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Embodied Pregnancy and Biomedical Support

Experiences of Middle-Class Women in Bangladesh

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ABSTRACT | This article examines how middle-class women in Bangladesh experience health-seeking support within biomedicalised maternity care, highlighting tensions between women's embodied knowledge and technology-driven medical authority. Based on twelve months of ethnographic fieldwork in Dhaka, including interviews with thirty women who delivered via caesarean section and observations in private and public hospitals, the study explores doctor–patient interactions and the structural factors shaping pregnancy care. I show that biomedical practice prioritises technological assessments and clinical categorisation over women's lived experiences. Women with 'high-risk' pregnancies received attentive care and empathetic guidance, enabling them to manage physical and emotional challenges successfully. In contrast, women with 'low-risk' pregnancies often had their distress minimised or dismissed, as their symptoms did not fit established clinical parameters. The findings demonstrate that medical acknowledgement depends on diagnostic validation rather than the severity of embodied suffering. The article contributes to debates on medicalisation, reproductive governance, and the social construction of pregnancy.

Keywords: biomedicalization; women's embodied experience; pregnancy care; medical authority; Bangladesh.

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Introduction

> I begged the doctor, 'Madam, please help me! I want to live… This pregnancy is different from my first one… I cannot drink a drop of water, only depend on coconut water… I am rarely able to eat… Even the smell of a cooked meal makes me vomit… The whole day I feel nauseated and I stay sad and I cry… I cannot tolerate my parents, relatives, or anyone coming to see me or staying with me except my husband… I only want him to stay with me… I do not feel like going outside, only stay at home only in my bedroom, only lying on my bed and only a certain side of the bed.' Then the doctor slightly smiled and replied, 'As I always say, your reports [indicating blood test and ultrasound result] are fine. All those [symptoms] are normal during pregnancy.' My husband asked the doctor whether I should see a mental health doctor: 'She sarakkhon paglami kore… chitkar kore amar sathe… amar kache eshob abnormal lage (she behaves crazy all the time… screams at me…it all seems abnormal to me).' He even gave an example to the doctor that I kept the air conditioner at 18 level, which made my husband and son feel so chilly they had to cover themselves with a blanket. Even still I felt hot and took my clothes off and wanted to lower the temperature further. We had arguments several times over the same issue. The doctor replied, 'All are normal as far as the reports showing everything in range.' I was desperate to know from her the reason I was facing such discomfort and how to get some relief, but then she buzzed the bell. An assistant came into the consulting room and reported that many patients were waiting outside… So we left!

This excerpt is from 27-year-old Taskia, who in her interview described how she felt she failed to get the needed attention and support for her physical and mental discomfort from the doctor, who ignored Taskia's situation as 'normal'. This lack of support eventually resulted in a condition that Taskia referred to as a 'joghonno' (terrible) condition during her pregnancy journey back in 2020. As she continued during the interview, 'My pregnancy journey was terrible for the first seven months… Whatever symptoms are considered normal during pregnancy, I had all those at an abnormal level… Every time, I told the doctors but failed to get any solution… I wish I could get my doctor's attention and explanation… I wish I would get some of her time!'

Taskia's account illustrates the profound disjuncture between women's embodied experiences of pregnancy and the biomedical frameworks that define, categorise, and often minimise them. Medical anthropology provides a crucial lens to interrogate this gap, showing how experiences of health, illness, and healing are always socially embedded rather than reducible to biology alone (Kleinman 1980: 117). Kleinman's explanatory models further show how differing cultural and experiential understandings of illness between patients and providers can cause miscommunication and inadequate care, especially when biomedical frameworks dismiss lived experiences in favour of purely clinical assessments. Building on this understanding Scheper-Hughes and Lock's (1987: 29) concept of the 'mindful body' further challenges biomedicine's mind–body dualism, revealing how emotions serve as crucial mediators connecting individual bodily experience with broader social and political forces in producing illness and healing. Martin’s (2001: 139-148) influential argument reveals biomedical discourse mechanises women’s bodies as production systems, treating birth as industrial labour requiring technological management rather than respecting women’s bodily autonomy. Similarly, Jordan critiques western global health interventions as forms of ‘biomedical colonization’ that impose ‘cosmopolitical obstetrics’ while systematically delegitimising local and Indigenous reproductive knowledge and practices (Jordan cited in Van Hollen and Appleton 2023: 5). Extending this critique, Davis-Floyd and colleagues demonstrate how reproductive technologies transform women into ‘cyborgs’, dependent on technological mediation (Dumit and Davis-Floyd 1998), and ultimately as ‘techno-sapiens’ – a new species where reproductive autonomy becomes subordinated to technological imperatives resulting in dominance of machine-based knowledge over embodied experience (Davis-Floyd and Chalmers 2021). Recent studies show how biomedical authority shapes reproduction. For example, Han (2021: 608-617) explains that pregnancy consultations act as ‘literacy events’, where medical language gives the main framework for understanding reproductive experiences. Her work demonstrates how medical knowledge influences how pregnancy is experienced and interpreted. Moreover, Wallace, MacDonald, and Storeng (2022) point out a gap between policy and practice. This gap arises from power imbalances, limited understanding of local contexts, and a focus on technoscientific solutions, which often hinder improvements in reproductive health and can increase maternal suffering. This body of scholarship points to biomedicalisation not merely as medical intervention but as a form of ‘reproductive governance’[1] (Morgan and Roberts 2012: 241-243), in which women’s capacities to reproduce are unequally valued and supported.

