MAT Medicine Anthropology Theory

RESEARCH ARTICLES

Fleshy Entanglements in Development Aspirations

Birth Position as a Site of Contestation in Bangladesh

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Received: 14 July 2022; Accepted: 11 January 2023; Published: 26 April 2023

Abstract

Encouraging women to adopt a position of their choice during birth has long been among the calls of scholars and activists challenging medicalised models of childbirth rooted in patriarchy to allow women to own their birthing experiences rather than accept the passivity of a lithotomy position. The encouragement of women to adopt a position of their choosing is now integrated within global health policy. Based on fieldwork conducted in Dhaka and Kushtia district, Bangladesh, this article examines the promotion of non-supine birth positions promoted through international development entities in Bangladesh. It argues that despite its emancipatory appeal, when subsumed by international development logics, the birth position operates as a site of political contestation in which women are rendered peripheral within a broader constellation of development imaginaries and ends. Within this constellation, the birth position is circumscribed as a technical intervention amenable to metricisation. Rather than a 'return' to more 'natural' forms of birth, 'non-supine' birth positions when instrumentalised in this context are broadly conceived of as 'foreign', and serve to expand the medicalisation of childbirth.

Keywords

Maternal health, International development, Childbirth, Ethnography, Bangladesh.

Medicine Anthropology Theory 10 (1): 1–27; ISSN 2405-691X; https://doi.org/10.17157/mat.10.1.7303.

Introduction

In Kushtia District Hospital, located in the western reaches of Bangladesh, long pink drapes cascade over the entryway to the labour and delivery room. Each pink curtain bears the Government of Bangladesh logo, and just below, a slightly larger logo of the international nongovernmental organization (NGO) Save the Children. These curtains invite one into an 'upgraded' labour and delivery room, configured as such through the efforts of Save the Children. Passing this threshold, posters and banners plaster the walls: one banner depicts the active management of third stage labour, a couple of posters show how to apply 7.1% chlorhexidine solution to the newborn's cord, a few others inform on immediate newborn care. The common thread connecting them all is a Save the Children stamp of approval. Most of the posters primarily present Bangla text, except for one. This poster lists 11 'Evidence-based routine care' points in English only (see Figure 1). These range from the vague, such as 'Respectful communication and patient focus' and 'No harmful practices' to the specific, including 'Hydration and nutrition in labour', 'Partograph', i.e., the ongoing tracking of labour progress and foetal status for decision-making during labour, and 'Upright non-supine and non-lithotomy positions'.

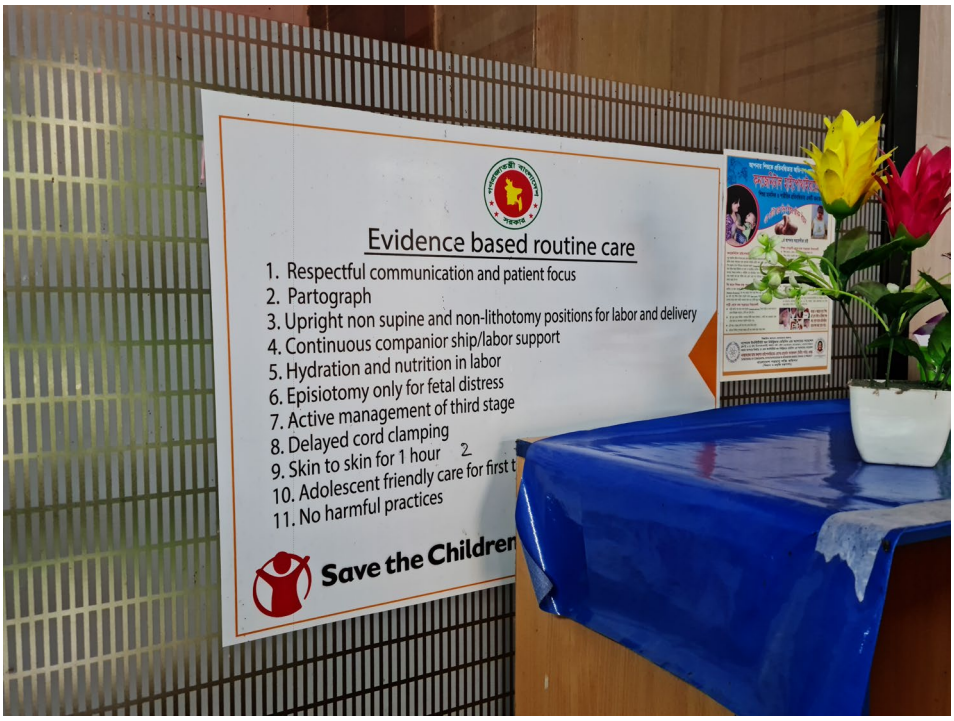

Figure 1. 'Evidence-based routine care' poster by Save the Children displayed on the wall of the Kushtia district hospital as part of the labour and delivery room 'upgrade'. Image by the author, 2021.

A dominating banner hangs next to the washroom door, framed by yet another set of pink Save the Children drapes that reinforce the evocation of physical positioning (see Figure 2). The poster is text minimal and displays illustrations 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 that women should walk, climb stairs, squat down with the support of a chair or an exercise ball, kneel on all fours, or lay down on their right-side during labour. On the top portion, illustrations indicate five potential birth positions. Sitting on the birthing stool and reclining positions seem straightforward enough. However, one image shows a woman squatting over a birthing bar, the likes of which is not available in this space. The final two appear decisively acrobatic—squatting and kneeling with a birthing ball.

