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‘You have to do some *dhora-dhori*’: achieving medical maternal health expectations through trust as social practice in Bangladesh

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Abstract: In contrast to prevailing conceptualisations of ‘trust’ as an object in popular and political discourses, this article takes the concept of trust as future-oriented practice as a launching pad for understanding relationships between people and medical systems in Bangladesh. Based on ethnographic fieldwork in Bangladeshi peri-urban and rural spaces, it focuses on expectations related to advanced maternal biomedical technologies delivered through medical institutions. These technologies have recently come to dominate practices and expectations around pregnancy and childbirth care and women’s navigations of health systems to realise these expectations. Within this context, trust in institutions in the public or private health sectors remains peripheral to women’s experiences of accessing desired maternal health resources. Rather, women leverage social connectedness through the patronage-related practice of *dhora-dhori*, translated as mutual grasping or holding. *Dhora-dhori* is based on social rootedness, trust in that rootedness, and reciprocity. Women act as embedded agents within their families to appeal to various social connections through *dhora-dhori* to tactically access desired services and resources, with the expectation that this will result in better care at a lower cost, whether in public or private health sectors. It is through such practice that women and families work to realise their expectations of care through institutions, collapsing distinctions between ‘trust’ in personal relationships and ‘trust’ in institutions, as it is through intimate relationships that relationships with medical institutions are engaged.

Keywords: trust, health systems, maternal health, childbirth, ethnography, Bangladesh.

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Introduction

Evocations of 'trust', long appearing in discourses related to medical systems, have multiplied in recent years, gaining momentum in moments of epidemic and pandemic response. Within this context, trust has been reified as an incontestable 'good thing' (Cornwall 2010) that societies simply need more of in relation to medical systems and institutions, an object that can be measured and built. Anthropologists have rightly critiqued the uses of 'trust' in these popular and political discourses, noting its lack of conceptual clarity equal to its prevalence in discourse (Carey 2017: 3, Storer & Simpson 2022), how it is evoked as a tool to be leveraged toward political interests, and its potential to be used as an 'anti-politics machine' (MacGregor & Leach 2022), stigmatising those who are 'deficient' in trust and exacerbating pre-existing marginalisation (Raschig 2022). Moreover, they note the ethnocentrism within these discourses, rooted in individualism and particular notions of the self (Coates 2019).

Building on anthropological scholars and in a call for more meaningful conceptualisations of trust in public spaces, Storer and Simpson propose a conceptualisation of trust as a verb, perpetually in the making and remaking (Storer& Simpson 2022). Trust as a verb is oriented towards expectations of particular futures. As Pedersen and Liisberg write, 'trusting is a mode of existence that shapes our outlook on the near future; a future that will probably develop according to implicitly or explicitly expressed expectations' (Pedersen & Liisberg 2015: 1). Within the social sciences, trust as a future-oriented mode of existence has been theorised in relation to personal relationships wherein the person is known, as well as in relation to systems in which the other is 'unknown' (Carey 2017: 5). When applied to medical systems, trust as a verb can be thought of as anchored around what forms of care one might expect within medical institutions of care, and the practices, both taken and imagined, to realise these expectations.

This article takes the concept of trust as future-oriented practice as a launching pad for understanding relationships between people and medical systems in Bangladesh. It focuses on expectations of advanced biomedical technologies delivered through medical institutions comprising much of the medical system, which have only recently come to dominate practices and expectations around pregnancy and birth care. I use the term medical institution broadly conceived as a space recognised as enacting biomedical knowledge. In the Bangladeshi context, these include an array of hospitals, clinics, and diagnostic centres operating in the public and private sectors under more or less formal legitimisation. While institutional pregnancy and birth care until quite recently remained uncommon in Bangladesh, seeking care through formal biomedical facilities for birth has increased

exponentially over the past fifteen years (NIPORT *et al.* 2019). These transitions are directed heavily toward the use of biomedical technologies in the form of foetal ultrasound and caesarean procedures (NIPORT & ICF 2019). While such technologies are only unreliably available in public health facilities (Billah *et al.* 2019), women find them widely available in private healthcare institutions, largely under-regulated, built up around the scaffolding of public institutions (Rahman *et al.* 2013, Sattar 2021).