In this article, I aim to demonstrate how middle-class[2] women in Bangladesh experience health-seeking support within the biomedicalised childbirth setting during their pregnancy. For this, I now illustrate ethnographic work on women’s reproductive health in South Asia. Then I zoom in on women's reproductive experiences in the Bangladeshi context, demonstrating how academic focus in the Bangladesh context has predominantly centred on poor women in rural settings, while middle-class women’s reproductive health treatment within biomedical settings has received little attention. I then discuss my methodology for this research, followed by examining middle-class women’s experiences from their own perspectives. Subsequently, I explore how medical professionals view women’s health-seeking experiences from their professional standpoint. Based on my findings, I conclude that women and doctors operate in a technology-dominated biomedical arena. Women rely on obstetricians to support their embodied pregnancy experiences, while obstetricians depend on technology, screening devices, and procedures to determine the clinical conditions of women’s pregnancy status and allocate their attention and support accordingly. My findings reveal that women with high-risk pregnancies have positive childbirth experiences when they feel supported by doctors; however, women with ‘low-risk’ pregnancies can experience adverse pregnancy outcomes due to inadequate support from doctors.

The Reproductive Health of Women in South Asia and Bangladesh

The institutionalisation of childbirth in South Asia, initially shaped by colonial ideologies and later by development agendas, systematically displaced traditional birth attendants by portraying them as responsible for increased maternal and child mortality due to unsafe and unhygienic home practices (Lal 1994; Ram 1998; Forbes 2005; Van Hollen 2003; Towghi 2012, 2024). Ethnographic research shows that reductions in maternal mortality since the 1990s have coincided with intensified medicalisation. This shift has emphasised population control and fertility management over women's needs, primarily driven by biomedical practices introduced through state and international partnerships (Jullien and Jeffery 2021). This historical trajectory continues to shape reproductive governance in the region, as highlighted by ethnographic studies.

For example, Cecilia Van Hollen's ethnography (2003) explores how modernisation reshapes childbirth among poor women in Tamil Nadu, India, as they navigate between traditional practices and biomedical care while confronting class-based discrimination in hospitals. Her study shows how poor women in Tamil Nadu accept medical technology but instead seek access to professional and technological aspects of modern birth outside the discriminatory institutional structures (preferably a home setting) that have failed to serve them well. Henrike Donner (2004) showed in her ethnographic work how medical authority is constructed through reproductive technologies like amniocentesis, Intrauterine Devices (IUDs), and caesarean sections, which middle-class Calcutta women perceive as beneficial health interventions while simultaneously serving doctors' professional and financial interests. This medicalisation process displaces traditional midwifery knowledge and eliminates women's customary practice of returning to their natal homes for childbirth support.

Similarly, Unnithan's ethnographic research in Rajasthan demonstrates India's 'conflicted reproductive governance', where rights-based reproductive health policies coexist with coercive population control practices. Through her work with the 'Accredited Social Health Activist' (ASHA), she shows how sterilisation 'targets' primarily serve to legitimise continued demographic management rather than enhance rural women's reproductive autonomy (Unnithan, 2022). In contrast, Towghi's work in Baluchistan, Pakistan, centres on traditional knowledge systems regarding women's reproductive health. She highlights how dhīnabogs (traditional Baloch midwives) possess expertise in herbal medicine and ethical midwifery, but their knowledge is being displaced by biomedical practitioners whose interventions often cause iatrogenic harm. Her ethnography reveals how colonial and postcolonial policies systematically erased Indigenous midwives' vernacular identities and therapeutic knowledge while promoting biomedical alternatives that frequently endanger, rather than protect, women's reproductive health (Towghi 2024).

