"Well, She's Entitled to Her Choice": Negotiating Technologies amidst Anticipatory Futures of Reproductive Potential

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Anthropologist Marcia Inhorn has argued that, 'In understanding women's health concerns, health scientists and policy makers must take heed of the fact that context does matter—that health research and interventions aimed at changing women's behavior must take into account the broader conditions shaping women's lives and women's resultant (in)ability to enact health-promoting changes in their living conditions and actions' (2006: 348). This chapter takes the relationality of care and specificities of context further to demonstrate how notions of routinized technologies are disrupted when considering the reproductive realities and situated constraints of ethnic and religious minority women.[1] In what follows, I take the case of caesarean sections and abortion care among ethnic and religious minorities in the United Kingdom to capture how routinized interventions are entangled in the anticipation of future reproductive potential. The idea of anticipatory futures serves as a reflection on what is perceived as 'possible, probable and preferable' (cf. Textor 2005: 2; Adams, Murphy and Clarke 2009) across the reproductive lifecourse, where technologies carry opportunities and implications that women and carers alike are tasked with negotiating.

This chapter integrates ethnographic and qualitative data from two minority contexts. It focuses on maternity care practices among Haredi Jews, who constitute a minority in the UK and among the country's Jewish population, and how providers approach requests for sex-selective abortion when caring for women of South Asian descent. Reproductive technologies emerge as being relational, reflecting various forms of compliance with kin as well as cosmologies that complicate the ethical value of 'choice' in women's healthcare. Taking inspiration from the reproductive justice framework (SisterSong; Ross and Solinger 2017), the chapter builds on a body of work that demonstrates how the concept of 'choice' is contingent and not inclusive of the situated constraints that can affect the reproductive lives of women from minority backgrounds.

While championing women's choice and autonomy has long been the cornerstone of the reproductive rights movement, advocates of reproductive justice argue that autonomy is constrained by structural conditions and social collectives. The reproductive justice framework is instrumental in centring analytical attention on the structures of oppression that women face, and seeks to re-address societal inequalities in order to afford women the resources they need to fulfil their reproductive decisions and desires (Ross and Solinger 2017). Within this approach, however, I suggest that there is a space to discuss how care providers attempt to facilitate as much autonomy and justice as possible within the situated constraints that women are living in and vis-à-vis their future reproductive life. Such a discussion underscores how *inclusive* care is performed amidst the broader struggle for justice – which is itself part of an anticipatory future. Below, I signal the analytical links between inclusion and justice in women's healthcare, and ethnographically illustrate how context shapes those links.

[1] By 'routinized' technologies of reproduction, I refer to the obstetric interventions and services that form part of everyday women's healthcare, which may enable decision-making but also 'decenter and displace women' (cf. Davis 2019: 9; Davis-Floyd 2004). One in three women in the UK will have an abortion in their lifetime and one in four babies are born by caesarean, making these services two 'routinized' areas of reproductive care.

Justice and inclusive care

The reproductive justice framework, as mentioned, is celebrated for moving beyond an exclusive concern with 'pro-choice' abortion activism, and addressing the intersectional, underlying and relational constraints that determine women's reproductive lives – especially for women of colour in the USA (SisterSong n.d.; Ross and Solinger 2017). Activists have articulated justice as 'the right *not* to have a child, the right *to* have a child and the right to *parent* children in safe and healthy environments. In addition, reproductive justice demands sexual autonomy and gender freedom for every human being' (Ross and Solinger 2017: 9). Reproductive justice is then profoundly concerned with human rights (Luna 2020), and the diverse ways that structural racism mediates the quality of care that minority ethnic women can expect to receive and the decisions they can make.

