Title
Scales of Marginalities: Transformations in Women's Bodies, Medicines, and Land in Postcolonial Balochistan, Pakistan

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Publication Date
2007-12-20

Peer reviewed|Thesis/dissertation

Scales of Marginalities: Transformations in Women's Bodies, Medicines, and Land in Postcolonial Balochistan, Pakistan

by

Fouzieyha Towghi

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Anthropology, History, and Social Medicine
(Medical Anthropology)

in the

GRADUATE DIVISION

Of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

AND

UNIVERSITY OF CALIFORNIA, BERKELEY

ProQuest Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

DEDICATIONS

To my grandmothers Āmina and Ājiran
To my parents Hasineh and Malek Towghi
To my friend Anju Gurnani
To all the Baloch women inspiring and inviting me to learn from them
And
In loving memory of Begu

ACKNOWLEDGMENTS

Many people have helped to shape the trajectory of my research interests. What we see, hear, and read become filters through which we perceive 'new' worlds we are privileged to encounter and witness. I have wanted to understand these 'worlds' and at times change them too. One of the worlds I continue to be imbricated in and influenced by is that which is embodied by my mother and is the world of pre and post-partition India and Pakistan in Iran and Balochistan- a world that I came to hear about and learn from during many moments of talk-story with my mother. As a teenager in the US I could have easily disconnected myself from the "other" world that I had briefly embodied in my pre-teens, however, my mother's stories and her experiences of adjustments and struggles as a Baloch woman, wife, mother of five sons and one daughter, sister of three women and two men who live oceans away, and a person who social science refers to as a non-literate immigrant woman in the US- would not allow such an extrication from that which I am unconditionally connected. I owe a great deal of my inspiration for activism and the persistent desire to struggle against sexism, racism, poverty, essentialism, and medicalization of social injustices to her. Upon hearing the stories I realized much later (since so much of our deeper motives pushing and pulling our life moves are unconscious) that my mother's stories and her unabashed display of vulnerability was a powerful force shaping not only what I would read, but my desire to trace the umbilical cord to the place of my birth (Karachi), to where I was conceived (Quetta), and where I chose to work and do research (Balochistan). I am also thankful that because of her oral skills and acumen with word and insistence to speak Balochi with her children, I did not

lose my mother tongue. This privileged me to know spaces, places, and lives I would not even be allowed to see otherwise. My mother's story had already subverted any false sense of dichotomy between 'tradition" and "modernity" I might have had. She is one among many courageous women writers of life who remain quiet and abiding influences on me.

Funding for my project came from an array of generous sources without which my Ph.D. studies and this dissertation would not have been possible. From beginning, to the end I have received U.C. Regents Fellowships from the University of California, San Francisco and Berkeley. The Center for South Asia Studies at UC Berkeley provided me with two-years of generous support for Urdu language studies. In addition, my dissertation research and writing was enabled by the American Association of University Women (AAUW) Educational Foundation, the American Institute of Pakistan Studies Fellowship Program, the Woodrow Wilson & Johnson & Johnson Women's Health Dissertation Fellowship, the Al-Falah Program Fellowship at the Center for Middle Eastern Studies (UC Berkeley), the Center for South Asia Studies (UC Berkeley), Designate Emphasis in Women, Gender, Sexuality Program (UC Berkeley), the Qayum Family Foundation (Center for South Asia Studies- UC Berkeley). I am thankful to them all.

It is impossible to name and sufficiently thank the many people who have helped make possible my research and journeys in Pakistan and Balochistan. I want to thank Nabi Basgh and his family, Zainab and Zainab's family- especially her grandmother Bibi for their unconditional love and generosity during my time in Khuzdar. They helped me tremendously during the early stages of my research in Panjgur. Without the skilled

driving and mechanical smarts of Gulam Nabi and Shabir to navigate the rugged unpaved roads of Balochistan, I would have lacked the privilege of witnessing the majesty of this geography and learning about the dignified suffering as well as the joys prevailing in the region.

Through Mohammad Ali I met my host family in Panjgur. Without Mas-Gul, Riaz, and their family my research in Panjgur would have been impossible. I learned from them a great deal. Their unconditional generosity, warmth, care of me during times of illness and stress, and their sincere and continued wish and enthusiasm for my success is an immeasurable gift that is impossible for any researcher to repay. All they ask of me is to return and visit them again and again. I made many other friends in Panjgur who helped me with my research and welcomed me in their homes including, Asya and family, Zulaigha and family, the staff of Nokhen Sohb: Ameen, Kishwar, Rehana and their families. In Panjgur I was also warmly welcomed and aided by numerous individuals and their families. Dr. Samad, Dr. Akram, Dr. Wahid, Dr. Amir Gitchki, Mr. Katchkul Ali, Dr. Bashir. I learned a great deal about the history of Panjgur from Inayattullah Qomi, Haji Fakir Ambar, Fakir Noorjan, and Dr. Gitchki. Fakir Noorjan became a good friend. I thank her for introducing me to her grandmothers and great-aunts, and the musicians in her family.

In Quetta, I could always count on my very smart and loving friends Zeenat and Sana. I have known them for nearly 15 years. They have taken me in as their sister and intellectual comrade. I miss our stimulating conversations and debates. I thank Zeenat and Dr. Sana and their beautiful family. And, Surat Khan and Begu and their beautiful

family made me feel like I was always returning to family in Quetta. They have taken care of me from the beginning during my repeated visits to Quetta that began in 1991.

I thank my father Malek Towghi for introducing me to Aga Shahid and Nawab Bugti. I want to extend my deepest thanks to Aga Shahid Bugti, Nawab Bugti and their family. Despite the dangers involved for their family and Nawab Bugti, Aga Shahid made it possible for me to meet and interview Nawab Bugti. It was indeed a privilege and honor to meet Nawab Bugti. I am only sorry that I will not have a chance to meet with him again.

In Karachi, my aunts, Masi Noorjan, Masi Hoosnia, Baji Zarina, and uncle-Mama Akar. They will be happy to know I am done with this "book". Masi Noorjan has been great friend. With her help I meet many of the *pensars* and herbalist in Karachi.

In Pakistan Farid Midhet, friend and colleague, was an important interlocutor around policy issues related to safe-motherhood and maternal morality. His clarity and commitment around advancing maternal health continues to be an inspiration. My dear friend Abida provided me with much needed love and nourishment many times after fully exhausting myself from my intense research schedule. This kindness was multiplied when I met Shazareh.

Thanks to friends and colleagues for intellectual support and/or personal encouragements. No matter how much we might imagine ourselves being able to write and complete the dissertation with pen, paper and one's mind mystified- alone, join a writing seminar or group and this myth is shattered. I want to thank all my writing co-conspirators and their love and kindness. Thank you: Huma Dar, Nell Gabiam, Lucinda Ramberg, Laura Hubbard, Chris Roebuck, Cristiana Gordiano, Chris Ganchoff, Ben

Peacock, Liz Roberts, Jerome Whitington, Alberto Sanchez, Robyn Kliger, and Angela Davies. Huma has been a wonderful and special friend and it has been an important journey co-finding with her and Irum Sheikh the Muslim Identities and Cultures Working group of Townsend Center for Humanities. More recently I've been blessed to be part of an amazing writing group with Roshanak Kheshti, Huma Dar, Mel Chen, and Rebekah Edwards. They are amazingly generous with their intellectual support, loving kindness, and sincere wish for my success.

The Department of Anthropology, History, and Social Medicine and the Department of Anthropology at UC Berkeley provided first class resources and support. I want to thank the Lowie anthropology library directed by Suzanne Calpestri. Thank you Ned Garret (UC Berkeley) and Clare Dunne (UCSF), you are the amazing skeletons that maintained the form of the flesh of my respective department's.

My dissertation committee was made up of five scholars whose generosity with their knowledge and support someday I hope to reciprocate. From the beginning I have worked with my Co-chairs Vincanne Adams (UCSF), Sharon Kaufman (UCSF), and Lawrence Cohen (UC Berkeley) and later I was privileged to also work with Paola Bacchetta (UC Berkeley) and Adele Clarke (UCSF). I've been blessed with an extremely talented, intellectually rigorous, and extremely kind committee. Each has influenced my scholarship in a unique and distinct manner. My Co-chairs Vincanne Adams and Sharon Kaufman have been extremely supportive. They watched and helped me struggle through the writings of my field statements and dissertation research proposals. Sharon Kaufman made sure that I would not relax for too long following my research and return from Pakistan. She pushed me to begin writing the dissertation immediately and for that I

cannot thank her enough. Her professionalism, editorial generosity, enthusiasm for my work, and sincere wish for my success helped me to trust my writing and survive the drama of doctoral studies. She has been a wonderful cheerleader. Adele Clark has been a wonderful mentor and I have been privileged to have her support and interest in my work-and that from such an important and accomplished scholar. She has been a close reader of my work and I have been honored and humbled to receive her insights. She too has been one of my great cheerleaders. Lawrence Cohen in particular has influenced the kind of medical anthropologist I am becoming and hope to be. I cannot thank him enough for his theoretical acumen and the heart and respect which are always at the center of his theoretical engagements. It is always a pleasure to listen to Lawrence Cohen and hear him think out-loud. I have learned a great deal from him and hope to learn more. I have learned to engage with his work in ways that I did not anticipate and it is with great pleasure that I look forward to our future scholarly collaborations and friendship. I was blessed to meet Paola Bacchetta a year before my oral comprehensive exams. She has been an excellent mentor and friend, intellectually giving and extremely generous with her time and thoughts. She is an important model for how I will link my activism with teaching. She has influenced my writing, helping it to advance leaps and bounds. I know we will be working together. Thank you all for your patience, commitment to my work, and for reading and reading. I look forward to working with you all.

In addition to my committee members I want to acknowledge Warwick Anderson, Gay Becker, Donald Moore, and Stefania Pandolfo, and Aihwa Ong. I worked very closely with Donald Moore on one of my Field Statements; thank you Donald for being there. They have all influenced my scholarship in important ways. If I could have had a

10-member committee I probably would have included them. I also want to thank Philippe Bourgois; he was the Chair of my department at UCSF during my Ph.D. studies. It was important to know that I could go to him to discuss Marx and Marxism if I needed to. My scholarship has been enriched also as a result of my engagements and support from the Designated Emphsis Program in Women, Gender, and Sexuality at UC Berkeley. Thank you: Trinh Minh-ha, Barrie Thorne, Charis Thompson, Minoo Moallem, and- of course my committee member Paola Bacchetta. I also want to acknowledge Eileen Andrade and Althea Grannum-Cummings for their work and support in the Gender and Women's Studies Department where I have been lucky enough to teach.

Of course no dissertation can be completed without the support of family and friends- though they may not agree with this sentiment. One can't blame them for thinking that there is no end in sight- when is it going to finish? You are still writing? Didn't you graduate? What do you mean you have to file the dissertation? I cannot Thank Anju enough for standing by and for supporting me through and through. I could not have done it without you. My mother's bread, my father's help with Balochi, my brother Nasser's help and wizardly-ness with computer, my brother Omar's brotherliness and the reminders to his kids that they have an aunt in San Francisco.

Others who have wished for my success- I know they will be happy to know I have filed this dissertation. Thank you: Cole, Ann, Dr. Cheung and Cindy, Jacqueline, Sunita and Sujata Mukhi, Situ, Papu, Sunita Dutt, Nina, Farouk, Abu, Sharif, Diamond Café, and Peasant Pies.

ABSTRACT

Scales of Marginalities: Transformations in Women's Bodies, Medicines, and Land in Postcolonial Balochistan, Pakistan

Fouzieyha Towghi, MPH

Balochistan, the largest Province in Pakistan, where more than ninety percent of births are attended by traditional midwives- outside of hospitals-functions as a site whose geography and population are racialized across multiple scales in colonial and postcolonial Pakistani state discourses. It is part of a region economically marginalized and divided between Pakistan, Iran, and Afghanistan. Through an ethnography of local medical practices and national development policies and analysis of discourses operating across these different scales, I address the relations between local midwives' practices, their knowledge about reproductive health and plant medicines and the historical and contemporary policy construction of their identities and social worth in the context of a multi-ethnic society. I examine political technologies of intervention to deconstruct the mechanisms by which the contemporary marginalized group of healers (local midwives), *Balochi* medicine, and Balochistan is represented through gender and racialized terms of 'backward tribes'.

In particular, I address how colonial medical practices and present flows of scientific knowledge informing biomedical and health development agendas intersect to influence contemporary power structures and the medicalization of the social body in Pakistan. I elucidate the latter context and link it to delineate how this impacts healing practices in Pakistan, shaping and constituting *dais'* (midwives) work and the production of *dais'* and biomedical practitioners' identities. Principally, I argue that epistemological and material violence are inseparable. That is, the discourses about "traditional birth attendants" enable a type of invisible violence against both them and the large number of women in Pakistan who rely on them. I argue that the conditional inclusion of local midwives is the violence that restructures social relations outside of the bio-medical context such that while the aim is to advance women's health, in fact it often damages it by producing new and reinforcing old hierarchical structures. Informed by a vast and multi-dimensional archive including ethnographic research comprising: interviews with local midwives, childbearing women, biomedical practitioners, policymakers, and government officials; archival research of organizational documents; print media; and the existing and historical literature on reproductive health and midwives, my research contributes to the understanding of an understudied region and people.

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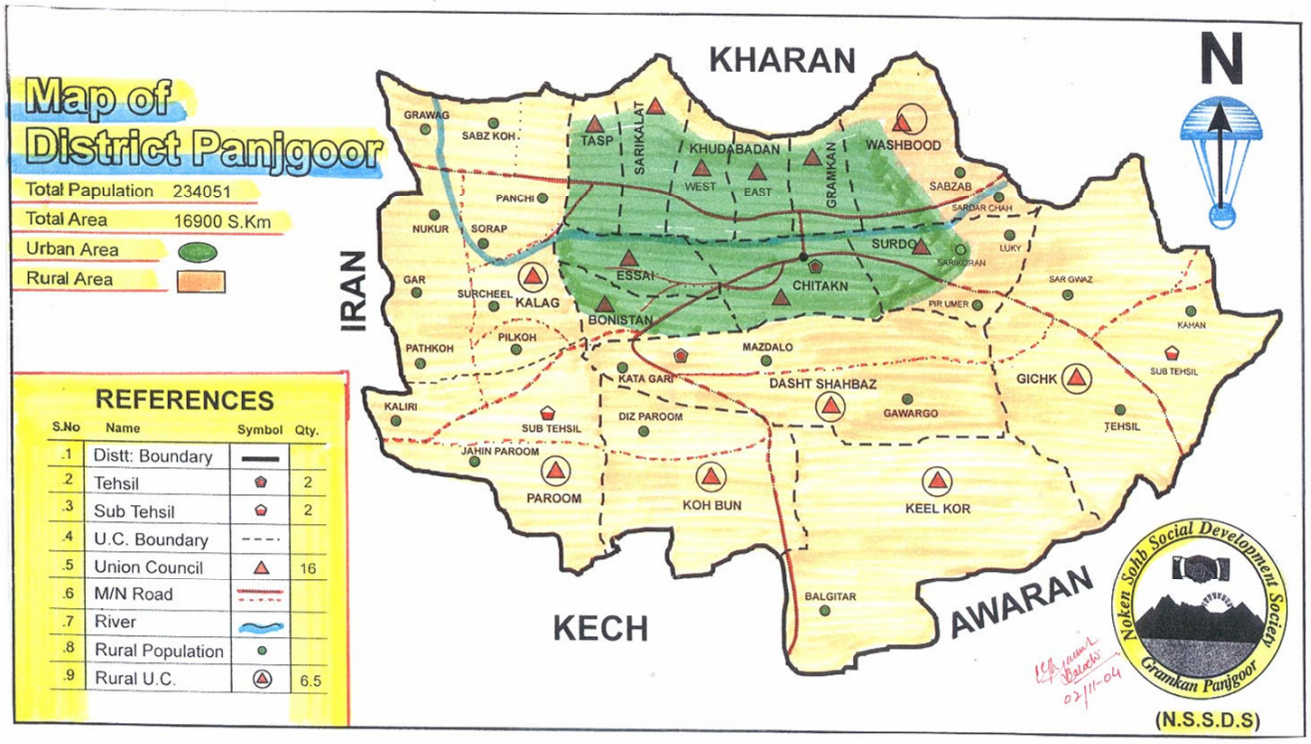
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INTRODUCTION: CONTEXTUALIZING THE LARGER PROJECT

> We must escape from the limited field of juridical sovereignty and state institutions, and instead base our analysis of power on the study of the techniques of tactics and domination. (Foucault 1972: 102)

> While holding fast to differentiation and specificity, we cannot afford to forget the overdetermining effects of the colonial moment—the 'work' which its binaries were constantly required to do to re-present the proliferation of cultural difference and forms of life, which were always there, within the sutured and over-determined 'unity' of that simplifying, over-arching, the binary, 'the West and the Rest. (Hall 1996: 249)

> The contradictions in postcolonial testimony and the ironies in postcolonial routine need to be seen in terms of how colonial subjects ascribed meaning to papers, among other objects and how they translated and continue to negotiate a mixed social reality of coercive and alluring messages. (Hunt 1999: 21)

> Recent historiography, anthropology, and feminist criticism inspired by Foucauldian, neo-Gramscian paradigms or post-structuralism problematize everything in terms of how identities are "invented," "hybrid," "fluid," and "negotiated." On the pretext of avoiding single-factor explanations of domination, these disciplines have reduced the complex phenomena of the state and power of "discourse" and "representations," forgetting that discourses and representations have materiality. (Mbembe 2001:5)

This dissertation asks what "rules of difference" shape the postcolonial project to improve women's health in Pakistan; to biomedicalize reproductive health care; and to ethnicize/racialize indigenous medical care and "tribal" life? And how is the project of social and medical reform (routed via development projects) accommodated and resisted locally? Chatterjee (1993: 18) argues that "the rule of colonial difference" is part of a "common strategy for the deployment of modern forms of disciplinary power" and that the history of the Indian colonial state is not secondary but significant in the study of the Indian modern state. He rests his argument on race as the mark of colonial difference especially during the late 19th Century. Similarly, in contemporary Pakistan the process

of Euro-medicalization of reproductive behavior-that is bringing the female and rural social body as an object of medico-government surveillance- is linked to broader and differential policy objectives of the state toward distinct population groups, e.g. "traditional birth attendants" (TBAs) and Baloch "tribes".

In Pakistan, 'transnational' development aid policies influence socio-economic policies and in turn, the government's development goals shape the nation's reproductive and medical care policies.[1] Despite medical pluralism, and the persistence of non-allopathic practitioners such as the local midwives of the global south who assist women during childbirth, the Pakistani state's development aid and planning agenda have held an un-yielding bias for allopathic/biomedical scientific knowledge and technology, which, concomitantly, holds an authoritative place in public health policy making. Yet the medical care hierarchy and health development policies in Pakistan have had a direct and often negative impact on the bodies of community midwives and other women. In Panjgur district (my primary research site), this was revealed within the prevailing context of local tensions about the conceptions of the efficacy of allopathic medicine versus *Balochi dewa* (i.e. Balochi herbal medicine). Further, the category of gender works and is worked by the category of the "traditional" in national and regional medical and social development planning.

The "Traditional Birth Attendant" (*TBA*)

In Pakistan local midwives broadly fall under the rubric of non-allopathic practitioners. The local midwives of the global south are categorized in the literature largely as traditional birth attendants or (TBAs), due to a World Health Organization (WHO) decision in the 1970s to promote their training and incorporation into the

allopathic/biomedical system in order to advance primary health care (PHC). In reports published as recent as 1992, a TBA is defined as a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs. Anthropologists, however, have long since recognized the narrowness of this definition.[2] As Pigg (1997) and others have shown, the term TBA produces a homogeneous effect that serves the policy perspective and the requirements of the project goals. TBAs are configured to possess similar skills, functions, and status within and across communities to justify the standardized intervention. Yet, as studies illustrate, including my ethnographic research, beneath the veiling effect of categories, "acronyms," and discursive effacements, there are profoundly complex subjects possessing distinct expertise.

In my study, the Panjguri care-givers and caretakers of women's bodies characterize these subjects. While some work has been done on deconstructing the homogenizing impact of the category TBA, there has been less emphasis on how distinct and dominant internal categories produced within nation-states or regions also function to veil the heterogeneity of female medicinal work. My work with local midwives in Balochistan, the largest Province in Pakistan in terms of land mass, where more than ninety percent of births are attended by traditional midwives, and my observations in Sindh,[3] confirm how the dominant transnational category of TBA and the dominant South Asian category of *dai* together function as reductive categories in Pakistan, and fail to adequately represent in name or content the diverse and eclectic *dhinabhugiri* or *kawwāsi* [midwifery] and healing practices of Panjguri female medical/herbal practitioners. In Pakistani health development and state discourses, the body of the

transnational pre-constituted colonial TBA is mapped onto pre-constructed ideas about rural land. Among all the provinces in Pakistan, Balochistan is the most rural, and least developed in terms of electrification, piped water, road and transport infrastructure, and access to schools, health facilities, and other modern infrastructures.

Therefore, through an ethnography of local medical practices and national development policies and analysis of discourses operating across these different scales, my dissertation examines the relations between local midwives' practices, their knowledge about reproductive health and plant medicines and the historical and contemporary policy construction of their identities and social worth in the context of a multi-ethnic society. I examine seemingly disparate discursive spaces across geographic locations (i.e. international, national, state, and local) to consider how categories such as "tribal" and "midwife" are produced and refracted in these distinct sites. I show how distinct sites (i.e. in hospitals/clinics, policy and human rights documents, government and non-government policy and project planning forums) produce the same homogenized conceptions of rural women whose bodies need protection and simultaneously construct local midwives and tribal culture as requiring transformation or eradication. I combine the study of contemporary medical practices with a historical analysis of colonial and postcolonial social policies to highlight the social and historical impact of health, medical, and social development interventions on midwives, reproductive women, and more widely the rest of the Baloch people.

In particular, this dissertation shows how the body of the local midwife in Panjgur and the social body of "tribes" in Balochistan rupture the conception that the Pakistani state holds about itself as a "modern" nation. By exploring how health development

policies transform rural life in Balochistan, especially the lives of midwives and childbearing women, I delineate the connections between the racialization of Balochs as "tribal" and ungovernable in women's human rights discourse with the desires and discourses of the Pakistani state to manage women's bodies via modern medical technologies, big development, and military interventions. My broad engagement with an interdisciplinary body of literature (i.e. critical medical anthropology of ethnomedicine; colonial histories of medicine and medical science; postcolonial studies of science and technology; and transnational/ postcolonial feminist criticism) allows me to consider how the "traditional" midwives are active citizens of a modern nation-state, while they are also considered obstacles to the bio-scientifically informed modernizing needs of the nation. Thus, I address how medicine, medical services, and medical technology intersect with the political economy to socialize and racialize rural subjects such as the midwives, childbearing women, rural Balochs, and the practices of their "traditional" medicines. I now turn to a discussion of some of the other major theoretical foci of my dissertation project.

Postcolonial theory, epistemological violence and ethnographic research

Postcolonial and critical race theorists remind us: it is necessary to understand what came before in order to understand what has occurred and is still occurring as a result.[4] Thus, any discussion of postcolonial theory to make sense of contemporary social processes, as I do in the context of postcolonial Pakistan, must involve a discussion of colonialism itself. Postcolonial effects are not only a result of colonial discourse, but also

relate to the institutionalization of specific and strategic policies of colonial rule that penetrated the legal, religious, and the medical lives of populations.[5]

Postcolonial scholars including historians and anthropologists, have widened studies of colonialism and colonial discourse by examining the place of colonial medicine in shaping the social, political, and economic life of the "colonized" as well as the "colonizers." In addition, they have examined colonial epistemologies and their connections with colonial institutions and political economy (Mbembe 2001).[6] Such studies examine how stereotypes, images, and knowledge of colonial subjects and cultures tie in with institutions of economic, administrative, judicial, and bio-medical control. In this scholarship the concept of the "discourse" is meant to uncover the interrelation between the ideological and the material rather than to collapse them into each other. Thus, examining colonial discourse entails not just unraveling how ideas, institutions, knowledge, and power intersect: rather, as I show in my work, it involves delineating the specificities of colonial ideologies and structures influencing and reworking the contemporary configurations of medico-socio structures and relations of power that accompany the production of discourse and policy aimed toward "traditional" midwives and "rural" Balochistan. For example, the contemporary discursive trope of blaming tribalism for "backwardness" of rural life, lack of development and progress in the Balochistan Province, and women's poor social status there, operates simultaneously with the transnational debates about the legitimacy of the community midwives as healers and health care practitioners. In postcolonial Pakistan, both "tribalism" and "traditional" midwifery are mapped onto the rural landscape and social body as essential characteristics that in turn provide the rationale for state intervention of these discursively

pre-constructed spaces and places. As such, albeit with a different vocabulary, the colonial discursive terrain is re-invented and reworked in Pakistani state and nationalist rhetoric in the name of "development", "progress", and "modernization."

Postcolonial theory enables a different kind of understanding of indigenous practices and discourses, "one which does not seek to determine whether something is authentic, original, or uncontaminated but which accepts cultural hybridity as a starting point in political projects that seek to empower subaltern, poor, and marginal groups" (Gupta 2000: 20). Gupta (2000: 20) defines his conception of hybridity as "a set of locations that are formed by structural violence and stratified by different kinds of inequalities". He prefers hybridities than the use of hybridity in order to avoid universalization of particular forms of colonial discourse—such as the one occupied by colonized elites. In this way, interrogating the false dichotomy between "tradition" and "modernity", scholars have illustrated how in postcolonial societies "traditional" practitioners simultaneously resist and selectively incorporate aspects of "modern" modalities and technologies (Adams 1995, 2002; Cohen 1998; Gupta 1998; Langford 2002; Comaroff 1993). Moreover, the results of interactions between "traditional" and "modern" scientific techniques are multiple, heterogeneous, and locally specific. Following these scholars, I do not seek a reified notion of local practices as rooted in an authentic, unchanging and culturally universal past. I do, however, remain concerned with how specific modernizing/westernizing efforts, through for example, the imposition of allopathic/biomedicine, impacts both practitioners and patients.

One of the central arguments of my dissertation is that epistemological and material violence are inseparable.[7] Epistemological violence (Spivak 1985, 1988, 1990,

2000) is inseparable from material violence as has been illustrated by Foucault (1980 [1972-1977]) in the context of Europe and by postcolonial theorists (Prakash 1990; Mitchell 1991; Chatterjee 1986, 1993) in the context of colonial and postcolonial governance (Cohen 1995).[8] What I mean by this in the context of my research is that, the discourses about traditional birth attendants (TBA) or *dai* enable a type of invisible violence against both them and the large number of women in Pakistan who rely on them. Following Spivak's notion of enabling violations, I argue that the conditional inclusion of local midwives is the violence that restructures social relations within and outside of the bio-medical context such that while the aim is to advance women's health, this state authorized and delimited inclusion of the TBA, in fact, often damages women's social conditions and the possibilities for diverse means and forms of bodily, emotional, psychic care and social support networks by producing new and reinforcing older colonial structures of hierarchies.

My argument stems also from a delineation of the ways in which the conceptions of ethnomedicines (any medicine not allopathic or biomedicine) in Pakistan are connected to power and knowledge, whereby the view of ethno-medicines held by state-medical functionaries and health development policy-makers influence Pakistan's medical care priorities and public health improvement efforts. Michel Foucault's work on power/knowledge explicates how mechanisms of power have been able to function through exclusions, the apparatus of surveillance, and medicalization, which are accompanied by ideological productions that have discursive effects.[9] Often the authority of biomedical practitioners over patients' medical care choices is exerted through the vocalized and written denigration of non-allopathic medicines and practitioners. This

ideological production about non-allopathic medicine is a mechanism that serves to exclude *dhinabhugs*[10] in Panjgur not only as legitimate herbalists, but also as legitimate birth attendants, with an explicit aim (so long as they exist) of reducing them as a referral base for allopathic practitioners. This was my observation and hearing in Panjgur in 2004—2005 and during my earlier work in Pakistan between1992—1999.

Situating Allopathy in Pakistan

> The Government is now seriously thinking to promote the use of indigenous resources and there is serious discussion in the Ministry of Health to regularize the herbal products for the purpose of quality assurance and safety assessment. (Government Press Release December 19, 2006)

Despite the persistence of medical pluralism in Pakistan from British colonialism, since independence in 1947, the state's development aid and planning agenda have been biased towards allopathy. Over the years this dominance of allopathy has intensified, and moreover, the all too many—largely foreign funded—health care program initiatives within Pakistan have exclusively relied on medical expertise derived from allopathic/biomedical perspectives about disease, illness, and corporeal bodies of targeted population groups.[11] Whereas biomedicine is the conventional reference to allopathic medicine in the United States and the World Health Organization (WHO) archives, in Pakistan the term "medicine" or "medical science" implicitly refers to allopathy or allopathic medicine. Here the pre-fix bio is absent. However, the Ministry of Health uses neither biomedicine nor allopathy as terms to describe medicine in Pakistan: allopathic/biomedicine is the unmarked medicine of the country. Increasingly, however, the term allopathy is deployed to mark it as the conventional medicine in the context of

discussions and publications about “traditional”, “alternative”, or “complementary” medicine, as is the trend in many countries, in north and south. Thus, allopathy is the binary opposite of all other medicines in the country and the referent to judge the standard of those other medicines. In recent years, allopathy is explicitly contrasted with homeopathy, Unani, or Āyurveda. This is in large part a result of the increasing push by the WHO on countries to regulate the so-called alternative medicines and modalities of care in the name of protecting consumers.

The public health paradigm in Pakistan, as in most countries of the global South, carries with it the heavy authority of WHO, and thus also the authority of biomedicine or allopathy. Moving beyond the point that biomedical care has been reshaped and reworked from its European origin, as many medical anthropologists and historians of science and medicine have illustrated, in postcolonial societies such as in Pakistan, allopathic medicine persists in the dominant position and in holds the power to de-legitimize and legitimize other modalities of care. For example, for the first time in Pakistan the Ministry of Health has opened “Traditional Medicine Centers.”[12] A central role of this government unit is to regulate non-allopathic medical services. Although the Federal Ministry of Health in Pakistan formally acknowledged homeopathy in 1951, the National Assembly only passed the Unani, Āyurveda, and Homeopathic Practitioners Act in 1965, after several years of debate. [13]

Despite these recent developments, in 2006 advertised claims that homeopathy can cure Hepatitis-C and other chronic diseases prompted the government to urge the homeopathic council to take action against such so-called “un-ethical” advertisements. In doing so, it made clear, implicitly if not explicitly, that claims to “cure” disease are

exclusively reserved for allopathically trained professionals. This battle for legitimacy was exemplified in interviews I conducted with biomedical doctors in Quetta and Islamabad in which several doctors articulated the issues that they had with government's efforts to register and integrate *hakeems* (male physician of Unani medicine)[14] into the biomedical institutions. One doctor felt that it was hypocritical of *hakeems* to work in hospital (an allopathic/biomedical institution), asking, *"Why don't they come up with their own hospitals- why do they want to use our tools?"* What he failed to consider here, however, is that *hakeems* continue to attract patients whether they are located in or outside of hospitals, and in fact their location in hospitals facilitates the implementation of state regulation of their practice. Attempts to pull "traditional" healers under the gaze of the state apparatus is not new. The histories of local midwives or the so-called TBA in Pakistan make this clear.

Transnational and trans-historical policy attempts to interpellate[15] TBAs or *Dais*

The Pakistani state bureaucracy has repeatedly called upon the *dai,* a figure who in the postcolonial health development context is often marked as the traditional birth attendant, to assist with national health improvement. The targeting of *dais* to serve state interests began in the late colonial period (Arnold 1993: 259). Since then the national health establishment has been keen to elicit and utilize the "natural" connection that *dais* are perceived to have with their communities, and to use them for infant and child health, family planning, and maternal health care programs. While the integration of *dais* into the health care system was considered crucial in accessing communities, conceptions of their value in health care have shifted over time. A *dai* during the colonial period was

considered to be "uneducated and dangerous," needing to be replaced by Western midwives (Arnold 1993: 259); in the post world war II period the *dai* was viewed as a figure in need of hygiene training, though useful for linking the clinic and community; and in the last ten to fifteen years, she has been seen to add to the risks associated with maternal death (Browere et al. 1998). British colonial policy in Asia aimed to eradicate "traditional" midwives. When this was found to be impossible, due to the persistent demand for the community midwives' services and women and families' refusal to enter hospitals, there was a reversal of policy to feature government-sponsored training for the midwives to improve child-delivery practices (Rogers et al. 1975). Despite the debates and contradictory findings evident in the literature about the capability of the so-called TBA to safely and effectively attend childbirths, in the 21st Century, Pakistani health development professionals agree with the WHO conclusion that even previously "trained" traditional midwives or TBAs cannot be categorized as "skilled" birth attendants, and concomitantly they call for the replacement of *dais* with modern health care professionals (WHO 2001).

Although there are no ethnographic studies of local community midwives in Pakistan that can support the soundness of such a position, a majority of the leading public health professionals in Pakistan involved in advancing national health policies for maternal, child, and reproductive health consider the static maternal mortality ratio of the last two decades in the country as a measure of, not so much the failed training and program attempts to integrate traditional birth attendants, but rather, the failure of TBAs to learn and acquire technical biomedical skills. Thus the high and stagnant maternal mortality ratio is discursively linked to the presumed impossibility of changing TBA

behavior. Consequently, a process is underway to redefine the term midwife whereby the focus on technical capability and learning capacity, measured by level of literacy gained through formal schooling, underlies the definitional parameters of who can and cannot become a midwife. In essence there is no space here for any notion of practical knowledge and its value, nor is positive value afforded to organic and common sense knowledge derived from experience and inheritance through an active network of kin and intergenerational engagements that I show persist despite the policy attempts stamp out the "traditional" in the midwife.[16]

Categories and Epistemologies: What kinds of subjects are presumed in the discourses of reproduction and production?

> I want to try to discover how this choice of truth, inside which we are caught but which we ceaselessly renew, was made—but also how it was repeated, renewed and displaced. (Foucault 1981:70)

> The traditional culture of birthing in most rural and urban areas of Pakistan hinders utilization of available [biomedical/allopathic] services. (Ministry of Health- National Report 2005)

> The Problem of traditional childbirth for women is rooted not in medicalization per se but in monopoly; monopoly of professional authority, of material resources, and of what may be called linguistic capital – the power to establish and enforce a particular definition of childbirth. (Treichler 1990:4)

Discourses do not exist in a vacuum but are in constant conflict with other discourses and other social practices, which inform them over questions of truth and authority. Hence, we can talk about how dominant discourses operate to exclude other discourses, leading, for example, to what Foucault terms as "subjugated knowledges". For Foucault, "subjugated knowledges" are those blocs of historical knowledge which

were present but disguised within the body of functionalist and systematizing theory and which criticism—which obviously draws upon scholarship—has been able to reveal." (Foucault 1980 [1972-1977]: 82) So there are two ways in which we can consider how discourse works to marginalize and exclude groups from dominant structures of society such as the access to state-based and private run legal and medical institutions. One is to construct specified knowledge about the group; the second is to entirely exclude the subjects in the public articulation of the discourse. It is precisely both of these forms of discursive limits that are operating in Pakistan: in one domain about the so-called TBA or *dais*—in the framing of maternal mortality as a leading public health problem; and in another national arena of development and reform efforts about the tribal Baloch ethnic group—in the framing of honor killing as a violation of women's human rights.

The dominant discourse is one that is supported by institutional funding and the provision of resources including human resources by the state, and is endorsed by a large segment of society. Foucault (Foucault 1980 [1976]: 101) considers the relationship of text/discourse to the real, and the construction of the real by discursive structures. The 'real' is formed through the constructs of discourse, rather than actual observation. The connection between production of knowledge and power relations is what Foucault refers to power/knowledge. The productive model of power explicated by Foucault is particularly useful when thinking about the material effects of discourse, for we can look for how discourse can be both an instrument and effect of power. Ferguson's (1994) study of development discourse and its material effects on the lives of the people of Lesotho illustrates well the effect of highly regulated groupings of utterances with internal rules specific to a particular discourse (i.e. development versus academic

representations of Lesotho); its relation to institutional mechanisms of reinforcement; and the recycling of knowledge and development interventions.[17] In this work Ferguson shows the imbrications of the construction of knowledge about Lesotho and the power of the development apparatus. It provides concrete instances of how development modalities objectify targets of development in their planning; such that what is political (i.e. stands outside of the grid of the planning rationality) is perpetually de-politicized in its grid of intelligibility. This planned development, which begins with a document (and statistics) about the place, people, and the problem to be solved, reveals a larger dynamic process in which a particular discourse and a development project intervention are intertwined.[18] Thus the very definition of the problem (as a technical one) simultaneously initiates and instantiates divisions of social life (e.g. politics, economics, medical) so as to ignore the social elements that might explain project failures and justify future correctives that are different, but remain technical for "improved planning". Moreover, as Chatterjee (1993: 282) explains, the relations between state development planning and national politics is one of "rational planning" and "irrational politics" that are inseparable logics of the state conducting its mandate. That is, the a priori construction of irrationality of politics works to legitimize rationality of planning, for what is science in one domain is rhetoric in another and they are inseparable in the constitution of the development of the nation, and shape the identity of the Indian state. These are precisely the processes in place today in advancing the World Health Organization (WHO) endorsed and mandated "safe-motherhood" programs and projects planned, designed, and implemented in the so-called developing countries, including Pakistan.

Discourses on Balochistan, "Tribes", and "Traditional" Midwives:

Balochistan is a subaltern site whose geography and population are racialized across multiple scales in colonial and postcolonial Pakistani state discourses. Economically marginalized and divided between Pakistan, Iran, and Afghanistan, Balochistan is an understudied region. On the one hand Anthropology and South Asia Studies are dominated by the study of India and Indian languages; on the other, Pakistan Studies (i.e. political science) is typically presented as a homogenized Islamic nation-state, despite the immense ethnic and linguistic diversity. Balochistan is thus part of a binary. Marked as tribal, the people and the region are simultaneously positioned opposite to the "secular state" and "Islamic nation" in International, State, and local discursive spaces.

Depictions of Balochistan as a *non-productive*, *unpopulated*, and *backward* region, have persisted since the colonial period. Now, these signs are framed in novel ways to justify Pakistani governments new cycle of engagement with Balochistan and Baloch nationalist leaders (Harrison 1981; Baloch 1987; Matheson 1997 [1967]). The Pakistani national discourse about the geography and ecology of Balochistan is a dominant one in the development aid and policy literatures. In this discourse, the rural aspect of Baloch social life is particularized through an emphasis on the "tribal nature" of life in Balochistan. While Matheson's *The Tigers of Balochistan* highlights the male centered aspect of the *sardari* system of the Bugti tribe, a recent report by Amnesty International (1999) naturalizes Balochistan's "tribal" life as uniquely prone to violence against women. Scholz's *Nomadism and colonialism: a hundred years of Balochistan-1872-1972* was published in German in 1974 and only translated in English in 2000. In

this volume the Balochs are characterized as "mountain people" and "nomadic tribes". As with several other texts that have debated and reconstituted the question of Baloch origin,[19] a focus of Scholz's text is to examine the genesis of the tribes of Balochistan. I highlight this not with an aim to elaborate on the particularities and debates of origin stories about the Baloch, but rather to pose the question: What purposes do such stories serve in the current nationalist politics of Pakistan?

In contemporary government rhetoric about advancing the economic and social status of the nation, *sardars* (tribal chief) and the *sardari* system is constructed as a central obstacle to national development. In high profile transnational media, the *sardari* system is projected as a central feature of the social life of the Balochs. This imagined system is portrayed as uniquely oppressive to the tribal people and worse, as the major violator of women's human rights in the country. I suggest that this notion of tribal life in human rights documents is imagined and orientalist because the claims of negative tribalism rely on secondary documents that lack primary or ethnographic research, inaccurate interpretations of statistics, and a few individual incidents of murders of women. Thus, while contemporary anthropological scholarship on the Baloch is largely concerned with the category of ethnicity, it is the term "tribe" that is captivated and circulated in national and development discourse about Balochs and Balochistan inside Pakistan. Discourses on tribalism construct Baloch "customs" and politics as "backward" and "primitive" and similarly, indigenous medical practitioners (i.e. midwives), who have been simultaneously peripheral and central to shifting discourses on advancing women's health and social status in Pakistan, are again constructed as obstacles—this time against

reducing maternal mortality rates, and thus are considered superfluous to modernization of obstetric care in the country.

The re-emergence of colonial gendered and racialized tropes travel across spatial boundaries in women's human rights discourse in which striking parallels arise between how immigrant cultures are racialized in the U.S. and how the Baloch ethnic group is racialized in Pakistan by the postcolonial State. Although the rise of ethnicity in scholarship coincides with the decline of race theory, whether the shift from race to ethnic identification and emphasis upon cultural relativism has displaced biologically based essentialist arguments to characterize group conduct can be and is intensely debated, for example, in arguments around the relationships between multiculturalism and women's oppression. My work directly engages with these debates.

Borders, Space, and Scales[20]

> 'Worlding" [is]: The assumptions that when the colonizers came to the world, they encounter it as un-inscribed earth upon which they write their inscriptions. (Spivak 1990: 129)
>
> In the broadest terms, specific geographical scales can be conceived as platforms for specific kinds of social activity. They are platforms of absolute space in a wider sea of relational space. (Johnston, Gregory, Pratt, and Watts 2000: 724)

Gay Becker in *Disrupted Lives* discusses the experience of bodily distress arising out of disruption to life. In Becker's (2000) important ethnography *The Elusive Embryo: How women and men approach New Reproductive Technologies* in the border between technology and the body in infertility treatments, technology is seen as a catalyst for disruption. Becker connects her thinking about disruption with the works of Ong and Peletz (1995) who address the body as a site of disruption in *Bewitching Women.* Also,

Ginsburg and Tsing in (1990) *Uncertain Terms* observe that because of pervasive uncertainties over gender constructs, gender meanings are subject to constant negotiation at both personal and the political levels. The contestation of meanings is most intensive, for example, at borders of communities, classes, cultures, and nationalities. In my study the contestation of meanings about the ailments, diagnosis, and bodily disruptions lie at multiple borders simultaneously: the rural vs. urban; herbs vs. pharmaceutical injections; *Balochi dewai* vs. hysterectomies; home birth vs. hospital births; past nomadic ways vs. the present city ways; and the ways of the *dhinabhug* vs. the ways of the *lady* or biomedicine. What I show is that Panjguri women and their *dhinabhugs* experience these borders simultaneously as matters of everyday unfold in their lives. Thus, I find it useful to consider the scales of burdens that are produced on the bio and socio bodies of women and their fellow *dhinabhugs* as consequences of the tensions, abrasions, and violence of development and medico-technologies of interventions that seem- by necessity as a product of the of the geo-constitutions of spaces (geohistorical, geopolitical, geophysical) - to cross all these borders.

The subjects of my research simultaneously face both bodily and social disruptions. The production of geographical knowledge has always involved claims to 'space' in particular ways.[21] "Worlding" is a term Spivak employs to describe 19th Century imperialism and colonialism as, the "Worlding of the Third World." (1985a: 128; 1990: 129). Influenced by Derrida's work, for Spivak there is no transparent correspondence between language and the "real world." She argues that a core problem of this model of language is that it has been variously used to represent and constitute the world [people, places, or geography], as a stable and knowable object of western

academy. Cohn (1996) provides a concrete study of how this took place in India under British colonialism. This western epistemology is linked with the history of European imperial expansion from nineteenth-century British colonialism to twentieth-century US foreign policy-making, the development policies of the World Bank and the World Trade Organization. Spivak (1990) refers to this dominant representation and processes of the world as "worlding." The descriptions of colonial territory as empty spaces and "people without history" justified particular forms of expansion and exploitation of spaces (Wolf 1982). In Pakistani postcolonial context such forms of "worlding" has not abated, for the many Pakistani "conscripts of modernity" (Scott 2004) involved in the "development" of the "nation" are busy re-inscribing their own vision of the modern sociality and spatiality that deems the rural, "tribals", and "midwives" as remnants of a perishing past whose arrival to modernity requires variety of medico-political technologies of interventions.

Production of scale is not arbitrary (Smith 1984). According to Henri Lefebvre (1990) all politics is at root spatial and as such research focus on space is essentially an agenda aimed at spatial control and spatial policy. This process is certainly in place in Pakistan, whereby the central government constructs rural Balochistan as a space controlled by tribal chiefs to justify its technologies of interventions throughout the province that among a myriad of development interventions include the constructions of Gwadar port, heavily militarized cantonments to control the source sites of gas and oil, and military intervention under the pretext of the "war on terror". Lefebvre (1990) suggests what is important is to attend to the *production of space,* and calls for theorizing how space is re-differentiated into recognizable places. In this line of thinking, scale, is neither given, nor, natural, but rather socially (politically/economically) produced as

argued by Smith (1984).[22] In my study, I use scale to think of geographical scale and the relations between people with bodies and embodied subjectivities, medicines, and places of varying scales within and across geographical spaces. These relations are mediated by a whole array of historical and contemporary processes and articulations of uneven power relations. I am concerned with how productions of people, medicines, and places as differentiated scales mediate relations between already differentiated spaces. So, for example, medical centers located in rural vs. urban areas are already differentiated in terms of forms of human and technological resources available in these medical places. Critical geographers argue that geographical scale is produced and is constituted by spatial differentiations. In my study, access and quality of roads and forms of transportation in rural vs. urban areas in myriad of ways determine the scaler differentiation within and the divide between a medical centers located in urban vs. rural setting. This effect, for example, unfolds and refolds in terms of ethics and ethical practices and in shaping the doctor-patient relationship such as in influencing the diagnostic and therapeutic decisions of doctors, thus also impacting the immeidate and long term bio-physical and bio-social experiences of the childbearing women marked by the uneven relationship between urban and rural physical and social lives and the varied understandings of one another.

Theoretical Engagements

In addition to what I have discussed above, in this dissertation, I engage with a number of pressing theoretical issues and build on approaches that examine how knowledge about health and healing practices influence the discursive formations and

knowledge about subjectivities (i.e. midwives or *dais*, childbearing women, rural Balochs). I focus on a category of practitioner that nominally is not "professional", and has been the subject of colonial and postcolonial efforts to incorporate them into modern medical systems. While I am particularly concerned with the cultural processes involved in the subjugation (Foucault 1972) of the so-called TBA or *dais'* knowledge about female bodies, reproduction, and medicinal plants, I also recognize that "traditional" midwives and the women they serve are not necessarily passive recipients of development and medical interventions, as it has been instantiated in my study and studies of other scholars (Hunt 1999; Vaughan 1991; Van Hollen 2003). Rather, my dissertation elucidates how Panjguri midwives themselves negotiate the heterogeneous expectations of their work.

By focusing on both state and non-state mandated development practices, my research directly engages scholarship on childbirth (Van Hollen 2003), motherhood (Ram and Jolly 1998), and healing (Hunt 1999) and how they have been influenced by missionaries, colonial administrative and social-medical practices, and the introduction of Western medical science and biomedical birthing methods. Medical anthropologists have not only documented what constitutes safe birthing practices cross-culturally (Jordan 1989), but have also highlighted the positive and negative effects of Western style biomedical services in the Third World (MacCormack 1994; Jordan 1989; Van Hollen 2003; Kaufert and O'Neil 1993; Davis-Floyd & Sargent 1997). While these studies reveal how midwives work in the context of pregnancy and childbirth, midwives' broader roles as healers is largely overlooked—Sargent's (1982) study of midwives in Bariba, Benin is one exception. My research adds to this body of work by observing the midwives' full range of practices in order to elucidate their complex historical and contemporary

position at the intersection of locally specific social relations that include the role of biomedical science in development. While the literature on childbirth tends to reduce the role of traditional midwives to that of birth attendant, the literature on traditional medicine overlooks midwives' broader role as healers. My focus on midwives' use of plant medicine permits me to address both of these gaps in the literature.

More broadly, I build on critical anthropological studies of medicine that show how medical phenomena in the context of cultural processes reveal not just aspects of healing and medicine in that society (Farquhar 1994), but also society itself (Adams 1998; Cohen 1998; Langford 2002; Lock 1993; Taussig 1987; Kaufman 2006). These studies emphasize the political and economic situations as well as presenting the social histories that shape local ways of knowing and doing medicine. In noting that medicine and the view of it as a distinctive domain in society is influenced by science and scientific knowledge (Farquhar 1994), such studies also recognize the impacts of political and economic conditions on lived experiences of illness, healing, and the practice of medicine (Lock 1993; Taussig 1987). Medical anthropologists informed by Foucault's historical analysis of development of human sciences, have delineated how the persistent privilege of biomedical knowledge over other ethno-medicines rests on biomedicine's relationship with science. They question biomedicine's privileged association with science, and the application of universal categories and concepts of disease, distress, and medical efficacy in understanding all medicines (Gordon 1988; Young 1981, 1982; Rhodes 1996). Influenced by science studies scholars like Kuhn (1962) and Feyerabend (1978), medical anthropologists are engaged in questioning assumptions about the timelessness of the "truth" claims of Western science (Farquhar 1994). They argue that identifying the

impact of this assumption on the study of other knowledge systems, demands the recognition that scientific thought and institutions, like other systems and institutions, are social products, as are assumptions about the "truth," or authoritative nature, of their special knowledge.

In large part, the history of development policy and intervention is a history of technology transfer and technological intervention. To examine the gaze of reproductive health policy in Pakistan, my project is also framed by scholarship on how colonial medicine and science constructed social groups as homogeneous (Vaughan 1991); viewed physical bodies as diseased (Arnold 1988); and impinged on local therapeutics and political economies (Hunt 1999; Comaroff 1993). This scholarship offers an understanding of colonial trafficking, and an alternative, nuanced reading of neocolonial forms of power and transnational movements of medical and scientific knowledge. Arnold (1993) shows that part of the power of colonial medical practice lay in the manner in which medicine self-consciously conceived of itself as a science, based on careful clinical observation and the simultaneous association of Indian concepts of disease and healing with superstition. Further, Hunt (1999) illustrates locally specific and heterogeneous forms of practices through deep archival research and attention to local history of cultural interaction. Similarly, Ludden (2000) has delineated the continuities from colonial to postcolonial development and shows how development has been linked in instrumental ways to the growth of the modern state, the preoccupations of colonial rule and general commitment to the "science" of economic production.

Yet, despite this superb scholarship, there are no studies that attend to how colonial medical practices and present flows of scientific knowledge informing

development agendas intersect to influence contemporary power structures and the medicalization of the social body in Pakistan. My dissertation explicates the latter context and shows how this impacts healing practices in Pakistan, shaping "traditional" midwives' work and the production of their cultural identities.

In postcolonial studies, science and technology, especially in their medical forms, are increasingly recognized as significant colonial projects, requiring further analysis (Anderson 2002). Science and technology studies scholars have illustrated how scientific facts are constituted through social practice (Shapin 1995) and the social is inextricable from the production of scientific knowledge (Latour 1993). For Anderson (2002: 643) the term "postcolonial" refers to new configurations of techno-science and to the critical modes of analysis that identify them. Linking science studies and postcolonial theory would not only provide instances of Western science and technology in different settings, but it may destabilize conventional accounts of techno-science in any context (Anderson 2002). In many of the studies of science and technology in the Third World, science and technology are viewed in terms of context-specific forms of knowledge and practice that interact with a set of globally distributed social interests (Shrum and Shenhav 1995). One way in which we can think of such globally distributed social interests is to consider how the individual and social identity of person from "traditional" or a "Third World" culture is reconstituted when one becomes a "modern" biomedical doctor. Therefore, I consider the discourses produced between and across the encountered spaces of a Third World "modern" biomedical doctor and the "traditional" midwife.

In my situated analysis (Haraway 1991), I examine how and with what implications the focus on obstetric complications associated with maternal deaths and the

singular effort to develop an emergency obstetric care response system may reify women's reproduction as a medical problem requiring a specific techno-scientific solution. Scholars of technoscience studies show how technologies shape users (Oudshoorn and Pinch 2003) and highlight the implications of overlooking the user perspective (Van Kammen 2000) in the development of contraceptive technologies. For instance, Clarke (1998) explains how users of contraceptives are "implicated actors", for although women, as the primary users of reproductive technologies, are usually not very involved in the process of technological development, they are nonetheless the central targets and configured thus by techno-science. Thus, I consider how the so-called TBA or *dai,* women, and reproductive health practices in Panjgur are configured by the necessity of the institutionally based medical intervention, emergency obstetric care (EmOC)—emergency interventions comprising of low and high technologies.

Research Setting

I conducted multi-sited research in Pakistan, London, and Geneva. In Pakistan my research questions took me to the Panjgur and Khuzdar districts of Balochistan province, and to the cities of Quetta, Karachi, Hub, Islamabad, and Peshawar. Balochistan was established as a separate province in Pakistan in its present form in 1970 and is located South-west of Pakistan. It is the largest province in the country comprising an area of 347,193 km, 44 percent of country's total area. With a current officially accepted population of 6.22 million[23], the province has a population density of roughly 11.5 persons per square km living largely in rural areas. Climatic conditions are extreme, ranging from tropical through sub-tropical to temperate type, and as a result the area is

traditionally supportive of various combinations of nomadic pastoralism, date-palm cultivation, dry-crop agriculture, trading, and (on the Arabian Sea Coast) fishing. The region's potential for cultivation is hampered due to government neglect and years of drought. Wheat, barley, sorghum, pulses and maize are some of the major rain-fed and flood agriculture crops. Makran, one the largest divisions in the province where Panjgur district is located, covers approximately 54,600 square km with a population of about 1million.

The Baloch who speak Balochi and Pathans who speak Pushto, are the two major ethnic groups in the province, though Brahui, Sindhi, and Siraiki is also spoken among groups residing in different regions of the province. The vast majority of the Balochs are Muslims of the *Hanafi* School of the *Sunni* Sect. The joint family organization is the predominant family system with a patriarchal lineage in most cases.

Panjgur

A large proportion of my ethnographic research took place in Panjgur district, one of the largest area-wise districts in Balochistan province located in southwest Pakistan, bordering Iran. A predominantly rural district, it is connected with other parts of the province and the country by air and road. The district has no railways. Air travel is limited to several times a week and to three destinations only—Pasni, Turbat, and Karachi. From Panjgur, Quetta (the capital city of Balochistan province) can be reached only by road. The total length of roads within the district is 1,655 kilometers out of which only 58 kilometers is made out of metal (black top), the rest are shingle unpaved roads connecting the district to other cities of the country. For public transport, limited numbers

of buses run daily to and from Karachi, Quetta, Turbat, Khuzdar, Kharan, and some other cities. These roads are difficult to travel during rains. As the roads cross small streams and flood channels without any bridge, the traffic has to wait till the lowering of the water level. Due to unavailability of metal roads the journey from Panjgur to Karachi takes about 24 hours and to Quetta about 20 to 22 hours. Private pickups also run daily between Panjgur and Turbat and a few other destinations such as Khuzdar and Karachi.

There are two predominant etiologic explanations about the word Panjgur. According to one, Panjgur is a combination of two Balochi words: *panch*, means five, and *gor*, means grave. It is said that five *aoliya* (saints) were laid to rest in this land. Therefore the area was called *panchgor,* which later became Panjgur. Some people claim that the original word was *Panchnur* (five lights) in reference to the five saints. The second perspective is a geographical one, marking Panjgur as the land of *panch* (five) *kor* (stream). The word *panchkor* changed, with the passage of time, to Panjgur.[24]
Panjgur is a cluster of about a dozen villages with no connecting public transport. Most of the residents use their private motorcycles or bicycles for inter-village traveling though only a very small percentage of families own motorcycles. The district headquarter is in Chitkan, the only semi-urban area of the district and the location of the old bazaar. It is in close vicinity to eleven other villages within a radius of 3 to 4 kilometers alongside the bank of Rakhshan River. Recent census estimates indicate that there are 45 *mauzas*/villages (excluding 3 un-inhabited) in Panjgur, about half with a population greater than 5000. Since independence for British colonialism, five population censuses have been conducted in Pakistan: in 1951, 1961, 1972, 1981, and 1998. Panjgur's population was estimated to be 234,051 in 1998 and projected to be 280, 882 in 2005.

According to the1981 census, only 5.9 percent of the population is urban, mainly located in Chitkan town committee area. Since then, more families have moved to semi-urban villages near Chitkan and the 1998 estimates for urban population was only 21, 301, so a large majority continue to live in the rural areas of the district. The highest of the urban population ratio can be observed at the time of 1961 census (20.8%), a sudden rise from 2.6 percent in 1951. In 1972 the percentage of urban population had decreased to 17.4 percent, which further decreased to approximately one third in 1981. This unprecedented change in the proportion of the urban population can only be explained changing definitions regarding what constitutes urban geography. That is areas that had been deemed urban were re-marked as rural due to the fact that they lack electrification and other forms of modern amenities.

The Baloch ethnic group constitutes about 98 per cent of the population in Panjgur. Other groups are the Brahuis speaking Balochs, who largely migrated from Kalat district; the Pushtuns who may have migrated to Panjgur from Quetta, Northwest Frontier Province, or Afghanistan; and Sindhis, Punjabis, and others. Balochi language is spoken in almost all the homes in the district. However this Balochi is distinct from the dialect spoken in Dera Bugti and Kohlu districts. Balochi spoken in Panjgur and Kech has more Persian words than the Balochi spoken in other areas of Balochistan. Urdu is the second major language for communication in the area due to the links that the Panjguri people have with Karachi, the requirements of government and bureaucratic means of communication, and the participation by some within the district with the wider Pakistan's national economy. While a few Afghan refugees have migrated to Panjgur, the large majority of people currently in the district have been residing permanently for many generations. A

majority of the people residing near the Rakhshan river are involved in agriculture as their central economic activity. Seasonal migration is observed in the area to some extent when livestock farming communities of the district migrate south to the date producing areas in the date harvesting season from July to October. Generally, families reside in a common compound. An entire village is often one kin-family group living in multiple compounds, though in some parts of Panjgur older forms of housing structures persist such as the scattering of numerous *gidam* like structures constructed out of date palm leaves (*gidam* is also spelled *gedom* is a tent panel made of black goat hair used for tent roof). Ideally, male siblings stay together in one compound and/or village and consider it their duty to look after their elderly parents and families of brothers who may be employed abroad or in distant cities.

Panjgur remained under the control of the Khan of Kalat during the colonial era, however the British rulers had influence in the affairs of the area and built a levies garrison in Chitkan to collect taxes. In 1960, all administrative offices were shifted to Chitkan, later assigned the district headquarters. After division of the Indian subcontinent into two sovereign states, Makran region, comprising the southern part of Balochistan, joined the Balochistan States Union in early 1949 along with Kalat, Lasbela and Kharan. In October 1955, Makran was given the status of a district of former West Pakistan province (now Bangladesh) after its accession to Pakistan.

On 1st July 1970, when “One Unit” was dissolved and Balochistan gained the status of a province, Makran became one of its eight districts. On 1st July 1977, Makran was declared a division and was divided into three districts, named Panjgur, Turbat (renamed Kech) and Gwadar. Prior to this, Panjgur was one of the three *tehsils* of Makran

district. These re-alignments have had significant impact on the locations of medical care institutions and thus populations' access to rural health centers (RHC) and basic health units (BHU) or dispensaries. For administrative purposes, the whole district is one sub-division, i.e., Panjgur, and further divided into one *tehsil* (Panjgur) and two sub-*tehsils*, named Gitchk and Parome. Land settlement was initiated in 1992 as preparation for the construction of the Mirani Dam but to date only four wards have been finalized in the whole district. Due to lack of appropriate and trained staff land settlement work is suspended. Since Pakistan's independence in 1947, only a limited number of new government buildings were constructed in the 1980s, including the new district hospital.

Methods: Why Panjgur?

My theoretical and research interests took me to Panjgur because of the reputation the midwives had in their excellent and skillful use of plant medicines. I had learned this prior to starting my Ph.D. studies during several years of public health work in a different district of Balochistan (Khuzdar). While working on a project in Khuzdar, I met two Khuzdari midwives there who explained that the use of herbs for "women's problems" is more common in Panjgur than Khuzdar. Both of them had family ties in Panjgur, though they now live in Khuzdar, still practicing their midwifery, which entails extensive use of herbs and plants. One of them was an eighty plus years-old woman who had practiced most of her life in Panjgur before moving to Khuzdar. I returned to interview and video her over a period of three days for my doctoral research. Her granddaughter had worked with me in 1997—1998 in the Balochistan Safe-Motherhood Initiative (BSMI) project (for which I was the co-investigator and research coordinator). The granddaughter's

uncle, a medical doctor, had contacts with district officials in Panjgur. It is through them that I made my initial contacts with the local Panjguris. There were, of course, other factors that led me to focus my research in Panjgur district, including my knowledge of the language spoken there and the availability of a network of contacts that would facilitate my ability to do the research there despite restrictions imposed regarding the conduct of research in Pakistan as a consequence of September 11, 2001 attacks in the U.S.

As I have discussed, my research deconstructs the mechanisms by which the marginalized region of Balochistan is represented through gender and racialized terms of "backward tribes" and other colonial tropes. I consider how dominant conceptions of *ethno*medicines connect to power and knowledge and how this view of "traditional" medicines influences Pakistan's public health improvement efforts, engagements with midwives, and medical priorities. The examination of the political technologies of development interventions in this dissertation is informed by research of vast and multi-dimensional archives, including ethnographic research that entails: interviews with local midwives, childbearing women, allopathic practitioners, policymakers, and government officials; archival research of organizational documents and print media; and analysis of the existing and historical literature on reproductive health and midwives.

I collected data over a period of 14 months in 2004—2005 and the summer of 2006. Participant observation and informal interviews were conducted in the context of the daily work of midwives, and formal interviews were conducted with midwives, women, health care professionals, non-government and government official and policy makers. Most interviews were conducted in Balochi, some in Urdu, and others in English.

The data are supplemented by library and archival research focused especially on the documentation of health care programs implemented in this area across the 20th century. The first nine months were devoted to ethnographic research in Panjgur district focusing on: (1) midwives' social worlds, and (2) local health infrastructure. The final three months focused on: (3) interviews with policy makers; (4) researching non-governmental and governmental archives; and later in 2006 I conducted archival research at the WHO offices in Geneva and the British Libraries in London.

Research Questions and Data Collection

I developed several broad guiding questions before designing a series of more specific questionnaires following preliminary interactions with the midwives and women of childbearing age. The general guiding questions were developed with the aim of exploring the daily activities of midwives and the attitudes of the medical establishment and district officials towards them. For the study of the daily activities of midwives and women, my questions included:

- How do Panjguri midwives or *dais* navigate their social worlds, including the externally imposed health program?
- How do women, their families, and other community members view and engage with *dais* and the local health care system for their reproductive health care needs?
- What are the relationships between plant medicines and Panjguri *dais*' practices?
- What health problems do the knowledge and work of *dais* address and how?
- How do dais knowledge, interactions with community of women, and their various encounters and engagements with allopathic/biomedical establishment shaper shape their identities and work, relations with family, childbearing women, plant medicines, other local healers?

I assumed that the local midwives and other women are part of a shared social world in which, as women, they embodied an understanding of pain and suffering that

emerges from the experience of traveling wide distances on foot, working on the land— planting and harvesting— caring for livestock animals and a whole array of domestic work that includes gathering wood, water, and plants, weaving, spinning, and washing. In stepping into this research I also assumed that the substance of midwifery in any place is conditioned by a wide set of gendered, social and economic, and symbolic considerations that give it particular shapes and meanings. I also assumed that empirical knowledge of plants among midwives does not exist apart from a broader socially informed understanding of the world. For example, detailed knowledge of plant medicines can co-exist with understanding about the physical body and the cosmos, which have not been empirically tested or cannot be tested in a conventional scientific sense. The values that *dais* might attach to plants may be multi-faceted, simultaneously materially/medicinally useful and culturally meaningful. Thus, I paid particular attention to the simultaneity of what local midwives said and did in their engagement with their medicines and with the women seeking their knowledge and expertise.

My goal was to make contact with all local midwives in the district, interview them about their practices and collect their life and work histories. But, when I planned this I assumed that I would find no more than 24 local midwives in the entire district. To my surprise and good fortune I learned that there were actually at least 100, if not more. This meant that I needed to meet and interview many more midwives. During my conversations with local midwives, usually at their homes, I was helped in identifying the active midwives and as I maintained contact with some of them, and became part of their daily activities, including their involvement in childbirth and in gathering, processing, and dispensing plant remedies, I met the women who had sought their healing and

midwifery expertise. I accompanied the midwives doing their daily work, at which time I had an opportunity to meet women in their homes, men in the community, local healers, and health professionals in the villages, clinics and hospitals. I spoke with these individuals and arranged follow up interviews.

To examine the views of the medical establishment and district officials about the reproductive health care needs of the district and how they viewed the role of the so-called TBA or *dais* in addressing these needs, I observed and interviewed a range of health care practitioners and administrators, including the lady health visitors (LHV), doctors, and the district health officers. In addition to the district hospital, there are approximately 20 other health facilities in Panjgur. I interviewed more than 50 staff at some of these dispensaries including female and male medical doctors, lady health visitors, lady health workers (LHW), female and male medical technicians (FMT/MMT), and compounders.[25] Here I explored the following questions:

- What are the views of district based government health professionals (e.g. medical doctors and lady health visitors (LHVs) about the *dais*' practices and their capabilities to provide reproductive health care to women?
- What do they understand *dais* to be doing?
- How do they situate *dais* in relation to the district health care delivery system and the communities within which they themselves are assigned to work as paid public servants?
- How do they view the development efforts to 'modernize' *dais*' roles and obstetric practice in general?
- What are their perceptions of plant-based medicines used by the *dais*?
- What do they understand to be the reproductive health care needs of women and do they feel equipped to adequately address those needs?

While it may seem that allopathically trained health care professionals will necessarily hold negative attitudes towards *dais,* my previous experience in Balochistan suggests that they too hold diverse and contradictory positions toward both existing

traditional health care and the modern medical establishment. Many of them belong to or continue to have links with rural communities and are part of families that have resided in Panjgur for generations, and whose mother, grandmother, grandaunt could be or may have been a *dai*.

I interviewed active members of the National Safe Motherhood Alliance and the National Commission for Human Development (NCHD) that in May 2003 finally undertook the task of developing a national program for training and deploying 15,000 community midwives in Pakistan, a strategy approved by the Prime Minister and the Federal Health Minister. The archival research in Pakistan focused on historical and contemporary policy about *dais*, their practices, and the future of midwifery in Pakistan. I conducted interviews with some of the key policy making individuals at UNFPA, UNICEF, Population Council and WHO, and government and private public health officials in Quetta, Karachi, and Islamabad.

The archival research is concerned with delineating the relationship between contemporary and the historical scientific representations about *dais'* reproductive health care practices and the Baloch people, against my ethnographic investigation of the social life of Baloch *dais* and other women in rural Panjgur. Thus, the archival research focused on two broad social areas: (1) Investigation of historical and contemporary policy about *dais*, their practices, and the future of midwifery in Pakistan, and the history of health and development interventions in Balochistan, particularly the contemporary documents related to plant medicines; (2) investigation of historical and colonial representations of Balochs and Balochistan.