In Bangladesh, ethnographic work has illuminated the complex realities shaping women's reproductive health choices and outcomes. Rozario (1998) shows that rural women use dai, or traditional birth attendants (TBA) services, not because they value them, but because economic constraints prevent access to biomedical care. She further notes that dais occupy a low social position due to their association with birth-related 'polluted' work. Afsana and Rashid (2000) argue that women's preferences for home delivery reflects sociocultural norms, family pressures, and the social legitimacy of TBAs. They emphasise that rather than focusing on abstract debates about 'over-medicalisation', interventions must address women's lived needs. In another study, Afsana and Rashid (2001) show that despite TBA training programs, rural women largely perceive childbirth as a natural domestic event and avoid hospitals due to cost, distance, discomfort, and fears of mistreatment altogether turning institutional care into a last resort only in cases of complication.

Afsana's later works deepen this analysis. In her book Disciplining birth, Afsana (2005) demonstrates how poverty, cultural logics, and systemic neglect rather than 'over-medicalisation' explain women's reliance on home births in Bangladesh, where institutional care is often inadequate or inaccessible. In another article, Afsana (2004) reveals how hospital deliveries impose devastating financial and emotional burdens on low-income families, who face corruption, unnecessary referrals, and crippling expenses that transform childbirth into both a medical and economic crisis. More recently, Afsana (2020) underscores that despite rising facility-based births, maternal mortality remains high because women continue to face neglect, multiple referrals, and systemic abuse, while education and empowerment remain essential for improving outcomes.

Building on earlier analyses of maternal health in Bangladesh, Perkins (2023a, 2023b) through her ethnographic research, focuses on marginalised rural and semi-rural women, examining how they navigate childbirth within contemporary healthcare systems. Perkins shows that interventions promoting 'non-supine' birth positions, though framed as empowering, often reinforce medicalisation and restrict women's autonomy (Perkins 2023b). At the same time, her research on dhora-dhori (which Perkins translates as 'trust') demonstrates how women leverage social networks and personal relationships to access care, revealing that trust and agency are grounded in community connections rather than formal institutions (Perkins 2023a). Through her works, Perkins extends prior scholarship by showing how even well-intentioned interventions must contend with marginalised women's economic, social, and cultural realities, emphasising the ongoing gap between policy ideals and lived reproductive experiences.

While this research has provided valuable insights into the power dynamics between medical professionals and patients, it has focused mainly on rural or economically marginalised women who access formal healthcare only in emergencies or through community programs. The experiences of middle-class women who regularly consult private doctors and can afford formal care remain largely understudied. Nevertheless, as Taskia's narrative at the beginning of this article shows, economic privilege does not necessarily protect women from biomedical dismissal or the normalisation of their suffering. Jordan's concept of 'authoritative knowledge' is particularly relevant here, demonstrating how medical institutions systematically devalue women's bodily knowledge in favour of technological procedure, arguing that 'the power of authoritative knowledge is not that it is correct but that it counts' (Jordan 1997: 58).

This article addresses that gap by focusing on women–doctor interactions and the embodied experiences of pregnancy among urban middle-class women in Bangladesh. It does not examine rural maternal health, policy evaluation, or large-scale epidemiology, but instead concentrates solely on middle-class women's pregnancy experiences while accessing biomedical support. The central question guiding this study is: how do middle-class women in Bangladesh experience health-seeking support within the biomedicalised childbirth setting during their pregnancy? I argue that biomedical dismissal functions as a subtle yet powerful form of reproductive governance, rendering women's distress invisible while consolidating medical authority. These everyday clinical encounters, I suggest, reveal dimensions of medicalisation that persist across class lines.

Methodology

This article is based on twelve months of ethnographic fieldwork conducted in Dhaka, Bangladesh, between October 2022 and October 2023 as part of my doctoral research at the Australian National University. The project explored why and how urban, educated middle-class women in Bangladesh decide or are compelled to undergo caesarean deliveries, and how they experience pregnancy, childbirth, and its aftermath in relation to their bodies, health, and well-being.

I worked in two hospitals representing contrasting spheres of maternity care in the city: Square Hospital,[3] one of the most reputed private institutions serving middle-class families, and Dhaka Medical College Hospital, the country's largest public tertiary facility. For this article, I draw mainly on interviews with thirty women who delivered by caesarean section at Square Hospital, along with four medical professionals, as well as observations in maternity wards and consultation spaces where women interacted with doctors and nurses.

All interviews were conducted in Bengali and later translated into English. Most participants were recruited through personal networks, including a closed Facebook group for mothers where I introduced my project and invited participation.

My positionality as a Bangladeshi middle-class woman and a mother who underwent a caesarean delivery at Square Hospital in 2017 profoundly shaped the research process. Entering hospital spaces as both researcher and former patient allowed me to build rapport with women and medical staff, who often saw me as sharing in their experiences. At the same time, balancing my second pregnancy and early motherhood in 2022 with fieldwork required careful negotiation. I remained attentive to how my embodied presence influenced the narratives and insights I was able to generate.

