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Abstract

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

Key words: Sex-selective abortion, arbitrating, reproductive governance, South Asian, UK

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Abortion is a unique area of healthcare where moral expectations of women's bodies manifest in diverse restrictions and ethical controls that comprise regimes of "reproductive governance." This particular form of bodily — and gendered — governance demonstrates how human reproduction is seized and acted upon through "legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and population practices" (Morgan and Roberts 2012; Morgan 2019). In this article we conceptualize how sex-selective abortion (henceforth SSA) is situated problematically in the framework of reproductive governance in the UK. Contested readings of legislation, as well as ethical dilemmas have arisen, significantly impacting contemporary abortion provision and raising questions of what constitutes "legitimate" reproductive choices and decisions. Against this backdrop we explore how abortion providers interpret the legal and ethical status of SSA and to what extent this falls under what constitutes "routine" care. We suggest providers perceived SSA as an ethnic minority issue, disrupting and expanding normative notions of reproductive decision-making. Even though requests for SSA were rare for healthcare professionals in this study, SSA was nonetheless viewed by them as an ethical and ethnic exception — which could result in diverse care outcomes and decisions. In the paper we propose the concept of 'arbitrating abortion' to capture the processes whereby providers think through the legal and ethical dilemmas that emerge when sanctioning care within an emerging terrain of reproductive governance and legal dispute.

Selective reproduction and care work

Contemporary abortion dilemmas in England, such as SSA, have gained insufficient traction and scrutiny among medical anthropologists,¹ despite being embedded in contests over reproductive governance at the national level as well as demographic controversies at the global level. SSA is a technique of selective reproduction based on “personal assessments of the economic burdens and benefits that the birth of a particular kind of child will entail” (Wahlberg and Gammeltoft 2018: 16). Selective reproduction against females is often caused by a preference or entrenched pressure to bear sons and male heirs, and is pronounced in patriarchal social structures. Increasing access to sonography since the 1980s has enabled foetal-sex determination leading to SSA, influencing childbearing decisions at the individual level and skewing sex-ratio imbalances at the population level across regions in South, Southeast and East Asia (Ganatra 2008; Guilmon n.d.; Patel 2007; World Health Organization 2011). Previous studies have indicated that selective reproduction is also being practiced among ethnic minority Indian families in the US and the UK (Dubuc and Coleman 2007; Puri et al. 2011), signifying how social practices and pressures around reproduction travel with families across medico-legal jurisdictions (REDACTED).

SSA presents a dilemma for policy-makers tasked with protecting the human rights of women against gender injustice, while not putting women at risk by denying access to safe abortion care to the full extent of the law (Ganatra 2008; World Health Organization 2011). Movements to govern SSA — by tightening controls over abortion — are entangled in contentious debates around gender justice vis-a-vis reproductive choices, coercion and care, dividing feminist ‘pro-choice’ activists attempting to protect and expand access to safe abortion

¹ Sociological studies have filled this void by exploring changes in abortion “work” (Purcell et al. 2017); abortion activism (Jackson and Valentine 2017; Lowe 2018); how providers classify abortion choices as legitimate/illegitimate in relation to the socioeconomic resources and life-stages of women (Beynon-Jones 2013); and how women justify their abortion decision-making, which Love (2017) critiques as practices of self and bodily regulation.

care in an otherwise challenging era for sexual and reproductive rights. Jurisdictions that place ethical controls on SSA have typically targeted abortion providers by imposing wholesale legislation (such as in India), yet such medico-legal interventions conflict with the perceptions of what constitutes care, and rights to care, articulated by healthcare professionals (REDACTED).

Anthropological attention to (and in) abortion politics is long established (Ginsburg 1989), and has intensified in recent years to chart how regimes of reproductive governance tighten controls over abortion, and how, on the other hand, activists lobby for women's access to comprehensive reproductive healthcare services as a human right (Andaya and Mishtal 2017; Andaya 2019; De Zordo, Mishtal and Anton 2017; El Kotni and Singer 2019; REDACTED; REDACTED). The contemporary era of Trump and Brexit reflect how reproductive politics are fluidly evolving and unfolding 'at the core of newly powerful and emboldened populist movements that openly articulate an explicitly racist, sexist, and fascist agenda' (Franklin and Ginsburg 2019).² The UK's SSA controversy, as we go on to explain, is a clear example of how ethnic minorities were framed by anti-abortion activists as a threat to prevailing moralities and values of gender equality in the UK (see Amery 2015), in order to advance restrictions on abortion legislation, which ultimately would undermine women's reproductive autonomy altogether (REDACTED). For this reason abortion is emblematic of how 'the "politics of

