# POLITICS OF CONTROLLING BIRTH: C-SECTION, USE OF CONTRACEPTION AND OBSTETRICS VIOLENCE IN BANGLADESH

A Thesis

by

SADIA SHARMIN

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SADIA SHARMIN

COMMITTEE MEMBERS

Dr. Rosalynn A. Vega
Chair of Committee

Dr. Margaret Graham
Committee Member

Dr. Servando Hinojosa
Committee Member

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ABSTRACT

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This study examines the increasing rate of cesarean birth in Bangladesh through the lens of the population control program. Based on three months of data collection, the study explores various politics of the government's population control program, leading me to argue that cesarean birth is an implicit way of controlling overpopulation in Bangladesh since it limits women's reproductive choices and thus contributes to population control. Using ethnographic vignettes, I discuss how my research findings point to the government's disparate population control politics and how this has given rise to various forms of obstetric violence against women. The study also addresses cesarean birth and obstetric violence as forms of "reproductive governance"—mechanisms to control women's reproduction. This thesis concludes by recommending further studies on the connection between cesarean birth and population control from a cross-cultural perspective.

# DEDICATION

The successfully completion of my master's studies would not have been possible without the love and support of my family. My parents, my husband and my sisters and brother, enthusiastically inspired, motivated, and supported me to achieve this degree. I am grateful to all of them. Thank you for your love and support.

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Also, I would like to acknowledge all my respondents who voluntarily participated in my data collection process.

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# CHAPTER I

## INTRODUCTION

This research aims to critically analyze the increasing rate of cesarean operations in Bangladesh through the lens of population control. Bangladesh is a South Asian country burdened with overpopulation—166,510,779 according to Worldometer data for 2020[1]—which hinders the development process. There is a popular notion in the country that a woman cannot have more than two children with a C-section. Using ethnographic methods, I argue that the government has used disparate population control practices to target the different socioeconomic classes.

The government's policy of population control includes a family planning program that encourages Muslim couples to use contraception for controlling birth; however, the use of contraceptives conflicts with Islamic ideology (Inhorn 2013) and also with Bangladesh's patriarchal culture in which desire for a son motivates couples to have more children. As a developing country burdened with overpopulation, Bangladesh is prioritizing family planning programs that include promoting modern contraceptive use by publicizing the slogan, "Boy or girl, two is enough, but one is ideal." Various population control policies target women's reproductive health and give rise to "obstetric violence" (Dixon 2015). The idea of "reproductive governance" (Morgan and Robert 2012) is a useful theoretical tool for identifying the mechanism

[1] See https://www.worldometers.info/world-population/bangladesh-population/

through which government and religious institutions control reproductive behavior and population practices in Bangladesh. I use the idea of "obstetric violence" as a form of reproductive governance to explore the mistreatment and healthcare disparities faced by women in hospitalized birth.

Cesarean birth in Bangladesh is another mechanism by which women's bodies and reproduction have become the targets of population control (Foucault 1976). Cesarean delivery is also a powerful example of authoritative knowledge (Jordan 1987) and stratified reproduction (Colen 1995), where hospital authorities exercise power and control knowledge over patients. Moreover, due to their lack of familiarity with technology-based hospital birth, pregnant women and their family members have low decision-making power over the birth.

In June 2019, the Save the Children study in Bangladesh showed that unnecessary cesarean operations have increased to fifty-one percent in the last two years, both in urban and rural areas. The upper- and middle-class women are often enticed to C-section and then suggested to have up to two children via cesarean. In 2018, eighty-six thousand cesarean operations occurred in the country, while up to three hundred thousand women who needed a cesarean operation could not afford it. The lower-class women are likely to have normal deliveries at home and in public hospitals and are suggested to take contraception and are enticed for sterilization. Causes of the increasing rate of C-sections include the commodification of birth, privatization of hospitals, doctors' unwillingness to give time for normal delivery, money, etc. With the rising modernity and capitalization process, women's reproductive health is commodified and commercialized. Private hospitals have their market incentives that provide better facilities and services instead of money. In private hospitals, women are often tricked into and enticed to have cesarean operations by doctors and hospital authorities, which cost them extra money.

My research teases apart the mechanisms that link the increasing rate of cesarean operation to population control. How does hospitalized birth give rise to obstetric violence? How does the unequal distribution of medical knowledge force women to cesarean operations?

To answer these questions, I conducted three months of intensive data collection using semi-structured, online interviews. These interviews helped me to uncover how population control strategies unevenly target Bangladesh citizens based on socioeconomic class.

# CHAPTER II

## METHODOLOGY

Since I have started my journey as a student of anthropology, I have studied how the pioneers of anthropology traveled to the remotest corners of the earth to study and observe people's culture and participate in their day-to-day life activities. This is the traditional way of obtaining ethnographic data. Thus, the original plan for this thesis was to conduct multi-sited ethnography in different hospitals in Bangladesh. Then COVID-19 hit. The present situation of COVID-19 has caused me to adapt my data collection methods to avoid in-person interactions. As a result, I switched to the online method of data collection for my thesis. I had to wait for almost eight months to get the IRB approval and to start my data collection.

Initially, I contacted friends and colleagues who were pregnant or new mothers. Subsequently, using the snowball recruitment method, I contacted more respondents via mobile and email. I used Zoom meetings, mobile, and messenger calls to interview those that agreed to join my study. Conducting research via these telecommunication platforms limited the number of encounters I might have otherwise had in a hospital setting. Thus, it was more challenging to reach and recruit respondents. Using a snowball recruitment method, I interviewed twenty women and five men in three months.

Interviews were conducted in the Bangla language. Throughout each interview, I asked respondents semi-structured questions and follow-up questions. Each interview took thirty

minutes to the one-hour maximum. Interviewees were asked questions about their cesarean birth experiences, use of contraception, barriers in access to healthcare service during pregnancy, cost of cesarean operation, and experiences of any violence, harm, or abuse in the hospital. Given the unique moment my research was conducted, I also asked respondents about the impact of the COVID-19 pandemic on their access to healthcare services. The respondents were encouraged to share their experiences and journeys of giving birth in their own words. I have used these words to describe their stories in my thesis narratively. I have also used the "thick description" technique to provide detailed descriptions and interpretations of local cultural beliefs and perceptions regarding birth, contraceptive use, and population control.

Observation is an essential data collection method in anthropology, and I have used this method to observe how respondents responded to my questions. These observations included their gestures, body language, and tone of voice. This digital data collection method also included using audio recordings of the interview to preserve every detail of information my respondents provided me. I have transcribed the essential portions of each recording and narratively described those in my thesis. Both recording and handwritten notes from my data collection diary were used to rearrange and organize the raw data. For the respondents' privacy and protection, I have used pseudonyms to address and identify the subjects.

# CHAPTER III

## INCREASING RATE OF CESAREAN OPERATIONS

With the rise of modernity, the natural birth process has been medicalized and switched from home to hospitalized birth. Nowadays, a greater number of babies are being delivered in a medically controlled setting with the help of doctors and healthcare attendants. The medicalization of childbirth has brought women's reproductive health, body, and sexuality under physician's surveillance. Women's reproductive choices are no longer their personal choices but, instead, have become a part of biopolitics where both local and global forces interact. People nowadays cannot even imagine childbirth without a doctor, and the hospital has become the primary place of birth and is synonymous with birth.

Though the initial reason for this shift from home to hospital birth was to reduce prenatal morbidity and mortality rates, the present increasing rate of cesarean deliveries reveals the increasing commodification of the healthcare system.

*On September 28, 2020, I contacted my first respondent via messenger. My first respondent is a university teacher who thinks of birth as a complicated process that requires medical assistance. As I prompted her with my questions and follow-up questions, she shared her experience of giving birth to her first baby. Her third trimester was not yet over, and she did not have any pain,*

*complications, or other labor symptoms; however, the doctor did not want to wait and suggested a cesarean section. She was scared when the doctor warned her that delaying delivery could negatively affect the child and cause cerebral damage. Since she did not want to take any risks with her child, she agreed with the decision and decided to undergo a cesarean section before her due date.*

*Mahmuda wanted to do a normal delivery, as she believed a cesarean would subsequently develop chronic illness. "I live in a village, and I need to do heavy household chores. So, I didn't want a cesarean, but the doctor recommended I have a c-section due to my asthma problem." She had to return to the clinic after the operation because the stitches ripped, and she developed an infection in that area. "I gave birth to my first two babies in a private clinic via cesarean, and now I am pregnant with my third child. Since the first one was a cesarean, the second one was also a cesarean, and the third one must be via cesarean too."*

*One of my respondents, Fatema, reported that the doctor discouraged her from a normal delivery due to her short stature of fewer than five feet. "I was eight and a half months pregnant with my first baby when I went for a routine checkup in a private clinic due to my swollen feet. I did not have any other problems, but the doctor admitted me to the hospital. They delivered my baby at eight and a half months of pregnancy." The doctor's reasoning was that, due to her short stature, the baby would not get enough space to grow in her womb. As a result of her first cesarean, she was told that her second birth would also have to be a cesarean. Her post-cesarean stitches came loose, her incision site became infected, and a discharge oozed from the incision for three months.*

*Another one of my respondents, Khushi, described her experience with her first baby. "I was so scared when the doctor told me that my baby would not survive if I attempt a vaginal delivery." The doctor asked her to sign a waiver indicating that they would not take any responsibility if the baby dies. "I didn't have any other option than to follow what the doctor said." As the interview continued with follow-up questions, she mentioned that she wanted a vaginal delivery for her second child. She consulted multiple doctors from different hospitals, but no one agreed to a vaginal delivery since she already had a prior c-section. One of the doctors told her, "We don't have time for normal deliveries." She has recently given birth to her second baby via c-section.*

*Tania's experience was no different than the other women's. She also wanted a vaginal delivery, and everything was progressing normally until the eighth month of her pregnancy. The doctor told her that due to the baby's rapid growth over the course of her pregnancy, a vaginal birth represented too much of a risk. She did not get a chance to state her opinion. So, she had a cesarean delivery at nine months. The baby was 3 kg (6.6 lbs) at birth, which is quite normal. She has been suffering from various chronic illnesses since her operation, and with a tone of regret she said, "If I had known that I would suffer so much from a cesarean, I would have delivered my baby vaginally, and I want to deliver my second baby vaginally at any cost*."

