortion legislation's wording that 'opposes' (Section 21 (1)) sex selection without further stipulation means that for practitioners providing abortions, at the point of service delivery the ambivalence of gender equality and reproductive choice is more pronounced. The transcript below demonstrates uncertainty in cases where requests are based in son preference:

> It has become more accessible for women because now women can front up by themselves and say "I don't want this" … if the baby is normal then they have to think twice: would I agree or would I not agree, you know? They do have a right to say no. But they also have a duty to say "okay, I say no, but I will get you to see someone else." It is very complicated. (OS1)

The practitioner's comment points to a space of ambiguity that sits beyond the conventional pro-choice v. anti-abortion dichotomies. Abortion providers, in fact, must choose between a range of equally weighted rights: that of the woman (for which they are not allowed to have

unconditional unconscientious objection), cultural rights, the (non) rights of the foetus, and the full rights of the baby, which in their words, makes a medical decision 'very complicated'.

Overall, although practitioners value reproductive choice, they recognise it as wrapped into, not independent of, legislative and institutional processes. The removal of procedural specificities while augmenting choices for women, in their view, seems to aggravate the gap between gender equality and reproductive choice.

Consumerism and the discourse of reproductive choice

A second discourse of 'choice' and 'agency' related to developments in reproductive technology and shifts in the delivery of pregnancy diagnostics towards the private for-profit sector. The overlay of reproductive choice with that of consumerism and commodification is well established in feminist critiques of neoliberalism (Bendix & Schultz, 2018; Moeller, 2018; Rao & Sexton, 2010). In the specific context of abortion, consumerist interpretations of choice have several ramifications. The privatisation of reproductive technology signals a transition from the construction of women as patients who can act only under the advisement of medical professionals to paid consumers with an entitlement to select from an array of choices. Commodification also creates a marketplace for reproductive technologies external to public healthcare services. The decriminalisation of New Zealand's abortion law has come at a moment when choices were already expanding vis-a-vis the private sector.

The participants in this study discussed the private marketplace for reproductive technologies for abortion and recognised the accompanying and positive expansion of choices for women. However, the practitioners also noted that as women's choices expanded, their own clinical expertise in abortion care, including the ability to manage conflicting moralities of choice, was less called for. These contradictions were particularly notable in the specific context of non-invasive prenatal diagnostic testing (NIPT). NIPT is a non-invasive blood test available to women early in pregnancy (usually 10–12 weeks) to test for foetal abnormalities. In NZ, it has been available since 2013 (Filoche et al., 2017). Although typically used to test for chromosomal abnormalities (13, 18 and 21), NIPT can also reveal sex of the foetus at that stage. NIPT is currently not offered as part of routine pregnancy care in NZ but is available in the private sector for purchase via referral from their lead maternity carer. Until the arrival of NIPT, the sex of a baby was determined – even if not necessarily revealed – only at 20 weeks by way of an ultrasound scan, by which time there would be no legal recourse to abortion unless there was clear indication of foetal abnormality. With NIPT, the potential timeframe where sex can be identified is now much earlier, within a few weeks of detection of pregnancy, leading to concerns about its misuse for sex selection (Bowman-Smart et al., 2020).

Our participants readily associated requests for NIPT with ethnic minorities. Asked to describe NIPT clients, practitioner GYN3 used terms like 'new immigrants' who have 'language barriers' and who were 'not necessarily … the richest people' or 'probably not working class because it is expensive' but new migrants who 'might be middle class' and 'not really well-moneyed'. Practitioners were also divided in their view that NIPT was – or could potentially be – used for sex selection (see Table 3). Those who felt that the NIPT would be used for sex selection argued that: 'it's a much easier termination than later on' (GYN1) and was 'a tool now that women can use for gender selection … because it's still up in that time frame to get an abortion' (MW4). Arguments against its misuse were based on practitioners' clinical experience that families only terminated foetuses that had abnormalities, not because they were the wrong sex:

> I have seen couple of ethnic families that had Down syndrome babies; the test came back positive, and they terminated. They didn't want to go ahead with it, but nothing to do with the sex, it was just the disability. (MW2)

These divergent perspectives notwithstanding, NIPT blurs the context of reproductive choice and gender equality. For one, abnormality and sex selection as grounds for seeking NIPT are not

Table 3. Practitioner Responses to the use of NIPT for sex selection.

