Belaboured Lives: An Ethnography of Muslim Women’s Pregnancy and Childbirth Practices in Pakistan’s Embattled, Multi-Sectarian Northern Areas

By

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

My doctoral thesis, “Belaboured Lives,” examines the relationship between Sunni Muslim women’s reproductive and maternal health practices, Islamic conservatism, federal and non-governmental health programming, intense Shia-Sunni conflict, interpersonal enmity and ‘occult’ forces in Gilgit Town, the economic and administrative capital of Pakistan’s semi-autonomous, federally-neglected and multi-sectarian Northern Areas. Over 14 months between 2004 and 2005, my doctoral ethnographic fieldwork involved research interviews and participant-observation among Sunni women and Gilgit Town’s biomedical, traditional and Islamic therapeutic service providers, as well as in household, community, mosque and clinical-settings. With Gilgit District’s maternal morbidity and mortality rate (MMR) being among the highest in Pakistan, my thesis argues that Gilgiti Sunni women’s reproductive and maternal health outcomes were the product of restrictive, inter-linked or mutually interacting structural and ideological forces, which were socio-economic, political, familial and religious in nature. By providing an ethnography not only of women’s home-centered health practices but also their experiences in clinical settings, I address the wide array of physical, symbolic and cosmological threats women perceived as being interwoven with their fertility, pregnancy and childbirth-related health. To different degrees and in different ways, women, their families and health providers described how the socio-spatial constraints associated with Islamic pardah (veiling, gender seclusion) and izzat (honour) paradigms, conflict-related service exclusions, iatrogenic risk and hospital funding insufficiencies, ‘black magic’ and spirit ‘attacks’ were contributory factors to women’s poor health outcomes.
But my participants’ reproductive health was not only the arena for wellness-seeking and crisis resolution, but also for the enactment and expression of cultural values and sectarian identity; the tension between doctrinal Islam and local interpretations, modern/traditional divides; Sunni militarism; and symbolic and structural violence. Moreover, Gilgit Sunni women’s reproductive and maternal health narratives demonstrated subjectivity, inter-subjectivity and reflexivity, resistance and negotiation, and gendered and reproductive agency. Within this context, any one pregnancy could evidence and communicate multiple domains of experience, as well as patient-provider interaction, access to care, its quality and relation to socio-economic factors, ideological stance or community-bound interpersonal relations. Ultimately, by using pregnancy and childbirth as a central point of inquiry, my thesis examines different aspects of Gilgit Sunni women’s health experiences: biomedical and traditional; urban and rural childbirth and post-partum practices; Family Planning, fertility and infertility, unwanted pregnancies and abortions; conflict-related constraints; medical malpractice and cosmological harm.
Acknowledgements

Without the love and encouragement of my husband, Wadood, children Kate, Nadeem, Imran and now Sofia, this thesis would not have been possible. I also wish to extend my wholehearted thanks to my parents, Deborah and Christopher Varley, and Elizabeth Varley, Orian Hutton, Robin and Cindy Varley for their unwavering encouragement. In Gilgit, I am deeply appreciative for the narratives and everyday experiences shared with me by my many research participants, neighbours and in-laws, including ‘Madheeya’ and her family. And to all in Gilgit – Sunni, Shia, and Ismaili - my sincere apologies for any errors or omissions. Importantly, without the camaraderie and guidance of my research assistant, Mrs. Fazeelat, during Gilgit’s and my own ‘tension times’, my fieldwork would not have been completed. (Indeed, the year in which I completed my fieldwork had been among the most difficult of my life.) I am also grateful for the kindness shown to me by ‘Dr. Sharifa’ at the Gilgit Medical Center (AKHS,P). In Pakistan, I also wish to thank Dr. Saba Gul Khattak and Mrs. Gulistan. In Canada, I owe special thanks to Heather Grierson, Peggy Kry, Sandra Shaul, David Schatzky, Sandra Lewis, David and the late Ruth Shaul, Bernard Jameson, Lorna Ali-Lucas, Maureen Murney, Kimberly Saxton, Monir Moniruzzaman, Shaylih Muehlmann, and Natalia Krencil for their friendship, support and guidance during the writing process.

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In Memory Of
Patricia and Ralph Bowers
Peter Varley
Sikander Myireh
Ayesha & Muqadas

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Northern Areas Districts and Sub-Districts

(Modified by author from the original: http://en.wikipedia.org/wiki/Northern_Areas; public domain image)
Gilgit Town Mohallas and Hospital Locations

(Modified by author from the original: http://www.geocities.com/johnmap2001/kkh/maps/gilgit.html; public domain image)
### Glossary of Terms & Acronyms

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<th>Description</th>
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<tr>
<td>AKES</td>
<td>Aga Khan Education Services</td>
</tr>
<tr>
<td>AKHS,P</td>
<td>Aga Khan Health Services, Pakistan</td>
</tr>
<tr>
<td>AKRSP</td>
<td>Aga Khan Rural Support Programme</td>
</tr>
<tr>
<td>as’Sihr</td>
<td>Islamic sorcery (A)</td>
</tr>
<tr>
<td>ayah</td>
<td>nurse or dayah’s assistant, nanny (U)</td>
</tr>
<tr>
<td>ayat</td>
<td>verse from the Qur’an</td>
</tr>
<tr>
<td>bachitani</td>
<td>uterus (U)</td>
</tr>
<tr>
<td>bazaar</td>
<td>commercial market (U)</td>
</tr>
<tr>
<td>burqa</td>
<td>single, tent-like Afghan-style garment that provides head-to-toe coverage of a woman’s body (including the face and hands); a large-sized veil which covers the woman’s body, with the exception of the eyes (U, F)</td>
</tr>
<tr>
<td>čiragaan</td>
<td>celebratory bonfires used during Gilgiti Shia and Ismaili ritual festivals (S)</td>
</tr>
<tr>
<td>chador</td>
<td>large veil used for covering the female body (F)</td>
</tr>
<tr>
<td>chowk</td>
<td>main street/thoroughfare, major intersection (U)</td>
</tr>
<tr>
<td>churriyl</td>
<td>witch (S)</td>
</tr>
<tr>
<td>Deobanism</td>
<td>orthodox Sunni religious movement, which originated at a North Indian religious seminary in Deoband; the Northern Areas Sunni ulema is primarily Deoband in orientation and practice</td>
</tr>
<tr>
<td>desi bilehn</td>
<td>traditional and/or indigenous therapeutic system, ‘medicine’ (S)</td>
</tr>
<tr>
<td>desi davaie</td>
<td>traditional and/or indigenous therapeutic system, ‘medicine’ (U), also known as Yunani Tibb or Hikmat</td>
</tr>
<tr>
<td>desi dayah</td>
<td>traditional, or untrained midwife (U)</td>
</tr>
<tr>
<td>DHQ</td>
<td>District Headquarter Hospital (also referred to simply as ‘District Hospital’)</td>
</tr>
<tr>
<td>dhum</td>
<td>Islamic invocation/prayer for protection (A)</td>
</tr>
<tr>
<td>jinn</td>
<td>Islamic spirit-entity, described in Qur’an and Hadith Al-Sunnat</td>
</tr>
<tr>
<td>dua</td>
<td>invocation which marks ritual event, supplication (A)</td>
</tr>
<tr>
<td>dubbas</td>
<td>mini-vans (U)</td>
</tr>
<tr>
<td>dusturkhan</td>
<td>oil-cloth, table-cloth (U, F)</td>
</tr>
<tr>
<td>fatawa</td>
<td>formal, Islamic edict (A)</td>
</tr>
</tbody>
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Glossary

FCNA Frontier Constabulary Northern Areas
FPAP Family Planning Association of Pakistan, Pakistan’s largest, non-governmental reproductive health organization
FPO Family Planning Organization, Pakistan’s primary federally-operated reproductive health organization

garam hot, warm (U)

Hadith Al-Sunnat collected sayings and practices of the Prophet
Hanafi one fiqh (school of jurisprudence) of Sunni Islam
hakim practitioner of Hikmat, Yunani Tibb and/or desi davaie (U)
hijab women’s public veiling/covering of the entirety of their visible body, with the exception of the face or eyes, hands and feet (A)
illaj treatment, medicine (U)
Imambargarh Shia mosque, place of worship and community congregation (F)
Ishtemah religious gathering or conference (U)
Islamiyaat Islamic texts, materials, literature (A, U)
ISO Imamia Students Organization
IUD intra-uterine device (contraception)
izzat honour (A, U)
Jamaat Khana Ismaili mosque, place for worship and mixed-gender community congregation (A)
jasoos spy (U, S)
kala jadu black magic (U)
KANA Kashmir and Northern Areas
Khateeb high-level Islamic religious leader, entitled to produce fatawas (U)
lashkar Islamic militia, religious team, religious fighting force
LMG light machine-gun
madrasah Islamic seminary (A)
Markaz Sunni religious headquarters; Gilgit’s main, Sunni mosque complex (A, U)
mangini engagement party/celebrations (U)
masjid mosque, site for religious worship and community congregation (A, U)
mohalla village, neighbourhood (humsayah gardee, U), community (social and geographic, U)
MMR Maternal Mortality Rate
maulana, mullah middle-level Islamic cleric (A); higher level than talib-e- ilm (religious student, U)
namaz prayer (A)
nazhar ‘evil eye’ (A)
nikah Islamic marriage ritual and contract (A)
nisab curriculum, education syllabus (A, U)
OT Operating Theater
pardah veil, curtain; Islamic practice that entails women’s veiling and spatial segregation from unrelated men (U)
Qari prayer leader (Imam), mullah (A)
qismat fate, destiny (A, U)
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
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<tr>
<td>ruiy</td>
<td>witch (S)</td>
</tr>
<tr>
<td>rukhsati</td>
<td>ceremonial departure of the bride from her family home after the <em>nikah, shahdi</em> (U)</td>
</tr>
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<td>shahdi</td>
<td>wedding celebrations, party (A, U)</td>
</tr>
<tr>
<td>shaheed</td>
<td>religious martyr (A)</td>
</tr>
<tr>
<td>shaitan</td>
<td>wicked, naughty, devilish (A)</td>
</tr>
<tr>
<td>sharam</td>
<td>shame, modesty (A, U)</td>
</tr>
<tr>
<td>Sipah-e-Sahabah</td>
<td>“Companions of the Prophet”, anti-Shia Sunni religious organization</td>
</tr>
<tr>
<td>supian</td>
<td>Gilgit spirit entity or force (S)</td>
</tr>
<tr>
<td>surah</td>
<td>chapter from the Qur’an</td>
</tr>
<tr>
<td>Tablighi Jamaat</td>
<td>Sunni, lay missionary movement founded in the 1920s in northern India; within Pakistan, it is centrally administered from its Raiwind (Punjab) headquarters.</td>
</tr>
<tr>
<td>tawiz</td>
<td>amulet, frequently containing quotes from the Qur’an</td>
</tr>
<tr>
<td>thabeeb</td>
<td>desi bilehn (traditional medicine) healer (S)</td>
</tr>
<tr>
<td>thana</td>
<td>jail (U)</td>
</tr>
<tr>
<td>ulema</td>
<td>formal religious community</td>
</tr>
<tr>
<td>Wahabbism</td>
<td>austere, strictly fundamentalist Sunni religious movement, founded in Saudi Arabia in the 19th century</td>
</tr>
<tr>
<td>Y’Ali</td>
<td>‘Oh Ali’, Shia religious invocation (A)</td>
</tr>
<tr>
<td>zakat</td>
<td>charitable donations representing 2.5-10% of an individual, or family’s annual household income; Islamic requirement (A)</td>
</tr>
<tr>
<td>zeher</td>
<td>poison (U)</td>
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At 9.30pm on July 20, 2005 – a starry, summer night - my husband Wadood, our children and I were watching TV when our front gate buzzer rang. I was immediately on-guard; visitors were uncommon this late and Gilgit was entrenched in Shia-Sunni ‘tensions’. After hearing through the intercom that it was our tenant, Ahmad, who rented a semi-detached room adjacent to our property, Wadood grabbed his pistol as a precaution (Shias were rumoured to sometimes use false names to gain entry to Sunni homes) and ran to the front gate. Ahmad burst in and the two of them sat for about twenty minutes in our high walled, darkened garden, talking in hushed and anxious tones. Although initially sure it concerned Shia-Sunni ‘tension’, I overheard instead that Ahmad and his pregnant wife Fouzia had been fighting. Ahmad had come to talk to Wadood about whether or not he should “let her go.” He had made an oath to talaq (divorce; A) her if she spoke with anyone about his interest in our neighbour Kulsoom’s beautiful teenage daughter, Tamana, and now he wasn’t sure if her gossiping had caused the oath to come into effect. Wadood called over to ask if I wanted to go and talk to Fouzia; I was concerned she’d been hurt during the fight.2

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1 The following article was taken from Pakistan’s “Dawn Online Newspaper”, July 21, 2005; “GILGIT: Hundreds of foreign and domestic tourists have left Gilgit and adjoining areas due to escalating tension in the town that persisted on the fourth day on Thursday. The tension and panic started gripping Gilgit town when unidentified assailants gunned down five passengers of a bus and wounded six others on Karakoram Highway on Sunday night near Chilas. The bus was going to Rawalpindi. The sources said tension heightened in Gilgit and suburbs on Wednesday when unidentified gunmen shot dead three people apparently in a tit-for-tat action. The dead included a union council chairman, taking the toll in the fresh spate of violence to eight. The sources said that on Wednesday night one more person was shot at and badly wounded in Jutial area where some arsonists also burnt shops. Almost all shopping markets and business centres in Gilgit were closed and traffic remained off the road on Thursday and a few people could be seen on abandoned roads, streets and markets and passengers avoided visiting Gilgit from adjoining areas. Huge contingents of police and Rangers were deployed in the troubled areas of Sonikote and Kashroot to ward off further clashes, the sources said.”

2 Because I am not a fluent speaker of Shina, I used Urdu to communicate with my neighbours and in-laws. All the conversations I recount between myself and my neighbours on this night used Urdu.
Shortly before 10pm, and the timed return of electricity to our neighbourhood, we both went over to see Fouzia. Ahmad was animated and angry but stayed in our garden so we could hear her side of the story. There was ‘load shedding’ that night in Jutial, so we were using our generator. The front gate lights were on and shone in through her windows. Their room was small, smelly and dirty, with a large bed pushed up against the left side of the room. Their two little girls, both under the age of three, slept in crumpled heaps of laundry on the floor. Instead of a traditional hand-woven Gilgiti daree (carpet; S), they had acid-green and yellow plastic-weave matting and a few worn-out floor cushions. Beside their only window, an area was set aside for their pressure cooker, a few chipped glasses and plates, and an inexpensive gas burner. On the wall above their clothing cabinet hung some of Fouzia’s framed embroideries – a blooming rose and ‘Allah’u Akbar’ (‘God is Great’; A) in stylized black stitching. For several minutes, I sat on the floor beside Fouzia and listened to her sob out her frustrations. Evidently, Ahmad had also been threatening to divorce her if this next baby was another daughter, and in his rage over her discovery of his interest in Kulsoom, he had pulled out chunks of her hair and beaten her back and shoulders with one of his plastic sandals. Despite the meager light, Fouzia pulled off her dupatta (veil; U) and hoisted up her kameez (shirt; U); I then began checking over her smooth skin for bruises or welts.

At that same moment, we heard three loud gunshots coming from nearby and behind our house. Our generator was still on, sputtering loudly in the thick nighttime blackness. Because of the importance of clear sight and sound during fighting, I shouted to Wadood to cut the noise and lights. He flew past me to the back of the house and turned off the generator. We were plunged into darkness and it was a few panicky minutes before our eyes grew accustomed to the night sky’s glow – moon, stars and town lights reflecting off iridescent blue clouds and the deforested, shining slopes of the high mountains surrounding Gilgit. I stood at our front gate and with my voice full of fear, hoarsely begged Fouzia to bring her two small daughters to our place. Ahmad, who had run briefly into the gullee (alley; U) to see where the shots

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3 In Pakistan, periods without electricity are called ‘load-shedding.’ Gilgit’s in-town neighbourhoods (mohallas; U) receive intermittent and weakly powered electrical supplies from river-fed hydel stations.
had come from, came crashing again through our gate, and then Wadood thundered back into the house to get a firearm.

Things happened very quickly. I began to hear screaming and crying rolling out from our neighbour Kareem’s house. A cacophony of noises rose up from all around us in the neighbourhood. Doors opening, men shouting, women calling and weeping, people running up and down the gullee (alley; U) outside our property. We ran back to our front gate, where Kareem and Kulsoom’s adolescent daughters - Tamana, Sushilah and Saira - stood screaming “Y’Allah!” (Oh God; A), asking loudly who had been killed and who had been shot, if it was Chacha (uncle; U), was the man alive and who did it, and crying “Shia, Shia, Shia!” Wadood stood quaking, his firearm in hand. Fouzia immediately began agitating for a fight, recklessly challenging Ahmad to go and kill some Shias if he could. A moment later, Ahmad dashed past us down to the main road and disappeared around the corner, heading up towards a ramshackle grouping of shops. (Along with other Sunni men he had gone to set fire to some of the Shia-owned shops at the chowk [intersection; U] a few hundred meters away from our house.) Fouzia stood opposite us in her doorway, and with my fourteen-year old daughter Kate at my side, we were frightened spectators to the commotion in the gullee, as men came pouring up and down the darkened road. Clustering at the main corner, they looked down the road from our Sunni section of the neighbourhood towards the nearby Shia homes. The weakly radiant road lights illuminated the spectacle, the power having come back on moments after the shooting. For the most part, however, people quickly cut their lights to minimize Shia lines of gun-sight into their homes.

Meanwhile, we heard shots coming from other parts of upper Jutial, and the screams of women coming from households behind ours and from up the road. I saw a group of men rushing down the gullee towards the main road. One man they were carefully examining as if he’d been hurt; four men held him up and helped him down the road. At one time there were perhaps fifty men in the gullee, some running up behind our house towards the scene of the shooting. One fellow shouted at Sushilah and Tamana to
stop screaming and told them to go inside their house, but they didn’t listen. They just sat prostrate with
grief and fear, yelling and crying, on their front steps. Wadood then told us that someone had been shot
at his auntie’s house, immediately above our house on the hillside. He had heard people shouting to one
another that “three Shias” had gone to the house and shot Wadood’s cousin Shakeel as he sat inside his
garden. In the post-shooting fracas, two Shia men had been dragged off a nearby road and were being
held in a local Sunni’s house; I feared that if they were guilty, they’d be killed. Shakeel’s father, who had
been beside his son during the attack, had gone to try to identify the men.

The majority of men carried weapons openly and confidently – Kalashnikovs, rifles, shotguns, pistols -
but none had them aimed or ready to fire. All the weapons hung at their sides. I was terrified that
Wadood might leave the house, fearing that some Shias could be nearby, ready for a fight. Or, the Sunni boys at
the corner - looking down the road - could go down into the Shia area to kill someone in retaliation. At one point,
Tamana burst into our garden, screaming “Wadood Bhai” (brother; U), over and over. It was clear she
wanted him to join the melee; I held her tightly by her shoulders and told her to calm down, not to make
so much noise. “How will this help? It will only make the problem worse! Please, calm down! Aram Kuro!”
(relax; U) My teeth chattering with fear, I realized their terrors and Wadood’s passionate sense of family
loyalty might compel him to leave. And more than once, I had to physically restrain him from leaving the
house. Modulating my tone so I wouldn’t further provoke him and looking straight into his eyes, I
reminded him that I, too, was his family and he had a responsibility to stay and protect me. Wadood then
angrily told me to go and get our ladder, which he propped against the garden wall so he could watch
out into the gullee. A few minutes later, while comforting our dog Saffy, I heard the distinctive thundering
of an LMG (Light Machine Gun), and then a group of women screamed in terror from somewhere on the
hillside above our house. I ran back in panic to tell Wadood. In the first forty-five minutes after the
shooting, I counted upwards of forty other shots. As Wadood and I stood together by our front gate, we
heard odd, muffled explosions - one after another - coming from up the hill. Wadood said it was gas

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cylinders exploding at the Shia-owned refilling station near the local *tahndoor* (bread oven; U), the store having been destroyed by Sunni arsonists. There were about fifteen such booms, low and bass.

At around 10.40pm, the police began to arrive, bumpily driving up our dirt *gullee* in vehicle after vehicle, past our house to Shakeel’s. At the front were the small Pajeros driven by high-ranking officers, followed by black canvas-covered Datsun Hi-Lux pick-ups packed with men. At the rear were Army jeeps with LMGs manned by standing soldiers. Punjabi soldiers, with their hats covered in canvas netting and wearing flak jackets, walked with grey-suited police officers between the last vehicles to arrive. Backlit by vehicle headlights, they trudged through the swirls of ochre dust that were raised by their heavy-booted feet. Peering out at the *gullee* from our half-closed gate, Kulsoom and Sushilah muttered that the police were “*puroh Shia*” (all Shia; S), but with the Army Rangers, “*Shia bahoot kam hen, Sunni zyada*” (there are very few Shias, more Sunnis; S, U). As the Army and police dispersed into the maze of local *gullees*, the streets emptied as men hurriedly spilled into adjacent gardens, trying to avoid arrest or having their weapons seized. Many hid their unregistered weapons on and around their properties that night, fearing that there would be another military weapons sweep, termed ‘Operation Clean-Up’ by the Army, and the thousands of dollars worth of arms and ammunition that people owned would be confiscated. In the absence of a rapid police response, this would carry devastating consequences for families’ personal security. At 1am, when the police had left and the neighbourhood was quieter, Ahmad surreptitiously reappeared, barking at the excitedly chatty Fouzia to “*Chup tey bey!*” (shut up; S) and quickly wash his clothes which were sooty from starting the fires.

In the hours at daybreak before the Army started a two-day curfew, we came back out onto our front steps. I could hear voices everywhere protesting, “This is the first time Shia-Sunni fighting ever happened here in Jutial!” “Look, the Shias did this!” “We Sunnis will say someone is a *dushman* (enemy; U), but Shias won’t say anything – they’ll just keep quiet and kill you!” “Shias have black hearts, and they believe in *maut* (death; U).” “For Sunnis, *Allah Pak heh!* (God is pure; U). We do our *namaz* (prayers; A)
and *dua kurtey beh* (perform supplications; U), we trust in God and love *aman* (peace; U)." “If we don’t hit them back, they’ll become bold and hit us again – watch! You’ll be next, so will I!” Later in the day Ghazanfar said bitterly to Wadood, “*Rah* (brother; S), we may as well put on *choorian* (bangles; U) and call ourselves women, we didn’t do anything tonight.” And about the dying Shakeel: “He didn’t like Shias, but he wouldn’t have done anything; but if Shias had done anything lower along our *gullee* and tried to escape, he wouldn’t be the kind of man to let them past his house – he would hit them, with no problems – I think they are trying to clean up the *gullee!*”4 “Shakeel’s father had been Shia, you know? He became Sunni to marry Shakeel’s mother…look what the Shias did to them now!” “He was the first son after six daughters, you know…a wonderful person, strong, so young!”