*On October 10, I was interviewing one of my respondents, Taslima, over the phone, and suddenly she told me her husband wants to speak with me. Since I wanted to include some male respondents in my research, I took advantage of the opportunity. It was my first interview with a male respondent, and it went very well since the man participated in the interview voluntarily and provided some useful information. Taslima gave birth to a healthy baby as soon as they*

*reached a local clinic near their village. Although it was a vaginal delivery, the hospital charged them for a cesarean operation. He refused to pay the extra money, but, finally, he was forced to pay. He explained, "I had no alternative; otherwise, they would not release my wife and the newborn from the clinic. I waited there for more than two hours to talk to the clinic owner, but the owner never spoke to me. We were lucky we arrived at the clinic late in the birth process, and my wife had a vaginal delivery. If we had arrived ten minutes earlier, they definitely would have taken my wife in for a cesarean operation." He reported that the suburbs are crowded with for-profit clinics where there is a lack of qualified doctors and quality care. He noted that almost every clinic contracts with agents who visit nearby villages and lure pregnant women into receiving a cesarean operation. Their job is to bring women to private clinics for cesarean operations, and they are paid a commission from the hospital administrators.*

*Another male respondent shared a similar experience. His wife had a vaginal delivery in a public hospital, and interacting with hospital staff had been "very difficult." Before they went to the public hospital, they visited several private hospitals. They decided on the public hospital because the private hospitals relentlessly insisted on cesarean delivery. Hospital staff tried to discourage them from vaginal delivery by mentioning the risks associated with it. Since they were sticking to their decision, the doctor finally told them, "We don't have time for a vaginal delivery. If we do a cesarean, it will only take twenty minutes, and we don't get extra money for the extra time we have to spend on a normal delivery."*

*My next respondent, Rima, was a master's student. She went to the municipal hospital after her water broke. There was no doctor on duty at that time, and after she was admitted, she had to sit*

*on the floor since no beds were available. As soon as the doctor came, he suggested she have a cesarean. "The doctor told me that my baby had grown too fast, and I needed a cesarean. Since my husband and I wanted a normal delivery, we decided to wait, and I had a healthy baby of 2.5 kg (5.5 lbs)."*

*I will incorporate my own experience of observing and participating in my elder sister's delivery in a public hospital in 2019 since it exemplifies some of the problems with the private and public healthcare systems. Due to her orthodox perspective, my elder sister did not want to visit doctors, perform any tests, or take medications while she was pregnant. On the day she started to feel labor pain, my parents took her to a private clinic first, but the doctor on duty refused to admit her since she did not have any lab reports. Moreover, it was already too late for a cesarean operation, and they did not want to spend the time required for a vaginal delivery. Since we had no other option, we admitted her to a public hospital. There were no available hospital beds, and my sister had to sit on the floor along with many other pregnant women. The entire room was overcrowded, the floor was unhygienic, and the atmosphere was heavy with the pregnant women's screaming. After nine hours of labor pain, the nurses took my sister to the delivery room, where my sister delivered a healthy baby boy via vaginal delivery. The entire scenario and experience would have been different if she had been admitted to a private clinic for a cesarean operation.*

*The following quote is an example of the physician's authoritative knowledge and hierarchical distribution of knowledge: "It was the final week of my pregnancy, and I was in severe pain. My*

*husband took me to a local clinic, which was very far from our village. After we reached the clinic, the doctor on duty didn't wait even a bit before recommending a c-section."*
*- Deepa, a 24- year-old girl.*

The most common consequence of the medicalization of childbirth is the unnecessary cesarean section, which has been increasing at an alarming rate. In some rural areas, third-party private clinic agents visit nearby villages and lure pregnant women into having cesarean births. Cesarean delivery is considered to be effective for reducing the risk of maternal and neonatal mortality during obstetric emergencies; however, the unnecessary cesarean section has threatened women's health as well as increased unnecessary expenditures (Ortiz-Prado et al. 2017).

Since the 1990s, the Bangladesh government has been implementing the "Safe Motherhood" program. This program has succeeded in ensuring safe motherhood and reducing maternal mortality. However, the increasing availability of emergency obstetrics care (EmOC) during pregnancy has also increased the rate of cesarean sections from four percent in 2004 to twenty-three percent in 2014 (Islam and Yoshimura 2014). According to the World Health Organization (WHO), no more than ten percent of births should be delivered by cesarean, and preferably, seven percent. The reason for cesarean delivery is to prevent maternal and newborn mortality, and when the rate increases above ten percent, there is no evidence that it has improved the mortality rates. The causes of the increasing rate of c-section are many; these include improved access to EmOC services and increasing maternal age (Begum et al. 2017; Haider et al. 2018).

At the same time, an increase in unnecessary cesarean sections has led to a "vicious cycle" in which women who have had a prior cesarean are counseled by hospital authorities that future birth(s) must also be via cesarean.

From a critical perspective, this leads to the commodification of birth, where women are enticed and sometimes even forced to adopt advanced technology, prescribed lab tests, and diagnostics, drugs, etc. Most of the private hospitals have their market incentives and disguisedly offer a "package service," which eventually forces patients to buy drugs, undergo lab tests, and even buy foods from them at a high cost. Even doctors at private hospitals are influenced by the market incentives of hospital authority and provide profit-based services. In government hospitals, physicians' unwillingness to give time for normal deliveries and patients' lack of knowledge of technology-based births often force women to undergo cesarean operations.

Women's choice of hospitals, either private or public, largely depends on their financial situation. Many physicians work in both public and private hospitals and offer radically different care in these respective settings based on one's ability to pay. Many women often try to avoid public hospitals because of poor quality of care. Despite this, the cesarean operation rate is lower in public hospitals than in private hospitals across Bangladesh. Though physicians are reluctant to spend the extra time required for vaginal delivery in public hospitals, they are also less likely to entice women into a cesarean section.

In my thesis, I uncover the politics of unnecessary cesarean sections in Bangladesh with ethnographic vignettes. Each interview has conferred new insight into how women are enticed, tricked, and forced into cesarean sections in different hospitals, both private and public, and clinics, both urban and rural, in Bangladesh. Hospitals target women for a cesarean section in

order to turn a greater profit; thus, hospital authorities often give women the impression of cesarean sections as a medical necessity when, indeed, no such medical necessity exists.

The stories were astonishing for me to learn how health care is commodified and women are trapped and tricked into unnecessary cesarean births. It is woeful to see how many private hospitals and clinics have turned into a profit-based organizations whose primary concern is to make a profit and not provide equal and quality care.

When pregnancies are medically managed, doctors, nurses, and hospital administrators impose their authoritative knowledge as a source of authority over patients. Due to their lack of medical and technological knowledge, women have less or, in most cases, no access to decision-making about their own medical care in the birth process. These vignettes address doctors' unwillingness to consider patients' preferences and the way doctors impose their authority on patients during the decision-making process. In essence, the hierarchical distribution of knowledge restricts women's participation in the decision-making in the technocratic birth processes.

# CHAPTER IV

# COMMODIFIED REPRODUCTION

# AND CAPITALIZATION OF THE HEALTHCARE SYSTEM

The transformation of childbirth from home to hospital, from the control by midwives to the control by physicians, and from a natural process to a technology-based birth has further commodified the birthing process. The joint venture of modernization and capitalism replaced the natural birth process with hospitalized birth where "hospitals" have become a profit-based organization that treats patients as "customers." Private hospitals and clinics are reluctant to admit patients for normal delivery. Their target is to encourage, motivate, trap, or even force women into cesarean births, which is more profitable due to the costs of operations, tests, hospital bills, and other expenses. The alarming rate of cesarean sections is a striking example of the commodification of health care and childbirth. Currently, as a part of their market incentives, hospital authorities and their agents (doctors, nurses) represent natural birth as "complicated" to entice women to undergo a cesarean section. Childbirth has become synonymous with hospital birth, and physicians are considered the only appropriate agents for assisting with childbirth.

Government hospitals in Bangladesh are beset with multifaced problems that include an influx of patients, lack of specialists, insufficient equipment, inadequate facilities, mismanagement, poor hygiene, and excessive corruption. Those who have the financial ability avoid public hospitals and rely on private hospitals for better service. This neoliberal model

limits people's equal access to health. Administrators at private hospitals give patients differential treatment based on their socioeconomic condition—leading to hierarchical distribution of health care and unequal suffering.

The following ethnographic stories unveil how the commodification of health care targets patients to fulfill its market incentives and represents private hospitals' commercial purpose by becoming synonymous with quality care in Bangladesh.