I conducted additional archival research at the India Office Library and the British Museum, sites that have documents and rare material about the pre-1947 British Empire, that included South Asia and what is now Pakistani Balochistan; as well as the British imperial zones of influence in West Asia/ the Middle East and East Africa, specifically Iranian Balochistan. In Geneva I visited the WHO offices and the United Nation's (UN) Offices. While there was very little information about projects specifically targeting the region of Balchistan, the League of Nation's for Health archives at the UN Office proved extremely beneficial in regards to the shifting focus on *dais* training programs. Unlike Balochistan, Sindh province experienced a large number of interventions aimed toward hygiene training and skill development in the early 1900s. While in general there is absence of any discussion about *dais*/midwives' involvement in the use of plant medicines, nonetheless my time at the WHO and UN League of Health Office provided access to archives of some of the contemporary (20th century) and late 19th century health related material. I now provide an overview of dissertation chapters.

Chapter Synopses

Chapter One, "*Tribalism," Ethnic Formations, and National Boundaries* provides an historical overview of anthropological writings about the Balochs and Balochistan and juxtaposes this with contemporary representations and political processes traced in my ethnographic research. In particular, I address how recent Pakistani nationalist discourses—in which emphasis is placed on the "brutal" nature of Baloch tribal practices affecting girls and women to convey the "pre-modern" and "uncivilized" characteristics of "tribalism"—has been mobilized indirectly and directly by the Pakistani government

and army to justify the militarization of the Balochistan province. In support of my analysis, I examine several textual sites such as DAWN, the largest circulating English language newspaper in Pakistan and Amnesty International Documents, in which the discourse on tribalism constructs Baloch "customs" and politics as "backward" and "primitive."

Chapter Two, *Situating the Transnational Health Development Policies in Pakistan*, focuses on the history of health and social development efforts to advance women's health and social status in the so-called Third World in order to delineate the shifting position of local midwives within the discourse of women's social reform. I particular, I discuss the political economy of Panjgur district and Balochistan province. The chapter provides an outline of the available medical services and health care infrastructure of Panjgur, the Balchistan province, and provides comparison with the rest of Pakistan. I use the material in this chapter to situate the *kawwās*—the local midwives in Panjgur—an analysis of which is then developed in Chapter Three, *Contested Categories: Discourses on Dhinabhug, Ballok, and kawwās*.

In Chapter Three, I place the discursive constructions of indigenous midwives in relation to colonial and postcolonial representations of Balochistan's geography and people. In order to trace the re-production of categories and the ethnicization of subjects and their medicines, I address the epistemological grids through which local midwives, constituted as "traditional" health practitioners, are known and contested in transnational, national, and local discourses. In this chapter, I interrogate colonial categories that are taken up to create new and maintain old hierarchies by the postcolonial state and transnational institutions in Pakistan. In particular, I explore the material effects of these

circulating categories on the corporeal and social bodies of already marginalized subjects, that is, rural and poor women; local midwives; and the Baloch population.

Chapter Four, *Contested Bodies: What Kinds of Bodies are Presumed in the Discourses of Reproduction and Production* and Chapter Five, *Contested Bodies II: "The Time of Ballok is no more; it is now the time of the lady"* address the theme of contested bodies and illustrate some of the ways in which the bodies of Panjguri reproductive women become biomedical objects of reform and are surgically managed for social-logistical reasons. The chapters show that epistemological and material violence is inseparable by addressing how the lives of local midwives, women and reproductive care are being transformed. I examine how routine injections around childbirth and increased hysterectomies among women in Panjgur are effects of the biomedicalization of women's bodies and reproductive health care. In Chapter Five entitled, *Contested Bodies II: "The Time of Ballok is no more; it is now the time of the lady"* I show, how state medical functionaries in government and private medical centers to justify routine hysterectomies can internalize a racialized form of medical care ethics. Specifically, I delineate how the local midwives marked as TBA or dais, and the rural women they serve, both reinforce and contest the tradition-modern dichotomy in their practical negotiations about health care.

In Chapter Six, *Producing Gendered "Tribalism": Can Human Rights Discourse and the Body Politic "Save" Bodies of Women from the "Tribal" Social Body?* I engage specifically with transnational feminist theory (including co-formations of gender, race, ethnicity, and postcoloniality). I address how arguments about universal rights for women end up re-invigorating primordial-biological notions that characterize tribal identity at the

cusp of the 20th and 21st centuries. I trace how older colonial notions of "tribalism" re-emerge in transnational discourse on human rights to frame the links between the construction of "tribal' ways, gender relations in Baloch "tribal" communities, and Pakistani women's social condition. Specifically, I show how the naturalization of Baloch "tribalism" in human rights and development discourses defending women's rights are re-produced by the Pakistani government and national policy makers in the name of developing Balochistan.

The concluding chapter is entitled, *Ethical Demands of Caring for the Body.* In this chapter, I extend the discussion on the ethical standards that the local midwives apply to their work and commitiment in caring for women's bodies, in providing reproductive health care to women, in passing on knowledge and skills to their kin, and in their management of reproductive emergencies in a context where medical and social forces are working to make them disappear.

CHAPTER ONE
TRIBALISM, ETHNIC FORMATIONS AND NATIONAL BOUNDARIES

Introduction

> The focal points of tribal life are widely dispersed settlements of small agriculture plots, located in valleys where broad, ill-defined riverbeds have been hallowed out by floods and on the northern plateaus where the rainfall is the greatest. Goats and sheep are the mainstay of the tribal economy and are carefully herded to protect them from wolves and leopards. (Harrison 1981: 7-8)

> One of the many ironies confronting the people who identify themselves as Baloch (and those interested in learning about them) is that, though they inhabit one of the largest and most strategic ethno-territories in Southwest Asia, they are one of the region's least studied ethnic groups. (Titus 1996:ix)

Edward Wakefield, a British political officer, traveled in Balochistan and made the following observations about the climate and geography:

> From Karachi, we traveled north by rail. Dawn was breaking as the two engines pulling our train laboured up the Bolan Pass. From our carriage windows Lalage and I looked out on a new world, a world that had nothing in common with the India we had known before. Here were rugged, barren, sun-browned mountains, cleft by deep ravines and gorges. Forbidding of aspect in the full light of day, the hills were now, in the first light of dawn, clothed with gentle effulgence that made them seem welcoming and friendly. The air, too, was different from that of India, but of the Central Asian plateau. Simply to breathe such air in such surroundings was exhilarating. [Quoted in Baluch, S. Khan 1977: 98]

Wakefield's enchanting colonial description of a rugged and mountainous Balochistan, contrasts sharply with what is so often considered an obstructive and stubbornly unchangeable region of Pakistan in postcolonial development discourses and Pakistani national politics. In contemporary nationalist and development discourses the tribal "nature" of Balochs and Balochistan is no longer romanticized as part of the warrior, masculine "martial races" discourses: commonly found in colonialist scholarship. Rather, in these discourses, Balochistan is depicted as the least "developed" province, not so much economically as socially, such that the social life of all Balochs is

deemed controlled by *sardars* (chiefs) and tribal 'norms'.[26]

Although, in 2005, government, UN, and World Bank reports identified poverty reduction as one of the eight priority millennium development goals (MDGs) to be achieved by 2015, the reports fail to mention the disproportionate levels of economic and political inequalities across ethnic and regional divides.[27] Similarly, there is zero attention to the current political upheaval in Balochistan that is a response to the economic deprivation and the historical and ongoing exploitation of the province. If we consider the political-economic situation in Pakistan, it is clear that the poor—mostly women, children, and rural—are the most disadvantaged. Stratified in another way, we find that the region of Balochistan, though resource rich, is economically the most deprived. Yet, the discourses of social improvement, now dominated by the goals to advance women's health and social status, rather than focusing on political-economic conditions and structural causes of social inequalities and inequities, locate cultural norms and their determinants as primary sites needing change. For example, whereas human rights documents portray the "tribal" men of Balochistan and the value structure which they uphold as the source of "honor killings" in all of Pakistan, transnational development documents concerned with advancing women's health condition and medical care for them, consider rural women overly reliant on unskilled pre-modern healers. Similarly, the so-called traditional medical practitioners such as the *dais* (midwives), who have been simultaneously peripheral and central to shifting discourses on advancing women's health and social status in Pakistan, are once again constructed as obstacles—this time against reducing the maternal mortality rate—and thus are considered superfluous to the goal of modernizing obstetric care in the country.

The latter constructions of midwives and the material implications of this on women's bodies are the object of discussions in Chapters Three, Four, and Five. In Chapter Six, I show how older colonial notions of tribalism re-emerge in transnational discourses on human rights at the turn of the 21st century to frame the links between tribal ways, gender relations in Baloch "tribal" communities, and Pakistani women's social condition. Here, in Chapter One, I address how the Pakistani nationalist discourse since at least 2003, in which emphasis is placed on the "brutal" nature of Baloch tribal practices affecting girls and women to convey the "pre-modern" and "uncivilized" characteristics of tribalism, has been mobilized indirectly and directly by the Pakistani government and army to justify the militarization of the Balochistan province. In this discourse, the s*ardars* and the s*ardari system* is considered central in the social life of Balochs. However, before I elaborate the links between national politics over natural resources and the demonization of *sardars,* it is important to situate Baloch tribal identity in relation to Baloch ethnic identity, for while the terms *tribe* and *sardar* captivate and circulate in contemporary national and development discourses about Balochs and Balochistan inside Pakistan, present day anthropological scholarship on the Balochs is largely concerned with the category of ethnicity.

Balochistan and Balochs in Anthropology

> 'Ethnicity' is a dazzling, ambiguous category, at once descriptive and evaluative-normative. It has long since ceased to be the exclusive domain of social scientists, having entered the practical vocabulary of politicians and social movements. In both spheres, the terms 'ethnicity' and 'ethnic group' frequently absorb, overlap or replace other concepts such as 'race' or 'tribe' which have become problematic." (Lentz 1995)

Tribalism, ethnicity, and nationalism are three aspects of Baloch identity that have

been central in scholarly constructions of Baloch socio-political life in anthropology, historiography, and political science. In the 1960s and 1970s a number of anthropologists[28] carried out fieldwork among the Baloch in both Iran and Pakistan. Shaped by the general characterization of Balochs as nomadic pastoralists and small-scale agriculturalists, these earlier ethnographies focused on ecological issues and tribal identity. While other scholars produced highly technical works on the Balochi language, many of the scholarly works by Europeans remain unavailable in English.[29] Moreover, the works of Baloch scholars are generally unavailable outside of Pakistan. Robert Perhrson's (1966) ethnography of the Marri tribe and Seligh Harrison's (1981) examination of the political implications of the Baloch nationalist movement are the only two major English language monographs on Baloch society that have been published in the fifty years since the colonial era came to an end in South Asia. A recent edited volume (Titus 1996) is the first attempt to consolidate some of the major contemporary scholarship produced in English about Balochistan. Ethnicity is one of the major themes arising in the essays of this volume.

In general scholarship the rise of ethnicity coincides with the decline of race theory. Before the 1930s ethnicity was not used as a term to categorize population groups. In the 1930s, criticism was mounting among anthropologists in Britain and the U.S. on the efforts of physical anthropologists and medical doctors to recuperate an anatomical basis for racial categories. Researchers questioned the genetic basis of any racial typology arguing that, "genes were distributed through a population and clustered geographically, not according to ideal types" (Anderson 2002:162). It was Huxley and Haddon's (1939) influential book *We Europeans* that criticized race theorists of the time

participating in “pseudo-science”. They recommended the replacement of the word *race* with *ethnic group* (Anderson 2002:163), as they argued for the importance of focusing on social problems rather biological factors for understanding social groups. However, the colonial constructions of tribal groups and the postcolonial re-emergence of categories of tribe and tribalism have blurred the distinctions between social and biological factors in understanding social groups and their social structural situations. As my ethnography illustrates, tribalism is equated with negative traditionalism.

Whereas British social anthropologists undertook studies of tribalism in the context of labor migration and urbanization in Africa in the 1950 and early 1960s, among political scientists, in the 1960s and 1970s, the focus of discussion centered on politicized ethnicity and nation-state integration. Nonetheless, in the 1980s Ranger (1983) and Vail (1989) were concerned with the question of colonial “invention of tradition” and “creation of tribalism”, respectively. In 1970 Southall (1970: 47-48) had already called for the replacement of “tribe”, a category commonly used among Africanists at the time, by “ethnic group”. The recommendation was based on the primitive connotations associated with the term “tribe” and a desire to avoid offense towards African colleagues. According to Lentz, (citing Dubow 1987) in South Africa, references to culture and ethnicity allowed liberal as well as Christian-nationalist Afrikaners to emphasize difference without resorting to the biological and discredited concept of race.

Whether the shift from race to ethnic identification and the emphasis upon cultural relativism has displaced biologically based essentialist arguments to characterize group behavior is intensely debated, for example, in arguments around the relationships between multiculturalism and women’s oppression (i.e. in Okin 1999 between Okin and

Homi Bhabha). And, as I will argue in Chapter Six, arguments about universal rights for women end up re-invigorating primordial-biological notions that characterize tribal identity at the cusp of 20th and 21st centuries. Here, for the purpose of discussion in this chapter, it needs emphasizing that in the disciplinary field of anthropology, notions of "culture" have undergone major criticism since the 1960s due to new understandings regarding power and history, illustrated by arguments around "inventions of tradition" (Ranger 1983) and British colonial meddling with local traditions in the works of many scholars (Dirks 2001; Cohn 1996; Inden 1990). Consequently, many scholars have forcefully and correctly argued that classic social divisions and categories such as class, race, and ethnicity that have been conceived as fundamental to culture must be localized, historicized, and constituted at the intersection of multiple discourses, larger systems and global processes of power, and "within dynamic fields of interaction and conflict" (Dirks, Eley, and Ortner 1994:4). It is in this critical spirit of inquiry that anthropological studies in Balochistan mark ethnicity as a salient feature of Baloch identity, and as a formation that requires consideration in understanding Baloch politics and social conditions in postcolonial Pakistan. Because many of the anthropologists' ethnographic enquiries about Baloch society have been influenced by Fredrik Barth's notion of ethnicity, it is useful here to highlight some of Barth's and his critics' ideas on ethnicity.

Barth and Baloch Ethnicity

> Whatever its basis, ethnicity provides for the people of Balochistan a solid and very real source of identity which cannot be dismissed as a polyphonous and contested reality. (Mahmood and Armstrong 1992:11)

In contrast to essentialist socio-biological ideas that are primordialist,

constructionists take ethnicity to be a historically specific and socially generated pattern of identity (Lentz 1995). For constructionists, influenced by Barth (1969), ethnic groups exist only in the plural. Barth criticized the equation of ethnicity with a common culture, insisting that ethnic groups are only constituted through the construction of social boundaries. Such boundary making is self-ascribed as well as ascribed by others outside of the group. Here the emphasis is upon the subjective manipulability, flexibility and strategic quality of ethnicity. In Barth's view, culture emerges as an implication or result, rather than a primary and definitional characteristic of ethnic group organization. That is, the meaning of ethnicity is context-specific.[30] For Titus (1996: x), one of several anthropologists writing about Baloch society:

> Ethnicity is reflexive; it emerges as people give significance to their way of life and their interaction with others. It is manifested in cultural practices that range from habitual or implicit customs to conscious political programs for ethnic mobilization.

Ethnicity implies difference and/or opposition between groups, governments, and institutions in the context of—often—rapid social change. I would agree with Titus, that placing ethnicity within a wider context reveals the conterminous relation of "modernity" and "marginality" that is characteristic of post-colonial nation-states. The contemporary situation in Pakistan that I describe in this chapter (see the section entitled, "Developmentalism vs. Tribalism") illustrates this point well: the modernizing track and rhetoric of Pakistan produces contradictory effects in which national power and disparities are evident along ethnic lines.

Lewin (1996) points out that by emphasizing the interactive dimensions of ethnicity, Barth (1969:xiv) presaged a current focus in anthropology on emergent and

interactive qualities of cultural studies. However, in contrast to the emphasis of post-modern analysis on the breakdown of identities and their fragmentations, the social categories of ethnic identification are firmly in place in practical politics and everyday practice. In her analysis of the production of Baloch ethnic identity, Lewin (1996) contradicts Hobsbawm's position that ethnicity should be programmatic, or a singularly political concept. She places her investigation of social change and ethnicity in Balochistan in the context of the "ferment" of ethnic collective movements worldwide. Informed by Barth, she posits that ethnic consciousness and "fissiveness" does not occur in a vacuum, but in the immediacy of social interaction and within contexts shaped by a myriad of external political and economic forces. Lewin's point affirms Lentz's (1995) argument that the global ethnicization of social identities and conflicts illustrates how "ethnic and tribal particularism is not the specifically African problem it once appeared to be."

Lewin (1996: xiii) argues that Barth's view of ethnicity advanced an understanding of boundary maintenance and interaction between distinct ethnic groups, but ignores the articulation of ethnic identity formation and its re-inscription in relation to particular programs of nationalism and state-making. Whereas, Barth (1969) has shown how Pushtun ethnic identity is maintained as individuals reproduce practices associated with a particular system of values, he is viewed as placing excessive emphasis on the stability of ethnic boundaries (Cohen 1978:387-88). Thus, his notion of a "culture-free" definition of ethnicity fails to adequately distinguish ethnic groups from other groups e.g. religious or political (Aronson 1976). Nonetheless, what seems clear in the debates about ethnicity is that *ethnos* serves as a *political* category, whereby ethnicity as a marker is an

important political resource and idiom for creating community.

In his analysis of the role of ethnic ties in postcolonial states, Geertz (1973) combined primordialist and historical-political arguments. Lentz (1995) explains that for Geertz (1973: 259), "it was only in the context of economic and political 'modernization' that ethnicity became a virulent idiom for defending particularist interests."[31] And in a similar thread, Fox (1992) argues that separatist ethnic nationalisms develop as people mobilize their own social and cultural resources as "a defense", a resistance against the "depredations" of what has been, for many, the largely empty promise of the liberal nationalism transported to the so called Third World. The rise in Baloch nationalism in Pakistan, as well as in Iran, is embedded within a similar framework of grievances, I will discuss later in this chapter.

Jehani (1996) presents a different reading of the forces shaping Baloch national identity. She argues that despite regional variation, a distinctive Baloch culture and Balochi language emerged and Baloch self-consciousness about their cultural, linguistic, and historical distinctiveness informs the expression of ethnicity and nationalism. Jahani's (1996) *Poetry and Politics: Nationalism and Language Standardization in Balochi Literary Movement* focuses on the intersection between patriotism, ethnicity, nationalism, and literary tradition. She traces the self-conscious development of Baloch literary efforts in conjunction with nationalist politics, particularly in the post-Independence context. In her analysis of the poetry, Jehani depicts the continuity with previous oral traditions—something central to Baloch culture—and the programmatic connection between literary efforts and the historicist concerns of nationalist scholars. In this analysis Jehani locates the tension between Baloch nationalism and socialist

internationalism, grounded on the *poetic calls for the overthrow of the sardari system* (p. 114-129) [emphasis mine]. In postcolonial Pakistan, the determination of the role of mother tongue in the face of national language standardization is unresolved and this question of language contributes to the tensions between the state and the nationalist desires of Balochs. Thus, the internal debates over Balochi language standardization and orthography cannot be viewed as separate from Pakistani government's efforts to integrate the economy of the Province as a national project, without due regard to the social (health and education) and cultural life of the Balochs. While the language question is not peripheral for ordinary Balochs, in the face of economic and political injustice committed by the state over the last fifty years, and the government's current claims to "develop" Balochistan and protect the people from the *sardars*, other pressing battles are presented to the Baloch people that have culminated in explicit struggles over control of Balochistan provinces' natural resources.

Also influenced by Barth, Fabietti (1996:4) focuses on how Baloch in Makran (the southern division of Balochistan where Panjgur district, my primary research site, and Gwadar port are located) continue to perceive their distinction from other groups as founded on practices and values. She posits that equality and hierarchy are two "ideals" on which Baloch society is founded and proceeds to analyze the contextual use of equality and hierarchy. The complexity of ideals and compliance with a particular code of behavior constitute the foundation of the egalitarian ideal in Baloch society. She evaluates how equality and hierarchy encompass each other according to the context of discourses. That, in her words, "despite the great differences that distinguish individuals in terms of status, and 'origin' [and I would add tribal group identification], the Balochs

declare themselves to be Baloch on the basis of their common language and their shared 'system' of values." That is, Baloch identity springs from the recognition of common values and ideal behavior, and this recognition is founded on the code (language) by means of which these shared values are reproduced. Fabietti goes on to discuss how in the context of the influences of modernity, the Balochs in Pakistani Makran manipulate the concepts of 'equality' and 'hierarchy' in a context of rapid social change. This point is highlighted through observations of shifts in marriage as a consequence of modernity. What is observed is a contradiction between ideals and 'real' marriage practices (Fabietii 1996:20), thus questioning the ideal that one's *Zat* [tribe] is perpetuated through marriage practices. I want to now shift and address Fabietti and other scholars' assessments of Baloch sociality in relation to my ethnographic findings.

Social hierarchies and exchange in Panjgur in 2005

Fabietti's (1996) point that perpetuating one's lineage is signified by the *khandan* (family) rather than the tribe as a consequence of changing political realities and strategic conditions, is one that is consistent with my own observations in Panjgur. It is important to emphasize that although family solidarity has subsumed the once primary tribal identification as a mode of relating and exchange[32], both forms of social identification continue to co-exist in Makran including in Panjgur. Marriage alliances continue as before to be formed largely within tribes/*khandan*. In Panjgur, tribal identity has neither disappeared, nor does it hold the power it once had over the people within and outside the tribe. The tribal leaders, *sardars*, *nawabs*, *kahodas* are still in Panjgur, but their role has been minimized in politics or decision-making. Nonetheless, prior to British colonialism,

it isn't as if *sardars* ever had unilateral decision-making power. Under the formal structure the disputes and differences at issue were settled unanimously, and in case of difference of opinion, the majority decision prevailed. The *sardar* also had a single vote and was bound by the decision of the *jirga,* which primarily dealt with judicial cases (Yar Khan Baloch 1975). Now, in cases of conflict, in Panjgur, parties usually go to a court of law instead of any tribal *jirga.* Political consciousness is widespread and political decisions are made individually or at the family level.[33]

However, while the structural and legal form of *jirga*—which provided a system under which the council of elders would make nearly all decisions—is largely absent in Panjgur and the Makran region, forms of social cooperation and conflict resolution that reflect some of the core values of such a structure persist. For example, besides dispensing justice and dealing with judicial cases, the *jirga* engaged with the economic, political, and social life of tribal society. At the lower level of clan or sub-clan it functioned as an advisory council, advising the head of clan or sub-clan in the matters concerning the welfare and uplift of clans and sub-clans. It also checked the condition of peace and effectiveness of the administration, the ground of which was the ideal of cooperation. People in Panjgur continue to co-operate in collective welfare activities and when necessary call upon elders and even respected *sardars* to resolve conflicts and disputes over water or land before or without ever resorting to the state legal system. Long-standing forms of co-operation that persist are *bijjar* or *sarrech* and *hawachk.*

Crudely, *bijjar* means financial help. Under this voluntary system a person could ask for financial help and reciprocate when they could and within their means. Financial help may be needed for marriage or funeral expenses, or to build a new house or an

embankment. Since this system is regarded as a debt of honor, a request for financial assistance could be made on behalf of another so the person in need would not be marked as a beggar. In the past, a *sardar* might intervene to make this type of request for a needy person within the tribe. Despite the corruption of the system in the 19th century, in Panjgur people continue to contribute according to their economic status that is typically reciprocated at a later date by, for example, the receiving party at a marriage ceremony. Due to the circulation of cash, friends and family loan to one another large sums of money expecting no interest. It may take two, three, five or ten years to repay, yet among the people that I met the view was that most people would eventually repay the entire sum they had borrowed.

Hawachk means help in the form of manual labor. Under this tradition a person could request help with physical labor to build a house, or for such tasks as tilling of the land and gathering of harvest. In Panjgur this type of exchange of physical labor continues today. Another form of labor exchange and cooperation is in the excavation of *karezes* and the utilization of the water that travels through this form of irrigation system. *Karez* excavation is physically demanding, thus potential users of the water combine their physical efforts or money toward this end. The water is to be distributed equally and a person among the shareholders called a *sarishta* is assigned the responsibility to care and protect the *karez* and arbitrate in case of disputes. The management of water supply schemes in which communities in Panjgur today are involved is not the completely new form of cooperation that sometimes development planners claim to be introducing. In Panjgur, these schemes are completed by the Public Health Engineering Department and afterwards are handed over to the community based Water Management Associations.

The associations fix tariff for water consumers, operate and manage the schemes, and arrange for minor repairs up to 10,000 rupees.[34]

Perhaps it is important to briefly historicize how the formal structure of *bijjar* in Makran disappeared and consider the multiple transformations of the s*ardari* system in Panjgur. I will contextualize this in relation to my ethnographic research. Prior to British colonialism, under the system of *bijjar*, the *sardar* and his subordinates also received contributions on a voluntary basis. However, later this was institutionalized so that *sardars* were helped after each harvest. The disintegration of the tribal system in the 19th century entrenched the *sardars'* power further and opened the door for corruption and abuse.[35] During British colonial rule, *sardars* were made responsible for administration of justice and maintenance of law and order and were paid by the British to raise and maintain a tribal militia force under British command.[36] Although the government of Pakistan officially abolished the *sardari* system in 1976, in Makran, resistance to such structures of rule was already a local phenomenon.[37] Thus pre-existing forms of social consciousness rather than state laws pushed for equality, particularly in the areas of land and water distribution and control. So when the government of Pakistan now deploys essentialist rhetoric about Baloch tribal identity and depicts tribal ways to be incompatible with the modernizing goals of the state, it fails to understand that their claims to protect the people from *sardars* would break down if they created space for, to quote Jehani, the "poetic call to overthrow the *sardari* system" among tribal people.[38]

Local Panjguris I met during my ethnographic research recalled this struggle and one man, who is a lawyer, had this to say about it:

> I remember, I was studying in the 4th grade, and my father was jailed. My father fought against the *Sardar*. They wanted 1/3 of the property, but the elders said

> 'we will not give it'. People stood up, there was fighting, struggle; people were jailed. This process of getting rid of the *sardars* began.

About the reaction of the government and army during these struggles he had this to say:

> They discredited us. But we had Fakir Baluch (a respected elder aware of the legal system) guiding us. We approached the courts; we fought in the courts for our rights. I had a relative; he was a person with agency. He was bold. He told the *Sardar* that, 'no, you won't take 1/3 of our property'…[Army], they were indifferent. They did not see us as human, the Punjabi army I mean. But, our people, despite the army and the establishment have educated ourselves. [KA: Panjgur 2005]

The fact that people in Balochistan have pushed for greater equality stands in contrast to a common assertion in development aid and policy documents about Baloch society, that "tribal chiefs have retained their authoritarian structure and are influential in tribal affairs."[39] In this and in myriad other ways, the British model of the *sardari system* that was overthrown in Makran, has returned in the current discourses of the postcolonial Pakistani State in the contemporary Pakistani nationalist developmentalist discourse, whereby essentialist rhetoric proliferates about Baloch tribal identity. The rhetoric characterizes the Baloch leadership steeped in "tribalism" and the people of Balochistan as subject to the misrule of the *sardars.* The discourse positions "tribalism" as anti-development and the key element obstructing the modernization of the Balochistan province and its people. This discursive attack seeks to impose unilateral state control over the Balochistan Province. Moreover, this imposition is marked by the current project of development of the Gwadar Port in southern Balochistan province on the Arabian Sea. Such a self-proclaimed "writ of rule" objectifies the space and places such as that of Gwadar district, as a site for the construction of a mega modern city and a national

economic hub that could rival the likes of, for example, Dubai.

Like a herd of bulls stampeding full speed with horns intact over all perceived obstacles, the Pakistani government and army, over the span of three years, have forcefully constructed army cantonments throughout the province in strategic areas to control some of the major natural resources of the Balochistan province. Thirty six percent of the gas produced in Pakistan comes from Balochistan, yet the province consumes only a fraction of its production. Although Balochistan is an anti-clerical province whose tribes have nothing to do with the sort of Islamism of the Taliban or al Qaieda (who are officially deemed terrorist in US media and by the Pakistani government), the Pakistani government has tried to tarnish the Balochs with the Islamist brush, in part to keep the international community distracted from the real issues in the province. The central government in Islamabad also has sought to blame the unrest on "foreign hands," with the main culprits being India, Iran and the U.S., depending on who the audience is. By the end of 2005, the government also suggested that "criminal elements" lay behind the insurgency.[40]

Who Belongs to the Nation? Geography, Incorporations and the Politics of Exclusions

> It would be easy to assume that the entire impetus of nationalist desires arises from the small percent of the literate in urban areas. But the strength of Baloch nationalism comes from the growing politicization of the countryside as a result of the 1973-1977 insurgency and the widespread acceptance of a common [leaders versus people] nationalist leadership cutting across the rural and urban areas of Pakistani Balochistan, and more tenuously, Iranian Balochistan as well. (Harrison 1981: 9)

> The Balochs have always had the barren ranges to themselves, and they have learned the hard way to find safe footing and where to hide. "The lofty heights are

> our comrades" goes a 16th century was ballad; "the pathless gorges our fiends. (Harrison 1981:9)

The British colonialists drew the nation-state boundaries separating Pakistan from Iran and Afghanistan without regard for the region's geographical, cultural, or historical factors. Nearly all Southwest Asian states maintain non-ethnic boundaries, such as the Afghan and Iranian "state-nations" that emerged during the 19th century due to the "Great Game" in which different nations were divided by British and Russian imperialism. One way in which the moment of postcolonial is defined is by a body of people gaining independence, and a renewed formulation of social contract between the state and civil society takes place, whereby rights are articulated through some constitutional arrangement. In the transition from colonial to postcolonial state, the question of who and how the people would become part of the new state-nation was central. Geopolitical and material interests were an important element of how the colonized regions were divided and consolidated in the process of anti-colonialism and of the transition to becoming an independent nation-state. Did Balochistan voluntarily become a part of Pakistan? And if so, was the social contract between the state and the Baloch people honored? In fact, Balochistan never became part of Pakistan voluntarily on the basis of the new state constitution. When the constitution was made the Balochs were not considered a constituent of the civil society. Balochistan remained a colony and an occupied land. The leaders of Balochistan agreed to join Pakistan after 1947 with a great deal of hesitation (Baluch 1958: 74) and there was fear at the time that an estimated one million Balochs, but not the land, would be deemed insignificant for the nation-building needs of Pakistan, as suggested by the following statement.

> If it were not for the strategic location of Balochistan and the rich potential of oil,

> uranium, and other resources, it would be difficult to imagine anyone fighting over this bleak, desolate, and forbidding land. (Harrison 1981:9)

The resolution for the creation of separate Muslim states in the subcontinent was passed in 1940 at the All India Muslim League session, where Balochistan was not represented. At this time M.A. Jinnah, the president of the Muslim League, was also serving as a legal advisor to the Khan of Kalat, helping him to fight a constitutional battle for an independent, sovereign state of Balochistan (Baloch 1987: 9). Despite the lack of representation of Balochistan in the meeting of the Lahore resolution, in 1947 the Khanate of Balochistan became an independent state, recognized by Pakistan only until 1948. With the collaboration of the British government, Pakistan managed the "accession" of the Khanate without the popular consent of the Baloch people. According to one Baloch scholar, it was the forced merger of Balochistan into Iran and Pakistan that instantiated the concern for the right of self-determination.

Although Balochistan was physically part of Central Asian plateau rather than part of the Indo-Pak subcontinent, in 1946, M.A. Jinnah, as the legal advisor to the Khan, demanded the separation of Balochistan from British India on geographical grounds. Similarly, Western Balochistan is separated from Persian-speaking Iran. Geography is considered an important factor preventing a permanent occupation of Balochistan by foreign invaders because of its difficult mountain and desert terrain. Prior to its incorporation, Balochistan's physical geography was a persistent factor involved in allowing for relative autonomy in the ways Baloch managed their social life, (including internal and externally imposed conflicts) and accordingly, the Persians, Arabs, Turks, Afghans, and the British, all failed to incorporate it into their kingdom and empires.

In the 7th century, Caliph Osman was warned about the difficulties of

communications and the harsh climate in Balochistan. An Arab Governor is quoted saying this about the road to Balochistan:

> Thou showest me that road to Makran (Balochistan) but what a difference there is between an order and its execution. I will never enter this country, as its name alone terrifies me. (Cited in Baloch 1987)

According to Baloch (1987), the same geographical features prevented the growth of a central government at Kalat to control areas over a long distance. *Dodai* chiefs and the *Khans* tried unsuccessfully to develop a communication system to overcome these natural barriers: The lack of communications resulted in the Khan's failure to mobilize the Baloch tribes in 1839, when the British army invaded Kalat (Baloch 1987:23).

With the rise of British imperialism, railways and roads were built in strategic areas to facilitate trade and economic control of the resources. Balochistan was connected with British India, Iran, and Afghanistan. During the first and second World Wars, new roads were built for military supply into Iran and the Arab Middle East. The Baloch nationalists were aware of the role of the communication system in the development of nationalism. When the Baloch National Conferences were held in 1932 and 1933, the conferences demanded the construction of new roads, and the opening of post offices. Supporters of one Baloch tribal/political leadership saw this as an opportunity to come into contact with modern thoughts and development. But another group of Baloch nationalists opposed a modern communications system on the grounds that it would give powerful enemies the opportunity to invade and occupy Balochistan. The communications system built by the British was limited and remained so at the time they were ousted and Balochistan was consolidated as a province of Pakistan. Many Balochs continue to be critical of the forced merger of Balochistan into Pakistan and consider it an

act of internal-colonial occupation of the province marked by post-colonial bombings, hegemony of the Urdu language in schools, control of the military and bureaucracy by the Punjabis and the Muhajirs, economic disenfranchisements, and political exclusions.

Today, there are three main grievances that reflect a general sense of being exploited as a colony by Punjab (the most powerful and populated province of Pakistan). First, the Baloch leaders demand a fairer share of royalties generated by the production of natural gas in their province. The federal government pays a much lower price for each unit of gas produced in Balochistan than it does for gas produced in other provinces. According to Bugti, Balochistan receives no more than 12.4 per cent of the royalties generated for supplying gas.[41]

The second major grievance is that the people of Balochistan want to be included, rather than marginalized, in large development projects, such as the Gwadar port construction located on the southern coast of Balochistan province and the Arabian Sea, near the Pakistan-Iran border. There is no technical school or college in the area to train locals for future participation in the development projects. Those employed so far have been daily wage laborers. Instead, many Chinese contractors and workers can be found building this enormous military port at the mouth of the Persian Gulf. Yet the strategic importance of Balochistan has grown since China started building Gwadar port for Pakistan. The port is close to the Strait of Hormuz, with a projected 27 berths, enough for a major Pakistani naval base. The Baloch ancestral homeland stretches west beyond Gwadar into adjacent Baloch-majority areas of eastern Iran, where there is a nascent Baloch rebellion against President Ahmadinejad.

The third grievance is that the Balochs reject the Punjabi-dominated army's

establishment of new military cantonments in their province, and abhor the selling of choice coastal property at nominal prices, by the central government to out-of-province developers. The government of Pakistan views Balochistan's natural resources as national property. It blames the rising conflict and resistance on the tribal leaders opposed to the development of the province. This above argument resembles that which the Punjabi-dominated central government made in the early 1970s toward East Pakistanis before massive violence and war with India erupted, leading to the creation of Bangladesh (Harrison 2006). Similarly the Musharraf regime has responded with military force, air strikes, and possibly the use of napalm in order to destroy the nascent Baloch liberation movement. To do this, the government has diverted ground forces and U.S. supplied air power from the Afghanistan front and from Kashmir earthquake relief efforts. According to U.S. intelligence sources in early 2006, six Pakistani army Brigades, plus paramilitary forces totaling some 25,000 men, were battling Baloch Liberation Army guerrillas in Kohlu mountains and surrounding areas. The independent Pakistan Human Rights Commission reported "indiscriminate bombing and strafing" by 20 U.S. supplied Cobra helicopter gunship and four squadrons of fighter planes, including U.S. supplied F-16 fighter jets, resulting in 215 civilian dead and hundreds wounded, many of them women and children.[42]

As suggested in the previous section, the current Baloch resistance in Pakistan is the fourth in 67 years. The Baloch were forcibly incorporated into Pakistan when it was created in 1947 and have subsequently staged two short-lived rebellions, in 1958 and 1962, as well as a protracted struggle from 1973 to 1977 that involved some 80,000 Pakistani troops and 55,000 Baloch tribesmen. The big difference between earlier phases

of the Baloch struggle and the present one is that Islamabad is no longer able to play off feuding tribes against each other and faces a unified nationalist movement. In this way, despite this ethnic solidarity and scholarly efforts to advance the more politically correct term ethnicity as an identifier of social groups, tribalism continues to serve as a political and social category in contemporary Pakistani nationalist and development discourses to particularize Baloch identity and Balochistan.[43] The discourse on tribal life in Balochistan is constituted as being incompatible to the modernizing aspirations of the Pakistani nation and the State.

Developmentalism versus Tribalism

DAWN, a leading English language newspaper in Pakistan, is one of multiple textual sites that is captivated by the terms tribe and tribalism in relation to the Balochs in Balochistan. Tribalism here is worked through the production of the binary between 'developmentalism' and 'tribalism'.[44] For many Baloch scholars, the perspectives published in DAWN reflect the establishment mentality. For them, the Pakistan government's position reflects that of the dominant elite and the industrialists, who happen also to be predominantly Punjabis and Urdu speakers (*mohajirs*). Since independence Pakistani industrialists have accused tribal leaders as *the* obstacle to the "development" of Balochistan. Indeed, there are Baloch political leaders who oppose federally sanctioned and supported access of material resources of minerals and oils and road development in Balochistan, but the reason for such a position is both complex and simple.

The simple reason is that many among the Baloch leadership, including Nawab

Bugti, distrust the motivations of the government and their claims to bring "true" development to the province. The fact that since independence the greater part of Balochistan lacks modern infrastructure in nearly every social and economic sector imaginable is blamed on the *sardars* and the tribal system that is understood to authorize the power that *sardars* maintain over their people. Yet, the record of the last 50 years of governance toward Balochistan reveals a shameful stain in the rhetoric of the government's desire to save the Baloch people from *sardars*, via state sanctioned big development projects and plans. The continuing tension between Baloch leaders and the central government reflects the ongoing grievances of Baloch leaders and their insistence that central government has failed to acknowledge its failure to fairly represent and deliver to the Balochs in Balochistan. Moreover this tension reflects the way the government deliberately side steps the main issues underlying persisting Baloch suspicion and antagonism towards not only the central government, but also the military and the state bureaucracies.

For instance, 56 percent of Pakistan's energy needs are met through the Sui gas fields in Marri tribal areas of Balochistan. It provides gas for all of Pakistan, but until recently even Quetta—the capital city of Balochistan Province—did not get any gas. People who historically owned these lands were to receive rent for the use of field. Also, there was an understanding that the local people would have at least some share of employment. Moreover, a percentage of royalty would be given to Balochistan's provincial budget. Yet the central government has not delivered on these agreements. Despite this situation, and major military operations against Balochistan that were carried out in 1948, 1960, and 1978 (Harrison 1981), tribal leaders have not resisted attempts to

start education and the building of education and health care facilities. In the same vein, Baloch leaders are concerned to prevent what happened in the Sindh province, which has experienced the largest restructuring of its demographics since Pakistan gained independence. Baloch nationalists' view is that Pakistani nationalists have always compromised, on the understanding that Pakistan will remain a constitutional federalist state (Baloch 1987).

Such historical realities have lead Baloch scholars to emphasize that they do not want to face the same fate as the so-called "Red Indians" or the aborigines of Australia as a result of development aid. This sentiment was echoed by Nawab Bugti (who was murdered in August 2006 by Musharraf government and army) during a face-to-face conversation I had with him in October 2005 in Dera Bugti, when he gave me a copy of Chief Seattle's famous speech and equated the plight of the Balochs with the Native American Indians during Chief Seattle's time. He spoke candidly with me about what he saw as an explicit state mandated plan to change the entire population structure of Balochistan.

Since 2003 the negative view of the Pakistani state among the Baloch has deepened due to the increasing involvement of the military in the "development" of Balochistan (building roads, army cantonments in resource rich areas of the province), and also due to the increasing control over the movement of petroleum from Iran to Pakistan, an activity that is part of an informal economic trade and source of employment and affordable fuel for the Balochs living in these border regions. When I was in Panjgur, there were daily criticisms against the state for ignoring the persistent and increasing economic poverty in Balochistan. This material reality, manifest in the

economic deprivation of the poor and the non-existent educational, medical, and commercial infrastructure, is only one of a myriad of historical and contemporary reasons for the general sense that the Balochs have about being used and abused by the Punjabi dominated state, national bureaucracy and army. The situation of deprivation felt by the Balochs and their mistrust of the government's stated goal to develop Balochistan was highlighted daily in the local vernacular press in Quetta, Karachi, and smaller towns in Balochistan and Sindh during the year I was in Balochistan. In the months since I returned to the U.S. in 2006 news of the increased militarization of Balochistan began to slowly trickle out in the international press (largely through BBC radio news).

The government's political and economic agenda to secure the vast resources of Balochistan required discursive demonization of Baloch National leaders in the national television and print media. Discursive assault marks them derogatorily as *sardars* (chiefs) and *tribal leaders* rather than as legitimate political contenders in the national politics of the day. This is an important point, for in marking these leaders as outside of politics, Musharraf can construct them as antithetical to his claims about the democratization of Pakistan through his devolution programs and anti-terrorism efforts. He continues to deploy development rhetoric (BBC news mid-March 2006) to position himself as the savior of the Baloch people from the "*sardari* rule". In this deployment of tough words (to be followed by tough actions) he is careful to never utter the term "Balochs" in his reference to the people of Balochistan. Rather, he has repeatedly emphasized in his public speeches that Balochs are not the only group living in Balochistan and that Balochistan is for *Balochistanis*. A Balochistani marks the identity of anyone, Baloch or non-Baloch, living in the province, even if they migrate there today.

This is important for him to emphasize in order to legitimate the takeover of Gwadar to build the second largest port of the country for the "nation's future". Those who can purchase land from the locals in Gwadar include non-Baloch industrialists, army officers and those who have close affiliation with a military and land owning family. Nawab Bugti, who has been the leading critic of the government's takeover of Gwadar and the constructions of army cantonments, has been projected as the number one problem/demon and enemy of the nation's goal to develop Balochistan. The present content of 'othering' in postcolonial Pakistan thus echoes the 19th century British view of the Baloch tribes. However, whereas the British were keen to re-invent the *sardars* and retain them with a new configuration of power relations between the *sardars*, their people and the colonial rulers, the Pakistani government wants to eliminate them. For instance, there were several attempts to assassinate Bugti. The army threatened to occupy Sui village in Dera Bugti in the name of protecting national resources. The gas from *Sui* is channeled into Punjab and Sindh and many parts of NWFP, but not much of the Balochistan province. *Sui* sits on Bugti land. The army is also attempting to build several cantonments at several key sites in Balochistan—where they would like to control major "national resources", including oil.

While the Baloch regions spread into two large and recognized cultural areas of Iran and India, the people of Balochistan are politically and socially on the periphery of both. Yet, attested by the recent military operations in 2005 by the Pakistani military and government in Balochistan, the postcolonial geopolitics and economic demands of nation building in Pakistan, as well as in Iran, continue to significantly shape the uses and abuses of the vast geographic region constituting and mapped as Balochistan, thus

contesting the normative assumptions that Balochistan is marginal to the nation-building needs of Pakistan. In Panjgur, local midwives, their practices, ethical stance, and critical outlook about the impacts of modern medical/technological interventions on the bodies of Panjguri women presents a significant contrast to an otherwise excessively silenced subject citizen[45] in health development policies. This is the focus of the next four chapters.

CHAPTER TWO
SITUATING THE TRANSNATIONAL HEALTH DEVELOPMENT POLICIES IN PAKISTAN

> The world health organization is committed to their training and deployment as a means of extending the reach of the limited health services available in developing countries. The training of traditional birth attendants can reduce the risk of [child] mortality and morbidity resulting from poor midwifery practice and, at the same time, help to improve the positive contributions of the traditional birth attendant to maternal and child health, family planning, and other essential components of primary health care. ... The (traditional birth attendants) TBAs constitute an important resource that could be mobilized to help achieve the social goal of health for all. (Mangay-Maglacas & Simons 1986)

Introduction

Following an initial meeting with Naz-Bibi, I returned to her home to conduct our planned interview and I learned that she knew much more about gynecological related care than she insisted. Moreover, while she would no longer leave her house as much as in the past to attend to childbirth and postpartum care in women's own homes, women nonetheless continued to come to her for advice, for instance, to ask her to prepare the *chillagi* (postpartum herbal care regime) for them. A woman could also end up giving birth and staying on for several days afterwards in the very room that I conversed with Naz-Bibi. On the day of the interview, however, Naz-Bibi was expecting me and not a birthing woman. As we entered the main door of the compound, my local guide and I could see her several hundred yards away sweeping the ground of the extended families' compound near her home/clinic. Sweeping is an everyday morning task carried out by one or more women in the household. Typically, if you enter any house in areas located near the central town of Chitkan in Panjgur district, between 8 and 10 am, one can be

sure to notice a young woman in the family doing the daily sweeping. This task is typically performed following the completion of all the other morning work routines, including the preparation of breakfast, waking all who still need to be woken, putting away the beddings, sending the kids off to school on a school day, and loading the water containers with water collected from a pump typically within the same compound or a compound nearby. Between 10 am to 12:30 pm and again between 2:30 pm to 8 pm on any given day, expected and unexpected guests, family, friends or neighbors can stop by. This routine is different for Panjguris living in areas more rural and located greater distances away from Chitkan whose lives continue to center largely around among other things, on the care of their livestock, chickens, camels, and land.

Once we reached closer to Naz-Bibi's room, she told us to go in and that she would join us soon. Naz-Bibi returned in five minutes, and after the usual *hal-awal* greeting ritual, she sat down in front of me ready to begin the interview. As I began introducing my topic again, she said, "*Yes, I know you want to know about Balochi dewai",* and proceeded to hand me a piece of paper with a list of herbs written in Urdu. She had her granddaughter create the list the night before since she could not remember them all during our previous visit. She had prepared the list in case her granddaughter was absent during our planned visit. This was thoughtful of her and indicated the first of many signs of the seriousness with which she took her *dhinabhugiri* and herbalism.

Naz-Bibi, Noorjan, and Hoosnia are just three of the many atypical *dhinabhugs* that I met during the course of my research in Panjgur. Naz-Bibi and Noorjan's atypical *kawwāsiness* (expertise) were, in one important sense, marked by the fact that neither had any children. Yet, they both had bustling herbal practices and attended childbirths. They

were unique as *dhinabhugs* who regularly attended to women's aches and pains with *kobag* (cupping), and Noorjan somehow managed to keep unbroken an old set of cups that had been made out of clay several generations ago in her family. Noorjan was confident and serene about her midwifery and herbal knowledge and work, and seemed more than willing to show and tell. She was busier than most I had met (at that time, two months into my research), with a schedule that entailed conducting quite a lot of 'prenatal care,' checking women during their pregnancies. She was also considered a skilled masseuse, a characteristic of her work that many women and other *dhinabhugs* would remark upon during the course of my year in Panjgur. She learned this massage technique from another famous Bibi who had died about ten years prior to my meeting with Noorjan. This famous Bibi's granddaughter is now a well-known MBBS (Bachelor of Medicine/Surgery) graduate lady medical officer (LMO) actively practicing in Panjgur. Noorjan, Hoosnia, and Soraya another *dhinabhug* who resided in the same region of Panjgur, were all known especially for their skills in shifting and re-positioning the fetus to its proper position. They used and prescribed *Balochi dewai* and spoke confidently with me about the uses of the herbs and detailed the many of their herbal formulas. During the course of numerous conversations Hoosnia told me that her daughter had died during childbirth under the care of a lady health visitor in Panjgur. Among other things in the story about her death, Hoosnia pointed to the overuse of injection as a cause of the death. Neither Noorjan, nor Hoosnia are against the use of injections when necessary, though they do not give the injections in their *dhinabhugiri* work.

Pakistani state's "safe-motherhood" policy formulations about the dominant categories of TBA and *dai* reproduce long-standing assumptions about the character and

subjectivity of a group of female medical practitioners involved in the care of female, male, old, and young bodies. Although *dhinabhugs* are already discursively excluded, and their presence in the lives of Panjguri women is obscured by the largely national, but also local public health professionals, in the 21st century transnational women's health development discourses the Panjguri and Pakistani TBA/*dai* is now further refigured as a non-midwife. Yet, the *kawwās* and *dhinabhugs* I met in Panjgur entirely defied the representation of the so-called traditional birth attendant (TBA) or *dai* as mere "baby catchers", or "baby killers". Their philosophical outlook and practical responses to the exigencies of childbirth and women's illnesses and bodily disruptions countered recent trends in transnational health development policy discourse that have implicitly revived a colonial discourse that explicitly viewed them as 'mother killers'.[46]

This chapter provides an outline of the available medical services and health care infrastructure of Panjgur, the Balchistan province, and provides comparison with the rest of Pakistan. I use the material in this chapter to lay groundwork for situating the *kawwās*—the local midwives in Panjgur, discussed in more depth in Chapter Three—and examine the factors that provide the backdrop to programs for intervening directly in women's reproductive lives.

The Making of the TBA for Primary Health Care and Maternal Child Health

Primary health care (PHC) emerged in the 1970s, underpinned by a growing realization that the supposed benefits of all the money spent on sophisticated curative medicine was not reaching the poor, mostly rural, populations who experienced the most disease. Among this population, women and children were identified as the most

vulnerable group. The goal of PHC, declared in Alma Ata in 1978 was, *Health for All by the Year 2000* (Mahler, 1978). The fundamental foci of PHC included: community participation, appropriate health technology, and reorientation of health services away from urban, hospital-based care toward national and community based health programs. In this schema preventive care and the employment of community health workers were emphasized.

Since the mobilization of community and maternal and child health was at the core of the PHC strategy, the training of the so-called traditional midwives seemed entirely in accordance with *empowerment* of the community. As a whole, in the decades of the 1970s and 1980s, training programs received great support from international organizations that increasingly saw the traditional midwives as necessary health agents and advocates for promoting maternal and child health care. Tens of thousands of traditional midwives were trained, mostly in Asia and Latin America, though also in Africa. Pakistan, like many other countries, agreed to train "traditional midwives" that over time were marked by the designation of traditional birth attendants (TBAs); in South Asia, they were also called *dais.* The premise in Pakistan and elsewhere in the global south was the same. These women would be trained to bridge the gap until all women had access to modern professional health services (i.e. give birth in hospitals).

The initial decision to train midwives for PHC in Pakistan and other postcolonial countries was based on the view that the midwives were numerous, attended sixty to ninety percent of births in their respective countries, already functioned as the primary care providers for many who had no access to health care, and had long done so. The TBA became a means to introduce new health care practices to large numbers of people,

and to do so relatively cheaply. More significantly, financial limitations and the lack of government trained health care professionals in rural areas, and their limited numbers in dense urban slum areas was a major impetus for recruiting them for maternal and child health care programs. In this seemingly pragmatic decision, TBAs were initially recruited and trained to help avert neonatal deaths and postpartum tetanus, considered to be the result of unhygienic delivery practices (WHO 1979, 1986). Later, the focus turned to including them as part of government health personnel (Awan 1987). Others saw them as important for linking women to health facilities for antenatal care (Favin et al. 1984; Viegas et al. 1987).

Consequently, local community midwives, more than any other "traditional" practitioner have been used in "Third World" health projects. The Pakistani state recruited an estimated 60,000 women for PHC to address transnational and nation-state concerns with family planning and child survival (Phillips 1984). The perception of the benefit of including TBAs in PHC prevailed up to the mid-1980s. The perceived potential of the TBA for achieving primary health care goals is reflected in the opening quote of this chapter. Yet, despite the fact that TBAs in PHC were identified as a unified group in name and by the tasks they performed, such as assisting in the delivery of a high proportion of births, in Pakistan, local midwives who over the years had been variously referred to as TBA, *dai,* or midwife, were at first recruited to promote family planning to meet contraceptive targets. This took place long before the state-sanctioned PHC/RH agenda was initiated in 2002 for national health care in the country.

Family Planning and Population Welfare

Programmatic efforts focused on bringing down fertility rates as quickly and efficiently as possible, after demographers and international development specialists began to document the high fertility and rapid growth of "Third World" country populations in the 1950s. Many in the international family planning field argued that good family planning programs could overcome the upward pressure that poverty or lack of industrial development might exert on fertility and population growth rates. Nearly every family planning program initiated in postcolonial countries began in the 1950s, India being one of the first, with support from the International Planned Parenthood Federation (IPPF) and the Population Council. With national and international support, programs were introduced during the 1960s, and gained additional strength and numbers in the ensuing decades. In the 1990s, 95 percent of the world's population could count on government or private financial and technical support for family planning.

In Pakistan, family planning was first initiated in 1953 in the private sector. In the First Plan (1955-60) the Pakistani government allocated a grant of 5 million rupees ($1.06 million) to the Family Planning Association of Pakistan (FPAP) to provide contraceptive services. The existing government based Population Welfare Program began with the second Five-Year Plan (1960-1965) (Pakistan Federal Bureau of Statistics 1998). These efforts received support from nearly all of the major international donors involved in international fertility reduction activities (Robinson et al. 1981).[47] Since local midwives attended nearly two-thirds of all births in the world, they became ideal subjects in promoting family planning, especially in rural areas (WHO 1979, 1986; Piper 1997). WHO and UNICEF policies encouraged using them as agents to promote contraceptive

use and a large number of countries in the global south made concerted efforts to recruit and train selected TBAs (Rogers and Solomon 1975). Governments had a similar underlying rationale in TBA recruitment strategies: namely, because TBAs were influential in their communities, their participation would reduce the burden on rural professional medical staff.

Experimenting with four approaches in family planning programs (*target-oriented approach* 1965-1969; *continuous motivation system* 1970-1973; *contraceptive inundation* 1970-1973; and *integration* 1978-present), Pakistan was one of the first countries to use local midwives as the main field workers for family planning. The first program strategy "was based on a large, complex bureaucratic structure at the center, and was supported in the provinces and districts by an extensive publicity campaign" (Robinson et al. 1981: 86). Annual targets were set to achieve acceptors of contraceptives and to reduce the birthrate from 50 to 40 per 1,000 in five years. The overall national targets were divided into provincial and subsequently into district-level targets. The plan called for employing 20,000 *dais* whereby each *dai* would cover a population of two villages in rural areas, or 2,000 people in urban areas. By 1969 approximately 50,000 *dais* had been trained to supply contraceptives to women (Zeichner 1988). The supplies could also be accessed through village shops, stores, pharmacies, and other public and private outlets. The Union Council Secretariats were to provide the vital link between the Family Planning Officers (FPOs), full-time employees of the program and the *dais* who were paid part-time wages. A *dai* was to receive a referral fee for each acceptor she referred for IUD insertion or sterilization. Besides enrolling doctors to make up for the shortage of trained medical personnel, to insert IUDs, a special cadre of paramedical personnel (Lady Family

Planning Visitors) was trained and employed to do IUD insertion. The *dais*, however, were not provided any technical training about contraceptives (Zeichner 1988).

The *target approach* for promoting family planning was terminated when the results of national impact survey (1968-69) showed that fewer than six percent of married women of reproductive age were using contraception. Gardezi and Inayatullah (1969) found that initially *dais* were unwilling to provide information on family planning. In the same study, they found that about one-third of the *dais* saw family planning as against their profession and only one-seventh believed that modern contraceptives effectively prevented pregnancy. It is unclear why Pakistani *dais* held the former view. Rogers et al. (1975) suggest that in Java and Bali, midwives' resistance may have been more to do with their hostility towards the health establishment than with their views about family planning.

In Pakistan, Robinson (1981) found that the activities emphasized for *dais*, distributing devices and getting new acceptors, were not equivalent to providing continuous, effective contraceptive protection for motivated couples. That is, the focus was on methods rather than clients. The state-mandated strategy contradicted pre-existing relations between the *dais* and women, relations in which they knew one another as whole persons, possibly on an everyday basis and through kinship ties. At the same time, the decision to recruit midwives for family planning failed to consider the potential conflicts this may have created within *dais* regarding the expectations community members had of them as healers and counselors. The government blamed *dais* for program failures, calling them "unreliable" family planning workers. The literate male-female teams, who were paid competitive wages, replaced the *dais*, but it became

impossible to recruit married couples for this, so the focus turned to the recruitment of young unmarried women from nearby urban areas. Yet, all the posts could not be filled. While the *dais* had enjoyed the confidence of the village women, the young 'educated' women were often not trusted by the older women whom they were assigned to serve. Still, the latter strategy was considered to have more impact than the target-oriented approach that had relied upon *dais* (Robinson 1981). This is due to the fact that impact was measured according to the number of contraceptives technologies dispensed.

Consequently, in Pakistan, just as in India (Mani 1980) and in Bangladesh (Simmons, Koening, and Zahidul Huque 1990), the national focus on population and family planning detracted from the local midwives' potential in the provision of maternal and child health as a whole. For example, due to the perceived ineffectiveness of midwives, in the mid 1970s, the Bangladesh government discontinued the training of local community midwives, and replaced them with family welfare visitors. This was done to prioritize the promotion of contraception at the community level and consequently compromised the provision of maternity care.[48]

TBAs as Instruments to Advance "Women's Health"

In part, my critique of reducing the TBA to an instrument for achieving contraceptive targets parallels the critique of family planning programs as an instrument toward advancing women's health and national development. Although many governments believe that family planning programs are a necessary source of health and other benefits for women and children, the principal motivation for most of these programs is to lower fertility and slow population growth. Family planning programs have been considered instrumental in lowering fertility in many countries. Programs in

"less industrialized" countries are considered to have contributed to a forty three per cent fertility reduction between 1960 and 1990 (Bongaarts 1990). In Pakistan the availability and access to family planning services has been largely through expansion of the family planning services, outreach programs with over 70,000 lady health workers (LHW) and which use the social marketing of contraceptives (mostly in urban areas). The population growth rate has fallen from 3 per cent per annum to around 2.1%. According to the most recent national survey, contraceptive prevalence stands at 30 per cent, compared with 24 per cent in 1996/97. The same survey found that there is a large unmet need (37%), more than half of women desire no more births, and 17 per cent of women still get married before reaching the age of twenty. These results are drawn from urban-based populations.

However, even with the widespread recognition of the success of family planning programs in lowering fertility, there has been disagreement over whether these programs should be the central way that governments or agencies attempt to effect demographic change. For example, at the 1974 UN World Population Conference in Bucharest, many less industrialized countries argued that, "development is the best contraceptive," and supported reducing population growth indirectly through efforts in social and economic development. By the next International Population Conference in Mexico City in 1984, however, many of the countries reversed their positions and deemed that family planning programs were necessary in reducing fertility. Still, many women's groups (local and transnational) called for broadening the focus of development programs. For example, women's health groups in South Asia lobbied their governments on a wide range of issues, including provision of a broad range of health services, from family planning to the elimination of prostitution and violence against women; and the need for broader

socioeconomic policies to improve human well being. Indian women's groups, for example, have campaigned against specific contraceptives and against the use of amniocentesis for sex-selective abortion (Shah 1993). Concerns with women's health have led to the formation of over 50 networks and groups working nationally in health, media, law, and the academy. The Women Living under Muslim Laws Network is one such network of Southern women, which exists in over forty countries (including Pakistan) and includes reproductive rights as a critical component of its research on women and the law. This and other networks reflect the active participation of South Asian women in shaping policy and strategies to improve the reproductive lives of all women in South Asia.[49]

Thus, women's situations, the activists argued, are more likely to improve if women's lives and well-being, rather than fertility reduction, are the main focus of development and health programs. In the end, at the 1994 International Conference on Population and Development (ICPD) and the 1995 United Nations (UN) Conference on Women in Beijing, policymakers worldwide agreed that both family planning and social and economic development were needed for countries to achieve sustainable rates of population growth, avoid damage to the environment, and enhance human rights (Ashford 1995; Lutz 1996. In consort with this position, women in these international forums called on policy makers, transnational development and lending institutions, and states to reconsider debt repayment, international trade agreements, and structural adjustment programs. They demanded the provision of adequate funds and support in government budgets for health and other basic needs (Sen and Grown 1987; Correa and Petchesky 1994; Desai 1994). Southern and transnational feminists in particular

considered such structural changes an essential element for lasting achievement of health and rights.

Women, Gender, and Health Policies

At the ICPD in Cairo in 1994, consensus was reached on a new agenda for population and development (Germain, Nowrojee, and Pyne 1994). The ICPD was a victory for those seeking to end the debate in the population field since the first World Population Conference at Burcharest in 1974; a debate between advocates of development—in its broad sense of promoting social and economic well being—as a necessary precondition to sustained fertility decline and those who argued that family planning services must be implemented to meet the high demand for fertility control throughout the Third World (United Nations 1994). Nonetheless, the primacy of improving women's reproductive health status has not been diminished. In 1994 soon after the ICPD meeting, the National Program for Family Planning and PHC was initiated in Pakistan. This programmatic goal remained more or less until 2002 when the priorities were reworked for Millennium Development Goals (MDG). The 1994 initiative is still the largest program in the health sector financed through the Pakistan Social Development Plan (PSDP) and supported by technical assistance from a large array of international development partners including UN agencies. The primary objective of the program is to ensure first, accessibility and outreach to PHC services at the community level through community health workers, and second, to increase awareness and participation of community members. The aim is to improve *health indicators* including maternal and child mortality and morbidity. Some of the important interventions are in

the area of maternal and child health which include: activities related to family planning, nutrition, micronutrient supplement, reproductive health, personal hygiene, breast feeding, complimentary feeding, and immunization. The program is claimed to provide a platform for various other health programs for service delivery and thus is viewed as vital for an *integrated approach.*

Since their introduction through the Prime Minister's Population Welfare Program under the leadership of Benazir Bhutto, it was expected that lady health workers (LHW) would be instrumental in implementing the child survival strategy package. Since the program began approximately 84,000 LHWs have been inducted with a total target of 100,000 to be achieved by 2005. Each LHW is responsible for catchments area of 200 families (population of 10,000), though there is some variation in coverage due to differences in population density and the physical distances between villages in Balochistan.

As policy makers in the 21st postcolonial century realize that positive national development is critically linked to the girls and women's social and economic status, programs are increasingly designed to place women's needs at the center of development. This is, of course, a product of the conceptual shifts in development over time that have included the movement from growth to growth with equity, from routine delivery of services to people's participation, from economic development to human development and from services endowment to empowerment (Moser 1989; Young 1993; Batliwala 1994a). After more than a century, following four UN World conferences on Women, international organizations, multilateral and bilateral agencies and national governments made a number of commitments to advancing women's status and ensuring women's

empowerment (Correa and Petchesky 1994; Batliwala 1994b). In the process there have been unprecedented numbers of non-government organizations (NGOs) and women's groups globally, working to redress gender discrimination and promote women's well being. A wide range of health policy initiatives has been endorsed and taken up by governments and non-governmental institutions to advance the cause of women's social and health status. The women's health movement played a significant role in reshaping the discourse on population policies at UN meetings by lobbying government delegations and producing position papers. Among activists were feminists who lobbied the government to maintain appropriate references to population policies, reproductive health and rights, and women's rights.

From within the academy, postcolonial and transnational feminists (Mohanty, Russo, Torres 1991) and post-development feminists (e.g. Mies 1986) have examined the gendered impact of development aid policies and programs on the lives of women in the global south. They called attention to the necessity of noting the heterogeneity of Third World women by recognizing both the power of women and their struggles, and also understanding them in relations to their acts, contexts, and relationships. Such scholars examined the effects of globalization on women and gender relations comparatively and historically, in the West and in the colonies, in order to identify the contradictory policies regarding women, and the simultaneous efforts among states and international aid regimes to maintain the capitalist growth-based model of development. Their work displaces the limitations of cultural relativist perspectives, which claim that women are divided by culture worldwide, whereas, in fact, women are both divided and connected by "commodity relations" (Mies 1986). Mies' postulation resembles what is now an

important response to globalization theory that calls for an accounting of the uneven effects of globalization and neoliberal economic and trade polices (Ong 2006). Thus, for millions of women the concerns articulated by Mohanty and Mies are not merely academic. This is attested by the results of the International Conference on Population and Development (ICPD) meetings, the grass roots women's movements and the global women's health movement from South Asia and other countries of the global south in general, that were able to articulate the complex experiences of women of the global south. That this perspective could penetrate the ICPD meetings was considered a major ideological leap forward for advancing women's social and physical status.

In summary, the basic message of the women's health agenda advanced at the ICPD meeting include access to quality health services—particularly reproductive health services and access to effective contraception and abortion—and respect for reproductive rights as fundamental for women worldwide. These, moreover, should be shaped by a concern for reproductive health and rights, not by demographic objectives, and should acknowledge that all policies and programs must treat women as their subjects, not objects. Another fundamental premise of the movement was, and remains to this day, is that women's health and empowerment are goals in their own right, not only a means to reduce fertility (Dixon-Mueller 1993). Finally, calls to reconsider debt repayment, international trade agreements, and structural adjustment programs, and to provide adequate funds and support in government budgets for health and other basic needs, have been among the core demands made by *Southern* women in international forums. Such changes are considered essential for lasting achievement of health and rights (Sen and Grown 1987; Corrêa and Petchesky 1994; Desai 1994).

Re-locating the M in MCH and the Persistent Absence of the W

Policy makers and planners have conventionally looked at women's health generally in terms of reproductive behavior and more narrowly in relation to childbearing-childcare roles. The changing emphasis on women's health over the past four decades, however, reflects a conceptual shift to considering women as primary subjects for health improvement rather than as marginal individuals secondary to the concerns of children, husbands, family or parents. Such a sweeping change on how women and their problems are viewed, measured and acted upon was not easy to bring about, for female gender oppression is socially ordained, professionally managed, and is largely politically ignored. The value of integrative efforts for women's health through maternal and child health (MCH) was frequently diminished through over-emphasis on child survival efforts, and the lack of prioritization for women's social status and economic development. The imbalance was made evident in less than adequate funding allocations for women's health and development from international agencies, national governments, and even NGOs (Kardam 1990; WHO 1985; UNDP 1991).