This article examines the future-oriented navigations of women and families for pregnancy and birth in this complex therapeutic landscape. It first sets out the backdrop for the discussion, examining shifts in maternal health service delivery and expectations in Bangladesh towards institutionalised biomedical care. It then turns to the future-oriented practices of women and families to access institutionalised forms of care in both public and private health sectors, tracing the stories of two women, Tasrin and Shilpi. These examinations elucidate the local construct of *dhora-dhori*, literally translated as mutual grasping or holding, as foundational to how women and families orient practice to achieve health ambitions vis-à-vis medical institutions. *Dhora-dhori* relies on the nurturing and give-and-take of intimate social relationships, and is drawn on by people to navigate different social fields and access resources and opportunities through these navigations. These can range from accessing institutional resources, including those officially delivered through state services, and job opportunities. It is through such practices that women and families realise their expectations of care through institutions, collapsing distinctions between trust in personal relationships and trust in institutions, as it is through intimate relationships that relationships with medical institutions are engaged.

Methods

This article is based on data generated during 18 months of ethnographic fieldwork in Bangladesh between September 2019 and March 2021 for my doctoral research. During fieldwork, I engaged in participant observation and conducted interviews in various maternal health settings, including maternal health policymaking and programming circles in Dhaka and government and private facilities in Kushtia district, located in the west of the country, alongside the Indian border. In Kushtia, I spent time with women and health service providers in antenatal care service points, labour and delivery rooms and operating theatres. In addition to informal discussions, I formally interviewed 65 women in health facilities and their homes. These interviews explored the participants' experiences of pregnancy and childbirth

and their navigation of the maternal health service terrain. I obtained ethical approval for this project prior to initiating data collection through the University of Edinburgh School of Social and Political Science and in-country through the ethical review committee of the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b).

Biomedical ensembles and desires

Since British colonial rule, pregnancy and childbirth in South Asia have operated as sites of biomedical interest, with efforts by the colonisers and missionaries to shift birth toward institutional spaces (Mukherjee 2017, Sehrawat 2013), an unfinished project taken up by state and development interests after decolonisation. However, despite these efforts, by the end of the 20th century, scholars noted that childbirth in Bangladesh remained remarkably similar to what it had been during the centuries prior, typically occurring in homes, with the assistance of female family members or non-professional*dais*, traditional birth attendants (Afsana & Rashid 2009, Rozario 1998).

As late as 2004, demographic data suggested that fewer than 10 per cent of women gave birth in institutional settings (NIPORT *et al.* 2005). Until this time, biomedical birth services were primarily offered through public health institutions. Indeed, the Constitution of 1972 committed the state to ensure medical services to people living in rural areas (People's Republic of Bangladesh 1972), which, in subsequent decades, materialised in the scaffolding of a public health system with a network of district, *upazila* (subdistrict), and union-level health facilities, managed through two directorates under the Ministry of Health and Family Welfare: the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). While health facilities under both directorates provide services for uncomplicated birth, Emergency Obstetric Care (EmOC) was primarily introduced through DGHS facilities as part of an EmOC project initiated in the early 1990s (Gill & Ahmed 2004). This project aimed to integrate EmOC, including emergency caesarean procedures, into health facilities down to the *upazila* level, a project which today remains far from complete (Alam *et al.* 2015, Sikder *et al.* 2015).

Still, by 2016, institutional birth skyrocketed to nearly half of all births (NIPORT *et al.* 2005. NIPORT *et al.* 2019). This trend was largely driven by the movement of birth toward private health institutions, while births in public institutions rose only slightly (NIPORT & ICF 2019). In recent years, unregulated and minimally-regulated private health facilities have mushroomed throughout the country in various froms, from large corporate hospitals and their satellites located in urban

and peri-urban centres, to small start-up facilities, spread into the most remote corners, providing opportunities to compensate for the fragmentation and unreliability in the public sector for people of all social classes. This has emerged particularly starkly for maternal health services. These trends not only expanded relationships between people and health institutions during moments of pregnancy and childbirth, but also resulted in enormous implications for the very mode of birth—in just over a decade, caesarean birth increased ten-fold, from just 3% to over 30% (NIPORT *et al.* 2019). While these transitions are consistent with trends toward medicalised childbirth across South Asia and globally (Jullien & Jeffery 2021, *Lancet* 2018), they have been particularly rapid in Bangladesh.