Towards dawn, Fouzia and I climbed clumsily into the moonlit bathed, shadowy branches of our apple trees so we could look over our garden’s high stonewall into the *gullee* and watch the Army and police set up curfew roadblocks. Somewhat dazed by the night’s violence and with fear about Wadood’s potential entanglement in the fighting still sitting heavy across my heart, I openly pondered why Shakeel had been hit. With one hand resting atop her belly, Fouzia whispered loudly, “He’s a Sunni, *bas* (enough; U)! What more do Shias need! See, this is why you should get married quickly and have children – so you have a son to live for your name, to keep it open against your enemies, and do *badal* (revenge; U) for you when he’s grown!”

**Part II Conflict, Enmity & Unmet Need**

At the end of this traumatic night, our Sunni Muslim neighbour Fouzia’s caustic remarks powerfully exemplified the coalescence of reproduction, family insecurity, revenge and sectarian conflict in Gilgit Town, the economic and administrative capital of Pakistan’s semi-autonomous, federally-neglected and multi-sectarian Northern Areas. By the time Shakeel died in July, I’d been conducting my doctoral fieldwork in Gilgit for the better part of ten months, trying, despite curfews, neighbourhood instability

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4 ‘Clean-Up’ was a euphemism commonly used by the Army, police, civic officials and community members. In this instance, our neighbours referred to increasing pressures on Sunni residents to leave Shia mohallas.
and threats of sectarian violence, to explicate the impacts of religious identity and sectarian territoriality on Sunni Muslim women’s reproductive and maternal health practices. Gilgit Town, dingy brown and slate grey at the heart of winter, verdant green and masked by foliage in the summer, is home to 60’000 evenly-divided populations of Shia, Ismaili and Sunni Muslims. In a country where Shias make up only 15% of the population, and with Gilgit District bordered by staunchly conservative Sunni areas, the size, political and economic clout of the Northern Areas’ Shia communities was unique. Although for three decades Gilgitis had witnessed accelerating rates of violence and sectarian machination, enforced by both covert Iranian Shia politicizing and Saudi-funded Sunni proselytizing, the fights of 2005 were entirely different.

Weaponization, tactical preparedness and the scope of the fight were unprecedented. Throughout these ‘tensions’, Ismailis remained staunchly pacifist and politically neutral observers to the Shia-Sunni hostilities.\(^5\) During the months of fighting, Gilgitis had gone without the reliable provision of basic foodstuffs, gas and firewood supplies, medicines or access to safe transport out of town. The area’s remoteness reinforced my enduring feeling that we were trapped in the chaos. Gilgit Town sits at the heart of the lofty, snow-capped Karakoram, Hindu Kush and Himalayan mountain ranges and is physically accessible only by intermittent, weather-dependent flights and the poorly maintained Karakoram Highway (KKH), by which it is a sixteen-hour drive to the nearest major city, Islamabad.

At the heart of Gilgit’s 2005 battles was the Sunni-orchestrated assassination of Syed Zia-u’din Rizvi, Gilgit’s main Shia Khateeb (religious leader), leader to Northern Areas’ Shias and the Gilgit branch of the banned Imamia Students Organization (ISO), and Pakistani Shias’ principal envoy to Iran. Zia-u’din’s January 8\(^{th}\) shooting and then his death on January 13\(^{th}\), sparked off a wealth of long-standing, locally-nurtured animosities and political rivalries between Gilgit Shiias and Sunnis. For the remainder of 2005, 

\(^5\) Gilgit Ismailis tread an uneasy divide between nationalist and separatist paths, often preferring instead to affirm pacifism, political and sectarian neutrality and their interconnectedness with minority Ismaili populations worldwide, united under the auspices of the quasi-secular Aga Khan Development Network (AKDN), which is the closest equivalent to Ismaili politicization in the Northern Areas. Gilgit Ismaili responses to conflict were typified by the values idealized in Jamaat Khana (Ismaili mosque) sermons; the “older Ismaili generation prefers to keep problems at a distance, [to] ignore community ‘tensions’, [to] apologize and make peace” (Gul Naseeba, Zulfiqar Colony: November 4, 2004).
Gilgitis endured periods of intense Shia-Suni fighting, Army curfews, police surveillance and media blackouts. Characterized by intense fear and targeted killings, Gilgitis from all sectarian communities referred to the hostilities as ‘halaat kharab’ (a bad situation; U) or ‘tension times’ (in English). Despite the Shias’ enduring cynicism, Gilgitis openly protested they were uninvolved in Zia’s death. One of the assassins, who had been killed in the initial skirmish, was identified as a Sunni Pathan. Newspapers soon reported he’d been recruited for the job from a Peshawar masjid (mosque; A). Ill prepared for the fallouts from January 8th, Gilgit’s Sunni community struggled through what would become a year dominated by retaliatory killings and exclusionary political and economic measures. Following the Pakistan Army’s January 2005 takeover of civil administration, issues of health service provision, physician safety and patient access were quickly de-prioritized. Security efforts were focused instead on guarding government offices, banks, Gilgit’s tourist centers and the homes of prominent businessmen and Army officers. Curfews and roadblocks within Gilgit and along the Karakoram Highway (KKH) led to dramatically reduced supplies of blood plasmas and the medications used to treat post-partum hemorrhage, which contributed to a higher incidence of maternal mortality in clinics. Impaired service access and patient transport meant fewer women received their post-natal tetanus toxoid (‘TT’) and Rh-negative Rhogam vaccines. Moreover, Sunni physicians were purposefully targeted and killed in sectarian attacks. And because Gilgit’s maternal health centers were located in exclusively or predominantly Shia enclaves, Sunni women in particular were profoundly impacted.

By summer 2005, thousands of pregnant Sunni women were either blocked from services by the Army during curfews or, as was more often the case, denied access by family members unwilling to accompany

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6 Note that ‘Pathan’ is an anglicized version of more traditional pronunciations, which appear variously as ‘Pukhtun’, ‘Pakhtun’, ‘Paxto.’
7 On January 8th 2005, Northern Areas Health Office Director Dr. Sher Wali Khan was shot and killed by assailants near the Gilgit District Headquarter Hospital. By summer 2005 a number of Gilgit’s Sunni physicians, including two of the city’s preeminent female obstetrician-gynecologists, had their names appear on Shia ‘hit lists’ and their homes subjected to grenade attacks. In important ways, such targeting echoed and inverted the killings of Shia physicians by Sunni militants in Karachi in the late 1990’s.
8 The physicians and hospital administrators I spoke with were generally uncertain as to why Gilgit’s major hospitals had ended up being located in Shia-dominated mohallas.
women seeking treatment in Shia-dominated mohallas. I learned of a number of clinically preventable maternal deaths which were directly attributable to curfew or safety-based constraints on movement for both patient and physician, or to security concerns for male attendants of the delivering mother (Islamic strictures require male family members to accompany women to and from health centers). With the exception of curfew-related constraints, Shia and Ismaili women described themselves as being unhindered by the concerns with boundary, identity and access plaguing the Sunni community (Gul Naseeba & Shamsa, Zulfiqar Colony: November 4, 2004; Dr. Sharifa, AKHS,P: April 30, 2005; Fieldnotes: August 29, 2005). Using informal statistics culled from hospital In- and Out-Patient Registers, my analysis of Gilgit’s clinic records between late 2004 and early 2005 showed a roughly 40% drop in the number of Sunni maternity patients. Service disruptions and associated higher rates of unattended childbirth compounded Gilgit’s high maternal morbidity and mortality rates. In 1999, the Northern Areas Health Project’s Baseline Survey projected the Northern Areas’ maternal mortality rate (MMR) as 500 per 100,000 live births (Karim 2004: 11). The biomedical, homeopathic, traditional (desi bilehn; S) and Islamic (Hikmat, Yunani Tibb; U) health providers I interviewed routinely claimed that Gilgiti Sunni women, and rural women in particular, comprised the greatest proportion of morbidity, mortality and unmet health needs. Even before the conflicts, Gilgiti Sunni women’s health indicators were characterized by high fertility rates, low contraceptive uptake and troubling increases in acquired sexual infections (Dr. Sunbool, FHH: May 15, 2005; see Rahman 1999). In addition to gonorrhea, syphilus, pelvic and urinary tract infections,

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9 The maternal mortality rate, or MMR, is defined as: “death while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (ICD-10 in Bhutta, Jafarey & Midhet 2003: 6).

10 In 2005, Canada’s MMR was 9 per 100,000 live births (WHO 2005: 16). In figures released by the Government of Pakistan in 2002, the nation-wide MMR was estimated to be 340 per 100,000 live births (Bhutta, Jafarey & Midhet 2003: 6).

11 In 2004, the Northern Areas population was estimated to be growing at an annual rate of 2.47% (FPAP, FHH 2004: 11) while a 1999 survey claimed the region’s crude birth rate was 40.7 per thousand individuals (Rahman 1999: 17). According to the National Institute of Population Studies, Pakistan’s annual population growth rate for 2001 was 2.1%, while the total fertility rate per woman was estimated to be 4.8 (National Institute of Population Studies in Karim, Ahmed, Ahmed & Qazi 2003: 88).

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HIV/AIDS now shadows the local community.\footnote{In the wake of increased border trade between Gilgit and China, where urban prostitution is associated with high rates of HIV/AIDS, sexual promiscuity among traders, when combined with cultural discomforts and religious prohibitions against condom-use, has recently culminated in Gilgit’s first quietly confirmed HIV/AIDS cases (Tameer Project on Border Traders, Gilgit: March 13, 2005).} Importantly, these indicators occurred alongside the dramatic lowering of fertility, maternal and infant mortality rates among Northern Areas Ismailis. Ismaili health indicators, which have been described as signaling a regional “health revolution” (Hertzman 2001:538), can be correlated with the establishment of over 200 Primary Health Centers (PHC) across the Northern Areas and upper Chitral Valley (North-West Frontier Province) by the Aga Khan Health Services, Pakistan. AKHS,P’s secularly-styled health programming began in the mid-1970’s and has been made available for all sectarian communities. However, Shia and Sunni discomfort with the Aga Khan’s prominence, both in photographs and institutional affiliation, had led many to feel these services were better suited for “Ismailis only” (Fieldnotes: January 7, 2005; Dr. Sharifa, AKHS,P: May 15, 2005). In many respects, Gilgit’s Sunni communities were already a case of ‘famine in the midst of plenty’, with Sunni women’s poor health status occurring in the midst of adequate physician coverage and low-cost reproductive and contraceptive clinical services. Regardless of economic standing, Sunni women’s ‘pre-tension’ (tension sey pehley; U) health status was deeply complicated, affected not only by male-dominated community life and household decision-making but by women’s educational background and Islamic conservatism. Seen in this way, ‘peacetime’ and ‘conflict’ scapes of maternal health were deeply interwoven.

**Part III Thesis Overview**

“Belaboured Lives” examines how Gilgiti Sunni women’s health practices were invested with meaning and were the product of inter-linked or mutually interacting structural and ideological forces, which were socio-economic, political, familial and religious in nature. My participants’ reproductive health was the arena not only for wellness-seeking and crisis resolution, but also the enactment and expression of cultural values and sectarian identity, the tension between doctrinal Islam and local interpretations,

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modern/traditional divides, and symbolic and structural violence. Women’s narratives also demonstrated subjectivity, inter-subjectivity and reflexivity; resistance and negotiation; and gendered and reproductive agency. Borrowing from Rhoda Kanaaneh’s ethnography “Birthing the Nation” (2002), the format and content of which heavily influenced my fieldwork and writing, Gilgiti women’s reproductive practices can be understood to;

...play on a shifting combination of socially constructed emotional and material desires....[and] are used as key markers to negotiate and daily re-create essential categories of identity....[and are] strategies deployed as part of local negotiations of personal and collective identity and daily engagements of power. (2002: 105)

Within this context, and as a number of participants’ narratives will attest, any one pregnancy could evidence and communicate multiple domains of experience: patient-provider interaction; access to care, its quality and relation to socio-economic factors; and ideological stance or community-bound interpersonal relations. In this way, and as suggested by Faye Ginsburg and Rayna Rapp, “reproduction serves as a deeply insightful ‘entry point to the study of social life’” (Ginsburg & Rapp 1995: 1 in Kanaaneh 2002: 251). Borrowing from Appadurai (1996), and by using pregnancy and childbirth as a central point of inquiry, my thesis examines different ‘scapes’ of women’s health experiences: biomedical and traditional; urban and rural childbirth and post-partum practices; Family Planning, fertility, infertility and unwanted pregnancies; conflict-related constraints, medical malpractice and cosmological harm. By elucidating more than just the structural problematics underlying the Sunni community’s grim ‘big picture’ statistics, I sought to uncover the household and community-bound hermeneutics of pregnancy. But rather than start from the 2005 conflicts, the first five chapters of my thesis (Part One) introduce the biomedical and ‘traditional’ health services used by my participants, and then examine Sunni women’s daily struggles to preserve or remedy their reproductive and maternal health.13 By first understanding the problematics and ideological complexities associated with Sunni

13 Because the schisms and suspicions between Shias, Sunnis and sometimes also Ismailis ran so deep during fieldwork, I was often unable to easily talk with Shia or Ismaili women about their own health histories or service outlook without risking ruinous gossip or destabilizing our sometimes uneasy relationship with Wadood’s family, who were our only
women’s ‘everyday’ health, readers are better equipped to understand the ways Shia-Sunni fighting dealt a crippling blow to an already difficult situation.

Chapter One details the sectarian ‘tensions’ that led up to Zia-u’din’s January 2005 assassination and then describes the impacts of Sunni missionization, religious conservatism and socio-economic change on Sunni women’s health access. It also discusses how Sunni women’s childbearing years in particular, were symbolically over-determined by Islamically-framed concerns with gender segregation, women’s social mobility and the imbrication of women’s sexual fidelity and reproduction with polemics of honour (izzat; U), modesty and shame (sharam; A). Chapter Two describes Gilgit Town’s biomedical maternal health services and women’s clinic-based experiences, and provides an overview of the pregnancy-related conditions and health complaints treated by local hospitals. The chapter begins by describing federally-funded hospitals services and the State’s nominal role in overseeing policy, safeguarding against iatrogenic risk or corruption, or ensuring non-discriminatory services, whereby women’s maternal morbidity and mortality epitomized service insufficiencies. However, Chapter Two also outlines the successes of non-governmental hospitals, and clarifies the contribution of providers’ own attitudes to women’s treatment and health outcomes, despite the contribution that structural neglects, poverty and regional disenfranchisement regularly make to Sunnis’ maternal health. Chapter Three examines Sunni women’s ‘traditional’ home-centered pregnancy and childbirth practices in both rural and in-town settings. Chapters Four and Five assess the wealth of religious, ideological and political freight attached to Family Planning services, with Sunni women’s use or refusal of contraception being influenced by competing and conflictive projects of Gilgiti identity, whether ‘modern’, ‘traditional’; Shia, Sunni or Ismaili. Chapter Four’s multi-layered discussion of Family Planning also draws on the research of Inhorn (2004, 2006b; Inhorn & Sargent 2006a) and Tober, Taghdisi and Jalili (2006 to discuss women, their reliable protectors during times of high conflict. And because the available literature on Northern Areas women’s health is so fragmented and disparate, there are few ways to reliably compare Sunni, Shia and Ismaili experiences.
families and the Sunni community’s creative navigation, use and fears of the sectarian, gendered Islamic
and local moral discourses concerning reproduction and sexuality.

Chapter Five then shows how men’s attitudes played a decidedly minimal role in what women described
were the counter-pressures to Family Planning, and thereby answers those demographers, such as Karen
Mason and Herbert Smith, who ask how, “even when the absolute level of unmet need is very high, the
husband’s fertility preferences cannot explain most of the failure to use contraception by wives” (2000:
308). By detailing women’s use of emmenagogues and abortifacients, I then address how women could,
in autonomous or women-centered ways, use a myriad of sometimes dangerous methods to extend birth
spacing and restrict family size (see Renne & van de Walle 1999). Chapter Five also attests to the direct or
financially supportive role that men can take in procuring abortions or ‘illicit’ deliveries, which is
suggestive of an under-explored break between Islamic discourse and men’s and women’s private
preferences. In many respects, Chapters Four and Five challenge assumptions in Critical Medical
Anthropology that “health decisions are far more constrained by objective social factors and macro-level
structures of inequality….than by subjective ‘beliefs’” (Good 1994: 42). Overall, the discussions of
exclusively women-managed practices covered by Part One of the thesis, which include desi birthing
methods and home-made abortifacients, unsettle assertions in the development literature that South
Asian Muslim women, and the poor in particular, are “lacking in reproductive autonomy” (Unnithan-
Kumar 2004: 6).

As a consequence of January 8th, the last four chapters of my thesis (Part Two) shift to examine the
‘tension times’ and in-community enmity. Indeed, Part Two is derived from the breaks between what, in
Part One, women narrated were ‘routine,’ everyday and predictably occurring health practices and crises,
and the more unwieldy, anxiety-ridden forces women faced during conflict or as a product of
interpersonal discord and the occult, when women worked against one another. But Part Two also marks
a temporal shift between times of relative peace and those fraught by sectarian violence, targeted killings,
curfews and restricted health service access. Chapters Six and Eight present a selection of my 2005 fieldnotes, which offer on-the-spot narration of Gilgit’s deeply frightening and protracted Shia-Sunni fights. Chapter Seven uses interviews with Sunni women and their health providers to explore the ways inter-sectarian discord affected women’s access to services as well as health service provision, or tarnished women’s clinic-based experiences. And while vengeance concepts (badal; U) were symbolically extended by women and their families to re-think medical malpractice during the ‘tension times’, the conflicts also reinforced Sunnis’ belief that women’s health deprivations were the product of inter-sectarian prejudice and deliberate historical neglects.

Meanwhile, from inside the Sunni community, the Shia-Sunni hostilities provided additional impetus for women’s already over-determined bodies to be re-deployed as sites for family and community-grounded projects of reactionary, sectarian and ethnic Gilgiti identity. In particular, sectarian conflict and its associated losses soon led to renewed pronatalist pressures, whereby Gilgit’s Sunni ulema (clergy; A) used mosque sermons and household visits to re-emphasize Islamic expectations that women have ‘as many children as possible’. Chapter Seven also discusses how, after January 8th, Sunni women’s service access constraints, unmet reproductive health needs and maternal deaths occurred alongside men’s vociferously protested conflict-related killings, yet they were unaddressed by either media coverage or Sunni political rhetoric. At governmental levels, the suppression of Gilgit Sunni women’s health crises reverberated alongside Pakistan’s state-sanctioned silencing of both women’s social and domestic vulnerabilities and the Northern Areas’ political and constitutional requirements, a silence which I am attempting to counter with my thesis.

Lastly, and in ways that unsettle Sunnis blaming Shias and Ismailis for their health deprivations, Chapter Nine illuminates the health risks and cosmological harms Sunni women claimed were directed at them within the Sunni community, and from their own families and other women. While heavily-armed sectarian battles relied on men’s active participation with women providing domestic back-up and
symbolic reinforcement of the family values and religious ideals ‘worth fighting for’, women’s interpersonal conflicts demonstrated a more unwieldy aspect of domestic life, involving subterfuge and morally complex interplay between subjectivity and inter-subjectivity, insecurity, enmity and vengeance. In this way, women’s domestic battles were the persistent shadow to men’s political confrontations, and the health repercussions stemming from interpersonal disputes were not necessarily any more benign than the health costs incurred by sectarian conflict.

My participants animatedly described the wide array of cosmological measures that were centered upon their reproductive health. Deliberate attacks used spells, substances and amulets (tawiz; A), ‘black’ magic (kala jadu; U) and Islamic sorcery (as’Sihr; A). Less frequently, women claimed that male and female spirit diviners could be paid to invoke attacks by jinn, witches (churriyl; S) or fairies (parri; S). Other methods were unintentional, such as the ‘evil eye’ (nazhar), yet still grounded in palpable acrimony.

Enmity allegedly also involved surreptitiously feeding inappropriate medications, body ‘matter’ (said to be spit, pieces of hair, fingernails), homeopathic therapies, herbs or even poisons (zeher; U) to the ‘other’. In this way, Chapter Nine explores the existence of ‘alternate’ cosmologies and the prominent role malevolent, women-centered forces play in explaining women’s health crises and losses. It also shows Islamic clerics’ everyday ‘treatment’ of women’s menstrual and reproductive health, and thereby challenges anthropology that over-emphasizes the role of gender segregation in matters of health. Because women frequently prioritized enmity’s health impacts over those related to the sectarian hostilities, Chapter Nine reveals that the Shia-Sunni hostilities were not the most important or salient constraint women faced. Moreover, women’s discussions of community and family-level battles permitted them to contrast, however obliquely, the ‘what is’ with ‘what should be.’ As such, women’s reflections on sectarian violence and inter-personal or cosmological harms relied heavily on inferred

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15 See Buckley & Gottlieb (1988) and Meyer (2005).
Introduction: Insurgent Moments

contrasts between the conditions and characteristics of peace or conflict, social balance or discord. Ultimately, Chapters Seven and Nine explore how conflict, interpersonal discord and the threats posed by ‘black magic’ altered women’s somatic and narrated expression of health and illness, and could also lead to women performing contradictory roles during crises; such as that of peacemaker and also crisis instigator.

In planning the thesis’s content and structure, I decided not to conflate peace-time with conflictive ‘scapes’ of reproductive experience, with the result being my analysis sits astride the boundary between medical and socio-cultural anthropology, and the anthropology of violence. At a primary level, I have sought to preserve the wider scope and internal thematic consistency inherent to the many ways in which Gilgiti Sunni women experienced and thought about their reproductive health. Parts One and Two were deliberately staggered one against the other so as to stress the crucial ways that health practices, service access and provision and my methods abruptly changed. Chapters Six through Eight are intended to better demonstrate how “violence is a total social phenomenon” (Henry 2006: 382) that leads to different reproductive struggles and service estrangements. Moreover, unrest occurred in multiple locales, including hospital labour rooms, which are ordinarily excluded from the medical anthropology and social geography of health literature as sites of intentional deprivation. Finally, and in ways that are similar to Rachel Chapman’s analysis of pregnancy practices in war-torn Mozambique, Gilgit’s ‘tension times’ not only altered Shia-Sunni relations and constrained service access, but also symbolically “reinforce[d] reproductive demands on women” (2004: 229). But as I have noted, Part Two does more than discuss the Shia-Sunni hostilities. It also explores the ways women understood their health crises as being the product of unseen cosmological and intentional occult forces, which were different in ‘extra-ordinary’ ways from the structural constraints described in Part One. The textual boundary between Part One’s analysis of ‘everyday struggles’ and Part Two’s ‘extraordinary fights’ therefore reflects the dramatically different ways in which women’s subjectivity and inter-subjectivity, health practices and
clinic access shifted to accommodate chronic unrest, and confront the restrictive structural and spiritual forces surrounding women’s at-risk bodies.