² There have been vocal attempts on the part of pro-choice activists to loosen abortion laws across the British Isles, galvanized by the Irish republic's Referendum result to enable lawful access to abortion in 2018 (see REDACTED for a commentary on events). The current push to "de-criminalize" abortion, especially in Northern Ireland, may even be read as a departure from the wave of increasingly punitive abortion laws being enacted in the United States — which have been enforced as part of a Republican pledge to restrict women's sexual and reproductive health rights (e.g. Andaya and Mishtal 2017). A closer and biographical inspection of abortion politics in England, however, indicates continuous attempts of attrition lead by socially-conservative politicians to further restrict national abortion legislation. The framework enabling legal access to abortion in England has "survived dozens of attacks in parliament," as Sally Sheldon and colleagues (2018: 3) note. Moreover, to quote a 2019 Lancet Editorial on the surge of restrictive abortion laws being imposed in the United States, "there should be no feelings of moral superiority in the UK" given the regime of reproductive governance in place (2019: 2099).

reproduction" cannot and should not be extracted from the examination of politics' and governance overall (Ginsburg and Rapp 1991: 331; Petchesky 1995; REDACTED).

A growing body of anthropological work is exploring how healthcare providers are situated, and how they situate themselves, in regimes of abortion governance and how they manoeuvre within legal constraints (e.g. Suh 2014, 2019). Anthropological studies of abortion in England are timely because technological innovations have recalibrated the responsibilities of women and providers in abortion care in recent years, causing a shift in how the management and "performance" of abortion ought to be conceptualised (see Jelinska and Yanow 2018). This reconfiguring of care means that "advocacy for equitable access to abortion requires understanding not only of the needs of women requiring treatment but also the challenges faced by healthcare professionals in providing it, that they might be best supported to do so" (Purcell et al. 2017: 92).

Drawing on a twelve month ethnographic research project into sex-selection against females in the UK, we argue that SSA is an issue that healthcare professionals struggle to reconcile within the current regime of abortion governance in England. Providers articulated diverse positions of what constituted care with regard to SSA, compared with other abortion encounters, signalling how the SSA dilemma marks a departure from accepted ideas of equitable access to reproductive healthcare in practice. Opposition to SSA was articulated in terms of non-compliance with provider expectations around "reproductive citizenship"¹ in England, signalling how access to abortion care can be stratified. Moreover, the ways in which SSA was expressed as an ethical and ethnic exception was itself revealing of unconscious bias in abortion provision towards women of Bangladeshi, Indian and Pakistani origin.

Abortion politics in England

Abortion is the most routinely performed gynaecological procedure in the UK, experienced by one in three women over the course of their lifetime (National Health Service 2016). The vast majority of abortions in England (98%) are funded by the National Health Service (NHS), with 72% of abortions performed by approved independent providers due to the outsourcing of abortion care (Department of Health and Social Care 2019). Women in England can access abortion care either by requesting a referral from their General Practitioner (GP), which would either be to an NHS service or an independent provider, or by self-referring directly to an independent provider (usually by telephone or online).³ Most abortions in England are performed medically up to ten weeks gestation, using the drug Misoprostol, exclusively, or in combination with Mifepristone (Department of Health and Social Care 2018).⁴

Abortion in England is governed by an overarching reproductive regime, but two key and historically-situated legal frameworks are noteworthy: The 1861 Offences Against the Person Act (1861 OAPA) and the 1967 Abortion Act. The 1861 OAPA is a Victorian-era law that was never repealed, and carries a maximum penalty of life imprisonment for any woman attempting to “procure” a miscarriage, with a lesser sentence applying to anybody who aides her. The 1967 Act provides exceptions-based grounds for lawful access to abortion: the vast majority of abortions in England are approved on the basis that two physicians have agreed “in good faith” that continuing a pregnancy would present a greater risk to the life of a woman than if it were terminated (Department of Health & Social Care 2018; UK Legislation 1967).

³ GPs refer women requesting abortion (up to 24 weeks gestation, the legal limit) to either an NHS or independent provider depending on regional contracts and tenders, and all abortions required after 24 weeks gestation (with legal dispensation, e.g. due to foetal abnormalities or risk to maternal health) are performed by NHS services. Not all clinics in the independent sector have the resources to perform abortions up to twenty-four weeks gestation.

⁴ Surgical abortion involves vacuum aspiration (up to 15 weeks gestation) or dilation and evacuation (15 to 24 weeks).

The UK Government, key legislators and public health authorities have framed SSA as illicit and immoral (Greasey 2015; also Sheldon 2012). As Greasley argues, their (inaccurate) positions have been reached by misreadings of the law and a consistent failure to separate the legal *grounds* for abortion (outlined in the 1967 Abortion Act) from the *explanations* for abortion:

The Abortion Act makes demands only about the grounds, not about the explanations behind them [...] All that is required of the explanation, legally speaking, is that the explanatory circumstances could plausibly place a woman within one of the section 1 grounds, usually by way of threatening her mental health, and, hence, that two doctors could plausibly form the good faith opinion that one of the grounds was met, this being (along with practice regulations) the consummate test for lawful abortion. (Greasley 2015: 541)