Figure 2. ‘Birthing and Labour position’ poster on a wall in the clinic. Image by the author, 2021.

This poster manifests the successful culmination of feminist activists’ and scholars’ engagement with birthing, which emerged in the United States and Europe in the

late twentieth century, and strived to emancipate women from the patriarchal control immanent to what Robbie Davis-Floyd referred to as ‘technocratic’ models of childbirth (Davis-Floyd 1992), and more commonly referred to as ‘medicalised’ childbirth. These activists and scholars advocated a return to more ‘natural’ models of childbirth, in which women would be freed from the unnecessary intrusion of biomedical technologies during labour and birth. Moreover, in these visions, women would exercise their authority throughout their birthing experiences, and thereby supersede the biomedical (read: patriarchal) authoritative knowledge inscribed in biomedicine.

Embedded within this larger movement, scholars and activists noted that giving birth in a horizontal (supine) position was historically relatively uncommon, and that traditional birthing practices favoured upright positions, such as squatting or kneeling (Dundes 1987). They suggested that the lithotomy position (i.e., assuming a supine position with legs bent at a 90-degree angle) was an outgrowth of the biomedicalization of this life transition, as it served to facilitate the work of the (usually male) obstetrician. Not only did a lithotomy position manifest patriarchal control over women’s bodies, they argued, but it also ran counter to human physiology and therefore impeded rather than facilitated birth (Davis-Floyd and Cheyney 2009; Bodner-Adler et al. 2003; Dundes 1987; W.R. Trevathan 1997). In proposing this critique, activists promoted women’s choice of birth position as a political act to allow women to reclaim authority over their bodies and a physiologic one to facilitate more anatomically suited births (Trevathan 1997). By the first decades of the 2000’s, these messages, bolstered by quantitative research evidence (Gupta et al. 2017), made inroads within the global health apparatus. They are now often 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 2018, 2014), and manifested materially on the walls of the Kushtia District Hospital.

In Bangladesh, while the promotion of women’s choice of birth position is not currently inscribed in formal policy documents, several large NGOs, including Save the Children and BRAC, have taken it on within their mission. Most recently, for instance, they have incorporated the promotion of non-supine birth positions within their support to the recently initiated National Midwifery Programme. During the 2010 United Nations General Assembly, Prime Minister Sheikh Hasina committed to form a cadre of diploma-qualified midwives trained in accordance with the global standards of the International Confederation of Midwives (Bogren, Begum, and Erlandsson 2017). While heralded as a government initiative, in fact some of the most powerful non-governmental, donor and multilateral organisations working in Bangladesh champion the National Midwifery Programme including BRAC, Save the Children and the UK Department for International Development (DFID).

This article explores the enactments of the promotion of non-supine birth positions as an intervention when subsumed by international development imaginaries. It begins by examining 'maternal health' within development imaginaries in Bangladesh, attending to how public health service providers narrate their engagement within international development initiatives in maternal health. It then turns to the enactments of the promotion of non-supine birth positions to illustrate how, when inscribed within international development logics, the birth position is 'rendered technical', the term Tanya Murray Li (2011) uses to describe the sanitation of issues from the their political and social embeddedness and repackaged as amenable to bounded technical fixes. In this research article, I argue that despite its emancipatory appeal, when subsumed by international development logics, merely promoting particular birth positions fails to undo the patriarchal medicalisation of childbirth. Rather, it reshapes and furthers medicalises birth, rendering women peripheral within a broader constellation of development imaginaries and ends.

Methodology

This article is based on data I produced during my doctoral research between September 2019 and March 2021 (with remote data collection taking place between April and October 2020 due to the COVID-19 pandemic). During this time, I engaged in participant observation and conducted interviews in various maternal health settings in national spaces, hosted by the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b), a global health research institution based in Dhaka. The ethnography included three months of participant-observation in maternal health policymaking and programming settings in Dhaka and around nine months among women and health service providers and managers in their homes, and in public, and private maternal health service delivery spaces in the Kushtia district.

Kushtia district is located along the western border with India, and is home to a population of 1.7 million people who primarily reside in rural villages. People's livelihoods are predominantly sustained through agriculture (Banglapedia 2021), and the district is well-known for its cultivation of tobacco as a cash crop (Rahman et al. 2020). Kushtia is divided into five *upazilas* (subdistricts). Public institutional services for birth are delivered in five *upazila* health complexes, which provide routine antenatal care, postnatal care, and institutional physiologic birth care. Kushtia was, in fact, selected as one of the first districts for rolling out the National Midwifery Project. For that reason, each *upazila* health complex in Kushtia is staffed with between one and four midwives, all of them posted with the first batch of midwives in the original staffing in 2018. None of these *upazila* health complexes

regularly offer caesarean services. Kushtia district hospital (the first-level referral hospital) is the only public facility which regularly provides caesarean services.

In addition to public health facilities, a wide range of private health facilities offer institutionalised care at birth, ranging from large private hospitals located in the administrative hub of Kushtia city, to small entrepreneurial start-ups offering a limited menu of services which typically encompass relatively simple surgical procedures, including caesarean. Such institutions now cater to women and families of all socio-economic strata, with varying clinical delivery and cost. While domestic and international development actors are present in Kushtia, few deliver institutional birth services directly.

In Kushtia, my research assistant, Tamanna, and I spent time with women and health service providers in antenatal care service points, labour and delivery rooms, and operating theatres pertaining to public and private health sector facilities in the five *upazilas* in Kushtia city. In addition to informal discussions, I formally interviewed 65 women and 57 health service providers in health facilities and their homes. These interviews explored the participants' experiences of and participation in pregnancy and childbirth and their navigation of the maternal health service therapeutic landscape. In addition to Kushtia, I visited other sites during my fieldwork, notably Sylhet, located in the north of the country, to broaden my understanding of the National Midwifery Programme, data I draw from in this article.