In Kushtia, none of the public subdistrict hospitals offers caesareans—the only public facility to reliably do so is the district hospital. However, the maternal therapeutic landscape is replete with private health facilities promising the delivery of advanced biomedical technologies—specifically foetal ultrasound and caesarean. Many of these are built up around the scaffolding of public health facilities. These facilities vary enormously, from a few (expensive) corporate hospitals located in the administrative hub of Kushtia, to many entrepreneurial starts-up, often comprised of an austere operating theatre, a couple of recovery rooms, and staffed by informally trained providers and a clinician who rotates among such clinics to perform basic operations, such as caesareans. Many of these facilities operate without formal licenses, and those with licenses are accorded these credentials based on a regulatory framework which dates back to 1982 (Government of Bangladesh 1982). Such facilities exist tenuously—it is common to hear stories of the ghosts of clinics past; those without the social, economic, or political resources to persist.

Women in Kushtia, irrespective of social class, express the desire to access biomedical technologies in the form of ultrasound and caesareans, contained in institutional spaces. Even my poorest interlocuters articulated ultrasound, whether or not it was paired with other forms of formal antenatal care, as a basic requirement and responsibility and had at least one, and often multiple, ultrasounds during pregnancy. Ultrasound technology, for them, is imagined as an oracle, letting them know if the baby will be okay, and foretelling whether the birth will need to be through caesarean. While most of my interlocutors said that they would like to try for a vaginal birth, there was often a general resignation that a caesarean may be necessary for any type of problem, and they desired the possibility to access this service if required. The promises of caesarean are perhaps oversold, particularly in the peripheries where ensuring clinical standards is elusive; nonetheless, the procedure is generally narrated by my interlocutors as the ultimate solution for averting potential harm, especially for the baby, and therefore inspires aspirations towards birth futures previously unthinkable.

The biomedical maternal therapeutic landscape is a tenuous space to navigate indeed. Women and families tend to use a mix-and-match approach, moving between public and private sectors to realise their expectations of care. In either sector, however, what one might expect to access is characterised by unreliability. In theorising 'mistrust', Matthew Carey pushes past mistrust as simply the absence of trust, proposing rather that mistrust captures a 'general sense of unreliability of a person or thing' (Carey 2017: 8). While my interlocutors did not articulate their relationships with the medical systems in terms of trust or mistrust, they did articulate their experiences with the these systems in terms of unreliability, and a reticence to place their expectations of possible futures in the metaphorical hands of these systems. Given this general sense of unreliability of health systems, what practices do people engage in to maximise the probability of realising a future in line with their expectations of pregnancy and birth care, now incorporating advanced biomedical technologies? The next sections turn to this question, centring the practice of *dhora-dhori*, the mutual grasping or holding embedded in intimate relationships, in the everyday navigation of women and families seeking to fulfil their health expectations to maximise their health and that of their babies during pregnancy and childbirth.

Dhora-dhori and navigating public maternal medical systems

Discourses related to trust in medical institutions tend to presume particular configurations in the nature of relationships between people and institutions. When taking public health institutions as a concern, these discourses often presuppose relationships between people and medical services based on citizenship, or the legitimate claims people can make on a state delivering entitlements. An alternative, competing, and increasingly prevalent type of relationship is imagined between people and private health service delivery, delivering services to people as clients, based on their willingness to purchase health commodities and health services through capitalistic forms of exchange.

While these typologies are a vast over-simplification, and are severely limited in their ability to represent the complex and blurred boundaries between and within biomedical health delivering entities in and beyond Bangladesh, they highlight the presumptions of forms of trust as a forward-looking concept in how one might aspire to access desired health-promoting resources. How do these typologies compare to trust practices in achieving health aspirations in rural Bangladesh? To examine this, I turn to the stories of two women, Tasrin and Shilpi, to illustrate the navigation of social relations to achieve maternal health ambitions. Tasrin and

Shilpi share similarities: both live in villages in Kushtia, both consider themselves poor, residing in the in-law's household, with livelihoods sustained through farming. Both had two young children, and sought to optimise their health and that of their babies during their pregnancies and births. Both imagined access to advanced biomedical technologies, ultrasound, and caesarean birth services if necessary, as central to these ambitions. Where they differed, however, was in the types of spaces in which they sought to fulfil these ambitions—Tasrin sought to achieve these through the public health sector, while Shilpi bypassed public services altogether, staying either at home or seeking care through the prolific private health sector.