Discourse	Practitioner	Excerpt
NIPT is not misused for sex-selection	OB1	And the gender side of things is more just they can't wait or … they're curious to know rather than stating their preference … [a]t least what's been expressed to me is more of the concern about abnormalities than gender as being more important
	MW2	They can [find it sooner] if they pay $700 and do a blood test called NIPT test, but that's something people do. People who have money they do it. I have seen couple of ethnic families that had Down syndrome babies; the test came back positive, and they terminated. They didn't want to go ahead with it, but nothing to do with the sex, it was just the disability.
	GYN4	Not from where I see. The ones who go for the NIPT test only want to know that the baby is healthy.
	GYN2	There's been a demand for it (*Int: Do you find that there's been a demand for this test by Asian communities?)* [nods] … but more, I think, more for the purposes of finding out any chromosomal problems.
NIPT has potential to be misused		
	GYN5	I don't think they'd have to disclose that it was because they wanted to select a gender. I think they just have to say, 'I'm worried, I want to know', and they would get the test.
	GYN1	It (NIPT) does (make it easier to sex select) because it's a much easier termination than later on.
	MW4	… it (NIPT) is a tool now that women can use for gender selection because you find out early enough. Because it's still up in that time frame to get an abortion …
No clear evidence although the possibility for misuse exists	GYN3	if a woman now wants to know the gender of the baby because she wants to consider sex selection, it's really easy. Way easier than it was before we had NIPT. … To be honest, to be fair, I'm not hearing anything about it (sex selection) … I think it's an ethically challenging area that you're looking at …

as distinct as made out to be. Although there is no need to reveal foetal sex during NIPT, on medical grounds alone, it might be necessary to reveal both as some of the chromosomal abnormalities are sex related:

> … you might have an XXY or XYY or something, so that [information on the foetal sex] is not necessarily a good thing to limit … (OS1)

Practitioners also told us that it was not uncommon for parents to request a test on the 'pretext of abnormality concerns' when in truth they were more interested in the baby's sex. Prior to NIPT, genetic abnormalities were identified through a first trimester ultrasound performed through the public health system, and the onus lay with the practitioner as to what information to give to the parent. Furthermore, practitioners also noted that Asian parents had a predilection for a 'normal' child and were more likely to request an abortion if any foetal deformity was detected (see also Berkowitz & Snyder, 1998).

> the Indian community and the Chinese community are very clear … if they find something abnormal, they don't want a bar of it. … (OS1)

NIPT, and the purported individual choices it offers, has been introduced in a context where there are already pre-existing normative and cultural valuations both around the sex and abnormality status of the foetus. Currently, the cost of the test is prohibitive so 'most people don't really know about it' (GYN1) but should NIPT in the future be publicly funded and accessible, there was a concern 'I do feel that it can be misused' (MW4).

A second key point raised by our interviewees pertained to the altered relationship between the medical professional and the patient since the introduction of NIPT. Practitioners pointed to the growing prominence – both medically and politically – of the private sector in women's health (GYN3: 'it's (NIPT) come in through the private sector because that's what women want and so it's come'). The fact that the test can be purchased means that women are able to request it even

in the absence of a medical history of abnormality as specialists rubber stamp the request. This point is emphasised by GYN5 who notes that 'any provider will agree' because it is a purchased service. Similarly, another practitioner remarked that there is 'no selection behind who gets the test or not' (GYN2). GYN 2 went on to point out that even if there were a good reason to deny information regarding the sex of the foetus – as they would have done in the past – practitioners are now unable to do so, despite ethical concerns given that clients are able to turn to the NIPT for recourse. One doctor notes the diminishing role as gatekeepers of foetal sex information: ' … And the truth is that you can find out the gender of the baby at 11 weeks if you do a NIPT' (GYN2).

Overall, the interviews suggest that advances in reproductive technology have increasingly reconfigured the client-professional relationship, relegating practitioners to service providers who are less relevant to the actual decisions around pregnancy. The implications of the potential demise of this role are considered below.