I strove to maintain ethical principles and ensure the protection of participants throughout this study. Prior to formal (or semi-formal) interviews, my research assistant and I informed potential research participants regarding the scope, purpose, and potential risks of the research project, ensuring them that they were under no obligation to participate, and obtained their verbal consent. We obtained verbal consent rather than written as paper-based forms tend to incite scepticism and discomfort among participants. We also felt that it could reinforce power differentials between us and research participants, and differentials between research participants.

Obtaining individual informed consent for participant observation was less amenable to a structured process. Despite this, I ensured the dignity and safety of participants throughout the process. I remained particularly attentive to ethical considerations when present during birth experiences. Whether in labour and delivery rooms or operating theatres, I obtained verbal consent for my presence from the woman and her companions. We approached each party to explain our presence and obtained consent. As non-clinician researchers, we explained that we provided no clinical services or advice. However, sometimes we advocated for the family or provided non-clinical support, such as in providing water or comfort

during birth. In the interest of confidentiality and anonymity, I use pseudonyms to refer to people throughout this article.

My positionality in this research project is critical to the knowledge generated through it. Being a White foreigner in a post-colonial context certainly shaped the way participants interacted with me and the relationships I developed with different groups of research participants. This also facilitated my access to spaces which may have been closed to me in other contexts. Health service providers carry ideas of what childbirth is like in what they referred to as 'my country', and likely also associated my foreignness with the foreign development initiatives they were charged with carrying forward. This likely influenced the ways in which they provided health services in my presence, although this effect appeared to wear off as I spent extensive time in these spaces.

In addition, prior to undertaking research for my doctoral studies, I worked as a health advisor to an NGO, and acted as a focal point person to a maternal health project in Bangladesh. Though I was primarily based in Geneva, I spent extensive time in Bangladesh within this capacity between 2012 and 2018. The transition from 'insider', working to implement international development initiatives, to 'outsider', as well as my previous experiences with international development work in the country, shaped how I generated data and how I interpreted it. Moreover, for the duration of my study I was hosted by icddr,b, an institution which has been recognised as a driving force of development in Bangladesh since the 1960s, when it was established as the Cholera Research Laboratory. Even in remote areas, people are familiar with icddr,b as the *Cholera Haspatal,* and my affiliation with icddr,b likely influenced the way health service providers and women associated me with particular ideas of 'development'.

In addition to my positionality, my research assistant's positionality also shaped this work. Tamanna is a junior anthropologist from Dhaka, and was affiliated with icddr,b too. This shaped how participants interacted with her, as well as her interpretations of our interactions in different settings, which in turn shaped mine. I remained attentive throughout this project to the ways in which our positionalities influenced our data generation, and my interpretations and analysis.

Narrating 'development'

Whether described as an 'aid lab' (Hossain 2017), or defined by the 'experimental exuberance' woven within its social fabric (Murphy 2017), Bangladesh has been noted for its vibrant landscape of social and economic models of development. Once characterised as a 'basket case', a label first used by an ambassador under Henry Kissinger and then used by Kissinger himself (Lewis 2011), it captures 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, 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). These initiatives built on a longstanding tradition of self-help and experimental exuberance (van Schendel 2021; Lewis 2011; Khan 1979; Murphy 2017). After the 1990's, the country effectively reinvented itself from 'basket case' to the 'golden child' of development, when it demonstrated unanticipated progress toward the Millennium Development Goals (MDGs) set out by the United Nations for 2015 (see e.g., Sen 2013; Chowdhury et al. 2013; United Nations 2015).

Far from being the only country in such a position, international development entities have figured prominently in its social and economic development landscape. While development aid has declined significantly over the past decades (van Schendel 2021; Khatun 2018), entities representing the ideological commitments of international development remain important within the country's social fabric. From the standpoint of health, these include multilateral organisations such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA), bi-lateral donors, notably the United States Agency for International Development (USAID) and the UK Foreign Commonwealth and Development Office (FDCO), as well as large international NGOs, including Save the Children and CARE International.

Well before the concept of 'development' as we know it today, women's bodies represented a key target of colonial, national and development interests and have been central to agendas and legitimation struggles in the region now comprising Bangladesh. Despite over a century of efforts to medicalise birth, traced back to colonial projects and sustained through development initiatives following decolonisation (Ram and Jolly 1998; Jolly 1998; Mukherjee 2017), transitions toward medicalised models of birth are relatively recent. 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). As late as 2004, quantitative figures suggested that over 90% of births occurred in domestic spaces (NIPORT 2005). By 2016, surveys suggested that nearly 50% of women gave birth institutionally, many through caesarean, which accounted for 63% of all institutional births (NIPORT, icddr,b, and MEASURE Evaluation 2019). With these recent shifts, birth has increasingly become a moment when women become entangled with not only the authority of biomedicine, but also within the competing authorities through which biomedicine operates, including the state and international development authorities.

In Bangladesh, one way in which international development actors engaging in health operate is by inserting large-scale projects into state health institutions, which is reserved for some of the most powerful and resource-rich organisations. Typically, these tend to be international NGOs, multinational organisations, donor organisations and research institutions primarily aligned with Western supranational development agendas, a corner of the development project which remains a critical force in shaping the maternal health service delivery terrain in Bangladesh by reshaping the public system.

