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MARKETS, MORALS AND MEDICALISED MATERNITY

Navigating a shifting health service terrain in Bangladesh

Submitted by Janet Perkins

A THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

SCHOOL OF SOCIAL AND POLITICAL SCIENCE
THE UNIVERSITY OF EDINBURGH

DEPARTMENT OF SOCIAL ANTHROPOLOGY

2022
DECLARATION

I, Janet Perkins, hereby declare that this thesis has been composed by myself, that this thesis is a result of my own research, and that no part of this thesis has been submitted to any other university for a degree or qualification.

Signature: Janet Perkins

Date: 13 July 2022
Lay Summary

Until recently, women in Bangladesh were characterised by academics, policymakers and global health practitioners as reticent to uptake ‘modern’ pregnancy and birth care. Well into the 2000s, the vast majority of the women in the country gave birth at home in the presence of non-professionalised attendants. However, recent years have witnessed rapid shifts toward highly medicalised practices during pregnancy and birth. Remarkably, by 2016, while half of women gave birth at home according to ‘traditional’ practices, over 30% of women gave birth through caesarean. Advanced biomedical forms of pregnancy and birth care, such as caesarean and ultrasonograms, are primarily made available through a minimally regulated private health care market which today places such technologies within reach of women of all social classes living in even the most remote areas. Based on 18 months of ethnographic fieldwork carried out among maternal health policymakers and programmers in Dhaka and among health service managers and providers in Kushtia district, this thesis seeks to make sense of the transitions toward medicalised and marketised maternal health care in Bangladesh. Anthropological scholarship has tended to view health markets as outgrowths of global capitalism and immoral. This thesis, in contrast, tends to how moralities, i.e., ideas about what is good, right or altruistic, emerge and are renegotiated in response to localised realities and transitions. It argues that the rise of maternal health markets in Bangladesh reflects a distinctly Bangladeshi political, social and economic context rather than a global homogenising agenda. It argues that maternal health markets in Kushtia have mushroomed not in response to a perceived retreat of the state but in response to a public health system perceived as fundamentally fragmented, failing to deliver ‘care’, and existing solely to respond to ‘the poor’ (gorib manush). This thesis contends that while maternal health ‘care’ in public settings often appears ‘uncaring’, this apparent ‘uncaring-ness’ is structured by government providers’ moral imperatives to provide ‘service’ (sheba), though not necessarily personalised, hands-on ‘care’ (jotno). While private health services come at a cost, both financially and in terms of clinical quality, women and families think of health markets as a space in which they will be able to access care that they seek, and perhaps even jotno. In addition to opportunities for women, maternal health markets expand economic possibilities for people of all social classes. Nevertheless, while opening economic opportunities where livelihood-making is more generally
precarious, this thesis argues that morality is also central to the project of health market-making in Kushtia. Both formal and informal actors navigate and negotiate moral ideas as they seek to secure livelihoods. This thesis traces women’s and their families’ navigation to access desired maternal health services in this shifting terrain. It argues that social connectedness is central to accessing resources in public or private health sectors. Indeed, rather than reflecting global capitalist forms, the maternal health terrain in Kushtia is made through the navigation of actors pursuing health, economic and moral ambitions, responding to and constituting states of flux and long transition inherent to the Bangladeshi experience.
Abstract
This thesis lies at the nexus of recent transitions towards medicalised childbirth, marketisation of maternal health services and moralities of care, examining how women, their families and health actors navigate maternal terrains in transition in Bangladesh. Until recently, women in Bangladesh were characterised by academics, policymakers and global health practitioners as reticent to uptake biomedical pregnancy and birth care. Today, the use of advanced biomedical maternal technologies, made available through minimally regulated health markets even in the most remote areas and placed within the grasp of women of all social classes, is ubiquitous. While anthropological scholarship has primarily approached health markets as an outgrowth of global neoliberal hegemony and as de facto ‘immoral’, this thesis destabilises these assumptions, attending to the situatedness of maternal health markets in Bangladesh and seeking to understand the ways that moralities of care emerge and are renegotiated on their own terms. Based on 18 months of ethnographic fieldwork within national health policymaking and programming circles in Dhaka and among health service managers, providers and women in Kushtia district, it argues that the rise of maternal health markets in Bangladesh is embedded in and reflects a distinctly Bangladeshi political, social and economic context, rather than a global homogenising agenda. It argues that maternal health markets in Kushtia have mushroomed not in response to a perceived retreat of the state but in response to a public health system perceived as fundamentally fragmented, failing to deliver ‘care’, and existing solely to respond to ‘the poor’ (gorib manush). This thesis contends that while maternal health ‘care’ in public settings often appears ‘uncaring’, this apparent ‘uncaring-ness’ is structured by government providers’ moral imperatives to provide ‘service’ (sheba), though not necessarily personalised, hands-on ‘care’ (jotno), challenging the often taken-for-granted coupling of clinical care and affective care. While commodified services come at a cost, both financially and in terms of clinical quality, markets provide imagined spaces where women might access ‘care’ (jotno) beyond ‘service’ (sheba). In addition to opportunities for women, maternal health markets expand possibilities to pursue formal and informal livelihoods for people of all social classes. Nevertheless, while opening economic opportunities where livelihood-making is more generally precarious, this thesis argues that morality is also central to the project of health market-making in Kushtia. Both formal and informal actors
navigate and negotiate this morally ambiguous space as they seek to secure livelihoods and conform to moral imperatives. This thesis traces women’s and their families’ navigation to fulfil aspirations for maternal health services in this nebulous space-in-the-making. It argues that social navigation principally demands nurturing and leveraging social connectedness to access biomedical resources, destabilising logics underpinning conceptualisations of health services either as ‘entitlements’, delivered by a state based on citizenship or as pure ‘market commodities’, delivered through a health market according to the principles of classical economics. Indeed, rather than a manifestation of hegemonic neoliberal ideologies, the maternal health terrain in Kushtia reflects the nimble and situated navigation of actors pursuing health, economic and moral ambitions, both responding to and constituting states of flux and transition long inherent to the Bangladeshi experience.

**Key words:** Maternal health, morality, social navigation, health markets, state, development, Bangladesh
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I am also grateful to Tapas Mazumder whose insights have always been central to my understanding of Bangladesh.

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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioural change communication</td>
</tr>
<tr>
<td>BDHS</td>
<td>Bangladesh Demographic and Health Survey</td>
</tr>
<tr>
<td>BMMS</td>
<td>Bangladesh Maternal Mortality Survey</td>
</tr>
<tr>
<td>CMU</td>
<td>Certificate in Medical Ultrasound</td>
</tr>
<tr>
<td>CPS</td>
<td>Civil service Pakistan</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for international development</td>
</tr>
<tr>
<td>DGFP</td>
<td>Directorate general of family planning</td>
</tr>
<tr>
<td>DGHS</td>
<td>Directorate general of health services</td>
</tr>
<tr>
<td>DMU</td>
<td>Diploma in medical ultrasound</td>
</tr>
<tr>
<td>DSF</td>
<td>Demand side financing</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency obstetric care</td>
</tr>
<tr>
<td>FWA</td>
<td>Family welfare assistant</td>
</tr>
<tr>
<td>FWV</td>
<td>Family welfare visitor</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IMS</td>
<td>Indian Medical Service</td>
</tr>
<tr>
<td>LMP</td>
<td>Last menstrual period</td>
</tr>
<tr>
<td>MATS</td>
<td>medical assistant training school</td>
</tr>
<tr>
<td>MCWC</td>
<td>Maternal and Child Welfare Centre</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MMR</td>
<td>Maternal mortality ratio</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NIPORT</td>
<td>National Institute of Population Research and Training</td>
</tr>
<tr>
<td>OGSB</td>
<td>Obstetrics and Gynaecology Society of Bangladesh</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of the High Commissioner on Human Rights’</td>
</tr>
<tr>
<td>OT</td>
<td>Operating theatre</td>
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<tr>
<td>PNC</td>
<td>Postnatal care</td>
</tr>
<tr>
<td>PV</td>
<td>Pelvic examination</td>
</tr>
<tr>
<td>RMO</td>
<td>Resident medical officer</td>
</tr>
<tr>
<td>SACMO</td>
<td>sub-assistant community medical officer</td>
</tr>
<tr>
<td>SAPs</td>
<td>Structural adjustment policies</td>
</tr>
<tr>
<td>SSC</td>
<td>Secondary school certificate</td>
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<tr>
<td>SSN</td>
<td>Senior staff nurse</td>
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<tr>
<td>UH&amp;FPO</td>
<td>Upazila Health and Family planning officer</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WMSI</td>
<td>Women’s Medical Service of India</td>
</tr>
</tbody>
</table>
Glossary

abbu  
father

age kar  
from an older generation

apa  
sister

aya  
non-clinical helping hands

Baccha manush  
child

bari  
home

beshorkari  
not government/private

bhabi  
husband's wife

bhai  
brother

bhodrolok  
gentlemen/women

bhut  
evil spirits

bideshi  
foreigner

biSh byaetha  
poisonous pain

bokshish  
tips

burqa  
long dress

byaetha  
pain/uterine contraction

cesta korbo  
will try

chacha  
paternal uncle

chachi  
paternal aunt

channachur  
a spicy snack

dadi shashuri  
grandmother in law

dai  
traditional birth attendant

dalal  
broker

dari  
beard

dhormo  
religion/moral world order

dhora-dhori  
mutual grasping or holding

digital poribesh  
digital environment

doya  
blessings

gorib manush  
poor people

gramir manush  
village people

grihosto manush  
faming people

gyne-consultant  
obstetrician-gynaecologist

hapataler lok  
hospital people

hature  
poorly-trained traditional practitioner

jhuki  
risk

jono sheba  
public service

jotno  
care

kobiraj  
traditional healer

kagoj  
papers

kameez  
tunic

khala  
maternal aunt

---

1 This glossary was developed in consultation with native Bangla speaking research participants and colleagues.
Map
Introduction

A decade of childbearing

Just off a potholed village road in Amla, Bangladesh, located in Kushtia district, hugging the western border with India, I sit on Shaheda’s firm bed under a corrugated tin roof, my research assistant Tamanna by my side. My feet dangle down, grazing the dusty, concrete floor. Shaheda sits in a wooden chair in front of us and narrates the stories of her two births. She married young, she tells us, but she cannot say at what age exactly. She remembers that her marriage was after she completed year six or seven (usually attended by children 11-13 years of age) at school. Her family was poor, and as one child of four, her parents arranged her marriage quickly, for which she discontinued her studies. While she tells us that this part of her life was a bit of a blur, she remembers more clearly becoming pregnant around four years after her marriage, sometime around 2005, with a baby she and her husband deeply desired. Her first pregnancy passed without any significant problem or discomfort, although she did experience some nausea at the outset. For that, she visited the kobiraj, a traditional healer, Kamrul bhai1, who maintains a medicine stall (oshudh dokan) in the local market. He gave her some medicine, and she soon felt better. She visited him from time to time throughout the rest of her pregnancy. A family welfare assistant (FWA)2 came to her home and checked on her once. She did not seek any other health services during that first pregnancy. She did not see why she would; she was not having any problems.

She returned to her mother’s home towards the end of her pregnancy to give birth, as young women from rural Kushtia are wont to do for a first birth. Her husband accompanied her. One night, labour pain shot through her body and jolted her from her sleep. There was no discussion about going elsewhere; it went without saying that she would stay home and give birth in her bedroom. “Would you have expected me to go to the hospital if there was no problem?” Shaheda asks us rhetorically. “The last time I visited the doctor [during my first pregnancy], I was told that the baby’s position was good, so the doctor said the delivery would be good. It is for that

1 Honorific used to indicate ‘brother’.
2 A community health worker under the Directorate General of Family Planning, they directorate under the Ministry of Health and Family Welfare (MOHFW) responsible for delivering family planning services. Family Welfare Assistants provide household level family planning services and antenatal care.
reason that the delivery was at home. There was no reason to take a decision, understand? In addition, my father and my husband brought the [village] doctor, and what was needed, he gave the treatment (uterotonics)\(^3\) and then went away.” The family called her *phuphu*, her paternal aunt, known for assisting women in the area during birth. Her *phuphu* rushed to her home and joined the women already assisting her, including her mother and grandmothers. It was an easy birth, she recalls. Around midnight, her healthy baby boy just slipped out.

Shaheda pauses her story to fetch a snack of biscuits, spicy *channachur* mix and a drink of fresh water. She sets these on a tray next to us. “Eat,” she instructs. We each politely take a biscuit and nibble at its edge. She was in no rush to have another child, she continues. Approximately ten years after her first birth, around 2015, she visited Kamrul *bhai* in the bustle of the village market. He gave her some medicine to help her become pregnant, she does not remember what kind exactly, which she did soon after. Except for nausea, for which she once again visited Kamrul, she experienced an otherwise uneventful pregnancy. Despite this, she visited the nearby union sub-centre, the local government health centre, for antenatal care (ANC) each month, where an FWA checked her. In addition, she had four ultrasonograms. For two of them, she travelled to the well-reputed Amin private hospital in Kushtia, the district administrative capital. For the other two, she visited Sad Ali, a private clinic located in the nearby town of Mirpur, also the site of the upazila health complex, the government sub-district hospital. She knew many people who had gone to Sad Ali, she says, to explain why she went to that clinic rather than to one of the several others located in the vicinity. When we ask why she had no ultrasonogram for the first pregnancy and four for the next, she explains that this digital environment (*digital poribesh*) did not exist when she was pregnant the first time. Nowadays, she says, people are doing ultrasonograms all the time. By her second pregnancy, undergoing ultrasonogram was necessary, she tells us, because, during pregnancy, you need to take care of your body; otherwise, the baby could get sick, or you could become sick.

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\(^3\) Uterotonics, such as Pitocin, mimic oxytocin, the hormone which triggers uterine contractions in the body and are sometimes used to induce or augment labour. While according to global and national clinical guidelines, these should be administered and monitored by formally-trained health service providers and only in equipped health facilities for labour induction and augmentation, in rural Bangladesh, it is common for semi-formal and informal health actors to administer uterotonics during home births.
At the time of her second birth, she stayed in her in-law’s home (*shashurbari*), as is common practice in Kushtia for subsequent births. This residency meant that her in-law family would primarily decide where she would give birth. By then, the prospect of home birth, the default option during her prior pregnancy, was out of the question. Her husband, on whom she relied and trusted to make the good decisions for her and the baby, insisted that even if she had a *normal delibheri*, the English cognate term women use to describe a vaginal birth, she would go to a formal biomedical health care facility. He said that these days women are having problems while giving birth. If they wait too long, something bad could happen to her or the baby while trying to reach the health facility. For him, a biomedical health facility held the promise that everything would go well.

Like the first time, her labour pain struck in the night. Her in-law family immediately took her to Sad Ali clinic. She explains that they could not take her to a government health facility as it was night, and they do not provide services after hours there. While the upazila health complexes should officially provide services in the evenings and nights, in reality staff are rarely present after the early afternoon. A couple of hours after admission in Sad Ali, she underwent a caesarean birth. She is unsure why the medical team recommended a caesarean, but she remembers the health service providers say she was losing amniotic fluid too quickly. Both she and her baby daughter sustained the surgery well.

A surgical birth was the presumed outcome when her in-law family took her to a private clinic for birth; an act of care imagined as the safest for her and the baby at a moment fraught with risk. Nevertheless, the surgical birth came at a physical toll on her. Years after the surgery, when we speak to her, she still feels pain at the incision site, a peculiar sensation that arises when she carries out her household labour. She feels the tension and worries that she will injure herself. There is nothing more peaceful (*shanti*) than a normal delibheri, she says. Despite the inconveniences her body bears for it, she does not question the decision or necessity of her surgical birth.

Shaheda’s story is in no way fantastic or out of the ordinary. Nevertheless, it illustrates how drastically ideas and possibilities around pregnancy and childbirth morphed in rural Bangladesh throughout one woman’s reproductive life—in only a
decade. These shifts can be understood as movement towards medicalised childbirth, reimagining this life transition within biomedicine’s social and political terms. While at the time of her first birth, Shaheda and her family saw little reason for seeking biomedical maternal health services and technologies, by the time of her second, it was nearly unthinkable not to do so. Her account speaks to transformations of desires, aspirations and moralities among women as pregnant and childbearing subjects and their families, refashioned through medicalisation. It also speaks to a novel world of biomedical possibilities newly accessible through the maternal health service terrain.

At the turn of the millennium, scholars of Bangladesh remarked how little childbirth ideas and practices had shifted over the previous century (Afsana and Rashid, 2009, Rozario, 1998). They observed that, despite the efforts to medicalise childbirth by the colonizers and then subsequently by international and national actors in the postcolonial period, birth practices at the end of the 20th century and early 21st retained a remarkable similarity to earlier non-biomedical practices. Birth here continued to be confined in the intimate sphere of the home, attended primarily by low-status dais, traditional birth attendants without formal biomedical training (Rozario, 1998, Jeffery et al., 1989, Afsana and Rashid, 2009, Jeffery and Jeffery, 1993). These stubborn ‘traditional’ birth practices were often imagined as holding women back from their healthy, flourishing potential within global and national health policy and programming discourses.

Quantitative figures parallel qualitative observations. That Shaheda relied almost exclusively on the care of a kobiraj during her first pregnancy was unremarkable; according to the Bangladesh Demographic and Health Survey (2005) carried out at the time, just over half of women attended any formally-recognized ANC, which included the care she received from the passing FWA, during pregnancy. It would have been highly improbable then for her to see her elder baby in utero through an ultrasonogram, as just over 1 in 10 women did so then, while just under 1 in 10 gave birth in a biomedical institution (National Institute of Population Research and Training (NIPORT) et al., 2005) A caesarean birth? Such a proposition would have been nearly unthinkable; fewer than 2% of women living in rural areas gave birth surgically at that time (National Institute of Population Research and Training (NIPORT) et al., 2005).
A decade later, when Shaheda became pregnant again, ideas and practices around childbirth resembled very little of those which predominated during her first pregnancy. By 2016, Shaheda was among the vast majority (80%) of pregnant women to see their baby through ultrasonogram technology at least once during her pregnancy. She was among the half of women who gave birth in a biomedical institution, many surgically (National Institute of Population Research and Training (NIPORT) et al., 2019). Indeed, by her second pregnancy, a new world of biomedical possibilities infused the maternal health service terrain. At the time of her first birth, had she decided to visit a biomedical institution, most likely she would have had little recourse but to seek care through the public health scaffolding. In 2007, according to official records, hospital beds in for-profit private health facilities represented fewer than half of those registered in the public facilities (16,105 vs 32,941) (Government of the People's Republic of Bangladesh, 2007), with most of these located in urban spaces (Baru, 2003).

By the time of her second birth, hospital beds in the for-profit private sector handily surpassed the number located in the public sector by over 60% (78,246 vs 48,934) (Government of the People's Republic of Bangladesh, 2016). The number of registered private hospitals and clinics quadrupled during the same period, from 1,005 to 4,596 (Government of the People's Republic of Bangladesh, 2007, Government of the People's Republic of Bangladesh, 2016). Given this, it is perhaps unsurprising that the increase in institutionalized birth was primarily within the private sector. Many such facilities would be within reach of rural women like Shaheda. Most would offer the tangible possibility of surgical birth.
This thesis lies at the nexus of transitions towards the medicalisation of pregnancy and childbirth, the rise of markets accommodating medicalized aspirations in commodified packages, and the moralities immanent to the reconfigurations of pregnancy and childbirth in Bangladesh. It takes the maternal health terrain Shaheda described as its backdrop, asking how women navigate a volatile maternal health service terrain to achieve ambitions as pregnant and childbearing subjects. The maternal health terrain in Kushtia, this thesis will demonstrate, is volatile, as services and resources available through state, market and charitable entities are perpetually in flux, requiring women to nimbly navigate these spaces to achieve their aspirations and fulfil moral imperatives. It argues that social connectedness, as opposed to alternative logics, such as those associated with citizenship, neo-classical economic rationalities or charity, operate as foundational to this navigation.

However, this terrain operates not only as a backdrop to this thesis but also as its object. The elusive and little-regulated for-profit private health sector has achieved what the public and non-profit sectors promised but never fully delivered—placing advanced biomedical maternal health technologies and services somehow within the grasp of most (if not all) women. This has been achieved mainly through the commodification of maternal health services. By commodification, I refer to assigning market value to resources and services that previously existed outside the

Figure 1: Use of biomedical maternal health services in Bangladesh, 2001-2016
Source: Bangladesh Demographic and Health Survey 2006, Bangladesh Maternal Mortality Survey 2019
market and submitting them to capitalist, market-based forces for redistribution. Financial exchange for maternal health services for basic pregnancy treatments and birth care through informal providers, such as the *kobiraj* Kamrul *bhai*, is not new in Bangladesh, a country noted for its high degree of medical pluralism (Shah, 2020). However, what is new is the commodification of maternal health care through advanced biomedical maternal health technologies, packaged and placed within reach of women of all social classes.

Previously in peri-urban and rural areas, such technologies, notably caesarean section and foetal ultrasonogram, were available primarily (and unreliably) through a public health system, which delivered health services to people theoretically based on their citizenship status or through philanthropic and other non-profit actors based on notions of health service delivery as charity. While commodified health service delivery through a for-profit private health market has a long history in Bangladeshi urban areas, often in the form of large corporate hospitals, this urban clustering of a formal for-profit private health sector can no longer be taken for granted. For-profit private health facilities now extend to the most remote areas of Bangladesh, catering to people of all social classes. Maternal health services are among those most widely delivered through this market, bringing women as pregnant and childbearing subjects into new commodified relationships with biomedicine. This market proliferation maps onto a historically fragmented and volatile scaffolding of services delivered through the state and international, national and local development entities, theoretically employing alternative logics to health services and resources, those of health services and resources as state-guaranteed entitlements or as charitable goods. This thesis asks, what do these shifts towards commodified maternal health services mean in the everyday navigation in peri-urban and rural spaces for women, their families, and those engaged in maternal health service delivery?

Indeed, the maternal health service terrain, refashioned through the proliferation of market-oriented health services, opens and reshapes opportunities for women and people across all social classes to stake claims to livelihoods within a largely unregulated biomedical terrain. This thesis demonstrates that in Bangladesh, where livelihood making is generally marked by precarity and unpredictability, this
terrain offers a wellspring of economic opportunities through formal and informal channels built on women as reproducing subjects.

Finally, this social constitution of the maternal health service terrain, and people’s navigation of it, cannot solely be understood through rationalities of choice, either for women aspiring to access desired resources or for the actors rendering them available. In addition to new medical terrains, these actors also navigate, negotiate and formulate new moral worlds (Zigon, 2009). Following Didier Fassin, I use the term morality in a broad sense to mean that which is “viewed as good, or right, or just, or altruistic” (Fassin, 2012). I also take inspiration from sociologist Andrew Sayer (2004), who defines morality (which he uses interchangeably with ethics) as “norms (formal and informal), values and dispositions regarding behaviour that affects others, and implies certain conceptions of the good.” This thesis asks, how are moral worlds enacted and refashioned within Bangladesh’s shifting maternal health terrain? While anthropological scholarship has primarily approached health markets as an outgrowth of global neoliberal hegemony and as de facto ‘immoral’, this thesis destabilises these assumptions, attending to the situatedness of maternal health markets in Bangladesh and seeking to understand the ways that moralities of care emerge and are renegotiated on their terms. It argues that ideas of what it means to be a ‘good’ mother, family, and formal or informal health service actor, and to do right within social relatedness is central to the constitution of the maternal health terrain, as people negotiate, navigate and constitute new forms of medicalized pregnancy and childbirth.

In drawing together these core themes, this thesis argues that rather than a manifestation of hegemonic neoliberal ideologies, the maternal health terrain in Kushtia is constituted through the creative and flexible navigation of actors pursuing health aspirations alongside economic and moral imperatives, both responding to

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*I propose this basic definition of morality, recognizing the fecund debates not only within the social sciences but also (and more fully embedded within) moral philosophy. Important and recent anthropological work has sought to elucidate genealogies of anthropological work around moralities and critiquing the fluidity of the use of this concept. Others have sought to delineate clearer boundaries between ‘morality’ and ‘ethics’. While I draw from much of this work in this thesis, I follow Didier Fassin (2012) who purposely does not deliver a categorical definition of ‘morals’ or ‘morality’, justifying this absence “not just because philosophers are still disputing it, but because for social scientists there is a benefit from proceeding from this inductive way.” This inductive way, he suggests, is to apprehend how people, through discourse and actions how people make sense of what it means to be moral, or good, or right or generous.
and constituting states of flux and transition long inherent to the Bangladeshi experience. It argues that social navigation within this terrain primarily demands nurturing and leveraging social connectedness at particular moments to access resources, rather than employing logics underpinning conceptualisations of health services and resources as ‘entitlements’, charitable goods or even market commodities. It contends that emerging imperatives in overlapping moral and social worlds are central to navigation.

Creeping towards medicalisation

As Shaheda’s account illustrates, the medicalisation of childbirth in Bangladesh is a relatively recent phenomenon, although the pathways towards these ends are not. Biomedicine arrived in west Bengal in concert with colonisation (Mushtaq, 2009). Initially a male-centric enterprise, biomedical practice was directed toward male British colonizers and eventually consolidated under the Indian Medical Service (IMS). In the 19th century, childbirth was among the first women’s health issue to be taken up within biomedical interest, initially to ensure medicalized childbirth among European women. These aims were soon expanded to the colonized, as it was in other colonized territories, to maintain a sufficient labour force for economic production and extraction (Lock and Nguyen, 2018, Ram and Jolly, 1998, Jolly, 1998). Colonizers established lying-in clinics and midwifery schools near IMS-affiliated medical colleges (Mukherjee, 2017). However, the IMS remained male-oriented and generally ambivalent towards women’s health, limiting the expansion of medicalized birth through the regime (Guha, 1998).

In contrast, Christian missions took up maternal and child health projects as central to their work. After 1813, when British rulers lifted prior prohibitions on

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5 The introduction of biomedicine to the region occurred in concert with British colonization itself, when ship surgeons serving the first British East Indian ship fleet arrived in 1600 (Mushtaq, 2009).
6 Advocates of biomedicine first directed its attention toward women in the early 19th century when biomedical treatment was used to treat colonized women engaged in sex work suffering from ‘venereal’ diseases, which were widespread at the time, as a strategy for reducing the transmission of these diseases among British soldiers and sailors (Levine, 1994, Whitehead, 1995, Peers, 1998, Mukherjee, 2017). During this period, ‘prostitutes’ were generally regarded as the vectors of disease, mapping on to ideas of ‘respectable’ and ‘non-respectable’ women (Whitehead, 1995), and the British soldiers and sailors the unsuspecting victims (Peers, 1998). Such diseases were rampant, leading to both health concerns for the men contracting these pathologies as few treatment options were available at the time, as well as embarrassment to the British colonial regime. In response, the colonial regime instituted surveillance programmes for prostitutes and forcibly held women with pathologies in “lock hospitals”, a practice common until the 1840s (Mukherjee, 2017).
missionary efforts, Christian missionaries instrumentalized biomedicine as a centerpiece of its evangelical mission (Arnold, 2000:87). Childbirth offered an entry point for missionary nurses to access women, and thereby men in the household through women for conversion (Nair, 1990). Moreover, colonizers viewed birth as needing to be 'cleaned up,' and therefore optimal territory for instilling Western values around hygiene (Mukherjee, 2017).

This perception was not altogether at odds with childbirth ideas among the colonized, though manifested quite differently. Social constructions around pollution played a central role in childbirth experiences in colonized India and Bengal. Birthing bodily fluids were considered among the most polluting bodily emissions. Therefore, containing pollution and preventing household contamination during birth preoccupied birth experiences (Jeffery et al., 1989). Birth traditionally took place in dirty household areas or small huts outside home structures to prevent contamination. Birth assistants used old clothing and cloth, as it would be either burned or given to the dai following the birth. The dai was typically a low-caste Hindu or low-status Muslim woman, someone already of low enough status to not be concerned by the potential contamination they could incur by coming into contact with the pollution of the birthing fluids (Mukherjee, 2017). Cutting the umbilical cord was an exceptionally unenviable task; therefore, the dai typically assumed it. If no dai was available, this work passed to the birthing mother herself. The cord-cutter generally used bamboo to slice through the cord and then cover it with cow dung (Mukherjee, 2017). Such practices contributed to colonizers’ perceptions that Indian rituals and norms were unhygienic, used to justify the further ‘othering’ of the colonized and reinforce the superiority of the science and customs of the colonizers. During this period, dais became a target of training interventions to encourage them to uptake ‘hygienic’ practices (Mukherjee, 2017, Jeffery et al., 2002), presaging traditional birth attendant training interventions which gained widespread global popularity in the second half of the 20th century.

The IMS persisted as a primarily military- and male-oriented establishment throughout the 19th century (Arnold, 2000), and the number of births occurring in lying-in clinics remained nominal (Rozario, 1998). Towards the end of the 19th century, Queen Victoria prompted the establishment of the Dufferin Fund to expand biomedicine to women’s health, including maternal health. Though this Fund
suspended tenuously between philanthropy, missionary work, and the state, it depended on British state support and was articulated alongside the IMS (Lal, 1994). The colonial regime resisted pressure to establish a regime-sponsored women’s medical service, preferring that philanthropic and private sectors deliver biomedical care (Sehrawat, 2013).

Proponents of a regime-sponsored entity for providing medical care to women foregrounded the colonizers’ rhetorical moral commitment to the ‘suffering woman of India’, a mainstay for sustaining support for the colonial regime in Britain. They accused the colonial state of failing to uplift the Indian woman and thus failing to fulfil their moral obligations (Sehrawat, 2013). While these arguments foregrounded moral sensibilities, they obscured the at least equally important motivations for expanding professional opportunities for British women trained as medical doctors in Britain (Sehrawat, 2021). Eventually, when the regime decided to introduce a woman-centric biomedical enterprise, the Women’s Medical Service of India (WMSI), this was funded through a state grant to the Dufferin Fund to appease those who wished to promote the philanthropic provision of medical services (Arnold, 2000:89). The WMSI took up maternal and child health as a core cause (Sehrawat, 2013). However, the WMSI was never a priority of the colonial regime and remained only a fraction of the size of the IMS (Arnold, 2000:89).

In 1947, after British colonizers withdrew from India, the region was partitioned into two counties, India and Pakistan, as Hindu- and Muslim-majority countries, respectively. The country of Pakistan comprised West Pakistan, modern-day Pakistan, and East Pakistan, modern-day Bangladesh—geographic areas united (to some extent) by religion but divided spatially, ethnically and linguistically. Many Bangladeshis (then East Pakistanis) experienced this period as another colonization. Health, including women’s health, was subsumed under a new civil service structure, the Civil Service Pakistan (CSP), forming the backbone of a state bureaucracy apparatus in the newly independent state (Islam, 2016), with West Pakistanis occupying most CPS posts, including throughout East Pakistan (Khan, 2013). The East Pakistan Directorate of Health functioned under the Ministry of Health, although this department remained weak and underfunded throughout the existence of East Pakistan (Greenough, 2011). The Directorate of Health established a Maternal and Child Health unit in 1952-53, which trained lady health workers, and by 1971
established ten maternal and child welfare centres (MCWCs) at district level and 152 rural health centres (National Institute of Population Research and Training (NIPORT) et al., 2003: p.1-2). However, the growth of the public health sector remained significantly slower than in West Pakistan. For example, between 1959-66, public hospital beds grew by 55% in West Pakistan, compared to only 15% in East Pakistan (Baru, 2003).

East Pakistan, though more populous, found itself neglected not only in terms of state financing but also in terms of foreign assistance. Despite having twice the population of West Pakistan living within its borders, East Pakistan received less than one-fifth of the foreign assistance funds channelled to the country compared to West Pakistan. This inequity was attributable primarily to geopolitical forces. Global superpowers sought to leverage the strategic and political positioning of West Pakistan in Cold War power games and the monopoly of decision-making was power purposively localized in West Pakistan (van Schendel, 2021). Nevertheless, this neglect did not result in the absence of development initiatives in the region. Instead, East Pakistan took their small portion of aid revenue and designed low-cost development models based on self-help and rural development, rooted in moral obligations of service to the poor, planting the seeds for later nationally-led development efforts (van Schendel, 2021, Lewis, 2011, Khan, 1979). Among these initiatives was an expansive presence of village self-help groups (Palli Mangal Samitis) and the Comilla Project, a bottom-up rural development model which countered the prevailing top-down models prevalent at the time (Lewis, 2011:112). This neglect ultimately laid the groundwork for lasting social configurations of what Michell Murphy refers to as ‘experimental exuberance’ (Murphy, 2017:78-94), an enthusiasm around experiments to improve life conditions outside of a coordinating, centralised apparatus. Rather than look to the Pakistani state to secure their desires for services and resources, people and organisations in East Pakistan experimented with self-help and rural development models to improve people’s conditions.

Eventually, resentments culminated in East Pakistan declaring its independence from West Pakistan and the subsequent war of independence in
1971. The leaders of the new nation-state of Bangladesh, notably Sheikh Mujib Rahman, still known by the monikers “Father of the Nation” and the “Friend of Bengal”, were sympathetic to the Soviet regime in Cold War politics and declared Bangladesh a socialist state (van Schendel, 2021). The constitution named socialism as one of the four fundamental principles (People’s Republic of Bangladesh, 1972), and perhaps at least in part due to this, the constitution prioritized rural health and committed the State to deliver public health services in rural areas, aiming to narrow disparities between rural and urban areas.

The new country faced extensive natural and political upheaval in its early years, which led to a general sentiment within the international community that it was doomed, which Henry Kissinger infamously referred to as a ‘basket case’ (Lewis, 2011). This characterization as a ‘bottomless basket case’ captured an obstinate sentiment that Bangladesh was fated to dwindle amongst the world's poorest countries and exist under perpetual aid dependence regardless of foreign and domestic efforts. Despite this, or perhaps even because of it, the country was swept up as a fertile testing ground for foreign aid and internally- and externally-led development initiatives (Guhathakurta and van Schendel, 2013:411, Hossain, 2017), building on a longstanding tradition of self-help and experimental exuberance (Murphy, 2017). Notably, in the aftermath of independence, BRAC, the largest NGO not only in Bangladesh but in the world today, was established (Mannan, 2009).

By the mid-1970s, strategic moves by Western powers to dissuade Bangladesh from joining the communist bloc materialised in a flood of foreign aid funnelled from these countries into the young nation. These investments provided an entry point for donors to influence national policies and politics, thereby playing a decisive role in guiding its direction (van Schendel, 2021:220). Unsurprisingly, the

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7 The war of independence is also considered a genocide, as West Pakistan directed efforts toward ethnic cleansing. One tactic used was mass rape of Bengali women by West Pakistani soldiers. Women raped during this period are referred to as *birangona*, war heroine. Following independence, *birangona* operated as a powerful nationalist figure in early nation-making endeavours under Sheikh Mujib Rahman. For an excellent account of the public representations *birangona*, see the work of Nayanika Mookherjee (Mookherjee, 2015). *Birangona* are also relevant from a maternal health perspective. In order to thwart the genocidal efforts of West Pakistan through military impregnation of women through rape, Bangladesh introduced ‘menstrual regulation’, essentially a euphemism for first trimester pregnancy termination, through the state system. This practice was later mapped onto family planning efforts and its legacy continues today. While officially, induced pregnancy termination is prohibited in the county, except when a judge rules that termination is necessary to save the life of the woman, ‘menstrual regulation’ is delivered both by NGOs and through the DGFP health facilities.
principle of socialism did not survive the decade, undoubtedly heavily influenced by transnational actors, which nudged the country towards privatization and adoption of liberalised economic development models (Lewis, 2011, Zohir, 1997). Non-governmental organisations (NGOs) proliferated in this era of ‘aid addiction’, contributing to fractured and uncoordinated public social programmes (Watkins et al., 2012) and continued domestic experiments with development. This legacy continues to have palpable consequences in people's daily lives today, manifested in a widespread presence of NGOs in all areas of social life (Watkins et al., 2012, Karim, 2013). Moreover, Bangladesh is not only an ‘importer’ of development initiatives but is also well known for ‘exporting’ development models, perhaps most famously the controversial microfinance model (Khandker et al., 2016, Karim, 2011, Hulme and Moore, 2007), the brainchild of Dr Muhammad Yunus, Nobel Prize-winning founder of Grameen Bank.

In the turbulent early years of nationhood, national health politics became hyper-focused on population control. The country’s First Five Year Plan included an ambitious fertility reduction target under the leadership of Sheikh Mujib (Rahim, 1975). In 1976, following the assassination of Sheikh Mujib and the coup overthrow of his Awami League party, the ruling Bangladeshi Nationalist Party (BNP), under the leadership of General Ziaur Rahman, pronounced population growth as the number one risk to the Bangladeshi nation.8 The government established an entire Directorate, the Directorate General of Family Planning (DGFP), alongside the

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8 Reported on the website for the Directorate General of Health Services: https://dgfp.gov.bd/site/page/ca81e7a3-33dd-442b-90bc-da21a34a0c13/History; accessed 9 Jul 2022.
Directorate General of Health Services (DGHS) under the Ministry of Health and Family Welfare to stem population growth.

The national fixation coalesced with global neo-Malthusian preoccupations with population growth. These racialized discourses framed population growth, particularly in the global South, as a threat to humanity, reflected most iconically in Peter Ehrlich’s 1968 book, *Population Bomb* (Ehrlich, 1968). Bangladesh occupied a
unique space within this imaginary and became an experimental testing ground for international and national population control initiatives (Murphy, 2017:82). In these narratives, both national and global security hinged on the bodies of Bangladeshi women. In the decades that followed, population control initiatives featured coercive and racialized tactics employed to drive down fertility at the expense of other social interests (Hartmann, 2016). These included the exchange of food and other material incentives for sterilization, military campaigns to round up and forcibly sterilise people, and fierce competition between health workers vying to secure family planning clients to reach ambitious targets set by the government (Hartmann, 2016). These initiatives were not without effect, and the country experienced a rapid decline in the total fertility rate from nearly seven births per woman in 1970 to 2.1 per woman today (World Bank, 2019). Despite its ethically compromised history the international development community hailed the country as a paragon of what aggressive family planning programmes can achieve (Greenspan, 1992, Larson and Mitra, 1992, Chowdhury et al., 2013).

From the 1970s well into the 1990s, maternal and child health was ideologically and materially tacked onto population control efforts. Ideologically, World Bank logic, reflected in the national sphere, ran that people would only be inclined to uptake family planning methods if child survival improved (see e.g., World Bank, 1985, National Institute of Population Research and Training (NIPORT) et al., 2003: 2) and thus viewed averting death as a mechanism to avert ‘excess’ life. Materially, the government included essential maternal and child health services among those provided at the union-level family planning outposts. However, these facilities were poorly equipped to assist women with complications, and they never proved able to draw women from their locale of birth at home.

In tandem, though less militantly, policymakers and programmers in Bangladesh generally followed in step with other global initiatives to promote biomedical birth. These included a focus on initiatives to train traditional birth attendants (dais) through the 1970s and 1980s to apply principles of medicalised

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9 While the country has officially moved away from this type of target setting, globally viewed as a violation of human rights, it is still quite common to hear family planning health care providers discuss targets for family planning.

10 A total fertility rate of 2.1 is considered replacement level and is therefore typically identified as the target of family planning efforts.
birth in homes. Following the Safe Motherhood Conference in 1987, which resulted in the Safe Motherhood Initiative, in 1993, the United Nations Children’s Fund (UNICEF) and other donors introduced a new programme for strengthening basic and comprehensive Emergency Obstetric Care (EmOC)\(^{12}\) (Islam et al., 2006, Gill and Ahmed, 2004). This initiative aimed to introduce advanced care for birth complications into the district and upazila health complexes, \(^{13}\) a project which remains far from complete (Sikder et al., 2015, Wichaidit et al., 2016, Roy et al., 2017). The introduction of this project represented a turning point in shifting the locus of public maternal health care from the household and locally-based DGFP structures designed for population control efforts to DGHS structures. The strategy also shifted the politics of public maternal health care and expanded sites of intersection between women as pregnant and childbearing subjects and state entities.

By the end of the 1990s, WHO definitively declared birth in the presence of a skilled birth attendant as the single-most-important intervention to improve maternal and newborn health. WHO defined a skilled attendant as “an accredited health

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\(^{11}\) Training ‘traditional birth attendants’ in ‘safe’ and ‘hygienic’ home birth is an intervention that is traced back to colonisation (Mukherjee 2017) and gained popularity during the late 1970’s through mid-1990’s to train dais in safe birthing practices both globally and in Bangladesh (Rozario, 1998, Rozario, 1995, Afsana and Rashid, 2009). These policies were designed in response to the observation that globally the majority of births occurred at home with the assistance of an attendant without formal biomedical credentials. They represented a category of ‘traditional birth attendants’ as a monolith, unable to account for their diversity and contextual specificities and were equally unable to account for the diversity of ‘training’—spanning between two weeks and years, delivered by various entities and with variable content. These policies and interventions were all but abandoned globally in the late 1990’s when WHO declared that TBA training does not serve to reduce maternal mortality, despite evidence suggesting that the intervention does successfully reduce perinatal death, and instead began promoting a ‘skilled birth attendant’ at every birth. Bangladesh followed suit and by the late 1990’s and early 2000’s the government and the Obstetric and Gynaecological Society of Bangladesh (OGSB) and the government introduced a new project aiming to train a cadre of community-based skilled birth attendants (CBSAs) to assist home births, still the main site of birth at the turn of the millennium (Ahmed and Jakaria 2009). These CSBAs were selected from among community birth attendants and trained during a 6-month course on managing uncomplicated birth. This training did not correspond to the definition determined by WHO, and while the programme is still included in national policy documents, momentum is not primarily behind the national midwifery project. However, development actors continue to carry out both small-scale TBA and CSBA training.

\(^{12}\) According to global guidelines, emergency obstetric care includes administration of parenteral antibiotics, oxytocic drugs and anticonvulsants; manual removal of placenta; removal of retained products; assisted vaginal delivery; caesarean; and blood transfusion. Basic emergency obstetric care provides the first six functions. Comprehensive emergency obstetric care provides all eight functions. A facility is considered functional in providing emergency obstetric care only if it provides all the functions to qualify as either basic or comprehensive.

\(^{13}\) At the time, these were referred to as thana health complexes, as thana was used instead of upazila to refer to the subdistrict.
professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (World Health Organization, 2004). This definition purposefully excluded traditional birth attendants. It recentred formal biomedical institutions as the singular acceptable birthplace, as skilled birth attendants, according to the definition, were most likely to be found in institutions, or if outside these institutions, skilled birth attendants were imagined to serve as a link between women in their homes and institutions. Bangladesh followed suit and officially abandoned (in policy, at least) traditional birth attendant training.

The political project to medicalise childbirth intensified when the country adopted the Millennium Development Goals (MDG) in the year 2000, which included a commitment under Goal 5 not only to reduce maternal mortality by three-quarters of its 1990 baseline before the 2015 cut-off but also to increase skilled birth attendance to 50% all births by this time. Moreover, during this period, global health actors reified maternal health indicators as ‘proxy’ indicators—meaning, it became about much more than women. Maternal mortality, in particular, despite its documented messiness to generate (Wendland, 2016, Oni-Orison, 2016, Strong, 2020), was accepted as a marker of health services access and a country's overall socio-economic development. However, despite state and development efforts, pregnancy and childbirth in Bangladesh had yet to take a decisive turn towards medicalisation well into the 2000s.

Throughout these policy and programming oscillations, anthropologists engaged in ethnographic fieldwork to elucidate Bangladeshi women’s meanings, experiences and perceptions of pregnancy and birth. Therese Blanchet (1984) was among the first to generate a rich ethnographic account focused on the social world of birthing in Bangladesh during this period. Her work illustrated the continued significance of pollution during pregnancy. In her work among villagers living in Jamalpur, she described birth pollution as representing the most polluting of bodily substances (Blanchet, 1984: 26), a similar understanding demonstrated later by Katy Gardner (1991: 26) in Sylhet and the Jeffrey et al. (1989) in North India. Bhut, a category comprised of different forms of evil spirits, were attracted to this pollution and therefore represented risks not only to women and babies, but also to other,
especially male, household members. Therefore, a paramount concern during birth was to contain this pollution (Blanchet, 1984).

Blanchet's (1984) work highlighted the centrality of dais in this work. Rather than recognised as having a particular expertise or skillset, Blanchet suggested the dais’ primary responsibility consisted of managing pollution, not providing medical services. Indeed, her work suggests that the presence of a dai was not mandatory and was primarily reserved for relatively higher-social status families who wished to maintain purity and prestige. She estimated that in two-thirds of births, there was no dai at all, at least not in the sense of a birth attendant legitimised as having a particular role or skillset; rather the majority of births were assisted by family members (Blanchet, 1984: 79), though many poor women gave birth with no assistance, particularly for a first birth (Blanchet, 1984: 80-81).

Blanchet also expanded scholarship around practices related to purdah, the seclusion of women. Common throughout the Arab world and South Asia, the institution of purdah designates the public space as belonging to men and the private space as belonging to women and ties a family’s honour to their ability to protect women from the view of unrelated men (Papanek and Minault, 1982). Blanchet’s work illustrated the significance of this institution in birth ideas and practices in rural Bangladesh. She demonstrated practices of purdah as decoupled from Islam, observed by both Hindu and Islamic families, and interwoven with ideas of pollution and avoiding bhut. According to Blanchet, purdah observed during the time of birth and during seclusion following birth was not only operative in protecting the woman and family from incurring shame, but also to protect the baby from evil spirits and the family from the pollution of the postpartum woman (Blanchet, 1984: 116-119).

Pollution, bhut, dais and purdah remained central to accounts of childbirth in South Asia over the subsequent decades (Rozario, 1998, Afsana and Rashid, 2009, Rozario, 1995, Afsana, 2003, Goodburn et al., 1995, Jeffery et al., 1989). Ethnographic accounts from Santi Rozario and Jeffrey et al. in Bangladesh and North India, respectively, highlighted the significance of pollution and the role of the dai as primarily to manage this pollution. Rozario illustrated this by noting that it was not uncommon for the dai to abstain from washing her hands prior to assisting the birth and only washing her hands following the birth (Rozario, 1998, Rozario, 1995). In contrast, Maya Unnithan-Kumar and Koasar Afsana’s ethnographic accounts at
the turn of the century suggested the dai’s importance went beyond managing pollution and was also attached to the indigenous skills and knowledge she brought to the birthing experience (Afsana, 2003:125-27, Unnithan-Kumar, 2002).

Rozario’s work expanded understanding of the importance of honour and shame in birth, emphasising the practice of purdah. She wrote of women’s, and their families’, hesitancy towards having their genitals exposed to others, particularly to men, including male village doctors who were sometimes called to provide emergency clinical care in the home, or medical doctors practicing in hospitals (Rozario, 1998). She suggested that the inability to maintain purdah in health facilities therefore operated as an important deterrent to seeking biomedical services (Rozario, 1995). Afsana (2003) also pointed to shyness as a source of reticence to biomedical health service-seeking, as well as to the incapacity of biomedical settings to incorporate critical indigenous knowledge related to birth. A home birth, in contrast, allowed indigenous knowledge to remain authoritative during birth experiences.

In these accounts, birth was generally considered a normal life transition. While managing birth pollution was a preoccupation in any birth, only aberrant circumstances were viewed as requiring medical intervention. As late as 2009, Afsana and Sabina Rashid wrote of childbirth in Bangladesh as part of daily life. As a normal life event, most births still occurred at home, with the support of an unprofessionalised dai. In their account, women differentiated between normal (thikmoton) and complicated (kolbekol) birth, the former of which women residing in villages did not see as requiring biomedical attention (Afsana and Rashid, 2009, also Afsana, 2003). They wrote of the villagers aversion towards hospitals, which they spoke of as having a particular smell (gondho) and put women at risk of being exposed, mapping onto ideas of purdah (Afsana and Rashid, 2009).

This body of work offered rich insights into the meanings of birth for women in rural Bangladesh, elucidating childbirth as socially organised. While these accounts varied in interpretations and emphasis, they remained consistent in several features: the centrality of containment of birth pollution during birth, the importance of avoiding bhut and the various rituals used for this purpose, the reliance on low-status dais for birth care (whether primarily for managing pollution or for their skills) and a general avoidance of medical institutions by rural women, at least partly reflecting ideas of purdah.
Within policy and programming spaces, this story unfolded as the ostensible failure of Bangladeshi women to uptake the promises of modernity through biomedical birth and was discursively constituted as an intractable problem by the global health community and national development and government actors (see, for example, Koenig et al., 2007, Government of the People’s Republic of Bangladesh, 2001). How to successfully lure women to give birth in biomedical institutions remained enigmatic even as it became increasingly indispensable to demonstrating the success of Bangladesh on the stage of international development under the Millennium Development Goal regime.

The 2016 surprise of the ‘Bangladeshi woman’

Throughout these transformations, the centrality of the ‘Bangladeshi woman’ trope remained steadfast. Indeed, global transitions from colonialism to postcolonialism did not attenuate the fervour around women as a category, globally or in Bangladesh but resulted in refashioning these narratives. Despite significant shifts in the ways international development addresses gender, a continuity is the discursive constitution of the trope of the ‘Third World Woman,’ a title Chandra Mohanty coined in 1988 but which remains relevant today (Mohanty, 1988). ‘The Third World Woman’ figure essentialises non-Western women as a homogenous group devoid of power and agency, victimised by tradition and patriarchy, and cast against their liberal ‘Western’ feminist counterparts as the standard (Mohanty et al., 1991, Chowdhury, 2003, Mohanty, 2003, Mahmood, 2011, Abu-Lughod, 2002). This grand narrative creates a binary of, according to Mohanty, the “‘Western woman as educated, as modern, as having control over their bodies and sexualities and the freedom to make their own decisions” and the typical ‘Third World Woman’, as “religious (read: not progressive), family-oriented (read: traditional), legally unsophisticated (read: they are still not conscious of their rights), illiterate (read: ignorant), [and] domestic (read: backward)” (Mohanty, 2003:22, see also Mutua, 2001). Despite postcolonial critiques, the ‘Third World Woman’ figure thrives today. Within global maternal health discourses, she persists as the deficient woman who either fails to accept ‘modern’ (read: biomedical) birth due to her ‘traditional’ mindset or is prevented from doing so by her oppressive family or ‘culture’.

The trope of the ‘Bangladeshi woman’ has long operated as a collective phantasm within global development imaginaries, epitomising the ‘Third World
Within the national development project, their reproductive bodies lie at the crux of state and development aspirations, at the intersection of ideas of progress and policy discourses. Development narratives tend to cast the ‘Bangladeshi woman’ (and ‘girl’) at once as subordinated victims of patriarchal social structures and as an untapped wellspring of development and progress (Shehabuddin, 2008, Hartmann and Boyce, 1983, Mohanty et al., 1991, Murphy, 2017). Within these discourses, actual women’s realities, interests, and well-being are often tangential.

Women’s bodies are woven throughout health policies and projects, articulated around women in their reproductive capacities. Three decades ago, Sarah White observed that “‘Women’ have a symbolic significance both for international aid agencies and the various groups that compete for power within the Bangladeshi nation-state” (White 1992:4), an observation which remains as accurate today as it was then. Maternal health continues to be one of the most vibrant battlegrounds for this competition, and the multiple players of the development apparatus vie to make claims to ‘conduct the conduct’ of women (Foucault 1991) in a palpably intimate and fleshy fashion. However, a constant is a hubris of knowing this woman, her deficiencies, and how to remake and ‘save’ her. Her body is central to these efforts. It needs to be refashioned to marry later, have fewer children, and give birth through the modernist biomedical project.

In the spirit of the metric enthusiasm permeating global health, the United States Agency for International Development (USAID) funded the first Bangladesh Maternal Mortality Survey (BMMS) in 2001 in establish reliable baseline indicators to track progress toward MDG 5. This mammoth survey of more than 100,000 households indicated that over 90% of births still occurred at home despite the extensive efforts to institutionalise childbirth. Moreover, while the maternal mortality ratio (MMR) had decreased by 20% over the previous decade, the figures suggested that 322 women per 100,000 live births died as a result of pregnancy and childbirth, considered high according to WHO definitions (National Institute of Population Research and Training (NIPORT) et al., 2003). When WHO released the Trends in Maternal Mortality Report: 1990-2008 (2008), references to Bangladesh were less than stellar: it noted Bangladesh among the 11 countries which comprised 65% of all maternal deaths globally, as one of only seven countries outside of sub-Saharan
Africa with a high maternal mortality ratio, and as eighth in the world in terms of the total number of maternal deaths (World Health Organization et al., 2008).

Nevertheless, when the state and development actors conducted a second BMMS in 2010, it revealed a paradoxical surprise. While facility birth still ‘lagged’ behind other countries in the world and region, the survey suggested a stunning plummet in maternal death over the decade. Whereas an estimated 322 women per 100,000 live births died at the turn of the millennium, by 2010, this figure stood at 194 deaths per 100,000 live births, a stunning 40% decrease (National Institute of Population Research and Training et al., 2012).

![Maternal Mortality Ratio, Bangladesh 1990-2010](image)

*Figure 3: Bangladesh maternal mortality ratio 1990-2010.*

*Source: Bangladesh Maternal Mortality Survey, 2012*

This finding represented much more than a disinterested health statistic (if there ever were such a thing). In the MDG era, the globally homogenizing agenda which set countries on a race toward quantifiably discernible change in development status (Adams, 2016a, Adams, 2016b), this finding operated as a wellspring of national pride. It placed the country on track to reach a ratio of 143 per 100,000 births by 2015 and achieve their MDG 5 target, and within an exceptionally exclusive

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14 In 2010, Bangladesh trailed in skilled birth attendance the region with Nepal and Afghanistan, with figures hovering near 20% in each of these countries. In contrast, over 40% of births were attended by a skilled birth attendant in Pakistan, and over 50% in India during the same period (source: Gapminder). Despite this, the survey revealed MMR to be similar to the ratio in India (estimated MMR 200/100,000 live births) and lower than Pakistan (estimated MMR: 260/100,000 live births).
category of countries on track to achieve MDG 5.\textsuperscript{15} Indeed, according to WHO estimates, the country experienced an annual reduction rate in maternal mortality of over 5% per year, one of the highest among countries identified as low- and middle-income (El Arifeen et al., 2014, UNFPA et al., 2012).

The international development community hailed these findings as a political success, and the UN awarded Prime Minister Sheikh Hasina, the daughter of Sheikh Mujib Rahman, a prize in 2011. Banners commemorating this event still hung in the upazila health complex corridors in Kushtia, when I undertook fieldwork there from 2019-to 2021. A man holds a large gold trophy toward the beaming Prime Minister, smiling and looking off past the camera. “For the achievement of MDG-5”, the words read below them. “The honourable Sheikh Hasina receiving the award.” While this image is traceable to the reception of an altogether different award, the South-South Award for facilitation of health services in Bangladesh using information and communication technology handed over in 2011, it stands as a manifest marker of the political relevance of women’s bodies in the Bangladeshi nation-state.

\textsuperscript{15} According to Trends in Maternal Mortality 1990-2010 (2012), only the following nine countries were on track to meeting the MDG 5 target in 2010: Eritrea, Oman, Egypt, Timor-Leste, Bangladesh, China, Lao People’s Democratic Republic, Syrian Arab Republic and Cambodia.
This achievement was even more surprising given the absence of the widely accepted prerequisite of ensuring institutional birth, or at least skilled birth attendance.\textsuperscript{16} Admittedly, the increase in institutional care, particularly at birth, was sluggish. The percentage of women attending at least one formal ANC visit had only notched up to 55\% from 41\%, and while the proportion of women giving birth in an institutional setting doubled, still fewer than a quarter of women did so (National

\textsuperscript{16} Besides maternal service utilisation, other important changes occurred during this period which are associated with improvements in maternal health. Bangladesh experienced improvements in socioeconomic status and girls’ formal education increased significantly. However, these trends are often accompanied by increased use of biomedical care at the time of birth, in contrast to the situation observed in Bangladesh, where institutionalised birth remained a small proportion of overall births.
That the country witnessed such a drop in maternal death whilst the figures for institutional care only slightly changed was considered both a paradox and an achievement. It suggested that the political project to reshape the way women gave birth, though resistant, was bearing fruit. No matter how small the change in biomedical care-seeking, the payoff was disproportionate in saving women. Such ideas energized maternal health discourses in the country, fomenting enthusiasm around maternal efforts and drawing increased financial resources and the drive towards moving women towards institutional birth.

This figure fit into a broader narrative of Bangladesh climbing out of its sticky basket case. Building on an influx of investment and resources in the 1990s, Bangladesh ascended to the status of a ‘golden child’ of international development during the MDG era (see e.g., Sen, 2013, Chowdhury et al., 2013). The country demonstrated remarkable progress toward MDG targets, including poverty reduction, school enrolment, child health (United Nations 2015) and, as evidenced by the BMMS, maternal mortality, even alongside steady foreign aid withdrawal (van Schendel, 2021, Khatun, 2018) and despite ‘weak’ institutions, poverty and relatively frequent natural and political upheaval (Chowdhury et al., 2013).

When development actors rolled out the next BMMS in 2016, the year Shaheda gave birth to her second child, expectations approached boiling point. Those in the development community eagerly awaited the survey results to discover the success of their efforts to reduce maternal mortality and whether they had reached the MDG target. Government and development actors widely expected that we would see an upshot in institutional birth this time, and, consequently, the survey would detect an accelerated plunge in MMR. I was among them. At the time, I was a health advisor for a Geneva-based NGO, Enfants du Monde (EdM). I served as the head-quarter’s focal point of the Bangladesh project, which aimed to ‘empower’

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17 Despite continued and steady foreign aid withdrawal, international development remains a highly influential industry and source of employment in the country. Foreign agendas and interests maintain a firm grip on specific sectors, including health, education and physical infrastructure (Khatun 2018). The landscape of players engaged in development assistance in Bangladesh is numerous. It represents various competing and contradictory agendas, including bilateral donors, multilateral organizations, international NGOs, national NGOs, private foundations and charitable bodies, international and national academic and research institutions, and private enterprises. It englobes religious and secular ideologies, ‘Western’ and ‘non-Western’.
women to seek institutionalised biomedical care for birth and obstetric emergencies and mobilise communities to overcome barriers to health services access. I, too, anticipated the results, eager to feel justified that our efforts contributed, even in a minuscule way, to the measurable improvement that was sure to be revealed by the survey. The development apparatus would bask in seeing the fruits of these joint efforts pay off. Would it show that the MDG target of 143 maternal deaths per 100,000 live births was achieved and cement the country’s status as a development superstar? At worst, even if the target were missed, it was sure to be narrowly so.

I learned the results of the survey before they were published. EdM partnered with icddr,b, an internationally recognised public health research centre, as an in-country implementing partner. Ehsan, the icddr,b focal point of our project, led the verbal autopsy and cause of death assignment, designed to capture maternal deaths in the sample population, in the 2016 round of the survey. “There is a problem with the mortality data,” he told me one day in confidence over the phone as I sat alone in my office. After the arduous data collection and coding cases of maternal deaths according to WHO classifications with the team, he explained that he sent the final number of maternal deaths to the MEASURE Evaluation team at North Carolina University: 175. According to the data, 175 women died among the study population from causes directly related to or exacerbated by pregnancy or childbirth. Icddr,b did not have the denominator, the total number of live births, when they shared the 175 figure with the North Carolina team, as this team was in charge of this crucial element required for calculating MMR. However, when the MEASURE group saw 175, they immediately knew that this was higher than predicted. They returned to Ehsan, suggesting that there must be some problem with the icddr,b data.

The icddr,b team dissected and probed the data from all possible directions in the following weeks. MEASURE consultants reviewed the process; another team reviewed each of the 175 maternal deaths identified in the verbal autopsy, hoping to shave off a few by determining that they were not maternal deaths but due to other causes. After they had exhausted all possible perspectives to scrutinize the data, the team had little choice but to entertain the idea that this was, in fact, the result of the survey. In turn, statistical analysis suggested that, no matter how they turned the

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18 MEASURE evaluation is a USAID-funded entity with the mission to support countries to better produce and use health data
data, the new MMR was a pesky 196 maternal deaths per 100,000 live births, up from the 2010 estimate of 194. This ratio meant that, at best, MMR stagnated during the 2010-2016 time period. At worst, it increased, if ever so slightly. Sure, the increase fell well within the margin of error, i.e., there may not have been a “real” statistical increase. However, what was suddenly shut out from the realm of possibilities was that MMR had continued its metrically perceptible tumble of the previous decade. Furthermore, this was the case, despite the upshot of institutional birth to nearly 50% of all births (National Institute of Population Research and Training (NIPORT) et al., 2019).

![Figure 5: Maternal mortality ratio Bangladesh 1990-2016](source: Bangladesh Maternal Mortality Survey 2019)

The stagnation of MMR juxtaposed against the rapid increase in institutional birth was not the only shocking result. While maternal death stagnated, another trend shot upward—that of surgical birth. While the 2010 survey suggested that just over 1 in 10 women gave birth through caesarean (National Institute of Population Research and Training et al., 2012), nestled within the World Health Organization recommendation of 5-15% of the time (Betran et al., 2016), the 2016 survey indicated that this was now over 30%. It was an astounding finding: in a country where approximately half of births still occurred at home, 1 in 3 births occurred surgically. Among institutional births, 65% were through caesarean. Most shockingly, 83% of all births in private health care facilities were through caesarean (National Institute of Population Research and Training (NIPORT) et al., 2019). Perhaps the
transition in the mode of birth would not have caused such an outcry were it not juxtaposed alongside stagnant mortality ratios. While few would go so far as to suggest that the rise in caesarean birth killed women, it was still hard to argue that mass surgical birth saved them, either.

