

CONSTRUCTIONS OF BIRTH IN BANGLADESH

This chapter is about the construction of birth in rural Bangladesh. In Bangladesh, maternal deaths are very prevalent, 320 per 100,000 live births annually, and the construct of birth that is produced in everyday life results in many unwarranted and unnecessary deaths. Various social constructions of birth are observed in everyday life, both in indigenous ways and hospital birth practices. The power of knowledge is multidirectional and influences individuals to follow certain norms and practices which critically shape health-seeking behaviour. This paper draws on numerous case studies and observational experiences from ethnographic studies carried out in 1998 and 2001 to highlight how understanding of birth is shaped by birth experiences of women and influenced by the context in which meaning is produced. In Bangladesh, most poor women prefer indigenous birth or home birthing. No matter where and how the birthing is constructed, ultimately it affects the marginalized populations, that is, poor, rural women. Women face poor care in a health system which is inadequate and over-medicalised and marginalises local knowledge and practices. The critical gap in understanding the meaning of home births as opposed to hospital obstetric care needs to be recognized, if we want to see improvement in the maternal health situation in Bangladesh.

As Jordan (1983) argues, ‘birth is everywhere socially marked and shaped’. Like many other cultures, there are many notions regarding childbirth practices in Bangladeshi society. Indigenous knowledge and practices of birth persist for generations, particularly in rural areas (Afsana and Rashid 2000; Blanchet 1984; Rozario 1998). This knowledge of childbirth is a culture of diffuse entity born within one culture and shaped and reshaped by social and political influences (Kay 1982). Indigenous knowledge of birth is marginalized in the face of modernity. Knowledge of hospital obstetrics is modern. The authoritarian knowledge of biomedical professionals is challenged by many scholars whose central concern is that women are subjected to medical authority while experiencing birth in hospitals (Davis-Floyd 1994; Davis-Floyd and Sargent 1997; Jordan 1983, 1997; Kaufert and O’Neil 1993; Kitzinger 2002; Martin 1989; Oakley 1984, 1993; Rothman 1982; Sargent 1990). Social legitimation of authoritative knowledge is produced within the tremendous power imbalance that precludes poor women from taking active roles in the process of birth, using their own knowledge and expressing their decisions. Furthermore, in a resource-constrained society, practices in hospital obstetrics have created a situation that is not at all congenial to rural poor women. Furthermore, birth practices are aggravated by global strategies, multi-nationals and more importantly, national strategies and programmes at the ground which do not always match up to the

lived realities of poor women's lives. The construction of birth has created disparities and inequities for women in accessing obstetric care.

We found a spectrum of knowledge and experiences shared by women and their families in villages and hospitals. These voices were strengthened by observation of birth practices and informal discussions in villages and hospitals.¹ In this chapter, we analyse the construction of birth from various perspectives, highlighting women's understanding of birth and their embodied knowledge, explicating silencing in birth and indigenous knowledge, delineating the environment of hospital birth and authoritative knowledge and the implications of national maternal health strategies.

UNDERSTANDING CHILDBIRTH

The concept of 'normal' and 'complicated' childbirth is constructed in the context of culture and social practices. Rural women perceive the act of childbirth as a normal, natural phenomenon. Childbirth or *bachcha khalash* is referred to as '*thikmoton hoiche*' (taken place normally) or '*kono oshubidha hoi nai*' (having no difficulties). In conversations, women also include a number of signs in defining normal birth (i) a smooth process without prolonged pain; (ii) membrane not ruptured before labour pain starts; and (iii) baby is born with intact *phul* or placenta. On the other hand, *kolbekal* or *bekaidai* (complicated) birth was defined as having the following symptoms (i) prolonged labour pain without further progress; (ii) membrane ruptured without labour pain, (iii) *nari* (cord) coming out beforehand; and iv) becoming pregnant after a long interval of 6 years or more.