These dynamics are embedded in the everyday health service realities of the public health system. During one visit to the district hospital, Tamanna and I chat with Mitha and Sharmina, two of the senior staff nurses (SSNs). We are standing in the buzzing nursing duty station, where health staff banter amongst themselves, write in registers, and occasionally answer questions when *rugir-lok* [the patient's party] ask questions. Mitha may be slightly older and more experienced than Sharmina. However, she demurs to Sharmina, who fills the room with boisterous laughter and slips into the role of public relations whenever the conversation turns to the different projects and initiatives that the labour and delivery room has served as a platform for, such as Kangaroo Mother Care, Helping Babies Breathe, the promotion of counselling health, and the promotion of delayed cord clamping. Today Tamanna and I are accompanied by two other icddr,b researchers who are collecting data for a delayed cord clamping intervention they plan to implement. Sharmina recites the scripts of these different projects by heart, raising her perfectly pencilled eyebrows at the right moments for emphasis.

Shapla *khala*[1]*,* one of the *ayas* (or helping hands) stands nearby. She is wearing a faded yellow *sari*, listening in on the conversation. Sharmina instructs her to show us the purple birthing ball Save the Children introduced to the hospital. The birthing ball is among the material artefacts that mark out the labour and delivery room as 'upgraded', supplied through an international development apparatus. This upgrade was a part of the Strengthening the National Midwifery Program (SNMP) project run by Save the Children, for which Kushtia was identified as one key site for its implementation. Shapla disappears momentarily, returning with the ball. Sharmina tells her to demonstrate how they instruct women to use it. After a moment's pause, Shapla sways her hips as she moves the large ball back and forth across her belly theatrically, causing us all to burst into laughter. Shapla smiles, revealing several missing teeth, and basks in the attention. While she is purposively comical, this interaction also hints at the birthing ball as an object which is not to be taken seriously in the delivery room. While proponents of birthing balls suggest several positions for its use to reduce pain during labour and facilitate

1 *Khala*, directly translating to 'maternal aunt', is the kinship term commonly used to refer to *ayas* and other support staff in addition to a term used to insinuate intimacy.

birth, including sitting on it, kneeling near and leaning on it, and squatting down with it, if used at all in the district hospital labour and delivery room it is generally rubbed across women's bellies. Daulotpur *upazila* health complex, which Save the Children selected as the *upazila*-level demonstration site, houses the other birthing ball they supplied to the district.

On rotation here this week, the young nursing interns mill around us in their olive-green uniforms, making them indistinguishable from the SSNs except for their youthful appearance. A couple of young women are dressed in the pink version of the uniform, materially setting them apart as midwifery interns. These interns are part of the broader initiative to introduce a new cadre of health workers explicitly dedicated to pregnancy, birth, and postnatal care, corresponding to the International Confederation of Midwives' (ICM) standards. Pink marks the initiative, it matches the pink of the Save the Children curtains in the room, and leverages pink as a symbolic representation of their organisation.

This cadre has been described as 'crucial for ensuring sexual and reproductive health and rights' in development narratives (Bdnews24 2018). According to these narratives, this cadre will 'save lives' and 'transform society as a whole' (Dhaka Tribune 2018), and is often framed as the silver bullet to reduce Bangladesh's embarrassingly high caesarean rate (see e.g., Masoom 2017), which rose from 12% of all births in 2010 to over 30% by 2016 (NIPORT, icddr,b, and MEASURE Evaluation 2019). The curriculum for building a cadre of midwives proposes a distinct philosophy, underpinned by the International Confederation of Midwives (ICM) 'Scope of Practice of the Midwife' (Bangladesh Nursing and Midwifery Council 2019,12). Giving birth in an 'upright position' is inscribed within this curriculum as part of the 'Fundamentals of Midwifery' (Bangladesh Nursing and Midwifery Council 2019, 47).

That the midwifery initiative is rooted in these international development agendas is a point neither missed by the other cadres of health staff nor the midwives themselves. While spearheaded by the Prime Minister of Bangladesh, health service providers tend to perceive the introduction of midwifery as a foreign project, with which they are all too familiar. While midwifery champions at the national level, such as BRAC University and Save the Children express concern with the integration of the new cadre, they tend to focus on the potential hurdles they face due to their young age, or that they may infringe on the responsibilities that the SSNs previously assumed, or that they must contend with the low value historically placed on those engaged in birth work (see e.g., Bogren, Begum, and Erlandsson 2017). However, in our discussions and interactions at the district hospital, the midwives in the Kushtia *upazila* health complexes did not specifically mention these as challenges. Instead, they mentioned the challenges of establishing

legitimacy based on their connection with a *bideshi* [foreign] project, which contributes to a sense of tenuousness that is not associated with other health professionals posted to the complex. This unease was made explicit by the following exchange with the midwives in one *upazila* health complex:

> Midwife one: They [the other *upazila* health complex staff] used to say that this [the midwife] post will close after a couple of days.
>
> Midwife two: No, we have to hear words like this.
>
> Interviewer: Why? Is this what people think?
>
> Midwife three: Yes, yes. People often think this about us, and it is challenging.
>
> Midwife two: Everybody says that it is a project. A *bideshi shongsta* [foreign organisation] most probably is helping to get it started, and it can close at any time.
>
> Interviewer: Okay, okay.
>
> Midwife three: Still, they say to us that it may just close at any given time.

This exchange illustrates prevailing differentiations that government health service providers make between 'state' and 'foreign'-run development, despite development actors' insistence on 'institutionalisation' and 'sustainability'. Among these health professionals, the state is imagined as providing the country's most reliable source of livelihood, imbued with a sense of permanence within a generally precarious space of maintaining livelihoods.