In 2018, the survey team presented the results at a national forum attended by the health minister. Shocked and afraid of the political ramifications, the minister demanded the team withhold the survey results and ordered his direct NIPORT reports to prevent publication after the dissemination. These results sent policymakers, programmers, and government officials into a tailspin. Ehsan described it as the “fall of the poster child of international development.” If not a complete fall, it was at least a blemish in the nation’s reputation as a surprising success. It unsettled the predominating discourses around maternal health in the country and how to ‘save’ women. It induced a reckoning wherein the development community and policymakers recognized their limitations to call forth a new future or knew how to do so.

Just as the paradoxical finding of the national survey, replicated in the Demographic and Health Survey following at its heels (National Institute of Population Research and Training (NIPORT) and ICF, 2019), destabilized narratives around what works to save women from death through pregnancy and birth, it also destabilized what had crystallized as the figure of the ‘Bangladeshi woman’. Who was this woman now? Previously, she had always been poor, ‘uneducated’, ‘traditional’; she was disempowered, she needed to be saved. Now, she was no longer uneducated; girls stayed in school longer than ever before (National Institute of Population Research and Training (NIPORT) and ICF, 2019).\(^{19}\) She was no longer simply ‘traditional,’ no, she now seemed to fully embrace the most medicalized form of ‘modern’ birth, and perhaps she was not all that poor if she could afford to do so.

It was not more than 24 hours after I arrived in Dhaka that I first found myself amid the sense-making of this new woman. It was near 5 pm in the icddr,b office,

\(^{19}\) According to the BDHS, between 2007 and 2017, the percentage of women attending no formal education decreased from 30% to 16%, while the percentage completing primary education increased from 6% to 30%, and those completing secondary education or higher increased from 6% to 17% (National Institute of Population Research and Training (NIPORT) et al., 2009, National Institute of Population Research and Training (NIPORT) and ICF, 2019)
and the Maternal and Child Health Department was nearly empty as young researchers descended to catch the icddr,b minivans charged to deliver them at home. I sat with several 20- and 30-something female icddr,b researchers; some were old friends or acquaintances, a few I had only met since my arrival. We talked about qualitative research, and the conversation gently segued towards caesarean birth and how they need more qualitative data to understand the trend toward caesarean birth in the county. I would soon learn that most conversations related to maternal health in Dhaka would eventually land on caesarean birth, often sooner than later.

At one point, Sadia, an English-educated researcher responsible for the research component of a large Save the Children project, spoke up. “Everyone thinks that women in the villages are being forced into c-section,” she said, “that the doctors do not get their consent. But these women want c-section! When I went to the field, there was a woman who did not have one ANC—not one!—during pregnancy, but then she went to a facility for birth and had a c-section! It was not an emergency; she just wanted one. Women think that if they go for c-section that it means that they have money and that they are higher status.” Moshumi, a friend from my previous visits to Bangladesh and soon to become my self-appointed urban fashion consultant, intervened. “It is about changing behaviours,” she said. “Everything is about changing the behaviour of the village people (gramir manush). Then the country can change.”

I would soon realise this conversation was illustrative of the predominant narratives around the emerging figure of the new ‘Bangladeshi woman’, a crucial figure which animates development and government discourses. This woman is distinct from the women I sat with on the 5th floor of the icddr,b building, who embody ideas of modernity and urbanity. Still, rural women, variously defined in Dhaka as gorib, poor, and gramir, of the village, are no longer simply ‘traditional’; they embrace elements of ‘modernity’, in this case in the form of highly medicalized birth; however, they do so in ‘wrong’ ways, and for ‘wrong’ reasons. This woman inappropriately responds to the message of modernization; yes, she is supposed to go to a biomedical facility for birth, but not for surgical birth. Through her mis-enactments of

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20 English medium primary and secondary education is available to middle-upper- and upper-class families in Dhaka, and is generally a marker of such status.
medicalised birth, she spoils the gifts offered to her through the state and development actors.

In Sadia’s comments, she points to class status aspirations as a ‘wrong’ reason to seek a surgical birth. Social scientists have long observed the potential for people who occupy lower-class positions to adopt practices as a manifestation of ambition toward upward class mobility (Goffman, 1978). Dominique Béhague in Brazil and Henrike Donner in India determined such class aspirations to be a critical driver among women toward caesarean birth (Béhague, 2002, Donner, 2016). Sadia dismisses this as an inadequate justification for a caesarean birth. I would soon learn that this was a less-cited reason for the swollen rates of caesarean birth. More commonly, the ‘new’ Bangladeshi woman is imagined as seeking surgical birth to avoid the pain of labour and vaginal childbirth or too weak to endure what their mothers and grandmothers did. Alternatively, they seek convenience, are impatient to wait for the birth, or want to give birth on a ‘special day’—Valentine’s Day, Victory Day, or a family member’s birthday. At the same time, she is still a victim, but not only of the patriarchy. She is now the potential unsuspecting victim of a predatory health marketplace.

Throughout this thesis, I challenge these representations, but the point I wish to make here is that, though it could take on many different manifestations, the figure of the woman at the heart of these discourses, though she accepts ‘modernity’, is imagined as not having done so in ‘good’ ways and still in need of ‘development’ course correction to shape the way she gives birth. Moshumi’s remark about the need to channel the behaviour of the village people (gramir manush), and this as the key to national flourishing, could be interchanged to reflect predominant development discourses since colonialism. Behavioural change communication (BCC), reminiscent of colonial initiatives to reshape the norms and practices of the colonised, was long a development priority in Bangladesh and is still a commonly evoked acronym in national and international development discourse. Such interventions aim to mould women’s ‘behaviour’ and shape their ‘choices.’

While these ideas have morphed into other constructs, such as ‘empowerment’ and ‘participation’, the idea remains the same—rural people require reformed ‘behaviour’, typically ‘behaviours’ imagined as reflected in middle-class
sensibilities. These messages have in many ways been heeded; for example, birth rates have plummeted in response to national efforts to reduce fertility, but moulding behaviour was never meant to be a finished project—indeed, to finish this project would render development as a field of practice futile, which is counter to how development operates in practice.

In these discourses, women responding to the promises of modernity are co-responsible through their ‘behaviour’ for what was now a national blemish: an exploded rate of caesarean. Sure, there can be good reasons for caesarean, so these narratives went, but these women purposefully sought them out for the ‘wrong’ reasons. These narratives hinge on the idea of choice, representing women as simply exercising ‘choice’ in either a moral or immoral fashion. Such discourse presumes that women operate as autonomous actors with a non-conditioned agency on a level playing field. In this thesis, I challenge these notions of the Bangladeshi woman. I desire to paint a portrait of women acting as embedded agents within complex family and social structures. Women respond to and employ various tactics to navigate a perpetually shifting maternal health care terrain that eludes them and the government and development actors who claim the power to shape it.

Of morals, medicalisation and markets

Moral negotiations are immanent to multiple overlapping spheres of life implicated in the worlds of pregnancy and childbearing: at the individual level in what it means to be a ‘good’ pregnant woman or mother, at the kinship level in commitments toward women and the foetus or baby, and at the institutional level in what it means to provide ‘good’ care during pregnancy and childbirth

Within biomedical discourses, at least three logics of the nature of biomedical health services and resources co-exist and compete. Theoretically, the public health system is rooted in a conceptualization of health services and commodities as ‘common goods’ or ‘entitlements’, most appropriately ensured by the state to its citizens, a conceptualization privileged by human rights-based discourses (Smith-Nonini, 2006). In Bangladesh, a co-existing yet at least equally relevant (if not prevalent in terms of health service delivery) non-profit sector, dominated by national and international NGOs, is rooted in the imaginary of health services as charitable goods, delivered as acts of generosity by the givers. A flourishing for-profit private
sector, in contrast, is grounded in the conceptualisation of health services as market commodities to be delivered and withheld based on a person’s ability and desire to pay. Narratives in negotiating these various constructs tend to be morally tinged. Indeed, health services and resources intersect with the most intimate spheres of life, including life itself and death, so they are rightfully viewed as unique, with moral questions fundamental to how they ‘ought’ to be considered and distributed.

A negative moral valence regarding market economies tends to prevail in these discourses, reflecting a broader critique of ‘neoliberalism’, which encompasses market-based (re-)orientations of health systems. In the social sciences, neoliberalism refers to free-market-centric economics most commonly associated with Milton Friedman and the Chicago School of Economics (Harvey, 2007). In essence, ‘neoliberal’ economic thought is characterised as promoting free-market economies with minimal state regulation as the superior mode of exchange and redistribution of resources. Core characteristics of this school of thought include the retreat of the State, a shrinking public sector and increased privatisation of goods and services. Neoliberal ideologies are understood as having been popularized under the Reagan and Thatcher administrations and deployed to countries of the global South through international development entities, notably the World Bank and the International Monetary Fund (IMF), which, according to scholars, provoked global neoliberalisation (Harvey, 2007).

Neoliberalism is pinned as the ideology behind the draconian structural adjustment policies (SAPs) of the 1980s and 1990s, under which these global donors demanded that states impose public budget cuts and promote privatization in exchange for funds (Pfeiffer and Chapman 2010; Summers and Pritchett 1993). Some scholars also identify neoliberalism as the driver toward NGO-isation within international development, as multilateral and bilateral donors preferred to lend directly to actors outside of the state rather than directly to the state and thereby undermined recipient states (Elyachar, 2015, Choudry and Kapoor, 2013, Schuller, 2009).

Scholarship against ‘neoliberalism’ and ‘neoliberalisation’ within anthropology has proliferated since the 1990s. Sherry Ortner associates this with the trends in the field towards ‘dark anthropology’, which she defines as “anthropology that
emphasizes the harsh and brutal dimensions of human experience, and the structural and historical conditions that produce them” (Ortner, 2016). She identifies two bodies of scholarship that have emerged premised on neoliberalism: the first documents the adverse effects of ‘neoliberal’ economic policies in the global North and global South, and the second demonstrates ‘neoliberalisation’ as a form of governmentality generating particular liberal subjects (Ortner, 2016). While these bodies of scholarship contribute a great deal in teasing out situated shifts in response to market-oriented economies, it is also true that it has become nearly impossible in anthropology to write against these predominating conceptualisations of an inherently immoral neoliberal world order.

This thesis veers from these predominating discourses in anthropology, sympathising with scholars who suggest that ‘neoliberalism’ lacks conceptual clarity and primarily serves to flag a moral stance (Laidlaw and Mair, 2015). In a compelling survey of social science publications, Rajesh Venugopal concludes that, while economists long ago abandoned ‘neoliberalism’ to denote a particular economic model, non-economists use it as a morally charged concept to describe an immoral economic order (Venugopal, 2015). Along these lines, James Laidlaw argues that adopting the term ‘neoliberal’ de facto equates to staking oppositional moral ground (Laidlaw and Mair, 2015). The moral presuppositions immanent to scholarship related to neoliberalism risk foreclosing nuanced accounts of the situatedness of localized market economies and capitalist practices and how moralities are reconfigured within them.

Some anthropological scholarship works to reveal how moralities emerge in even the most capitalist of environments (Browne and Milgram, 2009, Sampson, 2016). Katherine Browne suggests that all economies, even capitalist economies, possess a moral centre (Browne, 2009: 5). However, scholarship on health markets has been notably reticent in this regard. Anthropological scholarship on private health markets and the commodification of health care is overwhelmingly operates to critique private sector reforms and their foundational conceptualisations of health resources and services as market commodities in contrast to ‘social goods’.

In 2002, Barbara Rylko-Bauer and Paul Farmer explicitly called on anthropologists to contribute to a growing body of critique of health markets both in the US and abroad to highlight the harmful consequences of the privatization of
health services through the deployment of neoliberal ideologies and its contribution to health inequalities (Rylko-Bauer and Farmer, 2002). Anthropologists rose to the challenge and produced a breadth of scholarship which highlights how health markets harm both health service users and health service providers (Horton, 2006, Willging, 2005, Dao and Mulligan, 2016, Dao and Nichter, 2016, Ellison, 2014, Nandi and Schneider, 2020), exacerbate inequalities and generate new forms of inequality (Mulligan, 2016, Maskovsky, 2000), and compromise clinical quality (Mulligan, 2010, Lange et al., 2021). These strands of scholarship critique trends toward ‘neoliberal’ ideologies and private health markets share moral anxiety around these transitions, in some cases articulated as a threat to ideas of health as a human right (Abadía-Barrero, 2016, Nandi and Schneider, 2020, Jeffery and Jeffery, 2008). It tends to foreground the plight of the marginalized and reveal the unequal power relations between ‘oppressors’ and ‘the oppressed’ to demonstrate the detrimental effects of the rise of private health markets as a manifestation of neoliberal hegemony.

In addition, the negative moral valence around health markets may also be shaped by a prevailing discomfort with the commodification of ‘care’ labour, as a form of intimacy (Constable, 2009). While all health service delivery entails intimate and bodily encounters, birth work can be considered particularly intimate care labour, as it involves enactments within the most intimate spheres of physicality and spaces critical to the constitution of personhood (Kaufman and Morgan, 2005).

This thesis aims to forge a different path and open space to understand biomedical health markets, embedded within broader biomedical terrains and overlapping with other moral worlds, on their own terms. In this thesis, I aim to hold the moral presuppositions around privatization at bay, akin to Andrea Muehlebach as she explores the rise of volunteerism as a response to neoliberal reform in Lombardy, Italy (Muehlebach, 2012). While I do not seek to make a pro-market argument, I desire to understand how competing moralities are generated and negotiated within a more broadly volatile terrain of maternal health ideas and possibilities.

The rise of the private health sector in Bangladesh has occurred rapidly and introduced commodified formal health services in spaces in which advanced biomedical technologies were conceptually previously delivered primarily as
entitlements through public health services or as philanthropic services through non-profit entities. These transitions correlate to a phenomenon which Jarret Zigon refers to as a ‘moral breakdown’, a social moment in which people are forced to “step away from their unreflective everydayness and think through, figure out, work on themselves and respond to certain ethical dilemmas, troubles or problem” (Zigon, 2007). He argues that in these moments of breakdown, moral ways of being in the world are chosen, until they once again resume an unreflective state. Furthermore, he suggests that is it only during these moments that anthropology can make a meaningful contribution to the study of moralities.

I would be less bold than to assert, as he does, that moments of ‘moral breakdown’ are the only moments during which anthropology can contribute to the study of morality. However, the concept of ‘moral breakdown’ is useful for understanding the proliferation of the private health market and transitions towards medicalised pregnancy and childbirth as crucial moments of social transformations resulting in a reflective grappling of what is good or right.

This grappling is inscribed within broader conceptualisation of the ‘good’ and the ‘right’. In Bangladesh, religion plays a vital role in these ideas. While the majority of the population of Bangladesh identifies as Muslim (87%), the country is also home to a significant Hindu minority and a small group of adherents to Christianity, Buddhism and a variety of indigenous religions (Hackett et al., 2015). This religious pluralism has long been a defining feature of the country, with significant political and everyday consequences. While the country prides itself on its religious tolerance, moral sensibilities are often articulated in Islamic terms.

Religious beliefs and practices in Bangladesh are in flux, as they shift and are reshaped alongside other social and economic transitions, sometimes in seemingly paradoxical ways (White, 2012). Despite expectations of the ubiquitous secular development apparatus, people have not traded in religion for modernity; quite the contrary. Ethnographic accounts suggest that people integrate religious and secular ideas in context-specific ways that allow people to reach their own objectives, consistent with a much longer history of the country’s locally-specific, syncretic religious practice (Devine and White, 2013).
While much of the academic literature on religion in Bangladesh emphasizes religious specificities and differences, Joe Divine and Sarah White (2013) suggest that when looking at the lived realities of people, these differences between religions play a less important role than ideas about a shared moral order in general. They point to the double entendre of the word *dhormo*, which indicates both specific religions and a general understanding of a moral world order. They argue that this understanding of *dhormo* is more relevant in discursive practices and the ways people engage with religion than the distinctions between particular religions. This thesis is concerned with moral reconfigurations which emerge in these shifts at the juncture of the medicalisation of childbirth and commodification of maternal health services in Bangladesh. Religious ideas, or those related to *dhormo*, are one aspect of this and central to the moral grappling of health service delivery within this moment of ‘moral breakdown’. These go beyond religions and integrate broader ideas of a moral world order.

While moralities within this emerging market are one facet of this exploration, I contend that these can only be understood as overlapping with moralities within other life spaces and social worlds. This thesis tends to moral spaces outside the market, including those within the public sector and the social world of ‘development’, and examines how moralities intersect, conflict, and are contested. I also tend to the shaping of moralities among women and their families as they respond to a new world of emerging medicalized ideas and possibilities around pregnancy and childbirth.

**Shifting gaze: From rights to markets**

When I embarked on my ethnographic data collection, I was determined to explore human rights discourses concerning maternal health in Bangladesh, a topic I was passionate about as a development practitioner. During those years, global health discursive practice increasingly constituted maternal health as a human rights issue. In response to the observation that MDG 5 was the most sluggish to progress toward its target during the first decade following its adoption, the United Nations Human Rights Council issued a resolution in 2009 denouncing preventable maternal mortality and morbidity as principally the result of violations of women’s basic human rights (United Nations Human Rights Council, 2009). All subsequently elaborated maternal health global strategies and normative documents reflected human rights
lexicon. By the time I left development practice, ‘rights’ were taken for granted in even the most clinical maternal health service recommendations and guidelines (see e.g., United Nations, 2015a, World Health Organization, 2015, World Health Organization, 2016b, World Health Organization, 2016a). During these years, as a health advisor to EdM and as a consultant to WHO, I was involved in conceptualising and operationalising human rights-based approaches to maternal health, including within EdM’s health project in Bangladesh. However, as I worked with policymakers, health service providers and women, though we used the same verbiage, I could not help but be struck by a palpable disconnect between the global discourses and national and local meanings and realities. I carried this curiosity with me and desired to make sense of it through doctoral research, liberated from the imperative to import homogenizing global constructs.

I prepared to ethnographically trace the social reconstructions and consequences of global policies framing maternal health in human rights constructs as they took life in Bangladesh’s social and material worlds. What would their implications be in this setting? Would such discourses serve as a course correction to neoliberalism’s pervasiveness, which has long undergirded international development and global health (their proponents suggest they might (Farmer, 2003, Biehl and Petryna, 2013, Bustreo and Hunt, 2013, Amon, 2013, Nichter, 2008))? Would they shift the subjectivities of women (Merry, 2003)? Or would these discourses prove lacking substance (Uvin, 2010, Cornwall and Nyamu-Musembi, 2004) and be used instrumentally (Reubi, 2012) to serve neoliberal interests (Schepet-Hughes 2002) primarily? Would they augment Western hegemony (Asad, 2000, Mutua, 2001, Žižek, 2011, Cowan et al., 2001) and governmentality (Englund, 2006, Li, 2007)?

I held no pretence that the way these discourses circulated and were imagined globally would be reflected in Bangladesh or offer any simple answers. Still, I knew that human rights discourse was entangled somehow with maternal health in the country; the vision of both the 2001 and 2015 maternal health strategies were built around ‘women’s rights to safe motherhood.’ Moreover, the right to
medical care was included in the Bangladeshi Constitution and reiterated as the ‘right to health’ in the national health policy of 2011 (Ministry of Health & Family Welfare and Government of the People’s Republic of Bangladesh, 2011, Haque, 2020). I had something to work with, a ‘thing’ to follow (Marcus, 1995). Nevertheless, as I tried to trace and follow, I soon found myself holding onto threads in a terrain that I had only begun to grasp the surface of after nearly a decade inside the international development machinery.

Indeed, human rights maternal health discourses make many assumptions, often taken for granted and rarely scrutinized, which are often mismatched between their conceptualizations and the realities of the stated or unstated geographic ‘targets’ of development practice. These include assumptions related to the construction of health care as a social good to which citizens have a legitimate claim, instead of charity/philanthropy or a market commodity. They assume particular relationships between a Eurocentric notion of the state and its citizens, imaginaries of citizenship in which people expect to lay claims to particular entitlements, including health entitlements; and the existence of or potential for a robust public health system which is generally governed and governable by a state apparatus. They assume a state with regulatory legitimacy to oversee what happens within and beyond this public system. They assume imaginaries of women as ‘rights-holders’, who can and have a moral obligation to take up this subjectivity to claim these rights.

Rights to health are evoked in three acts of the Constitution. Act 15 requires the State, through planned economic growth, realize the steady increase of citizens’ access to the basic necessities of life, including medical care among other resources, blurring the distinctions between health and ambitions toward economic growth, and Act 16 commits the State to the improvement of public health in rural areas to reduce disparities between rural and urban areas. Act 18, entitled ‘Public Health and Morality’, is arguably the most explicit regarding the right to health. This article reads: “The State shall regard the raising of the level of nutrition and the improvement of public health as moving its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law of alcoholic and other intoxicating drinks and drugs which are injurious to health” (Bangladesh 1972). It then goes on to emphasize the role of the state in preventing prostitution and gambling, suggesting a slippage between the commitments of the State to maintain the health of its citizens and to uphold Islamic religious values. Intriguingly, the National Health Policy of 2008 deftly erases the nuances and slippages between health, economic growth and religion when referring to the Constitutional engagements with regard to the right to health. It reads: “Health is also a fundamental right of the population. Constitutionally the Government of Bangladesh is obligated to ensure provision of the basic necessities of life including medical care to its citizens [Article 15(a)] and to raise the level of nutrition and to improve public health [Article 18(1)].” Perhaps the links between the discourses encapsulated within these health strategies and the constitution remain purposely vague given the inability of the State to fulfil basic civil and political rights, largely due to the weakness of its institutions and rampant corruption, it is not surprising the economic, social and cultural rights, including the right, to health remain even further from fulfilment (Rahman 2006).
from a state entity. Although these discourses do not necessarily expect states to live up to these expectations or fulfil citizen’s rights, human rights mechanisms are imagined as allowing mobilized groups to transcend national boundaries and compel states to fulfil their obligations and responsibilities to respect, promote and realise human rights as the ‘primary duty-bearer’.

While rights lexicon is sprinkled throughout the Bangladeshi maternal health terrain, mixing human rights and citizens’ rights, I discovered soon after initiating fieldwork that national discursive practice only loosely raveled with the fabric of global discourses. Moreover, the recent rise of commodified health services delivered through minimally regulated for-profit private health institutions, which now dwarf the public sector, further muddled the conceptualisations of rights, questioning the role of the state as ‘primary duty-bearer’. The sense-making of this burgeoning for-profit private health sector dominated both the national discourses and the maternal health terrain in Bangladesh. While Bangladeshi women were previously characterized by policy makers and development programmers as reticent to uptake the promises of ‘modern’ medicalized childbirth, this no longer seemed to be the case. Though overwhelmingly outside the gaze of state and development projects, this for-profit private sector was an apparent driver of these trends toward medicalized childbirth, and a consequential force in reshaping an already complex maternal health terrain.

Indeed, this terrain resembled less a ‘system’, with identifiable and organisable components, and instead what anthropologist Anna Tsing refers to as a ‘frontier’. In her work exploring globalisation within the context of capitalist refashioning of Indonesian rainforests, she conceptualises a ‘frontier’ as not a “place or even a process but an imaginative project moulding both places and processes” (Tsing, 2011:p.32). She defines this imaginative project as an “edge of space and time: a zone of not yet mapped, not yet regulated. It is a zone of unmapping: even in its planning, a frontier is imagined as unplanned. Frontiers are not just discovered at the edge; they are projects in making geographical and temporal experience. Frontiers make wildness, entangling visions and vines and violence; their wildness is both imagined and material” (Tsing, 2011:28-29). For Tsing, the frontier is made in paradox, in the shifting terrain between legality and illegality, between public and private ownership (Tsing, 2011:p.33).
The Bangladeshi health service terrain has always been multifaceted. Bracketing off medical pluralism and co-existing healing traditions, which remain relevant in this contemporary terrain, the biomedical terrain has never been limited to the state-supported health service delivery system. Religious, philanthropic, non-governmental and private biomedical service delivery is nearly as old as the introduction of biomedicine under British colonial rule (Arnold, 2000, Sehrawat, 2013). However, the past two decades have witnessed an unbridled expansion of the latter. Still, this behemoth remains little known, and little regulated, and is intricately wound up with, yet beyond, public health service delivery, made and remade in the spaces between legality and illegality, between public and private ownership, as will become clear in this thesis.

Within such a frontier, rhetoric related to ‘rights’, I saw, be they human or citizens’, was far less relevant to maternal health than the organic proliferation of a private health sector outside the purview of state and development projects. Gillian Hart describes ‘big D’ Development “as a post-second world war project of intervention in the ‘third world’ that emerged in the context of decolonisation and the cold war” (Hart, 2001). Bangladesh, which Noami Hossain aptly refers to as an ‘aid lab’ (Hossain, 2017), occupies a particular space in the development imaginary and is thus a beloved target of ‘big D’ Development initiatives. This includes both international development as well as national and local development initiatives. However, as mentioned previously, despite extensive efforts through the state, international and domestic ‘big D’ Development, pregnancy and childbirth care remained predominantly informal well into the 21st century.

In contrast to ‘big D’ development, Hart defines ‘little d’ development as the “development of capitalism as a geographically uneven, profoundly contradictory set of historical processes” (Hart, 2001). This ‘little d’ development is characteristic of the growth of the formal for-profit private health market in Bangladesh. While in some south Asian country contexts, privatisation of health service delivery has been deliberately bolstered through state policies and direct state support to the private sector (Qadeer, 2013, Jeffery, 2018, Baru, 2003), in Bangladesh, an overwhelmingly uncoordinated and largely unregulated formal private health market has emerged organically, unevenly and piecemeal. While some direct policy initiatives were undertaken under the Zia and Ershad regimes in the 1970s and 1980s to promote
the privatisation of health care (Baru, 2003), enhancement of private health service delivery through the state since the 1990s has been nominal.

Therefore, institutionalised private health services delivery has primarily occurred within the context of ‘little d’ development and has mushroomed exponentially over the past two decades. This minimally-regulated formal private health sector has come to dominate transitions towards medicalized pregnancy and childbirth in Bangladesh. Moreover, while scholars critique private health insurance schemes as a manifestation of neoliberal market reforms (Dao and Mulligan, 2016, Dao and Nichter, 2016, Nandi and Schneider, 2020), in Bangladesh, health insurance schemes exist only in the world of ‘Big D’ Development pilot projects or within strictly limited sectors, such as the ready-made garment sector (Tull, 2018, Ahmed et al., 2018, Khan et al., 2020). Consequently, rather than disquiet around health insurance, anxieties emerge around ‘out-of-pocket’ expenditure on private health services and commodities and the burden that this places on the rural poor in particular (see e.g., Sarker et al., 2021, Molla and Chi, 2017). The predominance of ‘out-of-pocket’ expenditures also means that capitalist negotiation for private health services is direct rather than mediated.

This thesis situates itself at this intersection between ‘big D’ Development and ‘little d’ development, reflecting the preoccupation of my interlocutors in the country. Here, I include the state and non-state international development and national development entities in the ‘big D’ development category, as the state operates as central to ‘big D’ development. In contrast, the private health sector forged through the haphazard and organic ‘little d’ development tends to remain peripheral to the ‘big D’ Development gaze, mainly operating outside its influence.

As a development practitioner with nearly a decade of experience in the country, this ‘little d’ development of the private health sector was peripheral to my gaze as I attempted to apply global initiatives to local worlds. As an anthropologist immersed in and committed to making sense of these worlds, I could not ignore the private sector as a social force. However, it can also not be understood as an isolated force, as the private sector is constituted in conjunction with and in relation

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22 During the BNP administration under General Zia, low interest rates were offered to set up private hospitals, clinics and nursing homes. Under the subsequent Ershad regime support was more direct and the government offered encouraged the establishment of private medical colleges and provided particular support to establish and protect and indigenous pharmaceutical industry (Baru, 2003).
to other overlapping and competing entities. This thesis tends to these constitutions, co-constitutions and the moral projects which emerge within them and how these meet and mediate women's aspirations and moralities as pregnant and childbearing subjects.

This thesis offers an account of the transformed social context of pregnancy and childbirth in Bangladesh. It builds on the rich ethnographic accounts of previous anthropologists illuminating the social context of pregnancy and childbirth in the country. Such scholarship has been relatively quiet over the past decade. It seeks to pick up the story and make sense of new social organisations of childbirth, in which not only institutionalised birth has become normalised, but in which advanced biomedical technologies have become routinised and central to pregnancy and childbirth ideas and practices.

Fieldwork
Sites and methodology

When I set out for fieldwork in July 2019, I envisioned a project that would be multi-sited, allowing me to explore within spaces and the intersections, links, and connections between them (Francisco-Menchavez, 2018, Marcus, 1995). I ultimately embedded myself in the textual space of global health policy, national maternal health policy and programming spaces in Dhaka, and district and upazila (sub-district) spaces in Kushtia, located along the western border with India.

Textual Content analysis

At the outset of this project, I conducted a textual content analysis of the relevant policy and normative documents produced in global health spaces and national spaces in Bangladesh related to maternal health. The objective was to analyse both the text and aesthetics of these artefacts through the lens to understand how the global and local spaces come into view through the discourses they encapsulate (Riles, 2001). A primary focus was the intertextuality of the global and national policy documents, i.e. the interconnectedness of the documents produced in these spaces and the consensus and departures of concepts.

I reviewed 13 global documents and 11 national policy documents for a textual content analysis. I selected documents published after the 2009 Human Rights Resolution on preventable maternal mortality and morbidity at the global level. In this
Bangladesh, I extended my historical reach to the first sector development programme document published in 1997. While most recent policy documents are electronically available, older documents were more challenging to access. Specifically, the 1997 sector programme document and document and the first maternal Health Strategy, published in 2001, were not available online. My icddr,b colleagues helped me access these documents, though they also had to reach out to their social networks as they did not have them readily available. These early documents were priceless for understanding the shifts in maternal health discourses and dispelling my preconceived notions about these discourses.

I identified deductive human rights and maternal-health related codes that I had already determined would be relevant to my project. I added inductively identified codes to this initial list as relevant, which expanded the list to 141 concept codes. I combed through these documents, extracting all references to identified codes, iteratively returning to documents as the code list expanded. After completing this, I grouped the codes into themes, identifying 18 themes. Once I had this in place, I created graphs to visualize shifts in discourses and narratives over time.

While I expected this analysis to form an essential element of my final research thesis, it served a perhaps more important purpose. While less of the analysis of this work explicitly appears in this work than I initially imagined, it informs it. Moreover, when I began interviewing policymakers and development programmers in Dhaka, I found that this exercise was critical for establishing my legitimacy and credibility when interfacing with high-level development programmers and policymakers.

Dhaka

It had been less than a year and a half since my last visit to Bangladesh when I worked for EdM. During that trip, I said goodbye to the project and friends. When I returned in 2019, I slipped back into my familiar kameez23 and friendships. icddr,b officially agreed to host me for my research, even though their project and partnership with EdM had a rocky dissolution in the interim.

Ehsan’s team took me under their wing. Some of the team members I knew well from the previous years, as we had worked closely together to implement

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23 Traditional Bangladeshi suit composed of a long tunic, trousers and scarf.
development projects in a few different sub-districts throughout Bangladesh. Others, I knew, though we had not worked together previously. Still, others had joined the team since my last visit. Together they became my Dhaka family. As I shifted my gaze from a development gaze to an anthropological one, they allowed me to tag along with them in their development engagements. They took me to different external meetings, workshops and large national disseminations. They included me in internal meetings to plan maternal and child health programmes and make sense of the data they collected. They took me along for field visits to some of their project sites. These included a couple of trips to Sylhet in northern Bangladesh, where I visited the BRAC University midwifery training centre and their Midwifery-led Care Centre, and trips to Kushtia, where I ended up embedding myself for fieldwork shortly thereafter.

Kushtia

In December 2019, I moved my primary fieldwork locale to Kushtia, located along the western border with India. Selecting Kushtia was based primarily on happenstance. Ehsan’s team had brought several development projects to Kushtia. Though certainly no Matlab,24 the team I worked closely with was well established there. The team had three ongoing projects and initiated a fourth project to introduce pulse oximetry into the integrated management of childhood illness (IMCI) in government health facilities. My affiliation with them facilitated my entry into the government facilities and provided a support network through the field team.

Tamanna, a junior anthropologist, was assigned to collect extensive data on the IMCI project from the Dhaka-based team. Ehsan agreed to dedicate a portion of her time to support my research project, particularly for conducting interviews. In return, I mentored her and supported the icdrr,b team in qualitative data collection for other projects and junior researchers to prepare manuscripts for journal submission. In addition, I arranged the logistics and accommodation for Tamanna.

My data collection in Kushtia centred on participant observation in various maternal health settings. I divided much of my time between the five upazila health

24 Matlab is the site of the oldest demographic surveillance site not only in Bangladesh, but in a country considered ‘low- and middle-income.’ established by icdrr,b (then the Cholera Research Laboratory) in 1963. The site, and the people living within its bounds, has served as a testing ground for perpetually shifting experimental initiatives.
complexes, the subdistrict government hospitals. I spent the mornings with the health service managers and providers. In ANC corners and outpatient waiting rooms, I spoke to pregnant women and mothers there to visit the health service providers. When researching global health contexts, it was common to isolate female interviewees, as we expected this to reduce bias and ensure her ‘real’ responses. However, conversations often took place informally in these settings, as women stood in lines, sometimes packed into enclosed ANC corners. Tamanna and I approached women in waiting rooms and asked to interview them; we tried to find quiet corners amid the bustle. Sometimes we spoke to women alone; other times, she was accompanied by a mother, a mother-in-law, a sister or sister-in-law, or a dai accompanied her and very often by young children. At the beginning of the interview, we would typically ask to speak to her alone, but if she did not seem comfortable or family members resisted, we did not push it. Besides, the presence of other family members generated vibrant conversations and provided a broader understanding of pregnancy and childbirth as a ‘whole family’ affair.

In Kushtia city, I spent time at the MCWC, the district-level facility managed by the DGFP. This facility primarily staffs Family Welfare Visitors (FWVs). I visited the MCWCs on the days they provided ANC (two days per week). I observed the ANC visits and had informal conversations with the health service providers and women. I talked to women about their previous births and aspirations for their current pregnancies.

I started to venture to private health facilities in the afternoons from the public health institutions. While these had initially seemed impenetrable to me, particularly compared to the public health institutions to which DGHS had granted me formal access, I found it easier to enter than I anticipated. After the upazila health complexes grew quiet, Tamanna and I walked nearby to the various private clinics and diagnostic centres. More often than not, the staff of the private facilities welcomed us. They invited us in and gave us tours, introducing us to the various owners, health service providers and patients. We visited some of the clinics regularly, particularly in Daulotpur, Khoksha and Bheremara, and developed good relationships with the owners and health service providers practising in the clinics.

I also met women in their village homes to collect birth narratives. The icddr,b team assisted me in identifying these women based on a household survey.
conducted in 2016, something I discuss further in Chapter 1. Shaheda, whom I introduced at the outset of this chapter, was among the women I interviewed in her home, based on her initial participation in the icddr,b survey. These were extensive interviews, generally lasting between 1 and 1.5 hours, during which women graciously shared with me and Tamanna (and in a couple of cases, Shema) their birthing experiences. These were semi-structured, and we encouraged women to tell their stories in the most meaningful ways to them. Along with Tamanna and Shema, I conducted 12 such interviews. We recorded each interview with the consent of the interviewee. In contrast to the busy health facilities, we enjoyed more privacy when conducting these interviews. Typically, the woman invited us into her bedroom, and we spoke outside the earshot of other household members.

I returned to Europe in March 2020 when Covid-19 hit. I threw myself into data transcription and translation and carried out our remote participant observation with the icddr,b team of the Covid response in-country, returning to Kushtia to resume in-person fieldwork between November 2020-March 2021. With Tamanna, I reconnected with the site and the people, returning to upazila health complexes, the MCWC, and the private health care facilities where we had established relationships before my COVID departure. We continued participant observation in these settings and resumed interviewing health service providers and women. We also expanded our engagement to others in this setting, including ‘dalals’, brokers credited with enticing women from the public health sector to the private and medical representatives employed by various pharmaceutical companies to promote pharmaceutical use.

During this period, I spent more time at the Kushtia District Hospital. Our participation revolved around engaging with the hospital staff (e.g., nurses, gynecologists, intern doctors, midwife interns, nursing interns, medical assisting interns, and the ayas (non-clinical helping hands)) and with the labouring women and their families. We never performed clinical work, though we occasionally advocated on behalf of the family, calling for a nurse or asking for information desired by the family. It was a delicate balance as the relationship between the health service providers and patients is performed in particular ways, and a careful dance was

25 Corresponding to obstetrician-gynaecologists (OBGYN)
required on our side to avoid alienating the health service providers while still supporting the less powerful women and families, which felt like a moral obligation. This participant observation eventually extended into the obstetrics and gynaecology operating theatre.

Ethics

I obtained ethical approval for this project before initiating data collection through the University of Edinburgh School of Social and Political Science (approval date: 29 April 2019) and again (approval date: 13 November 2020) after resubmitting to resume data collection in the context of COVID. When I arrived in Bangladesh, I submitted and obtained approval for the project through the ethical review committee of icddr,b (approval date: 13 November 2019). The icddr,b team assisted me in obtaining administrative approval for data collection in public health facilities through DGHS. The programme manager of maternal health issued a letter of authorization (dated 2 December 2019) and circulated it to the civil surgeon, district-level health manager, and upazila health and family planning officers (UH&FPOs), the upazila-level health managers in Kushtia.

I ensured my research participants’ protection, respect, and dignity during all phases of this study. I obtained informed consent from participants when carrying out data collection. Prior to formal (or semi-formal) interviews and collection of birth narratives, we fully informed potential research participants regarding the scope, purpose, and potential risks of the research project. We informed them they could withdraw their participation at any time or exclude any information from use. We sought permission prior to recording interviews and did not insist in the case of a person expressing any hesitancy. We paused the recording when the interviewee requested and only resumed when they agreed once again. I provided each of my interviewees with a visiting card and informed them that they could contact me afterwards if they had any questions or requests.

We obtained verbal informed consent rather than written informed consent as it is more appropriate in Bangladesh for a few reasons. First, there is a high degree of variation in the participants’ ability to read and write. Even in Bangla, written informed consent forms further privilege participants who are already privileged to have benefited from more extensive formal education. In addition, paper forms are
associated with the British colonial rule in Bangladesh, where Bangladeshis were exploited and stripped of resources based on paper-based forms. Paper-based forms for obtaining consent tend to incite scepticism and discomfort among participants. It can also reinforce power differentials between researchers and research participants. Therefore, I ultimately opted for verbal informed consent rather than written. I recorded that verbal informed consent was obtained prior to the interview and kept this in my records.

In contrast, obtaining individual informed consent for participant observation was less amenable to a structured process. Still, I maintained ethical principles, including doing no harm and protecting participants’ safety, well-being, and dignity. In Kushtia, I met with the local health authorities to inform them regarding my study and secure their support. I was consistently forthcoming regarding my presence and purpose with health service providers in various settings. I tried to read signals conservatively and not impose my presence on those less inclined.

When addressing reproductive health, there are many occasions in which sensitive topics arise which may cause emotional distress. In Bangladesh, these include spontaneous and induced pregnancy loss, distress related to infertility, child loss, and experiences of disrespect and abuse within formal health services. In discussions with women, we remained vigilant about these sensitive topics and did not push women to discuss issues when uncomfortable. However, women were often eager to talk about these topics.

I remained alert to ethical considerations when present during birth experiences. Whether in labour and delivery rooms or operating theatres, I obtained consent for my presence from the woman and her companions. As I often only encountered the woman when she reached the labour and delivery room, she was generally in the full throes of labour pain by then. In almost all cases, female attendants accompanied labouring women. A sense of ‘publicness’ marks these rooms—there are four beds in the open room, in some cases fully occupied, and it is common for all sorts of health service providers to wander in and out and representatives of various development initiatives without prior introduction. Still, we approached each party to explain our presence and obtained consent.
As non-clinicians, we never attempted to provide clinical services or advice. However, sometimes we advocated for the family, provided comfort, for example, in the death of a baby, and, in the rare case in which a woman found herself without attendants, I filled in to perform the ‘care’ work of the family, e.g. hand holding, back massaging, hair stroking, giving water. Where newborn babies lay alone on a bed after birth and kicked off their coverings, we would approach to snuggle them more tightly.

A final note on ethics consists of my interactions with the icddr,b team, and friends. Many of these relationships go beyond the professional. They are friendships based on sharing, laughing, ‘being with’ in moments of tragedy and sadness, eating, watching movies late into the night, playing badminton, shopping, and going to the parlour. The time I spent with friends was personal but critical to making sense of the social world around me. We had many casual conversations, some related to development practice, but many not, which informed my thinking and ways in which my interlocutors may not be aware. I have been careful not to breach these friendships' confidence in my writing. When in doubt, I have contacted the person to ensure they are comfortable with the representation I am making in this text.

I maintained participants' confidentiality and anonymity throughout data analysis and reporting. Throughout the text, I use pseudonyms for all people unless the participant has given explicit authorization to reveal their identity or is a public authority. In contrast, I maintain the original names of places and organizations.

Positionality

As in any study, my positionality within this research project is critical to the knowledge generated through it, both in the ways people respond to me and how I interpret data. In this era of decoloniality and the efforts toward decolonizing anthropology, it is perhaps first essential to mention that carrying out this research as a white woman in a post-colonial setting shaded many ways that people engaged with me in Bangladesh. Being a foreigner, and a white foreigner in particular (although in Kushtia, Azim liked to play a game where people guessed where I was from, and a surprising number guessed China), brings both the baggage and privilege associated with British colonisation. I found myself on a fast track to being
called ‘Madame’, the highest honorific used for a woman, which I actively fought against, asking people to use the far more common term apa, sister. Without a doubt, my foreignness, and particularly my white foreignness, facilitated my access to various settings. It also made me a conspicuous presence in Kushtia.

In Dhaka, my foreignness proved less beneficial than other positionalities, that is, my connections with the development world. When I arranged meetings with different policymakers, my work within the global health community, not only with EdM but also as a consultant for WHO, boosted my credibility, as did my attachment with icddr,b. To the latter, I attribute my ability to penetrate most of the spaces in the national sphere. I quickly found a cold call email from myself and was unlikely to find any reply, but one with a high-ranking person from icddr,b in copy would. It was based not only on professional affiliation but also on personal affiliations, which different team members leveraged on my behalf. Even in Kushtia, dropping the name of icddr,b, and relying on Tamanna’s name badge, was critical to accessing different spaces.

My status as a married woman and mother was also critical to this work. Other anthropologists have documented their experiences working in the same site first as unmarried then as married women and have noted that their status as married women allowed them to penetrate topics related to sexuality and reproduction, which they were not able to prior to marriage (Abu-Lughod, 2008, Ahearn, 2001). I only have experience conducting this work as a mother, but I found that it facilitated my data collection. During interviews and in maternal health settings, health service providers and women alike were curious about my children and how I gave birth. However, my answers confused people and unsettled their assumptions about me. Here I was, a white foreigner, an American whose primary home was Switzerland but studying in the UK, which people associate with privilege. However, I had three children, considered a large family even in rural Kushtia, and associated with lower class and rural status. I gave birth vaginally three times, which is also associated with lower class and rural status. However, health service providers treated this as a badge of honour in health facility settings in the national push to lower caesarean births.

My non-clinician status proved an advantage with the health service providers and managers, both in public and private spaces, relieved that I was not trying to
assess their clinical practice. Of course, it would be naïve to suggest that my presence did not influence the services provided, although this diminished as time passed. Sometimes, the influence was apparent when the hospital staff became frustrated with a particular woman. On several occasions, nurses warned the ayas not to demonstrate too much frustration through physical means, sometimes going so far as to mention the bideshi, foreigner, among them. The ayas seemed to care less. I never did encounter health service providers enacting physical violence against women in the labour and delivery room, although I admit to standing a bit closer on a few occasions when health staff frustration grew palpable.

Chapter mapping

Chapter 1 lays the ethnographic background of the thesis. It takes as its object the volatile maternal health care terrain in Kushtia and rural women’s social navigation of it. It argues that rural women’s and families’ aspirations towards extensive and invasive use of advanced maternal health technologies, even in the most remote areas, are rooted in aspirations and moral obligations to avert ‘risk’. However, the provision of these services is characterized by perpetual flux, both within the public and private health sectors. Rather than accessing these services as a matter of ‘entitlements’ or as pure market commodities, they materialize by leveraging social connectedness, often in the form of the patronage practice of dhora-dhori.

Chapter 2 explores public maternal health encounters as spectacles in which the category of the state and people’s relationship to it is constituted through embodied performance. It asks why public maternal health ‘care’ often appears ‘uncaring’ in these settings. I argue that rather than a moral failing, apparently ‘uncaring’ care delivered by public health service providers is structured by moral imperatives to provide ‘services’ (sheba), though not necessarily ‘care’ (jotno), to a particular category of people, gorib manush. Service is delivered not as ‘entitlements’ to ‘citizens’, but as pity-based charity to people with limited alternatives. These encounters crystallise within a broader constellation of state imaginaries beyond these spaces, shaping expectations of state health services.

Chapter 3 examines public health spaces as sites where international development actors assert moral high ground through enacting specific maternal
health interventions. This chapter destabilises international development claims to moral authority, arguing that even the best-intentioned technical interventions become sites to override women's agency to justify perpetually shifting development ends when subsumed by development logics.

Chapter 4 shifts gaze to a new for-profit maternal health market. This chapter argues that this market is creatively constituted in response to situated social, political and economic realities to open opportunities for accessing services to women and opportunities for livelihoods for people from all social classes. While these shifts are met with moral ambivalence in global and national policy and programming discourses, those within the sector navigate a tenuous moral world in which market logics are not amoral or immoral but integral to service-oriented business.

Chapter 5 interrogates the presumed boundaries between the ‘public’ and ‘private’ sectors. Centred on the widespread and normalized simultaneous practice of government clinicians in both sectors, this chapter argues that rather than separate entities bounded by distinct logics, doctors' time-bound animation, though not always corresponding to biological timings of pregnancy and birth, defines public/private categories and what types of care women can access when, where and at what cost. Logics are also blurred in these enactments, as 'public' credentials are marketised as an extension of 'private' logics.

Finally, chapter 6 turns to the navigation of informal livelihoods made possible through the for-profit maternal health service market, focusing on the trope and actual practice of those identified as morally-compromised ‘dalals’, brokers bringing women and families from public to private health institutions. It argues that the trope of the dalal operates as a metaphor for immorality ascribed to morally ambiguous spaces of the private health sector, a way for people to negotiate a moral discomfort integral to applying market logics to health services. Dalal practice, in contrast, is rooted in economic precarity, primarily among young men waiting for better opportunities.

I conclude by connecting the maternal health terrain and people’s navigation of it to a more profound sense of what it means to inhabit a social and geographical space conditioned by precarity and unpredictability and the flexibility required to
navigate such a space. Rather than a manifestation of hegemonic neoliberal ideologies, the maternal health terrain in Bangladesh is constituted through the creative and flexible navigation of actors pursuing health aspirations alongside economic and moral imperatives, responding to and constituting states of flux and transition long inherent to the Bangladeshi experience.
Chapter 1: Navigating a maternal health care terrain

Categorizing a terrain of ‘choice’

Immediately upon my arrival in the nation’s capital to initiate my fieldwork, I was swept up into national debates around the transitions in childbirth in the country, mainly toward medicalisation, juxtaposed alongside a failure to reduce maternal death. This paradox stood as a spectre over development and state apparatuses. While these narratives did not go so far as blaming the stubbornly high maternal death ratio on surgical birth, neither could the predominance of caesarean be touted as serving to avert avoidable maternal death in nationally (and quantifiably) discernible ways. These discourses congealed into a two-pronged explanation for the exasperatingly high caesarean rates; first, the ‘greedy’, profit-driven private health sector, and second, the women demanding it in a personal effort to avoid labour pain and select the timing of their births, situating women as co-liable for the national stain.

From the national policymaking and programming vantage point, the maternal health terrain resembles a palette of choice easily categorizable in tables and figures. The palette is composed of politically desirable and undesirable choices, among which women choose from morally tinged options: institutional birth is discursively constituted as morally superior to staying at home, but only if the birth mode is vaginal rather than surgical. Indeed, while WHO long recommended a national surgical birth rate between 5%-15% (Betran et al., 2016), in recognition that caesarean is a potent biomedical remedy for some pregnancy and birth complications, a national caesarean rate over twice the highest threshold left at least half of caesareans both medically and morally suspect. But how does this maternal health terrain look from the vantage point of women, and how do they navigate it? How does the widespread availability of maternal health technologies reshape moral worlds and the navigation of a new terrain?

This chapter considers the volatile maternal health care terrain in Kushtia and rural women’s social navigation of it. Using the analytic lens of social navigation allows us to at once pay attention to the unstable environment and the ways that immediate (present) and imagined (future) volatility shapes action (Vigh, 2010).
Therefore, I use this lens to explore maternal health delivery as a volatile terrain women navigate to achieve their ambitions and moral imperatives as pregnant and childbearing subjects.

This chapter foregrounds the stories of two women, Mitha and Shanti, to illustrate vacillating maternal health ideas, moralities and ambitions at the intersection of a shifting maternal health service terrain. It argues that rural women’s and families’ aspirations towards extensive and invasive use of advanced maternal health technologies, even in the most remote areas, specifically ultrasound and caesarean, are rooted in aspirations to avert ‘risk’ and what it means to provide ‘good’ (read: moral) care, particularly for the baby. However, the provision of these services is characterized by perpetual flux, both within the public and private health sectors. Rather than accessing these services as ‘entitlements’ or as pure market commodities, they materialize by leveraging social connectedness, often in the form of the patronage related-practice of dhora-dhori, translated as mutual grasping or holding.

Both Mitha and Shanti reside in rural Kushtia; both define themselves as gorib manush, poor people, and ghrihosto manush, farming people. Both women married and started childbearing early in life; both live in their in-law’s homes. As pregnant and childbearing subjects, both aspired to maximise their chances of optimising their and their babies’ wellbeing. To do so was a challenge, as they had to interface with a perpetually oscillating maternal health care terrain. In so doing, they differed in their tactics to achieve their maternal health aspirations: Mitha attempted to rely on the public health sector, while Shanti avoided it altogether and relied exclusively on the for-profit private health sector. In both cases, realising aspirations proved challenging.

My journey to Mitha and Shanti started in Dhaka. In 2016-2017, Ehsan led his icddr,b team to conduct a large-scale household survey in rural Kushtia as a baseline study for a child health project they designed with Save the Children U.S. under the Saving Newborn Lives initiative. ¹ The project aimed to test a model to

¹ Saving Newborn Lives is a global initiative established in 2000 to increase newborn survival globally. The initiative was funded by the Bill and Melinda Gates Foundation administered through Save the Children U.S. Bangladesh was among the countries selected for initial implementation of the intervention, identified as one
strengthen public health facility management of newborn and child sepsis (Rahman et al., 2020), which the team rolled out in Kushtia district. During the baseline survey, the team interviewed 4,436 women in their Kushtia homes, asking women to respond to detailed questions about their pregnancy and birth experiences, which might hint at associations with newborn sepsis. Women who underwent caesarean participated in a supplementary questionnaire module enquiring about the conditions leading up to the procedure and their experience with it. The team invited me to join them to interpret the quantitative data they collected related to caesarean, the topic which dominated our discussions, in the interest of preparing a manuscript based on it, later published (Rahman et al., 2022).

When I arrive in Huddle Room 1 on the 5th floor of the icddr,b campus for the first meeting to discuss the data, only Afsana is there in the pristine white room. Afsana, who trained as a statistician in Canada at the prestigious McGill University, joined the icddr,b team from the BBC Bangladesh office within the past year. Though not necessarily passionate about public health, she is brilliant at what she does, and some other young researchers see her as (with at least a bit of jealousy) a rising star in the department. Discreet and independent, she is in her early thirties and a couple of years into marriage. She adores her adolescent niece and often shows me photos of her and her most recent artwork; however, she also shares her ambivalence toward her own prospects of motherhood and ferociously guards against her fertility defining her social acceptability.

“How did you deliver?” she asks me as we wait for the other team members to arrive. “I had all three vaginally,” I respond. Her eyes grow wide at my response, filled with surprise. “I guess my mother had three children normally,” she says thoughtfully after a moment’s delay, “so I guess it is possible... But didn’t it hurt?” I laugh out loud. “Yes,” I say, “a lot.” I then ask her how she thinks she would like to give birth if she decides to have children one day. Caesarean just seems simpler, she tells me, and why would she choose to go through the pain of childbirth if she could bypass it?

of the 12 countries where half of the world’s newborn deaths occur (Tinker et al., 2010). Icddr,b operated as a partner organization for national implementation of the initiative. This project represented one of several implemented by icddr,b through the initiative.
The other team members shuffle in and take their positions around the table, and we exchange pleasantries. When everyone arrives, Ehsan projects the excel spreadsheet on the large monitor. The rows list various characteristics collected during the survey to categorize women, i.e., age, years of education, husbands’ age, wealth quintile, use of formal biomedical services during pregnancy, and characteristics which might explain the outcome variables. The top row lists different variables attached to questions asked during the data collection about caesarean: the reason for undergoing caesarean, who proposed the idea to have it, when the decision was made, and the reason for surgical birth, which women reported. The reasons included those which suggested a medical indication (e.g., premature labour, cord prolapse, malpresentation, prolonged labour, obstructed labour, pre-eclampsia, diabetes, multiple pregnancies, and other complications during birth), history of caesarean, avoiding labour pain and convenience of time—the cells in between house the intersecting proportions of women qualifying for the explanatory variable and outcome.

We scan the cells and strain to make sense to construct associations between variables that may offer some clue into the enigma of why women now give birth surgically in droves. One thing is clear from these figures: surgical birth is not confined to wealthy women. While the procedure was incontrovertibly higher among the wealthiest women (70%), even 41% of the poorest women gave birth through caesarean. Moreover, among women who gave birth through caesarean, similar proportions of women among all wealth quintiles reported doing so for the ‘wrong’ reasons, that is to say, the avoidance of labour pain (approximately 20% among both the lowest and highest wealth quintiles) or for convenience of time (18% among lowest wealth quintile compared to 25% among the highest).

These findings dovetail with the predominating narratives in Dhaka, and I prepare myself to take seriously rural women’s desires to avoid labour pain and convenience when I move to Kushtia. However, in this setting, as I talk to women day in and day out about their birthing experiences and desires, I am hard-pressed to find any who articulate giving birth through caesarean as a way to avoid pain or for convenience, either when recalling prior births or for their planned births. One evening I discuss this with Ehsan over the phone. I tell him that while I am confident in the rigour and findings of the household survey, there must be some disconnect
between how women think about labour pain avoidance and convenience and how researchers fit their responses into these tiny boxes. Ehsan suggests that I go and talk to some of the women from to survey to find out. Mitha and Shanti both participated in the icddr,b 2016 survey, and both responded in a way that indicated that they gave birth surgically either to avoid labour pain or for convenience of time. In 2020, with the support of the icddr,b team, they were among the women who invited me into their homes and shared detailed accounts about their birth experiences.

Perhaps unsurprisingly, Mitha and Shanti’s stories, like the other women from the survey I met, revealed the categories of ‘avoidance of labour pain’ and ‘convenience of time’ as grossly inadequate for capturing the complexity of ideas, conditions and events that ultimately culminated in their surgical births. Despite my confidence in icddr,b’s rigour in carrying out quantitative research, there are simply limits on that which quantitative methods can reveal, despite the predominating global health dogma which holds that all phenomena can (and should) be metricised (Adams, 2013, Adams, 2016a). However, more than this, these accounts were revelatory for understanding how women and families negotiate ideas, moralities, possibilities and actions around pregnancy and childbirth in a nebulous Bangladeshi maternal health terrain. Although intimate and likely among the most profound stories of their lives, as birth stories often are, their stories are not exceptional. Instead, they are illustrative of the stories of the many women I talked to in their homes and health facilities doing their best to navigate the unstable maternal health care terrain in Kushtia to pursue their pregnant and childbearing ambitions.
It is a crisp winter day when Tamanna and I enter the courtyard of Mitha’s home (bari). The courtyard is a beehive, teeming with women and children and activity. Mitha waits for us on a small patio in front of one of the rooms. I met her earlier in the morning with Azim, the icddr,b field manager, so she expects us. She leads Tamanna and me inside the cove of her bedroom. The room is dim and well protected from the sun, which I imagine would provide a nice respite during the hot seasons, though now it leaves me feeling chilled. Mitha invites us to sit on her bed and then takes her place facing us. She casually pulls up one knee and drapes her arm around it. She wears a red kameez with black polka dots, and a long, sheer black scarf pulled loosely over her head. Gold earrings dangle below her earlobes, earrings which match a gold nose stud, still often a marker of marital status among women in rural Bangladesh.
Baccha manush. Child person. Mitha uses these matter-of-fact words to describe her 13-year-old self, pregnant for the first time. For a young woman to marry and bear children as a teen is quite common throughout Bangladesh, including in Kushtia; nevertheless, to do so by the age of 13 is remarkably young. Mitha tells us that though her family ‘gave’ her in marriage when she was 11 years old, she continued her education for a couple of years after the matrimony. She concluded her education earlier than she desired. “I wanted to study,” she tells us, “but my father- and mother-in-law are from an older generation (age-kar). They said that, no, that was enough.” They worried that she would become too ‘mature’ and perhaps eventually leave her in-law family by continuing her education. She shrugs. “They are a bit old, and I am a bit young,” she says.

We can hear the bustle from the courtyard, where women squat on the ground, slicing vegetables over moon-shaped scythes. Onions lay on a large tarp, drying in the sun, and young children chase one another. When they come too near, chickens dart from their path, clucking their vexation. Our presence engenders a stir in the household; it is not every day that a young woman from Dhaka and a bideshi (foreigner) invite themselves in. From time to time, older female household members wander from the courtyard into the cool room, curious to catch a glimpse of these strangers. Tamanna kindly tells them that we would like to talk to Mitha alone, but we would be happy to speak with them afterwards. They disregard her request as if they do not hear her until Mitha authoritatively demands that they go. They shuffle out the door and back into the busy courtyard.

The Demand-Side Financing (DSF) project, designed to assist women with limited financial resources just like Mitha, was in full swing in Daulotpur upazila, where she lives in the outskirts, by the time of her first pregnancy. Championed by the Department for International Development (DFID) of the United Kingdom, the DSF project in Bangladesh aimed to incite the most disadvantaged women to access institutionalised (read: biomedical) health services during pregnancy and birth through financial incentives (Ahmed and Khan, 2011, Khan and Khan, 2016). The

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2 It is common in Bangla to refer to women being ‘given’ in marriage (biye dawa), while men ‘do’ marriage (biye kore), though there is a shift toward using the active word ‘do’ for women among the higher socioeconomic and urban groups.

3 In 2020, DFID was merged with the Foreign Commonwealth Office to form the Foreign, Commonwealth and Development Office, effectively bringing diplomacy and development efforts under the same umbrella.
DSF project in Bangladesh is but one configuration of conditional cash transfer schemes, a popular fixture in the development apparatus since the late 1990s. Such schemes are most commonly associated with the World Bank and the global propagation of structural adjustment policies (Bradshaw, 2008).

While these schemes vary in form, they share a foundation of neoliberal principles which leverage individual responsibility and market motivations. They attempt to appeal to women’s economic sensibilities through financial compensation on the condition that they fulfil obligations set by programmatic forces. These may require, for example, they take their children to visit health facilities or enrol them in school (Millán et al., 2019, de Souza Cruz et al., 2017). Such schemes are popular among maternal health policymakers and programmers to coax women towards institutional pregnancy and birth services (Glassman et al., 2013). Indeed, in an ideal world, biomedical facilities would be equipped to quickly identify women experiencing complications and deliver the interventions to respond to them. Postpartum haemorrhage and eclampsia, both with relatively easy biomedical solutions, still account for over half (55%) of maternal deaths in the country, despite relatively easy biomedical remedies (National Institute of Population Research and Training (NIPORT) et al., 2019). However, while institutional birth is the globally-promoted solution, whether institutions in countries in the global South can deliver on these promises remains moot (see e.g., Strong, 2020, Gabrysch et al., 2019).

The Ministry of Health and Family Welfare, supported, as usual, by international development partners, introduced the DSF project through the public health system in 2006. Daulotpur Upazila, as a ‘disadvantaged’ and border area, was among the original 21 upazilas selected for the pilot project. The scheme initially provided vouchers for women based on demonstration of economic criteria (household income of less than 3,100 taka (~26 GBP) per month, landlessness and lack of other productive assets) to use institutional health services. However, programmers later dropped the requirement to demonstrate economic need. Implementors found it too challenging to maintain⁴ and reasoned that any woman

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⁴ A recurring problem in this respect was that in many upazilas selected for the pilot project, a higher proportion of vouchers were distributed than the estimated number of eligible pregnant women. Daulotpur was an extreme case, with 1537% of vouchers distributed as a percentage of eligible women during the first phase of implementation (Khan and Khan, 2016).
living in Daulotpur was likely poor enough to qualify. In the initial model, the voucher covered costs for women to attend three ANC visits, one postnatal care (PNC) visit, and institutional birth costs in a government (shorkari) facility, including transportation costs. On top of that, women received a cash incentive of 3,000 taka (~25 GBP) to give birth in a government facility, a handsome sum where a monthly household income of the same was the initial cut-off to qualify for the voucher. It is important to note that the project was never strictly limited to the 'demand-side.' From the outset of implementation, salaried government health service providers received incentives to provide services to women presenting the vouchers, despite these being routine services already included among their job responsibilities (see Chapter 4 also).