The narrow approaches to conceptualizing women's health and social problems have been a central focus of critique concerning how the development process impacts women. For example, the issues concerning women's health status were viewed so narrow that they created an outcry that the "M (mother) is missing from MCH" (Resenfield 1985). In fact, though, the "M" needed to be inverted to a "W" (women) to address the more complex issues before and beyond maternity. Of course, many feminists, activists, and women's groups around the world have for decades advanced the perspective that women are not merely mothers, thereby emphasizing outcomes for

women using development indicators that include health as the main thrust and direction. The general argument is that since health is very much a part of overall socio-economic and cultural development, the inequities that permeate systems will continue to retard women's health. The disparities in education, property rights and inheritance devalue women; reduce future opportunities; and promote extant stigmatized and obstructive gendered perceptions, creating wide gaps in wages between men and women. In the 1980s, researchers emphasized the role of "culture" in the perpetuation of health disparities between boys and girls, and men and women. For example, cultural biases were considered to have immediate consequences through discrimination in feeding and child rearing practices with the quantity and quality of food (Behrman and Wolfe 1984), and the care giving during illness to female children (Chen and Ghuznavi 1980). Increased morbidity and mortality for female children and women were noted to be global and were especially grossly prevalent in South Asia (D'Souza and Chen 1980).

The World Health Organization (WHO), one of the leading international health policy- making institutions, began an initiative on women's health in the 1980s with a focus on maternal health and family planning. With new knowledge and a deeper understanding of women's health problems that in many respects was influenced by the global women's health movement and the results of the ICPD meetings, the vision of WHO (1996) widened to view women's health issues more *holistically*, through the so-called *life span approach*, emphasizing the health needs and concerns of women at every stage and in every aspect of their lives, from conception to old age. The WHO's focus on women's health and its multiple determinants explicitly placed emphasis on the *gender dimensions* influencing women's health, and to date continues to call upon ministries of health in South Asia and elsewhere to do the same. Thus, following ICPD consensus,

governments proceeded to develop policies that would affect women's lives, including their health status, and ensure that a basic package of social policies and reproductive health services is in place. It was assumed that such an intervention would facilitate social equity and thus would reduce population growth (Sinding and Fathallah 1995).[50] Pakistan formally initiated its National Policy for Development and Empowerment of Women in 2002 (MH 2002).

According to a UNFPA fact sheet, the government of Pakistan is fully committed to a holistic approach in dealing with reproductive health and gender issues. The Ninth Five-Year Plan clearly endorses a comprehensive reproductive health approach and recommends the full integration of a service delivery network with health service outlets, from district level downwards, for the provision of reproductive health services, including family planning. It also plans to improve and strengthen coordination among line departments and encourages greater involvement of non-governmental organizations (NGOs) and the private sector in undertaking innovative activities, disseminating information and delivering family planning services with a focus on reproductive health. Informed by the transnational women's health care movements and the paradigmatic shift from population control to reproductive health care in its broadest sense, in Pakistan, much policy related work has been conducted in the form of workshops and research papers to broaden the approaches to women's health care, moving from a focus on control of women's fertility via large scale family planning programs to an emphasis on girl's and women's broader reproductive health concerns. Despite this policy shift, however, family planning programs largely marked by the dissemination of contraception

dominate the overall health care investment toward advancing women and girls' health status.[51]

In the next section I discuss the stated goals of the Pakistani government and describe some of the core national initiatives for advancing women's health. Many of these initiatives are being implemented as pilot projects in selected districts of different provinces in the country. The hope is that the pilot phases would eventually provide the necessary technical and feasibility (in terms of cost-effectiveness) information in order to translate the results into countrywide health care programs. The three major projects to advance women's health and that have a particular focus on the reduction of maternal mortality deaths include, Women's Health Project (WHP); UNFPA assisted Reproductive Health Project; and the USAID and DFID funded maternal and neonatal projects.

The women's health program was launched in July 2000 with assistance from the Asian Development Bank. The project envisages strengthening of human resource development through a nursing component, maternal and neonatal tetanus special immunization activities, health education, extension of comprehensive emergency obstetric care services to rural health facilities and advocacy, and community awareness and participation. The program aims to promote the concept of women friendly districts (20 districts) by the year 2006 and to significantly reduce the high maternal mortality rate. Panjgur district is one of the four districts in Balochistan selected for the pilot implementation of the Women's Health Project.

The Political Economy of Pakistan's *Millennium Development Goals*

> Goal 5: Improve maternal health by reducing maternal mortality ratio (MMR) by three-quarters, between 1990 and 2015: The indicator to measure progress toward

> this MDG include maternal mortality ratio and the proportion of births attended by skilled health personnel. (Pakistan's target is to reduce MMR to 140 or less, and to increase skilled birth attendance to 90% by 2015.)[52] (Ministry of Health, Govt. of Pakistan 2005)

The National Maternal and Child Health (MCH) Policy and Strategic Framework (2005-2015) was formalized in 2005 and presented in the Pakistan Development Forum that year. The MCH strategy, developed by the Ministry of Health in consultation with Departments of Health and public health professionals for the country, was first endorsed in the same year at a Public Health Forum held in Islamabad. The national health policy of the Ministry of Health outlines implementation modalities and sets targets and time frames for each of the key areas that are to be implemented over a 10-year period. Three out of eight MDGs are directly related to the health sector. The Pakistan Millennium Development Goals flow out of the Millennium Declaration adopted by 147 heads of State and Government in September 2000. In September 2004, Pakistan was among 189 member states of United Nations to re-commit to the declaration of this global development agenda. By 2005, 191 countries had signed the declaration that sets forth a set of interconnected and mutually reinforcing development goals as a cornerstone of the global agenda for development, pledging the world to meet Millennium Development Goals by 2015.[53]

The post 9-11 global context dramatically reconstituted U.S. foreign policy relationships with Pakistan and contributed to a shift in development aid. As a condition for Pakistan government's cooperation to fight against "terrorism" the U.S. government lifted all previous arms and financial sanctions. As a result, over the last six years the Pakistani government has been given enormous sums of financial aid for military and social development purposes. A significant proportion of this aid is for the improvement

of Pakistan's health sector; though the amount is minor compared to the allocation of funds for Pakistan's military to support US efforts to eliminate and prevent the regrouping of the "Taliban" and to apprehend Osama Bin Laden. For many Pakistani public health professionals that I interviewed, this sudden shift in the development aid context presented an opportunity to transform what appeared to many of them the persistently poor health status of the Pakistani population and a stagnant, deficient, and inefficient medical care infrastructure.

But for many, this shift described above, also presented a renewed and yet familiar risk. The risk is that large sums of money would once again be wasted, misused, and redirected for purposes other than the pressing public health needs of the population and the very priorities the government has signed on to address. Because the risk is viewed in large part to arise from the level of control and influence that the foreign aid institutions and workers have in designing Pakistan's development policies and programs, a group of Pakistani public health professionals decided to take greater control over the process during this renewed influx of foreign development aid funds. The same group has made tackling the prevalence of maternal mortality in the country the number one public health priority and has pressed the government to do the same.

Addressing the problem of maternal mortality is number five of the total of eight health indicators outlined in the Millennium Development Goals (MDG) adopted by Pakistan. Since 2002, maternal mortality has been highlighted as the most significant indicator for women's health status in official documents of government and non-government institutions. From a transnational feminist health perspective this is an important achievement, for it can translate into greater investment in addressing a long

neglected preventable public health problem and is a necessary shift from a singular focus on family planning as the core reproductive health issue. In the post-World War II health development aid context, maternal morality came under the radars of public health officials no more than twenty years ago. In the early years following the WHO recognition of maternal death as a major public health problem in 1987, the larger proportion of aid money to Southern countries, including Pakistan, was devoted to investigating the extent and causes of maternal deaths.

The documented average MMR in Pakistan ranges from 350 to 400 per 100,000 live births.[54] Population based studies done in the early 1990s indicate MMR ranging from 281 in Karachi to 673 in Balochistan (Midhet 1999). WHO and UNICEF in 1996 estimated that 1:38 women die from pregnancy related causes. However, Pakistani public health professionals agree that there are large margins of uncertainty in calculating MMR (Bhutta, Jafarey, and Midhet 2004). Thus, available data are unreliable in terms of monitoring trends in the short term. Providing comparison of MMR across and within countries is also constrained as different methodologies are used to derive the estimates (Ransom and Yinger 2002). Nonetheless, based on available records and program attempts to reduce maternal mortality in various regions of Pakistan, no appreciable decline in maternal deaths has been noted. Nationally representative data on MMR are not available. Community-based studies suggest that MMR ranges between 200 and 700 maternal death per 100,000 live births (AKU 1994). Using an indirect method, a national study in 2001 estimated the MMR at 553 for the period between 1988-1990 (NIPS 2001). The leading causes of maternal mortality are hemorrhage, puerperal sepsis, hypertensive diseases of pregnancy, and obstructed labor, which are responsible for about two-thirds of

all maternal deaths in hospital and community settings. Considered underreported, unsafe abortions are also a significant cause of maternal mortality and morbidity. In a report compiled in 1997 by UNICEF in Karachi following Sindh Provincial Seminar for Maternal Health, maternal deaths in Karachi hospitals were also attributed to anesthesia and surgical complications.

While debates continue about the "true" incidence and prevalence and the specificities of the social and economic influences of maternal deaths, there is near consensus regarding the biological causes—or what are referred to as direct medical causes. These include, hemorrhage (antepartum and postpartum), puerperal sepsis or infection, eclampsia or hypertensive diseases, and prolonged or obstructed labor. Obstructed labor and illegal abortions are sometimes marked as underlying factors that can contribute to hemorrhage and/or sepsis Abou-Zahr and Wardlaw 2001). In addition to these biological or medical causes, there is consensus concerning *the* most effective approach toward effective reduction of maternal mortality by government and non-government entities in nearly every country framing strategies to address the problem. The three-delay model posits that maternal deaths follow: 1) delay in deciding to seek care; 2) delay in reaching the healthcare facility where emergency obstetric care (EOC) is available; and 3) delay in initiation of treatment after arrival at EOC facility (Thaddeus and Main 1994). It is this model that underpins the routinization of injections of pharmaceutical drugs around childbirth, which I discuss in more detail in Chapter Five.

Formal Poverty Reduction Strategies

The Government of Pakistan's Poverty Reduction Strategy Paper identifies economic growth and the reduction of poverty as the twin challenges for Pakistan and reaffirms its commitment to improve public service delivery through structural and programmatic reforms as a key strategy for achieving the MDGs.

Poverty

> The effect of medical education with a colonial legacy and continually imported from the U.S. and Europe, with its hospital oriented and curative care is to strengthen the mal- distribution of resources and sustain the emigration of doctors from Pakistan to the U.S and European countries- worsening doctor-patient ratios. (Zaidi 1988)

In Pakistan, although 65 percent of the population lives in rural areas, about 70 percent of private health facilities are located in the cities. Despite the fact that most of Pakistan is rural, where livestock rearing and agriculture predominate, the national contribution to the GNP, employment, education, and health have been urban based. Since coined by Lipton (1977), 'urban bias' is a term often used to describe development policy in Pakistan (Zaidi 1988). Zaidi has been thorough in his description of how health policies have systematic overlooked urban-rural differential of the Pakistani population. Moreover, a large proportion of urban poor, whose dwellings are called "slums", do not benefit from high tech modern health services. Most medical doctors receive a Western oriented training that is curative in focus and designed to train practitioners to deal with diseases that are more common in the West, and that require expensive technology to treat (Zaidi 1988). This pattern of mal-distribution has not shifted in any significant level since Zaidi's evaluation.[55] The consequence of this socio-economic context in reproducing inequality of access to appropriate medical care has been well established

(Navarro 1974; Zaidi, 1988), and is an issue relevant to understanding the current medical care contexts of Pakistan, including Panjgur district, the primary site of my ethnographic research.

Similar rural-urban disparity is reflected within Pakistan, such that if an individual in a rural part of Pakistan chooses to obtain biomedical care for a so-called modern disease such as diabetes, they would need to travel for hours or days before reaching an equipped facility and a qualified medical doctor. To make health services available to rural areas on a more equitable pattern would require a restructuring of the medical curriculum as well as a greater focus on reorienting the infrastructure of the medical system in order to suit the needs of the local, mostly rural, population. Yet, successive governments have not taken any such steps. Instead the trends are toward decreasing investment in the social sector and a concomitant rise in military expenditure, reproducing and intensifying poverty and mal-distribution of basic resources (HDR 1997; Islam 1996; MH 2005).

Thus, despite the aim to bring women's social and economic needs to the center of development planning, in the last decades of the 20th century and beginning of the 21st century there has been a sharp decline in the commitment to public health in Pakistan. Along with decreasing state spending on health, policy measures have encouraged the growth of the private sector in health care, which is largely unregulated. More than 80% of curative health care provision is through the private sector; which includes both the non-profit and for-profit health sector. The for-profit private health care sector is not well regulated.[56] In the five decades since its independence, while Pakistan achieved economic growth and progress in the agriculture sector, social indicators in general, and

demographic indicators in particular, lagged behind countries of comparable economic level (MH 1997). Pakistan gained independence with a weak base in the health sector and had only 1200 doctors (one for 60 000 people), 15 000 hospitals beds (one for 48 000 people), only two medical colleges and fewer than a dozen training centers for other health staff (Khattak 1996). It had 292 hospitals, 722 dispensaries, 91 maternal and child health center and 3 tuberculosis clinics. Over the course of 50 years the state established a network of health care facilities throughout the country (Khattak 1996). The per capita expenditure on health increased from 3.52 Pakistan rupees per month in 1978 to 160 Pakistan rupees per month in 1997-98 (MH 1997). Yet, it was not until the early 1990s that Pakistan increased its attention to the social sectors (Tinker 1998). In 1997, the National Health Policy was revised as it was felt that it did not adequately cover all areas of primary health care (MH 1997). The health policy of 1997 is based on the concept of health with all its physical, mental and social dimensions, where health is an important indicator of quality of life and national development (Ali 2000).

Yet, despite the expansion of health facilities, the overall expenditure in the health sector remains low at around 1 per cent of the gross national product (Khattak 1996). Moreover, Pakistan has one of the worst records in female health, education, and gender equity. The sex ratio is unfavorable to women; this is a result of excess female mortality during childhood and childbearing. Each year approximately one in every 38 woman dies in childbirth. This excess of female mortality is unevenly distributed in the country. For example, *dowry* deaths in Pakistan are largely concentrated in Punjabi families (HRCP 1998). This indicates that the gap between policy initiatives and practical conditions of large number of Pakistani women is wide. Ensuring that growth translates into

sustainable employment, less inequality and the reduction of poverty is not a new challenge for the Pakistani government.

The government aims to employ a combination of growth promoting policies and direct interventions to attack the problem of poverty as part of its overall poverty reduction strategy. The plan includes a macroeconomic framework and public sector development programs. The main objective of the plan is the reduction of poverty, increasing the growth rate, and providing basic social services and safety nets. A series of measures, programs and projects has been identified as the means for enhancing equity, efficiency and effectiveness in the health sector through focused interventions. Currently, health care provision is through 916 district and Tehsil hospitals, 552 rural health centers, 5, 301 basic health units and 4582 dispensaries in the public sector. The health manpower in Pakistan includes 17,200 specialized doctors, 113,206 medical officers, 48,446 nurses, 6,741 lady health visitors and about 84,000 lady health workers, making evident that medical technicians and lady health visitors have a significant role in providing child medical care services in rural areas.

However, while the plan recognizes the limitation of an economic growth development strategy to reduce poverty and social inequality as evidenced by the history of abysmal social and economic statistics in Pakistan: economic restrictions and development through growth approach remains the primary modus operandi driving the national development strategy. This approach and the push toward privatization have been the central public rhetoric deployed by the government in the last five years.

Balochistan and Panjgur: Socio-Economic Context

Panjgur's health and medical care context

The Makran region of Balochistan is the least developed in terms of infrastructure and basic facilities. Certain regions along the Arabian coast and the mountainous areas remain effectively cut off from the rest of the province. Electricity is available only in central towns. Following Pakistan's independence from India, Panjgur faced two natural disasters. In 1958-59, a week of heavy rains resulted in heavy flooding, which destroyed the date trees and other crops. In 1960, cholera spread in the villages of Bonistan and Isai costing hundreds of lives. These two villages still have occasional incidence of cholera due to the lack of clean drinking water. The recent floods and drought in Makran have had an uneven impact on the districts. Many people were killed and lost their homes as a result of the storms in 2005. While there were only two or three reported deaths in Pangjur, there was great property damage, people's homes collapsed, livestock was destroyed, and electric and phone lines were damaged and remained so for more than two months. Despite the damage from the floods, many people nonetheless welcomed the rains following years of drought in the region. However, less than a third of the population has access to piped drinking water and its quality is often questionable.

The major source of irrigation in Makran is either *kaurjos* (small water channels from pits dug in perennial flow to the fields) or *karezes*. Although irrigation has long been practiced through the use of *karez*, diminishing water resources has resulted in men seeking seasonal wage labor in agriculture and employment in the central towns of the district, major cities in Karachi and also abroad in nearby Middle Eastern countries. Having been initially recruited to serve as soldiers in Oman, thousands of male workers

remain in Oman and other Gulf countries to continue to work there, and send remittances back to their families. This significant aspect of the local economy is not new, as migrant labor to the Gulf countries from Makran has been taking place for centuries. However, in the past several years, a large number of the gulf migrants who have returned from the Gulf countries are facing unemployment, resulting in unprecedented number of young men resorting to drugs.

Institutionalized Health Care in Panjgur

The local government at Panjgur district comprises eleven union councils, one district council, and one town committee. The only town committee in the district is Chitkan. Semi-rural, Chitkan was given the status of town committee in 1980. Among the eleven councilors, eight are elected directly, one from each of the eight wards; and these elected councilors elect two women and one laborer as councilors. The mandate of the local councils is to address various local socio-economic development issues. Many of the council members have been trained by a local NGO to plan and implement local projects based on needs assessment. These local councils are supervised and supported by the local government and rural development department through an Assistant Director at the district level. The union council is the smallest local government institution. The membership of each union council varies from 5-15 members. However, the elected councilors in every union council must elect two women and one farmer in their union council. The union council, ideally, provides an opportunity for the people of rural areas to participate in decision-making at micro level.

In the district, health services are provided at two levels. The primary level which includes 11 basic health units (BHU), 3 sub health centers, 15 dispensaries, and 4 mother and child health care centers (MCHC) are established throughout the district. The secondary level includes the headquarter hospital in Chitkan town. While I was there in 2005, a rural health center, which is a primary care facility, was under construction in Parome. Primary health care includes prevention of diseases through community health programs, cure of minor diseases, and provision of emergency medical services. Secondary health care includes provision of specialized health services to cure major ailments at the District Headquarters Hospital. A 42 bed indoor patient facility is available at the District Headquarters Hospital.

In Panjgur, the District Health Officer is responsible for primary health care and related facilities like basic health units, dispensaries, and mother and child health care centers and for EPI and school health services, the Prime Minister's program for family planning and the Basic Health and Leprosy Control Center. Secondary health care is provided at the District Headquarters Hospital located at Chitkan. A Medical Superintendent is responsible for proper functioning of the district hospital. While the federal government provides support to special health services like the EPI and the Prime Minister's Program for Family Planning and Basic Health in the district, the provincial government is the major actor in providing health services to the people of Panjgur. The private sector's involvement is limited to private clinics and medical stores.

There are 12 local NGOs working for women, child, and youth welfare. Two province-wide NGOs, the Helpers Association and Pak Public Development Society have established primary schools in Panjgur. There are no NGOs working exclusively to

address women's issues. However some women take part in various activities of the existing NGOs. The Family Planning Association of Pakistan (FPAP) provides family planning services in the district. Though their presence was not discernible when I was there, several international organizations have been active in the district, especially in the field of education, but also health, and rural development. The World Food Program (WFP) distributes cooking oil to pregnant women and the World Bank has provided assistance for water management through the On Farm Water Management Project.

Issues of Access: Female Medical Practitioners, the rural, and distance

Until recently the district had been facing major difficulty finding local-based female medical staff. However, in the last decade an unprecedented number of girls have been allowed to obtain formal schooling within the Makran division of Balochistan, largely as a result of local and non-governmental efforts pushing the education of girls. Panjgur district is among several districts in the division within which parents are increasingly allowing their daughters to continue their college education and professional training in Quetta, despite the eight-hour journey to Quetta over predominately unpaved roads. This is due in part to the increasing links some families have between provincial centers and their rural homes, such that young women can stay with other relatives during their schooling and training. Also, the availability of new, functional, all female dormitories and the enforcement of enrollment of district based provincial quotas for all eligible Baloch students has resulted in an available pool of female medical doctors, lady health visitors, and female medical technicians, who can choose to serve their district. When I arrived in Panjgur in 2004 the two female medical doctors (commonly referred to

as lady medical officers [LMO] in the Pakistani medical system) had been working at the district headquarter hospital for at least two years. Three other lady medical officers who had recently completed their degree have chosen to work in Panjgur. All of these female medical doctors belong to Panjgur and are part of families that have been living in the district for many generations. Although the one sole female technician working in Panjgur is a Baloch, all the lady health visitors assigned to work in the district, are from the Punjab, except one Brahui speaking Baloch. However, in 2005 among the new batch of LHV graduates in Quetta, one Baloch LHV decided to seek a position in Panjgur. In the history of Pakistan, we are only now seeing Baloch LHVs matriculating.

Despite this evolving pool of female medical workers, LMO and LHV posts are vacant in a majority of rural health centers and basic health units, particularly in the Balochistan province. Moreover, as I had expected, many of the Punjabi LHVs working in the district were preparing to transfer to districts located near their respective hometowns. Much to the chagrin of the district health officer, two of LHVs had received their transfer notice to basic health units in the Punjab. The district officer worked very hard to obstruct this transfer, arguing that this would create gap in services to women and children in the district. Such politics surrounding the transfer of medical personnel is widespread in Pakistan and not exclusively related to the transfer of female medical workers.

A 1997 ADB report on *The status and quality of women's health care in Pakistan: a situation analysis* found that the average distance to a FWC (family welfare center) in Balochistan is 47.5 km compared with 9.3 in Punjab. If women, after overcoming physical the physical exertion and obstacles of social mobility make it to the

service provider working in equipped medical facility, often they do not receive the desired quality of care from the service provider. Thus, the chances of women repeating the journey to a facility are minimal. This is one major reason why the visit to a health care facility is delayed until the physical condition of a woman becomes severe. However, as I discuss in Chapters Three, Four, and Five, the relationship between the sort of medical care women need, desire, and have available to them is highly complex and is not simply a function of the availability or non-availability of hospital-based biomedical care. The persistence of a large percentage of childbirths that take place outside of hospital settings is a stark reality that many policy makers in Pakistan recognize. Thus, the national policy to advance skilled midwives, and to encourage the development of partnerships between the community *dai* and LHW/VBFPW to address the concern about delayed decisions to seek care. The policy perspective is that, the figure of the *dai* is the most accessible and affordable option, and whereas the LHW lacks the "skills" of the *dais,* she has had the benefit of formal schooling and is underutilized. The national policy view is that since *dais* do not always adhere to hygienic practices and LHWs/VBFPWs are neither able to visit homes, nor are they regarded as a resource, since LHWs are young and inexperienced, *dais* and LHWs should be encouraged to work in partnership together. Within this discursive context, I address the making of "skilled midwives" also called "skilled birth attendants" in Chapter Three.

Poverty reduction, health improvement, and Structural Adjustment Policies

The long-standing World Bank and IMF sponsored structural adjustment policies (SAP) refers to a set of measures that countries need to implement in order to qualify for

loans from these agencies. In 1987 these SAP were expanded to create an enhanced structural adjustment facility to allow developing countries to borrow from it subject to their agreement to accept IMF conditions that include broadly, restructuring the national economy toward privatization and reducing government support for social programs. The SAPs are primarily geared towards achievement of fiscal and balance-of-payment stability, rather than stimulation of economic growth. The ostensible purpose of these economic measures is to improve debt repayments, reduce fiscal deficits, encourage private sector investment and move towards an export-oriented economy. The measures are targeted to allow the governments to undertake better long-term planning. It is thus anticipated that the consequent improvement in national economic efficiency will lead to stimulation of growth with subsequent 'trickle-down' benefits to the poor and vulnerable groups of the population. But the evidence supporting the benefit of SAPs on reduction of poverty and socio-economic inequalities is absent (Castello et al. 1994).

Many of the premises of SAP are geared toward improving the general socio-economic conditions and indirectly the health of the populations.[57] However, according to Peabody (1996: 823), while "from a purely economic viewpoint, structural adjustment economic reform policies are viewed as short-term austerities that lead to long term growth and development, these inter-temporal trade-offs, however, are not always acceptable in health". The quantitative data available on the impact of structural-adjustment programs provide a restricted view of the situation. In many countries, there are no reliable data (Lundy 1996) and available data do not assess the impact on people's live or the despair that the programs bring with them.

To capture multiple dimensions of poverty such as poor health, illiteracy and lack of access to safe water, nutrition and income, Mahbub ul Haq developed the Poverty of Opportunity Index (POPI). This broader definition of poverty includes indicators of basic human deprivations such as lack of access to income, education, and health (HDR 1997). Based on this definition, poverty of opportunity affects more people in each South Asian country, except for India, than poverty based on income alone. The most striking gap between POPI and income poverty exists in Pakistan. Poverty rates have risen in Pakistan in 1990s, a reversal of the declining poverty trend in the mid-1970s and 1980s. The rising poverty level in Pakistan during the 1990s is due partly to the slowdown of the economy, and partly to government inability to translate the good economic growth of the 1980s into a better life for the poor. Successive governments have played a marginal role in transferring income and opportunities to the needy. In the 1990s, only 0.22 percent of the GDP was transferred to the poor as *Zakat,*[58] less than 3 percent was spent on education and a meager 1 percent on health services.

Since the poverty-creating factors are different in rural areas than those in urban areas, separate strategies are required for rural and urban areas. Recall also Zaidi's (1988) thesis about the urban-rural disparity and the consequent mal-distribution of medical services. Rural poverty requires more immediate attention, as four out of five people live in rural areas. In this context, elimination of urban bias in public expenditures and redirection of resources to rural development, agricultural support programs, and health service infrastructure development are essential to addressing rural poverty. Moreover, strategies to reduce poverty must be situation specific, directly addressing the realities on the ground, building local capacities, improving asset distribution (including land

reforms), and providing micro credit. However, there is no indication that Pakistan's development policies, particularly evident in less than adequate investments toward the medical and economic sectors for rural areas, are based on the realities and needs of the majority of the population in the country.

Thus, although policy formulations point to the significant problem of malnutrition as a determinant of maternal and child morbidity and mortality, this aspect of poverty, which contributes one of the most profound and direct impacts on the bodies of childbearing women, is not central to programs designed to reduce maternal deaths in the country. However, recently several initiatives under the Tawana Pakistan Project have supplied food stamps, subsidized wheat flour to the poor, provided food items through the World Food Program and fed female students of primary schools in limited districts. These arrangements are not considered sufficient toward the goal of food security for the entire population of the country. They ignore the high rates of unemployment and the impact of drought on semi-nomadic and agriculture economies of large areas of the Balochistan Province. Both factors work together to limit access to a quantity and variety of foods. Also, concentrated urban areas, that are deemed slums, remain neglected, for example in Karachi, whereby each year the infrastructure is worsening and levels of gang and gun related violence increasing. Water is a key issue for rural and urban areas. Piped water remains inaccessible in a majority of slums, requiring localities to purchase water from mobile units that sometime run out of water before every household in a community has had a chance to make a purchase.

The government has outlined a broad based strategy called the Poverty Reduction Strategy Papers (PRSP), which emphasizes primary and secondary health care. It outlines

interventions for behavioral change, an awareness of health interventions and focuses on women and children. It reaffirms the government's commitment to improve the public service delivery as a means to achieve MDGs and attempts to provide and integrated focus to a diverse set of factors that impact poverty.

IMF visits to Pakistan are often followed by a rise in price of 'petrol' oil. This is arguably a result of Pakistan's agreements with the World Bank and the IMF to restructure its debt burden. Bhutta (2001) argues that the pre-requisites for ensuring the burdens of structural adjustment and austerity measures are equitably distributed are absent. The pre-requisites for him include: social justice, good governance, true democracy (as opposed to the sham democracy of the privileged elite or feudal class) and gender equity. He also locates levels of corruption, the lack of monitoring of social welfare programs and of systems for redressing grievances as additional factors obstructing SAP objectives.[59]

This chapter has provided an outline of the available medical services and health care infrastructure of Panjgur, the Balochistan province, compared with the rest of Pakistan, and it has discussed a range of factors that are a backdrop to programs that directly intervene in women's reproductive lives. In particular, I have described how national and transnational strategies that target women's health development have contributed to the Pakistani state's "safe-motherhood" policies and in doing so, reproduce long-standing assumptions about the character of particular female health practitioners, an reconfigure the Panjguri and Pakistani TBA/*dai* as a non-midwife. Chapter Three now turns to the ways that discursive constructions of indigenous midwives are linked to colonial and postcolonial representations of Balochistan's geography and people.

CHAPTER THREE
CONTESTED CATEGORIES: DISCOURSES ON *Dhinabhug, Kawwās, and Ballok*

Introduction

> Language—like the living concrete environment in which the consciousness and limited verbal artist live—is never unitary. It is unitary only as an abstract grammatical system of normative forms, taken in isolation from the concrete, ideological conceptualizations that fill it, and in isolation from the uninterrupted process of historical becoming that is a characteristic of all living language. Actual social life and historical becoming create worlds, a multitude of bounded verbal-ideological and social belief systems; within these various systems are elements of language filled with various semantic and axiological content and each with its own different sound. (Bakhtin: 288)

> Balochistan is coming out of darkness into lightness. (Ministry of Health Official speaking at a national forum advancing the formation of Skilled Birth Attendants in May 2005, Peshawar, Pakistan)

> People are not aware of what a "midwife" is. They don't know that not each and delivery can be conducted by a doctor. Midwives are much better than TBAs—trained or not trained. (Gynecologist, Interview in Quetta)[60]

This chapter is about categories and epistemologies and it situates the discursive constructions of indigenous midwives in relation to colonial and postcolonial representations of Balochistan's geography and people. It is concerned with the ethnicization and racialization of the subjects and their medicines. Conceptions of disease and health about populations have necessarily interpellated "traditional healers" in colonial and postcolonial times. In this Chapter I examine the epistemological grid through which local midwives constituted as "traditional" health practitioners are known in transnational, national, and local discourses?

Categories blind us more than they clarify. TBA is a well-established category in transnational health development aid and policy circles. Its authority as a category is reflected in the fact that the acronym has rarely demanded delineation into words in

Pakistan's health development discourse. There is another three-letter word that is more familiar to the readers of anthropology of childbirth in South Asia. *Dai* has become the universal nomenclature to categorize the South Asian TBA. Even anthropologists have not questioned the universality of *dai* as the designation for traditional midwives in South Asia. Both designations are readily deployed by public health professionals, state medical workers, and the policy making arm of the state in Pakistan. Indeed, national documents sometimes use the terms TBA and *dai* interchangeably.[61]

A survey of anthropological literature on women, gender, and childbirth shows that over time there is shift in the use of the general category that marks indigenous women's work in the care of women and children's bodies: namely from midwife, to traditional or indigenous midwife, to *traditional birth attendant* (TBA). Moreover, the production, circulation, reworking, and reproduction of midwifery related categories in discourses around advancing women and children's health and care-giving regimes have crossed disciplinary and professional borders (i.e. between health development studies and anthropology). The prefix "tradition" continues to mark out and distinguish the midwives of the global south from the now large numbers of professionally and biomedically trained midwives of the global north in both anthropological and health development literature.

While the term "tradition" is the first word in the acronym TBA, in my more than ten years of work in Pakistan, including my doctoral research in 2004 and 2005, rarely would I hear anyone take the acronym TBA apart when it was referenced to in discussions around reproductive health, safe motherhood, and the creation of a "new" cadre of so called "skilled midwives" or "skilled birth attendants". Although the category

would be used interchangeably with the other dominant category *dai*- the taken-for-granted category of TBA would not be spoken in its de-acronym form, "traditional birth attendant". Thus, the acronym TBA in Pakistan can stand as a term that further discursively erases the function of these women as legitimate "birth attendants". Now, influenced by the WHO medical and technical mandates to reduce maternal mortality, Pakistani public health professionals, as part of the international health and development aid writ community, are deeply immersed in the production and legitimization of the new category of "skilled birth attendant" (SBA), who are often also called "skilled midwives". The new category no longer requires the prefix "tradition," and functions to rework who can become a state sanctioned and thus legitimate "birth attendant". Here, the dumping of the word "tradition" reveals the policy assumptions operating about "traditional midwives" or "traditional birth attendants" which marks them as unskilled health care workers. It also suggests that WHO's original policy of giving biomedical training to TBAs and retraining them as key nodes of the health referral system is a transitional arrangement and was never a means to challenge the unquestioned dominance of biomedical discourse and authority in restructuring the medical care systems of postcolonial nation-states. I elaborate on this point in the next section.

Stacy Pigg (1995) has eloquently illustrated how the production of acronyms in health development discourse produces a specific form of violence that is an effacement of the variety and range of midwives in Nepal. In 2005, in Pakistan, the pre-conceptualized and homogenized TBA who is sometimes called a *dai* is now explicitly constructed as unworthy of acquiring the label of midwife. The label is now reserved exclusively for women trained in biomedical forms of health care. Thus, only they can be

called “skilled midwives” or “skilled birth attendants.” Their expertise will be marked by a minimum of two years training. These trained, so-called skilled birth attendants will receive a license to run their private practice, yet they will be registered with the government. The reworking of this definition is manifest in the shifting of a new set of categories and acronyms taking place over the last several years in WHO and Pakistan’s government and non-government policy papers; from community midwives, to skilled midwives, to skilled birth attendant. Midwife and birth attendant are suffixes deployed interchangeably.

The discourse of “skilled birth attendants” has not yet reached the Panjguri context. Nonetheless, as a result of the National Women’s Health Project in Panjgur, which is mandated, among other things, to address the public health problem of maternal mortality, two levels of categorical reduction are taking place through the targeting of Panjguri midwives for training. One is the usual reference made to them as TBAs (traditional birth attendant), and second is TTBA (trained traditional birth attendant). The second acronym is deployed by government health officers to underline the “efficacy” of the district health office in working for the state to successfully train, thus interpellate the so-called birth attendants or *dai.* Here I employ Althusser’s (1971) notion of interpellation to interrogate how the so-called traditional birth attendant or the *dai*, historically and contemporaneously has been located simultaneously in the “traditional” space outside of the so-called modern and at the nexus of “tradition” and “modern” in order to construct her position and practice within specific ideological and discursive operations to rationalize mechanisms for her reform. However, I do not assume a static ideology located in a given time or over time; I do assume that these operations in their

materiality have certain important consequences on the social life of the local midwives and physical bodies of women. I will return to address the specific process and effects of the two-years old TBA training program in this and the next two chapters.

Specifically, in this chapter, I address the unstable and contested categories currently circulating in postcolonial Pakistan that describe women who care for the bodies of other women, and in doing so, I show how this history/genealogy simultaneously disrupts the homogenizing conceptions of the transnational TBA and the South Asian *dai.* I consider the genealogy of categories operating at three overlapping epistemological spaces including: (1) Transnational categories—traditional birth attendant (TBA), *dai*, midwives nurses, medical doctors; (2) Pakistani state categories—traditional birth attendant (TBA); *dai,* lady health visitor (LHV); lady health worker (LHW); lady medical officer (LMO); nurses; and midwives; (3) Panjguri women's categories: *dhinabhug, kawwās, Ballok, lady, dai*.

Locating TBAs for primary health care

Foucault (1972) says, "one of the most productive ways of thinking about discourse is not as a group of signs or a sketch of text, but as practices that systematically form the objects of which they speak." (p. 49) It is in this sense that the category of the TBA (traditional birth attendant) is produced and reproduced through its deployment in transnational health development practices. This discursive reduction, and reproduction of "truth" is what authorizes the stereotype of the non-western midwife and is a discursive labor that excludes other forms of knowledge. It is a terrain of knowledge that can shed light on why and how non-western local midwives—who are *not* called midwife or TBAs in local/regional vernaculars of my ethnographic site—persist as sought after birth attendants and healers. More significant is that such an exclusionary discursive

labor is blind to why women in large numbers continue to insist on seeking that "traditional" midwife as their primary health care provider and healer.

Since the 1978 Alma Ata meeting on primary health care (PHC), in Pakistan, strategies to locate, train, and incorporate the so-called traditional midwife or TBA to advance national health care policies have been driven by international trends and donor priorities. Assessments of available resources were required for every new trend in health care strategy, from primary health care (PHC), child survival, family planning, and safe motherhood to reproductive health care. *Dais*, commonly known as traditional birth attendants (TBAs), were recruited to serve in short term, vertical, and target-oriented health care programs where their successful participation was measured by the number of vaccines for child immunization or contraceptives for family planning distributed in their communities (Parvez 1993). In this way, the work of *dais* was redirected from attending at childbirth to distributing contraceptives and improving the state's child immunization rates. This was done at the expense of the *dais'* unique and complex roles and women's varied health needs. At each new policy juncture a critical concern has been the availability of trained health personnel, with the view that a functional health system requires skilled workers who require training. But assessing who and how to train has been more complicated than imagined. A basic problem has been how trans-nationally produced and re-produced categories function to homogenize, thus erase the subjects, their work, and social location to fit the presumptions underlying the category.

Originally, training of "traditional midwives" was designed to benefit from their strength as available and acceptable providers to an otherwise neglected community. Yet, ironically, the approach towards them has resulted in: (1) devaluation of their potential in

safe motherhood initiatives and reproductive health care, and (2) curtailment of any improvement in women's health status. The focus of their "skill" development has been oriented exclusively on hygiene awareness and encouraging them to refer women to allopathic/biomedical practitioners for hospital births. In the 21st Century, the success of involving them continues to be assessed independent of their roles as childbirth attendants or locally specific and socially sanctioned roles and positions; but rather in relation to outcome measures like immunization, contraceptive, and maternal mortality rates. Consequently, a large majority of policy makers now consider them unqualified and incapable of conducting "complex" tasks of maternal and reproductive health care. In South Asia, detailed ethnographic study of *dais* within the framework of their broader life is entirely absent. Studies about South Asian *dais* almost entirely focus on their role as birth attendants. Even if available, there is no indication in policy documents that such studies are consulted to shape understanding about locally specific midwives. Thus, judged merely on achievements of externally imposed statistical targets rather than demonstration of real competency, policy toward "traditional" midwives reflects a sort of "victim blaming" by making the claim that their "practices are conditioned by strong cultural and traditional norms, which may also impede the effectiveness of their training" (WHO 1997; 2002).

This type of criticism remains hegemonic, in the sense that both leading international and national institutions view pre-configured and pre-categorized traditional practices and practitioner as obstacles to modernization of the medical care infrastructures and the cultivation of modern dispositions among childbearing women to proactively seek modern institutional medical care. In Pakistan within the recent national

framework, which prioritizes the making of "skilled midwives" to reduce the countries' maternal mortality ratio, public health professionals and policy makers also believe that local midwives' (i.e. TBAs/*dais*') learning ability and technical capacity to avert maternal death is linked to their level of schooling/literacy (ability to read basic midwifery textbooks in Urdu). Thus, because the existing TBAs/*dais* lack such schooling/literacy, they are neither considered "skilled", nor deemed capable of becoming "skilled midwives". There is a near consensus among government and non-government public health professionals, that in addition to the availability of emergency obstetric care (EmOC) in hospitals, educating young women to become bio-medically trained midwives in their service outside of hospital settings is the only means to reduce the maternal mortality ratio in the country.

Constituting the TBA as an obstacle to the provision of women's health care

> Two-thirds of women deliver at home and 80% do so without the assistant of skilled birth attendant. (Pakistan Planning Commission 2004: 25)
>
> Home deliveries are the norm, TBAs are preferred providers and importance of skilled birth attendance is not recognized. (Pakistan Planning Commission 2004: 25)
>
> [W]e must provide cash incentives to women to give birth in hospitals." [And cash incentives to TBAs to bring the women to the hospital.] (Pakistan Planning Commission 2004: 26)

Female health providers are scarce, especially in rural areas where women prefer to be examined by women. Around 33 percent of government facilities have no female health staff.[62] While almost one-third of physicians registered during 1993 were females, female physicians are concentrated in the cities.[63] Although the number of female and male doctors is almost equal, a small percentage of female doctors are trained in obstetrics and gynecology and even a smaller numbers are trained to perform cesarean

sections. Most female health workers are auxiliary workers. All the maternal and child health (MCH) centers are headed by lady health visitors (LHVs), who may be posted at a hospital, rural health center (RHC), or basic health unit (BHU), and until recently LHV was considered the equivalent of WHO's definition of a community midwife. In Pakistan, in terms of population coverage, LHVs are the next important service providers to doctors (medical officers). Thus, the lack of female health care providers in rural areas is not altogether due to lack of government trained and registered personnel. For example, over the years since 1947, 10,000 pupil midwives have been trained, yet no one can track them and locate them to ascertain if they are working (Kamal 2001).

In Pakistan there are three categories of midwives registered by the Pakistan Nursing Council:

- The nurse midwife who is a Registered Nurse (RN) and Registered Midwife (RM) with three years training in general nursing and one year's post basic allopathic training in modern midwifery. They seldom function as midwives and most avoid mentioning that they are registered midwives. A small number who do as midwives work in maternity units of institutions based in urban settings (Kamal 2001). According to Kamal (2001) the majority of these nurse midwives probably have not assisted a single woman during childbirth.
- The non-nurse midwife: She has one year training in midwifery only.
- The Lady Health Visitor (LHV), trained as a midwife for one year and as a public health worker for one year.

The trained so-called *dais* or TBAs are not registered with the Nursing Council. Although government sponsored training programs have attempted to employ some of

them to work in a government health facility such as an MCH center, BHU, or RHU where she can receive a scheduled monthly salary, the percentage of *dais* in such positions is minimal. Moreover, often their function in the health facilities is reduced to that of a peon: running errands, maintaining order in waiting halls of clinics and hospitals, and sweeping and tidying up the clinic. Officially she is not allowed to attend births or advice women while working in the facility and during official work hours. While a government *dai* is allowed to practice midwifery outside of the center in her spare time, if a birth were to take place in the facility—a rare event in Panjgur—the LHV or the LMO are the only two authorized medical officials to attend the birth. However, as it will become clear in later chapters, Panjguri *dais* often find themselves instructing and guiding LHVs and sometime newly matriculated LMOs about detecting the proper stages of pregnancy; the status of a laboring woman's cervical dilation; and can even end up managing complicated cases that LHVs and LMOs refuse to touch. Policy makers and public health professionals in Pakistan know well that *dais* and LHVs attend a majority of births in Pakistan in the public and private sectors.[64] Indeed, public health professionals, such as a biomedically trained nurse-midwife, view the persistent of women and their families' reliance on *dais* in rural and poor communities as a function of deplorable modern health care system. In her words:

> In a country, where nine babies are born every minute, where institutional delivery is not without financial implications, where health centers open in the morning only and where majority of births take place at home, the community has no choice but to turn to the *dai.*

Yet there is vast evidence in the literature that contradicts the above claim as a sufficient or significant rationale underlying women and their families' choices to give birth at home. In 2005, a medical doctor deeply immersed in public health work in

Karachi, having founded a non-governmental organization (NGO) to advance primary health care, discussed with me the difficulties that the staff faces in convincing women to give birth in the hospitals. In one of the dense and economically poor areas of Karachi where the organization works, there is no shortage of hospitals. The NGO also conducts outreach to educate women and the TBAs, encouraging women to attend the NGO clinic for prenatal care and have hospital births. Yet, Dr. Rabia told me that there is no shortage of TBAs attending home births and women seeking their services in the area, despite all efforts for well over two years to educate both groups to do otherwise. Women, it seems, even in the cosmopolitan city of Karachi, prefer home births attended by TBAs, rather than hospital births. While women do attend the BHU clinics and MCH centers in the hospitals for prenatal care, such an occasion largely fails to convince women to return for hospital births. Yet, a core assumption fostering the rationale for the making of 21st Century "skilled midwife" is that lack of physical accessibility to "skilled midwife" is what prevents women from attending clinics and hospitals for childbirth. The so-called "skilled-birth-attendant" serves an intermediary role to cultivate the necessary "modern" sensibility among rural women to learn to view hospital births as the proper place for emergency as well as non-emergency births, a function that was once imagined for the Third World "traditional" midwife in the 19th Century British Colonial period.

The *ladies-of-allopathy* and the new "skilled midwife"

> The government recommendation is to have deliveries with the SBA (skilled birth attendant) at home. This is because the socio-cultural context is such that we cannot push for hospital births. (Federal Coordinator of the Women's Health Project, Islamabad)

> All futile exercises have taken place in last 20 years. Nothing has given anything. You have to make the midwifery program because that is an agenda that has come from above. That is it. That is all. Finish! (Dr. Rubina, Gynecologist and Obstetrician in Quetta)

In the last several years, WHO and UNICEF suggest that the person best able to assist normal deliveries and manage or refer complications is the person with "midwifery skills" who is part of and lives in the community that she or he serves. Thus, the WHO no longer looks to "the TBAs [as] an important resource that could be mobilized to help achieve the social goal of health for all" (Mangay-Maglacas and Simons 1986). In Pakistan, despite the variety and large number of female health care workers noted above, there is a shortage of such well-trained health-care personnel. The auxiliary health care personnel, such as the LHV, assigned to provide maternity related services are now considered to lack the necessary "midwifery skills" to help avert the high rate of maternal mortality in the country. In terms of the existing pool of human resources, these workers are assumed to provide the current backbone of maternity services, thus their further training is also deemed necessary if they are to play an effective role in safe-motherhood. In Panjgur, as in many rural areas of Balochistan, such a 'backbone' is absent. These are longstanding problems in Pakistan that are now underlined as a rationale for the new conceived plan to produce another cadre of female health care workers, the "skilled midwives".

To supplement the normal facilities, the Prime Minister's Program (PMP) for family planning and primary health care was initiated in 1994. This program established a new cadre of service providers called lady health workers (LHW). These young women were selected from rural and urban areas to work in their respective communities and villages following a three and five month training sessions. The federal Ministry of

Health (MOH) has the responsibility for training, supplies and the salaries of the LHWs and their supervisors. Currently, the National Program covers about 40% of the country's rural population, and the MOH plans to gradually expand the program to achieve 100% coverage (Bhutta, Jafarey, and Midhet 2004). An estimated 97 percent are said to be from the communities they are assigned to serve. They are appointed on a contract basis and are required to maintain a link with the health centers in their regions. They are expected to provide services for maternal and infant care, provide advise on nutrition; assist with diarrhea disease, acute respiratory infections, immunization, community hygiene, sanitation, and family planning. It is expected that once the LHWs develop more skills they would have the incentive to establish their own private practice and become interested in attending births. LHWs are also at the center of debates about the formation of new cadres of female health care worker, the "skilled midwives". Whereas the so-called TBA/*dai* is unanimously deemed inappropriate for such a role, in some official circles the LHWs are marked as an available pool of female heath workers that possess the requisite potential to become "skilled midwives".

Whereas the government sponsored pilot project proposes to train a select number of LHWs, a pilot project in Sindh supported by private funds has taken a different approach to producing "skilled midwives". The program has recruited young women with 10^{th} grade level education from semi-urban and rural communities in several different districts of the Sindh and Punjab provinces. They are trained by medical doctors in one of the oldest private-based technical schools in Karachi. Essentially, the policy relies on the future desire and commitment of the new "skilled midwives" to reach out to the community and willingly attend home births. Yet, the technical training that these women

will acquire is largely dependent on the hospital infrastructure. The medical doctors and trainers I interviewed admitted that by the time the young "skilled midwives" or "skilled birth attendants" are released to set up their private practice they will not have had sufficient experience attending births.

So, how will they cultivate the disposition of the yet-to-be-made "skilled midwife" to attend home births? The central dilemma about how this new cadre will accommodate the "culture of home birth" remains unresolved, for one of their assignments is to encourage women to give birth in the private centers or clinics which they would be licensed to set up. The hope is that the vicinity of the centers will divert women away from seeking *dais'* services. Yet, achieving this goal appears doubtful in light of the historical and extant experience with LHVs. It had been hoped that LHVs who continue to be assigned to work in the hospitals, rural health centers, basic health units, and dispensaries of the country would conduct home deliveries and outreach work, particularly in the rural areas. Yet, in Balochistan at least, LHVs are not the sought after birth attendants for home births. This is particularly true in situations when communities can call upon the local *dhinabhug* or *kawwās*, who, in the minds of a great number of Panjguri women, is deemed more experienced. She is not only considered a more skilled and knowledgeable birth attendant, but also an expert post-partum care provider and herbalist.

I discussed this situation with a group of LHVs in Panjgur. Several of the young women, in their late twenties and thirties, conveyed to me with a degree of humor how over the three to four years of their assignment in Panjgur they have attended no more than one or two births—if any at all. "They don't call us", one of the LHVs told me,

giggling. The LHVs harbored no feelings of resentment about this, since after all, they received a regular monthly salary from the government. While attending births could bring them extra money, they are barred from accepting cash payment if the birth should take place during working hours. Creation of a new cadre of female worker certainly advances the cause of advancing female participation in the workforce. But it will be years, if not decades before this "skilled midwifery" program can be evaluated as a measure for reducing maternal mortality. This strategy also overlooks the intimate aspect of childbirth that, in Panjgur, seems to structure the relationship between the laboring woman and her attendant. This relationship is inscribed in who and what sort of person can attend childbirth and thus also the locally constituted category of *dhinabhug.* I elaborate on this point later in the chapter.

In Pakistan, the fact that many of the auxiliary workers, such as lady health visitors and female medical technicians, do not belong to the community in which they are assigned to serve can become an impediment to their work. Often many of them want to relocate as soon as they are posted in a center at a remote part of the country. During the first month of my research, I met three Punjabi LHVs who wanted to relocate to medical centers located closer to their hometowns in the Punjab province. While the scenario in Panjgur is slowly changing, where there are now a few locally based trained female medical technicians due to increased education of girls in the last decade and half, a majority of LHVs stationed in Panjgur are from provinces outside of Balochistan. Two of the most active LHVs who have taken up long-term residency in the district have private practices and are as active as the two female medical doctors. One LHV is a

Punjabi married to a local Baloch resident. The other LHV is a Braui speaking Baloch from another district of Balochistan.

Contesting the hegemony of the category *Dai*

As I began my research in Panjgur, it did not take long for me to learn that the category *dai* is not the dominant term used by women and Panjguri *dhinabhugs* to describe women who are deeply involved in midwifery and healing work. Although the term *dai* was sometimes used to refer to women who attend childbirth, the terms *dhinabhug, kawwās,* and *ballok* were the more commonly referenced when I would ask questions such as, in my first month of research: "Do you know any *dais* in your *mithag/ loog* (village)?" or, "Do you know where Bibi *dai* Hasina lives?" or, "Can you tell me when Haim-Jan will return home today?" Except for a type of response from a state medical functionary, the usual responses to these questions would be something like this, "We have several *balloks* …" or, "Yes, *balo* Hasina, yes, she is a great *kawwās*…" or, "No, Bibi Haim-Jan went to the homes of three women in *chillag* [to do her postpartum care rounds]…yes she is a busy *dhinabhug*." The repetition of these three Balochi terms (*dhinabhug*, *kawwās*, and *ballok* beckoned me to call into question my own assumptions about the category of the *dai.* The three terms were spoken interchangeably. *Dhinabhug* and *kawwās* were the more commonly spoken terms. In brief, *dhinabhug* means the one who assists with delivery; *kawwās* means one who is an expert; *ballok* means grandmother, as is illustrated below.

Bibi-Zainab

The second month of my research in Panjgur began with a visit to Bibi-Zainab's home in a region about 40 minutes drive from where I took up residence in the district. We had met earlier at the basic health unit (BHU) of this region where she had come to give the LHV the *list* of births she had attended in the previous month, which would be recorded in the center's log-book and later tabulated by the LHV and sent quarterly to the district health office (DHO) for review. Subsequently this list would become official government data for the national "Women's Health Project". Bibi-Zainab spoke fast and with great excitement and pride about her work and described the many difficult cases she managed. Although she attended the first ever series of TBA trainings the year before, she said with a hand gesture, "they don't know". What and who don't know I wondered? Before I could ask, Bibi-Zainab said *"come to my house I will tell you about our family, and my ballok*" and off she went in a hurry.

Here we were two weeks later in her home. Her daughter had recently had a child, and was now in her 7th postpartum day. She had just finished making more *chillagi dewai* (postpartum herbs) for her twenty-year-old daughter; attending to an eight month pregnant woman who had come to see her from a town nearby; and was getting ready to leave shortly to make her postpartum care rounds in several homes, walking and taking with her the *chillagi dewai* for three women whose babies were now 3, 5, and 14 days old But before leaving she would be the generous host like so many families I would visit for the first and every time in the district, providing tea and biscuits always, dates, yogurt, and mangoes and other fruits, depending on the season and the economy of the

households; and insisting that we eat lunch when the timing of our conversation would oblige them to do so.

Today my research assistant and I were privileged with dates from the family's date field not far from the compound where we were sitting, and with fresh *sheer/lassi* (yogurt drink) possibly from the very sheep—as we waited for the human hosts—that insisted on greeting us personally and evading, outmaneuvering, and resisting the repeated "whoosh"-ing away by the kids in the room. Once the spirited Bibi-Zainab finished instructing her daughter to bring this and that and finally sat down with us, she told me that most of her cases come from the mountain villages or she travels to the homes of women unable to make the journey to her home. They are called the *koh* (mountain) people. About eleven such regions exist in Panjgur district, that are also areas designated to be part of "rural" union council. While the entire district of Panjgur is mountainous, the regions that are highly mountainous and rich with mineral deposits and wild plants include Katagiri, Pilkoor, Gar, Guargo, Parom, Pathandar, Negar, Homag, Sabsap, Pirumar, Gidar. Expert Panjguri *dhinabhugs* (those who attend to birth and postpartum) and *hakeems* (physician; healer) would often refer to one or several of these regions to mark out the accessibility of edible and medicinal plants unavailable elsewhere. "Rural" as a designation, in addition to signifying the centrality of care of livestock and large fields of crops, also indicates that these regions lack electricity and phone lines, and have irregular access to gas, in contrast to most of the regions closer to the district headquarter towns in which people living in the more mountainous regions referred to as *sher* (city).

Bibi-Zainab's grandmother was a *kawwās* (expert) midwife and herbalist, and her husband works on and fixes broken bones. Asking Bibi-Zainab and the group of women sitting with us in the room about the list of names selected for TBA training and that was provided to me by the district health officer (see below), I learned that in this region Hawa-Jan is not considered a *dhinabhug,* but Murad-Khatoon, Lal-Khatoon, Rahim-Bibi are. Rahim-Bibi's mother also was a *dhinabhug* and a *kawwās*. Yet, Rahim-Bibi did not learn *dhinabhugiri* (work of a *dhinabhug*) from her mother. She was not so interested in such work when her mother was alive. The necessity of learning this work to support the health care needs of women in her village community compelled her to later ask Bibi-Zainab, who is not a relative, to teach her the basics of attending to women in pregnancy, childbirth, and postpartum. Whereas Sharaf-Khatoon is a *kawwās* and had attended to births and women's other medical and reproductive needs well before the first ever private or government-based TBA training; Lal-Malek by contrast, began attending births for the first time after attending the government sponsored TBA training that began in 2004. In attending an official training program, Lal-Malek represented the minority among more than a 100 *dhinabhugs* I met in Panjgur. She was not called a *kawwās* and very few people referred to her as a *dhinabhug.* It was too soon in her new found identity as a "trained TBA" or *dai* for her to claim the identity of a *dhinabhug,* according to what makes a "real" *dhinabhug*—in the words of many Panjguri women and reputable *kawwāsi dhinabhugs.* (I will return to the question of the "real" *dhinabhug* later in this chapter). She was also too young to be called a *ballok.* Just in this one region of the district where I first ran into *kawwās* Bibi-Zainab, among about sixteen women on the so-called TBAs list, I met an unexpected number of women who would be referred to as

kawwās by women and *dhinabhugs* living in the same region of the district. On different and multiple occasions during my research year in Panjgur, among the six fairly well known *dhinabhugs* in one region, Bibi-Zainab and Bibi-Amina or Mullah Amina—as many women called her—were all marked as outstanding in their work by women, men, and other *dhinabhugs* living in and outside of their respective communities. Yet, Nazal, not one of the six, is also a *kawwās.* Her mother-in-law, Bibi Khatoon was a *kawwās,* as I would learn interviewing Nazal many months later.

I will return to the significance of the three Panjguri categories and their etymologies and meanings for the women of Panjgur. At this junction I want to look to the category of the *dai* and its link to another dominant category, the TBA (traditional birth attendant) in the Pakistani and transnational health development programs and policy discourses.

The Dai

The term *dai* has Sanskrit roots and broadly refers to "traditional midwives" in South Asia (India, Pakistan, Nepal, Sri Lanka, Bangladesh). In an Urdu to English dictionary it is defined as a nurse, a midwife (literally *dai-janai*), or a maidservant. A wet nurse is called a *dai-pilai*. Also, a stand that children run and play hide and seek is called *dai-asil*. *Dai* is also defined as a superior maidservant, or a lady's maid. Related words include, *daya* (compassion), *daaee* (giving), being *daik* (giver), being part of the *daira* (circle), being *dar* (wife), and influenced by *dard* (pain and mercury) the planet nearest to the sun. *Aya* is another related word that has Arabic roots and means the one who raises children.

The category *dai* arrived in Pangjur at a specific historical moment following the partition of India and Pakistan. I came to learn of this through the story of Ballo-Bibi, who died in 2002. The story is that before Ballo-Bibi moved to Panjgur there were no *dais*. Certainly it seems *dai* was an absent category and not part of Panjguri vocabulary prior to Ballo-Bibi's arrival in the district. The fact that she was the first woman to be hired as a *dai* by the provincial health department in Panjgur clearly established for me the link between the *dai* and state medical institutions. On rare occasions she was referred to as *lady* when I attempted to ascertain if indeed there was no government *dai* in Panjgur before Ballo-Bibi's arrival. The response was that there was another *lady* before her. Here they would be making reference to female practitioners such as LHV or LMO from Quetta and Karachi, who would have been assigned for a short period to work at the district headquarter hospital either. So, *"the Engriz sought Ballo-Bibi and assigned her to work in Panjgur"*, explained to me Shama, the granddaughter of Ballo-Bibi. *"Gulam Haider, (Shama's paternal uncle) was born in the hands of Engrizy female doctor in Quetta Hospital that was run by the Engriz."* The word is that although Ballo-Bibi did not use *Balcohi dewai*, she did use the injection; she did *"doctori dewai"* and accompanied male medical doctors whom she would instruct to give the injection following observation of the laboring women's cervical dilation status. Ballo-Bibi moved to Panjgur from Quetta when kids were young, and was attached to the civil hospital Chitkan with a government salary. Though Shama does not remember much about Ballo-Bibi, she remembered her being good with the patients. Ballo-Bibi's husband died in Panjgur and Shama's uncle went to Dubai for many years. They stayed in Panjgur because he was away and Ballo-Bibi was working in Panjgur. They then made Panjgur

their home. All of Ballo-Bibi's children married here. I will say more about Ballo-Bibi in the next chapter where I elaborate on the postcolonial state policy to continue the British colonial project of making government *dais* in India and how in that process the state *dai* is set a part from and at the same time erases the *mulki dhinabhugs* (country/local *dhinabhugs*).

The meaning of *dai* is multivalent, such that in Panjgur the term does not hold the equal value for allopathic practitioners and the women participating in *dhinabhugiri* and herbal practices. As I have suggested above in my discussion about Sharaf Khatoon and Lal Malek, unlike for the so-called *dai* or TBA in many other parts of Pakistan, such as in Punjab and Sindh provinces and the major cities including Karachi, Lahore, Peshawar, and Quetta, and the South Asian countries of Nepal, India, and Bangladesh, there is a short history, if any, of TBA trainings in the Balochistan province. In Panjgur district, these types of trainings were introduced in 2004 via the newly initiated national "Women's Health Project". In 2004-2005 when I was there as part of the efforts to reduce maternal mortality, a primary objective of the Women's Health Project, the District Health Officer and his team working on this project had a compiled a list of so called TBAs or potential birth attendants who might be trained into TTBAS (trained traditional birth attendants) by the district health department. The production of such a list and these proposed trainings were the first ever in Panjgur. Only two rounds of TBA trainings had taken place in that district, and that only in half of the regions of the *entire* district. Among these, at least two entire Union Councils had had no trainings whatsoever.

Women in Panjgur want to give birth at home, and they rely on *dhinabhug* or *kawwās* who is usually not formally connected to a health facility. Thus, now as a result

of the funding from the Women's Health Project, the two most common strategies to link the so-called TBA with the government infrastructure include training them and requiring them to register the births they attend at a woman's home in a designated health care facility. This is the means by which a list of TBAs or *dais* can be produced. While the list I received was a useful reference, it was clear to me from the onset, based my previous work in Pakistan, that the production of such a list is a political process. As in other contexts, in Panjgur the question of who really is a *dai* and/or a TBA, or more significantly, who can and cannot be trained is complex, and takes on a distinct political flavor the moment an external body enters that context and decides to provide monetary remuneration to women for attending such trainings. The issues and debates on monetary compensations of community health workers are well documented in the international health literature and link to debates about volunteerism and community participation in the development aid literature. The production of a list is often the first step toward a surveillance measure. The list is made to recruit potential trainees, following which their work can be tracked. In Panjgur the focus is on tracking the birth attended by the "trained TBA". She is given an account book and a literate family member is asked to keep the records. She is to submit the record-book once a month to the LHV at the designated BHU or MCH center. Thus, this is one means whereby allopathic/biomedical practitioners as government workers are sanctioned figures of state authority. They have the "signature of the state" (Das 2004) to monitor, ignore, or reprimand the so-called TBA. In Panjgur the *dhinbhugs* and *kawwās* demonstrated their agency and resisted efforts by the medical establishment to frame the content of their work in distinctive ways, as the examples of Bibi-Zainab, Bibi-Begum, and Naz-Bibi will illustrate.

Defining Dhinabhug, Kawwās, and Ballok

In Panjgur the term *dai* was interchangeably used with the term TBA only among the LHVs, LMOs and male medical doctors. LHWs had learned to say *dai*, but also could be heard saying *ballok* and on rare occasions would say *dhinabhug*. Usually, a *dhinabhug* would be referred to with prefix *Bibi*, which is an honorific term that conveys the respectability of the person's social position. However, the reference to *dai* was marked predominately to characterize a government trained woman hired by the government and attached to a BHU, RHC, or the MCH center that was part of the gynecology and obstetric unit of the District Headquarter Hospital (DHQH). This government trained *dai* may or may not have been a *dhinabhug* prior to her government assignment. Many of the *kawwās* I interviewed emphasized that an inexperienced *dai* who "merely" cuts the cord is not someone who is qualified to be called a *dhinabhug*. While a *dhinabhug* performs and knows much more than a "cord cutter", a *kawwās* marks out the expert among a range of qualified *dhinabhugs.* The *kawwās* I met were generally the expert herbalists. There was some disagreement as to whether a *kawwās* refers to female expert herbalists only, or whether a male healer can also be called a *kawwās*. One person suggested that men can also be called *kawwās*, but generally men possessing certain healing and herbal expertise were referred to as *tabib*, sometimes *hakeem*, and usually by the specific type of expertise they possessed such as *dastbanduk/dast-o-band* (bonesetter) or *daghu* (one who cauterizes).[65] Among an array of Balochi healing techniques, the latter two healing techniques were also those in which Panguri women specialized. Moreover, usually women and not men with such expertise were marked *kawwās*.

Dhinabhug

Balochi language is part of the Iranian family of Indo-European languages that include Sanskrit, Balochi, Pushto, and Farsi. Arabic has also influenced the Balochi language. Indo-Iranian means that these languages have Indic roots. *Dhinabhug* is a Balochi word that means to help with delivery. If we break apart the word, *bhug* is a verb that means to loosen, or to soften. *Bhug* also refers to joints (*lankookani, hadani proosh ja*—literally the location of the body that can bend or break). *Bhug* also means the English inch. Related terms include *janbhugh* where *jan* can refer to the body, but also specifically to the uterus when spoken by women in the context of birth and reproductive ailments. *Dhina* is a woman who deals with women's body parts. Even women who are close relatives are not supposed to see each other's private body parts. *Dhin* is an Arabic term means faith in the religious sense. In Balochi, the literal translation of *broth* is brother but *dhinnay broth* translates into a woman's friend rather than her biological brother, or brother in the religious sense, akin to a God brother and having a non-sexual sacred relationship with the woman. This points to the potential closeness constituted in the relationship between women and *dhinabhugs.* It is this social position that a *dhinabhug* occupies that makes it possible for her to acquire information about intimate aspects of women's bodies and life situation. If she does not have the skills, she cannot be respected, if she cannot be respected, she cannot be entrusted with one's body (or the body of one's daughter, grand-daughter, daughter-in-law, niece): if she cannot be entrusted then she cannot be called a *dhinabhug.* The position of the *dhinabhug* demands a certain ethical mode of relating to women and to one's practice. She is like a saint in

one sense, a person helping a woman with the intimate and most private of bodily matters. If you will, she is a helper, healer, and server for the temple and care of the body.

Kawwās

Kawwaas or *kawwās* is a noun and refers to someone who is an expert, knowledgeable, and skillful. Related expressions include *rahani kawwās* (the one who knows the way); *karani kawwās* (a specialist of things); and *mulkani kawwās* (the one who knows the country or the land). When I asked women to tell me what makes a *kawwās* they would say that she is *zanugar* (knowledgeable) and *a zanth karin mardum* (a person who knows the way). *Kawwās* is a longstanding Balochified word that may have been barrowed from an old Arabic word *kays*, that has the root word *kiyāsah(t)*, which refers to a person characterized by smartness, intelligence, or cleverness. *Kayyis* is the adjective Arabic form meaning smart, intelligent, sagacious, wise, or adroit. In Panjgur *kawwās* was a designation that female herbalists and healers acquired not as a self-designation, but rather by way of building a reputation about their work with herbs; through the depth and breadth of their skill and knowledge; the specialization in one or more specific techniques; and on the successes of their medical interventions. During my research, not once did I hear a *dhinabhug* self-indentify as a *kawwās.* So it was usually someone else, another woman, man, or *dhinabhug, ballok*, and/or *kawwās* who might refer to such a person, with respect and admiration as a *kawwās*. So, in short, a *kawwās* is an expert, a highly respected person; someone considered possessing special knowledge associated with the care of the bodies of women, children, and sometimes men.

Ballok

Ballok is a Balochi term that means grandmother. It is a respectable term that in addition to marking one's own grandmother refers to other older female relatives, or a female person not of one's kin. The lay Balochi word for old is *pir* and the expression *pir o murshid* in which *murshid* is derived from *irshad* means guidance from a sage. Any living or sentient being can become *pir* (old and wise)*, such as a* tree or a plant. A plant that camels enjoy very much is referred to as a *pir*. Grandfather is called a *pirruk*, the wise is called a *pir* (ziarat), and *pir* in Farsi means guide or saint. Murshid in Arabic is a spiritual guide. Thus, older people are ideally considered to be sage like and wise.