Embodied Distress and Medical Dismissal

Whether medical or social, support during pregnancy includes emotional, informational, and practical forms of care that shape psychological and physical health outcomes. Research has long shown that such support can protect women from the harmful effects of stress and reduce the risk of perinatal depression (Cobb 1976; Robertson et al. 2004; McCourt 2017). When support is absent, women's physical and emotional struggles intensify, widening the gap between their lived experiences and biomedical frameworks that fail to recognise the personal and varied nature of pregnancy. The absence of these factors meant that some women experienced significantly greater distress than others. Taskia, whose narrative I cited earlier in this article, is one example.

Taskia was born and raised in an extended-family environment. Her father was a doctor and, to fulfil his elder brother's wish who was in the final stage of cancer, he arranged Taskia's marriage before she had finished her graduation. Taskia's husband, who was ten years her senior, worked as a high-ranking government employee. Since marriage, she found him to be a workaholic, spending long hours in the office and continuing to work from home afterwards.

Early in their marriage, she accepted his preoccupation with work. However, during pregnancy, this emotional distance became unbearable.

After giving birth to her first child in 2017, Taskia experienced an unplanned pregnancy the following year, which ended in a miscarriage at two and a half months. The dilation and curettage (D&C)[4] procedure that followed left her with persistent back pain, making it difficult to care for her toddler. From then on, she remembered repeatedly telling her husband she needed more support at home. In 2020, she became pregnant again. Unlike her first pregnancy, this time she experienced intense nausea, vomiting, and an inability to eat or even drink water—symptoms that persisted for months. She sought advice from her doctor during routine check-ups, but the response was limited to medicine for acid reflux and the repeated reassurance, in her words: 'This is very common in pregnancy. Everyone goes through this.'

Taskia reflected that her physical discomfort worsened despite taking the medicine and intensified after her husband was posted to another district. Left to manage alone with her young son and only a part-time maid for basic chores, her physical and mental health steadily declined. Although her parents lived in Dhaka and offered support, she consistently turned them away, expressing an unexplained aversion to their visits until eventually, they stopped coming. She described feeling completely overwhelmed, and despite repeatedly asking for help, her doctor offered little support. With visible pain, she admitted that she sometimes lashed out at her son for no reason. On one occasion, she recalled scrubbing his skin too roughly during bath time because she imagined he smelled bad. She could not bear him touching her while they slept, and she became fixated on sleeping in one exact position on the bed. During our interview, she grew emotional as she described the guilt of knowing she was mistreating her son yet feeling helpless to stop herself. That guilt, she said, was more painful than anything else.

Her emotional state grew so fragile that her husband eventually took time off work to accompany her to the obstetrician, hoping that if he explained everything himself, the doctor might finally listen and offer more time or assistance. That was when the conversation I described at the beginning of this article took place.

I present Taskia's case as representative of the experiences of middle-class women in Bangladesh. Despite seeking care at reputable private hospitals and expecting proper treatment, women like her often encounter inadequate support, highlighting systemic challenges rather than an isolated incident. Their dissatisfaction frequently stems from not receiving the level of attention they expect from doctors and from the limited time allotted to consultations—factors that contribute to adverse pregnancy experiences. Among these factors, time constraints emerged as a recurring theme across women's narratives.

Some of the interlocutors explained that although they carefully selected healthcare providers particularly obstetricians, based on reputation for supporting vaginal birth, surgical expertise, or the ability to manage complications, they nevertheless struggled to articulate their concerns about their pregnant bodies within the restricted timeframe of routine appointments. One interlocutor, Sumi, said: 'I saw my doctor always checking her watch while listening to my concern, which increased my tension and made me forget what I was supposed to say… I changed her and later went to a less busy doctor who was then just appointed to Square Hospital.' Another interlocutor, Zarin, explained:

> I chose my doctor based on her reputation for vaginal delivery… However, she gave me very little time during routine check-ups—a maximum of ten to fifteen minutes. Within this time, she checked my blood pressure, the baby's movement, and sometimes reports… I never got time to go beyond that and share my other concerns, as her assistant would open the chamber door and allow another patient in.

These narratives reveal that women wanted to be cared for through monitoring vitals and discussing test results, as well as opportunities to share their non-clinical concerns and queries. When that desire remained unmet, women like a third interlocutor, Minar, expressed frustration at not being adequately supported during pregnancy. As Minar said: 'I asked my doctor what I could try for eating, as any attempt at food created vomiting and nausea… She did not seem bothered except saying you can try to eat everything… I was not happy with the quick answer because I wanted her to elaborate on the options, at least suggest some foods.' The dissatisfaction voiced by women like Minar highlights how clinical interactions often overlook emotional and experiential dimensions of care. As Davis Floyd (2022: 112) explains, the technocratic model of birth conceptualises pregnancy as a mechanical process requiring standardised interventions, which systematically devalues women's experiential knowledge and emotional needs and treats patients as 'objects' rather than whole persons with complex concerns requiring individualised attention.

