DELIVERING THE STATE: State-Making through Maternal Health "Care" in Bangladeshi Public Maternal Health Spaces

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Rima lies in a fetal position, her knees pulled to her chest on the medical bed next to the window of the capacious labor and delivery room at Kushtia District public hospital, located in the west of Bangladesh. Her mother stands by her side, rubs her daughter's back, and chats with me and my research assistant, Tamanna, surprisingly energetic despite a previous sleepless night. Rima's labor pain started three days earlier, although her water broke only yesterday evening. The family had sent for a *dai*, a traditional birth attendant, to support Rima's birth at the family's village home. Unsatisfied with the progress of her labor and fearful, since Rima's previous and first pregnancy ended with the loss of the baby at six months' gestation, the *dai* instructed her family to take her to the government district hospital.

Rima's family, still haunted by the loss of the first baby, heeded the advice and brought her to the hospital in the morning, with all their hopes of the saving power of biomedicine and the promises of the state wrapped up in this institution. In passing through its entry gate (see Figure 1) they crossed a vital threshold shaping the forms that Rima's birth care would take, from care shaped by the intimacy of a domestic space and enacted primarily by female household

CULTURAL ANTHROPOLOGY, Vol. 40, Issue 2, pp. 328–353, ISSN 0886-7356, online ISSN 1548-1360. Cultural Anthropology *is the journal of the Society of Cultural Anthropology, a section of the American Anthropological Association.* Cultural Anthropology *journal content published since 2014 is freely available to download, save, reproduce, and transmit for noncommercial, scholarly, and educational purposes under the Creative Commons BY-NC 4.0 license. Reproduction and transmission of journal content for the above purposes should credit the author and original source. DOI: 10.14506/ca40.2.06*

Figure 1. Entry gate of the Kushtia district hospital. Photo by Janet Perkins.

members and close ones, to care delivered in a very much public space, shaped by what it means to be the "state" (*shorkar*).

Within anthropology, care operates as rich and contested theoretical territory, with much debate residing in the space between what we think care ought to look like in health service delivery settings juxtaposed with what care looks like in the ethnographic encounter. When addressing childbirth care, much of this scholarship stakes its footing in obstetric violence discourses, which also holds ground in global health policy and programming, suggesting that not only is institutionally-delivered maternal health care often uncaring but that it also crosses over the threshold into violence—manifesting, for example, as neglect, disrespect, and non-consensual overuse of biomedical technologies (see, e.g., Chadwick 2023; van der Waal et al. 2023; Davis 2019; Bowser and Hill 2010; Bohren et al. 2015).

In contrast, other social science scholars have considered how practices that, from an outside perspective, may appear as uncaring—for example, yelling at a patient, withholding information, or failing to obtain informed consent for procedures—counterintuitively function as demonstrations of care when situated in a social and cultural context (Strong 2020; Brown 2010; Livingston 2012). This big umbrella approach to care—that is to say, categorizing practices as care "despite our moral intuitions to the contrary" (McKearney 2020,

223)—has become common enough that Patrick McKearney (2020) refers to it as the "dominant trope" in anthropology.

This article suggests that both camps are insufficient for capturing the contours of maternal health care in Bangladeshi public health settings, often characterized as "uncaring." Rather, making sense of enactments of care in these settings requires considering how particular enactments of care are constitutive of everyday state-making (Sharma and Gupta 2009). As anthropologists have observed, despite appearances, the state is not a monolithic thing, but rather, as Paul Nadasdy (2003, 4) describes, "an ideological project, one that confers legitimacy upon the complex constellation of government institutions and processes that have many different (and often contradictory) agendas and interests." Public health settings operate as one space within this constellation, wherein the state as a project is enacted, experienced, and constituted. The specificities of care enacted here must be understood as extending beyond biomedical encounters, shaping and shaped by ideological state-making projects.

Over the past two decades, birth care in Bangladesh has shifted dramatically toward institutional spaces. In 2004, giving birth institutionally in Bangladesh was exceptional, as fewer than one in ten women ventured to a biomedical institution to give birth. Less than two decades later, this figure skyrocketed to 65 percent (National Institute of Population Research and Training and ICF 2023). While both public and private facilities deliver biomedical maternal health technologies and services, the public sector operates as an important point of contact within many women's maternal biomedical journeys where they seek care during pregnancy and as a reference point for imagining health services delivered through the state, *shorkari*, and through private facilities, suggestively referred to as *beshorkari*, "not state." Public maternity spaces in Bangladesh operate as among those, as Michel-Rolph Trouillot (2001, 126) suggests, in which state "processes and practices [become] recognizable through their effects." 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 state and who they are in relation to it (Sharma and Gupta 2009, 11). This article contends that the idea of the state is not tangential to how care is conceptualized and enacted in these settings, but rather fundamental to it.