When pregnant with her first child 11 years previously, Mitha secured a DSF voucher, which women refer to as the 'card,' seven or eight months into the pregnancy. While, officially, pregnant women obtained vouchers for a first or second child based on their residency status in the upazila and free of charge, women do not tend to explain it this way. Instead, they share stories in which they exercised their social networks to avoid financial exchanges to obtain the 'card.' "You have to do some dhora-dhori, apa," Mitha explains when we ask her how she secured a card. Dhora-dhori, literally translating to mutual grasping or holding, evokes the leverage of social networks to access opportunities or resources. "I mean, I have one of my relatives…because she is somehow related; she arranged this for me. The daughter of my elder brother-in-law works there [with the union parishad member5]. So, I got it through her, even though I was not directly a relative [of a member]."

Despite possessing the 'card,' Mitha anticipated giving birth at home with the assistance of her grandmother-in-law (dadi shashuri),6 experienced as a dai. However, as her due date passed and the days ticked by with no signs of labour, these aspirations evaporated. "My mother, grandmother, everyone over there, I asked them. They said I would need to go if [the labour pain] did not come. It was almost just like that. 'If you do not have the poison pain (biSh byaetha), you have to

5 The union parishad is the body of local government.
6 While global and national policy tends to represent 'traditional birth attendants' as a monolithic category, women in Kushtia rarely mention seeking birth care from a non-relative based on their status as a dai. Rather, they mention family members who have experience assisting birth as helping them during their birth. This is similar to what Sarah Pinto describes in India (Pinto, 2008).
go to the doctor's house,' they said." A week past her due date, her family took her to Ad-Din Hospital in Kushtia for what would be her third and final ultrasonogram of that pregnancy. Ad-Din, which staddles the space between a charitable non-profit and for-profit private hospital, is one of the most esteemed hospitals in Kushtia. She consulted with Dr Sharmina Khatun, a highly reputed obstetrician in Kushtia, whom Mitha describes not as a gynaecologist or obstetrician but suggestively as a ‘shejar doctor,’ using the English cognate women use to refer to caesarean.

"I did the sono (English cognate for ultrasonogram), and the doctor told me that the water inside was drying. When she noticed that there was not enough water, she asked which village we were coming from. Then she said that just like in the river [next to our village], if there is not enough water, then even the fish from the top layer will die, and it is like that for the baby. Therefore, a shejar was necessary." As she speaks, her headscarf slips from her head. She lets it drape around her shoulders for several minutes before rearranging it to cover her hair, framing the delicate features of her face.

With this news, the family returned to their home, determined to go to Daulotpur upazila health complex the following day to do the ‘right’ thing for the baby: follow the doctor’s instructions and liberate the baby before he became a fish out of water. It would be her first visit to the upazila health complex during her pregnancy. Her family only took her to Ad-Din previously as they were not confident in the quality of the services provided at the complex, particularly the quality of the ultrasonogram, her primary motivation for visiting any biomedical institution during pregnancy. However, going to the upazila health complex was an obvious choice for a caesarean. With the voucher, not only would the services be free of charge, but they would also receive the incentive. The procedure at Ad-Din would cost at least 20,000-25,000 taka, (~170-215 GBP), a sum her family could not afford. No less important, perhaps, was that her grandmother and her chachi (paternal aunt) lived near the upazila health complex. They could care for her and bring food during her recovery stay.

She was admitted at Daulotpur upazila health complex the following morning, which happened to be a Friday, at 10 am, ready for the operation. However, she was in for a long wait. "There was no doctor there," Mitha explains. "There was no doctor;
the doctor did not come until 10 pm. It was Friday that day. As Friday is a holiday, my mama (maternal uncle) went to fetch a doctor he knows. After going to him, he brought the doctor [to the health complex].” Once the doctor reached, he quickly performed the caesarean, and her son was born without any problem.

She spent the following seven days in the health complex in a cabin rented at an affordable price of 70 taka (approximately 60 pence) per day. Her mother and chachi stayed with her, caring for her and her new baby. She could not even stand, and therefore she needed one person to care for her and the other to care for the baby. One person would not be sufficient, she told us. Her family easily arranged food and other necessities, with her grandmother’s and chachi’s homes nearby. At the end of the seven days, the medical staff removed her stitches, and she returned home after a comfortable stay.

It was nearly seven years before she conceived again. She was in no rush to add another baby to her family until she accompanied a neighbour girl to Dr Sharmina Khatun one day. “While we were there,” she recounts, “[the doctor] said, ‘Why are you waiting so long to have the next baby? So many days have passed that you are not taking any baby. If you develop fat in your belly, [conceiving a baby] will become problematic.’ When I heard this, we decided to have the baby.” It is hard to imagine her developing fat around her belly, svelte as she is. Still, this injunction from the doctor motivated her to discontinue her Depo-Provera contraceptive injections, which she obtained from the family welfare assistants (FWAs) of the government family planning programme who regularly passed through her village, and she soon became pregnant.

She discovered, however, that the DSF project was no longer what it was during her first pregnancy, though she did not entirely understand why. Daulotpur upazila health complex discontinued caesarean services in the interim between her pregnancies; therefore, the vouchers no longer covered the procedure. Moreover, she found herself unable to secure a voucher as expected, even though she was well within the requirements, including the stipulation of continuous contraception use between pregnancies following the first birth to obtain a second voucher. She also enjoyed the same social connections. “We know that member (the member of local government) gives [the cards],” she explains. “But if he does not give it after
saying so he will, what can we do? He told me that the card was prepared. He took everything: the ultrasonogram papers, the head of household's photo, my photo, how many months pregnant I was, everything was written." She was not required to give money, which she again attributed to her connections with the local government member through the relative, but neither was she able to secure the card as previously.

"When I went to collect the card," she continued, "he said that the card had not been prepared. Now the government was no longer giving anything. Afterwards, he never gave that card to me in my hand. He told me I would not have the card in my hand this time. 'Tell me where you will have your operation,' he said, 'and I will hand over the card there.' So, I went and talked to Sharmina Khatun. She knew that I had the card in my previous pregnancy and asked whether I had the card. I said, yes, that a card had been prepared in my name, but that I did not have it in my hand. So, she arranged for the operation in the shorkari (government) hospital."

Mitha was not entirely committed to having a caesarean for her second birth and wished to try for a home birth, especially without the voucher and the possibility of undergoing surgery in the nearby upazila health complex. However, with one caesarean under her belt, no one wanted to "put their hand on her out of fear," meaning nobody wanted to assume the responsibility for treating her, given the risks that she may face in vaginal birth following a prior caesarean. Her dai grandmother-in-law was among those who did not wish to put their hand on her, as were the health service providers at Kushtia district hospital. She travelled there after the poisonous pain of labour struck her in the night. She could not fully articulate the risks of having a vaginal birth after a caesarean but explained that a body that has undergone a caesarean lacks strength for vaginal birth. For Mitha, this explained the reluctance of the health care providers to treat her, forcing her to spend the entire night in the hospital with the poisonous pain.

It was Sharmina Khatun who finally came to her rescue in the morning. Mitha credited her khala, or maternal aunt, for the arrangement. "I have a khala that stays in town. She stays in Kushtia. Sharmina Khatun knows us through her, so she did that [caesarean] in her free time. 'I will do the operation,' she said. 'It will not be any

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7 Women in Kushtia often refer to their husbands as the bariwallah, head of household.
problem.' So, she did it." Though Mitha did not label Sharmina Khatun as a government (shorkari) doctor, she recognised that she practised in both the district hospital and the private and was grateful to her for arranging the surgery in the government hospital. In the public hospital, she paid only 2,500-3,000 taka (21-25 GBP) for the caesarean, a fraction of the cost in the private facility. As for Sharmina Khatun, she explains, "She did not take any money for it. She did not take any money since she did it in the shorkari [facility]."

After the caesarean, however, charges piled up. The family spent another 3,000-4,000 taka (~25-35 GBP) for the medications required after the surgery. "I took everything that they wrote down," she said. Besides this, the space she rented to recover cost 170 taka (~1.5 GBP) per day. Unlike the comfortable cabin she rented in Daulotpur, she referred to this space as a go-down, a pejorative word referring to a storage unit. Family and friends were prohibited, so she stayed alone, assisted by the ayas. This help came at a cost, however. "Like, you know, even if you want to change a pad (sanitary napkin), they will say, 'Give me 25 taka'. I had no power to do it on my own at that time. I did not even have the power to get up and stand on my own. If I had to stand up holding on to somebody's shoulder, it would cost me 20 taka. If someone touched my body, I had to give money. To remove your soiled clothes and put on clean clothes, you have to give 100 taka." Her account is a stark reminder that commodification of care is not strictly a private-sector phenomenon and that hands-on care in government facilities is likely to come at a cost. She left after five days, with her stitches still intact. She later visited a village doctor near her home to remove the stitches.

She scoffs when we ask if she would like to have more children. "Take another baby with this body?" she laughs. "That hobby is complete! Meanwhile, I already had two shejars with this body," she explains, "Then what kind of risk (she uses the English cognate) should I take? From every direction, there can be problems. If I take another baby, I could be harmed." At 22 years old, Mitha considers her childbearing complete.

Mitha’s account elucidates shifts in ideas around birth aspirations, notably ideas of risk coalescing with the increased availability of technologies with the ostensible capacity of averting risk, which I discuss in more detail below. Her
account also highlights the challenges in pursuing these birth aspirations. While, in theory, government health facilities promise to deliver services to women as social goods or ‘entitlements’ from the perspective of women, this provision is characterized by volatility, delivered as a gift that may be offered one moment and withheld at another. It is unpredictable and riddled with holes. Development actors often use government institutions to test development interventions, such as the DSF project (see Chapter 3). This practice often translates into resources and services available at one moment, such as the vouchers, disappearing or appearing in altogether different forms at another moment, following the tides of development interests and agendas. These shifts map onto broader uncertainties in public health facilities, which promise services, but for which material access is experienced as highly unpredictable.

While discourses around public health systems suggest health resources and services delivered based on the state’s responsibilities to people based on citizenship, Mitha’s story illustrates that accessing these, even through the public health system, is achieved through leveraging social networks. Women often refer to this practice as dhora-dhori, the closest direct translation in English corresponding to ‘mutual grasping or holding’. Dhora-dhori, which appears throughout this thesis, indicates the moral leveraging of social networks to access opportunities or resources as pervasive in Kushtia as in Dhaka. Dhora-dhori enactments lie on the spectrum of patronage, integral to social relations and accessing opportunities and resources in the region (Guhathakurta and van Schendel, 2013, van Schendel, 2021, Gardner, 2012).

Much of the scholarly work on patronage in South Asia focuses on politics, viewing the rampant patronage in the region as an adulterated rendering of democratic ideals and stunting governance and development (Kochanek, 2000, Bardhan and Mookherjee, 2012, Chandra, 2007). In contrast, Anastasia Piliavsky takes a more generous position, arguing that patronage in South Asian politics is part of a moral universe rooted in mutuality and constitutive of social bonds (Piliavsky, 2014a). Dhora-dhori reflects this moral universe composed of social

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8 I employ the term dhora-dhori here rather than patronage/clientelism and as I feel that dhora-dhori is more evocative of the mutuality of such relationships and the shifting power dynamics within them. In contrast, patronage/clientelism evokes more static power relations.
bonds. Dhora-dhori is never spoken of as a bilateral or individual affair but is exercised within social networks. Embeddedness within kinship groups expands one’s access to social networks and potential linkages to desired services and resources.

Mitha’s account exemplifies the centrality of dhora-dhori in achieving maternal health resources and ambitions. Leveraging social relations was critical in enabling her to access development resources, i.e., the ‘card’ or voucher through kin connected to the local member of government (union parishad member), and access services at public health institutions. Mitha achieved her access to doctors not through the public health system as a matter of entitlement but through her social network. For both births, the first at the upazila health complex and the second at the district hospital, which provides the most comprehensive palette of biomedical services available in the district, no doctor was available to perform her needed caesarean. For her first birth, her maternal uncle (mama) contacted a doctor he knew personally and implored him to come to the upazila health complex to perform the procedure on his niece, even though it was the weekend. In the second case, her khala leveraged a personal relationship with Sharmina Khatun to insist that the gyneco-consultant attend to her niece much earlier in the morning than most gyneco-consultants arrive. Social networks, and opportunities which they open for dhora-dhori, were central in navigating the volatile maternal health service terrain and accessing maternal health services and resources as a matter of moral responsibility to ensure the health of the baby at critical moments.

Navigating maternal risks and technologies

This idea of risk articulated by Mitha is not limited to women facing subsequent caesarean births like her. Scholars once noted that women in Bangladesh considered childbirth a natural life transition only requiring biomedical intervention in the case of complications (Afsana and Rashid, 2009). Contrary to this observation, in rural Kushtia today, women articulate pregnancy and birth as sites of latent risk, injury and harm for the baby and themselves. While they occasionally use the Bangla term jhuki to discuss risk, they tend to privilege the use of the English cognate risk, which hints at the influence of the political project to deploy a lens of risk to view reproduction. These transformations in ideas around risk signal not only
shifts in how pregnancy and birth are conceptualised but also shifts in moralities around how pregnancy and birth 'ought' to be navigated.

In the introduction, I discussed the metric trends of maternal mortality in the country, which is generally characterised as a trajectory of rapid decline, suggesting that childbirth is becoming safer for women. Newborn mortality trends mirror these figures. In 1990, an estimated 64 newborns per 1,000 died before the end of the first month of life; according to the most recent estimate in 2018, only 17 per 1,000 do not survive (Hug et al., 2015). However, these achievements, lauded globally and nationally, are less discernible outside the metricised world of quantification and indicators. For women, the risk of potential mortality or physical harm hovers like a spectre over pregnancy and birth. It was rare to spend a day talking to women in their homes or health facilities without meeting a woman who suffered a stillbirth or loss of a newborn child. Women lucky enough to not have suffered such a loss themselves shared stories of close family members suffering maternal and neonatal death. The achievements celebrated as a political success in the national and global spheres are not palpable to women. For them, childbirth is infused with potential risk, injury or harm.

Of course, risk was always a part of pregnancy and birthing experiences, even if women did not imagine it in such terms. Perhaps what is new is the imagined promise of the saving power of advanced biomedical technologies. The proliferation of these technologies allows women to imagine new possibilities for birth, new futurities and pathways for potentially averting risks. The proliferation of the accessibility of caesarean birth, in particular, is imagined as infused with life-saving powers. Women refer to caesarean as its English-cognate shejar or shejar delibheri. While most women say that they plan to try (cesta korbo) for a vaginal birth, which they refer to using the English cognate normal delibheri, or simply as normale, they embrace the idea that if there is any problem, they will seek institutional biomedical care, and particularly its promise of caesarean birth. With the accessibility of these technologies and their promises, taking advantage of them is a moral imperative, particularly when it means ensuring the baby's health.

Women in rural Kushtia tend to articulate normal delibheri as preferable in the practical context of their daily lives, as they are often responsible for heavy labour in
their in-law’s home. They see shejar as disadvantageous as it inhibits their ability to perform this work. In addition, a shejar delibheri often requires that they arrange for someone to care for them during the recovery period if they stay in their in-law's home, as many do not wish to pass this burden to their in-laws. Many women describe pain at the site of the incision years after the surgery and pervasive fear that their stitches will burst. Therefore, women, especially village residents, suggest that they prefer a normal delibheri if Allah allows it, as, for Muslim women, Allah will ultimately determine the mode of birth.

However, they conceive shejar as the safest type of birth, the ultimate biomedical solution, particularly for the baby. While a shejar may lead to inconveniences (oshubhida hoy) for women post facto, they perceive shejar as the pathway to save a baby's life. A willingness to submit to the recommendation of caesarean birth, either based on an ultrasonogram carried out during pregnancy or a health service provider’s recommendation during birth, demonstrates caring for the baby and being a good mother. Indeed, the primary value of seeking institutional health services at birth is the possibility of availing of an entirely different type of birth, surgical birth. Without the provision of this most medicalised birth recourse, institutional birth offers little to be desired compared to a home birth from the standpoint of women.

Moreover, for women, institutionalised birth exacerbates the risk of a side-cut, the English cognate used to indicate episiotomy. Episiotomy, a cut of the perineum to enlarge the birth canal and thereby facilitate vaginal birth, is a practice associated with the medicalisation of childbirth, with questionable benefit, and a practice of which anthropologists have long been critical (Kitzinger and Simkin, 1984, Davis-Floyd, 1990). At the global level, it has fallen out of favour as a routine practice (Clesse et al., 2019, World Health Organization Division of Family Health Maternal Health and Safe Motherhood, 1996) but continues to be practised in many places. While public health service providers in Kushtia profess that episiotomy is practised conservatively, women view it as a looming threat. A side-cut birth is a distinct third category of birth type for women, alongside normal delibheri and shejar. Side-cut is decidedly the least desired form of birth and the most dreaded; if there is a choice between cutting the perineum and cutting the abdomen, women tend to articulate the latter as preferable. While the shejar birth may entail inconveniences, these pale in
comparison to those brought on by side-cut, notably, problems in maintaining sexual relations with husbands.

Rani, a 20-year-old woman pregnant with her first baby, was among the women worried about experiencing a side-cut birth. After visiting a midwife for routine ANC, Tamanna and I spoke to her in the Daulotpur upazila health complex waiting room. She was one of the few women I met in Kushtia who continued her studies after becoming pregnant and was in her second year of remote university study towards a Bachelor’s degree. She visited the upazila health complex regularly for ANC. She told us that the health service providers do good check-ups at the hospital, and all the women in her family come here for check-ups.

She explained that she hoped for normal delibheri because there can sometimes be problems with a caesarean. One of her aunts underwent a caesarean last year but had a stroke. She did not survive the procedure. Besides that, if she underwent shejar, she would need to arrange for a person to come and take care of her. She has no father, she explained, and her mother works a job as a private clinic aya in a different district. “If Allah makes a shejar happen,” Rani says, “she would need to ask for a (nonremunerated) holiday to come.” As her mother relies on this income, this would pose a significant inconvenience.

To maximize her chances of normal delibheri, she planned to give birth at her in-law’s home, where she moved upon her marriage the previous year. Her grandmother-in-law, well known in the area for assisting births as a dai, would attend her. Of course, she said, she will seek services outside if there is a problem. However, while she was happy to come to the upazila health complex for ANC, she would not consider giving birth here. She said that none of her people come to the upazila health complex for birth. She will go directly to a private clinic. “If you have a normal delibheri at the hospital,” she explains, “then for any problem, they will give you a side-cut.” She accepts that a clinic birth rules out normal delibheri, but despite this, she is adamant. Nor do the potential costs dissuade her. “Even though I will need to pay money at the clinic,” she continues, “I will not do it here.”

When describing the problems associated with side-cut, she cites that the procedure requires a woman have stitches “there” (in the perineal region). “Husbands and wives need to conjugate (milon korte hobe),” she explains, “and
many times there could be problems because of this.” One of her aunts came to the
upazila health complex after attempting to give birth at home. The baby weighed too
much, and her aunt could not push him out, Rani explained, so she came to the
complex. The health service providers performed a *side-cut*. Her aunt suffered so
much from this, including problems in her physical relationship with her husband.
According to her aunt, *shejar* is far preferable to a *side-cut*. Therefore, if Rani needs
institutional services for birth, she plans to bypass the upazila health complex and its
threat of *side-cut* and go directly for a *shejar* at a private clinic.

While the trend toward extensive use of surgical birth is a global phenomenon
(Betran et al., 2021, Betrán et al., 2016), Bangladesh is an interesting case given
the rapidity of this increase, alongside high rates of home birth. Anthropologists have
contributed important insights to the global phenomenon of caesarean birth,
localising the practice within particular contexts. Some scholars suggest that
increases in caesarean represent further manifestations of male domination over
women’s bodies and reinforcement of woman/nature and man/science dichotomies.
Claire Wendland, for example, suggests that caesarean reflects cultural valuation of
technology, institutions and patriarchy, which locate women’s bodies as sites of risk.
Women are ‘vanished’ through the procedure, in which their bodies are treated as
the foetal incubator (Wendland, 2007). In Brazil, Alex Edmonds and Emilia Sanabria
demonstrate caesarean as entangled with sexual aesthetics, operating hand-in-hand
with plastic surgery to maintain particular beauty standards, primarily for the benefit

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9 The global rise in caesarean birth has drawn a great deal of attention in the global health sphere over the
past several years (Lancet, 2018). While caesarean section can be an important surgical intervention for
averting maternal and newborn morbidity and death in certain circumstances, it is an invasive procedure
which carries iatrogenic risks (Victora and Barros, 2006, Souza et al., 2010, Sandall et al., 2018). Iatrogenic risks
are exacerbated in countries which already struggle with weak health systems. Bishop et al., for example,
found the risk of mortality for women undergoing caesarean in Africa to be 50 times higher that of women
undergoing the procedure in a high-income country (Bishop et al., 2019). Multi-country epidemiological
studies suggest that at the country level, caesarean rates above 10% are not associated with improved health
outcomes (Ye et al., 2014). While longstanding WHO guidelines recommended an approximate maximum of
10-15% of births be managed through caesarean section, the organization more recently stepped back from
this recommendation, assuming that it encouraged countries to implement intervention to achieve a certain
rate of surgical birth. Their more recent position emphasizes providing caesarean section to women who need
the intervention based on clinical indications (Betran et al., 2016) and they have even issued recommendations
on non-clinical interventions for reducing ‘unnecessary caesarean sections’ (World Health Organization, 2018a,
Betran et al., 2018).
However, focusing on caesarean primarily as a manifestation of male domination over women’s bodies may obscure women’s desires and strategies to achieve their own ends. Dominique Béhague demonstrates in Brazil how caesarean allows women to access the type of birth that they desire and to mark class status (Béhague, 2002), while Henrike Donner shows how middle-class women in India use caesarean as a means to secure a less shameful or painful birth (Donner, 2016). She also argues that caesarean birth allows women more extended periods of rest in a context in which they are expected to assume a great deal of household labour and a mechanism for managing birth pollution (Donner, 2016).

Among women in rural Kushtia, the fetishisation of caesarean is primarily rooted in the sense of risk and potential harm infusing birth and the idea of caesarean as a life-saving panacea. Caesarean is a way of securing what women and families view as the safest birth for the baby, thereby fulfilling moral imperatives to care for the baby. Among Tamil women in south India, Cecilia van Hollen (2003) also found desires for biomedical services interwoven with ideas of risk; however, caesarean figured less centrally among women in her ethnographic work. Nearly without exception, my interlocutors justified their caesareans in clinically indicated terms, which signal acceptable reasons for surgical birth. Ultrasonogram, which they call *sono*, is coupled with *shejar* in their narratives. While twenty years ago, few women underwent ultrasonograms during pregnancy, today, even the poorest women have at least one ultrasonogram during pregnancy, today, even the poorest women have at least one ultrasonogram (National Institute of Population Research and Training (NIPORT) et al., 2019, National Institute of Population Research and Training (NIPORT) et al., 2003). While the DHS does not report the number of ultrasonogram scans women undergo, many women in Kushtia mention seeking out several such scans during pregnancy.10

Knowing the baby’s status by seeing it in ultrasonogram is crucial to the possibilities women imagine for birth. Women in Kushtia imagine ultrasonogram technology as an oracle, trusting the sono to foretell whether the baby is okay and

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10 It is worth noting here that from a clinical perspective, ultrasonogram remains a contested procedure in terms of its benefits toward health outcomes. It was only in the issuance of its most recent ANC guidelines in 2006 that WHO made a recommendation in favour of widespread use of ultrasonogram during pregnancy, and they only in favour of one scan prior to 24 weeks gestation, and perhaps one after 24 weeks if no earlier scan was completed, and only if performed by a competent provider. In everyday practice in Kushtia, ultrasonogram is only loosely connected to other forms of routine ANC service provision.
whether the birth will be normale or through shejar. There is certainly interest to visualise the baby, but without exception, women discursively couple foetal ultrasonogram with the mode of birth and the predictive power of the former to determine the latter. In elucidating the social meanings foetal ultrasonogram takes on in various settings, anthropologists have identified the technology as central to selective purposes. In some cases, ultrasound mediates women’s decisions to discontinue a pregnancy if it identifies foetal abnormalities, both in global North settings (Getz and Kirkengen, 2003) and in the global South (Gammeltoft, 2014). In other settings, this technology is used to determine whether to continue a pregnancy based on the baby’s sex (Chen et al., 2013, Kasstan and Unnithan, 2020), notably in neighbouring India (Madan and Breuning, 2014, George, 2002, Unnithan-Kumar, 2010, Patel, 2007). However, these potential selective purposes tend not to arise in women’s articulations of ultrasonogram purposes in Kushtia. While women express some curiosity about knowing the gender of the baby, this did not arise as a reason women articulate for foetal ultrasonogram in Kushtia, nor did the possibility to discontinue a pregnancy based on identified foetal abnormalities. While it is possible that women may be reticent to articulate this potentiality due to stigma against pregnancy termination, that women tend to privilege later term ultrasonogram, when termination would be most medically and socially complicated, also suggests that selection is not central to ultrasonogram seeking here.

Women’s accounts of the predictive power of ultrasonogram to determine the mode of birth suggest that indications for interpreting the need for caesarean tend to be made liberally. For example, a malpositioned foetus, such as in breech position, at as early as six or seven months may indicate a caesarean, although many foetuses assume a cephalic position after this time. Low amniotic fluid, such as Mitha recounted as her baby becoming like a fish in the river when the water dries up, while relatively uncommon in clinical reporting, is exceptionally common in

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11 From a clinical standpoint, ultrasonogram is not necessarily recommended for establishing foetal position as this can be done either by feeling the belly or locating the foetal heartbeat position.
12 Clinical studies suggest that while at 28-29 weeks, 21% of foetuses are in a noncephalic (non-head down) position, this proportion reduces to 5% at 37-38 weeks (Fox and Chapman, 2006).
13 Oligohydramnios, the clinical term for low amniotic fluid, defined as less than 5 cm on the amniotic fluid index, is estimated to occur in 1-5% of all pregnancies (Moore, 1997). However, while clinical guidelines suggest increased monitoring of foetal status for women experiencing oligohydramnios, low amniotic fluid in itself is not considered a clinically justified reason for caesarean (Ahmad and Munim, 2009).
women’s articulations of the need for caesarean and the need for \textit{sono} to assess the water status. Women and their families are generally preoccupied with the idea of the water drying out (\textit{pani shukiye geche}) and trust the \textit{sono} to tell them the status of the water conclusively and justify a caesarean if low. The preoccupation with water in the uterus may be seen as mapping on to broader preoccupations in a geographic context in which lives, livelihoods, and navigation have historically, and continue today, to be shaped by water (van Schendel, 2021: p.3-10).

Another predictive power of ultrasonogram lies in its estimation of the due date. Women often cite being \textit{postdated}, the English cognate to refer to passing the estimated due date with no signs of labour, as a justification for a surgical birth. While the biological foundation of due dates is contested,\textsuperscript{14} estimated due dates are critical to shaping women’s and families’ birth aspirations. While many women know the date of their last menstrual period (LMP), which they supply to the health service provider during ANC to calculate an estimated due date, some do not. Few women seek ultrasonogram in the first trimester of pregnancy when pregnancy age estimations are clinically deemed most accurate (they tend to privilege later-term ultrasonogram, which they articulate as able to tell them how the baby will be born). Nevertheless, people tend to accept the ultrasonogram-estimated due date as a deadline. Some women who seek multiple ultrasonograms end up with widely variable estimated due dates. Still, these dates serve as a deadline for when the baby must be born. Reaching this date without signs of labour justifies a surgical birth for most women and health service providers.

While all of the upazila health complexes are equipped with ultrasonogram technology, none provides the service regularly, and women rely almost exclusively on the market to obtain ultrasound scans. Ultrasonograms are among the most widely accessible technologies in the private health market, and almost all diagnostic centres advertise at least one machine in regular use. These typically range between 400-600 taka (3.60-5.40 GBP). Even the owners of the newest diagnostic start-ups discuss their ambitions to purchase an ultrasonogram machine as their first technology when their basic lab tests have generated enough income. Such a

\textsuperscript{14} Clinical research suggests that even if measured exactly, gestational length between pregnancies varies widely, even up to 5 weeks (Jukic et al., 2013). Others have determined that only 5\% of babies are born on the estimated due date (Kambalia et al., 2013).
purchase legitimizes the business and maintains a steady income stream, which sustains diagnostic centre employees' livelihoods. The widespread commodification of ultrasonogram in Kushtia and women’s extensive use of the technology coheres with Tine Gammeltoft’s scholarship in Vietnam. She couples commodification with mass use (or overuse) of ultrasound technology, as women’s maternal anxieties and desires (Gammeltoft, 2007) intertwine with market-based motivations toward revenue generation (Gammeltoft and Nguyên, 2007, Gammeltoft, 2014).

The quality of the machines differs markedly, as do the credentials of those wielding them. On the most highly trained side of the spectrum, trained physicians complete training for one year for a diploma in medical ultrasound (DMU) or, more commonly, complete three months for a certificate in medical ultrasound (CMU). However, in practice, many different types of providers carry out ultrasonogram in private facilities, trained through short courses or informal, practical training. Women rarely question the predictions printed in the ultrasonogram report, despite high variability in the quality of ultrasonogram machines available in the different clinics and the skills of those who operate them.

While women almost without exception frame their reasons for caesarean in clinical terms, often justified by an ultrasonogram, some women may be reticent to express a desire for a caesarean for non-medical reasons, e.g., its potential as an escape from pain or for convenience as these would not signal morally justifiable reasons. Caesarean as a remedy for pain may seem at first glance counterintuitive. Indeed, while caesarean may offer an immediate solution to labour pain, it does so by expanding pain in terms of short-term recovery after birth and the long term. However, it must be understood within the social and health context. Few options exist in Kushtia for birth pain relief, nor is pain during normal delibheri articulated as a sensation one should reduce. Instead, pain is the mechanism by which the baby is born. To reduce it during a normal delibheri would only be to thwart the birth itself. The word pain (byaetha) is used as a metaphor for uterine contractions and is the only word women use to describe contractions. This is similar to what Cecilia Van Hollen discovered in her work among Tamil women in South India (Van Hollen, 2003). As among the Tamil, among women in Kushtia, the idea of reducing pain during childbirth is antithetical to the idea of normal delibheri itself. If anything, pain should be increased during labour, as it often is through the administration of
uterotonics, such as oxytocin/pitocin, delivered routinely in health facilities and homes by village doctors or dais. The administration of uterotonics in homebirths has been identified as commonplace in different regions of the world, including in South Asia (Jeffery et al., 1989 p:111-112, Van Hollen, 2003) and beyond (Jordan, 1993, Sargent and Grace, 1997). In Kushtia, these are a routine part of normal delibheri, whether in a shorkari hospital or at home, where these tend to be administered by village doctors, many of whom operate small pharmacy shops in tandem.

Fahmida, whom we will meet again in Chapter 2, was one of the few women I spoke with who unabashedly pronounced that she sees shejar birth as preferable to normale. When I spoke with her and her sisters-in-law, whom all live in their in-laws’ home and experienced both caesarean and vaginal births, she recounted gruelling experiences giving birth vaginally. While a foetal ultrasonogram justified a caesarean for her first birth, her mother-in-law forbade it. Her baby did not survive the birth, which she still holds against her mother-in-law. “[Normal delibheri] is really painful,” she told me, “but if I say [to my in-law family] that I want to do the shejar because of the pain, do you think they are going to do shejar? No, they are going to try for normal first. Never, ever will they take me. They will have me try for normal first. At the time of my son, I had so much suffering; why did they need to do it normal? My son did not survive like that.” While wealthier women may more easily insist on having a non-clinically indicated caesarean to avoid labour pain, such a request would be unthinkable for rural women, particularly for poor women living in their in-laws’ homes. Moreover, while Fahmida articulates the impossibility of requesting a surgical birth for the purpose of avoiding pain, she quickly returns to the imagined potential of shejar to avert risk, which she did not benefit from during her first birth, and the ultimate loss of her son.

Fahmida’s account is also a reminder that the navigation of maternal health is a family affair, and a caesarean must be sufficiently justified within the family. In her account, avoiding pain would never be a ‘good’ reason for justifying the procedure within her in-law family, even if that were her desire. However, she also highlights the potential of a caesarean as a life-saving procedure, suggesting that it was through normal delibheri that her son did not survive. If she had attempted surgical birth, perhaps he would have. This is a moral failure that she continues to attribute to her mother-in-law.
Moreover, she would have been able to avoid her own suffering. Her account brings us back to ideas of risk and the new imagined possibilities to avert them through biomedical technologies. Rather than women unwilling or unable to go through the process of *normal delibheri*, women in Kushtia respond to new possibilities of advanced maternal health technologies made available through health markets to maternal health technologies, believed to open up futurities to respond to risks and save lives. Within these shifting possibilities emerge new moralities around the types of technologies one ‘ought to’ access to demonstrate good care.

**Shanti and the navigation of commodified birth care**

Shanti greets Shema and me with a cheerful smile and leads us through the modest courtyard. We pass only her mother-in-law, who looks up from a broom to greet us, and her two children, four-year-old Moni and two-year-old Assiya, as we follow her into her small dark bedroom. A mosquito net hangs over the bed with one side pulled up, and we sit under it. Shanti sits next to us and smiles, basking in the attention.

Shanti’s name means peaceful in Bangla, but her early life was anything but. “My father died when I was a little girl,” she tells us. This tragedy left the family in dire financial circumstances. Because of this, she could never study, making her one of the few women I met who never attended any schooling. Though she spent her early years in Jessore, her chachas, or paternal uncles, arranged her marriage in Kushtia when she was only 12. “We are gorib manush,”—poor people—she shrugs. Despite the apparent tragedy of her story, Shanti bubbles as she recounts it. Shanti did not become pregnant until eight years after her marriage, though not for lack of trying. “No baby was happening,” she says, recalling her struggles with fertility. She consulted a kobiraj, a practitioner of herbal medicine. He gave her some medicine, and after taking it, she became pregnant, to which she credits Allah. Still, she suffered through the pregnancy, and there were many days she did not have enough to eat.

Her labour pain started after she reached full term. She intended to give birth normale at home because her husband is also a gorib manush, engaged in manual labour in another part of the country to support the family. After some time, her water broke. “There was so much water that broke,” she tells us. Despite intense pain and
broken water, the labour did not seem to progress, so her uncle-in-law brought a woman to the house to assist her. Shanti remembers the woman as someone who sees pregnant women and helps women give birth at home; she thinks maybe she also worked in a shorkari health facility, but she is unsure. She has since passed away. “After she came,” Shanti recounts, “She put her hand and me and examined me. That is, she checked the position [of the baby]. When she saw that it was in a bad position, then she took me [to the private clinic].” The woman rented an auto rickshaw and took Shanti to a small private clinic named Mordhane because she had connections there.

They reached Mordhane in the nearby town of Kumarkhali at around 11 pm on February 20, the eve of National Mother Language Day. The health service providers there examined her. “The doctor said that the baby was having some problems; like, the baby is going up [in my belly],” Shanti tells us. “Because of this, I needed to have the shejar. There was extra water going out. If I did not do a shejar, the baby would have problems. I really wanted this baby because I had been trying for eight years.” Shanti and her family did not resist the advice and accepted that the doctor’s instruction represented what was best for the baby. However, because of the National Language Day, the clinic could not arrange to have the surgeon come immediately. Assiya toddles about the small room as Shanti recalls the story. She grabs Shanti’s smartphone from the bed, which her mother promptly reclaims from her hands and tosses up to the top of the mosquito net, safely out of the little girl’s reach.

The doctor arrived mid-morning on the following day to operate. “I was terrified,” Shanti tells us of the moments leading up to the operation. “I was crying. My brothers-in-law were crying—because the baby was coming after we had tried for so long. My father-in-law and mother-in-law were crying.” The private clinic staff told the family that they needed to arrange blood for Shanti before the procedure in case she needed a transfusion, as few biomedical facilities stock blood. Her elder brother-in-law provided the blood, an act of profound care (discussed further in Chapters 2 and 6). Afterwards, the health team took her inside the operating theatre. “After they

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15 National Mother Language Day is recognized as one of the most important national holidays commemorating the 1952 Bangladeshi (then East Pakistan) struggle to maintain Bangla as a national language against West Pakistan. The day has since been adopted as International Language Day by UNESCO to be recognized globally.
took me inside, they laid me on the bed. I was so scared because that is how you lie a person out when dead; like *Israelir*\(^\text{16}\), the doctors come. It is like death is coming to see you. It is as if you are receiving punishment for your sins."

The doctor sensed Shanti’s terror. “*Ma*,” he addressed her affectionately, using the Bangla word for mother, “Why are you getting scared?” “Sir, I am very scared,” Shanti responded. The doctor urged her to invite a family member to stand by her side during the procedure. Shanti declined the offer, not wanting to subject her family to witness the procedure and inflict fear upon them. However, one of the clinic workers previously offered to stay with her, and the health team brought her in. The woman stood beside her head and comforted her, telling her not to be scared.

The medical team then administered the injection with the anaesthesia in her spinal cord. “When they give the anaesthesia, then it seems like you are never going to come back to the world again,” Shanti tells us. She lost most of the sensation in her lower body, but she could still feel the blade cut through her skin; like an itch, she felt as though they were drawing a long line on her intestines. She told the team that she felt pain. She could not see their work, her belly shielded by a white sheet. “I told them, ‘Most probably you are cutting my stomach. I feel pain.” The team soothed her and investigated whether the anaesthesia was working. The team spoke to her ‘beautifully’ through her anxiety, saying, “*Ma*, you are going to have your baby.”

And then, she did. The doctor lifted the baby from her incision. The clinical team wiped the *moila*, pollution, off the baby and then bathed him in the water before bringing him in front of his mother. “Seeing the baby, I felt a cool breeze wash over my inner soul. Allah made this happen. It was stunning,” she recalls. The baby was *phutphute*, adorable, she said, speaking of the now busy four-year-old entertained in the courtyard. He was *shada*, white, and his head was round to perfection—the perfect baby. He was also enormous, she chuckles. At a hefty four kilograms, he was the largest baby ever born at Mordhane. Now he is small, though, she says. After she witnessed her new miracle, the medical team took her out of the operating theatre. She saw her brother-in-law and then lost consciousness.

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\(^{16}\) Among Muslim Bangladeshis, *Israelir* is the angel sent by Allah to grab the soul and take the life away.
She regained consciousness hours later, near 11 pm. When she awoke, the miracle gave way to the traumatic memory of the birth. “I told my mother-in-law to throw Monir [the baby] away. It was because of Monir that I suffered so much. Because of him, I endured so much pain; throw him away. After saying these words, my mother-in-law cried. ‘Because of what, you had so much difficulty?’ she scolded. ‘We are spending so much money on this baby, and this is what you are saying?’”

The money was more than a minor consideration for the family. “I tell you the truth, apa,” Shanti confided. “For gorib manush, when they have a shejar, it is so difficult how much money is required. For farming people and things, it is so difficult.” Mordhane asked the family to pay 19,000 taka (~165 GBP) for the caesarean, an astronomical price tag for her family. She had one bhai17 who had connections with the clinic. He went to his hands and knees on the family’s behalf. Finally, the clinic agreed to accept 12,000 taka (~100 GBP), which covered the cost of the procedure and Shanti’s care in the following seven days. She remembers the health staff visiting her on rotation three or four times daily. The ‘big doctor’ came and talked to her. He measured her blood pressure. The clinic staff removed her ‘beautiful’ stitches on the seventh day, and she returned home.

Shanti fell pregnant unexpectedly only nine months after Monir’s birth, both blessing and a curse. Allah gave her this baby immediately, which saved her from more years of fertility struggles, but her body was not yet fully recovered from her first surgical birth. She tells us that if she became pregnant after five or six years, she could have tried for a normal delivery, but in this case, a subsequent caesarean birth would be inevitable.

Shanti’s labour pain hit with force late one evening, and amniotic fluid trickled from her body. Her elder brother-in-law wasted no time taking her to her clinic; perhaps the trauma of the previous birth, less than two years previous, still burned in his memory. Rather than returning to Mordhane, Shanti’s brothers-in-law took her to the well-known Alo Clinic in Kushtia, a presumed upgrade from the smaller Mordhane clinic set in the subdistrict. However, the clinic staff refused to admit her when they reached, presumably because it was night, a superficial excuse. “Why

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17 Brother, but refers to a family member of close friend.
“Won’t you admit her?” her elder brother-in-law demanded. “She will need blood because it is her second operation.” His pleas failed to sway the staff, however.

“What is your reason for not admitting her?” her younger brother-in-law lashed out. “Just because we are poor? We are not *takawalla* (people with money); there are no influential people among us. That is why you will not admit her.” This accusation appealed to the staff’s moral obligation to help them based on their status of *gorib manush*. After saying that, another person from the private facility entered the dispute. “What is happening here?” he demanded. Her elder brother-in-law explained. “Sir, look, my *bhabi’s* (brother’s wife) pain has come. Since she had a *shejar* before, we cannot keep her at home. It is for this reason that we brought her. Why will you not take her?” The staff finally relented and admitted her.

They immediately took her to the second floor. The trickle of amniotic fluid had escalated to a deluge by then, and she could not walk. “After they took me there,” Shanti recalls, “they checked my pulse. They did not do anything [else]. They just said that I needed to do a *shejar*. From the very first moment, it was *shejar*, just *shejar*.” Since it was night, they would need to call for the surgeon to come, but they would only do this at an additional cost—5,000 to 7,000 taka (~42-60 GBP). “Before everything started, the question was about money. Before they start, you must pay money,” Shanti said. They required a down-payment of at least 5,000 taka before they would call the doctor. The family did not have any money in hand. Back in the village, her *chacha* (uncle) pooled some money from the family and brought it to the clinic so they would call the surgeon.

While Shanti awaited the surgeon and the staff prepared the operating theatre, she lay on a bed beside another woman fresh out of her caesarean. “There was another lady beside me on the bed,” Shanti explains, “and I could see the health workers dress her [wound]. I could see that she was also poor. I could see what happened to her, and I could see that they would cut me like that. After seeing this, I said to myself, ‘Oh my God, they will cut me like that.’ Before they even cut my abdomen, I could see they would cut my belly like that. I cried and did not want to go through with the *shejar* anymore. I was crying and saying, ‘I do not want to do a *shejar* here; I want to go to Kumarkhali.’”
By now, such a proposition was out of the question. The clinic staff transported Shanti, petrified, to the operating theatre. In the operating theatre, one of the *apas* from the clinic told her, “You know, usually we do two or three *shejars* at a time when we do it. In the daytime, that is how we do it. We do the operation for two to three people together.” Since Shanti’s procedure was the sole one to be done at this time, and because they called the doctor to come specifically for her, it would cost more money. 5,000 taka to bring the doctor and 5,000 taka for being alone. A 10,000 taka (~85 GBP) surcharge for the misfortune of going into labour at the wrong time.

The next moments were some of the most excruciating that Shanti, no stranger to tragedy, faced in her life. The doctor came after the evening prayer and immediately operated. “When they did the operation on me,” Shanti tells us, “I had suffered so much…. The pain that I went through, I have never been through so much pain in my life. No one can understand the way this hurt.” She remembers watching the doctor stitch her belly back together. She recalls they were sloppy stitches; they did the stitches “so-so”. These stitches haunt her to this day.

Her agony extended into the days that followed. In contrast to her stay in Modane, she felt neglected in her care. She watched as hospital staff made rounds and attended to the other women. “For the *bhodrolok* (wealthy people)\(^{18}\), they dressed [the wound] beautifully. Sometimes they would do it two or three times.” The doctor never passed by to see her as she had in Mordhane. “It was just some woman who came to see me,” she recounts. “When the woman came, my mother would loosen the cloth from the site of the cut. I mean, the woman said to loosen the cloth. She would look a bit but not put her hands on me. She would only look.”

These visible manifestations of difference in treatment worked their way under the skin of Shanti’s family. “My *phuphu shashuri* (sister of her mother-in-law) had to call them to come to do the dressing. ‘Why won’t you come and do the dressing? Why won’t you come and give the pad?’ She would say many things like this. We were not giving taka. We had already given 10,000 taka (~85 GBP); why would they...

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\(^{18}\) While *bhodrolok* is perhaps more closely translated to ‘cultured people’, women in Kushtia tend to use the term to indicate people who are wealthy.
be asking for more?” Shanti remembers crying, “Why was I brought here? Why was I brought here?”

Shanti’s family finally arranged a stop-gap solution by leveraging the family’s social network. Her chachi shashuri (sister of her father-in-law) brought an acquaintance (porichito19) who had connections with Alo Clinic. “If there are any problems, tell this person,” her chachi shashuri instructed. This acquaintance advocated for Shanti. When the clinic staff made rounds, she would accuse them and say, “You are doing this because she is a poor patient,” appealing to their moral sensibilities to help the poor and demand that they provide better treatment. This intervention made the rest of the stay a bit more tolerable.

The payment still dangled in the balance, however. The family did not know how they would manage the remaining sum to pay the clinic bill, a further 10,000 to 12,000 taka (~85-100 GBP) in addition to the 10,000 already dispensed. Shanti worried that the clinic would not allow her to take her baby if she proved unable to show the money. She and her phuphu shashuri hatched a plan. “Then do you know what my phuphu shashuri said?” Shanti says with a mischievous smile, “She said, I am going to steal your baby away, and you will stay back here.’ I said, ‘I will stay back. You take my baby, and afterwards, I will go.’” Luckily, no one had to abscond from the clinic. The family took out a loan to cover the charges, although such a loan can be financially crippling to such a family. Shanti strokes Assiya’s dark curly hair as she recalls the story.

Shanti left, with baby Assiya, on day five, stitches still intact. The staff pushed on the wound to check for infection before she left. “They said that since I am fat, they were pressing to see if any pus came out. They saw that there was no [pus].” She returned home, but her wound filled with pus soon after, a clear indication of infection. Two days later, she returned to the clinic. The staff removed the stitches “forcefully.” When they saw the pus, the staff told her it was infected because that is what happens to fat people. It will get better, they said; it will be okay.

The clinic staff’s reassurance proved both true and untrue. Fortunately, the infection cleared up, as Shanti did not have money to purchase antibiotics. However,

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19 See Chapter 6 for further reflection on the significance of porichito.
even now, three years later, pain is her daily companion. She attributes this pain not only to the sloppy stitches but also to the injection for the anaesthesia. Sometimes it comes as an ache. Sometimes it is an excruciating burn. Sometimes it hits her like a “spark.” On these days, she is consigned to the bed for the entire day. Heavy work is out of the question. This work falls to her mother-in-law.

“Sitting over there,”— Shanti points to a chair in the corner— “I used to sit and cry all the time. Why was I taken to that place? For what reason did they take me there? Who provided the wisdom (buddhi) to take me there? I quarrelled with Monir’s abbu (her husband) over that place. ‘In that place, we had to spend so much more taka. Why didn’t you take me to Kumarkhali instead of Kushtia? Why did you take me to this place? If you had taken me to a nature (a derogatory term insinuating a poorly trained traditional healer) for the operation, the operation would have been better.’ I just sat and cried after. He said that he had not brought me there. ‘It was your elder brother-in-law and younger brother-in-law who took you there. Now, you call to Allah so that things go well.’”

The commodification of maternal health technologies has made even the most medicalized forms of birth widely accessibly, placing caesarean within reach of women imagined as the most disadvantaged, such as Shanti. With this availability, to secure advanced maternal health technologies is more than a desire; it is a moral imperative to demonstrate good care of the baby by the mother and good care of the mother by the family that supports her to use these technologies.

Shanti’s story is emblematic in the spectrums of experiences with care delivered in the private sector for maternal health services. Women share stories along these spectrums. Spectrums in the quality of delivery of care from their perspective: sometimes women share that the care that they received was good; occasionally, such as in Shanti’s case, they share that it was deplorable; spectrums in the dignity of care: sometimes clinic staff treat them well, other times poorly; spectrums in cost: some caesareans cost as little as 4,500 taka, others are in the order of 50,000-100,000 taka. Irrespective of the concrete cost, many women, even those with access to fewer financial recourses, report that financing a caesarean was

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20 It is common for women in Kushtia to refer to their husband as [insert the name of their eldest child]’s abbu, the Bangla word for father.
of little concern, while for a minority, this was financially debilitating. Spectrums of trust: some women were confident that the medical team was making the best decisions for them; others were less sure. Shanti is unique in living such polar experiences, albeit in the same sector and within a short timeframe.

Promises of advanced obstetric biomedical technologies are perhaps oversold in these peripheries, where cutting costs to make it affordable to a category of people who consider themselves gorib manush entails cutting corners, compounding iatrogenic risks (discussed further in Chapter 4). For example, it is common to circumvent the anaesthesiologist costs by relying on the surgeon or minimally trained non-clinical staff to inject regional anaesthesia. The low value placed on pain management means that few people contest such practices. The main cost for the clinics to provide caesareans is the surgeons' fees. Surgeons rotate between clinics, and it is not uncommon for them to leave even before they complete the sutures, leaving the final work to non-clinical staff. However, none of the upazila health complexes offers this service regularly. Therefore, the Kushtia district hospital remains the only real public option for availing the services, though it is only during limited hours. As Mitha’s story elucidates, the costs of travel to the administrative centre and obtaining the care needed during the recovery may quickly surpass the costs of undergoing the procedure in a rural clinic. Although if public and global health discourse imagines a public health sector as providing an alternative to commodified care, Mitha’s account suggests otherwise. While caesarean may be less expensive here than in the nearby private hospitals in Kushtia, once all unofficial charges for fares add up, the price is similar to undergoing the procedure in a small private clinic.

Shanti’s story, again, demonstrates the centrality of social connectedness in the form of dhora-dhori in accessing desired maternal health services during pregnancy and for birth, common for women in Kushtia. Dhora-dhori is essential to accessing better resources and opportunities, even those delivered through the market. In each instance, it is vital to have a known person connect you to the resource to optimise both clinical and interpersonal treatment. Although Shanti

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21 In Africa, Bishop et al. (2019) found anaesthesia complications, along with peripartum haemorrhage, to be the major driver of the 50-fold higher mortality risk following caesarean compared to that in high-income countries.
bypassed government and development entities in her birthing experiences, her story is a stark illustration of the variability of services one might enjoy based on the social connections one has to it. In the first instance, the birth attendant assisting her at home brought her to a clinic that she had a personal attachment to, and thereby this personal attachment extended to compassionate care delivered to Shanti and a reduced price of the services. In the second instance, her brother-in-law took her to a clinic with no personal attachment and no links to more powerful and wealthy people (takawallah) and made claims to care based on their status as gorib manush, poor people. Here, she recalled a much less compassionate experience, and it was only by bringing in an acquaintance (porichito) with a personal attachment to the clinic that the staff improved their service delivery toward Shanti.

Conclusion

This chapter examined the volatile maternal health terrain in Kushtia and women’s social navigation of it. Perhaps unsurprisingly, Mitha and Shanti’s stories, like the other women from the survey I met, revealed the categories of ‘avoidance of labour pain’ and ‘convenience of time’ as grossly inadequate to capture the complexity of ideas, conditions and moralities that ultimately culminated in their surgical births. Despite my confidence in icddr,b’s rigour in quantitative research, there are simply limits on that which quantitative methods can reveal, despite the predominating global health dogma, which holds that all phenomena can (and should) be metricised (Adams, 2013, Adams, 2016a). However, more than this, these accounts were revelatory for understanding how women and families negotiate ideas, moralities, possibilities and actions around pregnancy and childbirth in a volatile Bangladeshi maternal health service terrain. Their stories are illustrative of the stories many women shared in their homes and health facilities, women doing their best to navigate the unstable maternal health care terrain in Kushtia to pursue their pregnant and childbearing ambitions and provide good care to their babies.

I never interrogated Mitha and Shanti directly regarding their 2016 responses to the icddr,b questionnaire that categorised them as giving birth through caesarean either to avoid labour pain or for convenience of time. I simply asked them to share their birth stories in a way that made sense to them. Memory is a tricky thing, as is moulding lived and profound experiences into metrically graspable form. However, their accounts, and those of the other women I interviewed from the survey, never
reflected the national mirage circulating of them as arbitrarily selecting surgical birth at a private facility from a palette of easily categorizable choices simply to bypass pain or for trivial convenience. Their accounts only tangentially aligned with these reasons. Perhaps women suffering in labour for three days at home without success before going to a private clinic was interpreted as ‘avoiding pain’? Perhaps going into labour at night and seeking the only institutional care available at that hour through the private sector was somehow categorized as ‘convenience’? In the end, trying to locate positivist disconnects between their accounts and the layers of researchers making reductionist, quantitative sense of profound, corporeal experiences impossible to adequately fit into boxes seemed the least relevant part of my encounters with them.

Mitha’s and Shanti’s stories illustrate the rapidly shifting social environment of childbirth in Bangladesh, in which the use of advanced biomedical technologies figures into women’s birthing possibilities and aspirations to navigate a life transition imbued with potential risk. Moreover, these new possibilities reshape moralities of reproductions, transforming what it means to enact pregnancy and childbirth in ‘good’ ways. Biomedical technologies are now integral to what it means to be a good or caring mother or family that does all it can for the baby’s welfare. In this sense, the political project toward biomedical birth has been overwhelmingly successful in shaping women’s birthing ambitions and moralities in favour use of advanced biomedical technologies through institutions.

Critically, this chapter has demonstrated the centrality of social connectedness and dhora-dhori in women’s navigation of the maternal health service terrain, which will remain central throughout this thesis. While Vigh highlights social navigation as an individual affair, in which actors exercise agency under challenging conditions to advance opportunities in the immediate and the imagined future (Vigh 2006:128), navigation of the maternal health terrain in Kushtia is embedded within the kin group. Relying on extended social networks expands opportunities to employ tactics to secure desired recourses and services, particularly for those with limited access to financial resources. Vigh, drawing from Bourdieu, de Certeau and Deleuze and Guattari, differentiates between strategies and tactics in social navigation. He writes, “Strategy is action directed at defining, actualising or consolidating rules; tactics are actions directed at making the best use of them, using and bending them”
Women and their families have little influence in ordering the maternal health service terrain or rules dictating access to services and resources. However, embeddedness in kinship and social networks opens up a wide net of potential tactics through social connectedness and *dhora-dhori* to access biomedical services and resources and informally influence their quality and reduce costs.

In national and global health discourses related to women and gender, which privilege ideas of empowerment rooted in Western liberal constructs and seek to promote women as (mostly) autonomous agents planning birthing futurities through initiatives such as birth preparedness and complication readiness (Miltenburg et al., 2015), women’s navigations as embedded within their families may appear as un-agentive and disempowerment. However, within such a social environment, where social networks are the best way of accessing desired resources and services, relying on established social relationships offers the most expansive possibilities to materialize the technologies and services women and families envision maximizing health and wellbeing.

Moreover, discourses that privilege concepts of ‘planning’ and ‘choice’ suggest a stable social terrain with reliably available services and resources. In lived experiences, the Kushtia maternal health terrain is volatile, with accessible services and resources at a particular moment through the state, development and commodification in perpetual vacillation. This terrain does not allow for easy or reliable access to advanced services and technologies women and their families seek. Women experience this terrain as a perpetual appearance and disappearance of resources and services. Therefore, women act as embedded agents within their families and social networks to appeal to various social contracts to tactically access desired services in the immediate. This navigation requires flexibility and a perpetual reassessment of the fluctuating terrain and social tactics, including through *dhora-dhori*, to negotiate it.
Birth as statist encounter

Air bubbles rise steadily from the translucent tube towards the liquid surface in the plastic bag, which hangs from the metal rack, then pop to join the air above the surface line. The tube leads the liquid, uterotonics-laced saline\(^1\) to the cannula inserted in Rima's wrist and then into her bloodstream, intended at once to hydrate her and intensify her uterine contractions. She lies in a foetal position; her knees pulled to her chest on the medical bed next to the window of the capacious labour and delivery room at Kushtia district hospital. Her mother stands at her side and simultaneously rubs her daughter's back and chats with us, surprisingly energetic despite a previous sleepless night. Rima's labour pain started three days earlier, her mother tells us, although her water broke only yesterday evening. Her natal family, to

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\(^{1}\)Routine use of uterotonics, compounds to intensify uterine contractions, is not clinically recommended for routine use during labour and delivery, according to WHO guidelines (World Health Organization, 2018b), it is used routinely both in health facilities and in home births in Kushtia to intensify labour. In the Kushtia labour and delivery room, health service providers use the uterotonic Piton, a brand of pitocin, the artificial form of the hormone oxytocin which triggers uterine contractions. Uterotonics such as these are also used after birth to manage postpartum haemorrhage.
whom she returned to wait out the final months of her pregnancy, sent for a dai to support Rima’s birth at home. Unsatisfied with the progress of her labour and fearful since Rima’s previous and first pregnancy ended with the loss of the baby at six months gestation, the dai refused to put a hand on her (hat debe na) any longer and instructed her family to take her to the district hospital.

Rima’s family brought her from their village home first thing in the morning, still haunted by the loss of the first baby, with all their hopes of the saving power of biomedicine and the promises of the state wrapped up in this institution. In so doing, they crossed a vital threshold from birth as an intimate, familial affair to a very much public one within the purview of the ‘state’ (shorkari). This chapter asks, how is care enacted in public health settings? How do the specific enactments of public maternal health care constitute state imaginaries and one’s relationship to it? Public maternity spaces operate as among those Michel-Rolph Trouillot describes in which state “processes and practices [become] recognisable through their effects” (2001).

Encounters of care in these sites unfold as spectacles of state performance (Hansen, 2001) in which the state is enacted and during which women and families learn what it means to be the state and who they are in relation to it (Sharma and Gupta, 2009: 11). The care Rima encounters in this space, described later on in this chapter, is structured by and serves to constitute the state and her and her family’s relationship to it.

The chapter begins by elucidating co-existing conceptualisations of ‘care’ in Kusthia, focusing on jotno as the personal and intimate labour involved in forging kinship ties, in contrast to sheba, service-related labour. It then turns to the ‘public’ that the public health sector is imagined as tending to, specifically ‘gorib manush’, i.e., ‘the poor’, and how this social construct shapes care. The chapter then returns to Rima’s encounter in the Kusthia district hospital to illustrate how these enactments of care operate in everyday statist encounters in public maternity spaces. Rima’s birth experience in the district hospital is not exceptional but rather illustrative of typical encounters which tend to be characterised by international development practitioners, national policymakers and programmers, and scholars alike as ‘uncaring’. This chapter argues that, rather than ‘uncaring’, health care delivered by in government, or shorkari, maternal settings is structured by moral imperatives to provide ‘services’ (sheba), though not necessarily ‘care’ (jotno), to a particular
category of people, *gorib manush*. Service, therefore, is delivered not as a matter of entitlements for citizens but as a matter of charity to people who possess limited alternatives. Enactments of care which unfold in these spaces map onto and reify broader imaginaries of the Bangladeshi state.

**A state of ‘care’: Sheba and jotno**

Biomedical discourses make expansive use of the term ‘care’, pairing it with ‘health’ to generate the unquestioned term ‘healthcare’. Of course, care is much more than about health. Arthur Kleinman reminds us that care has little to do with medicine and suggests that care is foundational to what it means to be human (Kleinman, 2007). Other scholars, demonstrating kinship as socially produced rather
than rooted in biology (Carsten, 2003, Carsten, 2000), describe care as constitutive of kinship and relatedness (Ringsted, 2004, Weisman, 1995). Ermdute Alber and Heike Drotbohm take this concept a bit further, suggesting that care “not only connects kinsmen, and friends, neighbours and communities, but also collectivities such as states and nations” (Alber and Drotbohm, 2015: p.2).

Still, there is an important distinction to be made between ‘care’ as practice and ‘care’ as affect, the first requiring enactment, and the second requiring sentimental, affective emotion, a concern for the person's basic humanity. Within biomedicine, health service providers are often expected to deliver both, culminating in a “consensus that you cannot care for a person without first caring about that person” (Street, 2016). More than other biomedical professions, the nursing profession is widely coupled with the affective obligational of delivering compassionate care (Tierney et al., 2019, Livingston, 2012: 97, Chaney, 2021). This can at least in part be explained by the philosophical foundations of nursing, traced back to Florence Nightingale and her depictions of the nurse figure as virtuous, loving, kind, unselfish, and gentle-hearted (Bradshaw, 2011) as well as to the gendered nature of the profession, and the expectation that women ‘naturally’ possess the affect of care and the desire to care for others (Tierney et al., 2019, Chaney, 2021).