Black American, or African-American, women in the USA are the most poignant example of how systemic exclusion materialises in inequities and injustices surrounding access to reproductive health technologies and care (Roberts 1998). The USA offers an insight into how rates of maternal and neonatal mortality are rising in a high-income country; Black American women are two-to-three times more likely to die from pregnancy-related issues than White women, and the risk of death increases with age (Peterson et al. 2019). Similarly, in the UK, Back women are five times more likely to die and Asian women twice as likely to die during pregnancy than White women (Knight et al. 2018). Unlike the reproductive justice movement in the USA, the UK has experienced a relatively slower move to confront medical racism and to consider the experiences and expectations of minority women when it comes to reproductive care (Public Health England 2018; Decolonising Contraception n.d.).[2]

Commentators in the USA note that the issue of higher maternal mortality among Black women is intersectional; risk is influenced by immigration status, class and race (Peterson et al. 2019). What is striking is that the heightened risk of death cuts across socioeconomic status – so even Black women of a higher social and economic position are likely to die than poorer White women. To understand the issue of poorer maternal health outcomes among Black American women, scholars advocate for a need to understand how racism is applied through health interventions and technologies. Anthropologist Dána-Ain Davis (2019) proposes the concept "obstetric racism" to analyze Black women's pre- and post-natal encounters in terms of racism, and to theorize how Black women interpret their encounters with medical staff by illustrating the harm caused.

The body of work that Dorothy Roberts (1998) and Davis (2019) advance showcases the lived realities and situated roots of reproductive politics for minority groups in high-income country settings. However, my interest is in how ethnic and religious minorities raise implications for what *inclusive* woman-centred care can involve, how providers approach 'choice,' autonomy and justice in practice, and how their considerations reconfigure the otherwise 'routine' delivery of reproductive health services and technologies. This approach is important because the ethnographic record highlights how cultural, racial and religious stereotyping and typecasting occurs across the continuum of reproductive healthcare, from antenatal and maternity care to contraceptive, infertility and abortion care (e.g. Blell 2019; Davis 2019; Kasstan and Unnithan 2020; Purewal 2003, 2010). Taking these debates forward, this chapter is concerned with how providers

[2] The advocacy group 'Decolonising Contraception' (n.d.) was founded in 2018 by Dr Annabel Sowemimo, with a mission to work 'with [Black and People of Colour] communities to create culturally specific interventions with regards to SRH care.'

consider the lived constraints of women, and approach diversity in reproductive healthcare. Inclusion emerges as being analytically linked to reproductive justice, insofar as social context raises practical implications for how autonomy in women's healthcare is perceived, enabled and facilitated.

Autonomy over reproduction can also be impacted by the social and religious contexts of women, which raises broader implications for the politics of reproduction. Anthropologist Kate Hampshire and colleagues (2012) use the term 'relationality' as a conceptual tool to understand the role and responsibilities of kin in defining and shaping the experience of infertility among British Pakistani Muslims. They note that 'social and kin relations are important not only in shaping responses to infertility; they are also pivotal in the processes through which reproduction (or lack thereof) becomes defined as problematic in the first place' (Hampshire, Blell and Simpson 2012:1050-1051). Social pressure around reproduction exists along a continuum, and for example, the pressure to produce specific children as part of selective reproduction constitutes 'a form of intimate, gendered, and kin-based control' (Rapp 2017: viii).

Proponents of reproductive justice would agree, I think, that while we would all prefer to live in a world where reproductive autonomy is upheld, healthcare providers nonetheless have to respond to the daily challenges that women face in their reproductive lives (cf. Sheldon 2012). This reality makes responding to the situated constraints of women, as a form of inclusion, a necessary ethic of care amidst the social and legal pursuit of justice. In what follows I take the case of how Jewish doulas advocate against caesarean sections and how abortion providers approach requests for selective abortion to illustrate how they navigate framings of 'choice' and 'justice' when caring for women and how they mediate anticipatory futures of reproductive potential.