*One of my respondents, Khushi, wanted a vaginal birth with her second baby since she suffered from various chronic illnesses after her first cesarean. In her words, "I have visited seven clinics and hospitals in the capital and requested that doctors help me give birth naturally, but they discouraged me and even scared me by emphasizing various side effects." One of the doctors confessed they don't have time for vaginal births as they would not be paid extra money for the extra time necessitated by vaginal deliveries.*

*Another of my respondents, Shamoli, described how the hospital authority did not admit her because she wanted a vaginal delivery. "I was in severe labor pain and told the hospital staff that I didn't want a cesarean section. They said if I want a normal delivery, I should stay home and seek help from the local midwives." She further explained that the local midwives are not well-trained; otherwise, she would have delivered her baby at home.*

*A male respondent from the Mymensingh district shared his experience of suffering. Every time he and his wife visited the local health clinic for a routine checkup, the nurses encouraged them to have a cesarean birth by stressing the possible risks of vaginal birth. Almost every clinic in*

*their locality contracts with third-party agents who visit nearby villages, searching for pregnant women and encouraging them to have a cesarean birth. His wife gave birth via vaginal delivery as soon as they reached the clinic, and she was admitted as a patient. However, the billing department charged them the extra costs for cesarean delivery. "I was forced to pay the amount that is charged for cesarean birth, even though my wife only needed saline and an injection. They wouldn't provide the release order until I paid the amount they charged."* (Note: Inconsistent with info from Khushi's vignette that vaginal births cost more because they take more time.) *He further indicated, "While we were being forced to pay the extra charge, I pretended to be an agent and stealthily told a nurse that I know a few pregnant women and can bring them to the clinic for cesarean births. The nurse believed me and whispered in my ear that they usually give the agent a 2000-taka commission for bringing one pregnant woman to their clinic." Clinic agents also capitalize on village women's lack of access to medicines and contraceptives by selling these items at a markup when compared to those at the nearest pharmacy. The medicines they sell are samples that doctors receive from pharmaceutical companies, and many are not marked with expiration dates.*

*I can also incorporate my own experience here since it is relevant to the topic at hand. I was admitted to a private clinic and diagnosed with an ectopic pregnancy. After having been admitted for two days, a visiting doctor revealed to my elder sister, an oncologist in Bangladesh, that the clinic where I was admitted was not equipped for laparoscopic surgery, where I to need it. They keep patients admitted to their clinic, but if any surgery is needed, they release patients from the clinic. The entire night was a complete nightmare for me. I did not have any other option but to stay that night, praying to God and fearing a fallopian tube rupture at any moment.*

*I considered myself lucky to have a sister who is a doctor and who helped me escape from their deception. I cannot even imagine how many patients, who are poor, illiterate, and come from the villages, are taken advantage of.*

The commodification of reproductive health can be traced back to the earlier stage of industrial capitalism, where pregnancy and childbirth were presented as medical issues that require medical supervision. The devaluation of domestic health care and self-care at home and the favoring of professionalized medical care and prescribed medicine have legitimized the commodification process of health. This brought a major shift from home to hospital birth. Hospitals became the first choice to give birth, and physicians and hospital authorities gained the authoritative power to handle births, thus marginalizing traditional birth attendants like midwives. Midwives were not only marginalized and stigmatized, but also their indigeneity and traditionality were commodified (Benoit et al. 2010; Leng 2007; Vega 2016).

The concept of reproduction is reproduced, redefined, and reconstructed socially, culturally, politically, and economically with every discovery of new reproductive technology. Mass and print media play a powerful role in reproducing redefined reproduction. Newspapers are filled with news of the latest discoveries and advancements in biotechnology. Documentaries like “World of the Unborn” and “The Agony and the Ecstasy” give the audience the message that “birth needs help,” and this is the “fact of life” (Franklin 1995).

This medicalization of birth promoted newly discovered scientific techniques, knowledge, drugs, and services. Pregnant women became influenced by powerful knowledge constructed through scientific and medical practices. When pregnancies began to be managed medically, women were enticed and influenced in a way that they describe their bodily changes

through the language of technology (Greenhalgh 1990). For example, the use of assisted reproductive technologies (ARTs) has become a new way to conceive a child.

It is crucial to explore the impacts, benefits, and burdens of this reproductive technology from the multicultural voices of women and also to explore who delivers the sources of all the information that influence women's reproductive health (Rapp 1987). It is important to know how the power of biomedical language and technology has commodified the entire health sector and targeted women's reproductive health. The politics of reproduction of the powerful has made it difficult to establish reproductive health as a human right. Each time a new reproductive technology is discovered, it targets women of a specific class, race, and ethnicity. Normalization and routinization of using reproductive technology have vividly marked the continuation of the domination of the reproductive field. White male scholars have self-voluntarily taken the responsibility of the scientific field where "science speaks the language of universal authority and progress" (Rapp 1987:16).

According to the *American Pregnancy Association*, ninety percent of women who have previously had a cesarean section are able to give birth vaginally (Porreco and Thorp 1996). On the contrary, in Bangladesh, doctors strongly discourage vaginal birth after a cesarean. Cesarean birth is medically necessary in cases of prolonged labor, abnormal positioning, fetal distress, congenital disabilities, repeated cesareans, chronic health conditions, etc. In contrast, my ethnographic interviews with twenty respondents show that the reasons for their cesarean births include possible side effects associated with vaginal birth, asthma, previous cesarean delivery, short stature, rapid fetal growth, etc. Ironically, cases of cesarean birth without any valid reason are also very common.

Due to the privatization of health, health care has turned into a “commodity” where every patient has become a healthcare consumer. Money and the market have occupied a special place in the medical field where physicians and hospitals are providing profit-based services. This commodification of health has restricted people’s equal access to health where women’s sexuality and reproductive health are not exceptional, which has eventually endangered women’s reproductive choice and has given rise to health inequalities (Henderson and Petersen 2004; Timmermans and Almeling 2009).

Due to the commodification process, women’s reproduction has become a special market niche that targets women’s bodies and sexuality to promote and legalize newly discovered techniques and technology. Private hospitals have their market incentives that provide better facilities and services instead of money. In private hospitals, women are often enticed by doctors and hospital authorities to accept the latest technology that costs them extra money.

It is important to know how, in the postmodern scientific culture, the power of biomedical language and technology is constantly produced and reproduced to target women’s reproductive health. “Science says” is presented as a univocal language in the field of reproductive technology and has eventually placed scientific knowledge and language in the authoritative position regarding women’s reproduction (Haraway 1990).

Reproductive health and rights have been consistently targeted, and the consequences have been faced by countless women whose health and lives are endangered by their inability to obtain the safe, legal, and essential reproductive health care they need. The whole process of commodification and medicalization of procreation has disempowered pregnant women, placed physicians and hospital authority in an authoritative position, and has intensified the unequal access to health (Davies 2010)

# CHAPTER V

## POLITICS OF POPULATION CONTROL PROGRAMS:

## IMPLEMENTING CONTRACEPTION IN UNDERDEVELOPED COUNTRIES

The policies and politics of population control are contested in almost every society as a part of their development program. Imposing power tactics or biopolitics to influence women's reproductive choice to limit fertility has become a central focus and targeted issue for the development process. Women's bodies, minds, sexuality, and reproductive health have become targeted in order to control the population, regulate fertility, and produce "a better human race."

The politics of population control is a contested terrain where the developed countries take control over poor and underdeveloped countries and practice power dynamics through the authority of science (Ginsburg and Rapp 1995:1-18). Industrially developed, capitalist countries often blame poor and developing countries for global poverty, hunger, underdevelopment, and environmental degradation.

The Bangladesh government employs strident population control efforts, including **sterilization** of women through inducement or trickery. The experience of poor, illiterate women from the village is especially egregious, where they are enticed or forced to undergo sterilization after two children. Cases of sterilization without consent are also common with this group.

*Mahmuda is a health worker who is employed by the government's family planning program. She used to work under BRAC (Bangladesh Rural Advancement Committee), an internationally recognized development organization in Bangladesh, where her job was to visit villages in order to advise women about their reproductive health, counsel women about family planning, and persuade women to agree to sterilization. When teaching women about contraceptives, she emphasizes the issues associated with having more than two children. The family planning program also encourages men's participation since men are often the decision-makers regarding family planning.*

*Mahmuda also revealed that under the family planning program, one of their targets was to entice women for sterilization. Women who had a previous history of the surgical incision and were pregnant with second babies are the target group to whom they suggested sterilization. As she stated, "We usually warn women of the side effects of having multiple surgical incisions in the abdomen and encourage them to undergo sterilization after two births."*

*She stated that based on the number of children each couple had, they were provided with different contraceptives. Those couples that already had more than two or three children were motivated for sterilization or long-term contraceptives, while those with one child or newly married were provided with short-term methods. She indicated that persuading Muslim couples to accept sterilization and family planning is challenging since limiting fertility conflicts with Islamic ideology. In Islam, limiting fertility—primarily through sterilization—is seen as a sinful act. As a result, Muslim women are more likely to engage in short-term contraceptive use.*