Drawing inspiration from Joanna Cook and Catherine Trundle (2020), I attempt to move past conceptualizations of health care delivery in public maternal health spaces as somehow "tainted or absent" or an appeal to the "evaluative reversal" McKearney cautions against, toward an "ethnographic consideration of

the ongoing and morally ambiguous practices with which actors strive to grapple, achieve, or, indeed, curtail" (Cook and Trundle 2020, 180). Based on ethnographic fieldwork I carried out in Dhaka, the capital of Bangladesh, and Kushtia District between September 2019 and March 2021, this article tends to the nuanced conceptualizations and enactments of care in Bangladeshi public health settings, sensitive to the varying shapes and meanings they take, and, in particular, to how they map onto ideological projects of state making. During fieldwork, I engaged in participant observation and conducted interviews in maternal health settings, including in maternal health policymaking and programming circles in Dhaka and government and private facilities in Kushtia. With my research assistant, Tamanna, I spent time in Kushtia with women and health service providers in antenatal care service points, labor and delivery rooms, and operating theaters, as well as in their homes. Through these encounters, the "morally ambiguous practices" of maternal health care came into view.

This article illuminates the nuances of maternal health care, paying attention to its distinctive conceptualizations as foundational to understanding the unfoldings of care and the socialities constituted through these peculiar unfoldings. I do this by illuminating coexisting conceptualizations of care in Kushtia: *jotno* as the personal and intimate labor involved in forging kinship ties, and *sheba*, service-related labor. I argue that rather than being uncaring, health care delivered by providers in public maternal settings is structured by state-oriented imperatives to provide "services" (*sheba*), though not necessarily intimate care (*jotno*) to non-state heath service recipients. Enactments of care that unfold in these spaces map onto and reify broader imaginaries of the Bangladeshi state as an entity separate from the people it is designed to serve and underpinned by a sense of bureaucratic indifference. These enactments of care are naturalized as state processes, and transcendence is imagined as possible through the *beshorkari*, services provided outside of state structures.

CONCEPTUALIZING CARE: Sheba and Jotno

Biomedical discourses use the term care extensively, pairing it with *health* to generate the uncontested term *health care*. Of course, care encompasses much more than biomedicine. Arthur Kleinman (2007) reminds us that care has little to do with medicine and suggests that care is foundational to what it means to be human. Other scholars, demonstrating kinship as socially produced rather than rooted in biology (Carsten 2003, 2000), describe care as constitutive of kinship and relatedness (Ringsted 2004; Weismantel 1995). Erdmute Alber and Heike

Figure 2. Kushtia District Hospital labor and delivery room. Photo by Janet Perkins.

Drotbohm (2015, 2) push this understanding further, suggesting that care "not only connects kinsmen, and friends, neighbors and communities, but also collectivities such as states and nations."

Care is achieved through enactment. In her examination of diabetes care, Annemarie Mol demonstrates care as made through the social and relational practices of and between bodies that act. For, she and John Law tell us, we not only *know* and *are* bodies, we also *do* bodies. In enactments of care, bodies both act, and are enacted on (Mol and Law 2004; see also Mol 2008). Through care enactments, entities and phenomena come into being (or not), not only health conditions but also kinship and, as this article will argue, the state and people's relationship to it.

To understand care as practice that constitutes the state, it is helpful to disentangle coexisting notions of these practices in Bangladesh. When discussing maternal health care, my interlocutors often appealed to two coexisting conceptualizations of care. One way care was conceptualized was as *jotno*. In Kushtia, the women I engaged with spoke of *jotno* as the support they provided to their families and children, consistent with care that fosters kinship (Weismantel 1995). *Jotno* was associated with intimate practices that encompass attention and

concern. In their narratives of their encounters with biomedical institutions, it was sometimes evoked to describe care they experienced from health staff when seeking maternal health services, though more often used when describing experiences in the *beshorkari* sector.

However, *jotno* was not the only concept of care emerging among my interlocutors in Kushtia. Within the public health sector, the term *sheba*, which more closely corresponds to the English term "service," is privileged over *jotno*. In official policy discourse, the term *sheba* is paired with *shastyo*, health, for *shastyo 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 labor in which they engage. When public health service providers discussed their work, they framed their responsibilities almost exclusively in terms of providing *sheba*.

Both aspiring and seasoned nurses articulated the desire to provide *sheba* as a motivation for securing a job in the public health sector. One of my visits to the district-level Family Planning facility in Kushtia coincided with the clinical rotation of the batch of third-year nursing trainees from the Kushtia Nursing Institute. The energy of the dozen young women, dressed in matching green uniforms and pursuing their ambitions, bubbled in the antenatal care room. In the afternoon, when the room grew quiet, I chatted with them and asked them about their motivations to train as nurses. Their responses varied little; they were all enthusiastic about the possibility nursing training offered for obtaining a highly desired government job. A few said they might consider working in a private facility to earn income after completion, 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 explained, they would enjoy a reliable livelihood and earn more than they would in the private sector, thus benefiting their families more fully.