The idea that public health service providers do not ‘care’ is a common accusation in Bangladesh. Members of the icddr,b team used this charge to explain why, despite their efforts to surmount barriers public health service providers raised as obstacles to the implementation of particular health initiatives designed to improve the ‘quality of care’, they still did not enact programme actions as the team expected them to. Government managers often couch this idea in terms of ‘motivation’: public health service providers simply are not ‘motivated’. During a discussion I had with a national health programme manager responsible for improving the quality of care in hospitals and clinics, he described the health service providers’ lack of motivation as one of the main barriers to ensuring the quality of care in public health facilities. He mentioned that there are two mechanisms to motivate health service providers: financial and non-financial. Since government policymakers were not interested in using financial motivators, he told me, they focused on non-financial motivators. One of these was through recognition awards, though he admitted these were not
effective. Another approach which he championed was a ‘value-based approach.’ He explained, “Value-based means that we are trying to focus on ethical issues. We are trying to address social values, how they can be more motivated. Also, some religious issues.”

This health manager’s comments speak to a perceived moral discrepancy between how public health service providers ‘ought to care’ and how they actually ‘do care’. The idea of a ‘value-based approach’ was explicit in its attempt to rectify a perceived moral failing on the part of public health service providers through an appeal to their moral sensibilities. However, such an approach also assumes that public health service providers also perceive themselves as in breach of particular moralities and that an appeal to shared moral sensibilities, rooted, for example, in social and religious values, will help to bring them into moral conformity and thereby demonstrate ‘good’ motivation.

Anxiety that health service providers, particularly government providers, do not ‘care’, is certainly not exclusive to Bangladesh. Within the realm of international development, concerns around the pervasiveness of disrespect and abuse of pregnant and childbearing women at the hands of health service providers during birth care is reified as a pervasive problem, reflected notably in the White Ribbon Alliance’s ‘Respectful Maternity Care’ charter, outlining human rights dimensions to care during childbirth (White Ribbon Alliance, 2011, White Ribbon Alliance, 2019). The charter and its associated campaign, which rose to global prominence, aims to curtail what is perceived as pervasive disrespect and abuse of women and newborns during the perinatal period in biomedical facilities.

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2 The original Charter included seven articles articulating universal human rights dimensions of ‘respectful maternity care’: 1) Every woman has the right to be free from harm and ill treatment; 2) Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care, whenever possible; 3) Every woman has the right to privacy and confidentiality; 4) Every woman has the right to be treated with dignity and respect; 5) Every woman has the right to equality, freedom from discrimination, and equitable care; 6) Every woman has the right to healthcare and to the highest attainable level of health; 7) Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011). A revised charter released in 2019 included newborns within its purview and integrated the following human rights dimensions: 8) Every child has the right to be with their parents or guardians; 9) Every child has the right to an identity and nationality from birth; and 10) Everyone has the right to adequate nutrition and clean water (White Ribbon Alliance, 2019). See: https://www.whiteribbonalliance.org/respectful-maternity-care-charter/; accessed 11 May 2022.

3 While this campaign does not necessarily enjoy widespread prominence in Bangladesh, it is used in at least some of the midwifery training courses delivered through development actors (see Chapter 3).
Within medical anthropology, generative debates continue today regarding the discrepancies between what we think care ‘ought’ to look like in health service delivery settings in contrast to what care actually looks like in health delivery settings. Much of this work sheds important light on the political economic structuring of care, revealing how the political economy prevents health service providers from delivering ‘better’ care (Biehl, 2021, Strong, 2020, Livingston, 2012, Street, 2014), some centring ‘neoliberalism’ in these arguments (Zigon, 2010, Mulligan, 2014). Others propose competing logics as offering pathways to better care, such as Annemarie Mol’s proposition of shifting from a ‘logic of choice’ to a ‘logic of care’ in health service delivery settings and her idea of ‘tinkering’ in order to achieve this (Mol, 2008). Such stances tend to portray actualities of care as failing to adhere to a particular moral standard.

Other scholars have taken a different approach to consider how that which, from an outside perspective, may appear as uncaring, e.g. yelling at a patient, withholding information, or failing to obtain informed consent for procedures, may actually function as demonstrations of care (Strong, 2020, Brown, 2010, Livingston, 2012). Adrienne Strong, for example, suggests Tanzanian government nurses’ harsh treatment of women in labour in the maternity ward is justified by nurses’ beliefs that this is what is required to advance labour (Strong, 2020) or to protect the health of the newborn (Strong and White, 2021). Also in Tanzania, Hannah Brown (2010) argues that health service providers’ treatment of patients is viewed as good when it generates fear and respect, which they perceive as essential to producing good ‘recipients’ of care and facilitating good treatment. In contrast, Patrick McKearny (2020) refers to such interpretations as an ‘evaluative reversal’, that is, “revealing a practice to be, despite our moral intuitions to the contrary, really a form of care”. He suggests that the evaluative reversal has become a trope within anthropology and cautions against it (McKearney, 2020).

In this chapter, I do not argue either that care delivered in public maternal health spaces fails to adhere to previously conceived notions of what constitutes moral care, nor do I attempt an ‘evaluative reversal’. Rather I attend to the enactments of care, sensitive to the varying forms it can take. Drawing inspiration from Joanna Cook and Catherine Trundle (2020), I aim to move past conceptualisations of health care delivery in public maternal health spaces as
somehow “tainted or absent” towards an “ethnographic consideration of the ongoing and morally ambiguous practices with which actors strive to grapple, achieve, or, indeed, curtail” (Cook and Trundle, 2020).

To make sense of care delivered in maternal health spaces, it is first important to elucidate differentiated conceptualisations of ‘care’ in Kushtia. One way care is enacted is as jotno. In Kushtia, women speak of jotno (care) as the support they provide to their families and children, which corresponds to the type of care that fosters kinship (Weismantel, 1995). Jotno is associated with the affect of care and encompasses attention and concern. It may (or may not) be enacted by health service providers in maternal health spaces. For example, Shanti, from Chapter 1, uses the word jotno to distinguish between her caesarean experiences in two different clinics, the first positive and the second negative. During her recovery for the second caesarean at Alo Clinic she felt abandoned, as the doctors on rotation passed her by and attended to wealthier women. Other clinic staff refrained from touching her body; they would “just look a bit.” Shanti does not use the word jotno to describe her experience there but reserves it to compare this experience with her first at Mordhane clinic. “They did not do it like that at Mordhane,” she recalled. “At Mordhane, the girl (health service provider) gave a lot of jotno (Ei Mordhane meye holeo khub jotno koreche).” At Mordhane, the staff attended to her needs and comfort, which is embedded in the construct of jotno.

However, jotno is not the only concept of ‘care’ in Kushtia. Within the public health sector, the term sheba, which more closely corresponds to the English term ‘service’, is privileged over jotno, effectively decoupling ‘care’ from ‘health.’ In official policy discourse, the term sheba is paired with shasto, health, for shasto sheba, and thereby privileges the term ‘health service’ for the typical English use of ‘health care’. This is reflected in the way that health service providers articulate the labour in which they engage. When shorkari health service providers discuss their work, they frame their responsibilities almost exclusively in terms of providing sheba. Sheba encompasses clinical service delivery. While sheba can incorporate affective care, it can also be delivered free from such sentiments. Moreover, sheba, in contrast to jotno, is foundational to imaginaries of the state, beyond public health service delivery settings.
The focus on *sheba*, service, provision can also be read within the broader imaginary of the state apparatus filled with civil servants enjoying a *shorkari chakri*, a government job, associated with performing *sheba*. Government jobs promise a high degree of job security, enviable in a livelihood landscape otherwise characterised by precarity. While some scholars suggest that government work is now less desirable than previously (Haque and Haque, 2019: 49), for many people, particularly those coming from villages, government work is seen as the best opportunity to gain a solid foothold in middle-class status and maintain a reliable livelihood. Entry into government employment through the pathway of the health sector is seen not only to facilitate economic security, but also as a way to do so morally, which renders this a particularly desirable way to enter government service.

Both aspiring and seasoned nurses articulate the desire to provide *sheba* to people as a motivation that brought them into the profession. One of my visits to the Maternal and Child Welfare Centre (MCWC), the district-level DGFP facility in Kushtia, coincided with the clinical rotation of the batch of 3rd-year nursing trainees from the Kushtia nursing institute. The energy of the approximately 12 young women pursuing their ambitions filled the ANC room. In the afternoon, after the FWVs completed the ANC consultations, I chatted with the young women, dressed in their matching green uniforms, and asked them about their motivations to train as nurses. Their responses varied little; they were all enthusiastic about the possibility that nursing training offered for them to join a government job. They might consider working in a private facility to earn income, but this was considered only an interim space while they waited for the government to release the circulars for nursing applicants and to hopefully claim one of these enviable positions. With a government job, they would enjoy a reliable livelihood and earn more than they would in the private sector, and benefit their families.

Their second motivation was a desire to provide *sheba* to the people. Most of the young women came from villages in Kushtia, and they shared their desire to help (*shahajo korte*) the poor (*gorib manush*), who are unaware (*oshocheton*) of how to be healthy. In her work in Sylhet, Katy Gardner writes of the duty of the wealthy to “help their own poor” as both a source of pride and a moral imperative (Gardner, 2012: 146). She and Zahir Ahmed describe a moral order of ‘helping’ in Sylhet, in
which one first has a moral obligation to help one’s kin, followed by one’s ‘own poor’, defined spatially as those in need inhabiting one’s home village, followed by other poor (Gardner and Ahmed, 2009). Such moral imperatives play out in Kushtia. For the young women aspiring toward health service delivery, though the profession might not make them wealthy, they imagine the nursing profession as a gateway to satisfy an economic imperative to secure a stable livelihood, fulfil a moral imperative to help the poor, especially the poor in their home district, and solidify their social standing as distinct from the poor whom they serve.

While seasoned nurses may be a bit more jaded, they share similar accounts of the motivations that brought them to the profession and also evoke religious motivations. Senior staff nurses (SSNs) mention that, as nurses, if you provide good services, then people will bless you (doya korte). In Islam, these blessings from others result in benefits in this life and the afterlife when they help one to pass into heaven. According to one SSN, through providing sheba in the profession, people to whom you provide sheba give you blessings in turn, without any additional effort; or, as she put it, “We get blessing [on our behalf] just like that” (amra satte satte doya korte emni emni parbo).

Sheba takes on particular meanings within the government context. Indeed, sheba is a key characteristic connecting all types of bureaucratic and administrative work throughout public sectors. It is at these interstices of sheba, whether one applies for a passport, files a complaint with the police, or seeks public health services, that people encounter the materiality and processes of the state. It is therefore in these moments that people learn what the state is, and what it means to interface with this entity. In government settings, sheba is enacted through bureaucratic practice. Within bureaucratic practice, there is no moral obligation or expectation that sheba be coupled with the sentimental affect of care recognisable in jotno.

Michael Herzfeld (1993) explores the workings of bureaucratic practice in “Western” societies, asking why in societies otherwise imagined as committed to human rights and advancing human flourishing, bureaucrats can appear callous to human needs. He argues that formal regulation, everyday bureaucratic practice and reliance on symbols generates indifference, which he defines as “the rejection of a
common humanity” (Herzfeld, 1993:1), and justifies neglect. The postcolonial Bangladeshi state differs from the Eurocentric states considered by Herzfeld. Indeed, the modern Bangladeshi state, a ‘state in the making’ following dual decolonisations (Lewis and van Schendel, 2020), is not typically characterised as a beacon of human rights or as particularly warm. However, the concept of bureaucratic indifference is useful here, as is his argument that bureaucratic practice generates indifference. Sheba is at the core of bureaucratic practice and everyday encounters with the state. Within most bureaucratic functions, no one expects that sheba be paired with jotno, or otherwise sentimental, allowing indifference to permeate these processes and enactments.

While one might expect the interactions in health settings, and particularly those concerning pregnancy and childbirth, moments marked by a need for jotno at least as much as sheba, to be different (certainly development actors do), instead they tend to unfold as patently consistent with the bureaucratic practice of perfunctory sheba, a corporeal performance of indifference. While sheba does not foreclose the possibility of sentimentality, it does open up the possibilities for indifference in a way that jotno does not. That is to say, by definition, jotno cannot be indifferent. For government health workers, delivering sheba constitutes the moral core of their professional obligations.

A particular public

To make sense of public health encounters, it is also necessary to consider who the public health system is imagined to serve. The Bangladeshi constitution (1972) references the state’s responsibility to provide medical care to its citizens, though medical care as a state-guaranteed right remains conceptually vague. The constitution also commits the state to improve public health in rural areas to reduce rural/urban disparities. This commitment materialises in the expansive network of public health infrastructure in sub-national spaces, which has no counterpart in urban centres. However, if the constitution alludes to the state’s responsibility towards the health of its citizens, women and families seeking services through this system do not necessarily do so as ‘citizens,’ i.e. people who make legitimate claim to state services and resources based on citizenship status. Rather, most people who seek services within public institutions make claims within these settings based on their identification as a gorib manush, poor person.
Public health services in Kushtia are imagined to exist for the category of *gorib manush*. This category is discursively sustained by government health service providers who evoke their status at once as a matter of pity and a certain disdain. They complain of the ‘lack of consciousness’ of the *gorib manush* who come to them to seek services: they do not know how to eat well, poor pregnant women do not know the date of their ‘LMP’ (last menstrual period), they do not know their blood group. These characterisations do not necessarily reflect the majority of exchanges between women and government health service providers in public health settings that I observed. Rather, most women, who generally self-categorise as poor, reported their LMP to health service providers or their blood type confidently. However, these discursive practices crystallise in the constitution of a category of *gorib manush*, entirely distinct from the category of government, the *shorkar*.

The idea that public health services exist primarily for poor people is articulated by government health service providers and by people seeking services in public health settings. Therefore, these relations are structured by what it means to respect class hierarchies more generally in a social world still marked by strict hierarchies rooted in a legacy of colonialism. Within this context, being a state functionary operates as a marker of middle-class status and sustains the superiority of state functionaries over those marked as *gorib manush*. In government health spaces, these categories are tenuous. Except for medical doctors, who maintain a solid class position apart from other health service providers, many other health staff come from villages, and often lower-class status. Entering public service through the public health system is a way to gain a foothold in middle-class status. It is quite common to hear an *aya*, typically a position assumed by women of lower-class status, to beam that she sent a daughter to train as a nurse, a symbol of upward mobility of the family, or occasionally of a nurse to speak of their *aya* mother.

There are occasional exceptions in which women who identify as middle-class seek out public services. Middle-class women, most easily discernible in this setting as women who completed at least some post-secondary education, tend to explain their presence in public health settings through a relationship with someone inside the public facility, an SSN, for example, or sometimes an *aya*, who can assist the person to secure better treatment within the facility. Such accounts are consistent with the more general reliance on social connectedness and *dhora-dhori* (see
Chapter 1) to secure services and resources. In such situations, the interactions between health staff and the rugi, patient, are noticeably warmer. However, in no case do women articulate their claims-making in public health settings as based on ‘entitlements’ or on their status as a citizen (nagorik) and the corresponding rights (odhikar) that such would entail. This distinction is important. By defining the public health system as a system for the poor, ‘the poor’ are not constituted as citizens with legal entitlements but as recipients of charitable services. Despite the presence of ‘comment boxes’ in each of the waiting rooms of the upazila health complexes, I never encountered a woman who expressed any confidence that they could raise a complaint within the public health system and expect it to be remedied. Rather, women hold the possibility of having health service aspirations fulfilled elsewhere.

The mushrooming private sector is now also within the grasp of families to assuage state reliance. People refer to this for-profit private sector as beshorkari, ‘not state’, suggesting the extent to which this imagined space is discursively constituted in reference to the state, shorkar. While recourse to private facilities for
birth was initially driven primarily by wealthier women, the ‘not state’ private facilities now cater to woman from all rungs of the socioeconomic ladder. Wealthy women tend to favour private facilities as the public health system is generally perceived as a system for serving gorib manush. Nevertheless, poorer women are also apt to seek birth services in the private sector, despite their limited financial resources, as a way to fill in the gaps of a public system perceived as patchy. Suffice it here to say that this rise of a private health maternal health market also shapes the discursive constitution of that state apparatus as a site of broken promises. Women and families who do not entirely circumvent public spaces often use a mix-and-match approach, benefiting from what they can from the piecemeal public sector with expectations that they will need to move outside of this sector to pursue their maternal health ambitions.

Scholars have explored the phenomenon of dual health systems emerging through the expansion of private health markets. Emilia Sanabria suggests that in Brazil, parallel public and private health sectors have resulted in a neglected, underfunded public health system alongside glitzy private facilities. She argues that this has generated two different health systems serving two different publics, from which two types of citizens emerge. The first she describes as ‘sub-citizens’, people of lower-class status who cannot afford private health insurance to cover services in private facilities and are resigned to accepting sub-optimal care in public health institutions. The second group becomes ‘super-citizens’, those who can access high-quality health services through participation in private health insurance and marketised health services (Sanabria, 2010). In Bangladesh, this operates somewhat differently, as women do not tend to identify as ‘citizens’ when it comes to biomedical health service delivery or speak of rights as they do in Brazil and other Latin American settings.

Rather than ‘duty-bearers’ delivering entitlements to citizens, public health services in Kushtia are perhaps better thought of as constituting a system delivering services as a matter of charity to those with limited options. This co-constitutes health service providers as disbursers of generosity, of a gift. However, rather than a gift that will eventually be reciprocated and reinforce social bonds (Mauss, 2002 [1925]), this gift is, instead, rooted in pity for the recipients. Interpreting Hannah Arendt, Andrea Muehlebach writes, “Pity is not invested in the overcoming of
suffering or the production of equality. It revels in the status quo and locks those who feel pity and those who are pitied into an immutable, frozen embrace” (Muehlebach, 2012: 135). The gift of health services, enacted during public health encounters and rooted in pity, constitutes the category of *gorib manush* distinct and unequal to the category of the state which they encounter in these settings, shaping enactments of care in public maternal health settings.

**Gorib manush and government hospitals**

What does the navigation between *jotno* and *sheba* for *gorib manush* in the labour and delivery room of the Kushtia district hospital look like? This section foregrounds the birth encounters of two women, Rima, whom we met at the outset of this chapter, giving birth to her first baby, and Najma, giving birth to her third, in the public health space of the Kushtia district hospital. Both women identify as *gorib*, and both experience care in the labour and delivery room structured by conceptions of *jotno* and *sheba*. However, while one closely adhered to expectations of a ‘good’ birthing woman, a *lokkhi meye*, good girl, the other resists, which also works to shape enactments of birth care.

Rima and her mother are alone in the labour and delivery room when Tamanna and I meet them, the young woman lying in foetal position attached to the saline drip. Rima is between 20 and 22 years old, her visibly concerned mother tells us as she kneads her daughter’s lower back with her fingers. She looks much younger. She breathes steadily, her belly pushing up toward her chest on the inhales, the only part bulging on her otherwise slender body. Rima tells us that she is worried; the last time she felt the baby move was before she arrived here at 7 am with her family, who, upon crossing the hospital’s perimeter, transformed into *rugir-lok*, the patient’s party. Mid-sentence, she tightens her face and clutches her mother’s wrist, forcing her hand into her back, a cue that the *byaetha*, pain in the form of a uterine contraction, hit. Her mother digs into her daughter’s back and gazes helplessly at us. The baby is not moving; what should we do? she asks, her eyebrows stitched with worry. I look around the room, palpably bereft of health service providers, though several SSNs chat and giggle on the other side of the pink curtain flowing from the entryway, thinly veiling the labour and delivery room from the nurses’ duty station.
We ask them to be patient; the gyne-consultant\(^4\) will pass soon to do rounds; she will let them know what to do. Rima shakes her head. "Ma," she whines, "I cannot take any more; take me away from here." Her mother looks at her sympathetically and reminds her that when the doctor passed through previously, she did not indicate whether she would take Rima for shejar (caesarean). They must wait for the verdict on the gyne-consultant's next round. Rima pays her no attention. "Ma, take me away from here," she implores, beseeching her mother to take her away from the district hospital. Her mother rubs her daughter's back more vigorously and sighs helplessly but does not respond to her daughter's pleas.

A cool February breeze whooshes through the window's metal bars. The three other beds of the room stand empty, an ephemeral peaceful moment in a typically dramatic space of life and death, joy and agony. The long pink curtains marked by the Government of Bangladesh and Save the Children logos spread open within a moment, and three new women pass through. The pregnant woman in the centre, Najma, hangs over her sisters-in-law, her purple-flowered burqa\(^5\) draped over her protruding stomach and a sienna scarf over her head. One of her sisters-in-law tells Tamanna and me that this is Najma's third baby; her first two babies were born normale, vaginally, though this is her first time in the district hospital. Her first was born in a small private clinic that since shut down, her second at home. The three of them lumber across the stained white floor tiles. Najma furrows her eyebrows, her eyes underneath determined, stoic. The three women trudge towards Rima, still curled on the bed, and her mother. Rima's mother whispers their concern about the baby not moving as Najma's party looks over Rima consolingly. They then turn back and stride down the length of the labour room towards Tamanna and me.

Rima moans every several minutes when a byaetha grips her uterus. She squeezes her eyes shut and shakes her head from side to side into the plastic sheet of the bed. Asmani, a middle-aged SSN wearing a signature olive-green nursing uniform, enters and approaches Rima and her mother. Rima moans and writhes. Eyes fixed on her daughter, Rima's mother asks Asmani whether Rima can have a shejar. Have you arranged blood? the nurse asks Rima's mother, short of patience. No, the doctor did not yet say whether the baby will be born normale or through

\(^4\) Equivalent to an obstetrician-gynaecologist

\(^5\) Long dress typically worn by women residing in rural Kushtia, either with or without head covering.
shejar, Rima's mother explains, defensive. If they have not arranged a blood donor, there is no way to do the shejar, retorts Asmani. When was the last time she drank? the SSN demands. Give her water. Rima's mother follows the instruction and holds the disposable plastic bottle the family brought to the hospital to Rima's lips as Asmani turns to leave the room.

When Rima finishes drinking, she curls back into her foetal position. Rima's mother exits the room to discuss with the other rugir-lok, Rima's father, husband, and several other men and women. We overhear as they scramble to identify someone with O-positive blood, like Rima, a particularly challenging blood type to find a match for, so that she can have a caesarean, the outcome they all desire. Blood transfusion can be a life-saving procedure for haemorrhage, the complication which claims the greatest proportion of maternal deaths globally and in Bangladesh (National Institute of Population Research and Training (NIPORT) et al., 2019, Say et al., 2014). However, stocks of impersonal blood stored at health facilities are an anomaly in the country and generally unavailable even in the best equipped hospitals. The labour of locating blood falls to the family, who leverages social networks in moments of crisis to identify a person whose blood matches to contribute the life-saving corporeal substance. However, when people from villages travel to urban centres, access to their social network can prove challenging. Luckily, though they are far from their village home, Rima's brother-in-law knows some people (porichito) in Kushtia; he agrees to contact them.

Afroza, one of the young physician interns, whooshes into the labour and delivery room. Her face breaks into a smile under her surgical mask when she spots us. She greets us with a hug before moving to the labouing women. With Afroza here for rounds, the room now brims with women and their rugir-lok. Najma glides towards an examination table. She steps up the small moveable stairs and assumes position, her burqa and the petticoat underneath pulled up around her waist, her thin legs spread. One of her sisters-in-law stands near her head and fans her face with a banana leaf fan.

Afroza weaves through rugir-lok toward Rima, prostrate on the bed, knees bent and pointed towards the ceiling. Her mother strokes her hair. The SSN Asmani and one other SSN stand within arm's length of her side. The nurses eagerly
relinquish responsibility for the vaginal examination, which they refer to as a PV, shorthand for prevaginal examination, to the aspiring doctor. Rima’s mother hands Afroza a packet of fresh medical gloves she purchased from a private pharmacy outside of the public hospital. Afroza tears it open and slips the latex over her hands. She approaches Rima, but the young woman clamps her knees together. Afroza persists, but the young woman uses the force of her tiny, clenched legs to push Afroza backwards. She squeezes her eyes as tightly shut as her knees and crinkles the plastic sheet as she shakes her head resolutely.

Meanwhile, an SSN performs a PV on another woman on the adjacent examination table, touching the young woman only to check her cervix with a gloved hand. "I am breaking the water (Pani bhengtechi)," she announces to the hospital staff. She inserts the metal hook into her vagina and quickly jumps back out of the line of fire, avoiding the spray of amniotic fluid.

Afroza, defeated, bucks the task of Rima’s PV back to Asmani and moves on. Asmani shakes her head. "They will need to do a shejar," she remarks, seemingly more for her own catharsis than a promise to give Rima what she wants. The SSN knows that only the gyn-consultant can make the call but appears eager to wash her hands of the young woman’s presence. "Be soft," she urges. Rima holds her body rigid, exposed knees glued together. If you do not allow me, Asmani threatens, I will discharge you (chuti diye debo). Shahanaj khala, the dai-turned-aya regularly present in the labour and delivery room, and Rima’s mother join forces to pry her knees open. Her mother, patience giving way to frustration, struggles with Shahanaj khala to pry her knees apart to allow the SSN to enter her gloved hand in her daughter’s vaginal canal. Rima shrieks. "How!" she cries out. The SNN retreats. "Ten cm," she announces--Rima’s cervix is fully dilated; now, she just needs to push.

Najma lies on the bed, lithe legs apart, on the other side of the room. Her sister-in-law unties her hair, strokes oil through her tresses, and then twists and fixes her hair back into a bun. An SSN approaches to check her cervix quickly with a gloved hand; she does not speak to her party or touch her body otherwise. Najma’s eyebrows crease during the examination, though no sound escapes her pursed lips. "Six cm," announces the SSN, and promptly moves on. Najma fixes her petticoat and
climbs back down the mobile stairs. With all cervixes successfully inspected, the health service providers march out of the room.

Rima gets up from the bed. She stiffens, pushes her belly out and moans, gripped by another byaetha. Her mother’s face is twisted with tension as she exits the room to liaise with the other rugir-lok in the nurses' station. The other women, cervixes checked, rearrange their petticoats and leave the room with their respective companions to continue pacing in the hospital corridors as the SSNs instructed, leaving only Rima, along with Tamanna and me. Rima creeps toward the entryway, planning an escape. She glances toward us, as if wondering whose side we are on, as she skulks towards the doorway. A thin man with a short, white beard appears through the curtains when she gets close. His tan plaid shirt and blue lungi (sarong) contrast against the pink of the curtains.

Rima leans against the door frame. "Let's go, let's get out of here," she begs her father to go somewhere else, away from the district hospital. "Where will we go?" he demands, scowling. They both know that just outside the hospital, a vast private market offers any number of refuges. It is common for women in labour to attempt first to give birth at the district hospital to surreptitiously disappear with their rugi-lok, without a word to the health service providers, who simply shrug off these disappearances. Outside of the district hospital gates, they can quickly find commodified services. However, since Rima’s family travelled to the district administrative centre, any of these private hospitals and clinics will be much more expensive than those near their village. We are gorib manush, poor people, he tells Rima. He cannot afford to take her to a private clinic with the promise of surgical birth. He disappears through the curtains. Rima hovers near the entryway for a moment. She glances towards us once more, then absconds through the pink into the nurses' duty station. Tamanna and I follow her out.

In contrast to the stillness of the delivery room, the reception room is aboil. Asmani sits at the large desk over a paper register, a material marker of the centrality of paper (kagoj), and doing paper as a bureaucratic practice, not only within the public health space, but throughout state spaces. She squints behind her glasses, makes notes and flips through pages. Rima's mother, father, young husband, a couple of related older women and young men stand in front of her. We
have arranged blood, says Rima's father, the achievement of the young brother-in-law. Can you arrange the shejar now? Eyes still glued to the register, she says it will still take some more time before the doctor decides whether to do a shejar, at least an hour. Rima perches on the wooden chair. She moans, eyes shut, and shakes her head from side to side.

The blood donor is here, her father presses. What should they tell him, then? He cannot stay here all day. He can stay here, mutters Asmani over the register, or he can go home and wait. The family persists until Asmani finally looks up from the register. Look, she cedes, I can explain the situation to the blood donor. Rima's father sends for him. Within a couple of moments, a thin young man sporting a faux leather jacket and blue jeans peers into the nurses' duty station. Look, praises Asmani, it is good that you want to help this gorib manush, poor person, praising his moral sensibilities. However, she says, it will still take another hour or more, so either you can wait here, or if you live nearby, you can go and come back when they call. The young man nods. I can come back later, he says, then promptly disappears.

Asmani's procrastination has not only biological ramifications—if she withholds shejar long enough, then the baby is likely to be born normale, especially since Rima's cervix is fully dilated—but also an institutional one. By the early afternoon, all the gynecologists will leave the district hospital to resume work in private hospitals and clinics (see Chapter 5), and carry with them the possibility of caesarean in the public health institution. Rima's family knows that time is running out to obtain the procedure within their financial means.

Rima's cries out and begs her family to take her away. "I will not stay here!" she wails. Asmani ignores her and continues to turn pages and scribble notes in the register. Her father stands over his daughter and yells for her to return to the labour and delivery room and try to give birth normale. A woman here with another rugi sits nearby. Why would you want to do a shejar when you can do normale? She encourages Rima. To give birth normale is peaceful (shanti). If you have a shejar, you will suffer. Rima ignores her. She looks so small but steadfast as she squeezes her eyes shut and shakes her head. Her thin, young husband, wearing a red faux-leather jacket and a blue surgical mask underneath his chin, towers over her between Rima's mother and father. He strokes his face with his index finger and
Shahanaj *khala* joins Rima's mother and together manage to manoeuvre her back into the confinement of the delivery room. Rima grasps the bed and moans over it. Her mother sits back a bit, her arms crossed. "Let's go from here, let's go," Rima begs. Where will I take you? yells her mother, her patience worn off by now. Will your husband pay 15, 20 or 30 thousand taka for you to go to a private clinic? She shakes her head. Your mouth is so strong, she scolds, but you will not use any of that strength to push the baby. Another *aya*, wrapped in a long yellow shawl, sprawls on the bed by the back window, a casual spectator. She pulls the purple exercise ball close to her and rests her elbow on it. She mentions to no one in particular that if Rima has a *shejar*, they will give her the injection (anaesthesia), and she will not feel any pain. Rima nods vigorously. Her mother scowls and storms out of the room, shaking her head.

Asmani and two others SSNs enter the room. Najma follows them in and obediently assumes her position for another PV. One of the SSNs performs a PV on another woman and then does the same for Najma. The other SSNs and Shahanaj *khala* stand together and discuss what to do with Rima. She has become a real problem to them now. One SSN says that she will cause them more problems. Asmani surveys the room. "Where did Rima go?!" she exclaims.

Perched once again in the nurses' duty station, Rima pleads to leave, "Let's go, let's go." Her father glowers. Where will we go? he yells. Do you think that if you kill the baby you will like that? her mother scolds, appealing to Rima's moral sensibilities as a soon-to-be mother. You need to go back and do this *normale*. Her husband stares on, frozen. One of the SSNs mutters that they should just insert a cannula and take her to the operating theatre, but it is not their decision; only the gynae-consultant can make that call. I try to recall how much time has passed since Asmani declared Rima fully dilated. It was at least 45 minutes ago. Was it an hour? More? It feels like a lifetime. I can only imagine her resolve to resist what must be an incredible urge to push, something I did not even know was physically possible. Could she be obstructing her own labour? I think to myself. Finally, her mother and Shahanaj *khala* join forces to drag her back to the delivery room. "Go, go!" orders
Shahanaj *khala*, using the *tui* verb form, which can operate as the most affectionate construction or the most disrespectful. In this case, the verb form insinuates the latter. Asmani cautions Shahanaj *khala* to be careful and looks in my direction. Shahanaj responds that Tamanna and I can also see what they are dealing with, insinuating that we will also interpret this use of force as justifiable. I cannot see this as justifiable, but I also know that I am only capturing a sliver of all of the dynamics at work in this space, particularly within Rima’s natal and in-law family dynamics. I stand just a bit closer to Rima.

With this teamwork, they overpower Rima and steer her to the bed in the back of the delivery room. The sound of a slap crashes through the room. I see the aftermath: Rima’s face turned downward, her mother standing over her. The strike seems to achieve its objective, and Rima is soon in a prone position on the bed. She nestles into a stillness, her mother at her side. Najma’s *rugir-lok* glance over from their steady march, the delivery room otherwise deserted. With Rima now acquiescent on the bed, her mother settles back into her role in delivering *jotno*, stroking her daughter’s thick black hair.

After several minutes, Asmani returns and approaches Rima to push her twig-like legs wide apart. She then pushes her knees back, revealing her pelvic floor. She attaches the saline bag to the cannula, and the liquid drips into the young woman’s veins once again. Rima rubs her belly. Her mother stands next to her daughter’s head and gives her some sips of water from the repurposed Sprite bottle. She holds her daughter’s hand. Asmani spreads a green plaid cloth over Rima’s knees. “Is there no *byaetha*?” she asks; no pain? There is no response. “Is she sleeping?” she asks. Asmani presses her fingers inside her vaginal canal. The baby is yet to descend towards her fully dilated cervix. Najma quietly leans over the purple exercise ball and rolls it across her belly on the neighbouring bed. Her sister-in-law massages her lower back as she does so.

Suddenly, Rima moans, gripped by *byaetha*. Shahanaj *khala* assists Asmani to tie on the long, blue plastic apron. She takes position below Rima’s hips. "Give pressure!" she enjoins. Rima bears down. She passes stool in the process, and faeces tumble into a strategically placed bucket below her hips. Shahanaj *khala* grunts and presses her headscarf to her nose. "What a smell!" she derides. "Like a
khataish!” comparing the odour to a notoriously foul-smelling animal. You are the one delivering the baby, complains Asmani to Rima, but our souls are coming out (jaan bere hoye jay). The baby's head protrudes visibly from Rima's pelvis with the next push.

Nearby, Najma climbs up on the adjacent recliner bed. Her stoic silence is overcome by quiet moans, a hint that she is approaching full dilation. Nevertheless, all eyes are on Rima. Asmani's voice softens. I hear a woman chant beside me, a heavyset woman with a red floral headscarf from another woman's rugir-lok. Her eyes are also fixed on Rima as she recites surah passages from the Quran in prayer on Rima's behalf. "Push, push," Asmani coaxes each time the byaetha hits. Rima grunts as she bears down. Her mother strokes her hair. "Give a good push," urges the SSN. "Lokkhi meye," she praises, good girl, the highest ideal a woman in the delivery room can aspire to.

Five minutes pass, and a small moon of thick, dark baby hair appears. "Push," urges Asmani. "The suffering (koshto) is over, push." Rima grunts and bears down. "Give…give…give [pressure], push!" A bit more of the baby's head appears. "Very good," praises Asmani. "Beautifully done." She pulls back on the elastic of Rima's vaginal canal with a gloved finger, trying to make space for the baby's head. Shahanaj khala squirts thick white medical gel onto her pelvic floor from a small distance, hoping that some extra lubricant might do the trick. Najma's nearby groans crescendo.

With the next byaetha, and the next push, more of the baby's head appears. "Push, push, push," enjoin Asmani. Asmani heaves a sigh and leans against the next bed over. "The baby went away," she announces, indicating that the baby retreated into the vaginal canal. The next byaetha comes without delay. "Push, push, push," cajoles Asmani and the baby's head surfaces. " Good girl. good girl (lokkhi meye, lokkhi meye)," praises the SSN in response to the progress. Najma moans alone on the adjacent bed, as even her companions are now riveted spectators of Rima.

Rima continues to push diligently with each byaetha. Five minutes pass, then ten, 15. The medical staff deliberate; should they do a side-cut, a much-dreaded episiotomy? A couple minutes tick by, and one of the SSNs prepares the scissors
and holds them dangerously close to Rima's perineum. Under this threat, Rima heaves and bears down with all the force she can muster. The baby's head ejects from her vaginal canal, the thick purple umbilical cord firmly around the baby's delicate neck. Brownish amniotic fluid squirts out with the baby's head, dangerously stained with meconium. What kind of mother and baby is this? sneers Shahanaj *khala*. The mother is passing stool; the baby is passing stool, she chides, shaking her head. Asmani moves the baby's head at an angle, and another SSN cuts the cord, releasing the baby's neck from its grip. Asmani orders Rima to push; the baby's body slides into Asmani's hands, her waxy skin a worrisome mustard hue, in contrast to the reassuring mauve of healthy newborns. She promptly places the newborn girl on her mothers' belly. Asmani remarks that the baby ate so much meconium. I hold my breath as the seconds tick by, 15, then 30. Finally, the baby musters a weak cry, more like a complaint. The assisting SSN moves her to the nearby bed.

With the baby born, and alive at that, a sense of relief floods the room. For Rima, however, the suffering is not yet over. Asmani settles in a chair in front of her pelvic floor to inspect the damage. Blood spills from her body. With a slight shift of her leg, she inadvertently projects several drops of blood towards Asmani, which land on her green nursing gown. Asmani huffs and pulls back. What are you doing? she scolds as if the young woman stained her intentionally; this is dirty!

The damage to Rima's perineum is significant; she has deep internal tears. Without any local anaesthetic, Asmani inserts the needle to suture the tears, in one side of swollen flesh and out the other. "Ohh, Allah," Rima cries out, as her mother holds her knees back. "Oooh, Allah!" Asmani chatters as she perfunctorily threads Rima's body back together. You are a bad girl, she says. I think you disobey your husband, too. You are *beadop*, she says, not mincing words to indicate that she finds the young woman arrogant and disrespectful. She passes the needle through again. Rima jerks back slightly and cries out.

Najma wails from her bed, ready to push. One companion fans her vigorously with the banana leaf fan; another holds her hand and recites verses from the Quran. Najma regains her composure, though pain contorts her face. Asmani quickly ties off Rima's sutures and moves over to her, still equipped with the plastic apron. "Den, *den,*" she says, using the *apni* form of the verb indicating respect, give, give. "Lokkhi
meye, lokkhi meye," she praises. The baby is crowning. Najma grunts and heaves her breath out. "Push, push a bit more, Allah…beautifully done. Very good, good girl, give one more," cajoles Asmani. The baby’s head emerges, then her body, a lovely mauve. "You gave birth to a beautiful girl," announces Asmani. The newborn’s delightful squeal ricochets through the room.

Rima and Najma's simultaneous state encounters are typical of those enacted in maternal health spaces in Kushtia. These are enacted during vulnerable moments for women, i.e. pregnancy and childbirth, times marked more generally by an elevated need for care. However, these encounters sometimes appear uncaring or indifferent, whether, as in Najma’s case, the labouring woman adheres to the expectations of a lokkhi meye, good girl, or, as in Rima’s case, she does not. In both cases, however, their encounters are illustrative of the bifurcation of care between sheba and jotno categories constitutes social categories of the state and those who interface with the state and the relationships between them.

Enacting sheba and jotno in the labour and delivery room

As illustrated in the above ethnographic encounter, in public biomedical health settings, sheba is embedded in expert knowledge and technologies. It often consists of invasion into the body, the insertion of cannulas to introduce oxytocin-infused saline into the bloodstream to speed up labour, or a metal hook into the vaginal canal to rupture the amniotic sac, the performance PVs. Vaginal examinations are among the contested practices of medicalised childbirth, and even WHO recommends them no more often than once every four hours (World Health Organization, 2018b). However, during birth in the public hospital, they are central to health service providers’ performance of sheba, and labouring women flock to the labour and delivery room when gyné-consultants or nurses decide to perform PVs according to the service providers’ schedules, rather than women’s. Occasionally,

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6 Vaginal examination during labour, the practice of health service providers inserting their fingers into a labouring woman’s vagina to determine the progression of labour through the opening of the cervix, was introduced though the medicalisation of childbirth. However, there is currently little clinical research to suggest that this is an effective practice for monitoring labour or improving health outcomes, and such examinations are associated with physical and emotional discomfort and unnecessary medical intervention (Moncrieff et al., 2022, Kitzinger, 2005). Moreover, there is some research which directly associates increased vaginal examinations with febrile morbidity (Gluck et al., 2020). Feminist critiques root the pervasiveness of the practice in patriarchy and make a compelling case for vaginal examination as a form of obstetric violence (Shabot, 2021). Despite this, vaginal examination of labouring women is carried out routinely, and often, by health service providers in public birthing spaces in Kushtia.
though not routinely, *sheba* entails an incision of the perineum with scissors for an episiotomy, another contested feature of medicalised birth, when the nurses see fit. It comprises suturing this cut or, more often, perineal tears, generally *sans* local anaesthetic. *Sheba* is deliberate, punctual.

Gatekeeping *sheba* is also state work, that is, determining whether clinical services will be granted or withheld and when. Rima’s state encounter was demonstrative of this. Though she and her family desired that Rima undergo caesarean and hoped to have this wish granted by the health service providers, the service was withheld. While she ultimately gave birth *normale*, she was aware that outside of government hospital there were spaces which would grant her a surgical birth, where commodified health services would be granted on her request, and ability to pay rather than relying on the state gatekeeping; however, as *gorib manush*, such a proposition was outside of her family’s reach.

In contrast to *sheba*, *jotno* encompasses the sentimental work of care. *Jotno* is personalised, hands-on and supportive. *Jotno* is rooted in relational labour. It involves sentimental physical touch, enacted as massage, holding a hand, stroking hair, massaging oil into locks. It subsumes the physical support of women’s labouring bodies, and entails encouragement and (often) comforting words, sometimes enacted in the recitation of Quranic verses. It involves nourishment, primarily giving water. It also is enacted through management of bodily pollution. Whereas government health service providers perform *sheba*, they tend to pass the sentimental work of *jotno* on to *rugir-lok*. The encounters of Rima and Najma in the district hospital were characteristic of this boundary work. These encounters were punctuated by moments of *sheba* provision by the health service providers; the affective *jotno* was consistently performed by the *rugir-lok*, at times under the direction of the health service providers. However, when Rima resisted the health service provides, the care of her *rugir-lok* appeared less as *jotno* as they struggled to have her submit to the expectations placed on her in that space.

That government nurses in Bangladesh perform relatively little ‘hands on care’ is well-documented (Hadley and Roques, 2007, Zaman, 2009). These stories tend to be written as scathing indictments of the failure of Bangladeshi nurses to adhere to the ethos generally associated with nursing as the delivery of patient-centred and
compassionate care (Livingston, 2012:96-97, Zaman, 2009). However, to single out nurses as an isolated category draws attention away from the ways in which they and all other cadres engage to enact the state in public health settings. Indeed, it is not only SSNs but also medical officers, interns, midwives, and ayas and other periphery hospital staff who enact the state in public maternal health care settings, and the ways that they do so are strikingly similar. Here, I do not mean to insinuate that such enactment is exclusive to the public maternal health staff; indeed, rugir-lok also provide sentimental care to rugi in private health institutions. However, in public health settings, this embodied performance excluding jotno reifies state categories as those which deliver sheba, often to the exclusion of jotno.

The management of pollution remains a critical aspect of the boundary work between sheba and jotno, constituting state and gorib manush categories in the labour and delivery room. The preoccupation with the containment and avoidance of bodily pollution, long central to ideas around birth in the sub-continent (Jeffery et al., 1989, Mukherjee, 2017, Rozario, 1998, Rozario, 1992, Blanchet, 1984) maps onto statist encounters in public health service delivery spaces. Here, it serves to mark state/non-state categories, as well as categories within state hierarchies. In her seminal work Purity and Danger, Mary Douglas writes that the power of pollution lies in its inherence to the structure of ideas and that this power “punishes a symbolic breaking of that which should be joined or joining of that which should be separate” (Douglas, 2003:114). Within public maternal health spaces, these ideas require a separation between state and rugir bodies, the margins of which are located at the fleshy boundaries of human bodies. As Douglas points out, margins are always dangerous, as this is where the structure of ideas is at its most vulnerable (Douglas, 2003:122). At the margins of human bodies, pollution threatens distinctions between the state and the gorib manush whom state functionaries serve.

No one among the health staff is particularly keen to manage the various bodily excretions inherent to the birthing experience: urine, vomit, blood, faecal matter, amniotic fluid, regardless of job title, religion, class or marital status. It is not uncommon for hospital staff to deride or scold a labouring woman for defecating, urinating, vomiting, bleeding or spilling amniotic fluid, or to complain of the smell, as Shahanaj khala did during her encounter with Rima. Furthermore, the ayas, understood as present to do the ‘dirty work’ (nongra kaj) express as much disgust (if
not more) as they push the management of bodily emission onto rugir-lok and deride patients for their pollution, such as Shahanaj khala did to Rima.

Consider the account of Runa, 18 years old and pre-eclamptic, in labour with her first baby. All morning we waited to find out if she would give birth normale or whether the hospital staff would send her to the operating theatre for a shejar, given her dangerously high blood pressure. We wait in anticipation, hoping the gynecological consultant rounds come sooner than later. Finally, two gynecologists enter. One is the young Dr Parvin, whom Tamanna and I know from the operating theatre, though she does not pay us any attention. She wears a long black dress, a modern grey headscarf, and her signature black rectangular glasses. The other is another gynecological consultant whom we have not seen before. She wears an elegant green satin burqa under her white doctor’s coat and a billowy beige headscarf. The doctors always wear beautiful clothes, occasionally covered with a white medical jacket, while the nurses don matching green uniforms.

The gynecological consultant that we do not know moves toward and talks to Runa. She decides to break her amniotic sac to speed up the birth. The SSN takes the hook and positions herself at Runa’s pelvic floor, prepared to break her water. Another SSN and Shahanaj khala stand next to her. The gynecological consultant, Dr Parvin and Farzana (an intern doctor) stand a bit further back at what they seem to think will be a safe distance. However, Runa’s amniotic fluid shoots out about four feet when the SSN breaks the water. The doctors jump backwards as if they are avoiding getting splashed by acid. The SSNs start to giggle, and the doctors scowl. Shahanaj khala laughs out loud. The doctors flee to the other side of the room as they mutter about their dresses being nongra, filthy. Everyone turns to inspect their dresses. After Farzana and Dr Pavin summarily inspect theirs, they turn to check on the gynecological consultant’s green satin dress. The gynecologist takes a seat and shakes her head but seems relieved that her dress was spared. “What about me?” says the SSN, “My dress is also filthy (nongra); the water (pani) is mostly on me.”

The SSNs return their attention to Runa, and the next thing I see is Runa’s mother on the ground, wiping the amniotic fluid off the floor with a cloth at the feet of the health service providers. The SSN instructs her where to wipe up the floor. She is visibly distraught. The doctors leave the room, and shortly after, the SSNs turn to
go. Runa’s mother begs them not to leave. I will buy you soap, she pleads. You do your job; please do not go from here (Ami saban kina debo. Apni koren, apni ekhan theke jaiyan na). They pay her no attention and disappear.

In this account, all categories of hospital staff, doctors, nurses and ayas alike exhibit an aversion to bodily substances, despite the immanence of these very substances to the professional work in which they are engaged. The enactment of this avoidance indexes hierarchical divisions: the protection of doctors from contact with pollutants is prioritised, as doctors constitute a class apart as ‘first-class gazetted officers’ and occupy a decisively higher social status, followed by SSNs. While technically, the ayas are responsible for the dirty work (nongra kaj), they tend to pass this off to rugir-lok and hand them mops, bedpans and cloths to do the work. The SSNs regularly complain of the ayas’ convenient absences when there is nongra kaj to be done. However, though their formal power may be limited, ayas often have connections with influential people, which imbues them with power and makes it difficult to hold them responsible for doing this work. Moreover, ayas tend to occupy a similar status to the gorib manush in public health institutions, placing them at particular risk of having boundaries break down between them and the gorib manush with whom they interface in these settings.

While concerns around birthing pollution also play into the enactment of birth in the private sector, the predominance of surgical birth in private facilities partially curtails transgressive pollution. While bodily fluids are present in caesarean as in vaginal birth, corporeal substances are more easily predicted, controlled and contained in the surgical encounter: tubes suck amniotic fluid and blood into glass containers as soon as the belly is open, catheters drain urine from the bladder. While this does not eliminate the nongra kaj, it constricts the opportunities for engagement around the spontaneous release of birth pollution, transgressions that are integral to and unpredictable in the experience of vaginal birth.

Blood also figures centrally in sheba/jotno divides. While health service providers may carry out the clinical sheba of blood transfusion, arranging the blood to be transfused is a profound act of jotno. Blood in Bangladesh is personal. Similarly, Jacob Copeman writes of the social significance of blood and blood donation in north India. His work demonstrates that far from an impersonal
endeavour implied by predominant public health discourses, blood donation in north India is imbued with social, cultural, political and religious significance (Copeman, 2009, Copeman and Banerjee, 2019). Similarly, in Bangladesh, blood donation acts to constitute and reinforce bonds within kin and social groups.

Knowledge of one’s blood type acts as a status marker. It comprises a responsibility of any educated person (for this reason, it was a joke among the icddr,b team that I did not definitively know mine). Not only is this important on an individual level, but within the social world. Even in the most reputable public hospital in the country, impersonal blood stocks are only unreliably available. If a person needs a blood transfusion, this is most likely to be arranged through the care work of the family and social network. Phone calls and WhatsApp messages from friends calling for potential blood donors with the appropriate blood type matching a family member’s requiring a blood transfusion were common enough to be routine throughout my fieldwork. Knowing one’s blood type is an act of care—it allows one to be ready when these moments arrive and perform a most intimate care practice within an extended social network.

In addition to enacting sheba in the fleshy dances with service-seekers, sheba is enacted through paperwork. The excessive amount of time that government nurses in Bangladesh spend engaged in paperwork is well-documented (Hadley and Roques, 2007, Zaman, 2009). In his ethnographic account of a district hospital orthopaedic ward, Shahaduz Zaman observes that “It appears that Bangladeshi nurses are primarily caretakers of papers and registers, rather than caretakers of patients” (Zaman, 2009). Papers and paperwork hark back to the centrality of documents within the colonial project in South Asia, such that the term ‘Kaghazi Raj’, Document Rule, assumed synonymity with the British colonial regime (Hull, 2012b:7). Matthew Hull (2012) describes how governance through documentation became central to the colonial project as a reflection of the need to ensure accountability from a distance. He demonstrates how the legacy of paperwork maintains centrality to the postcolonial state-making project in Pakistan.

Paperwork also remains crucial to the postcolonial state-making project in Bangladesh. On the one hand, this reflects the preoccupation in the state-making project with enumeration, one facet of rendering the population legible (Scott, 1998,
Gupta, 2001), for the purpose of which vast infrastructures have been constructed throughout the country (Murphy, 2017). However, beyond this telos of legibility, the spectacle of doing paperwork is central to the state *sheba*. In any context, *sheba* will entail some type of paperwork. In Kushtia *shorkari* maternal health spaces, paperwork is critical to state-making. Therefore, this is achieved in the art of *doing of* it, not necessarily in the accuracy of what is recorded. In the Kushtia district hospital labour and delivery room, for example, partograph information is only ever recorded *after* a delivery. Designed for ‘low-resource settings’, partograph is the World Health Organization-endorsed paper-based technology proposed to track labour progress, identify complications and inform decision-making. The technology requires health service providers to use paper-based graphs to track foetal heart rate, uterine contractions, cervical dilation and drugs administered throughout labour (World Health Organization, 2018b).

*Figure 10: Whiteboard partograph hung on labour and delivery room wall*

*Source: Photo by author, Kushtia district hospital, 11 Jan 2021*

Using the partograph after a birth strips its usefulness in its presumed decision-making purposes, but it figures into constitution of the state through the

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7 The World Health Organization recently distanced itself from the focus on partograph, and has rebranded the practice within the WHO Labour Care Guide (2020)
doing of paperwork. Performing paperwork, which Annemarie Mol refers to as the “enactment” of bureaucratic objects in practice (Mol, 2002), is part and parcel of doing the state. In this enactment, documents come to be constitutive of “bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, outcomes and even the organisations themselves” (Hull, 2012a), even in the maternity ward.

The partograph is one of the many papers shorkari health service providers are responsible to complete, which occupies much of their duty time. In contrast, paperwork occupies a peripheral space in private health facilities. Paperwork is not absent in private settings, and sisters (nurses) will often produce papers with basic tallies marking the number of shejar and normal delibheri conducted each month when asked. However, I hardly came across health service providers doing paperwork in private settings. In addition, although many clinic owners say that they are supposed to report their numbers to the civil surgeon’s office each month, they also admit that they do not do this regularly, if at all. They only provide these numbers to the state apparatus if directly requested by the civil surgeon’s office, a rare occurrence indeed. Thus, paperwork in the private sector disconnects it from, rather than connects it to, state processes.

Although health workers complain about the amount of paperwork required, this paperwork becomes a locus of power and a site for them to resist or comply with the various development initiatives tacked onto their task list (discussed further in Chapter 3). It is also a site in which the legitimacy of the state’s right to “write society” (Hansen, 2001) is reaffirmed, as health service providers carefully guard authority over paperwork. In the labour and delivery room, this can go so far as withholding discharge certificates when women leave to seek care elsewhere (an elsewhere in the private sector) (see the Chapter 3 for an example of this), which leaves women and their rugir-lok with no medical documentation of their labour history in this public health space when they seek care elsewhere through the beshorkari, ‘not state’.

It is not only in these embodied encounters in government maternal health settings that these imaginaries of the state through sheba and jotno are reified. They are also discursively constituted (Gupta, 1995) in the discursive circulation of such
One day, I sat with Fahmida, Papish and Mala, three sisters-in-law who we encountered in Chapter 1, in the buzzing courtyard of their in-law’s home in a small village, where they recounted their birth experiences. Each gave birth three times, and each gave birth both *normale* and through *shejar*. Though they identified as farming people (*grihosto manush*), they mostly avoided the public maternal health sector and privileged home birth or birth in private clinics. The exception was Fahmida, whose water broke when she was only eight months pregnant with her third birth baby. She went to the home of a government doctor whom she knows personally, who advised her to go to the district hospital. She recounts this experience as follows:

*After going to Kushtia, I was admitted to the hospital. When I went there, the hospital people told me to take a paracetamol and lie down. If you lie down, then everything will be okay, and we are not going to do anything… Let’s just say that they did not do anything. They did not care about how many months pregnant I was, that I still had time to go, one month to go. My shejar date was one month later. So that way, they are not going to do a shejar. Also, [they said] you cannot have it *normale*. You are not going to have the baby *normale*, and we are not going to do a shejar; they were saying things like that. The hospital doctor did some tests, and she said to lie down like this and take some paracetamol, and you will be fine.*

*Then my abbu (father) said, no, you will not sit around here and die just taking paracetamol. What am I going to do with my money? I have earned money for my children. If I cannot save my children, then what was the point of earning this money? After saying that, he took me to Sono Tower (a private hospital), where Dr Shamsul sits on the fourth floor. Dr Shamsul was about to go out right when we got there. Dr Shamsul is a very good doctor. He saw me with good care (*jotno*). He checked me over with adoration (*ador kore*), and he said, come with me, I will help you go. I will admit you to the clinic, and you stay there, and I will do the shejar [when it is time].*

Fahmida’s story is emblematic of representations of the state which circulate. Through these, the state is reified as an entity that does not ‘care’ (affect) for those within its purview. In Fahmida’s recollection, the state was even willing to let her die, an uncanny, if macabre, echoing of Foucault’s maxim of biopower as the power to ‘make live’ and ‘let die’ (Rabinow and Rose, 2006, Foucault, 2003: 239).

In contrast, in Fahmida’s account, care in the form of *jotno* was to be found outside of state spaces, within a health marketplace. Of course, not all women experience care of the type described by Fahmida in the private sector. Her sisters-
in-law quickly pointed out that she had the advantage of accessing care at the most expensive and reputable private hospital in Kushtia, thanks to her father, a privilege that neither of the others enjoyed, although they were also satisfied enough with their own experiences in smaller private clinics. That the little-regulated private health market is wildly variable both in terms of sheba and jotno is no secret. Still, the private health sector, the ‘not state’ (beshorkar) sustains its representation as an entity in which one might receive jotno, even if for a price. In contrast, no one expects jotno within the public shorkari spaces.

Conclusion

“They just don’t care.” I often heard this refrain from my icddr,b colleagues when frustrated by the lack of interest demonstrated by the government health service providers they enlisted to implement various development interventions. Sometimes I could not help by think it to myself. I certainly did when I watched the events of Rima’s birth unfold, and even more in the rare moment when a woman arrived with no rugir-lok (hospital security held them back at the gates) and was therefore deprived of all forms of jotno from hospital staff, even when she was in labour with twins at 29 weeks and on the precipice of losing them. But we must interrogate the expectations that health service providers care (affect) about the inherent humanity of the people they serve. Alice Street argues that such expectations remove care from its rootedness in social relations and are “premised on an old opposition between self-interest and altruistic compassion that leads inevitably to the impression that professional care is morally compromised” (Street, 2016).

While the apparent lack of compassion may appear as ‘uncaring’ in public health settings, my aim in this chapter has been to demonstrate that public maternal health spaces constitute a crucial stage in which the state is performed and constituted. Public maternal health spaces, e.g. antenatal care corners and labour and delivery rooms in upazila health complexes and district hospitals, function as sites of embodied performance (Butler, 1990) in which ideas of state are constituted. On this stage, the state is instantiated through the embodied performance of government actors, i.e., medical officers, SSNs, midwives, interns, even the ayas, vis-à-vis the ‘patient’ rugi, i.e. pregnant and birthing women, and their family accompanying them, their rugir-lok, and more generally as a gorib manush. These
encounters unfold as enactments of stylised repetitions of acts (Butler, 1990:191) of particular bodies, during which categories of state and rugi and the rugir-lok are mutually constituted, and the authority of the state is asserted over the body politic (Scheper-Hughes and Lock, 1987).

These enactments need to be understood within the context of class, in which government health institutions are imagined as existing to serve a particular category of people, gorib manush, not as a matter of entitlements for citizens, but as a matter charity to people who possess limited alternatives. This hierarchical rootedness entails the social reproduction of class categories by enacting rules governing class hierarchies. It also entails the maintenance of class distinctions through their performance in these stages. The enactment of care is pivotal to these embodied performances, and to care too much about the gorib manush and cross lines into jotno risks compromising these hierarchies.

These encounters must also be understood within the context of imaginaries of the state in which government staff are expected to deliver ‘care’ as service, sheba, while not necessarily jotno. To return to Alber and Drotbohm’s assertion that care connects not only kin and communities but also states and nations (Alber and Drotbohm, 2015: p.2), public health encounters in Kushtia also serve to disconnect, that is to say, disconnect government health service providers and maintain distinctions between them and those to whom they provide service, through specific enactments of care.

While the performance of public health staff can sometimes appear as ‘uncaring’, I argue that these encounters are shaped by broader imaginaries of the state and morally consistent with what it means to be a state functionary. Through the re-enactment of these embodied performances, government health service providers and staff enact boundary work around service (sheba) and care (jotno), reifying the ‘state’ as an entity which delivers service, though not necessarily ‘care,’ to people occupying lower-class status crystallising within a broader constellation of imaginaries of the state and one’s relationship to it.

Representations of these encounters circulate and map onto broader imaginaries of the state, shaping expectations of public health institutions and those animating these institutions as providers of sheba, most likely to be characterised by
indifference. The recent rise of the private health sector, referred to simply and suggestively as *beshorkari*—‘not government’, offers the promise of an alternative and perhaps the possibility of some affective *jotno*, even if that comes at a price.
Whose territory is the Kushtia District Hospital labour and delivery room? And by extension, whose logics, moralities and agendas operate as authoritative? Perhaps it seems obvious. The rickshaw driver drops Tamanna and me off at the teeming government hospital courtyard as our entry point to locate the space. Posters of the prime minister, Sheikh Hasina, her father, Sheikh Mujib Rahman, and local politicians adorn the façade. “Badam, badam,” calls out a willowy man wrapped in a plaid lungi, a long sarong poor men commonly wear here, to advertise freshly roasted peanuts in a woven basket; another man hoists a lofty pole adorned by balls of hot-pink candy floss. A small group of people assist a man with a makeshift white bandage wrapped around his head to step down from a flat-backed bhan as the driver sits patiently on the saddle of the attached bicycle. A woman’s wail rises above the bustle, signifying the loss of a loved one. We weave through the crowd to the security guards at the entrance of the drab concrete building. The tweets of their whistles jar through the corridor as they hold the crowds back behind the gates. One guard catches sight of us and waves us through, whistle still balanced between lips.
We ascend the ramp, pressing our bodies against the wall when the grating of metal wheels against the concrete floor warns us of the arrival of a stretcher. We wind through the maze of corridors lined with people sprawled on various chatai, colourful woven bamboo mats. Some of the mats’ occupants are attached by the wrist to bags of saline; some have bandaged noses, others bandaged legs; some are old, some are young, most would consider themselves gorib, poor. They form an incidental community of tragedy, people who put their health and lives in the hands of the state for remedy. Tamanna once remarked that the labour room is the only happy place in the hospital. I suppose it is a happy place for some. But even there, we have witnessed no shortage of devastation. Signs point us to the maternity ward, a left, then another left, then a right. We dance to avoid stepping on a chatai, or a person.

We enter the nurses’ duty station. A few senior staff nurses (SSNs) in their signature green nursing uniforms sit at the large desk and gossip. One of them giggles as she writes over a register. Some men and women occupy the wooden chairs in front of the desk, likely the birth of a new family member imminent. Two passages lead out from the duty station. One opens to the postnatal room, lined with back-to-back beds, each occupied with a woman here to recover from a recent birth and her companions.