Reproduction in two minorities

Reproduction is a major conjugal responsibility in Haredi or "ultra-Orthodox" Judaism, with the imperative for men to 'be fruitful and multiply' the collective body, and the pressure for women to be its bearer, imparted through a range of scriptures and legal codes. Haredi Jewish women have among the highest total fertility rates in the country — over three times that of White British women (Staetsky and Boyd 2015), also reflecting similar demographic patterns in the Jewish populations of Israel and the United States. Much attention to Orthodox and Haredi Jews in the social study of reproduction has focused on the ethical dilemmas of technologies, interventions and bodily education, and the careful navigation of religious authorities (Teman, Ivry and Bernhardt 2011; Kasstan 2017; Taragin-Zeller 2019; Taragin-Zeller and Kasstan 2020). Attention to the reproductive lives and engagement with maternity services is crucial because Haredi Jewish women are engaged in continuous childbearing and childrearing until they reach the menopause (Teman, Ivry and Bernhardt 2011: 70). Contraception among Haredi Jews takes on a conceptual shift as techniques to space births (Birenbaum-Carmeli 2008), indicating how technologies are used as part of the aspiration to have large families. Looking at routinized interventions, such as caesarean sections, capture how healthcare services constitute a borderland where multiple – and at times opposing – notions of bodily governance encounter each other, and where concerns around cultural perpetuation are performed (Kasstan 2019).

Whilst forming a very different minority in England, women of Bangladeshi, Indian and Pakistani origin offer an interesting comparison to explore issues of reproduction. There are wide variations in total fertility rates between these minority groups, and sociological

research has noted how higher total fertility rates among British Pakistani women are sustained by pro-natal worldviews – childbearing is viewed by women as culturally mandatory and childlessness as socially unacceptable' (Culley and Hudson 2009: 252; also Shaw 2004; Blell 2019). Yet, the absence of a son can constitute a form of 'social infertility,' and can be equated with childlessness (Hampshire, Blell and Simpson 2012). Scholars note that son preference is shifting, and that son preference does not necessarily engender prejudice against daughters (e.g. Purewal 2010). Moreover, scholars have observed that shifts towards matrilateral kinship have taken place among British Pakistanis (Qureshi 2016; Shaw 2004), which signals how strong mother-daughter bonds influence values around gender.

Whilst the reproductive care needs differ between the two minority groups presented in this chapter, my comparative approach pinpoints how healthcare providers encounter and approach relationality between care and context.

Methods, people and place

This chapter draws on ethnographic and qualitative data from two separate projects, one focusing on the maternity care needs of Haredi Jewish women in Manchester (2013-2016) and childbearing decisions among women of Bangladeshi, Indian and Pakistani descent in England (2017-2019). Semi-structured interviews were conducted in both studies, in English. Interviews were recorded using a digital audio recording device, when permission was granted, and detailed notes recorded. Recordings from interviews and other encounters in the field were transcribed verbatim, and analysed on both a separate and comparative basis. Participants provided verbal or written consent.

The Haredi Jews of Manchester

Haredi Jews account for, at most, 16 percent of the UK's Jewish population (approximately 275,000) at the time of the 2011 census (Staetsky and Boyd 2015). Haredi Jews live their lives in accordance with the teachings derived from the Hebrew Bible as well as a voluminous body of rabbinic literature, commentary, and rulings. Haredi Jews can be distinguished from other Jewish streams (Progressive, Conservative, Orthodox) by their self-protective stance and avoidance of secular education and professional training. This selective-engagement with the outside world, in turn, presents implications for healthcare, with forms of male (rabbis) and female (doulas) expertise mediating the delivery of services, interventions and technologies. In practice, the Haredi sector consists of multiple groups, each with their own religious leaders (rabbis), teachings, and observances. This population can be loosely divided into Lithuanian yeshiva-based (Torah learning) communities, Hasidic dynasties, and Sephardi Haredim (who trace their origins to the Iberian peninsula, North Africa and the Middle East). Differences aside, all the sector's members are easily identified by their more or less uniform dress code: black hats and darks suits for men; and similarly coloured ankle-length skirts, long sleeves, and head coverings for women.