*Mahmuda also added that the health workers were given a quota for how many women they needed to persuade to undergo sterilization each month (generally, two to three). Their bonus and compensation largely depended on the number of women they had motivated to undergo sterilization. Authorities threatened to fire health workers from the job or withhold health workers' salaries if they fail to meet the monthly quotas. As a result, workers were desperate to persuade and even trick women into sterilization by giving money, food, and clothes as incentives. They also encouraged couples to visit local clinics where they would receive a hospital birth and be placed under a physician's surveillance, as it was then easier for them to persuade or entice women to undergo sterilization. Another respondent, Fatima, said her mother was a health worker in their village. As she stated, "Every month, the health workers were given a target number to sterilize women, and my mother was not paid if she could not fulfill her target."*

*Sometimes women were sterilized without their consent. Mahmuda revealed one case study of a village woman who was sterilized during her cesarean operation without her consent. Failing for a long time to conceive another child, she visited a doctor and was advised that she had been sterilized.*

*My respondent Nasrin used to work as a health worker for twelve years. According to Nasrin, the target group was men and women from ethnic and religious minorities. "Nowadays, it's difficult to convince people for sterilization as most of the village people are literate, so we target Hindu and indigenous women for sterilization. It was the increasing literacy and awareness rate and the Muslim religious ideology that conflict with long-term contraceptive use*

*and sterilization. It was easier to entice poor Hindu and indigenous women to whom they usually gave two thousand taka, foods, and clothes if they agreed to sterilization. They brought women to the local clinic for sterilization, where they had a prior contract with the authorities. Moreover, they motivated pregnant women to have a hospital birth and cesarean operation, as in her words, "It is easy to sterilize women during a cesarean operation, and so we also encourage women to have a hospital birth." Part of their job also included arranging monthly meetings where they asked village couples to join the meeting. Men are least interested in attending these types of meetings, so they used to encourage women to participate by providing suggestions on contraceptive use, creating awareness about the problems of having more children, etc.*

Limiting women's reproductive choices that result from having undergone a **cesarean birth** is another deceitful population control effort of the Bangladesh government.

*Cases where the physicians directly frighten women with the risks of having multiple children by cesarean are also widespread. Shilpi had an infection in her surgical area since her stitches ripped. "When I was admitted to a hospital for my first baby, they told me not to have more than two children since it's risky to go through the surgical operation multiple times. During the birth of my second child, the doctor strongly forbade me not to have any more children." Ruma's case was no different where the doctor told her that if the first child was via cesarean, the second must also be via cesarean, and to not have more than two children. She mentioned her elder sister had three cesarean babies with no complications.*

*Doctors gave the same warning to Khushi when she had her second baby. Other respondents also claimed that they were recommended to limit their number of children to two. One of the respondents mentioned, "I have two daughters, both by cesarean, but my husband and in-laws want a son. I don't know what to do because the last time I visited the hospital, the doctor strongly forbade me from having more children.*

*Mahbub's story is slightly different; her husband told her to undergo a cesarean since vaginal birth is a painful process. Her experience with a second baby via cesarean was very painful, and the doctor strongly advised her not to have any more children.*

*Tania has recently given birth to her first baby via cesarean. She also believes that she should not have more than two children via cesarean. She stated, "When your doctor tells you that having more than two children via cesarean is risky, you have to listen since he or she is the specialist here." Tania's case is a prime example of how doctors practice authoritative knowledge, and the mass population's lack of medical knowledge regarding technology-based birth limits their decision-making power.*

Other contraceptive methods

*Women are the most targeted group for population control and contraceptive politics. Most of the family planning programs target women and exclude men, while in a country like Bangladesh, men are the decision-maker and main influencers of reproductive choice. As one of*

*my respondents, Khushi, mentioned, "I have given birth to two babies, and every time doctors advised only me about contraceptive use."*

*Many women find it troublesome to use contraceptives, as their husbands are least interested in using protection. Moreover, the contraceptives they get from health workers, health clinics, or village pharmacies have multiple side effects. The side effects of these contraceptives are worth mentioning. Many of my respondents claimed they have suffered from multiple problems after taking contraceptives, including irregular menstrual cycles, nausea, and weakness. These factors constrain their choices toward long-term contraceptives such as IUD and injection or sterilization.*

*"Health workers from both governmental and non-governmental organizations visit our villages and sell contraceptives to women at a higher cost while the government usually provided them for free. They have contracted with the village pharmacies and nearby clinics to collect different types of contraceptives and medicines. Most of these are low-quality medicine that has no expiration dates. They also trick women into sterilization, using money as an incentive. One of my neighbors got three thousand takas for sterilization. She had one son and one daughter, but after she got sterilized, her son died in an accident which left her with great regret." - Taslima's husband*

Both global and local forces play a powerful role in population control programs. For example, the politics of contraceptive research regarding Norplant in Brazil sheds light on the interconnection between government policies and international interests that influences

contraceptive research. Women from poor and underdeveloped countries are targeted as test subjects regarding the impact and effectiveness of newly discovered contraceptive methods (Petryna 2009). These women are intersectionally vulnerable and are thus treated with less regard for their human rights (Crenshaw 2015).

Mass media plays a powerful role in reaching out to a country's remotest corner by broadcasting advertisements and dramas to create awareness. Mass media furthermore plays an influential role in promoting newly discovered contraceptives while hiding their side effects (Barroso and Correa 1995). For example, in the late 1960s, the media represented contraceptive use as "women's key to sexual liberation" while hiding potential side effects, and as a result of this mediatized narrative, many women ended up in hospitals with IUD complications (Hartmann 2016:23). This example hints at how contraceptive use is largely shaped by the politics and power of population control (Ginsburg and Rapp 1991).

In many developing countries, government policies increasingly focus on modern contraceptives, sterilization, and legal abortion. As a result of local and global campaigns, government hospitals in developing countries entice women into using contraceptives. In Bangladesh, women are often counseled regarding contraception by hospital staff shortly after giving birth. Many postpartum women leave the hospital with contraceptive methods that have been forced upon them. In Mexico, government hospitals are crowded with people who lack health insurance and cannot afford medical care. In 2002, under the government's reproductive health program, eighty-five percent of contraceptives were provided to women immediately after birth without giving them enough information or receiving their consent (Castro 2004). Thus, I argue that the provision of a contraceptive method during the birth process is a disguised way of exerting population control. Worse yet, doctors in developing countries have sterilized women

without their consent (Vega 2018). In 2000, the modern contraceptive method of sterilization was used on forty-four percent of Mexican women. This example demonstrates how population control is disguised and how government policy is inscribed on women's bodies (Castro 2004).

In Bangladesh, in the absence of social and economic development, a "vigorous" and "aggressive" family planning program reduced the birth rate from seven to five births per woman between 1975 to1990. When creating and implementing this program, the Bangladesh government faced intense pressure to please the international agencies that provided millions of dollars in funding (Hartmann 2016:236-238). As short-term contraceptive methods emerged (e.g., pills), the World Bank became concerned about the decline of sterilization—the most "cost-effective" form of contraception. Thus, the Bangladesh government set a goal to sterilize one-third of contraceptive users. According to reports from 1993, almost fifty-nine percent of rural women were sterilized (Hartmann 2016:248). Forced sterilization reflects axes of intersectional inequality since the figure is a mere sixteen percent for educated women. I argue that, in this context, poor women from rural Bangladesh were clear victims of contraception politics. To this day, they are often unable to take full control of their reproductive health and demand their reproductive rights.

Contemporary population control programs often target women's bodies by first shaping women's understanding of contraceptives and reproductive technologies. This development-oriented production of scientific knowledge reinscribes social inequalities and undergirds stratified reproduction (Rapp 2000). For example, in the 1970s, the government of China, under Deng Xiaoping's regime, wanted to become a more "modern" country by implementing the one-child policy (Greenhalgh 2008). The Chinese government insisted to the masses that overpopulation was the nation's most crucial problem, hindering the nation from becoming an

industrially developed country. While the one-child policy was in effect (1979-2015), the Chinese government convinced its citizens that by regulating their reproduction, they could improve the nation's population quality, thus making China a more modern nation. The Chinese people were forced to accept this painful reality and internalize its logic (Anagnost 1995), or else face the government's brutal sterilization and abortion campaigns.[2] Nearly twenty-one million men and women who had two or more children were sterilized (Greenhalgh 2008). Similar to Bangladesh, these forced sterilizations reflected social inequality in Chinese society since wealthier couples could afford to pay a fine in order to have a second or third child.

The Bangladesh government has implemented various policies of family planning to regulate the rapid population growth. With the help of national and international NGOs and foreign donors, the government has enacted a door-to-door awareness program, which includes providing free contraceptives, counseling couples via health workers, carrying out awareness campaigns with different religious representatives, and providing money and gifts as incentives for accepting long-term contraceptives.

In my thesis, I categorize the government's population control policy and program into two broader tactics—explicit policy and implicit or disguised politics and program. Based on this categorization, I propose a hypothesis that cesarean birth is an implicit or disguised form of population control in Bangladesh. With the cesarean birth, women are recommended to have no more than two children, which is compatible with the government's current population control policy promoting the two-child policy[3] while emphasizing the benefits of having one child. As

[2] Examples of these campaigns were enforced nationwide in 1983.
[3] According to Mohammad Sharif, director of Bangladesh Directorate of Family Planning, the government's target was to reduce the fertility rate to two children per woman by 2021.

an anecdote, the prime minister of Bangladesh recently advised the health ministry to take lessons from China's one-child policy; however, the Bangladesh government excludes China's "one is better" slogan and instead applies lessons from China to Bangladesh's two-child policy.