The case of Raheemon is typical. She had to observe the norms and rules of pregnancy. For example, she could not go out alone at noon or in the evening, or on Tuesday or Saturday for fear of evil spirits and winds which were known to harm her pregnancy and baby. These are popular understandings on appropriate behaviour which young mothers are expected to follow. Her baby girl was born at home assisted by her mother-in-law, a *daini* (locally popular birth attendant). Raheemon explained:

I was having *kini kini bedna* (little pain) for two to three days. I didn't tell anyone. But my sister-in-law understood that I was developing *baccha houner bedna* (labour pain). I was doing my normal household chores, like cooking and cleaning. In the evening, after dinner, the pain started in my belly. My mother-in-law touched my belly and said, "It will

take bit longer.” The baby was born normally very early in the morning without any problem.

In another event, Shahanara, a young girl of 18 and first-time mother, started labour pain. She experienced stronger pain as time went on, but the baby’s head was not descending. The *daini* announced, “Baby’s head is on one side of the abdomen and the feet on the other side. Take her to the hospital.” The following morning, she was taken to the closest hospital and afterwards to a tertiary Medical College hospital. Shahanara had a Caesarean section late at night.

In Bangladesh, rural women’s understanding of birth is located within the social model of health. Pregnancy and birth are considered part of daily life (Wagner 1994: 32) and treated as normal events. In rural Bangladesh, although birth is seen as a normal event, the construction of *thikmoton* and *kolbekol* birth is the result of the dominant cultural practices of the society. Understanding of birth is not only shaped by the birth experiences of women, but is also influenced by the context in which the meaning is produced. In fact, these meanings are produced in the light of their similarity or dissimilarity to births regularly occurring in the village.

Rumi, a second time mother who was very emaciated, faced tremendous difficulties while giving birth. She had prolonged labor pain and did not have any energy to bear down. Even though her husband was finally convinced to take Rumi to the hospital, the *daini* did not allow this to happen. When her first child was born in hospital, Rumi did not relish the experience and was afraid to return. After many hours, the baby was finally born at home with the help of two *dainis*. In Bangladesh, like most developing countries, childbirth practice still depends on indigenous knowledge of birth where traditional midwives play a special role. Many of *dainis*’ skills are practical, usefully facilitating the process of birth. Rumi later said, “I had so much difficulties and the baby was born amidst immense pressure. But the dainis helped me.” The baby’s situation became critical and the mother became frail, yet she was still not taken to the hospital.

Although birth is centered on *thikmoton* and *kolbekol*, various experiences across this dichotomy impart plurality to the meaning of birth. Because of this unfixed meaning, the paradigm of *thikmoton* includes births that are managed at home but require medical assistance. The delivery of a contracted pelvis or breech presentation regularly occurs at home with the use of “simultaneous resorts” (Kleinman 1980: 187), such as amulets,

sanctified water, herbal roots and even, medications from local village doctors. Jordan (1983: 79) argues, “Discrepancies between the local and the medical definition militate against the utilization of the resources of hospital obstetrics even for the cases that clearly fall into the medical realm”. In rural Bangladesh, however, health care seeking is very much influenced by the plural meanings floating between *thikmoton* and *kolbekol* birth. When complications arise, accessing obstetric care is delayed due to socially constructed understanding of birth that, at times, can prove fatal to mothers and neonates.

EMBODIED KNOWLEDGE AND ENGAGEMENT IN BIRTH

While giving birth, Rahee seemed controlled. She occasionally asked her mother to massage her limbs. All the women sitting beside participated in the birth event and shared their own birth stories. They all stressed that a woman cannot give birth without having *moner shahosh* (mental strength) and *shoriler shakti* (physical strength). All of a sudden, water was seen trickling down Rahee’s legs. She started to push down, “Please grandma, put your big toe on my anus.” Tuljan, the *daini* sat against the bamboo wall and guarded the perineum by placing her big toes on Rahee’s anus. Rahee was bearing down. The baby’s head was seen through the birth canal. She pushed down hard four to five times and shared later, “I felt that the baby was coming down forcefully”. Rahee was giving instructions to Taljan what to do.