Manchester has among the fastest growing Jewish populations in the UK and Europe due to higher total fertility rates among Haredi women (Staetsky and Boyd, 2015). Twelve months of ethnographic research was conducted in Manchester (2014-2015) to evaluate perceptions of maternity care and infant health among Haredi Jewish families. Key research participants involved local parents as well as a network of Haredi Jewish doulas who provide the full continuum of antenatal, birth and postpartum support to local Jewish women.

Women of 'South Asian' origin in England

The term 'Asian' in the UK is often used as a collective category for people of Bangladeshi, Indian and Pakistani origin, who constitute the largest ethnic minority group, numbering approximately 5.3% of the population (just under 3,000,000) at the time of the 2011 census. The collective categories of 'South Asian' or 'Asian' that appear regularly in academic and public discourse, in reality, obscure a diverse mosaic formed of colonial and migration histories, religious traditions (Christianity; Hinduism; Islam; Sikhism;), languages, social hierarchies (e.g. caste system and class) and intra/inter-group relations that influence reproductive decision-making in nuanced ways.

The paper draws on a dataset of sixteen semi-structured interviews conducted with abortion care providers, including administrators, midwives, nurses, physicians and clinic managers, on the issue of sex-selective abortion in England. The purpose of the study was to explore whether, and how, providers encounter requests for sex-selective abortion, and how they reconcile requests with legal and ethical parameters.

Caesarean sections

Mrs Sofer has been practicing as a doula in Manchester for twenty years, and she told me that state maternity services are among the primary times that Haredi Jews 'touch the outside world.' In taking maternity care as a point of crossing, the doulas see themselves as strategic for enabling access to public healthcare. Yet their roles are about caring for biological as well as social reproduction – which reproductive technologies are perceived to threaten – and in turn require negotiation from the doulas. Obstetric interventions, especially caesarean sections, form a particular concern for Haredi Jews due to the relationality between care and cosmology, requiring careful negotiation and intervention to protect processes of social reproduction.

A network of Jewish doulas in Manchester supported women through the process of maternity care, and some would seek to secure particular birthing outcomes. Mrs Nadler has been providing doula care to Haredi Jewish women for over twenty years, and had become increasingly concerned that if a caesarean is performed on a woman's first pregnancy then there was an increased likelihood that a caesarean would be performed in future pregnancies as a practice of risk management. She was concerned that 'you can only have so many caesareans,' which could limit a Jewish woman's reproductive potential.

Mrs Nadler's concerns reflect increasingly routinized biomedical realities and practices. When rising rates of primary caesarean section are coupled with a decrease in the numbers of vaginal birth after caesarean (VBAC) being performed, then it is likely that the number of women having to undergo subsequent and multiple caesareans will rise (see Nisenblat et al. 2006). As a result of the heightened social value of childbearing among Haredi Jews, Mrs Nadler said, 'in the *frum* [Yiddish, pious] world, people would rather not have caesareans.' For this reason, Mrs Nadler often advocated against caesarean sections that she perceived to be medically unnecessary and avoidable. In one encounter surrounding an undiagnosed breech, Mrs Nadler recalled:

> The doctor said, 'right, this has got to be a caesarean,' and I told the [pregnant] lady, 'leave the talking to me, please.' I said to the doctor, 'she doesn't want a caesarean. She's labouring nicely and she's happy to try for a natural [vaginal].' So the doctor said, 'I've never delivered a natural breech.' I said, 'I hear you, but this is her request.' A bit later she came in to say, 'Miss so-and-so who is the top consultant on the unit is coming out.' This was four in the morning, and the staff

whispered to me, 'we have never seen this before.' I said, 'well she's entitled to her choice.' (April 2015)