Sex-selection, like rape and incest, is not a lawful *ground* for abortion under the 1967 Act; rather it forms part of the “explanatory circumstances” that are necessary to comply with the social reading of the legal framework — and what constitutes a ‘risk’ to a woman’s life. UK Parliamentarians, however, continue to misinterpret abortion legislation in their most recent legal “clarifications”:

Sex selection is not one of the lawful *grounds* for termination of pregnancy. It is illegal for a practitioner to carry out an abortion for that reason alone, unless the certifying practitioners consider that an abortion was justified in relation to at least one of the grounds in the Abortion Act 1967 such as a gender-linked inherited medical condition. Anyone with evidence that sex selective abortion is occurring should report it to the police. (Parliament UK 2018 [emphasis added])

The above legal “clarification” is open to further dispute because there is no obligation to report an “illegal” abortion in England,⁵ which underscores the inconsistency and uncertainty that abortion providers navigate vis-a-vis SSA (as we describe below). The ambiguity demonstrated by providers and policy-makers as well as abortion activists continues in the moral contests over what constitutes the “right” abortion choice and what can be considered appropriate and lawful care.

The legal limitations and quagmire described above have taken place in a context of broader controversy around SSA in the UK, some of which is useful to re-trace. A study carried out in 2009 showed the existence of skewed sex-ratios at birth in favour of males among Indian-born women in England and Wales, with the most “plausible explanation” being sex-selection against females due to a combination of son preference and declining fertility (Dubuc and Coleman 2009). Three years later, in 2012, the *Telegraph* newspaper sought to covertly record healthcare professionals agreeing to provide “illegal” abortions on the grounds of foetal sex for “South Asian” women,⁶ and claimed the practice was “widespread” and typically performed for “cultural reasons” (Newell and Watt 2012a, 2012b; also Lee 2017).⁷ Emboldened by “evidence” constructed in the 2012 *Telegraph* sting, anti-abortion politicians (unsuccessfully) sought to tighten and impose controls on women’s access to abortion (for a detailed critique of events, see Greasley 2016; Lee 2017; Purewal and Eklund 2017; REDACTED). Of particular relevance to our article is how the *Telegraph* reportage vilified the physicians involved, and framed them as accomplices to “gendercide” (Lee 2017). Studies have since explored the profound impact of the

⁵ Personal correspondence (12 March 2019) from Sally Sheldon, Professor of Law at Kent Law School.

⁶ Our article explicitly makes reference to women of Bangladeshi, Indian and Pakistani origin. We refer to the generalized category of “South Asian” when quoting directly from past studies.

⁷ The SSA controversy can be situated in a social history saga of racism against British Bangladeshis, Indians and Pakistanis, provoking media scrutiny and political interventions. These include homogenizing representations of forced and bogus marriages; youth violence; religious fundamentalism and terrorist activities; and opposition to “British values.”

controversy on abortion care providers in the UK: doctors are fearful of prosecution and feel obliged to perform even routine terminations of pregnancy cautiously (Lee, Sheldon and Macvarish 2018; Womersley and Domoney 2018). Further to this, attempts were made to undermine the integrity of medical authority in UK abortion provision, by attacking the legitimacy of their “good faith” opinions (described above) when approving access to abortion care. The SSA controversy is consistently used by anti-abortion politicians to oppose any reform of abortion legislation, which in their view, would give licence for women to request SSA “on demand” (see Hansard, UK Parliament 2018).⁸ To capture the highly dynamic and evolving nature of the politics and governance logics associated with SSA we also need to account for the moral anxieties around SSA which pre-date the 2012 controversy, and have presented implications for equitable access to reproductive care for “South Asian” women engaging with the National Health Service (NHS) in England. Studies have demonstrated how NHS sonographers discriminatively withheld foetal-sex disclosure when providing ultrasound services to women of “South Asian” origin, as an attempt to protect fetuses that were interpreted as being at “risk” of selective abortion due to “culture” (Purewal 2003, 2010). As Purewal demonstrates (2003), providers in England selectively applied ethical controls in reproductive health services at the time to intentionally withhold pregnancy-related information from ethnic minority women.

The medical governance of the foetus, practiced through arbitrary acts of “protective” care at the local-level, reflects anthropological notions of the foetus as intensely social rather

⁸ Activists have presented the issue of SSA as requiring ethical controls across the British Isles. The Isle of Man, a self-governing island territory (for which the UK is responsible for) with its own legislative assembly, decriminalized abortion and made the healthcare procedure available to women up to 24 weeks gestation in 2019. Jasvinder Sanghera, who heads a UK-based South Asian women’s group and previously campaigned for the criminalisation of SSA in the UK, lobbied for an explicit SSA clause in the Isle of Man (see Darbyshire 2018), though was unsuccessful. If passed, this would present a precedent for an explicit SSA clause in the UK.

than “a biological fact of life” (Han 2018: 60). There remains little understanding of the extent to which SSA can be read as protective for women in the UK context (REDACTED), or how SSA is perceived by abortion care providers — despite being entangled in the controversy. Studies conducted in India offer a comparative context through which broader and situated conceptualisations of reproductive care, choice and rights emerge vis-a-vis SSA. When women and men are faced with the socio-economic pressure of smaller families, healthcare services that enable prenatal sex determination and selective abortion are viewed as a form of care and physicians described as trusting, qualified and supportive (Khanna 2015). As REDACTED has demonstrated, SSA is viewed by providers in Rajasthan as a social service in a context where “gender inequality remains a social reality,” and is framed as agential for women when the consequences of not bearing sons is high and SSA is thus viewed as protective against discrimination — for themselves and their unborn daughters. An anthropological approach to SSA therefore has the potential to re-frame SSA as a conflicted care practice when considering the coercive constraints that reproductive decision-making occurs in.