The other passage beckons with two long pink drapes cascading down over a doorway, obscuring the interior. Each pink curtain bears the Government of Bangladesh logo, and just below, a slightly larger logo of the international NGO Save the Children. These curtains invite us into an ‘upgraded’ labour and delivery room, i.e., a ‘better’ labour and delivery room than one would typically expect to find in a government hospital. Passing this threshold, we realise that the curtains were a mere teaser; inside, posters and banners plaster the walls: one on active management of third stage labour, a couple on the application of 7.1% chlorhexidine solution to the newborn’s cord, others illustrating immediate newborn care. The common thread which connects all the posters is a Save the Children stamp of approval.

Most of the posters present Bangla text primarily, except for one. Only in English, this poster lists 11 points of ‘Evidence-based routine care.’ The ‘evidence-
based’ practices enshrined on this poster range from vague, such as ‘Respectful communication and patient focus’ and ‘No harmful practices’ to the more specific, including ‘Upright non-supine and non-lithotomy positions,' ‘Hydration and nutrition in labour’ and ‘Partograph.’

![Figure 12: ‘Evidence-based routine care’ poster](source)

Source: Photo by author, Kushtia district hospital, 11 Jan 2021

One dominant banner fascinates me. It hangs next to the washroom door, framed by yet another set of pink Save the Children drapes. The poster is text-minimal and displays pictograms of faceless women composed of bright blue, pink, orange and yellow hues. The top half proposes ‘Birthing Positions’ and the bottom ‘Labour Positions’. This poster indicates ‘good’ ways for women to labour: they could walk, climb stairs, squat down with the support of a chair or a birth ball, kneel on all fours, or lay down on their right-side body during labour. On the top portion, pictograms indicate five acceptable birth positions. Sitting on the birth stool and reclining positions seem straightforward enough. However, a third shows a woman who squats over a birth bar, the likes of which is not available in this space. The final two appear decisively acrobatic—squatting and kneeling with a birth ball.
So, to return to my initial question, whose territory is this? Who claims the authoritative logics, moralities and agendas within this space? Perhaps the answer is not an obvious one. As described in the introduction, development forces, spanning international, national and development entities, are gravitational in Bangladesh. These entities include bilateral donors, philanthropic and religious organisations, and a remarkable number of international, national and local NGOs. The latter are so pervasive that Bangladesh is described as the country with the highest density of NGOs globally (Watkins et al., 2012, Rahman, 2006). While these entities vary markedly in their agendas, methods and spheres of influence, what they share is a claim to moral authority, a claim to know what is ‘good’ and ‘right’ and how to make this material in the world.

Among the most prominent and powerful international development actors engaged in health, trends have moved towards the insertion of agendas within the public health system, which reflect global trends towards ‘health systems strengthening’. In Bangladesh, policy documents, debates, and, increasingly, large
scale development projects which apply the lexicon of ‘health systems strengthening’ reflect these discourses. While these discourses highlight four categories of health service delivery actors engaged in a health system, i.e. government, for-profit private, non-profit private and development (Ahmed et al., 2015, Joarder et al., 2019), practically, the narratives and projects tend to employ the terms ‘health system’ and ‘public health system’ synonymously. International development entities with sufficient clout and power use the public health system as a ‘platform’ to insert agendas and test ideas. While these interventions tend to be masqueraded as technical, or ‘rendered technical’, the term Tanya Murray Li uses to describe their sanitation from the their political and social embeddedness and packaged as amenable to bounded technical fixes (Li, 2011), they are foundationally rooted in moral projects and claims to know what is ‘good’ or ‘right’. Within the public health system, they seek to rectify what they perceive as suboptimal care, such as described in Chapter 2, and thereby assert moral authority over a ‘deficient’ state, as well as stake moral claims to intervene into people’s lives and shape they way that they ‘behave’.

As maternal health has long been a popular development zone of intervention, women in Bangladesh often find themselves in the confluence of development initiatives and moralities as they navigate pregnancy and childbirth. Even when they seek services in sites identified as state settings, they are often unwittingly at the heart of competing moral projects. They find themselves at the centre of unknown and volatile performance expectations which are used to reinforce particular entities' legitimacy and justify development initiatives during pregnancy and childbirth. This chapter explores the Kushtia labour and delivery room as a space in which women become entangled in competing moral claims over their bodies and the conduct of their bodies within development aspirations and agendas. It argues

See, for example: UNFPA’s Better Health in Bangladesh: Health Systems Strengthening Technical Assistance, funded by the United Kingdom and implemented in collaboration with WHO (https://www.unfpa.org/better-health-bangladesh-health-systems-strengthening-technical-assistance; accessed 11 July 2022); Save the Children (and partners) MaMoni Health Systems Strengthening Project (Barkataki et al., 2020); UNICEF’s Transforming the health information system in Bangladesh through the implementation of DHIS2 (https://www.unicef.org/rosa/reports/health-system-strengthening-transforming-health-information-system-bangladesh; accessed 12 July 2022).
that, despite best intentions and moral claims, the enactment of such development initiatives, subsumed by development logics, tend to depart from their own moral ideals. Moreover, they exacerbate the volatility of public maternal health services and contribute to the fragmentation and unpredictability more generally associated with these spaces.

Narrating development in the government space

I am doubtful Laboni expected to be caught in the middle of these competing agendas and claims to moral legitimacy when her family brought her to the district hospital to give birth to her first baby. Tamanna and I pass the 22-year-old in the corridor just outside the maternity ward on our way to the nurses’ duty station. She supports her heavily pregnant body with the concrete half-wall open to the courtyard below, and breathes steadily over her protruding belly, brows furrowed. The muscles in her face struggle to hold back a cry. An older woman stands to her right, her hand on the young woman’s shoulder; another woman chatters to her on her left. A young man hovers nearby and throws nervous glances in the young woman’s direction.

When we reach the nurses’ duty station, we meet Rabeya apa, one of the SSNs on duty. She tells us that Laboni arrived around 8:00 in the morning, about an hour before us. Tazima apa, another SSN, checked her when she came — she was only 2.5 centimetres dilated. I could only imagine her disappointment at hearing this news; Laboni’s pani, water, started to leak around midnight and the byaetha, labour pain, hit an hour later. Surely, she expected to be further along when she reached the district hospital after a sleepless night. Tazima sent her out to the corridors to walk and urge the process along.

The labour and delivery room rests empty behind the pink Save the Children curtains, a sharp contrast to the buzz of activity in the nurses’ duty station, where the health staff banter amongst themselves, write in registers, and occasionally answer questions when rugir-lok, companions to the women admitted to the maternity ward, poke their heads in. Tamanna and I chat with Rabeya and Tazima. Rabeya may be slightly older and experienced than Tazima. However, she demurs to Tazima, who fills the room with boisterous laughs and slips into the role of public relations whenever the conversation turns to the different projects for which the labour and delivery room has served as a platform: for example, kangaroo mother care, helping
babies breathe, counselling, delayed cord clamping, ‘sitting delivery’, application of chlorhexidine to the umbilical cord. Different NGOs bring different topic to them, she tells us. Both the nurses agree that it is helpful to have the NGO interventions. The clinical world is upgrading quickly, they say, and this support helps them learn new things. I take this enthusiasm with a grain of salt, given that, even today, Tamanna and I came with two other icddr,b researchers collecting data for a delayed cord clamping intervention they plan to implement. As Tazima recites the talking points by heart, she lifts her perfectly pencilled eyebrows at the right moments for emphasis. Rabeya seems relieved to cede the role of spokesperson to Tazima.

Shahanaj khala\textsuperscript{2}, one of the ayas, helping hands, stands nearby, wearing a faded yellow sari, listening in on the conversation. Tazima instructs her to show us the purple birth ball Save the Children introduced to the hospital as a material artifact to transform the labour and delivery room as ‘upgraded’ through an international development entity. This upgrade was part of the ‘Strengthening the National Midwifery Programme’ run by Save the Children. A large programme in its own right, the ‘Strengthening the National Midwifery Programme’ is significantly smaller than the MaMoni programme, the largest maternal health programme in the country, which they also lead, making Save the Children the most dominant NGO in the country with regard to maternal health. The Save the Children team selected Kushtia as one site to introduce the ‘Strengthening the National Midwifery Programme’. Shahanaj disappears momentarily and returns with the ball. Tazima instructs her to demonstrate for us how they use it. After a moment’s pause, Shahanaj sways her hips as she comically moves the large ball back and forth across her belly. We all burst into laughter. Shahanaj smiles, revealing several teeth missing, and basks in the attention. Daulotpur Upazila Health Complex, the complex which Save the Children initially selected as the upazila-level demonstration site, houses the other birth ball the NGO delivered to the district.

On rotation here this week, the young nurse interns mill around us in their olive-green uniforms. They are indistinguishable from the SSNs except for their youthful faces. A couple of young women wear a pink version of the uniform, which marks them as midwifery interns. These interns are part of a broader initiative to

\textsuperscript{2} Khala, directly translating to ‘maternal aunt’, is the kindship term commonly used to refer to ayas and other support staff in addition to a term used to insinuate intimacy.
introduce a new cadre of health workers explicitly dedicated to pregnancy, birth, and postnatal care which corresponds to the International Confederation of Midwives' standards. Pink is the theme colour the initiative, visible also in the pink of the curtains, and the colour Save the Children uses for symbolic representation of their organisation.

During the 2010 United Nations General Assembly, Prime Minister Sheikh Hasina committed to form a cadre of trained diploma midwives, comparable to the internationally recognized certified diploma midwives (Bogren et al., 2017). While heralded as a government initiative, some of the country's most powerful non-governmental, donor and multilateral organisations champion the midwifery programme in addition to Save the Children, including BRAC University and DFID. In 2018, the national midwifery project produced and posted its first batch of trained diploma midwives to public health facilities. Their pink uniforms function as a perpetual maternal reminder of difference. In their pinkness, they are wrapped in development actors' hopes and moral aspirations. These actors narrate this cadre as 'crucial for ensuring sexual and reproductive health and rights'. They will 'save lives' and 'transform society as a whole', and operate as the silver bullet to reduce Bangladesh's embarrassingly high caesarean rate (see e.g., Masoom, 2017). Four of the five upazila health complexes in Kushtia filled posts for the recommended four midwives (although in many cases, there were only 2-3 actively engaged as they rotated through maternity leaves). While no diploma midwives are posted to the district hospital, those in training come here on rotation as part of their education.

That the midwifery initiative is rooted in international development agendas is a point missed neither by the other cadres of health staff nor the midwives themselves. Despite the Prime Minister's claim to the initiative, health service providers tend to perceive the introduction of midwifery in this form as a foreign project of the kind that they are all too familiar with. While the midwifery champions are preoccupied by the presumed integration challenges of the new cadre, they tend

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to focus on the potential hurdles they face due to their young age, to infringement on the responsibilities that the SSNs previously assumed, or to the low value historically placed on those engaged in birth work (see e.g., Bogren et al., 2017).

However, in our discussions and interactions, the midwives in the Kushtia upazila health complexes did not specifically mention these as challenges. Rather, they mentioned the challenges to their legitimacy based on their association with a foreign (bideshi) project. This contributes to a sense of tenuousness of the professions that is not associated with other health professionals posted to public health facilities, demonstrated by the following exchange with the midwives in Kumarkhali Upazila Health Complex:

*Midwife 1:* They used to say that after a couple of days this post will close.

*Midwife 2:* We have to hear words like this.

*Interviewer:* Why? Is this what people think?

*Midwife 3:* Yes, yes. People often think this about us, and it is very difficult (koshto).

*Midwife 2:* Everybody says that it is a project. A foreign organization (bideshi shongsta) most probably is helping to get it started, and it can close at any time.

*Interviewer:* Okay, okay.

*Midwife 3:* Still, they say this to us, that at any given time it may just close down.

This exchange illustrates prevalent differentiations government health service providers make between the ‘state’ and ‘foreign’ development. Despite its shortcomings, the state is at least imagined as relatively permanent in sustaining the most reliable source of livelihoods in the county (also discussed in Chapter 2). It is virtually unheard of for someone to lose a government job, and though I never came across a specific policy to confirm it, the believable narrative that I often encountered is that to remove a person from a government position requires going all the way to the Prime Minister herself, an action no one would undertake. A health manager might reprimand a health service provider through a ‘show cause’, which means that health management will keep a closer eye on the provider, but that, too, is extremely uncommon. As such, government positions are discursively constituted as the most permanent of any within this precarious space of livelihoods.
As a new project, the number of young women who enter the midwifery curriculum is limited to the number that will be placed in government jobs coming out, so the ratio of students to government postings is exceptionally high compared to all other cadres of health service professionals. This may seem to make midwifery a desirable health profession to pursue; however, this putative benefit is tempered by its precarity as a profession based on its association as an international development project. In contrast to the imagined permanency of the state, development initiatives are imagined as infused with impermanence.

In addition to perceptions related to tenuousness, the logics guiding development-oriented practice tend to be distinct from state logics. International development logics suggest an ideology in which the development apparatus moves ‘traditional’ people and societies linearly toward ‘modernisation’ and development (Pigg, 1993, Gow, 2008); they represent people and places as embodiments of development ‘problems’ which ‘expert’ practitioners can remedy through their contemporarily favoured technical solution (Ferguson, 1990, Pigg, 1992, Escobar, 1994). This ‘rendering technical’ consists of the process by which experts define a development ‘problem’ and draw boundaries around it in such a way that allows development actors to manage the defined ‘problem’ through their preferred technical solutions, sanitising these ‘problems’ of their political and social dimensions (Li, 2011, Li, 2014). Global health discourses tend to parade these technical solutions as ‘evidence-based’ interventions, defined as such based on a particular intervention’s amenability to metricisation, imbricated within broader concerns within the field of global health related to ‘return on investment’ (Adams, 2013). ‘Evidence’ and ‘evidence-based’ have taken on the status of dogma within the field of global health, and increasingly so with the rise of corporate-minded entities which now dominate the field and the focus on quantification and measurement (Adams, 2013). The subtext of ‘evidence based’ is that which is beyond reproach, as an authority has determined what ‘works’ and, therefore that which is ‘good’. Vincanne Adams traces the transitions from ‘evidence based medicine’ in clinical practice to its evolution into a hegemonic model of knowing through quantification and metrics in global health. She argues that it has become ‘tyrannical’ in clinical practice and public and global health (Adams, 2013). While anthropologists have developed an extensive body of work demonstrating the social embeddedness of these trends
toward ‘scientization’ of the field of global health (Parker and Harper, 2006), the point I wish to make here is how moral projects are subsumed under the banner of ‘evidence’.

Ideas labelled as ‘evidence based’ become incontestable objects of ‘truth’. However, the application of methods to generate evidence related to social interventions is particularly murky, such that global recommendations tend to appeal as much to moral sensibilities as they do to ‘evidence-based’ sensibilities. Indeed, some ‘evidence-based interventions are justified as a matter of moral principle, rather than based on ‘evidence’. Here, I do not mean to suggest that there is no value to the scientific research generated to formulate these ‘evidence-based’ packages, but rather to highlight that they reflect particular moral sensibilities which stand at odd with predominating sensibilities in these public health spaces, as discussed in Chapter 2.

As such, ‘evidence-based’ constructs assert moral authority over the state. The preference of some development entities to use the state institutions as a platform to insert agendas mirrors a trend within the development apparatus to discursively assert the state’s primacy. This discursive trend is reflected, for example, in shifts toward discourses around health systems strengthening, sustainability and the pedestalisation of rights discourses even in the most technical of spaces. Such discourses take for granted a state which assumes responsibility. The Millennium Development Goals and subsequent Sustainable Development Goals are a clear case. These homogenising goals, elaborated in a transnational space imagined as transcending nation-states, require the endorsement of and collaboration with states who publicly claim the objectives as their own (United Nations, 2015b, United Nations, 2015c). This pedestalisation hangs in tension with

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5 A good case in point here is the document, “WHO Recommendations on Intrapartum Care for a Positive Birth Experience” (World Health Organization, 2018b). These recommendations, like others disseminated by WHO, are explicit in situations of randomised control trials (RCTs) at the pinnacle of the evidence hierarchy. It reads, for example: “By default, RCTs were considered to provide high-certainty evidence, while non-randomised and observational studies provide low-certainty evidence” (p 14). However, despite this, many recommendations are made based on evidence identified as ‘low certainty’. Based on these classifications, most included recommendations are admittedly based on very-low’ or ‘low’ quality evidence, with a handful based on ‘moderate’ evidence. Rather, many of the recommendations included reflect a morality, such as respectful maternity care and interpersonal communication. While these are included based more on principle than on ‘evidence’, and perhaps justifiably so, this also bring to mind Andrea Cornwall’s scholarship on ‘buzzwords’ in the field of international development, boundary objects which conceal multiple agendas and crystallise into ‘good things’ beyond reproach (Cornwall and Brock, 2005, Cornwall, 2010), reflecting a particular morality.
an imaginary of the postcolonial state as unable and unwilling to respond to its citizens (Hansen and Stepputat, 2001). In this dialectic, the development apparatus claims a space of moral authority over a ‘deficient’ state, and a claim to know what is best for women under the banner of ‘evidence’.

“But we must not do lithotomy”

Over an hour later, Laboni interrupts Tazima’s talking points when she breaks into the nurses duty station. She slings her body forward, one arm wrapped around her mother’s neck, the other around her nonod, her husband’s sister. The two willowy companions struggle under her healthy weight. Tazima turns her eyes toward them, one perfectly shaped eyebrow raised. The young woman moans and throws her head forward. Tazima instructs them to enter the labour and delivery room. Rabeya stands and walks alongside the party of three. She guides them to the non-reclining bed adjacent to the Save the Children bed; the two beds separated only by yet another pink sheet bearing the Save the Children logo which hangs over a metal bar. Laboni’s mother and her nonod help her to lift her body onto the bed. Her long black hair dangles off the bed as she lays back, greasy from scalp to end with the oil that her companions applied to soothe her.

Tazima struts into the room, towering over everyone else in the room. Laboni’s mother hands her a small paper bag. Tazima rips it open to pull out the cream-colored medical gloves, which she then slips over her hands and wrists while Laboni writhes and moans on the bed. Her mother assists her to hoist her long brown burqa studded with colourful jewels over her protruding belly and pull her burgundy petticoat around her waist to spread her legs wide. Shahanaj khala tears off a piece of yellow-hued patterned cloth and spreads it over Laboni’s pelvic area. Tazima performs a quick pelvic examination (PV). “Five cm,” she announces as she strips off the gloves and throws them in a bucket. Laboni moans.

Shahanaj khala bursts out in a laugh, her grey hair peeking out from under her headscarf. Are you tula rashi? she teases Laboni, referring to the zodiac sign of Libra. Tula rashi cannot bear the pain, she says, shaking her head, as if Laboni’s zodiac sign was the source of the young woman’s perceived shortcoming in bearing the labour pain. She then instructs Laboni to stand. The young woman resists, begging to stay in bed. No, says the khala. She must get up and walk. If you want to
have the baby, you must get up. Tazima and Rabeya nod in agreement. The young woman’s mother assists her to sit up and climb down from the bed. Shahanaj instructs her to come and roll the birth ball across her belly. Laboni does so. With shut eyes, she moans as she rolls it over her stomach.

Rabeya apa watches the young woman from a distance, arms crossed. “Stomp,” she instructs, and demonstrates how to do so. Holding on to her mother, Laboni tromps through the room with stiff legs. She moans and grabs her back when the byaetha strikes; her mother and nonod steady her. After a few moments, Laboni’s mother leads her to the washroom, and her nonod wanders towards us. She slouches down in one of the plastic chairs reserved for the SSNs. Her cheekbones jut out of her cheeks under her long orange headscarf. Tamanna and I take a seat next to her and talk for a few minutes. She tells us that she has three children herself, two were born at home, and the last through caesarean at a private clinic. We ask her why she and her family brought Laboni here, to the district hospital, for birth. She looks at Tamanna and then at me as if to verify that we are serious about the question. Is it not obvious? When she sees that we are, she shrugs and answers with one word, “Gorib.” Poor.

Tazima glances over and catches sight of us perched in the plastic chairs. She storms toward us and scolds Laboni’s nonod for occupying the seat reserved for the health staff and ‘guests’ accorded enough honour to sit down, a category in which I and the other icddr,b researchers are included, but from which Laboni’s nonod is definitively excluded. Apa, we speak up, we wanted to talk to her, jumping to the woman’s defence. Tazima concedes but proceeds to lecture Laboni’s nonod for wearing her surgical mask on her chin, rather than over her nose and mouth according to Covid-19 regulations. Laboni exits the washroom, her mother in tow. Tazima orders them to go back to the corridor and walk there. She is only five centimetres dilated, she reminds her, it will still take time. Laboni, obedient, vacates the room in her awkward stomp; her mother and nonod escort her.

With the room quiet, Shahanaj khala hops up on the bed near the window. She stretches out lazily, one elbow resting on the purple Save the Children birth ball. Her greying hair is pulled back and visible under her loose headscarf. In the stillness, Tamanna and I ask her to tell us her story and how she ended up working here as an
aya. She is a bit nostalgic as she recounts her days supporting women to give birth at home as a dai. She is happy to have a job in the district hospital now, she tells us. These days it is too risky to be a dai; too many women have shelai, stitches, that threaten to burst open when they give birth at home. She does not want to be responsible for that.

Laboni breaks through the curtains with a groan, trudging back toward the birth ball, a midwife intern and her nonod close in tow. “I do not feel good,” Laboni cries. “I cannot take any more.” She yowls as she vacillates the birth ball back and forth across her belly. She abandons the ball and walks with support across the room as instructed.

A ring tone fills the room. Laboni turns and moves back to the bed by the pink curtain. She reaches inside her purse, sits on the bed, and pulls out her phone. She takes a deep breath and then answers. “Hello?” she says, suddenly composed. Her husband calls from the district hospital’s corridors, keeping a safe distance from this woman-only space. He is worried about the bleeding that Laboni experienced previously. He wants to take her somewhere else, to a private clinic. “I cannot take anymore,” she says to him, though her voice is still composed. She passes the phone to her nonod. His sister reassures him that this is normal; he should not have any tension. As soon as she hangs up the phone, Laboni resumes crying.

Tazima apa reappears and instructs Laboni to return to the ball and use it to push the baby down. She does as instructed, but only momentarily before returning to her stiff-legged strut across the room. “Let me lie down,” she pleads to her mother, but her mother ignores her under Tazima’s gaze. Her mother recites the doya Yunus, passages from the Quran which speak of the suffering of Jonah trapped in the belly of a whale, while steadying her daughter. Laboni closes her eyes as her mother leads her across the floor, her head cocked to her left shoulder. I cannot tell whether her pain or her exhaustion is consuming her body more.

Tazima apa returns and says that she will recheck Laboni’s cervical dilation. The young woman shuffles over to the bed. Her mother hoists her up, and she lays back on the reclined Save the Children bed, her eyes still closed. Her moans and groans transform into melodic hums, perhaps from the simple relief of lying down. Tazima approaches Laboni. On the cusp of the performance, the room is suddenly
full of life. Four nurse interns and one midwife intern crowd around Laboni’s hips as Tazima performs the PV. Laboni suddenly grunts and bears down. The interns huddle in. Rabeya apa unhooks one of the blue plastic aprons from the wall and ties it onto Tazima’s neck and waist. Tazima takes position at the bottom of Laboni’s bed, ready to catch a baby. Laboni’s mother stands at her head and strokes her long, oily locks. Her nonod grips her hand. “Byaetha, byaetha,” cries Laboni, pain, pain.

Without warning, another woman bursts in through the pink curtains, her thick black hair exposed, cascading down her back. She wears a brown-hued floral kameez, a long tunic, marking her as distinctly urban. She parks in the middle of the room, arms crossed as she scans the territory through narrow eyes. Tazima catches sight of her and immediately stands at attention. The interns follow suit. Wide-eyed, Rabeya apa discretely hooks the three-legged birth stool stashed under the bed with her ankle. She slides it towards Laboni’s bed as imperceptibly as possible, peering at the woman from the corner of her eye. The command that the woman engenders in this room, despite her youth, can only mean one thing: she is a daktar, a doctor. Even Laboni’s attendants stand at attention, and only the labouring young woman seems incognizant of the palpable change. She moans each time byaetha seizes her uterus, her contractions occurring one on top of another. She closes her eyes during each short moment of respite in-between, seeming to gently nod off to sleep before another gripping contraction rudely awakes her.

Within moments, SSNs, nurse interns, midwifery interns flood the room. The woman approaches Tamanna and me and asks who we are. We introduce ourselves. She nods and turns away from us without introducing herself. We soon learn, however, that she is not just any daktar. This woman is Sayeeda apu, the Save the Children daktar, responsible for capacity development for the Strengthening the National Midwifery Programme. Sayeeda apu glowers at Tazima and Rabeya. Why is the rugi, patient, lying down? She points toward the poster of the Evidence-based Routine Care. At no point should the woman be in lithotomy⁶ position, not for labour, not for delivery, she shouts. The two SSNs cower. Suddenly, Tazima, previously dominant and towering, seems small.

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⁶ While a clinical definition defines lithotomy position as supine with legs bent at a 90-degree angle, I use the term here to indicate a supine position, as it is used by the health service providers in Bangladesh.
She orders Tazima to move the labouring woman to the reclining bed. Laboni cries at the prospect of moving but to no avail. Tazima orders her mother and nonod to shift her off the bed. Apa, says Tazima, addressing Sayeeda, we tried to do the *counselling* (English cognate), we did so much *counselling*, but the patient still insisted on lying down.

Sayeeda *apu* pays her no regard and moves toward the poster in our direction. Tamanna and I dodge to stay out of her line of fire and take refuge in the crowd. What are the components of evidence-based routine care? she interrogates her captivated audience. The interns whisper amongst themselves, and then they start to call them out. Meanwhile, Laboni’s mother reties her petticoat around her daughter’s waist. She and her *nonod* then hoist her out of bed. An arm around each one of them, she stumbles against her will towards the reclining bed. However, the crowd blocks them in their path, and the three stand still as Sayeeda continues the lecture. Finally, Laboni cries, “*Ma, I want to lie down.*” The chitter-chatter of the lecture hall continues drowning out Laboni’s voice. Then again, she cries, “*Ma, let me lie down.*” Sayeeda takes notice this time, as does her audience. They clear a path so that Laboni’s mother and *nonod* can find their way to the reclining bed, with its back up. She hobbles up the three ‘Save the Children’ steps onto the bed.

Sayeeda *apu* positions herself at Laboni’s pelvic floor but at a safe, three-foot distance, hands on her hips. Laboni groans. The nursing and midwifery interns, approximately 12 of them, gather around. “I feel like we are in a lecture hall,” Tamanna whispers. Laboni cries out and bears down. Her *nonod* stands at her head, rubbing more oil onto her scalp and hair. Laboni turns on her left side. Sayeeda *apu* interchanges scolding, directed towards the SSNs and nursing interns, interspersed with softer words directed at the midwife interns.

“My stomach is tearing apart; I cannot take this anymore!” Laboni cries out. Her mother massages vigorously into her back. Sayeeda *apu* crosses to the other side of the room. She calls Tazima over and rebukes her for something about the instruments. Apa, I did not do it, she said, deflated. It was the *khala* who did it, whatever ‘it’ was. Sayeeda is not satisfied, ‘it’ was Tazima’s responsibility; she should not have asked the *khala* to do ‘it.’
Sayeeda apu returns to the side of the room with Laboni and her companions. She holds up her phone towards Laboni, scoots back to frame an angle, and snaps a couple of photos. She then moves toward the poster of the Evidence-based Routine Care again. All eyes follow her, and Laboni disappears into the background, which I can only imagine is a relief. She places her index finger on point number 3: Upright non-supine and non-lithotomy positions for labour and delivery. “We need to do the delivery according to the patient’s choice,” Sayeeda instructs her audience, “but we must not do lithotomy (Amader patient choice delivery korate hobe, kintu amar lithotomy korbo na).” Nowadays, the project monitoring is strict, she says, and they need to ensure non-lithotomy deliveries. She glances towards Laboni when she groans once again in the background and bears down. Tazima glances toward her pelvic floor, but there is still no sign of crowning. Sayeeda apu approaches, hands on her hips. She huffs. Tazima apa announces that she needs to go to the washroom. She tugs off the blue plastic apron theatrically and thrusts it toward Rabeya apa. She pulls off her rubber gloves as she storms outside through the pink curtains. Rabeya looks at the apron like it is a hot potato to be passed on as quickly as possible; she does not put it on.

Sayeeda apu orders no one in particular to shift Laboni to the stout birth stool. Another SSN pushes it forward. Laboni’s mother and nonod nudge her to manoeuvre back down the Save the Children stairs and through the crowd of interns to take a seat on the wooden stool. Laboni groans as she sits. Her companions hoist her petticoat above her waist. Laboni, eyes closed, leans back into her mother behind her, her nonod to her side. “What is your name?” barks Sayeeda apu. It suddenly strikes me that since Sayeeda’s arrival at least 30 or 40 minutes previous, this is the first time she directly addresses Laboni; more than that, she did not even care to learn her name until now.

“What is your name?” she demands again, losing patience when Laboni does not answer.

“Laboni,” her nonod finally sighs. Sayeeda asks her nonod what Laboni has eaten. Her mother responds that she has not eaten since she went into labour, so nothing since midnight.
She has not eaten all night? Sayeeda exclaims. How can she even have the energy to push if she has not eaten! She needs to eat. Laboni’s nonod rushes out through the pink curtains. Her mother steadies her on the stool. Laboni closes her eyes and hangs her head toward her right shoulder. A contraction seizes her stomach, pulling her from her rest. She screams out and bears down. As soon as the byaetha passes, she leans her head on a shoulder and drifts off again until the next contraction pulls her awake.

Sayeeda apu shouts at Rabeya apa, and accuses the medical team of a failure to comply with the monitoring when her superiors visited. We tried to do good, apa, Rabeya protests. Well, Sayeeda responds, you may think that you are all good, but even if there are only one or two who are not good, I will not take that chance, so it would be better for you to tell me who is not doing good.

She then stands back and holds up her phone once again. I can see Laboni on her phone screen from this position, exposed and vulnerable. Click, the screen flashes and Laboni’s image stands frozen in time. Sayeeda says yesterday she saw a Facebook post that another Save the Children staff posted showing a peaceful image of a woman holding her baby just after birth. They should not post photos like that, she says. They should post photos like the one she just snapped of Laboni, photos showing the struggle of labour. Laboni grunts and pushes down. Sayeeda looks at her and then shifts her gaze around the room.

Where is Tazima? Sayeeda demands as if she just noticed her absence, which is now well over 20 minutes. No one answers. She went to the washroom, someone from the crowd finally responds. Who is in charge then? Sayeeda demands. She scans the crowd with narrowed eyes. She finally settles in on one person. You, she says, have you ever done a delivery? A midwife intern lights up. Yes, one time, she responds. Get ready, Sayeeda says. The thin young woman pulls on medical gloves up to her pink sleeves while another midwifery intern ties the blue apron around her waist and neck.

Sayeeda orders someone to massage Laboni’s stomach. The midwife intern with the apron obediently follows orders and massages Laboni’s stomach. Not you! yells Sayeeda. You cannot touch anything once you have put on the gloves! The
midwife intern retreats, and one of the nursing interns moves forward. The baby inside does not budge, despite her pushes.

Laboni’s *nonod* returns with a hardboiled egg. Her mother supports her head while her *nonod* pushes the egg in her mouth. Laboni opens her mouth and chews reluctantly, too tired to resist. Her mother cradles her daughter’s head in her hands; her eyes stay closed while her jaw moves to chew. Sayeeda *apu* scolds them. What are you doing? she barks. Do you think this the time for eating an egg? She shakes her head while Laboni’s mother and *nonod* stare blankly towards Sayeeda, not sure what to do with the egg retrieved at the *daktar’s* behest.

Sayeeda *apu* instructs the nurses to do counselling. One of the SSNs comes near Laboni’s face and puts her hand on her head. Laboni opens her eyes and gazes at her. The SSN tells Laboni that it is all in her head. If she makes up her mind, she can do it. Laboni’s eyes fix on her, delirious. Finally, Sayeeda instructs one of the midwife interns to do a PV to check her cervix once again. Is she really fully dilated? Why is the baby not further down? The midwife intern crouches down near Laboni’s pelvis and performs the PV. After several seconds, she reveals her verdict: 8 centimetres. She is only 8 centimetres dilated. The energy of the room deflates like a popped balloon. Sayeeda purses her lips. Why were they trying to get Laboni to push? The young *daktar* scowls. No one answers.

Without saying goodbye to Laboni or her attendants, or anyone else for that matter, Sayeeda spins around and storms out through the pink curtains. A procession of SSNs, nurse interns and midwife interns trails behind her, leaving the room nearly empty. Only a couple of young nursing interns remain. Laboni, whom I can only imagine must be more forlorn by that news than anyone, grabs on to her companions and rises from the confinement of the stool. She begs to lie down, but they, well-disciplined by the medical staff, refuse her request. Instead, they lead her back over to the birth ball.

We can hear Sayeeda rebuke the SSNs and interns in the nurses’ duty station as Laboni cries and rolls the ball across her belly. They need to be more careful about the monitoring, Sayeeda lectures. Suddenly, Laboni heaves and retches, the sound of previously consumed water and egg crashing down on the birth ball, the plastic sheet on the bed and the floor. The smell of vomit floods the room. She
retches again. The two nurse interns stare, stunned. She is vomiting! one of them whispers, stating the obvious. It smells so bad! As soon as they remobilise, they rush out of the door to the duty station, which is left silent after Sayeeda’s departure.

Laboni’s nonod helps her back to the stool. Her mother dutifully takes a piece of cloth and wipes the birth ball, managing her daughter’s corporeal pollution. She takes the corner of the plastic sheet off the bed and begins to roll it up to contain her daughter’s vomit. Finally, Shahanaj khala shows up with a bucket and mop. I am surprised when, rather than mopping, she hands it to Laboni’s mother. She takes hold of the mop and sways it back and forth under Rabeya’s gaze.

Laboni sits on the stool and cries. Her husband calls again. This time she is not composed. “All night, all day [I have been doing this], but it will not happen; it will not happen. There are no people here; take me to wherever there is a doctor, I will not stay here,” she complains. With Sayeeda clear from the premises, Tazima trudges back through the pink curtains. Apa, Laboni’s nonod says, addressing the SSN, she does not want to stay anymore, she wants to go somewhere else.

Almost as if on cue, a doctor intern in a floral dress and white medical jacket breaks through the curtains. She chatters into her phone without looking at Laboni. Finally, she hangs up the phone and faces Tazima. Tazima explains that the rugi’s family would like to take her elsewhere. The intern doctor turns to Laboni’s nonod. Fine, she can go, she says. However, they will not give her a charpotro, a discharge certificate. It will be as if she were never at the district hospital.

Laboni does not hesitate. She does not look directly at the intern doctor when she says, I do not need anything; I just want to go. The intern doctor shrugs, spins around, texting on her phone as she rushes out. Laboni’s mother and nonod gather her things, a large plastic water bottle and an orange plastic net containing medicines and supplies purchased from a private medicine shop. Tamanna and I say goodbye to them as they pass through the curtains, but we do not ask where they will take Laboni, her cervix now at the least 8 centimetres dilated.

The room feels tragically empty, with only Tamanna and I remaining with Tazima and one of the midwife interns. Tazima holds her head high. Apa, she says, did you see what that madame did? she says, referring to Sayeeda with the highest designation for a woman. She made us do these things, and she did not allow us to
do things our way. If it were me, I could have given the saline [with the oxytocin], and the rugi would have delivered by this time. But she would not let me give the saline, and she scolded me, which is why the rugi left. The proudness of her voice is a superficial cover for her humiliation as she articulates that Sayeeda apu prevented her from providing good care as she knows it.

Tazima turns to the midwife intern. Where were you? she rebukes. You were supposed to be here—you are their people. Your salary comes from their project. I am not their staff, so I have nothing to do with them. I do not want to do their deliveries, so I just left. The midwife blushes and stammers something about how she was just trying to learn, but I am sure she struck a nerve with that comment; the midwives commonly express the derision they face for presumably embodying a bideshi, foreign, project.

Tamanna and I never learn where Laboni finally gave birth, whether it is normale or shejar, or how she and her baby fare once all is said and done. We do not know how much the family paid in seeking out health services within the beshorkari, ‘not state’, health market outside of the purview of the state and this international development force, and how the family arranged the financial resources. However, if Laboni is like most women, she will later tell this story as her experience in a shorkari haspatale, the government hospital, shaping how she and her family imagine the state and their relationship to it. Perhaps they never realised who Sayeeda apu was, and they most certainly did not grasp the competition of moral agendas that they had become entangled with as the Save the Children daktar struggled to bring the government health service providers to conform to the agenda, using Laboni’s labouring body largely as a prop in the process. Nevertheless, they were cognizant that the criteria for good performance in this setting were a moving target as they struggled to comply. Of course, it is not only women and their families who struggle to comply but also shorkari health services providers, for whom the waves of different agendas, competing interests, and appeals to moralities are integral to their reality of the provision of public health services.

The ‘development’ of Bangladeshi women’s pregnant and childbearing bodies

In Bangladesh, working through the state health apparatus at large scale is reserved for some of the most powerful and resource-rich organisations. Typically,
these tend to be international NGOs, multinational organisation, donor organisations and research institutions, primarily aligned with Western supranational development agendas, a corner of the development apparatus which remains a critical force in shaping the maternal health terrain in Bangladesh by infiltrating and reshaping the public system itself.

Development actors depend on women's correct 'behaviour' to demonstrate the viability of their actions and justify their very raison d’ être. Indeed, while the notion of empowerment remains one of the most popular development buzzwords globally and in Bangladesh, this idea of empowerment is almost without exception to empower 'beneficiaries' towards the programmer’s ends (Cornwall and Brock, 2005). As Barbara Cruikshank elegantly summarises, “The will to empower may be well-intentioned, but it is a strategy for constituting and relegating the political subjectivities of the ‘empowered’...The object of empowerment is to act upon another’s interests and desires in order to conduct their actions toward an appropriate end” (Cruikshank, 1999:68-69). In Laboni’s case, this conduct was narrowly defined in the injunction to position her body in a particular way at a particular time, preventing her from even lying down to rest after a sleepless night and in the throes of exhaustion. Through the midwifery programme, ‘counselling’,7 for which the English cognate is always used, was introduced as the latest mechanism for shaping women’s behaviour toward an appropriate end in Bangladesh, reflecting global trends towards counselling for maternal and newborn health care (World Health Organization, 2013). Promoted as a technical intervention, ‘counselling’ in this context operates as a repackaging of behavioural change and ‘empowerment’ models, designed to generate a particular subject towards particular ends, emphasizing communication as a tool to produce a subject who embraces biomedical knowledge and regimes in ‘good’ ways during pregnancy and childbirth.

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7 The WHO document Counselling for maternal health care: A handbook for building skills (2013) defines counselling as follows: “Counselling for maternal and newborn health is an interactive process between the skilled attendant/health worker and a woman and her family, during which information is exchanged and support is provided so that the woman and her family can make decisions, design a plan and take action to improve their health.” This definition, certain parameters are assumed as constituting a good plan, and singular pathways for improving health, with only superficial attention paid to the broader context. Within public health services delivery settings, health service providers tend to point to moments of advising women on pregnancy care as ‘counselling’, and do not clearly articulate at difference between ‘counselling’, for which the English cognate is used, and the Bangla ‘poramorsha doya’, which means to advise.
Metric forms of demonstrating ‘impact’ have become increasingly important in the development community, part and parcel of shifts toward ‘results-based management’ and audit culture rooted in corporate-oriented ideologies (Strathern, 2000). These concepts are used to determine the ‘goodness’ of development initiatives and justify their moral claims. Therefore, development actors are under immense pressure to quantify their ‘impact’ in their influence zones (Adams, 2016a, Fan and Uretsky, 2017). One way this ‘impact’ is demonstrated is by quantifying women’s ‘behaviours’. This preoccupation with measuring and monitoring is used to justify the intrusion into some of the most intimate spheres of women’s lives in Bangladesh, where entire infrastructures have been established for measuring and controlling women’s reproductive ‘behaviours’ (Murphy, 2017). Under the pressure of producing metrics, women’s bodies themselves become metricised.

The case of birth position is a particularly perverse form of the manifestation of how intimate the intrusion of the development apparatus can be. The Kushtia Civil Surgeon’s office and the upazila health complexes are equipped with a large pink board presenting the Strengthening the National Midwifery Programme’s indicators. ‘Non-lithotomy position’ is included among the indicators of labour room success. In this model, a woman who gives birth in a supine position has failed to conform to expectations and represent a successful vaginal birth within this development agenda set for her.

Certainly, the initiative is well-intentioned. Birth in horizontal positions is relatively uncommon historically, as traditional birth practices tended to favour upright positions, such as squatting or kneeling (Dundes, 1987). Lithotomisation of birth was an outgrowth of the biomedicalisation of this life transition as supine birth facilitated the work of the (usually male) obstetrician. In the subcontinent, supine birth was introduced as part of the broader colonial project to reshape the way women reproduce and give birth (Naraindas, 2009). Towards the end of the 20th century, scholars and activists alike challenged this practice as at once a manifestation of patriarchal control over women’s bodies and running counter to human physiology and therefore impeding rather than facilitating birth (Davis-Floyd and Cheyney, 2009, Bodner-Adler et al., 2003, Dundes, 1987). These messages coupled with mounting quantitative research on the topic (Gupta et al., 2017) made inroads within the global health apparatus and are now reflected in global initiatives.
and technical guidance, recommending that women be encouraged to adopt the birth position of their choice, including upright positions (World Health Organization, 2018b, World Health Organization, 2014).

One might read these developments as promising. However, in this setting, this agenda serves to map the very physical positionality of women’s bodies onto ideas of the ‘Third World Woman’ (Mohanty, 1988) when subsumed by the broader logics steering development imaginaries. In the Kushtia District Hospital ‘upgraded’ labour and delivery room, the ‘Third World Woman’ is imagined as inappropriately physically positioned during labour and birth, with colourful posters standing of markers of how women’s bodies should be positioned for redemption. Proponents of upright and non-supine birth positions rightly point to these positions’ historical prominence and physiological and evolutionary justifications (Trevathan and Rosenberg, 2000, Dundes, 1987, Davis-Floyd and Cheyney, 2009). From this vantage point, a return to non-supine birth positions is imagined as an opportunity for reclaiming woman-centred birth practice. However, in these settings, non-supine positions are stripped of their reclaiming potential, as they are appropriated as yet another technical intervention requiring women’s conformance. Like the immotile objects of representation, the purpose is not to expand movement and agency but to manoeuvre bodies into specific and static states, which can stand in as evidence of
redemption through development and thereby the success of the development project.

Across the country in Sylhet, BRAC University supports an experimental midwifery-led care centre. Though branded as a stand-alone structure, a government union health and family welfare centre houses the space where six BRAC-hired midwives provide 24/7 midwifery care. Besides the usual upgrade offerings, like the posters and the birth ball, this centre boasts a birth chair. The chair resembles a throne, with a high back fixed with army-green padding, footrests, and a black horseshoe-shaped padded seat, open to a blue bowl receptacle.

In the nearby BRAC midwifery training institute, the local implementing partner's project manager presents the project to me during a visit using text-heavy slides. He lingers on one slide that is less text heavy than the others in the presentation. It presents three colourful figures which demonstrate the key measures of success of the midwifery-led care centre. The usual suspects are there, number of ANC visits (between 136 and 320 per month) and number of deliveries (31 to 102 per month). However, it is the third figure which catches my interest: a blue and red pie chart labelled ‘Delivery position.’ According to this figure, 541 women,
representing 86% of the women who gave birth in the centre during the past year, gave birth in a ‘chair-sitting’ position. Only 85 women gave birth in ‘lithotomy’ position. The project manager beams as he presents this figure, a key indicator of success, their fruitful enforcement of one (good) birth position over another (bad) position. The very physical positionality of women’s bodies is metricised, and women’s bodies are manoeuvred in specific ways to yield desired metrics. Quite clearly, the interest at stake is more about the justification of the project, and perhaps the chair, which thereby serves to justify a development workforce and apparatus, and less the women, whose bodies are contorted to fit into these boxes.

Back in the Kushtia District Hospital, lithotomy position during birth is the norm and probably the easiest way for women to conform to the health services providers expectations to be a lokkhi meye, a good girl, disciplined and obedient, during childbirth, consistent with other postcolonial contexts in which birth takes on significance as a site for civilising women (Boddy, 2007). Despite the gargantuan poster on the wall and the other efforts to promote non-lithotomy position, in my experience, except for the moments when Sayeeda apu appears, health service providers do not encourage or propose a different position. On the other hand, neither do women. Moreover, the latest ‘evidence-based’ recommendations of the World Health Organization most certainly contributed this zeal, promoting woman’s position under the banner of discourses of ‘empowerment’ and ‘choice’ at the time of birth (World Health Organization, 2018b), reflecting the nurturing of particular sensibilities and concealment of the politics, power and realities that women confront to navigate biomedical birth.

The entanglements of the development apparatus in the public health system have significant implications in constituting imaginaries of the state in Bangladesh. While the development apparatus is an integral thread of the Bangladeshi social fabric, people tend to distinguish between services and opportunities that they avail through state and those outside of this imagined entity. However, when they seek services in the state sector, they are unlikely to distinguish between state and non-state influences in these spaces. What happens in these spaces is absorbed into people’s experiences with the everyday state and shapes how the state is imagined (Gupta, 1995, Sharma and Gupta, 2009). Despite their appeals to long-term, ‘sustainable’ health systems strengthening the perpetual entrance and exit of these
actors and the shifting tides of their agendas fuel the perpetual flux of availability and non-availability, unreliability and fragmentation constituting ideas of public health apparatuses.

However, if distinctions of 'state' and 'development' are merged for women encountering these spaces, this ambiguity is not shared by the government health service providers taken as the front-liners of development initiatives. Indeed, the government health service providers are well acquainted with the comings and goings of different organisations, new posters with new logos going up, old posters with old logos coming down, new registers to capture new measures of ‘success,’ others slipping towards irrelevance. Promises kept, promises broken, new training for ‘capacity development’ to digest, others to forget. Government health service providers caught in the winds of these agendas yet rarely privy to their drivers as they change directions.

Hospital staff, including Tazima and Rabeya, are well versed in the initiatives and eagerly pay lip-service to them when required. However, their practice quickly betrays this lip-service as these sites become spaces for health service providers to contest these external demands. Indeed, technical interventions claim a blissful ignorance to what it means to be government, and how these interactions are both shaped by and shape the state-making project, as discussed in Chapter 2. Admittedly, the SSNs staffing government health spaces navigate these initiatives creatively, often to their resistance. For example, despite Sayeeda apu’s insistence on rigour in monitoring, the SSNs admittedly do not precisely track the position women finally assume to give birth. Instead, nurses ‘estimate’ the number of women who gave birth in a non-lithotomy position each month, numbers which are thereafter sent through the parallel state and development chains to support the legitimation and justification of each.

Conclusion

The labour and delivery room is not the only space in the Kushtia District Hospital in which claims for moral territory are at stake, blurring ownership and responsibility, state and development enactments. Using the public health system as a ‘platform’ is commonplace for non-governmental actors to ‘test’ interventions or insert agendas, at least those with sufficient power, resources and links to sway state
apparatuses in a country Naomi Hossain appropriately refers to as an ‘aid lab’ (Hossain, 2017). Popular development issues, i.e., newborn care, integrated management of childhood illness, pregnancy care, kangaroo mother care, are well-marked by the seals of various development actors. Meanwhile, less ‘sexy’ development issues, such as general gynaecology (non-obstetric related) and emergency care, turn into zones of abandon

In Kushtia, women often unwittingly find themselves caught up in development initiatives and their accompanying moral claims within public health spaces. In these interfaces, women’s pregnant and childbearing bodies become quite literally and intimately entangled in broader development ambitions at the sites of state processes. The dictation of birth position is a particularly graphic example of how Bangladeshi women are imagined as ‘Third World Women,’ whose bodies must be positioned in particular ways for redemption. However, this is far from an isolated phenomenon, with the conduct of women’s bodies toward particular ends a preoccupying concern within development imaginaries.

I do not intend to suggest that government health services in the absence of development meddling would result in ‘better’ care imagined from the moral and clinical stance of development practitioners. Passing through ‘zones of abandon’ would suggest otherwise, as would the graveyard of corners of development initiatives in government spaces, such as the Kangaroo Mother Care room, which was promptly locked as soon as icddr,b lost funding to continue encouraging government health staff to use it. Instead, I contend that in the enactment of development agendas, even the best-intentioned technical interventions, when subsumed by development logics, become sites to override women’s agency in the interest of justifying development ends, thereby undermining the morality of such initiatives according to their own stated moral aims. Moreover, shifts in appealing to development trends located far from the women taken as the target of intervention, the development apparatus contributes precisely to the aspects of the state which render it a space of preferred avoidance, the fragmentation and the enactment of indifference.
Chapter 4: "Service through business, not business through service": The makings and moralities of maternal health markets

Maternal health privatisation and national discourse

Despite a long-standing ideological commitment to a private health care market underpinned by market-centric ideologies infusing international development practice in Bangladesh, it is only recently that social, economic and political forces conjoined to trigger a proliferation of an institutionalised private biomedical health sector. Nationally, policymakers and programmers have met these shifts with ambivalence. National policies and strategy documents mention people’s swelling reliance on the private health sector, but treat the private health sector as a peripheral entity, a somewhat unwieldy potential ‘partner’ (Government of Bangladesh, 2016). They evoke the poor quality of private sector services, the unregulated costs, and the burden on service users (Government of Bangladesh, 2017).

In the introductory statements of the Maternal Health Strategy 2015, the Secretary Health Services Division writes:

*Bangladesh has huge public sector health system spread out all over the country. Starting with the District Hospitals at the district level, there are Upazila Health Complexes (UHC), Union Health & Family Welfare Centers (UH&FWC) and Community Clinics, respectively, at the Upazila, Union and community level. Unfortunately, this wide network of health facilities does not function in its full capacity for a variety of reasons, including but not limited to lack of specialists, support workers, drugs and logistics. It often results in patients being denied health care or turned to private facilities where quality care is either absent or very expensive.*

This statement is illustrative of prevailing moral anxiety around the private health sector in national policy and programming spaces. It discursively constitutes an underperforming public health system as responsible, culpable even, for the expanding health market and is explicit in characterising the sector as delivering poor quality services and suggesting their exploitative potential. These ideas reverberate through Dhaka discussions with national policymakers and development actors. The moral concern surrounding the proliferation of commodified health services emerges in most discussions related to maternal health. These tend to be
articulated around caesarean birth, and include some version of the comment, “Private facilities are performing unnecessary caesareans because they want to make money.” Such narratives reflect broader inclinations to posit market logics as antithetical and even oppositional to morality (Muehlebach, 2012: 5-6).

The discursive anxiety around the private health sector is magnified in relation to peri-urban and rural spaces, where growth of for-private private health institutions has been both rapid and far removed from institutional gaze of national health officials. After the turn of the millennium, formal for-profit private health institutions were almost exclusively located in urban settings, with the vast majority in Dhaka (Baru, 2003). Even today, discursive practice tends to treat private health sector expansion as an overwhelmingly urban phenomenon (see e.g. Sattar, 2021). However, such representations fail to capture the pervasiveness of private health institutions in peri-urban and rural areas. Today, private health institutions that offer advanced maternal health technologies stretch out into the most remote areas of the country and figure centrally to the biomedical palette women navigate during pregnancy and childbirth.

This chapter explores the rise of maternal health care markets in rural Bangladesh. It focuses on the case of Daulotpur upazila, a borderland subdistrict, as a microcosm of private maternal health care expansion. It explores the local realities that have coalesced here to produce this health market and how livelihoods are entangled within it. It argues that the constitution of the maternal health market in Kushtia reflects localised political, economic and social realities. This creatively constituted market opens opportunities for accessing advanced maternal health technologies for women and their families, while simultaneously responding to livelihood imperatives for people from all social classes. It contends that while health markets are widely met with moral ambivalence, the marketisation of maternal health services in Kushtia is embedded and renegotiated within moral orders and sensibilities, as those within the sector navigate a tenuous moral world in which market logics are not amoral or immoral, but integral to 'service-oriented' business.
The making of a maternal market

Although technically just over an hour of jolting CNG journey through tobacco fields from the administrative hub of Kushtia (assuming the CNG driver knows the roads), India-hugging Daulotpur feels a world away. It is here that Tamanna and I first encounter the rural private health market. An overcast and chilly winter morning, Tammana and I arrive in Daulotpur huddled in the back of a CNG, wrapped tightly in shawls to protect ourselves from the cold air which whooshes in through the grated doors. We make good time, despite the fog, as this CNG driver knew his way. He drops us in the nearly deserted upazila health complex courtyard. We make our way to the UH&FPO’s office for our perfunctory visit and peak inside. The lights are out, signalling not the UH&FPO’s absence (though he is absent) but that the electricity is out again.

We cross the resident medical officer (RMO), the clinical manager of the upazila health complex, as we turn away from the dark office. He approaches and tells us what we already know. We are too early. It is only 9 am, and it would be another hour before the other health service providers meander in. It is winter, after all. He suggests we go grab a cup of tea to kill some time. Tamanna does not like tea, but we follow his instructions and turn out of the courtyard into the dusty streets of Daulotpur. As for me, I would be more than happy to find a tea stall serving some milky dudh cha tea or perhaps some ginger tea to warm me before spending the following hours in the frigid health complex.

Tamanna and I debate whether to take a right or a left down the quiet street in our tea quest. The dirt road nearly deserted, a couple of men amble along, in no hurry. We saunter down the street when, no further than 50 meters outside of the entrance of the upazila health complex, we catch sight of five or six women in front of a basic concrete building. A banner hangs from the roof of the building with large white Bangla lettering set against a green backdrop. It reads Jonari Private Clinic. Below in yellow is a tagline: Here, we do all types of operations, including normal delivery with care (jotno). On either end of the banner, the image of a white woman, worn and faded with time, hovers over a baby, loose curls cascading down the non-visible side of her face. The white baby smiles with her whole face, gaze fixed toward

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1 Small, three-wheeled vehicle which runs on compressed natural gas. These are the most common mode of transportation between upazilas in Kushtia.
Within a moment, the women catch sight of us and gesture eagerly for us to approach. The women’s curiosity peaked by the presence of two strangers, they rattle off the usual questions. We answer them in turn: where we are from, what we are doing, whether we are married, and, since we answer to the affirmative, how our husbands manage to eat during our absences. Tamanna, from Dhaka, is only slightly less foreign than me here, but being Bangladeshi, she is also just slightly less forgivable for the sin of leaving her husband alone to feed himself. One woman with a red-flowered headscarf draped over her head introduces herself as Ithi. Ithi tells us that she is a sister, the generic term used to refer to any nurse, whether trained formally or informally, in the clinic and attends normal delibheri here. On this first meeting, she tells us that she is the wife of the clinic owner, Tagore. We learn on subsequent visits that they are not a married couple and that, instead, she is also a malik, owner, of the clinic, making her and Tagore business partners rather than
husband and wife.\textsuperscript{2} We never ask her later why she told us this when we first met, not wanting to embarrass her, and we never know whether this fib was for our benefit or the other women in the clinic. We assume it is a more straightforward story to tell in a place where few women are clinic maliks, particularly women from lower-class backgrounds such as Ithi.

We catch a glimpse of a tiny baby sleeping peacefully against the chest of an older woman, presumably the mother or mother-in-law of a young woman who gave birth through caesarean here yesterday. The young mother soon steps out onto the patio and eyes us up and down, as someone has gone to fetch her for the spectacle. An older woman follows her with a matching baby, the twin of the first. We admire minuscule twin girls and the new mother beams.

A woman named Shopna self-designates as our tour guide and invites us inside to take a look around the facility. We remove our shoes and enter the dark waiting room, the electricity outage not limited to the upazila health complex, in our bare feet. Middle-aged and garrulous, Shopna tells us that she is an aya, helping hand, at the clinic. She is the aya at all three, yes, all three, of the private clinics located here. By ‘here’, she literally means right here, at this intersection: she points directly across the street the Meyirhashi Clinic and next-door to Al-Arafa Clinic. There used to be one more, kitty-corner from Jonari on the last remaining corner of the intersection. We can read the faded paint which advertised Daulotpur Clinic. Do all the clinics provide shejar? we inquire. Yes, they all provide shejar. Who conducts the procedure at the other clinics? The same three doctors. She rattles off their names. They rotate between the three.

\textsuperscript{2} Wendy Vogt (2018) writes of heterosexual marriage simulation as legitimation and protective practice during migrant journeys (146-147). This could also figure in to Ithi’s account.
Shopna invites us to sit, and a group of women gather around us. We go through the pleasantries once again, then ask the women a few questions of our own. How do they decide which clinic to go to? There are three right here, are some better than others? Shopna interjects, saying they are all equally good. Where women go depends on whom they know. People who have relatives or acquaintances (porichito) from this clinic come here. Also, sometimes the nurses from the upazila health complex will refer women to the different clinics when they send them outside for shejar. The women nod in agreement. One woman mentions that shejar is not performed at the upazila health complex like it used to be. Another adds that there is no longer any doctor there to perform shejar. Shopna says that she thinks shejar was discontinued in the upazila health complex about eight years ago. She mentions that Dr Munirul Ali, who now performs caesarean here, used to do so at the upazila health complex but has since been transferred to a different upazila health complex.

How much does shejar cost? It varies. The official price is around 7,500-8,000 taka (~65-70 GBP), but poor women can get a discount. Also, if a woman brings her medication from outside, the cost can be reduced to 4,500 (~40 GBP) taka. In
contrast, in Kushtia the cost of the procedure runs somewhere between 20,000-100,000 taka (~175-865 GBP). If a woman has a normal delibheri here, a service they provide with care according to the outside banner, Ithi tells us it will cost between 3,000-4,000 (~25-35) taka, so hardly less than a shejar. Which do women prefer? Of course, they prefer normal, she says, but sometimes they must do shejar, for example, if the cervix is not opening, or sometimes the woman’s family does not want her to go through the pain of normal delibheri. Despite the professed commitment to normal delibheri, caesarean is the primary mode of birth in the clinic; it is the beginning of the second week of February, and so far, this month, they conducted 12 caesareans and only assisted two normale.

The propitiousness of the location of Jonari clinic manifests in the multitude of clinics, diagnostic centres, medicine shops (oshudh dokan) lining both sides of the street passing in front of the upazila health complex. Ithi tells us that Tagore, the malik of Jonari Clinic, owns one of the medicine shops. We later learn that Rajib, the adjacent Al-Arafa Clinic owner, owns another. Rajib’s medicine shop location is most enviable, just next to the metal gate of the upazila health complex entrance, facing the mosque. From here, he can easily combine selling medications and identifying potential clients for his clinic. All three clinics at the intersection base their business on providing birth services, mainly through caesarean. Indeed, if feels to me that is must be easier to obtain a shejar along this road than a proper cup of tea, which Tamanna and I never find the morning of our first visit to Jonari Clinic.

How did caesarean birth become so common here, of all places? In a place where safe surgery is difficult to ensure and tertiary care so difficult to access if something goes wrong? Perhaps this can at least in part be explained by the fact that the upazila health complex used to propose caesarean birth to residents. Why was it discontinued? The desire for surgical birth has not dissipated—this procedure seems to be nearly singlehandedly keeping at least three private clinics located just outside the upazila health complex gate solvent.

On another hazy winter morning, Tamanna and I visit Azam sir, UH&FPO of Daulotpur upazila health complex, hoping he can shed light on this. Azam motions us in with a movement of his head when he sees us in the doorway. We enter and take the seats in front of his desk. The electricity is out at the upazila health complex,
again, leaving the room particularly sombre with the sun hidden by the winter clouds. Azam consults with a patient, an older man with a dyed-orange beard matching his hair and bundled in a warm sweater. Azam measures his blood pressure. He then recommends an electrocardiogram. “Where can I get it?” the man inquires.

“Anywhere outside.” Azam does not even look up from the white paper he scribbles on as he replies.

“Don’t you have it here?” inquires the man, likely hoping to secure the service free-of-charge in the public facility rather than pay for the same service in the health marketplace.

“Yes,” Azam responds, ”but it is no good. It is better to get it from outside.” The man takes the white paper Azam holds out to him and rises from his chair. He addresses Tamanna and me before leaving the room with the woman accompanying him. He announces that he was a freedom fighter in the liberation war and smiles. We praise him for this, and his smile grows wider. He then turns to leave.

Azam turns to us and asks how he can help. We tell him that we are curious about the provision of caesarean birth in the facility and its discontinuation. We try to pass it off as an innocuous question, but his eyes narrow. He presses the bell to call for his support staff without saying a word. A man shuffles into the room. Azam instructs him to send for Faruq, one of his administrative staff. The man leaves as quickly as he came. Azam explains that he was not the UH&FPO at its discontinuation, and Faruq would know better. We sit in awkward stillness, waiting for Faruq. Azam, who is waiting out his final days as the upazila health manager before retirement, always struck me as friendly, so his sudden coldness catches me off-guard.