**Part IV Previous Regional Literature**

Over the last one hundred and fifty years, the Northern Areas strategic location – poised between Pakistan’s Indian and Afghan borders and sitting astride Pakistan’s sole land route to its primary trading partner, China – has rendered it the focus of covert international strategizing. In the latter half of the 19th century, Gilgit was the scene of largely covert British and Russian Imperial intervention, labelled the ‘Great Game’ (Baloch 2004; Dani 2001). For nearly sixty years before Partition, the Gilgit Agency (as Gilgit District was then known) represented the British Empire’s most isolated Northern Indian outpost. Because of its isolation, the area was only infrequently visited by explorers, administrators and the occasional Anglican missionary. Gilgit’s importance was primarily logistical; the British garrison in Gilgit Town had successfully deterred a steady encroachment of Russians, who had “broken all treaty regulations with impunity” (Knight 1891: 289). Before becoming the focus of Imperialist machinations, Gilgiti residents had been long-suffering. Dominated and partially enslaved by Kashmiri Dogras, Gilgitis endured frequent warring raids by their Chilasi neighbours to the south (Keay 1977; Knight 1891; Sokefeld 2002). Writing in 1891, E.F. Knight observed,

“...[a] great loss of life, a fearful sum of human misery, a vast waste of the State funds, and all with no result – such was the history of the Gilgit garrison...up to the inauguration of the wise policy by which the defenses of Gilgit have been put into the hands of a British Agency.” (Knight 1891: 285)

With the naturally fertile river terraces surrounding Gilgit largely unfarmed due “to a very large extent [by] the abandonment of the cultivated lands by the persecuted inhabitants” (Ibid: 288), British defensive measures enabled local inhabitants to re-establish prosperous and well-populated communities. Yet in spite of Gilgitis’ regular enslavement by Chilasi raiders, many ‘free’ families in Gilgit District’s southern villages were willingly “allied by marriage to the Chilas people” (Ibid: 360), a scenario British administrators found confusingly repugnant. Nevertheless, Knight’s late 19th century recollections are not
very different from how Gilgit appears today, despite the town having expanded gradually across both sides of the Gilgit River.

“I had heard so much of the desolation of the Gilgit district that I was much surprised, on reaching the plateau of Jutial, and looking down on the famous fortress, to find it surrounded by one of the largest and best-cultivated oases I had beheld since leaving fertile Kapalu [Baltistan]. The mountains here recede from the river, leaving on the right bank a broad plain, well watered by little streams. I walked through orchards of ripe peaches, under clusters of purple grapes, across fields of rice, millet, maize and Indian hemp....” (Ibid: 316)

Until Partition, historical accounts of Northern Areas cultures were often heavily imbued by Orientalism. Locals were described as exhibiting an “indifference to human life characteristic of [their] race” (Ibid: 310), “stupefied by bhang [hashish; U]” (Ibid: 327), “sinister and squint-eyed” (Ibid: 274); Gilgit’s Dardic inhabitants were “a sturdy people, thickly-built, of rather dark complexion, and generally of rough-hewn and homely features” (Ibid: 277). Another explorer attempted to summarize Gilgitis’ basic qualities; “bold, but who, though not caring much for human life, are not bloodthirsty; a people who will meet one on even terms, without sycophancy or fear on the other hand, or impertinent self-assertion on the other” (Drew in Knight 1891: 277). The ingenuity of Northern warring tactics, in particular, drew uneasy admiration from British colonial administrators. After one commander was shot in the leg, his British surgeon extracted - not without surprise - a “garnet enclosed in lead” (Ibid: 405). More ominously, Gilgiti Sunnis were accorded special recognition as “slumbering” fanatics (Ibid: 327), who had turned the desolate trade routes leading to Gilgit Town into “robber country” (Ibid: 373).

Women only very occasionally featured in British accounts. While stopping for tea in Sakwar, a village just to the south of Gilgit Town, E.F. Knight was “regaled by the people with grapes and milk” (Ibid: 315), and noticed the “girls, who were not particularly shy, but who, with unveiled faces, peeped at the stranger from round the corners of walls and trees, [and] were really very pretty, having rosy complexions, good features, and lovely eyes” (Ibid: 316). Time did little to expand these brief glimpses into Northern women’s worlds. In 1977, Dervla Murphy portrayed Gilgiti women far less picturesquely as “hidden,
tongue-tied [and] pallid” (38), while in 2002 Kathleen Jamie described Gilgit’s laneways as
“full of gangs of veiled women, in lines, like geese, going to visit each other...great and doughty,
breasting the alleyways like galleons, with their veils billowing around them” (40-41).16 My fieldnotes
raise rich contrasts to Murphy and Jamie’s descriptions. Poorer women, their dupattas smelling of smoke,
sun-soaked hay and sour milk, baking pfitti (S) bread in covered pots over open cooking fires, the flames
steadily fed by pine-cones and twigs; young wives excitedly sewing bazaar-bought, brightly coloured
polyester into a new shalwar kameez (pant shirt; U). Older mothers using their pinched fingertips
to run ‘Kala Kola’ dye along greying strands of hair, dabbing khusbool (perfume; U) by earlobes laden with
heavy raw ruby earrings, aging hands adorned by lozenge-cut garnet and gold rings (angouti; S).
Teenage girls deftly applying sorma (antimony, kohl; U) to their eyelids’ inner rims with the edge
of a pinkie finger, smoothing sarsoh (mustard; U) oil into thick swathes of chestnut hair, pulling on shining
handfuls of glass bangles, some shattering apart as girls eased them over the widest part of their hand.

While ethnographies of the Northern Areas remain uncommon, social geographers have contributed to a
widening range of research examining the Karakoram Highway (Kreutzmann 1991; Miller 1981),
2002), and the experiences of expatriates working in the Northern Areas (see Cook 2006a, 2006b). Gilgit’s
position as a point of intrigue in Pakistan’s ongoing dispute over Kashmir has also caught the attention of
numerous journalists including Canadian Eric Margolis, who wrote “War at the Top of the World” (2002).
Since the mid-1990’s there has been a quiet foray into local language studies by the U.S.-based Summer
Institute of Linguistics (SIL) (see Rensch, Decker & Hallberg 1992), most of which has focused on
Burushaski, the language isolate spoken by Ismailis from Hunza Sub-District, which neighbours Gilgit to

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16 Notable among contemporary travelogues are Nick Danzinger’s (1988) travels through Gilgit along the ‘old’ Silk
Road, and Dervla Murphy’s calamitous trek and pony-ride across Gilgit into Baltistan, accompanied by her young
daughter (Murphy 1977). More recently, Kathleen Jamie’s “Among Muslims” (2002) recounts her friendships with
Shias living in Gilgit Town and Shia-dominated Baltistan, which neighbours Gilgit District to the east.

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Prominent in the recent literature are multiple qualitative assessments of socio-economic development across the Northern Areas, much of which has been conducted on behalf of the Aga Khan Development Network (AKDN). Because of their cosmopolitanism, marked liberalism concerning women’s social roles and mobility, and perhaps more importantly because of the relative ease by which anthropologists are able to work in men’s and women’s social spheres, Northern Areas Ismailis have been researched nearly to the exclusion of local Shia and Sunni populations (Allan 1990; Clark 1956; Flowerday 2006; Holzwarth 2006; Neelis 2006; Sabir 2006; Sales 1999; Staley 1969; Stellrecht 2006). The distinctive and vibrant nature of Ismaili Hunzakut culture, in particular, has been the focus for numerous studies funded by the Aga Khan Culture Services (AKCS) (Beg & Khan 2006; Bianca 2006; Hughes & Lefort 2006; Parkin 1987; Willson 2002), a recent AKDN offshoot, as well as several health surveys (see Javeed, Mahmood, Mustafa & Hussain 1992; Shaikh, Haran & Hatcher 2008). The bulk of recent Northern development research, however, examines sustainable mountain development (Kreutzmann 1991, 2006; Wood & Malik 2006), community infrastructure (Malik, Effendi & Darjat 2006; Malik & Piracha 2006) and village organizations (Gloekler & Seeley 2006; Varley 1998) to micro-finance (Hussein & Plateau 2006), education (Felmy 2006; Sales 1999) and natural resource management (Gloekler 2006); many of these authors are current or former employees of the AKDN and its Gilgit-based subsidiaries, including AKRSP and AKHS,P.

Notwithstanding earnest attempts at critical analysis, most of this material is distinctively partisan in institutional loyalty, research positioning and by nature of its sustained focus on Northern Ismaili communities (this despite anthropological claims that “Pakistan’s Ismai’ilis have received very little scholarly attention” [Marsden 2005: 16]). Moreover, this well-funded and prolific branch of Northern

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While Gilgitis see SIL in purely secular terms, these language retrieval projects are ostensibly conducted in order to produce local language Bibles.
Areas research, both implicitly and directly positively contrasts Ismailis against their ‘less developed’ sectarian neighbours, including Gilgiti Sunnis.\(^\text{18}\)

In addition to Ismaili-positioned research, there are a growing number of works examining the Northern Areas from Shia perspectives, such as Kenneth MacDonald’s research on Shia Baltistan (1998). In addition to Kathleen Jamie’s account of Gilgit Shia ‘everyday life’, Martin Sokefeld’s research into Shia sectarianism is forefront in the regional literature (1998, 1999), while his recent writings go on to interrogate what he calls the Northern Areas’ “post-colonial colonialism” by the State of Pakistan (2005: 939).\(^\text{19}\) Ethnographic treatments of the Northern Areas’ Ismailis and Shia communities frequently attend to their more eclectic or transnational qualities which, for Shias, includes the highly spiritualist Northern Nurbaksh movement, a local proliferation of Persian poetry, saint worship (\textit{urs, dars; U, F}), ‘Persian’ cuisine and women’s dress (\textit{chador; F}), Iranian-style community organizations (\textit{jalsas, majales; U, F}) and religious training (see Sokefeld 1998, 1999). On the other hand, Gilgit Sunni communities have not been – to my knowledge – a specific focus for Northern Areas research.\(^\text{20}\) Instead they are the subject of occasional, arms-length assessments in which they are characterized as spiritually austere, rigidly conservative, lacking in humour or cultural innovation, socially reactionary and politically stagnant. The ethnographic literature for Northern Pakistan often appears to reinforce such views. For example, Maggi’s ethnography (2004) of ‘pagan’ Kafir Kalash tribes in Gilgit’s neighbouring Chitral Valley provides a typical summation of Sunni culture.

“For outsiders, much of Chitrali life is obscured by the eight-foot high mud or cement walls, which shield colorful gardens and intimate family life from the eyes of strangers, or rather, of strange men. Chitrali culture, like many conservative Islamic societies, makes a

\(^{18}\) Despite the Ismailis’ present-day pacifism, Ismaili-Sunni relations were once wracked by bitter hostilities and occasional bloodshed. In 1891, British traveler E.F. Knight noted rumours that “Hunza Maulais hate all Sunis [sic], and whenever they catch one roll him in cotton, bleed him to death, and then distribute the blood-stained cotton among themselves, to be preserved as a charm” (Knight 1891: 361).

\(^{19}\) In her book “Among Muslims,” which concerned Shias living in Gilgit Town and Baltistan, Kathleen Jamie described how community accounts accorded narrative primacy to 1988, when Sunni militants - “who ran amok” (2000: 40) - attacked the Shia village of Jalalabad, across the river from Gilgit Town (see Chapter One, pages 56-57).

\(^{20}\) It is worth pointing out there are a number of geological, geographical and agricultural surveys of mineral resources, livestock development and irrigation technology in Astore and Diamer (see Nusser & Clemens 1996).
strict division between male public and female or familial private space. While the division between public and domestic has received two decades of criticism as reductive (Moore 1985:21-24), in Chitral these categories are meaningful descriptions of a social world that is divided in two...the feeling that male public spaces are no place for women is so strong that even my most liberal Chitrali friends would never think of accompanying their sisters, wives or daughters to the bazaar or polo field or other male gathering spots. Chitrali women themselves would not think of going anyway, for keeping strict purdah is a powerful expression of women’s morality and devotion to Islam.” (2004: 12)

While Maggi’s work accurately illustrates the structural ‘truths’ of Northern Pakistani life, she oversimplifies the experience of gender segregation. Maggi’s work is attentive to the positive, symbolic meanings of purdah-related boundaries, but disregards the deep curiosities, transgressions and exceptions inherent in women’s actual experiences of social mobility or access to ‘public’ spaces. After having spent two summers living among Sunni Chitralis (1993, 1997), I knew that Chitrali women, like Gilgitis, found multiple, non-confrontational ways to move beyond the domestic domain. For example, the main irrigation channels (wei yup; S) set high on the hillsides above villages, offered private spaces for women to walk between communities, or meet female (and sometimes male) neighbours for picnics or chats.21

Rather than challenge a social space, women simply moved around it.

In the absence of Sunni-specific research for the Northern Areas, it is only by looking to ethnographies set in Pakistan’s North-West Frontier Province that one can find work that captures the cultural and spiritual dynamism of Northern Sunni culture, although they do so by foregrounding ethnic identity over religious practice or ideology (see Barth 1956, 1959; Keiser 1991).22 For instance, Magnus Marsden’s lyrical

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21 See Azhar-Hewitt (1998) for a discussion of the changes in gender interaction brought about by village bathing practices in Shia Baltistan. Also see Marsden (2007) for ‘exceptional’ relationships, love and elopement among Sunnis and Ismailis in the Chitral Valley (North-West Frontier Province).

22 Notwithstanding the Northern Areas’ strategic importance, the majority of historical travelogues (Curle 1961; Curzon 1896; Morant 1936; Murray Abdullah 1990) and contemporary anthropological research on Northern Pakistan focuses predominantly on rigorously conservative, gender polarized Paxto communities (Ahmed 1980; Ahmed 2006; Barth 1956, 1959, 1965; Grima 1998; Gul Khattak 2002a; Lindholm 1982, 1988; Keiser 1991; Tapper 1981, 1991; Sweetser 1993). In some respects, this reflects Britain’s colonial fascination with Afghanistan and the Khyber Pass. Accordingly, Sunni ‘Northern Pakistan’ is often treated in the literature as analogous to Paxto ethnic identity and cultural practices, which predominate in much of the North-West Frontier Province (Sarhad) and those portions of Baluchistan that border Afghanistan. Through the medium of conservative Sunni strictures, Paxto and Gilgit cultures do share a wide array of conceptual beliefs, including their foregrounding of honour (izzat; U) and modesty
ethnography of Sunni and Ismaili Chitralis living in the high mountain valleys west of Gilgit District provides a forceful challenge to popular representations of Northern Pakistani society. Instead of affirming treatments of Northern Sunni culture as rife with “tribal blood feuds, fanatical religion, and the seclusion of women” (Marsden 2005: back jacket), “Living Islam: Muslim Religious Experience in Pakistan’s North-West Frontier” documents the intellectual creativity (Ibid: 11), poetry and love for dancing and gamesmanship (Ibid: 4-5, 14-15) that characterizes Chitrali culture. Though his analysis acknowledges the importance of Sunni strictures to everyday life and decision-making, Marsden foregrounds the salience of ‘ethnic’ Chitrali identity for his participants. Specifically, his analysis addresses the efforts that “peaceful” and “trustworthy” (Ibid: 14) Chitralis make to differentiate themselves from ‘other kinds’ of Sunnis, including neighbouring Pukhtun communities (Ibid: 14). By consequence, Marsden’s analysis pays less attention to the ways Sunni doctrine and ritual practice continue to exist at the core, and underwrite much of what Chitralis assert is their ‘ethnic’ versus ‘religious’ identity.

In turn, Amineh Ahmed’s “Sorrow and Joy Among Muslim Women: The Pukhtuns of Northern Pakistan” (2006) provides an animated elite-level analysis of the Sunni Muslim Bibiane, “wives of the landed wealthy”(4), whose quasi-administrative control of kinship groups is confined to the domestic sphere. In contrast to “conventional academic portrayal[s] of Muslim societies as contexts in which men claim a greater measure of reason or social sense than women” (Ibid: 4), Ahmed’s work affirms how Bibiane “call the shots’, exercising minutely differentiated senses of both social propriety and personal strategy in negotiating procedures” (Ibid: 4). Notwithstanding her work’s obvious potential for expanding discussions of Muslim women’s agency, Ahmed’s work often seems to characterize Bibiane’s negotiated

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(sharam; U). However, Paxto communities can evidence striking differences in dress, cuisine, language, architecture and the practice of pardah. By comparison with Gilgiti Sunnis, Paxto gender segregation is stricter, more widely applied, and with transgressions enacting harsher and more frequent penalties. As such, my use of the Northern Pakistani ethnographic precedent becomes slightly problematic.

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agencies as elite deviations from ‘traditional’ Sunni precepts. In this way, women’s use of domestic contexts as a “space of agency” (Ibid: 4), and their strategic management of honour paradigms (izzat; U) and pardah (gender seclusion, veiling; U) practices, are representative of Pukhtun culture but not of Sunni identity and values. By positioning Chitrali and Pakhtun identity as the primary sources of cultural creativity and individual agency, Marsden and Ahmed argue that multi-hued, widely variable community and family life are fuelled by ethnic and customary values, rather than being also representative of local-level ‘Sunni’ practice and sociality. In my opinion, such positions neglect the creative practices and flexible agencies that Gilgitis, not unlike other Northern Pakistanis, wholeheartedly believe are rooted in Sunni discourse.

Part V Medical Anthropology & Ethnographies of Reproduction

After having personally experienced the wider spectrum of Gilgiti conflict, both intra-familial and inter-sectarian, my intent has been to animate how women’s health practices dynamically reflected sectarian, ideological, in-family and interpersonal disharmonies. By doing so, I hoped to clarify the structural and symbolic violence (Farmer 2004) implicated in women’s health, the so-called ‘everyday’ violence and ‘peacetime conflicts’ (see Scheper-Hughes & Bourgois 2004: 267). At a primary level, I began my fieldwork determined to illuminate the risks, fears and joys experienced by my Sunni women in-laws in their reproductive lives. By the time we returned to Gilgit in summer 2004 I was already sensitized – in helpful ways – by my personal experience of the physical and emotional trials of infertility, pregnancy, childbirth and infant loss, and hoped to use these insights to better direct my analysis of Gilgiti Sunni family life. But perhaps more than this, it was my growing awareness of the absence of research on Northern Areas Sunni communities that motivated me to carefully chronicle the many deprivations, difficulties and symbolic complexities associated with Gilgiti Sunni women’s maternal health.

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23 This actually ran counter to my Gilgiti experiences. At our local mosque, the Qari (prayer leader; A) argued that local customs (riwaj; U) were far more misogynistic than even the most conservative Islamic edicts. He argued that if families followed ‘purely Islamic strictures’, women would be able to re-claim their spiritual equality and ‘natural’ rights and dignity.
Because of an unexpected change in my fieldwork site away from urban Pakistan to Gilgit (which I describe further on in the Introduction), my doctoral research began without the benefit of either a Ph.D. thesis proposal or regional research precedent concerning Gilgit’s Sunni community. In addition, Gilgit Town’s unique and underexplored demographics ensured there was no easy starting point in the Northern Areas anthropology or development literature from which to orient myself. The questions I initially formulated were not so much devised in anticipation of fieldwork, as they were born of my own memories of Gilgit as a newly married wife in 1998, and then tailored to respond to the concerns of my first research participants. Over the first four months of my fieldwork, a number of thematic queries emerged. In what ways were women’s health practices shaped by local political and sectarian processes, or questions of identity? What was Gilgiti women’s experience of the ‘body politic’, the “regulation, surveillance and control of bodies...in reproduction and sexuality” (Schepa-Hughes & Lock 1987: 7-8)? Given that health does not occur in a moral vacuum, how did local interpretations of Islam affect women’s health beliefs, service use and outcomes? Following from Anita Winkvist and Humaira Akhtar’s research in Pakistan’s urban centers, did women’s childbearing patterns or infertility affect the ways people treated them (see 2000: 78)? How did Family Planning encompass and communicate what Stacy Pigg and Vincanne Adams argue are divergent “moral”, secular and faith-based agendas (2005: 20)? Finally, how did what Linda Green calls the “lived experience of violence” (1998: 3) affect pregnancy and childbirth?

Theoretically speaking, my research was grounded in a particular type of medical anthropology, nuanced by feminist anthropology and accompanied by an interest in gender and agency; Islam, identity and violence; and embodiment and somatization.24 However, my thesis fundamentally follows from critical interpretive medical anthropology which, according to Green, “insists on the importance of narrative and

lived experience” (1998: 187). In particular, my analysis of maternal health beliefs and practices draws on recent ethnographies of Islamic reproductive practices and embodiment (Boddy 1989; Inhorn 2004, 2006b; Malti-Douglas 2001; Nourse 1999; Rasmussen 2006; Tober et al, 2006), and phenomenological and narrative accounts of illness (see Csordas 1990, 1994, 1997; Good 1994). My work is also informed by research that details the socio-economic, cultural and religious salience of reproduction, son preference and infertility in Islamic societies (see D’Addato 2006; El-Gilany & Shady 2007; Inhorn 2002, 2006a, 2006b; Morsy 1978, 1988, 1991) and South Asia (see Bhatti et al, 1999; Chandran et al, 2002; Donner 2003; Fikree et al, 2003; Jeffery & Jeffery 1993; Kazi et al, 2006; Mumtaz & Salway 2005; Saleem & Bobak 2005; Winkvist & Akhtar 2000). Prominent among such works are Janice Boddy’s pivotal discussions of the idiomatic nature of women’s ritually-managed bodies, fertility and spirit possession in the Sudan (see 1988, 1989, 1994). My overall approach is similar to Carla Obermeyer’s qualitative examination of Moroccan women’s birth practices, where she analyzed:

“…knowledge and practice surrounding birth [using] women’s narratives of their recent birth experiences, observations of medical encounters, and statements about prescribed behaviors during pregnancy and birth, as well as the vocabulary used to refer to physiological processes, disease conditions, and social relationships….Women integrate biomedical and local knowledge and practices and simultaneously seek care from ‘traditional’ and ‘modern’ practitioners, creatively combining elements in accordance with their situations and the means at their disposal. Birth narratives show the eclecticism and flexibility that characterize women’s attitudes and behaviors....” (2000: 180)

My fieldwork methods and thesis analysis approaches have also followed from a feminist politics of reproduction, which accords analytic primacy to women’s subjectivity, inter-subjectivity and reflexive ‘voice’ (see Kahn 2000; Rapp 1999; Ginsburg & Rapp 1991, 1995), and seeks specifically to place reproduction

“… at the center of social theory [whereby]...attention is called to the impact of global processes on everyday reproductive experiences...(Ginsburg and Rapp 1995). Of central concern in this framework are the ways that the ideological and socio-political dynamics of gender organization articulate with the social mechanisms by which local power

relations and global forces impinge on women’s bodies.” (Browner and Sargent 1995: 213; Morsy 1995: 31). (Chapman 2004: 254)

By nature of feminist anthropology’s attention to the role of ‘power’, my work also appeals to Critical Medical Anthropology which, according to Hans Baer, Merrill Singer and Ida Susser, explores “the degree to which issues of power, inequality, oppression, [and] exploitation” (2003: 50) shape well-being, illness and mortality. However, because I focus heavily on local dynamics, I sidestep the assessments of “global power relations” favoured by the approaches of Critical Medical Anthropology or a feminist politics of reproduction (Good 1994: 44). And while my thesis provides numerous examples of women’s embodiment of socio-cultural and religious values, my interests leaned far more toward health practices whereby, borrowing from David Mechanic’s illness behaviour model, women “monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system” (1982 in Good 1994: 42). The key distinction is, of course, that while pregnancy is not by definition pathologic, for Gilgiti women it involves a far higher degree of risk than many other health conditions. In fact, by specifically examining the social risks and physical dangers inherent in pregnancy and birth in ‘unstable’ settings, my thesis helps redress the ways in which “ethnographers have been relatively silent about the dangers of childbirth and how these figure in the imaginations of our subjects” (Lambek 2007: 197).