The usage *ballok* in reference to some *dhinabhugs* evoked for me the notion of a "granny midwife". Valerie Lee (1996) in her book, "Granny midwives and black women writing" discusses the multiple ways in which society has constructed the black midwife, beginning with her very name "granny", which in itself is a contested term.[66] Lay midwives, indigenous midwives, and folk or common midwives are alternative names for the granny.[67] Almost exclusively associated with black women's lay midwifery practices and experiences, and rooted in the notion that most midwives are older, the granny has been both a burdensome label as well as a handy nomenclature. Lee explains that granny is a label that never let women forget that they were black lay midwives. In *Ballok,* the granny equivalent is *ballo***,** and usually iterated to mark out an older *dhinabhugs.* With respect it was sometimes deployed to refer to an older *kawwāsi dhinabhug*. Whereas *grannies* is a grouping by vocation, (the women who delivered the slave population were sometimes called *cotton dollies*, in contrast to the *plantation mammies* who delivered the plantation owner's women and raised their children), in Panjgur an older woman is

sometimes called a *ballok* out of respect and also because of her vocation as a *dhinabhug*. Thus, not all *balloks* attend childbirth or engage in herbalism. But as a consequence of their age, *balloks* have life and lived experiences that set them apart from younger women. They may be perceived to have sage like qualities. They may have certain knowledge about plants and herbs by virtue of being around and taking care of many female and male members of the family, working in the field taking care of animals and feeding the family. A *ballok* can also be a keen navigator and guide on mountainous and open terrain by virtue of living a semi-nomadic life in which groups of women and children walking long distances from one distant village to another is not uncommon. Whereas "granny" is term that, like "black" went from disfavor as an externally imposed term to favorable reclamation by the community itself, the category of *ballok* never undertook such a journey. Lee explains that after the U.S. Civil War the "mammies" usually remained on the plantation to care for the owner's children, whereas the "granny midwives" or "cotton dollies" assumed the role of itinerant midwife for local African American communities. It is the latter group that eventually came under the supervision of the state health department (Lee 1996:57). Unlike the granny midwife or the *dai,* neither the *balloks, dhinabhugs, nor the kawwās* have been interpellated as a category into the Pakistani medical state and health development discourses. In Panjgur, these three categories of women certainly did not feel compelled to identify themselves as a *dai* when I searched throughout the district for what now is clearly the imagined *dai* of my original research proposal.

…Not a dai, not a TBA, not the "skilled midwife" to be, but not a not either

Bibi-Zainab whom I introduced earlier, is one of many Panjguri midwives whose life and work speaks to the terrain of contested categories. One day I went to Katagiri, about three hours drive from the center and Bibi-Zainab's town. By then this was the most distant place I had been from my temporary home in Panjgur. In our second visit there we went directly to the basic health unit (BHU). Rabia, in her thirties, local to Katagiri, and the government hired/trained TBA/*aya* assigned to the BHU was waiting there for us, along with a woman and her daughter. Rabia was called interchangeably a TBA, a *dai*, or an *aya*, even though she did not attend births or prepare herbs. Through family connections, somehow she had managed to participate in the TBA training in 2004. During the year I was in Panjgur there was no medical officer assigned to this BHU and her government position at the BHU meant that she had the key to the building and would dispense basic biomedicines stored there in the absence of the compounder. Thus, she had some degree of control and authority, so much so that in my group conversations with the local *dhinabhugs,* she would sometimes interject by way of telling a *dhinabhug* how to understand my questions and what to answer. Needless to say, the more outspoken of the *dhinabhugs* would remind her with statements such as, "*what do you know, you don't attend births, you are not a dhinabhug."*

At the front patio of the BHU, a mother (Hawa) and her daughter were waiting to see the compounder, who never showed up during the four hours we were there. While Rabia left to inform, in her words, the *dais*, about our arrival, I had a brief conversation about *dhinabhugs* and *Balochi dewai* with Hawa, who had brought her three-year-old daughter to get treated for *dil-lap* (diarrhea). She said that Sapoora is more *kawwās* than

Khadija, but that both are *kawwās*. I learned that Nabi Basgh, Hawa's great uncle, gives *dagh* and that he is also a *dast-banduk* (bone-setter). He is Hawa's mother's *naku* (uncle). Khadija, the *kawwās* also gives *dagh.* Later, Jan Bibi and Khatoon came by, two of the oldest *dhinabhug's* I had met by then. They were both very thin, so it was difficult for me to accurately gauge their age, but they both looked to be in their late eighties or nineties. Although Khatija was in her mid-forties, no one really keeps track of age. Later when I did the life history interviews with them, my guess of 80 to 90 years was about right. That day I ended up doing a group interview of five of the *dhinabhugs* living in the Katagiri region. Among them, I had already met two women (Khatija and Fatima) in my earlier visit to Katagiri when I had separate and long conversations with both of them. Fatima's mother, who I had interviewed with Fatima, is a well known *dhinabhug* and *kawwās.* Her mother is practicing in another village in Katagiri region, so could not attend the focus group discussion. The daughter continues to learn from the mother. I will say more about the Katagiri *dhinabhugs* and *kawwās* in the next two chapters.

Bibi-Begum

About twelve weeks after I met Bibi-Zainab and having already met the Katagiri women, I found myself in a very different region—no mud houses, no electricity and no schools—called *kohsabz* (green mountain), located on the edge of northwest Panjgur, bordering Iran. There I met four *dhinabhugs* in several different villages in the area. Instead of mud houses, there were *gidam*[68] (tent) like structures constructed out of dried date palm leaves, the infrastructure of which was formed and held up by logs of various lengths and circumferences. The roof and walls of the house are constructed with panels

of mats that are woven with dried date palm leaves. Women and men are both involved in construction of the house. Bibi Begum, an expert herbalist and a *kawwāsi dhinabhug*, was born there, and after initial meetings took me to her current residence located nearer to the central town, about three hours drive on unpaved roads from *kohsabz*. The women of *kohsabz* continue to refer cases to Begum if they seem too complicated to handle by the less experienced *dhinabhugs* living in the area. Over the years, Begum has insisted that her daughter, who still lives in *kohsab,* learn and thus taught her the "necessary skills" of attending to pregnant women and their childbirth, including the preparation and use of the herbs to help women to recover after childbirth. She told her daughter to get over her fear because the people need her. *"There must be someone here who knows how to manage childbirth and support the women during pregnancy and after the childbirth"*, she explained to me while her daughter was standing with us as we prepared to drive toward the mountains nearby to gather plants and herbs that Begum wanted to take back with her to her current residence, where she has a bustling practice attending kin and non-kin women. So busy is her practice that the second time I met her around 11a.m., she had just returned from a long night of attending a birth and was preparing to leave to carry out her postpartum care rounds in five separate households the very next morning.

So, by this path, Begum's daughter Murad Bibi is on her way to becoming a *dhinabhug*. Though not yet someone who can be called a *kawwās, s*he may have the potential to become as committed and devoted to the care of women as her mother. She is young—twenty-five years old—and attended five cases of childbirth the previous year; a number that is certainly many more in a year attended by LHVs and the new so-called skilled midwives I had interviewed in Panjgur, Karachi, and Quetta. Significantly, Murad

Bibi has never attended any of the recent government sponsored TBA training sessions (not that she has been asked) that aims to impart a sense of urgency in the TBA to the care of women in childbirth. Bibi-Begum's kin live in scattered and distant villages in *kohsabz.* They have taken residence near several different natural water sources or springs in the valley. Thus, it would be easier for them to journey to Murad-Bibi's village or for Murad-Bibi to go to their villages than to wait around until the next pick-up to drive by in order to hitch a ride to Begum's place, or to the *lady* in the *sher* (city of Chitkan), or for Begum to hitch a pick-up ride to come to them, or until that elusive government sponsored TBA training comes to them, purportedly, to change the situation of the lack of health care providers.

Bibi-Begum's daughter is unique in some respects. While in Panjgur the heriditary *dhinabhugs kawwās* are not rare, the newest generations of daughters ranging in age from twenty to thirty years and the granddaughters or grandnieces are not readily taking up *dhinabhugiri* work. Some of the reasons for the latter trend include that they are put off by the smell of the herbal formulas; or that they are still busy having children and thus managing other pressing responsibilities; or perhaps it has more to do with the increasing reliance on the ways of the *ladies of allopathy*. Yet, there are definite exceptions to this trend. During some of my home visits I would ask the daughters and daughters-in-law of a *dhinabhug* and *kawwās* if they were interested in learning *dhinabhugiri.* Many of them said they were and would do so once they completed having their children and the children are grown a little. I also found situations in which the largely extended family context of shared living and the day to day encounters of multiple generations in one compound continue to influence and inspire some of the

younger women to learn about herbs and childbirth. These were the sorts of familiar contexts that provided the conditions of possibility for hands-on learning, including through rich and rewarding inter-generational interactions. This type of influence could form as the result of a daughter or granddaughter regularly and frequently assisting an older female family member, who would, in turn instruct a younger assistant to prepare and cook the herbs. Others gained the interest in their mother, grandmother, or great-aunt's work and fame as *kawwāsi dhinabhugs*; a fame that was made possible by the circulation of discourses about them and women's experiences with them.

For example, Guljan from Doznab referred to Bibi-Hawa who was so famous that she was known all over Panjgur. "We called her Bibi-Hawa and *Mullah*-Hawa. She was a *Mullah* (religious teacher) and she was a *dhinabhug*." Bibi-Hawa is Guljan's grandmother, but she spoke of her as if she was the grand-woman of Panjguri childbearing women. Bibi-Hawa's fame was marked by her willingness to attend to women confronted with difficult childbirths. For example, she was known to successfully handle many cases of childbirth in which the position of the fetus was transverse. She would take on and attend to women when no one else would, neither a *dai*, nor a *lady.* Or, in case of a delay in the delivery of the placenta, the attending *dhinabhug* might call her for assistance. Thus, family members witnessed and heard about the successes of the work of their relatives and other *dhinabhug* or *kawwāsi dhinabhug.* In this way, family members could make their own judgments about necessity (as in the situation of Bibi-Begum's village, discussed above) as well as the kinds of rewards (not measured by cash) that this work would provide a person, such as the reward of having done something

positive and fulfilling a responsibility of one's gift from "Allah". Naz-Bibi, introduced in the section next, is one such role model for the women of Panjgur, both young and old.

Naz-Bibi, the specialist of skin and tissue dis-eases

I went to meet *kawwāsi dhinabhug* Naz-Bibi at her home in a region of Panjgur entirely different from where Bibi-Begum and Bibi-Zainab live. After taking off our shoes, as my assistant Sher-Bano and I entered, what looked at first like a guest room, turned out to be the clinic, that also served as the space for the neatly folded piles of bright colors of mostly reds, brown, and green beddings. Five women and three kids were all sitting on the ground covered by the *chittai* (woven mat made of date palm leaves). Naz-Bibi was also sitting and faced close to a woman whom she was attending, advising her about how to apply the herbal formula she was handing to her and that she had just prepared over the two unit gas stove positioned behind her. The woman, accompanied by another female relative, had walked for two hours from another town (the same town that Bibi-Zainab lives) to see Naz-Bibi. After handing over the herbs to the woman, Naz-Bibi walked into an attached wash and storage room made out of cement and partitioned by a 3x6 feet curtain to wash her hands. At that moment, I realized why she had been hesitant about shaking our hands earlier; she had just finished examining the woman's *zaghm and danag* (wound/sore/growth) located around the woman's pelvis and had followed this by giving the woman some of the cooked herbs prepared specially for this woman's wound/growth. She told the woman to apply the herbs on the affected area for the next two days in the mornings two to three times a day and to return in two days so she could do an "operation" to cut out the sore. The woman left with her other female relative.

I stood up as Naz-Bibi walked back toward me from the washroom, and this time we shook hands and did the proper *hal-awal* (greetings). We then sat down facing each other. I gestured to explain the purpose of my visit, yet before I could properly explain, she was ready to talk with me right then and there. I had intended to arrange a time for a longer discussion the next day, for it was 12:30 in the afternoon when we had first reached Naz-Bibi's home. I was conscious of the fact that lunch is typically eaten around 1-1:30 p.m. in Panjgur, and that most of the women would be busy preparing for it for the extended family living in the same walled compound (approximately 4000 square and 12 feet high). But it became clear that Naz-Bibi, in her fifties, is a grandmother and there were enough younger women around to take care of such daily work.

All this time there was another woman in the room waiting to be seen by Naz-Bibi and who was accompanied by two of her female relatives. I said to Naz-Bibi that I could wait and speak with her once she was done examining the woman. The middle finger of her left hand, which had likely labored over the care of children, domestic chores, and on the fields to gather wood, water, and the harvest, was evidently swollen and filled with pus. She was in a lot of pain. She had already put some sort of greasy remedy on the sore. It turns out to have been *roghan* (*ghee*; clarified butter). Naz-Bibi softly stated, as she held up the woman's hand, eyeing and touching her middle finger, *"This is what everyone does, everyone thinks that oiling it like this will help because it helps calm the pain at first."* She did not think that the application of the *roghan, e*specially on open sores, was such a good practice, since it seals the sore, rather than help drain the pus out. Naz-Bibi proceeded to clean the finger and the rest of the hand with *dettol* (disinfectant) mixed with water. She followed this step on the same areas of the

hand with a little hydrogen peroxide, at the same time showing me one of the bottles. While wiping the woman's finger, she consoled her observable but quietly expressed physical pain. Looking at her face, one could not miss this fact of the pain. To the woman, Naz-Bibi said in a gentle but firm voice, *"you should have come sooner."* Naz-Bibi turned her back to the woman and faced the stove to cook the pre-mixed and ground powder herbal formula called *Barz* for the woman to take home. *Barz* is cooked in water. Naz-Bibi made a point of emphasizing that it is not cooked in oil, because she explained, *Barz* includes the *daru G.G*. that is already oily. She went on to describe a formula for sores, boils, and other types of skin eruptions, including some that she said were the "cancerous" type. I soon realized that I'd met a *dhinabhug* who is also a *kawwās,* possessing an expertise in treating *danags* (skin wounds and internal growths)*:* An expert whose name would be uttered in other regions/villages of the district as far away as 3, 8, or 12 hours of drive away from her home.

How can an "illiterate", "untrained" "traditional birth attendant" claim to be treating "cancer", you the reader, the *lady*, allopathic doctor, or Pakistani public health official might ask? She must be a quack you might exclaim! Shouldn't she be disciplined (i.e. trained) to not do what she is doing, or not to claim that she is treating cancer?[69] What makes it possible for her to make such claims anyway? What is interesting about Naz-Bibi is that, although she was presented with several opportunities to attend recently introduced government-sponsored training programs; she refused to do so. She had no need to boast about her knowledge and skills to me, for they were in one important respect illustrated by the almost daily flows of groups of women who came to seek her advise, treatment, and herbal formulas from distant locations within and outside of the

districts. She had patient visitors from Karachi who had learned about her special area of knowledge. Unlike Bibi-Zainab, Naz-Bibi had a more reserved personality, a serenity with her work and perhaps at some level surrendered to the forces of allopathic/biomedicine to which women of Panjgur and their bodies were increasingly exposed. She did not make grand statements about her achievements. In some sense she did not need to, for women across the district were doing that work. For example, women and *dhinabhugs* in Katagiri, an area of the district many miles from Naz-Bibi's hometown, told me that though they have several *kawwāsi dhinabhugs* in the area, no one knows how to treat skin related problems the way Naz-Bibi can. *"We go to her if we have problem with our zagdan* (uterus)*"*, one woman told me. Her healing successes did not require advertisement on the web, an infomercial, or a seminar. Naz-Bibi had also built a reputation for successfully treating uterine related pain and sores, something that Naz-Bibi did not discuss with me until I insisted in one of my multiple interviews with her.

In contrast, though Bibi-Zainab attended the TBA training, she did not refer to the training even once to me in order to help validate her capability as a *dhinabhug*. Rather, her reputation as a *kawwās* had already been established. Moreover, she was in fact, among several of the more than hundred Panjguri *dhinabhugs* that I met who presented a clear contrast to the stereotypically constructed low-caste, poor South Asian *dais*.[70] She belongs to a relatively wealthy land owning family. The day I went to her home, I was privileged to tour her ancestral land that cultivated dates and grains, including barley, and herbs and vegetables. It had become quickly clear to me that Bibi-Zainab, at least, did not require the income from her *dhinabhugiri* work. The robust energy with which she spoke about her cases and went about her postpartum care rounds reflected a certain passion for

the work. Though she lives in one of the more densely populated areas of Panjgur she told me that she looked forward to walking freely and often alone to women's homes. And indeed it seemed that this work offers a certain level of social legitimacy as a woman in public and freedom to move around alone. This was an attractive aspect of the work that was echoed by the many of the *kawwās* with whom I spoke. The fact a wealthy, land-owning forty-years-old woman that had no need to earn an income was a *dhinabhug;* spoke greatly to the sense of social responsibility, value, and status associated with this type of work. She defied the stereotypes about age and economic status of *dais*/TBAs.

In yet another example countering the hegemonic discourse about the so-called TBA was the fact of the female *"Mullah"* or *"tabib"*, such as Bibi-Amina as a *kawwās* working simultaneously in the realm of childbirth and death. Bibi-Amina was known for her knowledge of herbs and the Qur'an and would be called upon to wash the bodies of deceased females; thus presenting us further evidence of the respect granted to expert women working with birth, blood, placenta, and post-parturient (mother and child) bodies. The care of the living and dead female bodies are both considered respectable work and can be performed by the same woman. The communal reception of seemingly such contradictory labor by the same *dhinabhug* and the work of attending to childbirth by middle class women in Panjgur troubles the deep ideological dichotomy of purity and pollution; a construct that according to anthropological studies of childbirth in South Asia, functions to determine the "polluting" status of childbirth and thus defames the activities of, social location and status of the birth attendant: that is, the *dai*.

In Panjgur, for many of the *kawwās,* the social status and responsibility of attending birth and caring for woman's ailing bodies was equivalent to washing and

preparing a woman's dead body for burial: a social duty indistinct from a religious one. Though Bibi-Zainab was in her forties, Bibi-Begum in her sixties was no less energetic about her work and postpartum care rounds. When I accompanied her she walked briskly and with certain urgency so that before 1 p.m. she would complete her visits of five cases. However, during the visit there was no visible sign of this urgency, as she examined the women, asked them questions about mother and child's condition, massaged the mother, and perhaps if necessary gave the women more *chillagi* herbs. Herbalism constituted a central aspect of Bibi-Zainab, Bibi-Begum, and Naz-Bibi's midwifery work, marking them as expert healers or *kawwās*. However, as suggested in my earlier discussion, Naz-Bibi's expertise functioned beyond the care of the female body exclusively influenced by the exigency of childbirth.

What dhinabhugs know and won't say to the lady

Naz-Bibi was not too interested in talking about *dhinabhugiri.* She was much more animated about her herbal work with *danags*. She had learned to treat skin ailments and internal growths from her mother, known to have been a famous *kawwās* and known especially for treating all kinds of sores, wounds, lumps, and other types of growths and skin relate eruptions such as *bawasir* (hemorrhoids) and injuries like the women that Naz-Bibi treated during my first visit. Naz-Bibi also practices *kobag* (cupping) and giving *dagh* (cauterization technique with a hot metal).

A number of times I asked Naz-Bibi if she knew about *chillagi,* a common formula I learned about two months into my research. This was usually given to women a day or so after childbirth and repeated for a varying number of days in postpartum,

depending on the need and mood of the laboring women, the expertise of the childbirth attendant, and contingent upon the availability of the herbs that are included in the formula, that at times has as many as twenty different ingredients. Naz-Bibi told, each of at least three times I asked, that she was against the use of the *chillagi*, stating: *Chillagi mann nakana* (I don't do *Chillagi*). Though she knew the formula well, she claimed in our first a few meetings that she longer used the formula. "They told us not to use *Balochi dewai"*, was her refrain.

> NB: *"I don't do chillagi, they told us not to."*
> FT: "Did your mother use *chillagi dewai*?"
> NB: *"No, they said it is harmful for the woman."* [Later it became clear that her mother did use *chillagi*]
> FT: "Have you seen a woman get harmed or sick from the herbs?"
> NB: *"NO."*
> FT: "Then why not use it? According the other *dhinabhug*s in Panjgur I've met, women who use it seem to benefit from it."
> NB: *"They say, the lady doctors say not to. Why should we anyway, they (the women) don't give money. And then they [the women] will end up making a case against us. The lady told us in training not to do Balochi dewai."*
> FT: "What if someone ask for the *chillagi*?"
> NB: *"No. I will not do it."*

This exchange between Naz-Bibi and I points to one of the effects of the state sanctioned training programs and the circulation of discourse via the *lady* medical workers about the constructed illegitimacy of the work of the so-called TBA (i.e. Panjguri *dhinabhug*). Hunt (1999: 20) in her study of Zairian midwives in the "colonial lexicon", learned how one midwife, whom local people named with the French word *accoucheuse,* stopped practicing her craft because sometimes people were fined for giving birth outside of the dispensary. She explained to Hunt that this was a result of "state troubles" and that it was the dispensary nurse who had told her threateningly that

she should not assist women in childbirth anymore. Similarly, despite only two years of efforts to bring the Panjguri *dais* under the gaze of the biomedical state, in Panjgur, *dhinabhugs* feel the imposition of the *ladies'* weight of authority, even if it is indirectly through the childbearing women who come into contact with the *ladies-of- allopathy.*

Indeed, over the course of my conversations with Naz-Bibi it became clear to me that while she treated women's reproductive health problems surrounding pregnancy, childbirth, and postpartum with herbs like the application of *chillagi*, it did not comprise the bulk of her practice now and she refused to speak with me at first in any detail about this aspect of her work. She repeatedly emphasized that she referred all "serious" cases to a *lady* in Panjgur or directly to a tertiary hospital in Karachi, Quetta, Khuzdar, or Turbat). However, when I asked her about *hoshband* (postpartum care herbal formula and technique), she told me about it in great detail, naming the herbs, explaining the role of each herb in the formula, discussing the methods and techniques of application, and therapeutic goals of the formulas. She, moreover, demonstrated the cupping (sometime a necessary part of the *hoshband* technique of care) on the body of my research assistant and told me that if I wanted to observe her prepare the herbs I would need to provide her with the herbs and spend a day with her.

Naz-Bibi as the herbalist

When I asked Naz-Bibi about the herbs and how she might have obtained them, she told me that she would give me the names another day. While many of the herbs that Naz-Bibi uses regularly in her practice are available in the central town of Panjgur, she tends to send for these herbs in Karachi where her niece lives (sister's daughter) because there is a greater variety and it costs her less to purchase more. But as I would learn again

and again during my eight months in Panjgur, Naz-Bibi's choice to rely on her resources in Karachi represented a myriad ways in which herbalist *kawwās* have had to improvise in the making of formulas, due to the increasing unavailability of some of the Panjguri herbs that they could have more readily relied upon during the days prior to the drought, that at the time of my visit in 2004-2005, had been ongoing for at least seven years. Fewer people were gathering the "*khodrathi"* (natural) herbs for their own uses or to sell to the *pensar* (herb gatherer/seller; pharmacist); the land was not as abundant; and even animal parts included in some of the herbal formulas had become difficult to obtain without purchasing them from *pensari* shops located in the central town of Panjgur district and more often from shops located in Karachi. Some of these herbs would be among the collected from disparate regions of Panjgur district itself by ambitious collectors willing to search the heights and crevices of more mountainous regions and sell to shop owners as well as Pakistani companies herbal companies.[71]

Naz-Bibi's granddaughter, who could read and write 7th grade level Urdu, usually prepares a list of the herbs for each of the formulae. The list is then sent through the hands of a family member or friend traveling to Karachi for a variety of other reasons, usually on a bus, and a family member receives the list at the bus station in Karachi or goes to the home of the person bringing the list. The herbs are then brought back to Panjgur when family and friends return. Often the Baloch bus drivers, known in Panjgur and/or Karachi, take on the role of a mailman and the bus stations and stops often serve as points of giving, receiving, transferring goods and money across great distances. This method of movement and exchange of goods and objects prevails in lieu of the unreliable postal service in the greater part of Balochistan province and outside of the provincial

capital city, Quetta. So, Naz-Bibi obtains the herbs she needs in raw form. She grinds them into powder and makes formulae for the women. As I videoed Naz-Bibi's preparation and cooking of the herbs, she began to name the variety of *danags* (skin sores/boils).

Once the herbs were cooked and paste like, she took out a piece of clean cloth and smeared a spoonful of the paste of the cooked herbs on a torn piece of cloth that was kept among other pieces in a plastic bag, wrapped the cloth around the woman's wounded finger, then used a piece of gauze to tie and secure the cloth on the finger. She scooped a few spoons full of the cooled, cooked herbs in a torn out plastic and advised the woman to clean the finger and re-apply more of the herbs at night and the next morning. The woman asked if she should come back. She was told to come if she wanted to. *"Maybe you'll want more herbs."* Naz-Bibi emphasized later that this treatment is to drain the pus and water trapped in the wound. Once all this is drained the pain will lessen, and this is when the healing should begin. Naz-Bibi made a point of speaking about how the wrong use of herbs can cause *nokhs* (harm). While all this was taking place, I observed, as I did so often in scenes such as this, the exchanges of narratives between women, in which they recalled similar cases of sickness and injuries, what was done for it and what ultimately was the outcome. This time there was the story of the *liluk* (black bug) that had traveled into the skin of a man's left temple creating a *danag* (boil/skin eruption/rash). The man was treated with *balloki dewai* (grandma's medicine (sic), herbs) and the "operation"/*burrag* (cutting). The *liluk* (black bug) came out. More herbs were applied to the affected areas after the cut. The story is that he got better.

During the interview, Naz-Bibi decided to demonstrate to me how she cooks one of her most common herbal remedies: *Zahrin dewai*, a generic name that emphasizes the bitterness (*zharin*) of the mustard oil. In this formula an abundant amount of mustard oil is used. She warned me early on about the potent odor of these herbs during cooking. She insisted several times out of concern that I would not be able to handle the smell. I assured her that I would. About an hour into the interview, two women, mother and daughter from a distant town walked into the room to see Naz-Bibi,. The daughter Zubaida had a breast lump. She had already gone to Dr. Rubina for the same problem. (Dr Rubina is one of the now five lady medical doctors practicing in the district). She had diagnosed anemia and prescribed three different medications, including folic acid. Zubaida said that she did not have any improvement from the medication. Naz-Bibi proceeded to examine Zubaida's breast, and said that the lump, which was under the skin, had become *langard* (more manifest, unfolding like a gaping wound, a deepening of the lump). Naz-Bibi questioned why she had not come to see her right away, *"now it will take a lot more work; it would have been very easy to clear your danag (skin wound) had you come earlier."* Naz-Bibi whispered to me that this was "cancer". She told the woman to apply two herbs (PB and GG herbs) and come back to see her. The significance of PB and GG as central ingredient of herbal regimes of care returns again and again in the treatment of serious wounds. This was the first step to a series of herbal applications that Naz-Bibi carried out to help heal this woman's lump and internal wound.

Panjguri *Dhinabhugs'* Ethics of Caring for Women's Bodies: More than Birth Attendants

> If the outcomes of the application of reproductive technologies do not coincide rather closely with widely shared societal values, they may well be judged as

> disruptive to the moral order no matter how well packaged and promoted. (Lock 1995: 235)

Despite more than fifty years of state and private efforts in Pakistan to reduce local midwives into *dais* and TBAs, Panjguri *dhinabhugs* and *kawwāsi dhinabhug* thrive and irrespective of their social and economic status, and provide an eclectic range of health care services to women, children, and men. Beyond labor and delivery and prenatal and postpartum care, they provide massage for the newborn and the mother; handle childhood illnesses; and address women's infertility problems. They also advise on the use of herbal and allopathic-based contraceptive methods, support and assist women in performing abortions, and address gynecological and other female health related problems for which they recommend and prepare herbs. There are Panjguri *kawwās* who specialize in bone setting, others who specialize in treating childhood ailments, and yet others who diagnose skin diseases and internal boils, sores, eruptions, and tumors. Many of the *kawwās* treat injuries of boys and men, as well as those of girls and women. In villages near to and distant from the district's central town, women specialists provide *dagh*, which is a method of cauterization to destroy an infection or alleviate pain. In a Balochi-Farsy dictionary *dagh kanag* or *dagh dayag* means to cauterize. It seems to work like a tranquilizer. It is also applied to treat a *nasur* a term that refers to a cancerous boil or wound; or a *reesh* (wound) that turns infected. A group of doctors I interviewed in Parom, Panjgur told me that they thought of the method as somewhat analogous to radiation therapy. The technique could be deemed a form of thermo-cautery or electro-cautery and also resembles the technique of moxabustion that is common in Traditional Chinese Medicine. A variation of the method of *dagh* is called *trikole*.

Practically every *kawwāsi dhinabhug* I met knew about the *hoshband* technique, describing and demonstrating the procedure of herbal preparation. The method serves as an important, usually preventive, but sometimes curative technique for women who have had four or more pregnancies, and combines herbs and *kobag* (cupping) to reposition the uterus back in place by way of pressing and gathering up the uterine muscle. This treatment is applied in order to prevent a descended uterus and uterine tears, termed respectively in biomedicine a prolapse of the uterus and uterine rupture. Naz-Bibi and nearly every *kawwās* with whom I spoke discussed the *hoshband* technique and the misfortunes that some women encountered as a consequence of not having access to this technique of care. I read Panjguri *kawwās*' concern about the health of the uterus, their herbal practice, and techniques of care as an approach to the body shaped by conceptions and assumptions about healthy women's bodies, plant bodies, and disease and illness. Moreover, their locally specific knowledge and techniques of caring for women's bodies persist despite the more than fifty years of Pakistan state interferences and policies targeting *dais* to transform them as servants of the biomedical regime in the nation's women's health reform campaigns.

The *kawwāsi dhinabhugs* described the varying degrees of descent (prolapse) of the uterus and the difficulties women can experience when confronted with this situation. They described the techniques of managing a descended uterus and discussed with me the limits of what they could do, if and when a woman comes to them after the uterus has descended too far. In such situations they opined that not only had the woman waited too long to see them, but more importantly women could have prevented the uterine prolapse had they taken the *chillagi dewai* and obtained the proper postpartum care immediately

after the birth of the child and during the period of *chillag*. Thus, they were clear about when they would and would not intervene. This attitude characterizes many instances in which Panjguri *kawwās, dhinabhug,* and/or *balloks* reflected openly about their work. In reflecting about the herbs and their uses, many of them felt that they knew very little compared to their grandmother, great-aunt, or someone even farther back than the grand-women in their family lineage. While they may or may not have directly learned from them, in their memories the woven and re-woven oral histories that they reproduced for me, marked out a 'real' *kawwās* (expert), in whose fame and accomplishments survived a vision of healer that far surpassed what they perceived to be their own knowledge and skills. So one of them would say, *"My great grandmother was so much smarter, so much better. She knew so much more. She could handle so many difficult problems. So many people knew about her. I don't know about nearly as many herbs as what she knew about. How she made them! How she got her good results."* This comparative frame was not debilitating for them. Rather, in their self-imposed sense of duty and responsibility to offer their expertise, they nonetheless made judgments about the possibilities and limits of their skills and knowledge to care for the bodies of women and children, and how to manage the medical crises confronting women.

These were medical crisis that in many instances are a consequence of negligence and malpractice among lady health visitors and lady medical doctors in and outside of Panjgur district. Yet, in as much as they criticized, for example, the malpractice of injections use in and around childbirth among allopathic/state medical practitioners, they were also critical of opportunistic Panjguri women who proclaimed to be *balloks*, "trained" *dais* as result of TBA trainings or merely because state medical establishment

said so. They saw it as wrong for someone to claim to be a *dai* simply because they have *"cut one or a few umbilical cords."* The view among many of the *kawwās* as articulated by at least three exactly in this way was that, "*they are the ones who give us a bad name*" and there was such a thing as a *"true dhinabhug"* or a *"true dais"*. Such categorization works against the grain of the biomedicalization of women's bodies and reproductive health care that, in the eyes of many Panjguri women and *kawwās* in particular, is associated with "new" problems, including an excess of hysterectomies linked to the increased use of pharmaceutical injections in labor and postpartum through routine injections of pharmaceutical drugs. Therefore in the following chapter, I consider how shifts in the medical care of women's bodies are related to Pakistan's public health strategies to reduce maternal mortality.

CHAPTER FOUR
CONTESTED BODIES I: What Kinds of Bodies are Presumed in the Discourse of the Reproduction and Production?

INTRODUCTION

> There is a dialectic between biology and culture in which both are contingent. (Lock 1993: xxi)
>
> "Misoprostal is a promising alternative for treatment of postpartum hemorrhage in low resource setting." [72]

Feminists and medical anthropologists have long argued that the centrality of obstetric technologies has specific consequences for women and how their children are born. Whereas high rates of cesarean sections, episiotomies, sonography, and labor inducing drugs are, now, largely normal parts of a majority of women's experiences of pregnancy and labor in the US, in Panjgur, these are techno-medical interventions on women's bodies that are contested in myriad of ways. Modern biomedical obstetric technologies are neither normal, nor actively sought out by women in Panjgur: however that is not to say that they lack influence, disrupting women's bodies and everyday life. State-based and state-sanctioned medical policies focused on the management of women's obstetric care and reproductive bodies, invariably, have had to deal with the trans-locally constituted figure of the "midwife". In Pakistan, efforts to interpellate women and the pre-figured "traditional" midwives, in order to bring them under the ambit of the biomedical state and public health establishment, is not new. The quest by the state apparatus to reach, control, manage, and protect women's bodies, their reproductive capacity, and lives was fully in place in India toward the end of the 19th century British colonial rule. This is a point to which I will return in this chapter.

Medicalization is a contemporary theme in medical anthropology. It is a process of turning physical and psychological complaints, symptoms, and disturbances into a disease-entity. Medical anthropologists have reflected on how physical and psychological complaints are funneled in the medical system, and the causes of the complaints located exclusively in the biological, leaving out the social-cultural context and influences on the complaints. Locating the source of the complaint within biological and physiological processes as understood by biomedicine requires a particular universalizing and bioscientific construction and understandings of the body that is in effect distinct from other medical conceptions of bodies, such as found in Traditional Chinese Medical, Āyurvedic, or Tibetan philosophical/ methods of care.[73] For example, through the concept of *local biologies*, Margaret Lock interrogates the taken-for-granted universal body in biomedicine in her work of conceptions of menopause in Japan and North America. Here the concept of local biology not only conceives the body as one that is experienced differently in diverse contexts as in Japan and North America, but also conceives the physical body as one that is formed and re-formed due to the interplay of shifting socio-environmental and historical contexts with that of the physical body. As such, the reformed body may also be a reformed biology that then would contest the universality of the biological body on which biomedical diagnostic and therapeutics approaches rely. Medicalization is one important consequence of the colonial and postcolonial transnational traffic of biomedicine. Thus, the medicalization of women's everyday life and bodily functions is a global process, where such things as hunger, and maternal mortality come to be viewed as primarily caused by biological disorders and treated with institutionally based biomedical interventions on individual bodies rather

than with attempts to transform the social structures that give rise to such problems (Scheper-Hughes and Lock 1987; Frank 1992; Friedson 1970).[74] I suggest that the medicalization of Pakistanti women's reproduction has transformed local midwives' practices and their relations with women, marginalizing "traditional" non-allopathic medical practices and increasing the reliance on Western scientific conceptions of the body and women's physiology.[75] The latter shift is evident in the rise of cesarean-section rates throughout the world, even while most births still occur outside of the hospitals (MacCormack 1989; Morsy 1995).

The medicalization of public policy objectives that are focused on the reduction of maternal mortality rates through safe motherhood and reproductive health programs ends up broadly erasing the role of global economic, social, and structural inequities in shaping the reproductive problems of Pakistani women. At a more specific level, however, I argue that the standardization of hysterectomies and routinization of "injections" around childbirth in Pakistan is a consequence of a particular framing of the causes of maternal mortality that prioritizes biological etiologies over other social and economic factors that contribute to maternal deaths.[76] This is also a frame that holds a reductive view of women as fertile reproductive beings. In this national reproductive health care policy frame, any concern for high hysterectomy rates is absent, despite transnational recognition that women experience morbidities in the Third World in epidemic proportions. In Panjgur the consequences of the trend toward the biomedicalization of childbirth was made evident to me in the increased use of pharmaceutical drugs around childbirth and in the rise of hysterectomy rates. Both of

these factors are influencing Panjguri women's health conditions in predictable ways, at least from the perspective of many of the Panjguri midwives.

Clarke and Olesen (1999) explain biomedicalization as the ongoing extension of biomedicine and technology into new and previously unmedicalized aspects of life.[77] Bio/medicalization can have different targets or local domains of action including the body, the population, policy, and the state. These different forms of medicalization often work together, but at times they may contradict each other and may even become failed attempts to biomedicalize.[78] There are historical examples of such failures. In *Colonizing the Body*, David Arnold (1993) discusses the assault on Indian bodies with Western medicine used by the British colonial medical establishment. He writes how the character of Indian responses to anti-plague measures marked Western medicine as alien and malevolent, even in the closing years of a century of growing state intervention and gradually increasing dissemination of Western medical and sanitary programs. As early as October 1896, the press protested over the segregation of plague suspects and voiced a general repugnance at the way in which hospitalization was being carried out. Native communities were against segregation. In November 1897 the Mahratta paper printed how the unpopularity of hospitals was a result of difficulties patients experienced in keeping in touch with their families. The opposition to state medicine was particularly strong among those Indians who saw in plague a form of divine retribution, a visitation against which medical and sanitary measures were neither useless nor impious, writes Arnold. "We will not go to hospital," declared a young Muslim in Bombay in December 1896. "Our Masjid is our hospital." (Arnold 1993: 213).While more than a century later, in 2005, the women in Panjgur do not proclaim the Masjid (Mosque) as the space for

their health care and healing (not that they ever did), but neither do they view the hospital as a locus of better healthcare.[79]

In this and the next chapter I address how routine injections of pharmaceutical drugs around childbirth and increased hysterectomies among women in Panjgur district are modern consequences of the bio-medicalization of women's bodies and reproductive health care. I consider how these shifts in the medical care of and technocratic interventions in women's bodies are related to Pakistan's public health strategies to reduce maternal mortality. I highlight how campaigns to reduce maternal mortality have universalized women's bodies and biomedicalized their lives: a bio-medicalization while not altogether successful, at times demands a racialized rationale for its techno-medical procedure. This has occurred despite and the minimal institutionalization of childbirth in Pakistan. This is what led me to consider how hysterectomies are an indirect result of biomedicalization and at the same time its failure, a point I elaborate in the next chapter. The *kawwās* in particular, though by no means alone, were among many Panjguri women who associated the "new" problems, including an excess of hysterectomies increasingly confronted by women's bodies, to the increased use of pharmaceutical injections in labor and postpartum. While I address the problem of hysterectomies in Chapter Five, in this chapter I focus on the politics of home births and pharmaceutical injections.

Births, Babies, and Bad Injections

Zar-Bibi attended the birth of Noorjan's second child and daughter. Noorjan had called for Zar-Bibi, asking her to come to see her. Due to the rains and lack of transport, Zar-Bibi was unable to carry out her usual postpartum visit the day before. These visits

are conducted for up to forty days after the woman delivers her child and such visits and care are usually carried out by the same *dhinabhug* having attended the childbirth. The visits are more or less daily for fourteen days; then after the twentieth day the visits are about five days apart. This is not a schedule strictly followed by every *dhinabhug* I met, nor is it care that every *kapthuk* or woman in *chillag* (postpartum) has the privilege of obtaining from a *kawwās*. Generally, however, when such care is given, the first fourteen days of postpartum are commonly observed. It is also expected that if a woman should need it, the *dhinabhug* may be called upon anytime during forty days postpartum. Even in cases of hospital or clinic deliveries in the hands of lady medical officer (LMO) or lady health visitor (LHV), women in Panjgur quickly return home the same day or night and call upon *dhinabhugs* or the *kawwās* for postpartum care.

When I accompanied Zar-Bibi it was Noorjan's sixth postpartum day. We headed to Noorjan's home once completing my first interview with Zar-Bibi. Zar-Bibi had not had access to transport and despite the fact that she had injured one of her legs, she was concerned about Noorjan and planning to walk to her home to check on her. She told me, "They should send me transport, today my leg is in too much pain to walk all those miles; they don't know that this is why I couldn't see her yesterday." So I offered to take her. Before leaving for Noorjan's place, we had tea and she described the herbal formulas she prepares for a variety of *janinani bemari* (female related health problems). I learned quickly that like many *dhinabhugs* I met in Panjgur, Zar-Bibi had a specialty. As a *kawwāsi dhinabhug,* she was considered an expert herbalist. While she also treated men with such problems as allergies, coughs, colds, and stomach related ailments, she was

sought specially for her experience treating common and not so common infant and childhood diseases.

When we arrived at Noorjan's place late afternoon, she was lying down on the left corner next to the wall parallel to the entrance. She was tucked away in a corner along with her baby who was in a typical Panjgoori cradle located above Noorjan's head. A huge colorful sheet, tied from one corner of the north wall to the other corner of the east wall, veiled the mother and child—north here is facing the door. This sheet is called a *killah* and it is behind this *killah* that mother and child must rest for forty days or less after childbirth. The *killah* has Arabic roots. The Arabic form is written *qiĺah* which means fort or fortress. It implies a protected space from any outside attack, inconvenience, or irritation. A *killah* in Panjgur is put up as an improvised protected space for women and child to rest and deflect away any *nizar* (evil eye, negative energy). A more decorative *killah*, made out of *karshani* fabric is put up for a bride during a wedding. She can sit and sleep comfortably behind this as the wedding can last up to seven days. A *killah* is also put up the day before the first day of wedding for the groom who is taken to the *koragan* (river ceremony) to take a bath. The forty-days postpartum is also a period during which family, friends, and neighbors visit once or more, to wish the mother and child well, sing songs and chants, and in their first visit leave a small gift of cash for the child and mother. The first days and nights are the busiest with visitors. The sixth night is called the *shashigan*, the ceremony of the sixth night, usually the biggest night celebrating the formation of the mother-child dyad. Women gather with the children who cannot be left behind home. Eating, chanting, singing, and smoking the *hookah* can go on as late as two, three in the morning.

Zar-Bibi explained to Noorjan why she could not stop by the previous day and that she was only able to come at all because of 'us'. Noorjan, lying on her left side said she had not been able to move out of the same position since four in the morning, and it hurt each time she tried to shift her body. After we did the formal greetings, Zar-Bibi moved closer to her, asked Noorjan how she was feeling, asked about the baby, and explained why I was there. Noorjan didn't seem to mind my presence and made eye contact with me. She was in too much pain to fully smile back. Zar-Bibi asked Noorjan if she could turn on to her stomach, which she couldn't. Could she shift onto her back? This she slowly maneuvered. Zar-Bibi massaged Noorjan's abdomen and the area surrounding it, focusing particularly on the lower part of the abdomen. She located Noorjan's pain—"yes that's it!" uttered Noorjan, as she sighed deeply. Zar-Bibi worked on that spot for sometime, gently and firmly kneading the area, pressing inward and outward on the skin. I asked Noorjan if she felt better, she said not much. She said she had been cursing Zar-Bibi earlier today for failing to come by to see her yesterday. She also said she had not felt this stiffness and this pain after her first child, who is now four years old. Her first childbirth was attended by a different *dhinabhug* named Pari. She mentioned Pari several times—who had given Noorjan pharmaceutical medications to induce her labour. Zar-Bibi became offended, and in a defensive, but calm tone said "maybe you should have called Pari if she was so helpful to you. I need not have come all this way. I've come despite my aching leg." She swung her arm up in a flash pronouncing, "I don't do *soochin* (injections)!" Noorjan replied in a faint voice: "If I wanted Pari why would I have called you?" After the massage Noorjan was able to shift positions easily. Zar-Bibi then remarked, "You should have let me do the massage the first day, this would not have

happened to you." Then she advised Noorjan to shift her body frequently in different positions to prevent further aches and pains, as she demonstrated with her own body how Noorjan should fold the knees up toward the stomach when lying on her side. Then, Zar-Bibi stated loudly to no one in particular, but for everyone to hear, "This is what happens when women lay down for hours in one position."

During Noorjan's first childbirth, the placenta had taken a "long" time to deliver and Pari had injected her three times to help push it out. The injection to induce the delivery of the placenta was given by a male "*compoder"* (compounder) upon Pari's instruction and presence. Noorjan's younger sister, who was sitting nearby, suddenly began to criticize Pari and all the *ladies* for using too many injections and using them too soon. She had worked as a lady health worker (LHW) for a brief period of one year and visited women in their homes about child immunization. LHWs are not permitted to give injections. She told me, referring to this experience, "Women if they give birth in the "hospital", the *lady* (referring to lady medical officers) always gives the *soochin*." After our chat about birth, babies, and bad injections, the recent floods in Balochistan and the tsunami in South and Southeast Asia, we left. On the way back in the pick-up truck Zar-Bibi said about Noorjan for everyone's ears, "She didn't want the massage on the first day, she didn't want the *Balochi dewai;* so what do you expect?"

In 2005, in Panjgur, despite the prevalence of pharmaceutical drugs, drug stores, allopathic practitioners, and clinics, many women and *dhinabhugs* I met opined that the work of *dhinabhugs* is superior to the work of the *lady* (allopathic practitioners).[80] While, alongside this, I also witnessed several women who requested the labor inducing drug injections to quickly get over the sheer pain of labor, many other women told me that

they had not asked for the labor inducing injections the first time they were given it. The first time I learned of this was when I accompanied Zar-Bibi in one of her regular postpartum visits, as narrated above. Over time I learned that despite the prevalence and routinization of injections of pharmaceutical drugs, largely given to women by state trained medical doctors and paramedics, many *kawwās* and *dhinabhugs* were critical of this trend. Moreover, some outright refused to use these drugs in their busy *dhinabhugiri* and *kawwāsi* work. Many Panjguri herbalists, *dhinabhugs* and childbearing women also saw a direct and problematic link between the increased uses of *soochin* and the hysterectomies with which some Panjguri women were ending up.

The biomedicalization of the "culture of home birth"

Feminists and anthropologists have shown how childbirth in the U.S. takes place in hospitals because a definition of childbirth as a medical event is powerful enough to determine its physical location for nearly every woman. In examining how childbirth is constructed, codified, and mobilized, Treichler (1990) shows how meanings within a culture hold considerable power to influence material conditions, including the location of birth. Yet, my ethnography of the Panjguri context illustrates that neither linguistic capital, nor policies to remove childbirth from the hands of the so-called traditional birth attendants has managed to push childbirth into the hospitals. Moreover, women need not enter the hospital before their bodies become biomedicalized, and they need not actively pursue reproductive technologies (simple or otherwise) for the cure of their myriad maladies in order to encounter and face the effects of biomedical technologies. In Panjgur, even though the presence of reproductive technologies is ubiquitous, its use by

the local Panjguri women is not hegemonic. In the previous chapter, I discussed how the 21st century skilled birth attendant (SBA) discourse is centered on delineating how to get the medical care technologies to women deemed necessary to prevent maternal mortality. The SBA or community midwife and the risk management role that she is to fulfill is a stop-gap measure to promote technical interventions- that from the standpoint of biomedicine should ideally and eventually be conducted in a hospital setting. Increasingly, this new cadre under creation has become the number one object of hope for addressing the problem of maternal mortality. The new faith in the so-called skilled midwives to reduce maternal mortality is (1) a direct result of the conclusion that training TBAs has had no impact on the two decades old global policy goal to reduce maternal mortality, and (2) that births do not take place in the hospitals and will not in the near future. The yet-to-be-made skilled midwives hold the promise of effective and timely management of obstetric complications that are deemed the direct causes of maternal deaths.

However, the focus on skilled midwives has overshadowed a pre-existing emphasis on the dissemination of prostaglandin drugs used during childbirth outside of hospital settings. The so-called *culture of home birth* (an oft quoted refrain that in recent Pakistani public health policy documents implicitly denigrates home births) has necessitated the resort to low-tech medical workers like the compounders and lady health visitors (LHV) situated all across the rural and dense urban areas of Pakistan. Despite official policy barring these two cadres of medical workers from administering these types of injections, the stratified socio-economic and medical context between the "West and the Rest" has forced states to implicitly rely on them to apply the revised policy for

preventing maternal mortality. This revision, that I argue is a form of *medical relativism,* is aimed at the so-called "resource poor countries" like Pakistan. Here, the injection of prostaglandin to avert and arrest postpartum hemorrhage is the transposition of medical triage that would typically unfold in a hospital setting. But just as medical interventions that may have been initially designed exclusively for emergency situations later become normalized procedures as a consequence of routinization (i.e. caesarean sections and a whole array of obstetric interventions), medicating with prostaglandin injections and pills has become a routine form of care. From a medical and public health policy point of view, such medications have become a necessary routine in so-called "low-resource settings" and in light of the persistence of home births and the high rates of maternal mortality. The persistence of home-births in Pakistan has forced policy makers to reconstitute biomedicine's relationship with both childbearing women and the function of the so-called real midwife, raising the question of who is authorized to provide which type of technologies, and when, to women at risk around childbirth. Misoprostol is one such "emerging" technology. While the safety and efficacy of misoprostol is debated, the drug is already being marketed and used in many countries, north and south.[81]

In the next sections, I present the politics of the *soochin* (needle/injection) as it creates new kinds of self-constraining subjects.

Politics of the *Soochin*:[82] (Needle or Injection)

> For delivery purposes the injection came with our LHV [lady health visitor], *dais*, and lady doctors. LHV started with training, they were trained with it. Unfortunately when *dais* got to know about it, they began to misuse it. They thought they were helping the patient. (59 year-old male medical doctor interviewed in Quetta)

> We can't say the *dais* always do the case wrong, main thing is they have to be aware of cleanliness and to avoid the injection." (Lady Health Visitor in Quetta assigned to work in the labor & gynecological unit of the provincial hospital)
>
> You go and get an injection for the pain, become a little better; then it is the back to the same stomach, that pain is the same pain. (Panjguri *dhinabhug*)

In Pakistan, the routinization[83] of the use of medical technology has become a national medical policy directly in response to the transnational health development, Safe Motherhood Campaigns and the persistence of home births. In Balochistan about 90 percent of all births are attended by local midwives outside of hospitals, despite the availability of well-equipped hospitals in some parts of the Province.[84] During my 2005 research year in Panjgur, only three women chose to give birth in the district hospital, which had been fully equipped and staffed the year before. Since 2001 a foreign-funded national Women's Health Project has prioritized the reduction of maternal mortality and this priority has firmly and primarily focused on developing emergency obstetric response systems in tertiary hospital settings to address the five leading risk factors associated with maternal deaths.[85] In Panjgur district, health officials hope that in due time all women will deliver their babies in hospitals: both those deemed risky as well as those that up to now were deemed normal births. However, prior to and during my research in 2005 there was no one fully qualified to perform caesarean sections at the district hospital. One lady medical officer was recently trained to perform caesarean sections in 2004, but the first and only attempt to conduct a caesarean section led to the death of the woman. The cause of her death is unclear, but no one explicitly blamed the doctor. Faulty equipment related to the transmission of anesthesia was referenced by several LHVs and LMOs working in the district.

Hameed, a male medical technician working in the gynecological ward and in charge of the upkeep of the patient registers, equipment, and medicines for the unit at the district headquarter hospital (DHQH), showed me that in the previous month sixteen women were admitted to the ward for cases of what many referred to as "abortion". Miscarriage is an outcome of pregnancies that women and *dhinabhugs* in Panjgur referred to as *ishkind*. They had more specific names depending on the month of pregnancy in which a miscarriage occurred. He had seen one woman admitted due to this just a few days prior to our conversation. According to *dhinabhugs* (mostly 40 years old or older) with whom I discussed this problem, not only are increasing numbers of women experiencing *ishkind* more than before, women are having more than one miscarriage in the history of their pregnancies. In contrast to the prevailing view held by LMOs and LHVs that miscarriages are caused by lifting heavy loads, Hameed associated, what seemed even to the district health officer (DHO), an unusually high number of "abortions", to the increased use of ultrasound and injections. Hameed unknowingly echoed the general perceptions of *dhinabhugs* in Panjgur who dismissed the heavy load theory, by pointing out that women have always lifted heavy loads and lived a much more physically demanding life as *khana badosh*[86] (nomads) herding sheep and camel, roaming the mountains, setting up and breaking down their homes as demanded by the seasons and the need for food and water. Now women are living in a liminal space that is neither completely nomadic nor sedentary, but rather, a space in which they could speak about the past and the present without looking back and journeying too far. The criticisms that the *kawwās* and women held about excessive and improper uses of pharmaceutical drugs and injections concomitantly encompass the local narratives about excesses of

reproductive morbidities confronting women, and why Panjguri women are weaker now. As my ethnographic research progressed it became clear that the narratives about the extant declining Balochi or nomadic life, including the rise in injections of pharmaceuticals around childbirth, are inseparable from the discourses about the forces of the *sher* or sedentary city ways.[87]

To be sure, the rise in the availability of pharmaceutical drugs was not deemed the exclusive cause of the excesses of Panjguri women's ill health. The *kawwās*, *dhinabhugs*, and older women linked this discourse of past versus present physical health conditions of women to the displacement and decline of Balochi herbal and non-herbal healing methods and the increasing absence of healers and knowledgeable herbalists living in reasonable distance from one's home. There were other specific articulations all across the district that were offered as explanations for the deteriorating bodies of Panjguri women and the chronic illnesses experienced by them. Some of these include the recent seven years drought and the subsequent loss of livestock and the declining access to vegetables and plants of the *koh* (mountains). Nonetheless, despite this context, where shifts in the natural environment have reduced the availability of local plants, which are also important ingredients of local herbal formulas, *dhinabhugs* like Zar-Bibi, spoke of women refusing the injection. Some of them went as far as to avoid visiting a *lady* because of the practitioners' "habit" of using the injection and because of accounts they heard about women who were harmed by the overuse of these injections. Many women also spoke of the damage to the uterus as a result of hormonal contraceptives, the *gooli* (contraceptive pill) and the other kinds of *soochins* (injections). These labor inducing, speeding, and uterine contracting drugs were more commonly prescribed and given to

women by allopathic/biomedical *lady* health care practitioners including lady medical officers (LMO) and lady health visitors (LHV). In Pakistan, the traditional birth attendant (TBA) or the *dai* is officially barred from giving such injections. But even if they could, many *dhinabhugs* spoke to me of their local herbs, plants, and herbal formulas to possess similar functions. Thus the view among many was why stop using something that is not only effective in treating the problem, but is also not harmful to the body in ways that the injections seem to be.

Among the five biological risk factors associated with maternal death, postpartum hemorrhage (PPH) is recognized as the leading direct cause of maternal deaths worldwide. Thus, preventing PPH should lead to significant reductions in maternal mortality. The transnational focus on this single biological/physiological cause of maternal deaths has led to the enactment of policies for the active management of the third stage of labor with uterine contraction drugs such as oxytocin, misoprostal, and or ergometrine. Governments and non-government institutions that are funded for safe-motherhood projects are asked to enact such a policy to enable health care providers to perform active management of the 3rd stage of labor (the period after childbirth and before the delivery of the placenta).[88]

The labor room at the Panjgur district head quarter hospital is stored with equipment to conduct episiotomies, clamps for "normal labor", blankets, and a heater, as it can become very cold in Panjgur, although when I visited the hospital several times during my research year in Panjgur, the heater and the blankets always seemed to be missing. In the hospital "*cento"* (syntocine) and methergine prostaglandin drugs are typically available for the contraction of labor "if the patient does not have the *himath*

(strength)". According to the head LHV assigned to work in the labor room, methergine is given to women to push the placenta out. However, each doctor has her own method of delivery. While some will wait until the head comes out, then *cento* and methergine is given simultaneously, others give both, after the delivery of the placenta. The latter approach is to help "close the cervix" once the placenta is delivered with the *cento*. To stop the bleeding the methergine or "cento-methergine" is given together to remove the clots and remaining pieces of placenta tissue. Transmine is also stored in the labor room to control the bleeding in case of postpartum hemorrhage. Valium injection is available "to put her to sleep—if we need to stitch." Ampiclox is the antibiotic in the gynecological ward. Flagyl and saline drips are available for anemia patients in extreme situation, and applied until blood can be arranged for her. If the hospital runs out of equipment, there are many private drug stores nearby. However, injections of pharmaceutical drugs are given to women largely outside of hospitals authorized to do so.

In Quetta, the provincial capital of Balochistan, I discussed with Dr. Rubina, a leading gynecologist and obstetrician, about what appeared to me to be the routine use and overuse of injections of pharmaceutical drugs around childbirth outside of hospitals in Panjgur district, primarily by female medical officers, lady health visitors, population welfare workers turned into lady health visitors, and at least one female medical technician trained and authorized to attend childbirths. Here, what I mean by *routine* is in the sense that the practitioners injected prostaglandin drugs in and outside of hospital settings for each and every woman to induce labor and "help" women give birth. And if the birth of the child (live or still) took place in their presence, the labor induction invariably was followed by injection of uterine contracting drugs. What I mean by

overuse is in the sense that it was not uncommon to observe and learn from women, *dhinabhugs*, and the female doctors and lady health visitors about the multiple injections given to the same woman. Dr. Rubina explained that this "routine" is necessary in order to prevent maternal deaths that are largely caused by postpartum hemorrhage. In the absence of universal emergency obstetric care (EmOC) and transport, the normalizing routine injections of prostaglandin can only be deemed the next best intervention. However, she explained, mostly these injections are given incorrectly by LHVs practicing in their home-based private clinics all across rural and urban areas of Pakistan. Not only is the use of injections overdone for each woman, the women are often injected at the improper time, usually too soon and often end up in the tertiary hospitals of Quetta and Karachi due to complications; then there is a need to perform a caesarean section to save at least the mother's life. Dr. Rubina is especially aware of this context since she has come across innumerable such cases in Quetta that required emergency care. Fetal deaths associated with the improper and overuse of these injections is a common occurrence in rural and urban areas of Pakistan, a problem that I heard about in Panjgur as well and in national meetings I attended in Islamabad and Peshawar.

"They Inject and Inject; they inject too much"[89]

> Misuse of injections, it is everywhere…I think it is generally the doctors and nurses who are blaming the TBAs for the problem. Nobody ever looks at how many wrong or unnecessary injections are given by general practitioners. And steroid…nobody ever blames general practitioners for contributing to the spread of hepatitis in Pakistan by unnecessary injections… Because the TBA is at the lowest rung, she's an easy person to blame. Because we have decided she is illiterate and dying out, so blame her. How many people misuse injections throughout the country?" Asks Asghar rhetorically. "I mean there is no Law, which stops an unqualified person from giving injection. It's not only TBA, but

> others also. So let's look at the other part of the problem." (Pakistani UNICEF Officer in Karachi)

In Panjgur, the trend to demand injections of pharmaceutical drugs among the new generation of childbearing women prevails alongside the critique of it by the *dhinabhugs* and *kawwās*. One way the sense of routine and too many injections was expressed was when the *kawwās* and childbearing women would emphasize the repetitiveness of such action in statements such as, "*soochin jana kay jana; jana soochin jana." Jana* is from the verb *janag*, which means to hit; here we define it as [to inject or to give injection], thus the expression: "they inject and inject; they give and give the injection". Or they would say, "*encho soochin jana, baaz jana" Encho* means so many or countless and *baaz* means too much, thus the expression, "they give so many injections; they inject too much." The transnational and state endorsed public health policy of routinization of injections as an example of biomedicalization is linked with two interrelated assumptions: (1) about causes of maternal death and the view that postpartum hemorrhage (PPH) is the major risk factor leading to the death of women; and (2) about what should be done in "resource poor" countries such as in Pakistan where there is an complete absence of or limited access to EmOC services. In Pakistan, the medical doctors are the only health care providers that have the formal state-sanctioned authorization to give injections. The LHV, nursing orderly or compounder can give these injections under authorization and/or supervision of a doctor only. Yet, it is well known, as the statement quoted above by the Pakistani UNICEF official indicates, that LHVs in their private practice are giving these injections not only in Panjgur, but all across the rural and urban areas of Pakistan. At a National Seminar on Maternal, Neonatal, and Child Health

(MNCH) I attended in Peshawar in 2005, LMOs explicitly held LHVs responsible for the overuse and misuse of labor inducing drugs. They vocalized this view in front of approximately 400 participants and considered this prevailing situation as a direct and major obstruction to their practice and ability to provide effective care to women. Frustrated with such a context, they attributed to the malpractices of LHVs the impossibility of saving the lives of women who arrived in the public hospitals in extremely severe conditions. One LMO was blunt in a statement about LHVs:

> They have a strong monopoly. Male community members protect their monopoly so they are immune to criticism. The lower staff [in NWFP are all local] and belong to those communities. We get patients who are 99 percent in dying condition. We are investigated, so is the hospital and the gynecological department every time a woman dies. What about the accountability of LHVs? Who is regulating them?

Similarly, back in Panjgur, in a discussion with three of the newest LMOs working at the District Head Quarter Hospital, the doctors complained about LHVs and FMTs performing diagnostic and treatment procedures reserved for the LMOs, despite the fact that medical officers were exclusively officially authorized to perform these medical interventions. They were not wrong. One LHV I interviewed in Panjgur, in her private clinic rather than her day job at the government facility Basic Health Unit (BHU), told me openly that she "puts one shot of cento [syntocin (synthetic oxytocin)] in the drip when the patient is fully dilated." She also uses methergine, though "not too much", and does not give the injection "to patients that have high blood pressure or have vomited too much". She does this despite the rule following their two-year midwifery training allowing them to provide glucose drip only. Compounders—paramedics trained to perform outreach—are also called during home deliveries to provide such injections. In

Panjgur some *dhinabhugs* discussed with me the increasing pressure put upon them by childbearing women and family members to induce the woman's labor with the *soochin.* This, arguably, is a consequence of the women's increasing exposure to the artificial induction and quickening of labor in the hands of allopathic/biomedical practitioners. As a national policy, however, in Pakistan the so-called TBA or *dai,* and thus the *dhinabhugs* in Panjgur, are barred from giving pharmaceutical injections, yet, ironically, the medical establishment has historically trained *dais* to give injections, which they would give or instruct a male compounder to do.

Compounders (usually male) have had a long-held, institutionalized, paramedical position in giving injections to women, men, and children. A *dhinabhug* during a home-based delivery might call upon a compounder, usually the same one, instructing them when to inject the arm of the woman with drugs to induce labor or avert excessive bleeding. However, there were many other *dhinabhugs* I met and heard about, who were confident about their practice and so refused to give these injections. The latter group of *dhinabhugs* was aware that as a consequence of this refusal they would turn away some women who would then seek out a lady medical doctor or lady health visitor who was in the business of routinely giving such injections to ensure that the birth of the child takes place in their private clinics. For, as it is understood by LMOs and LHVs, when one "catches the baby" the condition for the demand for payment from the birthing woman's family is fulfilled. Indeed, I was told by a number of women how LMOs held back the baby until they received the full payment demanded of them.

A Brief History of the *Soochin* (Injection) in Panjgur

The policy mandate to *routinize* injections of obstetric pharmaceutical drugs is recent and endorsed by public health professionals in Pakistan as a rationale to prevent maternal deaths. However, as I have suggested, injecting pharmaceutical drugs around childbirth has a longer history in Pakistan. The uneven development of the medical infrastructure in Pakistan might suggest that doctors trained and working in the Balochistan province would have minimal if any exposure to advancements in medical and surgical technologies. While this is the case for many forms of advanced medical technologies, pharmaceutical drugs and technologies such as syringes, the manpower to provide injections of the multitude of allopathic drugs, and many types of general, gynecological, and obstetric surgeries were made available in the province of Balochistan years before Pakistan was formed in 1947.

Well into the 19th century the British colonial government was producing Annual Reports on the Hospitals and Dispensaries. One of the earliest such reports is mentioned in *The Madreas Quarterly Journal of Medical Science* (MQJMS), published in 1863. This issue carried a review of the presidency's annual reports on mortality that happen to also touch on the high rate of maternal mortality. Such reports were compiled from the works of dispensaries located throughout the Balochistan province, including one in Panjgur.[90] Unlike the Sindh province, which was part of the Bombay Presidency during British colonial rule, reports about the Balochistan dispensaries were made available later. The earliest annual report I found at the British Library in London was published in 1921.

The structure of these reports is standard for all regions. The reports tabulate the surgical operations performed in the State-Public, Local Fund and Private Aided Dispensaries. Thus, in Balochistan at least as early as 1921, operations on the "female generative organs" were taking place.[91] These included and were categorized as follows: "ovariotomy; curetting of retained placenta; plastic operation of the rupture of the recto-vaginal septum and perineum; ventral fixation of prolapsed uterus; and removal of fallopian tube for ectopic gestation". Another list of related operations was indexed as "gynecological operations" including: "dilatation of cervix uteri; removal of polypus; replacement of prolapse uterus; retroverted uterus; plugging uterus; colporrhaphy; recto-vaginal fistula repaired; trachel orrhaphy; artesia vaginae; and perineum repaired". A third series of operations indexed as "obstetric operation, incomplete abortion" included: "separation of placenta; completed abortion; incision of perineum; cervix curetted; forceps applied; dilatation of cervix; craniotomy; contraction; and podalic-version". Each year from 1921 to 1934, years for which records on Balochistan could be found, the number of surgical operations increased. Four outcome categories are tabulated in the report, namely: cured, relieved, discharged otherwise, and died. In 1922 a total of 29 such operations were performed on women. Two women's deaths were linked to the surgical procedure of "separation and extraction of placenta after delivery". In 1923, 39 deaths were associated with operations of any kind. One death was linked to the ovariotomy procedure, another death was the outcome of curetting retained placenta; a recto-vaginal fistula repair was also linked to a woman's death, and one death was associated with "completing an abortion"—a surgical procedure.