Tasrin was a young teen when she became pregnant for the first time. The Demand-Side Financing (DSF) project was in full swing in Daulotpur upazila, where Tasrin lives in the outskirts, by the time of her first pregnancy. Championed by the Department for International Development (DFID) of the United Kingdom, the DSF project aimed to lure disadvantaged women to institutionalised health services during pregnancy and birth through financial incentives (Ahmed & Khan 2011, Khan & Khan 2016). The DSF project in Bangladesh is but one configuration of conditional cash transfer schemes, a popular fixture in the development apparatus since the late 1990s (Bradshaw 2008). Such schemes remain popular among maternal health policymakers and programmers (Glassman *et al.* 2013). While these schemes vary in form, they share a foundation of market-oriented principles which leverage individual responsibility and market motivations.

The Ministry of Health and Family Welfare, supported by international development partners, introduced the DSF project through the public health system in 2006. Daulotpur upazila, identified by the programme as a 'disadvantaged' and border area, was one of twenty-one upazilas selected for the pilot. The scheme initially provided vouchers for qualifying women based on economic criteria to use institutional health services. In the model, the voucher covered costs for women to attend three antenatal care visits and one postnatal care visit, including transportation. On top of that, women received a cash incentive of 3,000 taka (~£25) to give birth in a government facility, a handsome sum where a monthly household income of the same amount was the initial cut-off for qualifying for the voucher.

When pregnant with her first child, Tasrin secured a DSF voucher, which women refer to as the 'card', seven or eight months into the pregnancy. While, officially, pregnant women obtained vouchers for a first or second child free of charge, they tend not to describe it this way. Instead, they share stories of exercising their social networks to avoid financial exchanges to obtain the 'card'. 'You have to do some *dhora-dhori*', Tasrin explains when we ask her how she secured a card, evoking her leverage of social networks to access opportunities or resources. 'I have one of my relatives … she arranged this for me. The daughter of my elder

brother-in-law works [with a member of local government]. I got it through her, even though I was not directly a relative [of the member].'

Despite possessing the 'card', Tasrin anticipated giving birth at home with the assistance of her grandmother-in-law (*dadi shashuri*), experienced as a *dai.* But as her due date passed and the days ticked by with no signs of labour, these aspirations evaporated. 'My mother, grandmother, everyone over there, I asked them. They said if [the labour pain] did not come, I would need to go. It was almost just like that. "If you do not have the poison pain [*biSh byaetha*], you must go to the doctor's house", they said.' A week past her due date, her family took her to Al-Arafa Hospital in Kushtia for what would be her third and final ultrasonogram of that pregnancy. Al-Arafa, which straddles the space between a charitable non-profit and for-profit private hospital, is one of the most well-reputed hospitals in Kushtia. She consulted with Dr Sabina Khatun, a highly esteemed obstetrician in Kushtia.

'I did the *sono* [English cognate for ultrasonogram]', she recounted, 'and the doctor told me that the water inside was drying. She noticed that there was not enough water... Therefore, a caesarean was necessary.' With this news, the family returned home, determined to go to Daulotpur upazila health complex, the government subdistrict hospital, the following day. It would be her first visit to the government facility during her pregnancy. Previously, her family took her to Al-Arafa as they were not confident in the quality of the services provided at the government complex, particularly the quality of the ultrasonogram, her primary motivation for visiting any biomedical institution during pregnancy. However, the upazila health complex was an obvious choice for a caesarean. With the voucher, the services would be free of charge, and they would also receive the incentive. In contrast, a caesarean at Al-Arafa would cost at least 20,000–25,000 taka (~£170–215). That her grandmother and her *chachi* (paternal aunt) lived near the upazila health complex and could care for her and bring food during her recovery stay was no less important.