Moreover, pregnancy involves the interests and investments of a wide array of social actors, which in turn amplify women’s social recognition and importance. Especially for a setting where younger wives and mothers could claim few opportunities to directly confront, or call attention to, inequity or discontent, pregnancy-related somatic complaints in particular could then be deployed as a communicative medium. This idea draws on the work of Thomas Csordas (1993), Byron Good (1994), James Wilce (1995), Janice Boddy (1988) and Michael Lambek (1980), each of whom addresses in different settings and to different degrees, the communicative value of health, reproduction and, in ways that concern Chapter Nine, spirit possession episodes. Such approaches are, in turn, complemented by Setha Low’s analysis of somatic ailments as demonstrating “resistance, [and not being] just a response to or
communication about socio-political and familial distress” (Low 1996: 141). And by borrowing from a more embodiment-oriented reading of women’s health, Schepet-Hughes and Lock’s notion of ‘body praxis’ - the experience of “someone living out and reacting to his or her assigned place in the social order” (1987: 53) - provides an especially useful tool for analyzing the “experiences of women in connection with menstruation, childbirth and menopause, and the variety of ways in which they embrace, equivocate about, or downright reject dominant ideologies” (Ibid: 53). To this point, through my discussions of the role of doctrinal Islam, and community- and mosque-interpretation of the Qur’an and popular Islamic discourse (Islamiyyat; A) in women’s health, my thesis answers Marcia Inhorn and Carolyn Sargent’s call for research examining “culturally-grounded, local interpretations of the links between Islam and reproduction” (2006a: 7; see also Lambek 1990). Indeed, rather than take Islam as a given, I attempt to show how ‘Islam’ itself is situated within a specific social and political milieu (see Ahmed 2006; Duomato 2000; Lambek 1988; Marsden 2005; Privratsky 2001; Sokefeld 1998; Werbner 2003).

**Part VI Practice Theory & Agency**

By nature of my focus on Gilgit women’s reproductive health as a consequence of unequal access or restrictive ideologies, and inspired by a feminist politics of reproduction approach, my fieldwork looked for the ways women “resist[ed] and change[d] oppressive structures...[or] accommodate[d] oppression” (1995: 272).26 As the thesis will demonstrate, women’s health practices and especially their occult-related narratives could sometimes be conceptualized as “disruptions,” which Sharon Roseman argues afford women explicit but also indirect commentary on “unequal social relations [or] socially constructed ...cultural categories” (Roseman 1999: 212). Yet even when it broke away from the restraints associated

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26 Unlike feminist anthropology, however, I do not reflect on the ‘ethics of engagement’ or explicitly advocate for women’s empowerment or change. Though my thesis tries to diagnose the problematics of women’s health-seeking, my work diverges from feminist approaches that seek to provide “a prescription for changing the situation of women who are understood to be marginalized, subordinated, or oppressed” (Mahmood 2005: 10). Where feminist ideals of ‘freedom’ and autonomous will are “normative to feminism” (Mahmood 2005: 10), they are highly non-normative for Gilgit women and run counter to women’s own desire to live at the helm of complex inter-dependent familial and neighbourhood relations. Because the landscape of available power for women remains grounded in the domestic sphere and stems from interpersonal connections, feminist notions of autonomous ‘selfhood’ necessarily remove women from any source of locally recognized, and thereby, effective power.
with pardah (veiling; U), gender segregation and male-decision-making, women’s agentive, resistive health seeking retained an element of moral and social acceptability by nature of its focus on well-being. As Janice Boddy notes for Hofriyati women, the centrality of Islam and related cultural discourse ensured my Gilgiti participants had both “the desire to maintain social, cultural, and physical boundaries, and the practice need to overcome them, albeit selectively” (Boddy 1988: 8). In important ways, Holly Wardlow’s discussions of ‘practice theory’ complement my grounded focus on the strategizing, structural limitations and acts of agency inherent to Gilgiti women’s health practices. In her analysis of Huli women, sexuality and agency in Papua New Guinea, Wardlow notes;

“...I take an approach informed by “practice theory,” which, as Karp observes, “provides an analytic frame which allows ethnographers to describe the complex relations among the agents’ strategies, the symbolic forms they invoke in their actions, and the distribution of power in society.” (1986: 1321; see also Bourdieu 1977; Bourdieu and Wacquant 1992).

By drawing on Sherry Ortner’s discussions of actor-oriented analysis (see 1984), Wardlow goes on to note how the “conceptual orientations and modes of analysis that are loosely grouped together under the term ‘practice theory’ differ” (2006: 5) in key ways. First, ‘practice’ approaches do not merely oppose the individual against static and changing ‘systems’ or ‘structures’ (see Wardlow 2006: 5, 6), but “instead acknowledge that the system powerfully shapes and is shaped by human action” (Ibid: 5). Second, ‘practice theory’ integrates and focuses on “asymmetrical relationships of power” (Ibid: 5). Third, it “conceptualizes the actors’ desires, goals and imagined possibilities as thoroughly cultural” (Ibid: 5), whereby;

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“…actors may be “rational” and “strategic,” but their rationality proceeds according to specific cultural logics and values, and their strategies are generated and constrained, both imaginatively and materially, but socio-cultural context.” (Ibid: 5)28

Key for understanding the Gilgiti context, and indeed as it was for Wardlow’s Papua, New Guinea fieldsite, is a finer sense of women as being enmeshed in a series of ever-extending, overlapping networks of relationality, obligation, allegiance and also enmity, from which women’s health practices emerge. Following from the work of Marilyn Strathern (1988), Lois McNay (2000) and Wynne Maggi (2001), Wardlow carefully distinguishes how, before proceeding with actor-oriented ‘practice theory’, anthropologists should attend to the ways women live amid networks of affiliation. This, in turn, affects how anthropologists apply ‘agency’ concepts to our research.

“Most theorizations of agency tend to assume an individual actor as the locus of desire and action. This singular actor is not fully autonomous and does not enact some sort of abstract, voluntaristic ‘free will’ – in the sense of being completely disembedded from social context; indeed, unmediated, free-floating will is impossible in anthropological understandings of practice (Ahearn 2001; Maggi 2001). Moreover, the individual actor may – according to more poststructuralist renditions – be conceptualized as “emerging from the uneasy suturing of incommensurable discursive positions” (McNay 2000: 17) or be adversely positioned within intersecting hierarchies.” (Ortner 1995). (Wardlow 2006: 6)

In reconfiguring ‘practice theory’ and ‘agency concepts’ for a Gilgiti context, Wardlow’s discussions of Huli women as “relationally constituted person[s]” (Ibid: 6) offer several useful parallels for my analysis of the ways in which women and their health practices were nuanced by domestic and community relations.

“Persons, in this perspective, are “constructed as the plural and composite site of the relationships that produce them” (134), or as Biersack puts it, the “dividual” is “a s/he who is multiply authored or caused and who is complexly positioned without a network of consanguines and affines...born of others and dependent and interdependent rather than autonomous.” (1991: 148). (Wardlow 2006: 6)

The primary risk of over-attending to the relational aspects of ‘self’, however, is the assumption that (as Martin Sokefeld notes for Gilgit), “anthropology’s subjects have an identity (shared with others, derived from a culture) instead of a self” (1999: 418 in Wardlow 2006: 7). In many respects, this is where Gilgiti

28 In ways that assist my analysis of the emotional weight and anxieties associated with pregnancy and childbirth, Wardlow adds; “...as Ortner notes, the notion of structure includes ‘emotional and moral configurations, not just abstract ordering principles’ (1989: 14)” (2006: 5).
women’s individual narratives help counter any of the generalizing qualities inherent to relationally-attuned ‘agency’ concepts. In response to this tension in the theory on ‘agency’, my work deliberately follows the path of several recent ethnographies of reproductive health and birth, which include Henri...
local medical pluralism, I also sought out the narrated perspectives of male and female traditional medicine purveyors (desi bilehn thabeeb; S), herbalists, spirit mediums and diviners and Sunni clerics (mullahs; A). 29 Even with a wide range of research addressing Pakistani women’s reproductive health (see Ahmed 1993; Ahmed et al, 1998; Almaric & Banuri 1993; Harcourt 1992; Midhet, Becker & Berendes 1998; Jafarey, Hardee & Satterthwaite 1968; Khan & Kazmi 1998; Robinson, Shah & Shah 1981; Shehzad 2005, 2006; Saigol 2002; Sultana & Qazilbash 2004), ethnographies combining a woman’s, her physicians’ and midwife’s personal and professional perspectives in this way are rare.

The social geography of health adds an additional dimension to my analysis (see Diez Roux 2004; Oakes 2003; Smith & Easterlow 2005), especially in Chapter Seven, in that it facilitates discussions of the ways “perceptions of health, illness, and the environment in various places are socially constructed...[spatially and] historically contingent” (Halvorson 2000: 207; see Halvorson 2002 and 2003). Salman Keshavjee’s examination of Ismaili health practices, child death and economic deprivation in post-Soviet Badakhshan provides an especially useful ‘critical’ precedent. By situating his “ethnographic analysis at the juncture of symbolism, historical materialism, political economy and a phenomenology of the local...[he] reveals the moral and political nature of local medicinal practices in societies undergoing social, political and economic transition” (2006: 85). Similarly, my need to understand how Gilgiti Sunni women’s reproductive practices were situated against a backdrop of conflict led me to examine “changes in local reproductive ideologies and practices in relation to daily processes of survival and continuity under deteriorating circumstances” (Chapman 2004: 254).

Part Two’s analysis of Gilgit Town’s Shia-Sunni ‘tension times’ drew me to two key works. Where Julie Peteet’s “Icons and Militants: Mother in the Danger Zone” (2002) identified the impacts of the Intifada for Palestinian notions of ‘motherhood’ and maternal sacrifice, Rhoda Kanaaneh’s “Birthing the Nation: Strategies of Palestinian Women in Israel” (2002) detailed how the frictions between Islamic

29 Also see page 43.
'traditionalism' and Israeli 'modernity' (2002: 133) were expressed through women's health practices. Because Kanaaneh's ethnography also addresses the relationship between religious militancy, civil unrest and the "fetishization of fertility" (and sons in particular) during political strife (Ibid: 65, 229-249), it affords crucial insights into Gilgiti maternal practices during the 2005 'tension times'. In a similar vein, Peteet's Palestinian research can be extended to ask how Gilgiti "women manage maternal practice [and health] in situations where conflict is endemic" (Peteet 2002: 139). And in ways that also apply to Gilgiti Sunni women's navigation of religious identity, biomedical 'modernity' versus 'traditional' practices and Family Planning, I ask how women "simultaneously incorporate...and [challenge] dominant cultural images and political policies" (Ibid: 140) through their reproductive and maternal health practices. Maintaining analytic consistency over such a broad range of topics has been complicated. My belief was, and is, that ethnographic writing and fieldnotes' "multivocality...and texture" (Rosaldo 1996: 484) helps accommodate the mass of inconsistencies and complementarities that led Martin Sokefeld to "despair of [Gilgit's] abounding contradictions" (1998: 125). In ways that uphold my choice of multi-themed ethnography to illuminate the rich complexity of Gilgiti women's experiences, Sokefeld adds: 

"I regularly had to face a differing, often contradictory account. Such contradictions not only refer to 'soft' subjects like attitudes towards others but also shared subjects like rights and meanings of indigenous terms...It is impossible to give something like a generalized account of culture in Gilgit while being true to the data. Generalization would distort the data, it would eliminate ambiguity and distortion. Thus, an 'attentive' ethnography has to remain impressionistic, like a collage or medley, including fragments and breaks." (1998: 124, 125-126)

Similarly, in explaining his use of thickly descriptive ethnography to explore the aesthetics of healing in Nepal, Robert Desjarlais notes: 

"The potential gain is to more richly describe the experiential fabric of another way of life, conveying through the magic of indirect speech ('show, don't tell') dimensions of cultural practice often neglected in ethnographic writing. Much of culture-as-practice [or, health as practice] occurs in the varied events, dialogues and habitual exchanges of daily life....this is the nonlinear complexity that scholarly writing, by its analytic nature, has such a hard time pulling together, but that storytelling, with its technology of open synthesis, can orchestrate so well." (1992: 31)
Storytelling ethnographies abound; those works which influenced my prioritization of women’s ‘stories’ ahead of theoretical exposition include Nancy Scheper-Hughes’ “Death Without Weeping” (1992), Kahn’s “Reproducing Jews” (2000), and the narrative-exclusive, “Doing Daily Battle: Interviews with Moroccan Women” (Mernissi 1988) and “Islam in Practice” (Loeffler 1988). Lastly, and with regard to Rapp’s work on amniocentesis, women’s subjectivity and sense of risk in “Testing Women, Testing the Fetus”, she describes how anthropological analysis of complex societies or “multiply-inflected cultural objects” – or, for the purposes of my thesis, practices - is frequently characterized by “a lack of clear boundaries to units of analysis” (1999: 12). In light of these arguments, ‘thickly descriptive’ ethnographic precedent, the disrupted nature of my fieldwork, and using reproduction as a central point of inquiry, led me to aim for analytic consistency across specific domains, such as Family Planning or ‘magical’ malfeasance, so as to unduly avoid interconnecting disconnected spheres, or risk obscuring their stark contrasts and ideological ruptures.

Part VII Narratives

Like Doug Henry, a medical anthropologist who researched Sierra Leone’s refugees, “my choice of narrative as a method to convey [experience] was made less by personal choice than because that [was] how people around me related themselves” (2006: 382). My use of ‘narratives’ as a form of representation is not directed by semiotics, semantic analysis or linguistic anthropology (see Wilce 1995). Instead, I approach narration “as a form of social interaction [which] ‘embodies the relationship between narrator and culture’” (Chase 1995: 2 in Gubrium & Holstein 1997: 147), and which functions as a “meaning-making process” (Gubrium & Holstein 1997: 148). Narratives “need not be full-blown stories with requisite internal structures, but may be short accounts that emerge within or across turns at ordinary conversation” (Ibid: 147). Anthropologically speaking, “patterns of narrative linkage [represent] ...‘horizons of meaning’; these are the contextual contours of the stories assembled by meaningfully linking together life experiences” (Ibid: 148). Evelyn Early’s ethnography of Egyptian women’s
therapeutic narratives (1982) provides a useful framework for understanding why Gilgit women shared their maternal health experiences with each other.

“These stories...[allowed] the women she studied to develop an interpretation of the illness in relation to local explanatory logic and the biographic context of the illness, to negotiate right action in the face of uncertainty, and to justify actions taken, thus embedding the illness and therapeutic efforts within local norms.” (Good 1994: 141-142)\(^3\)

In Gilgit, shared narratives were the primary means by which women engaged with each other over the course of everyday family and community life; soliciting women’s accounts of their reproductive and maternal health histories was anything but difficult. Over the course of nearly one hundred and thirty interviews, I encountered a broad range of Gilgit narrative styles, including those that were distinctly ‘gossipy’, which Heba El Kholy defines as “a form of communication that transmits information about customs, change, and ideas as well as opinions about ideas” (2002: 69). Shifts in political instability or interpersonal vulnerability affected how women shared their experiences. Whenever sectarian ‘tensions’ peaked or interpersonal battles climaxed, women’s narratives were imbued by a revitalized cadence and focused structure. Women and health service providers’ narratives demonstrated politicized and religiously attentive analysis of pregnancy and childbirth experiences during both conflict and peace, and showed how in situations of conflict, “as group interests change, so can the narratives that reflect them” (Gottschalk 2001: 6).

Benedicte Grima’s work on Northern Pakistani Paxto women’s “misfortune narratives and life stories” (1992: 2) helps explain the performative quality that was sometimes apparent when Gilgit women talked among each other about their health. Grima suggests that for the Northern Paxto women she researched, some of whom were Afghan refugees, their health narratives followed a traditional, performative format (gham-xadi, ‘sad-happy’; P) that became exaggerated by the tensions and traumas of war. In particular,

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\(^3\) Within medical anthropology, narratives are frequently used to explore and explain the individual, contextually-situated experience of health, illness and also risk. In describing his research on the experiences of epileptics in Turkey, Byron Good defined narratives as; “...the form of experience which is represented and recounted, in which events are described along with the experiences associated with them and the significance that lends them their sense for the persons involved. But experience always far exceeds its description or narrativization” (1994: 139).
Introduction: Insurgent Moments

Paxto women expressed their health experiences - powerfully conflated with personal and community honor, modesty and shame (paxto, P; izzat, U) - through contexts of “sadness, grief and suffering” (Ibid: 2). Because Gilgiti women’s narratives are structured as ‘kachi-mish’ ('bad-good'; S), they evidence marked similarities to Paxto gham-xadi practices. There are several other resonances between Grima’s work and my research. For example, Paxto women’s narratives illuminated disparities between men’s and women’s communication of ‘self’ and personal experience. Not unlike the Paxto, Gilgiti men and women are “socialized so differently that the major concepts and notions described by male ethnographers...are [often] only so for the male population” (Grima 1992: 2). Northern women therefore “have their own behavioral expectations, emotions, rites, self-images and public discourse” (Ibid: 2-3).

Sarah Halvorson’s doctoral thesis on Gilgiti Ismaili and Shia women appears to agree. She noted that because her women participants were often unable to “respond to how much land the family owned, nor the ages and education of their husband, [this demonstrated] how women’s and men’s life-worlds differ” (Halvorson 2000: 197), and proved that social knowledge was gender-linked (see Abu-Lughod 1993). With insights gained from several years’ worth of married life in Gilgit Town, my opinion differs slightly. By experience, I understood women knew a great deal more about community life than they initially admitted to me, or other researchers. And during the 2005 conflicts, it was quickly apparent that women actively monitored, strategized and intervened in men’s political and sectarian battles.31 But by self-narrating as unaware, disenfranchised and sidelined within their natal, spousal and affinal relationships, these calculated ‘un-knowings’ were wryly reflective of women’s dissatisfactions with their life circumstances, and the barriers enacted against their overt participation with household decision-making. Similarly, after sharing fieldwork results with my husband, and thereafter from his talks with our male neighbours, it seemed many men professed they knew (and often wanted to know) nothing of the structure,

31 Although men often reserved political debates for their visits to local chai stands, the home was the primary setting for intense discussions of family life, community politics and sectarian combativeness. Women actively monitored and often added to in-household discussions, but reserved their most heated responses for after male guests had departed.
practices and extent of women’s reproductive and maternal health or the enmities haunting women’s
domestic lives. For example, Wadood’s professed naiveté, whether intentional or not, regarding women’s
disharmonies and health practices within his own immediate family offered striking proof of men’s
deference to ‘women’s issues’.

Taking a narrative approach to women’s health experiences required that I look beyond the surface-level
concealments inherent in gender-polarized fieldwork to also address questions of ‘selfhood’, emotion and
the limits of acceptable social expression.\footnote{Anthropological treatments of ‘concealment’ in Pakistani
communities include Magnus Marsden’s recent ethnography of Chitral (2005). He confessed that his interests in
processes of ‘concealment’ stemmed from his confinement to an array of “shadowy zones between the public
and the semi-public” (2005: 22). Throughout his fieldwork, Chitrali \textit{pardah} practices denied Marsden substantive
or regular access to women-centered or ‘private’ realms. In such cases, male anthropologists face
undeniably steep socio-spatial challenges to analyzing the full scope of Muslim social life and interactions.
Because of my marriage, my work more easily explored the inter-personal connectedness, loves and
enmities ordinarily ‘concealed’ beneath surface level, everyday social realities.}

Where Paxto women’s suppression of “the inner self [is] an effort to make all behavior and expression conform to a norm” (Grima 1992: 3), it also reflects how rigid Paxto strictures concerning acceptable self-expression served to “close the gap between culture and the individual” (Ibid: 3). Whereas Paxto women’s narratives conformed heavily to a “conscious effort to control emotion itself” (Ibid: 4), Gilgiti women’s shared story-telling and narratives were often attended to specifically because of their dramatic unpredictability, which was weighted with symbolic meaning and masked deeper strategizing about the effects garnered by different modes of emotional display. As I note in a recent publication:

“Gilgiti women, unlike men, were largely unable to call direct attention to themselves and
their needs without risking criticisms that they were ‘selfish’ or harmfully destabilizing
traditional emphasis on self-sacrifice, and women’s prioritization of family and honour (\textit{izzat}) over ‘self’. Instead, Gilgiti women obliquely expressed individual need through
narratives concerning their social ‘others’. By emphasizing their contributions as mothers
or wives, their victimization by ‘enemies’, or their sufferings due to health complaints,
women indirectly sought resolution and social attention for their individual needs or
struggles.” (Varley 2008b: 154, fn 4)
Intromroduction: Insurgent Moments

Not unlike Doug Henry’s descriptions of refugee narratives, Gilgiti women used emotionally-charged pregnancy narratives to “express both trauma and their own marginality” (Henry 2006: 380). Many such narratives offered poignant examples of the ways community instability and women’s fears were expressed somatically through pain. In turn, women’s pains and the ‘ailments’ women understood them to entail differential use of biomedical, Islamic (Prophetic, Hikmat, Yunani Tibb), homeopathic and ‘traditional’ (desi davaie, U; desi bilehn, S) therapeutic systems (see Browner 1991; Khare 1996; Shaikh & Hatcher 2005; Sharma 1993).

Part VIII Unstable Entrées & Fieldwork Methods

The entirety of my fieldwork was bounded by political instability, security concerns and personal vulnerability. My husband, daughter, two sons and I returned to Gilgit at the end of July 2004 after unsuccessfully scouting for safe field sites for my doctoral research. I had planned to investigate Afghan refugees’ maternal health practices in Rawalpindi, the steamy, dusty and sewage-scented twin city to Pakistan’s capital, Islamabad. Afghan friends and aid workers had cautioned me that extremist Islamist elements - quasi-Taliban, quasi-jihadi - abounded in and around Rawalpindi’s refugee camps. Current angers with President Bush’s Iraqi offensives resulted in a profound lapse in security for foreigners. Not entirely unhappily, we abandoned my original research plan in favour of travelling north to re-visit my husband’s natal community in Northern Pakistan’s stunning Karakoram Mountains. Wadood assured me that his family’s extensive connections would permit me unprecedented access to field sites and easy entrée into Gilgit’s Sunni community. There, my early fieldwork was inspired by my health-seeking misadventures after marrying Wadood in 1998, when my access and use of Gilgit’s health services were first constrained by my Sunni in-laws, producing scenarios which were then critiqued by Shia and Ismaili friends and doctors. In light of these early experiences, I had learned that patient-physician encounters and women’s service access were capable of expressing the wider political and sectarian ‘tensions’ constraining Gilgit’s communities and could lead to verifiably negative consequences for Sunni women’s
health. Accordingly, I anticipated my research would interrogate the restrictions placed on Sunni women’s health practices and service use by Gilgit’s multi-sectarian, medical landscapes.