During colonialism the British established two systems: curative and preventive. Curative services were provided in the hospitals and the dispensaries. Preventive services were part of a separate institution that included sanitary staff to clean the ditches and the wells to prevent cholera, malaria, and small pox. A medical doctor I interviewed in Quetta remembers:

> The health delivery system was the best during the colonial period. Like anywhere, where the government colonial establishment was working, near the railroad line, they established dispensaries and hospitals. When we say dispensaries, it is an established center. It was curative only. (Baloch Medical Officer, one of the first to work in Panjgur and other parts of Balochistan beginning as early as 1964; in his sixties at the time of the interview in 2005)

It was not until the World Health Organization (WHO) entered the scene in the 1970s to influence state medical establishments to redefine preventive services that resulted in the shift of balance of services in the periphery from largely curative to preventive care. Thus, the hospitals and dispensaries that had been primarily servicing the military officers and their families during the colonial period were transformed into rural health centers (RHC) that would be linked to three sub-centers (Basic Health Units (BHU) and or a dispensary). A team of male and female doctors, an LHV, and a *dai* would serve in these centers on a rotating basis. Each RHC was to cover a population of 10,000 and the sub-centers were to cover 3000 people with some variation depending on how the population was dispersed. The hospital in Panjgur that was built by the British was thus turned into a RHC. In 1969 when one of the first Baloch medical doctors went to work there after obtaining his MBBS (Bachelor of Medicine and Surgery) degree in Quetta in 1966, the RHC services combined curative and preventive services and remained the only hospital in the district.[92] Now residing and working in the private

medical sector in Quetta, in an interview, this is what he recalled about the medical care infrastructure in Panjgur:

> Panjgur was one of those places in Balochistan that had a civil hospital around 1935 or 1936. The Makran Levies Corps was posted there. Panjgur itself was a cantonment[93] as a result hospital was established for the army. I don't know who would have been the first doctor. There was no record of it when I went there in the 1960s and 1970s. I know there were British, Hindu, Sikh doctors, and then of course Pakistanis- Quetta-ites from Punjab. I met some of these doctors in Panjgur, Dr. Jaffer who is no longer living. Dr. Abdul Samad, Dr. Ghaffur. They were all from Quetta since they were in the government servants during the British. They spoke Urdu and Pushtu. Actually the first doctors and paramedics came from India. It was the British government so they would be transferred to Quetta or directly to Panjgur. The main centers in Balochistan were in Loralai, Sibi, and Quetta. Later on they preferred to send Muslims. Previously there were no Muslims, Sikhs perhaps. But there were surgeons working in the hospital in Panjgur. When I came in 1969, the operating theatre was as it is now, but it was functional. There was an electric generator specially made for the hospital. It was dismantled when I came because of its shabby condition. But, the building was there-—the structure—you know the base of the engine. The bulbs were even hanging. The signs of the surgery unit could be observed.

The government employed compounders and *dais* under British colonial rule and later under the government of Pakistan. These health workers were key figures involved in the introduction of medical and obstetric technologies in the rural areas. According to Gitchki, while *"in those days the general things available were mostly powders, mixtures, tablets, and a few limited sulfa drugs"*, though rare, injection of penicillin and streptomycin (for tuberculosis) was also available to the public. The market was not yet flooded with the new generation of antibiotics. Not everyone wanted the injection, as they thought it painful. Gitchki explains that in those times, "the needle was in untrained hands, the needle was broken as it was removed from the skin causing infections. Compounders were giving these injections and when people would hear of these cases, even if a few, they would become scared. Today everyone wants injections." There were

quinine injections for malaria. The "IV", according to Gitchki, is a new phenomenon, emerging suddenly in the 1980s. So now there is the means to inject inter-venous fluids and the injection of prostaglandin right into the fluid.

Injection before Training

Thus, while TBA trainings in Panjgur began only in 2003, nearly 50 years later than when they were made available in many other parts of Pakistan and more than 100 years after *dai* trainings were conducted in British India, the district of Panjgur was introduced to the medical technology of pharmaceutical drugs for various health care objectives, at least as early as when the first civil hospital was built there in the late 19th century. Similarly, the availability of pharmaceutical drugs that would be used around childbirth in Panjgur can be traced back to as early as the mid-1950s. However, ergot[94] and possibly quinine were commonly used around childbirth in the dispensaries and hospitals run by British medical officers. Illustrated by Gitchki's experience, vaccinations against infections were in full use in the 1960s. He explained:

> Small pox was everywhere when I came to the district in 1964 and 1965. When I was a medical student I was stopped in my village. The village was under quarantine. There were cases of small pox. I was proud to be a doctor. I introduced myself as a doctor, so they allowed me to go in and out of the village. In 1968 I was a medical officer and there was an epidemic, and then another one in 1971. In 1972 I was in Khuzdar where there was an epidemic of small pox. After that I didn't hear of it. It declined slowly. I directly dealt with two epidemics…I saw many people die. I saw a very strong young man working on one day and the next evening I could not recognize him. He was swollen, red eyes, nose, mouth, and skin. The next day he died.

This history raises at least two questions. (1) Why routinize labor inducing and uterine contracting drugs as a policy if a large cadre of LHVs, compounders, and lady health workers (LHW) located throughout the rural and urban areas of Pakistan have for

decades been informally authorized (though not adequately trained) to apply these "simple" (though not innocent) obstetric technologies by the medical establishment? (2) If allopathic-medical based obstetric technologies are not so new to the experience of rural women in Balochistan, why then have women in Panjgur not whole-heartedly embraced these obstetric technologies? The answer to these two questions rests in part on how the so-called traditional birth attendant or the *dai* has been governed by the allopathic/biomedical state to reach Panjguri women's reproductive bodies.

Governing *dais* and *mulki dhinabhugs*

> The Lady Dew Motor Dispensary made two long tours in Makran and two in the Zhob and Loralai Districts affording Medical aid to 1,255 patients at their homes who would otherwise have been unable to attend Dispensaries. [Statement in 1924 in annual "Review by the Hon'ble the agent to the Governor General and Chief Commissioner in Baluchistan", p.ii)

Dai Bibi's transfer to Panjgur district as a government employee is one of the earliest moments in which a boundary is marked between a "*mulki dhinabhug*" (local midwife) and "*sarkari dai"* (government midwife). As the term *mulki* suggests, Bibi's entry also demarcated who would and would not be authorized to legitimately inject pharmaceutical drugs around childbirth. *Mulki* derives from the word *mulk* which means country, and thus *mulki* refers to a person who is of the country/region itself and can be defined multiply to mean indigenous, local people, as opposed to settlers, and refers to the Balochs living in Panjgur for generations. It would appear that despite "illiteracy"—as in lack of formal schooling among the government *dais*, in the 1950s at least—some women who worked as government *dais* were deemed capable of acquiring the so-called "skill" to give injections. This was a kind of a skill that for those who endorsed it as a

positive and status enhancing gain, spoke of it at the same time as directly opposed to and better than *Balochi dewa*, without altogether giving up *Balochi dewa*. Moreover, the possession of such a skill was often placed directly in opposition and superior to *dais* and *dhinabhugs* doing *Balochi dewa*, or to those maintaining their herbal practice along with the use of allopathic drugs. In 2004, when I began my research in Panjgur, it had been about five years since Bibi's death at seventy-five years of age. She was born around 1925 and began working as a *dai* in her twenties and seemed to have been assigned to the Panjgur dispensary in her thirties, where she worked through her sixties. Though I did not meet her, there were many individuals other than her relatives who remember her, including Raheem, the seventy-years-old retired compounder who had crossed paths with Bibi many times in their work context as early as the 1950s and in1960s; and Mah-Jan, a government employed Panjguri *dais* now working at the district civil hospital maternal and child health center.

Raheem had a great command of the English medical vocabulary due to his years of work as a compounder. Out of respect for his years of experience and now also due to his age, all the medical officers in Panjgur including the MS (Medical Superintendent) and District Health Officer refer to him as a doctor. For years, he was one of only two compounders working in the entire district. At that time the civil hospital was located in Chitkan (central town of the district). The creation of the civil hospital brought with it compounders, nursing orderlies, and later, vaccinators. The first vaccinator came to Panjgur in 1982-83. Before that, compounders were the vaccinators and LHWs came later. Male nurses worked in the operating theater and were trained to give anesthesia and were involved in post-operative care. Other posts included *chokidar* (guard; gate keeper),

peon, and cook. Raheem was one of the first medical workers in Panjgur to witness the first cholera outbreak in the district in 1962. Nurses and compounders were brought from other parts of the Balochistan Province and regions of Pakistan to respond to this outbreak. Penicillin was available and medical workers were quickly trained to provide the cholera *tikka* (injection).

Raheem remembers that polio drops were introduced in the district in 1982, though he did not recall polio being such a big problem in Panjgur. The big problem, he claimed, was one faced by women, for it was more difficult at the time to go to Karachi due to the lack of paved roads and limited means of transportation. At the time, all doctors were men, so women were sent to Quetta or Karachi. He recalled the experience of one woman whose child died in-utero. "The doctor said, take her to Quetta, Karachi! But, this was not possible so Dr. Bandi told *dai* Bibi, 'I give you permission to do what you can to save this woman's life.' So the dead fetus was taken out with forceps." Then for "cleaning" she was given injection of methergine. Then to "clean" the uterus, "*quanine* mixture of powder was used." According to Raheem, Malaria was common. "Now there is the *gooli* (pill); but before if someone got an attack of malaria the pill in powder form was put in the syringe then the person was injected."

In separate conversations with them, although both Raheem and Mah-Jan emphasized that Bibi did not use *Balochi dewa*, and rather used "*Engrizy dewa*" (English medicine) and did the *soochin* (injection), they differed on whether *dai* Bibi stood as more skilled in maternity care than the Panjguri *dhinabhugs*. According to Raheem, *dai* Bibi learned to give injections in Quetta and that, "she was the first *dai*". And, "when a case became difficult they [*dhinabhugs*] took the women to her." If Bibi could not handle

the case, she then would call the *"doctir*" (meaning the compounder). But, here Raheem clarified that Bibi would never choose to inject the women in the absence of the "*doctir*". She would advice him of the timing, and he would then inject the drugs in the arms of women. Raheem recalled some of the views that BiBi held about the Panjguri *mulki dhinabhugs*, explaining to me that, "Bibi would pronounce that, they [*dhinabhugs*] don't know. They make a mess. They make the case septic."

Although there was a functioning hospital in Chitkan (central town of the district) with a surgical unit and operating theater primarily for British officers—though open to the public—Bibi nonetheless attended deliveries at the homes of her clients.[95] However, she did not stay on to provide postpartum care, as was and is still a common and customary care giving regime of the Panjguri *dhinabhugs* and *kawwās* that I met throughout the district. Raheem's recollection about Bibi's criticism of "*mulki dhinabhugs*", however, contrasts with Mah-Jan's story about Bibi. Mah-Jan tells me with a tone of pride that, "*Bibi a zid koorth goon mani masa"*, that is: "BiBi opposed, quarreled, and adamantly questioned my mother. She refused her authority, saying to her, 'you are a public's *dai* and I am a *maulazim* (government servant), why do you go to do the cases?' My mother told her, 'I don't tell anyone to come and take me to a case, but if at anytime they take me I will go.' Then the officers told Bibi, 'we bring her ourselves; she is *our mother*[96], why should you be bothered? Why are you jealous of her? We know you are a *sar kari dai* (government employed *dai*), and she is *our mother*.' She, my mother was such a *kawwās"*, concludes Mah-Jan. Bibi was a *nokar* (servant of the government) like Mah-Jan is now. Still, mostly people would go to Mah-Jan's mother, even though, Bibi would give *darday soochin* (pain injection). Bibi would also give one

unit of methergine, which continues to be injected today and Mah-Jan is one of the a few government *dais* in Panjgur who are locally officially authorized to inject this and other drugs to women.

Like *dai* Bibi, four decades later, Mah-Jan is now one more government employed *dai,* trained and authorized to give injections of pharmaceutical drugs around childbirth. Mah-Jan, in her fifties when I met her, had an ever-present personality, simultaneously commanding and welcoming, equally respected by doctors, LHVs and *dhinabhugs*. Unlike Bibi, however, Mah-Jan does not rely on the compounder, and was trained and authorized to inject the women herself. She was trained to do this by several different lady medical doctors, who over the years of Mah-Jan's thus far nineteen years career, have come and gone from their district civil hospital positions. She tells me, "Before I was a *nokar* (servant), I did not give *soochin*, nor was I a government employed *dai*. My mother never gave *soochin*. I did cases before becoming a *nokar*, I watched my mom." Mah-Jan, thus, would do cases as instructed by her mother, beginning her career after giving birth to the seventh of her eight children. Mah-Jan explains:

> My mother told me to do it, I said to her that I was scared, but I did attend birth of my sister and aunt's children. My mother said to me, 'a time will arrive when you will have a peace of mind in your home in having this work. With your help, God will make lives of other Muslmans[97] better. Your work will be of help to others. This is a very good and right type of job (profession). It is not just a job for living; it is also a service to humanity.

In this classic Balochi expression: *hakin jaga hak dayanth; swabi jaga sawab-en*, Mah-Jan's mother conveyed one of the core moral and ethical responsibilities of their work as *dhinabhugs* or *kawwās*, articulated to me by many of the *kawwāsi* as well as non-*kawwāsi dhinabhugs* (expert and non-expert midwives). The expression loosely translates

to mean that doing *dhinabhugiri* (work of *dhinabhugs*) is a type of work that one should do without expectation of any material gain. Mah-Jan insisted that neither she nor her mother ever used *Balochi dewa* (i.e. herbs). Rather, she attributed her mother's *kawwāsiness* (expertise), thus her own talents as well, to the ability to manage complex situations such as mal-positions of the fetus, and what she referred to as *dozay dard,* a term that in part refers to false labor pains. Explaining to me as such, "You say *joot-en dard* [Urdu for false pain]; we in Balochi say *dozay dard*."

Given that practically every *kawwās* I had met in Panjgur before meeting Mah-Jan, continue to use herbs today for prevention and healing of an array of both gynecological and non-gynecological ailments, I was not easily convinced that her mother did not apply herbs. Although Mah-Jan remained adamant about the non-use of *Balochi dewa*, she then would quickly contradict her own claim. For, following a point about her mother's uses of pharmaceutical prescriptions, she immediately recited a list of herbs used by her mother including, "r*az, izbook, aligdar, badam, kishmish, akhroot, kamar kash.*" She said that her mother would mix it and give it to the women after attending to their childbirth deliveries. "So, isn't this *Balochi dewa*?" I would ask. No, not so, according to Mah-Jan, for her mother would give this to women orally and not vaginally. Typically, the *chillagi dewa* (postpartum care herbal regime) is taken vaginally as is instructed by many of the other *dhinabhugs* practicing in Panjgur today. Even if Mah-Jan disclaimed the use of *Balochi dewa* and contested what could and could not count as *Balochi dewa*, she nonetheless articulated a stronger criticism toward the misuse of the *soochin* than the fact of the persistence of herbalism among *dhinabhugs*. This reality, that pharmaceutical obstetric drugs could cause more harm to women than the

dhinabhugiri dewa, is one that Mah-Jan iterated toward the end of our three hours of conversation.

> Dhinabhug noo wa soochin jana. Har jaga noo berayan dhinabhug asth. Agay zana, nazana dema ninda, napaga borran, k man dhinabhug-an! Hakikathin dhinabhug Zar- Malek- en o Kapooth en. Ah mortha. Dega Murad Bibi en, ah kawwāsi dai en. Ah dewa kanth. Kassia zag nabith, ah komaki kanth wathi darmana. Ah baaz sharing. Balay mani matha eh dewa nakoortha.

> Dhinabhugs now give injection. Everywhere you go there are dhinabhugs. If they know or not they sit in front of the woman, cut the cord just to say 'I am a dhinabhug'. The real dhinabhugs are Zar Malek, and Kapooth. She has died. There is another, Murad Bibi, she is an expert dai". She does herbs. Anyone unable to get pregnant, she helps them to become pregnant with her Balochi medicine. She is a very nice woman, but my mother did not use these medicines.

Initial reluctance to openly talk about *Balochi dewa* emerges repeatedly in my interviews with *dhinabhugs*, such that over time, during my research, I began to notice a pattern among the state-employed *dais.* Although many had, on the surface, become effectively interpellated by the state to self-surveillance over their individual articulations about *dhinbugiri* roles and practices around *ladies-of-allopathy*, male medical doctors, and even around childbearing women distantly located from their kinship circles; what became clear is that once they understood I was neither another *lady* doctor, nor was I another arm of the medical establishment temporarily entering their lives to train them with biomedical rules and methods, they became freer to talk about the *Balochi* medicinal ways with me, including about *dhinabhugs*' medical involvement in resolving women's infertility concerns. The problem of primary and secondary infertility[98] arose as an important concern for many Panjguri women and healing it was a central preoccupation of many *dhinabhugs.* Herbs for abortion seemed less of a focus than preparing herbs to help women become pregnant. A *dhinabhug* who could address and resolve infertility

problems usually acquired the mark of a *kawwās*. I return to the point about infertility in the next chapter. The evolving understanding of my subject-position, in part, was a result of news circulation about my locally escorted wanderings all across the Panjgur district. Moreover, many of the *dhinabhugs,* women, and men in Panjgur had come to know that I had also been spending extensive time with *dhinabhugs* that were not recognized by the state as either *dais*, or TBAs, or midwives. Thus, the interest I took in their locally specific forms of medicinal work, located largely outside of direct purview of the biomedical state apparatus, interrupted the normative modes of interactions between a *dhinabhug* and a *lady-of-allopathy*. This un-*lady* like interest of mine would be indexed by statements such as, "no *lady* has asked us about our *dewai*." "You are not a *lady*, you want to learn about our *daru.*" "Come visit us every day, I will tell you about our *dewai*." While Mah-Jan spoke in the present tense, Raheem spoke about the past uses of *Balochi dewa*, so that even when people were turning toward use of "*engrizy dewa*" in the hospitals, *Balochi dewa* was not just a home based medicine, for sometimes compounders had resorted to local herbs in the absence of the pharma drugs.

> FT: During your time did people use *Balochi dewa?*
>
> Raheem: Yes, but not in the hospital. There was a time when *goordir* (a local herb) was used, when quinine powder was not available. The doctor would order the *goordir*. It is soaked at night, then strained in the morning and then put it in a bottle, then given to the sick. This was helpful, *thaal* en (It is bitter). It is still used sometimes. Hazm was used for fever. This would be like the quinine powder mixture. These days it is the time of *gooli* (pills). "Doctirs" [compounder] no longer know how to prepare mixtures, but dispense *gooli* and *soochin*.

Raheem recalls the first time that he witnessed a problem with injecting allopathic drugs:

> There was an Imam Sheikh. He was sick, having coughing fits; he was brought to the OPD. I was sitting at the time on my duty. He was given a prescription of injection of the antibiotic. There was a nursing orderly. He was the injection

> *janook* (one giving the injection). Doctor did not check, he was injected, he reached the ward and he died in the ward. There were screams all around. The doctor was perplexed. What kind of medicine is this? It turns out the man had an allergic reaction. So after this incident, anyone prescribed this injection or any antibiotic must be first tested for allergies. Another time a family brought their own B-complex vile for the woman to be injected in her arm. I did not know she would have a reaction to the ambiclox. Women are given B-complex capsule now. Women must be tested before given the B-complex injection.

Raheem did not recall injections ever being made an issue among the people in Panjgur. He claimed that some people did fear it because they thought it was a contraceptive. But he said, once they were educated about the actual reason for the injections, slowly people accepted. Now, according to him, people demand the injection because they don't feel they have had a treatment without having received an injection.[99] Yet as I learned, traveling all across the district of Panjgur, this demand for injection around childbirth was never and is not an altogether unchallenged trend. Not all women consent to receiving the injection.

Contesting the hegemonic value of the soochin

> Two years of injection! You are closed and closed [infertile and infertile]. Now you tell me if giving birth is better or stopping pregnancy? [Words of a *dhinabhug* communicated to a female patient seeking her medical care].

Despite decades since the introduction of pharmaceutical drugs for gynecological and obstetric care, my conversations with women and men throughout the district indicated that the uses and desire for these drugs is not hegemonic and is point of contestation between women as well as between women and men living within same households. In the previous chapter I wrote that Begum's daughter, still young in her twenties was compelled to listen to her mother's insistence that she learn the art of

dhinabhugiri. She was allowed only briefly to complain about the "smelly herbs" and sight of the fluids and *gand* (messiness) of the birth. Begum was the attending *kawwās* for all three of her daughters' deliveries, giving them full postpartum care including the *chillagi dewa* and massage. A woman and a distant kin of Begum with whom I spoke, in a village without mud houses and only *gidam* like-structures made of wood and dried date palm leaves, located two hours from Chitkan and an hour away from Begum's current residence, told me that every one of her five childbirths were attended by Begum, and that not once did she need the injection. All of her children are alive. Moreover, she went on to tell me, although the younger generation of women, like her daughter's, complain about the smell and messiness of herbs: "We tell them, do you want a bloated stomach and suffer? We cannot afford the sickness; so, no, we do not allow them to get the injection. I didn't have injection, my mother didn't, and our *ballok* (here the reference is to a female elder or grandmother) didn't." Then, ending her commentary, she proclaims, "*Kās eda engriz nain* (No one here is an *engriz*!)"

So why do some pregnant and laboring women and their families demand the *soochin?* Even though a *dhinabhug* can recognize and caution childbearing women about the needlessness of the *soochin,* a woman might still demand it. One mother and daughter (Fatima) team of *dhinabhugs* were not the first, nor the last to tell me about what they saw as the increasing dependents of women's bodies on the injection, or in their words, "they do it as a habit now". They emphasized that some women don't have the "*sabr"* (patience), and thus ask for the *soochin* for a quick delivery. In the process they have learned to manage such situations with words and what can be read as an ethical mode of

performing their *dhinabhugiri* work. Khatija explains how she manages impatient women thus:

> We tell the women that the child is about to be born, and that it is in its place. And you yourself will deliver the baby, and the child will be born as it is supposed to, and it is in position as it is supposed to be. We tell them that, *'shomara Allah Tala Rehmat kan'* (God will have mercy on you). In the past they would wait, now they are focused on getting the baby out, even when labor is not hard.

As Fatima and others explain to me, it is the same women who have difficulty facing labor that are then told by the *lady* to not use any *Balochi dewa* and thus end up asking for the injection because they cannot bear the labor pains. According to many of the *dhinabhugs* this is precisely the type of situation that required Balochi *dewa.*

Khatija, Fatima and her mother told me that in general women do listen to them when they distinguish for them the proper and improper times for the *soochin*. If the women refuse to listen, they are instructed to go to the *lady*. Generally, the laboring women's family members ask if they should call the compounder to give an injection. If *dhinabhugs* feel that such an intervention is necessary they tell them "yes".

> We tell them that it is up to them to get the *tagath wala gooli* (the strength giving pill), but we don't allow the *garmi soochin* (hot injection). *Taghathi soochin is marzi wala* (the strengthening injection is the one they can choose). The child will die with the *garmi soochin* if injected when the child is too far up.

In the past, women's strength to endure the labor of childbirth depended, among other foods, on boiled milk and *roghan* (ghee), both an extremely important dietary source, access to which has been dramatically disrupted by the drought. *Dalda*, the commercial ghee available in the market is unaffordable for most families in Panjgur. Consequently, glucose and IVs are increasingly the alternative normalized routine,

injected to strengthen women to bear the labor of childbirth. Fatima explained the decision-making process about the injection in this way,

> *Doctir*/compounder stops by and asks, is she in the condition for the soochin, if so then we say yes, and injection is given. If we say no, they only give the thagathin soochin- glucose so that she becomes alive, so she gains strength, awareness/ energy. Now if you don't communicate to the compounder the condition and he injects her without knowing her condition and the child is far and high up- and Allah has not killed the baby, the baby is still alive and healthy… If the child is near, Allah will do the necessary work.

Inter-generational Relations Reworked

So who is demanding the *soochin*? Among the more than one-hundred childbearing women I met and spoke with in Panjgur, those who had experienced receiving pharmaceutical injections around childbirth were among the youngest—married women in their twenties and thirties. Many had already one or more living children. Among these women, no one's mother or mother-in-law had experienced getting these injections. Many women like the one above said that they did not really need it, since they could use the *Balochi daru, darman or dewa* (herb or medicine). There is a class of words, such as *darman*, common within the members of the Iranian and Indo-European languages—Farsi, Balochi, and Kurdish. *Darman* is the Indo-European based Balochi word meaning medicine. *Darman* and *daru* are common Farsi and Balochi words meaning medicine. In Urdu *daru* is *ilaj,* which means treatment. But *daru* can also refer to liquor and in poetic terms can mark someone, a special object or a story as medicine of the heart. The expression *darman darag* also means treatment (literally holding medicine). *Darman* is what can heal the pain. A related word includes *dard* which means pain or suffering. Thus, *daru* is treatment of pain or suffering. *Dewa* is the Arabic-based word commonly spoken in Balochi to mean medicine. *Dewai* is the Urdu/Hindi version

meaning medicine and often spoken by women without annunciating the letter (i) thus, leaving us with *dewa*. Sometimes *dewai* would be spoken to refer to a specific medicine. In Panjgur, the iteration of *dewa* sometimes referred to medicine as a general mode of care or solution to a problem. Women in Panjgur would employ these terms primarily in reference to indigenous Balochi medicines, usually referring to their herbalism and related healing techniques. *Dewai* or *dewa* was stated more often than the word *darman*. In Panjgur *daru* was usually deployed to a specific herb or group of herbs or the herbal formula that was indexed by the central herb in the formula. More often though, plants, herbs, and herbal formulas were named by their specific local Balochi names that included herb names usually lacking an equivalent in Urdu, Farsi, or Arabic languages.

It is important to note that the LMOs and LHVs, as well as a majority of the lady health workers (LHWs) are all among the same generation of women now resorting to labor inducing and uterine contracting drugs. The age range of the five LMOs working in Panjgur included one woman in her forties and all the others were in the Thirties. Thus, the conflict between the medical care values of government lady health practitioners trained in allopathy/biomedicine and those of *dhinabhug* and *kawwāsi dhinabhugs* using *Balochi dewa* or *daru* also presented itself as an inter-generational tension. This relational formation became most explicitly apparent when I spoke with groups of twenty or more LHWs, ranging in ages seventeen to thirty, in gatherings at various basic health units (BHUs) across the district. Despite the fact nearly every LHW had been born in the hands of *dhinabhugs,* and many had family members who had been or continue to be active *dhinabhugs*, some of them famous *kawwāsi dhinabhugs;* there was nonetheless a

consensus in formation among them that *dhinabhugs* are not "skilled", expressed in terms such as "they don't know."

The problem with *dhinabhugs,* the LHWs learned in their government training, was "hygiene". Though many of the LHWs birth of their own children were attended by *dhinabugs* without a problematic outcome—so far as they revealed to me—some of them would say that for their next birth they would go to the lady doctor. When I probed to clarify why they thought birth in the hands of a lady doctor is better, as many of them claimed, the response was largely about hygiene and based on what they were hearing in their training rather than first hand experience—notable by the fact that *dhinabhugs* were their birth attendants. Several of the LHWs hinted that, "lady doctors say don't go to the *dai.*" At first, I found myself feeling amazed at this discrepancy between LHW discourse about *dhinabhugs* as less than capable birth attendants and the reality of how mostly they are giving birth at home in the hands of *dhinabhugs.* This was a discrepancy that included LHWs admitting the use of *Balochi dewa* and concomitant indexing of the hygiene issue. Yet, it became clear that LHWs, as modern medical workers, are liminally positioned, in which the influences of older generations of women continue to be exerted in their day-to-day lives, despite their evolving role as a *lady* of modern allopathic medical workers. Thus, to express the association between *dhinabhugs* and the hygiene problem was effectively a display of their own knowledge and role, for as LHWs, they are authorized and expected by the biomedical establishment to impart the value of hygiene to TBAs. LHWs' articulations about how the "trainings of TBAs*"* has improved *dhinabhugs'* "practices", is in one very important sense a greater statement about their own capabilities and legitimacy as community health workers assigned to supervise

dhinabhugs by the authority of the state medical establishment. In contrast, the personal 'choices' they made about their own childbirth indexed a respect for their elders and perhaps the positive effects of Balochi medicine. Thus, the continued presence of *dhinabhugs* as birth attendants and herbalists in their lives challenged the self-articulated perceptions they held about *dhinabhugs'* skills. The following ethnographic clip further illustrates the formation of inter-generational tension mediated by values of allopathic/biomedical establishment and the declining nomadic life ways, shaping especially some younger women's attitude toward familiar herbal formulas historically commonly used around childbirth.

Allopathic mediations and the formations of inter-generational tensions

> Two nights ago Asha comes to my home to tell me that her daughter-in-law is not well. The daughter had already seen a lady in Chitkan who had given her garmaish soochin (hot injection) and gooli (pills). The daughter had refused Balochi dewa, saying she does not like it.

Khatija told me this in a group conversation, sitting on the patio of the Katagiri basic health unit (BHU), with four other *dhinabhugs*, the BHU *dai*, and my research assistant. This was my second meeting with Khatija and Fatima, who were in their forties and thirties, respectively. We had met the day before in their respective homes, four hours with Khatija and three hours with Fatima and her mother. Today we were joined by three other *dhinabhugs* who had traveled several miles from their respective villages. Like Asha's daughter about whom Khatija spoke, two of the oldest *dhinabhugs* sitting among us, one in her late sixties, and the other in her mid-eighties, explained that their daughters also refused *Balochi dewa* because of the odor of the cooked herbs. One of

them refused despite not being able to "have a child" (i.e. get pregnant) for nearly seven years. And for the other, the reason for refusing herbs was *"mana bāzhy, mani dila bāzhy"* ("It makes me noxious, it is noxious to my heart/ I feel repulsed.") The latter would become one of the more typical explanations that the older generation of *dhinabhug and kawwāsi dhinabhugs* would convey to me about the younger generation of women's attitudes toward Balochi herbs and methods of care. This was a sentiment that spread across the district. A majority of women with this attitude lived near the central towns of the district, where there is the concentration of the district's LMOs and LHVs. By contrast, the farther I traveled away from the central towns of Panjgur district, such as to Katagiri, the greater the criticisms against the injection—such as from people of Kohsabz, where Begum's relatives, mentioned above, live.

Khajija interjects, "yes they say, *mara bāzhy* (we are noxious). I myself have three daughters." And to my inquiry about whether any of her daughters would take up *dhinabhugiri* if they were so repulsed by the herbs, she said, "Allah knows", and joined by others as if in a chorus, "someone will take it up. It will be. For sure some one will take it up." Followed by Zarina's comment, "My daughter-in-law knows how to cut the cord and Sher Khatoon is another person learning. *Rab* (God) him/herself will produce them. For all these times *lady* has not taught us. We ourselves have delivered children." Stated with a slight tone of cynicism and defiance, Zarina was conveying to me the point that Panjguri women and *dhinabhugs* have not been so completely re-socialized that they would outright give up their indigenous medical care methods. These were not mere words, for *Balochi daru and darman* (herbal medicine) had many important uses beyond facilitating a successful and safe childbirth, as I came to learn over the course of my

research in Panjgur. Moreover, many *dhinabhugs* and *kawwās* felt that they knew very little as compared to their grandmothers, great-aunts, or a more distant female relative in their kin lineage. Although a good number of *dhinabhugs* that I met had not have directly learned from the women they now spoke of in inspiring terms, they had nonetheless woven into their memories descriptions of a 'real' *kawwās* (expert). This *kawwās* was framed with one possessing fame and having a practice that presented to me a vision of a healer that far surpassed the perception of their own knowledge and skills. Thus the statements,

> My great grandmother was so much smarter, so much better. She knew so much more. She could handle so many difficult problems. So many people knew about her. I don't know about nearly as many herbs as what she knew about. How she made them! How she got her good results.

Chillagi Dewa **or the** ***Soochin*** **(Injections)**

Chillagi is a practice that implicitly carries the mark of Balochness. A Punjabi woman asks a Panjguri *kawwāsi dhinabhug*, "How do Baloch women keep their stomachs so flat, small, and prevent bloating and gas?" The *chillagi dewai* for the *kawwās* was a source of pride that grew out of faith in the efficacy of the formula. References to such stories and encounters between the Punjabi woman and Panjguri *kawwās* reveals how cross-ethnic exchanges hold significant power to validate the continued worthiness of herbal practices in women's lives in Panjgur. Such stories serve to re-signify and de-emphasize the "new" as better and remind the young generation of childbearing women about the corporeal consequence of giving up the "old".

As I continued my conversations in Katagiri, Gul Bibi, the oldest of five *dhinabhugs* in her mid eighties explains rhetorically, "there was no *'doctir'* or *'lady'* in

the past (past here means twenty or thirty years ago); "so" she continues, "how could we have given women *soochin*?" Khatija adds, "You see there is one problem with *soochin janag* (giving injection). I observe, is the child far? If I see that there is no hope of the child's birth now, in this situation, I don't give injection. Now if it is near, now that it has reached near the *nooky* (cervix), you know it- and you think the child may slide back up, you tell the 'doctir' to give the *thaghathin soochin* (strengthening injection)." Here Khatija is referring to glucose, a word with which many *dhinabhugs* were familiar, including Khatija, and would use it interchangeably with the word *thagath,* which means strength. "If it looks as if she is weak, if one is to give her an injection, one gives her the *thagathin soochin*. As soon as she becomes alert and gains strength, then she gains life in her heart. Once the doctir [compounder] injects the glucose, and when strength comes to her (i.e. when she gets some strength), she is able to give into the pain or bare and push through the pain. This is given to her before the start of labor pain, the child is far, and the child is not ready to be born."

Khatija follows this description of childbirth and injection with talk about *Balochi* herbal methods of addressing similar situations confronting laboring women. "Now ours is *jaoshir*, a little bit of *sohr bonay peemaz*, this is put inside (like a vaginal suppository). Now I notice that there is no water, the child is dry, now I put this inside, already wrapped into a cotton ball and put it underneath. As soon as the odor from this transmits into the body, we see the effect. We see the work of *khodrath* (God/nature). Now we see that that *dozin githa* (she is caught in false labor). Now I place this inside, once the water begins to flow, her *rag-o-band* (veins and joints or blood and bones) lift/rise up. The mouth of the path opens. Nature and God open the way; God gives/bestows strength,

opening the way." As Khatija states these last words, the other *dhinbabugs* sitting with us pronounce in near unison, '*patch kanook Allah-en* (the opener (of the path [metaphorically] cervix [literally] is Allah).' The child is born, and with it the cotton slips out."

In a study of childbirth in Tamil Nadu, India Van Hollen (2003) found that one of the reasons women there accepted allopathic medicines to induce labor is because there already existed a wide spread use of *kasāyams* and other homemade medicines to induce labor.[100] On the surface, it would be easy to make a similar conclusion about the trend toward the acceptability of labor inducing drugs among some women in Panjgur. However, in comparing two distinct forms and content of medical interventions, although Khatija understood both the allopathic injecting drugs and *Balochi dewa* as medicines that could be used for similar objectives, for her, *Balochi daru* remained less risky and even superior in several ways. Thus, the injection to induce labor, she argued, should be reserved for specifically difficult situations. And in contrast to the Tamil Nadu context in Van Hollen's study, herbal medicine and its persistent uses in Panjgur, while in decline, nonetheless appear to have the effect of limiting the resort to pharmaceutical injections around childbirth. This is in part because the function of herbs in Panjguri women's lives is multiple, and includes uses beyond the pregnancy, childbirth, and postpartum context. This form of valuation about herbs is linked with the concept and the meaning of *kawwāsiness*, that is the *dhinabhugs'* expertise in the recognition, preparation, and application of herbs, forms of expertise that are empirically visible in the healing successes experienced by Panjgur women. However, it is also a result of deeply

embedded set of preventive regimes of care that struggle to thrive in the hands of the *dhinabhugs* and against the incessant deprecation of it by allopathic/biomedical doctors.

Referring to an herbal formula, *dozay daru,* given to women to simultaneously determine the nature of the labor pain and to ease women's discomfort of pain and itching, Khatija explains, "I can apply the *Balochi darman* when the child is far and even when the *nooky* (cervix) is not dilated enough", Khatija repeats the make-up of the herbal formula and the application technique that she had described to me a number of times before. "Once you place this in the cotton, put it underneath; the veins and joints or blood and bones soften, labor begins. When she is caught in *doz* (false pain), as she experiences the false labor pains, I place this inside. Once you put this inside it, the labor pains will seem as if she is ready to drop out the baby. But, when you put this inside, you will see that the baby will not be born, and the pains disappear. For at least ten days or even longer she may not experience or feel the signs of labor pain. When they take these herbs, they learn that these were *dozay dard* (false labor pains; literally: the stealer of the real labor pains). All this pain, all of it will disappear." She may become *chillag* later and at that time when the *dozay dewa* (literally: the herb for the thief of the real labor pain) is given to the woman she will become *chillag* (post-parturient); that is to say she will have given birth. In addition to *chillag*, *kapthuk* is also a term marking the postpartum status of the woman.

For one *dhinabhug*, *"doz is that which holds on to the baby—it holds the baby back."* The woman could be in her seventh or eighth month of pregnancy and may feel like she is going into labor. She feels discomfort, and "When I give this *dewai*, if it is not her month, she becomes calm and returns to see me when it is time. If it is time and it is

the ninth month, I give her this in the morning and by night she is ready to go into labor. I give this to her so she can become relaxed. If there is pain, it opens the pain."

Khatija explains to me that when she uses *dozay darman*, she does not use the allopathic injection. She says, "With the *soochin* the pain speeds up. Hit her [with the injection], hit her again, hit her to make the labor pains faster, and again to make it faster." The word *bejani* means to hit. The same word is used to refer to "inject" or to frame a photo, or a poster on a wall. In this way the '"doctors"' don't end up delivering the child. "I have seen situations like this, where there is nothing; no real labor. You cannot force the pains. If the pain is real, than *khodrathy* (naturally) the pains will speed up." As explained by Khatija, some of the symptoms of *dozay dard* include, *jan choon tanchith, zahgay dard tirook pa tirook kaith, ma gooshin ishi a dard githa*: that is the body tightens and pulls, and the labor pains come in a prickly, pulsating way. "We think she is in pain of labor. Some women have itching. But many don't experience the itching. It is better if they do itch. They give them a cream. But ours is *jaoshir* (a local herb), you give this and the itching disappears. *Ah k lappay taha gi, ah gran thirinith* (the pain that takes place inside the body, that causes heavy pain). In this case as long as you don't give her the *dozay dewa* the child *nakappi* (will not come out, will not be born)"- that is, the birth of the child is obstructed. "Now for this situation we give the herbs, Allah provides mercy; this helps the child to be born. We know that, the situation needed the *Balochi darman*."

Past versus the Present

According to a Panjguri *dhinabhug*:

> Today, if someone says I don't want a child, she [the lady health worker (LHW)] will give the woman gooli (the pill). But, she will give the soochin (injection) if

> the woman asks for it. She [the LHW] calls her husband who is a doctir [compounder] to give the injection. In the city, the lady will do the tanka, [stitch for episiotomy]. She at least takes this much zemadari (responsibility). Or, you go there when you are pregnant. The lady tells you there is a child, and for you to return in three months for the tokka (TT shot). She is told about the three tokkas. So, women return to get the tokka during pregnancy. Yes, many do go back as long as they have transport.
> Why this tokka? I ask.
>
> Hemishi hisabay bemari nagiri. Dasth guath nagiran, pad guath nagiran. Bemari nagiri. That is, so that she won't catch the hisabi sickness. Her hands and feet won't become swollen. So that she won't get the sickness- explains to me the dhinabhug.

Khatija also spoke about what was done "in the past" when women faced childbirths, at a time when *soochins* were unavailable. The entire skin of a goat or lamb, depending on the specific condition of the person, was put over a woman's entire body, as she lay supine on her back, in order to soften the insides of her body, veins and joints. The method is better described as placing the coat of the goat on the body of a sick woman, man, or child. The healing technique is embedded in a particular philosophy of the physiology of the body which, to put it in very simple and crude terms, is the hot-cold conception of the body, disease, sickness, plants and animals. The practice is in decline though not entirely obsolete, and exists across Balochistan in the rural and mountainous areas such as in the Kohsabz region of the district where I met Begum's family. The technique is not applied on women's bodies exclusively for childbirth related problems and is also applied on men and children for illnesses that manifest in what *dhinabhugs* marked as different types of fevers. The decline is in part associated with the loss of livestock due to the previous and more recent droughts and the consequent forced shifts in nomadic ways of living in the region. The *poosth kanag* (goatskin cover healing technique), according to Khatija, is no longer practiced, at least not in the regions of

Panjgur about which she was familiar. Rather, "now, when one is in difficulty, in need, or *thang beeth* (becomes distressed), then immediately she is taken to the doctor."[101]

While the *soochin* is something that Khatija is not entirely against, since it can provide relief, she saw, nonetheless, problems caused by the *soochin* that could be avoided if one was to instead use the Balochi herbs. "Yes there are problems with the *soochin*, problems in this way that if the baby is far and you inject the needle and she doesn't have real pains or you want to get the placenta out and if the child is not ready to be born, the child will die, or you can damage the uterus." These types of situations have occurred often, with a *lady* and sometimes with *dais*. One *dai* who was a *ballok* (elder or grandmother), meaning not a *dhinabhug* or *kawwās*, had given a woman too many injections. Ten days later the woman went to the *lady*. "*Lady* said, the child *sariddítha* (has spoiled/decomposed) and now you have brought her to me, now what can I do with her?" The lady doctor referred her to Karachi and there she ended up with a hysterectomy and died later that same year. She had three separate operations attempting to address her bleeding problem and abdomen pain. "So this is a huge damage due to the *soochin*. This *ballok* did not check to see if the child is far." That is, the child was not ready to be born because the cervix was not fully dilated. Khatija remarked that *dhinabhugs* should be taught to give the injection. She explained, "The *lady,* in any case ask us about the woman's condition. Where is the head of the baby, how much is her *jan* open (status of cervical dilation)? And then when we tell them, they give the injection. They are not checking the woman; they rely on us [to tell them about the level of dilation). Now they should teach us, they don't teach us."

Like Khatija, neither Fatima nor her mother held a dualistic or hierarchical view about the past versus the present situation confronting childbearing women. If Khatija could be pragmatic in her view about the injection, Fatima's mother similarly did not hold an entirely romantic view about the past condition of women, nor was she enamored about the modern and too often *cutting* technologies of childbirth increasingly pushed on women by the state and the private allopathic/biomedical medical establishment. Fatima's mother tells me, "Yes, there were difficulties in the past. Now things are improving, it is better now. In those times *Khoda* (God) herself brought them into the world. Things could be stressful in the past. Yet, now when one is in difficulty, immediately she is sent to the doctor. Once they reach there, immediately the cord is *cut*. Those who are sent to Karachi get *operated*. Now days, this is the difficulty. In those days she would be in labor pains for two-two, three-three days. Allah delivered the baby. Now there is not this much time given to labor. Now as soon as she is in labor, the child is born, if child is not born, she is sent to the city (central town Chitkan). If the birth occurs in the hands of the *sher* (Panjgur city), then okay, if not she is sent to Karachi, Turbat, or Quetta, and immediately she is *cut*." Fatima uses the term cut and operated in multiple senses. Cut here is in reference to cutting of the cord and cutting of the abdomen for cesarean section, but it also refers to the episiotomy cut. Operation here refers to cesarean section, a manual removal of the uterus with an instrument, or a hysterectomy.

To be sure not all *soochin* (injections) are equal. So far as made visible and audible to me, neither *dhinabhug* nor pregnant women had any issues with the *tokka* (tetanus toxoid vaccine injection) for the prevention of neonatal and maternal tetanus. Thus, according to Fatima, while certain things have improved for birthing women,

artificially quickening the labor pain has its own set of consequences, for there are new difficulties that they must confront. These are difficulties prevalent now that, according to her mother and many other *dhinabhugs,* were by largely absent in the past. "When we did not have the *soochin*, the *zagdan* (uterus) would not spoil and the child would not rot/decay and decompose. If the birth does not take place today, then perhaps it will tomorrow. Now God will open the way. If it is in Allah's plans to take it then it won't be born. But, it will be born the day it is to be born. Now, forcing the birth with *soochin*, *garmin soochin* (hot injection) is forcefulness that causes harm, damages the woman's *jan.* Those who do not understand this, may they not be." Fatima's mother explained that she knows when it is right and wrong to give the injection. Her own mother taught her to make sense of the labor pains and baby's positions and now, she is teaching the same to her daughter Fatima. "Where was training in those days??" she pronounces rhetorically. "I have always been *Baloch"*. Here, Fatima's mother is referring to recent government sponsored TBA trainings in Panjgur conducted through the Women's Health Project.

What does it mean when Panjguris state, "I am a Baloch"? It is not a political statement, per se. I encountered with Panjguris a variously expressed sense of being a Baloch that was interspersed in conversations having nothing explicitly or even implicitly to do with national, political, ethnic, tribal, or any other social identity. I came to understand the iterated claim: "I am a Baloch", as a form of self-identification that marked what was deemed simultaneously positive, negative, humorous, and sad about being a Baloch. This identification often explicitly indexed a distinct way of living associated with camels, mountains, lambs and goats, the gathering and use of herbs and wild plants, living in particular type of housing structures, and being a generous and kind

host to visitors and weary travelers. In general, the utterance distinguished the rural from city folks and ways; doing so by sometimes nostalgically speaking of how some positive rural ways are losing ground to the negative and less hospitable city ways—even though many Balochs live in the *sher*. Within this meaning of being Baloch, Balochness was very much also about how to manage childbirth and situations like *dozay dard* with *Balochi darman*. "When the real labor pain does not arrive, I put *Balochi darman.* The pain subsides if she has *doz* or some other situation such as vaginal or internal itching. Then for three to four days or even ten days she will be ready to give birth. If in the first the time she had [real] labor pains, then the pains will speed up after using this *darman. Allah talah Shafa kanth* (God the exalted will heal her.)" *Shafa* means to heal; *Shafa Kanth* means one who heals. *Shafa* is a term that was used sparingly by *dhinabhugs,* and only in reference to God's work, though occasionally in reference to the healing work of the plant/herbs. Never did I hear the term used to refer to the work of the *dhinabhugs*.[102]

Together, Khatija, Fatima, and her mother located three problems attributed to the use of injections of allopathic/biomedical drugs to induce labor and contract the uterus including: (1) Excessive use; (2) Inappropriate timing of injection as a result of misdiagnosis of labor pains; (3) Injection of women when it is entirely uncalled for. Clearly, for these *kawwāsi dhinabhugs* from Katagiri the issue was not allopathic drugs versus *Balochi darman*. Rather, as for many of the more than a hundered *kawwāsi* and non- *kawwāsi dhinabhugs* I spoke with in Panjgur, their principal concern was the safety and future health of the mother and child that they felt was further jeopardized due to the declining use of *Balochi medicine*. Injecting allopathic drugs could quicken labor, and perhaps reduce the duration of the pain, or force out a dead or alive baby obstructed in

childbirth, or a stuck placenta, but they also saw the negative consequences of allopathic medical technologies on the fetus and the bodies of women; consequences that in many instances could have been prevented if women had used *Balochi darman*.

Lady's views versus Balochi Darman

> Ladies don't accept it. *Lady namani*. They say not to do *Balochi dewai*. They say inject the soochin or take the *gooli*. (*soochin bejanay, gooli bewaray-* to the women). They say, but it is these pills and injections that give pain to our stomach; we don't do it. Our Balochi people say, our lap/stomach doesn't become clean or better with *gooli* and soochin. [Panjguri *dhinabhug*]

> They should teach us to give the injection. The lady, in any case ask us about the condition of the woman; where is the head of the baby? How open is she? And when we tell them, then they give the injection. The do not check [examine] the woman. Now they should teach us, they don't teach us. Here [meaning in Katagiri] there is no lady. There [meaning central district towns] they don't teach them and they send them [the laboring women] to the city [Karachi or Quetta] when they can't help them. They should teach us. They charge three, four, five thousand rupees then they say to us [the birthing woman and her family and accompanying *dhinabhug*], if you don't give money we won't give you the baby. [Panjguri *dhinabhug*]

As I have suggested in the previous chapter, if the *kawwās /dhinabhug* can be critical of their own "peers" for falsely taking on the *dhinabhugiri* identity, they can just as well be critical of the abuses carried out by the *ladies of allopathy*. The critical outlook about the injection and the caution against it by *dhinabhugs* and *kawwās* contrasts dramatically with the general perception that public health professionals and policy-makers hold of the so-called *dais* and TBAs.

> For delivery purposes the injection came with our LHV, dais, and lady doctors. LHV started with training, they were trained with it. Unfortunately when dais got to know about it, they began to misuse it. They thought they were helping the patient. [59-year old male medical doctor interviewed in Quetta].

> We can't say the *dai* always do the case wrong, main thing is they have to be aware of cleanliness and to avoid the injection. [Lady Health Visitor in Quetta, assigned to work in the labor & gynecological]

> You go and get an injection for the pain, become a little better then, it is the back to the same stomach, that pain is the same pain. [Panjguri *dhinabhug*, Katagiri]

The view that TBAs tend to mismanage childbirth and are marked out as the main actor involved in the misuse of injection certainly did not fit the prevailing discourse and practices concerning the use of injections that I came across in Panjgur. The perceived lack of behavioral change that is desired of the TBAs is also associated with the idea, held among some of the biomedical doctors and health policy-makers- that the TBAs act exclusively in the interest of protecting their own market share of childbirth cases.[103] In Pakistani public health discourse, TBAs or *dais* are typically characterized as holding on to the laboring woman as long as possible. It is said that, for the purpose of a little money, they wait to refer the women to the hospital only until the situation becomes difficult for them to manage. This was also a common sentiment among British medical officers in 19th century India (Arnold 1993). Yet, what I witnessed in Panjgur was quite the opposite in the sense that the promise of capital underlying childbirth produced a set of practices among the lady doctors and health visitors that far outweighed the level of harm that Panjguri *dhinabhugs could* or desired to generate. Nor did they have the type of financial incentive or authority available to LMOs and LHVs to hold back the pregnant or laboring woman or the child following childbirth. For example, local midwives often did not get paid on time, if at all, and their payment was much lower. At most they might receive 500 rupees ($10), often months, perhaps even years after having attended a woman's childbirth and provided her the postpartum care. Lady Health Visitors could

expect 1500 to 3000 rupees ($30 to $60), and lady medical doctors demanded no less than 2500 to 5000 rupees ($50 to $100) per delivery. Thus, *the ladies-of-allopathy* were much more proactive in ensuring that the birth should take place in their clinics because the live birth of the child in the clinic would ensure the largest payment from the patient's family. Narratives of childbearing women and *dhinabhugs* communications to me in Panjgur indexed a number of ways in which the LMOs and LHVs intervened to ensure that women came to them rather than to seek the TBAs. They intervened through their vocalized denigration of *Balochi deway* (Balochi herbs), by holding back pregnant women in their private clinics despite the distant timing of the birth, by inducing birth before time, and by holding back the newborn.

In Panjgur, both the positive ownership among the local midwives and the negation of herbs among allopathic practitioners is marked by the pre-fix that identifies the ethnicity of the user [i.e. Balochi dewa (Balochi medicine) or Balochi *daru* (Balochi herbs/plants)]. As I have discussed in this chapter, in 2004 and 2005 while many local midwives and childbearing women spoke positively about the efficacy of *Balochi dewai*, allopathic practitioners consistently and actively dissuaded women from seeking care from local midwives and using the prescribed herbal medicines. Women were often deplored for having used the herbs before arriving at the government hospital or the public and private clinics in which the female medical doctors, lady health visitors, and female medical technicians work. This marked tension between the value of allopathic ways and Balochi medicinal one's was made evident to me through the conversation I had with *dhinabhugs*, women, the biomedical practitioners themselves, as well as through the observations of childbearing women's engagements with the biomedical

establishment and *dhinabhugs*. One LHV, originally from Punjab, but a long time resident of Quetta assigned to work in the labor and gynecological wards of the DHQH, had this to say about the general policy operating in at the hospital toward the so-called *dais* or TBAs.

> They (female relatives of childbearing women) say that 'we do Balochi *daru*, we give daru so that her *pait saf ho* (uterus (literally stomach) is cleaned); *jo mushkil hain wo dur hojathayhain* (whatever difficulty she is experiencing is removed)'. So when they trust their elder, as they see it works, then they continue this way. But, we- in our new duty say to them, leave this. We say this because they work without gloves. There are things that I have removed after pelvic examination during labor. Things under the cervix, exactly where we place a *gooli* (pill). They deny that they done this.

Besides the economic incentive that shapes the desires of allopathic practitioners to attend a woman's childbirth in their private practice, where they can demand direct cash payment, the public positions of the practitioners, particularly the female practitioners, concerning the Panjguri midwives and their practices, reflect colonial and postcolonial imaginary about the "old women" attending birth and rural life needing to catch up with modernity. The irony is that although all of the female medical doctors now working in Panjgur belong to this district, and have longstanding ancestral ties there, they have nonetheless developed an unflinching "modern" sensibility about rural women's bodies, that harkens back to the views held by ladies and men of the English medicine (*engrizy dewa*) about South Asian bodies in the colonial era, making it clear that in the 21st century allopathy continues to colonize the "epistemological space"[104] about the corporeal bodies of women.

However, despite such criticisms of *dhinabhugs* and the persistent verbal pressures to dissuade women from seeking the services of *dhinabhugs,* the *dhinabhugs*

were devoid of neither words, nor reason in defending *Balochi dewa,* nor was there a shortage of demand for *dhinabhugs'* expert services. In Chapter Two I discussed Zar-Bibi's thriving practice, in which although the focus of her work had largely shifted to exclusively treating benign and serious skin ailments, she did not turn away women who came to her resident clinic to give birth and provided these women with her repertoire of childbirth related herbal formulas. More relevant to the discussion in this chapter, as I have illustrated in the previous section, while Khatija felt that *dhinabhugs* should be taught to give the injection rather than have to rely on the local compounder, she remained resolute about the positive value of Balochi medicines. She and many other *kawwāsi dhinabhugs* persevered with an almost defiant position about and for *Balochi darman*. This was so in spite of the barrage of negative remarks and declarations, largely from allopathic lady medical practitioners, against their *dhinabhugiri* and herbal practice.

> We continue to do our Balochi work." Khatija declares. "The lady say, no, don't take this *dewai.* I have been told not to do the Balochi dewai. When the child is born, don't do *dewai*. After the birth buy the *gooli* (pill) and give it to her. They say, in the morning don't massage the mother with oil. We oil and massage her. They say give her *gooli* and inject her with *soochin*. Sometimes the women say we will not do the injection.

Kawwāsi dhinabhugs refusal to do the injection is contrasts with the push for it and its ill effects.

> We have continued to use our *Balochi dewai*." Why is *Balochi darman* preferred? I would ask. And variously I would hear, "The mess inside come out, our stomach gets better (*wāsh bain*). The lady gives us things that pain our stomach. These things don't make our insides better. The *gooli* (pill) bloats our insides (gives us gas). Causes sickness to our body, makes it bad. Balochi medicine is better for us. I do the *Balochi dewai*.

As I have delineated in this chapter, how the *Kawwās* understood the effects of the two dominant modalities of medical care (allopathic/biomedical injections versus *Balochi* medicine) on the bodies of women in Panjgur was far from black and white. Many *dhinabhugs* like Khatija, made it clear that the impact of the pressure that the lady medical doctors exert on the childbearing women to refuse or to discontinue the uses of *Balochi medicine* and herbs was less than successful. According to Khatija, though women are incessantly subject to "don't do this", "don't do that", they will not listen to it. "They (the childbearing women themselves) say, 'we ourselves will do the *dewa*'. Those *ladies* talk their talk (*wathi gapan gooshan*). We go to them, we will take women to them if we need to; the women will go and give birth there and will have their cord cut by the *lady*. But then they come here and all of them do the *Balochi daru* (*moch Balochi daru kana*). Here they do their Balochi. Someone from here went to the *lady*. *Lady* told her not to do *Balochi dewai*. But her stomach became bloated (*lappi pād ahthk)*. On the fifth day she did *Balochi dewai* or *chillagi daru.* How her fever disappeared! Then the *gand* (mess) came out. The *gand* had entered the uterus. She had one child. Her uterus had turned bad. She had not done the *dewai*." It was the husband who had contacted Khatija. The *lady* had kept her for four days. On the fifth day her insides were full of gas and the *lady* let her go with the fever. She prepared the *dewai* and after the woman took these herbs her fever dropped (*tappi aala daath*). "The good thing about this *dewai* is that it opens out the fever (*tappi patch be*)." Then the mess and fragments come out. The body becomes stronger (*jan takkrda be*); then she gets better. The pain leaves her, disappears; then she becomes relaxed and her condition improves. The word *gand* here refers to the undesired/bad fluids and tissues. It is literally opposite of the word *shar* (good). It is word

often used to mean dirt or mess (i.e. the *gand* (dirt) in the bathroom needs cleaning. When children turn the house into a *gand* (mess); or the politicians has made a *gand* (mess) of the situation.

In the following chapter, I turn to the question of how a racialized form of medical care 'ethics' can become internalized by state medical functionaries working in government and private medical centers to justify routine hysterectomies. Hysterectomies, that the *dhinabhugs* in Panjgur considered a direct result of the overuse and misuses of pharmaceutical injections on childbearing women's bodies. Moreover, I delineate how the local midwives marked as TBA or *dais*, and the rural women they serve, both reinforce and contest the tradition—modern dichotomy in their practical negotiations about health care.

CHAPTER FIVE
CONTESTED BODIES II: "The Time of *Ballok* is no more; it is now the time of the *lady*" [a repeated refrain spoke by many of the *dhinabhugs*]

Introduction

> "It is the functioning of the relationship between doctor and patent to restructure those understanding and that personality and bring them back into the fold of society and to plant them firmly within the epistemological and ontological ground work from which society's basic ideological premise arise. In modern clinical practice and medical culture, this function is camouflaged. The issue of control and manipulation is concealed by an aura of benevolence." (Taussig 1980: 4)

Despite the prevalence and routinization of injections of pharmaceutical drugs around childbirth, given to women largely by state trained medical doctors and paramedics, many Panjguri *dhinabhugs* were critical of this trend, and were influenced by their own forms and methods of caring for women's bodies. Indeed, some outright refused to use these drugs in their busy *dhinabhugiri* work, as Zar-Bibi's stance illustrated in the previous chapter. Many of them perceived a direct and problematic link between the increased uses of *soochin* or injections and hysterectomies. This was reflected in a refrain spoken by many of the *dhinabhugs*: that *the time of ballok is no more; it is now the time of the lady.* In this chapter I present the stories and rationales underlying the hysterectomies that the bodies of Panjguri and other women in Balochistan must confront. I discuss how the framing of the maternal mortality problem and the bio-medicalization of women's bodies in Pakistan is linked to and implicated in the normalization of giving injections around childbirth and the resort to hysterectomies.

Many of the symptoms typically addressed with herbal formulas and other healing techniques by expert herbalists, are the same symptoms that increasingly were marked as

medical problems requiring hysterectomies in biomedical institutions. These were the same symptoms that Panjguri *dhinbhugs* and many women considered a consequence of the routinization of the *soochin* (injection) of pharmaceutical drugs around childbirth. Though these women did not speak a word that we can directly equate with the term "routine", they did feel that too many women were getting too many *soochins* at the peril of their uteri, babies, and bodies. A number of *kawwās* spoke about the danger of unnecessarily habituating the body to always want the injection to "lift the labor pains up (*darda chisth bekan*)". They spoke about the women becoming dependent on the *soochin* to induce labor and stop the bleeding. They felt that some bleeding was a necessary part of removing unnecessary materials and fluids and that such unnecessary use of injections lead to stagnation, bloating, and other discomforts, which women could not afford to experience. Confronting the physical discomforts resulting from these unnecessary injections requires time, money, and energy.

In addition to hysterectomy, dilation and curettage (D&C) is another surgical procedure performed routinely for uterine related disorders in the hospitals of Quetta, Karachi, and other cities in Pakistan. In Quetta D&C operation is performed to remove fibroids. Many *kawwās* also thought this type of frequent "cleaning/*safae* "—that is the enlarging and scraping of the lining of uterus (endometrium)—is unnecessary. Dr. Rubina, the leading gynecologist in Balochistan I interviewed in Quetta seemed to agree with many of the *kawwās* in Panjgur when she explained that:

> This *safaee* (cleaning) term and business in the hospitals and clinics is ninety-nine percent fraud. Only one percent is genuine, which is the D&C right after an abortion to remove leftover afterbirth pieces. Otherwise this thing that 'you have pain we'll do a cleaning', fraud! 'Can't get pregnant, we'll do a cleaning', fraud! Do you get my point? This PID [pelvic inflammatory disease] and STD [sexually transmitted disease] is a result of lack of proper and unhygienic care during birth.

Ironically, the Panjguri local practice of *chilla* during *chillag* (postpartum) centers on the prevention of future problems and many of the *kawwās* described it as a sort of cleaning. "Cleaning" in this sense is a multi-objective postpartum herbal and massage regime that serves to remove pieces of placenta and tissue that may have remained behind in the uterus. It is also something like an ensure-ance against future reproductive problems ranging from the simple and benign (bloating and gas) to the serious, such as infertility and *rasoolis* (fibroids). Over time, the *dhinabhugs* and *kawwās* made it clear to me that in addition to *chillagi* and *hoshband* (the postpartum herbal regime), the *dozay darman* (labor herbal regime) for clearing symptoms of false labor and assessing real labor pains, are formulae and techniques of care that for generations of Panjguri women served not only similar, but also additional functions over and above allopathic drugs, such as: clearing out dead tissue; supporting the contraction of the uterus following delivery of the placenta; preventing a prolapse of the uterus by ensuring that the uterine and surrounding muscles and organs are pushed back in position; and preventing postpartum gas, bloating, and excessive bleeding.

I now want to now turn to this story about hysterectomies in Panjgur.

"**Neym mardum; Neym Insann (Half a Person; Half Human)"**

> Medical practices are not simply practices performed on passive bodies, but are sets of cultural practices, which constitute and colonise bodies as well as the social spaces between them. (Witz 2001:37)

Guljan, a *kawwās* or expert healer, well known in her community, eighty years old at the time of our meeting, and no longer practicing outside of her home, felt that too many women's uteri are removed unnecessarily. She said this is making women into

"*neym mardum, neym insann"* (half a person and half human). She knew of six women living in her neighborhood that are now without their uterus, all of whom had this medical surgery the previous year. Guljan, having intimate knowledge about the experience of these women, went on to describe what led up to the surgical removal of their uteri. Here is what she said about one woman's experience.

> This was Zarine's second pregnancy; her child was born dead (still birth) at nine months. At her seventh month [of pregnancy] she had pain around her gorday (kidney). The lady [LMO in Panjgur] advised her to go to the doctor in Quetta or Karachi. They kept her there for two to three days. When she first went to the lady in Panjgur, she had labor pains, but the child would not be born (zagay dard-a, balay zag peda nabi). So, she next went to Dr. Roxana in Quetta who refused to take her. She was told that if she had come to her before reaching to such a condition then she would have done an operation [cesarean section]. She said the child is dead and the uterus is khrab (bad). She said if you want I will remove the zagdan (uterus). So they agreed. She has one girl, her first baby.

Why and how did the doctor determine that the hysterectomy is the best solution for this woman? Why did she refuse to assist the woman to give birth to the fetus, even if it was dead? These are a few of the questions that set me on a track to unravel. Guljan explained to me that women work too hard and this can damage the uterus, but they also have difficulty once they lose their uterus. "They become weak and half a person. The whole thing is heavy on their body and they are not old." She continues:

> "I'll tell you why. My thinking is that it is because they don't do dewai." Here, Guljan is referring to a trend in Panjgur among women who according to her "*annigi zaman-aya* (in these times)" refuse to take the common herbal formulas given to women after childbirth and for postpartum care that lasts about 14 to 40 days. She emphasized that "*pesha* (in the past) there were *daru* (herbs) and other ways, like using the skin of the goat, to take care of women's pain and abnormal bleeding. But now, more and more women go to the lady, and "their treatment is *borag* (cutting) and *kashag* (removing)."

We have seen already in the previous chapter how the demarcation Guljan and other *kawwās* and women made between the past and present, was messier than at first encounter. While there were certainly instances of giving up "past" practices, there were many *kawwās, dhinabhugs, and balloks* dispersed across the district of Panjgur who remained very busy with their herbal, *dhinabhugiri* or *kawwāsi* practices. Moreover, their agency was not marked by choosing allopathic/biomedical forms (i.e. hospital settings) and content (i.e. injections of labor inducing and uterine contraction drugs), but rather by refusing these and insisting that the younger generation in their families use what works and is less harmful.

At first Guljan did not specify to me, nor did it occur to me to ask, if removing the *zagdan* (uterus; literally child's sac) meant removing the cervix and one or both of the ovaries as well as the uterus. It became clearer to me later that when women said *dohra* (the entire) uterus, it indeed meant that the ovaries and possibly the cervix were removed along with the uterus. Later in the evening after the first day of my conversation with Guljan, I wondered if Guljan's reference to women becoming "half a person, half human" had something to do with the physiological change that some women undergo during menopause, perhaps by looking androgynous or relatively more masculine than before. Yet, neither Guljan nor any other woman would ever say that removing the uterus makes the woman into a man. So what could this phrase symbolize? What meaning did it hold beyond an older woman's rant about impatient younger women's resort—on both the patient and practitioner side—to injections to quicken the labour? Could the absence of a uterus be a reference to a forced status of permanent infertility—that to not ever be able to reproduce meant being incomplete as a woman or human? Or, perhaps the phrase

was much more about what was at stake in women's everyday embodied experiences. I would learn that for Panjguri women and *dhinabhugs* the care of the uterus is inseparable from the care of a woman's body, mind, and emotions and reflects more than or not even the wish to preserve reproducibility.

For example, I would hear repeatedly from other *kawwās* that, women are unable to do the work as they had before the hysterectomy and they socialize even less than under conditions prior to the hysterectomy. What was at stake was the daily-ness of living, not just domestic and childrearing work, collecting and transporting water, and attending births of animals, but the spontaneity of visiting a neighbor and relatives, and participating in engaged hospitality, that is, living forms of sociality for which stamina, enthusiasm, and interest for others is required night and day. This is a type of sociality that connects women to worlds outside of pure domesticity. Despite the mobility restrictions and the formation of urban style enclaves in the center town of the district, women in Panjgur still walk and travel great distances to live a connected life with friends and kin, as they would have living a nomadic life. Thus, to not have a uterus was less about a reductive notion of womanhood, but more about having a functioning and healthy enough body to work and fully participate in one's social world.

Discourses about reproductive morbidities confronting women and why Panjguri women are weaker now, is a central theme that cut across many of my conversations in Panjgur. Women "today" experience more and more morbidities (i.e. sickness, weakness, infertility, tiredness, uterine prolapse or descendtion, aches and pains, too many pregnancies and children, not enough blood and not enough breast milk) than "in the past". And this, many felt, is largely due to the shifts taking place from how women took

care of their bodies before and what they do and do not and can and cannot do for their bodies today. For example, from their perspective, symptoms that had been addressed by Panjguri expert herbalists with herbs and various indigenous techniques were being managed increasingly and unnecessarily through hysterectomies performed by the lady medical doctors (allopathic/biomedical practitioners).

In my conversation with Guljan, I followed up on her claims about *Balochi dewa*, and asked, "You are saying that if they had used *daru* (herbs), perhaps they would not have these problems?" Guljan responded that many women now go to the doctor to treat a *rasooli, danag, reesh, or zakhm* (eruption, internal growth, or wound), bleeding and other abnormal symptoms that cause them discomfort, pain, and infertility; the same symptoms for which hysterectomies are performed on some women who go to the hospital in search of care for an ailment for irregular bleeding or the cessation of menstruation. Women returned home without their uteri and often without information about what could be the reasons for their symptoms, a matter about which Guljan made her own keen observation when she stated: "How can they do other than *cut*, if they don't even understand why women are bleeding and in pain. If they don't understand why she is sick, then for them, it is best to take the uterus out." Guljan in fact provided here a criticism that is echoed by a leading histo-pathologist working in Quetta and by clinical studies conducted in Pakistan, U.S. and Britain. That is, despite the absence of a fully derived direct link in medical diagnosis between causes of abnormal uterine bleeding and painful symptoms experienced by women, surgical removals are not only common to the gynecological and obstetric care experiences of Panjguri women, but also for a large

number of Pakistani and non-Pakistani women. I will return to this point later in the chapter.