What is important is how Mrs Nadler felt the need to intervene in this clinical encounter, and to formulate and assert the birthing woman's 'choice,' because of her personal and professional concern with how technologies of saving were becoming routinized in ways that did not consider the implications for future childbearing. While she went on to acknowledge that operative births can be lifesaving in some instances, she explained there 'are few reasons that I would say need to have caesarean.' Not all Haredi Jewish women, however, felt that the advice given by doulas was appropriate, or at risk of 'overstepping the mark.' While studies note that the presence of a doula in NHS maternity care can reduce the likelihood of a caesarean being performed, it is also worth noting that the presence of a doula also indicates that women desire and pursue particular birthing outcomes (Brigstocke 2014). The care practices of Mrs Nadler may be read as coercive against clinical policies that are centred on respecting individual patient autonomy, though in a context of Haredi Judaism, the individual is directly centred in the reproduction of collective life (Kasstan 2019).

Part of Mrs Nadler's opposition to caesarean sections lies in the fact that the intervention can disrupt processes of social reproduction and the chance of a firstborn son having a *Pidyon HaBen* (Hebrew, redemption of the first born). This birth rite is bestowed when a first-born child, who is male (*bechor*), reaches the thirtieth day of life. However, this rite of birth is only held under certain conditions. The ceremony is held when a *bechor* 'opens up the womb' of the mother, but this 'opening' is interpreted as being strictly by way of vaginal birth – whereas 'if you've had a caesarean, the baby has not come through the womb and opened up the womb.'

This ethnographic vignette forms one part of a broader issue around the routinization of caesareans in women's healthcare. The number of caesareans performed around the world does not reflect the ideal rate of 10-15% of births advocated by the World Health Organization, meaning that many caesareans are performed for reasons that do not reflect clinical need or necessity. Scholars have subsequently sought to examine how caesareans are entangled in the politics and economics of healthcare (Béhague 2002; Davis-Floyd 2004), by questioning what counts as evidence in the production of obstetric knowledge and medical risk (Wendland 2007; Topçu 2019), how caesareans can reflect a 'misrecognition of need' (Tully and Ball 2013), and maternal 'choice' (Romanis 2020). The intervention of Mrs Nadler reflects broader interests in reducing medically unnecessary caesareans, though what is different is the relationality with context.

When the ability to produce large families can enable women to perform and achieve highly prized notions of motherhood, caesarean sections can be refused and opposed. Anthropologist Lucy Lowe (2019) has demonstrated how Somali refugee women in Kenya can oppose caesareans to protect their 'fertile futures' amidst uncertainty, migration and chronic precarity. She notes how, 'Cesarean sections are a heavily relied-on solution to obstetric problems, yet they can result in profound crises for women and their families who perceive motherhood not in the singular act of producing a child but in the ongoing process of perpetual reproduction' (Lowe 2019: 199). The care work of Jewish doulas captures how opposition to caesarean sections reflects an interest in safeguarding reproductive potential beyond the case of displacement, and according to vernacular values placed on childbearing. Attention to how biomedical 'technologies of saving,' as Davis (2019) puts it, are negotiated then reveal broader concerns with saving reproductive

potential across the lifecourse as well as the saving of collective identities that play out on women's bodies.

Abortion

Abortion, especially for sex-selection, illustrates how pregnancies can be terminated as part of a pressure to pursue particular reproductive futures – especially regarding sons and male heirs. Sex-selective abortion (henceforth SSA) is a form of selective reproduction, which entails "personal assessments of the economic burdens and benefits that the birth of a particular kind of child will entail" (Wahlberg and Gammeltoft 2018: 16; also van Balen and Inhorn 2003). The preference or pressure to bear a son can intensify at higher birth orders, amidst conditions of lowering fertility, and often, the economic imperative of having smaller family sizes. The following conversations took place against the backdrop of public controversy surrounding SSA in the UK since 2012, where abortion politics had involved a discursive focus on son preference among South Asian families. While re-narrating the controversy is beyond the scope of this chapter, what is important to briefly reiterate is how ideas of appropriate reproductive choice and rights were projected, and attempts to restrict national abortion laws were engendered (for a full critique of events see Lee 2017; Unnithan and Dubuc 2017). SSA holds an ambiguous legal status in the UK, and can be permissible if a woman's mental health or socio-economic position may be at risk (Greasley 2016; Sheldon 2012). Yet, practitioners perceived SSA in diverse ways and sought to include requests in the scope of care.