Our move, however, was not without its dangers. We returned to Gilgit at the tail end of 2004’s violent Nisab (Curriculum; U) Riots, when Northern Areas Shias protested the predominantly Sunni-tone of the federal education syllabus. In the early summer months of 2004, a number of Sunni businessmen, religious leaders and government employees were reported as injured or killed, and several Federal offices were burned by arsonists. Gilgit Town’s predominantly mono-sectarian neighbourhoods (mohallas; U) devolved into hostile zones for the opposing sect. Quick response by the Army, principally in the form of rotating neighbourhood-by-neighbourhood curfews and mass arrests of Shia protestors, served to quell the Nisab’s momentum. Notwithstanding the disquiets incurred by the Nisab Riots, for the latter half of 2004 Gilgit was an idyllic, happy place. In November 2004 I had begun interviewing physicians and nurses at the Aga Khan Health Service’s Khomer Chowk Clinic, and by the start of January 2005 I was observing patients’ visits to the Gilgit Medical Center, where AKHS,P had shifted their services shortly after I began my formal fieldwork. AKHS,P’s new hospital location was only a short walk from our house in Chenar Bagh, a heavily treed riverside Shia mohalla. But one week after New Year’s, things fell apart.

On January 8th 2005, after I completed morning interviews at the Gilgit Medical Center, my children and I sat warming ourselves by our bukhari (wood stove; K). Small bursts of pistol fire popped through the still, cold air. This was quickly followed by bursts of automatic gunfire loud enough to waken my sleeping infant son, and which set our hearts racing. As the gunfire and our anxieties increased, my husband arrived home from the bazaar, telling us breathlessly that Sunni gunmen had assassinated Gilgit’s primary Shia cleric, and the town was descending into sectarian war. With the Sunni-organized assassination of Zia-u’din, it was immediately apparent that Gilgit would suffer unprecedented fallout from the region’s long-standing religious, political and ethnic discontents (see Chapter One). We hastily threw some clothes into suitcases and fled to the security of an Ismaili-owned hotel on the edge of town. During a curfew break
several weeks later, we finally resolved to abandon the profound insecurities of the all-Shia Chenar Bagh and shifted to a desi-style (traditional; U) home in Jutial Mohalla.\textsuperscript{33} Security had been one of our primary concerns, but we were also drawn back by happier memories. Wadood’s formative years had been spent living beside one of Jutial’s larger Sunni mosques; his father had been its Qari (prayer leader; A) for seven years. And in the ‘tensions’ following Zia-udin’s death, Jutial Mohalla’s predominantly Sunni neighbourhood, buffered on its eastern side by a military cantonment and the Frontier Constabulary’s headquarters, offered obvious securities. Not only were the majority of our new neighbours Wadood’s relatives and close friends, but even in neighbouring Shia Khomer Mohalla, Wadood was related, he said, to many through two Shia maternal great-aunts. Even despite the ‘tensions’, it was Wadood’s Shia relatives who offered us our first and heartiest welcomes.

We moved in on a snowy winter’s day, when swaths of mist covered the nearby mountainside. Luckily, our azure-blue house had one desi room with a hearth large enough for our cooking bukhari (stove; K), and wood-beamed ceilings which kept the home warmer and drier than cement-block houses. Decorated in local style, with inexpensive brightly hued carpets, quilted floor mats and cushions against the walls of every room and framed embroideries on our white-washed walls, we subsisted through the bitterly cold winter months with the help of two bukharis, using a constant flow of local firewood (jhuke; S), and juniper (maroch; S) kindling brought from Wadood’s father’s forest properties in Diamer District. Our garden held three apple and two apricot trees, had flowerbeds full of Siberian irises and roses, and was surrounded by an eight-foot high rock wall. From our screened-in veranda, we could sit and watch sunset pinks and tangerines play across the northern glacial caps of Hunza’s Rakaposhi and Dumoni Mountains.

\textsuperscript{33} Cut across by multiple irrigation channels, crowded with single-story, whitewashed houses, family-held agricultural plots and summertime clusters of fruit trees, Jutial Mohalla was ‘middle-class’ in that most families could afford electricity, education, basic health services and occasionally a vehicle.

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Kot Mohalla’s interconnected and inter-related Sunni households provided an ideal environment for my community-based fieldwork. Prior to the 2005 conflicts, my methodological approach was inspired by Heba El Kholy’s Egyptian research, where she focused on “processes of negotiation within household units, which may take conflictual forms and may perpetrate domination and hierarchy along gender lines, or may invite resistance” (2002: 76). Household-level analysis carries its own particular hazards; Caplan and Bujra caution against ethnographically presenting “households in isolation from one another and from the broader context in which they are embedded” (Caplan & Bujra 1982 in El Kholy 2002: 76). Similarly, Hannerz draws attention to the perils of anthropology that locates itself too firmly within the matrix of sub-cultural studies, thereby “giving only minimal consideration to their embeddedness in a wider system” [1986: 365]. In response, El Kholy recommends examining the “ways in which women within different households are linked to one another through broader relations of cooperation, exchange or conflict, and on the interrelations between women’s patterns of negotiation within the household” (2002: 76).

Between November 2004 and September 2005 I researched my in-laws’ and neighbours’ pregnancy (umidwar, U; sapoie; S), childbirth and maternal health experiences. And by tracking out- and in-marriage between Kot Mohalla, Amphari Mohalla, Sakwar and Minawar (villages bordering Gilgit on its east and west sides), I solicited women’s narratives from across Gilgit’s socio-economic, ethnic and sectarian spectrum, which permitted a far greater breadth of analysis and ethnographic scope. Because my research was interspaced by periods of peace and instability, it was possible to see how pregnancies, births and deaths played out against ever-shifting social and political landscapes. In order to maintain narrative consistency, I diligently followed specific participants; these women’s deeply personal experiences reflected and interconnected multiple ‘scapes’ of identity and embattled social and sectarian spaces. But because the information I gathered was sometimes so divisive and had marital, familial and political implications, I was forced to retreat from a purely neighbourhood-level analysis of women’s
health practices. Rather than focus on particular people or households I attended instead to arenas of health and practice. In my thesis, I have also made careful efforts to avoid over-specifying women’s experiences and accounts, which risks my participants being identified by local readers.34

My formal ethnographic methods involved multi-sited participant observation, formal and informal individual and group interviews. I ultimately collected maternal health narratives from approximately fifty Sunni women (between the ages of fifteen and fifty), with special attention paid to women who were or had been pregnant in 2004 and 2005. At all stages of my fieldwork, arranging for women’s participation was not difficult. I was a known quantity and linked with many through my marriage. Because many of my women neighbours had grown up alongside Wadood, they routinely called me Bhabhi (elder brother’s wife; U). Inextricably embedded and unavoidably obligated by my position as an in-law to Wadood’s extended family (many of whom were among our neighbours), I enjoyed far greater everyday access to my participants than many Gilgit-based anthropologists and social geographers.35 Although my daily fieldwork focused nearly exclusively on women, my ability to speak with local women, and the support I received to conduct on-site interviews at all of Gilgit’s major hospitals necessarily required the cooperation of husbands, fathers, and male hospital administrators. Beyond identifying specific topics or spaces for research, I did not use a standardized questionnaire or other survey methods. By being open in this way, and responsive to my participants and local events, I learned of a multitude of issues which would have been, I suspect, far less accessible to me otherwise. And because pregnancy and childbirth is

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34 Post-January 8th’s sectarian conflicts heralded perceptible increases in federal surveillance of the region and its peoples, to which I was not exempt. Monitoring by the ISI (Inter-Services Intelligence), Pakistan’s equivalent of the CIA), also involved the tacit, paid co-operation of Gilgitis themselves. Gilgit ‘informants’ were said to have aided the ISI by providing detailed accounts of the politics and everyday activities of their sectarian ‘others.’ At least two participants boasted about spying on other Gilgitis for the ISI, and then warned me that I was likely watched. Months later, after several ambiguous and strangely unsettling meetings about my pending Pakistani citizenship with the FIA (Federal Investigation Agency), I was told my application had been denied.

35 Nancy Cook’s 2006 ethnography of Western women aid workers living in Gilgit confirms that because most of her participants worked in male-dominated offices, they only “rarely encounter[ed] the roughly 40 percent of the local population who are not men” (232).

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wrought up by women’s beliefs, expectations, hopes and fears and bound up in specific periods of time, an individually-attentive, narrative approach was particularly effective.

While my research was initially focused on my participants’ use of biomedical health services or pharmaceuticals, it soon shifted to analyze the impacts of sectarian affiliation for service use and health practices. The chaotic early days after Zia-u’din’s assassination reinforced my long-held belief that community contexts as well as clinic locations were deeply affected by sectarianism. And, besides shaping women’s health service access or patient-physician encounters, sectarian identity was also bound up with women’s traditional (desi) and Islamic health practices and beliefs. As a result, my research focus expanded again to include Islamic health ‘purveyors’, including mullahs, ‘magicians’ (jadugar; U) and spirit diviners. Whether directly solicited by myself or Wadood, secondary participants therefore included approximately thirty health service providers, homeopathic doctors, Islamic medicine (Hikmat, Yunani Tibb; U) practitioners and traditional herbalists (desi davaie, U; desi bilehn; S), approximately 10 governmental and non-governmental health service proponents and policy developers, and five members of Gilgit’s Sunni clergy. At institutional levels, fieldwork was conducted at Gilgit Town’s three hospitals (District Headquarter Hospital [DHQ], Gilgit Medical Center [AKHS,P], Family Health Hospital [FPAP]), private maternity clinics, and governmental and non-governmental reproductive health centers (Family Planning Organization [FPO], Family Planning Association of Pakistan [FPAP]).

For the most part, fieldwork interviews were informal, participant-directed and thematically crosscut the socio-cultural, religious and political variables underlying Gilgiti Sunni women's health practices and beliefs. I spoke with women at their homes and interviewed physicians, health support workers and traditional practitioners at either their place of work or their home during off-duty hours. Due to low levels of female literacy, especially in the nearby villages of Minawar and Sakwar, my research assistant

36 For these interviews, Wadood worked as my research assistant and translator.
Fazeelat translated and read aloud my ‘research information’ (see Appendix, page 498) and ‘informed consent’ forms.37 While women who were literate agreed to sign and keep copies of these documents, most were reluctant to have paper records of their ‘official’ time with me lest it arouse suspicion among their in-laws or husbands, even though they had already received permission from their husbands and families to participate. By the same token, women generally refused to be tape-recorded. During fieldwork interviews, women shifted frequently between Shina and Urdu. For in-town and village-based participants, Shina is used for the majority of everyday conversations while Urdu is typically restricted to business, legal, governmental or educational activities. Urdu also functions as a ‘lingua franca’ when neighbours or colleagues speak one of the Northern Areas’ innumerable other languages such as Burushaski, Uigyr or Khowar. For participants who had been formally schooled or who were interviewed at their place of work (including health service personnel, hospital administrators, policy analysts), Urdu was the language most frequently used during interviews. Because I am conversationally fluent in Urdu, I actively participated in a number of these discussions and sometimes conducted interviews by myself. (A number of physicians, however, preferred to speak English with me.) No interviews were tape-recorded; instead, I made carefully detailed notes which were reworked into typed narratives immediately after each session concluded.

At Gilgit’s dispensaries, clinics and hospitals, permission to conduct on-site participant observation and interviews was obtained in all instances by first securing the verbal permission of clinic or hospital administrators, and then by approaching individual physicians, nurses or support staff, all of whom received research information and consent forms. When participant-observation included attending births, I was first introduced to both the patient and her family by hospital staff and then secured

37 Due to the ‘tensions’, recruiting assistants and translators was especially difficult. Many women were unable to partake in formal employment, due to low literacy levels or male antipathies towards their work in the public sphere. After several months, an acquaintance from my first year living in Gilgit in 1998, Fazeelat, agreed to work with me. Fazeelat spoke beautiful English, had a fondness (like me) for joking and gossip, and became one of my dearest friends and supportive allies.
permission to write fieldnotes once the delivery was completed. Interviews were supplemented by
textual analysis of private, governmental and non-governmental clinical records, policy documents and
media documentation. Although Gilgit’s ‘tensions’ ended in spring 2006, the majority of research
participants remain uncertain of the implications of public recognition. Throughout all written materials,
I have designated my participants by pseudonyms and generalized job titles. The only exceptions were
when individuals gave me permission to use detailed descriptions of their employment duties. For
participants who were more deeply concerned about being recognized in thesis writings, I have provided
pseudonyms, false mohalla locators and interview dates, and misleading descriptions of them, their
work or family life.38

From the outset of each interview and participant-observation session, I made it clear remuneration was
neither available nor would it be offered. Some women came to me in the mistaken assumption that I was
a ‘lady doctor’ and could remedy their reproductive complaints or infertility, but most arrived well
informed about my research and were delighted by my explicitly Sunni focus. (Many women, in fact,
said that they would never have participated in a mixed Sunni-Shia study. Despite their deep curiosities
about Shias, they didn’t want to risk my sharing their stories with ‘their others.’) During tensions,
others felt I could arrange police assistance for patient transport. The majority, however, soon understood I was
largely powerless. Instead, they were openly hopeful that my thesis might counter the government’s
inattention to their health and education requirements. Moreover, all the health service providers and
organizational employees I spoke with about the ‘tension times’ were on-the-record about their feelings
and experiences.

38 My in-text citation of interviews follows a particular format; e.g. (Shaista, Jutial: June 2, 2008). I first provide the
name or job title of the speaker, then the location where the interview took place. For health service providers, this
was typically the hospital or organization where they worked and I met with them. For women, interviews
predominantly took place in the mohallas where they lived. Lastly, I have provided the date of the interview. My
fieldnotes are only specified by date and do not include the location.
During the 2005 conflicts, I had to work more carefully to ensure my research assistant’s and also my own security. When fighting occurred, interviews often took place in my own home rather than risk our safety as we travelled through high risk mohallas, or, more specifically, when I visited hospitals or clinics in Shia mohallas. Whenever the ‘tensions’ abated, Fazeelat and I returned again to interviewing women in their flat-roofed ‘traditional’ homes (desi ghot; S), where news of our arrival sometimes led to crowds of spectators, who disappeared once my participants ‘shooed’ them away. I have only the happiest memories of these hearthside interviews, which offered a welcome reprieve from the poor hygiene of Gilgit’s public sector health services. With the acrid smell of old fires hanging heavy in the darkened family rooms that form the heart of traditional homes, women preferred to share their stories over chai (tea; U), sitting beside a sunken cooking hearth (bathogaree, angeti kich, trzhamool; S) which was then surrounded by one or two raised tiers (thalee; S) for seating or sleeping. The family room’s most distinctive feature was its ceiling, carefully overlaid by a heavily painted, nearly shellacked crisscrossing of cut timbers, leaving a two foot by two foot octagonal or diamond-shaped opening (sohmoh, dumaye asohmoh; S), producing an effect architects call ‘cribbage’ (see Figure 1). When the noonday sun shone on the earthen-roof, the hearth was brightly lit by a solid shaft of sunshine as it streamed down from the smoke-hole above us, beaming through sifting motes of dust to illuminate the rosy-cheeked faces of my family, friends and neighbours.

Throughout my research, my experiences of in-field inter-subjectivity, which Marcia Weskott defines as when “the researcher compares her work with her own experiences as a woman and a scientist, and shares the resulting reflections with the researched” (Weskott in Hale 1991: 125), were not as much a
natural byproduct of my local connections as they were demanded of me by my deeply curious participants, family and friends. Because our ‘mixed’ marriage was decidedly uncommon and unusual, we drew considerable attention from all our neighbours, whether Sunni, Shia or Ismaili. In Wadood’s teenage years, Gilgit’s in-town mohallas had been far more mixed, although there had always been distinctive pockets of sectarian affiliation. From the Ismaili and Shia visitors who regularly came to see us whenever the ‘tensions’ had diminished (much to the dismay of my most militantly Sunni in-laws), it was obvious Wadood was still popular among his former neighbours. I also enjoyed close friendships with former colleagues from AKRSP, including members of the regional Jamaat Khana’s (Ismaili mosque) Executive Council. And after meeting us during a NATCO bus trip to Islamabad in early winter 2004, Mian Jaan, an Ismaili friend from the nearby village of Oshikandass, always brought us the latest political news, offered advice on how we could best defend ourselves amid rising ‘tensions’ and provided light comic relief by mimicking the eccentricities and predilections specific to each sectarian community and its members.

Yet our local friendships, Wadood’s family connections with many of our Shia neighbours and our ability to laughingly engage with sectarian stereotypes or bigotries helped complicate my understanding of Gilgit sectarianism. Without these connections and their related insights, I would have too easily bought into people’s more political assertions that Shias, Sunnis and Ismailis were “completely polarized” (Fieldnotes: March 9, 2005). Women’s everyday use of Ismaili-operated clinics or their treatment by Ismaili and Shia physicians, midwives and herbalists – even in the midst of open conflict – confirmed that Gilgiti life was far more complicated than that.

39 In 1998, I had worked as an Intern for AKRSP’s Monitoring and Evaluation Research unit (Gilgit Headquarters). Between June and September I conducted twelve-weeks of fieldwork in Ismaili, Shia and Sunni communities in Ghizer and Gilgit Districts. My research concerned AKRSP Women’s Organizations (WO) and the impacts of membership and income generation for women’s household decision-making (see Varley 1998).

Emma Varley
Part One: Everyday Struggles
Chapter One: Life & Health Between the Nisab Riots & Zia-u’din’s Assassination

Part I  Introduction: Sectarian Starts

My awakening to Gilgit’s conflict-hued undercurrents caught me off-guard and left me surprised at my inability to tune into the stresses that so obviously suffused my neighbours’ and in-laws’ everyday life. It was mid-October and the summertime warmth and greenery was giving way to morning chills, the smoky odour of evening fires and burnt umber, autumn foliage. We had returned to Gilgit three months earlier and I had not yet launched into fieldwork. We had sub-let our house and surrounding fields from a Sunni Pakhtun family two months earlier, and were still readjusting to local family life after an absence of five years. On one crisp sunshine-filled afternoon, I was raking up leaves from the thick carpet of grass in our front garden. The children were riding their tricycles round and round the carport nearby and the vast blue expanse of the sky above me, framed on its horizon by jagged mountain peaks, was unmarked by even a single wisp of cloud. I looked up from where I worked to see our neighbour, a middle-aged Shia farmer, standing by the front gate, holding a billy goat by a rope lead. He had been stacking bales of hay in the covered barn opposite our front gate all morning, and was now taking the goat down to graze in our property’s lower fields. He was slightly gruff and only made occasional light conversation with Wadood, and even more rarely with me. Seeing him now, obviously wanting to talk to me, was unusual. I put down the rake and walked over quickly and greeted him.

“A’Salamat Aleikum, Mol,” I said, addressing him as ‘Uncle’ in Shina.

“Waleikum A’Salam, Bhabhi,” he answered with a nod of his head. Knowing I couldn’t speak Shina, he began a quick conversation in Urdu that left me feeling slightly staggered. “You know,” he began, “we’ve had problems in this mohalla over the past few months. In case anything happens again or there are any more problems, I want you just to stay inside the house and lock these gates.¹ Turn off the lights and make it look as though there is no one inside.” Because I had only heard that there had been light political ‘issues’ between Shias and Sunnis in the previous months, his warning raised a snaking, cold fear

¹ Mohalla in Urdu can mean either ‘neighborhood’ or ‘locality.’ The term conjures not only a sense of physical locality but also of social communities.
through my gut. I realized Wadood, in his perpetually frustrating efforts to protect me from worrying, had neglected to tell me the whole story of the recent Nisab (Curriculum; U) protests, which had led to a week of Army-enforced curfews in the summertime months, and had only ended a few weeks prior to our return in early August. Angered at the Sunni tone of the Federal education syllabus (nisab), Gilgit Shias had been agitating for over a year to see course textbooks expanded to include Shia perspectives on prayer, faith and ritual practice. My early misgivings at moving into a Shia-dominated mohalla had been alleviated by flippant descriptions of students marching, of banners raised and, slightly more ominously, occasional calls for Shia independence from the State of Pakistan. I had been told there was no more than this.

“What do you mean, Mol? What could go wrong?” I asked, trying to glean more information from him.

“During the summer, they set fire to that government building over there,” he said, pointing to a small guest-house over the property wall which still had scorch marks on its whitewashed walls. When we had first moved in, I had been told the fire had just been a juvenile prank gone wrong. “The rioters came to this house afterwards and wanted to set fire to it, too. I stopped them, you see, because I am a Shia and they believed in me. I protected the woman inside and her children and they went away. If they do the same again, I will protect you too. Just tell your husband to be very careful. I may not be able to help him if they find him during such ‘tension times.’” (‘Tension times’ was the suitably vague moniker Gilgitis applied to any time of increased sectarian hostility or open conflict.²)

“But there must be other Sunni families around us, and we’re not in that much danger, Mol,” I answered.

“No, you’re the only Sunni family in Chenar Bagh Mohalla,” he answered with a wry smile. “So khabardar [be careful; U], and remember I am here to take care of you, too. You people are my izzat [honour; U] as well.” His clarification of our vulnerability and our aloneness stunned me and threw my memory back to one night a week after we had moved in. After dinner one evening, as we began settling the children

² Because Gilgitis differentiated between the ‘tension times’ as conflict versus tension as an everyday emotional state, I distinguish the ‘tension times’ related to Shia-Sunni hostilities through the use of single quotation marks.
Chapter One: Life & Health Between the Nisab Riots & Zia-u’din’s Assassination

down to sleep, Wadood’s younger brother Haleem and a tall, lumbering, heavy-browed cousin had arrived with weapons from Diamer, the tribal-dominated, mountainous district to the south of Gilgit District, whose peoples were scathingly described by Gilgiti Sunnis as ‘primitive’ and ‘regressive.’ He had told me to close all the curtains on the windows facing the homes surrounding ours, and then settled down for a night of chai (tea; U), rambling political diatribes and occasional cigarettes with Wadood, who was keeping them company. Angered that our quiet evening had been disturbed, I had asked Wadood what precipitated their armed arrival.