From 2008 to 2016, cesarean births in Bangladesh have increased from 4.0% to 31.0%. Since the cesarean birth limits the number of children women could have, we can arguably tell that the increasing rate of cesarean births indirectly reduces fertility in Bangladesh. According to the United Nations' Worldometer data from February 23, 2021, the fertility rate in Bangladesh remained consistent at 2.18% between 2016-2019 and then dropped to 2.05% in 2020. Despite the reduction of the fertility rate, Bangladesh is the eighth-most populous country in the world. Since Bangladesh had gained its independence in 1971, the government has achieved significant success in reducing the fertility rate from almost 7.0 births per woman to 2.05 births per woman.

I argue that the number of cesarean births depends more on the physician's perception of the ideal number of children than on actual clinical recommendations. In Mexico, the number of cesarean births has decreased to three as physicians think this is the ideal number of children a woman should have. The underlying truth, which is horrific, is that most health institutions provide women with a contraceptive method at the time of their third cesarean birth that permanently ends their fertility. In Mexico's public hospitals, a majority number of women undergoing cesarean births are provided with tubal ligation, and this number is three times as high as for women having deliveries in private hospitals (Castro 2004).

One of the most common pieces of information that I gained from all my respondents is that having more than two children by cesarean birth is a risk for women's bodies and health. Almost all the respondents have heard this, either directly from the physicians/nurses or from any of their family members. It is not only about what they heard; it is also about what they

believe, and most of the respondents also believe that more than two surgical operations could be risky.

In the context of Bangladesh and its two-child policy, cesarean operations are similarly a disguised way of exerting population control. Women in Bangladesh are taught that, once they have a cesarean section, subsequent births must also occur via cesarean. They are furthermore inculcated to believe that it is only possible to give birth up to two times via cesarean section. Cesarean births have brought women's reproductive health under physician's surveillance, making it easier to exercise power over women's bodies and to influence women's choices. I argue that cesarean section rates are more indicative of obstetricians' desire to limit women to the "ideal number of children" than of biomedical necessity (Castro 2004).

The government's desperate population control program includes enticed and forced sterilization, and poor village women and ethnic and religious minorities were the worst victims of the government's population control politics. Sterilizing without obtaining consent is an extreme case of obstetric violence and clearly a human rights violation, but the poor socioeconomic status of poor, illiterate, or indigenous women limit their voices against this unlawful act.

While women from poor, developing countries are targets for population control in the form of forced sterilization, abortion, and unnecessary cesarean sections, women in developed countries are able to preserve their extra embryos for the chance of having more children (Roberts 2007). Many reproductive health facilities are only accessible to highly privileged couples, thus excluding the poor and marginalized social groups. This unequal access to reproduction is a form of discrimination against poor and marginalized women.

The family planning program in Bangladesh is an example of how authorities validate their policies regarding population control and contraception, using the logic that overpopulation causes poverty and hinders the development process. I argue that much emphasis has been placed on targeting poor women's reproductive health, and not enough has been placed on how rich countries consume an extremely unfair share of the world's resources, thus driving poverty in underdeveloped and developing countries. In Bangladesh, development planners were more concerned with reducing natality than targeting poverty. Hartmann goes as far as to assert that the general consensus was "It's all right if the poor stay as poor as ever, just as long as there are fewer of them born" (Hartmann 2016:238).

The failure to establish women's reproductive health as human rights have endangered women's reproductive choices and have given rise to obstetric violence, discussed in the next section

# CHAPTER VI

## OBSTETRIC VIOLENCE

One target of the Bangladesh government's Millennium Development Goals (1990-2015) was to reduce child mortality and improve maternal health by enforcing hospitalized birth, as hospitals are considered the safest place for mothers and newborns. While the transition of childbirth from home to hospital has successfully reduced the child and maternal mortality rate, it has also simultaneously given rise to various forms of obstetric violence experienced by women in both public and private hospitals of Bangladesh, and the intensification of this violence varies based on one's socioeconomic condition.

Problems with medical curriculum and training create the gendered stereotype that women exaggerate their pain and symptoms compared to men (Chattopadhyay, Mishra, and Jacob 2018), thus contributing to obstetric violence. Medical personnel scold beat, and neglect birthing women—sometimes demanding that they suppress their screams during labor. At its core, obstetric violence relies on converting a natural process into a pathological one to justify the inappropriate behavior of medical personnel.

In my thesis, I argue that an unnecessary cesarean section is a form of obstetric violence. The rate of unnecessary cesarean births in Bangladesh's private hospitals has turned into an epidemic that serves these hospitals' commercial purposes. Unnecessary cesarean births not only cost the patients extra money but often cause various chronic illnesses after the operation.

In most cases, women are limited in their reproductive choices or induced or forced to undergo cesarean births, making them vulnerable to obstetric violence.

As a part of the government's population control program, the target population—women from poor, indigenous, and religious minorities—were encouraged and fooled to undergo sterilization. Health workers induced women to undergo sterilization by providing money, clothes, and food as incentives. Some of the cases show that they were sterilized without their consent.

The term "obstetric violence" is synonymous with dehumanized care and mistreatment against birthing mothers and their relatives in a medical setting. Obstetric violence is defined as "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, abuse of medicalization and pathologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" (Castro and Savage 2018). Thus, obstetric violence includes verbal and physical abuse (e.g., beating and scolding women during labor) and all other ill-treatment that negatively impacts women's birthing experiences (Dixon 2015:437-454).

*Shyamoli is a primary school teacher. She had her first baby via normal delivery but was encouraged to have a cesarean during the birth of her second child. As she stated, "My third trimester was complete. One early morning, I started to feel pain. Still, as I was physically sound, I completed all my household chores, cooked my lunch, and then went to the clinic. When my husband and I reached the local clinic, the duty doctor was not present; she instructed a nurse over the phone to give me medicine for my pain. I started to feel severe pain after I took*

*medicine. An ultrasound was performed after the doctor came, and I was informed that since there was no heartbeat, they had to go for a cesarean immediately. My baby was born with a critical condition, and the hospital authorities refused to treat my baby; they would not take any responsibility if something serious happened. I was admitted to the clinic while my husband took my baby to the government hospital. They admitted my baby but warned that my baby might not survive. How cruel it was to declare, without any sympathy, the most brutal truth to a parent that his child would not survive!"*

*After Shyamoli's baby by cesarean was admitted to the government hospital's neonatal unit, she and other parents were subjected to further obstetric violence. The neonatal unit was crowded with newborns, and the atmosphere was heavy with their crying. The outside atmosphere where the parents were waiting—worried, scared, and anxious for their babies—was even heavier. They didn't allow parents inside the neonatal unit, and the mother was called only when her baby needed to be breastfed. If a baby was in a serious condition or had died, they announced it and called the parents over a microphone. Every time they started an announcement, all the parents waiting outside would panic and worry it might be their child.*

*"After my husband admitted our baby to the neonatal intensive care unit, we didn't hear anything about our baby for almost five days. I was sick but could not control myself, and I rushed there even though I was supposed to be admitted to the clinic. They didn't have a specific place for the waiting parents, so we all had to wait on a veranda outside the unit. The whole situation was indescribable in words. I was still sore from my stitches, and I developed a post-cesarean wound infection. Sitting and lying on the floor outside the unit, I could hear the*

*screams of hundreds of babies inside and the sobbing of their parents outside. Whenever a nurse came out of the unit, all the parents waiting outside rushed over, asking about their babies. We didn't find any sympathy in their behavior; rather, they screamed at us and scolded us for creating a crowd. Almost five days had passed, and we still hadn't heard anything about our baby. Finally, I heard my name in the announcement; my heart stopped beating, anxious that something serious has happened. I rushed to the unit with my husband, and they told me to go inside and feed my baby."*

*She also claimed that the behavior of the duty nurses was the harshest. They didn't show any affection to the babies or offer any sympathy to the parents. In her words, "It seemed they were throwing the babies in their mother's lap. The doctors were so busy that we hardly had a chance to ask them any questions. They became annoyed with the parents' questions and concerns and avoided answering most of our questions. The parents came from remote villages, and the situation of the poor was the worst. Not only the nurses but also the ward attendants kept scolding them for small things. Not only the hospital corridors but also the neonatal unit where they kept the babies were dirty and smelled bad. We wanted to take our baby out of this horrible place; we had to bribe the nurse and the ward attendant to release our baby from the hospital. The whole situation was pathetic for us since we could not trust either private or public hospitals."*

*"During the birth of my second baby via cesarean, the doctor mentioned another small operation—sterilization. I was on the operating table, barely conscious, as I have just given birth to my baby. I was familiar with the Bangla meaning of it but didn't know what sterilization*

*meant. (Unclear.) Thus, I was tricked into sterilization, and it ended my hope of another baby." - Rani.*

*"I was in so much pain during the birth of my first baby that I could not control myself from screaming loudly. The doctor scolded me and asked the nurse to tie my hands and legs so that I could not move." - Shakila.*

*Shyamoli also shared her experience of giving birth to her first baby. Since she wanted a vaginal birth, she waited until she felt strong contractions. After she was admitted, they gave her an injection to induce labor. She was screaming from pain, and the duty nurse scolded her to keep quiet. She claimed that no one wants to cooperate if you want a vaginal birth. "The doctor kept telling me that she didn't have time, and the nurse kept coming in frequently to check my dilation with fingers, which hurt really bad, and I was not allowed to scream; if I did, they would scold me."*

*Doctors' mistreatment of their patients is also a common scenario. As one of my respondents revealed, "The same doctor will treat you differently in different hospitals. The quality of their services differs significantly when they provide services in a government hospital in the morning, and when they serve patients in the private hospitals in the afternoon."*