The significance of the potential for securing a government job cannot be overstated in this context. Bangladeshi livelihoods tend to be marked by a sense of precarity, except for those who manage to secure a government job (*shorkari chakri*) (see also Perkins 2024). Government jobs are seen as secure: it is practically unheard of to lose government employment, at the end of which one receives a pension for retirement. The focus on *sheba* can be read within the imaginary of the state institutions animated by civil servants enjoying a *shorkari chakri*, a government job, associated with performing *sheba* across state institutions and

agencies. Many people, particularly those coming from villages, see government work as the best opportunity to gain a solid foothold in middle-class status and maintain a reliable livelihood. These livelihoods benefit not only the person holding the government position but also their families. Thus many parents aspire to have their children obtain a government position, and these young women felt the weight of these aspirations.

Entry into government employment through the health sector is seen not only as facilitating economic security but also as a way to do so morally, which renders it a particularly desirable way to enter government service. Indeed, the second shared motivation of the young women was 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*), whom they considered unaware (*oshocheton*) of how to be healthy. The young women aspiring to health service delivery imagined the nursing profession as a gateway to satisfy an economic imperative to secure a stable livelihood and contribute financially to their family. Simultaneously, it would allow them to fulfill 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. Indeed, rather than servicing a general citizenship, public health services in Kushtia are imagined to serve the category of *gorib manush*. This category is discursively sustained by government health service providers, as well as public health service users, who often explained to me that they had gone to a public health facility because they were *gorib*.

While seasoned nurses seemed more jaded, they shared similar accounts guiding them to pursue the nursing profession and evoked religious motivations. Senior staff nurses (SSNs) articulated that, as nurses, if you provide good service, then people will bless you (*doya korte*). In Islam, these blessings from others result in benefits in this life and the afterlife, where they help one pass into heaven. According to one SSN, through providing *sheba* in the profession, people to whom you provide *sheba* give you blessings in turn; or, as she put it, "We get blessings [on our behalf] just like that [i.e., without additional effort]." For government health providers, delivering *sheba* constitutes the moral core of their professional obligations.

While these articulations of *sheba* illuminate its moral underpinnings as something good that one does, *sheba* does not require the intimate, kinship-oriented engagement entailed by *jotno*. Indeed, *sheba* takes on particular meanings within government settings, connecting the constellation of bureaucratic and

administrative work throughout dispersed government institutions. 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. Therefore, in these moments, people learn what the state is and what it means to interface with this entity. In government settings, *sheba* is enacted through bureaucratic practice, without expectations that *sheba* be coupled with the intimacy of care recognizable 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, 3). The postcolonial Bangladeshi state differs from the Eurocentric states considered by Herzfeld, and is hardly imagined as a beacon of human rights, most recently brought into relief in the violent use of state force to quell what started as peaceful protests against the government job quota reform (Corea and Erum 2024). Still, the concept of bureaucratic indifference proves useful in everyday encounters with the state in Bangladesh, as does Herzfeld's argument that bureaucratic practice generates indifference.

Sheba lies at the core of bureaucratic practice and everyday encounters with the state, including in public health service encounters. In most bureaucratic functions, my interlocutors did not expect *sheba* to be paired with *jotno*, or otherwise intimate care, allowing indifference to permeate these processes and enactments. While one might expect the interactions in health settings to differ (as development actors do), they often unfold as consistent with the bureaucratic practice of perfunctory *sheba*, a corporeal performance of indifference. While *sheba* does not foreclose the possibility of sentimentality, it fosters possibilities for indifference that *jotno* does not. These enactments of care play out in the labor and delivery room in care enactments in Kushtia, as health service providers deliver *sheba*, while kin provides *jotno* to birthing women.

ENACTING *SHEBA* AND *JOTNO* IN GOVERNMENT HOSPITALS

How do enactments of maternal health care unfold in the labor and delivery room of the Kushtia District Hospital? This section returns to the birth encounter of Rima, introduced at the beginning of this article, as a typical birth encounter in the district hospital labor and delivery room. Rima is between

twenty and twenty-two years old, her anxious mother tells Tamanna and me as she kneads her daughter's lower back. Rima tells us that she is worried; the last time she felt the baby move was before she arrived here at 7 a.m. "The baby is not moving; what should we do?" Rima's mother asks us, her eyebrows stitched. I look around the room, bereft of health service providers. Several SSNs giggle on the other side of the curtain thinly veiling the labor and delivery room from the nurses' duty station—aware of but unfazed by Rima and her family's worry.

Asmani, a middle-aged SSN, enters and approaches the mother and daughter. Rima's mother asks whether the young woman can have a *shejar* (cesarean section)—the outcome they both desire and the primary reason for coming to the district hospital where they might access it at a lower cost than a private facility. "Have you arranged blood?" the nurse asks. No, the mother admits. Then, there is no way to do the *shejar*, Asmani tells her.

Rima's mother holds a bottle of water to the young woman's mouth. When Rima finishes drinking, her 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, in hopes the hospital staff will thereafter approve the cesarean they all desire. Blood transfusion can be a life-saving procedure for hemorrhage. However, stocks of impersonal blood stored at health facilities are uncommon in even the best-equipped hospitals. The task of locating blood falls to the family, who leverage social networks to identify a person whose blood matches to contribute the life-saving corporeal substance.