Daulotpur upazila health complex admitted her the following morning, a Friday, at 10 am. However, she was in for a long wait. 'There was no doctor there', Tasrin explains. 'It was Friday that day. As Friday is a holiday, my *mama* [maternal uncle] went to fetch a doctor that he knows'. Once the doctor arrived, thanks to her *mama*'s *dhora-dhori*, around 10 pm, he quickly performed the caesarean, and her son was born without any problem.

When she became pregnant again after seven years, Tasrin discovered the DSF project was no longer what it was during her first pregnancy, though she did not understand why. Daulotpur upazila health complex had discontinued caesarean services in the interim between her pregnancies; therefore, the vouchers no longer covered the procedure. Moreover, she could not secure a voucher, though she was

well within the requirements and enjoyed the same social connections. 'We know that member gives [the cards]', she explains. 'But if he does not give it after saying so he will, what can we do? He took everything, the ultrasonogram papers, the photos, how many months pregnant I was, everything was written.' She did not provide any financial transaction, thanks once again to her connections with the local government member through the relative, but neither was she able to secure the card as expected.

Tasrin travelled to the district hospital after the labour pain struck her in the night. However, as it was night, no doctors were available to perform the surgery. Sabina Khatun finally came to her rescue at 6 am. Tasrin credits her maternal aunt's (*khala*) *dhora-dhori* for the arrangement. 'I have a *khala* that stays in Kushtia. Sabina Khatun knows us through her, so she did that [caesarean] in her free time. "I will do the operation", she said. "It will not be any problem." So, she did it.' She was grateful to Sabina Khatun for coming to the government hospital outside of regular hours to perform the surgery rather than requiring her to come to her private practice. She spent only 2,500–3,000 taka (~£21–25) for the procedure in the public hospital.

Tasrin's account highlights the challenges in pursuing birth aspirations through public medical institutions. While government health facilities promise to deliver services to women as entitlements, from the perspective of women, this provision is characterised by volatility, as a gift that may be offered one moment and withheld at another. Development actors often use government institutions to test development intervention, such as the DSF project. This practice often translates into resources and services, such as the vouchers, appearing at one moment, then disappearing or reappearing in altogether different forms at another, following the tides of development interests and agendas. These development-shaped volatilities map onto broader unpredictabilities in public health facilities, which promise services but often fail to deliver, manifesting in the vacillating presence of health staff, logistics, pharmaceuticals, and technologies.

While discourses around public health systems suggest health resources and services delivered based on the state's responsibilities to people based on citizenship, Tasrin's story illustrates that accessing opportunities and resources, even through the public health system, is often achieved through leveraging social networks. *Dhora-dhori* indicates the moral leveraging of social networks to access opportunities or resources as pervasive in Kushtia as in Dhaka. Its enactments lie on the spectrum of patronage, integral to social relations and accessing opportunities and resources in the region (Gardner 2012, Guhathakurta & van Schendel 2013, van Schendel 2021).

Much of the scholarly work on patronage in South Asia focuses on politics,

viewing the rampant patronage in the region as an adulterated rendering of democratic ideals and stunting governance and development (Bardhan & Mookherjee 2012, Chandra 2007, Kochanek 2000). Others take a more generous position. Anastasia Piliavsky, for example, argues that patronage in South Asian politics is part of a moral universe rooted in mutuality and constitutive of social bonds (Piliavsky 2014). *Dhora-dhori* reflects such a moral universe composed of and generating social bonds. Tasrin's account exemplifies the centrality of *dhora-dhori* in navigating maternal health resources. Tasrin achieved her access to doctors through the public health system not as a matter of entitlement but through her social networks. Leveraging social relations was critical in enabling her to access development resources, i.e., the 'card' or voucher, through kin connected to the local member of government and access services at public health institutions, both in the upazila health complex and the district hospital. Social networks and the opportunities they open up for *dhora-dhori* are central to navigating the volatile maternal health service terrain and accessing desired maternal health services and resources at critical moments within the public health system.

'If there are any problems, tell this person': realising expectations in the private health sector

As mentioned previously, trends towards increased institutionalisation of birth care in Bangladesh occurred alongside a mushrooming of the for-profit private health sector, expanding delivery of maternal health services. Indeed, quantitative data suggests that the increase in facility births occurred chiefly within the private health sector (NIPORT *et al.* 2019). Many such facilities deliver services at prices affordable to poor families, and many such women bypass the public sector altogether and depend solely on private health services during pregnancy and birth.