Custodianship and choice

A third narrative around sex selection and abortion related to the increasingly uncertain role of practitioners as the custodian of women's rights. As in other countries (e.g. Stifani et al., 2018), medical practitioners and health associations in NZ, along with feminist groups and civil society groups, have played important advocacy roles in progressing legal abortion on the political agenda and in public opinion agenda for decades. Some practitioners we interviewed were passionate about abortion as a woman's right and identified as feminists ('I'm very strong feminist. I'm like in all sorts of women's groups and stuff'; GYN3) tied to NZ's history of enabling access to abortion. They were involved in the 'whole kind of underground of trying to get access to abortions' (GYN3) in the 1980s and 1990s. For women health care practitioners, these struggles for women's rights were especially fought within the health system: 'We've all worked really hard, and I've really challenged our colleagues around women's rights' (GYN3).

Thus, regardless of their own ethnicities, practitioners recognised the complex cultural histories underpinning sex selection. As GYN3 notes below she is disappointed about gender (de)valuation but also empathetic with the women who have to make these choices.

> part of me is really sad and disappointed that girls are less valued than boy babies. … but at the same time, I feel very sorry for these women in front of me, that they're having to make those kinds of requests and choices and that's the environment they're in … if she doesn't, then she's going to be that daughter-in-law that never had a boy. (GYN3)

The morality of choice is even more complicated for practitioners from minority cultures. On the one hand, as medical professionals and 'insiders', they are bound to uphold institutional norms of women's reproductive choices. However, as cultural 'insiders', they recognise both the underlying social pressures and benefits of son-bearing as well as the social censure of having only daughters. Echoing diaspora feminists (e.g. Puri et al., 2011), one practitioner told us: 'I've been part of it … I do understand why that happens. That literally, women are being protective of their own daughters by choosing not to have them' (GYN5). As such, ethnic minority – and even more so, female – professionals carry a burden of negotiating choice of their minority clients made as if these are conducted in contexts of liberal freedom, although they recognise these choices as an outcome of a biased socio-cultural ecosystem.

In line with their values, practitioners were continually making judgments to determine if women are coerced and act in ways that safeguard them. They seemed to believe that it was their responsibility to intervene in any suspected case of sex-selection, even if that meant infringing on women's reproductive rights. Clients expect them to share or appreciate their cultural values and, thus, advocate or assist in any form of sex-selection. In turn, practitioners adjudged their responses to these needs on a case-by-case basis given the legislative authority vested in them. In doing so, practitioners willingly or unwillingly became the self-appointed custodians of the unwanted/unborn girl child or for the women who they believed had no voice or agency for reproductive choice.

Participants highlighted several strategies to fulfil this role, such as insisting on speaking to the woman privately (without her partner/family member) to rule out any cases of coercion for abortion. In some instances, they flatly refused to comply with requests to know the gender of the child or to terminate the foetus, which could almost be a relief for the ethnic women. One practitioner noted how she weighs in for ethnic minority women who are 'terrified of what she has to hear and she's under all this pressure and there's a lot of pressure for these women to produce a boy' (GYN3). The practitioner decides that she 'would clearly not do it' if she felt that women were requesting an abortion under duress and for the women, 'that's a relief because suddenly these decisions are out of their hands' (GYN3). On other occasions, practitioners 'felt morally or at least professionally obligated' to reveal the sex of the baby: 'I felt like I had to inform her of the truth … if she's asking me "is there any way I can find out the gender", I can't lie' (GYN2). Thus, practitioners walk a fine line trying to provide a safe environment where women are not forced into reproductive decisions in the guise of 'choice'. With the reform, however, any clear-cut authority or positioning as custodian has flailed. The abortion reform has disabled their ability to be custodians of the rights of women and the girl child.