“Oh, it’s nothing,” he reassured me. “My father heard there were ‘tensions’ tonight, and he didn’t want us to be alone.” I asked him to explain what he meant. “There were talks in town that the Shias were going to strike at someone, or they were upset still about the Nisab, and Abu [father; A] didn’t want us to be alone. So he asked Haleem to come stay with us for a few days.” I was still confused because even though I had thought we were living amid a Sunni minority in this predominantly Shia riverside mohalla, I knew that Wadood’s parents’ home in the village of Sakwar was one of a cluster of Sunni households which were in turn banked by a hillside of Shia homes. Surely, they were equally vulnerable and needed Haleem’s attentions. “Emma, it’s not important, and I promise they’re just being nervous. I can take care of us,” Wadood retorted, obviously trying to allay my nervousness. Knowing that all we had for protection was an antiquated Lee-Enfield rifle standing in a locked cupboard in our bedroom, I wasn’t easily calmed. But the more I pestered, the less Wadood would say, so I let it rest, hoping the story would unfold naturally over the next few days. But as was the case with many of Gilgit’s sectarian frictions, when the initial ‘tensions’ receded people preferred to leave their fears behind them. Therefore, it was another two months before we faced the harsh consequences of our initially happy but profoundly misguided decision to live amid Chenar Bagh’s towering chenar (maple; U) and walnut trees, within earshot of the rushing, roaring, glacier-fed Gilgit River.
Chapter One: Life & Health Between the Nisab Riots & Zia-u’din’s Assassination

Part II Sectarianism, Strategizing & Politicking

The summertime Nisab Riots and the tension-filled months that followed not only foreshadowed the conflicts to come, they also foregrounded many of the community-wide factors affecting Sunni women’s health and service access. Because subsequent chapters address Sunni women’s health practices through the medium of sectarian identity, it is worth clarifying the nature of religious politicization, the Shia-Sunni hostilities which preceded the 2005 conflicts and the impacts of competitive Sunni and Shia conservatism for Sunni women’s access and use of clinical health services. Specifically, the first half of this chapter examines the fractious state of Northern Areas politics and Shia, Sunni and Ismaili community relations when I began my fieldwork in 2004. The chapter’s second half analyses the relationship between Islamic conservatism, gender segregation and Sunni women’s social mobility. In particular, I examine the impacts of the Tablighi Jamaat and Wahabbist-aligned missionization movements for Gilgiti Sunni gender practices and women’s use of clinical biomedicine. In order to better understand the domestic context for women’s health, I then examine Gilgiti Sunni women’s experience of married life, home-based economies, health-related decision-making and service access. The chapter concludes with a discussion of the problematic ways Sunnis and their health status were viewed by Gilgiti Ismailis and Shias.

Understanding the sectarian ‘tensions’ that dominated my fieldwork and which, during the 2005 conflicts, interfered with my participants’ access to local clinics, requires a quick revisit of the Northern Areas’ post-Partition history. In some respects, the genesis of Gilgit’s recent regional ‘tensions’ may be traced to 1947 when Pakistan’s Partition from India was being bloodily executed. For over a year after Partition and the formation of the State of Pakistan, Gilgit and the larger Kashmiri territories remained an undecided zone. The Sikh Maharaja of Kashmir had taken a year following the 1947 Partition to decide on his long-term national allegiances. After he chose India as the recipient of his Kashmir territories, the largely Muslim populations of the present-day Northern Areas revolted. Led by the Gilgit Scouts, local Shia, Sunni and Ismaili communities successfully repulsed the Maharaja’s Kashmiri forces to assert their independence, and sent delegations to Karachi to announce their desire to be incorporated by the State.
Pakistan, however, was an initially unwilling beneficiary of these tribal, ethnically disparate and geographically unwieldy areas (see Baloch 2004: 136-155).³

It was only after several years of active lobbying by Gilgit’s interim governments that Pakistan agreed to extend protectorate status to the Northern Areas, known locally as the Shmailee Alakah (U). This, however, came with a caveat. Until the larger issues of Kashmir and the disputed Pakistan-Indian border were resolved, Pakistan would neither accord the Northern Areas official provincial status, grant its residents voting rights nor allow local representation at Federal levels. The result has been that since the Northern Areas’ 1949 Independence, the anniversary of which is half-heartedly celebrated every November 1ˢᵗ, the region has languished due to insufficient Federal administration, weakly-helmed local governance and a corrupt judiciary. Without consistent federal funding, Northern Areas residents have also gone without adequate education or health service coverage. Despite active lobbying by pro-State Northern Areas organizations, the Pakistani government’s distinctively colonial management of the Northern Areas peoples and resources persists to this day, while the Northern Areas Legislative Assembly remains a politically ineffective showpiece. In the words of Northern Areas researcher Martin Sokefeld, Pakistan’s perennial disinterest in advancing full citizenship to Northern Areas residents can be neatly characterized as “postcolonial colonialism” (2005: 939).

Until relatively recently, sectarian commensality among Gilgit Town residents had been commonplace. In Wadood’s family, for instance, intermarriage between Sunnis, Shias and Ismailis was a regular occurrence. But by the mid-1970’s, local Sunni and Shia communities had begun to militarize and acquire weapons and ammunition caches; “from 1975 onward, weapons were used in [sectarian] encounters, which regularly resulted in losses of life” (Sokefeld 1999: 420). In many respects, sectarian discord and militarization were inadvertently tied to the 1975 completion of the Karakoram Highway (KKH) which

³ Gilgiti Sunnis are not an ethnically homogenous group. In addition to Gilgiti, Diameri, Kohistani, Kashmiri and more rarely Pathan, Hunzakut, Nagari, Balti, Chitralti, Kashgari and Uighyr descent, Sunnis are also defined according to caste and qom (clan; S) variations. See Sokefeld 1998 and 1999.
first linked Northern Areas communities to a year-round food supply and trade routings within Pakistan. The KKH also provided Pakistan’s sole land routing to its largest trading partner, China, with Gilgit Town being Pakistan’s primary processing depot for goods from China. Moreover, the KKH presented immensely profitable opportunities for Gilgitis to export their vast timber resources ‘down-country’ to the cities of Islamabad, Rawalpindi and Lahore. From the mid-1970’s onwards, Gilgitis rapidly gained access to expanding food and silk economies, while Gilgit Town and its surrounding villages were quickly, albeit inefficiently and only intermittently, electrified. Because the KKH alternately bypasses Ismaili, Shia and Sunni dominated Sub-Districts, economic and logistical co-operation between Gilgit’s Shia, Sunni and Ismaili communities was an essential component of the region’s development.

But intensive competition between each group concerning the economic and trade sectors they controlled soon led to protracted disputes over land-ownership, access to resources, and market and retail enterprise not only within Gilgit Town but also between outlying Shia, Sunni and Ismaili communities (see Sokefeld 1998). By forming monopolies over mountain portering, transport trucking and retail sales, traders from Shia and Sunni Sub-Districts worked to surreptitiously bypass federal taxation and duty-collection. Smuggling rackets moved vast quantities of silk, electronics and a largely unmonitored proliferation of Chinese-made Kalashnikovs and heroin between China and Pakistan’s major cities. Ultimately, the profitable merging of Shia, Sunni and Ismaili economic interests was not reason enough to allay Sunnis’ and Shias’ fractious, religious differences. Principally because of the power vacuums created by federal inattention and an ineffective judiciary, Ismaili, Shia and Sunni communities increasingly relied on local

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4 Because of the rapid influx of inexpensive and ‘modern’ consumer items and foodstuffs, traditional Gilgitī trade networks of salt (pajurī; S), timber, silk, semi-precious gemstones, fruits, spices and mountain herbs are giving way to the stock electronics, fabrics, and grocery products of Chinese trade, Punjabi industry and ‘down-country’ farming.

5 In villages surrounding Gilgit Town, electricity only arrived in the last ten to fifteen years. Telephone ‘land lines’ are still relatively uncommon and very expensive. The cellular phone industry is now accessible and affordable for the majority of residents.

6 Import duties and customs are managed at Soust, Pakistan’s northernmost dry port, a 3-hour drive north of Gilgit on the KKH. Shias enjoy control over most trade in the Shia-dominated districts between the China-Pakistan border and Gilgit Town, while Sunnis handle the Sunni districts lying between Gilgit Town and Islamabad, a 19-hour drive to the south.
structures of governance, such as mosque- and community-based parochial schools, competing systems of Shia or Sunni Islamic jurisprudence (fiqh; A) and community-based tribal ‘courts’ called jirgas. In turn, these schisms fuelled highly structured, politicized movements for reform, economic development and also sectarian segregation.

In the 1970’s, Shia and Sunni politicization had gained substantial momentum from the 1979 Iranian Revolution’s dramatic revitalization of Shia religio-political ambitions within Central Asia, and General Zia Ul-Haq’s pro-nationalist, anti-Indian and vehemently anti-Shia Islamization schemes. Zia had tailored a wide array of legislative edicts to support the comprehensive integration of the Sunni Sharia (Islamic law) with Pakistan’s legal system. More than this, Zia funneled State funds and diverted the Army’s energies to providing tacit, logistical support for national Islamist organizations such as the conservative Jamaat Ulema Islam (JUI), as well as anti-Shia militancy networks. Zia’s most obvious legacy, however, resides in the hundreds of thousands of private, unregulated and often Saudi-funded madrassahs that continue to provide the lion’s share of free education for impoverished communities across Pakistan (see Evans 2006). Besides serving as symbolic reminders of the presence and political ambitions of Gilgiti Sunnis, they also offered a tacit counterbalance to the ascendance of Shia politicization and militant extremism.7

Prior to the firefights and targeted killings of 2005, sectarian animosities had culminated most dramatically in the 1988 massacre of several hundred Shias in the neighbouring villages of Jalalabad and Danyor by a lashkar (religious militia; U) of combined Gilgiti, Diamer District and Kohistani Sunni militants, presumably in response to the targeted assassination of a prominent Sunni cleric (Dani 2001:

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7 In the same way that Iran and the ISO seized on the Northern Areas’ instability and sectarian frictions, Saudi-funded benevolence organizations used the region’s vulnerabilities as a pretext to establish Islamic madrassahs in Sunni-dominated districts, Sub-Districts, villages and Gilgit Town mohallas. Not only did these madrassahs relieve Sunni dependence on the region’s generally weak and ineffective federal school system, but these privately-funded schools allowed Sunni residents to more directly interweave Sunni edicts (fatawas; A) with everyday life. And because they were low- or no-cost, they alleviated many of the financial woes of poorer families. Indeed, Sunni madrassahs were more common in the impoverished, conservative Sunni villages surrounding Gilgit Town. Notable among these madrassahs were the Iqra'atulla Schools (Fieldnotes: July 24, 2005).
In the years after the 1988 killings, “Gilgiti community histories and memory, and ethnic, religious and gendered identities were strategically reconfigured. Some shifts to Northern Areas traditions were authentic, while others smacked of deliberate, ‘ethnocidal’ innovation – with community history and identity revised to accommodate transnational and political interests” (Varley 2008a: 58). Following the 1988 killings, the Shia community also began to actively militarize. Over the next two decades, there were massive armaments purchases, and the alleged establishment of covert weapons training camps for Shia men and women in isolated villages throughout Nagar Sub-District, an hour’s drive north of Gilgit Town.8 Motivated by the traumas of the ‘88 massacres and driven to remedy their economic and political vulnerabilities, from the late 1980’s, Gilgiti Shias made concerted efforts to not only establish themselves as Pakistan’s pre-eminent and most politically active Shia community, but to diversify and strengthen their religious and political connections to Iran. Characterizing this process was a dramatic increase in cultural and study-trips by Gilgiti Shia students to Iran’s secular universities and religious seminaries, and an overall ‘Iran-ification’ of local fashion and even cuisine.9

Augmenting Gilgiti Shias’ ties to Central Asian and Middle Eastern Shia governments were Iranian-subsidized pilgrimages to the holy cities of Karbala in Iraq or Isfahan and Qom in Iran. These efforts coincided with pro-Hezbollah funding drives and local protests in support of Iraqi Shias during Saddam Hussein’s regime. After 1988, there were periodic bouts of violent sectarian ‘tension’, which were inexorably connected to annual cycles of Islamic ritual devotion, with Iranian proselytizing actively encouraging the dramatic revitalization of Shia religious practices, social values and gender behaviours. Sunni antipathies with Gilgiti Shias often climaxed during the violently expressive Shia mourning festival of Ashura when shirtless men and teenage boys paraded through Gilgit’s main streets, self-flagellating with zahnzeer (small knives swung on hand-held chains; F, U) and rhythmically beating at their chests

8 Economically disadvantaged and predominantly rural Nagar Sub-District, with a majority Shia population, sits between mixed-sect Gilgit Town and the predominantly Ismaili Hunza (also known as Gojal) Sub-District.
9 Changes in apparel are most obvious among the younger generation, with men adopting Western dress clothes or dress jackets over their shalwar kameez (pant shirt; U). More observant Shias cut their beards close to the jaw-line, unlike Sunnis who typically wore their beards longer, or Ismailis who were clean shaven.
until their knuckles, backs and breastbones were raw and bloody. Many Shias, on the other hand, were openly concerned about some Gilgiti Sunnis’ increasingly Wahabbist tendencies towards emotional and spiritual austerity and their overall disregard for the Caliphate of Ali, the Prophet’s son-in-law and spiritual progenitor of Shia-Islam.

In recent years, particularly with the improvement of Pakistan-U.S. relations, Federal officials and Sunni religious organizations sought to minimize Shias’ political power in the Northern Areas. Government officials were specifically attentive to the growing powers held by one of Gilgit’s most charismatic, popular and politically problematic religious leaders, Syed Agha Zia-u’din Rizvi, spiritual leader for Northern Areas Shias, including Shia-dominated Baltistan which borders the Pakistan-India ceasefire line. Ideologically fuelled by the Iranian Revolution, Zia-u’din, it was said, harboured aggressive plans for self-governance and the establishment of a Shia state within the Northern Areas’ present borders. In response to Zia-u’din’s increasingly vocal calls for autonomy, there were concerted and covert efforts by the Federal government to undermine Gilgiti Shias’ in-country support by exacerbating internal rivalries between Zia-u’din and Syed Allama Naqvi, religious leader of Pakistani Shias. Their national rivalries drew strength from pre-existing tensions between Pakistan’s ethnically disparate Shia communities, with Zia-u’din’s Gilgiti and Naqvi’s Punjabi and Sindhi supporters occasionally squaring off in violent skirmishes in Karachi and Lahore. Immediately before Zia-u-din’s assassination, there were intense discussions among Gilgiti Shias about how to secure Zia-u’din’s long-term position as Pakistan’s foremost Shia envoy to Iran, a role zealously held by Naqvi. Zia-u’din’s ascension to nation-wide power came unexpectedly. In October 2003, Naqvi was arrested and imprisoned on charges of having been involved in plotting the assassination of Maulana Azam Tarik, leader of the anti-Shia Sipah-e-Sahabah organization.

With Naqvi in jail, Zia-u’din took over Naqvi’s position as Iranian envoy, which reportedly incurred the anger of Naqvi’s supporters across the Punjab, in Peshawar and Karachi. When combined with his position as Gilgiti leader of the officially banned, albeit highly active Imamia Students Organization (ISO), Zia-u’din
was able to significantly advance financial and political ties between Gilgiti and Iranian Shias. Iran, meanwhile, made no secret of its support for the establishment of a Shia state in the Northern Areas. In order to achieve this goal, Zia-u’din and his supporters used funds collected from across the Northern Areas, Pakistan and Iran to openly advance local weaponization and cultivate their economic and political strengths. Many of their efforts were described as preliminary steps towards separation and state-hood. Zia-u’din was also vocal in his discussions of the enormous financial commitments his nationalist endeavors required from interested outside parties such as Iran.

In the two years before our 2004 return, inspired by the triumphs of Iraqi Shias as they gained political dominance over their Sunni Baath party oppressors, Gilgiti Shias worked harder and more militantly to promote their regional ambitions. Zia-u’din’s intensified push for statehood and the integration of Shia beliefs into the Federal education syllabi, or nisab (U, A), were proclaimed in impromptu rallies and radio addresses, and were covered by Imambarag (Shia mosque) news releases and Gilgit’s Shia-owned newspapers. Many of my Sunni participants argued that before the 2005 conflicts, Gilgiti Shias’ political ambitions had surfaced in the most spectacular and alarming way with the summer 2004 Nisab Riots. Ostensibly out of a concern with the predominantly Sunni tone of Pakistan’s Federal education syllabus, or Nisab, Shia protestors overran and set afire Gilgit’s main Police Department and training facility, after first robbing it of ammunition and hundreds of weapons. In addition to the targeted killings of Sunni officials and residents, Shia rioters burned and looted a number of government offices, along with dozens of government vehicles. Army curfews and mass arrests quickly followed, but the delayed prosecution and long-term imprisonment of hundreds of Shia detainees only served to further estrange Gilgit’s Shia and Sunni communities (Khan, Dawn: January 14, 2005). The sum effect of the Riots was that Shias

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10 *Imambarag* can also be spelled as *Imambargah*. In my thesis, I adhere to the spelling and pronunciation used by Gilgitis.

11 During a visit to the District Headquarter Hospital’s Officer’s Ward in late August 2004, I observed Shia prisoners, accompanied by their family and guarded by police, being treated separately from other patients. Even up until we left Gilgit in September 2005, there were still several hundred Shia prisoners held in Gilgit Town *thanas* (jails; U), including one specifically built to house Nisab detainees in Jutial Mohalla.
characterized Gilgiti Sunnis as being inextricably bound up with an anti-Shia, government agenda.

Sunnis, meanwhile, began to describe Shia activism and militancy as a violent obstacle to their own calls for economic and political development. In direct response to the growing economic and political clout of Northern Areas Shias, and by drawing on their alliances with Sunni political parties across Pakistan for leverage (including the Jamaat Ulema Islam [JUI], led by Maulana Fazlur-ur-Rehman and the Muslim League [ML], led locally by the Hafiz-ur-Rehman), Gilgit’s Sunni community worked assiduously to develop their political strengths.12

Throughout the summer of 2004 which was marred by targeted killings and violent protests, Gilgit’s overtly pacifist Ismailis attempted to defuse Sunni-Shia ‘tensions’ by organizing and manning ‘Peace Conferences’ at which they and official representatives of the Aga Khan, spiritual leader to the world’s Ismaili-Muslims, would broker interim ceasefires and religious sensitization programmes between Gilgit’s Shia and Sunni community leaders.13 The 2004 Nisab crisis was eventually defused through a three-stage memorandum in which it was promised that in areas dominated by one sect, “nothing against the faith of the local people shall be taught”; moreover, for government or private schools where students came from both Shia and Sunni communities, teachers were expected to “explain the viewpoint of both the sects” (Dawn: June 6, 2004).

Finally, it was anticipated that materials deemed controversial by the Anjuman-e-Imamia - the Central

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12 Hafiz-ur-Rehman was the younger brother of the immensely popular Saif-ur-Rehman, a Sunni politician who had been murdered two years before by one of his cousins. Saif-ur-Rehman had been a vocal critic of Shia and Sunni weaponization, and at the time of his death he had been trying to ‘secularize’ local government.

13 During my 2004 and 2005 research, these leaders were the Shia Khateeb Syed Agha Zia-u’din, his successor Syed Agha Rahat’ul Hussaini, and the Sunni Imam Qazi Nisar.
Executive for Gilgit’s Shia *ulema* (clergy; A) - would be removed from school exams or testing materials (Dawn: June 6, 2004). However, despite concerted efforts at inter-faith reconciliation and the Federal Government’s promised accommodation of Shia religious beliefs in future educational syllabi, the Shia community’s unresolved frustrations with the *Nisab* resurfaced throughout 2005 and were deeply entangled with reactions to Zia-u’din’s death.

By the time the Army and Gilgit’s police forces had quelled the worst of the 2004 *Nisab* Riots, it was clear that the Northern Areas government seemed incapable of gaining any real foothold against rising sectarian ‘tensions.’ At their core, the *Nisab* Riots demonstrated the Shia community’s tactical preparedness and wholehearted commitment to Shia independence. In many ways, the *Nisab* suggested there would be no return, at least from the Shia perspective, to the commensality and cooperation that had once characterized Gilgiti Shia-Sunni relations. More than this, the *Nisab* confirmed the Sunni community’s worst fears in that the ISO had efficiently recruited, trained and outfitted Shia men from across Gilgit District and neighbouring Nagar District. In the midst of Iranian funding and the post-Gulf War reclamation of political power by Iraqi Shias, the Pakistan-wide Shia *Imamia* Students Organization (ISO) had become the most popular and well-funded arm of Shia militancy. However, its logistical and political strengths have been extremely problematic for the Sunni dominated Federal government, which found itself shadow-boxing with Iran through the medium of community organizations and *Imambaragh* (Shia mosque; see Figure 2) politicking.

Established in 1972 in Lahore, the ISO had worked hard to develop and maintain interlinkages between Gilgiti Shias and minority Shia communities throughout Pakistan, and claimed its membership from a growing cadre of young, unemployed or underemployed Shia students. Among nineteen, nation-wide ‘divisions’, the Gilgit Chapter is widely characterized as the being among the most vociferous, militant and violent components of the ISO network (Fieldnotes: April 3, 2005).14 Nurtured, perhaps, by the

14 See the Gilgit ISO Chapter website for more information: [http://www.isogilgit.up.to/](http://www.isogilgit.up.to/)
frailties of Northern Areas governance and the State of Pakistan’s administrative neglects, the ISO’s nationalist ambitions seemed within reach, and operated in competitive parallel with other Kashmiri and Northern-Areas independence organizations such as the Balawaristan National Front (BNF).\footnote{After Sipah-e-Sahabah leader Azam Tarik’s assassination in October 2003, and under pressures by the United States to dismantle ‘terrorist’ religious organizations, President Musharaff declared ISO was officially banned and its members subject to Federal prosecution or imprisonment under Pakistan’s post-9/11 Anti-Terrorism legislation. This was hardly the organization’s end, however, as it was almost immediately resurrected under the new name Anjuman-e-Imamia.}

Throughout town, ‘ISO’ was spray-painted on bazaar and shop walls, on boulders alongside the KKH and written in massive rock-formed letters on the hillsides surrounding Town (see Figure 3). Because of their prominent role in Nisab violence, the ISO’s more ominous intentions were indisputable. Members of the Sunni community, including myself and my husband, had been deeply unnerved by the ISO’s theft of so many weapons from the Police Academy, although Gilgit Town’s main Imambaragh’s Executive Committee later claimed the guns had been thrown into the Gilgit River several weeks after the Riots ended. I had once held deep sympathies for Shia weaponization. During my 1998 internship with the Aga Khan Rural Support Programme (AKRSP), my Shia landlord described how, compelled by his fears that a Sunni lashkar might one day return to Gilgit, he had scraped together the funds for a Kalashnikov. But in the intervening years, individual concerns for personal defense had given way to highly organized and more aggressive militancy where directed pre-emptive violence was loosely described as a ‘means to an end’ for Shias’ sectarian competitions and regional insecurities.
Militarization, quasi-terrorist training camps, weaponization and nationalist movements were not the monopoly of local Shias. In response to Shia activism was the promulgation of Sunni religio-political goals by several highly active youth and professional wings of the banned *Sipah-e-Sahabah*, or ‘Companions of the Prophet’, whose leader Maulana Azam Tarik had been assassinated on Shia orders in 2003. The *Sipah-e-Sahabah* made even rigorously conservative, but non-militarized Sunni political parties, like the *Jamaat-Ulema-Islam* (JUI), seem comparatively “neutral” (Fieldnotes: March 11, 2005). As one of Pakistan’s largest and most violently anti-Shia terrorist organizations, the *Sipah-e-Sahabah* (SSP) thrived in the shadowy spaces of Sunni village life where it had gained new recruits after the *Nisab* Riots, when the Sunni community had been outraged by the targeted attacks and killings of several prominent Sunnis, and the destruction of Sunni businesses and properties. Yet despite the SSP’s earnest efforts to enlist and weaponize local ‘commanders’ and ‘officers’, local Sunni militancy remained internally fractured by economic competitions and disparate tribal loyalties, and seemed to be more than outmatched by the Shia community’s political prowess and tactical threats. Disappointed by the federal government’s insufficient efforts to protect them against property destruction or death during the *Nisab* Riots, the majority of Sunnis were no longer particularly enamored with the Pakistani State.