A saying circulated in Apurbabari village, “*Baacha houner shomey moner shahosh aar shoriler shakti lagey* (to participate in childbirth experiences, one needs to have mental strength and physical vigour).” The rural women put emphasis on the two issues in order to have a normal birth; one was *moner shahosh* and the other was *shoriler shakti*. In reference to that, Marsheeda said, “If birthing women are not mentally and physically strong, they won’t be able to give birth by themselves.” The relationship of *moner shahosh* and *shoriler shakti* with psychological and physiological experiences was reflected in the words of Tohmeena, “Your mental strength arises from your mind and your physical strength from your body.” Women believe that this knowledge influenced them to understand their bodily mechanisms and enabled them to give birth. For example, Raheemon observed, “Only if you have *moner shahosh* and *shoriler shakti*, you can correlate your labour pain with the downward movement of the baby and understand when to push.” On the other hand, Kamila, a *daini*, added, “If women do not sustain

moner shahosh and *shoriler shakti*, they lose their *disha* (sense) during the birth event and become confused with labour pain and the movement of foetus.” This knowledge has been circulating among rural women for generations. They acquired the knowledge of *moner shahosh* and *shoriler shakti* from other women, such as their mothers, grandmothers, sisters, relatives, neighbours, and *dainis*. *Moner shahosh* and *shoriler shakti* were seen to influence each other. The women considered the psychological and bodily experiences of childbirth as a collective power.

In rural birth settings, women’s articulation of the collective influence of *moner shahosh* and *shoriler shakti* is the expression of uniting mind and body in giving birth. This harmonious connectedness and understanding of bodily mechanisms is intensified by the synchronized cooperation of all women participating in the birth event. Rural women share their bodily experiences by telling stories and providing emotional support.

Similar practices observed in birth events across cultures are considered useful by many experts (Cosminsky 1982; Jordan 1983; Kay 1982; Kitzinger 1997; Belle 2002). As Jordan (1983) stated, birth is a communal or collective event and *dainis*, similar to *parteras* of Latin America, along with birthing women, participate together and are mutual exchangers of knowledge. The understanding of bodily experiences influences women to participate actively in birth. Davis-Floyd (1994) denotes it as an inner knowing or women’s intuition, which is an important characteristic of the indigenous model of birth. Graham and Oakley (1981) claim that this knowledge is women’s own capacity to sense and react to the sensations of their bodies. This inner knowing is socially constructed created from women’s personal and shared experiences that become embodied.

During observations of deliveries in rural Bangladesh we found non-restriction of movement, intermittent walking and resting, holding onto a bamboo pole or rope, taking on different postures, self-evacuation of bladder and bowel, non-interference in actual birthing, and methods employed for perineal protection and placental expulsion. In addition, women are served warm rice and encouraged to drink warm water or milk, and warm compression applied over the perineum improves the healing process, quickens uterine involution and gives comfort to birthing women. In birth events, massaging oil on the birthing women’s head and abdomen, shaking their waists and lubricating the perineal

area with oil are commonly performed by *dainis* to ease the process of birthing. Other women assist by pressing the limbs and embracing the birthing women.

The *dainis*' role remains significant for providing both physical and emotional support to birthing women. In birth events, even with their experience and skills, *dainis* try not to take over the birthing experience, but to open a space where birthing women play a pivotal role. *Dainis*' supporting role is expressed in their voice and touch, and familiar rituals are important to make physical and emotional attachment with women, which is missing in hospitals. Mutual communications with *dainis*, sharing of knowledge and continual encouragement create a horizontal, non-hierarchical relationship where women gain confidence to participate actively. Moreover, the role of other women, especially female relatives, was crucial to the success of the total birthing process. These women provided emotional and physical support to birthing women. During the birth, women shared their own stories and tried to make the environment cheerful and relaxed. Kamila explained how she retold "stories just to keep the atmosphere lively" and assist the birthing women. Women prayed, "Please God, help this poor woman. Give her strength to bring the baby out," and a number of them also recited Koranic verses to provide emotional support and reinstate birthing women's mental and physical strength.

According to Trevanthen (1997: 84), "Perhaps one reason that birth is such a powerful emotional as well as physical experience for all women is that it is these emotions (e.g., fear, anxiety, uncertainty) that lead them to seek assistance, whereby mortality is reduced". Companionship is critical in birth events.