Methods

This article forms part of an interdisciplinary investigation into son preference and sex selection against females in the UK, with a specific focus on the childbearing dynamics among families of Bangladeshi, Indian and Pakistani origin.⁹ Here we draw on a subset of sixteen qualitative interviews conducted between January 2018 and January 2019, with five consultant obstetrician-gynaecologists; two nurses; three midwives; three counsellors; three managers and administrators. We engaged with clerical and clinical professionals to be inclusive of the full

⁹ The multidisciplinary research project was funded by REDACTED (grant code: REDACTED).

continuum of abortion care, and to examine how requests for SSA are flagged and handled at different points of provision. The 1967 Abortion Act requires two physicians to sign ‘in good faith’ that a woman’s grounds for abortion have been met. Often this information is gathered by clerical staff, midwives and nurses (and then passed to physicians for consideration) — thus making them important interlocutors or arbiters in SSA encounters.

Participants were providers of abortion care as part of the National Health Service (ten), and the independent sector (six). There was some fluidity between these two sectors, with midwives and nurses working previously as part of NHS maternity services before joining abortion care provision in the independent sector. Engaging with participants across these two sectors of abortion provision enabled us to compare approaches to SSA vis-à-vis routine requests for care, and to compare data as a test of reliability, as well as comment on the extent to which the SSA controversy has resulted in stereotyping on the basis of ethnicity in abortion care. We specifically sought participants who provided SRH care in regions with substantial Bangladeshi, Indian and Pakistani communities, including suburban (eight respondents) and urban (eight respondents) areas. All participants were actively providing SRH care, except for one consultant who was retired. Two providers in the independent sector declined to participate in our study on the basis of “research fatigue.”¹⁰

The study involved observations of provider engagement with UK and global abortion dilemmas, to identify the various webs of reproductive governance that SSA is entangled in. 2017 marked the fiftieth anniversary of the 1967 Abortion Act, which made abortion care legally available in England. SRH providers simultaneously celebrated and seized the anniversary as an opportunity to lobby for further reform and liberalisation of abortion law. Our

¹⁰ Their refusal reflects an increasing academic interest in abortion provision amidst public and political debates of legislative reform in the UK and Northern Ireland in the 2017-2019 period, particularly following the 2018 Referendum result to repeal the Eighth Amendment in the Republic of Ireland.

ethnographic research involved attending a range of events organized between 2017-2018 by representative bodies — such as the Royal College of Obstetricians & Gynaecologists and Doctors for Choice UK (an abortion rights advocacy group) — as an opportunity to recruit participants and to enter the “field” of provision.

Gaining the trust of providers was a critical methodological issue to navigate due to the prevailing climate of stigma towards abortion care provision in England: clinicians widely perceive abortion care to be poorly valued and to have “low prestige” in medicine, which is an issue exacerbated by the intimidation tactics of anti-abortion activists and continuous attempts of politicians to further restrict services (Royal College of Obstetricians & Gynaecologists, no date). Moreover, there is a national shortage of physicians equipped with the requisite skills to provide routine abortion care up to the legal limit of twenty-four weeks gestation (Royal College of Obstetricians & Gynaecologists, no date). Working with SRH providers in this current climate does, present the challenge of reflecting critically on provider practices. Evaluating the practices of providers does not, we suggest, equate to an anti-abortion research stance, but instead offered us an opportunity to question the extent to which services are responsive to the needs of women in increasingly diverse populations.

A limitation of our research design was its focus on family-making among women of Bangladeshi, Indian and Pakistani origin, rather than being a UK-wide study. The ethnic minority focus of our study consequently provoked references to “culture” and “religion” during interviews, which revealed stereotypical reflections of women of Bangladeshi, Indian and Pakistani origin held by participants. Our view is that these references often pointed to assumptions and imaginings based on the *ethnicity* of non-White women originating from regions where SSA is more widely practiced (as mentioned in the introduction). The majority of

study participants were White British (eleven), with five participants being of Indian, Bangladeshi and Pakistani origin. We encountered a slippage in references to ‘culture’ and “religion” (as influencing recourse to SSA) in the interviews conducted with White British providers, which can be situated in a broader context of misunderstanding ethnic minority groups as well as ethnic stereotyping in NHS healthcare provision (cf. Blell 2018; Purewal 2003). To mitigate how participants were influenced by the focus of the project, we probed providers on their encounters with “gender balancing” in the White British population.¹¹

Ethical approval to conduct this study was granted by the Research & Ethics Committee at REDACTED, and from the independent abortion care provider. We first conducted pre-study visits to introduce the research project informally as part of a process of informed consent, with interlocutors invited to participate in semi-structured interviews at a subsequent date. Participants were provided with detailed project information (in English) and informed consent was obtained in writing. Interviews lasted approximately sixty to ninety minutes, and were recorded using a Dictaphone when permitted and transcribed by the lead author. The names of all participants have been replaced with pseudonyms in this paper to protect their identities.