When some women expressed disappointment at doctors for not extending their time or offering adequate support, others revealed how medical advice itself could worsen their health. Sumi's case is such an example. At twenty-eight, Sumi was diagnosed with gestational diabetes and high blood pressure. Her obstetrician assumed she might not carry her pregnancy to term and prescribed an extreme diet of four eggs and a litre of milk daily, claiming it would prepare her for an early caesarean and ensure a bigger baby. Despite her family's concerns and her own distress, Sumi complied out of fear after the doctor warned, 'If your baby is under 2 kg, I'll send them to the NICU [Neonatal Intensive Care Unit].'

Her condition worsened, leading to emergency hospitalisation at thirty-two weeks, followed by an emergency caesarean after her baby stopped moving. Her newborn then spent a month in the NICU. A different doctor later treated her and strongly criticised the dietary advice as potentially dangerous. Even seven years later, Sumi still cannot eat eggs. She carries the lasting trauma of medical interventions that were presented as care. Her case was significant in that, although she herself experienced severe discomfort and her family through experiential knowledge of pregnancy also recognised that the diet could be harmful, none of them dared to challenge the doctor's authority. While women possess legitimate knowledge about their bodily states, this knowledge is often rendered invisible within hierarchical medical systems that privilege biomedical expertise above other sources of health knowledge (Jordan, 1997: 56-57). Sumi's experience exemplifies what Cheyney and Davis-Floyd (2019: 8) term as 'obstetric paradox', when biomedical interventions intended to make birth safer introduce new harms.

Most women I interviewed felt that the clinical support they received from obstetricians during pregnancy check-ups was relatively respectful, especially compared to the mistreatment poorer women faced in public hospitals. However, the narratives of Taskia, Minar, and Sumi also revealed ongoing frustrations with the quality of clinical care. Their interviews made it clear that negligence and subtle forms of disrespect particularly through language were not absent in middle-class contexts either.

Shumona's experience during routine prenatal care illustrates this. At thirty-seven weeks pregnant and hoping for vaginal birth, she underwent an unexpected cervical examination during which her doctor proceeded without warning or consent. In Shumona's words: 'She lifted my clothes and inserted her hand without informing me. Her hand came out full of blood. I cried out loud. She said, "If you want a normal delivery, I'll do this every hour. Why are you afraid?"' This incident characterised by lack of informed consent, extreme physical pain, and verbal intimidation ultimately led Shumona to abandon her preference for vaginal birth and schedule a caesarean instead.

This case exemplifies what feminist theorists describe as obstetric violence—the systematic use of medical authority to override women's bodily autonomy while presenting coercive practices as medically necessary (Zacher Dixon 2015; Shapiro 2018; Cheyney and Davis-Floyd 2019; Davis-Floyd 2023). Importantly, obstetric violence is not confined to resource-poor countries; it is also prevalent in high-resource nations, though often in more subtle forms. Women across contexts experience non-evidence-based interventions and mistreatment (Cheyney and Davis-Floyd 2019: 7-10). For instance, US hospitals routinely implement standard procedures, including frequent, often painful (and usually unnecessary) cervical examinations, to ensure that the labouring body-machine produces 'on time' (Davis-Floyd 2023). In rural Pakistan, medical staff use fear tactics and harmful injections to compel Baluch women into hospital births, exploiting them financially while inflicting medical harm (Towghi 2018). Similarly, in Mexican public hospitals, poor and marginalised women have been subjected to unauthorised IUD insertions, reflecting systemic abuse within reproductive healthcare (Zacher Dixon 2015). Shapiro's (2018) theoretical framework is especially useful here, as she highlights the paradox of medicine: a profession devoted to healing that simultaneously perpetuates multiple forms of violence. Shumona's experience illustrates all three dimensions of this analysis. First, bodily violence occurred through an invasive examination that caused bleeding and pain. Second, metaphoric violence emerged in the dehumanising treatment that reduced her to a malfunctioning object in need of correction. Finally, decommunicative violence was evident in the intimidating language that dismissed her fears and coerced compliance. Shumona's encounter, then, highlights how obstetric practices can silence women's embodied knowledge, setting the stage for broader patterns of medical reification across diverse contexts.

Taken together, these cases reveal consistent patterns in which women's intimate knowledge of their changing bodies was systematically invalidated through standardised medical responses. What Taussig (1980) describes as medical reification operated powerfully in these encounters. When doctors responded to complex pregnancy experiences with phrases like 'all those symptoms are normal during pregnancy' (as in Taskia's case), they transformed fundamentally social and relational experiences into depersonalised clinical categories. This process stripped symptoms of their social meaning, reducing them to standardised biological events requiring no further attention.