Afroza, a physician intern, whooshes in. With a doctor here for rounds, laboring women flood the room. The intern weaves toward Rima, prostrate on the bed, her mother stroking her hair. Without addressing the young woman, she approaches to perform a pervaginal examination (PV), or pelvic exam. In protest, the young woman clamps her knees together, eventually using the force of her tiny, clenched legs to push Afroza backward. On the adjacent examination table, a nurse performs a PV on another woman, touching her only to check her cervix with a gloved hand. "I am breaking the water," she announces to no one in particular. The nurse inserts the metal hook into her vaginal canal and quickly jumps back out of the line of fire, avoiding the spray of amniotic fluid.

Afroza moves on. Asmani shakes her head. "Be soft," she urges. "If you do not allow me [to do the PV]," she threatens, "I will discharge you [*chuti diye debo*]." Shahanaj *khala* (honorific which denotes aunt), a *dai*-turned-*aya* (helping

hand) of the hospital, works to pry Rima's knees open just enough for Asmani to check her cervix, with success. "Ten centimeters," the SSN announces. Rima's cervix is fully dilated; now she just needs to push.

Rima's mother's face is anguished as she exits the room to liaise with the *rugir-lok*. The other laboring women, cervixes checked, rearrange their petticoats and evacuate the room to pace the hospital corridors. Rima creeps toward the entryway. A thin man with a short, white beard appears through the curtains. "Let's go, let's get out of here," Rima begs the man, her father.

"Where will we go?" he scowls. They both know that outside the public hospital, a vast private market offers any number of refuges. It is common for women in the labor room of the district hospital to surreptitiously disappear with their *rugir-lok*, without a word to the health service providers, who shrug off these disappearances. However, since Rima's family traveled to the district administrative center, any of these private hospitals and clinics will be much more expensive than those near their village. "We are *gorib manush* [poor people]," he says, disappearing through the curtains. Rima hovers near the entryway for a moment. She glances toward us again, then absconds through the pink into the nurses' duty station.

In the station, Asmani sits at the desk over one of many oversized registers. She squints behind her glasses, flips through pages, jots notes. Rima's mother, father, young husband, a couple of related older women and young men stand respectfully in front of her. Rima's father tells her that the family has successfully arranged a blood donor and asks whether the nurse can now arrange the *shejar*. Eyes still glued to the register, she says it will take some more time before the doctor decides whether to do a *shejar*.

Rima cries out and begs her family to take her away. "I will not stay here!" she wails. Asmani ignores her and turns pages and scribbles notes in the register. Shahanaj *khala* takes hold of Rima and steers her back to the delivery room. After several minutes, Asmani returns to the labor and delivery room and approaches Rima. She then pushes her knees back, revealing her pelvic floor. Her mother stands next to her daughter's head and gives her some water from a repurposed Sprite bottle. She holds her daughter's hand. Asmani presses her fingers inside Rima's vaginal canal.

Suddenly, Rima moans, gripped by a contraction. Asmani positions herself below Rima's hips. "Push!" she urges. Rima bears down. She passes stool in the process, and feces 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 odor to a notoriously foul-smelling animal. "You are the one delivering the baby," complains Asmani to Rima, "but our souls are coming out." The baby's head protrudes visibly from Rima's pelvis with the next push.

All eyes are on Rima. A woman from the nearby laboring woman's *rugir-lok* recites *surah* passages from the Quran on Rima's behalf. "Push . . . push," Asmani coaxes. Rima bears down while her mother strokes her hair. Five minutes pass, and a small moon of thick, dark baby hair appears. Rima pushes diligently with each contraction. Five minutes pass, then ten, fifteen. The medical staff deliberate: Should they perform a much-dreaded episiotomy? One of the SSNs prepares the scissors and holds them dangerously close to Rima's perineum. Under this threat, Rima heaves. The baby's head, then body slide into Asmani's hands. She promptly places the newborn girl on her mother's belly. I hold my breath as the seconds tick by—fifteen, then thirty. Finally, the baby musters a weak cry. With the baby born, and alive at that, relief floods the room.

Rima's family exhibited more exasperation than many of the *rugir-lok* in trying to achieve the desired birth, in this case, a low-cost cesarean section, compared to the more expensive procedure outside in a private facility. When this service was foreclosed, they became desperate for her to give birth vaginally. Rima's birth experience in the district hospital was otherwise unexceptional and illustrative of typical encounters that unfold in the Kushtia district hospital labor and delivery room. These encounters are structured by coexisting conceptualizations of care, ideas of how and by whom these forms of care should be delivered, and the nature of relationships that proceed from the work of caring. Delineations between *sheba* and *jotno* figure centrally within this social world of care at the hands of the state. Launching from Rima's birth encounter, the following section will illuminate how these forms of care, and the boundaries between them, emerge through embodied enactments.