The advocacy role of practitioners is further eroded by the emergent discourse of 'family balancing', namely, the practice of gender selection during in-vitro fertilisation for the purpose of ensuring a family that is representative of desired genders (Macklin, 2010, july). Although family balancing is not legal in NZ currently, among practitioners nationwide there is growing debate that it is an exercise of reproductive choice for parents. Practitioners alluded to the need to address family balancing as an issue in the HART Act which was 'not with the current technology or flow' (OS2). The problem with legalising family balancing is the potential for comparisons with sex selection, and the possibility that rights under both requests would be seen as indistinguishable or even worse, as equivalent. For practitioners to negotiate rights and choice within this context added further complexity of determination of intent. One of two approaches were taken to resolve this dilemma. One practitioner ruled out undertaking any form of balancing, with or without sex selection, because 'it (right to choose fetal sex) just creates a bias that overflows into everything else in life, into later on in life, into the workplace, into the family life' (OS2). For other practitioners, the resolution was to categorise some forms of family balancing as 'okay' while others were not. Unfortunately, such categorisation implicitly racialises clients with family balancing assigned to non-ethnic/European parents who have 'good' intentions for their family while cultural minority parents, who make parallel decisions about the sex composition of their families, are automatically assumed to have nefarious intentions.

But they (gynaecologists) were trying to make it so that family balancing was okay so long as there wasn't, you know, everybody wanting boys or everyone wanting girls or something and making it really skewed, I guess. (OS2)

However, in practice, practitioners admitted undertaking extra scrutiny of ethnic couples seeking to exercise their reproductive choice. In one such example, a practitioner acknowledged that any request for sex-selection from EM communities was refused ('perceived negatively': OS2) during assisted reproduction 'even if in context of family balancing' (OS2). The practitioner further emphasised the need to maintain checks on sex selection 'even if we do change the treatment-potential options [i.e. family balancing] going forward' (OS2) suggesting the possibility of delineating reproductive choice by cultural group.

Rethinking agency and autonomy: Concluding remarks

New Zealand's abortion reform, passed in 2020, marks a significant moment in women's rights to choose and the agency over decisions about their body. This victory, however, has been alloyed by concerns around sex selection; it has not only informed political and public debate on abortion but, beyond that, has also had implications for abortion seeking and care. In contextualising the findings, this concluding section points to political ambivalence of reproductive rights in multi-

cultural societies. Mediated via multiple actors – ethnic women, their families, culturally diverse communities, health practitioners, white/western feminists, lawmakers, and institutions – reproductive agency is a contested normative value. Indeed, the differences among actors, overriding concerns around sex-selection prevalence, pose broader socio-political questions: what constitutes sex-selection? How are rights defined, by and for whom? and Who can claim these rights?

The NZ legislation on sex selection – almost purposefully it seems – is simultaneously specific and open-ended. The legal clause specifically decries the 'preference for the foetus to be of a particular sex' (ALA20, Section 21 (1)). However, given that its overall intent is to encourage a legally permissive framework centred around women's freedom of choice (Romanis, 2023), the NZ state has avoided a more interventionist role advocated by gender-equality, Asian-diaspora feminists (Moazam, 2004). It has instead placed focus in the law on reporting and evidence gathering. In part, this open-endedness may be – similar to the UK (Lee, 2017) – an outcome of the insufficient actual evidence of sex selection being practised. It may also reflect the impossibility of defining a singular 'lens of gender justice' within the context of multi-cultural societies (Ganguli-Mitra, 2021). On the other hand, as Mills (2016), writing about prenatal NIPT testing in Australia notes, permissibility (or the 'Apparatus of Choice'), while ostensibly about freedom of choice, implicitly places the moral burden of prenatal decision-making on pregnant women and furthermore, 'the responsibility of anyone else involved in that apparatus is not recognised' (Mills, 2016, pg. 8). The roles and responsibilities of practitioners in NZ's post-reform abortion governance structures have certainly been among those inadequately recognised in this apparatus.

While widely welcomed, the passage of the abortion law appears to have a range of implications for health practitioners. Firstly, there are limitations in operationalising individual rights and choices in a health system where there is a prevailing trust deficit. The scaling down of bureaucracy, potentially beneficial for women's privacy, instead revealed gaps in the health system as it seeks to transition to trust-based and client-driven rather than process-based and expert-led abortion delivery. The trust deficit was particularly heightened for ethnic women's requests for abortion, knowing the pressures of culture and community but also the nonchalance of the health system to minority needs more generally.