Abortion care as part of reproductive governance

Our primary aim was to explore perceptions and experiences of SSA across the continuum of abortion provision (including administrative, counselling, and clinical care), and to understand how providers viewed SSA in relation to the “routine” requests for abortion in terms of law, ethics and reproductive citizenship. More specifically, we sought to explore whether providers

¹¹ Gender balancing is a form of selective reproduction, which was also discussed in the UK media and formed the subject of academic scrutiny during the period of study (e.g. Shahvisi 2018)

have been approached for abortion care on the grounds of foetal sex, how they have dealt (or would deal) with the request, and how they would identify a woman at risk of coerced or sex-related abortion. A small minority of providers had been explicitly approached for SSA (two in a twenty year period), but in reality, SSA was a less familiar request to be faced with, yet perceived as a major ethical dilemma.

The process of routine abortion care affords several opportunities for women to discuss their pregnancy decision-making with trained providers. In the first consultation, a counsellor or healthcare professional will verify the personal details of the woman presenting for abortion care, and will assess if a woman is medically suitable for treatment. Then a counsellor or midwife will see the woman alone to support them with their pregnancy decision-making, confirm that the abortion is consensual, and identify any safeguarding issues (especially regarding women under the age of eighteen, or vulnerable adults). Importantly, the woman's reason(s) for requesting an abortion is obtained to comply with the 1967 Act. Women have an ultrasound scan to identify the stage of gestation, which determines whether the procedure is performed medically or surgically (and if onward referral is required), and then women are guided through the relevant process of informed consent. Approval for the abortion notice is sought from two authorising physicians, and providing there are no concerns, the treatment can be performed routinely.

Kelly, a White British counsellor with over twenty years of experience as an abortion counsellor, had previously experienced a request for SSA and had become convinced that Bangladeshi, Indian and Pakistani women might not be revealing their "true" grounds for requesting a termination as a conscious strategy. In her words, "I am sure there must be people who are having sex-selection tests [foetal sex determination] and then coming to us [for abortion]. And I've probably seen them, not knowing." Her claim that women intent on

undertaking SSA will engage in deceitful strategies to access abortion care reflects past anxieties that “South Asian” women covertly practice SSA when accessing NHS maternity care — or whom Purewal (2003) conceptualizes as “devious aborters.” One counsellor instead described how the “other” discussions (with non-Asian women) around sex (or “gender balancing”) would signal a preference for daughters but no intention to engage in selective abortion, indicating the generalisations on the basis of ethnicity:

All the other discussions around sex, the larger proportion of them is the other way around, women saying, ‘I’ve got three boys and I’d really like a girl, but they all say, if I could find out [the foetal sex], I would carry on, but I can’t find out, so I’m going to have an abortion because I don’t need or want another child, it’s not appropriate, we haven’t got the money, we’re too old.’ All the same reasons that people give, but they would say, ‘*if* it was a girl, I would continue.’ (Emphasis added)

Abortion providers projected diverse ideas around why they thought Bangladeshi, Indian and Pakistani women would go in for SSA, on the one hand, procuring “illegal” abortions subversively, and on the other, transgressing “cultural” norms by accessing “routine” abortion care. Della (White British), who practiced as a midwife for twenty years before entering abortion work, described how, “I was very shocked when I came here, I mean I was very shocked with the abortions they do for a start. I just didn’t think, I suppose *culturally*, I didn’t think that Asians, I know that sounds really bad, probably didn’t have abortions” (emphasis added). While providers described a commitment to enabling the reproductive decisions of all women, the particular needs of Bangladeshi, Indian and Pakistani women were unnecessarily (and perhaps incorrectly) read and coded by providers as “cultural” issues based on their “Asian” (read:

ethnic, non-White) origin. The views of abortion providers are consistent with how women and men of Bangladeshi, Pakistani and Indian origin encounter racism and cultural stereotyping across the continuum of NHS reproductive care, including antenatal screening, inherited disorders, maternity, and infertility services (Blell 2018; Bowler 1993; Jomeen and Redshaw 2013; Purewal 2003; Shaw 2009).