Compassion with Conditions: Biomedical Responses to High-Risk Pregnancies

While the previous section highlighted how women like Taskia, Minar, Sumi, and Shumona struggled to receive adequate support during pregnancy, other women, despite having high-risk pregnancies, mainly reported positive experiences when their doctors provided attentive care. Although they experienced significant physical discomfort, women such as Nazia and Anita emphasised how timely guidance, reassurance, and empathetic support helped them navigate these challenges successfully. To illustrate this, I turn to Nazia's case.

Nazia was 28 years old during her first pregnancy in 2017. From the beginning, she experienced regular spotting, and her doctor classified her pregnancy as high-risk. She was prescribed complete bed rest for the first five months, which forced her to resign from her job at a pharmaceutical company. In her words:

> Due to my regular spotting, the doctor prescribed complete bed rest. I had to take progesterone injections twice a week for the first five months in my hip muscle. I had mobility restrictions… I even had to use a bedpan for the toilet… My whole life was stuck in bed. Still, I'm very satisfied with my obstetrician… She always answered my calls or called back when she was on duty… In the third trimester, I also developed obstetric cholestasis and was suffering from extreme itchiness. I would have been devastated if she had not been there for me, alongside my husband and parents.

Similarly, Anita's story illustrates how a doctor's empathy and support can make a significant difference, even in the face of serious medical challenges. Anita was 27 years old in 2016 when she was diagnosed with an ovarian cyst during pregnancy and underwent surgery to remove it while still pregnant. Although she lacked family support particularly from her husband in a nuclear household setting, she found reassurance in her doctor's calm and clear explanations. When she expressed fear about the cyst's impact on her baby, the doctor explained: 'Your cyst is in your ovary, and your baby is in your uterus. How do you think the cyst can harm your baby?' Later, when Anita grew anxious about having another surgery for childbirth, her doctor reassured her again: 'The cyst removal surgery was tricky during pregnancy, not this one. Please relax.' Anita believed that this compassionate communication eased her fears.

When Anita became pregnant for the second time—unplanned, just eight months after her first child's birth, she initially felt overwhelmed, worried about her health and her ability to care for her older child. Yet her doctor's consistent support changed her perspective and gave her the confidence to continue the pregnancy. During the caesarean section for her second child, another cyst was discovered and removed. Reflecting on her experience, Anita shared:

> My obstetrician always explained my condition clearly and positively, which helped me gather the courage to undergo three surgeries one for the cyst and two caesarean births within two years. I had almost decided to

> abort my second child, but her support and encouragement held me back. If anyone I know becomes pregnant and asks for a recommendation, I always mention her name.

Both Anita and Nazia described their obstetricians as reliable, accessible, and compassionate. They valued being able to reach out when needed, received clear answers to their health concerns, and most importantly, felt assured about the safety of their deliveries despite complications. For both women, the sense of being genuinely cared for by their doctors was central to their positive experiences with high-risk pregnancies. Yet, deeper analysis reveals a critical distinction: these women received medical attention and empathy precisely because their conditions were deemed clinically significant through technological screening and biomedical assessment. Nazia's regular bleeding appeared in ultrasounds, and her obstetric cholestasis was identified through blood tests; Anita's ovarian cyst was detected through intra-vaginal imaging. Their doctors' supportive responses were triggered not only by the women's distress but also by the clinical data that validated their symptoms within biomedical frameworks. By contrast, Taskia's repeated attempts to draw attention to her discomfort were dismissed, as her doctor placed greater trust in ultrasound and blood test results, which did not reflect her embodied experience. This dynamic reflects what scholars have shown about reproductive screening technologies such as ultrasound: they are not neutral diagnostic tools but technologies that reorder authority by privileging medical images over women's embodied knowledge. As Balsamo (1999) argues, such technologies actively shape the social meaning of pregnancy, reinforcing medical control by validating women's experiences only when they align with biomedical evidence.

Here, my intention is not to overshadow the doctors' supportive behaviour toward women but to examine the underlying structures that shape these differential responses. The contrast between Nazia's and Anita's experiences and Taskia's highlights a recurring pattern in biomedical care. Women whose clinical reports show low-risk pregnancies often struggle to attract medical attention, whereas those labelled high-risk (as in both Nazia's and Anita's cases) receive focused care and prompt responses to their concerns. This disparity reveals the underlying systemic forces in biomedical settings that determine not only doctors' expected conduct but also whose voices among women are taken seriously in medical contexts.