*She further added, "A private hospital or clinic will not even want to admit patients if they want a vaginal birth. Some doctors now agree to make time for a vaginal delivery, but they charge so much extra money that it is beyond the affordability of a middle-class family. If someone has a*

*familiar doctor recommended by friends or family, he or she could expect better service and treatment from the doctors and nurses."*

*One of my male respondents shared, "When I admitted my wife, the hospital authority told me they didn't have any hospital bed, and she had to stay on the floor. Finding no other option, I kept my wife on the floor. After some time, an agent came to me and whispered in my ear that if I gave him some money, he would arrange a bed for my wife as he had connections with the authorities."*

The idea that birth is dangerous and dysfunctional is prevalent among most physicians around the world. This commonly held belief validates the requirement of technological intervention in the birth process. Biomedical technology has embraced and grasped the field of pregnancy and childbirth by redefining its nature. In Brazil, the rate of surgical birth is close to one hundred percent due to the high rate of cesarean deliveries and cases of episiotomies during vaginal birth. In Mexico, the frequency of cesarean births in private hospitals is almost equivalent to that of Brazil (seventy to ninety percent). Studies show that ninety percent of women in Mexico have to go through episiotomies in their first vaginal birth (Davis-Floyd 2003:5-20,131,192). In both Brazil and Mexico, physicians perform episiotomies when babies are large or in a breech position or speed up the delivery.

The interconnection between medicalized birth, unnecessary cesarean operation, and increased obstetric violence are all are facets of reproductive governance—mechanisms through which actors from different social, religious, and financial institutions (e.g., church, hospitals, NGOs) interact with state government and control reproductive behavior by imposing various

legislative controls, economic incentives, “moral injunctions,” and direct coercion (Castro and Savage 2018). Brazil serves as an apt example of these entanglements: despite the movement against medicalized birth since the 1990s, one in four women in Brazil experience some form of violence in the hospital that restricts their choices regarding their body and sexuality (Olivia and Penna 2017). Moreover, Brazil has the highest rate of unnecessary cesarean births (fifty-four percent) compared to other countries in the world.

Brazil was the first country to hold the first international conference on “humanized birth” in 2000 to upraise a voice against obstetric violence and to promote human rights in childbirth. Countries like Venezuela, Argentina, Mexico, and South America have passed legislation to criminalize violence during delivery (Lokugamage and Pathberiya 2017; Sadler et al. 2016). Nonetheless, at present obstetric violence continues to be a pressing issue due to poor rapport with women, socio-cultural discrimination based on socioeconomic position, and inadequate health system conditions (Castro and Savage 2018).

The terminology of “obstetric violence” has been used to advance distinct, interrelated feminist critiques worldwide. According to feminist critique, reproductive technologies have established social and patriarchal control over women’s bodies, limiting their reproductive choices and autonomy. The overuse of technological intervention adversely affects women’s experience of giving birth, produces changes in society’s core value system, and establishes control over women’s bodies and minds (Davis-Floyd 2003:306; Edu 2018:556-573). More specifically, the medicalization of childbirth has placed pregnant women’s bodies under (predominantly male) physician’s surveillance and has given rise to unequal distribution and inappropriate use of medical procedures, thus exposing many women to physical and psychological risks.

Mexican midwives first used the term "*violencia obstetrica*" when arguing against hospitalized birth and protesting violent, dehumanizing practices against women. In 2007, in Venezuela, researchers and policymakers codified obstetric violence as a punishable act against women. In the United States, feminists view obstetric violence as a form of "gender-based violence" that targets women due to their lack of empowerment and autonomy. According to this critique, the health system is highly embedded in a hypercapitalist and patriarchal culture. On the other hand, in the Global South, women see obstetric violence as a form of "gender-based" violence embedded in the sociopolitical and historical context of discrimination against marginalized women (Chattopadhyay, Mishra, and Jacob 2017).

Despite these critiques, government hospitals in many developing countries have paradoxically become a "safe" place to decrease maternal and child mortality but a "violent" place for women in labor. For example, as part of its Millennium Development Goals, India's government promotes hospitalized birth to reduce the maternal mortality rate, which constitutes seventeen percent of the world's maternal death annually. The majority of the patients in government hospitals are poor and marginalized women. In these hospitals, the hierarchical distribution of health care produces tangible and symbolic violence—one example is unnecessary episiotomies without anesthesia. According to the World Health Organization (WHO), physicians should not perform episiotomies on more than ten percent of birthing women in India; yet the study finds episiotomies occur in ninety percent of vaginal births; however, physicians justify their actions, explaining they are engaged in "risk mitigation" (Chattopadhyay, Mishra, and Jacob 2017).

By pointing to this paradox, I argue that "safe motherhood" not only includes successful childbirth but also ensures women's equal access to quality care, privacy, and autonomy during

labor, as well as the respectful treatment of their supportive kin. Concerning the cesarean section, I specifically argue that an unnecessary cesarean operation is a form of obstetric violence that gives rise to other forms of violence against women. Women are forced to accept a cesarean operation when physicians withhold information and constrain their birthing choices.

Artificial management of women's labor increases unnecessary labor complications, cesarean deliveries, and medical costs. Robbie Davis-Floyd has identified technology-motivated birth as a "technocratic model of birth" (Davis-Floyd 2003:44-60). In this model, the "technocracy" implies using the technological process as a source of political power and demonstrates its hierarchical, bureaucratic, and autocratic dimensions. The technocratic model sees the human body as a machine, where the male body is a "good" machine. In her famous work, *The Woman in the Body*, Emily Martin (1987) demonstrates how discriminatory language is used in the biomedical field to identify women's biological processes compared to those of men. While women's ovarian egg production, menstruation, and menopause are described as "decay," "degeneration," and "failed production," men's sperm production is identified as "remarkable" and "amazing," thereby validating the assertion that women's body and reproduction system are faulty and require medical attention and physician's assistance (Davis-Floyd 2003:44-60).

There are significant differences between technocratic, holistic, and natural childbirth. The holistic birth model, where the female body is considered as healthy as the male body, is quite the opposite of what is identified as technocratic birth. It views childbirth as a natural process and home birth under a midwife's care as giving value to nature over science and technology. The holistic birth model considers labor pain as natural, which has its rhythm and can be long or short and should not be induced with medication. The natural childbirth model

involves women's active participation in their birthing process with the presence or absence of obstetric procedures. Natural childbirth has separated from "prepared childbirth," which sees birth as usual and natural but inherently dangerous and requires a physician's assistance (Davis-Floyd 2003:160-165). Countless women end up with cesarean sections, or with vaginal deliveries with episiotomy, or use of epidurals, although they had planned to do a natural birth.

In 1985, the *New England Journal of Medicine* defined "natural birth" as a "dangerous" and "traumatic process" resulting in maternal and infant deaths and proposed increasing cesarean deliveries to reduce the risks of normal deliveries (Davis-Floyd 2003:54). The denial of vaginal birth after a cesarean delivery is one reason behind the increasing rate of cesarean births. Lewis Mehl, M.D. and colleagues performed a comparative study among 1,046 home and hospital births (Mehl et al. 1977a). They found that, due to the risk of uterine rupture, physicians strongly discourage vaginal birth after cesarean and prohibit delivery by midwives, which forces women to resort to cesarean operations in the hospital. However, Mehl et al.'s findings show that cases of uterine rupture often occur due to physicians' overuse of inductive drugs (e.g., Pitocin, Cytotec) and the use of single-layer instead of double-layer suturing in C-sections (Mehl et al. 1977b).

Furthermore, Mehl found that home births are safer for both mothers and babies. Compared to home births, hospital births had a higher incidence of maternal high blood pressure, meconium staining, shoulder dystocia, postpartum hemorrhage, higher rate of perinatal and neonatal deaths, higher rate of birth injuries, infection, cases of a fractured skull, fractured clavicle, brachial nerve injury, eye injury, higher rates of episiotomy and anesthesia, and a higher rate of C-sections. The drugs physicians use during labor can remain in the baby's system for several days, and the baby may be born with medications in their bloodstream. The pain-

relieving drugs have some long-term side effects on babies, including the risk of developing childhood cancer before age ten. In sum, hospital birth does not necessarily minimize the risks associated with labor, and home birth does not increase their chances; nevertheless, people consider hospitals the safest place to give birth (Davis-Floyd 3002:180-283).

Microaggression, a demeaning behavior toward patients that negatively influences the interaction between patients and physicians, is also a form of obstetric violence. Microaggression is caused by structural factors, including the healthcare system and the historical context of a country. For example, public hospitals in Mexico are often overcrowded with patients, which leads to feelings of exhaustion and frustration among physicians (Smith-Oka 2015). Furthermore, the historical context of Mexico creates and perpetuates the intersectionality of social categories that divide people based on their class, ethnicity, gender, skin color, and location (e.g., rural vs. urban). This historical context shapes physicians' attitudes toward the poor and impoverished population in Mexico.

Since physicians treat women based on class- and "race-" based stereotypes, the quality of health care one receives largely depends on one's socioeconomic class and skin color—despite the goal of many developing countries to ensure equal access to health care and to reduce discrimination between affluent and poor citizens. In Latin America, poor women with dark skin face more violence in public hospitals (Castro 2019:103-114). Unnecessary cervical examinations are one example of inhumane medical practices against low-income, marginalized women. Cervical examinations are performed at least every half hour in some Mexican public hospitals, despite the recommendation of the WHO that cervical tests be limited to one every four hours (Smith-Oka 2013).