A second implication relates to the diminished relevance of the health practitioner in abortion decision-making. De-criminalisation and commercialisation are seen to have irrevocably reconfigured the client-expert relationship, reducing reliance on professional judgements. Prior to the reform, legal stipulations, as much as intuition and reflexivity, guided practitioner decision-making, holistically assessing clients' interests. The post-reform relationship, where these judgements were no longer admissible, was perceived as negative for ethnic women on whose behalf practitioners have acted as adjudicator. In the sphere of assisted reproduction – the comparator context where these stipulations were extant and clearer – practitioners demonstrated confidence in making firm and definitive decisions, including challenging cultural traditions.

The interviews also point to the wellbeing ramifications for practitioners in the post-reform era caught between perceptions of furthering sexism and racism (Berkowitz & Snyder, 1998), or as victimised by added moral and institutional burdens (Lee, 2017). Some outlined their concerns for personal risk and emotional safety in the new context. As one participant noted: 'It is good that [abortion] has been taken out of the Criminal [Act] … definitely. However, I don't think much thought has gone into how to keep the doctor safe' (OS1). Additionally, there was also a perceived increase in the moral burden brought on by the change in law, particularly around decisions about whether to act or not, and how. To some extent, the open-ended language and operationalisation of the law has resulted in devolving the burden of determination to individual practitioners, but the current framing of women's reproductive rights largely positions them as observers. As women's rights to choose are enabled, practitioners' own professional agencies are impacted. For some of the practitioners, the perceived silencing was a reversal of their own personal feminist biographies as actors and agents for women's rights within the health system. The post-abortion landscape has brought with it new subjectivities, moralities, and rules of ethical professional practice that are still in the process of being clarified. Interestingly, debates on sex selection have not been picked up by NZ

civil society, media, or diverse feminist groups, and alliances across ideologically based groups, unlike in the UK (Unnithan & Dubuc, 2018; Unnithan & Kasstan, 2022), have been less pronounced. Thus, these conversations of ethical practices are largely located within institutional practice.

Underpinning these reflections are shared constructions among participants about culture and gender. Most practitioners, regardless of their own ethnicity, portrayed ethnic women as unable to fully exercise reproductive agency within their cultural contexts. Associated with this, cultural traditions were constructed as inherently antithetical to the interests of women and poised to counter their freedoms. Whether these are grounded in experience, observation or conjecture is unclear; more importantly is the ramification for racialisation of reproductive choices. The detailing of 'ethnic' clients who seek abortions, and the empowering and risk-free assessments of family balancing as opposed to sex-selection are subtle examples of the differential discourses of choice allowed to ethnic and non-ethnic women. Again, this issue has not been extensively debated in New Zealand although some scholars overseas have characterised this as 'racial profiling' (Lee, 2017, p. 29).

In sum, the findings reiterate that the lines between sex selection and woman's right to terminate her pregnancy is a blurred one. While these distinctions appear clearer in the formalistic language of the law, in the complex and messy realities of everyday medical decision-making, where one ends and the other begins is harder to calibrate. The rightness or wrongness of decisions, if anything, are localised in the everyday encounters between practitioner and client. An analysis of this relationship is all but absent in the ongoing debates around abortion and sex-selection in New Zealand.

Notes

1. Up until then, the legal framework for abortions in New Zealand was set out in the Crimes Act 1961 (the Crimes Act) and the Contraception, Sterilisation, and Abortion Act 1977 (the CSA Act). The 2020 amendments moved abortion out of the scope of the Crimes Act and aligned it on par with other health services, removing stringent regulatory processes for its access including requirements for mandatory counselling for women seeking abortion and approvals from two certifying physicians. See https://www.legislation.govt.nz/act/public/2020/0006/latest/whole.html#LMS237600.
2. Ruth Dyson, MP (Labour), for instance, in taking a pro-decriminalisation stance, noted that '[w]e expressed opposition to any abortion for the purpose of sex selection' while Simeon Brown (National) who voted against the measure argued that 'it is shocking that this law allows for discrimination against unborn baby girls purely on the basis of their sex under the guise of a woman's right to choose'.
3. Ruth Dyson, MP.

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