Despite the social and emotional support, in rural societies, birthing tends to be a secret matter. A proverb in this village was, "*Joto rao hobe, toto deri hobe baccha houne aar toto koshto hobe* (the more people talk about the birth event, the more time it requires and the more suffering occurs when giving birth)." Thus, to avoid birthing problems, birth events were observed very secretly in Apurbabari village. When labour began, birthing women carried on their daily chores. The other women in the household also remained silent. They did not even aspire to share this with their male counterparts. Women who were likely to attend the birth event asked the birthing women about the progress of their labour and simultaneously carried out their daily tasks as if nothing was happening. The event was performed so quietly that close female neighbours were

sometimes not aware of it. Enduring pain in silence was commonly observed during childbirth. Birthing women were invariably eulogized for their silence in labour. This cultural expression of pain brought them self-pride. The women wanted their labour process to be quiet and did not intend to express pain unless it became unbearable. Kamila, however, gave an opposing view about the understanding of birth secrecy, “Birth event is performed secretly not to avoid prolonged labour but to avoid a gathering of people.” While women had different views on these issues in the village, most believed that maintaining silence was important and showed their endurance of pain and ability to control their bodily experiences. As Rownak explained, “I was having a severe headache during my labour pain, but did not tell anyone. Later on, I lost consciousness and was taken to the hospital. At the end, I gave birth to a dead baby.” Sometimes, as in this case, women’s silence led to life threatening situations and delayed access to timely obstetric care, which might result in the death of the mother and baby.

MEDICALIZATION OF BIRTH AND AUTHORITATIVE KNOWLEDGE

The word hospital derives from the Latin “hospitalis” which refers to “hospites” or guests (Turner 1987). The original meaning of the term is preserved in the notion of hospitality. But the hospitals in Bangladesh carry a sense of fear for countless rural women and their families. One woman said, “I pray that Allah does not take anyone outside the home for childbirth and delivery!” As Oakley (1980) states, giving birth in hospital means submitting oneself absolutely to medical authority. The dominance of biomedical professionals and the devaluation of birthing women was observed in medicalised birth events occurring in Bangladeshi hospitals and has been documented elsewhere (Afsana and Rashid 2000).

For many poor families coming to a hospital is filled with uncertainty and fears of enormous costs which they cannot meet. Many families who arrive with the pregnant women usually collect some cash, but have no idea about the amount of money required for delivery in a hospital. The first initial cost incurred is transportation, and the situation is aggravated by denial of admission and treatment by different health facilities, forcing families to move frantically from place to place. For example in Romila’s case, before reaching the Medical College Hospital, the family had to change transportation several times. Her husband said, “We took the rickshaw to go to the Thana (government) hospital

but later, they sent us to the district hospital. We took a bus to reach there. They also couldn't treat my wife's problem. From there we hired an ambulance to come to this big hospital." Another woman's husband comments, "Our home is far from here. It takes three to four hours by bus and then we have to take a rickshaw to reach home."

Once they arrive, poor women and their families are faced with much unfamiliarity and anxieties, from the teeming crowds of patients to large rooms and buildings. Shahana's case was a perfect example. Her mother and mother-in-law were scared to death in hospital buildings. When the doctor instructed them to buy medicine, they embraced each other and started crying. For fear of getting lost, they were hesitant to leave each other. Her mother said, "We were terrified by the massiveness of the building. It's like a puzzle. One can easily get lost. We feared losing contact with each other." The mammoth structure of the buildings did not bear any resemblance to the small huts in their own villages. Families were also confronted with congested and dirty environment of wardrooms and toilets. Floors were discoloured, sticky with dirt, and speckled with sputum, blood, vomitus and urine in some places. Leftover bits of food, used cotton balls and papers were scattered on the floor. The tin bowls used as rubbish bins were left open under beds resulting in a foul smell. The bed sheets were discoloured and old, and were only changed when new patients arrived. The windows were mainly closed, creating a suffocating atmosphere. Patients, attendants, ayahs [a female hospital aide] and even nurses threw water on the floor and wall while cleaning their hands or rinsing their mouth. People also spat on the floor and walls. For many women the feeling was, "to get good services in the hospital, you need to know someone there. If you don't know anyone, you are in trouble."