INTIMACY, THE MANAGEMENT OF SUBSTANCES, AND PAPERWORK

As mentioned, *jotno* encompasses the intimate care constitutive of kinship bonds. Care enacted as *jotno* is personalized, hands-on, and supportive. *Jotno* is rooted in relational labor. In the labor and delivery room, laboring women were, almost without exception, accompanied by one or several female family members, often a mother, as Rima was, but also by mothers-in-law, sisters, and

sisters-in-law. These women attendants maintain close physical proximity to the birthing woman and enact *jotno* through massage, holding the laboring woman's hand, stroking her hair, massaging oil into her locks, untying and retying the woman's hair in and out of a bun, and fanning the laboring woman with banana leaf fans. *Jotno* by the patient's party subsumes providing physical support to women's laboring bodies as they pace to spur labor or make their way up and down from beds as instructed by the health service providers. It also entails encouragement and often comforting words, sometimes enacted in reciting Quranic verses. It involves nourishment, primarily by giving water. It is rare to see a public health service provider enact the intimate work of *jotno* in the labor and delivery room.

In contrast to *jotno*, the embodied enactments of *sheba* tend to be mediated through the materiality of biomedical technologies. It often consists of using technologies to foray *into* the body, the insertion of cannulas to introduce oxytocin-infused saline into the bloodstream to speed up labor, or a metal hook into the vaginal canal to rupture the amniotic sac. Occasionally, though not routinely, *sheba* entails an incision of the perineum for an episiotomy, a contested feature of medicalized birth, when the nurses see fit. It comprises suturing this cut or, more often, perineal tears, generally sans local anesthetic. The performance of PVs—vaginal examinations to check the dilation of the cervix, another contested practice of medicalized childbirth (Moncrieff et al. 2022; Shabot 2021; Kitzinger 2005)—is a routine feature of health service providers' performance of *sheba*. Although these examinations are not mediated through material technologies like many other *sheba* practices, they are mediated by latex gloves purchased and provided by the patient's party, which maintain physical boundaries. Laboring women flock to the labor and delivery room when doctors or nurses decide to perform PVs according to the service providers' schedules. *Sheba* is deliberate, punctual, and typically enacted according to the health service providers' timetables. Physical touch is curtailed to the most limited type. Health staff rarely refer to women by name or honorifics such as *apa* (sister).

The management of bodily substances, historically considered polluting in South Asia, features centrally in the boundary work between *sheba* and *jotno*. The preoccupation with the containment and avoidance of bodily pollution, long central to ideas around birth in the subcontinent (Jeffery, Jeffery, and Lyon 1989; Mukherjee 2017; Rozario 1998, 1992), 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 patient bodies, the margins of which are located at the fleshy boundaries of human bodies. Douglas (2003, 122) contends that margins are always dangerous, as this is where the structure of ideas is at its most vulnerable. At the margins of human bodies, pollution threatens distinctions between the state and non-state bodies.

No one among the health staff demonstrates comfort in managing the various bodily excretions inherent to the birthing experience—urine, vomit, blood, fecal matter, amniotic fluid—regardless of job title, religion, class, or marital status. It is not uncommon for hospital staff to deride or scold a laboring 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 emissions onto *rugir-lok* and deride patients for their pollution.

Indeed, all categories of hospital staff—doctors, nurses, and *ayas* alike—exhibit an aversion to bodily substances, despite the immanence of these very substances to their professional work. The enactment of this avoidance indexes hierarchical divisions: the protection of doctors from contact with pollutants is prioritized, 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, they tend to pass this off to *rugir-lok* and hand them mops, bedpans, and cloths to do the work. *Ayas* tend to occupy a similar social 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 figure into birth enactments in the private sector, the predominance of surgical birth in private facilities—83 percent of private facility births occur through cesarean (National Institute of Population Research and Training and ICF 2023)—significantly curtails transgressive pollution. While bodily fluids are present in cesarean and vaginal births, 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, and 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 integral to and unpredictable in the experience of vaginal birth. While I never witnessed a vaginal birth in a private facility—accounts from my interlocutors suggested that these primarily occurred when a surgeon was unable to reach a particular health facility in time, times I was also unlikely to be present in a facility—the *ayas* did not demonstrate the same avoidance of the *nongra kaj*, and I did not witness them passing this on to the *rugir lok*, who were, in general, treated with more respect by the private health staff.

Blood also figures centrally as a bodily substance to be managed in *sheba/jotno* divides. While health service providers carry out the clinical *sheba* of blood transfusion, arranging the blood to be transfused is a profound act of *jotno*. In northern India, Jacob Copeman writes of the social significance of blood and blood donation. His work demonstrates that far from an impersonal endeavor implied by predominant public health discourses, blood donation in northern India is imbued with social, cultural, political, and religious significance (Copeman 2009; Copeman and Banerjee 2019). Similarly, in Bangladesh, blood donation constitutes and reinforces bonds within kin and social groups. Even in the most reputable public hospital in the country, impersonal blood stocks are unreliable. If a person needs a blood transfusion, this kinship-constituting substance must be arranged through the care work of the family and social networks.

In addition to enacting *sheba* in the embodied encounters 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; Hadley et al. 2007; Zaman 2009). In his ethnographic account of a district hospital orthopedic ward, Shahaduz Zaman (2009, 367) observes that "it appears that Bangladeshi nurses are primarily caretakers of papers and registers, rather than caretakers of patients." 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 describes how governance through documentation became central to the colonial project as a reflection of the need to ensure accountability from a distance and maintains centrality to the postcolonial state-making project in Pakistan.