Clarke et al. (2003: 170-171) reflect on this dynamic as stratified bio-medicalisation, a process in which technoscientific innovations create differential access to care based on risk categorisations. Rather than simply expanding medical care uniformly, biomedicalisation operates through practices that divide patients into hierarchical categories of medical worthiness (Clarke et al. 2003: 184). Under this system, technological assessments take precedence over women's embodied experiences, with high-risk patients receiving focused attention while those deemed low risk by biomedical metrics struggle to have their subjective concerns validated. This pattern reveals a fundamental limitation in the functioning of medical authority, where women's embodied knowledge gains legitimacy only when it aligns with clinical findings driven by technology. Taskia's psychological distress, Sumi's physical deterioration from a prescribed diet, and Shumona's trauma from invasive procedures were each dismissed because they fell outside the narrow biomedical parameters that privilege measurable indicators over lived experiences. The result is a healthcare system in which women receive compassionate care conditionally, only when their suffering can be validated through medical technology rather than through their own embodied understanding of pregnancy.

During fieldwork, I conducted follow-up interviews with doctors, including those at Square Hospital, to understand their perspectives on women's expectations during routine check-ups and childbirth. These discussions revealed how institutional structures shape physicians' responses to patients. Dr. Taimur (also a key informant in my research) acknowledged listening to patients but cited 'long patient lines' as barriers to addressing all concerns. Similarly, when asked about patients' expectations for sufficient consultation time, Dr. Shahana gestured toward the crowded waiting area, emphasising the practical constraints of seeing as many patients as possible within limited timeframes. Both stressed that they attended only to problems requiring 'medical attention'. Their perspectives highlight how clinical priorities determine which aspects of women's experiences are granted acknowledgement further justifying the claims of women like Taskia, Sumi, and Minar that their concerns were overlooked. In Dr. Shahana's words:

> The protocol is to give women clinical service… The ultrasound report, assessing baby movement with dopplers, measuring blood pressure, and reviewing other blood test reports are vital to assess the nature of pregnancy… When I find both the woman and baby are doing fine, I do not see why women are still worried.

Dr. Shahana's account illustrates how obstetric practice privileges technological findings over women's embodied experiences. This reflects critiques that the field has developed 'an almost religious belief' in monitoring technologies, replacing the fallibility of human judgment with that of machines (Wendland 2007 as cited in Smith-Oka and Spiegel 2023: 86) while simultaneously diminishing the value of women's embodied knowledge (Wolf 2018 as cited in Smith-Oka and Spiegel 2023: 86). Dr. Shahana also believed that women should seek non-clinical knowledge and support from family, friends, or other sources, as physicians see their role as providing only clinical care. While she expected women to reserve consultation time for strictly medical queries, Dr. Taimur reflected her frustration with patients who desired vaginal births without prior knowledge, expecting her to help fulfil that choice. In her words:

> Women come in expecting a normal delivery after watching a ten-minute YouTube video… They ask me when they should be admitted, and I reply: when the pain starts. They ask me how to do a vaginal delivery when they are afraid of the pain, and I say: if you want a normal delivery, you must tolerate the pain… There is no chance to learn these details during check-ups; they need to learn from family or other sources.

Such responses reveal an expectation that women should arrive with pre-existing knowledge about labour and possess the mental strength to endure it, while the clinical encounter itself offers little space for detailed guidance. It resonates with Illich's critique of biomedicalisation, where doctors maintain authority by controlling what knowledge is shared, presenting health in technical terms inaccessible to patients (Illich 1976 as cited in Van Hollen 2003: 117). In this process, women's enquiries about everyday practices of self-care and learning related to pregnancy are devalued or redirected outside the clinic. As Van Hollen argued, biomedical authority defines valid knowledge, creating further mystification that strips people of their healing power and diminishes their capacity to control their bodies and environments (Van Hollen 2003: 117).

Another doctor, Bilkis Ahmed, characterised affluent patients as having a 'sensitive nature' when they sought medication for symptoms, she deemed normal. In her words: 'Era khub sensitive… Kono kichu normal vabe nite pare na… Shob kichur jonno oshudh chay. (They [referring to the middle-class women] are very sensitive… They cannot take anything as normal… They ask for medicine for everything.)' Her narrative reflects medical attitudes that generalise 'normal' symptoms across all pregnancies while dismissing individual variations in severity and impact, effectively reducing women's concerns to oversensitivity.