Many families borrowed money to pay for the costs of blood transfusions, medicines, Caesareans and paying off brokers, bribing ward boys and ayahs in the hospital for access to basic facilities. They incurred huge debts. Each patient was charged slightly over the standard fee, paying Tk 10 instead of Tk 7.50.ⁱⁱ Furthermore, many women and their families were asked for "special" payment by special ayahs and ward boys whose job was to assist patients to settle in at the hospitals. . On refusal of payment, the patients and their families were misguided and the staff became uncooperative. The estimated total costs for normal childbirth was about Taka 800 at the government Thana Health Complex

and Taka 1,600 at the Medical College Hospital; for Caesarean sections it was about Taka 15,000 in the government Thana Health Complex. Nurses also expected to be paid for assisting in child delivery. To pay for all these costs required cash, which was not accessible to the poor. They usually did not have assets or savings and thus borrowed money from the moneylenders at very high interest rates.ⁱⁱⁱ They also raised money by selling cows, goats, land and even the tin-roof of their huts. As one woman explained the typical experience for many, “In the hospital, we don’t know anything. We can’t read and write. We run here and there... Who has so much time to accompany and who has so much money to bear the costs? I hate moving around and being taken advantage of.” Because they had few reading and writing skills, birthing women were disempowered in the hospital, and humiliated and betrayed at every point.

A major fear of pregnant women who come to deliver at hospitals is the possibility of “being cut open” and seen by male doctors. Having an episiotomy incision was considered a social stigma, “a mutilated body”. A woman who underwent episiotomy said, “Body parts become defective when one cuts the vaginal area. It also affects the sexual relationship with the husband^{iv}.” Many of the women from this village were worried about the presence of male doctors in hospital births. Rural women linked the presence of male doctors with the issue of *sharam*. Sharoma said, “I don’t dare to go to the hospital. *Purush* (male) doctors work there. They will see your body. It’s a matter of *sharam*. Everyone in the village will know that a *purush* doctor has seen your body. They will tease you and also insult you”.

Sharam was very much related to revealing private parts. Birthing women felt *sharam* by exposing their private parts; even *dainis*, who are always women, avoided seeing a woman’s vagina when delivering the baby in home births. In home births, women covered their perineal area by pulling their petticoats over their legs. In hospitals, women felt over exposed and ashamed that a male doctor was able to view their bodies and they had no control over the situation. All the women interviewed were concerned with the violation of their privacy by the presence of male doctors in birth events. The entire experience of labour can be traumatic for the uninitiated in the hospital environment. Women are typically placed on a labour table with restricted movement and instructed to bear down by an intern doctor who stood near the birth canal. Below is an experience by

Rubina in the labour room of a tertiary hospital, which is fairly typical for poor rural women in Bangladesh:

When I met Rubina, she was lying on the bed. Her family was frantically running around in the large hospital with its maze of corridors, unfamiliar spaces and unfriendly faces. Her mother said, “I get lost here. For any help, people ask for money. Paying in each place is a major problem.” Rural women do not feel comfortable lying undressed on a labour table in front of strangers and the lack of privacy in the crowded hospital wards compounds the problem. She explained, “In the labour room, the *apas* removed my petticoat from the bottom. As I was trying to cover my private part, they said that there was nothing to feel shy here. When I tried to straighten my legs, they pushed my legs back.” Rubina was not allowed to get up and go to the toilet. She was ashamed, fearful and felt humiliated. In Papreen’s case, the nurse examined her and immediately started saline and oxytocin. She did not communicate verbally with Papreen at all. The female attendants responded to her inquiries. The nurse inserted her gloved hand into the vagina consistently stretching the vaginal walls. Within an hour, the baby was born. Papreen later shared, “I was very scared. I had so much pain, but didn’t utter a word. I wanted to be quiet. I didn’t know what they would do to me or to my baby. I didn’t see anyone in the labour room. It’s only the nurse and the ayah. I wanted to shout and cry, but couldn’t. I wanted my mother there, but couldn’t tell them.” In another case, Rumpa was not allowed to move and she had her two hands strapped down during delivery. Oxytocin in intravenous saline was being administered...an intern doctor gave her instructions to bear down, “Push, push.” Rumpa expressed her dissatisfaction, “It is strange! One can’t choose to stand or sit in the labour room or even move on the labour table.” Rumpa’s verbal consent was neither taken nor was she informed of what was being done to her body.