I want to emphasize that the Panjguri women who were ending up in the hospitals were usually not the women who first sought a *hakeem* or a *dhinabhug*. These were the type of cases that if a *lady* doctor or lady health visitor[105], were unable to manage, would refer to Quetta or Karachi for the *second tier of tertiary* care. The phenomenon of referrals from *first tier of tertiary* care to the second tier of tertiary care is one that contradicts an understanding of the hierarchy of resort to medical care in some of the national health policy statements. These assume that when everything else local, indigenous, or non-allopathic fails, then patients turn to biomedical services. Rather, medical care decisions among Panjguri women parallels the reverse trend that has been observed in the US, where patients dissatisfied with biomedicine are seeking alternative modalities of care.[106] For instance, a 2003 study of 400 infertile women in five different hospitals in Karachi found that though both physicians and traditional birth attendants (TBAs) were the commonly sought providers for their infertility concerns, 75 per cent of the women had first sought a physician. In Panjgur, the problem of hysterectomies and injections around childbirth has had the effect of women returning to *dhinabhugs* to help them address the consequences of the biomedical interventions. This is a trend that we could read as a failure of biomedicalization and in Panjgur a social formation that has had the effect of reinforcing *dhinabhugs'* and women's assumptions about the benefits and legitimacy of their *Balochi medicine.* I return to this point about the failure of biomedicalization in this chapter.

The Triangle of Morbidities, Infertilities, and Hysterectomies

As I have suggested, Panjguri women and women from other areas of Balochistan undergo the hysterectomy operation in the hospitals of Quetta and Karachi. Let me first trace how I learned about the enormity of the number of women undergoing hysterectomies in Panjgur. I will follow the discussion next with detail about the biomedical context of hysterectomies taking place in Pakistan and examine the transnationally located biomedical and biotechnical rationale for these surgeries.

Over the course of the first three months of my ethnographic research, conversations with the *kawwās, dhinabhug, balloks* and other women revealed that women ranging from their mid-twenties to mid-forties had had their *chokdan* or *zagdan* (uterus) removed. These were unsolicited stories about women, who, following a visit to a tertiary public or private hospital in Quetta or Karachi for abdominal pain and or abnormal bleeding would return home without their uteri. Many had been referred to a tertiary hospital by one of the Panjgur lady medical officer (LMO) or female doctor due to abnormal bleeding, a *zakhm* (uterine wound), a *rasooli* or *rasooli-ay danag* (formation of wound/lump-fibroid), or sickness due to a *kharabin chokdan* (bad uterus) or *jan soochag* (burning body). The non-English terms I reference here are Balochi and are terms that were spoken by Panjguri *dhinabhugs* and childbearing women. Allopathic/biomedical practitioners did not speak these terms, but rather they exclusively used English and allopathic terms such as fibroid and irregular bleeding. Some terms such as *zakhm* overlap with Urdu usage and it is a term that generally refers to any wound on the body. But this word can also be spoken in Urdu, often poetically to refer to emotional pain (i.e. I have pain in my heart).

It began to disturb me that nearly half of the 30 Panjguri midwives and 50 women I interviewed three months into my research knew at least one or two women who had undergone a surgical removal of the uterus. What was additionally alarming, as I was to find out later, is that many of the women did not have any appreciable improvement in their overall health condition. Nor was there a change in the symptoms that led them to seek institutionalized medical care, as a result of which a woman may end up with a hysterectomy. This required further investigation to ascertain which women are undergoing this surgery, and why and how surgeries are taking place. To answer these questions I conducted a survey, with assistance from Dr. Aziz (district coordinator of the National Program) and his team of lady health workers (LHW). I also spoke to women who had undergone the surgery, had focused discussions with Panjguri midwives and interviewed several doctors in Panjgur.

The survey, covering five regions of the district, revealed that 17 percent (118) of the 600 respondents had had their uterus removed. A majority of the 118 women who responded to the survey had more than 5 pregnancies, and the average number of live births among them was 6.2; five women had only one or no children at all prior to their hysterectomy. Nearly half (56) of the respondents said that they did not feel any better after the surgery. Among the women who said they had the hysterectomy due to a "bad uterus", a majority said they felt physically the same as before: *Ma hemishoon* (I remain as is; I am the same as before). Many complained of chronic pain around the abdomen or burning sensation in their arms, legs, or the entire body. For a majority it had been four to five years since the removal of their uterus. Several of the women had their uterus removed just three months prior to the survey. *Rasooli* [fibroid] (44 women) was the

most common indication women mentioned for the removal of the uterus. A *zakhm*, a uterine wound of some sort was the second common reason (22 women); followed by heavy and frequent bleeding, experienced by 12 women. Another 12 women also said that they were told their uterus was *kharab* (bad), and ten women had some sort of "*problem with the uterus"*. Two women's hysterectomies were due to "the uterus coming out with the baby" during childbirth (prolapsed uterus in biomedical language); one woman said that her hysterectomy was a consequence of a uterine tear (ruptured uterus in biomedical language); and one woman was told that she would die unless she had her uterus removed. Only three women said that their uteri were removed immediately following a cesarean section. One of these women had the cesarean following the birth of her tenth and last child, and another two after five and fewer children. This suggested to me that women's hysterectomies in Panjgur were less about multiparity, though this was certainly a plausible factor. Rather, what seemed significant to me is the link between symptoms experienced by women, women's concerns about infertility, and the removal of their womb after ending up in an allopathic/biomedical institution. Further conversations with women and *kawwās* clarified this. This triangle (of morbidities, infertility, and hysterectomies) marks in many respects the contexts of the tensions between *dhinabhugs'* regimes of care and the allopathic/biomedical services—a tension that is literally embodied by women. These multi-layered tensions are imbricated by the views of *ladies of allopathy* working in Panjgur and Quetta, the increased availability and normalization of prostaglandin injections, the declining availability of herbs and expert *dhinabhugs*, and the seven-year drought.

Burdens of fertility and infertility

> Childbirth is not about shaking one's sleeves[107] and saying here is the baby. The baby does not drop out like that. Not that easily. It would be nice if it were like that. But then, there would be a lot more babies. Too many of them! Good thing we have the pill and the injection now. Because even though giving birth is not as easy as shaking one's sleeves, we still have lots of babies. On the other hand, Sakina's sister can't get pregnant for the last six years. She has tried everything: Gone to Karachi to get her zagdan [uterus] clean. Sakina also had a rasooli [fibroid like growth] before she was married. She had it removed. She got cleaned (had D&C) then she got married. Still she cannot have a baby. (Comments of a Karagiri *dhinabhug*)

A primary task of LHWs (lady health workers) is to impart information about family planning and to dispense contraceptives. Thus, when they visit women's homes they are privileged to hear women's concerns related to infertility, fertility, and their attitudes to contraceptives. Invariably, in each of my meetings with distinct groups of LHWs, the issues about the problems associated with contraceptive pills arose in light of discussions around *disrupted* uteri and concerns about the problem of infertilities. I could not help noticing the degree to which discussion about contraception and too many pregnancies was inflected by the problem of infertility. The side effects associated with contraceptive pills appeared ubiquitous in younger Panjguri women's lives, one of which was the difficulty of becoming pregnant again. Several LHWs present in the meetings said that they experienced heavy bleeding when they took the pill. One woman stopped because she became weak as a result. Others switched to different methods for a while. My discussions with LHWs also highlighted the expanding role of *dhinabhugs* in treating the iatrogenic related disruptions increasingly experienced by the younger generation. The following vignette illustrates this point and also foregrounds an inter-generational encounter and the shared sufferings that is neither entirely about too many pregnancies,

nor the inability to get pregnant. Rather, it is an inter-generational engagement that is imbued by the extant modern medicine of allopathy and the modernization of the "national" economy. While the problem of infertility is not new, and while for ages in Panjgur and trans-locally, someone like the figure of the "midwife" has been sought by women for concerns around infertility as well as fertility, nonetheless the biomedical interventions on bodies of women has added to the *dhinabhugs'* collection of concerns and understandings of the determinants of women's ailments and illnesses.

Khatija, following our two-hour conversation, examined two young women both in their late twenties to early thirties, who had walked for five hours from their home village to seek Khatija's advice. Both women were having uterine pain. The first woman, Sameera, hadn't had "a child" (i.e. pregnancy) for six years. The second woman, Suraya, had been using the hormonal contraceptive injection and pill together, thus ingesting more than the biomedically determined necessary dose of artificial hormones to help her prevent another pregnancy. She looked tired and overworked, was very thin, and slightly short of breath when she first entered the room where a group of about ten women and five or more children were gathered. For Suraya, it had been a little more than two years since her menstruation had stopped, just about as long as when she began taking the contraception. In her mid to late thirties, she has eight children, and though now in severe pain, refused to stop either the pill or the injectable hormonal contraceptive. She was adamant about not getting pregnant and felt assured that taking both injection and pill was a better guarantee than just taking one or the other.

This determined view was formed by the experience of another woman who had become pregnant despite taking the hormonal injection. Half giggling, Suraya made it

clear to Khatija that she wanted to avoid the same fate (of getting pregnant)—thus her insistence to take both methods of contraception simultaneously. The effect of all this on her body was clear; if not so much by what we could see on the surface shadowed by her deliberate smiles and jokes about her extant fate as mother of eight and being "finished" at such a young age, then certainly evident in her mild voiced responses to Khatija's high volume and passionate iterations while she pressed and examined Suraya's abdominal area. "You have bloating, no menstruation, and you are in pain. All of this you know", stated Khatija to Suraya. Khatija told both Sameera and Suraya they needed to take *Balochi dewa*. They listened attentively, wide-eyed to Khatija's instructions. But Sameera and Suraya, resided far from the main towns of the district, and this restricted their access to *Balochi dewa*. Ironically, getting pills and injections was easier due to the presence of the lady health workers (LHWs) and compounders in the area. If the *dhinabhugs* do not have the needed herbs available in their homes, it is up to the patient and the family member to purchase the ingredient with which *dhinabhugs* prepare the formulas. So what we have here is an example of non-use of *Balochi dewa* due to unavailability and un-affordability of the necessary herbs, that is, in part, a result of lack of transport. Also, the seven years drought in Balochistan has reduced the availability of local plants and herbs usually found on and around the mountains.

Khatija felt particularly distraught about Suraya's condition, and pleaded with her to stop using the contraceptives, beseeching her that, *"This is harming you, drying your jan (body). This is worse than having a kid, you are finished."*[108] However, Suraya gave no sign that she would be willing to stop. She would rather suffer rather than face the possible consequence of getting pregnant again. Earlier Khatija had evaded my question

about the use of *Balochi dewa* for abortions. Other women in the room asserted that it does happen—women do resort to *Balochi dewa* when they can get it and know how to use it. Women had ways to prevent pregnancies too, but no one would talk about how this was done with herbs. The empathy that Khatija and some of the other women in the room expressed about Suraya's fate by statements such, "what is wrong with her husband!" suggested that having eight children was neither a normal nor desired state of affairs, nor was it socially valued. Having "too many" children or *no* children, brought with it different forms of sufferings.

In the previous chapter we saw that for Mah-Jan one of the qualities of an expert *dhinabhug* is one who is deemed to have the skills to treat women's infertility. A *dhinabhug* called Khatoon, having attended the childbirth of her four daughters and two daughter-in-laws without using *"soochin"* and "glucose", recalled one woman's struggle with infertility that was linked with the use of injection of a labor inducing drug. Naz could not have any more children after her first pregnancy. She had a difficult labor. The first child died the same day after childbirth. She told me that the baby died after the doctor (compounder) had given her the injection. She said she did not know why she was given the injection and believes this is what killed the child. There was no attending *dhinabhug* during the childbirth. A relative tried to remove the baby, but was unsuccessful. Later, a *dhinabhug* was called to help. The *dhinabhug* told her to go see the *lady* after she helped remove the fetus. Throughout her pregnancy the husband had been away in Muskhat where he married his second wife, and periodically returns to Panjgur to be with his first wife. Naz's father told her, many times, to divorce the husband. However, since the loss of the baby, Naz traveled near and far in the hopes of a cure for

her infertility, showing no signs of interest in a divorce. She tried *Balochi dewai* three to four times without success. She was told that the *Balochi dewai* would soften and straighten the uterus. She traveled to Gwadar to see a famous *kawwāsi dhianbhug* and a *hakeem*. She went to Turbat to obtain treatment from one of the local lady medical doctors who gave her pills, cream and carried out a D & C to "clean" the uterus. She went to Karachi to seek the services of another *dai* who had a reputation for curing women's infertility problems with her herbal formulae. In Karachi she also met a famous *hakeem* and received an amulet from him. She traveled as far as Muskhat and Dubai where medical doctors prescribed pills. At one time or another, she sought medical advice from each of the five lady medical officers working in Panjgur. Doctors told her that eventually she would become pregnant. After all this, she went to another *dhinabhug*, endearingly called Bibi-Jan. Naz was told by Bibi-Jan that her uterus was *chootin* (twisted) and that something had happened to it in her childhood. She was less optimistic about Naz's future for pregnancy, being sure to not give Naz any false hopes.

Naz is not unique in seeking a variety of modalities of medical care that included the services of *kawwāsi dhinabhugs* and *hakeems*. Women were willing to travel great lengths to widely dispersed regions in search of resolution to their infertility concern. The content of Naz's journey for such a search is illustrative of the reality that infertility is one of the central motivations of women seeking services of the *kawwāsi dhinabhugs* as well from the allopathic medical practitioners. Ironically, it is in such a context that many women end up with a hysterectomy in the biomedical hospitals in Quetta or Karachi.

The journey to Quetta and the scale of the burden

The hysterectomy surgery is unavailable in Panjgur because of the lack of facilities and qualified practitioners. Therefore, despite the long distances, difficult road conditions, the certainty of vehicle breakdown, and the likelihood of further aggravating the medical condition that women would have to endure for 12 or more hours, medical doctors are routinely referring women to go to Quetta or Karachi for more "advanced" biomedical treatment that may or may not include surgery. Traveling from any part of Panjgur to Quetta or Karachi is a long and arduous journey that requires about 8 to 12 hours of travel by bus or by pick-up truck on mostly unpaved and shingled roads. Air travel is unavailable to and from Panjgur, except to Karachi and that only twice a week in small planes. If families are lucky, and can get seats and afford the cost, they might take the small commercial flight to Karachi. In the local absence of proper medical protocols and resources (i.e. medical technologies, drugs, instruments, and trained doctors or surgeons), the next best option within the biomedical system of care is a referral to what I have come to see as the *second tier of tertiary care* located in Quetta, and/or to a third space that holds the promise of the best tertiary care in Karachi. Despite this spatially constituted hierarchy of medical care that moves from district, to provincial city Quetta, to big city cosmopolitan Karachi, from the point of view of Panjguri women and *dhinabhugs*, nowhere can satisfactory biomedical care can be found.

In other words, while 65 percent of the population in Pakistan is rural about 70 percent of private health facilities are located in the cities.[109] In the last six years, since at least 2000, the Pakistan government has initiated the process of decentralization in which upgrading the health centers is an implicit policy mandate. This includes a targeted focus

on sub-district and district level to improve emergency obstetric care. The priority activities in this upgrading objective include emphasis on training doctors and motivating them to live and work in *remote* areas, equipping and maintaining operating theaters, and securing emergency transport services. However, there is a large gap between policy and implementation that mirrors the gap between national rhetoric in Pakistan and the local realities in Panjgur district and the Balochistan Province.

The locus of this divide is largely marked by an urban imaginary and construct about rural sociality. This is also a Punjabi and Muhajir imaginary about Baloch's and Sindhis that converges with the imaginary they have about "tribalism". This *ism* is the category that is inscribed on to the social bodies of rural and urban Balochs in particular—a point that I discuss in other chapters. I do not want to suggest that disparities are absent within urban settings. Nonetheless, despite the fact most of Pakistan is rural, where livestock rearing and agriculture continue to predominate, the national contribution to the Gross National Product (GNP), employment, education, and health have been urban based. Since coined by Lipton (1977) 'urban bias' is a term used often to describe the development policy in Pakistan (Zaidi 1988). Zaidi has been thorough in his description of how systematic health policies have been in overlooking urban-rural differentials of the Pakistani population. As I have discussed in an earlier chapter, the rural-urban differential also intersects with ethnic differentials when it comes to access to economic resources. The diversion of gas from Dera Bugti regions of the resource rich Balochistan province to the major cities in Pakistan and large numbers of smaller cities in the Punjab is an important example of unequal distribution of resources. The necessary government investment to build the necessary infrastructure to transport the gas, for

example, within Dera Bugti and the rest of the Balochistan province is largely absent. Similarly, the distribution of health services, human resources required to deliver the services, and the technological means to deliver those services, is skewed to benefit urban middle and upper class populations. Yet a large proportion of the urbanites are also economically poor, many living in the so-called "slums", and although high tech modern health services maybe in their reach, there is little indication that they benefit from it in any meaningful way.

The spatial and scale divide that obstructs access to health care also reproduces and reifies the tradition versus modern binary. One way that I was able to have a sense of this divide is when I decided to take the bus journey from Panjgur to Quetta to help me understand how and why so many women are ending up with hysterectomies. The survey results I described earlier in this chapter made it clear to me that hysterectomies were common enough in Panjgur to warrant my visiting hospitals in Quetta where many women had their hysterectomies. I chose a journey that Panjguri people would rather avoid under duress and in an emergency. Unfortunately this is particularly the moment that people in Panjgur are unable to choose otherwise. In 2005 the one-year-old equipped district hospital had made little impact, if any, on changing where families would turn to and journey for emergency obstetric care. It is true that private clinics run by medical doctors and lady health visitors are busy in Panjgur with women and families seeking their services. However, these doctors referred many complicated cases to Quetta, Karachi, or Khuzdar, sometimes also Turbat. These were cases of complications that too often were a result of untimely and overuse of injections in the same private clinics from which women were being referred.

In Quetta

In Quetta, I interviewed Dr. Zahur, the one and only histo-pathologist in Balochistan actively involved in research and teaching at the provincial medical school. Through him, I later met Dr. Banur, a gynecologist and a Fellow of the College of Physicians and Surgeons at a private hospital where both she and Dr. Zahur work in the evenings in addition to their day time civil service jobs at the only two civil and teaching hospitals of the Balochistan province. At the private hospital, a large portion of Dr. Banur's time is taken up performing gynecological surgeries. Starting at around 8 p.m. we spoke for an hour in her office at the end of her evening, which typically ends after performing surgeries and waiting for the hospital bus that drops off the female hospital workers to their homes. Since she had so little time, I decided to get right to the point of my visit and ask her why women were ending up with hysterectomies.

Dr. Banur explained to me that for what she called "benign causes" such as "uterine bleeding" the hospital policy is to remove the uterus. This is:

> …because our people are living in remote areas. The women travel 400-600 miles. Medical treatment (that is non-surgical treatments) require repeated visits, follow up, but our people are poor, and because of poor transportation, poor facilities, they cannot come to Quetta frequently so that is why medical treatments do not suit them. So it is better, when and if the families agree then we provide them the ideal treatment—that is surgery to just remove the uterus.

"What about at the civil hospital, how do you approach this problem there?" I ask. *"This is how it is everywhere"* explains Dr. Banur. So, I ask, what about the lack of "work-up" to examine and understand the symptoms; and to decide if surgery is needed?

Dr. Zahur, who is part of this conversation, responds to this query and confirms what he had told me in an earlier conversation.

> "Yes, this problem is there. The problem of infertility, the dis-uterine bleeding, so they are not being worked up in order to identify their hormonal status; that is other physiological and psychological examination are lacking. Also because of the poor status of women they cannot afford to get the necessary medical consultation."

And. Dr. Banur interjects:

> "We only remove the uterus when they are having a problem; a benign problem. The situation is medically treatable in the developing countries, such other minimal interventions like doing microwave, burning the endometriosis, just removing the endometriosis. But, we are going for the major surgery because our patients will not come for the follow up visits necessary for any kind of medical/ non-surgical treatment."

In this statement, Dr. Banur states very clearly that the hysterectomies taking place in the hospitals in Quetta are not necessarily performed for serious conditions. Rather, the lack of intermediary medical interventions, according to her, "medically" demand that women's uteri must be removed to eliminate the manifest symptoms that are considered a consequence of a problem located and originating in and around the uterus.

Here I want to consider Dr. Banur's premise and views of the management of rural women's corporeal and social bodies. In one stroke, the marginal "rural, illiterate, poor" woman and marginal rural life are co-reified to justify hysterectomies. Taussig (1980) refers to the naming of diseases and diagnoses in clinical settings as a process of reification and thingification of the patient, such that what happens to the patient is the same as what happens to the commodity in the Marxist sense. The patient is objectified through the mark of the disease. In this way the disease, thus the patient, are understood in isolation from social relations and contexts, and thus veiling how social context

influences the manifestations of bodily ailments and perceived disease of the patient.[110] However, the women of Balochistan ending up with hysterectomies are doubly reified. Dr. Banur reifies the social relations and the rural context in which the women live and at the same time reifies women's bodies. Thus, no matter the specific malady, from the biomedical viewpoint the uterus is a uterus and the same uterus for all women. But not all women are socially (geographically and economically) equal, thus for rural women of Balochistan, normalizing hysterectomy is seen as the best medical decision for women stepping into the hospital. We might say that this is a particular form of social triage for the rural.

The "Operability" of In-operability

In a study in India, Lawrence Cohen (2004) links state funded sterilization of women, private renal transplantation, and the castration of *hijiras* through the concept of *operability*, "the degree to which one's belonging to and legitimate demands on the state are mediated through invasive medical commitment" (Cohen 2004,169). Women in Chennai have become "bio-available" to the gray market of the kidney transplant industry because of their post-operative status. They had all undergone the state supported sterilization surgery in exchange for the promise of a better future. Pakistan, just as India, is high on the list of countries considered overpopulated and has had an official policy to curb population growth since 1965 (Sathar 2001).[111]

The population program is almost the sole organ through which government population policy is expressed. By and large the program has only changed in the specifics about how it ought to deliver services, but has remained focused on women and

has been based on a model that expects women themselves to seek services. Although the program lacked funds and political commitment at various points in its history (i.e. during Zia's regime for two to three years), there has been a distinct revival of interest in population policy from the mid 1990s (Sathar 2001). Although since independence the entire thrust of population or family planning program in Pakistan has aimed to encourage women to reproduce less, unlike India, Pakistan has never advanced an explicit policy promoting sterilization. In this period, health outlets were given a key role in providing family health services and the Ministry of Health launched a scheme of its own to provide 40,000 lady health workers (LHWs).

Unlike the situation in Chennai India, where the medical arms of the state arguably coerce women to obtain the tubal ligation operation, in Pakistan, despite the absence of any extant state-sanctioned incentive for women to remove their uteri, unnecessary hysterectomies— another form of sterilization—are taking place in large numbers. Hysterectomies are neither free, nor a condition for another operation such as the removal of kidney in Chennai. Yet, like the Chennai situation, women in Panjgur are not seeking medical service for sterilization surgery. In Panjgur, most of the women were in search of a solution for bodily ailments manifest in abnormal bleeding and/ or bodily aches and pains. These symptoms were often linked up with concerns about infertility. Thus, hysterectomy, for the many women who end up with it, marks a break of their future. The kind of future they seek is not secured here, not even the improvements in their health condition that might enhance day-to-day living.

Moreover, while transplant bioavailability came to depend on new ways of conceiving the body as more or less dead according to (Lock 2001); in Pakistan,

however, hysterectomies are not a result of new ways of conceiving the body as half dead and half alive. Unlike transplant surgical technology, surgical removal of the uterus is an intervention on lively bodies seeking resolutions to unexpected bodily "disruptions," such as infertility. As a surgical intervention that further disrupts women's daily lives, this too produces additional bodily disruptions (i.e. side effects).[112] The problem facing medical doctors is the fact that women's bodies are complicated. It is not so much that a woman is more or less finished being a woman or finished having babies, but rather the cervix is removed because sometimes it is too difficult to remove the uterus only. Thus, one type of in-operability provides the medical rationale for another operation—the hysterectomy. I suggest that this is an example of the operability of in-operability. For the frustration with the uterus in the 19th century and now for the medical establishment in the 21st Century is, in one important sense, a confrontation with the complexity of women's corporeal bodies. Thus, there is nothing emergent here, and as we saw in the earlier discussion about Dr. Banur's reasoning, the perceptions and realities of rural women add one more social dimension to that complexity.

As an ethnographer it is important for me to ask why most of the women receiving hysterectomies are less than forty years of age and how this is justified. What makes such an extreme procedure an acceptable necessity for women who may have at least another ten years before experiencing pre-menopausal symptoms? How does the biomedically-influenced perception about the "menopausal" stage mark hysterectomy in some sense as almost banal and inconsequential for women's bodies and everyday life? In the survey I conducted, 108 women ranged in age from twenty-five to forty-five years at the time of the surgery. Yet, Dr. Banur claimed that it is only when women "have the

complete family", that the "medical" decision for hysterectomy "is the best decision for them." This contradicted the reality that I learned about in Panjgur, which is that a fewer women are marrying young, and that many women in fact had not "completed their family" before surgically losing their womb. There were several women in the survey who had not had a single pregnancy or child prior to the hysterectomy. This is a trend not unique to Panjguri women, illustrated by published results of clinical studies conducted in several hospitals of Pakistan. In one study, among the 400 women (aged 15 to 35 years) seeking services from infertility clinics in five different tertiary care hospitals in Karachi, 45 per cent had 1 pregnancy, 21 per cent had 2 pregnancies, and 78 per cent had not had any live children before confronting her infertility problem: 95 per cent of the women who had children only had one before becoming infertile.[113]

Throughout our conversation, Dr. Banur emphasized the social and logistical factors rather than the medical reasons for the hysterectomies. According to Dr. Banur, women are "poor" and "remote", thus hysterectomies rather than non-surgical medical procedures are the first line of intervention in the hospitals of Quetta. This is so despite the availability in Quetta and Karachi of less invasive non-surgical medical technologies to address women's uterine-related disorders and distress. Dr. Banur admits that medical options other than hysterectomies are medically available, such as the "burning of the endometriosis by endoscopies". This is a procedure that she herself views as the ideal treatment. Yet, visiting the hospital in which she works have never been provided with such a treatment, nor is it a common treatment in Karachi, for according to Dr. Banur most women and their families cannot afford it.

> Dr. Banur: In Balochistan, the basic problem is that we don't have the interaction often with the patient. They come from Gwadar, let's say, or Dal Bandin. We

> can't follow to ensure they take the medication. We can't rely on follow up visits. So it is better to counsel them to do the surgery.
>
> FT: How are they properly advised about their options?
>
> Dr. Banur: Yes they are. Suppose they are not cooperating. They are reluctant because they need more children, and if they do not like surgery, if they have associated medical problems, we keep the patient on the medical treatment. I am not saying that each and every person…I mean to say in the developing countries, we are not going with the medical treatment such as the removal of the endometriosis. The ideal treatment is the burning of the endometriosis, by endoscopies, and procedures like it.

There are several different non-surgical medical treatments available in Karachi. Even in the private hospital in which Dr. Banur works, the (GnRHa) hormonal injections to "regress" the fibroid tumors and stop associated bleeding are available.[114] So why aren't women getting this medical treatment for fibroid or *rasoolis*, as the Panjguri women would say? Why are hysterectomies performed to take care of fibroids? Fibroids are the most common indication for hysterectomies worldwide. This fits the results of my survey. According to Dr. Banur, a single shot of (GnRHa) costs 10,000 rupees ($200); and a woman would need 6 injections over 6 months, costing in the end about $12,000. During this treatment, the ovarian hormones are temporarily suppressed. As with endoscopies, described above, Dr. Banur said she has never provided this treatment, nor is it a common treatment in Karachi because most folks cannot afford it.

> FT: You mean to say these techniques are available?
>
> Dr.Banur: "They are available in Pakistan, in Karachi, but not in Quetta. We only remove the endometriosis by dilation and curettage. This is one sort of surgical procedure. This is available here and everywhere. D&C is used for Fibroid treatment. There are medical treatments for fibroids, such as injection, but again we need follow up after 6 months. It will only respond if she will continue to take it. It is expensive.

I wondered about the issue of cost and time that Dr. Banur claimed deterred people from repeatedly traveling great distances to search for a solution—medical or otherwise—for their physical ailments. I discussed the issue in a separate conversation with Dr. Zahur's wife, Zarina, at their home in Quetta. Zarina asked me about the cost of the surgery: we calculated that it would be about 50, 000 rupees ($1000). According to Zarina it is easier for rural folks to pay less over time even if ends up a little more in the end. Zarina, thus, disagreed with Dr. Banur's assessment that women would not make the necessary number of journeys back to the hospital to follow up medical treatments. In the same conversation Dr. Zahur says: "But one thing that she (Dr. Banur) said is correct. That is, the Balochs from these areas do not go to the hospital as often as the Pataans. The Balochs ignore their sickness for a long time. This has to do with the social situation of having less money." Yet, his wife, Zarina argues against this view and says that the:

> [V]illage people care for themselves, their body and health. They take care of their health; they sell their gold and jewelry, everything- all their wealth- to spend on their health. We don't do all this for our self-care in the city. We don't have it in us. We ignore everything because we think and say that we are near the civil hospital, doctors are near so when we have an emergency we can quickly reach a doctor or the hospital. But they, the village folks know that they live far, and doctors and hospitals are far.

Zarina goes on to argue, keenly observing the problematic rationality underlying Dr. Banur's reasoning about why the hysterectomy is the best option- that is giving injections benefits the pharmaceutical companies that produce the medication, whereas performing the surgery benefits the doctors and the hospital. In her words, "I know that Dr. Banur alone makes two lakh's monthly ($4000.00) doing these surgeries."

In Zarina's statements I could hear echoes of dhinabhug Guljan's views and why in her mind women can become "half a person, half human" following a hysterectomy.

The sense that the body is not the same after the surgery is paramount for both Zarina and Guljan.

Cohen explains that, "What matters in delineating structures of genealogies of bioavailability is an articulation of vital technique and forms of care with neoliberal entrepreneurship."(85). If we agree with Zarina's analysis of the contradictions that underlie Dr. Banur's stated rationale, we can detect the infiltration of neo-liberal ideology, whereby the medical standards set by the national scientific community are trumped by pre-determined fee- for-service, and a cost and social-effectiveness strategy from the perspective of the medical provider who is in the business of ensuring fees for her services. Keep in mind that most of these surgeries are taking place in private hospitals and a majority of surgeries performed by Dr. Banur take place in the private hospital where she works rather than in her civil service job.

Zarina also balked at Dr. Banur's suggestion that women experience minimal to no post-operative side effects and in her words,

> When Dr. Banur says there is no effect from this surgery, what is she thinking? Absolutely there is an effect. What does she think, that we are insane? The body has surgery, what is she thinking. Absolutely there is an effect. What does she think, that we are insane? The body is such a thing, that you remove one part, then that spot is empty- yes indeed. Don't you think if you cut off one of your fingers it would look bad, and everything would change—adjusting to driving, eating etc. Then the entire body is not the same. How can she say there is no effect?

Dr. Banur had explained assuredly that women do not usually develop "serious" complications following the surgery, and moreover any complication that might develop " is typically "benign" and primarily "psychological". Stating, "[S]ome of the patients develop psychological problems adjusting to the fact that they cannot have more children after the surgery…It is mostly that she develops psychological problem because she puts

on weight, she's not menstruating. Because she is not menstruating her hemoglobin improves so she puts on weight." She further explained:

> [I]f we see that a patient is having a problem in the ovaries, and the patient is young- under 40, we remove only one ovary. Any doctor who is conscious knows this is the ethical practice. If the patient is too old, 70-80 years old, and the ovaries are looking unhealthy then this is ideally to be removed. Or we take the history and if there is history of carcinoma in the family, breast cancer or other things, the patient is given positive result in the first family, especially the mother, or sister then it is better to remove the ovaries in these patients. The ethical practice is that one ovary is left behind in order to minimize or avoid the consequent hormonal disturbances- or to ensure the maintenance of the hormones.

The Colonial "Medical Gaze" Revived

Anne Witz's (2001) historical investigation delineates how European women doctors practicing in India were colonizing women because they brought Indian women into the purview of the "medical gaze" which was at the same time an "imperial gaze" (p. 39). She argues that European women doctors were implicated in the project of medical imperialism in both the colonial context of India and in Britain. In one sense, Dr. Banur's so-called ethical perspective resembles a process that Witz terms European "female medical discourse" that was simultaneously colonizing and democratic toward Indian women's individual and social bodies (p. 38). In large part the Pakistani urban imagination of what is "rural" is a Punjabi and Muhajir imaginary about Balochs and Sindhis that converges with the imaginary they have about "tribalism". This *ism* is category that is inscribed onto the social bodies of rural and urban Balochs in particular—a point that I discuss in Chapters One and Six. In Dr. Banur's outlook, hysterectomy is the necessary techno-medical intervention. This pervades the biomedical and biosocial imaginaries that converge to trump the range of other bio-scientifically available

interventions that could prevent hysterectomy as the ultimate fate of women. I will return to this point.

Later that evening Dr. Zahur and I continued our conversation, along with his wife who teaches at the Balochistan University; and their four children at their home over dinner. I asked Dr. Zahur how common was the "ethical practice" of removing only one ovary? According to Dr. Zahur this is not common at all and that a majority of the organs he receives in his laboratory include bi-laterally removed ovaries. The next day I visited Dr. Zahur in his histopathology laboratory at the newly built government teaching hospital, where he showed me the "specimens" that he receives from "Makran to Zhob to Chaman" (in other words from all over the Balochistan province). He also showed me the only machine available in Balochistan that is used for tissue biopsies. If the organs and tissues are not sent here, then they are sent to Aga Khan University (AKU) in Karachi, the leading high tech private hospital in Pakistan. In his ten years of experience, Dr. Zahur found that it was medically necessary to remove just two out of ten uteri; 80 per cent of hysterectomies were unnecessary with no evidence of fibroids, malignancies, or wounds. As he was showing me several of the removed uteri and the bi-laterally removed ovaries stored in his lab, I wondered if we could have better evidence than this for the countless unnecessary hysterectomies that are taking place annually worldwide. In the absence of other treatments, the hysterectomy becomes a form of medical treatment that in reality is primarily social and logistical management. Women are advised to have hysterectomy without proper assessment of their physical complaints or diagnosis of the reasons for abnormal bleeding, to determine if perhaps a less invasive procedure would do.

For Dr. Banur, the effect that the temporary or permanent disappearance, reappearance, or absence of reproductive hormones could have on women's psyches and bodies did not warrant much concern. These emerged as points that were almost banal against what she considered as the right and *ethically* necessary intervention to remove the symptoms emanating from women's bodies. Besides holding a reductive view of menopause as a phase without bleeding, her firm views suggested to me a kind of medical relativism. For women living in "rural" and "remote" areas of Balochistan hysterectomy is the "ethical" choice, even if "sometimes" this requires removing one or both ovaries. Thus, the limit of this hybrid of medical and social ethics resides in deciding whether one or both ovaries must be removed, in addition to the uterus.

However, Dr. Banur's apparently good intentions and sense of medico-ethical responsibility belie several important social facts. My survey and myriad conversations with women in Panjgur indicated that women's pains, aches, and the very symptoms that led to the surgical removal of their uterus did not disappear after the surgery for many of the women. The medical literature suggests that post-operative complications of hysterectomies are quite common worldwide, irrespective of the availability of the most advanced, high tech facilities. Consider that in one clinical study in Pakistan, tracking 30 cases of peripartum hysterectomy during a period of two years, the average stay in hospital due to preoperative and postoperative complications was 12 days, ranging from 7 to 21. Among the 30 women in the study, 25 had received total abdominal hysterectomy and five received sub-total abdominal hysterectomy. Uterine rupture was a major indication for emergency peripartum hysterectomy. The article linked injudicious and improper use of syntocinin during the third stage of labor and blamed TBAs (Sumera,

Mahmood, and Akram 2003). Yet, my ethnographic work in Panjgur as reflected in my discussion in the previous chapter points to the upsurge of private run clinics by LHVs and LMOs.

In contra-distinction to Dr. Banur's claim that women primarily "develop psychological problems adjusting to the fact that they cannot have more children after the surgery", and that there are few post-operative complications, the medical literature suggests that hysterectomy is not a simple, benign procedure. During surgery, ligaments and nerves are frequently damaged or severed, leading to problems such as constipation, urinary incontinence, and disturbed sexual response. Clearly, if women and their families are eager to leave as soon as one day after the surgery and rarely return for follow-up due to the constraints of cost and distance, as Dr. Banur claimed, then she would have limited if any information about the rural women's post-operative status. What one can know and see about individual and group suffering is in any case partial. This is no less true for the well-intended clinical gaze of the medical doctor. Yet, research published in medical journals provides a more startling assessment of the effects of this surgery on the bodies of women and how it multiplies women's suffering. One key fact here is that most hysterectomies involve the complete removal of the uterus and both ovaries. Further, in a large percentage of cases in the hospitals of Pakistan as well as in the U.S., the cervix is also removed.

Particularizing rural bodies to normalize hysterectomies

As I have hinted already in the previous sections, it turns out that Guljan and Dr. Zahur were on to something bigger than any of us imagined. Medical literature published in Pakistan, the U.S., and Britain suggests that while hysterectomies are no longer based

on the diagnoses of "hysteria", hysterectomies may be more prevalent today than in 19th Century Europe. In some respect, the social, which in the 19th century was reduced to women's psychology, continues to have a powerful, even if residual, role in determining the medical management of women's corporeal suffering, which are linked to the mal-function of the uterus. Certainly Dr. Banur, in making reference to the psychological, locates the post-operative complaints concerning women's feelings of angst associated with loss of the uterus, in their heads. Moreover, the psychological issue is quickly dismissed as a transitory emotional state: "they eventually get over the absence of the uterus", she tells me. Thus, just as in the 19th century, neither the pre-operative, nor the post-operative physical sufferings of women are taken seriously enough beyond their locus within the uterus. Even if no longer understood as directly linked to psycho-emotional states, the disruptions to a healthy reproductive body, is ultimately located in the uterus. Consequently, in seemingly disparate trans-local medico-economic contexts, *cutting* it out is the solution, and what follows thereafter is minor—if relevant at all from a biomedical ethical perspective.

I want to prevent a reductive reading of Dr. Banur's acts, speech, and claimed medical expertise and the extant high incidence of hysterectomies in Pakistan as one about a "cultural" or "Third World" problem marked by poor quality of care and professional greed. Current data suggest that the U.S., Britain, India, China, Pakistan, and Bangladesh are among countries with the highest incidences and prevalence of hysterectomies per year in the world.[115] Thus, we might ask, why do these high rates exist, despite the presumably divergent levels of medical and technological resources, for example between Pakistan and U.S.? Do the medical rationales underlying Dr. Banur's clinical decisions in Pakistan about hysterectomies deviate in any

significant level from those in hospitals of U.S. and Britain? The Eurocentric medical view of the uterus as useless, functionless, overused, and "bad," remains a central problem produced in discourse. This discourse, a consequence of the spread of biomedicine and biotechnology, is widespread globally. It influences medical diagnosis and the possibilities and limits of treating women's physical sufferings worldwide.

Perfected in the 1870s in Europe, hysterectomy was eagerly adopted by some doctors as the "solution" for a variety of women's problems. At a 1971 meeting of the American College of Obstetric and Gynecology the prevailing attitude toward the uterus was summed up by a medical doctor as follows: "It's a useless, bleeding, symptom-producing, potential cancer-bearing organ."[116] The latter statement by a biomedical expert clearly locates the source of women's physical and reproductive ailments no longer in the heads and minds of women, but rather points to the uterus, an organ unique to women, as the culpable agent.

This attitude toward the uterus and the technical difficulties it presents for determining a procedure other than a hysterectomy for the malformations and malfunctions in women's bodies is neither unique nor exclusive to the Pakistan context. Hysterectomy as a universal surgical procedure in biomedicine seems to hold the promise of a *clear-cut* solution to surgical risks and technical dilemmas, and perhaps to the inconvenience of irregular bleeding, despite the specificities of women's lives and regardless of the presence or absence of high-tech medical resources. This is one result of the globalization of biomedicine. If we take the high rates of hysterectomies in the U.S. and Britain, it would appear that how to deal with the "unruly" uterus is as much a problem for medicine there as is in Pakistan.

Though "hysteria" no longer exists as a diagnosis, hysterectomy is the second most commonly performed surgery in the United States (after cesarean section) on women 40 to 44

years. The AMA, in 1988, found that 50 per cent of the 700,000 annual U.S. hysterectomies were unnecessary. Fibroid is a common reason for a hysterectomy. A myomectomy (removal of the fibroid) would preserve the cervix and ovaries, but this is an uncommon procedure, due to the fact that it is considered a technically more difficult procedure than hysterectomy. A myomectomy surgery requires six hours, whereas a hysterectomy can be performed in one hour. Cervix removal leaves some women with a shortened vagina resulting in painful intercourse for the rest of their lives. The cervix plays an important role in urinary, bowel and sexual function. Older medical doctors in the U.S. have been trained to always remove it (the cervix), which they do 95 per cent of the time. Although among the women having hysterectomies less than 1% have ovarian cancer, 60 per cent of hysterectomies also remove the ovaries. Ovaries have an important function throughout a woman's entire life—producing androgens, affecting her sense of wellbeing, muscle strength and libido. Fibroid tumors are often the cause of heavy bleeding, but abnormal bleeding is rarely caused by cancer. What I am suggesting here is that biomedicine's perception of the uterus and the diseases associated with it has not altered significantly, despite the transformations in obstetric and gynecological technologies and understandings about the determinants of uterine, cervical, and ovarian disruptions. Thus, the social, that which I suggest constitute the boundaries of human capacity to apply and work within limits of bio-technology is deeply implicated in mediating bio-scientific understandings of body-disease that invariably result in the bypassing of less invasive and less debilitating biomedical interventions. However, the social is also implicated even when biomedical procedures are clearly not hindered by technological limits as I witnessed in Panjgur.

In the hospitals of Quetta and Karachi, hysterectomies are performed and justified as a normal treatment protocol because people are "poor" and live in "remote" areas. Doctors I spoke

with were up front about the fact that the procedure is largely medically unnecessary, but a vague concern about the structural conditions and constraints of the lives of women provides the social, and not the medical, rationale they require to do the "ethical". What biopolitical imaginaries are at work here concerning the marginal that justify particular medicalized treatments of women's bodies? Here I want to point out two contradictory imaginaries that are at work. One imaginary at once particularizes and universalizes the rural women of Balochistan. Whereas rural women's bodies are particularized through the conception of women's social bodies, their bodies and wombs must also be universalized to justify the universal intervention of removing their uteri. Yet, the uterus as a universal biological object and hysterectomy as a universal medico-technical intervention is shaped less by scientific priority than by technical limitations. Rural women's lives are provincialized in the sense that these women can "take it", regardless of the side effects. Under implicit state authority, the practitioner will decide that the measure of life resulting from a hysterectomy is far better than what the women would have to endure without such an intervention.[117]

Conclusion

In this hierarchy of resort in science, the calculus of risks and benefits for medical techniques places the onus on the social bodies of rural women. Yet, what is hidden in this biomedically authorized position is the calculus of risks that is embedded by another social factor that influences the medical and surgical techniques that medical doctors apply within the context of the hierarchy of technical skills. The less radical technique is a greater challenge to surgeons than a radical removal of the uterus.[118] Contraceptives are what Foucault termed "disciplinary technologies." I suggest that hysterectomies come to stand for another kind of disciplining of the bodies of women that are result of failure of

biomedicalizationg. As Dr. Banur's comments suggest, rural women's bodies in Balochistan were bound up by the perception among the medical practitioners about the remoteness of women's economically rural lives from the "normalcy" of the medical possibilities for urban and more well–off women. In a sense the medical establishment fails to completely medicalize the range of choices available to rural women. The concentration of more advanced medical, technical, and surgical procedures in the urban settings of Quetta and Karachi and the social facts of physical distance and lack of appropriate and incomplete medical facilities and qualified practitioners, opens the way for a different approach to the rural, poor, and the distant. Here, of course, the physical distance is deeply intertwined with the social distance between a certain urban-modern marriage and the resolute faith that Dr. Banur holds about what biomedicine can offer.

As noted in the Introduction, Chatterjee argues in relation to India that "the rule of colonial difference," marked by race, is part of a "common strategy for the deployment of modern forms of disciplinary power" (1993:18). Similarly, in Pakistan the medicalization of reproductive behavior is linked to broader and differential policy objectives of the state toward different population groups that, in turn, are internalized by state functionaries working in government and private medical centers. As I have argued here, medicine, medical services, and medical technology intersect to socialize and racialize rural subjects in order to justify the medical relativism/"proper" care for the rural women of Balochistan. But while the "benevolent" state is present here via the medical system, it is absent in other ways, for example, in terms of the historical and present lack of investment in the infrastructure of Balochsitan.

In the following chapter, I engage specifically with transnational feminist theory (including co-formations of gender, race, ethnicity, and postcoloniality). I address how arguments about universal rights for women end up re-invigorating primordial-biological notions that characterize tribal identity at the cusp of the 20th and 21st centuries. I trace how older colonial notions of tribalism re-emerge in transnational discourse on human rights to frame the links between tribal ways, gender relations in Baloch "tribal" communities, and Pakistani women's social condition. Specifically, I show how the naturalization of Baloch "tribalism" in human rights and development discourses defending women's rights are re-produced by the Pakistani government and national policy makers in the name of developing Balochistan.

CHAPTER SIX
PRODUCING GENDERED "TRIBALISM"—CAN HUMAN RIGHTS DISCOURSE and THE STATE "SAVE" THE BODIES of WOMEN from the "TRIBAL" SOCIAL and BODY POLITIC?

Introduction

> Colonialism may be dead, yet it is everywhere to be seen. (Dirks 2001:303)

> The contribution of customary and tribal norms to the discrimination against women has only recently received attention; given the flagrant deterioration of women's rights in Pakistan during, and as a consequence of, the Islamisation drive in Pakistan in the 1980s, women's rights activists and human rights groups focused on this source of deterioration of women's legal and social status and are only now turning to other sources of discrimination. (Amnesty International [AI] 1999: 45) [119]

> States have an affirmative obligation to confront those cultural practices of the community which result in violence against women and which degrade and humiliate women, thereby denying them full enjoyment of their rights. International standards require that there be concerted State policy to eradicate practices even if their proponents argue that they have their roots in religious beliefs and rituals…This can be achieved through legal measures. (AI 1999: 4)

While contemporary anthropological scholarship on the Balochs is largely concerned with the category of ethnicity, it is the term tribe that has captivated thinking around social and economic development of the nation and circulates in discourses about the Balochs and Balochistan province inside Pakistan. The contemporary constructions of particular subjects (i.e. local midwives and Baloch tribes) and social practices (midwifery and tribal ways of life) that are the object of development in Pakistan, possess a good deal in common with earlier colonial reifications and fetishizations of unfamiliar ways of life, albeit with a distinctive character that derives from the politics of Pakistan's contemporary national identity, in which tribal ways are opposed to national ways. The current national discourses view Baloch culture as tribal and remote and Baloch villages

as controlled by *sardars* (tribal leaders) and dependent on unskilled, 'pre-modern' healers. This framework operates across different scales and discursive spaces, and leads to solutions that posit the need for replacement of rural healers like the *dais* (UNDP 1998) and elimination of tribal customs. Contemporary focus on tribalism as a national problem becomes a rationale for designing policies of improvement that parallel in myriad ways 19th Century civilizing discourses of British colonialism in India.

In this chapter, I draw the connection between the racialization of Balochs as "tribal" and its people ungovernable, with the desire to modernize through large-scale development technologies.[120] Specifically, I address how the naturalization of Baloch "tribalism" in human rights and development discourses defending women's rights implicitly endorse the eradication of tribal life. Moreover, in Chapter One, I addressed how the demonization of tribalism is re-produced by the Pakistani government to justify its national policy and militarization in the name of "developing" the Balochistan province. This rhetoric of development is also gendered and sexualized. I develop these themes in this chapter, and provide an example of how women and honour are rhetorically and literally made to collide by the President and the Army of Pakistan. The state's attempt to frame a popular tribal chief (Bugti) for the rape of Shazia Khalid by an army general unsettles Amnesty International's and other human rights organizations' discursive framing of the state as the savior and defender of women against tribal/customary laws.

International human rights documents are an important site needing critical examination of the re-inscription of colonial discourse. In analyzing an Amnesty International (1999) document, entitled *Violence Against Women in the Name of Honour*,

in which Pakistani feminist legal and political activists and journalists are extensively quoted, the gendered violence against women called "honour killings" is constructed as a "cultural practice" that is unique to tribal value structure and a "tribal norm". The call to link transnational feminism and postcolonial criticism entails the recognition that colonial gendered and racialized representational strategies impact the material realities of postcolonial subjects and social relations. In these documents, which rely largely on intra-national feminists to address gender related social problems across social and national boundaries, artificial demarcations are made between culture as a discrete sphere separable from economic and political processes. Moreover, in this discourse of women's human rights, culture is further broken down to distinguish and produce hierarchies of patriarchies between tribal, religious, and national value structures.

What binaries and essentialisms are produced as a result of feminist concerns in human rights campaigns about violence against women in Pakistan? What are the potential consequences of such constructions? And what are the implications of invoking culture and tradition to particularize forms of violence within nation-State boundaries and simultaneously insist on a universal legal and state-empowering solution? In examining one human rights document, in which in its hierarchy of patriarchy tribal cultures are designated as more patriarchal than Islamic culture, which in turn is considered more patriarchal than 'secular' culture (AI 1999: 43-46), I delineate a problem in human rights documents that engages gender in a comparative frame within and across "cultural" and national borders; I explore the politics of universalist and particularist claims in human rights discourse; and I point out how the rhetoric of universalism relies on a colonial type of relativism.

I want to be clear here that I do not deny the existence of violence against women and their murders in Pakistan. However, I am interrogating where the *cause* of honour killing is located. What I am arguing is that while the report in its righteous narration and tone denigrates the tribal value system through what it calls honour killings, it does not show that it understands what this tribal value system is in first place. If the tribal system is nothing more than condition of possibility for honour killings, then honour killings will end when the tribal value structure is eliminated. How do we then eliminate a value structure without impacting a way of living? Is it possible to keep the people, while getting rid of a way of living? Who are the judge and jury in this process? These are not questions of concern in the report.

The 1999 Amnesty International (AI) document is one of an increasing number of high profile documents in the late 20th century in which the attention to "traditional practices,'' considered particularly harmful to women, has increasingly become the yard-stick for evaluating the constitution of cultural norms in human rights discourse. The human rights discourse about violence against women is part of an international campaign involving human rights activists and feminists. The AI report describes the different facets of the "phenomenon" of "honour killings" in Pakistan. It purports to look at the "*traditions* that form the framework of such killings, particularly the *commodification* of women and the notion of honour" (emphasis added; AI 1999: 2). The report argues that, "the notions of what defiles honour have continually widened beyond defiance of sexual norms to include other forms of perceived defiance of social norms by women" (ibid). The report is the fourth in a series that AI has published on different aspects of women's rights in Pakistan. This is the first report on abuses of women's rights

by "private actors"—meaning not state functionaries or employees. I will show how the notion of "tribal honour" in the AI report rests on the view of women's life in Pakistan as a statistic; tribal life as static and a-historical; and on the misconception of how the concept of honour functions in tribal communities.[121]

The Contest of Bodies: Women's Physical Bodies versus their Tribal Social Body

> The government of Pakistan has failed to ensure that women are aware of their constitutional rights and to put in place adequate measures to ensure that these rights and freedoms take precedence over other norms, which deny women equality. ***Women's lives*** are by and large *confined to the private sphere* with little access to information outside of their homes. As their lives ***are inevitably governed by the traditions of the community and tribe***, women in Pakistan do not enjoy or benefit from the fundamental rights recognized in the Constitution of Pakistan nor the provision of Muslim personal law. (Emphasis added; Amnesty International 1999: 45)

The notion, in the AI report, of fixed tribal "customs", including the uncomplicated understanding of honour, ignores the continued reinvention of a subjectivity that is both an effect of and produced by technologies of control (Foucault 1973, 1978). The human rights policy document I examine holds implicit assumptions about physical bodies of women, the tribal social body, and Pakistan's body politic. In this section, I examine how Amnesty International's conception and construction of violence against women as "honour killings", including its causes and proposed solutions to end the violence against women, frame Pakistani women's bodies, the tribal social body, the nation-state body politic, and the relationship between these three bodies.[122]

Nancy Scheper-Hughes and Margaret Lock's (1987) conceptualization of the three bodies, following Douglas's (1970) "two bodies"—physical and social—offers an analytics to examine how human rights and development policy documents inscribe the

tribal cultural "norms" onto the disembodied representation of women's bodies. The three bodies are: individual body, referring to the lived experience of the body as self; the social body, constituted by the representational use of the body as symbol of nature, society, and culture; and the body politic, having to do with regulation and control of the bodies. In the AI report, the subject-position of women vis-à-vis the tribal collectivity is one that is constructed as simultaneously dislocated from tribal sociality and habitus and controlled by it.[123] Tribal sociality is also conceptualized in relation to the national body politic, wherein a call is made for increased surveillance of tribesmen who are considered to be problematically sitting outside of the regulatory reach of the state and are represented as a threat to the temporal and spatial edges of modernity. Body politic is the element of society that is concerned with regulation and control and in its modern form is inextricably associated with state power and the national legal infrastructure. The government of national bodies, while no longer in the hands of an absolute monarch, is nonetheless shaped by the controlling processes of state derived policies and institutions. However, investing national bodies or socializing subjects to voluntarily submit themselves to technologies of control is not exclusively endorsed and enforced by state-based infrastructures. Intra and international non-government organizations, including human rights groups increasingly share the normalizing goals of the state, are in fact calling on states to more effectively conduct their responsibility in shaping the conduct of all social bodies of the nation. This point is well illustrated in the quote above and elsewhere in the AI document, in which reporters explicitly call on the Pakistani state to take on a pro-active stance in policing the customary practices—as they understand

them—of the "tribals".[124] This discourse pits women's physical bodies against the tribal social body and pervades the entire Amnesty International document.

The Disembodied Pakistani "Tribal" Women

> The rationale of honour killings: Two main factors contribute to violence against women in the name of honour: women's commodification and conceptions of honour. The end result is that the "right to life of women in Pakistan is conditional on their obeying social norms and traditions. (Hina Jilani quoted in Amnesty International 1999:9)
>
> Women are unfamiliar with public transport, usually have no money and are highly visible, suspect and vulnerable to further abuse if they move around alone…Many of the women who simply run in panic without plan or goal, are caught and killed in the fields, hiding in a graveyard or trying to reach a road. (Amnesty International 1999:29)

As the quotes above indicate, according to the Amnesty International report, it is impossible for women to escape the brutal "tribal justice system" (AI 1999:29).[125] Leaving aside for the moment whether women escape the tribal legal system, I want to take up the question of the "brutality" of this system and the presumed benevolence of the state in this claim. According to Scheper-Hughes (1994), the body is "both unquestioningly real and existentially given, even though its very giveness is always historically and culturally produced." (p. 230). Human beings live in bodies and communities and embodiment concerns the ways that the people "inhabit" their bodies (1994: 229). I would also add that embodiment concerns how they respond to suffering and the everyday as well as to extraordinary violence. Illustrated by the quotes above and below, in the Amnesty International's conceptualization of women's suffering, bodies are not embodied in this sense. The embodiment of the life of tribals is extrapolated and understood only through the statistics of murdered women.[126] In so far as this Amnesty

International policy report is concerned, the women's embodied experience is that they are relentlessly physically violated. There is a kind of epidemiological gaze operating such that the bodies of all Pakistani women are conceptualized as disembodied and detached from their social life. But the discursive gaze extends beyond statistical representations, such that tribal women are simultaneously written as hyper-socialized in so far as the women are considered *commodified* beings that require the intervention by the state to bring them into the national social sphere. Moreover, the problem of domestic violence (a term rarely deployed in the report) in Pakistan is simultaneously defined through women's bodies. The concept, or rather the misconception of tribal honour codes that produce honour killing is not merely a sign for the epidemic of violence against women in Pakistan, but is the very definition of tribal life. As the following quotes illustrate, the notion of honour functions as one that authorizes all tribal men to conduct deeply a-social acts against women.

> The logic of tribal tradition turns conceptions of victim and perpetrator, right or wrong on their head: women who are killed or flee a killing are not victims but the guilty party in the tribal setting. The man to whom a woman, whether a wife, sister or daughter, 'belongs', has to kill to restore his honour…In the tribal setting, an honour killing is not a crime but a legitimate action, seen as the appropriate punishment for those who contravene the honour code…It is not the truth that honour is about, but public perception of honour. (AI 1999: 12)

> Karis remain dishonoured even after death. Their dead bodies are thrown in rivers or buried in ***special hidden kari graveyards***. Nobody mourns for them or honours their memory by performing the relevant rites. Men by contrast are <u>reportedly</u> buried in the communal graveyard. (Emphasis added, AI 1999: 13)

> Honour killing was punishment for violating the honour code but the tribes have subverted the custom of killing not for honour but to obtain the compensation that the tribal settlement awards to the aggrieved person. (AI 1999: 24)

The Reification of the Social Body

> Honour in the traditional setting is a male prerogative, it is men who possess *zan, zar, zamine* (woman, gold (money), land…women have no honour of their own. (AI 1999:12)
>
> The possession and control of desirable commodities, especially *zan, zar, and zamine* are closely linked to the perception of man's honour. (Nafisa Shah, quoted in AI 1999: 11)
>
> A woman is an object of value and therefore is an integral part of the honour of a man, tribe etc. Therefore, when the rights of a woman are transferred from her father to the man she is marrying, the guardianship of honour shifts as well. (AI 1999: 11)
>
> The concept of ownership has turned women into a commodity, which can be exchanged, bought and sold. (Dr. Tahira Shahid Khan quoted in AI 1999:9)

As the quotes above should illustrate, the AI report repeatedly posits a causal link between "commodification" of women's bodies and violence against women. A six page section is titled "The rational for honour killings: commodification of women and the honour code" in which the report aims to show how " the concept women as an object or commodity, not a human being endowed with dignity and rights equal to those of men, *is deeply rooted in tribal culture*" (emphasis added; AI 1999:9-15). Citing Tahira Shahid Khan of Shirkatgah (a women's resource center based in Lahore and Karachi), the report takes as given that all women in Pakistan "are considered the property of the males in their family", and that "the owner of the property has the right to decide *its* fate" (emphasis added; AI 1999:9). Journalist Nafisa Shah is quoted:

> In the tribal society of Sindh and Balochistan, a woman is equated with money…But although she has monetary value, her worth is essentially that of a commodity and this view goes far towards creating a situation when she may be butchered if she transgresses the conditions under which she is bound to a man for life. She may also be freely traded or given away as part of an honour killing settlement. (ibid)

To construct the experience of Pakistani women as essentially one of violence and as objects of exchange between male kin is to *reify* her not only as an agent-less subject, but as a constant sexual object that exists outside of general community relations—neither having habitus, nor existing as part of a social habitus (Bourdieu 1992: 127).[127] According to the Amnesty International report there is nothing meaningful in tribal life other than the report's notion of honour. There is no "existential experience of the practical and practicing human subject" (Scheper-Hughes 1994: 232). The bodies of women as well as the tribal social body are devoid of subjectivity, for the problem of domestic violence against women is located in the subjectless male dominated "communal grip on the individual [female] body" (Weiss 2002: 22).

According to Lukacs, the nature of a *modern capitalist society* is such that commodity fetishism extends to all fields of human activity, including consciousness itself. Human beings literally appear as *things* rather than the active agents of economic activity and historical change. The only form of consciousness that can escape and transcend *reification* is the active collective consciousness that is embodied (emphasis added, in Macey 2000: 326-27). Here reification can refer to an extreme form of alienation induced by commodity fetishism. According to the Amnesty International report, it is in this very sense that women are alienated from tribal life. For the AI report women are only *things* in tribal society, and in this move, ironically, the "commodification" of women is not construed as a consequence of factors deriving from the processes of modernization or modernity (signs of which are that women are increasingly murdered with guns in urban and major cities of Pakistan), but rather is considered a result of its notion of the unique characteristic of tribal, pre-modern, and

pre-capitalist realm.[128] Thus, what is constructed as the *essence* of tribal social life, and without any empirical evidence, is a bounded world characterized by incessant fetishism of women who are objectified and transformed into commodifiable flesh and whose use-value and exchange-value together are shaped and controlled by the desires of tribal men. Quoting Nafisa Shah, a Pakistani feminist, the report asserts:

> [A] whole honour killing ***industry*** has sprung up with a range of stakeholders including **tribes people**, police administration and ***tribal mediators***. (Emphasis added, AI 1999: 25)

This statement is followed by an example of a murder of a Punjabi woman in Lahore, Punjab.

> In Pakistan, feudal and tribal custom dictate that ***property*** be kept in the family. It is not uncommon for girls to be married to a paternal uncle or aunt's son… (Emphasis added, AI 1999: 25)

In the report, the representation of tribal women as disembodied requires the reification of the tribal social body. Bourdieu (1992: 54) writes that the production of habitus occurs within particular fields which have "objective conditions . . .[and] certain possibilities and prohibitions, freedoms and necessities; these conditions then generate dispositions objectively compatible with these conditions." In other words, subjects are constituted through social relations and intersubjectivity. However, in the Amnesty International report, the reality of an intersubjective engagement in tribal spaces is effaced. The tribal social body has no history. Csordas (1999:182) explains that "embodiment is about neither behavior nor essence *per se*, but about experience and subjectivity, and understanding these is a function of interpreting action in different modes and expression in different idioms." Following Barth's (1986) notion of work and text, Csordas reflects on the relationship between body and embodiment. He suggests that

the body can be viewed as a biological entity and that "embodiment is an indeterminate methodological field, defined by perceptual experience and by mode of presence and engagement in the world."[129] Also, following Meleau-Ponty (1962), for Csordas, perception is basic bodily experience, where the body is not object but a subject. He posits that the body is an existential condition of life that encompasses multiple modes of embodiment. In the Amnesty International report, however, neither women, nor tribal society are constituted by embodiment. What do women think and do? How do they manage their variously constituted relationships? Are women simply passive victims of oppressive tribal culture? Women are presented, even if by name, only after death, and only in the form of statistics. As a postcolonial document, the AI report entails core elements of how European colonial regimes perceived the so-called Eastern or Oriental cultures, in which culture is reified to mean a fixed and primordial tradition and custom. Discursively stripped of agency, subjectivity, and even embodiment, according to the report, Pakistani women's voiceless bodies cannot but demand protection from the state. And this demand is made through the voices of some Pakistani feminists who are authorized by the report to represent tribal social life in anyway they want without necessarily ever stepping into that social sphere.

Violent Projections and Violence of Mis-translations

The Amnesty International document quite explicitly re-inscribes the 'tribal' as an ancient and deadly source of tradition when it writes:

> The logic of tribal tradition turns conceptions of victims and perpetrator, right or wrong on their head: women who are killed or flee are not victims but the guilty party in the tribal setting. The man to whom a woman, whether wife, sister or daughter, 'belongs', has to kill to restore his honour…In the tribal setting, an

> honour killing is not a crime but a legitimate action, seen as the appropriate punishment for those who contravene the honour code…It is not truth that honour is about, but public perception of honour. (AI 1999:12)

Tribal people of Balochistan and the North Frontier Province and their "value system" are produced as "Other". For example, the "tribal" denotation given to Balochs and Pathans (and at times Sindhis), are the central object (I use the singular because the Balochs and Pathan are represented as one throughout the report) through which honour killing of women by men is relegated as simultaneously primordial and lacking history. The tribal "customs" are inscribed onto the territorial bodies of Balochistan and Northwest Frontier Provinces and the social bodies of Balochs, Pathans, and Sindhis—though never Punjabis. In the AI report neither the Punjabis nor the Urdu speaker (also know as Muhajirs) are ever constituted as tribal.[130] As unmarked groups, both are considered part of the Muslim and secular national social world (AI 1999). What is important to note here is that both the activist and feminist cited in order to support the AI report's thesis about the causes of honour killings are primarily Punjabi. Yet, despite the fact that the greatest numbers of murders of women are taking place in the Punjab among Punjabi families, and in the guise of honour, Punjabis and Mohajirs are not marked as "tribes" mired in customary practices. The explicit individuation of Punjabis is evident in the following quote:

> Honour killings are no longer only reported from remote rural areas but also-though less frequently-from ***towns and cities*****.** The modes of killing vary somewhat…In Punjab, such killings usually take place by shootings and appear more often ***based on individual decisions*****,** occurring in an urban context and not always perpetrated in public." (Emphasis added, AI 1999:6)

However, despite the disparity in where and who is committing violence against women, the effect of the tribal notion of honour is inscribed on the bodies of *all* Pakistani

women, for the report argues that all Pakistani women are potential victims of "honour killings". There is a precise manner in which this inscription occurs of what is conceived as a-cultural pathological tribalism. Repeated reference is made to two local Sindhi and Balochi terminologies in an attempt to give valence to what I argue is the invented category, "honour killing," reserved for the East to emphasize "the origin of the practice" (AI 1999:9). These terms are *siah kari* (in Balochi language) and *karo kari* (in Sindhi language). Both terms are inaccurately defined as black person (either black man or black woman). The correct definition of this expression is 'negative action'. The literal translation is black for (*siah; karo*) and act for (*kari*). The term *kar* in Balochi means work and in Sindhi work is expressed as *Kari.*

This definitional problem permeates the entire AI document, and simultaneously essentializes women of Pakistan as victims and the tribal social body as misogynistic. It thus illustrates my point that locating the act of honour killing on the body/person of the killer and killed (e.g. the black person), leads to elision of a possibility that there is a moral/social discourse associated with the concepts of *siah kari* and *karo kari*. You might ask what the implication is of arguing that the moral condemnation is not of a person, but of an act. My assertion for what this wider discourse means suggests possibilities for moving beyond the denigration of an entire cultural group for individual acts (that in our present historical moment are influenced by individual abuse of traditional or religious moral discourses and modern technologies). The attention to internal, situated, and historical specific meanings of cultural terms, particularly those deployed in the AI report, can provide a window for thinking about how mutually reinforcing ethical positions, whose aim it is to protect and defend the rights of women, can come together to

achieve effectively those ends. It also points to the necessity of listening to women and reflecting upon exactly what women from across social and class divisions want and what protection they need; and moreover it demands attention to how women in their varied social, political, and family contexts want to work toward that end.