As a new project, the number of young women professionals entering the midwifery curriculum is limited to the number of government posts expected to become available by their graduation. So, the ratio of students to government postings is exceptionally high compared to all other cadres of health service professionals. The high likelihood of securing a government position after obtaining a diploma is intended to make midwifery a desirable health profession to pursue. However, this ostensible benefit is tainted by its precarity as a profession based on its association with international, foreign development interventions. In contrast to the imagined permanency of the state, development initiatives are imagined as infused with temporariness, which casts a shadow over the otherwise permanent sense of having a government job for the midwives. Their association with foreignness undermines their credibility within the broader public health system, as they are imagined as part of a 'project', likely to disappear at any time as projects are wont to do.

The logics guiding development-oriented practice tend to be distinct from state logics, particularly in postcolonial settings. International development logics suggest an ideology in which the development project moves 'traditional' people and societies linearly toward 'modernisation' and development (Pigg 1993; Gow 2008), representing 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). While these interventions tend to be masqueraded as technical, they seek to rectify what they perceive as suboptimal care in the public health system. Thereby, they assert claims over a 'deficient' state, as well as authority to intervene into people's lives and (re)shape the ways they 'behave'. It is within such a context that the agenda of promoting non-supine birth positions has been inscribed.

Laboni's labour: Contesting the birth position agenda

Beyond discourse, how are birthing agendas negotiated at the intersection of state and international development agendas? This section turns to these negotiations in the Kushtia District Hospital labour and delivery room, recounting the story of Laboni's labour. Laboni, a 22-year-old woman in labour with her first baby, enters the nursing duty station, one arm wrapped around her mother's neck, the other around her *nonod* [her husband's younger sister], while Tamanna and I chat with the SSNs. The young woman moans, throwing her head forward. Sharmina instructs them to enter the labour and delivery room. Mitha 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 hanging over a metal bar. Laboni's mother and her *nonod* help her lift her body onto the bed. Sharmina arrives, towering over everyone else in the room, and quickly performs the pelvic examination (PV). 'Five cm,' she announces as she strips off the gloves and throws them in a bucket. Laboni moans; I imagine this was a disappointing declaration for the young woman who had laboured all through the night. She instructs Laboni's attendants to return to walk with her in the corridors.

After a while, Laboni returns, trudging back toward the exercise ball, a midwife intern and her *nonod* close in tow. 'I do not feel good,' Laboni cries. 'I cannot take any more.' She moans as she vacillates the exercise 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 is calling from the district hospital's corridors, keeping a safe distance from this women-only space. He is worried about the bleeding that

Laboni experienced previously. He wants to take her somewhere else, to a private clinic. Just beyond the parameters of the district hospital, a jungle of private hospitals and clinics offer institutionalised birth services to women like Laboni, primarily through caesarean. ‘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 entirely normal.

Sharmina *apa* (sister) 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. On the cusp of the performance, the room is suddenly full of life. Four nursing interns and one midwife intern crowd around Laboni’s hips as Sharmina performs the PV again. Laboni suddenly grunts and bears down. The interns huddle in. Mitha *apa* unhooks one of the blue plastic aprons from the wall and ties it onto Sharmina’s neck and waist. Sharmina takes position at the bottom of Laboni’s bed, ready to catch the baby. Laboni’s mother stands at her head, stroking her long, well-oiled locks. Her *nonod* stands on the other side of her, gripping her hand.

Without warning, another woman whooshes in through the pink curtains. Her thick black hair is exposed, cascading down her back. She wears a brown-hued floral tunic, marking her as distinctly urban. She stands in the middle of the room, arms crossed as she scans the space. Sharmina catches sight of her and immediately stands at attention. The interns follow suit. Wide-eyed, Mitha *apa* discretely hooks the three-legged birthing stool stashed under the bed with her ankle. She slides it towards Laboni’s bed as imperceptibly as possible, perhaps to make it seem that it was there all along. The command that the woman engenders in this room, despite her youth, can only mean one thing: she is a doctor. Even Laboni’s attendants stand at attention, and only the labouring young woman seems incognisant of the palpable change. She moans each time a contraction seizes her uterus.

Within moments, SSNs, more nursing and midwifery interns add to the already packed room. The woman approaches Tamanna and me and asks who we are. We introduce ourselves. She nods and turns away. We soon learn that she is not just any doctor. This woman is Afsana *apu*, the Save the Children doctor responsible for capacity building in the Strengthening the National Midwifery Programme (SNMP) project in Kushtia. Afsana *apu* approaches Sharmina and Mitha. ‘Why is the *rugi* [patient], lying down?’ she asks as she points towards the poster of the Evidence-based Routine Care. She instructs that at no point should the woman be in the lithotomy position, not for labour nor delivery. The two SSNs stay silent.

Afsana instructs Sharmina to move the labouring woman to the reclining Save the Children bed. Laboni cries at the prospect of moving, but to no avail. Sharmina orders her mother and *nonod* to shift her off the bed. '*Apa',* says Sharmina, addressing Afsana, 'we tried to do the *counselling* (English cognate), we did so much *counselling*, but the patient still insisted on lying down'. Afsana *apu* pays her no regard and moves toward the poster in our direction. 'What are the components of evidence-based routine care?' she interrogates her captivated audience. The interns whisper amongst themselves, and then they call them out.