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16 Providing a shadowy complication to Sunni extremism was the presence of Muslim Uighyrs, Chinese cross-border traders and smugglers, who sometimes use the Northern Areas as a base for separatist endeavors. In China, Uighyr separatists were labeled Muslim terrorists and are frequently blamed for bombings, targeted killings and ‘illegal’ riots. Gilgit-based Uighyrs, in response, recounted the many Uighyr men and women who had been publicly executed on Beijing’s orders since separatist agitation had begun in earnest in the mid-1990’s. Because of these “injustices” (Fieldnotes: February 10, 2005), Uighyr politicization enjoyed considerable, albeit quiet financial and logistical support from Gilgit’s religious hardliners. (While the ethnically and linguistically Turkic Uighyrs of China were Sunni, across the border in Hunza’s Gojal, Passu and Shimshal regions, Uighyr-speaking residents were Ismaili.) During my fieldwork, a number of smugglers were caught with heroin and were imprisoned in Gilgit’s Central Thana (jail). But because of their militant stance towards nationhood and the imposition of *Shariat* law in Xinjiang Region, and despite Islamic prohibitions against alcohol and drugs, Uighyr prisoners were often described in heroic terms.

17 There were other surprising reasons for this shift away from the State and the redirection of local energies to supporting regional Independence organizations. Ironically enough, one of the greatest threats posed to the government’s control stemmed from the Pakistani Army. Despite the government’s fervent protests that they did not fund, train or mobilize *mujahideen* (religious fighters; A) to secretly cross the border into Indian-held Kashmir, among my in-laws I could easily count at least a half-dozen young cousins who had done just this and who offered detailed accounts of their training and outfitting by the Army. Motivated on the one hand to surreptitiously and illegally ‘defend’ Pakistan against India, many of these *mujahideen* were unable to reconcile Pakistan’s massive
By the time we had returned in 2004, it was also obvious that the Saudi’s romance with Northern
Pakistan, which reached its zenith with the Afghan mujahideen movement and India-Pakistan ‘tensions’
on the Kashmir border, had come to a fairly abrupt halt. Prior to 9/11, Saudi-funding had played a
prominent role in regional Sunni politicization. For the ten years prior to my fieldwork, many Gilgiti
Sunnis had their Hajj pilgrimages to Mecca indirectly subsidized by Saudi monies, while prominent
mullahs were sent on paid junkets to Taliban-controlled Afghanistan, or ‘study missions’ to the Gulf
States. By summer 2004, however, Saudi monies had largely disappeared, due largely to Saudi annoyance
with Pakistan’s post-9/11 alignment with the United States and American bombings and targeted attacks
in Afghanistan and Pakistan’s Federally Administered Tribal Areas (FATA). Largely bereft of
incoming Saudi funds, and with the Pakistani Government preoccupied with deflecting attacks against the
American’s enormously unpopular Afghan-border offensives against Sunni militants, the Gilgiti Sunni
community found itself more politically and logistically vulnerable than it had been for many years. In
the face of Shia aggressions and undeniable evidence of the Iranian Government’s financial support,
many Gilgiti Sunnis continued to direct their allegiances to federal and state-supported governmental
mechanisms such as the Muslim League and the Pakistan People’s Party (PPP), even though the Gilgit-
PPP chapter had been led by elected Shia representatives for many years. By tethering themselves to
State-aligned nationalist movements, Gilgiti Sunnis hoped their loyalties would eventually be repaid with
logistical protection and funding. But the Pakistani Government’s inattention to Sunni security during the
Nisab left the Gilgiti community increasingly disillusioned and actively questioning their hitherto
steadfast loyalties to the State. Their insecurities, in turn, fostered increasing calls for Sunni independence
and the secession of the Northern Areas from Pakistan’s administrative grip. Gilgiti Shias, well-organized
and , it seemed, well-supported by their Iranian and Iraqi counterparts, seized on the Sunni community’s post-9/11

expenditures on Azad Kashmir with the profound deprivations and neglects they experienced in their home
villages. The more the government spent on funding Kashmiri raids, the less convinced the mujahideen were these
same energies would ever be applied to remedying the Northern Areas’ economic and political woes. Gilgit’s
Independence movements used the mujahideen’s doubts to successfully fuel their regional separatist endeavors.

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vulnerabilities to fast-track their nationalist ambitions, and reasserted what they claimed was their ‘ethnic’ and ‘ancestral’ rights to Gilgit Town and its surrounding environs (see Sokefeld 1998).

For Gilgiti Sunnis, the Northern Areas’ October 2004 elections, the first in five years, came at an especially important time. In the two months before the October elections, and deeply cognizant of the rising perils associated with Shia separatist movements, pro-Sunni political parties worked to recapture the Sunni community’s once steadfast State allegiances. Still recovering from the Nisab Riots, Gilgiti Sunnis were profoundly motivated to strategize their way back to electoral power.18 In the two weeks preceding the October 12th election, Wadood and I had taken the children on frequent afternoon drives through the town and surrounding villages, taking pictures of the election banners, roadside graffiti and billboards.

Gilgit was almost entirely subsumed by an overwhelming array of Jamaat Ulema-Islam (JUI; FR), Muslim League (ML), Pakistan People’s Party (PPP) and independent party election slogans and posters.19 Prominent among these were highly-colored pictures of the JUI’s perpetually bucolic, Taliban-aligned leader, Maulana Fazl-ur-Rehman. JUI supporters had produced masses of black and white striped JUI flags which they placed at Sunni-owned businesses, outside mosques or hung in festoons across major roadways. Indeed, many local political pundits predicted the JUI would enjoy remarkable success in the elections, due in large part to the recent triumphs of the Mutahida Majlis-e-Amal (MMA) Government in the North-West Frontier Province, where a coalition of hardliner Sunni Islamists had swept to power in 2002, and were focused on replacing secular government with Taliban-style jurisprudence and social dictates. Although teeming masses of young men hoisted aloft the JUI’s flag at all Sunni mohalla polling stations on Election Day, the JUI suffered an overwhelming defeat to secular candidates. Despite the 2004

18 I felt the Sunni community’s search for power was far more symbolic than actual. The Northern Areas Legislative Assembly remained more showpiece than effective political mechanism; Northern Areas residents have no local representation in Pakistan’s National Assembly. During my fieldwork, the Northern Areas was administered from Islamabad by the Federally-appointed, ethnic Punjabi KANA (Kashmir and Northern Areas) Minister, Syed Faisal Makhdoom Shah.

19 Although General Musharaff’s Electoral Commission had banned the use of explicitly religious imagery in Northern Areas election campaigns, the JUI circumvented such measures through basic, highly effective symbolism. The outlined image of a book - with the Urdu word ‘Kitab’ (book) written on it - was clearly meant to demarcate the ‘Holy Qu’ran’, and was used on JUI election posters, press releases and wall graffiti.
election campaigns exposing high levels of popular support for Sunni political parties such as the JUI, the October 12th election’s results revealed Gilgiti Sunnis were unwilling to formally commit to a blatantly religious agenda in local government. (Many residents, I felt, were deeply hesitant to add additional religious ‘tensions’ to Gilgit’s instabilities.) Instead of voting along sectarian lines as had been widely predicted, half a million Northern Areas residents from Ismaili, Shia and Sunni mohallas voted according to the political and economic concerns common to all three communities (Dawn: October 11, 2005).

The 2004 elections signaled a hopeful shift away from sectarianism. In the 1999 elections, sectarian loyalties had led to Shia candidates winning in Shia mohallas and Sunnis in Sunni mohallas. But because of subsequent widespread corruption by their poorly performing, in-community representatives, Gilgiti voters used the 2004 elections to directly challenge in-community cronyism and nepotism. Thus, Hulka (Region; U) 1, encompassing a primarily Shia area of Gilgit Town and which had been held by Shias for many years, was now held by new, surprisingly secular Sunni leadership, as were a number of other Shia mohallas throughout Gilgit Town and neighbouring villages. The elections resulted in the majority of Gilgit falling under Sunni leadership for the first time in many years; a power-transition that was quickly undermined by Shia extremists in the months following Zia-u’din’s death, with Sunni elected officials being targeted for violent attacks and their names appearing on ISO ‘hit lists.’

In the run-up to the elections, sectarian-specific political grand-standing led to women being employed, yet again, as symbolic markers of identity and each community’s adherence to ‘modern’ or ‘traditional’ ideals. In marked contrast to the Gilgiti Ismaili community’s liberalism, Shia and Sunni women’s rights were de-prioritized or politically exploited by competitively conservative trajectories. Gilgiti Shia women - generally educated, with greater in-town social mobility and Imambaragh participation and, if rumours were correct, aided by weapons training - were seen by Sunnis as dangerously progressive. Absent from mosque politics and stereotyped as being more likely madrassah-educated (if educated at all), Sunni women were characterized by Shias as regressive and over-controlled. Sunni notions of Shia ‘progress’
weren’t entirely incorrect; many Gilgiti Shias, including women, were widely traveled thanks to spiritual and educational pilgrimages to Pakistani, Iranian and Iraqi madrassahs (seminaries; A) and jalsas (religious meetings; U, F). The particular influence of Iranian cosmopolitanism was obvious; it was not uncommon for men to bring home stories of what “women in Tehran did” (Fieldnotes: October 11, 2004). The local drive towards ‘modern conservatism’ resulted in what the Gilgiti Sunnis called ‘contradictory’ behavior. At the same time Gilgiti Shia women had taken to wearing the all-encompassing Iranian-style black chador, the local community boasted increased numbers of women’s school attendance and formal employment. This did not mean, however, that Gilgiti Sunnis weren’t also enthralled with cosmopolitanism. Many women were enchanted by the freedoms of Ismaili women or, after watching innumerable PTV (Pakistani Television) dramas, were envious of the materialistic excesses apparently enjoyed by urban, Sunni Pakistanis.

Operating as a quiet backdrop to Shia and Sunni economic competitions and armed hostilities, and playing a deliberately minimal role in local elections, Gilgit’s Ismaili community was avowedly against weaponization, preferring instead to develop their strengths through economic and education initiatives. Starting in the late 1970’s and led in policy, funding and religious matters by His Highness, Prince Aga Khan - spiritual leader of the world’s Ismaili Muslims - the Aga Khan Development Network (AKDN) produced the Northern Areas’ most radical transformations and alternative governmental processes by using funds derived from the worldwide collection of Ismaili zakat (annual tithe; A) monies. Through the medium of village-based outreach, social motivators and men’s and women’s Village Organizations (VOs), the Aga Khan Rural Support Programme (AKRSP) began making profound and lasting inroads into local communities. As the AKDN’s first non-governmental foray into the Northern Areas, AKRSP’s...
programme outreach began among Hunza Sub-District’s Ismaili communities, a two-hour drive north of Gilgit along the KKH. The combined efforts of the Aga Khan Diamond Jubilee schools, Aga Khan Health Services (AKHS,P) hospitals and primary health centers, AKRSP link roads, agricultural support, and the Aga Khan Culture Service’s (AKCS) ‘revitalization’ programs led to a dramatic upsurge in Ismaili school attendance, increased crop production, Family Planning and, more recently, the directed resurgence of ‘traditionally’ Northern, Ismaili cultural practices and language (Burushaski). Moreover, Ismaili women in rural and semi-rural communities throughout the Northern Areas – almost without exception – have experienced profound increases in their social mobility, personal decision-making and economic independence.

In the face of Ismaili development, and notwithstanding their fierce disapproval of Ismaili gender practices and reverence for the Aga Khan, Gilgit’s Shia and Sunni communities had become increasingly distressed by the obvious economic disjuncture between themselves and Ismailis. By the early 1980’s, occasional armed skirmishes, protests and the harassment of Ismaili residents motivated the AKDN to support more equitable access to their socio-economic programming, specifically by initiating a series of similarly designed outreach programmes in Shia and Sunni communities. By the late 1980’s, AKRSP had successfully extended its socio-economic initiatives into the Northern Areas’ Shia (Nagar, Baltistan) and Sunni Districts and Sub-Districts (Gilgit, Astore), albeit far less often in Sunni areas (see Chapter Seven for more detail). By the time I worked for AKRSP in 1998, the AKDN’s reaches were obvious throughout town, and its mandate had mushroomed to include a number of additional activities. The Aga Khan Rural Support Programme (AKRSP), Aga Khan Education Services (AKES), the Aga Khan Health Services,
Pakistan (AKHS,P), the Aga Khan Culture Service (AKCS) and the Aga Khan Building and Planning Service (AKBPS) have their offices in Shia and Ismaili mohallas throughout town.22

Even while hardliner Shia and Sunni community members disavowed the Aga Khan, the AKDN and its development initiatives, many remained openly envious of the Ismaili community’s successes and were threatened by the moral and religious implications. “Does God favour them?” one Sunni man asked me (Fieldnotes: September 14, 2004). (This having been said, Shias made much more use of AKDN’s services than Sunnis. My research assistant remarked that some Gilgiti Shias drew on the theological and doctrinal connections shared with Ismailis to assert how they were equally entitled to receive support from the AKDN and, more distantly, the Aga Khan.) Paralleling the AKDN’s Northern Areas successes were an ever-expanding variety of grassroots NGOs, some distinctly competitive and religiously-aligned in their institutional orientation. Iranian interests frequently sponsored Shia non-governmental programmes, while Saudis and Pakistanis funded Sunni welfarist groups (see Gloekler 1998). As with the AKDN, Shia and Sunni programming placed a heavy emphasis on economic and agricultural development, while also promoting a quiet type of social engineering.

In marked contrast to the AKDN, which advocated for Ismaili girls’ access to secular education and biomedical health services, Shia and Sunni programming was more diligently attentive to upholding and amplifying Gilgit’s more conservative, sectarian differences. Through the mechanism of these religiously conservative ‘development’ programs, Shia and Sunni gender roles were heavily, albeit differentially, modulated. Northern traditions began yielding to identifiably Iranian or Saudi-styled dress (chador, F; hijab, A), social practices or ideological approaches. In accordance with dramatically escalating in-community conservatism, sectarian factionalism and militancy, such measures were not merely intended to compete with or co-opt the AKDN’s careful synthesis of Ismaili gender practices and ‘modern’

22 Federal, private and parochial schools such as the Aga Khan Diamond Jubilee (AKDJ) schools – covering Nursery to Matriculation (Class 10), and thereafter Graduation (Class 12) - are usually found in clusters throughout Gilgit’s residential enclaves.
secularism, but to also counteract and block the encroachment of Ismail ‘liberalism’ to Shia or Sunni communities.

Section III  Sunni Conservatism, Pardah & Women’s Mobility

Notwithstanding Gilgit’s sectarian ‘tensions’ and rural-urban health divides, Sunni women across Gilgit Town described their everyday service access and use as being constrained by the same key factors. These included religious conservatism, *pardah* (the social segregation of women from unrelated men; U), family power hierarchies, economic constraints and, finally, the Shia or Sunni mohalla location of Gilgit’s public or private hospitals and clinics. What remains crucial to clarify from the outset, however, is that the constraints placed on women’s health access were not always representative of dissonance or contradiction between traditional or allopathic systems. From my own observations, women typically weighed up service providers or therapeutic options by their affordability, the distance to clinics and by the etiology – biomedical, traditional or Islamic – which women believed were at the core of their health complaints or which allowed them to ‘speak’ to their life’s condition or sense of faith (*deen*; A).

Because of its prominent role in women’s health decision-making and access, my discussion starts with *pardah*, which in the ten years I have known Gilgit has been noticeably impacted by conservative Sunni missionization movements. Political and social conservatism among Gilgiti Sunnis can perhaps be traced first to the influence of Pathan proselytization. Over the last century, Pathan missionaries (who claim ancestry from central Afghanistan) had traveled northward from Pakistan’s urban centers along the old Silk Road and then the KKH into the heart of the Northern Areas. Starting in the mid-1970’s, with General Zia Ul-Haq’s tacit support, Pathan proselytization was increasingly funded by independent and unregulated Saudi ‘benevolence’ organizations. Missionization succeeded in radically changing the nature and practice of Northern Sunni identity and, in many respects, managed to shift Sunni Gilgiti sociality toward an exclusionary, conservative and codified version of Islam. During my fieldwork, Wadood noted how this inter-relationship between Pathan and Gilgiti values was in ready evidence at

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Gilgit Town’s Sunni Markaz (ulema headquarters; A). There, Juma (Friday; A) sermons were spoken in both Shina and Urdu and demonstrated a blending of Taliban-style austerity and Pakhtunwæli, the conflict-hued ‘code of honour’ subscribed to by Pakistan’s ethnic Pathans. As described by Lincoln Keiser (1991), pukhtunwæli carries “four obligations: to commit vengeance, to provide hospitality, to give refuge for anyone asking for it (even a mortal enemy), and to treat with generosity a fallen adversary who sues for peace” (40). But since the Karakoram Highway’s 1975 opening, a number of other movements have come to enjoy similar proselytizing successes. Foremost among these is the Tablíghi Jamaat, or ‘Community of Evangelists’, which “has become one of the most potent forces” (Keiser 1991: 41) in Northern Pakistan.

Early on, the Tablíghi Jamaat’s leadership drew its inspiration from Deobandism, a Sunni movement which began in the 19th century at a North Indian seminary (Metcalf 1978). Deoband followers strove to “bring Muslims back to the right path, that is, to the prescribed observances such as daily prayer” (Sokefeld 1999: 421). Their regional successes were such that “most Sunni ulema [formal religious communities] in the present-day Northern Area belong to the Deoband school” (Sokefeld 1999: 421). As the Tablíghi Jamaat’s ideological progenitor, the Deoband school had worked to disconnect Islamic practices from ‘unIslamic’ customs (riwaj; U), which led to Deobandism being described as one of the most orthodox interpretations of the Hanafi-Sunni fiqh (school of jurisprudence; A). (Its conservatism, however, pale in comparison to the austerities of Saudi-funded Wahabbist proselytization which were

23 The Northern adoption of Pukhtunwæli differs in remarkable ways from “more orthodox fundamentalism found in other parts of the Muslim world [because of a] special set of accretions [focusing] on death enmity” (Keiser 1991:40).
24 According to Lincoln Keiser, the Pakistani Tablíghi Jamaat began “...sometime in the 1950’s in the village of Raivind near Lahore in the Punjab. Maulana Mohammed Zikria, a wealthy textile mill owner and noted religious scholar, founded the organization. His book Tablíghi Nisab, ‘Syllabus for Preaching’ remains today the group’s charter of purpose, and copies exist in most rural villages in Pakistan....No clear-cut rules dictate Tablíghi membership, for any man [or woman] can join. Participating in the group’s preaching automatically makes one a member, and those who take part regularly become known as tablíghis, or ‘preachers’” (Keiser 1991: 41).
25 See Metcalf’s discussion of men’s and women’s participation in the Pakistani Tablíghi Jamaat (1998), and her analysis of the North Indian Tablíghi Jamaat’s Urdu- and Hindi-language Islamiyaat literature (1993). See also Sanyal’s overview (1998) of the Northern Indian Ahl-e-Sunnat movement during the twentieth century.
recently popularized by the military successes and political strategizing of the Taliban movement. As is the case for Tablighi Jamaat members across Pakistan, Gilgiti tablighis (student, preacher; A) were expected to make regular visits to,

“...people living in a chosen locality, usually near members’ homes...at other times, tablighis travel to different neighborhoods in the same community...[or in] deputations [that] journey outside their home villages, and on rare occasions even outside their native country.” (Keiser 1991: 41)

In addition to the movement’s primary text, the “Tablighi Nisab” (“Syllabus for Teaching”; U), Gilgiti tablighis drew on a number of interpretative Islamiyaat texts, including the “Faidail-e-A’mal” (Kandhalwi 2003; English translation from Urdu), “Riyadh us Saliheen” (“Gardens of the Righteous”; An-Nawawi 1998) and the “Tawhid.” According to Wadood, who attended a number of Tablighi events, their sermons were crafted to appeal to the widest possible audience, with mullahs and tablighis carefully integrating Tablighi Nisab edits with Taliban-aligned Pakhtunwali ideals. More recently, sermons and Tablighi literature had also begun promoting quasi-secular discussions of Islam as the source for modern medicine, chemistry and biology.

Tablighis who ventured beyond the Northern Areas often returned with a renewed sense of the importance of gender segregation and women’s veiling (pardah; U), or of isolating Sunni practices and sociality from local Shias and Ismailis. Young students returning from Saudi Arabia were said to harshly restrict female relatives to the domestic sphere, allowing them few if any visits beyond the

26 The differences between Kohistan (NWFP) and Diamer District’s Saudi-oriented and austere Wahabbist-styled movements, and Gilgit’s comparatively cosmopolitan Tablighi Jamaat movement relates, perhaps, to the eclectic nature of Gilgit’s Sunni communities. Sunni communities in and around Gilgit Town have historically enjoyed close interactions with, and been influenced in matters of education, health and to some extent women’s rights by Northern Areas Ismaili communities who, not without justification, self-characterize as being ‘liberal’ with regard to such issues. The result has been that Gilgit Sunnis enjoy a more cosmopolitan and educationally progressive environment than the majority of Northern Pakistani, semi-urban and rural Sunni communities. As such, the Wahabbist nature of mobilization movements popular in other parts of Northern Pakistan were not as appealing to Gilgit Sunnis as homegrown, more liberal manifestations of the mainstream Deoband Tablighi Jamaat movement, which has achieved remarkable successes in maintaining local loyalties by establishing a number of low- or no-cost boys and girls madrassahs.