Similarly, paperwork 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 what James C. Scott (1998)

describes as rendering the population legible, and thus justifying projects of "high modernity" to organize it in particular ways (see also Gupta 2001). In Bangladesh, vast infrastructures for rendering legible health practices and behaviors of the population have been constructed throughout the country (Murphy 2017). The concern with counting predates but was galvanized further by the recent trends in global health practice to insist on the metricization of health for the justification of health interventions (Adams 2016, 2013). While this trend is evident throughout global health practice, quantification of maternal health rose to prominence as an object of metricization in the 2000s, as reducing maternal mortality became a focal point of the Millennium Development Goals (MDG) for health. The concern with tracking maternal mortality was further propelled by the global observation of the imperviousness of maternal mortality to discernable improvement on a global scale nearly a decade into the MDG era (Wendland 2016; Storeng and Béhague 2017). Countries were thus impelled to devise strategies to better trace maternal health-related indicators. To these ends, the Bangladesh Maternal Mortality Survey, a population-based household survey of hundreds of thousands of households, was implemented to render the childbearing population and their practices legible. National health policymakers, programmers, and global health practitioners consider this survey, along with the Bangladesh Demographic and Health Survey, as authoritative for understanding maternal health in the country.

In contrast, metrics generated through the public health information system and fed into the national health information system, are viewed as suspect by international and national policymakers and programmers. Thus, despite the emphasis on doing documentation in public health spaces and the push by numerous actors to improve documentation processes to result in "reliable" data, this documentation remains peripheral to what is considered authoritative by national policymakers and programmers (Begum et al. 2020).

Still, the spectacle of doing paperwork is central to state *sheba* in Kushtia public health spaces. State-making is thus achieved through the embodied art of *doing* it, not necessarily in the accuracy of what is recorded, or how it will be used thereafter. A good case in point is the use of the paper-based technology of partograph. Designed for "low-resource settings," partograph is a WHO-endorsed, paper-based technology to track labor progress, identify complications, and inform decision-making. The technology requires health service providers to use paper-based graphs to track fetal heart rate, uterine contractions, cervical dilation, and drugs administered throughout labor (World Health Organization

Figure 3. Whiteboard partograph in labor and delivery room. Photo by Janet Perkins.

2018). However, in the Kushtia District Hospital labor and delivery room, I only observed health service providers recording partograph information *after* birth. In the still of the labor and delivery room during lulls between births, an SSN would sit down and piece together the women's names and estimate their labor progress according to the aspects demanded by partograph, documenting these on the paper form.

Using the partograph after birth strips its usefulness in its presumed decision-making purposes, but it figures into the constitution of the state through the *doing* of paperwork. Performing paperwork, which Mol (2002) refers to as the "enactment" of bureaucratic objects in practice, forms part of *doing* the state. In this enactment, documents come to be constitutive of "bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, outcomes and even the organizations themselves" (Hull 2012a, 251) in the maternity ward. Unlike the intimate work of *jotno*, which fosters kinship, the enactment of paperwork *sheba* serves to disconnect public health service providers from those they serve, and is only loosely organized around birth events in this setting.

Although public health workers complain about the amount of paperwork required, this paperwork becomes a locus of power and a site at which the legitimacy of the state's right to "write society" (Hansen 2001, 225) is reaffirmed, as health service providers carefully guard authority over paperwork. In the labor 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—which leaves women and their *rugir-lok* with no medical documentation of their labor history in this public health space when they seek care outside. Presumably, when the SSN threatened to discharge Rima if she did not behave appropriately, part of the risk was foregoing these discharge papers.

In private health facilities, paperwork plays a tangential role in health service delivery. While small and medium-sized clinics kept basic tallies of services delivered and would count these up when we as asked about the number of cesarean procedures and vaginal births in a given month, paperwork was less visible in enactments of health service delivery in these settings. Each facility had its own system for managing this information. Although they admitted that they were expected to share this information with the district-level public health manager, few did so. Among the many managers I spoke to, only the son of the Kushtia District Hospital manager, who managed the clinic owned by his mother in a neighboring district, indicated that he regularly provided this data to the local health manager, and suggested that their clinic was the only one to do so in the area. Thus paperwork in private facilities separates these spaces from state-making projects.

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 indictments of the failure of nurses in such settings to adhere to the ethos generally associated with nursing as the delivery of patient-centered and compassionate care (Livingston 2012, 96–97; Zaman 2009). However, to single out nurses as an isolated category draws attention away from how 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, *ayas*, and other hospital staff who enact the state in public maternal health care settings, and the ways that they do so strikingly resemble each other.