The discursive move in which individual acts among colonized groups, unlike for the unmarked European colonizer, come to stand for a defect in the entire culture, was a common colonial modality of power that extended from the domain of colonial medicine to the law. For example, Vaughan (1991) shows that the accumulation of medical knowledge served the ideological articulation of the colonial system and was not merely a matter of scientific interest. Concerned with the constitution of the individual versus collective dichotomy, Vaughan describes how the individuation of subjects that took place in Europe denied a colonized people.[131] Colonial discourse conceptualized Africans as members of groups and it was the groups, rather than individuals, who were said to possess distinctive psychologies and bodies (1991:45-46).[132] The idea that colonial biomedicine was never without its cultural and social preoccupations and premises is one that is also operative and more transparent in human rights discourse. As I am arguing in this chapter, in postcolonial contexts, individual acts of violence within racialized groups continue to mark norms of certain persons' culture in human rights discourse that also endorses differential approaches to populations in the legal domain. For example, in Pakistan the binary between tribal laws and Islamic laws is produced as the government decides which regime of non-secular power it must confront first to defend women's rights in the country. Implicit in this choice making is the desire to defend one form of social life (Islamic) over another (tribal). We also see similar tension taking place in the

United States and Europe in arguments around the compatibility of multiculturalism and women's rights. For example, Okin (1999), a lawyer and leading spokesperson of liberal law who operates with the premise that there exists an essential culture and an essential woman, argues the inevitability of clash between multiculturalism and feminism. She says:

> Indeed, they might be much better off if the culture into which they were born were either to become extinct (so that its members would become integrated into the less sexist surrounding culture) or, preferably, to be encouraged to alter itself so as to reinforce the equality of women—at least to the degree to which this value is upheld in the majority culture. Other considerations would, of course, need to be taken into account, such as whether the group suffers from prejudices such as racial discrimination. But it would take significant factors weighing in the other direction to counterbalance evidence that a culture severely constrains women's choices or otherwise undermines their well-being. (Okin 1999:22-23)

Many of the writers responding to Okin's call for the extinction of anti-women cultures are caught in this constructed binary. Who can risk being called sexist or anti-feminist and argue against the point that "establishing group rights to enable some minority cultures to preserve themselves may not be in the best interests of the girls and women of those cultures even if it benefits the men" (Okin 1999: 23). The difficulty of taking a stance against such a position lies precisely in the fact that debates within feminism against multiculturalism ignore how the terms of the discourse about oppression of women have been pre-determined by a reified conception of culture, religion, state, and history. Moreover, Okin's position regarding liberal law reveals the limits of liberalism. For Okin it is impossible for liberalism to simultaneously accommodate group rights and individual rights.[133] Nineteenth Century historians and anthropologists were well exposed to the bourgeoning ideas of Western liberal political thought on the relationship between the individual and the social/political/state. As Mehta

(1999) argues, the marriage of Western liberalism with colonialism led to different articulations about the social worlds of the colonized under colonial rule. When Okin writes:

> In many cultures, strict control of women is enforced in the private sphere by the authority of either actual or symbolic fathers, often acting through, or with the complicity of, the older women of the culture. In many cultures in which women's basic civil rights and liberties are formally assured, discrimination practiced against women and girls within the household not only severely constrains their choices but also seriously threatens their well-being and even their lives. And such sex discrimination—whether severe or more mild—often has very powerful ***cultural roots***. (Emphasis added, Okin 1999: 21-22)

Okin endorses a liberalism that parallels not only Mill's (1869) conception of the "Other" outside of Europe, but also colonial anxiety with what Mehta (1999) refers to as the "unfamiliar". In Okin's position underlie anthropological assumptions (though long critiqued within the discipline of anthropology) about structure and agency, custom and tradition, religion and ritual practice that continue to influence how immigrants who were once part of colonized societies are constructed and produced in the 21st century.[134]

While it is difficult to gauge the degree to which human rights documents, such as the Amnesty International report, directly influence legal frameworks in Pakistan, it is clear that honour killings and tribalism are part of a similar discursive paradigm in contemporary Pakistani national politics, as they are in human rights documents and non-government organizations. In discussions of violence against women, the discourses of tribalism and honour killings are co-constitutive, each reproducing the worst notion of the other, yet this sort of discursive framing is absent in discussions about Islamic laws that some Pakistani feminists and women's organizations also view as endorsing violence against women and as antithetical to women's human rights. The impact of the Islamization of Pakistan's laws on women and the passing of *Hudood* ordinances by

General Zia-ul-Haq in 1979 (on the recommendation of the Council of Islamic Ideology) has been an important concern of many Pakistani feminists for more than a decade.[135] Since the passing of these oppressive laws by the state, feminists in the country have worked to reverse them. Yet as I will later explore, it has been much easier for the President of Pakistan to publicly speak against "honour killings" than the Islamic based legislation that many Pakistani feminists find oppressive to women.

As I have discussed thus far, Amnesty International's understanding of how and why "honour killings" occur is based on a reductive view of the meaning and function of honour. Control of women's bodies, gold, and land is considered the centerpiece of a tribal value system and provides the ground for the systematic and 'culturally' sanctioned violence against women. In her ethnography of a Bedouin tribal society in Egypt, Abu-Lughod (1999: 86-87) writes about the complex meanings and function of the concept of *asl-* the primary metaphor for virtue of honour and she explains how the ideals or moral virtues of Bedouin society together constitute the Bedouin code of honour.[136] She reveals the complexities of Bedouin social life without denying the reality of gender inequality and status hierarchy embedded in that society.[137] She writes:

> In Bedouin society, social precedence of power depends not on force, but on demonstration of the moral virtues that win respect of others, in particular dependents (i.e. women). Such persons must adhere to the ideals of honour, provide for and protect their dependents, and be fair, taking no undue advantage of their positions…Those in authority are also expected to respect their dependents' dignity by minimizing open assertion of their power over them. (Abu-Lughod 1999: 99)

She explains that a tyrannical husband is not tolerated in Bedouin society and if a husband and his family fail to respect these requirements of honour, a woman can leave

for her natal home. “This is the approved response to abuse, and it forces the husband or his representatives to face the scolding of the woman’s kin” (ibid: 101).

The literal mis-translations of the local terms inscribed onto the bodies of the women and tribal people reveals the degree to which the object of the AI report’s discourse is pre-formed, then performed as a “culturally sensitive” stance, leaving no room for a conception of a socialized body that Abu-Lughod describes in her work about Bedouin tribal society. To be clear, I am not suggesting that Bedouin tribal society represents Baloch or Pathan society: rather I point out how the AI report denudes all signs of complexity and sociality in the lives of tribal communities who also happen to hold distinctive ethnic identities in Pakistan.[138] The point that I want to emphasize is that the local expressions *siah kari* or *karo kari* that are readily deployed and mistranslated in the Amnesty International report actually mean “negative action”—literally black deed—and refer to the committing of black deed against the social mores of society, as an *act* that is understood to require a social response in order to maintain group cohesion, social harmony, and mutual respect between the families of the woman and the man. Although the moral discourse remains one that is patriarchal, in the sense that elder tribal men are framing and authorizing the rules of gendered social interactions, the mores underlying *siah kari* are intended to prevent adultery by women and men, with the assumption that both sexes are equally sexual and desiring beings. Women and men are to be equally punished for a transaction that is viewed as disturbing the harmony of the social group. And as we know, moral discourses do not retain the same meaning for everyone in any context; moreover, such discourses often lead to contestations and re-workings.[139] Indeed, there is often, albeit variable, disjunction between the requirements of any moral

discourse and its concrete/practical unfolding that are contingent upon shifting socio-economic and political contexts.[140]

In Balochistan the term *siah kari* is an indirect expression used to refer to an act of adultery committed by a woman or a man. The reference to 'black'—unfortunately as in many social contexts across the world in West and the East—signifies bad or dishonourable. There is no significant evidence, even in the AI report, about the acts of adultery in Balochistan and whether there is a direct relationship between such acts and the murders of women in Balochistan. The complex and heterogeneous meaning of "honour" is not understood in the Amnesty International document. Neither is there an explanation of why, in Makran, one of the largest divisions of Balochistan province, there is not a single record of so-called honour killing in at least the last two decades, if not longer.

Similarly, the report does not provide any ethnographic detail about the murder cases to help the reader and policy makers to delineate the disjunctions and convergences between moral discourses, social rules and women's practical experiences. Nor is there any indication that increased violence against women in the cities may have something to do with increased unemployment, and the shifting face of poverty due to, for example, structural adjustment policies, international drug and weapons trafficking. The potential relevance of these factors for specific cases of murders of women, in the words of Cohen (1999:148) have "become second-order phenomena and ethics", which are reduced to 'bad' values of tribal cultures and the failure of a national legal infrastructure to promote the 'good' values of Islam and the secular state.[141] More importantly however, the statistics deployed in the report tell a story that is in fact disjunctive from the report's

own analysis of the causal links made between tribal values and the increasing murders of women in Pakistan. For example, the report locates large numbers of murders of women as having occurred in Karachi and Lahore, two of Pakistan's largest cities respectively located in Sindh and Punjab provinces. A majority of the total murders discussed in the report have occurred in Sindhi and Punjabi households.

> "According to the non-governmental Human Rights Commission of Pakistan (HRCP), *888* women were reported deliberately killed in 1998 in *Punjab alone*. Of these, 595 killings were carried out by relatives; of these ***286 were reportedly killed for reasons of*** **honour**. The Sindh Graduates Association said that in the first three months of 1999 alone, 132 honour killings had been reported in Sindh. (AI 1999: 6). But, "Honour killings are no longer only reported from remote rural areas but also- though less frequently-from towns and cities. The modes of killing vary somewhat…***In Punjab***, such killings usually take place by ***shootings*** and appear more often ***based on individual decisions,*** occurring in an ***urban context*** and not always perpetrated in public." (ibid). And, "Samia ***Sarwar was killed*** on grounds of honour in April 1999 ***in Lahore [Punjab]*** Riffat Afridi and Kunwar Ahsan were attacked in Karachi [Sindh] or having defiled Riffat's family's honour by marrying against their wishes."(Emphasis mine: AI 1999: 7)

While the three women mentioned above are neither d, nor did the murders take place in Balochistan, (Samia Sarwar is from a Pathan family and was murdered in Lahore city, Punjab), the report follows its elaboration of the statistics and specific cases of murders with the following statement about Balochistan and NWFP:[142]

> In surveys conducted in the North West Frontier Province and in Balochistan, men and women stated that in their communities, men often go unpunished for 'illicit' relationships whereas women are killed on the mere rumor of 'impropriety', any form of sexual contact outside marriage. (AI 1999: 8)

And, about Sindh and Balochistan:

> Perceived as the embodiment of the honour of their family, women must guard their virginity and chastity. By entering an adulterous relationship a woman subverts the order of things, undermines the ownership rights of others to her body—and indirectly challenges the social order as a whole. *She becomes black, karokari, or siahkari*. (Emphasis added, AI 1999: 12)

The Amnesty International report also provides statistics of murders due to burns, that have occurred exclusively in Punjabi households, but these murders are not associated with honour, for while Punjabi women are subject to tribal values infiltrating the predominately Punjabi urban national body, Punjabi's are not constituted as 'tribal people'.

> Of the 183 women reported to have died of burn injuries (Of 28 burn victims) allegedly while cooking in Lahore in 1998, only 21 complaints were registered with police and only three persons were finally arrested despite a High Court ruling three years ago that all burn cases be fully investigated by police. (AI 1999: 54)

Thus, despite the largest numbers of murders taking place in the Punjab, the logic in this document locates the cause of these murders in the tribal value system that is considered to be rooted in and also prevails in Balochistan and the Northwest Frontier Province (NWFP), rather than based on **"**individual decisions," as suggested in the case of murders in Punjabi families.

Inventing Tribal Misogyny

The discursive de-socialization of "tribal" women's bodies in the report via the use of statistics produces a simultaneous reification of all women's bodies and the demonization of tribal social life.[143] Stripped from their socio-historical context, which is, in fact, linked to the politics and history of the formation of the Pakistani nation-state (Harrison 1981), the tribal community or (non-community according to the report) is discursively set apart from and placed outside of the nation.[144] For example, the report states in four lines that Amnesty International does not intend to be culturally insensitive, claiming that it is all for diversity and that it recognizes that all cultures contribute

positively to society;[145] yet the focus of the entire fifty plus pages is on the "backwardness" and "violence" of tribal cultural values. The report argues that "these tribal values" have penetrated Islam as well as the "liberal democratic" state infrastructure. While there is an effort in the report to point to the contingent nature of Islamic extremism, such as by making reference to the political forces behind the autocratic insertion of selected aspect of Shariat into the Pakistani legal system by Zia, the report is quick to re-locate the "origin" of honour killing as part of the Baloch and Pushtun tribal "customs".[146]

> Originally a Baloch and Pashtun tribal custom, honour killings are now reported not only in Balochistan, the North West Frontier Province (NWFP) and Upper Sindh which has a strong Baloch influx, but in Punjab province as well. Honour killings are no longer only reported from remote rural areas but also - though less frequently—from towns and cities. The modes of killing vary somewhat. (AI 1999: 6)

> The government of Pakistan has not only failed to educate the public in general and women in particular about rights and freedoms laid down in the constitution and state law, it has also failed to remove widespread misperceptions that Islam sanctions crimes of honour. Islamic scholars in Pakistan have repeatedly pointed out that Islamic teachings do not condone such killings and observers and analysts of the phenomenon of honour crimes in Pakistan identify *tradition and custom as the source* of this form of violence against women. (Emphasis added, AI 1999: 48)

In this rendition tribalism is also equated with feudalism, and "honour killing" equals "tradition", so it is reasoned the Pakistani State must beef up its postcolonial 'liberal democratic legacy' in order to STOP the honour killings. Simply put, the report calls on the Pakistani State to take even more control of all "customary practices" which are defined as anti-women and anti-universalist and also rooted in tribal value systems. Nonetheless, as my analysis shows, even statistics used to prop up the discourse of honour related murders fail to demonstrate the report's claim that 'tribal values' are the

root of the crime of domestic murder. Yet it is the same logic that serves the Pakistani government to justify intensified state violence in territories deemed 'tribal'.[147]

Amnesty International takes no position on religious, customs or specific legal regimes; it welcomes the rich variety of cultures and believes that the universality of all human rights, far from denying diversity, can only benefit from it. The organization recognizes that the contribution of different cultures, at the local and the global level, enrich the understanding of human rights giving them their local form and language…While recognizing the importance of cultural diversity, Amnesty International stands resolutely in defense of the universality of human rights... (AI 1999:4)

> …*[H]onour system derives from tribal traditions* in Pakistan, which are often in conflict with other traditions in national life, such as Islam and liberal democracy; as a result women find themselves caught between competing and conflicting 'traditions' in Pakistan." (Emphasis added, AI 1999:4)

Skaria (1999:xi) writes:

> Wildness was to remain crucial in the twentieth century. As nationalist thought developed, these emerged as primitivism, which celebrated tribes as natural beings: Spontaneous, free, and uninhibitedly masculine, possessing some of the qualities needed for a struggle against the British. But that primitivism was also underwritten by a profound marginalization of the 'tribals'.

No future was envisaged for the tribal in postcolonial India. In the 21st Century, in Pakistani national *mediascapes*, there is no shortage of discourses of primitivism that equates the Baloch tribes with a premodernism considered antithetical to the modern nation-state form.[148] Just as the Bedouin tribes of Jordan, in political speeches and newspapers, have been constructed to be a retrogressive barrier to development, and whose positions are seen as antithetical to loyalty to the state, in Pakistan tribalism is blamed for the marginalization of the Baloch people in Balochsitan.[149] In this way, the

Pakistani government is assigned total immunity in its failure to win the loyalty of the people. Rather than the state, one tribal chief becomes the escape goat for the disenfranchisement of an entire people, when, for example, a journalist in a leading Pakistani magazine, the "NEWSLINE" in 2005 writes:

> Nawab Akbar Bugti—guardian angel for his tribesmen, or as symbol of the region's oppressive *sardari* system, fiercely protecting his stronghold on the rich natural gas reserves in the land under his sway? …The fact that successive governments have gone the extra mile to appease Bugti, giving him not just a free hand to rule as he will in his backward area, but also showering him with assorted perks and privileges, is clearly the payback for his cooperation… And even if the ruling Pakistan Muslim League Chief Chaudhry Shujaat Hussain's diplomacy or the now beefed-up security arrangements in the province manage to defuse the situation in Sui, it is likely to be just another interlude before trouble erupts again—inevitable given the *grossly unjust and primitive tribal system that continues to thrive in Pakistan* well into the 21st century (Emphasis added, Siddiqui 2005:26)

The colonial discursive invention of tribalism and the primitive connotations associated with the term tribe (Hobsbawm 1983; Ranger 1983; Vail 1989) are presented as *fact* in the Pakistani *mediascapes* and in the AI report.[150] The representative of these supposed facts fails to understand that descriptions are never neutral and are strategically framed for a specific argument. Within a certain discursive paradigm there are certain things that can be said, cannot be said, are imagined, and are not imagined (Zizek 1994:8). Zizek considers this point in relation to ideology and how a new fact is misperceived as old. He writes "it is easily possible to lie within the guise of truth"; for incidents of murders of women in Pakistan are real, and it is quite likely that men, due to their structural and social advantage over women do exploit, misuse, and abuse the concept of honour and exonerate themselves of a crime. But we must ask whose ideological assumptions and received ideas are inscribed in the AI report that conceptualizes male domination as a social fact grounded in the material order of things

and uncontested by women and other 'tribal' community members? As Zizek (1994:10) writes, "the 'zero level' of ideology consists in (mis)-perceiving a discursive formation as an extra-discursive fact."

Skaria makes a similar point when he writes, "Myths can be seen as the naturalization of meaning or the moment when meanings take on given-ness and fixity, and when the process that have created meanings, as well as the contingency that always characterizes meanings, become invisible." In this sense then, history is a myth of modernity in which the association between history and Western modernity is naturalized. Thus, the descriptions in the "NEWSLINE" magazine and the AI report fail to capture the fact that in Makran, the largest division of Balochistan where Panjgur district (my primary research site) is located, the *Sardari* system was overthrown long ago. Moreover, there is no evidence of murders of women linked with honour in the entire division of Makran, where the Pakistani government initiated the 248 million dollars Gwadar deep seaport in 2001.[151] More significant, however, is the contradiction between the official statistics of murders presented in the report and the fact that not a single case of honour related murder presented in the report has occurred in a Baloch family or in Balochistan.

In an effort to understand the reasons behind the rising incidence of women being murdered in Pakistan constituted under the rubric of "honour killings", this Amnesty International report is not only engaged in the troubling practice of the discursive reification of tribal culture, but it also redeploys colonial discourse to produce and define "honour killing" as a normative rural Baloch cultural practice in Pakistan. It constructs what it argues are the norm of the cultures in which the violated women belong. These

norms are placed in opposition to the liberal democratic values of the West and to Islam. The terms of the discourse about the oppression of women and honour killing are not based on primary investigation of incidences of murders, nor are they based on an understanding or examination of the social, political, and economic contexts of the rising violence against women in Pakistan. Rather, the report's premises reflect a reified conception of culture, religion, state, and history. Tribal culture and religion are conflated and both blamed for endorsing "violence" and "terrorism" against women. While the report faults Islam as well as tribalism as the cause of honour killings, it nonetheless creates a hierarchy of blame. In producing a hierarchy of patriarchy, the report designates tribal cultures as more patriarchal than Islamic culture, which in turn is considered more patriarchal than 'secular' culture (AI 1999: 43-46). For example, based on an interview in ABC Nightline Riffat Hassan, a Muslim feminist from Pakistan interested in reinterpreting Islamic sacred texts from a feminist perspective, is quoted as saying that the practice of honour killings has nothing to do with the teachings of Islam but "*has its roots in ancient tribal customs which became incorporated in many cultures"* (AI 1999: 48). Ironically, the defense of Islam seems to require the demonization of tribal customs and reinforces religion as the locus of social and cultural life and as the only legitimate place for the healthy socialization of the citizenry. The implication here is that those groups, for whom tribal identity is primary, are neither religiously Muslim enough nor socially secular. The following quotes further illustrate the points of the above discussion.

> In Pakistan, many of the inequities that women are subjected to are laid at the door of 'Islam'. Much of the debate on women in Pakistan; is being waged by male religious leaders on the one hand and Pakistani feminists (mostly women) on the other. This debate is, therefore, focused on "Women and Islam', rather than on

> women within specific…Pakistani contexts…The often stronger role of traditional and customary laws in shaping the lives of women is only recently beginning to be recognized. (Quoting Simi Kamal and Asma Khan in AI 1999:45, fn #72)
>
> The status of women in Pakistan has been described as defined by the "interplay of tribal codes, Islamic law, Indo-British judicial traditions and customary traditions…[creating] an atmosphere of oppression around women, where any advantage or opportunity offered to women by one law is cancelled out by one or more of the others. (AI 1999: 44-45)
>
> Traditional norms, Islamic provisions and state law diverge in many areas relevant to women's lives. (AI 1999: 46)

The production of the binary that pits tribalism against Islam cannot explain why the so-called honour related murders of young women that have occurred in the cities of Britain, Canada, and Europe are all among non-Baloch Muslim families. Despite this transnational phenomenon and the incidence of killings among modern Muslim Punjabi families, even the Pakistani state has openly constructed the tribal legal system of *jirga* as un-Islamic. This position, taken up by the state, is welcomed and quoted in one of the highest circulating transnational human rights documents. According to a 2002 Amnesty International report on "the tribal justice system", President Musharraf has been the most outspoken state official condemning both "honour crimes" and the assumption of a judicial role by *jirgas.* Indeed, at the Convention on Human Rights and Human Dignity in April 2000, General Musharraf said:

> It shall be the endeavor of my government to facilitate that there is an environment in which every Pakistani can find an opportunity to lead his life with…freedom…The Government of Pakistan vigorously condemns the practice of so-called 'honour killings'. Such actions do not find any place in our religion or law." Musharraf vowed that, "the name of 'honour' is murder and will be treated as such. (AI 2000)

Moreover, echoing the near exact statement made by Riffat Hassan in the 1999 AI report, a government statement in July 2000 stated, *"The practice of [honour killing] is carried over from ancient tribal customs which are anti-Islamic…"*

Nature vs. Culture and the Disorderly Tribal Body

> Many analysts in Pakistan have concluded that [the]…crisis related to ideology, the democratic process and the breakdown of the civic order, has turned urban populations to alternative models, such as that inspired by the Taleban movement of Afghanistan[152]…These observers have also pointed out that the apparent 'tribalization of formal law' may have created the impression of official sanction for this orientation which plays into the popular perception that it is acceptable to take the law into one's own hands. "The distance between the state law and the informal codes is being bridged. (AI 1999: 33)

> Thus, under cover of *karo kari*, men kill innocent women to settle old vendettas, to acquire land, to secure money to pay off debts, to be freed from the obligation of paying back debts, to get a second wife, to get rid of an unwanted woman, and so on...the man who kills his woman as *kari* is not a murderer but the victim of 'dishonour' who is entitled to compensation… however, in its current form it has given a new twist to the commodification of women as usable, disposable and exchangeable objects: a dead woman can fetch a hefty 'prize' in cash or kind for her family. (In DAWN 2004 reproduced from a research report).

> President Musharraf has spoken of the tribal system which blocks democracy. The supremacy of the tribal order and the preeminence of the tribal *sardar* is too well known. The frontier province, with its sprawling tribal areas, and Balochistan are strongholds of the tribal *sardars.* We see their might in the North and South Waziristan now. But democracy and the tribal order cannot coexist forever. (DAWN 2006)[153]

The government's view of tribalism as a system that is more misogynist than the Islamic Laws, including the retrogressive Shariat, is evident in its near exclusive focus on honour killings in official government debates regarding Pakistani women's rights. In the state's effort to be pro-women, the oppressive Hudood Ordinances, which affect a large majority of women in Pakistan, are entirely ignored. Despite the decades of focus among some Pakistani feminists and women's groups to overturn the conservative and

religiously extreme Islamicized anti-women government laws introduced during Zia's regime, Musharraf's government has side-stepped these particular feminist demands. A Baloch lawyer, Mr. Ali, who at the time of my interview was the MPA of Panjgur district and the leader of the Balochistan assembly,[154] told me that the focus on honour has become a convenient cover for a government that seeks to be viewed as pro-women without alienating the Islamist parties (i.e. Muttahaida Majlis Amal (MMA) or the United Action Council), whose support it relies on. According to Mr. Ali, this is a "double game" on the part of the government that shows its lack of concern for the social agenda.[155] Because Mr. Ali spoke up in the assembly about the *Zinnah* ordinance several Mullahs put a *fatwa* over him.[156]

He spoke to me about this situation and of his dismay about what he viewed as the blatant paradox of government's position about women's legal situation in Pakistan. He said:

> There you have raped the woman and then punish her after raping her. I said to them, you call this your Shariat? I have taken a big stand about this. Over such stands I have been condemned." He tells me, "The army rules by the *danda* (stick) and the gun and Mullah rules by name of the spiritual holy Quran. This is the shape of hypocrisy. I have said this in my own political speeches, that politics and Mullah's cannot mix...People are in their religious philosophy and their old traditions, whether they are Baloch, Pushtun, or other, the two philosophies are interlinked to some extent for the people. But our religious figures have cheated the people, Quran is there, society is there, all things are here. Mullah's, when they interpret this, they do it without character. When there is a split between deeds and saying, then the people will over time understand you, they will understand the hypocrisy. Our Balochi traditions have respect for people, and honour is about respect. You see, in the past I was *karawni* (nomad). You could have asked your neighbor to take care of your child, now you won't do this because you are concerned about your *maal* (goods). Values have changed.

In this conversation, Mr. Ali spoke to me about the "abuse" of the concept of honour and condemned the highly publicized gang rape of Mukhtar Mai by six men in

Meerwala, Punjab, as a shameful and "dishonourable" act of violence, stating: "This is not the Baloch way." Nawab Bugti, in an interview I had with him in October 2004 referred to the same case and stated that Punjabis do not have honour. For Bugti, the honour of protecting women is the same honour as the fulfillment of one's obligation to protect one's people. For him, the Pakistani state has failed to fulfill its social contract with all the citizens of Pakistan, as it has not equally invested in building the educational, medical care, and economic infrastructure of all the provinces.

The Amnesty International Report focuses deliberately on tribal culture as opposed to criticizing patriarchies and fratriarchies—which could be a more reasonable focus that might open the way for considering how, for example, from one context to another and/or from one historical period to another, ideals take on different meanings at the practical material level under religious or secular rule; and how ideologies are interpreted multiply, often in contradictory terms by different actors within a community, nation, or discursive space. The view of women's subordination in the report is premised on stories similar to those underlying Mill and Engels's conception of gender inequalities. The hypothesized beginning of women's subordination in both Mill's and Engels's work, are located within historical shifts in Europe, in the functions of governance by and in the economy (the social sphere). While liberals like Mill located power within the state and Engels located it in the social sphere, the Amnesty International report and Pakistani feminists it cites, locate it in both the national laws sanctioned by the patriarchal state and reductively in the social, where the sole sovereign member and dictator of the cultural group is a man with feudal and tribal mentalities.

Thus, just as in colonial discourse the *other* is posited as the child without a past (Fabian 1983), in the Amnesty International report the tribes do not have pasts. While they belong to an ancient culture, their ways have remained unchanged even in the context of an Islamic nation and a state striving towards vague and militarized secularism. In the report, the past remains what was once the pre-colonial in colonial modern discourse. This ancient past—the pre-colonial and pre-Islamic—is natural (as opposed to social). It is fixed and bad. And, as in colonial discourse, according to AI, what has potential for changing the tribal value system for better (toward liberal democracy) is the modern (state and legal infrastructure). The tribe and tribalism connote primitivism.[157] The tribal value system connotes a system in which men have total domination over women and women have neither any space for maneuver and resistance, nor do they attempt to resist. All tribal women are represented as victims of honour killing. Spivak (1985) explains this process of "othering" such that people are homogenized into a collective, then distilled down to generic timeless, and agent-less entity. The othering is made possible in this report by locating the problem of rise in honour killing first and foremost in the "belief system" of the tribals and at the exclusion of any understanding of the economic situation or the historical and contemporary political dynamics of the country. So, rather than the call for white man saving brown women from brown man (Spivak 1985, 1986, 1988), the AI report is asking the state to save all Pakistani women from tribal men.

In the Amnesty International report, the interpretations of violent acts on women's bodies serve not only as signs of "backward" tribal culture, but also stand for the dysfunctional modern legal structure. Tribal Balochistan is inscribed in a coercive

language of power calling on the state to monitor the social body in order to save women's bodies. The suffering bodies of the women are reduced to statistics, and constructed as under constant attack from the tribal male dominated social body. In this way, the tribal social body is discursively pathologized and conceived as chaotic, unruly and needing to be policed. The tropes of savagery and anarchy, animality are deployed freely in this policy document to demonize a regime of values in tribal society.[158] The locus of all tribal values is "honour", but not as a mark of anything positive about the social life of tribal people. Rather, the tribal is fixed at the boundary between animal and the human, wherein women are located somewhere in between tribal men and Muslim/Secular men of Pakistan. It is at once a point of identity and a problem. In this way regimes of meaning are co-produced about tribal ways and Pakistani women's situations to legitimate the necessity for legal intervention. As I have come to learn during my ethnographic research in Pakistan in 2004-05 and through a survey of Pakistani newspapers, the discourse of discipline, and the tropes of savagery and animality used to construct the tribal man are not unique to human rights. For instance, aimed at the Baloch nationalists and the three Baloch "tribal chiefs", Musharraf stated in a televised talk in Geo TV in January 11, 2005, "Don't push us. It isn't the 1970s when you can hit and run and hide in the mountains. This time you won't even know what hit you."

In one stroke he marks the Baloch resisters as nature-bound and as enemies of the state. Furthermore, "this time" means that the state will not hesitate to use the full force of its military armament to go after the "miscreant". The "writ and rule of Islamabad" cannot be challenged to "develop" Balochistan and free it from *sardari* system and

tribalism according to the Musharraf government. Since at least 2004, the public justification for the mega-development projects in Gwadar and elsewhere in Balochistan require the demonization of tribalism and the *sardars*.[159]

The 1999 Amnesty International report and the 21st Century Pakistani government discourse map the Balochs, in particular, as a tribal male "type" and another form of human morality and reason, locating this tribal economic and political man outside of culture and in nature. Moreover, in this scheme, women are located somewhere between nature and culture, and Amnesty International is calling for the separation of women from nature through the intervention by modern culture. In the context of the tribal social body women are constructed as unnaturally violated by the natural tendency of tribal social norms. And since culture exists outside of the tribal social body and exclusively in the "national" body of Pakistan, it is only when women are brought into the national social body can they become full social beings (i.e. proper subjects) with political rights that can be protected via the "modern" national legal infrastructure and mechanisms.

Although Amnesty International describes systems of religious norms that negatively govern women's bodies, it nonetheless suggests that those norms are contrary to modern conceptions of human rights and are residues of tribal pre-modern social norms. Thus, to have religion is to be cultured, but the failure of the full actualization of ideal Islamic values underlying marriage, for example, is blamed on tribalism. Because the Amnesty International report interprets the function of marriage in "tribal societies" as the exchange of commodities, women representing one form of commodities in that exchange, it fails to consider the influences of ideologies—patriarchal as well as

Islamic—and the structure shaping the substance of marriage in Pakistan as a whole. Therefore, in the report marriage is not understood as the perpetuation of the family line; the conservation of domestic property; and the preservation of the ancestral inheritance that are simultaneously morally and materially imbricated; but rather marriage in tribal context is conceived as a *practice* that is constituted for the sole purpose of fulfilling the desire of men to possess and control women's bodies, that are made available to them for their sexual needs, in exchange for non-corporeal forms of wealth. In other words women are only "commodified kin" (Sharp 2002).

> [Women are killed] for reasons of honour [and] are invariably targeted by the male relatives of the women whose alleged breach of the code of honour constitutes the rationale for such acts. (AI 1999: 4)
>
> The concept of women as an object of commodity, not a human being endowed with dignity and rights equal to those of men, is deeply rooted in tribal culture. Dr. Tahira Shahid Khan of Shirkatgah, a woman's resource center, points out:" Women are considered the property of males in their family irrespective of their class, ethnic, or religious groups. The owner of the property has the right to decide its fate. The concept of ownership has turned women into a commodity which can be exchanged, bought and sold… (AI 1999: 9)
>
> In the tribal society of Sindh and Balochistan, a woman is equated with money…But although she has monetary value, her worth is essentially that of a commodity and this view goes far towards creating a situation when she may be butchered if she transgresses the conditions under which she is bound to a man for life. She may also be freely traded or given away as paret of a *karo-kari* settlement." (Nafisa Shah in Amnesty International Report: (AI 1999: 9)

The report states that the Pakistani government has failed to control the disorderly tribal ways and criticizes the state for its failure to implement and enforce the internationally mandated pro-equality laws (p.43-46). For:

> The status of women in Pakistan has been described as defined by the "interplay of tribal codes, Islamic law, Indo-British judicial traditions and customary traditions…[creating] an atmosphere of oppression around women, where any advantage or opportunity offered to women by one law is cancelled out by one or more of the others. (AI 1999: 44-45)

National Body Politic (i.e. state) to Rescue Women's Cultural Bodies:

> State Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of inferiority or the superiority of either of the sexes or on stereotyped roles for men and women. (AI 1999: 12)

> The government of Pakistan has failed to ensure that women are aware of their constitutional rights and to put in place adequate measures to ensure that these rights and freedoms take precedence over other norms, which deny women equality. Women's lives are by and large confined to the private sphere with little access to information outside their homes. As their lives are inevitably governed by the traditions of the community and tribe, women in Pakistan do not enjoy or benefit from the fundamental rights recognized in the Constitution of Pakistan no the provision of Muslim personal law. (AI 1999: 45)

> The government of Pakistan has not only failed to educate the public in general and women in particular about rights and freedoms laid down in the constitution and state law, it has also failed to remove widespread misperceptions that Islam sanctions crimes of honour. Islamic scholars in Pakistan have repeatedly pointed out that Islamic teachings do not condone such killings and observers and analysts of the phenomenon of honour crimes in Pakistan identify tradition and custom as the source of this form of violence against women. (AI 1999: 48)

What I have described in previous sections is Amnesty International's representations of the tribal as a fixed reality, which is at once other and yet entirely knowable. I am of course, echoing something that was part of the iconography of colonial control. While by now most anthropologists and postcolonial historians are aware of the attempts among colonial administrators and historiographers to remake the tribal frontier space in the imagined sign of Western reason through reform and discipline (Dirks 2001; Inden 1990; Cohn 1996; Arnold 1993), the human rights discourse apparent in the

Amnesty International report explicitly admonishes the Pakistani state for its failure to capture the tribal social body and interpellate it into the biopolitical apparatus of the national body politic.[160] Since in the Amnesty International report honour killing is constructed to reflect the social morality of tribalism, honour killing signifies everything tribal. Thus, the demonization of the tribal way of life marks the social life in which women also belong as bodies that require protection and saving by the state via the elimination of tribal social life. This call for state intervention requires the construction of tribal honour as a social risk for non-tribal members of the nation as a whole. Agamben's (1998) reflection on "humanitarianism" and the Declarations of Rights from 1789 to the present, offers a means to capture the contradiction and self-defeating trajectory undergirding Amnesty International report's objective end: that is, for the state to more effectively stop the rising incidence of murders of Pakistani women and eradicate all customary laws (considered inherently anti-women).

In "Homo Sacer", Agamben (1998: 129-31) asks that we consider the real function of the modern state. He posits that the Rights of Man represent above all the original figure of the inscription of bare natural life in the legal-political order of the nation-state.

> That bare life (the human creature) which in the ancient regime belonged to God, and in the classical world was clearly distinct (as zoe) from political life (bios), now takes center stage in the state's concerns and becomes, so to speak, its terrestrial foundation.

Agamben's reflection on the limits of "humanitarianism" and the nation-state ideology of what constitutes a political community to adequately protect all life—such as refugees who are non-citizens—highlights a dilemma that, I argue, confronts Amnesty International's desire to protect the life of Pakistani women. The tribals, unlike ideal

refugees, do not hold a temporary status, nor are they legally de-nationalized. Nonetheless, just like the refugees, tribal existence in Pakistan calls into question the principles of the nation-State. They are simultaneously political and non-political subjects. In so far as they are perceived to defy the norms in the Amnesty International human rights discourse, the tribal represents a disquieting element for the order of nation-State.[161] How can the state bring the territory into its legal and political ambit and assign national rights to women, while at the same time discursively strip the tribal people/men of their national rights? This dilemma, described in Chapter One, is playing out fully in current Pakistani politics today.

However, unlike colonial discourse about the tribal landscape and life in which both the space and life of tribals was deemed reformable through disciplinary means, the Amnesty International report calls on the Pakistani state (body-politic) to essentially eradicate all signs of the tribal social body; we can read this as discursive social genocide. The order of the nation-state is dependent on the functioning of the state legal apparatus by means of which the disorderly tribal mode of settling disputes must be disciplined, and all traces of tribal value structure eliminated. Unlike the colonial era, when imperial discourse saw tribal as well as the peasant social domain as bounded, the Amnesty International report's emphasis is on the "problem" of leakage and the spreading of tribal social values (constructed as essentially misogynistic) into the national sphere.[162] The leakage theory is a necessary one, for how else can writers of this report ignore their own statistical facts, presented in the report, that most murders of women are occurring in urban and semi-urban areas of Punjab and Sindh. The majority of rural based murders are also in Punjab and Sindh. Yet in this Amnesty International report these discrepancies

appear only as anomalies to its larger goal of illuminating the cause of its invented category of "honour killing". We, the readers, are only required to understand that murders of women are intimately linked to the embeddedness of the notion of honour in Pakistan. We are not expected to understand the meaning of this complex and contingent notion outside of Amnesty International's construction of it in relation to protection and violation of women's bodies.

In the Amnesty International report, the underlying assumptions about structure and agency, custom and tradition, religion and 'traditional' practice influence and produce problematic and consequential conceptions of places (e.g. Balochistan and Northwest Frontier Province) and people (e.g. Balochs and Pathans). The same conceptualizations, then, about people and places often get taken up by some Western feminists, intra and international human rights activists, and development thinkers, to do good for "all oppressed women" in their own country and the Third World, and for Third World immigrants in the West.[163]

Women's Dis-Honour and Development over Tribalism

> Bochistan is a tribal and traditional society. The major ethnic groups in the province are Baloch, Brahui and Pathans. Tribalism and sardari system amongst Baloch is more prevalent and in practice than that of in Pushtuns of northern Balochistan. The system is stronger among Marri, Bugti and Mengal tribes of Baloch. (Syed Fazl-e-Haider 2005),
>
> You must understand the environment in Pakistan. This has become a money-making concern. A lot of people say if you want to go abroad and get a visa for Canada or citizenship and be a millionaire, get yourself raped. (General Musarraf President of Pakistan quoted in the Washington Post September 13, 2005)
>
> This is not [the] 1970s, we will not follow them up into the mountains; this time they won't know what hit them. (General Pervez Musharraf warning in a televised

> comment on January 11, 2006 aimed at the Baloch nationalists rather than the enemy of the state quoted in Herald, February 2005)
>
> They must not only pay for the rape of Dr. Shazia [Khalid] but also for the 50-year-long rape of our land and resources. (A Bugti tribesman in Dera Bugti in Herald February 2005:58)

Bacchetta et al. (2003:85) discuss the need for transnational feminists to "analyze thoroughly gendered and racialized effects of nationalism, and to identify what kinds of inclusions and exclusions are being enacted in the name of patriotism." However, the human rights discourse on gendered violence and their demands on States to apply stricter measures against "tribal" men is an indirect endorsement for the Pakistani State, for example, to perpetuate its racialized and exclusionary practices against particular sectors of the nation—now a reality. In short, human rights documents, although unintended by the entities producing such documents, can become a tool for the state that can be deployed in very specific and consequential ways against social groups in the name of protecting women.

Since Pakistan gained independence, industrialists, who are predominately Punjabi, have accused tribal leaders as of being a hindrance towards development. There are Baloch political leaders who oppose federally sanctioned and supported access to material resources such as minerals and oils, and road development in Balochistan. The reason for such a position is both complex and simple. The simple reason is that a majority of the Baloch leadership including, Nawab Bugti, distrust the motivations of the government and their claims to bring "true" development to the province. The more complex reason is embedded in the fact that since independence, the greater part of Balochistan lacks modern infrastructure in nearly every social an economic sector imaginable. This is blamed on the sardars and the tribal system that is viewed as

authorizing sardars to maintain their power over their people. Yet the record of the last fifty years of governance toward Balochistan reveals a shameful stain in the rhetoric of government's desire to save Baloch people from sardars via state sanctioned big development projects and plans. The continuing tension between Baloch leaders (as well as the resistance movement that is not directly lead by the accused sardars) and the central government reflects the ongoing grievances of many Baloch people and politicians against a central government that is perceived to have failed the Balochs in and outside of Balochistan. In addition to the ever increasing dire situation of the people in Balochistan, the economically poor conditions of large segments of the Baloch population residing in Karachi is considered to be a significant example of state failure to fulfill its social contract with the Baloch people. The government is also accused of deliberately sidestepping the main issues underlying the persistence of the Balochs' suspicion and antagonism toward not only the central government, but also the military, and the state bureaucracies.

In the non-fictional drama over land and natural resources, discussed in Chapter One, culminating in the assassination of Nawab Bugti, and the occupation of Sui village in Dera Bugti in the name of protecting national resources and security of the country, women and honour were once again made to collide literally over the question of nationalism. This collision of women and honour was then taken up immediately by the state to frame and demonize the sardar (specifically Bugti), this time both as someone who is anti-development, and as the rapist of Dr. Shazia. This rape was actually carried out by a high-ranking general of the Pakistani army and became a public pretext and justification for "national security" and to take military control of Sui village and the gas

pipelines. The question we should ask then is who is being protected here; the woman, natural resources, or nation, by whom and for whom? This crisis began on the night between January 6 and 7th, 2005. The rape of Dr. Shazia Khalid of Pakistan Petroleum Limited (PPL) by a high-ranking army officer in Sui brought the Pakistan Army into a direct confrontation with the Baloch nationalists. The inter-service public relations spokesman on television referred to Shazia's rape as a "choti si baat" (a minor manor). Many Balochs, who protested the incident and demanded the arrest of the rapist, saw and continue to see the rape of Shazia as an affront to their honour, which in the world of the Bugti chief and the nationalists' leader "must be avenged at all costs." When the Bugti people reacted, the government responded by turning the heat on the nationalists instead of arresting the suspect—the General who raped Dr. Shazia. Immediately following the incident, new reports described Dera Bugti as a "virtual battle ground".

Around the same time Bugti and his people were accused of targeting the gas installations in Sui. Bugti denied this and accused the government of creating a pretext to legitimize his invasion and occupation of Dera Bugti in light of the failures of political dialogue. Indeed, the period of January 7-11, 2005 seemed to pave the way for the establishment of a military garrison in Sui and reports since point to the rape of Shazia as the cause of the "insurgency" in Balochistan that has since become the rationalization for the militarization of the Balochistan province.

Reified Gender in Reified Culture

Gendered violence has long been a concern of local women's movements in many countries, North and South. Although feminists have mobilized across national

boundaries to protest violence against women for at least two decades, since the mid-1990s violence against women has become a "common advocacy position" of the women's and the human rights movements (Keck and Sikkink 1998). In the process, linking women's rights to human rights has given shape to a particular human rights discourse that is increasingly visible in internationally circulated human rights documents such as the Amnesty International document examined here. While the international campaigns, which became prominent in the 1993 Vienna UN human rights conference, have succeeded in uniting women's groups across different locations, concern has been voiced regarding the side effects of and universalistic assumptions undergirding anti-gendered violence campaigns (Ong 1996; Spivak 1996). Despite such concerns, however, the human rights discourse is hostage to colonial conceptions of the "Other", wherein "culture" is viewed as a barrier to the realization of human rights and is a tool for legitimating violence against women among men of those culture groups. While Ong (1996) and Spivak (1996) have criticized the individualist formulation of "rights" that is Western-specific, and the elision of the distinctive political-economic contexts of women's lives, such criticisms from the academy do not appear to influence the formulations of the causes of gendered violence in human rights documents, where culture is represented as a-historical, and women from those cultures are represented as lacking agency.

As Moore (1988), in her historical review of anthropology and feminism delineates, anthropology provided the evidence for the "exotic and the alternative" to historians in particular, and Western feminists in general. They read gender difference and structures of hierarchy in colonized sites as natural and primordial rather than as a

product of contingent forces. Although a great deal of internal criticism, debates, and shifts about the notion of culture is evident within anthropology, (evident in the increasing emphasis among anthropologists, for example, to consider history, political economy, and local contestation and struggle in understanding the nature of gender-based violence), in contemporary human rights documents the translation of gendered violence appears to require not only the reification of cultures (tribal as well as national cultures), but also the production of binaries between tribal life and Islam; and tribal social life and the nation-state. This process of essentialism is extremely transparent in the human rights discursive representation of forms of gendered violence in the Middle East and Pakistan. Here, violence against women is particularized and called "honour killings" and also considered rooted in "tribal norms." The Amnesty International report illustrates how the traffic in ideas about honour, about "tribal" women in particular, and their needs, is legitimated by the authoritative quality embodied in human rights documents, partly due to the role of lawyers and legal scholars as researchers, and the presumed neutrality of statistical representations of gendered violence.

Confirmed by the Amnesty International report analyzed in this essay, human rights documents typically represent any given social problem as country-based; and the head offices rely extensively upon "local" actors (e.g. Pakistani feminist lawyers, journalists, and published activists.). Thus, the voice of these "local" representatives, which we might more accurately call national representatives, not only become authorized in ways that are not in their own heterogeneous national settings, but also come to represent a certain homogenizing 'truth' about the substance of violence that has a limited basis in the reality of most women's lives in Pakistan. That is, the implicit

assumptions held in the report about the physical bodies of women, the tribal social body, and Pakistan's body politic, leads to an explicit erasure of heterogeneity of national and social life, to the construction of lies, and to the demonization of particular social/ethnic/tribal groups.[164] In the postcolonial context, some national elites, including feminists, have internalized the orientalist and historicist skills of "othering", and produced binaries embedded in the civilizing discursive practices of 19th century colonialism.[165] Far from what is required for an "pedagogy of the oppressed", many of the feminist and human rights activists in Pakistan speak for a group of women about whom they lack the relevant knowledge, leading them to unequivocally and vehemently denigrate the tribal social value structure that in reality may serve to protect those tribal communities from state sanctioned misrule.

As I illustrated in brief above and in greater detail in Chapter One, the application of this mis-rule is taking place now in Pakistan. Out of the great heterogeneity of feminisms in Pakistan, this particular form of feminist "voice" in the Amnesty International report is reflective of the complete disregard about power of the "ideological state apparatus" and political element embedded in the history of the relations between tribal/ethnic groups and the Pakistani state controlled by "non-tribal" ethnic groups, whose political and economic interests are served by the denigration of tribal communities. If tradition in some fundamental sense is produced through the history of what Cohn (1996) refers to as the colonial modern, then what we find in the Amnesty International report is another instance of how the same 'history' has penetrated both what is understood as tradition and modernity in the postcolonial context, and inscribes it as the present reality and future of women's lives.

Conclusion: Relativism in the Guise of Universalism

> [B]ody is directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs. (Foucault 1984 [1977] in Rabinow 1984: 173)

How do we disentangle patriarchies from culture—indeed, can we? How do we talk about patriarchy without universalizing it and without reifying culture? The tension that the notion of patriarchy poses and has posed against a more plural and dynamic understanding of culture is revealed in the Amnesty International Report. Forms of patriarchy are historically embedded in the same way that culture is and patriarchy intersects with many other social (including political and economic) factors, yet this is overlooked in the report, just as it was in Mill's "Subjection of Women". The report reproduces the monolithic discourse of cultural stereotypes by relying on reported cases of honour killings, in much the same way that British colonialists relied upon ancient texts to argue for the "norms" of Sati (widow-burning) in India and within Hindu tradition (Mani 1998). British jurists assumed the role of commentators and interpreted the ancient texts according to what they believed were the new requirements of contemporary Hindu and Muslim society. By overemphasizing the ancient scriptures, they undervalued the role of later commentators as well as local custom. "Since they could not comprehend the plurality of the prevailing non-state legal system, and locally-evolved practices, British jurists disturbed established customs of the community" (Agnes 2002: 119-20). According to Agnes, gradually the non-state legal systems were transformed into state-controlled and state-regulated legal systems. British interpretations of ancient texts became binding on Indians and made the law certain, rigid and uniform. What appeared as a potentially positive intervention was in fact a forum for the collusion

of local patriarchal interests with the anti-women biases of British jurists. And contrary to popular belief, this led to the decline of women's rights in India.

The Amnesty International report ostensibly aims to ameliorate women's condition in Pakistan by calling on the Pakistani state to activate its legal machinery to save women from "honour killings". However, in re-inscribing colonial and imperial conceptions of "tribal" life, wherein the tribal social body and body-politic are merged, then homogenized and conceived to have a purely violent and uncivilized justice system; Amnesty International report's discursive solution to eliminating violence against women, describes honour killings as the responsibility of and requirement for the Pakistani state (as a mandate of international law) to eliminate tribal way of life in its entirety. This discursive solution is made possible by the report's construction of the absence of tribal civil and social bodies. If there is any failure on the part of the state to serve the cause of women, in the AI report it is located in the Pakistani state's negligence and inability to adequately biopoliticize —discipline and punish—the unruly tribal men and their leaders. How, then, given the discursive logic operating in this report, that requires the elimination of anything tribal, can the 'tribal' bodies of women in Pakistan be "saved"? A savior discourse functions in the report and constructs women as "tribal," as in wrested in a timeless zone of backwardness, already preconceived as lacking agency, whose "repeatedly violated" bodies serve unequivocally for the report to convey that the tribal women exist only as a 'commodity fetish' for the "murderous and insatiable" men of the tribes. Thus, in this tribal way of life, a woman does not belong to herself. Rather, her body is tribal flesh, exchanged and protected by men who will either violate her if she crosses any regulated "tribal norm", or if her body is crossed by another

man whose "property" she is not, or dispense with her by killing her. This is the central and persistent representational theme of the 1999 Amnesty International Report that, ostensibly, seeks to give voice to the women of Pakistan. The report seeks to confront any reader who might be deluded to think that tribal life has anything to do with community, family, love, friendship, pain, loyalty, betrayal, history, pedagogy about the cosmos, dissent, struggle, grievances against the state, or simply having social habitus.

Rather, as I have argued in this chapter, in the human rights discourse of Amnesty International, tribal culture is equated with a type of " tradition" that is juxtaposed with women's human rights to equality. The meanings of culture implicit in the human rights discourse are most apparent in debates about cultural relativism. Culture is increasingly understood as a barrier to the realization of human rights and as a tool for legitimating violence against women among men of those cultural groups. In this discourse cultural relativism is critiqued for perpetuating misogynistic cultural and religious practices. As the following statement illustrates, cultural relativism is not only viewed to be an obstacle for modernization, but modernity itself.

> The struggle against honour killing is inseparable from the struggle for women's civil liberties, for the separation of Islam from the State, the struggle against political Islam and Islamic States in the region. All restrictive and backward cultural and moral codes and customs that hinder and restrict women's freedom and independence, as equal citizens, must be abolished. Severe penalties must be imposed for the abuse, intimidation, restriction of freedom, degradation and violent treatment of women and girls. These are the tasks of women's liberation movement along with the progressive and egalitarian movements in the region as well as in the West. (Kamguian, Azam 2003:7)

Ironically, the fact that the Amnesty International report focuses on "honour killings", rather than "domestic violence" steers it away from its ideology of

universalism. The term domestic violence is reserved for the West, and the invention of the category "honour killings" explains to the reader the "uniqueness" of the "private" violence against women and the rising murders of women in Pakistan. Because "honour" as a determinant of the murders of women is constructed as an "ancient" non-western notion, and is also tied up with ideas about women's sexuality, it can simultaneously serve as an exotic and demonic sign. What we have here is a cultural relativism of the colonial type, and echoes of discursive violence in the construction of the " Other", that has been part and parcel of colonial historiography and colonial state policies that meddle with perceived and constructed ideas about "customs" and "traditions" (Thomas 1994:172). Premised on a binary conception of other cultures, in the report there is a call for the "policing of tradition" (Dirks 2001) not unlike the British colonial state policy after the 1857 uprising in India. The report participates in discourse—that in constructing the "primitive", and "barbaric", simultaneously posits, as an internationally supported body, sympathy and progressive legal intervention towards those very same constructed subjects (ibid).

Dirks (2001) explains that under colonial rule, although the term custom seemed to refer to a single set of social practices and principles, custom steadily became a trope for a society that was outside of history and devoid of individuals. Therefore, "within a world dictated by custom, agency is held out as a tantalizing promise of freedom" (ibid). As I have argued, according to the Amnesty International report, Pakistani women have no agency. How can subjectless objects have agency? In the colonial state this freedom to be an agentful subject was held out to adjudicate the difference between criminology and barbarism and not, according to Dirks (2001), to open up any genuine opportunities

for freedom of choice. Custom, of course, varied from place to place, yet the colonial administration constructed the essence of custom as primordial and fixed. Thus, the alterity of the colonized embodied within this static custom served to "resolve the issue of agency oppositionally, by creating a world in which agency and individuals did not exist, thus simultaneously disparaging the traditional world as uncivilized and heralding European modernity as the only haven within which agency was possible and individuals could achieve proper autonomy." (Dirks: 170). "Agency thus can be seen as a profoundly problematic category precisely because it disavows the possibility of consent—or anything resembling purposive individual action—outside of particular cultural worlds, at the same time it uses this condemnation as the pretext for dismissal, surveillance, and control" (Dirks: 171). In contemporary Pakistan, similar tactics are being deployed by the state to justify the occupation and militarization of the Balochistan province in the guise of the development of the social and economic situation of the Balochs living there.

CONCLUSION
ETHICAL DEMANDS OF CARING FOR THE BODY

Bibi claimed that no child or mother has ever died in her hands in her work as a *dhinabhug*. She could not recall if such deaths occurred in the hands of her grandmother/great aunt who had taught her the skills of *dhinabhugiri.* In claiming this, Bibi was not so much as boasting about her *dhinabhugiri* abilities and knowledge, but instead she was conveying to me the unpredictability of the outcomes of any given case of childbirth in which "*khodrath"* (Gad.nature) is seen to have a central and yet inexplicable place in childbirth experiences of women in Panjgur. She tells me, "God brings them to the world. If he brought death, then there was death. If there was no death, then the child was not killed." However, this did not mean that the Panjugiri *dhinabhugs* would not do whatever in their means, capacity, and experience to save a woman and the lives that she is to give birth to.

Since international efforts, investments, and tracking of maternal mortality rates that began in 1987 following the report of WHO interregional meeting (WHO 1986), the reductions in maternal mortality have been low if not entirely static in Pakistan. In many other regions such as in Afghanistan the rates of maternal deaths have worsened due to the obvious reasons of war and obliteration of its infrastructure. Yet, as I discussed in Chapter Two, the disappointing results of the maternal death rates over years are blamed on "culture and behavior", especially on the behaviors of local midwives, rather than on historical and ongoing structures of inequalties and the very programs and interventions designed to reduce maternal deaths. Underlying the medical causes there are a range of social, economic, and political factors that contribute to poor maternal health, yet the reductive focus on the biological factors, as I discussed on Chapters Four and Five, have

overshadowed this all important context that would provide us with important locale-specific clues about the failure of declines in the rates and ratios of maternal deaths. The Panjguri midwives (*dhinabhugs, kawwās, and ballok*), from whome I was privileged to learn, counter in name and content the reductive transnational categories TBA and *dais*-categories that are neither purely local nor cosmopolitan. In Chapters Three and Six, I showed how the construction of these categories parallels the production and contemporary circulation of another colonial based category "tribal". Both discourses about- maternal mortality and honour killing- are embedded in humanitarianism (saving women's lives) that discursively demands the disappearance of certain bodies (The "traditional" body of the midwife and "tribal" social bodies). Both discourses operate based on limited information about the subjects they aim to reform and save.

Since the nation's independence from British colonialism and India, the increased availability of modern health services in Pakistan has not eliminated the inequalities in access to institutionalized health care services nor has it prevented the continued use of multiple modalities of health care from herbalists, midwives, and faith healers. The WHO agreed that medical pluralism could be a resource rather than a barrier to the health of the society.[166] Yet, the benefits of medical pluralism are shaped by long-held negative perceptions about "traditional" practitioners. The perceived positive and negative roles of the so-called traditional practitioner have resulted in multiple and repeated attempts to integrate them and recruit new cadres of female health care workers, and training them according to the prevailing biomedical/allopathic derived conceptions of disease diagnosis and techniques of treatment. This is a paradigmatic approach to the care of the body that is largely unquestioned by public health professionals in Pakistan. That is to

say, in Pakistan the value of the so-called traditional practitioners to provide needed services is simultaneously accepted and rejected. So, what they provide may have social and emotional value, but ultimately their role and medical care contributions are deemed inessential. These perceptions about "traditional" practitioners and hence the uses and attempts to integrate them have been largely shaped by the dominant transnationally circulating biomedical paradigm. That is, 'yes traditional practitioners provide needed services, yet what they provide is not medical care'; thus the question of efficacy remains mute. The focus is on the harm side of the harm-benefit equation. The issue of their integration into the state biomedical establishment has been inseparable from the public health discourse on harm reduction- largely wrapped around the question of hygiene.[167] The benefit of what traditional practitioners do is typically linked to other aspects of her practice, which are presumed harmful. Within this frame, for a while, as I outlined in Chapters Two and Three, the so-called TBA or *dais'* necessity for advancing the shifting public health foci had been shaped not by the conception of technical and medical expertise that they may already possess, but rather more due to their link to and trustworthiness within their communities. Now, even the status of trustworthiness previously ascribed to them is replaced by the desire to form the "skilled birth attendant" or "skilled midwife" that by definition and in practice inscribes the "traditional birth attendant" inessential or as already obsolete.

Many months into my research I would hear once more about the reputation of another *dhinabhug,* Bibi-Zainab's work when a respected male allopathic/biomedical doctor, and not a relative of Bibi Zainab, would refer to her as a "*true dais*". So what is a true *dais*? This is the very point that is at the heart of the current transnational debate

about who can and cannot be a "skilled midwife" in the 21st Century. When I interviewed the LHV at the BHU where I had first met Bibi-Zainab, she told me that she had learned from Bibi-Zainab about how to assess the proper fetal position and determine the proper level of cervical dilation in order to know exactly when it would be appropriate to inject the labor inducing drugs. Although the LHV is authorized provider who can give the injection in this situation, the LHV openly told me that were it not for Bibi-Zainab's guidance she would not know when to give the injections. This raises the question about who possess the requisite skills to be a good attendant of childbirth. Yet, the national policy on promoting the so-called skilled midwives or skilled birth attendants is clear. According to this policy, the LHV by virtue of her training and educational level (because she can read basic obstetric medical textbooks in Urdu if not in English) can become skilled. For her it is simply a matter of attending more births and attending some refresher trainings. Whereas, Bibi-Zainab, despite the years of experience and her *kawwāsiness* (expertise) would neither be considered skilled nor can she ever gain the pre-conceptualized biomedical form of skill by virtue of the fact that she lacks the formal level of education and literacy to read basic obstetric medical or midwifery textbooks. This black and white perspective about what can be marked as skill and who can acquire this exclusionary modern form of skill contrasts with the very meaning of skilled or *kawwāsi dhinabhugs* in Panjgur.

The narratives about the work of *dhinabhugs* and/or the *kawwās*, pointed to a set distinguishing features between what constitutes just a good *dhinabhug*, versus a *kawwāsi dhinabhug* or a *kawwās*. The criteria of who is a *dhinabhug* or a "real *dhinabhug"* made it clear that it would be difficult for someone to claim this identity merely by virtue of

attending “TBA trainings”. There is no guarantee that as a “trained TBA”, you would be called upon to attend a birth. Thus, the *kawwās*/experts is someone considered to possess special skills. The characteristic *kawwās* that I met was someone who seemed to have developed a keen interest in learning and applying her skills and knowledge toward new and complicated situations. The general tune currently among Pakistani makers when they describe the “*dai*”/”TBA”/ is that they are not “skilled” and are not suitable for the making of a “skilled midwife”. Moreover, according to them currently “skilled midwives” do not exist and that a TBA or *dai* is incapable of attaining the knowledge required to have the “The Skills” necessary for primary interventions to reduce maternal mortality. Thus, policy makers plan to ‘make’ skilled midwives. The use of “skilled” here refers to possession of knowledge of a particular kind and is linked with the use of particular biomedical instruments.

In my dissertation I have shown how *dhinabhugs* and Panjguri *kawwās* (expert midwives) challenge the attempts to constitute childbirth and reproductive morbidities as a privileged site of the biomedical gaze. Speaking truth is a political practice and also a practice of the self. In this sense there is no differentiation between politics and ethics. I have shown how many of the established *dhinabhugs* refused to participate in the state-sponsored “TBA” training programs. Naz-Bibi, for example, continued to practice Balochi medicine, despite the indirect pressures from the *ladies-of-allopathy* via childbearing women and direct pressures exerted on *dhinabhugs* to end their herbal medicinal practices. Her commitment to insist on *Balochi dewai* in the care of women’s bodies was reinforced by women’s own commitments to obtain a form of medicinal regime of care that could heal their ailments. While the allopathic/biomedical

practitioners hold a level of prestige and authority that attracted some childbearing women to their institutionalized regimes of care, the failure to achieve the healing and desired results (i.e. resolution to infertility) brought the same women back to *dhinabhugs* to obtain care from them. The truth of the efficacy of Balochi medicine and its persistent use among *kawwās*, *dhinabhugs*, and *balloks*, thus, was less about the art of persuasions through words and traditional forms of authority, but rather through the quiet care of the bio-body and its empirically evident positive results.

This commitment to the care of women's bodies is one that is passed on from one generation to another, less through any clearly defined social structures of inheritance or customary hierarchy, but rather through one's own understanding of ethical imperatives. Of course lady medical doctors who in my study chose to provide hysterectomies as legitimate form of care to rural women of Balochistan possessed their own forms of ethical imperatives. However, unlike *dhinabhugs'* ethics, a lady medical doctor could draw on normative ethics of biomedicine sanctioned by institutionalized 'scientific' authority in which case she is not accountable to the patient in the same way that the *dhinabhugs* are responsible and accountable for their patients and the communities within which patients and *dhinabhugs* belong. I have shown, in Chapter Five, how in the urban-based medical centers bio and social imaginaries of medical doctors converge to trump a range of possible bioscientific interventions for one that is most radical such as the hysterectomy.

Foucault's notion of power is understood as a complex web of relations that operates not only through the law and the economy, but also through social norms and cultural practices. In this way, techniques and technologies of power do not reside in

institutions alone (such as the state), but work their way through them into myriad of state and non-state space and places, including, most of all, the bio-body (Dreyfus and Rabinow 1983). As such, all social relations are power relations. In this schema, how do we account for resistance? Where do we find ethics and the ethical subject? Whereas Foucault's earlier work focused on technologies of power and domination, in his later work he began to write on the techniques and the care of the self (Foucault 1984 [1986]). However, technologies of the self do not replace the technologies of domination, but rather co-exist. In my research context, "the time of the *lady"* is not a triumphant arrival [replace *lady* with biomedicine]. In this dissertation I have shown how the ethical self is embodied and socially constituted as reflected by choices *dhinabhugs* made regarding the medical care of childbearing women's bodies despite the persistent power and intrusions of biomedical interventions.

For example, Khatija explained to me that her aunt Sher-Bano used to go to Beroont, a region outside of Katagiri to attend births and care for the women after the childbirth. When Sher-Bano died, her daughter Sapoora took up the *dhinabhugiri* work. She would make the long journey on a motorcycle driven by one of her son's. In Khatija's words, "It is a difficult road to travel from here to Beroont, full of sand and gravel. Sapoora would also walk there, but now it is too difficult for her so I go there, and she can no longer ride the motorcycle, so I go there now." Khatija travels outside of Katagiri to Gwargo as well, but traveling to Beroont is more difficult so now Khatija goes there for childbirth cases. In the absence of any other *dhinabhug*, Khatija felt compelled to go to these distant locations in spite of the difficult road conditions. "Why should I like it, I don't have a *gardi* (car/transport), and my younger son wants to sell the motorcycle. I

told him not to sell it. He tells me the cycle is too old. Whatever condition it is in, it is available to us. There will come such a day that I won't be able to walk and Ill need it. My older son will be going to Dubai. I told him to leave the motorcycle. There will be a day when a woman is labor and *chillag* (postpartum) and I won't be able to walk to her. Beroont is not near!" Here Khatija's resounds the intergenerational tensions prevailing in Panjgur in 2005 and that I discussed in Chapter Four. Unlike the predominate reasons for the tensions between younger and older women, in this narration of Khatija the conflict between she and her son is less about the value of *Balochi dewai* vs. biomedicine. Rather, it is related to economic necessities, problem of transport, and the ultimately the ethical demands of Khatija's work. For Khatija, the economic and ethical demands of her work are equally significant and hold indistinct social value. Thus, if she was to continue to fulfill the ethical demands of attending to women in distant locations that lacked qualified or any *dhinabhugs* whatsoever, and at the same time have a means of transport to respond to the urgency of variety of reproductive health situations confronted by women living in those places, the least she could do is ensure that this not so fancy, yet functioning motorcycle remains in the family. For her the asset contained in the motorcycle lay in its availability and functionality and thus the means of mobility to attend to women in labor in distant locations. This was more important to Khatija than the cash her son was seeking to obtain with the sale of the motorcycle. She was determined to keep the motorcycle, knowing well that attending childbirth cases in near or distant locations did not guarantee the monetary remuneration that lady medical doctors and lady health visitors could and did demand of their patients and pateints' families.

In my dissertation I discussed in detail Bibi-Zainab, Bibi-Begum, and Naz-Bibi's work and outlook about the demands of their work and the pressures of modernity marked by their encounters with other subjects formed by allopathic medicine and the biomedical institutions. Their stories show that there is no such subject as a typical TBA, *dai,* or "midwife"; or more to the point of the this dissertation, there is no typical *dhinabhug*, *kawwās*, or *ballok* in Panjgur. Living in disparate regions of the Panjgur district, one may have learned of a *dhinabhug's* name, reputation, and distinct expertise of her work, without ever meeting her. Bibi-Zainab, Bibi-Begum, and Naz-Bibi, represent just three of the more than fifty *dhinabhugs* and *kawwāsi dhinabhug* with whom I had depth conversations. Each of them presented to me their unique qualities and outlook toward life within a context being shaped by the specificities of their local contingencies and the shared global terrain of the biomedical and national health policy encroachments in Balochistan.