Meanwhile, Laboni's mother and *nonod* hoist her out of the static bed and assist her to the reclining bed, its back upright. She hobbles up the Save the Children three-step ladder onto the bed. Afsana *apu* positions herself at Laboni's pelvic floor, but at a safe distance, at least three feet from her. Laboni groans. The nursing and midwifery interns, approximately 12 of them, gather around. 'I feel like we are in a lecture hall', Tamanna whispers to me. 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. Afsana *apu* interchanges stern words, directed towards the SSNs and nursing interns, and softer words directed at the midwife interns.

Afsana *apu* returns to the side of the room with Laboni and her companions. She holds up her phone towards Laboni, scoots back to frame the angle, and snaps a couple of photos. She then moves toward the Evidence-based Routine Care poster again. All eyes follow her, with Laboni disappearing into the background, which I can only imagine feels like a relief. She places her index finger on point number three: 'Upright non-supine and non-lithotomy positions for labour and delivery'. 'We need to do the delivery according to the patient's choice, but we must not do lithotomy' [*Amader patient choice delivery korate hobe, kintu amar lithotomy korbo na*]', Afsana instructs. 'Nowadays, the monitoring is strict', she says, 'and we need to ensure non-lithotomy deliveries'. She glances towards Laboni when she groans again in the background and bears down. Sharmina glances toward her pelvic floor, but there is still no sign of crowning. Afsana *apu* approaches again, hands on her hips. Sharmina *apa* announces that she needs to go to the washroom. She tugs off the blue plastic apron and thrusts it toward Mitha *apa*. She pulls off her rubber gloves as she storms outside through the pink curtains. Mitha looks at the apron like it is a hot potato to be passed on as quickly as possible; she does not put it on.

Afsana *apu* orders no one in particular to shift Laboni to the stout birthing stool. But another SSN pushes it forward. Laboni's mother and *nonod* nudge her to manoeuvre back down the Save the Children ladder 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 closes her eyes and hangs

her head toward her right shoulder. A contraction seizes her stomach, pulling her from her respite. She screams out and bears down. As soon as the contraction passes, she leans her head on a shoulder and drifts off again until the next contraction pulls her awake.

Afsana *apu* complains to Mitha *apa* that the medical team failed to comply with the monitoring when her superiors visited. 'We tried to do good, *apa',* Mitha protests. 'Well', Afsana 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 well.'

Afsana then stands back and holds up her phone once again. I can see Laboni framed on her phone screen. *Click*, the screen flashes and Laboni's image, evidence of a non-supine position during labour, stands frozen in time. She says that yesterday she saw a Facebook post by another Save the Children staff member showing an image of a woman holding her baby just after birth. She instructs the room that they should not post photos like that. According to her, they should post photos like the one she just snapped of Laboni—photos during labour. Afsana looks at her and then shifts her gaze around the room.

'Where is Sharmina?' Afsana asks, 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?' Afsana demands. She scans the crowd. 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', Afsana 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.

Afsana *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. She adds that if she makes up her mind, she can do it. Laboni's eyes fix on her, delirious. Finally, Afsana instructs one of the midwifery interns to do a PV to check her cervix once again. 'Is she really fully dilated? Why is the baby not further down?' she asks. The midwife intern crouches down near Laboni's pelvis and performs the PV. After several seconds, she reveals her verdict: Laboni is eight centimetres dilated. The energy of the room deflates like a popped balloon. Afsana purses her lips. 'Why were they trying to get her to push?', the young doctor asks. No one answers.

Without saying goodbye, Afsana exits through the pink curtains, a procession of SSNs, nurse interns and midwifery interns trailing behind her, leaving the room nearly empty. Only a couple of young nursing interns, Laboni and her companions,

Tamanna, and I 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 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 birthing ball.

We can hear Afsana talk to the SSNs and interns in the nursing duty station. 'They need to be more careful about the monitoring', she says. The preoccupation with 'monitoring' that Afsana refers to may indeed have very real consequences for people like her, a point to which I will return to in the following section. While government health service providers enjoy job security, expecting to maintain their post until retirement and benefit from a pension thereafter, those working in development, whether domestic or international, cannot expect the same. Those working for international development entities may benefit from higher salaries; however, their employment is precarious, and dependant on donor commitment to projects. Their job performance often relies on their ability to demonstrate the achievement of numerical targets and impact, an illusory control over the broader social worlds in which their influence can only reach so far. In this case, Afsana *apu's* influence reaches as far as her ability to reshape the practices of health service provider teams when her supervisors visit, and to ensure that they produce the numerical values she relies on.

Laboni sits on the stool, crying. 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 Afsana clear from the premises, Sharmina 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.'

A doctor intern breaks through the curtains almost as if on cue, wearing a white medical jacket. She chatters into her phone without looking at Laboni. Finally, she hangs up and faces Sharmina. Sharmina explains that the patient'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 would 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 and 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 retail 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 least eight centimetres dilated.

The room feels tragically empty, with only Tamanna and I remaining with Sharmina and one of the midwife interns. Sharmina holds her head high. '*Apa.* Did you see what that madame did?' she says, referring to Afsana 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 patient would have delivered by this time. But she would not let me give the saline, and she was scolding me, and that is why the patient left.' The proudness of her voice is a superficial cover for her humiliation.