The regulatory framework for such facilities dates back to 1982—outdated and mismatched to the contemporary landscape of private health service delivery. Many private health facilities remain unlicensed or operate under expired licenses, and even those with licenses tend to compromise on the minimal requirements in practice, for example in employing fewer professionalised health staff than required, as the standards are deemed too difficult to maintain, particularly in a rural context. Without institutional measures to ensure that promised health services adhering to a minimal level of quality will be maintained, women and families rely on other mechanisms to decide where and how to achieve their expectations for care.

Like Tasrin, Shilpi lives in a village, where her family relies on farming to maintain their livelihood. Also like Tasrin, she considers herself poor, and is among the exceptionally few women I met who never attended any schooling—her father passed away when she was young and her family could not afford to send her to school. Due to economic necessity, her paternal uncles arranged her marriage when she was 12 years old. Shilpi did not become pregnant until eight years after her marriage, though not for lack of trying. Once she did, and in contrast to Tasrin, who attempted to access services and resources through the public health system, and only successfully so through leveraging intimate relationships, Shilpi circumvented public health service delivery entirely.

Her labour pain started after she reached full term. She intended to give birth *normale* at home, as many women like her try. After some time, her waters broke. Still, her labour did not progress, so her uncle-in-law brought a woman to the house to assist her. Shilpi remembers the woman as someone who sees pregnant women and helps women give birth at home; she thinks she also worked in a government health facility. 'After she came', Shilpi recounts, 'She put her hand on me and examined me. She checked the position [of the baby]. When she saw that it was in a bad position, she took me [to the private clinic].' The woman took Shilpi to Meyirhashi, a small private clinic where she had an established relationship.

They reached Meyirhashi in the nearby town at around 11 pm. The health service providers there examined her. 'The doctor said that the baby was having some problems; like, the baby is going up [in my belly]', Shilpi tells us. 'Because of this, I needed to have the *shejar* [the English cognate women use to refer to caesarean birth]. There was extra water going out. If I did not do a *shejar,* the baby would have problems. I really wanted this baby because I had been trying for eight years.' Shilpi did not resist the advice. The doctor arrived mid-morning on the following day to operate. 'I was terrified', Shilpi tells us of the moments leading up to the operation. 'I was crying. My brothers-in-law were crying—because the baby was coming now after trying for so long. My father-in-law and mother-in-law were crying.'

The clinic staff took her inside the operating theatre. 'After taking me inside, they laid me on top of the bed. I was so scared because that is how you lie a person out when they are dead. It is like death is coming to see you.' The doctor sensed Shilpi's terror. '*Ma'*, he addressed her affectionately, using the Bangla word for mother, 'Why are you getting scared?' 'Sir, I am very scared', Shilpi responded. The doctor urged her to invite a family member to stand by her side during the procedure. Shilpi declined the offer, not wanting to subject her family to witnessing the procedure and thereby inflict fear upon them. However, one female clinic staff member stood next to her and comforted her, telling her not to be scared. The team

spoke to her 'beautifully' through her anxiety, saying, '*Ma*, you are going to have your baby.' Soon after, the doctor lifted the baby from her incision. The clinical team wiped and bathed him before presenting him to Shilpi. 'Seeing the baby, I felt a cool breeze wash over my inner soul. Allah made this happen. It was extraordinarily beautiful', she recalls.

In the days that followed the procedure, however, the family struggled to cover the charges. 'I tell you the truth', Shilpi confided. 'For the poor, when they have a *shejar*, it is so difficult how much money is required.' Meyirhashi demanded 19,000 taka (~£165) for the caesarean, an astronomical price tag for the family. She had one family friend with connections to the clinic whom they contacted to enact *dhora-dhori*. He pleaded to the clinic owners on the family's behalf. Finally, the clinic agreed to accept 12,000 taka (~£100). She remembers the health staff visiting her on rotation three or four times a day. The 'big doctor' would come and talk to her and measure her blood pressure. The clinic staff removed her 'beautiful' stitches on the seventh day, and she and the baby returned home in good health .