Procuring “explanatory circumstances” for approval

The dilemma Kelly raised (above) sparked discussions with providers on how they reconcile and arbitrate (if necessary) requests for SSA against the 1967 Act, as part of the process of routine care. Providers, in practice, employ diverse strategies to obtain a woman’s justification for abortion in order to comply with the 1967 Act. Della described being assertive in her approach to obtaining information around pregnancy decision-making, “I think because right from the start, with my consultation, I always ask them why they’re here today and I say to them, they ‘may not be suitable for treatment so I need all the information you can give me,’ because they’re so desperate for the treatment, they will give you the information that you want.” Some providers thus emphasized the legal restrictions on abortion in England to “procure” the necessary information from women in order to grant lawful access to care.

It was rare for providers to encounter requests for SSA during the process outlined above. Providers described how they would have to rely on a woman’s disclosure that SSA was the “true” reason she was presenting for care (which Kelly was sceptical of), whereas Meera (Indian-born consultant gynaecologist) felt it would take an expert provider to identify a covert case of SSA in the time allocated for consultations. In the absence of defined care protocols and procedures vis-a-vis SSA across the providers, participants presented a range of approaches that

they would take, in theory, if a woman requested SSA. David (White British, Manager) described their response in a case where a woman presented for a termination on the basis of sex. Reflecting on the past request that was flagged to him, he perceived the issue of son preference leading to SSA as having an underlying “religious” (ethnic) basis that could result in reproductive pressure or coercion (constituting lawful access to care):

I mean if somebody says, ‘I want to have a termination because I don’t want a girl or I don’t want a boy,’ what we’re meant to do is explore the impact that [continuing the pregnancy] would have on them. I guess if they say, ‘I don’t want a boy because I’m a woman and I want to be able to dress someone up in pretty dresses and buy them dolls,’ we might not think that’s really meeting the legal criteria so we could not do one on that basis. But, as was the case with this woman [who came to the clinic 6 years ago], if someone says, ‘if I have a girl I’ll be at risk of being beaten by my husband, by my family,’ then it implies that it meets the ground that it would impact on their mental health and possibly on the ground where you have to think about the other children she might already have, so we really take it from that angle, I guess. No one’s, to my knowledge, been sort of as blatant to say ‘I want a boy or a girl’ because it’s just a preference rather than, you know [because], ‘it’s a religious thing I guess and if I have a girl then my family will beat me up or my life will be made hell, really.’

What is important about David’s statement is that SSA requires careful consideration and arbitration by service providers to mark it as a legitimate case for care. For David, SSA was not encountered as a choice for the woman concerned, but rather a lack of choice, which requires an essential service of care to support women’s reproduction under constraints. In such rare cases, a

careful effort is made to gather the “explanatory conditions” to satisfy the grounds outlined in the 1967 Abortion Act, whereas the absence of clear conditions could result in the denial of care.

Jessie (White British, midwife) claimed she would attempt to identify the “religious” reason that might underlie a woman’s decision to request SSA, but said, “ultimately you can’t force people into giving you information, and you can’t deny a woman’s right to an abortion, but you can certainly deny the rush to treat them.” Melissa (White British, Managerial) viewed the issue of SSA as engendering a *protective form* of care that is performed reluctantly when childbearing decisions are made in coercive contexts (which involve a broad range of economic or social pressures that are not confined to selective reproduction):

M: It could actually be a very protective thing for a woman who’s knocked out 3 or 4 girls if she knows she’s having another girl, to have another girl.

Q: But can I play devil’s advocate now and flip it round, and say, what if she wants the child but the husband doesn’t want it because it’s a particular sex?

M: We perform terminations very reluctantly on women that don’t want terminations, because the same things apply. If the woman says, ‘I have no choice, I have to have this termination because otherwise he said he will leave me, he’ll take the children, whatever.’ We’d talk to her about it, we’d suggest she goes to talk to an agency that might give her some advice about her options, but if ultimately, she says, ‘I don’t want this termination but I have to have it’ – we would provide her with it, and that doesn’t sit easily with us, because we know that the consent she’s giving is a result of coercion.

For clinical providers, the reasons that influence recourse to SSA simply formed part of the diverse range of reproductive pressures that shape abortion decision-making for women regardless of ethnicity. Dr Chowdhury (Bangladeshi provider) made this clear when asked if a pressure for SSA had arisen in clinical encounters:

Not particularly based on sex-selection, but there is a pressure of abortion, there certainly is pressure of abortion. It could be financial, it could be many children, but there are cases when there is pressure.

Providers overwhelmingly imagined requests for SSA as an issue exclusively confined to married couples with multiple daughters (at higher order births), with women facing a subsequent pressure from her husband and extended family to abort a female foetus. SSA was not considered by providers as a choice that women would pursue voluntarily. The approaches adopted by the providers in our study demonstrated that a continuum of strategies were involved in arbitrating abortion, either by delaying access to care for further qualification, or framing it as a protective form of care. What is interesting, however, is that SSA was considered by clinic managers to be the *only* dilemma that could provoke hesitations or delays in approving abortion provision among adult women (vis-à-vis legislation), signalling how ethical controls were or would be applied selectively in local-level care:

Q: Are there any other situations where a request for abortion would get flagged up and that you would have to get involved or is it just this issue of foetal sex?