She 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 do not have anything to do with them. I did not want to do her deliveries, so I just left.' The midwife blushes, stammering something about how she was just trying to learn, but I am sure Sharmina's comment struck a nerve with her; 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 she gave birth vaginally or through caesarean, or how she and her baby fared. However, if Laboni is like the majority of my interlocutors and research participants, the question of the birth position was unlikely to be at the forefront of her mind when she and her family arrived at the district hospital. Women and families I engaged with would often discuss the desire to avert risk when articulating decisions to seek institutional care at the time of birth. While many still stayed at home to give birth, or expressed an intention to try at home, there was a broad inclination to seek institutional birth services if there was any problem, as biomedical care was often imagined as able to provide an answer, particularly in the form of caesarean birth. Given such considerations, and against the backdrop of prevailing hierarchies within these institutions, the question of birth position did not figure among the other birth considerations of women, primarily the mode of birth, i.e., by caesarean or vaginal.

However, the above account demonstrates the extent to which birthing positions have become imbued with ideological meaning within public health spaces in Kushtia. Rather than expanding women's agency, or obstetric justice, the birth position becomes an ideological space of contestation when enacted through international development logics. Through this space, claims about how women should give birth are staked or resisted, not by women, but by state and development actors. Women are rendered peripheral through these enactments, in which broader agendas are contested. Rather than an antidote to the patriarchal institutions infused in medicalised childbirth, the birthing position is reduced to a technology to further extend medicalisation.

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

Development entities depend on women’s correct ‘behaviour’ to demonstrate the viability of their actions and justify their very *raison d’ être*. Indeed, while ‘empowerment’ remains one of the most popular development buzzwords globally and in Bangladesh, this idea is almost without exception to empower people 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 to conduct their actions toward an appropriate end’ (Cruikshank 1999, 68–69). In Laboni’s case, this conduct was narrowly defined in the intervention 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 an exhausting labour. Much anthropological scholarship has been dedicated to demonstrating the ways corporate-mindedness has infused global health and international development (Adams 2013, 2016). 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 market-based ideologies (Strathern 2000). Therefore, development actors are under immense pressure to quantify their ‘impact’ in their influence zones (Adams 2016; Fan and Uretsky 2017). One way this ‘impact’ is demonstrated is by quantifying women’s behaviour. This preoccupation with measuring and monitoring justifies the intervention into some of the most intimate spheres of women’s lives in Bangladesh, where entire infrastructures have been established to measure women’s reproductive behaviour (Murphy 2017). Under pressure to produce metrics, women’s bodies themselves become metricised within the projects of development.

The case of promoting non-supine birth positions is a manifestation of how intimate the intrusion of development entities can be. The Kushtia Civil Surgeon’s office and each of the *upazila* health complexes are equipped with a large pink board presenting the National Midwifery Programme indicators. The ‘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 somehow failed; failed to conform to her expectations, and failed to represent a successful vaginal birth within this development agenda.

In this setting, the agenda of promoting non-supine birth positions maps the physical positionality of women’s bodies when they are subsumed by the broader

logics steering development imaginaries. In the Kushtia ‘upgraded’ labour and delivery room, women are imagined as inappropriately physically positioned during labour and birth, in contrast with colourful posters standing as markers of how women’s bodies should be appropriately positioned. 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 a woman-centred birthing practice. However, in these settings, non-supine positions are stripped of their reclaiming appeal, as they are rendered as a 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 as evidence of the success of the development project, not as a remedy to the medicalisation of childbirth, but rather a new manifestation of it.

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 exercise ball, this centre boasts a birthing chair (see Figure 3). 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.

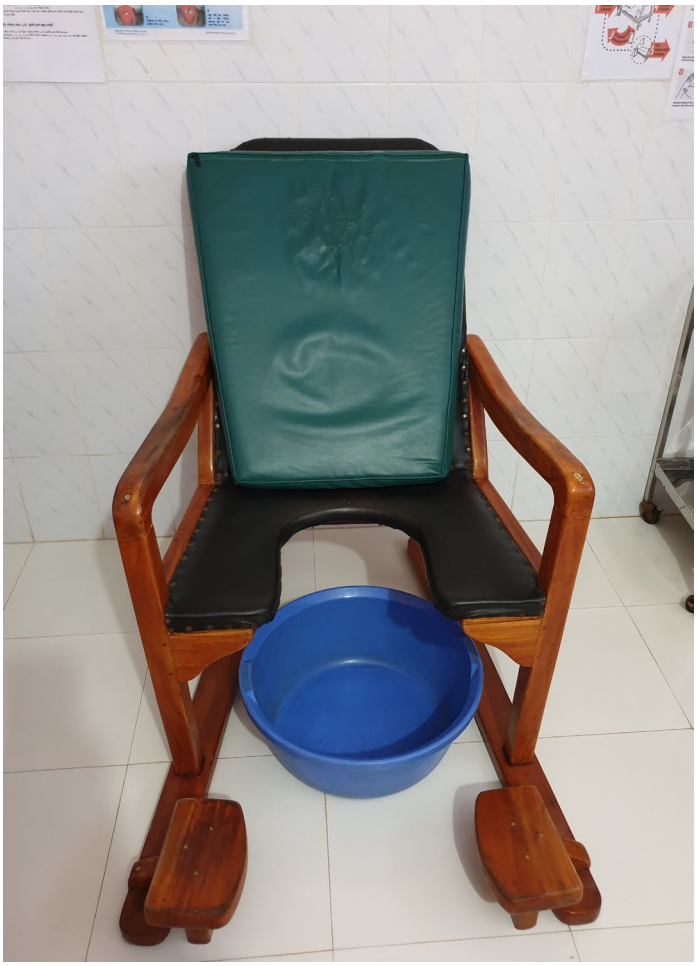

Figure 3. Birthing chair used in the midwifery-led centre in Sylhet, Bangladesh. Image by the author, 2020.