Shilpi fell pregnant unexpectedly only nine months later, both a blessing and a curse. She recounted that Allah gave her this baby immediately, saving her from suffering through more years of fertility struggles, but her body was not yet fully recovered from her first surgical birth. Shilpi's labour pain hit with force late one evening, and amniotic fluid trickled from her body. As her husband was away working in another part of the country, her brothers-in-law wasted no time taking her to a private clinic. Rather than returning to Meyirhashi without the social connection they enjoyed the last time, they took her to the well-known Amin Clinic in Kushtia, a presumed upgrade from the smaller Meyirhashi clinic set in the subdistrict. However, the clinic staff refused to admit her when they reached it, saying they could not admit her in the night. 'Why won't you admit her?', her younger brother-in-law charged. 'Because we are poor? We are not people with money [*takawalla*]; there are no influential people among us. That is why you will not admit.' After saying that, another person from the clinic entered the dispute. 'What is happening?', he demanded. Her elder brother-in-law explained. 'Sir, look, my brother's wife's pain has come. Since she had a *shejar* before, we cannot keep her at home. This is why we bought her. Why will you not take her?' The staff relented and admitted her.

The trickle of amniotic fluid had escalated to a deluge by then, and she could not walk. The staff transported her to the second floor. 'After they took me', Shilpi recalls, 'they checked my pulse. They did not do anything [else].' Since it was night, they would need to call for the surgeon to come, but they would only do this at an additional cost—5,000 to 7,000 taka (~£42–60). 'Before everything started, the question was about money. Before they start, you must pay money', Shilpi said.

They demanded a down-payment of 5,000 taka before calling the doctor. The family had not brought money with them. Back in the village, her uncle pooled some money from other family members and brought it to the clinic so they would call the surgeon.

After the payment, the clinic staff transported Shilpi, petrified, to the operation theatre. Once there, one of the clinic staff told her, 'You know, usually we do two or three *shejars* at a time. In the daytime, that is how we do it.' Since Shilpi's procedure was the sole to be done at this time, and because they called the doctor to come specifically for her, it would cost more money. 5,000 taka to bring the doctor, 5,000 taka for being alone. A 10,000 taka (~£85) surcharge for the misfortune of going into labour at the wrong time.

The next moments were some of the most excruciating Shilpi, no stranger to tragedy, faced in her life. The doctor came after the evening prayer and immediately operated. 'When they did the operation', Shilpi tells us, 'I had so much suffering … . The pain that I went through, I have never been through so much pain in my life.' She remembers watching the doctor sloppily stitch her belly back together.

Shilpi's suffering extended into the days that followed. In contrast to her stay in Meyirhashi, she felt neglected. She watched the hospital staff make rounds, dressing women's wounds. 'For the wealthy people [*bhodrolok*], they dressed [the wound] beautifully. Sometimes they did it two or three times.' The doctors never passed by to see her as they had in Meyirhashi. 'It was just some woman who came to see me', she recounts. 'When the woman came, my mother would loosen the cloth from the site of the cut. Meaning, the woman said to loosen the cloth. She would look a bit, but she would not put her hands on me. She would only look.' These visible manifestations of difference in treatment irritated Shilpi's family. 'My mother-in-law's sister had to call them to come to do the dressing. "Why won't you come to do the dressing? Why won't you come and give the pad?" She would say many things like this.'

Shilpi's family arranged a stop-gap solution by leveraging the family's social network and enacting *dhora-dhori*. Her father-in-law's sister brought an acquaintance with connections to Amin Clinic. 'If there are any problems, tell this person', she instructed. This acquaintance advocated for Shilpi. When the clinic staff made rounds, she accused them, saying, 'You are doing this because she is a poor patient', and demanded that they provide better treatment. For Shilpi, this intervention made the remaining stay tolerable.

The payment still dangled in the balance, however. The family did not know how they would manage to acquire the remaining balance for the clinic bill, a further 10,000 to 12,000 taka (~£85–10) in addition to the 10,000 already dispensed. Finally, they took out a loan to cover the charges, although such a loan can be finan-

cially crippling to such a family. Shilpi left five days later with her baby. However, she still suffers pain from the incision site, which she attributes to the 'so-so' stitches.