Earlier Ruminations

In an earlier paper (experimental writing), three years ago I wrote, the *dai* sits in a liminal position located outside the limits and obligations imposed on other village women. Yet, at the same time, she is inside the *dairas* (circles) of the community. She lives also in-between the old and the young; she remembers the birthings and becomings of many womb-en, whose stories are made complete once told in the *daira* of womb-en. The *dai* complicates everything about what it is to be a womb-an. She also opens the way to knowing womb-en in a different way. That is, a womb-an in a village is not as un-free as assumed or essentialized in narrations about the so-called traditional midwife. If we listen to a *dai'*s life and experience marked by her relations with many generations of

women, also indicates that we cannot know all women the same way, because she knows that not a single womb-an's path of becoming is predictable. The woman to mother transformation is never the same and some women don't become mothers but they transform because the *dai* is working in all the realms of fertilities that include the many women's struggles with the fact and implications of infertility. Women discuss with her about their desires to not becoming a *dar* (wife) but to be to one-self, to not belong to another man, and yet to remain part of the *daira* of the community.

Then, as in now, each time I listen to write the voice of the *kawwās, dhinabhug, ballok, or a dai,* she says *do not essentialize me, I am an exception to the rule but I am not the only one.* They are unexceptional, and yet in another sense they are exceptional. There is more than one more than exceptional/unexceptional woman concerned with the care of women's bodies. Neither these women, nor the wombs they take care of can be essentialized. I see them as anti-essential village women; yet essential they are in the lives of womb-en. While I do risk, here, essentializing the *dhinabhugs'* anti-essentializing characteristics, my aim is to re-direct the normative assumptions about the so-called traditional midwife/ birth attendant of the so-called Third World. These normative assumptions that operate in the Post-WWII health development context social reform projects and discourses are a product of a longue durée of colonization during which women's social and health status and the reform of the "traditional" midwives and behaviors figured central to the "civilizing" and missionary projects of the colonial rule.

In my work and research, speaking to a woman familiar with multiple circles of women's lives, *She* would laugh and then become serious if you ask her what a typical birth of the many she has assisted is like. There is no typical birth, no typical family,

mother-in-law, or husband, and thus no typical *kawwās dhinabug* in Panjgur. *You see,* She might say to me: *Rajgul, didn't want the fifth pregnancy, but her husband did and the mother-in-law said it would be good to have a daughter, you don't have a girl, girls undergo* [metamorphoses] *and take care of you- I have helped give birth to many darhk*'s *sons, but every mother needs at least one janik (girl) [daughter-friend] who helps you and listens to your sorrows- so she did, she did keep the child and God willing she will have a girl. Then there is Noor Bibi- she is a different story, she goes to the Pir asking he/she to bless her so she can have a child…married for five years the husband will not get a check-up- some men are like that they blame it on women…There is another janaeine* [wife-woman]. *She is my brother-in-laws mother's sister's daughter who wants a third child, but the husband says two-a girl and a boy- are enough. He is a wise husband, but she is afraid-what if the second child doesn't survive. I have not told you about Noor Bibi* [whose time is near]*, she refuses to get married and pleading to her parents to wait, maybe she will have her wish-God willing- she wants to go to college, the problem is the schools are faraway, sending her to Quetta to live among strangers* [in a dorm]- *but now a days families are sending their daughters, in Quetta, two unmarried girls were sent…because their brother is also there studying in college. Noor Bibi has convinced the father, but her brother is stubborn-well-you see- brothers see the world and they think they know the world outside and must protect their sisters. They come to have ideas about how men/boys look at other girls/women. It is not a surprise that he takes this stance-he looks at other boys' sisters. So this is the problem in Noor Bibi's home. But Noor Bibi is tough and what is good is that the grandparents are on her side.*

The *dhinabhug/dai* is mobile, she moves independently without the company of other men. She talks loud, she laughs loud, she is quiet, sometimes secretive, but often confident and at time boastful about what she knows. She works in the realm of the fertilities and infertilities…

For decades the transnational feminist and women's health movement has shown how listening to what women themselves have to say about their health and wellbeing is of vital importance to policy-making. Inhorn's (2007) recent review of ethnographies focusing on women's health assesses some of the major themes of large body of literature, asking what the ethnographic record on women's health has contributed to knowledge production. She highlights what she considers to be some of the most important thematic messages about women's health emerging from the 157 ethnographies. Her point is that a specific ethnographic approach to women's health leads to a particular set of insights that are important, timely, and quite different from women's health research agenda currently being promoted within biomedical and public health circles. My hope is that this ethnography of Panjguri women and *dhinabhugs* will also make such an intervention.

[1] I employ the term transitional rather than international to suggest that categories, ideas, and in particular development documents circulate in multiple directions and do not originate within the bounds of the so-called national, nation-state inscribed, or international institutions despite their ultimate mandate and acquired legitimacy due to the marriage (formal agreements) between nation-states and international organizations. Such translocal movements of categories, ideas, etc. take place within national boundaries across state and non-state type institutions, across boundaries of nations, and across time. Transhistorical and translocal circulations of categories, ideas, development, and human rights documents may or may not be mandated by international organizations. International organizations acquire their status and legitimacy from multiple states and/or transnationally located non-government organizations. However, this does not translate into legitimacy from all localalities. Thus, as I show in my dissertation, the use of the term international belies the complex context of the genealogical formations, circulations, and reformations of categories, ideas, documents and the contextual understanding of subjectivities.
[2] See the collection of work in Davis-Floyd, Robbie E & Carolyn Sarge (Eds.) (1997) On *Childbirth and Authoritative Knowledge,* Pigg (1997) on "Authority in Translation: Finding, Knowing, Naming, and Training 'traditional birth attendants' in Nepal".
[3] Sindh is the second largest populated province in Pakistan. Karachi, once the capital of Pakistan and one of the most populated cities in the world where a majority of the urban poor of Pakistan live is located in the Sindh province.
[4] Hall, Stuart (2002) "Race, Articulation, and Societies Structured in Dominance," and "Reflections on 'Race, Articulation, and Societies Structured in Dominance." In *Race Critical Theories*, Essed, P. and Goldberg, D. eds. Oxford: Blackwell, Pp. 38-68, 449-454.
[5] Many postcolonial scholars have illustrated how the practices of colonial governance influenced the forms and processes of anti-colonial movements, postcolonial state building, and the nation-states' conceptions and formulations of 'civil society'. Ludden (1992), Moore (2003), and Packard & Cooper (1997), for example, provide concrete examples of the impacts of the legacy of colonialism on the contexts of postcolonial development in India, postcolonial resettlement policy in Zimbabwe, and international health policies and practices in the Third World, since the end of formal colonialism, respectively.
[6] In his book *On the Postcolony* Achille Mbembe (2001) is critical of some postcolonial theorists for writing on colonial discourse disconnected from colonial materiality and histories of colonial political economies.
[7] Epistemology usually is defined as the theory of the origin, nature, methods and limits of knowledge. The question of epistemic violence is related to the problem of who produces knowledge and what knowledge is produced about which subjects and what regions and spatial terrains, for example. It is concerned with how power and desire appropriate and condition the production of knowledge. In Gayatri Spivak's (1988) formulation, epistemic violence results when in postcolonial discourse; the subaltern is silenced by both the colonial and indigenous patriarchal power. Spivak. 1988. "Can the Subaltern Speak?" In *Marxism and the Interpretation of Culture.* Urbana: University of Illinois Press. Pp. 271-313. (Spivak, Gayatri Chakravarty. 1992. "More On Power/Knowledge." In *Rethinking Power*, Albany: State University of New York Press, Pp. 149-73; reprinted in *Outside,* and in *The Spivak Reader.* Spivak, Gayatri Chakrabarty. 1985. "Subaltern Studies: Deconstructing Historiography." In *Selected Subaltern Studies*; Eds Ranjit Guha & G. Spivak, Pp. 3-32. New York: Oxford University Press. Spivak, GC. 2000 [1999]: 147. *A Critique of Postcolonial Reason: Toward a History of the Vanishing Present.* Cambridge & London: Harvard University Press. (See page 147 in Spivak's *the postcolonial critic*). See also the works of Cohn 1996, Arnold 1993, Scott 1995, Mitchell

1991, Prakash 1999 who discuss the epistemological grids through which colonial governmentality was operationalized in a variety colonial sites.

[8] Foucault (1980: 197) in response to an interview states: "If you like, I would define the *episteme* retrospectively as the strategic apparatus which permits of separating out from among all statements which are possible those that will be acceptable within, I won't say a scientific theory, but a field of scientificity, and which it is possible to say are true or false. The *episteme* is the 'apparatus', which makes possible the separation, not of the true from the false, but of what may not be characterized as scientific." In *Power/Knowledge: Selected Interviews& Other Writings 1972-1977.* Ed. Colin Gordon. New York: Pantheon Books. See also Cohen's (1995) "The Epistemological Carnival: Mediations on Disciplinary Intentionality and Āyurveda."

[9] Foucault (1980) in *Power/Knowledge* focuses on discursive effects and the power of representation. He sees "truth" as discursively produced and discourse as having effects due to the interrelated nature of truth, power, and knowledge, what is also understood as a discursive formation. He is less interested in what is *the* truth, than the mechanisms by which truth is produced and upheld and thus becomes part of the dominant discourse. So while socioeconomic and cultural factors shape discourses, they do not originate from there. This is made clear in his work, "The Archeology of Knowledge", where Foucault discusses the analysis of 'discursive structures', what he calls 'archeology' and defines it as a term that: *"does not imply the search for a beginning, it does not relate to geological excavation. It designates the general theme of a description that questions the already-said at the level of its existence, of the enunciative function that operates within it, of the discursive formation, and the general archive system to which it belongs. Archeology describes discourses as practices specified in the element of the archive"* (Foucault 1972:131).

[10] *Dhinabhug* is a local Panjguri category referring to a woman involved in attending childbirth and conducting healing and herbalism around childbirth and other reproductive and female bodily concerns. I address the meanings and genealogy of this and other related local categories in Chapter Three.

[11] See David Arnold (1993) and Gyan Prakash (1999) for the history of allopathic medical influence on colonial and postcolonial Indian states. See also Partha Chatterjee (1986; 1993) on the shaping of the Indian state as the planner of the Indian social development.

[12] "Traditional Medicine Centers will soon be set up in the Federal Health Institutions." This was stated by the Minister for Health, Mr. Muhammad Nasir Khan while talking to the members of National Council of Homoeopathy on December 19, 2006. The Minister said that homoeopathic treatment is a cost effective treatment and the Government wants to promote traditional system of medicine in the country and urged the members of the Council to improve their performance and specially the standard of homoeopathic education. "He took a serious notice of un-ethical advertisement from certain homoeopathic doctors in the print and electronic media claiming to cure the Hepatitis-C and other chronic diseases and urged the Council to constitute a committee to take action against homoeopathic doctors who involve in such un-ethical advertisements. He told the participants that the Ministry of health would not approve any advertisement without recommendation of the Council. He proposed to formulate various committees, including committee for examination, committee for quality control of homeopathic medicine, committee for export of homoeopathic medicines, committee to review the rules and regulations, committee to review the syllabus of homoeopathic system of education." (Press Release, December 19, 2006).

[13] On homeopathy in Pakistan: The Board of Homeopathic System of Medicine working under the Federal Ministry of Health was renamed in 1983, the National Council for Homeopathy. The council is a corporate body, having perpetual succession. This council is now responsible for conducting examinations, appointment of committees and sub-committees, provision of research in the system, registering practitioners, and recognition and licensing of homoeopathic medical

colleges, and forwarding the pending cases of new homeopathic colleges for approval to Federal Ministry of Health Govt. of Pakistan. All homoeopaths are required to undergo four years of training and courses in homoeopathy medical sciences. They are then awarded a diploma (DHMS). After a six-month apprenticeship and house job with a qualified homeopath, they may be registered with the National Council for Homoeopathy and become eligible to practice. The number of homoeopaths registered with the council is about 100,000. There are more than 125 recognized homoeopathic colleges in Pakistan, with about another 15 awaiting recognition. Any Allopath MBBS (MD) doctor may legally practice homoeopathy if he can satisfy the council that he has done six-months of apprenticeship house job in the field of homeopathy. There are a number of MBBS (MD) doctors practicing homoeopathy. Government hospitals also employ homoeopaths. There are more than 155 free Government homoeopathic dispensaries in district head quarters (DHQ) and *thana* headquarter (THQ) Hospitals supervised by the National Health Services (Ministry of Health Govt. of Punjab), and about 27 homoeopathy dispensaries that work under the city Government in Lahore city.

[14] An *hakeem* is a medical practitioner, usually male, trained in the Unani medicine.

[15] Interpellation or to interpellate is a concept developed by Althusser (1971) to describe how people are brought into ideology as subjects. While subjects are born into ideology, subjects are also agents. Thus, one ideological form can counter another.

[16] See Sahlin's (1976) work on practical knowledge and Gramsci (1992, 1996) on organic and common sense knowledge.

[17] Ferguson (1994) is engaging Foucault's ideas in "The Archeology of Knowledge", where Foucault considers the relationship of text/discourse to the real, and the construction of the real by discursive structures. The "real" is formed through the constructs of discourse, rather than actual observation. In this way the connection between production of knowledge and power relations is power/knowledge.

[18] Chatterjee (1986) also discusses the rise of the "planning regime" in and for the economic and social development of India. He understands "planning regime" as an aspect of development practice that illustrates how colonialism was fundamental and not incidental to the postcolonial state rationality and development ideology. Chatterjee (1986: 282) explains that the relations between planning and politics is one of rational planning and one of irrational politics that are inseparable logics of the state conducting a "passive revolution". Irrationality of politics works to legitimize rationality of planning, for what is science in one domain is rhetoric in another and yet they are inseparable in the constitution of the development of the Nation, and comprise the identity of the Indian nation state today.

[19] See (e.g. Baloch 1958, 1965, Bray 1913, Broadfoot 1840, Bruce 1884, Dames 1904, Hughes Buller 1902, Leech 1843, Spain c.1963, Tate 1896, Yate 1906).

[20] Scale refers to "one or more levels of Representation, experience and organization or geographical events and processes. There are three discernible meanings of scale in geographical research: The cartographic, methodological and what can be called geographical scale." (Johnston, Gregory, Pratt, and Watts 2000: 724).

[21] Johnston, Gregory, Pratt, and Watts (2000)

[22] "Geographical scale, then, is a central organizing principle according to which geographical differentiation takes place. It is a metric of spatial differentiation; it arbitrates and organizes the kinds of spatial differentiation that frame the landscape. As such it is the production of geographical scale rather than scale *per se* that is the appropriate research focus (Smith 1992a)." "Thus Taylor (1981) has proposed that there is 'Political Economy of scale' specific to capitalist society. The specific forms taken by different scales may be constantly transforming but there is a central necessity, inherent to the logic of capitalist expansion, for the differentiation of some system of absolute spaces as particular scales of social activity (Smith 1984)." In Johnston, Gregory, Pratt, and Watts (2000: 725).

[23] Government of Balochistan (1994): Situation Analysis of Health in Balochistan, Health Department of Govt. of Balochistan, Pakistan.
[24] Discussion with the *Nokehn Sohb* (A New Morning) Non-government organization located in Panjgur district, male and female elders residing in the district, and a local historian of Panjgur also residing in the district.
[25] I describe these various categories of health workers (LHV, LHW etc.) in Chapter Two.
[26] Typical statements include: "Tribal norms and traditions in Balochistan, have lead to a state of gender discrimination and a social culture where male-female segregation, in every aspect of life, is very distinct and gender imbalances are quite evident. The prevailing traditions restrict women's access to health and education facilities and even to food, in some instances" (UNDP 1998). Similar statements can be found in government and transnational documents such as in documents published by the World Bank and Amnesty International that circulate widely across and within nation-state institutions.
[27] Ministry of Health, Pakistan (2005).
[28] Brain Spooner (1969; 1973), Nina, Swidler (1969; 1972; 1973), Warren Swidler (1968; 1972; 1973; 1977), Philip Salzman (1971; 1974; 1978), Carroll Pastner (1971; 1978), Stephen Pastner (1971; 1978) and Stephen and Carroll Pastner (1972).
[29] M.A. Barker and A.K. Mengal (1969), J. Elfenbein (1966). Non-English works include works by Fred Scholz and Erwin Orywal.

[30] Ethnicity in the Greek traditions was once associated with articulation of we/they distinctions, "others", and a lower stage of civilization or political development. That it was in the "context of the consolidation of the Ottoman Empire in the fifteenth century did ethnos become a term of self-identification for Greek Orthodox Christians and, finally in conjunction with nineteenth-century Greek nationalist efforts, a term connoting a 'we group' with a common culture and history." (Lentz 1995)
[31] Although scholars like Hobsbawm (1992:5) called for rejection of a primordialist theory of ethnicity, Comaroff (1993: 33-34) points to the frequent recasting of the controversy between (neo) primordialists and constructionists: "Ethno-nationalisms see their own roots in primal attachments: it is by virtue of these attachments—and by effacing the traces of their historical construction—that claims to ethnic self-determination are typically conceived and justified. As a result, primordialism appears to account for, and to valorize, this kind of identity. By contrast, Euro-nationalism [that envisages a secular state founded on universalist principles of citizenship and a social contract] locates its origins in narratives of human agency and heroic achievements. It is, alike for those who hold it as worldview and for those who seek to analyze it, an historical creation; not surprisingly, it seems most persuasively illuminated by one or the other form of constructionism. And hetero-nationalism [that seeks to absorb ethno-national identity politics within a Euro-nationalist conception of political community] tends to be rationalized and explained by recourse to neoprimordial instrumentalism. Both the former and the latter hold that cultural identity has a primal basis; an immanent, enduring essence that is bound to express itself as soon as its bearers find cause and/or occasion to assert common interest. And both agree, explicitly or implicitly, that—inasmuch as such assertions are founded on 'natural' affiliations—they are undeniably right and proper".
[32] The joint family organization is the predominant family system with a patriarchal lineage in most cases. Generally, families reside in a common compound. But an entire village is often one kin-family group living in multiple compounds, in some parts of Panjgur in older forms of housing structures. Ideally, male siblings stay together in one compound and/or village and consider it their duty to look after their elderly parents and families of brothers who may be employed abroad or in distant cities.
[33] I witnessed this process within the family that I stayed with during my research. What I

observed was how the family dealt with a conflict between members of the extended family and a neighbor that had been brewing over three years. Also, several elections took place during my research, thus I was able to observe how and what families discussed about the contenders, election process, and whether or not they vocalized to each other who they would vote for. Many women in Panjgur were an active part of the election process. Several of the respected local midwives were selected to monitor election sites by the designated local committees, for it was clear that women, as in past, would go to vote.

[34] *Nokeen Sobh* Social Development Society, Gramkan, Panjgur (Report, 2005)

[35] JanMohammad (1982). The British enforced two Acts in British Balochistan: The British Baluchistan Bazars Regulation, and the Quetta Municipal Law. The local governments introduced by the British were designated as a special purpose non-representative government. They were set up purely for taxation purposes.

[36] See also the far-reaching affects on Balochistan due to British intervention that are examined by Scholz (1974, 2002). Salig Harrison (1981) describes the precursor to the Baloch nationalist movement. The origins of the Baloch nationalist movement go back to the forcible incorporation of the Baloch into Iran by Reza Shah Pahlvi in 1928 and later, into the new State of Pakistan left behind by the British Raj in 1947. The Baloch waged unsuccessful military struggles of varying magnitude to preserve independence and have been fighting intermittently ever since to throw off Pakistani and Iranian domination (Baloch 1987).

[37] According to Inayatullah Baloch (1987) in 1937 the Kalat State National Party was constituted, the goals of which were to negotiate with the British to re-establish the Kalat state as an independent state and to struggle against the so called sardari system in Balochistan.

[38] In Makran division including Pangjur district, historically three levels of social strata can be located, namely *Hakim*, Baloch, and *Hizmatgar,* locally known as *Drazad* or *Golam*. Hakim constituted a privileged class of society, with the Baloch being the intermediate class who were basically pastoralists, partially settled, and semi-agriculturlists. They were in a relatively better position than *Hitzmatgar*, who were in the lowest social and economic stratum. The *Hakim* lost their influence as tribal chiefs and the social class gave way to economic compromises. Presently, all inhabitants of the region are known by a common name, Baloch, and calling someone *Drazada* or *Golam* is derogatory. A significant number of *Hizmatgar* are educated, such that now they have become a political force, while educational expansion has helped to further break down older forms of social and economic hierarchies.

[39] UNDP (1998).

[40] See DAWN December 22, 2005. Also see Coverage by Herald magazine in 2004 and 2005.

[41] Interview with Nawab Bugti of Dera Bugti in October 2004.

[42] (Harrison 2006)

[43] While the meaning and constitution of *ethnos* shifted increasingly expressing a sense of "we-ness" in nineteenth century Greek nationalist efforts, the history of the term *tribus* took on an opposite trajectory. Lentz has ascertained the term initially referred to the three lower groups of the early gentilitial Roman popular assembly, and only later to the populace at the periphery of the Roman Empire. There are traces of the latter usage in early British colonial vocabulary, which at first distinguishes 'tribes' from 'kingdoms'.

[44] "Development of Tribalism" in DAWN: July 23, 2002.

[45] I use the term subject citizen deliberately to emphasize the contradiction between the official discourse about them that entail their discursive subjugation by the state for the health-development of the nation and their grounded subjectivity and selective negotiations with biomedical state attempting to interpellate them.

[46] See Lefeber and Voorhoeve (1998) (eds.) on the proliferation of this view about local midwives in Asia, Africa, and Latin America. See Van Burren in this volume on the popular belief in Indonesia that the midwives are native death angels. See Lal originally published in 1962

republished Lefeber and Voorhoeve suggesting that midwives are directly responsible for the infant and maternal deaths in India.

[47] Major international donor agencies included U.S. Agency for International Development (USAID), United Nations Fund for Population Activities (UNFPA), the World Bank, the Swedish International Development Authority, the Ford Foundation and The Population Council.

[48] For example, due to the perceived ineffectiveness of midwives, in the mid seventies the Bangladesh government discontinued the training of local community midwives, and replaced them with family welfare visitors. This was done to prioritize the promotion of contraception at the community level and consequently caused the provision of maternity care to be compromised (Simmons et al., 1990).

[49] Women's health groups in South Asia lobbied their governments on a wide range of issues, including provision of a broad range of health services, from family planning to the elimination of prostitution and violence against women; and the need for broader socioeconomic policies to improve human well being (Dixon-Mueller 1993; Germain and Ordway 1989; Hartman 1987; WHO/HRP and IWHC 1991). Indian women's groups, for example, campaigned against harmful contraceptives and the use of amniocentesis for sex-selective abortion (Shah 1993). In Asia over 50 networks and groups formed to address specifically their concern with women's health nationally (Fabros in Garci-Morenoa and Claro 1994). For example, Development Alternative with Women for a New Era (DAWN)—by now well known—is a network of Southern women, researchers and activists created an international South-South network to promote development from a feminist perspective (Sen and Grown 1987). In 1990, DAWN decided to move beyond its original focus on "women's right to control their own bodies and reproduction" to a new five-year agenda to specifically address population and reproductive rights, along with economic structures and the environment, as priority concerns (Garcia-Moreno and Claro 1994). The Women Living under Muslim Laws Network is another major network of Southern women, which exists in over 40 countries (including Pakistan) and included reproductive rights as a critical component of its research on women and the law. These two networks are two examples reflecting active participation of South Asian women in shaping policy and strategies to improve the reproductive lives of all women in South Asia.

[50] Following the ICPD, the governments of many South Asian countries initiated the processes for the implementation of the ICPD program of action. For example, the Maternal and Child Health Program of Bhutan was expanded into a Reproductive Health Program, and includes among it objectives, education on reproductive health (RH) for adolescents, and reduction of early marriages and teenage pregnancies. In Myanmar, RH was on the agenda ever prior to ICPD, and was featured in its National Health Plan of 1993-96. Based on experiences gained from the Health and Family Planning Program, Bangladesh developed a new health and population strategy, and launched the Health and Population Sector Program in 1998 to advance the health and family welfare status among the most vulnerable women, children and the poor. India launched its Reproductive and Child Health Care (RCH) Program in 1997 in order to provide need-based, client centered, integrated services. Nepal's National Health Policy, adopted since ICPD, recognizes the reproductive and sexual health rights of women, adolescents and youth. Under the new Population and RH Policy in Sri Lanka, a number of programs were initiated to advance the health status of youth and the elderly (WHO 2001).

[51] One of the unanticipated findings of my ethnographic research in 2004 and 2005 in Pakistan includes the extant high incidence of hysterectomies experienced by Panjguri women. Subsequently, through the examination of the medical literature and clinical based studies, I have found that Pakistan is among the top five countries in the world having the highest incidence and prevalence of hysterectomies (US Census Bureau 2004a,b). The connection between Pakistan's deep and persistent investment in population control (i.e. family planning programs and contraceptive dissemination through public and private sectors) and the high incidence and

prevalence of hysterectomies is difficult to overlook. I will discuss the problem of hysterectomies in chapter five. Panjguri women's hysterectomies are related to the routinization of pharmaceutical injections of drugs. In chapter four I address this process of routinization and how the policy of prostaglandin injections is linked with projects to avert maternal deaths in Pakistan.

[52] In addition to this goal, the government of Pakistan envisages increasing, by the year 2015, the contraceptive prevalence rate (CPR) from the current 34% to 55%; proportion of pregnant women receiving prenatal care from current 31% to 100%; and reducing, the total fertility rate (TFR) from the current 3.9 to 2.1 (replacement level fertility) (Ministry of Health 2005).

[53] The key ongoing public sector initiatives focusing on attainment of MDGs include: National Program for Family Planning and Primary Health Care; Women's Health Project; Reproductive Health Project; Maternal and Neonatal-Special Immunization Activities; Enhanced HIV/AIDS Control Program; the National Nutrition Program; and Population Welfare Program (Ministry of Health 2005).

[54] This is mostly attributed to high fertility rate, low skilled birth attendance rate, illiteracy, and insufficient access to emergency obstetric care services and malnutrition. The situation for women is expected to worsen due to the high fertility rate, improved child survival rates and the limited availability of emergency obstetric services. Only 27% of the female population seeks biomedical forms of antenatal care. Iron deficiency and anemia is a major public health problem for women of childbearing age- more than 58% of childbearing age women are anemic. Antenatal visits are a context in which it is hoped the anemia problem for women can be addressed. Yet, the rates of antenatal care visits remain low. Access and quality of basic and comprehensive obstetrical services is low in Pakistan. Only 5% of the government's health facilities are estimated to offer EmOC services around the clock.

[55] See edited volume by Bhutta, Z. (2004) for more recent distribution of health services. See also Tinker's (1996) World Bank report on this point and its implication for reproductive health care services.

[56] Similar trends are evident in India. India is considered to have the largest and least regulated private health care industry in the world. In India access to health care has declined sharply over the years. The policy of levying user fees has impacted negatively upon access to public health facilities, especially for poor and marginalized communities and women. Medical expenditure is emerging as one of the leading causes of indebtedness. At the same time, this has been accompanied by policies that have reduced access of the poor to public distributions systems of food so that per capita availability of food has shown an alarming decrease. Mohan Rao (2005) has critiqued India's health policy in a recent book entitled *From Population Control to Reproductive Health: Malthusian Arithmetic.* New Delhi: Sage Publications.

[57] Abbasi, K. (1999) "The World Bank and world health. Focus on South Asia- II: India and Pakistan." *British Medical Journal* 318: 1132-35.

[58] *Zakat* is a form of donation to the poor that is collected by local elected official who are responsible for the distribution of this resource to the poor and needy.

[59] Bhutta's (2001) study is a first review of the impact of SAP in Pakistan and raises important concerns about what should be done in the immediate future in Pakistan.

[60] This claim is made despite the absence of any record of so-called midwives ever practicing in Quetta.

[61] See Pakistan Ministry of Health Reports 1997 and 2005 for examples.

[62] Pakistan Federal Bureau of Statistics (1996) and (1999). This ratio of female health workers to health facilities has not improved in any notable level. See edited volume by Bhutta (2004).

[63] See footnote 3.

[64] This was made evident to me in interviews with Pakistani Public Health Professionals and Officials working in the Government and UN offices. Also see 2005 Government of Pakistan

Ministry of Health Policy Position in "The Roadmap for Action: Millennium Development Goals In Pakistan."

[65] *Tabib* is an Arabic word from the abstract noun Tibb and/or Tabābat (Tabābah). A person practicing Tabābat is a Tabib or Tabiba. Tabābat means medical treatment, medicine, or medical science. From this Tabib means physician/doctor. Hakeem by extension is a Tabib. A person practicing hikmat is hakeem. Hikmat in Arabic means wisdom and judiciousness, and also it means philosophy. Hakeem also means intellectual, wise man, a sage and judicious person. It is also from a multidimensional world Hukm, which means to give an opinion. So Hakeem is one who has an expert opinion about medical matters. Hakim is one who gives orders or a decree, a ruler. In non-Arabic speaking world, Hakeem is simply used for doctor/ physician. Hakeema is the female version of Hakeem.

[66] Lee (1996) explains, "'Granny' was a label that never let women forget they were black lay midwives. By the early decades of the twentieth century, "granny" had become a term so associated with ignorant, southern, black women that one would have thought its usefulness irrecoverable. But as members of a group known for taking names thrust upon them and reinventing those names with their own sets of meaning, the grannies, as if assured of their place in history, have themselves in past decades [1970s and 1980s] embraced "granny", not as a racial epithet, but as a derivative of *grand*—wise women who stand tall in their communities. It is in the spirit of this recovery of the term that I use it in my study" (p. 5).

[67] Valerie Lee (1996) examines the lives of African American "granny midwives" and other healers of the South illustrating how States in the U.S. have never been uniform in their position of lay midwifery. 1619 is when the first black midwife came to America (p.6). The African American midwives of the South were everything from herbal to ritual specialists. Delivering babies was respectful, ancient work. From reconstruction to the end of the 19th Century, black lay midwives continued to deliver babies of both black and white women, particularly in rural, southern communities. Edna Roberts, director of PH nursing for the Mississippi State Department of Health is quoted to say that, "the granny midwives of cotton dollies were women who delivered the slave population. Mammies delivered plantation owner's women and raised their children."

[68] *Gidam,* also spelled *gedom,* is a traditional Baloch housing structure common in Southern Balochistan, Pakistan and in the Sarhad Plateau of southeastern Iran. The tent panel is made of black goat hair used for the tent roof. The walls are made out of mat woven with the fronds of date palm leaves. .

[69] In the U.S. Traditional Chinese Medicine (TCM) practitioners, for example, are legally barred from diagnosing cancer. If the practitioner states to the patient that they can treat cancer, she or he would be at risk of being sued by the government or the AMA, of the Board of Consumer Protection. No such restrictions are in place on biomedical practitioners in U.S. or in Pakistan.

[70] See the volume by Ram and Jolly (1998) and also the works of Jeffery, Jeffery and Lyon (1989) and Jeffery and Jeffery 1993.

[71] Cori Hayden (2003) has noted similar forms of circulations, and shifts in local and trans-local networks influencing gathering and access to plants in her research in Mexico.

[72] Shannon, Caitlon S. and Winikoof, Beverly, eds. 2004. "Misoprostol: An Emerging Technology for Women's Health." Report of a Seminar. New York, New York: Population Council, Inc. 7-8. May

[73] Kuriyama (1999), Farquhar (1994). For example, Lock's (1993) comparative study of menopause in North America and Japan considers the link between the process of medicalization and constructions of middle age and women's bodies with these societies. Whereas the dominant way of thinking about menopause in North America is heavily influenced by the medical world, in Japan women's self-conception of 'menopause' is shaped by whole set of other distinct local

histories and cultures including Japan's "local corpus of scientific knowledge about end of menstruation that sits in uneasy alliance with international scientific discourse." (page xxviii).
[74] See Scheper-Hughes (1992) regarding the medicalization of hunger; and Morsy (1995) on the medicalization of maternal mortality.
[75] Pigg (1997)and Morsy (1995) have all identified similar trends in the context of their respective studies.
[76] See Lock (1993: 370-71) on a useful discussion about "scientific tradition of reductionism."
[77] "This is often imagined as a juggernaut of technological imperatives bearing distinctive Western biomedical assumptions." (Clarke and Olesen 1999: 20) are citing Koenig (1988) and Gordon (1988). See also Clarke et al. (2003). "Biomedicalization: Technoscientific Transformatios of Health, Illness, and US Biomedicine. *American Sociological Review,* 68 (2): 161-194.
[78] I want to acknowledge Lawrence Cohen for this useful articulation that helps me to effectively clarify my observations of the contradictory and non-hegemonic responses to the heavy-handed imposition of biomedicine on Panjguri midwives and women.
[79] According to Arnold (1993: 258), the general reluctance of women in India to enter hospitals had not greatly changed by World War II, even among the middle classes. In 1913 some 3, 687 births Madras city took place in hospitals, but this represented less than fifth of the registered births in the city.
[80] The view that their indigenous medicine is superior to biomedicine was a common perspective that Laderman (1983) had found among rural women some twenty years ago in Malaysia.
[81] See Report, "Misoprostol, an emerging technology for women's health," The Population Council, Inc. 2004.
[82] *Hajinag:* Technique in which several sewing needles held and tied together with a thread and applied on the skin for beautification. Traditional this technique has been applied to heal joint pain, especially wrist, ankle, and knee pain. Typically this is work done by women. About four to five small sewing needles are used. *Dagh* (similar objective as moxibustion) a healing method and technique carried out by men and women, but mainly by women.
[83] See Barbara Koenig (1988) for a critical discussion of the "social creation" of routine practice in biomedicine in the U.S. See Charis Thompson's (2005) *Making Parents* for a discussion of the implication of routine practice in fertility clinics- also in the context of the U.S.
[84] The national survey published in 2000, showed that in Pakistan 80% of deliveries are conducted at home (Federal Bureau of Statistics, 2000 Pakistan Integrated Household Survey 1998-1999, Islamabad). Thus, only 20% of births in Pakistan take place in hospitals.
[85] Mention the risk factors here.
[86] *Khana Badosh* means, one who carries his/her house on his/her shoulders- referring to nomadic life ways.
[87] Many families living in more distant locations from the central towns of Panjgur district expressed to me their concerns about the declining population of camels due to the longstanding drought in Balochistan. They worried about the next generations, wondering if they would ever have a chance to know what it means to live a nomadic life. They were concerned about how the future generations might gain the necessary skills to live such a life, e.g. to prepare the camel for the nomadic journey, to know how to manage and socialize the camel, to be able to put up the *gidams* and undo them in their nomadic journeys, would they recognize the wild edible and non edible plants? Etc. There was an expressed sentimentality about the loss of this form of living and they mourned the possibility that their children may never come to experience the nomadic wanderings and know how that connects them to the mountains (*koh*) and plants of *koh*, thus the joys of such a life. For a large segment of the population in Panjgur, the sedentary situation has not brought with it the perceived benefits of the urban life that among many elements includes regular and consistent access to modern transportation and medical care.

[88] Methergine is a prostaglandin that stops cramping in women immediately following childbirth. It is part of the ergometrine family and is an ergot derivative. Ergometrine increases serotinin. Methergine is similar to Pitocin and Oxytocin, and is injected to slow down bleeding by contracting the uterus. All three drugs can augment labor. Pitocin can cause seizure and death. Methergine is even worse. Misoprostol is being advanced for so-called Third World resource poor countries; a process, I argue that is a form of medical relativism. Misoprostal is marketed by Pfizer Inc. as cytotec for the prevention of gastric ulcers induced by the use of non-steroidal anti-inflammatory drugs (NSAIDS). Cytotec is registered for use in 780 countries. Several generic misoprostal products have recently become available for labor induction. According to reports, use of misoprostal including self-administration is widespread. One report asserts that apart from highly technical scientific literature, it is difficult to find comprehensive, accurate information on misoprostol's use on women's health. Yet, it is known that the risk of uterine rupture increases for women (1) with advanced gestation, greater than 16 weeks, or (2) having previous cesarean section. The drug is not recommended for women with either classical-vertical or low-vertical incisions following the cesarean section. Administration of dose of misoprostal to more than 25ug may lead to faster deliveries but also to more unpredictable or uncontrollable uterine stimulation. The report itself notes: "the effect of this trade- off on maternal and neonatal outcomes is unclear" (p.21). A meta-analysis indicated that while induction with oxytocin does not significantly increase the risk of uterine rupture compared to spontaneous labor, induction with prostaglandins (disnoprostone and misoprostal) does. Misoprostol's medical and scientific promise: One study compared oxytocin and misorpostol finding that the frequency of observed side-effects with misoprostol is higher but side-effects subside 2-6 hours after treatment. They suggest, thus, in hospitals and other tertiary care settings where active management of the 3rd stage of labor is the norm and oxytocin is available, results of trial do not support the use of misoprostal in its stead. In Gambia ergometerine is the current standard treatment to prevent excessive blood loss. According to the report, they asked for more potent drugs. Population Council and Medical Research Council of U.K. began collaboration in 2001 on studying and advancing misoprostal for the prevention of postpartum hemorrhage (PPH) at the community level. See footnote (i) for citation of Population Council Report.

[89] This is the exactly stated sentiment of a number of Panjguri *dhinabhugs.*

[90] At the time Panjgur District along with Kalat, and Turbat (Kech) were part of the Kalat Division. These three were among twenty-six "State-Public" dispensaries spread across six divisions. Quetta and Pishin were part of one Division in which two of the six dispensaries included H.A.G.G.s Camp dispensary and the Lady Dew Motor Dispensary. In addition to these so-called public facilities the Private-Aided medical care facilities in Balochistan included the Lady Sandeman Dufferin Hospital in Quetta, the McIvor Female Dispensary in Sibi, the Female Dispensary in Laralai, and the Dufferin Hospital in Fort Sandeman. In addition there were three non-aided "Native State Hospitals", and eight "North-Western Railway Dispensaries". There were two mission hospitals in Quetta as well, one for females and the other for males.

[91] Cite the Reports.

[92] This scheme was established in a few other places in Balochistan including, Awaran, Pishin, Khuzdar, Wadh

[93] Cantonments refer to clusters of temporary housing for troops or the assignment of troops to contemporary quarters.

[94] See Tansey (2001: 195) in women and modern medicine to elaborate on the use of ergot in the late 19th and early 20th centuries.

[95] *The Annual Reports on the Hospital and Dispensaries in Baluchistan* from 1921 to 1933 show that small number if any women and men were attending the available facilities. In 1921 no woman is recorded to have attended the dispensary in Panjgur and just thirty-four men attended

that year. By 1933 there was significant change in numbers, but the number of women attending such facilities remained extremely low.

[96] The iteration of *Mother* is not a reference to the biological mother, but is employed figuratively to denote the respect granted to Moh-Jan's mother equal to one anyone would and should grant to one's biological mother. In Baloch cultural tradition, reflected in folks and oral poetry, the figure of the mother is highly respected. The value of the respect increases with the age of the mother. For example, it is more respectable to refer to one's wife as the mother of my children, rather as one's wife- (i.e. Amina, the mother of my children).

[97] Muslman means Muslim, which literally means one who surrenders to God. Here, the reference to people outside of Mah Jan's mother's kin.

[98] Here I am deploying primary vs. secondary infertility in its biomedical understanding in which primary refers to infertility prior to ever getting pregnant and secondary refers to infertility following having had at least one pregnancy.

[99] In Panjgur there were no family planning campaigns during the British colonial rule.

[100] The herbal formula *kasāyam* would be used "starting at the beginning of the last month of pregnancy, some women…took a mild, diluted kasaym every night just before going to sleep. Most people made this by boiling ground ginger and jaggery in water and drinking the mixture while it was warm. Others made it out of individual ingredients—dried ginger, jaggery, cumin, anise, black coriander seeds—and took one such kasayam each night. These mild kasayams were said to enable the pregnant woman to pass urine easily and frequently and to help bring on labor pains gradually." "The stronger kasayams were taken as a kind of litmus test to determine whether or not the pains which the woman was experiencing were genuine labor pains." (Van Hollen 2003:124-126)

[101] This fits longstanding appreciation in medical anthropology about the formation of medical pluralism and different systems of care.

[102] According to Fatima's mother, children are dying now more than before.

[103] During my visits of the Hamdard University in Hub (a town bordering Karachi and the Balochistan Province) I visited the University Hospital. This is a training hospital for Unani medical students. The maternal child health unit of the hospital had devised an outreach project to motivate the local "*dais"* living near the hospital. To avoid marginalizing the *dais* the program developed a cash incentive scheme to attract referral of childbirth cases, paying the *dais* for each referral. I was told that the *dais* gladly participated in this scheme. I did not have an opportunity to discuss this scheme with the local *dais* and childbearing women of *hub.* However, what was clear is that the from my discussion with the Hamdard staff, the *dais* accompanied the women to and from the hospital suggesting that their care-taking did not begin during labor or end following the referral of women to the hospital.

[104] Witz (2001)

[105] Lady Health Visitor is local category for a nurse practitioner. I discuss this and other local professional categories in Chapter Three.

[106] See Eisenberg and et al. (1993). The article discusses the unanticipated extraordinary rise of private expenditures on "alternative" medical care among the public in the US.

[107] The Baloch style chemise worn by the Panjgur women is wide and long running over the knees, heavily embroidered in the front. The sleeves are also wide and long. The sleeves of the Balochi chemise have an important function in the daily lives of the women. In rural and economically poor urban communities, and among the servants in wealthy homes the sleeves can help grab hold of a hot pan or kettle, it can be used as fan for oneself or for a child sleeping. It can keep the woman cool or warm.

[108] "*Jan"* is a word readily spoken in Balochi, Urdu, and Farsi- it refers to body as well as the soul. It is also a term of endearment, so to say, *"mani jan"* is to say my dear or you are dear to

me. It can imply affection as well as closeness. Often conveyed affectionately to children, but can also be employed poetically to one's beloved.

[109] Thus, for many development studies scholars, it is unsurprising that in Pakistan, just as in many other "developing" countries; people have no choice but to resort to self-treatment for their health care. Some development studies scholars have looked at this reality in the context of prescriptions drugs that are sold over the counter (Fosu 1989; Price 1989). They highlight the implication of health risks associated with prescription drugs sold casually over the counter because of inadequate access to doctors and lack of consumer education. They link this phenomenon to the malfunction of professional care, lack of adequate drug regulations, and aggressive marketing of pharmaceuticals.

[110] "It is the functioning of the relationship between doctor and patient to restructure those understanding and the personality and bring them back into the fold of society and to plant them firmly within the epistemological and ontological ground work from which society's basic ideological premise arise. In modern clinical practice and medical culture, this function is camouflaged. The issue of control and manipulation is concealed by an aura of benevolence" (Taussig 1980: 4).

[111] Pakistan's efforts to control the population through family planning programs has a much older history that its official starting date of 1965 and is linked to developments about the relationship between reproduction and production in the British colonial period in India. I discuss this point in Chapter Two of the dissertation.

[112] See Gay Becker in *Disrupted Lives* discusses the experience of bodily distress arising out of disruption to life.

[113] Hysterectomies in Pakistan: A study in the 2005 Journal of Ayub Medical College, Abbottabad. Identified Vesico Vaginal Fistula (VVF) as one of the "side effects" of hysterectomy surgery (13.3%) of mostly Hazara women (21 to 40 year-old) ended up with VVF following the surgery. The study also identified a high frequency of morbidity and mortality associated with hysterectomies and recommended alternative less invasive treatments. Some of the complications encountered due to the surgery included hemorrhage and damage of the surrounding structures. Another study in Karachi identified infectious complications following "abdominal" hysterectomy (International Journal of Gynecology and Obstetric (2001): Karachi, Pakistan. Ahmad F, Wasti S. (AKU). The post-operation infection rate was 22%.

[114] Generally, symptomatic fibroids require treatment in the form of hormones or surgery (Christiansen 1993), Al-Taher and Farquharson (1993). Hysterectomy has been considered the traditional and definitive treatment of symptomatic fibroids (Garcia 1993).

[115] US Census Bureau (2004)

[116]See Sherrill Sellman's (2000) essay "Hysterectomy Heresy" In Hormone Heresy: What Women Must Know About Their Hormones.

[117] On my use of 'provincialized' see Chakrabarty, Dipesh. 2000. Provincializing Europe: Postcolonial Thought and Historical Difference. Princeton & Oxford: Princeton University Press.

[118] See Adele Clarke's "Disciplining Reproduction" on "technoscience story of hierarchies" pp. 206 for discussion of the politics and sociality of low and less invasive medical technologies are displaced by high medical technologies. Trend toward uses of high technology is not necessarily a mark of improved quality of care.

[119] Amnesty International. "Pakistan: Violence Against Women in the Name of Honour." Index ASA33/17/99.

[120] For helpful meaning and conceptualization of racialization see Omi and Winant (1994) *Racial Formation in the United States: From the 1960s o the 1990s* and Miles' (1989) *Racism.* Following Omi, Winant, and Miles, Silverstein (2005) provides a useful conception of race and racialization: "Race is defined as a cultural category of difference that is contextually constructed as essential and natural—as residing within the very body of the individual—and is thus generally

tied, in scientific theory and popular understanding, to a set of somatic, physiognomic, and even genetic character traits. Racialization correspondingly refers to the processes through which any diacritic of social personhood—including class, ethnicity, generation, kinship/affinity, and positions within fields of power—comes to be essentialized, naturalized, and/or biologized. Racialization thus indexes the historical transformation of fluid categories of difference into fixed species of otherness." Silversetien (2005) "Immigrant Racialization and the New Savage Slot: Race, Migration, and Immigration in the New Europe". *Annual Review of Anthropology* Vol. 34, Pp.363-384.

[121] The terms "tribal honour" and "custom" are deployed interchangeably to describe the so-called tribal other in the entire 50 page + AI (1999) document.

[122] The three bodies are the individual body, referring to the lived experience of the body as self; the social body, constituted by representational use of the body as symbol of nature, society, and culture; and the body politic, having to do with regulation and control of the bodies (Scheper-Hughes and Lock 1987).

[123] The habitus as understood and defined by Bourdieu is a "system of durable, transposable dispositions" that are generated and reproduced through practice/practical functions. Habitus is a person's navigation of the social world—how an individual combines past experiences, social norms, and personal flourishes in his/her mode of operation in the world. This is largely based on history, the integration of past experiences/perceptions into the individuals' unconscious, yet is also a function of the individual's current circumstances; together these guide his behaviors and typically lead him to adhere to social expectations. The habitus, therefore, is constantly being defined and refined over the life course of life.

[124] An entire section of in the Amnesty International Report is called, "Failure of the Government of Pakistan to act on honour killings." (AI 1999: 42). Another section is called, "Failure of the Government of Pakistan to end parallel systems affecting the rights of women." (AI 1999: 44). Besides calling on the Pakistan government to take stronger action against tribal "practices", the report calls for an end to gender stereotyping.

[125] In so far as Balochistan is concerned, the tribal legal system has been abolished in Makran, the largest subdivision in Balochistan and where district Panjgur is located—the central site of my ethnographic research.

[126] "According to the non-governmental Human Rights Commission of Pakistan (HRCP), 888 women were reported deliberately killed in 1998 in Punjab alone. Of these, 595 killings were carried out by relatives; of these 286 were reportedly killed for reasons of honour. The Sindh Graduates Association said that in the first three months of 1999 alone, 132 honour killings had been reported in Sindh. (AI 1999: 6).

[127] "Habitus being the social embodied …[C]ontributes to constituting the field as a meaningful world, a world endowed with sense and value, in which it is worth investing one's energy." (Bourdieu 1992: 127-128).

[128] I have deliberately chosen the term realm rather than social life, for there is no reference to the tribal as entailing social life in the Amnesty International Report (1999).

[129] Csordas, Thomas (1999) "The Body's Career in Anthropology." In ed. Henrietta Moore, *Anthropological Theory Today* Cambridge U.K.: Polity Press. Barthes, Roland (1986). *The Rustle of Language,* trans. R. Howard New York: Hill and Wang. Merleau-Ponty, Maurice (1962). *Phenomenology of Perception* trans. James Edie Evanston, IL: Northwestern U. Press.

[130] Nearly every individual example refers to a Punjabi woman murdered by her family: "Ghazala was set on fire by her brother in Joharabad, Punjab province, on 6 January. According to reports, she was murdered because her family suspected she was having a relationship with a neighbor. Her burned and naked body reportedly lay unattended for two hours as nobody wanted to have anything to do with it. Ghazala was burned to death in the name of honour…" (AI 1999: 2). "Honour killings are also reported from the Pakistani community living abroad. In the UK, the

Nottingham crown court in may 1999 sentenced a Pakistani woman and her eldest son to life imprisonment for murdering the woman's daughter, 19-year-old Rukhsana Naz, a pregnant mother of two children, in Derby in March 1998. Rukhsana was perceived by the family to have brought shame on them by having a sexual relationship outside marriage. Her brother reportedly strangled Rukhsana while her mother held her down." (AI 1999: 11)

[131] Vaughan, Megan. 1991. *Curing Their Ills: Colonial Power and African Illness.* Stanford California: Stanford University Press.

[132] "Stanus's concern with physical 'types' and their relationship to environment was replaced with a concern with cultural difference. This focus displaced attention from the larger environmental and economic causes of disease and towards the idea that Africans were differentially susceptible to certain diseases on account of their cultural practices. It tended towards the attribution of blame. In Britain this shift in medical discourse had taken place at the beginning of the century and was largely focused on individual pathology and individual responsibility. In colonial Africa it took a different form, focusing not on the individual but on the 'tribal' collectivity. Susceptibility to disease in Africans, then, was defined not through an analysis of the conditions under which they lived and worked, or through notions of individual lifestyle and responsibility (though missionary medicine stressed exactly this), but rather through the idea that the cultural practices of different ethnic groups disposed them to various disease patterns." (Vaughan 1999: 46).

[133] In one sense she may very well be correct if we think about the ways in which US corporations are protected by liberal law, because in order for them to be protected they have to be so as individuals. However, Okin's object of critique is not the corporations, nor is it the Klu Klux Kan's (KKK) right to assemble and protest. For, even if women are discriminated within corporations or the KKK, they can still resort to the 'benevolent' legal system for protection, by mere fact that they belong to the majority culture. After all, corporations and the right for free speech (that has now extended to a farcical meaning of right to accumulate wealth and use it to buy off politicians) reflect the achievements of majority liberal cultures of the West. On the other hand demand for group rights among minority cultures are tantamount to risking the loss of precious achievements made by liberal societies meaning the West-US in particular, achievements especially made for "women's equality". If the notion of progress is exclusively an element of liberalism, then by definition consideration of alternative value structures is retrogressive. This peculiar view- the impossibility of change in minority cultures without the assistance of liberalism of the majority culture screams of 19th Century anthropological and historiographic construction of agency and descent among the colonized in the colonies.

[134] See Silverstein (2005) for a review of how increasingly the immigrant category is a racialized subject-position. See Thomas (1994: 172) for a discussion of how in the late 19th Century anthropology became the official discourse in which the policing of tradition was transformed into the knowledge of tradition.

[135] The Hudood Ordinances are related to offences concerning private property, adultery, fornication (*zinnah*), false accusation of adultery (*qazf*), and consumptions of alcohol. The ordinances also defined a series of punishments that were ordained according to the severity of the offense.

[136] "The values of the Bedouin honour complex are not those f the Iliad, nor those of the complex found in Spain, Sicily, Algeria, or any other Mediterranean society. The critical term in the Awald 'Ali honour code is *asl* (ancestory/orgin/nobility), a term expressive of a range of ideas. It is the basis for the proud differentiation of Bedouin from non-Bedouin…It also implies the moral character believed to be passed on through" [blood/kin relations]. (Abu-Lughod 1999:87).

[137] Explaining the relationship between gendered power relations and social honour, Abu-Lughod (1999: 85) writes, "in Bedouin ideology, the tension between the ideals of equality and independence on the one hand and the reality of status differentials on the other is mediated

through the notion that authority derives neither from the use of force nor from ascribed position, but from moral worthiness. Hierarchy is legitimated through beliefs about the disparate possession of certain virtues or moral attributes. Bedouins act as though authority must be earned. Because authority is achieved it can also be lost."

[138] Similar to the situation described by Abu-Lughod about the Bedouins, in Makran, the largest division in Balochistan province located southwest of Pakistan and in other parts of Balochistan, including among the Baloch's living in Karachi, Sindh province, and Iran a woman abused by her husband and/or in-laws has the right to leave for her natal family. It is usually the women of natal family the woman that will intervene to confront the in-laws in case of mal-treatment and abuse that includes the issue of whether the woman is being fed or overworked. Of course these are ideal value positions and circumstances vary, including the physical distance between the home of the natal family and the in-laws', as to how successfully this social value is practically applied.

[139] It is important to understand that the terms *Siah Kari and Karo Kari* are expressions known in Balochi and Sindhi languages and that a Punjabi and Urdu speaker unfamiliar with these languages will fail to grasp the correct meaning unless they attentive and interested in obtaining the correct meanings. The Pakistani feminists who are the central resource for the Amnesty International report on "honour killing" are Punjabi and Urdu speakers.

[139] The Amnesty International report also provides statistics of murders due to burns that in this report have exclusively accord in Punjabi households, but these murders are not associated with honour. "Of the 183 women reported to have died of burn injuries (of 28 burn victims) allegedly while cooking in Lahore in 1998, only 21 complaints were registered with police and only three persons were finally arrested despite a High Court ruling three years ago that all burn cases be fully investigated by police." (AI 1999: 54).

[140] See Lila Abu-Lughod (1999 [1986]). *Veiled Sentiments: Honour and Poetry in a Bedouin Society* and Abu-Lughod (1993) *Writing Women's World's: Bedouin Stories* for examples of disjunctions between social idea and practical reality in the context of Bedouin society. .

[141] Cohen, Lawrence (1999) "Where It Hurts: Indian Material for an Ethics of Organ Transplantation." In *Daedalus* 128 (4): 135-166.

[142] The Amnesty International report also provides statistics of murders due to burns that in this report have exclusively occurred in Punjabi households, but these murders are not associated with honour. "Of the 183 women reported to have died of burn injuries (of 28 burn victims) allegedly while cooking in Lahore in 1998, only 21 complaints were registered with police and only three persons were finally arrested despite a High Court ruling three years ago that all burn cases be fully investigated by police." (AI 1999: 54).

[143] Arguably this is a common effect of statistical arguments, what is distinctive in the use of the statistics in this report is the blatant misreading of the statistics for the sake of the "sociological" argument deployed here about tribalism, honour, and women.

[144] The report does not use the category community, for the use of such a category would imply the existence of the social and cultural life which would complicate its reduction of tribal as merely a sanctioned domain for the violation of women.

Harrison…

[145] "Amnesty International takes no position on religions, customs or specific legal regimes; it welcomes the rich variety of cultures and believes that the universality of all human rights, far from denying diversity, can only benefit from it. The organization recognizes that the contribution of different cultures, at the local and the global level, enrich the understanding of human rights giving them their local form and language…But cultures are not static…This report shows how even the traditions of 'honour' in Pakistan, are used to justify violence against women. It also highlights how the honour system derives from tribal traditions in Pakistan, which are often in conflict with other traditions in national life, such as Islam and liberal democracy." (AI 1999:4).

[146] Outside of the human rights discourse the term tribal has captivated development thinking and is deployed in national and development discourse about Balochs and Balochistan inside Pakistan. For example, in the editorials and articles of DAWN, a leading English language newspaper, we readily find the production of the binary of 'developmentalism' and 'tribalism', in which the tribal "laws" are constructed to be the obstacle to modern national development such as the constructions of roads, highways, and pipelines for the flow of oil.
[147] I discuss this in detail in Chapter One.
[148]Mediascapes is a concept coined by Appudurai. Appadurai, Arjun. 1990. "Disjuncture and Difference in the Global Cultural Economy." *Public Culture* 2(2): 1-24
[149] The discourse of tribalism in Jordan is discussed in Layne, Linda. 1987. "'Tribalism': National Representations of Tribal Life in Jordan". *Urban Anthropology.* Vol. 16(2), Pp. 183-203.
[150] Hobsbawm, E. and Ranger, T., (1983) (eds.) *The Invention of Tradition*. Cambridge: Cambridge University Press; Ranger, T. "The Invention of Tradition in Colonial Africa". In Hobsbawm and Ranger, 211-262; Ranger, T. (1993) *The Invention of Tradition Revisited: the Case of Colonial Africa*. In Ranger T. and Vaughan O. ed. *Legitimacy and the State in Twentieth Century Africa,* London: Macmillan: 62-111. Vail, L. (1989) *The Creation of Tribalism in Southern Africa. S*cholarly interest focused at first on the function of invented tradition s in cementing authority, a phenomenon which Ranger (1983) saw as rooted in a partial congruence of interests between colonial masters and African chiefs and elders (Lentz 1995: 318). Vail (1989) points to labor migrants' interest in the consolidated rural tribes and 'traditional' chiefs who protect their wives and families during their absence, defend land rights and, in the face of urban insecurity, provide an all-important home during crisis. Lentz also points out that Ranger (1993) has self-critically noted that the term 'invention' overemphasizes the mechanical, authorial aspects and the fictionality and rigidity of the creation of tradition. Hobsbawm's phrase (1983) 'the invention of tradition' referred to neo-tradition (coronation ceremonies, flags, uniforms, national anthems, etc.); which were deemed invented by identifiable actors at identifiable points in time in the context of 19th Century European industrialization and the building of nation-states.
[151] In Chapter One I discuss the so-called *sardari* system, the colonial re-formation and meddling with the system, and its overthrow in Makran. The government hopes to use port as a gateway to Central Asia via Afghanistan. But until that route, blocked by the instability prevalent in Afghanistan, opens, the government intends to use it as a trans-shipment point, envisaging big businesses from the established ports of the Gulf and Iran. According to one Gwadar port authority official, the port "will prove to be a cheaper point for goods shipment because of its strategic location." (Newsline 2005:28).
[152] In November 1998, Prime Minister Nawaz Sharif, who is a Punjabi, advocated the adoption Taleban-style justice as a model for swift punishment and effective deterrence to end violence, crime and corruption.
[153] DAWN, Pakistan's most widely circulated English language newspaper, since at least 2003, has carried many editorials in which "tribalism" is critiqued from a variety of national and international locations. A few of the quotes I include in this footnote illustrate the construction of tribalism as anti-democratic and anti-women that also echoes the position of the 1999 Amnesty International Report. "President Musharraf has spoken of illiteracy as a major deterrent to democracy. Neither the feudal lord, nor the tribal chief is interested in getting their people educated. In fact, the two are antagonistic to each other. Education, enlightenment and social equality undermine the tribal supremacy. They cannot co-exist. Hence, many feudal lords see schools as something they would like to see in their rivals' territory, while preferring ghost schools in theirs. Tribal chiefs and feudal lords are opposed to girls' education in particular, while some of them have given higher education to their daughters." (October 12, 2006 in DAWN, article entitled "Feudalism, Literacy and Democracy" By Sultan Ahmed. "His oppressive tribalism and brutal style of ruling over his clan drove terror in the heart of many of his tribesmen

and earned him enemies among his own Baloch people." After Akbar Bugti, what? April 30, 2006 in DAWN, article entitled "After Akbar Bugti, what?" By Zubeida Mustafa. "I have mentioned that the condition of our women is perhaps worse than in the time of 'Jehalat', for in those days the woman was only murdered if she was a real 'kari'. Today a woman does not have to be a real '*kari'* to be axed to death. Research by Shirkat Gah in rural Sindh indicates that in approximately 50 per cent of 'kari' cases the allegation was a falsity or slander, the real motive being greed or property. Thus, under cover of *karo kari*, men kill innocent women to settle old vendettas, to acquire land, to secure money to pay off debts, to be freed from the obligation of paying back debts, to get a second wife, to get rid of an unwanted woman, and so on...the man who kills his woman as *kari* is not a murderer but the victim of 'dishonour' who is entitled to compensation...however, in its current form it has given a new twist to the commodification of women as usable, disposable and exchangeable objects: a dead woman can fetch a hefty 'prize' in cash or kind for her family." (Reproduced from the research report in DAWN, January 25, 2004). "In pre-Islamic history, women had no rights to inheritance, to marital rights or perhaps anything else. It was Islam, the last of the great Semitic religions that bestowed basic rights on women. Polygamy was restricted and made strictly conditional; women were given inheritance and marital and legal rights perhaps for the first time in human history. What Islam did for the status of women in the 7th century was truly revolutionary. Women finally entered the comity of the human race. What is happening today in Pakistan to women because of tribalism and "condonment" of murder in the noble name of Islam is truly retrogressive, reactionary and repulsive. Nothing could be further from the spirit of Islam. Also remember what the Taleban did to the women of Afghanistan and what their imitators are doing to the women of the Frontier today." (January 25 2004 in DAWN, in article entitled "The new Jehalat" By M.P. Bhandara.

[154] The Balochistan Nationalist Party nominated Mr. Ali as the opposition leader of the Balochistan assembly. The Balochistan assembly won the election during the formation of the government in…The federal government approached the assembly to join the Muslim League. But, the Balochistan assembly refused because Muslim League is considered to belong to the "dictator Musharraf". Musharraf is the head of the Muslim League. Mr. Ali explains, "We are democratic, a democrat cannot join a ruler or dictator. Therefore, we have decided it would be better for the interest of politics to sit on the opposition bench."

[155] The Muslim League and People's Party have generally support any power in control. Most MMA members from Balochistan are from Pushtun area. The Muhajir Quami Movment (MQM), now Mutahaida, MMA, the Muslim League, and also a faction of the PPP which comes out of the Muslim League are part of the Musharraf government. Islamic party has been pro-Taleban, and there has been an ideological commonality between the military and its supporting party, that includes the Muslim League.

[156] The Hudood Ordinance was one in a series of five separate laws promulgated by the martial law of government of dictator General Zia-ul Haque in 1979. The Hudood Ordinances that are based on the Shariat are related to offences concerning private property, adultery, fornication (*zinnah*), false accusation of adultery (*qazf*), and consumptions of alcohol. The ordinances defined a series of punishments that were ordained according to the severity of the offense. Shariat means Islamic law based on the teachings of the Quran and Sunnah (model) of the Prophet Mohammad. Sunnah of Mohammad means what he said, did, and approved of during his prophetic life circa 610 to 632 CE. Fatwa is a verdict on one or more issues given by an Islamic scholar (Alim) or a number of scholars (Ulama) based on the Islamic Shariat.

[157] "A discourse employing terms such as primitive, savage (but also tribal, traditional or whatever euphemism is correct) does not think, or observe, or critically study, the "primitive"; it thinks, observes, studies *in terms* of the primitive. *Primitive* being essentially a temporal concept, is a category, not an object, of Western thought." (Fabian 1983: 17-18)

[158] The best way to illustrate this is by quoting directly from the report: "In the tribal society of Sindh and Balochistan, a woman is equated with money…But although she has monetary value, her worth is essentially that of a commodity and this view goes far towards creating a situation when she may be butchered if she transgresses the conditions under which she is bound to a man for life. She may also be freely traded or given away as part of an honour killing settlement." (Nafisa Shah quoted in Amnesty International 1999:9); "A woman and a *karo* is ritualistically killed and hacked to pieces, often in view of and with the implicit and explicit sanction of the community. In Punjab, such killings usually take place by shootings and appear more often based on individual decisions, occurring in an urban context and not always perpetrated in public." (AI 1999:6) The latter point about Punjab contradicts the fact that one of the most public cases of public abuse of woman was in the Punjab. "Large sections of society share traditional conceptions of honour and approve of honour killings—even mothers whose daughters have been killed on grounds of honour." (AI 1999:7). "Many of the women who simply run in panic without plan or goal, are caught and killed in the fields, hiding in a graveyard or trying to reach a road." (Amnesty International 1999:29)

[159] I discuss this point in greater detail in Chapter One of the dissertation.

[160] Interpellation is a concept developed by Althusser (1971) to describe how people are brought into ideology as subjects. While subjects are born into ideology, subjects are also agents. Thus, one ideological form can counter another.

[161] Scholars have similar fears about "tribals" in the context of Middle Eastern countries, and in China. For China See Dru C. Gladney's. 2004. *Dislocating China: Muslims, Minorities, and other Subaltern Subjects.* Chicago: University of Chicago Press.

[162] In an editorial in the DAWN newspaper (the leading English language newspaper), tribalism is even blamed for the worst aspects of feudalism; the latter a category that is more often deployed to describe the condition of the Punjab province: "Still, there are miscreants and criminals who wish to break the rules of not just the law, but of decency and honour everywhere, and you will often hear of cases where the ancient codes of tribalism overtakes the rule of law, the considerations of Islam, or the feudal code of honour itself. To elaborate further, feudal and tribal systems often overlap in the rural areas of Sindh, particularly those bordering Balochistan, because a lot of Balochs with Baloch tribal traditions have settled in these areas, assimilating within the earlier Sindh feudal social order. In the process, they have added a different dimension to the local ethos. This mixing of feudalism and tribalism has resulted in the very worst excesses that we see today in the rural areas: *karo kari*, bonded labour, the use of women to settle scores of honour, and so on. The influence of the tribal system, mixed with the high levels of illiteracy and ignorance in the rural areas are a dangerous mix indeed." (DAWN August 28, 2005. Some Home Truths about Feudalism by Bina Shah

[163] See for example Okin's work in which we can clearly locate her view of 'custom' as essential and timeless. She argues for an inevitable clash of multiculturalism and feminism in the West precisely because she operates with the premise that there exists an essential culture and an essential woman: "In many cultures, strict control of women is enforced in the private sphere by the authority of either actual or symbolic fathers, often acting through, or with the complicity of, the older women of the culture. In many cultures in which women's basic civil rights and liberties are formally assured, discrimination practiced against women and girls within the household not only severely constrains their choices but also seriously threatens their well-being and even their lives. And such sex discrimination—whether severe or more mild—often has very powerful *cultural* roots." (Okin 1999: 21-22).

[164] The three bodies are the individual body, referring to the lived experience of the body as self; the social body, constituted by representational use of the body as symbol of nature, society, and culture; and the body politic, having to do with regulation and control of the bodies (Scheper-Hughes and Lock 1987). Repetition-delete footnote

[165] The production of knowledge about "India" and "Africa" in the nineteenth Century coincided with the period when there was the greatest degree of colonial involvement. Said's *Orientalism* launched an attack on the authority of western scholarship about Asian societies in general (and the Middle East in particular) by suggesting that such works were bound up with the process by which Europeans had sought to exercise colonial power over other "races" and cultures. In particular, by constructing the Arabs as an 'other'—something different from, and opposite to, European characteristics of rationality and a faith in secular progress—such works provided a rationale for Western dominance. But, as Mitchell and Prakash show in their study on the colonization of Egypt and India, respectively, the role of Egyptian and India elite was central to how ideas about the postcolonial nation and its people would be taken up among and about different segments of the Nation. Mitchell, Timothy. 1991. "Preface to the Paperback Edition"; "After We Have Captured Their Bodies", in *Colonizing Egypt.* Berkeley: UC Press, ix-xviii; 95-127. Prakash, Gyan. 1999. *Another Reason: Science and the Imagination of Modern India.* New Jersey: Princeton University Press.

[166] (Fasu 1989)

[167] This is point that I leave for development in my post-dissertation writing.

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