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 figures demonstrating the key measures of success of the midwifery-led care centre. The usual suspects are there; the number of antenatal care (ANC) visits (between 136 and 320 per month), and the number of deliveries (31 to 102 per month). However, the third figure 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 the 'lithotomy' position. The project manager beams as he presents this figure, a key indicator of success, their fruitful enforcement of one position for birth over another. The very physical positionality of women's bodies is metricised, and women's bodies are manoeuvred in specific ways to yield desired metrics. This suggests that 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 moral claims, and less the women, whose bodies are contorted to conform with project metric categories.

Back in the Kushtia district hospital, the adoption of the lithotomy position during birth is the norm. Despite the imposing poster on the wall and other efforts to promote a non-lithotomy position, in my experience, except for the moments when Afsana *apu* appears, health service providers do not encourage or propose a different position. On the other hand, neither do women. Moreover, while the latest evidence-based recommendations of the WHO promote the encouragement of women to adopt labour and birthing positions of their choice under the banner of 'empowerment' and 'choice' at the time of birth (WHO 2018), these discourses conceal the politics, power, and realities that women confront when giving birth in institutional spaces.

Hospital staff, such as Sharmina and Mitha, are well versed in the initiatives and eagerly pay lip-service to them when required. In practice, however, they soon betray their own opinion in the moment these sites become spaces for SSNs to contest these external demands. Health service providers on the ground implementing interventions rendered technical can claim a blissful ignorance of the political aspects at play (Li 2007, 7–12). Admittedly, the SSNs staffing government health spaces navigate these initiatives creatively, often evidenced in the ways they resist them. Despite Afsana *apu's* insistence on rigour in monitoring, the SSNs do not precisely track the position women such as Laboni finally assume to give birth. Instead, nurses estimate the number of women who give birth in a non-lithotomy position each month, numbers which are then sent through the parallel state and development chains of information to support the legitimation and justification of their active projects.

Conclusion

The natural childbirth movement in which the birth position of choice is embedded remains relevant today, with the goal to expand reproductive and obstetric justice, as it seeks to expand women's autonomy over their bodies and experiences during birth (Davis 2019b, 2019a; Bridges 2011). Feminists and scholars advocating for women to determine their position of choice during birth imagined this as an emancipatory initiative, designed to allow women to wrest control of their birthing experiences from the patriarchy inherent in medicalised childbirth. However, we must be cautious when expanding these logics to specific contexts. Transitions toward biomedicalisation of childbirth in Bangladesh are not analogous to the trajectories that played out in other parts of the world, nor are the historical contexts, or people's relationships to and with institutions.

This article has explored this initiative of promoting birth position choices through its inscription in international development projects in Bangladesh. In this context, the promotion of non-supine positions during birth has been adopted as an ‘intervention’ by large and powerful international development actors, an example of what Sreeparna Chattopadhyay (2022) refers to as the ‘instrumentalization of women’s health’ in her work in obstetric spaces in India.

While well-intentioned, when subsumed by international development logics, the birth position is rendered technical, and the ‘position of choice’ becomes the more easily measurable ‘non-supine position’. Rather than a ‘return’ to more ‘natural’ forms of birth, non-supine birth positions are paradoxically mapped onto biomedical models of birth and broadly conceived of as ‘foreign’. It thereby loses it emancipatory appeal as it becomes bounded in the terms of development logics, and through the enforcement necessary to generate metric forms to justify development initiatives.

Within these imaginaries, demonstrating the interventions’ effect in the form of metrics becomes crucial. Scholars including Adrienne Strong (2020) and Adeola Oni-Orison (2016) have explored the pressures to demonstrate quantifiably discernible improvements in maternal health at the national level, embedded within the UN’s Millennium Development Goals (MDGs) and later Sustainable Development Goals (SDGs) through documentation practices and systems of accountability. These scholars have illustrated the ways in which efforts to display ‘improvement’ and adherence to these expectations have resulted in harm to women. While I would not go so far as to suggest that the imperative to reshape women’s birth positions necessarily harms women, I would argue that international development interests, and the requirement for a metric demonstration of intervention success, run parallel to the interests of birthing women.

While proponents of non-supine birth positions envisaged this as a return to a more natural and physiologically conducive way of giving birth, in Bangladesh it has become associated with ideas of ‘the foreign’ and inscribed in, rather than imagined as a reaction to, medicalised childbirth. Instead of liberating women, the instrumentalisation of a particular ‘birth position’ in this context operates not to undo the medicalisation of childbirth, but rather to reshape and expand the very medicalisation it sought to dismantle.

Authorship statement

This article is the sole work of the author.

Ethics statement

I obtained institutional ethical approval for this project through the School of Social and Political Science at the University of Edinburgh (received on 29 April 2019) and the in-county ethical review committee of the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b), a Dhaka-based public health research centre (received on 13 November 2019).

Acknowledgements

This project was only possible thanks to a great number of collaborators who shaped my thinking and supported and participated in my data generation process. I would like to acknowledge Jeevan Sharma and Lucy Lowe for their support and guidance throughout the project and providing feedback on this manuscript. I would also like to acknowledge my research assistant Tamanna Majid, for her dedicated and tireless assistance and valuable insights, and Dr Ahmed Ehsanur Rahman of icddr,b, for integrating me on his team, facilitating access, and providing feedback on this manuscript and assistance in Bangla language editing. I also thank two anonymous reviewers for their detailed and thoughtful insights. Finally, I would like to acknowledge all of the women who welcomed me into their lives and allowed me to share in the birth stories. This project received financial support from the Tweedie Exploration Fellowship grant at the University of Edinburgh.

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