Faruq breaks the silent awkwardness several minutes later when he struts into the office and sits at the desk. He looks to me as if he is ready to face a blizzard, with his heavy coat and a green scarf wrapped tightly around his head. He shoots us a smile and nods while Azam explains that we are interested to know why the upazila health complex discontinued shejar. Faruq has been here for ages, he tells us. He will know better.
Still, Azam sets the backdrop of the story, tracing it to 2006 when the Demand-Side Financing (DSF) project was introduced in Bangladesh, the same project that played a pivotal role in shaping Mitha’s births in Chapter 1. Azam articulates the DSF project as a UK project meant to attract women to the health complex for birth based on financial incentives. As discussed in Chapter 1, the project incentivised health service providers to deliver the services in tandem, providing them financial remuneration for each procedure promoted within the project beyond their regular salary, although these were officially part of their job responsibilities anyway. Emergency Obstetric Care (EmOC) was part of the DSF package, including caesarean birth. To fully implement EmOC meant posting a surgeon and an anaesthesiologist to the upazila health complex, a core component of EmOC, but a condition that had proven elusive in practice, despite the wave of development momentum behind it. While operating theatres are available in all upazila health complexes, they are rarely staffed with providers to animate them. Most stagnate and function only during designated times, such as during the National Family Planning Week, when they open to carry out permanent family planning procedures, or a few scheduled caesareans each month. The DSF project staffed some of the upazila health complexes, including Daulotpur, with a gynaecologist and anaesthesiologist to provide regular surgical births.3

The scheme proved alluring. Between 2011-2015, births in the Daulotpur upazila health complex far exceeded those in any of the other four upazila health complexes. Institutional births fluctuated between at least five times higher than the second-highest birth assisting complex in a given year4 to almost 13 times higher5 (see Figure 17).6 Surgical birth during this period hovered between 36% and nearly 50% of all births. While Daulotpur extends over a larger geographic area and

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3 For some of the upazila health complexes located in the DSF project pilot sub-districts, the project formed agreements with selected private providers to perform caesarean through the voucher scheme (Strengthening Public Financial Management for Social Protection (SPFMS) Project, 2017), though this has never been the case in Daulotpur.
4 Compared to Kokshaw in 2013.
5 Compared to Bheremara in 2014.
6 Icdrr,b monitoring data, collected through 2011-2019.
comprises a somewhat higher population than the other upazilas, this alone does not suffice to explain these divergences, nor the precipitous plummet in store.\footnote{Project evaluators of the DSF project in other implementation sites observed similar tendencies. Evaluators found, for example, that in other DSF areas, the caesarean rates for all births in the upazila health complexes were 40\% for voucher holders, compared to 6\% for non-voucher holders (Strengthening Public Financial Management for Social Protection (SPFMSP) Project 2017).}

**Figure 17:** Total institutional births in the five upazila health complexes in Kushtia, 2011-2019

*Source: icddr,b programme data*

**Figure 18:** Births in Daulotpur upazila health complex

*Source: icddr,b programme data*
Faruq recalls the financial incentives as lucrative for the health service providers. Not only did they receive compensation for each caesarean procedure they performed, he tells us, but there were many one-off EmOC trainings for which they received honorarium in exchange for their participation. Faruq marks 2015 as the year when caesarean in the upazila health complex unravelled. I expect the reason to be institutional, an arbitrary decision made by programmers somewhere in Dhaka or the UK, based on shifting agendas or interests, the type with which I was familiar from my time working in international development. However, the story that Faruq shares next resembles nothing of institutional banality.

His story goes something like this: In 2015, the Daulotpur Member of Parliament (MP), the highest-ranking local government representative, was a particularly notorious figure. The MP, who owned a private clinic in the nearby town of Taragunia, sent his brother to the functioning UH&FPO. Faruq takes a deep breath before recounting the escalating torment of the hospital staff, himself and the previous UH&FPO included, by the MP and his brother, insisting that the UH&FPO discontinue caesarean procedures in the complex. The harassment climaxed in an episode where the MP’s brother locked the UH&FPO in a room. The brother’s message to the UH&FPO left no ambiguity: Stop performing caesarean in the upazila health complex. Caesarean provision evaporated from the upazila health complex almost overnight.

The monitoring data mirror his story: 2015 marks not only the year that caesarean births disappeared, but the year that institutional birth in the upazila health complex plummeted. By 2019, births assisted in the upazila health complex were a mere 13% of the 2015 figure, falling behind or levelling alongside the numbers of the other four upazila health complexes in Kushtia.

Azam peers absentmindedly through papers on his desk. Faruq looks toward his manager, asking whether he can go with his eyes. Azam looks up, catching my stunned gaze. “Anything else?” he asks, our welcome evaporating.

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Providing ‘honorarium’ to government health managers and providers is a normalised ritual within development practice in the health sector. This involves providing a sum of money to government staff to participate in a meeting with a development organisation or a training. This is provided in surplus to a regular salary and is highly motivating to government staff.
"Well," I venture, "Now that there is a new MP, would you be interested in trying to bring caesarean back?" Both shake their heads vigorously. If they reintroduced caesarean, the UH&FPO said, it would only be a matter of time before history reproduced itself.

Today, the DSF project continues its operations in Daulotpur, one of 55 project upazilas. However, in Daulotpur, it no longer encompasses caesarean procedures. These days, a large, red sign hangs outside the ANC corner in the upazila health complex. It reads: "If you do normal delibheri at the hospital, 2500 taka (~20 GBP) will be provided by the government (conditions apply)." (Haspatale normal delibheri korle shorkar theke 2500/- (taka) prodan kora hobe (sorto sapekkhe)). These conditions include no history of surgical birth and proving that one's household income is low, yet also managing enough money and know-how to open a Dutch Bangla mobile bank account, into which the government can deposit the money. Shiwly, one of the midwives, explained the new incentive scheme seven months after it was introduced. She was yet to see someone qualify. A pregnant woman asked about the proposal during one ANC visit. "You do not qualify," Shiwly said tersely without looking up from the register. "You already had a shejar."

Figure 19: Poster in the upazila health complex advertising the new DSF proposition in the form of a cash transfer for vaginal birth

Source: Photo by author, Daulotpur upazila health complex, 27 Jan

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The microcosm of Daulotpur brings into relief the unanticipated interplay of political, economic and social forces which generated a market for commodified maternal health services in this remote area of Bangladesh. On the one hand, this account can be read as an example of the 'unintended consequences of development.' Here, state and development forces joined to produce demand for institutional birth care, mainly through surgical birth. Through financial incentives, the project encouraged both women and health service providers to participate in a market of surgical birth, a market sponsored by state and international development entities. While the propensity towards institutional care and surgical birth, in particular, cannot be explained simply by the rational choice theory of classical economics, which lured women to facilities with cash incentives, the market-based incentives most certainly served as a tug toward institutional services. Pulling surgical birth from the upazila health complex left a vacuum for this desire to be met through a health marketplace detached from the state and ‘big D’ Development (Hart, 2001) initiatives. As we saw on page 40, Gillian Hart describes ‘big D’ Development "as a post-second world war project of intervention in the 'third world' that emerged in the context of decolonisation and the cold war, and 'little d' development or the development of capitalism as a geographically uneven, profoundly contradictory set of historical processes" (Hart, 2001). It was the net of 'little d' development, localised enactments of capitalism which generated a maternal health market, which caught the fallout of the fragmentation left in the wake of ‘Big D’ Development and political forces.

Although state and programmatic monitoring mechanisms no longer capture the number of caesarean births in this area, this does not mean that fewer occur or that aspirations towards caesareans have diminished. Many of the women I encountered in the upazila health complex underwent caesareans in the upazila health complex for a previous birth and were left to find alternative options for subsequent births. However, it is not only women seeking caesarean after a previous surgical birth who desire local options for the service.

On one visit to Daulotpur, Tamanna and I visit Al-Arafa. When we arrive, the operating theatre is in full action, Dr Munirul Ali midway through a caesarean on a young woman giving birth to her first baby. Rajib, the *malik*, yells over the hum of the generator for us to come inside and observe the rest of the procedure. We opt
instead to stay outside, as we did not have the chance to talk to the young woman before the surgery. Three women chat outside the clinic on a narrow dirt path separating Al-Arafa clinic from Sojib Clinic. We raise our voices to talk to the women over the *whirr* of the generator. With the unpredictability of power provision in Daulotpur, the generator makes sure the lights stay on for the caesarean in the small clinic, even if they do not in the upazila health complex. A thin older woman with delicate features introduces herself as Rajib's *apa*, sister; another woman tells us that she is an *aya* from Al-Arafa.

Rajib's *apa* is the most talkative of the three. She tells us that the clinic is doing well. She says that it is primarily through word of mouth that people decide to come to Al-Arafa, especially when they have a relationship with someone attached to the clinic. She has 8-10 family members who bring all the people they know to this clinic. She then tells us that the third woman standing with us was her sister-in-law and the mother-in-law of the young woman undergoing surgery in what she suggestively refers to as the 'shejar room.' It was through this personal connection that the young woman came here. Thanks to this relationship, Rajib was kind enough to reduce the procedure price: the family paid only 5,000 taka (~45 GBP) rather than the ticket price of 6,500 taka (~55 GBP). They were unlikely to find a better price than this at another clinic, and in any case, according to Rajib's *apa*, the quality of all the clinics are equally good.

If cost was the most important concern, though, we ask why the family did not instead take her to the Kushtia district hospital, where services are theoretically free of charge. The mother-in-law agrees that the *shejar* would be free of charge at the district hospital, but if they went there, the family would need to arrange for the transportation and food; in the end, the cost would be more than the service provided in Rajib's clinic, and much less convenient.

Besides that, Rajib's *apa* explains that to get the service for free at the district hospital, they would need to get the 'card', the voucher associated with the DSF project. Obtaining the card would require going to a member of the union parishad, the local government body, which is problematic. Sometimes you get one, sometimes not, and sometimes you need to give money to obtain the card. Another woman wearing a black burqa with a long pink headscarf, balancing a toddler on her
hip, slowly approaches our conversation. She tells us that there used to be shejar at the upazila health complex, but not anymore. She also talks about the card and how you can get one from a family planning personnel or a union parishad member. She says that the card is free but takes time. In any case, people had been unsuccessful in obtaining the card for two years now.

This conversation highlighted the confusion in the face of the shift of ‘big D’ Development initiatives. While services delivered at the district hospital are officially delivered free of charge (though this does not count the costs of travel, food, medications, materials, and the ‘tips’ (bokshish) expected by health staff (see also Chapter 1)) and entirely unrelated to the DSF project, this was obscured in the account of the women. While Rajib’s apa could be using this as a marketing ploy, yet another reason to entice women to stay in Daulotpur for the service rather than travel to Kushtia, it is just as likely to reflect honest confusion. Indeed, women never experienced the DSF project as the straightforward initiative outlined on paper. Local politics always mediated it, and in no case did the women expect to obtain the card for ‘free’: it was always obtained through effort, either through dhora-dhori or through payment.

Moreover, with the design and decisions localised in a nebulous elsewhere, the shifts in the project lack any logic but rather operate as a mysterious space in which resources and possibilities appear and disappear. By the time I was in Daulotpur, there was officially no more physical card to speak of. To obtain the incentive, the project required women to open a bank account with Dutch Bangla Bank. The insistance on registration for mobile banking not only raises the question of who benefits from having women enrol in this specific bank but also suggests a process unfamiliar to many women, who may or may not have the access to the technology, i.e., a mobile phone that supports the application, required. While approaching the union parishad member might be a hassle, at least it was a familiar process, not mediated through technology. On more than one occasion that Tamanna and I spent in villages, women approached us to ask if we could help them obtain a card. Although we had nothing to do with the DSF project or the card, women paired our foreignness with the project’s and hoped that we might serve as a
link in navigating access to resources. Indeed, accessing the resource through us would make as much sense as other networks they might leverage for such access.

However, the changes in the DSF project, now designed to promote normal delibheri exclusively, and the abolishment of caesarean services through the upazila health complex appear to have done little to shift the desire for access to caesarean birth. Many of the women I encountered in the upazila health complex, like Mitha in Chapter 1, underwent caesareans in the upazila health complex for previous births and were left to find a new locale for a subsequent birth. Besides these women, most women desired at least the possibility of caesarean birth. Still, Tamanna and I never met a woman in Daulotpur who expressed an intention to access the services in Kushtia district hospital. Instead, they preferred to seek services in the smaller private clinics in Daulotpur. Often, they would mention that they planned to go to a private clinic in the nearby town of Taragunia. Taragunia hosts many private clinics catering to women from various class strata. Among these clinics is the one owned by the current local MP.

Each of the three clinics outside the upazila health complex describes caesarean as a primary service they deliver. While these are less reputed than those in Taragunia, they still maintain a steady stream of surgical births. What they may lack in reputation, they make up for in proximity. One day that we met Ithi apa from Jonari Clinic, she criticised the providers at the upazila health complex as not being ‘aware’ (oshocheton) and sometimes keeping women in the upazila health complex much longer than they should hoping for a normal delibheri. Just the other week, she said, a woman went to the upazila health complex for birth, and, according to Ithi, they kept her for one and a half days. Finally, the health service providers surrendered and told the woman to go to ‘any private clinic outside’. The woman came to Jonari, and the clinic staff arranged the procedure immediately. For women who try without success to give birth in the public facility (and potentially benefit from the DSF incentive for a successful vaginal birth), a short walk across the street for a

9 Referral from different tiers of public health facilities tends to be disorganised and once women leave a particular health facility for more advanced treatment there is generally no follow up. However, Daulotpur Upazila Complex maintains a functioning ambulance (most upazila health complexes do not), and while most transfers with the ambulance require payment, the costs are covered for labour and birth complication transfers to the district hospital. Despite this, most women still prefer to stay nearby and seek care from a private clinic.
surgical intervention may appear the best option when one does not have other attachments to a particular clinic. Each of the three clinic owners tells us that they conduct somewhere around 25 or more such procedures each month, no small number for each small private clinic offering the same limited menu of services, one operating theatre and a couple of cabins for recovery each.

There are several important takeaways from this account of a generation of a market for surgical birth in Daulotpur. The first is the complex relationship between 'big D' development and 'little d' development (Hart, 2001, Venugopal, 2018). The interplay between 'big D' Development and 'little d' development is at work throughout the biomedical terrain in Bangladesh. 'Big D' development reflects the trend toward projectification, in which problems are, as Mitha Murray Li describes, 'rendered technical' (rather than political) and amenable to preestablished technical interventions (Li, 2016). 'Big D' Development projects offer limited technical solutions to particular aspects of health that are considered pertinent at a particular moment and later rescinded, sustaining fragmentation in biomedical health service delivery. While some development projects may not open much opportunity to be filled by the commodified resources or services, state and 'big D' Development initiatives promoting advanced biomedical technologies do. In many cases, 'little d' development in the background has risen to fulfil aspirations for profitable technologies.

The case of the market for surgical birth in Daulotpur can be seen as the interface between 'big D' Development and 'little d' development. The DSF project operated as a manifestation of 'big D' Development: a purposive project with the intent to achieve a particular reshaping of society, in this case, the relocation of birth to public biomedical institutions. However, this 'big D' Development was backgrounded by 'little d' development. Economic growth over the past decades has meant that people have increased access to resources for investment. Many have invested in building an extensive market for maternal health services. This background of 'little d' development was only superficially captured through project or state reporting; therefore, it remained little visible in these realms. While the demand for surgical birth cannot be entirely attributed to the 'big D' Development project, indeed, trends towards surgical birth are perceptible throughout Kushtia and the country, the incentives certainly whetted the appetite for advanced maternal health
technologies and the period during which the upazila health complex provided caesarean remains engraved in the collective memory. In tandem, 'little d' development of a private health market was mushrooming around these efforts, designed to deliver advanced health technologies to people with only limited financial means to pay for them. By the time caesarean was discontinued in the upazila health complex, the maternal market produced through 'little d' development was ripe for profitable response to the aspirations and demands for advanced maternal health technologies.

This unfolding of events also foregrounds the importance of politics. Although not always as nefarious as Faruq described, politics act as a potent mediator of services and resources, determining what people can access through the state and development initiatives, who will thrive in the health marketplace, and at which moments. While the DSF project seeks to define national politics and is anchored in national policy, the roles of local politicians and other influential people (and those linked to them) are often decisive in determining how opportunities and resources will be accessed through the project at a particular moment in time and for whom. In this case, local politicians not only mediated who could access the DSF vouchers and through what means but also shaped the services available through the public health system. In many cases, official policy and practice of politics are disconnected spheres of activity and often in conflict with one another. In official narratives, however, the role of local politics is generally written out of the story.

Clinics and livelihoods

If influential people profit through expanding health markets, it is not only the powerful who benefit. It was almost by happenstance that Ithi of Jonari Clinic found herself a key player in the maternal health service terrain in Daulotpur, at least in part fuelled by the tides of the DSF project. In 2007, when she lived in Jessore in the home of her in-law family (shashurbari), her husband tried to go abroad for work. He engaged a broker for support, but this broker made off with their money and the promised job never materialised. Ithi scrambled to find a way to support her family amid this tragedy. It was a miserable life at this time, Ithi recalled, as she had one son and no means to support him.
Ithi’s work options were limited; she only had academic qualifications up to her Secondary School Certificate (SSC), corresponding to a completion of ten years of formal education. While this is more schooling than many girls from rural areas complete, she did not consider this sufficient for securing a good job. However, she had a good relationship with the community health workers attached to the local Smiling Sun (Shurjer Hashi) Clinic, an NGO-run facility. When these providers visited the area near her village, she welcomed them to her home to drink water and rest. She lamented her situation to the health workers, who suggested that she come to the clinic and apply for a job there. At first, she resisted. Who will give a job to an SSC-passed student? she thought. She then relented, she had nothing to lose.

Smiling Sun offered her a job as an ayā. She accepted, eager to draw in some income to support her family. However, her husband did not share her enthusiasm. He was infuriated. Why would you do the job of an ayā? he demanded of her, angry that she would accept such a lowly position. She recalled that he swore at her and beat her at that time. She remained steadfast. Finally, her mother- and sister-in-law sided with her and confronted him. He was not employed and therefore did not contribute to the family expenses; why would he further deprive them of economic resources through Ithi’s job? He finally agreed, and she worked for a meagre monthly salary of 1,800 taka (~15 GBP).

Ithi worked tirelessly at Smiling Sun. There was not even a moment to sit down, she recalled. She cleaned the entire clinic; she even cleaned the washrooms. Late one evening, she approached the manager, busy entering data into a computer. Since she could read and write, she offered to read off the written register data while the manager entered it. He agreed and was thrilled by the speed with which he could complete the task with Ithi’s assistance. In addition, a doctor regularly travelled to Smiling Sun to perform caesareans. Ithi approached him, asking whether she could assist him in the operating theatre. Before long, he preferred her to the nurses and regularly requested her support. Eventually, the clinic manager promoted her from an ayā to a sister. This represented a significant promotion from a helping hand responsible for completing the dirty work (nongra kaj) to a respectable nurse.

Ithi, by then a mother of two sons, requested that the clinic manager hire her husband, still unemployed, when a position opened. He agreed, and the couple
worked at the clinic together. This arrangement was short-lived; after several
months, the clinic cut staff. The manager and his wife, a paramedic, gave her an
ultimatum: either she or her husband would have to go. They could not support both
salaries. They advised her to leave the job. The assured her that she would easily
find a job outside, given the qualifications she gained through her experience at
Smiling Sun. She agreed with the recommendation and, in any case, feared that her
husband would beat her again if he lost his job.

The paramedic arranged a job for her as a sister in a private clinic near
Meherpur. She only worked there for three days when another job offer came. This
one was from Daulotpur, where her parents lived. Meyirhashi Clinic, located in the
building where Jonari Clinic stands today, was equipped with everything they needed
to open, except for one nurse. Without a nurse, they could not open. She declined,
saying she had joined the clinic in Meherpur only three days previously; how could
she possibly leave for a new job? The maliks then requested that she come to
Daulotpur and work at the clinic for ten days only. If she would come for these ten
days, they could show that they had a nurse to the officials and public and
inaugurate and open the clinic. Afterwards, they would arrange something else. She
agreed and travelled to Daulotpur for the inaugural ten days of Meyirhashi Clinic.
During this sojourn, Dr Munirul Ali took a liking to her, and encouraged her to stay.
She agreed.

Like at Smiling Sun Clinic, Ithi worked dedicatedly as a sister. Before long,
however, her situation soured. Initially, Meyirhashi counted 11 maliks. One malik
decided to leave the business and sell off her share. Hearing this, Ithi thought, why
not me? She had managed to save a small nest egg, so why not purchase a share
and enter into the clinic's ownership? Well, the other partners saw plenty of reasons
why not. How did she, a lowly sister, be so arrogant to think of herself as their equal?
She should know her limits. A dispute ensued, culminating in Ithi's resignation from
the clinic.

She went home and recounted her predicament to her chacha, paternal uncle.
In addition to being a police officer, he was also the landlord of the building housing
Meyirhashi Clinic. Hearing about their injunction for her to know her limits, he
responded that he would show them her limits and that she would become the malik
of a clinic. With that, he evicted them from the building. This event was a significant blow to Meyirhashi. Not only did they lose their location in the dispute, forcing them to move across the street, but also seven of their 11 maliks. Ithi and her chacha then invited Tagore and one of the other Meyirhashi maliks to join them to establish Jonari Clinic, where it stands today.

Ithi’s story illustrates the ways lives and livelihoods are wrapped up in the private health sector. For many, the private health market offers a way of making ends meet in an environment marked by precarity. People without formal clinical qualifications, like Ithi, often take advantage of the livelihood opportunities provided through the market and animate private health facilities in rural areas. It also serves as a ‘waiting place’ for health service providers formally trained, as they attempt to secure the most enviable of all jobs for many, a government job before they reach the cut-off age of 30 (see Chapter 2). While people tend to articulate their pursual of nursing or medical assisting as a potential pathway into government service, considered the most secure job by many, far more people complete training as health service providers than the public sector accommodates. The private sector is one interim employment space. The least qualified and least experienced health service providers tend to populate private health facilities in rural regions as they wait for better opportunities in the government sector or, if nothing else, better equipped, reputed, and located private facilities.

Private sector provision of shejar in rural settings, the primary generator of revenue for many small clinics, expands opportunities to support livelihoods across different socioeconomic strata, for both people like Ithi apa, without formal clinical qualifications, as well as for medical doctors and maliks. This is often cast as a criticism against the private health sector. However, precarity is a fundamental characteristic of livelihood-making in Bangladesh. The private health sector opens the promise of a living wage or better for many. Indeed, health spending in one place is health earning in another. Policymakers, programmers and researchers tend to frame spending on caesarean specifically (Haider et al., 2018) and earnings in the private health sector in general as a regressive and problematic consequence of inadequate public investment in health systems financing (Sarker et al., 2021, Molla and Chi, 2017). Moreover, in the absence of private health insurance markets, costs for services fall directly on consumers. Nevertheless, the fact remains that these
expenses, in turn, support an expansive network of livelihoods of people performing biomedical services formally, semi-formally and informally.

**Business through service, not service through business**

Until now, this chapter has illustrated the political economic context of the burgeoning maternal health market in rural Bangladesh and the ways in which this market generates opportunities to meet economic imperatives. Perhaps this can be read as congealing with predominating narratives of private health institutions’ exclusive interest in maximising profits. The moral valence of this accusation is rooted in a perceived tension between market logics and the logics of health as ‘care’, and the tendency of discourse to characterise market economies as either amoral or inherently immoral. This is reflected in national discourse, as well as in the bulk of scholarship related to health markets. However, the rise of the private health sector and the ways in which it operates cannot solely be understood by political economic considerations. This section turns to moral renegotiations and navigations within maternal health markets in Kushtia.

Walking across the street from Jonari Clinic, Ithi’s previous business partners continue to maintain Meyirhashi clinic. One of the four remaining *maliks*, Iqbal, tells us that he trained as a Local Medical Assistant of Family Planning, one configuration of village doctor (*polli chikitshok*) training, many years ago. He hoped that this training would lead to secure employment as a semi-formal health professional, but he could not find a job and finally established a medicine shop. Two of the other

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10 Village doctors, *polli chikitshok*, occupy a particularly murky position in the health service delivery landscape in Bangladesh. *Polli chikitshok* are populous group of health service providers straddling the divide between biomedical formality and informality. In programming and policy circles, the term ‘village doctor’ is a catchall to refer to allopathic practitioners practising in villages mainly outside the purview of state regulation, including pharmacists and kobiraj, traditional healers. Some, like Iqbal, have completed semi-formal training. Many people categorised as village doctors have completed some form of biomedical training. A six-month Rural Medical Practitioner programme trains participants in six basic areas of biomedicine (anatomy, pathology, surgery, ob-gyn, pharmacology and medicine) is delivered through some semi-formal institutions but provides those who complete the course with not formal accreditation. The Local Medical Assistant and Family Planning (LMAF) programme is a semi-formal 1-year programme which includes the topics of the LMAF training course and adds family planning (Gani et al., 2014). Following completion, successful participants are offered no formal accreditation. A further *polli chikishok*, countryside treatment, training programme was instituted through the government in the 1980’s, but later discontinued (Ahmed et al., 2011). While recognised as the first point of contact for health service in villages, this nebulous category is often framed as engaged in harmful practice (Ahmed and Hossain 2007; Mahmood, et al. 2010). These discourses often ignore that many ‘village doctors’ have participated in training or development initiatives endorsed somehow by the government or perceived as government-endorsed, intending to extend biomedical care provision into villages.
owners also maintained medicine shops at that time, and the fourth owner inherited a diagnostic centre and a medicine shop from his father. There were also some other partners initially, said Iqbal, though he does not say more than this. Because they all had patients (rugi) in their lines of business, they started questioning why they were sending them to different clinics. Why not start a clinic themselves? Then they could keep their patients. This initial toying with opening a private clinic to maximise profit by more fully exploiting an existing client base was consistent with market logics.

However, while there was no doubt a financial motivation, this was, and is, not their only motivation for maintaining a clinic. Iqbal prides himself on running a ‘service-oriented business’ (sheba-mulok business), providing services to the poor, gorib manush. He articulates placing services within reach of gorib manush as a primary motivation. As he puts it, “Service through business, not business through service (Shebar madhomer business kora, businessir madhomer sheba na).” Here he highlights that profit results from providing service, especially to the poor with few alternatives, rather than a primary incentive. He articulates his motivations in religious terms, as fulfilling obligations to serve the disadvantaged within Islam and benefitting from doya, or blessings, from the people they serve.

Of course, he readily admits that providing discount services comes with a catch—serving gorib manush also means that they do not generate enough revenue to conform to the government's formal licensing requirements, much less more stringent clinical recommendations. According to government regulations, he should have six diploma-certified nurses, formally trained nurses certified through the Bangladesh Nursing Council, on staff. This is a difficult enough task for even the larger, more firmly established private hospitals in Kushtia, much less in the Daulotpur peripheries. Iqbal explains that even if he could find a diploma-certified nurse, he could not afford to keep one on full time. He serves the poor, he says again. To place caesarean, the primarily health service provided in the clinic, within their reach, he charges only 5,000-6,000 taka (~45-50 GBP) per caesarean procedure. If he were to keep one doctor and one nurse, he claimed he would need to charge at least 25,000 taka (~215 GBP) per procedure, a price entirely out of reach of his clientele. He explained that after paying all the costs associated with caesarean, all that is left over as profit is 500-700 taka (~4-5 GBP) per procedure. From this profit, he still needs to pay the clinic staff. Despite his admitted straying
from the already minimal formal regulations, five licenses are tacked on the wall behind Iqbal’s desk in the Meyirhashi office, a converted kitchen.

Private health managers justify pervasive cutting of clinical corners by evoking the moral imperative to help the poor by delivering health services within their financial reach. This often translates into tactics in health service delivery departing significantly from global and national clinical standards. One particularly striking, yet commonplace, example is the clinical enactment of anaesthesiology. Delivery of anaesthesiology as a core component of surgical birth is one example of how private clinics trim back clinical services. While all the public upazila health complexes are equipped with operating theatres, none of them function to perform emergency caesarean, which health managers explain as due do the lack of a gynaecologist/anaesthesiologist pair. Although close in geographical proximity to public facilities, private clinics do not experience this bottleneck. They are rarely short of surgeons who show up to perform the procedure, including government doctors (see Chapter 5). However, while a surgeon is considered essential for caesarean procedures in private clinics, and anaesthesiologist is not. Rajib of Al-Arafa explained that if he calls for an anaesthesiologist, this will explode the procedure’s cost. The anaesthesiologist alone will demand 3,000 taka (~25 GBP), which is sometimes even more than they pay the surgeon, he asserts, even though analgesic is widely available and inexpensive through medicine shops. Rather than call an anaesthesiologist to administer it, the clinic can cut a substantial portion of their costs if the surgeon administers it or if another staff member does so. Rajib explained that they only call an anaesthesiologist if they perform a caesarean for a VIP, if the woman has some problem, or is a ‘fatty shejar.’ While clinically this can be extremely dangerous (Sobhy et al., 2016), few women, families, health service managers or providers view the presence of a trained anaesthesiologist as obligatory for a caesarean. Cutting anaesthesiology costs by relying on informally trained staff

For example, in a meta-analysis conducted by Sobhy et al. (Sobhy et al., 2016) published in the Lancet concluded that over 13% of all maternal deaths following a caesarean in countries identified as low- and middle-income were attributable to anaesthesiology, and that 3.5% of all direct maternal deaths were due to anaesthesiology, although the authors acknowledge wide variability in reporting and quality of data. A prospective study conducted by Bishop et al. in 22 African countries concluded maternal mortality in Africa to be 50 times that in ‘high-income’ countries, and attributing postoperative death primarily to haemorrhage and anaesthesiology complications. Moreover, this study was carried out in well-established hospitals, which means this likely presents a best-case scenario (Bishop et al., 2019).
are among the tactics that clinics use to ensure that services prices are within reach of the *gorib manush* who constitute their clientele.

Another strategy is to maintain minimal staffing. At times they struggle to compensate the minimal staff they keep on. Meyirhashi clinic, for example, only maintains one informally trained *sister* and one *aya*. The *sister*, Ambia Khatun, studied until year ten but never completed her SSC, as *Ithi apa* did, placing her at a greater disadvantage than *Ithi*. Additionally, as a divorced mother of a four-year-old daughter, Ambia’s vulnerability is compounded. While divorce is becoming more common throughout Bangladesh, particularly in urban areas (Afroz, 2019), women in rural areas continue to navigate a territory characterised by what Deniz Kandyoti refers to as ‘classic patriarchy’, organised around patrilocally-extended households within which women rely economically and socially on men through marriage within a ‘patriarchal bargain’ (Kandiyoti, 1988). While this is shifting somewhat even in rural areas, for women in Kushtia from lower social classes, many of whom discontinued their education in their early adolescence to enter into a patriarchal bargain through marriage, divorce represents a devastating breakdown of the social order, leaving them in a precarious position.

Before coming to Meyirhashi clinic, Ambia worked for six months at the Kushtia District Hospital as an *aya* and then in a private clinic in Mirpur upazila. Through her work, she financially supports both her young daughter and her mother, who cares for the girl. The job at the clinic is a lifeline. She tells us that this job allows her to generate income through her monthly salary (and the tips (*bokshish*) provided by patients) and develop health service skills that she uses to provide care for people in her village to supplement her income. Hearing her story, it comes as no surprise that Iqbal counts it among the good works of the clinic to employ the staff that they can.

Still, Iqbal’s understatement of the clinic’s profitability reflects the tightrope that clinic owners walk to justify delivering health services at an accessible cost as they negotiate a tenuous moral terrain. While not only a moral endeavour, private facility *maliks* do not articulate profit and morality as mutually exclusive. Rather morality is integral to the market logics employed in their health service delivery. While they do not deny that they generate profit through the commodification of health services
which could otherwise be obtained in non- (or less-) commodified forms through public health institutions, they view this as integral to the longstanding moral project of helping the poor, both by placing desired maternal health services and resources within their reach, and also using the proceeds to support further livelihoods.

While the three groups of owners in the Daulotpur clinics had experience in the health sector running small medicine shops, this is not always the case. Often, maliks have no prior experience in the health sector but find themselves with some resources available for investment. In Khoksha, for example, Jamal, the malik of Khoksha Health Care Diagnostic Centre and Clinic, is a government engineer. He joined with two businesspeople to establish the clinic. He explained that he decided to invest in the private health sector rather than other potential business ventures because he was attracted to running a service-oriented (sheba-mulok) business. After Daulotpur, Khoksha is second poorest upazila in Kushtia, therefore, running the clinic here, he explains, he is able to provide services to the poor, who would otherwise need to travel to the adjacent, wealthier upazila of Kumarkhali to access services of equivalent quality, but at a higher cost, to those offered through Khoksha Health Care Diagnostic Centre and Clinic. Though services in Khoksha Health Care are at least 50% more expensive than those delivered in the small clinics nearby, which he explains as necessary to maintain a certain level of quality, they are still significantly less expensive than those in Kumarkhali, particularly after building in the travel costs. With his home in Kushtia, he could well have chosen a different upazila to establish a clinic, but desired to help the poor. In return for service provision to the poor, he not only makes money, but also obtains blessings (doya). His logic reflects Iqbal's, although Iqbal's establishment of a clinic may have been a more natural extension from his previous work within the health sector.

Other maliks further this moral justification by pointing to the failure of the public health sector to deliver the services people need and desire. Down the street from Khoksha Health Care Diagnostic Centre and Clinic, Borosha apa, a family welfare visitor (FWV) in the Khoksha Upazila Health Complex by morning, manager of the very basic Borosha Clinic by afternoon, suggests that the upazila health complex is not even a real hospital; it is a 'health complex.' At the upazila health complex, she complains, there is no shejar. "Because there is no doctor," she explains. "There is a big problem with doctors. Here we have an x-ray; they do not
have an x-ray operator (person who operates the x-ray machine). Here we have a (basic) lab; we do some tests and things. People do not want to go to the government lab for help these days. It costs 5-10 taka (less than 10 pence) to get them from outside. Outside there are many technicians, from them they can take it. They have good technicians." For those who need advanced biomedical technologies not reliably delivered in the upazila health complex, they would instead come to a small clinic like theirs, she explains, because it is expensive to travel to the district hospital, and once they reach it, nobody, not the doctors, nurses or anyone, "cares" (she uses the English term). For Borosha, her engagement in managing the small clinic just outside the public facility is morally justified response to the failure of the state to adequately and reliably deliver the care which people desire and need.

While private clinics profit from the fragmentation and gaps within the service delivery people seek today in the health sector, they respond to real aspirations and needs for biomedical health services. Indeed, the rapid expansion of private biomedical offerings has coincided with people's increased ability to pay for such services. The private health market now caters to people of all layers of socioeconomic status, placing even the most medicalised birth technology within the grasp of the poorest families, and a space to claim basic services which the state does not reliably deliver.

Rather than amoral or immoral, for those within the for-profit private health sector, health service delivery pairs profit generation and moral labour. This moral labour is exercised at once by providing desired health services to people who otherwise have limited possibilities for accessing biomedical services, as the public health system has never adequately provided these services. Moral labour also appears as supporting livelihoods for staff employed by the clinics. Profit generation and morality are not mutually exclusive in these articulations. Instead, they are co-constitutive, as profit-making makes possible moral labour, generating further profit.

While in many places, private health insurance mediates relationships between people and health markets, financial transactions and relationship between people and health markets in rural Kushtia are direct, personal. Women in Kushtia, even the rural poor, generally express being able access financial resources, either
independently, through social networks, through a family member working abroad or, as a last resort, through loans provided by NGOs or other actors to pay for desired and needed health resources. Where there is mediation, it operates through personal relationships, through *dhora-dhori*. It is through social connectedness that costs of care are negotiated and compromised. Moreover, without the production of risk pools offered through health insurance schemes, the prices of health services must be adapted to the direct financial resources families have at their disposal, requiring cost cuts. This necessitates compromising clinical quality standards (for example, in forgoing trained anaesthesiologists when performing caesarean procedures or skimping on the staffing of formally trained staff).

Indeed, health service delivery as a financial transaction is not necessarily considered an amoral or immoral endeavour for those within the private health sector. Rather it is indispensable to the moral world of the constituted market order. While clinics may not adhere to government regulations, creative workarounds are justified to deliver essential services to people with limited options, and as a necessity to fill in the gaps generated by a state which people have never expected to wait for. They place desired resources within reach through the market when a public health sector has repeatedly failed to deliver on its promises. Although this admittedly means that they do not maintain even the most basic regulations, this is justified as imperative within the broader political economic context.

**Capitalist globalities and localities**

Until now, this chapter has focused on the situated making of maternal health markets in rural Bangladesh. But what of the interplay of the circulation of global capitalism and their associated logics? As described in the introduction of this thesis, critical medical anthropology scholarship tends to view private health markets through the lens of a global expansion of neoliberalism, defined as the propagation of ‘free’ markets and a retreat of the state. These ideologies were popularised under the Reagan and Thatcher administrations in the 1980’s and deployed by the World Bank and IMF throughout the global South within the machinations of international development (Harvey, 2007). This work overwhelmingly aims to ‘unveil’ the negative consequences of these shifts, coalescing with a larger body of scholarship, writing against ‘neoliberalism’ as a hegemonic, capitalist global order.
Privatisation of health service delivery falls within the purview of ideologies identified as ‘neoliberal’, promoting market-based reforms of the health sector within countries. These ideologies offer a competing conceptualisation to the conceptualisation of health care as a common good or human right, enshrined most notably in the global Alma Ata declaration adopted following the Alma Ata conference of 1978 (Packard, 2016:262, World Health Organization, 1978). The Alma Ata conference was organised by the Soviet Union and designed to promote socialist ideologies and showcase the USSR's success in health service delivery through socialism. The United States unofficially participated in the conference, which further solidified the conference’s legitimacy (Fleck, 2008). The Alma Ata declaration on Primary Health Care was a watershed marking a global commitment to achieve ‘health for all’ and a reiteration of the conceptualisation of health as a human right. This declaration regained prominence under the Sustainable Development Goals and Universal Health Coverage discourses, which also foreground a commitment to ‘health for all’ (World Health Organization and UNICEF, 2018, Jungo et al., 2020, Rifkin, 2018).

However, almost as soon as the declaration was enshrined, it fell under heavy criticism by those who asserted it was idealistic, unrealistic and overly sweeping (Cueto, 2004). The years which followed the declaration coincided with a turn towards market-oriented policies embraced by the Thatcher and Reagan administrations, imagining capitalist free-markets as the key to economic development. The promises of these ideologies hinged on shrinking government, stimulating privatisation and reducing regulation, the benefits expected to ‘trickle down’ to all (Pfeiffer and Chapman, 2010). Structural adjustment policies (SAPs), designed based on this economic school of thought, were developed in response to the oil crisis of the 1970s and early 1980s. These served as a primary instrument in this endeavour, linking fund transfers from transnational bodies to conditionalities of governments adopting market-oriented economic policies (Pfeiffer and Chapman 2010; Summers and Pritchett 1993). The World Bank and International Monetary Fund (IMF) spearheaded the deployment of this economic agenda to countries throughout the global South (Harvey 2007).

Privatisation of health care figured into ideologies encapsulated in the SAPs, marking a decisive shift in the conceptualisation of health care as a common good or
human right, reflected in the Alma Ata declaration of 1978, to a market commodity (Packard, 2016:262, World Health Organization, 1978). A market-oriented model of health care promoted by the World Bank and IMF imagined health services and commodities as market goods like any other, with privatisation promising to improve quality and drive down costs in response to market competition. The 1980s onward witnessed a concerted global push towards the marketisation of health care services in the global South embedded in broader capitalist-oriented economic transformations, obliging countries to reduce state intervention and regulation in health and move toward privatisation (Navarro, 2007). The breakup of the Soviet Union in the 1980s and retreat of socialism internationally resulted in the disappearance of a counterbalance to free-market ideologies and socialist country bilateral support to countries in the global South, thereby facilitating the hegemony of capitalist ideologies (Packard, 2016: 276).

By the early 1990s, transitions towards market-oriented health service delivery were consolidated in the World Bank’s 1993 World Development Report. This report, building on a 1987 report entitled Financing Health Services in Developing Countries (Akin et al., 1987), unambiguously promoted a state retreat from the health sector. This report called for a three-pronged strategy: advancement of an economic environment which fosters people’s autonomous improvement of their own health, redirection of government health financing away from health system investment and towards disease-specific intervention, and encouragement of private sector delivery of health services and spurring competition among both public and private health service providers, and among private insurance providers (World Bank, 1993). The report suggests a highly restricted role for the government, limited to influencing health ‘behaviours’ through deployment of health information, public health finances to support the poor to access essential health services either through health market participation or through free public services, compensating for market and health uncertainty, fostering competition among health service providers to drive down service costs and improve quality, and regulating privately delivered health services to ensure safety and quality (World Bank, 1993: 5-7). Even within these restricted assigned roles, the report views government involvement sceptically, stating, “If governments do intervene [in the health sector], they must do so
Intelligently, or they risk exacerbating the very problems they are trying to solve (World Bank, 1993: 5).

International development entities, already a presence in East Pakistan before 1971, became more firmly entrenched in the nascent independent Bangladeshi state following independence (Hossain, 2017). The new government entered dialogue with the IMF as early as 1972 and the World Bank in 1973, paving the path for a journey towards economic liberalisation. By 1986, Bangladesh became one of the first countries to institute SAPs (Zohir, 1997). In 1996, the World Bank homed in on the health sector and threatened to withhold funding unless the government adopted a comprehensive, sector-wide approach to health (Hossen and Westhues, 2012). The Health and Population Sector Program devised in response to this injunction aimed to strengthen integration between the public and private health service delivery, decentralise the public health system and find a path to sustainable health financing (Vaughan et al., 2000, Government of Bangladesh, 1997). However, while national health policies from this time and the subsequent decades mention the private sector as an invaluable partner to the public sector for delivering health services, it is treated as an ancillary one, without any clear pathway toward its construction, regulation or partnership with the public sector. This contrasts with other countries in the global South, and notably its neighbour India, where the government has played a more active role in promoting a private health sector (Chakravarthi, 2018).

Global and national discourses imagine state regulation as the key to oversight of the private health sector. Within national policy and programming, the lack of state regulation of the private sector is often evoked as at least partly responsible for perceived private sector misdeeds and increased regulation as crucial to reigning in the immoral inclinations of the private health sector including widespread 'unnecessary' caesareans. The private health sector regulatory policy en vigueur in Bangladesh dates to 1982 (Government of Bangladesh, 1982), with current licensing processes rooted in this policy. Policymakers and programmers alike acknowledge this regulatory framework as antiquated and flimsily matched to the contemporary realities of the private health sector. As Katherine Browne describes, formal regulatory policies are one mechanism through which moral norms and ideas regarding ‘right’ and ‘wrong’ can be instilled and enforced (Browne, 2009:25). While it is not necessarily the case that stronger regulation would bring
about stricter adherence to these hypothetical regulations, indeed, they often engender more creative ways to circumvent regulations, what is evident in Kushtia is that the flimsiness of regulation leaves open moral malleability and creative rendering of advanced biomedical technologies.

Vocal critics accuse neoliberalisation as a global hegemonic form of capitalism which fertilises the growth of private health markets and thereby undermines health care systems and simultaneously exacerbates health inequities, both globally and in Bangladesh (see i.e., Forster et al., 2020, Thomson et al., 2017, Hossen and Westhues, 2012, Sengupta et al., 2018, Pfeiffer and Chapman, 2010, Homedes and Ugalde, 2005, Rylko-Bauer and Farmer, 2002). Moral anxieties tend to be articulated in relation to compromised quality of care as well as the financial expenditures required to access needed health services.

These and other critiques contributed to a shift towards conceptually fluid re-integration of human rights lexicon around health in the global development sphere and a push toward (re-) conceptualising health care as social good distinct from other market commodities (Pfeiffer and Chapman, 2010, Farmer et al., 2013, United Nations Population Fund (UNFPA) and Harvard School of Public Health, 2010). While the idealism of such alternative approaches is tantalising, they take for granted the existence of a body that is willing and able to efficiently and equitably deliver such goods and services. This de facto body tends to be ‘the state’, placing Western liberal democratic notions of the state as the standard, in which a welfare state acts to redistribute social goods based on social contracts rooted in state citizenship. However, this conceptualisation of the state deserves a re-examination. Rather than a "substantiated entity separate from society," ‘the state’ is constituted through the perceptions and ideas of the state (Abrams, 1988 [1977]). These are instantiated and reified in everyday state practices and state representations (Sharma and Gupta, 2009, Gupta, 1995).

As argued in Chapter 2, the public health system is one space in which imaginaries of the state are made and sustained. At these interfaces, people constitute what it means to be state and what types of claims they can make within this constitution. In state-delivered maternal health care, women accept what the public health system offers, which varies from year to year and day to day. They hold no pretence that their status as nagorik, or state citizens, affords them any basis for
staking claims to services or care. This mirrors broader imaginaries of the postcolonial Bangladeshi state, marred by distrust and scepticism. The state is not imagined as servicing people’s interests as its citizens in the public health sector. The ability to transcend the state by exercising alternative social claims to access maternal health care is a desired graduation.

Neoliberalism is often associated with a shrinking government. The withdrawal of the state entails scaling back state influence over the redistribution of social goods, including health services and resources. Anthropological scholarship on health markets tends to approach enquiries from this perspective, exploring the effects of marketisation of health care in contexts where there has been a tradition of a strong presence of a welfare state or at least an ideological commitment to a welfare state and the right to health. Some scholars have demonstrated how privatisation of health services exacerbates health inequalities (Mulligan, 2016, Maskovsky, 2000, Rylko-Bauer and Farmer, 2002). In Brazil, Emilia Sanabria has demonstrated how health markets give rise to two classes of citizenship, one for those with financial resources available to participate in the private health market and another for those who do have little option but to rely on the poorer quality public health system (Sanabria, 2010).

In Kushtia, this has played out a bit differently. Of course, the biomedical health service terrain operates as one space in which inequalities, class divisions and hierarchies play out. The exorbitant costs of large private hospitals located in Dhaka and the administrative hub of Kushtia mean that they exclude most people residing in the rural peripheries. However, swathes of private facilities cater to people with more modest economic means, placing alternatives to public facilities within reach of the masses. The expansion of the health market is experienced not as state withdrawal for poorer women but simply the availability of something not previously available.

This flourishing private sector, the beshorkari ‘not state’, in Bangladesh allows women and their families to exercise social contracts and transcend what the state offers. Some scholars argue that neoliberalism seeks to constitute this new type of citizenship, self-reliant ‘entrepreneurial citizens’ exercising agency as responsible consumers, rather than looking to the state, to access desired resources and
opportunities (Jeffery and Jeffery 2008; Rose 1999). In neoliberal logics, responsible 'entrepreneurial citizens' make choices based on the quality of care, spurring competition between those engaged in private health service delivery to improve quality and reduce costs, thereby improving services and commodities delivered.

In everyday encounters with the private health market in Kushtia, women rarely make such judgements and claims based on the clinical quality of care. Instead, they access services based on availability of economic resources and personal connections to particular clinics. This is generally aligned with the ways people expect to access desired resources and services more broadly. Whether in the public sector, non-profit, or for-profit private, people expect to access better services by leveraging social networks rather than based on 'objective' quality indicators. Indeed, assessing the nebulous space of clinical quality defies all but those trained as clinicians, much less people living in rural areas for whom the accessibility of biomedical services is a relatively new development. Women and families attempt to maximise perceived quality of clinical services and interpersonal interactions with health workers through personal linkages to particular spaces.

Undoubtedly, economic liberalisation and under-investment in public health services have shaped the health service delivery terrain in Bangladesh. However, we should be cautious in assigning too much deterministic credit to this global agenda-setting. A global hegemonic capitalist agenda is not the only force shaping this terrain. Private health facility *maliks* do not talk about such agendas or global capitalist forms, nor do government or development actors in Dhaka and its peripheries, nor do women. The juxtaposition between 'Big D' Development and 'little d' development is once again instructive here. Policies promoting economic liberalisation while influencing 'little d' development, were primarily concerned with 'big D' Development, the large projects and initiatives designed to shape the country's situation. In the backdrop of this 'big D' Development, 'little d' development, as the inconsistent and unpredictable reshaping of the social world in response to capitalism, which reflect and reformulate capitalist logics through commodification but outside a grand project, gained momentum. Biomedical services were marketised on a small scale through this 'little d' development, as village doctors and small medicine shops gained prominence within a deeply pluralistic context and then
expanded through more deeply institutionalised biomedical services through private clinics and hospitals offering advanced biomedical technologies.

This 'little d' development occurred in a context in which the public health system is imagined as unpredictable and fragmented, justifying the filling in of these gaps by a parallel private sector. We have no access to a counterfactual; that is to say, we cannot imagine what Bangladesh would look like in the absence of a capitalist-centric 'big D' Development agenda. We cannot assume that absent global 'neoliberalism', the postcolonial Bangladeshi state would be imagined otherwise or operate as a welfare state that would more fully serve citizens' needs, desires and expectations. To attribute too much credit to neoliberalism discredits the Bangladeshi experience of state-making following dual-decolonisation, a project still well underway (Lewis and van Schendel, 2020).

The expansion of a private maternal health market is welcomed by people as an addition to the maternal health terrain that allows women and their families to access desired resource by leveraging financial resources and a broad base of social networks. Some might dismiss this as desire generated through the extension of capitalist logics and the production of consumers. Yet, while it is true that commodification of maternal health technologies is now pervasive, women's and families' aspirations cannot simply be explained by this. As argued in Chapter 1, aspirations towards using advanced maternal health technologies is embedded in lived experiences of life, death and suffering, and the imaginary of these technologies offering a birth otherwise. These conceptualisations inform moral sensibilities about what good care means, how one should mother, and how a family should care for a pregnant and childbearing woman and the unborn baby. Thus, while the quality of the clinic care of the private sector may not withstand even superficial scrutiny, particularly in remote areas such as Daulotpur, these facilities and providers offer an answer to a void, an opportunity to access services which are desired, in a space in which distrust and fragmentation infuse the discursive constitution of the public health sector.

Conclusion

This chapter examined the making of a private health market within the specific political-economic world of the Bangladeshi peripheries and how moralities
are negotiated within it. The proliferation of a maternal health market in Daulotpur was never inevitable; it resulted from a confluence of political, economic and development agendas both within and beyond Daulotpur. The deployment of global neoliberal agendas is one story, but it is not the only story. This chapter has argued that the proliferation of a private maternal health market in rural Kushtia must be understood beyond neoliberal hegemonic determinism. While global forces have arguably influenced the biomedical health service delivery landscape, it is more directly moulded by localised political-economic and social realities, and localised responses to capitalistic forms generated through largely off-the-grid, 'little d' development. While the experience of Daulotpur is situated, it is also a microcosm. Private maternal health care services burgeon like vines around the public health sector in Bangladesh, adding valuable opportunities to meet livelihood ambitions and health objectives. While these shifts are met with moral ambivalence, those within the sector navigate a tenuous moral world in which market logics are not amoral or immoral, but integral to service-oriented business.

While national discourse tends to portray those animating the private health sector as ‘just wanting to make money’, positing market logics against care-based logics, in these spaces, private health service clinics operate as a space for supporting much needed livelihoods in a precarious political economy. While these livelihoods are more lucrative for some than others, they offer a vital formal and informal economy for those with a variety of former qualifications.

Simultaneously, this market opens women’s opportunities to access advanced maternal health technologies, which, as argued in Chapter 1, now figure centrally in women’s aspirations as pregnant and childbearing subjects and what it means to care for the baby. While these services are delivered by cutting clinical corners, and thus depart from national and global standards of clinical quality, private health service actors justify clinical corner-cutting as necessary response to local realities and to fulfil their moral obligation to help the poor by placing biomedical technologies within their reach. This moral justification is further supported by the discursive constitution of a public system failing to respond to people’s needs and desires. Rather than waiting for the state to respond, these actors view themselves as providing needed and desired alternatives to a state which, as Borosha apa put it, does not ‘care’.
Chapter 5: "No caesarean in the afternoon": physician dual practice and public-private co-constitution

Public/private representation

By now, I must be at least seven hours into a journey back to Dhaka from Kushtia with several icddr,b team members, though I have long abandoned counting hours on these trips or following my journey in Google maps. Google maps is a tease, I learned on these commutes: the estimated arrival time creeps later and later as I grasp for it, always stubbornly just out of reach. The bouncing of the SUV over potholed roads has given way to the stop-and-go jerking characteristic of the late-evening Dhaka traffic that hovers dangerously close to gridlock. Despite my exhaustion, these journeys are not necessarily unpleasant and are a welcome respite from my usual long bus rides. I whittle away the hours with the team in waves of chitchat, naps, tea breaks and conference calls, which the team accepts even past midnight to accommodate the time zones of donors and international development partners.

Tonight, the call is with Johns Hopkins University, a heavyweight within the international development apparatus. With 16 hours of difference, it is still early in the day in Maryland. It is an update call concerning a study trying to understand Bangladesh's enigmatic success in maternal and neonatal mortality reduction over the past few decades. The study identified Bangladesh as an 'exemplar' in that the country experienced more significant improvement than expected based on broader socio-economic development trends and even exceeded that of other countries in the region. Most puzzling is that this occurred even in the absence of what the development community considers the silver bullet for reducing maternal mortality—institutional birth. The study is driven by more than mere curiosity. The underlying assumption maintains that if the researchers can identify the key contributors to these unexpected developments, these can be packaged and repurposed for application in other countries. This vision maps on to the global project of homogenising international development and global health.

During this call, a Johns Hopkins researcher presents his team's work on trends and determinants of neonatal mortality in Bangladesh, secondary data
analyses drawing from data sets from the most authoritative national surveys: the Bangladesh Demographic and Health Survey (BDHS), backed by USAID, the Multiple Indicator Cluster Survey (MICS), backed by UNICEF, and the Bangladesh Maternal Mortality Survey (BMMS), also backed by USAID. I doze off a bit and avoid looking at the telephone screen, worried that it will make my stomach more uneasy than it already is, as the presenter clicks through the slides. His deep and confident voice narrates the associations they found between neonatal mortality and maternal socio-demographic characteristics. When the presenter reaches the section of the presentation entitled 'Mortality by Proximate Determinants,' by which he means the potential immediate factors associated with newborn death in epidemiological jargon, I perk up. In these four slides, the researchers identify two conditions as proximate determinants, 'c-section' and 'place of birth', presented as line graphs. In these graphs, 'public' and 'private' are represented as distinctly demarcated lines of death, gradually descending across evenly spaced grids of time.

There is nothing particularly novel in these graphs; I must have encountered figures such as these hundreds of times before, in national dissemination workshops, in BDHS reports. To be fair, I even designed figures such as these as a development practitioner when I prepared manuscripts and presentations. In some cases, 'public' and 'private' categories appear as columns in histograms, sometimes as slices in pie charts, this time as a line connecting dots through time. Despite their banality, something about these charts captivates me at this moment. The delineation of these lines, their sharp edges, inspire confidence that we all know what these representations contain, that we can distinguish between who and what is public and private, and that, by extension, women know as well and simply make choices as ‘rational’ actors between one or the other. At one time, these distinctions seemed evident to me; yet, after the months spent in Kushtia straddling these sectors, these boundaries somehow feel mushy and murky now.

In both global and national spaces, policy and programming narratives around health systems and privatisation of health care treat ‘public’ and ‘private’ as dichotomous and oppositional categories, guided by two fundamentally distinct logics. These narratives hinge on the assumption of a de facto divide between that which is considered the ‘state’ from that which is ‘society’ and ‘economy’. Timothy Mitchell challenges these distinctions, contending that they are internally rather than
externally drawn, and always tenuous (Mitchell, 1995, Mitchell, 1999). These boundaries are forged through discourse and everyday enactments. Indeed, just as Begoña Aretxaga writes in relation to the separation between ‘civil society’ and ‘the state’, separations between ‘the economy’ and ‘the state’ do not exist in reality, but are rather produced as ‘phenomenological realities’ through everyday encounters, discourses and practices of power (Aretxaga, 2003). One space in which these separations become phenomenological realities is through discursive constitution and everyday encounters with ‘public’ and ‘private’ health service delivery sectors.

Within discursive practice, a public health system is imagined as designed, managed and staffed by a cohesive state entity, guided by the interest of maximising the health and well-being of its citizens. In this logic, health services and resources are social commons to be distributed to populations as a function of citizenship.¹ In contrast, a private health market is imagined as driven by a vision of health services and resources as market commodities to be bought and sold per rational choice theory espoused by classical economics, thereby improving them through the process of competitive refinement (Rose, 1996). These assumptions crystallise in official narratives, in national presentations where ‘public’ and ‘private’ are represented as clearly delineated columns, pie slices or lines in proportion to one another, suggesting that there are two camps of biomedical actors espousing and enacting these competing logics. However, what happens to these distinctions when the same actors animate both columns, pie slices and lines?

In the Bangladeshi maternal health terrain, government medical doctors play a pivotal role in the nebulous constitution of boundaries between state and economy in the health service terrain as they animate both sides of this tenuous divide between public and private biomedical service delivery sectors. Dual practice, the simultaneous engagement in public and private health sectors, is common in many contexts (Moghri et al., 2016). Policy and public health narratives tend to cast this practice in negatively morally connotated terms (see i.e., Garattini and Padula,)

¹ Such discourses manifest in the shift towards human rights-based approaches to health which are now prevalent within the global health apparatus (see for example Bustreo and Hunt, 2013, World Health Organization, 2017). However, such discourses sit uneasily with neoliberal ideologies which continue to underpin international development practice and assume Euro-centric/Weberian notions of the state willing and able to redistribute social commons, often at odds with the ideas of the State operating in the countries which tend to be the object of international development practice.
2018). Particularly related to global South settings, global health literature predominantly emphasises presumed negative consequences of dual practice. This scholarship pairs dual practice (sometimes referred to as ‘moonlighting’ (see e.g., Biglaiser and Albert Ma, 2007)) with deprioritisation of public health institutions and absenteeism by public providers (Ferrinho et al., 2004, Askildsen and Holmås, 2013); provider misuse of public resources (Socha and Bech, 2011, Ferrinho et al., 2004); 'cream-skimming' wealthier patients from the public sector to the private; and physician encouragement of patients in public facilities to seek expensive, unnecessary procedures in their private practice (Jan et al., 2005, Gruen et al., 2002, Bir and Eggleston, 2003). These narratives take on negative moral valence, for example, in contrasting "dedicated" and "sincerely behaving" public health providers from their "utility maximising moonlighters" (see i.e., Biglaiser and Albert Ma, 2007). In contrast, Moghri et al. highlight the lack of empirical research on dual practice, which they underscore as particularly problematic given the versatility of the practice in various contexts. They also conclude that studies carried out to date on dual practice tend to over-rely on theoretical methods to predict the implications of such practice (Moghri et al., 2017), in essence challenging the predominating moral stance within the scrutinized scholarship.

This chapter interrogates the presumed separations between the 'public' and 'private' health sectors. I aim to step back from questions regarding 'positive' and 'negative' consequences of physicians' dual practice in Bangladesh rooted moral sensibilities. Rather, I seek to explore such practice as a social fact. Centred on the widespread and normalized simultaneous practice of government clinicians in both sectors, this chapter argues that rather than separate entities bounded by distinct logics, doctors' time-bound animation, though not always corresponding to biological timings of pregnancy and birth, define public/private categories and what types of care women can access when, where and at what cost. Logics themselves are also blurred in these enactments, as 'public' credentials are marketised as an extension of 'private' logics. I start this exploration in the Kushtia District Hospital operating theatre on a hectic afternoon to examine the everyday dual practice of clinicians and what this looks like from the vantage point of the public health system. Section two then examines the logics of commodification, arguing that the dichotomy of public services as uncommodified versus private services as commodified breaks down as
providers commodify government credentials. The third section brings us back to Kushtia district hospital to explore doctors' dual practice from the vantage point of women navigating the maternal health terrain.

Kushtia district hospital operating theatre

![Image](image.jpg)

**Figure 20: Caesarean in the Kushtia District Hospital operating theatre**

*Source: Photo by author, Kushtia district hospital, 9 Feb 2021*

It is 2:05 pm in the obstetrics and gynaecology operating theatre in the Kushtia district hospital. I stand a safe distance from Madame² and watch as she wipes the thick copper-coloured sanitiser over Annie's protruding abdomen with the cotton ball wielded by a metal clamp. She glowers over Annie's body, the next belly

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² The designation ‘madame’ is commonly used as a designation to indicate the highest level of respect for women; therefore, the highest ranking female physicians are often referred to as ‘madame’, including the in-charge of the obstetrics and gynaecology in the Kushtia District Hospital.
in a steady stream since morning. Two medical assistant training school (MATS)³ interns stand opposite her on Annie's left; both young men adorned in green scrubs and blue hairnets, one tall and slender, the other stocky. As soon as she sets down the metal clamp, the stocky intern, Assif, hands Madame a scalpel before she even asks and successfully averts a potential reprimand, of which he has been on the receiving end many since I arrived in the morning. The operating theatre for obstetrics and gynaecology functions as a factory even more than usual today, the two beds perpetually filled by silent rotating women, all but one is here for a surgical birth. Although I know Madame, the in-charge of gynaecology and obstetrics at the district hospital, this is my first occasion to be with her in action in the operating theatre. I, too, try to keep a safe distance so as not to irritate her. She sinks the scalpel into Annie's flesh and slides it back towards her, smooth and hasty. Madame stuffs greyish cloth inside the incision, sops up the droplets and pulls it out stained with scarlet. A bit of blood splatters the sheet draped underneath Annie. Assif cannot circumvent this scolding; somehow, he should not have let the blood stain the sheet. She hastens to make the next incision into the deeper recesses of Annie's flesh.