Delores is a registered midwife in her fifties, and had joined abortion provision in 2016 after serving in maternity care for many years. She explained how she would be upfront and say to a woman that a request for abortion on the grounds of sex-selection 'is an illegal reason.' While, as mentioned, SSA can be lawfully provided depending on the explanations presented by women, Delores would highlight the legal constraints around abortion as a technique to extract as much information as possible to inform access to care:

> If she was honest in saying, "we're doing it 'coz of sex selection," then I think I'd have to ask for more information. It wouldn't make me feel any different about doing the abortion. I would write as much detail as possible, but then I would probably discuss it with the Manager. It would shock me, but I still wouldn't judge somebody on it because [then] I wouldn't be pro-abortion. (October 2018)

While being careful to convey her commitment to being pro-choice ('pro-abortion'), in another breath, Delores would be shocked by a request for SSA and would escalate the request to senior management. Senior management approached SSA as a 'protective' form of care for women when unable to exercise choice over their reproductive decisions, as Monica explained:

> Actually, it could be a protective factor for a woman having a child of the "wrong" sex, to have a termination actually. A large proportion of our clients don't actually have very much choice in terms of who they marry or how many children they are going to have. If they decide to leave a relationship, they'll know that if they leave that relationship, they're going to have to leave their children behind. So, if you extend that argument into the kind of decisions behind sex-selection, it could actually be a very protective thing for a woman who's knocked out three or four girls if she knows she's having another girl. (November 2018)

Dr Ahmed, a Bangladeshi physician, described that she had not encountered a pressure to bear sons and abort a female foetus in her ten years of work at a woman's health clinic in London. More common, she said, was the general economic pressures on women that lead to abortion. Suriya, an abortion counsellor, had encountered requests for SSA in her thirty years of experience but noticed a shift:

> Ten years ago it was a little bit more common, but now Asian people have reduced this sort of 'you've got five girls, and now you're going to have another girl,' but now I have noticed that even though they have got a few girls and no boys, they're not talking like that. They're coming for abortions because of financial situations and things like that, but not because of the gender [sex]. (November 2018)

These abortion providers placed a high value on being 'pro-choice,' as a necessary ethic of care, yet negotiated reproductive 'choice' alongside power dynamics that range from financial hardship, and in the specific case of SSA, patriarchal family structures. The difference, however, was that SSA was recognised by providers as forming part of an anticipatory future of bearing sons to protect their position vis-à-vis kin relations. At the same time, some providers indicated a sense of 'shock' around the issue of SSA, perhaps falling outside the domain of routine care (Kasstan and Unnithan 2020), and signalling how such requests may result in decisions to delay access to care.

While sonography to identify foetal sex and SSA is criminalized in India, the practice can be used as part of reproductive planning and to achieve a sex-balanced and small family size among professionals who move to New Delhi (Khanna 2015). Physicians in Northern India view the practice as a 'social service' amidst a 'social fact' of gender inequality and when the ability to bear a male heir can secure the position of lower and middle-class Hindu and Muslim women (Unnithan-Kumar 2010). Yet, Rishita Nandagiri (2019) has demonstrated how community health intermediaries in the South-West of India can conflate laws around abortion (legal) and sex-selection (illegal), which compounds stigma and perpetuates ideas of 'good/bad' abortions that determines access to a critical area of women's health care.

Abortion care providers, in this case, attempt to offer protective interventions to support women within their lived and situated constraints (which was perceived to be shifting by Suriya). Care is not always practiced or envisioned as part of a one-off clinical encounter or short-term intervention, but as part of a woman's lifecourse and the longer-term implications that a pregnancy might entail. Moreover, the practices of abortion providers signal the tensions in providing care amidst social change and constraint. By acknowledging and responding to the diverse realities of women, providers practice reproductive inclusion amidst an anticipatory future of justice.