The commodification of maternal health technologies has made even the most medicalised forms of birth widespread, placing caesareans within reach of the least advantaged women, such as Shilpi. Her story is emblematic of the volatile spectra of experiences with services delivered in the private sector. Women share stories along these spectra: spectra in the quality of delivery of care from their perspective —sometimes women share that the care that they received was good, occasionally, such as in Shilpi's case, they share that it was deplorable; spectra in the dignity of care—sometimes clinic staff treat them well, other times poorly; spectra in cost: some recount caesareans costing as little as 4,500 taka (~£40), others in the order of 50,000–100,000 taka (~£425–850). Often, the difference between these hinges not on the particularities of the clinics, but rather on the social relations one is able to leverage to mediate the relationship with the clinic.

Shilpi's story elucidates the centrality of social connectedness in the form of *dhora-dhori* in accessing desired maternal health services through the private health sector. Although Shilpi bypassed government and development entities in her birthing experiences, her narrative illustrates the variability of services one might enjoy based on social connections. In the first instance, the birth attendant assisting her at home brought her to a clinic that she had a personal attachment to, and thereby this personal attachment likely extended to compassionate care delivered to Shilpi and a reduced price of the services. In the second instance, her brother-in-law took her to a clinic where they had no personal attachment, and she recalled a much less compassionate experience. It was only by bringing in an acquaintance with a personal attachment to the clinic that the staff improved their service delivery toward Shilpi. *Dhora-dhori* was essential to accessing better resources and opportunities delivered through the market, maximising immediate benefits and reducing costs.

While some facilities enjoy name recognition, engendering confidence in the services one might receive, these are primarily larger corporate hospitals located in the administrative hub that remain difficult to reach and even more difficult to afford for most women residing in villages. Moreover, as Shilpi's story illustrates, reputation does not necessarily translate into the type of care one receives within its boundaries. This care is primarily determined by social relationships one can leverage through knowing someone and being able to appeal to that relationship. *Dhora-dhori* entails the work of building and maintaining relationships which extend before and after the moment in which these built relationships are leveraged.

Conclusion

The idea of 'trust' in medical systems has become reified in global health discourses as a 'thing', a noun, with the tendency toward instrumental use, appearing, for example, in training guides (see e.g., WHO 2015). Building on scholarship approaching trust as future-oriented practice (Pedersen & Liisberg 2015, Storer & Simpson 2022), rather than as a 'thing', this article has explored trust as practice through *dhora-dhori* in Bangladeshi women's and their families' navigations of a complex maternal health therapeutic landscape. Indeed, in Kushtia, my interlocutors did not employ a lexicon of 'trust' in institutions to articulate decisions or desires for care-seeking or the outcomes of this. As in many post-colonial contexts, institutions are not imagined as entities to be 'trusted'; they are spaces within which one may need to negotiate to potentially access goods and services which are experienced as unreliably delivered, harking back to the unreliability characteristic of mistrust which Carey describes (Carey 2017: 8).

In Kushtia, women leverage social connectedness through the patronage-related-practice of *dhora-dhori* to access expectations and desired forms of care. *Dhora-dhori* maps onto patronage-related practices which are common throughout South Asia for accessing opportunities and resources in the region (Gardner 2012, Guhathakurta & van Schendel 2013, van Schendel 2021). It is based on social connections, mutual leveraging of those connections, and reciprocity. As the English translation suggests, i.e., mutual grasping or holding, *dhora-dhori* is built in practice, in the forging of social connections through reciprocity. It is future-oriented—the practice involved in forging these connections may not be leveraged today, but perhaps next month, next year, or for the next birth. Women act as embedded agents within their families to appeal to various social connections through *dhora-dhori* to tactically access desired services and resources, with the expectation that this will result in better care at a lower cost, whether in public or private health sectors.

In both popular and scholarly discourses, a bifurcation is often made between trust embedded in social relationships of the 'known other' and trust in systems or institutions composed of the 'unknown other' (Carey 2017). In the maternal health landscape of Kushtia, these distinctions are collapsed. Indeed, it is directly through intimate relationships, the result of the ongoing practice of investing in personal connections, that one might expect to access the care they expect and desire. Trust forged in intimate relationships and trust in institutions are collapsed, as the latter depends on the former, manifest in *dhora-dhori*.

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