My stomach rumbles with hunger, despite the scene in front of me. It is late; usually, by this time in the afternoon, the operating theatre is cleared from patients and medical staff, with only interns and ayas straggling behind to do the clean-up. The medical doctors have long disappeared to their afternoon workstations in the lucrative private sector. This is when Tamanna and I remove our scrubs and head back to the office to join the icddr,b team for lunch, as there is nothing left to observe. Today, in contrast, there are still three women in line for caesareans. At the other operating table in the room, Yasmin, a tall, young surgeon with sharp eyes whom Madame finds relaxing, prepares to perform a caesarean on Sharmin. Annie lays quiet, eyes fixed on the ceiling behind the white sheet which shields her body from her view. Within moments, I see Annie's smooth pink uterus. Madame slices through it, and the vigilant Assif inserts the thick plastic tube leading to the

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³ The medical assistant training school prepares students to serve in jobs as auxiliary health workers, such as Sub-Assistant Community Medical Officers (SACMOs), pharmacists, and lab technologists. The MAT training centre is located within the Kushtia District Hospital campus, which may explain why MAT interns are often present in the operating theatre. However, the training is not designed to technically prepare MAT students to support work in operating theatres, nor for such work following completion of the training.
receptacle jar. The sound of the tube sucking the amniotic fluid and excess blood from the interior of Annie's body fills the room.

Madame reaches her gloved hands into Annie's uterine incision for the baby. I fix my gaze, as this part usually is ephemeral; if I blink too long, I may miss the moment when the surgeon scoops out the baby. The ringtone of Madame's telephones blares through the room. The ringtone serves as background music as Madame inserts both hands inside Annie's womb. Madame pulls up, but there is resistance. She pulls again; still no baby. Another yank. She orders Assif to stretch the uterine muscles apart, but not too much. He takes hold on either side and gently pries the muscle layer back. Madame manipulates this way and that to dislodge the baby, in an uncanny resemblance to a vaginal birth when the nurses work to free the baby from the vaginal canal. Finally, one last tug does the trick, and she proudly holds up her catch, a wriggling mauve newborn, covered in the thick paste of vernix glistening under the halo of theatre lights. The baby is attached to his mother via the placenta, still nestled inside Annie. The slender MAT intern fixes the sliver clamp around the purple twisty umbilical cord and then snips the baby free. Madame slaps the baby's back to spark a cry and then places him on the metal platter the aya holds next to her. The aya shuffles to the corner to clean him off.

2:13 pm: Madame used plyers to hold the needle and insert it into one side of the incision of Annie's uterus and out the other side, binding her uterus back together with thick, red sutures. Madame stitches Annie's muscle back together, then the inner layer of her epidermis, and then the final layer of skin, in seeming record speed. She is quick this time, rushed. Her ring tone interrupts my concentration as it reverberates through the room once again. Annie's baby, which we learn by then is a boy, wails in the background.

Twenty minutes later, she takes a seat in the corner with a couple of the medical interns for a small break while the MAT interns sterilise and bandage Annie's wound. She motions for Tamanna and me to sit with her, and we each pull up a metal seat from the adjacent wall. Madame's phone resounds again; she answers this time. It is a call from her private practice. She is irritable with her interlocuter and says she will be there as soon as possible. She first needs to finish her work at the district hospital. The woman there will just have to wait for her caesarean. As the
ayas dress Annie and move her out of the room and the next woman in, Madame tells me stories of when she worked at the Leprosy Mission Hospital, the largest leprosy hospital in Bangladesh. That is where she started her career, she tells me. The patients loved it there, she says. They thought that the white mission doctors were gods. She tells me that the foreign health staff even fed the patients there, and she laughs aloud at the memory; perhaps as such an action would be unthinkable here. I smile politely, not sure if she is somehow praising or mocking my own whiteness.

She is currently pursuing a promotion to become a government professor, she tells me, among the highest positions a government doctor can obtain in the country. Such a position is not only a wellspring of pride but also opens opportunities for income through increased name recognition as a private practitioner. To obtain the position, she tells me, she needs some publications. Could I help her with that? she asks. She reassures me that I would be the first author; she just needs to have her name there as an author. I blush at the request, caught off guard by her forthrightness. Luckily, I do not need to respond, as the next woman is ready for her caesarean. I politely tell her that I would like to observe Raihan, the lanky and cynical anaesthesiologist, administer the analgesic, so would she please excuse me? She nods, and I move toward the operating table.

2:50 pm: Jhumki lays on the bed previously occupied by Annie. Her belly rises and falls with her inhales underneath a faded kameez. Raihan approaches her. He sports a short beard trimmed to perfection, a beard that marks him as distinctly urban in contrast to the longer, less-kempt (and sometimes henna-coloured) religious beard. While most health staff welcome our presence, Raihan was initially standoffish. He eventually warmed when he discovered that he and Tamanna are batchmates, meaning they completed their secondary schooling the same year, which is a powerful commonality to hold. Raihan keeps up to date with international guidelines and harbours a real passion for the profession, a passion whose flip side is a deep frustration with the plight of the undervalued anaesthesiologist in Bangladesh.
When Raihan approaches Jhumki, he berates her for being a fatty shejar.\footnote{It is not uncommon in both the public and private sector health staff refer to fatty shejar to refer to caesareans birth for women who they deem overweight; however, this assessment is made on a highly subjective basis. Some private clinics place a surcharge on fatty shejar, claiming that it is more difficult and can be more complicated. For example, clinics may assess that they need to call in an anaesthesiologist for a fatty shejar, as it may be more difficult to locate the correct area in the spinal cord to administer to analgesia, while for a non-fatty shejar they tend to deem the intervention of an anaesthesiologist as unnecessary.} Doesn't she know they do fatty patients (rugi) in the morning? Fatty shejars take longer. This interaction is a departure from his typical interactions with women, which tend to be warmer. Perhaps he, too, is frustrated by what is an extended workday for them. Jhumki does not respond but follows Raihan's instructions to roll onto her side so that he can insert the needle into her spinal cord. Madame takes over from there and perfunctorily performs her last public hospital caesarean of the day.

At 3:23 pm, Madame completes Jhumki's internal stitching, though her skin still gapes open. She hands the sutures to the Assif, which he accepts without hesitancy to abet her retreat from this public surgical space. The head of the gynaecology and obstetrics department then glides to the corner of the room, snatches her black handbag, and flees the operating theatre without saying goodbye. The MAT intern continues where she left off. He tucks and sutures internal corporeal layers safely back inside the cutaneous boundaries of Jhumki's body.

Jhumki moans quietly. Raihan glances towards her; she should not feel anything. He approaches and takes hold of her wrist to check her pulse. He glances over her vitals on the electronic screen. He then strides toward Tamanna and me and says he will go too. Allah hafez, he says and disappears through the double door.

I scan the room. It is quiet except for the rhythmic beeping of Jhumki's electronic monitor, slightly out of sync with that of Sharmin's, who still occupies the adjacent bed. The room is devoid of doctors and their material remnants (e.g. fancy handbags). The medical officers are now scattered throughout nearby private hospitals and clinics, carrying out the more lucrative aspect of their professional life: their private practice. The two MAT interns work alone to complete the last layer of sutures and cover Jhumki's and Sharmin's wounds. The ayas mop the blood and amniotic fluid from the floor and empty the receptacles filled with these liquids sucked from women's bodily interiors. Assif passes the needle into Jhumki's skin and then over and up the other side, basic stitches, in contrast to the more elaborate and
delicate 'cosmetic stitches' that the medical doctors prefer. He looks up at us and gives us a slight smile. You want to try? he offers. It is quite easy, he assures us. We decline.

That the operating theatre dedicated to gynaecology and obstetrics of the district hospital, the most reliable place to avail advanced services through the public health system in the entire district, was bereft of clinicians by 3:30 pm, even before Annie's and Sharmin's bodies were put back together, was in no way exceptional. What was a bit exceptional on this particular day was that the clinicians were here to perform the surgeries after 2 pm.

The clinicians' engagement in both public and private health care spaces is the norm rather than the exception to the rule. Dual practice of public health service providers in the private health market is common both among doctors and other health staff in Kushtia. While non-clinicians holding a government position, e.g., SSNs, SACMOs and FWVs, are formally prohibited from engaging in service delivery in the private health sector, some do so, and it is common to hear about SACMOs affiliated with private clinics or SSNs attending births in homes.

However, non-physicians tend to engage in this practice discretely, and it is more common to hear about it from women who have benefitted from their services outside the public sector from them. For example, in Bheremara, Roshunara apa, the SACMO who regularly worked in the ANC corner alongside the young midwife Milli, posted to the complex, was widely known as the maternal health expert in the area. Present in the complex since 1984, women in the upazila health complex mention that they come specifically to see her. When the SACMO is absent, women tend to leave rather than visit the young midwife. Many report that Roshunara apa attended their births at home or in her small private chamber. However, in the upazila health complex, Roshunara apa never discusses this practice and dissembles if we ask about it in that space. In the complex, Milli whispers in frustration that Roshunara apa assists birth outside the facility, undermining the young midwife's effort to promote institutionalised birth. It is only when we visit her home and small chamber that she talks to us openly regarding her private practice.

In contrast, formal regulations permit medical doctors to engage in private practice openly. Dual practice of medical doctors in both the public and private
sectors dates to British colonial rule when surgeons of the East India Company were permitted to practice privately in addition to their Company-related duties. This private practice was the source of substantial income, a compensatory draw for British surgeons to supplement their incomes after 1830, the year in which they were prohibited from engaging in banking, commerce and landholding activities (Arnold, 2000:60). Private practice continues to offer lucrative opportunities for government medical doctors to augment incomes. Some studies suggest that dual practice of physicians in Bangladesh is among the highest in the world, estimating that 80% of public clinicians engage in private practice (Gruen et al., 2002, Berman and Cuizon, 2004). While others challenge this widely circulated figure as unreferenced (Hipgrave and Hort, 2014), what is clear is that dual practice among Bangladeshi government physicians is widespread.

While the dual practice of doctors in public and private institutional settings enjoys a history dating back to the introduction of biomedicine, the flourishing private health care market over the recent decades has expanded to nearly limitless possibilities such engagement. Given the proliferation of private hospitals and clinics, government doctors can easily maintain a private chamber in a hospital or clinic and rotate to provide services in several private institutional settings. While according to official regulation, medical doctors can only have their names registered to one private health facility, in practice, many rotate between several facilities.

The predominance of technology in private maternal health care sites lubricates the slippage of doctors into private settings. As I have argued earlier, imaginaries of availing surgical birth and ultrasonogram are central to women's and families' desires to seek out biomedical maternal health services. However, while these technologies are materially present in government facilities, their operation is inconsistent. For example, all upazila health complexes possess equipped operating theatres. However, these operating theatres, almost without exception, remain padlocked. UH&FPOs tend to attribute the lack of availability of caesarean to lack of 'manpower', which, in this specific case, means that they do not have a surgeon and anaesthesiologist pair posted to the facility.

In contrast, droves of women undergo surgical birth just outside the public hospital doors in strategically-located private clinics. It is not only government
doctors who perform in these operating stages. However, the sheer number of these theatres, combined with the desire of private facility *maliks* to contract government doctors and the absence of bureaucratic barriers, means that government doctors slip easily into these sites of lucrative medical performance. These stages open up virtually unlimited opportunities for government doctors to benefit from health markets and to do so without being held back by regulatory standards established in government facilities. One of the clearest examples of this is the case of anaesthesiology. While UH&FPOs tend to point to the absence of a posted anaesthesiologist as a reason for withholding the provision of caesarean, private clinic owners do not mention this as an obstacle. As discussed in Chapter 4, private clinics often administer analgesics in clinically creative ways that generally bypass trained anaesthesiologists altogether, allowing surgeons to practice even in their absence.

As for ultrasonogram, all upazila health complexes are equipped with ultrasonogram machines, and often with multiple machines. However, rarely are these machines used, and many break down and linger in disrepair. Rifat sir, the UH&FPO who succeeded Arobindo at the Daulotpur Upazila Health complex following his retirement, set out to rectify the absence of ultrasonogram provision in the complex. In his early 30's, Rifat is the youngest UH&FPO in Kushtia. He claims to be one of the youngest UH&FPO in the country and at once brags about this and overcompensates for it by wearing cufflinks to his upazila health complex office, which seems a particularly uncomfortable fashion choice given the relentless heat and humidity.

He boasts that he already reintroduced ultrasonogram to the upazila health complex during his short time as UH&FPO. Dr Rahim and Dr Selina, young medical officers posted to the complex during the last posting, perform the ultrasonograms at the upazila health complex. Both completed a Certificate in Medical Ultrasonogram (CMU), a three-month short course in ultrasonogram. Nevertheless, I only find the ultrasonogram room open when I ask Rifat sir to visit. Rifat then calls a hospital administrative staff to open the padlocked door and calls one of the doctors to come. When the midwives send women from the ANC corner to undergo an ultrasonogram in the complex, I often find them later with disappointment rather than an ultrasonogram report. The ultrasonogram room was locked and no one was
performing the service the midwives promised them. But that is okay, they tell me; they will go to a private clinic later. They never expected to be able to have an ultrasonogram at the government facility. Though more expensive, they expect that ultrasonogram in the private clinic will not only be provided, but it will also be better. Even Dr Rahim and Dr Selina complain about the poor quality of the ultrasonogram machine in the upazila health complex. With only limited training in ultrasonogram, the suboptimal machines only amplify their lack of confidence in the reports they generate.

While the doctors may or may not be found to perform the ultrasonograms on the promised days in the upazila health complex, they will reliably be found in the various private clinics just outside of the upazila health complex in the afternoons, and Tamanna and I cross them several times in these spaces. An ultrasonogram machine is a mainstay technology in the private clinic, and while expensive, these machines offer a quick return on investment. The drive of clinic owners to invest in ultrasonogram technology means that Dr Rahim and Dr Selina enjoy almost limitless stages on which to perform and use higher quality technologies that are therefore easier to use. While they most certainly privilege some clinics over others, all nearby clinics claim these two doctors regularly frequent their clinics to perform ultrasonogram. Claiming to have a government doctor credentialed in ultrasonogram operates to draw to attract clients to specific clinics. Therefore, the government doctors have their choice regarding the spaces into which they slip.

While the widespread availability of technology lubricates the movement of doctors between public and private settings, health managers and providers further encourage the movement of people out to private facilities. Indeed, even when the technology is present in a facility, managers and providers often steer patients outside the public facility to services in private diagnostic centres and clinics. They often tell people that the technology in the upazila health complex is either broken or not good; they should go outside to a private clinic for the same service.5

Complaints about the lack of ‘manpower’, for which health managers and providers use the English cognate, reverberate throughout all health system levels.

5 Recall in Chapter 4 when Azam sir referred the man to ‘any clinic outside’ to do an electrocardiogram, even though the upazila health complex provides this service.
among health service providers, managers and policymakers alike. These crystallise into an insurmountable imagined burden. However, these narratives are belied by the parallel private health market, in which managers never complain of lack of ‘manpower’ to animate their spaces and wield the technologies. On the one hand, this reflects low public financing for the public health sector and difficulties retaining staff in public sector facilities. However, the ‘manpower’ in the public health sector is also divided. Few doctors plan to dedicate a substantial amount of time to public practice. In all public facilities, the district health complex and district hospital only expect the presence of physicians for a narrow window of the day, officially between 8 am and 2 pm. Even these hours tend to be whittled down, and a person is most likely to find health providers between 10 am and 1 pm, making for quite a narrow window for delivering public health services, and even more so when it comes to pregnancy and birth care.

Indeed, while care-seeking for many health events can be delayed or timed in accordance to schedules, childbirth is only predictable in its unpredictability. Spontaneous childbirth onsets at any time, and the speed of labour among births is highly variable. Moreover, while most births occur without problems and do not necessarily require biomedical interventions, most complications that do occur cannot be predicted. When they do, availability of ‘manpower’ to deliver a biomedical response, such as an emergency caesarean, neonatal resuscitation or management of haemorrhage, basic services that are promised through public health institutions but only available during narrow time slots, can mean the difference between life and death.

Commodification of government credentials

If financial benefits of clinical work are localised primarily in the private sector for doctors, this begs why clinicians aspire to government practice and what government credentials mean for private practice. While many ancillary health service providers, e.g., paramedics, nurses, and midwives, aspire to government positions to secure a reliable livelihood and a firm foothold in the middle classes, as discussed in Chapter 2, medical doctors possess other motivations. Those who enter medical colleges hail from middle- and upper-middle-class backgrounds. Medical school is both enviable and competitive in Bangladesh. While aspirations to become a doctor figure in caricatured representations of South Asia, it remains that medical
practice is highly desirable and carries the promise of status and financial comfort. The icddr,b researchers qualified as MBBS doctors recalled the pressure they experienced from family to enter a medical programme and their decisions to forego medical practice as a rebellion from their families’ desires and a cause of disappointment. Despite being employed by a nationally and internationally renowned research institution, maintaining a high social status and financial security was perceived by their families as far less sure as a researcher than as a medical practitioner. Given the paucity of opportunities for entering public medical colleges, which are fully funded through the government, to do so requires either that one has access to the highest levels of primary and secondary education, special tutoring and possible personal connections. While the entry requirements to private medical colleges may be less stringent, these demand significant financial investments.

The appeal of medical training is visually material when one walks down the main streets and dusty side streets of Kushtia, where posters advertise coaching centres specific to the medical school admissions test, an industry in and of itself. The standard poster showcases rows of black and white (or sometimes colour) passport-style photos of some 12-20 students from Kushtia whom the company claims obtained a seat in medical school thanks to the optimal tutoring of the company, along with each student’s ranking in the last admission test batch. These images of serious-looking young people evoke the potential of bright futures, constituting the best and the brightest headed toward financial comfort. Aspirations toward medical practice are rooted at least partially within economic aspirations localised in a private health sector, free of the caps on income levels for doctors working in the government sector.
The first time I meet Rifat sir in Daulotpur with the icddr,b team, he slides his visiting card toward me across his desk with his index finger. This surprises me, as the other UH&FPOs had not made the same show of their visiting cards when we first met, though they each possess unassuming, white-backgrounded visiting cards with the government logo and basic black script. Rifat sir's card, in contrast, reflects an effort to design a card unlike the others. I look down at the glossy card; the black background seems an appropriately regal match for the cuff links. I read his name in yellow Bangla print at the top of the card. The prominent text in the middle of the card reads "Bheremara Adunik (Modern) Diagnostic Centre," the diagnostic centre which houses his private chamber. The name of the diagnostic centre makes an unequivocal appeal to the idea of ‘modernity’ as superior, contrasting to many of the other local diagnostic centres and clinics adopting religion-inspired names or the name of a person. The business card lists his credentials below his name: "MBBS" indicates his qualifications as a medical doctor, which he completed at a private medical college, and next to it, "BCS (health)", indicating his credentials as a Bangladesh Civil Servant. Below he lists his other specialisations, "DMU (ultra)", indicating his diploma in medical ultrasonogram, requiring completion of a 1-year programme, in contrast to the 3-month CMU qualification, and "CCD (Brdem)", a short course on diabetes management. The line below reads, "Specialist in diabetes"
and “general practitioner”, a small purple box on the side, "Patient consultation every day by appointment, Friday all day." The upper left hand of the card bears the logo of the Government of Bangladesh, a seal of credibility. Indeed, it is precisely the foregrounding of this logo that legitimises the other private services offered on this card.

The government logo on the card and his name become mutually constitutive and reinforcing as government doctor names assume semi-celebrity status. Even in villages far removed from the district and sub-district centres, women can easily mention the names of high-profile government doctors, particularly gynecologists who practise in Kushtia. The pomp and circumstance of Rifat's card reinforces his name recognition as both a government civil servant and a private clinician. Each time I encounter him, he points out that he is from here, or more precisely, a 'boy from this place' (ei elakar chele). The subtext of this statement is that he cannot be taken advantage of, even in this remote and reputedly lawless subdistrict, and that he can manage the people. He boasts of his close relationship with the local MP to bolster this aura. However, being an ei elakar chele has another advantage. It allows him to take full advantage of his government status within the local private health service market.

Rifat sir invests heavily in his private practice, rushing to his private chamber in the neighbouring sub-district of Bheremara, which is his home upazila, at the end of each morning spent in the Daulotpur upazila health complex. He claims his ties to Daulotpur are just as strong, as his family is scattered throughout the two upazilas. While this may seem an irrelevant detail, given the insularity and secrecy of the social world of Daulotpur, Rifat sir must demonstrate these connections. His private chamber in Bheremara is located in front of the local train hub, only minutes down the road from the Bheremara Upazila Health Complex. He does not limit his private work to his chamber, however. When called, he provides health services at other clinics and diagnostic centres throughout Daulotpur and Bheremara.

An omission on Rifat's card strikes me as I scroll down the various credentials listed. Although not formally trained in anaesthesiology, he participated in training in emergency obstetric care (EmOC), during which he completed an anaesthesiology short course. For several years, the Government of Bangladesh offered a short
course of EmOC to introduce advanced obstetric care into upazila health complexes. Anaesthesiology was integrated into this training, preparing participants to provide basic anaesthesiology during caesareans when paired with a surgeon. Rifat sir completed this training. However, this training was not designed to train participants to practice as an anaesthesiologist unless they complete a further two years of training, and participants were placed under formal prohibition from anaesthesiology practice in the private sector.

Nevertheless, despite the omission on the card, everyone knows him for his work as an anaesthesiologist. Although he does not provide anaesthesiology in the upazila health complex, he circulates to nearby clinics to perform anaesthesiology for caesarean. I crossed paths with Shiwly, one of the diploma midwives I knew well from the Daulotpur ANC corner, in the upazila health complex nurses' duty station a couple of days after she gave birth to her son. Although the midwives are recruited as cheerleaders of normal delibheri, she had a caesarean, which she explained as medically indicated since she reached her due date without any signs of labour. Therefore, she went to one of the reputable private clinics in Taragunia for a caesarean on her estimated due date. She blushed when she told us that Rifat sir performed the anaesthesiology. While she was glad to be under his care, and this was likely to be the best clinical provision of anaesthesiology in the upazila, she was still embarrassed to expose her lower back to him in this way, not only an unrelated man but also her boss, and she giggled as she recounted the encounter to the SSNs, Tamanna and me.

In the three clinics just outside the upazila health complex, each manager mentions Rifat sir in the context of anaesthesiology. "We have our Rifat sir (Amader Rifat sir ache)," they say when we ask them directly about the delivery of anaesthesia in the facility for caesarean. Although having a government-certified anaesthesiologist posted to their vicinity lends to their credibility, when I press them, they admit that Rifat sir has never actually come to perform anaesthesiology in their

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6 From a clinical guidance perspective, the estimated due date suggests a point indicating a radius for a baby to be born up to three weeks earlier than this date and up to two weeks after it. Therefore, estimated due dates are always at best approximations. In Kushtia, however, despite the minimal standardization in the ways estimated due dates are approximated (i.e. confusion over last menstrual period dates, questionable reliability of ultrasound reports), these dates tend to be treated as hard deadlines, defining moments for justifying a medically-indicated caesarean.
clinics. Though well-located, these small clinics, which crowd the space near the entrance of the upazila health complex, are less well-reputed. The unstated subtext is that Rifat would not stoop to the level of their clinics; instead, he frequents the larger clinics in nearby Taragunia. Still, having him in their midst, a government health manager and reputed anaesthesiologist boosts their credibility, a vicarious commodification of government credentials.

Like other government health service providers, Rifat sir leverages his qualifications as a government service provider to bolster his credibility as a private clinical practitioner. His business card is a striking emblem of the public/private straddle and the commodification of government credentials. While his business card functions primarily as an advertisement of the private health services he is prepared to deliver, the government logo in the corner serves as a stamp of credibility and trust.

If we take for granted the public and private health sectors as distinct entities, harbouring opposed logics, it may seem advantageous for the private sector facilities to favour clinicians who are fully dedicated to the private practice. If nothing else, such a dedication would promote a greater availability on the part of clinicians. However, private health facility maliks express a preference for government health service providers and use the government status of affiliated providers in advertisements in banners, flyers and loudspeaker announcements to draw in client, although this means that health service availability is determined by doctors' schedules, as government doctors are officially unavailable for private practice during government hours.

While finding a public health clinician who does not practice privately or does not aspire to private practice would be exceptional, the inverse is not true of private practitioners. Young medical practitioners (those under the cut-off age of 30 for entry into government service) engaged exclusively in private practice often aspire to obtain a government job. Anika apa, a medical practitioner at Khoksha Healthcare Diagnostic Centre and Clinic, is among the clinicians who work solely in the private sector. Khoksha Healthcare is located a 10-minute walk away from the upazila health complex along the main highway between Kushtia and Dhaka. It is the largest clinic in Khoksha and in a league of its own in this corner of Kushtia regarding
resources, services, and equipment. Photos decorate the clinic's wall showing different scenes from the inauguration and open house events. Looking for Sharif sir, the UH&FPO of the upazila health complex just down the street, in these photos is like playing an easy version of Where's Waldo; he is somewhere present in all the photos, usually the centrepiece.

Anika apa followed her husband to Khoksha in December 2019, when the civil service posted him to the upazila health complex as a new government medical officer. She joined Khoksha Healthcare, a recently established private facility, soon after. Anika serves as the radiologist and gynec-consultant in the clinic. By the time I meet her in person, I know who she is through word of mouth. Women at the upazila health complex drop her name as the person who performed their ultrasonogram or caesarean. Her husband knows Tamanna and me from the upazila health complex. Even if we do not know him well, he smooths our entry into Khoksha Healthcare, vouching for us in front of Jamal, the clinic malik, and encouraging Anika to talk to us.

Anika is decidedly the most qualified radiologist I meet during my time in Kushtia. After completing her training as a medical doctor (MBBS) from the government Khulna Medical College, she pursued a short-term placement in radiology during her subsequent internship. Here, she discovered a passion for ultrasonogram, which led her to undertake the three-month CMU course at Khulna Medical College after her internship. However, she did not feel like this prepared her to perform ultrasonogram with confidence and therefore followed this up with the one-year DMU. These qualifications were unparalleled among other ultrasonogram technicians in Kushtia, where ultrasonogram training can range from informal on-the-job training and short courses delivered through the development apparatus to the officially recognised CMU short course up to the DMU. In Kushtia, a DMU qualified medical doctor is a rare find.

Nevertheless, she feels that her qualifications and reputation fail to compensate for the lack of government credentials. When we ask her about her lack of status as a government doctor, she frowns. She tells us that previously she did not intend to pursue a government job. She invested heavily in her skills and qualifications. She was not inclined to go through the hassles to enter government
service, which requires multiple exams and eventually completing a post-graduation medical programme, particularly as she has a young daughter. However, now after working solely in the private sector for a couple of years, she would like to secure a Bangladesh Civil Service position before she reaches 30 years of age. Despite her other qualifications and expertise, people like to know that they are being seen by a government doctor when they go to the private clinic, she says. Her patients commonly ask whether she has a government job, as they prefer government practitioners.

Assessing the quality of biomedical health services is a nebulous endeavour for anyone, perhaps apart from the trained clinician. Such a task becomes exponentially more challenging in a biomedical terrain such as that found in Kushtia, which is replete with unregulated services and actors with various formal and informal credentials. In the absence of direct social connections to vouch for a particular clinician's service provision, government endorsement is perhaps the only ubiquitous and recognisable standard to establish confidence. Although the state as an entity may not be imagined as one to be trusted, people do recognise the laborious vetting process required to obtain a government position, as many people aspire to join government service to establish middle-class status or aspire to have their children or some family members do so. The idea of the state as an entity that stands above (Ferguson and Gupta 2002), identifiable as standing apart from society, provides a stand-in for clinical confidence. People are aware of the selectiveness of entry into civil service, and especially entering clinical practice as a government practitioner, which inspires confidence in these providers as a category separate from other clinicians.

Indeed, the government logo may serve as an anchor in a terrain wherein other symbols to assess quality, barring personal connections, are mostly ungraspable. Government credentials and name recognition are mutually reinforcing categories. Women mention specific doctors' names as government doctors, even when they seek services from them through the private health sector. However, women tend to mention the specific clinic where they sought services and mention in tandem the public health facility where the physician 'sits' (bose). The category of government provider follows the physician into their private practice, operating to bolster their delivery of commodified services.
Could working only in the private sector also be an advantage? we ask Anika. By committing herself fully to Khoksha Healthcare, we venture, she must be more available and dedicated to her patients in the private practice. She explains that she has patients from every educational background. Some are highly educated; she sees the wife of a Bangladesh Bank deputy director, for example, and a university professor's wife. The educated people understand that she is a doctor who provides good service; they do not bother about it. However, she says that her 'uneducated' patients and those from low economic backgrounds do not have that much knowledge, so sometimes they ask if she is a government doctor, and they are disappointed that she is not. According to Anika, she must attain a government job to maintain her *dignity*, for which she uses the English term.

Although she hesitates to expound on how her *dignity* is implicated in her desire the seek a government position, this can be interpreted in several ways. First, government credentials provide a symbolic layer of status to MBBS-qualified doctors and places one within an exclusive group that cannot easily be compensated for through other credentials. An absence of these credentials places one outside of this exclusive group and limits opportunities to move up ranks, potentially compromising one's dignity. Moreover, entering public service, if not on its own a sure pathway to wealth, places one within an exclusive system to move up through hierarchical ranks of medical practice in the county. Becoming a government professor, such as Madame aspired to (though people tend to articulate such as appointment as politically determined rather than merit based), is among the highest such honours and only open to government civil servants.

Another layer lies in Anika's relation to the people she serves in her private practice. After Daulotpur, Khoksha is the poorest upazila in Kushtia, and the *maliks* of Khoksha healthcare established the clinic intending to deliver health services to poor people (see Chapter 4). Most of Anika's patients are among the poorer classes, in contrast to her middle-class status. She also emphasises that most of her patients are uneducated. Having poor and uneducated people situated below her in social hierarchies question her capacity based on her lack of government credentials can therefore compromise her dignity.
Another layer of dignity can be located in her relationships with private clinic *maliks*. While Jamal and the other two *maliks* of Khoksha Healthcare and Diagnostic Centre speak highly of Anika and value her, there is no question that they would prefer she have government credentials, such as some of the other physicians attached to the clinic. These credentials are included in advertising banners and announced through micing—advertisement through loudspeaker-toting rickshaws. Government credentials draw clients to particular facilities and are only viewed as offering an advantage. *Maliks* do not conceal their preference for onboarding government providers. The lack of such credentials is a shadow over Anika's other extensive credentials, another mark against her dignity. The desire to maintain her dignity spurred her to pursue a government job. She has passed one exam required to apply for a Bangladesh Civil Service position and soon plans to sit for the next.

While discourses related to public vs private health service delivery tend to emphasise a theoretical division in guiding logics, these logics are intertwined in the Kushtia health delivery landscape. In this terrain, inundated with options for marketised health services but opaque in ways to assess differences between them, government credentials operate as marketable differentiation. Clinicians commodify their government status to bolster credibility, confidence and legitimacy in the private health market. Private facility *maliks* use these same credentials to attract clients to their facilities, compounding the remunerative potential. Clinicians who lack these credentials may still attain commercial success in their private practice, but they face hurdles to surmount the lack of the government seal of approval. Rather than separate logics, in this context, public qualifications are subsumed by private logics and adopted as a critical point of competition within the private health care market.

**Afternoon zones of abandon**

What does this co-constitution of public and private sector as enacted by medical doctors mean for women and families aspiring to biomedical maternal health services? In most cases, women and their families easily navigate the public/private divides constituted by doctors' schedules for routine ANC. If they wish to consult with a health service provider at minimal cost, they know to come to the health facility after mid-morning and before the afternoon meal. They may not find what they are looking for during this block, but know they will not find it outside this time when the doctors have most certainly made their way to their private practice. If one enjoys the
luxury in which money is less of an issue, they wait until the afternoon to visit a private clinic, where they can confidently access that which they seek. However, timing in the private sector is less rigid, and private facilities boast that women prefer their services because they can bring a doctor at any time—a stark contrast to the public sector facilities.

Of course, biological schedules often do not match the public/private availabilities constituted by the doctors, as labour and complications associated with pregnancy and childbirth, by their biological nature, arise unexpectedly. This comes into relief when women who do not have the luxury to go to a private facility seek these services in the public sector outside of its doctor-allocated availability. Kushtia district hospital is the site of the district’s most comprehensive level of biomedical service delivery. When women seek care for birth at the upazila health complexes, health service providers refer them to this facility when advanced care is required. However, while the types of complications that can make a surgical birth a lifesaver can arise at any moment, caesarean surgeries are performed almost exclusively during specific hours at the district hospital, from approximately 10 am to 2 pm. In Mitha’s account, a centrepiece of Chapter 1, we recall her gratitude towards Dr Sharmina Khatun, one of the celebrated public/private gynae-consultants of Kushtia, who came to her rescue in the district hospital at 6 am to perform her caesarean. This was only the result of an appeal by Mitha’s aunt (khala), who had a personal relationship with the obstetrician and was able to exercise it through dhora-dhori. Indeed, the arrangement of an early morning caesarean in the district hospital is quite remarkable, and this was the only time I heard of it occurring.

Women without a personal attachment to the district hospital are more likely to be met with the impossibility of a caesarean in the district hospital outside the approximately 10 am-2 pm block. Shilpi was among the women I met who did not have such a connection to leverage. It is 2:45 pm when Shilpi enters the labour and delivery room with an entourage of five women. She struggles to move her heavily pregnant body to the examination table. Shilpi is in labour with her fourth baby; she previously gave birth to three baby girls vaginally at home. Her labour pain hit her two days ago, and her family decided to bring her here as the labour was not progressing. The SSN Sabina just arrived for the afternoon shift and immediately approaches Shilpi to perform a PV, her first clinical act of the day. She pulls cream-
coloured medical gloves over her hands before inserting one hand into Shilpi's vaginal canal to check the dilation of her cervix. When she pulls the glove out, I can see from my position several meters away that dark greenish-brown streaks cover it. “The water colour is not good, not good,” Sabina says, shaking her head as she states the obvious. There is no doubt that the source of this ‘not-good colour’ is meconium, meaning the baby passed stool in utero, and this stool was now dissolved throughout the amniotic fluid. Such a condition places the baby and Shilpi at increased risk for numerous sequelae (Mitchell and Chandraraharan, 2018). The meconium is not the only clinical problem, however. The baby is stubbornly in a breech position, and Shilpi suffers from high blood pressure. Each of these factors alone could potentially justify a clinically indicated caesarean.

Sabina, whom I consider one of the more attentive and warmer SSNs, is aloof as she removes the gloves and tosses them in the bin. Although neither Shilpi nor any of her entourage dares to ask, Sabina pre-empts the question that I assume preoccupies them as it does me. "There is no shejar in the afternoon (Bikale shejar hoy na)," she announces, or, a more direct translation, caesarean does not happen in the afternoon. "Now is not the time for shejar (Aekhon shejarer shomoy nei)," she continues. “There will be no shejar (shejar hobe na).” With the possibility of a surgical birth in the district hospital categorically foreclosed, Sabina reiterates to Shilpi and her companions that the baby is in breech position, which is not a good thing, and they cannot know how the baby is doing in the womb7, so there are no guarantees. When the baby is born, they will know its condition, but the health service providers will not take any liability. Having washed her hands of the precarious situation, Sabina turns from the women and disappears from the labour and delivery room. Shilpi moans and writhes on the bed while one of her companions, a woman wearing a bright orange headscarf, strokes her hair.

I am taken a bit aback by Sabina's demeanour, contrasted with her more typical courtesy. I have always thought of her as a particularly attentive SSN, directing affection toward poor women whom other health service providers tend to

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7 While foetal heartrate monitoring in common during institutionalized birth in many contexts and is a central element of monitoring the progress of labour and foetal condition and often used as the basis for decision-making in labour and delivery rooms. I never saw an SSN monitor the foetal heartbeat during labour, and only on a couple of occasion witness a gyne consultant do so, using a stethoscope. Some SSNs told me that they do not foetal heartrate monitoring because they do not have electronic foetal heartrate monitor technology.
deride. With the district hospital devoid of gyne-consultants, likely already busy consulting patients or carrying out caesarean births in private facilities by now, the best she could offer was to wait and see. Indeed, even if she could offer increased monitoring of the baby, that is to say, even if she performed partograph to monitor the labour as included in her work tasks, it could not be used as a 'decision-making tool' with the ultimate medicalised intervention pre-emptively off the table.

After she leaves, Shilpi’s companions discuss their options, with Shilpi’s moans as their score. They are at an impasse. People who have money can go straight for shejar (in a private facility), complains one sister-in-law, but those who do not have money (like themselves) cannot do anything. This side comment captures almost too perfectly the material reality of doctors’ slippage through the pores of public-private sectors. Those with financial resources possess liberty to purchase commodified health services in the market equivalent to those provided in the public facilities from the same providers who deliver the services in the public sector without timing constraints. Those lacking sufficient financial resources, or personal attachments to the public facility, are left at the mercy of what is leftover in this divide. The decision to travel to Kushtia, where private services are substantially more expensive, only exacerbates the dependence on this mercy, as the options to seek care at budget clinics are foreclosed. Another sister-in-law approaches Tamanna and me. This, she tells us, is precisely why I am scared of this thing (giving birth). This is why I was not brave enough to take another baby. She had one son, and after that, she could never garner enough courage to take another one. With nothing more to do than urge the labour along, Shilpi’s companions help her out of bed, and they march out of the labour and delivery room to walk in the corridors. In her wake, Shilpi, barefoot, traces a path of brownish footprints, a trail of meconium-stained amniotic fluid.

Within 30 minutes, Shilpi returns to the labour and delivery room, ready to push. Sabina takes her position at her pelvic floor. Shilpi groans and heaves down—two tiny feet pop out of her birth canal. Another push and little legs and a torso emerge. Another SSN wraps the tiny body with a cloth to better grip the slippery little body. Sabina manoeuvres the baby a bit the next time the byaetha strikes Shilpi and dislodges a small but living baby girl. Under Shilpi’s hips, the white tiled floor looks like a war zone, covered in greenish amniotic fluid and blood. Although the baby is
presumably full term, she appears to be wearing skin about two sizes too big. The aya takes the baby girl, wipes her down, and wraps her. After sucking the fluids from her nose and throat with the penguin sucker, she carries the baby to the scale. “2.5 kg,” she announces, although that seems a very generous reading—she looks about a kilogram smaller than that. The baby is good, the aya announces, the baby’s condition is good. At least it was good enough for the moment.

Luckily, as far as I know, Shilpi was spared the worst-case scenario, even without undergoing a surgical birth which gyne-consultants would likely have deemed clinically warranted. Still, this encounter brings into stark relief the implications of the dual work of medical doctors. For women who rely on the public health system and require surgical invention to respond to complications after hours, the most reliable solution is to leave the government health sector and find a doctor in the private facility to perform the surgery. Those who cannot have little choice but to wait and pray for the best outcome. This lack goes well beyond surgical birth. The promise to women of institutional birth hinges on the imaginary of biomedical institutions as a space in which complications can be adequately addressed through biomedical responses. These include remedies to the primary clinical sources of maternal death, haemorrhage and eclampsia, which have relatively easy fixes. However, this promise hinges on the presence of clinical staff trained to carry out their remedies, which non-doctor staff is generally unprepared, untrained and unable to deliver.

In addition to the real-world material implications of this phenomenon which deprive women of services within the spaces in which they are promised, this phenomenon constitutes public/private distinctions in situated ways. Rather than guided by separate logics, these boundaries are constituted based on doctor’s practice, as health service providers and managers move seamlessly between these two sectors and determine what type of services and resources are available when and where. Women and families know that there is time pressure for doing a caesarean in the district hospital and that if they wish for a surgical birth, they will need the convince the health staff before the doctors do a disappearing act into the private sector, marking the moment after which caesarean no longer happens in the
public sector. Caesarean is only one of many services influenced by this phenomenon; however, it is a crucial example of a routine procedure that can mean the difference between life and death.

Women understand that health service providers constitute public/private divides based on schedules that are incongruent with biological timings. Women often articulate this as a reason for going to private facilities in their villages. In Chapter 1, I referred to the survey icddr,b conducted in Kushtia and the women who were categorised as reporting that they gave birth through caesarean as a matter of convenience of time. When I returned to talk to these women, I could loosely make the connection between this categorisation and the detailed birth stories that they recounted to me; however, the 'convenience' that I found in these stories had much more to do with when they needed or decided to seek biomedical attention. For rural women whose families took them to seek care at the time of birth after the early afternoon, going to a local private clinic was the only foreseeable option; the prospect of accessing desired services even in the district hospital after narrowly defined hours was a gamble. Moreover, the stakes were too high when the financial implications of travelling to Kushtia betting that the services would be offered were considered. The only potential manoeuvre around this is to possess personal social contacts within the district hospital. Barring this, the line dividing public and private opportunities are dictated by doctor-delimited scheduling.

This could be read as a departure from the way care ‘ought’ to be delivered, indeed, both national and global clinical guidelines promote the availability of 24-hour maternity services. However, in Kushtia, the separation of public and private health sectors along doctor-determined timings is rarely challenged on moral grounds. Rather, this co-constitution and co-animation of public and private maternal health services is accepted as the ‘phenomenological reality’ (Aretxaga, 2003), despite their incongruence to biological realities, constituted through everyday enactments and encounters with local health institutions.

Conclusion

It is months later when I see a draft presentation of the John’s Hopkins/icddr,b study on Bangladesh as an exemplary case with all the pieces assembled. I read the

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8 See also Rima’s birth story in Chapter 2
single key finding regarding the private sector, which lauds the private sector as contributing to raising health care access and the quality of care, effectively staking a moral claim in favour of health marketisation. It seems like it comes out of an IMF playbook, heralding superiority of capitalist logics. Indeed, marketisation aims to reorganise the relationship between people, as capitalist clients, and experts through choice as opposed to compulsion and introduce competition in sectors once associated with welfare (Rose, 2013:60), including healthcare, as the way to increase access to and quality of services. The statement in the draft report suggests that in Bangladesh, this has occurred successfully. While these findings mirror nearly perfectly capitalistic ideologies, they seem a very surface reading of the complexity of the private biomedical health care terrain in Kushtia. Indeed, while the tenability of these logics themselves are highly problematic in high-income and low-income countries alike, they first and foremost assume a clear distinction between the profit-driven market economy of health and an entitlement-driven public health sector.

These narratives assume *a priori* the existence of a state that stands apart from society and the economy. Timothy Mitchell (1999) argues that the imaginary of ‘economy’ as a social reality is a 20th-century invention rooted in a particular political practice that came to construct the idea of a self-contained unit encompassing production, distribution and consumption. The boundary of this self-contained unit was constituted in reference to the nation-state (Radice, 1984) and is therefore intrinsic rather than external to it. Mitchell warns that “we must take such distinctions not as the boundary between two discrete entities but as a line drawn internally, within networks of institutional mechanisms through which social and political order is maintained. The ability to have an internal distinction appear as though it were the external boundary between separate objects in the distinctive technique of the modern political order” (Mitchell, 1999: 77). Indeed, the state has proven an elusive object of study because of the porous and shifting boundary between it and both society (Mitchell, 1991) and economy (Mitchell, 1995). Mitchell contends that distinction between the state and economy as an even more tenuous boundary than that which divides the state and society (Mitchell, 1999: 77). In Kushtia, the boundaries between public health service delivery through the state and private health services delivered through the market operate as particularly elusive, as they are animated by the same actors.
The simultaneous and dual engagement of government clinicians runs through all layers of the medical hierarchy, from government managers to medical interns. While public discourses treat this engagement as morally ambiguous, such practice is inherent to what it means to be a clinical practitioner in Kushtia today. Clinicians commoditize public credentials and leverage these to legitimize care provision outside the public sector. Indeed, public credentials stand in as a marker of the quality of clinicians’ services and bolster name recognition where people struggle to evaluate the quality of care on other terms. Doctors operating solely as private practitioners often consider themselves at a disadvantage, as people tend to prefer clinicians who boast the government seal of approval.

In traversing these porous public/private divides, government physicians co-constitute and co-commoditize them in everyday practice, thereby producing these separations as ‘phenomenological realities’. Once established as government practitioners, government doctors who operate along all strata in the institutional hierarchy commoditise government credentials to increase credibility and confidence when practising in the profitable private sector. This is at least in part achieved as they leverage the symbols of the state (Ferguson and Gupta, 2002). These symbols stand as a mark of quality where the assessment of biomedical quality remains evasive. In such a context, rather than representing competing logics, ‘public’ credentials themselves are marketised as an extension of capitalist logics. Therefore, rather than a morally-compromised practice, the dual practice of physicians in Kushtia, which provides government doctors lucrative advantage, also allows people a mechanism to assess the quality of health services. This practice unsettles the imaginary of public/private as distinct categories based on differing logics.

Moreover, government doctors’ schedules, uncoupled from biological timings of pregnancy and birth, biological processes which cannot be predicted or scheduled, figure centrally in separating public/private categories and defining what types of care women can access when, where and at what cost. Rather than women making ‘rational choices’ related to care-seeking in either a public or private health facilities, these ‘choices’ are often dictated by what is available where, often through the same actors, when biology demands. Rather than imagined as a moral failing,
this represents a ‘phenomenological reality’ which women navigate according to financial resources and social connectedness.
Chapter 6: “Beware of *dalals*” (brokers): a moral world of public-private bridging

The painting on the wall outside of the Daulotpur upazila health complex labour and delivery room reads, “Beware of *dalals* who pick up on patients”. The man standing next to the entrance appears to be a young man engaged in ‘dalal practice’.

*Source: Photo by author, Daulotpur upazila health complex, 17 Feb 2021*

**Beware of *dalals***

“Beware of *dalals* who pick up on patients” (*Rugi dhorar dalal hote shabdhan*). These painted red words mark the walls of the Daulotpur Upazila Health Complex, ominous. These warnings take as their object the mythical brokers of private health care facilities who loiter at public facilities to propose privately-delivered services in the health market which linger just outside the upazila health complex gates. This signage alerts the potential victim at every turn in the building: the outpatient waiting room, the entry to the labour and delivery room, and throughout corridors. Such literal writing on the wall cautions visitors in all Kushtia upazila health complexes. A blue sign in Bheremara reads, “Beware of *dalals* and deceivers (*Dalal o protarok hote shabdhan*),” a perspicuous coupling of deception with the *dalal* figure. These visual markers evoke a contemptible, self-interested trope. Although never evoked in official policy, in informal discursive practice among policymakers, development practitioners, health service providers and managers, this figure emerges as deceiving people away from a public health system which (officially) offers services...
for nominal user fees to a private health sector, where these services will be obtained at a (potentially exploitative) cost and perhaps unnecessarily.

The recent proliferation of the private health sector has supplied new horizons for economic benefits for many actors, both formal and informal. This chapter turns to the navigation of informal livelihoods made possible through the for-profit maternal health service market, focusing on those identified as morally-compromised ‘dalals’, brokers bringing women and families from public to private health institutions. Though far from bounded within the health service delivery landscape, dalals as a discursive figure occupy an indissoluble fixture within it. If medical doctors, as discussed in Chapter 5, and other government health service providers straddle the public/private divide with variable legitimacy, but always with impunity, the figure the dalal falls decidedly beyond the licit, beyond the moral.

Discourse around dalals is immanent to debates around the private health delivery sector. In practice, and despite formal prohibition, young men identified as dalals are omnipresent within the upazila health complexes linking women and families attending public health facilities with private maternal health services. Following Johan Lindquist (2015) and Lisa Bjorkman (2018), this chapter seeks to make sense of how the valuations of the figure and practice of the dalal in the maternal health terrain at this particular historical juncture are related to broader shifts within institutional and moral terrains. In it, I ask the following questions: How does the trope of the dalal serve as a metaphor for the immorality of health care markets in discursive practice? How is this category bracketed out from the broader moral universe of the private maternal health care sector? Furthermore, what disjunctures emerge between dalal discourse and dalal practice?

This chapter sets forth on this exploration in Dhaka to unravel dalals discourses in the national sphere before moving to the discursive constitution of the figure of the dalal in Kushtia. It then tends to the actual practice of those identified by these discourses as dalals and to people’s engagements with them. It argues that the trope of the dalal operates as a metaphor for immorality ascribed to morally ambiguous spaces of the private health sector, a way for people to negotiate a moral discomfort integral to applying market logics to health services. Dalal practice, in
contrast, is rooted in economic precarity, primarily of young men waiting for better opportunities who negotiate and balance moral and economic imperatives.

Conjuring the figure of the *dalal* in Dhaka

The figure of the *dalal* to which the upazila health complex walls allude are situated within a broader social world of brokerage. A large body of scholarship explores the ubiquitous and nebulous practice of brokerage in different world regions. Thomas Bierschenk, drawing on Geertz (Geertz, 1978), describes the 'paradigmatic' practice of brokerage as occurring within a 'bazaar economy', an economy which functions according to market principles but within a highly unequal distribution of knowledge. Those engaging in brokerage practice exploit the space of knowledge differentials between parties for personal benefit (Bierschenk, 2021).

Scholars of South Asia, in particular, recognise brokerage as a ubiquitous practice which manifests in various forms as morally ambiguous intermediaries standing as gate-keepers between people and desired opportunities, services and resources, taking their cut in the chain (see i.e., Piliavsky, 2014b, Björkman, 2021, Huberman, 2010).

*Dalals* fit into the broader brokerage landscape in Bangladesh. However, this specific term indisputably evokes negative connotations rooted in historical contingencies—the *dalal* figure is unequivocally imagined as an immoral actor. The etymology of *dalal* can be traced back to Persian, in which it simply meant 'agent' or 'broker'. In Bangladesh, however, the term is isomorphic with deception and betrayal. Nusrat Sabina Chowdhury points to the Independence War of 1971 as the moment when the figure of *dalal* crystallised as a traitor. In this historical context, the term *dalal* was employed to insinuate Bengali-origin co-conspirators of the Pakistani state who fought against the establishment of an independent Bangladesh. These traitors sought to thwart pro-independence efforts as they passed information to the Pakistanis in exchange for financial remuneration (Chowdhury, 2019:128). In this historical moment, the figure of the *dalal* was reified as an antagonist opposed to other protagonist categories in the fight for independence, including the *muktijoddha* (freedom fighters), *Naxalite* (radical Maoists), and *Bihari* (Urdu-speaking refugees in East Pakistan) (Chowdhury, 2019:132). Following independence, the term was used throughout indictment proceedings of accused traitors. Within these discourses,
dalals work in shadows to conspire with the enemy against friends and neighbours for individual gain.

While not written into official policy narratives, the discursive figure of the dalal emerges prominently in discourses regarding the private health sector in Bangladesh. In Dhaka, policymakers and programmers alike bemoan dalals, also referred to as the English term ‘agent’.¹ Actors within this sphere imagine dalals as those who draw unwitting patients from free-of-charge public health services (also the site of many development initiatives) to financially exploitative and sometimes unnecessary private health services. Within maternal health policy and programming spaces, these narratives blame dalals for sweeping women away from the possibility of normal delibheri in a public health facility to a certain, and likely unnecessary, surgical birth in a private facility. In these unofficial narratives among national policy and development practitioners, dalals work through the art of deception to convince potential consumers that they need something that they do not, including an expensive surgical birth. As deceivers and profiteers of their deceptions, the figure of the dalal is decidedly immoral.

Soon after arriving in Dhaka, I met with a high-level representative of the Obstetrics and Gynaecology Society of Bangladesh (OGSB), the powerful professional body representing the interests of obstetricians and gynaecologists in the country. On a Thursday night, I made my way through the viscous Dhaka traffic to Dhanmondi, where the OGSB madame maintains her private chamber in one of many skyscraping private hospitals located in this business centre. The revelation of the exploding caesarean birth rate/stagnating maternal death juxtaposition (National Institute of Population Research and Training (NIPORT) et al., 2019) turned the spotlight on a squirming OGSB, an obvious culprit. Thrown into defence, OGSB embarked on an awkward dance of apparent collaboration with the Stop Unnecessary C-section campaign² and other public engagements to reduce surgical birth rates in the country. Nevertheless, as one of my interlocutors (non-doctor) from

¹ However, the term ‘agent’ also operates as an umbrella term for those involved in many sorts of brokerage work.

² However, the OGSB madame takes issue with the term ‘unnecessary’—“It may not be medically-indicated, but it is not ‘unnecessary’,” she posits during our meeting.
Save the Children put it, “Who is it, in the end, that is performing c-sections? It is the doctors.”

“C-section is high,” the OGSB Madame concedes when I finally have a chance to sit at her desk at around 11 pm following the slew of patients. “But it is not always the fault of the obstetrician,” she says. First and foremost, she says, it is attributable to women, educated women in particular, who demand surgical birth. Knowing I am interested in human rights, she adds that this is a women’s rights issue, as most women want a caesarean birth, so what should the obstetricians do? She then explains, “Another bad thing is that there are some syndicates at the community level. And there are some agents, agents with the private clinics and with the grassroots level health workers. And these grassroots-level health workers, they are the first contact point of the pregnant women. And they are also acting as an agent for the private clinics. And these private clinics, many of the private clinics in the rural areas, they have no labour room, they have no midwives, no nurses. They [women] are transferred from home to the OT (operating theatre). There is labour going; she will be in the OT. Because they do not keep any labour room.” Given the context, it is perhaps unsurprising that she blames the bloated surgical birth rates in the country squarely on the private health sector and the ‘agents’ who bring them there. Still, I cannot help but be struck by the irony as we sit in her own private practice, where she is widely known to perform a steady stream of caesareans. On the one hand, the OGSB madame may appear to be criticising the private sector for not providing the option for vaginal birth. However, the broader critique here seems to be about who can benefit from the private health market with moral impunity (i.e., the doctors erased from her narrative) and who benefits immorally (i.e., syndicates, agents and private clinics, presumably owners who seek to profit by only offering lucrative caesarean birth).

OGSB madame’s comments illustrate several standard features of the whispered discourses around dalals/agents in Dhaka. First is the link to what she refers to as ‘syndicates’. In Bangladesh, the term ‘syndicate’ implies a network of brokerage that carries a morally charged baggage akin to ‘mafia’, a form of organised crime. In these narratives, the agents act in the interest of a loosely self-organised syndicate against the interests of women. They benefit from the commodification of surgical childbirth, if not ‘unnecessarily’, then at least in ‘non-
medically indicated’ fashion. She also illustrates the nebulous nature of the agents (or *dalals*), in this case, blurred with the categories of grassroots health workers. She refers to the cadres of community-based health workers integral to the Bangladeshi health landscape\(^3\), who operated both as government and non-government actors. Doctors are conspicuously invisible in her narrative as she moves directly from the agents to the operating theatre space, effacing the doctors who animate these spaces. As their representative, the OGSB madame’s erasure of doctors is perhaps exaggerated. Still, her statements reflect a tendency among my interlocutors to gloss over an implication of medical doctors.

Instead, these narratives often frame doctors as victims at the hands of the *dalals*. A member of the icddr,b team told me of his obstetrician wife as she worked to initiate a private practice early in her career. After she completed her postgraduation and entered the ranks of the Bangladesh Civil Service, he leveraged his social connections through *dhora-dhori* to secure her an enviable position in a Dhaka-based government hospital. However, facing the fierce competition of an inundated private health care landscape in the capital, she travelled to Manikganj, a neighbouring district to Dhaka, every weekend to practice privately while slowly building a clientele base in the capital.\(^4\) When she arrived, the clinic *maliks*, owners, instructed her to invest in relationships with the *dalals*. The *dalals* are the most powerful link between the villages and the clinics, they told her, and they determine which doctors will have clients and which will not. It does not matter the quality of the doctors’ work; if they ‘oil’\(^5\) the *dalals* and pay them their cut when they bring clients, the *dalal* will inform the villagers that the doctor is good and bring clients to that

\(^3\) Community health workers are a mainstay in the Bangladeshi health delivery landscape. Both the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) employ their own cadres of community-based health workers. In addition, both large and small NGOs employ their own cadres of community health workers. Notably, BRAC claims to employ some 106,000 community health workers (https://www.bracuk.net/impact/the-people-we-work-for/whats-in-your-bag/; accessed 13 July 2022), dwarfing the 60,000 claimed by the government (https://reliefweb.int/report/bangladesh/bangladesh-community-health-workers-heart-stronger-health-system-and-fight-against; accessed 13 July 2022).

\(^4\) While many government doctors aspire to establish their private practice in Dhaka, and therefore leverage social and political connections to clinch a government position in the capital city, young doctors posted to the city may not be able to practice privately initially, given the overflowing market availability. Therefore, early-career government doctor lucky enough to secure a Dhaka-based post may travel to the nearby districts, generally during their weekends to perform their private practice while they establish a client-base in the capital.

\(^5\) ‘Oiling’ is a widely used term to indicate the Bangla term ‘*tel mara*’, literally translated as ‘to massage with oil’, which refers to stroking someone’s ego, or pandering.
doctor. Though a cut of the proceeds will go to the dalal, the doctor will have more clients, and consequently, the clinic—ultimately, everybody wins, according to them. If the doctor does not do this, the dalals will say that the doctor is not good, and the doctor will have no clients, to the detriment of both the doctor and the maliks.

The injunction morally repulsed my friend’s wife. Why should a dalal benefit from doing ‘nothing’, in contrast to the productive work undertaken by doctors? They were deceptive in not bringing women based on the quality of care but instead based on the kickback provided by the doctor. She staked her moral high ground and refused to engage in the practice in this account. I do not know whether she ultimately relented, and it would be uncouth to ask. Despite the common understanding that this is widespread, no medical doctor openly admits to working with dalals. To do so would not only equate to an admission of immorality but also hurt one’s pride. If doctors provide quality care, this practice should speak for itself to draw clients; a good doctor should not need to engage in ‘dalal practice’.

However, this account illustrates the imagined power of the mythical dalal figure to make or break doctors and thus the potential for doctor emasculation at their hands. It also highlights the immorality of advancing one’s professional career in this manner. As examined in Chapter 5, the dual practice of medical doctors is a normalised practice that rarely comes under moral scrutiny. It is common knowledge that doctors use their public practice to build a private clientele. While building a private practice by leveraging one’s public practice or one’s social network is by no means considered immoral and can be framed in terms of run-of-the-mill dhora-dhori, working with a dalal is deemed as neither moral nor respectable. This highlights the divisions between those who benefit morally or immorally from the private health market despite analogous enactments.

Stories of powerful dalals acting against medical professionals circulate as folk narratives. Sadika, one of the icddr,b researchers, shared such stories with me over milk tea and fruit as we sat on the thin mattress on the floor in my living room. Mou holds her MBBS from a private medical university. Despite initial aspirations to practice medicine, she abandoned this ambition after pursuing an internship at Dhaka Medical College, the country’s most prestigious public teaching hospital. When she explained her decision to opt-out of medical practice, she included the
figure of the *dalal*. *Dalals* have more power than anyone in Dhaka Medical College, she told me. Sometimes they go so far as to provide treatment to patients. She even knows of cases where they killed patients by giving them blood transfusions with unmatched blood, she tells me. Such an account is layered with social significance. First, she evokes power and the audacity of *dalals* to bypass a doctor by initiating a blood transfusion without doctor approval, an act which undermines the doctor’s power and breaches social hierarchies. Moreover, the *dalal* does this without the ‘appropriate’ biomedical knowledge, also laden with power.

This account portrays another meaning embedded in blood’s significance. As discussed in Chapter 2, rather than an impersonal substance, as imagined in public health narratives, blood in Bangladesh is infused with social meaning. In a space where impersonal blood acquired through blood banks is virtually non-existent, people rely on their social networks to identify a suitable blood donor when needed. To offer one’s blood this way is an intimate act of care. However, many people, particularly those who travel long distances to health facilities, may not have access to their close social networks in crucial moments of need. According to my informants, people may turn to *dalals* to procure this life-saving corporeal substance. Perhaps, for this reason, the story of a *dalal* who initiated a blood transfusion but got it so mortally wrong rings so salient. This act not only demonstrated a usurping of power over doctors, but it was also a fundamentally immoral act of sacrilege in blood care. While I cannot be sure about the factfulness of this story, it illustrates how myths are built around *dalals* as villains.

These narratives of *dalals* circulating among doctors and development workers in the biomedical health delivery landscape cohere with the somewhat mythical figure of the *dalal* in Bangladesh and other contexts outside the social world of health service delivery. Standard features of this figure include secret operation (though perhaps as an open secret) and using other positionalities to veil their work as a *dalal*. They operate through power through non-formal structures and threaten to upset deeply engrained social hierarchies. Furthermore, and perhaps most

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6 This account also aligns with Judith Justice’s observations of the work of ‘peons’ in a Kathmandu hospital, which not only serve to ‘translate’ doctors’ advice to health service-users, but also perform (illicitly) biomedical procedures (Justice, 1986: 102-103).

7 See also the work of Jacob Copeman on the social significance of blood and blood donation in north India (Copeman, 2009, Copeman and Banerjee, 2019).
critically, they generate personal benefit through arts of deception at the expense of unsuspecting victims. In these discourses, this expense can even be a person’s mortality.

While my interlocutors also talk of dalal practice as rampant in Dhaka, many of these narratives (Sadika’s is an obvious exception from this section) concern figurative dalal practice far from the capital city. They conjure the figure of the dalal in places such as Kushtia, where the writing on the walls warns unsuspecting potential victims against falling for the dalals’ deception. Beyond this ominous cautioning of these walls, what narratives circulate here, in this proximity to dalals operation within the subnational private health care terrain? In the next section, I turn to the shaping of these narratives in Kushtia.