The interactions between the doctors and the women did not involve direct verbal communications. Rather, interactions commenced with frequent handling of the woman’s body, as the doctors conducted clinical examinations and initiated medications. Only in a few cases did nurses in local government clinics allow mothers to recite verses from the Koran and in one case, herbal roots was tied to a woman’s thigh to induce labour. As the nurse said, “It does not hamper our conducting labour. Why should we discourage it?”

Overall, the experiences of giving birth in the hospital brought to the women a feeling of alienation, of being in a different world—a world of isolation where they sensed a smell—the smell of hospital ‘*huspateler gondho*’.”

In contrast to home births, touch is expressed as restraining or punitive (Kitzinger 1997) in the hospitals of Bangladesh when doctors and nurses restrict women’s movement and disgrace them with verbal and occasional physical abuse or completely ignore them. This feeling gives rise to a desolate experience where women feel victimized, violated and invaded, which Kitzinger (1997: 229) denotes as “violence against women”. In most cases, rural women feel intimidated when interacting with health providers, and are often scared to voice their feelings as they fear facing abusive and condescending behaviour from doctors and nurses. The communication of biomedical professionals with their patients was predicated on muteness among the latter. When women were keen to express their subjective experiences of physical problems, their voices were muted either by being ignored by non-response, or being abused with a harsh response. A number of observations outlined below highlight this situation.

Patient: *Apa*, (sister), I am having so much pain. I can’t bear it anymore.

Doctor: Didn’t you remember that when you slept with your man?

A birthing woman was left unattended on the labour table. Suddenly, her perineal area was bulging and the baby’s head was seen. The woman started to hold her legs together to prevent the baby coming out. A doctor rushed to her scolding, “*Magi* (a prostitute), how dare you? Open up your legs.” She spanked on the woman’s thighs. The woman, frightened, spread open her legs and the baby came by itself. In another instance, a birthing woman was screaming due to her intolerable pain. The attending doctor spanked on her leg and shouted, “If you scream one more time, I will hit you again.” The doctors were usually not aware of their own behaviour.

The medicalised experience of birth and unusual experiences in the hospital reinforce rural women’s patience and silence. The body becomes the place of contestations of power to make patients disciplined and self-regulating—“docile” bodies (Foucault 1978). As a consequence, rural women silently conform to the authority of doctors and nurses. As Foucault (1978) reasons, where there is power, there is resistance. Women’s silence

does not indicate agreement with everything; rather it is expressed as resistance against the medicalised experiences. Silence is approved as a mark of discipline, but resentment is expressed within silence. Social legitimation of authoritative knowledge is produced within the tremendous power imbalance that precludes women from the process of birth. Jordan's (1993) explication of authoritative knowledge in American hospitals establishes physician and medical staff as the dominant possessor of knowledge. The authoritative knowledge of biomedical professionals developed on Baconian scientific rationality produces the "medical gaze" (Foucault 1973: 137) that deeply infiltrates into rural women's bodies to know their invisible meaning, but not their clinical or personal realities (Nandy 1995). In the process, childbearing women deliver a baby, but their embodied knowledge is disqualified as "subjugated knowledge" (Foucault 1980a: 81). Jordan (1993: 165) and Rothman (1982: 181) observe women's positionality in hospital birth versus homebirth. In relation to hospital birth, Jordan comments, "She is not giving birth, she is delivered". On the other hand, Rothman states, "A woman at home is not delivered. She gives birth".

The arguments explicitly underpin the situation in Bangladesh where the dominant authoritative knowledge of biomedical professionals ascends over rural women's experiential knowledge, making the women marginal in their own birth experience. With these bitter experiences, many rural women go back home. Their terrible experiences create fright among other village women and make them disinclined to seek hospital obstetric care.