BESHORKARI "NOT-STATE" CARE: Imaginaries of Maternal Health Care Otherwise

It is not only in these embodied enactments of care in government maternal health settings that these imaginaries of the state through *sheba* and *jotno* become reified. They are also discursively constituted (Gupta 1995) in the circulation of

narratives. With the widespread availability of maternal health care through the *beshorkari* private health sector, these narratives are often formulated in reference to these not-state services. One day, I sat with Fahmida, Papish, and Mala, three sisters-in-law, in the buzzing courtyard of their in-laws' 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 facilities 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 knew personally, who advised her to go to the district hospital. She recounted the 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 OK, 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 adoringly (*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 circulating representations of care in state and non-state spaces. Through these, the state is reified as an entity that does not care for those under its purview. In Fahmida's recollection, the state was even willing to let her die, an uncanny, if macabre, echo of Michel Foucault's maxim

of biopower as the power to "make live" and "let die" (Rabinow and Rose 2006, 239; Foucault 2003).

In contrast, in Fahmida's account, care in the form of *jotno* was to be found outside of state spaces in the *beshorakari* private sector. The possibility of accessing *jotno* was borne out in my encounters in private health settings and with those animating these settings. Although private health managers and providers discussed their engagement in delivering private health services as a moral work of providing *sheba*, they also expressed a desire to provide the kind of care to women that they do not experience in public health facilities. Astha *apa* (honorific used to denote sister), a government health service provider and private clinic manager in one of the Kushtia subdistricts, described her motivation for engaging in private health service delivery as propelled by a desire to compensate for public health services wherein, even when women reach them, "nobody, not the doctors, nurses, or anyone, 'cares'" (for which she uses the English cognate). She advertises the possibility for women to benefit from *jotno* at the private clinic she manages. Even at the gate of the clinic one reads that "With care [*jotno*] and low cost, we do normal delivery" (see Figure 4).

Figure 4. Clinic entry gate reading "With care (*jotno*) and low cost, we do normal delivery." Photo by Janet Perkins.

Private health clinic managers and providers in Kushtia rarely described the advantage of the services they delivered as superior to the clinical care available in the public facilities. Rather, they highlighted the fact that services would be reliably delivered at any hour of the day and with interpersonal care. Talking to two managers and a health service provider in the well-established Jonari clinic in the Bheremara subdistrict, I heard them describe the sincerity of the care they provided as the principal draw for women to come there. As the manager summed up, "[At the government facility] they don't give care like this. The hospital does not give beautiful care [for which he uses the English cognate] like the private [sector] provides to them, so that is why they come to the private." This claim is borne out in practice, where health service providers attend to women with more warmth, exhibited through more physical touch and calling mothers-to-be by their names or affectionate honorifics. Even for health service providers working in both the public and private sectors—a common practice among doctors (licitly) and other categories of health service providers (illicitly)—their interactions with women in the private sector tend to be marked by more intimacy and warmth.

Of course, not all women experience care of the type described by Fahmida in the private sector. That the little-regulated private health market wildly varies both in terms of *sheba* and *jotno* is no secret. Still, the private health sector, the *beshorkar*, sustains its representation as an entity in which one might receive *jotno*, even if for a price, and, as I have explained at length elsewhere, by drawing on personal and kin-based bonds (Perkins 2023). In contrast, none of my interlocutors, whether health service users or providers and managers, expected the offering of *jotno* in public *shorkari* spaces.

CONCLUSION

"They just don't care." I often heard this refrain from my interlocutors engaged in development practice when frustrated by the lack of interest demonstrated by the government health service providers enlisted to implement various development interventions. Sometimes I could not help but think it 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 labor with twins at twenty-nine weeks and on the precipice of losing them.

Arguably, such enactments of (un)caring could be viewed through a lens of obstetric violence. Certainly, the embodied enactments of care that unfold in the Kushtia labor and delivery room resemble little the ideals set forth in the Respectful Maternity Care Charter (White Ribbon Alliance 2022), or those of person-centered care now included in all global health guidelines for maternal health (see e.g., World Health Organization 2018). However, women and their families rarely described the treatment in public health facilities as violence or mistreatment. Rather, they accepted the *sheba* delivered in public health facilities as what is. In one sense, this reflects what Nadasdy refers to as the totalizing project of the state, in which people embrace the state as "the natural order of things" (Nadasdy 2017, 8). As people have accepted that this is what constitutes the state, just as he describes, it becomes difficult to question the "legitimacy of these processes or the implicit assumptions that inform them" (Nadasdy 2003, 8–9).

In the public health setting, one of the implicit assumptions guiding enactments of care is that the state delivers state-making bureaucratic practices of *sheba*, almost always to the exclusion of intimate, kinship-fostering *jotno*. While the apparent lack of compassion may appear as uncaring in public health settings from an outside perspective, my aim in this article has been to demonstrate that public maternal health spaces constitute a crucial stage in the performance and constitution of the state, and that embodied enactments of care through *sheba* and *jotno* prove central to this constitution. Public maternal health spaces function as sites of embodied performance in which ideas of state are constituted. On this stage, and acting on and with bodies (Mol and Law 2004), the state is instantiated through the embodied enactment of service as *sheba* by government actors (i.e., medical officers, SSNs, midwives, interns, even the *ayas*) vis-à-vis the non-state (i.e., pregnant and birthing women, and their families accompanying them, their *rugir-lok*). These enactments are significant beyond the health service encounter—they operate to legitimize the state-making project and materialize the state as an entity that stands above (Ferguson and Gupta 2002) and separate from those who seek *sheba* at its interstices.