Dalal narratives in Kushtia

In Kushtia, the dalal figure operates at once as embedded in and distinct from the private health service terrain. In the upazila health complexes, dalals are discursively constituted as a scourge to the public health facility managers. These narratives are not only written on the walls in alarmingly red paint. They discursively emerge as the bane of UH&FPOs, tasked with the prevention of infiltration of their facilities with these deceivers.

Tamanna and I visited the UH&FPOs each morning we arrived at the upazila health complex. We chatted for a while, sometimes we sipped on hot black tea and other times declined, saying we were in a hurry to get on with our work. As we sat in the different offices, I found myself increasingly drawn to the CCTV coverage of the facilities in play on screens positioned to the side of the UH&FPOs’ desks. Only the Daulotpur upazila health complex was not equipped with such a security system, though Rifat sir assured us that he would soon rectify this. The screens presented scenes captured by four to nine CCTV cameras surveilling the complex and its grounds, one of many manifestations of a national preoccupation with surveillance. Grey bodies floated through the various nondescript scenes, screen squares rotating through the images captured by multiple strategically placed cameras in corridors, waiting rooms and complex grounds. The strategic position of the screens next to the UH&FPOs desks imbued these managers with an omniscient gaze over the space, it suggested that they can see what is hidden from others. In most of the meet and
One morning, Tamanna and I linger with Sharif sir, UH&FPO of Khoksha upazila. We accept his offer for tea, and he sends a support staff to prepare it. While we wait, I ask him why this surveillance is necessary. The first reason he cites is the obvious: the security of the health service providers. Though rare here, altercations between health service providers and communities circulate in Kushtia as they do throughout the country (see for example Hasan et al., 2018). During my fieldwork, I heard of two such incidents through the icddr,b team, though these were limited to verbal altercations that my colleagues essentially shrugged off. The more violent encounters show up in the news outlets. Personal security preoccupies health facility staff. However, Sharif says, the CCTV mainly was not for this. The tea arrives, and we sip warm, bland teabag tea from dainty ceramic teacups, chipped at the ridges. Sharif explains that the CCTV cameras and monitor allow him to surveil the health facility staff to ensure they are present when and where they should be. They also allow him to monitor dalals and ensure there are no dalals on the upazila health complex grounds. If he sees dalals, he claims, he gets rid of them, suggesting the visibility of this figure.

As he explains this, I am reminded of the visit Tamanna and I made to Khoksha Healthcare Clinic and Diagnostic Centre, located a 10-minute walk down the road from the upazila health complex on the main highway. We arrived at the façade, composed of mirrored story-height windows below a modern plastic sign that lights up at night. The words, written in Bangla, sound out to create the English-cognate name of the clinic, a further appeal to modernity. As we enter, we pass a large banner that decorates the window next to the door, presenting the different doctors operating in the facility, including Anika apa, whom we met in Chapter 5. At the reception desk, we met a young man wearing faded blue jeans, rectangular glasses, and a confident smile, and a young woman with a floral headscarf and thick, charcoal eyeliner. We began to introduce ourselves, but the tall young man cut us off. “I know who you are,” he said with charming swagger. “I have seen you many times at the upazila health complex.” Tamanna then said that she thought she had seen him as well as I racked my brain to try to conjure a memory of him. However,
until then, my gaze in the upazila health complex waiting rooms had overwhelmingly been directed toward women.

When we asked if we could visit the clinic, he told us that the three nurses were occupied at the moment. Could we wait for maybe 10 minutes until they were free? He invited us to take a seat in the metal chairs in the waiting room. Approximately 30 metal bench chairs stood in the waiting room, many occupied. We followed him to two free chairs. With his charm and disarming demeanour, I thought to myself that I would probably be comfortable following him from the upazila health complex to the clinic if I were a patient, just as I followed him from the reception desk to the chair. After he left us there, Tamanna immediately whispered to me, “He is a dalal.” She had noticed him before in the waiting room of the outpatient building in the Khoksha upazila health complex. He was among the (almost always) young (always) men, who loiter in the waiting room, scan the space and approach different patients from time to time. While I did not immediately recognise him from among the other young men in this space, later, I would cross him on several occasions on the complex grounds, and we would chat for a moment or two before moving on to our respective work.

Before she can say more, an older man approaches us. He positively beams under a heavy grey scarf and woollen cap. Did we remember him? he asked us as he smiles, revealing blackened teeth. He reminded us that we met him a couple of days back in the upazila health complex. We spoke with his daughter, Shepa, then a young woman pregnant with her first baby, now a young mother who just gave birth. I recalled that Shepa was not only accompanied by her father that day but also by a thin, garrulous dai. She spoke more than Shepa, gesticulating with a well-worn white surgical mask in her hand, which everyone was still supposed to be wearing in the health complex according to Covid-19 guidelines. Shepa sat by her side, looking shy. Another man accompanied her, as well. The father explained to us that day that this man was a pharmacist from their village. The family called him as Shepa’s pregnancy was *post-dated*, that is, she had reached her estimated due date with no convincing signs of labour, and the pharmacist brought them the upazila complex to see what to do.
The aged man radiated the glow of a first-time grandfather as he relayed that his daughter gave birth to a baby girl through caesarean at this clinic yesterday. The surgery went well, but after the baby was born, they discovered the infant had a tumour on her back and a sixth finger on one of her hands. They performed surgery on the baby and removed the tumour. The finger will stay. He and the family were so happy with the care from the clinic he said. It was excellent care. I could not help but wonder who ultimately brought the family here for the surgical birth and who would get the credit. The dai? The pharmacist? The young man at the reception desk? Moreover, among them, who would be deemed a dalai in discursive practice?

Once they were available, the nurses took us on a tour of the clinic interior. We passed by to congratulate Shepa, who looked simultaneously satisfied and exhausted, and admire her new baby girl cradled in the arms of her mother-in-law. Afterwards, we met Jamal, the 30-something government engineer by morning, private health clinic malik by afternoon. Just outside his office’s sliding mirrored-glass doors, printed snap-shot photos decorate the wall—these capture typical ceremonial occasions related to the clinic, opening ceremonies, open houses. At the centre of smiling groups of clinic staff and politicians, Sharif sir stands, beaming, an honoured guest at the clinic’s events. Jamal bragged about his relationship with Sharif. Sharif’s association with the clinic was incontrovertibly a boon to business as Sharif was local to Khoksha and well-respected. Sharif attends all of their events, Jamal told us. He would be present for the upcoming service day they planned on Victory Day, a day for mass provision of commodified health services at discounted prices. I was struck by the irony of this juxtaposition of private facility linkages. Despite the analogous telos—facilitating the movement of people from the public facility to clients at the private clinic, one is narrativised as immoral (the young man moving back and forth between the clinic and the upazila health complex) the other as moral (Sharif moving back and forth between the upazila health complex and the clinic).
In contrast to the other popular narratives surrounding the trope of the *dalal* in other social contexts, private facility *dalals* are understood as visible, such as Sharif suggested in articulating CCTV as a mechanism for rendering the *dalals* visible. This also manifests in the idea that if they are not visible, they are not there. When Rifat sir took over in Daulotpur Upazila Health Complex after Azam sir’s retirement, ridding the complex grounds of *dalal* infiltrators was a priority in his agenda to clean up the upazila health complex, along with manicuring the complex gardens. In addition to his young age, Rifat bragged about his relationship with the local Member of Parliament (MP) each time we met. My observations substantiated this claim, locally-important people seemed to be in his office, busy flattering him, on many of our visits. I did not witness this type of encounter during my interactions with Arobendo. When we visited his office during the Covid-19 vaccination campaign, the MP’s mother- and father-in-law occupied Rifat’s office. The mother-in-law enthusiastically told me about her children who have settled in New York.

On another occasion, there was an older man, a local politician. He praised Rifat sir for the visible transformation of the upazila health complex during such a short tenure. The grounds were well manicured now, certain irritating trees removed. According to the politician, it was remarkable that he no longer saw *dalals* wandering around the upazila health complex grounds. They used to be everywhere, he recalled. They hovered by the gates, lurked around the courtyard. Rifat nodded in
self-satisfaction as he listened. Dalals no longer come here, the young UH&FPO confirmed. He threatened to break their legs, he told the politician, if they come around here. Now they stay away.

The narratives around dalals in the Kushtia upazila health complexes vary in some ways from the narratives in Dhaka. My informants in Dhaka tend to emphasise the power of dalals and accord them a power that can even challenge the doctor. In Kushtia, these narratives imagine the dalals as significant annoyances but not necessarily challenging the doctors’ authority. Instead, if they overwhelm the doctor’s authority, it is primarily through sheer strength in numbers.

More important, however, is what these narratives share in common. In all cases, the work undertaken by the figure of the dalal, that is to say, luring women from the public health facility to the private, is considered an immoral act. The immorality is bracketed off from the health service delivery sites from which the dalals bring women and the health service delivery sites to which they bring them. On a couple of occasions, I pressed health service providers or policymakers as to why the dalals, in particular, were doing something wrong when there were so many links to private health service facilities. Often, they mentioned that sometimes they take women to poor-quality facilities. Still, the immorality is attributed to the dalal rather than to misdoing on the part of the private facility. While my informants generally blamed movement from public to private facilities on shortcomings within the public sector, this condition tended to be narrated as an unfortunate inevitability rather than couched in moral language.

The figure of the dalal stands in as a diversion from other places where immorality could be attributed and is discursively bracketed as culpable. While the private sector as an entity is imagined as a morally ambiguous space (see Chapter 4), many actors who bridge the space between public and private entities in many cases benefit from this ambiguity. As discussed in Chapter 5, the operation of clinical practitioners simultaneously in both spaces, which also serves as a link, is rarely scrutinised in moral terms and is the case for other health services providers, despite the formal prohibition for them to engage in the dual practice.

However, the figure of the dalal, despite little difference in operation, is excluded from the benefits of this ambiguity. Dalals are set apart as uniquely
culpable, despite their analogous function to other types of private health sector linkages and their facilitation of movement from the public facilities, where promised services are unavailable, to private facilities, where they are available. This bracketing of *dalals* as a discursive category allows health service providers to negotiate the moral tensions associated with the private health sector in a moment of significant change and sense-making, without addressing the broader sources of discomfort in a meaningful way or challenging other actors. These higher status actors benefit from analogous enactments without moral scrutiny.

**Operating as a *dalal***

What does brokerage work look like from the viewpoint of those designated as *dalals*? Despite Sharif sir’s many CCTV cameras, *dalals*, such as the charming young man from Khoksha Diagnostic and Healthcare Clinic, are a permanent fixture of the Khoksha upazila health complex grounds, just as they are in all of the upazila health complexes. However, the justification of CCTV cameras as a way to ‘catch’ *dalals* was perhaps more instructive in pointing to the general discourse of *dalals* as elusive, immoral and secretive agents, as opposed to actual practice. In her work on *dalals* as multinational corporation collaborators working against the people’s interest, Chowdhury emphasises the mystical characteristics of *dalals*; they were never to be located in the material; instead, they were identified through rumour and whispered accusations (Chowdhury, 2019).

In contrast to these discourses, in public health settings, *dalals* are hardly secretive. The *dalals* associated with the private health sector in Kushtia represent a stark, material contrast to such representations. Rather than confined to shadows, the figure of the *dalal* crystallised in discourse, the *dalal* warned against on the government health facility walls, has a material counterpart which operates in the daylight. They are easy to spot in the upazila health complex waiting rooms: young men, often wearing modern casual clothing, stonewashed jeans, faded name-brand t-shirts, faux-leather jackets (in the winter, at least). They are distinct from other men in this setting, those who accompany women and stand close to these women, or those who are here to seek services for themselves and stand purposefully in lines waiting for a doctor’s attention. They are also distinct from the ‘medical representatives,’ male pharmaceutical representatives who wait for the health service providers attention in the early afternoon after seeing patients. These men
are also common in upazila health complex waiting rooms, marketing their pharmaceuticals and offering benefits to health service providers who prescribe them. They are distinct in their dress; they sport professional suits and shiny black dress shoes and always carry professional briefcases. While they stand in the waiting room, they ask patients departing from consultations to see their paper (kagoj), the prescription for a particular medicine that the health service provider sent them away with. The person typically hands the paper over, and the medical representative scans it to see whether the provider prescribed the medicine from the company they represent.

Sometimes the young men corresponding to the idea of dalals imagined in discourse huddle and chat, each keeping one eye on the crowds milling through the waiting room. When they spot a person wandering aimlessly, perhaps holding a white prescription paper, one may take leave from their group and approach. With a bit of luck, a dalal will leave with a potential patient by 1 pm, when the waiting room clears out, and the health care providers close up their workstations for the day in the government facility.

Mere meters from the Rifat sir’s office, where he threatens to break dalals’ legs and claims to have rid the complex of their infestation, Hassan roams the outpatient waiting room. He hovers just outside the ANC corner, near the wall where the painted red print warns potential victims to beware of dalals and deceivers. He scans the room for people who look lost and stands near the open door where the midwife rotates women through ANC visits. He casually strains to overhear what the midwife suggests for their care.

When the women exit the room, he waits for the right moment and then approaches and suggests different services they may benefit from at Elija Diagnostic Centre located down the road. He is a familiar face in the Daulotpur upazila health complex waiting room. A stout young man no older than 25, he greets Tamanna and me each time we enter the Daulotpur outpatient building to sit with the midwives in the ANC corner. Typically, we briefly exchange pleasantries and then head on our way to spend time with the midwives or to talk to the pregnant women. However, the waiting room is practically empty on one cold winter morning. Hassan, like us, loiters and waits for pregnant women to appear through the gates. He lights up and readily
agrees when we ask him to tell us his story. The three of us sit on the concrete benches which float from the concrete wall. The Kushtia winters suck anything which resembles warmth from the interiors of buildings, and the concrete bench feels like an ice block under me. Hassan wears a striped green and grey jacket and a blue-beige scarf wrapped around his head and neck to keep warm.

Though garrulous, he talks in hushed tones as he recounts his story of tumbling into this particular line of work, certainly not what he planned for himself as an aspiring engineer at university. After he obtained his diploma, he planned to enter the Bangladesh Civil Service as an engineer. Unfortunately, tragedy struck when it came time for him to undertake the rigorous studies required to pursue this path. His mother passed away suddenly, an event which set dominoes of troubles into motion. His father soon remarried, and he and his shotma, stepmother, struggled to establish a relationship. The stress-induced by this relational strain damaged Hassan’s neurological health and brought on fainting episodes, which he refers to as ogaen, during which he remains senseless for one to two minutes. Stress triggers his ogaen attacks, so he abandoned his ambitions to pursue the Bangladesh Civil Service. Instead, he took up a job in a national company in Comilla, on the other side of the country. However, his neurological problems continued, and soon forced him to abandon his employment.

He returned home to Daulotpur as he was unable to work. He sought comfort in religion, striving to become a pious man. He grew a dari, beard, a mark of piety in the Muslim community, and attended mosque regularly to perform namaj, prayers. One day while performing namaj, he spotted another man with a dari. He recognised this man as Tapas, one of the sub-assistant community medical officers (SACMOs) working in the upazila health complex in Daulotpur. Hassan presumed that since he was meeting him in the mosque and Tapas also maintained a beard, perhaps he was a good man. He approached him, explained his situation and appealed for his assistance in finding a job. Tapas listened and then instructed him to come to the upazila health complex in the next couple of days, and he would see what he could do. Hassan felt optimistic that Tapas would arrange something for him at the upazila health complex. However, when Hassan met Tapas at the upazila health complex, the SACMO introduced him to the owner of Ma Clinic and Diagnostic Centre, located several meters away from the upazila health complex on the main road. The malik
agreed to take him on to work bringing people to the clinic (i.e. as a *dalal*) and doing some basic assistance work, such as handing tools to the surgeon during a caesarean, in the clinic. While this arrangement worked well initially, the *malik* eventually learned of Hassan’s neurological problems. He said that he could not keep him because he could not do the assistance work in the operating theatre. Hassan soon found a job in Elija Diagnostic Centre, located about the same distance down the road from the upazila health complex in the opposite direction, where he brings patients for services to this day.

So, what exactly is your designation with Elija? we ask. “To tell you the truth,” (*shotti bole*) he says, “the people call us *dalals*; the work we do is like a *dalal* (*manushtha dake dalali bole; amar kaj dalalir moto*).” He does not try to sugar-coat it, like many young men in his same line of work do, although he just barely steers clear of using a word as derogatory as *dalal* to refer to himself. His primary responsibility is to bring people to the diagnostic centre for health tests. He does not have a fixed salary; instead, he gets a 20% cut of the fees that the people whom he brings to the centre pay for the diagnostic services.\(^8\)

He is not proud of the work. “All of this work is not good (*Ei shob kaj kamta bhalo na*),” he says, but he tries to do it as honestly as possible. How does he attract people to the diagnostic centre? He says that he can offer a 30% discount if they seek services through him at the diagnostic centre. Like other men in his line of work, he stands near the ticket counter to overhear the reason that brought people to the upazila health complex, or next to the doorways where the SACMOs and the medical officers consult patients. The SACMOs and the medical officers consult patients. The SACMOs and the medical officers, whom Hassan refers to as the ‘sirs,’\(^9\) have relationships with the men operating in the practice of *dalals*, and sometimes the sirs will recommend that people seek tests that they do not need so that these young men can take them for the services, he says. “They will pretend that the people need the test, and they prescribe them some tests like that (*Ei jonno porikkha phon kore, kichu porikkha dei*).” Hassan does not like working that way, he says. He would prefer finding more honest (*shotota*) work. In the meantime, he always tries to do his *namaj* and be honest (*shot*) as far as possible. He maintains a delicate balance in the effort to negotiate the moral

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\(^8\)This is not true for all of the *dalals*; some claim to have a monthly salary.

\(^9\)Referring to the SACMOs as ‘sirs’ demonstrates where he situates himself in the social hierarchy.
ambiguity of his line of work. Religious practice serves as a salve and allows him to maintain moral integrity while responding to economic imperative through the only means he currently sees as available to him. Compounding his moral dissonance, he will not be able to get married before he secures a more reliable income. He visits a neurologist in Rajshahi about his neurological condition, and he thinks that perhaps he could work for him. He asks us to pray for him (doya kora) to find a better job.

Hassan meets us once again at the end of the morning when the SACMOs and medical officers pack up. It was an unsuccessful day; he did not find any patients to take to the diagnostic centre. Nevertheless, he will not show up at home empty-handed. He holds up a bag of medications and smiles, a consolation prize. One of the health service providers wrote him a prescription to get the medications for free from the upazila health complex, a meagre offering to his family. Such a practice falls outside of sanctioned institutional regulations; pharmaceuticals procured through the government system are intended for people seeking services in the facility. Moreover, they are a scarce resource; stockouts are common. SACMOs often complain that they first need to check the list of available pharmaceuticals in the facility at the beginning of each day to not irritate the patients by prescribing them something unavailable. People often mention free-of-charge pharmaceuticals as drivers to seek public health services, so the frustration is understandable. Though formally illicit, the SACMO, who has the power to prescribe, offered this gift to Hassan. This gift reinforces the relationship and, like every gift, is offered with the expectation of reciprocation in the future. This reciprocation will presumably take shape in the form of Hassan’s support to that SACMO’s private practice. Nevertheless, on that day, for Hassan, it allows him to return to his family and offer medication, which stands in as a material form of caring and contribution.

Narratives around dalals seek to disconnect this figure from the social worlds they are integral to, from the private health clinic owners and service providers who charge them to bring patients to their doors, and from the health service providers who work in concert with them. While health service providers and managers speak of the dalals in derision, the visible amicability between the health service providers and the actual people identified as the embodiment of these discursive figures in waiting rooms belies this discursive contempt. In contrast, Hassan’s experience
demonstrates how entangled these social worlds are and how small a piece the work of those enacting the practice of *dalals* is.

However, the category of *dalals* and those enacting these narratives are perhaps the easiest scapegoats. Those who exclusively engage in the work of *dalals* tend to be those with the fewest options available to them. They are often young men like Hassan, who have few other avenues due to life’s circumstances, or young men who left school early for one reason or another. When Hassan described himself as doing the work ‘like a *dalal*,’ that is the closest that most will come to uttering the word. They are much more likely to describe themselves in long-form as being someone who brings patients to clinics or diagnostic centres. While the young men performing this type of work may not necessarily define it as moral, it is justified by economic necessity and livelihood ambitions when they have few other opportunities. Still, as the most vulnerable component of this system, the category of *dalals* comprises an easy target for attributing immorality.

This enactment of *dalals* in upazila health complex must also be understood within the context of broader negotiations of youth masculinities in South Asia within the political-economic context. Craig Jeffrey describes the unemployment of educated young men as a product of globalisation (Jeffrey, 2010b). He describes large categories of young men in India who have participated in the promise of education but have been unable to secure reliable livelihoods within a context of economic reform and precarity and therefore find themselves in the space of waiting (Jeffrey, 2010a). He and others demonstrate the possibilities which brokerage opens for unemployed youth ‘in waiting’, focusing on the social forms these take within the practice of political brokerage (Jeffrey, 2010b: 135-170, De Vries, 2002, Hoffman, 2004, Hansen, 1996).

Those operating as *dalals* in the health service terrain in Kushtia can be understood as existing within this space of precarity and waiting. For Hassan, engaging in the work of a *dalal* is not the end he imagines for himself, but rather a temporary fix given the failure of the promise of education to open up better opportunities. While he attributes this at least in part to the neurological problems he encountered upon his mother’s death, he finds himself one among many such young men with limited opportunities, and the private health care market opens up a space...
to bide the time hoping that something better will come along. The private health market opens up space for claiming livelihoods for women without formal education to obtain employment as ayas or sisters. For men without formal biomedical education, economic opportunities for economic engagement are more likely to be found among the highest tiers as clinic maliks, those with existing social or economic capital, or among its lowest ranks as representatives acting as dalals.

However, who exactly is considered a dalal is also fuzzy. There is little ambiguity with people like Hassan, whose specific (and only) job is to bring patients from the upazila health complex to the private health facilities, although most avoid uttering the word dalal as a label for their work engagement. However, many people attached to the private facilities mill about the public facility grounds in addition to these young men. Imagine this scene: Tamanna and I turn off the main road toward the entry gate of the Daulotpur Upazila Health Complex. As we enter, we greet Rajib bhai, the owner of Al-Arafa private clinic located down the road, sitting in his small medicine shop facing the mosque. His hair is greying, and his dari is dyed orange with henna, a symbol of piety. Behind the counter, the medicine shop’s interior is spacious enough to fit three plastic stools, behind which small white medicine boxes fill the shelves. Rajib smiles and teases us for not visiting recently. We smile and respond that we tried, but he was not in his medicine shop when we passed by last. He says that he must have been out for namaj. He revels in the medicine shop’s location—the perfect spot to practise namaj at the adjacent mosque and identify potential Al-Arafa clients.
We enter the dusty courtyard, splattered with faded billboards with health messages from long-abandoned initiatives, like a development project graveyard. Tagore, the malik from Jonari clinic across the street, spots us and approaches, smiling behind his thick-rimmed glasses. He asks whether we will visit his clinic this afternoon. We plan to, we tell him, inshah Allah. We climb the short ramp from the courtyard into the bustling outpatient waiting room. Shahuar Khan, the malik of Ma Clinic and Diagnostic, Hassan’s previous boss, sits casually on the concrete bench next to three women. He looks jovial, and I imagine he must be cracking jokes since the women giggle, enchanted. We climb the stairs to see if there is any action in the labour and delivery room.

We pass Nasnin, the young midwife on labour duty, in the corridor. She informs us that no one is in labour right now and sits to chat for a few minutes. While we chatter, a middle-aged woman approaches. Tamanna and I recognise her as Shopna, the aya who first invited us into Jonari clinic the first time we visited (Chapter 4). She greets all three of us with equal enthusiasm. After a brief exchange, she continues down the corridor with a young, pregnant woman in tow whom she identified as her niece. How do you know her? we ask Nasnin, surprised by her
apparent familiarity with the private clinic *aya*. She is one of the labour room *ayas*, Nasnin responds. She does not ask how we know her. It is an open secret that *ayas* often link people who come to the public facilities with private services.

Such a typical scene forces us to interrogate the composition of the *dalal* category. Just as the OGSB madame mentioned the community health workers acting as *dalals*, all of these actors would likely be considered *dalals* in the predominant narratives by doctors, health managers, policymakers and development actors. Indeed, all these actors bring women from the public facility to private practices, and all are understood to receive remuneration for it, whether an immediate or time-lapsed kickback in cash or kind. However, these actors can appeal to their other titles.

Furthermore, this is to say nothing of the health service providers and their associations with the private facilities, as was the subject of the previous chapter. Indeed, health service providers practice on both sides of the public/private divide (doctors with legal sanction and other service providers without) and send patients to the clinics with which they have relationships. Over lunch in the icddr,b field office one day, Azim told me of his visit to Khoksha in the morning. He told me a woman came to Sharif sir as he sat in his office. Sharif had previously sent the woman to a private clinic for some type of medical test. The woman returned to him with her report. She handed it to him, but he became livid when he looked it over. She had not gone to the clinic which he instructed her to visit. Why did she not go there? he demanded. He yelled at her, Azim said, laughing a bit as he tried to make sense of his observation. He was shocked, he said. I was as well, mainly because Sharif seems easy-going and non-threatening. Azim did not remember to which clinic Sharif sent her. I wondered whether it was Khoksha Healthcare and Diagnostic Centre, where Sharif stands as a centrepiece in the photos.

In the upazila complexes in Kushtia, young men operating as *dalals* function as analogous to these other categories and often in collaboration with them. In all cases, these actors lubricate the movement of women and families from the public facilities to the private. In all cases, they receive some benefit for successful movement to particular clinics. However, rather than power in shadows, *dalals* operate as the more vulnerable among these ‘brokers’, relying only on this line of
work in their engagements with the private health sector. Offering up a scapegoat in the trope of the *dalal* turns attention away from other forms of bridging from public to private facilities. Sustaining the trope of the *dalal* as both distinct from other forms of bridging and as uniquely immoral is socially significant. It opens up the possibility to, at once, negotiate moral ambiguity related to the private sector while simultaneously offering cover to allow fluid movement between public and private sectors by other actors.

**Women, dalals and porichito**

The next time Tamanna and I visit the Daulotpur upazila health complex after our long discussion with Hassan, we find the waiting room teeming. A line of pregnant women winds outside the ANC corner. I watch Hassan in action. He approaches a well-dressed couple; the woman is holding a baby. They chat for a moment, and then he moves on. He approaches a woman named Robina, to whom Tamanna and I spoke earlier in the morning. She is wearing a long pink headscarf over a dusty rose *burqa*. Her headscarf is pulled over one ear and tucked behind the other, revealing a gold ear stud with a chain dangling on the backside of her lobe, suggesting that she may be a likely candidate for paying for health services. She visited the midwife, but she is looking for a doctor to get a prescription. Hassan approaches her. He smiles as she hands him her *kagoj*, papers. He scrutinises them then points toward the waiting room entrance. I follow his finger and spot another young man identifiable as practising as a *dalal* on the other side of the waiting room. This person, embodying *dalal* practice, another regular, greets a 30-something man whom I recognise as Ouassim, the *malik* of Digital Diagnostic Centre. Hassan continues to talk to Robina. They then part ways.

Hassan approaches us. We ask what he discussed with Robina. He proposed some tests, he tells us, and also an ultrasound. These are services that Robina desires, as she believes that they will help her understand better the status of her pregnancy. Officially, she should be able to avail these services from the upazila health complex, but it is more likely that she will not be able to. He suggested doing them at Elija Diagnostic and offered her a discount. She does not have money with her, so she agreed to return on Saturday. He doubts she will return, however. She mentioned that she knows someone from another diagnostic centre, a *porichito*, acquaintance.
As demonstrated throughout this thesis, the private health sector is a formidable space to navigate. The sheer number of facilities that deliver biomedical maternal health care services and the variations in quality and prices create a maternal health landscape that defies sensibilities of ‘rational choice’ presumed by capitalist discourses. Private clinics attract potential clients primarily based on personal relationships rather than competition based on improved clinical quality at more affordable prices. Besides the few large private hospitals known for the clinical quality of the health services (for whom the cost of services remains handily out of reach for many women), people rarely speak of the quality of services as the driving force towards a particular clinic. Rather, it is having a porichito of the clinic, which will largely determine the quality of care, both in terms of clinical attention and interpersonal interactions, and influence the cost of the services. This maps on to the deeply rooted practice in Bangladesh of leveraging social networks through dhora-dhori to access desired resources and opportunities.

Thus, the porichito, acquaintance, assumes a critical place as a linkage to health services through the private health sector. Almost without exception, when women discuss how they decided to go to a particular clinic, it is based on a personal relationship, which often appears as a porichito. In many cases the person that served as a link is specifically named. This relation could be a brother (bhai), an aunt (khala), a traditional birth attendant (dai), or a village doctor (polli chikitshok). When this person is a bit more distant or occupies a more nebulous relationship, the person appears as a porichito.

Asifa, a rural woman living in Shenaida, was committed to giving birth normale and therefore determined to give birth to her first baby at home. She had heard stories of the problems with caesarean and especially the injection of the anaesthetic. She also wanted to avoid the costs of institutional delivery, as her parents, responsible for paying for this first birth, were impoverished, and her mother had heart problems requiring expensive medical care. Giving birth at home seemed to maximise the probability of normal delibheri. However, the birth proved difficult. When her pain came, her father’s aunt (phuphu), who assists deliveries in the area, came to attend her. After being with her for three days, the phuphu finally announced, “It is impossible with me. You go to the doctor.”
The family had not thought of where they would go if things did not go as planned. Her *phuphu* insisted that she go to a facility, saying that if there were an accident for her or the baby, it would be on the *phuphu*, and her in-law family would create problems. Asifa agreed to go to a clinic, but not until the morning. The family decided to take her to the nearby Nobha Clinic. “I was not sure to go to Nobha Clinic,” recalled Asifa when I spoke to her, “I was not sure to go to any clinic. Everyone was saying things, then afterwards I had my middle uncle (*kaka*), and he said, ‘I will take you to this clinic. I have a *porichito* there; I will take you to this clinic.’ Then he took me to this clinic.” The family took her there first thing in the morning, and by the afternoon, she gave birth to her baby through caesarean. After her caesarean, they gave good services, she recalled. There was no lack of care (*jotno*).

For women, access to good services and care often hinges on a *porichito* link to the private health care venue. Rikta, whom I talked to at the Bheremara upazila health complex, was brought by a village doctor to Hashiyara Clinic, where she eventually gave birth, for care during her pregnancy. This village doctor, an informally trained health care provider, rents a stall at the local market and is well-known for providing good care to pregnant women. However, the village doctor also works as a broker to link people to health services in other spaces. Rikta explained, “The doctor sits in this shop, and the doctor helps the patients come and go (like a brokerage house). This doctor has good relationships with other doctors, and that is why I went with him. If you go anywhere, if you go with someone familiar to that place (*manusher porichito to she jaigai hoile*), then everything will be a little bit better.” The practice of the village doctor is far from exceptional. It is common practice for private facilities to establish a relationship with people in villages, e.g. village doctors, pharmacists, *dais*, to direct people to their specific clinic, a service delivered for a financial exchange. This penetration is central to the ‘competition’ that occurs among private facility *maliks*. People come to their particular clinic, in general, based on whom they know. For, as Rikta astutely articulated, it is by so doing that ‘everything will be a little bit better.’

The village doctor took her to Hashiyara Clinic for an ultrasound towards the end of her pregnancy. He did not say which services she would be able to access at Hashiyara, she told us. “He just said that if I go over there, the service will be good. Do not worry, you will see.” At Hashiyara Clinic, the staff conducted an ultrasound.
and told her that the water in her belly was low. They gave her 21 saline infusions over the next couple of weeks, she recalled, but still, the water was drying. Finally, she underwent a surgical birth at Hashiyara. She was satisfied with the services. Thanks to her linkage through the village doctor as a porichito of a clinic, everything was ‘just a little bit better.’

Those acting as dalals, bringing women to particular private facilities, map on to the logic of porichito. In the absence of defined social relationship specifiers, women will refer to them broadly as porichito, acquaintances. In this way, those acting as dalals, constructed as acquaintances, function with little difference compared to how women are accustomed to accessing care and are therefore not considered by default as immoral as a linkage to private health services. Here I do not suggest that people do not locate immorality in the private health care sector. Women occasionally complain of the potential of exploitation at the hands of the private health sector. However, this immorality is lodged in the actors who animate private facilities and not attributed to the people who bring them to particular facilities, including those engaged in dalal practice, in contrast to the discursive practice reifying the trope of the dalal in policy and programming discourses.

Moreover, while economic interests may be the primary motivator for those enacting dalal practice in public health spaces, they engage with people to establish relationships with them and assist them in various ways to navigate the often-perplexing public health sector. Some demonstrate concern in a setting where women and their families more commonly encounter disregard and perpetual broken promises. Consider the following scene from a upazila health complex in Khoksha upazila health complex: It is around 11:00 on a Thursday morning. Patients mill about in the waiting room. A sole midwife provides services for pregnant women, one SACMO sees children, but there is no medical officer. Three young men identifiable as dalals stand in the back by the open window next to the IMCI corner. Warm sunbeams pour in over them as they laugh amongst themselves. Several mothers balance babies on their hips, a couple of fathers stand nearby, waiting to see the SACMO. One of the three young men ventures from his posse and approaches a baby on a woman’s hip. He gets near the baby and makes funny faces—the baby squeals in delight as his mother smiles.
Another young man embodying a *dalal*, wearing stonewashed jeans and sandals, a large brown shawl wrapped around his shoulders, approaches a small group of people. Where is the *daktar*? one woman complains. It must be because it is Thursday, she says, an insinuation that since it is the day before the Friday holiday, the doctor has decided not to come and take a long weekend. She shakes her head. I will not come back here on a Thursday, she proclaims. The young man in stonewashed jeans approaches the group with a small plastic bag of peanuts. He chats with the group as casually as he shells the peanuts and pops them in his mouth. A small older woman approaches him and shows him her ticket. Where is she supposed to go? she asks. He looks over her white paper. Room number six, he responds and points her in the direction. She shuffles along on her way.

A medical officer, the young and charming dental surgeon posted at to the upazila health complex as a medical officer to provide general health services, finally appears and struts through the waiting room. Tamanna and I met him in the morning already in the UH&FPO’s office, where he thumbed through a newspaper and engaged in the usual morning banter with Sharif sir. He casually greets the young man in the stonewashed jeans and brown shawl as he passes and unlocks the door, ignoring those who await him. The crowd rushes to form a line in front of the door. The young man stands next to the line. He cracks peanut shells with his fingers and then throws them in the nearby garbage can. He chats casually with the people in the line. They laugh from time to time. At one point, a woman in a long coral headscarf complains that there is no female doctor today. Why is there no female doctor? The young man responds that there are female doctors nearby; they are just not here in the upazila health complex. It is a simple matter of spending a bit of money if she wants to see one. The woman holds her ground in the line.

The young man surveys the line. It is composed of seven women and two men. Why are there not separate lines for women and men? he muses aloud. The women look around nervously. *Bhai*, he says to the men, keep a bit of distance. He gestures for them to move back, and the men follow his instructions. The young man throws another nutshell in the tall metal garbage can.

Such is a typical scene in upazila health complex waiting rooms. Despite the signs on the walls trying to delegitimise them as deceivers, young men operating as


dalals are a perpetual and visible presence. While their intentions are market-oriented, they also provide service and care that people do not obtain otherwise in the government health sector. These young men present themselves as available to the people and assist people who navigate the interior of the public health system, not only to move outside it. Moreover, they can lead people to access the services simply not available in the public health setting.

For those who do not have other links to private health service facilities, people identified as dalals may offer the next best mechanism for allowing women and their families to materialise their aspirations for biomedical health services through the private health market. Sitting on the cold benches in the Daulotpur upazila complex one day, Tamanna and I watch as one woman weaves her way through the crowd of people, pausing to talk with a few of the young men working as dalals. Eventually, she takes a seat not too far from us. We scoot near her and tell her that we noticed her talking to the men. Could we ask what she discussed with them? Without any visible embarrassment, she tells us that her daughter needs some services, some basic tests and an ultrasound, so she was trying to find out where she could get it for the best price. She was making her rounds to try to negotiate where she could get the best deal.

While capitalist logics presume that market forces will naturally reduce the cost of health services (again, while simultaneously improving their quality), the arbitrariness of cost-setting in this health care market precludes such an operation. Just as if you know someone, ‘the care will be just a bit better,’ women believe that if you know someone, the cost will most likely be less. Without knowing someone, there is no guarantee. If we recall the account of Shanti from Chapter 1, it was through a personal kin connection to the clinic where she underwent her first surgical birth who advocated on her behalf that the clinic team accepted a sum substantially less than the first quote. Her bhai, who had connections to the clinic, went to his knees on the family’s behalf, and the clinic agreed to accept 12,000 taka (~105 GBP) instead of the 19,000 taka (~165 GBP) for the procedure, a nearly 40% reduction on the marked price. The family had no connection to the second clinic where she underwent a caesarean, forcing the family to take out a loan to cover the crippling costs. In the absence of other connections, young men functioning only as
dalals, such as Hassan, offer women and families a further mechanism for negotiating prices of services

In contrast to the trope of the dalal that resound in national and subnational official settings that bracket this category off as an immoral figure distinct from the private health delivery landscape, women and families engage with those operating as dalals as an extension of porichito. Indeed, dalals map onto a broader social world that prioritises dhora-dhori to access resources. People who operate as dalals do not act as deceptive informers but rather as an extension of porichito, who link women and families with desired health services without other kin or porichito. Just as Jonathan Parry notes in people’s engagement with ‘dalals’ to acquire public employment in India, such engagements are not necessarily marked by trust (Parry, 2000:36). However, for those who have no other recourse, that is to say, no other personal attachments to the private health care landscape, those who embody dalals may be a last-ditch effort to access care that is thought to be ‘just a little bit better’ and just a little bit less expensive.

Conclusion

Embedded within the practice of patronage, the figure of the ‘broker’ is ubiquitous throughout South Asia, appearing in myriad contexts (Piliavsky, 2014b, Berenschot, 2014, Huberman, 2010, Jeffrey, 2010a). In this chapter, I have suggested that ‘brokerage’ as it appears in the ‘dalal’ trope and ‘dalal’ practice is elucidative of broader social, political and economic contingencies (Björkman, 2018) in this moment of ‘moral breakdown’ (Zigon, 2007) with relation to capitalistic shifts in maternal health service delivery. Rather that starting from an assumption of the immorality of such brokerage, I have attempted to remain ‘morally agnostic’ (Lindquist, 2015) so as to understand how this mediation can inform renegotiations of moralities within this historical juncture.

In Bangladesh, brokerage remains alive and a permanent fixture of bureaucracy in the shadows. It is common for people to speak of contracting brokers to lubricate bureaucratic navigations and access artefacts as fundamental as passports and driver’s licenses. This type of brokerage is understood as both ubiquitous and morally repugnant, mirroring broader conceptualisation of brokerage even within anthropological scholarship to view brokerage as immoral (Lindquist,
2015), though a sort of necessary evil to access resources and opportunities. Dalals are incontrovertibly imagined as the worst type of broker in this setting, a deceiver working in the shadows as a traitor and deceiver of the people for depraved self-interest.

Against this backdrop, the everyday practice of dalals in public health spaces might seem paradoxically banal. The operation of dalals in public health facilities is a striking contrast to the trope of the dalal. For example, despite the contraindications on the walls, the work of dalals takes place in open and visible spaces. Moreover, women and families do not exhibit shame in conversing with them in the open. Despite the political project raising this spectre, people who operate as dalals are not viewed in this orchestrated way by the women and families who engage with them. In her research on migration in Central America, Wendy Vogt observed that, while discourse attempted to villainise ‘smugglers,’ in practice, people related to and engaged with actors identified as such in nuanced ways (Vogt, 2018: 99-100). Similarly, despite villainising discourses, people in Kushtia engage with dalals in ways that map onto the broader social world in which social connections are central to accessing services, resources and opportunities through dhora-dhori. They may also expand agency for women and families as market actors to negotiate better care at better prices.

In investigating the role of dalals in political movements against multinational corporations, Nusrat Sabina Chowdhury writes of their power as an intriguer or a collaborator in their ability to confuse and collapse binaries of "local/foreign, friend/enemy, or neighbour/dalal (Chowdhury, 2019:133). However, in Kushtia and concerning the private health sector, dalal practice assumes a diametric function from this, serving as a lynchpin in maintaining boundaries already collapsed: the public/private divide of health service delivery. On the one hand, directing attention to the figure of the dalal serves as a smokescreen to facilitate the fluidity between private and public sectors, from which doctors (licitly) and other health service providers (illicitly) and those with other titles benefit. While these public/private crossovers are functionally analogous, only dalals are imagined as fundamentally immoral in narratives.
Indeed, *dalals* are uniquely constructed as an immoral category, with material and discursive reminders all around, the writing on the walls, discussions around ridding public health settings of their presence. These boundaries of illicitness function as if *dalals* operate outside a broader system. However, the private sector itself comprises a morally ambiguous space. The rapid expansion of this market as a social form has reconfigured the maternal health terrain in ways which result in what Jarett Zigon’s conceptualisation of a ‘moral breakdown’. It is in these moments that usually unreflected, embodied moralities are reconsidered and renegotiated (Zigon, 2007). The expansion of the private health sector in Bangladesh demands of renegotiation of the moralities associated with biomedical health service delivery and care.

As demonstrated throughout this thesis, the rise of the private health sector represents, at least in part, a perhaps unsurprising outgrowth of, and attempted compensation for, the unpredictability and unreliability of the public health sector. While providing needed and desired biomedical health services, people struggle to make sense of this market, as nebulous as it is fertile. The fantasy of the *dalal* stands in as a representation of the immorality associated with the private health sector, without needing to point to the immorality of the private health sector in general. Indeed, the private sector delivers much that is desired, in the form of material biomedical services for women and families and economic potentialities for health service actors, from medical doctors to *dalals*. The figure of the *dalal* operates as a metaphor of immorality ascribed to morally ambiguous spaces of the private health sector, a way for people to negotiate a moral discomfort integral to applying market logics to health services. Bracketing out *dalals* shifts focus away from the patchiness and unpredictability of the public maternal health care service provision, and from the discomfort with the application of market logics to health service delivery, provides a constituted category to contain the onus of immorality.
February 4, 2020, Kushtia. Ehsan, Raiyan, Aniqa and Shema of the icddr,b Dhaka team are in town. Yesterday, they organised a workshop to introduce the IMCI project they brought to the district to local NGOs in the presence of public health managers. Zia had identified around 75 local NGOs working health in the area, from which some 20 were invited to participate. Most were small organisations that I was becoming acquainted with for the first time, with the exception of Save the Children. As usual during the icddr,b Dhaka team visits, we stayed up late long after the workshop; we did not take our dinner of rice with thick fish and chicken curries until 11 pm, and we chatted long after that. Still, I wake up early. Ehsan and Raiyan are already working in front of their computers, but they propose we go on a walk and enjoy the morning tranquillity and a *dudh cha*, tea sweetened with viscous, condensed milk, at the small stall by the river.

After sipping the tea, we delicately descend the riverbanks, silt giving way under our feet. The river water is now exceptionally shallow. The months when the rainy season filled the river to the brim seem like a distant memory. During those
months, bamboo-constructed temporary docks welcomed crowds of passengers onto rickety boats to carry them, and sometimes their bicycles or motorbikes, from one side to the other, as they made their way between village homes on one side to Kushtia livelihoods or schools on the other. The water levels deflated as the seasons grew drier and colder. Temporary bamboo docks were unbuilt and then rebuilt to follow the water levels. The water is so shallow these days that there is no need for a dock. Instead, a makeshift bridge composed (again) of bamboo provides a narrow strip of solid ground to pass over the water depression that can hardly be called a river.

We watch the stream of people pass over the bridge from the village side to the Kushtia side. Boys and men push bicycles across; women carry sacks of goods. Two men sit in a makeshift toll booth, collecting a bit of taka from each passer-by. Although I doubt anyone sees these men as villains, I cannot help but see their resemblance to the young ‘dalals’ in the upazila health complexes, in this case very literally ‘middlemen’ engaged in the precarious work of gathering a small fee for passage from one side of the riverbank to the other. Nearby, a fisherman throws a large net optimistically into a puddle of river water.
As we breathe in the cool winter air and take in the scene, Ehsan and Raiyan talk about their own sense of precarity. Though middle-class and Dhaka Medical College-educated doctors, both declined to pursue a government job. Besides being independently wealthy, a government job is virtually the only option to shed the sense of existential risk. Everyone, they say, wants a government job because of the security such employment brings with it. However, government jobs are boring, they say. While an icddr,b position is highly desirable and infinitely more interesting than a government job, according to them, they are exhausted by the amount of effort required to generate the steady stream of resources through ‘big D’ Development to ensure their jobs and those of the other team members. In many ways, this ‘soft money’, as Ehsan refers to it, is as soft as the sand on the river beach: It could wash away at any time under their feet based on a donor’s whims. Lack of social safety nets leaves people, not only people from lower classes but also middle classes, perpetually insecure. “These people deserve something better,” Ehsan sighs as we watch.

While that is most certainly true, indeed, few people would claim to revel in existing in a state of precarity and insecurity, and I would not defend conditions and
structures which contribute to such realities, the bamboo bridge also stood as a symbol of possibilities in the face of these situated realities. Despite shifting and unpredictable conditions, it stood as a material marker of finding a way, something I repeatedly encountered in Kushtia and with not only the icddr,b team but also my research participants. So many times, when I saw insurmountable barriers, others saw puzzles to solve, walls to scale.

When I sit down to draft a conclusion for my thesis for the first time, this moment comes to mind. I scroll through the photos I took during fieldwork, looking for the one which opens this conclusion. I am surprised when I locate it and realise that I had snapped it precisely one year before, to the day. It strikes me then that this fleeting moment symbolised how I had come to understand and admire the people of Bangladesh. Yes, there is a deep sense of precarity for most, but there is also a sense of finding a way amid incertitude and unpredictability.

Willem van Schendel begins his History of Bangladesh with a description of the country’s geography as viewed from above, described as plainland characterised by perpetual reconfiguration of land and through the geographical processes of the deposit of silt from the Himalayas, flooding and erosion. Van Schendel writes:

*Managing the natural environment has been a central concern for all societies and states that have occupied the Bengal delta. The people of Bangladesh have never been able to lull themselves into a false belief that they controlled nature. They live in an environment where land and water meet and where the boundaries between these elements are in constant flux. As a result, settlement patterns have always been flexible and often transient* (van Schendel, 2021: 9).

This sense of flux and flexibility underpin my understanding of Bangladesh, its people, the reworkings of biomedical terrains, and women’s navigation of these terrains as pregnant and childbearing subjects.

The natural landscape in Bangladesh stands as a metaphor for the broader social conditions people navigate, including the maternal health terrain. Policy and programming discourses tend to represent the finality of maternal health ‘behaviours’ as a series of possible choices, informal care sought at home, or formal care sought through the public, private or NGO sectors, as if they are static, fixed. The subtext of these representations is of women exercising choice in either desirable or undesirable ways, either conforming to or failing to conform to development ‘ideals’.
However, the realities of navigating ‘choices’ to reach maternal health aspirations is much more nebulous than can be captured through such representations. It occurs in the meeting and flux of women and their families and the volatile social terrain of health service delivery.

This thesis took this maternal health terrain as among its objects, opening the boxes of representation to understand the terrain on its own terms. One finds here a complex weaving together of shifting health services, traditions and ideologies which together form a volatile frontier for women to navigate for care during pregnancy and birth: government hospitals which promise maternal care, but provide only piecemeal and unpredictable biomedical service; donor-driven initiatives implemented through the public health system in perpetual metamorphosis, creating a hide-and-seek of opportunities, resources, demanding reconfigurations of bodies based on international development agenda tides; a kobiraj, practitioner of herbal medical, serving as the link to advanced commodified biomedical technologies located in private diagnostic centres and clinics; government nurses and medical assistants ‘illegally’, yet openly and with legitimacy, assisting home births; village doctors refashioned as private clinic maliks specialising in providing rudimentary caesarean services; small private clinics popping up under one state regime only to be promptly closed following a regime change; government doctors moving smoothly throughout public and private stages to perform maternal health technologies and thereby determine when, where and how health services are accessed; local NGO maternal health projects disappearing as quickly as they appear. These forces weave beside, together and around each other in both (somewhat) predictable and unpredictable ways to create a perpetually shifting terrain which women and their families must be adept and flexible to navigate.

This terrain resembles less a ‘system’ and rather Tsing’s conceptualisation of a ‘frontier’. Below easily boxed-off components represented on PowerPoint slides and health service reports within policy and programming discourse reigns a maternal health frontier, ungoverned and not yet governable. This confluence of maternal health care, services, resources, commodities and world views in Bangladesh operates as a volatile frontier. Recognising this confluence as a frontier is perhaps not desirable from the vantage point of ‘Big D’ Development (Hart, 2001), as it complicates ‘rendering technical’ (Li, 2007). Such a frontier eludes ‘rights-based
approaches,’ which would hope to place a functioning state at its helm. Still, in its everyday enactments, this frontier expands opportunities for pursuing maternal health ambitions. It also delivers opportunities for maintaining livelihoods in a context of precarity.

Like the perpetually shifting river dividing Kushtia city from its villages, the maternal health terrain is perpetually refashioned, carving new possibilities, opportunities and resources while foreclosing others. These shifts are not merely a response to women’s health needs but to shifting social, political and economic realities, within which more than the health of women and newborns is at stake. Indeed, reshaping the way women give birth towards medicalised ends was a mainstay of colonial and postcolonial projects, though the tactics and material resources to achieve this remained both peripheral to women’s pregnancy and birth experiences and unpredictable, lodged primarily in a patchy scaffolding of a public health sector and piecemeal international, national and local development initiatives.

With the recent proliferation of the private maternal health market, mass medicalisation of childbirth has become a reality, centring advanced maternal health technologies in pregnancy and birth experiences. These new opportunities have inundated the maternal health service terrain in unpredictable and ununiform ways, with vast variations in quality, experience and cost. They share the promise of delivering maternal health services and resources as commodified packages within reach of women and families of all social classes.

While Bangladesh has long been noted for its ‘medical pluralism’ (Ahmed et al., 2013, Shah, 2020), the rapid commodification of maternal health services accelerates the reshaping and reimagining of maternal health aspirations and the actors vying for places to meet these aspirations. In this space of the (mostly) unmapped, the (almost entirely) unregulated, the mass availability of advanced maternal health technologies summons new birth futurities and new ideas of what could be and should be. While previously, women may have articulated birth as a ‘normal’ life event, in rural Kushtia today, birth is infused with a sense of risk. However, one must no longer simply submit to these risks—the expansiveness of advanced biomedical maternal technologies breeds imaginaries in which these risks may be averted, where one must not simply wait and see.
These imaginaries are embedded within social imaginations of caesarean birth as the ultimate biomedical solution for averting risk, particularly that of the baby, and ultrasound technology as an oracle to foretell the mode of birth. The imagined futurities these technologies animate do not simply shape aspirations; they crystallise as moral imperatives. Imagined as a panacea to averting risk, it becomes not only a convenient choice to seek them but a moral imperative. For a woman to submit to surgical birth when counselled to do so by a health service provider or based on an ultrasound operates as a moral act demonstrating care for the baby. For a family, with whom many decisions rest, to support a woman to access technologies, in turn, operates as a moral act of care, one worth sacrificing for and pooling resources to avail.

The findings presented in this thesis provide an alternative perspective of women’s mass inclinations towards medicalised pregnancy and birth aspirations. It argues that in Kushtia, women’s real and palpable personal experiences with pregnancy and childbirth coalesce with the imaginary technologies conjure as a remedy to risk, thereby reshaping aspiration towards these technologies as a moral imperative. Indeed, I suggest that patriarchal control over women’s bodies is insufficient for understanding transitions toward the most medicalised forms of pregnancy and birth care. Nor is taking seriously women’s desires to subvert patriarchy, aspire to higher class status or achieve their own ends, although this is critical. Here I do not suggest that other ends do not figure into the use of these technologies in Kushtia, but rather that these are secondary and, at their root, aspirations towards advanced maternal technologies operate as a marker of morally infused care, particularly for the unborn child.

The promises of these technologies are certainly oversold in the peripheries. Indeed, even in the best-equipped conditions, there are no guarantees, much less in spaces and conditions such as these, which demand the unapologetic circumnavigation of clinical quality standards, compounding the iatrogenic risks. Still, they offer alternative futurities for pregnancy and birth that other forms of institution birth care do not necessarily evoke, such as normal delibheri in a formal biomedical institution which is imagined as offering little more than a dai or other health service provider might provide at home.
This thesis has argued that medicalised aspirations and markets offering advanced maternal health technologies are co-constitutive. This market is the result of ‘little d’ development, the uneven and unpredictable enactments of capitalism, and is primarily responsible for transitions towards mass medicalisation and placing advanced maternal technologies within reach of all social classes. While burgeoning outside the purview of ‘Big D’ Development planning, these market forces pull not only women and families into their orbit but also public sector and informal health service providers.

This thesis has demonstrated how maternal health service delivery and utilisation play out in the social world of Kushtia. The maternal health terrain in this space is socially constituted, existing as an agentive by-product of the political economy and structural conditions. The for-profit private maternal health sector has reshaped this terrain in expansive ways. This phenomenon is co-constitutive of women’s desires, imaginaries and futurities as pregnant and childbearing subjects. It allows people to compensate for or even bypass a state that is imagined as not ‘caring’, not displaying the affect of care. While private institutions may not necessarily deliver affective care, it is imagined as a space in which one might, for the right price and with the right social connections, secure ‘care’, in contrast to public spaces in which ‘service’ is effectively detached from ‘care’.

This market operates within a broader world of political-economic precarity. It has emerged as a space where livelihoods can be established and maintained. In Kushtia, these opportunities span social classes. The private maternal health market allows medical doctors limitless opportunities to boost income through the performance of advanced maternal health technologies on endless stages. It allows maliks, owners, to expand on their middle-class livelihoods, young health service providers aspiring to middle-class status to maintain a livelihood as they wait in hopes to secure a more desirable government job, health service providers who have aged out of this possibility a place to sustain an income. It offers lower-class women opportunities to secure jobs as ayas and perhaps one day obtain a promotion to informally trained sisters or young men waiting for better opportunities to earn a living as a broker. In Kushtia, many private health institutions cater primarily to women seeking institutional care at the time of birth and care during
pregnancy in the form of ultrasound, attesting to how central women’s bodies are to sustaining this network of livelihoods.

The mushrooming of the maternal health market has refashioned the maternal health service terrain so rapidly and entirely to amount to what Zigon (2007) refers to as a ‘moral breakdown’. While the metaphor of breakdown perhaps inappropriately evokes the idea of breaking, something no longer working, the idea he encapsulates under this title is fitting, a change leading to a moment of conscious moral reckoning, in which moral enactments in the world are renegotiated and re-enacted. Indeed, markets tend to be discursively constituted as immoral, particularly when applied to the intimate sphere of health and care. This is as true within global health discourse as in national, where the private health sector is often imagined as a necessary evil: filling in where the government is unable, but only at the expense of quality and exacerbating exploitation and inequalities.

Anthropological scholarship tends to be highly critical of health service privatisation and health markets, suggesting a neoliberal determinism. While I do not aim to give neoliberalism a pass or romanticise health markets, I also wish to refrain from assigning neoliberal determinism. Doing so would discredit Bangladeshi ingenuity and agency and the multitude of ways people employ to navigate their lives under conditions of volatility. Indeed, such ingenuity was part of the social fabric long before global market-oriented trends were introduced as ‘neoliberalism’. Bangladeshis have never waited for a centralised force to fulfil their desires or needs, whether a colonial regime or postcolonial state, and have fostered traditions of self-help and communities to meet needs.

Moreover, this thesis has argued that rather than inherently immoral, moral worlds are reconstructed and renegotiated within maternal health markets in Kushtia. Private health service managers and providers are not merely motivated by economic imperatives but also morality. In the near absence of formal regulation to consolidate moral norms and rules, they appeal to longstanding moral sensibilities. These are often rooted in religion, in which providing services, including health services, is perceived as moral work. These ideas expand beyond the particularities of specific religion and form a composite moral world order captured by the concept of dhormo. A longstanding moral imperative within this dhormo to help one’s poor is
centred in these efforts and remains relevant in Kushtia today. Rather than tainted by financial transactions, market ends and moral ends are articulated as co-constituted as each facilitates the other. While profit gained through private health service delivery is often understated, suggesting the moral ambiguity, health managers emphasise the moral sensibilities of delivering services.

While private health sector actors may not always adhere to these moral ideals, they imagine and articulate their enactment of a health market at least as much in moral terms as in market terms. In contrast to global and national discourses, which tend to emphasise the compromised quality of private health services as a moral failing, for those within the moral world of private health service delivery, the cutting of clinical corners is morally justifiable in the face of the political-economic realities. Indeed, it is only by cutting corners and costs that one might provide services to the poor. Moreover, it is justifiable as a natural response to providing that which the state never has reliably. In these articulations, providing maternal health commodities is as much a moral endeavour as an economic one.

This thesis proposed morality, ideas related to the good, as an analytic to understand the ways people make and make sense of these new possibilities and ideas around pregnancy and childbirth. This does not equate to providing a pro-market argument. Indeed, unfettered capitalism has undoubtedly led to numerous less-than-desirable global, national and local effects. Moreover, in the everyday enactments of private health service delivery, there is no question that many private health facilities, in their effort to ‘make-do’, fail to conform to international and national quality standards of health service provision. It is also true that people, even poor people, bear the financial burden of paying for commodified health services that are, perhaps, more appealing imagined as ‘entitlements’. Finally, it is also true that certain private health institutions are responsible for breaches that few would consider moral. A notable example during my fieldwork included the Regent Hospital scandal, where a large corporate hospital in Dhaka was found guilty of providing falsified Covid certificates. It was not my purpose to bolster or disprove these indictments. Instead, I tended to how moralities are reworked and contested through the expansion of capitalist logics in maternal health service provision. Though existing in the space of moral ambiguity, the negotiation of morals by both those who
animate private sector sites and those who seek services through them operates as a social process to make sense of these changes.

Finally, this thesis asked how women navigate this volatile maternal health service terrain to achieve ambitions as pregnant and childbearing subjects. Just as the shifting river demands flexibility in tactics employed to cross it, so the volatile maternal health terrain demands varying tactics to achieve morally-imbued aspirations. Rather than relying on a postcolonial state, people navigate this frontier by creatively leveraging resources and networks beyond it to pursue their aspirations and meet their needs. Whether installing a makeshift bridge to move from villages the work in the city, Ehsan and Raiyan securing steady pots of funding through development actors to maintain their employment, or women finding ways to access the biomedical maternal health technologies they desire, people nimbly employ tactics and leverage social networks.

Despite the new predominance of markets in the maternal health terrain, the introduction of market-centric biomedical care has not generated new ‘neoliberal’ subjectivities in which people act as ‘responsible’ consumers, exercising ‘rational’ choice based on quality and cost, thereby fostering competition which leads to improved quality at a lower cost. Rather, navigation is rooted in social connectedness, based on subjectivities and processes long part of the Bangladeshi social fabric, sometimes derisively referred to as ‘patronage’. Women rely on family members to exercise connections through dhora-dhori, looking toward porichito, acquaintances. Where no other connections exist, ’dalals' may fill in as a connection to allow women and families to negotiate the best possibilities and prices.

Social connectedness, rather than competition, is fundamental to pursuing quality health services. Indeed, it is not based on quality control checklists or other ‘objective’ measures that women and families determine where and how ‘good’ maternal health services can be accessed. Instead, ‘good’ services depend on leveraging relationships or financial resources. Rather than through market-inspired competition, it is through direct connections that quality and cost might be influenced. Moreover, the centrality of social connectedness in navigation transcends the ‘market’ and applies to any space where women seek care. Service delivery is direct, with health services only minimally mediated through regulatory mechanisms and not
mediated at all through insurance mechanisms. Service delivery negotiations are directly between consumers and providers, mediated by social relationships.

The multiplicity of constraints to ‘development’ is a tired record in international development circles: lack of resources, lack of investment, poor governance, and corruption. Nevertheless, despite these constraints, the people of Bangladesh have been advancing towards improvement in human flourishing, discursively culminating in the ‘Bangladesh paradox.’ It is this paradox that some development actors, such as those in the Johns Hopkins study (see Chapter 5), aspire to capture, place in a box and exploit in other settings targeted by the development gaze. However, these stories of Bangladesh tend to be told through ‘big D’ Development narratives, stories of progress, or stagnation. Stories of ‘surprising’ failures and successes as consequences of state and development interventions. This thesis has offered counter stories that fall outside the capture of project log frames, management and information systems (MIS), and public-private categorisations.

Rather than a stable palette of ‘choices’, the maternal health terrain in Bangladesh, like the river flowing through Kushtia, is a shifting terrain in perpetual flux, configured and perpetually reconfigured by the actors who constitute it. Navigating this terrain, this frontier, now inundated with advanced biomedical maternal technologies, demands agility in the face of flux in response to constraints. Like the docks and boats giving way to makeshift bamboo bridges to cross, the mechanisms and tactics women use to navigate through this volatile space shift to navigate new ideas, aspirations and moral imperatives.
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