I argue that class is important in shaping women's health-seeking behaviour. Women reported during interviews that they sought knowledge about pregnancy, childbirth, and associated discomforts from senior female relatives, friends, and social networks, but they also acknowledged relying predominantly on formal medical providers, considering their advice more reliable. Being educated and oriented toward modern practices, they view technology and well-trained doctors with up-to-date knowledge as trustworthy sources, perceiving these as scientific. Moreover, my fieldwork revealed that many women turned to doctors for guidance on nearly every aspect of their health during pregnancy. This occurs because biomedicalisation frames seeking medical care as an ethical responsibility rather than a personal choice. Women like Zarin and Minar, who reported dissatisfaction with limited consultation times, also believed that by seeking biomedical help they were ensuring their baby's safety. As Kaufman (2004) argued, health becomes a commodity in the biomedical framework and routine medical interventions are normalised within this system as necessary expressions of responsible care.

Consequently, women consistently expressed to their doctors a desire for counselling and functional guidance, including advice on nutrition, activity modification, fatigue management, and daily adjustments for physical and emotional changes. Nevertheless, such guidance was rarely offered, as medical professionals focused primarily on pathological aspects while overlooking psychosocial dimensions. Drawing on Ginsberg and Rapp's (1991) work on the politics of reproduction, I argue that middle-class women's educational and economic resources create a paradox in reproductive healthcare. While their class position enables them to access information, choose providers, and navigate medical systems, it simultaneously pressures them to conform to biomedical authority as a marker of responsible motherhood. This double-edged dynamic grants women agency in healthcare decisions while devaluing personal knowledge and subjecting them to new forms of surveillance, transforming reproductive choices into moral imperatives in which accepting intervention becomes synonymous with being a 'good' mother. This pattern suggests a more complex reality in which women's needs extend far beyond the narrow clinical focus that dominates institutional pregnancy care.

Conclusion

This article demonstrates how middle-class women in Bangladesh experience health-seeking support within the biomedicalised childbirth setting during pregnancy. By focusing on doctor–patient interactions during consultations, I explore the factors that shape these encounters and influence the type of care women receive. I find that technology-driven assessment systems and fragmented approaches to health and illness largely govern doctors' practices. Within this biomedical framework, women's bodies are treated as machines requiring technological monitoring, with mind and body separated and only clinical symptoms prioritised.

As a result, women with 'low-risk' pregnancies whose reports show normal parameters receive less attention and time from doctors. Their support-seeking behaviours for non-clinical concerns are often neglected by medical practitioners, leading to experiences of being labelled 'normal' and their embodied struggles overlooked. It contributes to negative pregnancy experiences, where women's physical and emotional discomforts remain unacknowledged. In contrast, women whose pregnancies are classified as 'high-risk' through technological screening receive focused attention and support, enabling them to navigate their pregnancy journey more successfully, even when facing significant physical challenges.

I also show that middle-class women, being educated and modern, feel ethically compelled to seek both clinical and non-clinical guidance from doctors, perceiving them as the primary authorities for ensuring safe births. While these women may engage with other sources of advice, their primary health-seeking practices remain situated within biomedical institutions. Doctors, in turn, operate within institutional constraints that reinforce reliance on technological assessments, shaping the nature and scope of care they provide.

Through this examination, I demonstrate that economic privilege does not shield middle-class women from inadequate support. Unlike poorer women, whose health needs are often neglected due to limited access, middle-class women, despite having resources and access to private care, still encounter gaps in attention, understanding, and responsiveness. Access to biomedical care, therefore, does not guarantee the respectful, comprehensive support women expect or need during pregnancy. Importantly, this article does not frame doctors as acting against women's interests; instead, it highlights how systemic reliance on technology and standardised protocols can inadvertently overshadow professional judgment and diminish attention to women's embodied experiences.

Ethics Statement

This research received institutional ethical approval from the Australian National University Human Research Ethics Committee (Protocol Number 2022/322, approved 28 October 2022) and the Bangladesh Medical Research Council Ethics Committee (Ref: BMRC/NREC 2022-2025 / 327, approved 27 October 2022).

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Notes

1. Morgan and Roberts (2012: 243) conceptualise ‘reproductive governance’ as the mechanisms through which various actors such as state institutions, churches, and NGOs employ legislative controls, economic inducements, moral injunctions and direct coercion to regulate reproductive behaviours and practices.

2. Following Martin's (2001) ethnographic work and her middle-class women selection process, I define middle class as those who have white-collar jobs, prestigious official positions, who work by preference not obligation, who have life's security and savings, who seek institutional help instead of relying on kin and relatives, and also women who are not employed but come from wealthier households.

3. From my previous observations, middle-class urban women in Dhaka usually prefer to visit doctors in Square Hospital Pvt. Ltd. considering its reputation, popularity, and convenient location, so I chose women who received treatment and doctors who worked in this hospital during my fieldwork.

4. This is a medical procedure involving opening the cervix and scraping the uterine lining to remove tissue from the uterus. It is used to clear the uterine lining after a miscarriage or abortion in Bangladesh.

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