David: I'd say really it would just be the issue of foetal sex, I can't think of anything else.

Ethical controls: SSA vis-à-vis 'routine' care

Abortion provision may be approved depending on the particular sensitivities of the carer as suggested by Kelly (below). Recalling a past request for SSA, Kelly demonstrates how the application of ethical controls (when abortion is or is not "approvable") are directed by the particular sensitivities of the carer:

Q: Has it ever happened that you've encountered somebody requesting abortion on the grounds of foetal sex?

K: Once and I said, 'sorry.' I almost said, 'you can go somewhere else, just don't say that,' but that would have been against my ethics, so I just said, 'because you've told me that I'm afraid we can't carry on the consultation.' It was ages ago, it was ten or more years ago. I wasn't harsh, I was very kind, but I was covering my own back. Also she needed to know that it wasn't legal for her to ask to have an abortion based on sex.

Q: So what would happen if I came to your clinic today to request a termination, and I said it's a girl and if I have another girl then I could be at risk of divorce, I might be abused?

K: I would probably just be really kind and just say it's not seen as a legal reason to have an abortion provided on the (basis of the) sex of the foetus. [...] I think because it's a rare situation, if someone looked it up [the 67 Act] and saw that, they would be *careful* about what they said. I

assume people just pick up on it, I suppose it's the way that we're brought up and educated in this country, most people would just think it's a very bad thing [...]

The interview exchange with Kelly (above) demonstrates how SSA is embedded in a range of assumptions (culture, ethnicity, religion) around normative and moral notions of “reproductive citizenship.” Put simply, providers assume that women raised and educated in the UK would be opposed to SSA. Ethnic minority women are nonetheless expected to know how to subvert the 1967 Act by being strategic and not revealing their true grounds for abortion. Providers may decide to decline requests for SSA as a practice of “defensive care” if, as Kelly put it, women are not vigilant enough when it comes to withholding information in consultations. For Kelly, declining a request for SSA was based on an ethical and legal reading of the practice, rather than the constraints surrounding a woman's reproductive decision-making (which, as stated, can lead to lawful provision of care). When juxtaposed with routine requests for abortion, the ambiguity of SSA emerged for providers, prompting Kelly to reflect critically on her selective application of ethics:

K: Quite regularly we'll get someone [in the White British population] who is having infertility treatment and has had a fling [...] one of my close friends it happened to, where the sex becomes all mechanical, about getting pregnant, and they just lose their mind almost, they're so upset and distressed about not being able to get pregnant, that they have a fling, just for some good sex. Because they think it's not going to happen, they don't even bother about contraception because their body as far as they're concerned is rubbish. Then they get pregnant. This happens *a lot* and it's awful. It's the most distressing thing to see because they want a baby more than anything, but it was a grenade in the marriage to go ahead with it, because they might have to tell their

husband, but that's a reason a lot of people have abortions. It's really sad. [Emphasized in original]

Q: So how is that legal?

K: It's a really good question, it's not something we ever discuss. Under the 67 Act I would say it puts the woman's mental health and safety at risk because of the stress and strain they'd be under if a relationship ended or if they had a baby that was not from that relationship.

Q: So how does that meet the grounds of the 67 Act? But if I was about to be divorced or abused because I didn't have a son, that wouldn't meet the grounds?

K: Good point, it's never discussed, it's never come up as a comparison. That's interesting isn't it? But then it's the same thing you could say, why is someone *allowed* to have abortion with a baby with down syndrome? Why is a woman *allowed* to have an abortion with someone who is spina bifida? Or with a cleft lip, which is something that is cosmetically really easy to repair, a perfectly healthy amazing potential child? There's so many things that are in the same ballpond which I've never even thought about until you've said that. If you're going really far, that could be a huge cultural assumption and almost racial bloody something about, in this country you're not *allowed* to do that but you're *allowed* to do this and this and this and this. [emphasis added]

Requests for abortion emerge as "legitimate" (or "allowable") in certain cases and not in others demonstrating that the provision of care is stratified. Anthropologists have conceptualized "stratified reproduction" as the ways in which "physical and social reproductive tasks are accomplished differently according to inequalities that are based on hierarchies of class, race,

ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces” (Colen 1995: 78). Kelly’s initial reflections demonstrate how abortion provision is stratified along ethical and ethnic lines due to the social reading of legal constraints, which demarcate interpretations of legitimate and lawful grounds for care (such as extra-marital affairs or foetal abnormalities) from what is perceived to be illegitimate – or socially sanctioned from a perspective of “good” (reproductive) citizenship. SSA requires arbitration by providers, who are tasked with mediating the ambiguity of abortion regulation.