How healthcare professionals use obstetric violence to control poor women's reproductive health is another example of reproductive governance. Reproductive governance creates a fault line between wealthy female "consumers" who receive the best care in private hospitals and poor "charity beneficiaries" who only have access to limited health resources in public hospitals where they experience various forms of obstetric violence. As a concept, reproductive governance sheds light on "obstetric violence" as a coercive form that provides reproductive rights to a privileged group of women while limiting the reproductive rights of marginalized women (Castro and Savage 2018; Morgan and Roberts 2012).

In Bangladesh, the intensity of obstetric violence differs based on socioeconomic condition, social status, and power. People with money, power, and status have better access to quality health care and respectful treatment from the hospital authorities. In contrast, the poor are the worst sufferers of obstetric violence in both public and government hospitals. Poor women expect "mistreatment by physicians" and do not deem this behavior abusive. They put up with the violence they face in the hospitals, thus demonstrating "overtly subservient tendencies"—a form of resilience that Nobel laureate Amartya Sen has defined as, "The underdog learns to bear the burden so well that he or she overlooks the burden itself" (Castro and Savage 2018). Since poor women have meager expectations, they may see real violence as trivial (Castro and Savage 2018; Castro 2019:103-114; Sen 1984; Chattopadhyay, Mishra, and Jacob 2017). This unfortunate phenomenon is described by Castro (2019) as "adaptive preference." Adaptive preference was the main obstacle for me in collecting data about obstetric violence because the poor and marginalized view and accept these mistreatments as "normal." To my question, "Have you faced any mistreatment from doctors or nurses or hospital authorities?" their answer was, "No," but their stories revealed extreme cases of obstetric violence.

The authorities of government hospitals are also highly corrupted. To get access to treatment, patients have to offer bribes to watchmen, ward attendants, and nurses. Hospitals are crowded with third-party agents who have an "inside understanding" of the hospital authorities. They often mislead patients and their attendants to extort money from them.

To prevent obstetric violence, in 2015, the World Health Organization officially gave the following statement:

> Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research, and advocacy on this important public health and human rights issue" (Lokugamage and Pathberiya 2017; Sadler et al. 2016).

In the modern birthing culture, certain reproductive technologies (including episiotomies, electronic fetal monitoring, ultrasound, and labor-inducing drugs) are utilized in a way that suggests pregnancy and birth require medical oversight and intervention. As a result, some women believe their bodies are not suitable for a natural delivery. Even in geographic contexts characterized by lack of doctors, an unhygienic environment, and insufficient equipment, mothers prefer hospital birth in the hope that "they will save you if you suffer" (Davis-Floyd 2003:183-195; Sargent 1997).

Technology-based birth repositioned male physicians in authoritative positions and led to the hierarchical distribution of knowledge (Sargent and Bascope, 1997). Feminists have long critiqued overly scientific and technology-motivated methods that objectify women in male-dominated health interventions, resulting in the use of reproductive technologies that strengthen male supervision over the female body and limit women's reproductive choices. In a technologically advanced society like America, women give more importance to technology and

science and readily accept the technocratic birth model. Women's domain is highly influenced by technology, and they consider technocratic birth as empowering. Their dependency on technology has offered them a way out of the home and has ensured their larger participation outside the home. Moreover, women's achievement in social and political arenas is indistinguishably linked with technological advancement and has become a prerequisite for success in the technocratic society.

Medical and technological interventions have done a tremendous job convincing women that their reproductive health is defective and needs the "technocratic model of birth." Electronic fetal monitoring almost doubles the rate of cesarean operations. The use of epidurals by anesthesiologists to reduce labor pain may adversely affect the labor if given before the cervix is dilated five centimeters, thus increasing the need for operative deliveries. Epidurals are also used to suppress the sound of laboring women or to reduce the level of attention physicians are supposed to give women during labor (Davis-Floyd 2003:01-05). Additionally, the use of an epidural may increase the mother's body temperature, creating confusion as to whether it is because of the epidural or because the baby has developed an infection. The techno-medical intervention of childbirth is irrational and harmful for mothers and babies.

The overuse of biomedical and technological intervention in obstetric practices has brought women's bodies under physician's surveillance and intensified obstetric violence worldwide. Establishing and normalizing "childbirth" as a hypermedicalized event adversely target women's bodies, sexuality, and autonomy. Simultaneously, given most women's limited medical and technological knowledge, overutilization of medical technologies constrains women's decision-making regarding their birth process. Thus, the increasing emphasis on medicalized birth marginalizes women during their birth experience and makes them vulnerable

to obstetric violence (Dixon 2015:437-454; Sargent and Bascope 1997). The techno-medical intervention of childbirth is irrational and harmful for mothers and babies.

Although technology has provided women with more choices and information, what we often overlook is that "it is the power which gives one control over both information and choice." The aim of these reproductive technologies should be assisting women with birth and not establishing control over their bodies and sexuality; but, paradoxically, it has set physician's surveillance over women's bodies. These oversights are psychologically disempowering and dehumanizing to women and have created a technocratic socioeconomic hierarchy that has intensified inequalities (Davis-Floyd 2003:283-291).

The cross-cultural investigation of childbirth in four cultures demonstrates that the birthing system in the U.S. differs in several respects from the Dutch, the Swedish, and the Maya Indians of Yucatan. The Dutch and Maya Indians regard birth as a natural process that requires low technology and less physician interference. Low-technology birth is collaborative where authoritative knowledge is broadly distributed among women. In Sweden, women are informed about what kinds of medication are available, the conditions under which they are not advisable, and any known and possible side effects. Laboring women in Holland and among Maya Indians have a strong voice in the birth process. Only in the United States is birth defined as a medical and pathological event (Jordan 1993).

These vignettes exemplify poor people's unequal access to health care, hierarchical distribution of treatment, authorities' authoritative knowledge and practices due to patients' lack of medical knowledge, and patients' submissive posture due to their poor socio-economic condition. To decrease and eliminate all forms of obstetric violence against women, it is high time to promote "humanized birth" and establish reproductive rights as a human right.

The failure to develop women's reproductive health as a human right has endangered women's reproductive choice and given rise to numerous forms of obstetric violence and violation against women. Women's reproductive health and reproductive choice are under consistent attack. The health and lives of countless women are in danger due to their inability to obtain the safe, legal, and essential reproductive health care they need. Obstacles that hinder establishing women's reproductive rights are not being challenged to explore possible solutions, and they are difficult to establish due to a lack of political will at the domestic and international level. It is necessary to establish reproductive rights as human rights, as well as to develop a framework for a reproductive health paradigm that will reform women's healthcare system and prevent obstetric violence (Davies 2010).

# CHAPTER VII

## HEALTH COMMUNICATION

Islamic doctrine and jurisprudence have a significant influence on women's reproductive choices in many Muslim cultures. In Gilgit-Baltistan of Pakistan, the government and the conservative Sunni Ulema (clergy) targeted women's reproductive choices differently due to their ideological conflict. Pakistan is the world's sixth most populous country globally, and to mitigate the demographic crisis, the government has promoted contraceptive use and family planning projects. The government and non-government organizations have announced contraceptive use to reduce fertility as a "rational choice" and to have a larger family as an "irrational choice." On the other hand, due to the socio-economic and religious barrier to contraceptive use in Islam, the conservative Sunni Ulema promoted and honored frequent childbearing. The mosque-centered religious authorities in Pakistan encouraged women to have more children as they believed women have an obligation to reproduce to increase the number of believers in the "global Ummah." This ideological conflict had become a significant barrier to successfully promote the two children policy and overcoming the demographic crisis. To make a bridge between the two ideologies, government and non-government organizations have used Islamic doctrine as a mechanism to promote and validate fertility reduction. These Islamized family planning strategies have become a form of biopower (Foucault 1978) that are used to establish control over women's bodies, minds, and reproduction (Varley 2012).

To successfully promote the idea of a smaller family, government projects have used culturally acceptable techniques. The idea of smaller families and contraceptive use was promoted as a convenience to the family's economic status and the children's health and education, and not only as a solution to the demographic crisis. The cultural acceptability techniques include workshops, seminars, and training with Islamic clerics and local Islamic representatives about the benefits of family planning, mother and children's health, economic challenges due to larger families, sterilization, etc. The family planning organizations have also published and distributed leaflets in the Urdu language containing the Islamic doctrine interpreting the Islamic position on reproductive health. In Islam, coitus interruption is the only contraceptive permitted, and the Prophet Muhammad strongly prohibits permanent contraception. The government's Islamized family planning project used the interpretation of the Islamic doctrine as a device to prove that Islam permits contraceptive use to maintain a time gap between births. They used the Holy Quran verse to justify smaller families and "rational reproduction" (Varley 2012). In my thesis, I argue that, as a Muslim-majority country, the Bangladesh government has also used a similar tactic to tackle conservative Islamic ideologies regarding contraceptive use.