Conclusion

This chapter has sought to highlight how reproductive technologies are negotiated as part of anticipatory futures of reproductive potential, and in ways that reveal how care is not always concerned with a singular action or event – but rather the lifecourse. The power of anticipation lies in the value of reproduction as a strategy to cultivate personhood, and in the cases at hand, to secure and attain social status. It is important to reiterate that there are considerable differences between the minority groups presented in this chapter, marked by positionality in contemporary Britain and engagements with state reproductive health services (Blell 2018; Hampshire, Blell and Simpson 2012; Kasstan 2019; Qureshi 2016). My comparative approach nonetheless highlights the continuities and

discontinuities in how context matters (cf. Inhorn 2002), as reproductive technologies and interventions are negotiated in anticipation of the lifecourse and to meet the social and religious expectations that shape reproduction.

While caesareans form part of a repertoire of 'technologies of saving' (cf. Davis 2019) that are increasingly routinized, they can be viewed as an intervention with implications for social reproduction among Haredi Jewish doulas. Abortion care is a critical area of women's health, yet the issue of son preference leading to SSA raises ethical and legal dilemmas that providers are tasked with negotiating carefully. By focusing on reproduction in ethnic and religious minority groups, decisions and desires emerge as relational and are often negotiated in line with cosmology and kin in ways that might be read as being in conflict with clinical guidelines premised on consent and autonomy.

The healthcare workers in both settings placed a discursive value on women's 'choices,' while consciously and unconsciously revealing the constraints that shaped decision-making. While the concept of 'choice' has been widely critiqued in the social study of reproduction as a fallacy (Ross and Solinger 2017), it clearly performs a salient role in healthcare provision and everyday clinical encounters. The reproductive justice framework is a revolutionary force in engendering academic debates and social change surrounding women's reproductive health and decisions beyond the confines of 'choice,' but justice is also a *process*. While the reproductive justice movement privileges the lived realities or lived experiences of women in 'their drive to possess reproductive autonomy' (Ross and Solinger 2017: 7), my interest in care provision signals how justice is approached *within* lived constraints and how providers mediate the parameters of inclusive and woman-centred care. These healthcare providers, I suggest, recognise that the relationality between context and care will not disappear overnight, and that care decisions are made as part of a continuously shifting social life.

Anthropologists have been prolific in capturing how medical professionals disregard the needs, desires and decisions of pregnant and birthing women from minority backgrounds, which Davis (2019) conceptualises as 'obstetric racism' in the US context. Yet, I have demonstrated how healthcare providers attempt to listen to women's needs and read between the lines of constraint and consent, and facilitate reproductive autonomy while that autonomy is constrained by the social, cultural and religious expectations. Reproductive healthcare is an intimate area of biomedicine where carers draw on a situated knowledge of women's lives in their everyday clinical encounters, acting as barriers and enablers to woman-centred care (Nandagiri 2019). Feminist scholars should continue to examine how the slow dismantling of entrenched inequities on the basis of sex and sexuality, age, race, ethnicity, religion, and ability impacts reproductive healthcare at local levels amidst the global pursuit of reproductive justice.

On an empirical level, the chapter contributes to this collection's interdisciplinary and integrated approach to the study of reproduction by demonstrating how technologies in one pregnancy are situated in the anticipation and calculation of future potential. Conceptually, the chapter raises further questions and provocations concerned with the politics of reproduction, and the forces that determine what is possible, probable and preferred (Ginsburg and Rapp 1991; Franklin and Ginsburg 2019; see also Textor 2005: 2). Technologies increasingly invest the reproductive lifecourse with potential and anticipation, which calls on feminist scholars to understand the dilemmas posed for inclusive models of care beyond the discourse of 'choice.'

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