Situating the issue of SSA in the broader anthropology of abortion illustrates how reproductive governance plays out in clinical practice from global to local levels, and how frameworks are subverted through the pursuit of protective care. Siri Suh (2014, 2019) has explored how health providers in Senegal negotiate restrictive abortion laws when caring for women who illegally self-induce abortion and require post-procedural care. There, police expect healthcare providers to collude with law enforcement investigations if women are suspected of self-inducing an abortion, which is prohibited under all circumstances. Healthcare providers push back the effects of reproductive governance by “interrogating” women to gather information on the abortion “type” to “cover their backs” in case a police investigation occurs, but in official records they deliberately re-write and disguise most induced miscarriages as spontaneous as a form of protective care — for themselves and the women concerned (Suh 2019). Thus official abortion records likely render most illegal abortions invisible, and render women as complying with normative expectations of a childbearing mother (Suh 2019). Abortion governance in Senegal and England exposes a common consequence of restrictive legislation, as providers feel compelled to practice their care defensively, and at times discriminatively, when they find women defying the normative models. The case of SSA in England demonstrates how the

existing exceptions-based framework of abortion legislation reinforces notions of legitimate and illegitimate, or ethical and unethical, reasons for abortion among providers, leading them to respond to requests for SSA in ways that often demonstrate inequities in access to care.

Conclusion

Abortion providers in our study projected assumptions of Bangladeshi, Indian and Pakistani women (prevalent in the highly politicized backdrop of the UK's SSA controversy) to frame the abortion dilemmas of ethnic minority women as non-compliant with reproductive citizenship in England.

Providers perceived SSA as an issue pertaining to ethnic minority women alone. Whilst they rarely encountered requests for SSA, as we saw in our study, this specific care need held disproportionate influence in their abortion practice — marked by specific strategies to deny, delay and defer care decisions. In this sense, abortion carers navigated and arbitrated the UK framework of reproductive governance, and abortion laws, based on selective and defensive readings of what constitutes “legitimate” access to care. The broad typecasting of SSA by abortion providers reflects broader patterns that ethnic minority families experience in terms of inequities in access to care in the NHS (also see Blell 2018).¹²

Arbitration emerges as a useful concept to explore how healthcare professionals manoeuvre within an ambiguous and disputed medico-legal domain, and through the selective application of ethical controls, when encountering SSA. Whilst the letter of the law makes

¹² In her work with British-Pakistani men, for example, Mwenza Blell (2018) has shown how NHS healthcare professionals assimilate narrow ideas of what constitutes “legitimate” marital and childbearing decisions from mainstream political and media discourse, which then ‘take on the character of discrimination’ in reproductive care provision for infertility.

explicit the requirement of two physicians to assert “in good faith” that the legal grounds for abortion have been met, our study illustrates how a broader range of expertise is involved in the procurement of those vital “explanatory circumstances” and ultimately the arbitration of abortion requests. Not specific to the authority of physicians, non-clinical professionals too framed their roles in the language of arbitration. In making the case for arbitrating abortion, we contribute to the anthropology of abortion by exploring the entanglement of care and governance in a context of legal ambiguity — where the widespread mis-reading of national abortion laws has left an imprint on local-level services.

Our study contributes an anthropological perspective on contemporary abortion politics by illustrating the everyday social and ethical practice of providers in a context where abortion is available under certain conditions, outside of which, women can face life imprisonment for procuring an abortion deemed to be illegal. Providers in England are mandated to deliver care within the exceptions-based framework of the 1967 Abortion Act, which requires a social reading of grounds rather than explanations – and thus does not cover SSA explicitly. The voices in this study clarify how abortion providers encounter requests for SSA as an exception. Their professional expertise appears to conflict with the claims of anti-abortion activists and politicians that SSA is a “widespread” practice in the UK. This is a tension that further research should explore because the issue of SSA is consistently cited in calls to tighten reproductive governance, or to oppose the liberalisation of abortion legislation. The reading of SSA as a legitimate service of care on the part of providers signals the potential for the practice to be included and protected within plans to liberalize abortion legislation. Whilst we would prefer to live in a world where women are not pressured into abortion, because of foetal sex or any other reason, a legal protection *for* SSA may be necessary until that image of reproductive autonomy is

a reality (see also Sheldon 2012). Moreover, an anthropological glance at how states have struggled to address SSA through legal interventions, such as India (See REDACTED), makes a convincing case *against* criminalisation.

Global abortion governance contains a range of convoluted laws and restrictions that “do not make any legal or public health sense” (Berer 2017: 24), and remain a barrier to providing abortion care that is accessible and woman-centred (UK All-Party Parliamentary Group on Population, Development and Reproductive Health 2018). Woman-centred abortion care involves channeling expertise to enable women within the social, legal or economic confines of their decision-making, crafting a space for “women to be at the forefront of the service at a time when they were at their most vulnerable” (Lipp 2008: 18). Exceptions-based frameworks of abortion governance undermine this vision of woman-centred abortion care, and the case of SSA exemplifies how providers are obliged to arbitrate access to reproductive health services based on stratified and selective notions of ethics. Supporting providers to understand how SSA is a legitimate care need is important to meet the diverse reproductive health needs of women to the full extent of the law.

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Attached separately.

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