Islam is a pronatalist religion that encourages its followers to increase its number of believers. To reproduce, Islam permits in vitro fertilization if the fertilized egg is transplanted back to the same prospective mother who provided the egg. Islam does not allow sperm and egg donation and surrogacy with third-party involvement and strictly forbids third-party donation from *Zina* (an Islamic legal term, meaning illicit or extramarital sexual relations) because it confuses kin relation and descent. Transfer of any reproductive materials is considered

dangerous, against nature, against God, and *Haram*—forbidden or proscribed by Islamic law (Inhorn and Tremayne 2015; Arousell and Carlbom 2016). However, the situation is slightly different for the Shia Muslims, though they support the majority Sunni Islamic view like the Sunni Muslims do. Shia Muslim authorities consider donor technologies as "marriage survivors" that prevent marital disputes due to infertility. Assisted reproductive technologies are widespread in Muslim majority countries like Lebanon, Iraq, and Bahrain (Inhorn and Tremayne 2015). In sperm donation, the donor will be the biological father, and the sterile man will be the adoptive father of the newborn, and the newborn can inherit from the biological father. On the other hand, the child of the egg donor will inherit from the donor, and the infertile woman will be the adoptive mother of the newborn. Thus, many Muslim couples rely on their close relatives for gamete donation to prevent untoward outcomes.

*Mahmuda Akhter used to work as a health worker under the government's population control program. Her work was to visit every house in the village she was assigned to provide contraceptives and advice on family planning, reproductive health, etc. She also used to motivate local women for long-term contraceptives and sterilization. Besides the door-to-door service, she arranged monthly meetings in the yard with the village chairman, where men and women were invited to share their opinions. From an anthropological perspective, the meetings were like "focus-group discussions" where participants shared their views and perspectives in a group setting. Sometimes, they invited village representatives (village chairman, clergy from the local mosque) to advise and motivate the village people on family planning. Participants were provided with special foods, gifts, and clothes to encourage their participation in the meetings.*

*Recruiting village women as health workers to provide door-to-door service to spread the government's message to people proved very effective in reducing the fertility rate. Nasrin worked as a health worker for almost twelve years. She used to distribute contraceptives to the village women. As she claimed, "We were instructed to provide information on the benefits of having a smaller family, of using contraceptives, and of sterilization. Nowadays, women themselves are very aware and don't want to have many children. When I started working as a health worker twelve years ago, it was difficult for us to convince them to adopt contraceptives; also, contraceptives were not available in the village, but this situation has changed radically."*
*- Nasrin, a health worker.*

*My interview with the health workers revealed that women from religious and ethnic minorities other than Muslim were more likely to be persuaded to undergo sterilization. "Most Muslim women think sterilization is a sinful act. So, we try to entice them with money to sterilize them under fraudulent representations after birth or motivate them toward contraceptive use."*
*- Nasrin*

*The following ethnographic vignette is another example of how Islamic ideology influences a woman's reproductive choice. One of my respondents' husbands was an imam of a mosque. She explained, "I already have three children, and I am pregnant with my fourth child. My husband is an Imam of the mosque, and he doesn't allow me to take any contraception. We will take as many children as God provides us." Three of her children were delivered at home with the help of a midwife since she has to maintain purdah (veil).*

Islamic ideology plays a significant role in influencing women's reproductive choice in Muslim countries like Bangladesh since its ideology conflicts with contraceptive use, abortion, and sterilization. The government's population control program is also in conflict with Islamic ideology since it promotes the idea of a smaller family. Among conservative Muslims, sterilization, abortion, or using contraceptives to limit the number of children is considered a sin. The common notion that persists among them is that "it is God who gives lives, and it is God who will feed them." The ideological conflict was one of the main obstacles to the government's population control program. The government had to use different tactics to combat this obstacle.

One successful tactic was the "community-based approach" that involved providing training to village women on primary medicine and family planning and doing door-to-door outreach to supply contraceptives to them. Involving village women in the government's family planning program was a part of the "cultural acceptability technique" since these health workers were better received in the village. By so doing, the government has successfully promoted "cultural acceptability techniques" and "Islamized family planning projects" to deal with conservative Islamic ideology. Literate women from rural and urban areas are now convinced that smaller families are socially and economically desirable and are willing to use contraceptives. However, the poor, illiterate population of rural Bangladesh and conservative Muslims are less likely to be motivated to limit their reproductive choice. Also, sterilization and abortion are still considered sinful and are prohibited among most of the population. This is one reason why ethnic and religious minorities were the first targets for sterilization as part of the government's extreme population control policies.

Health workers are the government's representatives to circulate newly produced knowledge regarding reproductive health, contraceptive use, family planning, etc. There are

politics behind the knowledge circulation that target women differently based on their social class and status. Previously, while television was not available in the villages, radio was a powerful source for circulating new information. Currently, TV commercials are a popular medium for spreading information. Moreover, while giving interviews, most of my respondents provided the information that they came to know about the population control program in primary school. *"The slogan of taking no more than two children is included in our textbook, so we are already aware of this." -Akhter,* in response to my question of where she heard the population control slogan.

Earlier, I discussed how biomedical knowledge is produced, distributed, and contested from high authority knowledge producers to the mass population, in a modality perhaps describable as 'biocommunicability.' This circulation of knowledge shapes and dominates people's preexisting knowledge and behaviors. Each culture has its own way of accepting and adopting new knowledge that we can identify as "cultural acceptability techniques." For example, "Islamized family planning" was one of the government's cultural acceptability techniques to deal with conservative Islamic ideology, which was the main obstacle behind the population control program. In rural areas of Bangladesh, Islamic seminars arranged by the local mosque representatives are a common scenario where people from all over the village spontaneously gather. Since the government has also provided training to these religious representatives on population control awareness programs, their speeches in the Islamic seminar also play a crucial role in distributing the government's message.

Health communication is significantly an effective way to spread health messages to the mass population living in Bangladesh's rural and urban areas. To incorporate the idea of smaller families with preexisting conservative Islamic ideology, "health communication" was a

successful tactic of the government to reach people living in the remotest corner of the country. Besides broadcasting educational advertisements, drama series, and animation related to population control, the community-based approach played a substantial role in spreading the government's message to the mass population. As a part of this community-based approach, village women were trained on primary medicine and family planning; they provided door-to-door service on contraceptives distribution, counseling village women on family planning, etc. My interviews of health workers reveal that health workers played a significant role in health communication by informing and influencing people about contraceptive use and limiting reproductive choices in Bangladesh

# CHAPTER VIII

# CONCLUSION

Anthropologists have worked immensely on the politics of population control in different countries worldwide, and there are numerous anthropological works on women's reproduction, cesarean birth, and obstetric violence. Nonetheless, I have brought population control politics and cesarean birth under the same microscopic lens that sheds light on a new horizon. I have critically studied the increasing cesarean birth rate in Bangladesh and tried to reveal its connection with population control politics.

While developing countries of the world have focused more on population control and dealing with improving the population quality for economic development, the government of Bangladesh is also following similar stages of development. Started in 1976, when the government declared overpopulation as the number one problem of the country, it has achieved notable success in reducing fertility, but still, the country is one of the most overpopulated countries in the world. I have critically studied the government's population control programs and divided this into two subcategories: explicit policy and program and implicit or disguised policy and program. The target people for the population control program in Bangladesh varied based on their socio-economic condition, where poor women from religious and ethnic minorities were treated differently. Moreover, the intensity of the program also varied, where

some women were provided with short-term and long-term contraceptives while some others had to go through forced sterilization. Some of the policy implemented openly, while others were implemented disguisedly. Since cesarean birth in Bangladesh limits women's fertility to two children, I have explained how cesarean birth is a disguised way of reducing fertility.

I found Castro's work (2004), which sheds light on the politics of fertility reduction in developing countries like Mexico, very relevant for my research. Castro addressed that the ideal number of children in Mexico depends more on physicians' perception than on actual clinical recommendations. In Mexico, three children are considered ideal, and women are provided with permanent contraceptives at the time of their third cesarean birth that permanently ends their fertility, thus contributing to fertility reduction. My work is based on this literature, where I have hypothesized its relationship with population control politics.

In Bangladesh, the notion that women can only have two children via cesarean is also a physician's perspective, not a clinical recommendation. Based on this existing literature, I made a unique hypothesis that cesarean birth is a disguised politics of limiting and reducing fertility in Bangladesh. I argue that the increasing rate of cesarean birth is an implicit way of population control in Bangladesh since the two-child policy via cesarean is compatible with the government's ideal number of children for each woman. I propose that cesarean birth is indirectly limiting women's reproductive choices and reducing fertility for the country.

To avoid a narrow perspective, I have also discussed other possible reasons for the increasing rate of cesarean operation. All these causes are previously addressed from different perspectives in numerous existing literatures, but none of these connected with the population control politics of a country. From this perspective, my research has revealed a new horizon that will make a unique intervention in the existing literature.

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# BIOGRAPHICAL SKETCH

Sadia Sharmin completed her Master's in Anthropology from the University of Texas Rio Grande Valley (UTRGV) in 2021 and her Bachelor's in Anthropology from The University of Dhaka, Bangladesh in 2014. Her research interests include medical anthropology, reproductive health, obstetric violence, health disparities, gender studies, inequality, and indigenous knowledge. She maintained a GPA of 3.73/4.00 throughout her graduate study and was awarded "Presidential Graduate Research Assistantship." She has 2.5 years of teaching experience as a lecturer at a public university in Bangladesh and, as a master's student, worked as a teaching assistant for one year. She is now motivated to continue her studies at the doctoral level. Upon completing the Ph.D. degree, she plans to pursue a career in academia and research.

Permanent Mailing Address: 52/3 West Rajabazar, Panthapath, Tejgaon, Dhaka, Bangladesh, 1215. Personal Email: sadiaea71@gmail.com.