ROLE OF THE STATE AND MATERNAL HEALTH

Bangladesh is a modern state and the power of modernity shapes ideas and practices relating to health policy and planning. The National Maternal Health Strategy emphasizes the reduction of maternal mortality and morbidity by modernizing obstetric care. In Bangladesh, more than 85 percent of births occur at home. Of the total estimated annual births, only 7.1 percent take place at government health facilities and 7.6 percent at private clinics (BDHS 2007). The state cannot afford to provide adequate obstetric services to seven percent of births and thus, it would be a dreadful situation if the number of births at public hospitals increases. The under-resourcing of hospitals occurs not only because of the "lack of resources" in the country, but also because of "who has control

over these resources” (Navarro 2000: 673). This is reflected in the maldistribution of resources at the national level where defence expenditure in Bangladesh represents 1.15% and health 1% of the GDP (Ministry of Finance 2008).

The tremendous costs of hospital services essentially prevent rural, poor families from seeking hospital obstetric care. The expenditures put appalling demands on poor families, which Kothari and Mehta (1988: 187) refer to as “fiscal violence”. Modern, biomedical treatment is economically and socially distant from the poor. The majority in Bangladesh do not have the capacity to bear the expenditures. The costs incurred in normal birth in Medical College Hospital are close to the monthly income of many poor families. The combination of hospital costs and processes on the one hand, and the circumstances of poverty, on the other, make rural women vulnerable to the fiscal and social violence of modern biomedical treatment.

Indigenous knowledge of *dainis* is continually challenged. The disregard for traditional midwives is the result of colonial devaluation of indigenous knowledge. In ancient India *Dai* practices were highly criticised for the lack of hygienic standards decided by the missionaries and white woman doctors (Somjee 1991; Ram 2001). To ensure safe delivery, the TBA (Traditional Birth Attendant) training program began throughout the developing world with the Safe Motherhood Initiatives of the World Health Organisation and UNICEF. In Bangladesh, under the Directorate of Family Planning, a nationwide TBA training program began in 1979 to improve maternal and child health (Akhter, Rahman, Mannan, Elahi, and Khan (1995). In the mid-nineties, TBA training was discontinued because the program did not seem to reduce maternal mortality (Ministry of Health and Family Welfare 1998). Failure of the program is blamed on TBAs for not incorporating biomedical knowledge into their own practices. A new cadre of midwives known as community skilled birth attendants have recently been introduced in Bangladesh to improve maternal health situation. However, *dainis* continue to serve the community, but because of new policies they are not included as providers in the maternal health strategy. As result, rural, poor, women who mostly seek care from *dainis* fail to reach hospitals on time because of the social, cultural gaps and loopholes in the health system.

Bangladesh continues to acknowledge and strengthen modern, obstetric practices while it marginalizes indigenous birth practices. This eventually results in a situation where the state's approaches to reducing maternal mortality and morbidity turn into a charade for rural, poor women for whom it is intended.

Childbirth is constructed in discursive practices that influence women's use of birthing care. Understanding of birth, women's silence, active participation in birth, a supportive environment, and trust and dependence on *dainis'* skills persuade women to adhere to indigenous birth practices. On the other hand, the authoritative knowledge of biomedical professionals, the medicalised experience of birth, the interpersonal relationships with doctors and nurses, hospital costs, and unpleasant experiences cause women's resistance to hospital obstetrics. Childbirth is medicalized and turned into a commodity in modern, capitalist society. The state facilitates modern, obstetric practices making the whole system into a business enterprise which is socio-economically and psychologically distant from the rural, poor women. The construction of birth produced in power struggles of social, cultural, economic and political forces affects rural women's health seeking, which may not always be conducive to the survival of mothers in rural Bangladesh.

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ⁱ The case stories in this chapter are based on interviews with over 100 rural women using data from original ethnographic fieldwork along with participant observation of home and hospital births. The fieldwork was carried out in 1998 and 2001 in rural villages of Bangladesh.

ⁱⁱ US\$1 = Taka 70 BDT as of August 2008

ⁱⁱⁱ A study done in Dhaka city demonstrated that the total costs for normal childbirth at the hospital was Tk. 1,275 (US\$31.9), and for Caesarean sections Tk. 4,703 (US\$ 117.5) (Nahar and Costello, 1998).

^{iv} Similar issues were raised by women in other research conducted in Bangladesh (Afsana and Rashid, 2000).