These encounters are usefully understood within the context of state imaginaries in which government staff are expected to deliver care as service, *sheba*, while not necessarily kinship-constituting *jotno*. Here I expand on Alber and Drotbohm's (2015, 2) assertion that care connects not only kin and communities but also states and nations to show that it equally *dis*connects. The enactments of bodies in public maternal health encounters in Kushtia serve to *dis*connect, that

is to say, *dis*connect 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, 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 that delivers service, though not necessarily the intimate care that fosters kinship, crystallizing within a broader constellation of imaginaries of the state and one's relationship to it.

ABSTRACT

Within anthropology, care operates as contested theoretical territory, with much debate residing in the space between what we think care ought to look like in health service delivery settings juxtaposed with what care looks like in the ethnographic encounter. In Bangladesh, public health service providers are often represented as not caring in health encounters. Based on ethnographic data generated in maternal health settings in Kushtia District, this article nuances conceptualizations of care in government health settings, centering the concepts of sheba *(service), which is rooted in clinical care, and* jotno *(care), intimate, hands-on care that constitutes kinship. Through the enactment of embodied performances, government health service providers and staff enact boundary work around* sheba *and* jotno*, which serves to constitute the state during and beyond health service encounters, crystallizing within a broader constellation of imaginaries of the state and one's relationship to it.* [care; state; maternal health, childbirth; pollution; ethnography; Bangladesh]

সারসংক্ষেপ

নৃবিজ্ঞানের পরিপ্রেক্ষিতে যত্নের ধারণাটি একটি তাত্ত্বিক বিতর্কের ক্ষেত্র- যা মূলত স্বাস্থ্যসেবা প্রদানের ক্ষেত্রে যত্ন কেমন হওয়া উচিত বলে যা আশা করা হয় এবং নৃতাত্ত্বিক নিবিড় গবেষণায় যা দেখা যায় এই দুটোকে পাশাপাশি রেখে বিভিন্ন আলোচনা-সমালোচনাকে কেন্দ্র করে আবর্তিত। বাংলাদেশে জনস্বাস্থ্য পরিষেবা প্রদানকারীদের প্রায়শই স্বাস্থ্যসেবা প্রদানের ক্ষেত্রে 'যত্নশীল নয়' হিসেবে উপস্থাপন করা হয়। কুষ্টিয়া জেলায় মাতৃস্বাস্থ্যসেবা নিয়ে পরিচালিত নৃতাত্ত্বিক গবেষণার ভিত্তিতে, এই নিবন্ধটি সরকারি স্বাস্থ্যসেবা ব্যবস্থায় উপস্থিত যত্নের সামগ্রিক ধারণাটিকে সূক্ষ্মভাবে উপস্থাপন করছে মূলত দুটি ধারণাকে পাশাপাশি রেখে: প্রথমটি 'সেবা' যা চিকিৎসাকেন্দ্রগুলোর চিকিৎসা বা রোগ উপশমকেন্দ্রিক যত্নের সাথে সম্পর্কিত এবং অন্যটি এমন ধরণের

‘যত্ন’ যা ঘনিষ্ঠতা ও প্রত্যক্ষ সহায়তা সংশ্লিষ্ট যা আত্মীয়তার সম্পর্ককে গঠন করে। সরকারি স্বাস্থ্যসেবা প্রদানকারী ও সাধারণ কর্মীরা তাদের মূর্ত ক্রিয়াকর্মের মাধ্যমে সেবা ও যত্নকে ঘিরে কিছু বিভাজন রেখা তৈরী করেন- এখানে এই বিভাজনক্রিয়াটির মাধ্যমে স্বাস্থ্যসেবা প্রদানকালে এবং এর বাইরে রাষ্ট্র প্রপঞ্চটি গঠিত হয়ে থাকে, যা বৃহত্তর পরিসরে রাষ্ট্র ও ব্যক্তির সাথে রাষ্ট্রের সম্পর্ক নিয়ে কল্পনাসমূহকে ঘিরে পুঞ্জীভূত হয়। [যত্ন; রাষ্ট্র; মাতৃস্বাস্থ্য; সন্তান প্রসব; দূষণ; নৃতাত্ত্বিক গবেষণা; বাংলাদেশ]

NOTES

Acknowledgments This work was made possible thanks to funding awarded under the Economic and Social Research Council (ESRC) Postdoctoral Research Scheme of the United Kingdom Research and Innovation (UKRI) (Grant number ES/Y010299/1). I would like to acknowledge my research assistant, Tamanna Majid, for her dedicated support and invaluable insights. I would also like to acknowledge Jeevan Sharma, Lucy Lowe, and Ahmed Ehsanur Rahman for reviewing previous drafts of this article. I am particularly indebted to the health service providers and women who welcomed me into their lives, shared their stories with me, and allowed me to take part in their birth experiences. I obtained institutional ethical approval for this project through the University of Edinburgh School of Social and Political Science (approval date: April 29, 2019) and in-county through the ethical review committee of the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) in Dhaka (approval date: November 13, 2019).

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