27 In the most general sense, pardah restrictions “do not apply within the immediate kin unit, but only outside it” (Papanek 1973: 289), and begin – along with sex-role allocations – at puberty.
household, even for the purposes of watering crops or feeding livestock. Correspondingly, women’s use of the *dupatta* (veil; U) was re-invested with additional symbolic freight, with women now ordered to veil within the household and even in the presence of their adult brothers or brothers-in-law. At the Sunni *Markaz, Tablighi Jamaat* sermons repeatedly exhorted men to ensure their wives and daughters should never been seen by unrelated men.28 Among Gilgiti Sunnis enraptured by the *Jamaat*, there have been profound decreases in the number of mixed-gender mohalla spaces where women once moved about with ease and without facing criticism. Women’s domestic seclusion was, in turn, extolled as increasing family integrity (*ghrairat*; U) and said to exemplify women’s positive contribution to neighbourhood honour.29 More than this, women’s strict adherence to *pardah* was said to demonstrate her abandonment of local, ‘unIslamic customs’ (*riwaj*; U).30 The end result has been that Gilgiti Sunni families uniformly observe *pardah*; the only easy place for Sunni women to avoid seclusionary measures is within the home and away from unrelated men. It was during their discussions of the risks posed by unrelated male visitors that women most carefully foregrounded the rules associated with *pardah*:

“We keep male guests separate - *izzat biley* [honour happens; S] - and we always advise our daughters that if they are going somewhere, don’t go in front of men. Sit separately with the ladies and girls. *Sharmoh hiya* [to have modesty; S] is good, then their marriage will be good.31 After she is twelve years old, she is not allowed to be around other men. Until a boy is eighteen or nineteen years old, it is OK for him to be around, but after the age of twenty it’s a dangerous time. But a married man, with children, is OK for our young unmarried daughters to be around.” (Madheeya, Jutial: June 22, 2005)  

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28 As Lincoln Keiser noted for Sunni communities in Dir Bajaur, a mountainous tribal area of the North-West Frontier Province, visiting *tablighis* (students, preachers; A, U) encouraged women to avoid using public fields for the purposes of washing or defecation (Keiser 1991: 72), reducing the chances they would be seen in compromising situations by unrelated men. More trees were planted around the domestic space, limiting visibility out and in. Garden walls likewise increased in height, and as women were forced away from traditional community mobility, greater household responsibilities were placed upon young children, husbands and hired laborers.

29 As Keiser notes for Dir Bajaur, women’s behavior and social mobility were said to be “a matter of male Muslim identity because the way women act directly impacts on *ghrairat*, men’s gift of personal integrity from God” (Keiser 1991:42). But the importance of *ghrairat*, which is largely analogous to the more well-known term *izzat* (honour; U), has a great deal more to do with those behaviors that are visible to unrelated men, than reflecting men’s concerns with women’s personal spiritual integrity.

30 Over-invested by the *Tablighi’s* conservatist polemics, Sunni women’s veiling and honour (*izzat; U) were also used to positively contrast Sunni women’s ‘piety’ and ‘modesty’ (*sharam*; U) against the ‘unIslamic’ social practices of Shia and Ismaili women.

31 Madheeya was implicitly referring to women’s belief that if a bride entered married life with an ‘unblemished’ social record, her husband and in-laws would be more likely to treat her with respect and affection.
Under the Tablighi Jamaat’s influence, Gilgiti architecture has even begun to change.\textsuperscript{32} According to Wadood and his family, in previous generations when pardah strictures had been less rigorously followed, traditional homes (desi ghot; S) had been set in open compounds.\textsuperscript{33} These one- or two-room homes were not gender-divided; instead, extended families slept on tiers around a common hearth. Wealthier families could now afford to follow Tablighi edicts, and built separate guest rooms for male or female guests, or to permanently demarcate areas of the house as men’s (mardana; U) or women’s (zenana; U). In the poorest households, space and privacy were precious commodities and families were unable to afford separate areas for men and women.\textsuperscript{34} Instead, when women guests arrived with flocks of children for chai or meals, as they usually did throughout the day, impromptu pardah zones could be created by drawing a curtain across the center of a room. This physical demarcation of male and female spaces was also evident in Gilgit Town’s hospitals and clinics with men’s and women’s waiting rooms, separate entrances or, as with Maternity Hospitals, women-only wards.

None of this meant, however, that Gilgiti Sunnis were the Northern Areas’ most conservative Sunni community. My participants conceded that by comparison to Gilgiti Ismailis, Sunni sociality was gender polarized. However, they argued that Gilgiti Sunnis were still more open-minded, Islamically liberal and therefore in practice ‘better’, ‘more educated’ and appropriately observant Sunni Muslims than their relatives and Sunni ‘brothers’ in neighbouring Diamer District where the majority of residents lived in

\textsuperscript{32} After thirty years of Shia-Sunni ‘tensions’, a disconcerting architectural synthesis of pardah and conflict had developed. This meant that Sunni homes were set in tightly enclosed courtyards, with higher surrounding walls. Although these compound walls were theoretically intended to restrict unrelated men’s ability to see women living within the domestic space, families also described them as affording security against incoming gunfire, or invading ‘marauders.’ In southern Gilgit District, families had begun building homes that mimicked the traditional fortresses found in Diamer District and Kohistan (NWFP), where multi-storey guard towers overshadow walled-in domestic enclosures.

\textsuperscript{33} Whitewashed, wattle-and-daub or rock-walled desi homes are still common in the villages surrounding Gilgit, and are especially popular among poorer Gilgit Town residents who can ill-afford the supplies required to build more rooms, or heat multiple rooms in the wintertime.

\textsuperscript{34} Generally speaking, closely-related men and women mixed freely within the zenana, while the mardana is reserved for unrelated male guests or male social gatherings. Unrelated female guests were either welcomed into a guesthouse which is separate from both the mardana and zenana, or visited the zenana after warnings are paid to males from the household to avoid this area for the duration of the visit.
forested valleys branching off the Indus River. In light of Diamer’s violent tribal enmities, deep social conservatism and the widespread practice of polygamy, Gilgit’s more upwardly mobile, quasi-urban Sunni communities viewed their southern relatives with considerable trepidation. During sectarian ‘tensions’, when Gilgitis welcomed staggering numbers of their vehemently ‘ill-mannered’, ‘animal-like’ (janowar; S) but also helpfully ‘warlike’ Diameri cousins as additional security, they continued to discretely describe them as ‘poor examples’ of Islam. Indeed, there were noticeable differences in Sunni practice between Diamer and Gilgiti residents.

While Gilgiti Sunnis positively affirmed the gendered division of social worlds – with men in the public sphere, women in the domestic – lines were regularly transgressed, manipulated and modified. Despite most Ismaili and Shia research participants arguing that Sunni women were comprehensively ‘forbidden’ to leave their family home without their husband or another male relative accompanying them, I found there were wide variations in the degree to which women practiced pardah, or how families chose to express their religiosity through women’s social mobility. For example, most extended family households were located in large clusters. If the majority of local homes were owned by close relatives, this offered women a kind of ‘safe zone’ – a spatial band of allied family members - for when they walked unaccompanied. This also ensured that women enjoyed easy access to nearby shops owned or operated by close relatives or in-laws. But if women felt vulnerable to neighbourhood gossip, abuse or recrimination from within the household, they could ask woman relatives or neighbours to walk or travel with them. Or, so no one could say they were technically ‘alone’ (akelah; U), women sometimes took small boys - their sons or nephews - with them on their outings as a concession to pardah and venomous rumours. As such, I am wary to predicate too much of my analysis on the notion that pardah’s restrictions

35 The majority of Gilgiti Sunnis trace their ethnic ancestry and caste to two ancient lineages. These are the Yashkun, or indigenous peoples of the Northern Areas’ Shia and Ismaili communities, and the Shin, warring clans hailing from Diamer District and Kohistan. The Shin caste was pre-eminent, and always trumped Yashkun identity; in the past, Shin women were barred from marrying Yashkun men.

36 Even more interestingly, perhaps, was how during the Shia-Sunni conflicts many Sunni Yashkun families de-emphasized their mixed-sect Yashkun heritage, preferring instead to place primacy on their Diameri Shin ancestry.
for social mobility was the principle constraint on women health access (Mumtaz & Salway 2005; Shah & Bulatao 1981).37

Because the boundaries between gendered terrains were revised with great regularity, prototypically Islamic penalties such as ‘honor killings’ were meted out far less frequently. By contrast to frequent honor (izzat; U) killings and domestic abuse occurring among Diameri Sunnis, Gilgiti Sunnis’ comparatively lenient practice of pardah and infrequent punishments were viewed by Diameris as evidence of their immorality. According to our own Diameri visitors, Gilgit Town’s residents had been ‘softened’ and ‘corrupted’ by easy, urban life. And despite Gilgitis listing off ayat after ayat (Qur’anic verse; A) in support of women’s decision-making or social mobility to their predominantly illiterate kinsmen, they were unable to stymie Diameri critiques that there were, in fact, no Qur’anic justifications for Gilgitis’ so-called ‘religious deviance.’ Our own Diameri visitors often happily spouted off a wealth of (as we soon discovered) manipulated, mistranslated or misremembered ayats, with many having been tailored by Diameri mullahs to support their own preferences for local sociality and gender practices.

Section IV Household Economies, Women’s Decision-Making & Health Access

Because women’s mobility and decision-making were not only affected by pardah and izzat, it is important to discuss some of the more pragmatic obstacles impeding women’s health access. Indeed, even after women decided they needed medical help, their access to health services had to be negotiated and was predicated on the economic, emotional and logistical support of their husbands, in-laws, natal family and even neighbours. From the beginning of their married lives, Gilgiti Sunni women were intensely

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37 See Mumtaz and Salway’s discussion of women’s social mobility, Islamic gender segregation and reproductive service use in the rural Punjab, where they argue that “…seclusion has never been absolute, and that observed mobility outside the home cannot simply be equated with some notion of ‘freedom of movement’” and that “at the broader level, we have seen how an insecure ‘mahol’ [mohalla], strict gender-class hierarchies and poor infrastructure, combine to act as a powerful deterrent to women’s desire to travel” (2005: 1752, 1763).
vulnerable to the whims of their in-laws and new husband (see Figure 4).\textsuperscript{38} Pakistan’s generally high infant mortality rates, by extension, are frequently attributed to women having

“...limited autonomy in the early years of their marriage ... in part because they move from their natal home to their husband’s home, women may be under new types of stresses that reduce their ability to adequately care for their children. (Agha 2000: 205)

In recent years, Sunni women’s decision-making authority has been increasingly connected to their educational status. Participants who had graduated with their Matriculation or a College degree were often accorded more say in household decision-making, particularly if their mothers-in-law were illiterate or less well educated. Or, women were less shy to involve sympathetic neighbours to help convince recalcitrant in-laws to get them medical help. One newly married woman recounted how

“...in our area, mothers-in-law are allowing their daughter-in-law to easily go to visit – no one says anything! But sometimes if they don’t get permission, the daughter-in-law will fight with her mother-in-law.” (Qaseema, Amphari: August 12, 2005)

It was specifically because of the potential conflicts and power struggles between unrelated mothers- and daughters-in-law that many families preferred close, in-family marriages.\textsuperscript{39} These marriages were often lauded as being free of the vulnerabilities endured by wives in marriages brokered between families who they described as ‘strangers’ or ‘pardesi’ (outsiders; U). As one young wife in Amphari said, “If our

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{image.png}
\caption{Family breakfast in a Sunni mohalla (2005).}
\end{figure}

\textsuperscript{38} The domestic sphere in Gilgit is fundamentally defined by kinship groupings (qom; S). Each qom is individually characterized by patrilineal and patrilocal patterns of lineage endogamy. (In ways that mimic pardah strictures, the qom’s communal, domestic domain is a territorially defined household unit that is off-limits to unrelated men, wherein related men and women enjoy unrestrained social interaction.) Within the domestic sphere, men are identified as the primary decision-makers for major financial and familial issues, such as the education and marriage of children, designating household tasks among other men or bestowing the authority to do the same among women to a senior female (Varley 1998: 11-13).

\textsuperscript{39} Women marrying into unrelated households seemed far more hesitant to ask their husband’s sisters for assistance. But in first-cousin marriages, young brides argued their sisters-in-law were ‘doubly’ obligated to help; not merely as a result of the marital bond between a woman and her in-laws, but also because they were first cousins.
husband is not gharwalley [relative, ‘home people’; U], visiting can be harder” (Qaseema, Amphari: August 12, 2005). As Donner notes for maternal health access in middle-class Indian families (2003), Gilgiti women’s health decision-making was processual and embedded in wider networks of family and neighbourhood relations or questions of status and socio-economic class. That Gilgiti women routinely considered a wide array of variables when thinking through service access was demonstrated by an exchange between myself, an older Sunni ‘auntie’ and her middle-aged niece.

[Emma] “What is your husband’s role in your health decision-making or ability to access services?”
[Shahibas, aunt] “We don’t discuss anything with our husbands, and they never take us! [laughs] Now maybe some men are caring, and taking their wives to doctors, but not in our day.”
[Shailah, niece] “For fourteen years I was sick with a problem in my bachitani [uterus; U], but neither my husband nor my mother-in-law asked me about it or helped me, so I tried to help myself. I got desi davaie [traditional medicine; U], and went to doctors, but nothing worked…”
[Shahibas, aunt] “If we’re in pain, and having great difficulty, we don’t need our husband’s permission to go – we just go. We keep money at home for times like this. For the taxi, clinic costs, doctors fees, as much gunzaish [money, fees; U] as we can save. Sometimes Rs 300 [CDN $6.80], sometimes Rs 1,500 [CDN $34.10] – depending on how much our husbands make. I take my son with me when I go. The eldest is twenty or twenty-two years old, and the youngest is twelve. I can’t go alone…this is bad. If there’s no man at home, it’s even alright to take a five year old with us, but they must be male. A mother and daughter, though, can’t go together. Men are not all the same, some are less trusting. If both are women they can’t protect themselves. And people in this mohalla talk, they don’t think a woman who is out alone is respectable. They think maybe she’s corrupt. Don’t forget, this is a jaheel adab mohalla [ignorant-mannered neighbourhood; U, A], and people are close minded. I think that women are more advanced thinking than men….it all depends on the house, the family, their level of advancement.” (Jutial: August 18, 2005)

A woman’s social mobility, her decision-making abilities and economic reach ultimately rested on a fragile axis of natal family and marital support, or the lack thereof. Women’s mobility was most profoundly determined by the strength of her husband’s convictions and personal beliefs. Religiously conservative men were more likely to restrict access for their wife, daughters or sisters to non-related households, local stores or clinical settings. This included accessing public sector health services or even local shops for food or fabric. Even if a woman decided she needed medical attention, her husband, his
father or brothers or even his adult sons from a previous marriage, held the authority to permit or prevent her from travelling outside the home for treatment. Many younger wives characterized ‘stronger’ husbands as being able to negotiate for their mobility on their behalf, rather than restricting it at the request of his dictatorial or socially anxious mother. Sunni men who self-styled as ‘cosmopolitan’, ‘liberal’ or ‘modern’ were far less likely to openly monitor or micro-manage their wives’ social mobility, inclusive of clinical access. Older women, conversely, argued that if a husband confined his wife to the home, it was because he “loved her” (Fieldnotes: April 28, 2005; see Figure 5).

Only rarely were husbands who were vehemently against their wife’s visit to a clinic convinced to change their minds. Neighbours or family who intervened too forcefully on a wife’s behalf risked being characterized as a ‘bad’ influence and banned from the home. For women who visited clinics without permission and then incurred their husband’s wrath, the principal insult was not viewed as the women having sought biomedical care but her defiance of his wishes. Husbands could also be angered by their wives ‘open’ behavior once outside the home. This included not veiling ‘enough’, or having spoken ‘unnecessarily’ or ‘too freely’ with male acquaintances, hospital orderlies or even their doctors. Even Ismaili women hospital employees were subject to the same kinds of criticisms, which illustrates how men’s anxieties over women’s ‘openness’ were not restricted to Sunnis.

“When I first started working at [the hospital], my in-laws and friends of my husband would monitor me from a distance. They would see me when they were visiting other patients, and told my husband that I was ‘very free’ with the male relatives of female patients. I was upset, and said to my husband, who got angry at me, ‘If you want the

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money, let me work undisturbed! Otherwise, you can come up with the money yourself and let me stay home!’ He had lost his job at that time.” (LHV V, DHQ: August 23, 2005)

Women’s health-related decision-making or their ability to find the time to visit local clinics, was not only restricted by gendered decision-making or *pardah*’s spatial and *izzat*-related polemics, but by daily housework, childrearing and caring for frequent guests (*mehman*; U). As one woman noted, “…usually visiting is easy for women. The exceptions are if there is a lot of work to do at home, and the mother-in-law or husband might not give permission for her to leave” (Qaseema, Amphari: August 12, 2005). Across Gilgit Town and in the outlying villages, women’s daily work centered first on the upkeep of children, in-laws and guests, and then taking care of chores, livestock or agricultural duties. Among my participants in Minawar, a Sunni village at the outskirts of Gilgit Town, women were responsible for a daunting array of household and farming tasks. While juggling agricultural, poultry and dairy production, they also managed informal, household-to-household sales of foodstuffs, preserves and sometimes embroidery. Regardless of where women lived, the amount of women’s work depended on the size of the extended household. (To this point, women’s preference for traditional, extended families was a partial reflection of their need to share daily tasks, child-rearing and agricultural work.) If two or three women lived together in one household, one usually performed tasks associated with livestock, one with fieldwork and one with housework, cooking and childcare (see Varley 1998). By extension, these domestic co-operations meant most women could leave their small children with their in-laws whenever they visited town clinics.

Most household budgets were typically made up of monies generated by men’s in-town employment, contracted roadwork, seasonal agricultural stints in neighbouring villages, or temporary jobs in Pakistan’s urban centers as security guards or office peons. In the villages surrounding Gilgit Town, agricultural work, animal husbandry and small-scale enterprise activities made up the bulk of families’ annual incomes. Sunni women worked side-by-side with men in farming activities, or took sole responsibility for
these tasks, yet had no deciding power or access to the funds generated (Varley 1998: 13). And by relieving their husbands and fathers of the costs of hiring day-labourers, women’s unpaid fieldwork formed an essential, albeit underrepresented, component of the household economy (Varley 1998: 7). The clear disjuncture was that despite their contributions, rural Sunni women especially had considerably less decision-making authority (over education, health care, children’s education, household budgeting and expenses) than their husbands, whose work was more seasonally-intensive (see Sales 1999: 411; see Varley 1998). In many ways, this reflected Islamic notions of household decision-making and gendered ideals of personal agency. It also reaffirmed that household authority was not based solely on economic contribution but also relied on other ideological factors.

Broadly speaking, increases in Sunni women’s individual decision-making power were associated with gains in status, whether ascribed or achieved through age or marriage, merit, finance or experience. For example, as a woman grew older, depending on the number of sons she had borne or her husband’s position among his brothers (for example, as the more powerful eldest or least autonomous youngest), the more she gained correlated increases in her decision-making. But there were other more unexpected opportunities for Sunni women to gain decision-making authority. Firstly, and despite previous Aga Khan Rural Support Programme reports indicating that women were rarely left to head households alone, and that there had been no significant increases in Sunni women’s decision-making (see Kuriakose 1996), evidence I gathered from across the Northern Areas in 1998 suggested that this was not always so. The increasing nucleation of Sunni households is the partial result of what AKRSP terms ‘male-out migration’ (see Kuriakose 1996; Sales 1999: 411; Varley 1998: 8). Drawn to seek seasonal or permanent

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40 Sunni Gilgiti women usually only enjoyed undisputed control over the money they earned from traditionally female tasks or, if they were fortunate enough to participate in Aga Khan Development Network programming, small-scale Women’s Organization (WO) income-generating activities (e.g. poultry [the sale of chicks, eggs, hens, meat], vegetables, handicrafts) (Varley 1998: 10-11).

41 An increasing number of Northern men frequently work as contract labourers for construction projects in Pakistan’s major cities, or as seasonal farm-hands in more prosperous districts of the North West Frontier Province, northern Punjab and also Baluchistan. More infrequently, adolescent boys work as hired hands or household servants (‘domestics’) in wealthier Gilgiti homes. Women with absent husbands became completely responsible for
high-wage labor in Pakistan’s urban centers, an increasing number of husbands worked away from Gilgit District for up to a year at a time, leaving their wives alone to cope with a much wider range of household activities, regardless of the previous division of labour by gender. Secondly, among my in-town participants, women regularly took part in informal home-based economies; this very often enabled poorer families to survive month-to-month. By following the example of those in-town Ismaili women who took part in AKRSP-administered income generation projects (which included raising chickens, selling eggs or running small ‘tack’ shops), Gilgit Town participants were frequently inspired to take up home-based embroidery projects (slaiye; U), grew additional vegetables or prepared fruit for sale in the local market or stores or to their neighbours. (In-town Sunni residents enjoyed far easier access to retail consignment shops than their village relatives.) They also wove traditional goat-hair rugs (sharma; S) and sold or traded dried vegetables and home-made preserves, including pickled cabbage (achar; S, U).

Although husbands rarely acknowledged their wives’ earning potential, the monies gained by these activities were not paltry. For example, a one-by-two foot embroidered ‘scenery’ of flowers or traditional geometric cross-stitching could be sold for nearly Rs 2,000 (CDN $45.50). When two to three of these were produced each month, women’s earnings sometimes surpassed those of their husbands. Women also knit sweaters or leggings for infants and small children, which could be sold for Rs 200 (CDN $4.50) to Rs 500 (CDN $11.40); my mother-in-law was capable of knitting a man’s cable-cord sweater over the course of two or three evenings. In the same way that women’s increasing age and authority over daughters-in-law

the growth, harvest, processing and sometimes sale of wheat, barley and maize crops - a task otherwise done by men. Prior to their husband’s departure, and for the duration of his time down-country, women often only received minimal advice on how to school their children, plant certain crops or whom to go to in the village if they needed additional information or help (Sales 1999: 411-412; Varley 1998: 8). As an unintended result, women were left very much to their own devices as they managed the household and took over formerly male-only decision-making. But ‘male-out migration’ did not always mean that unattended wives and daughters were able to more easily visit clinical health services. Women with small children, for instance, carried a heavier weight of household responsibilities than women with older sons, who were able to take over a range of tasks left behind by their fathers (Varley 1998: 7). Occasionally brothers-in-law or fathers-in-law, as was the case in joint households, were able to also help fulfill these responsibilities; the downside was that in exchange for their help, many of these male relatives expected a greater say in household decision-making or a large share of the family’s agricultural profits. In order to avoid this, women who had enough money hired seasonal labourers to help out in busy times, such as harvesting or preparing and transporting fruit for sale in local bazaars (Varley 1998: 8).

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afforded them increased decision-making, women’s ability to generate significant, additional income upheld their overt participation with marriage arrangements, land or animal purchases (see Varley 1998). Among my fifty-plus participants, twelve were formally employed and another ten earned a small monthly income through home-based handicrafts work. Such women weren’t yet the majority in Gilgit’s Sunni community, but their numbers were increasing.

As I first discovered in 1998 (and which remained true in 2004 and 2005), Sunni women’s health access was not merely interconnected with household incomes or decision-making hierarchies, but was also affected by her dowry, income and personal savings. Traditionally, Sunni women’s personal assets were restricted to the dowry (meher; A) they received from their husbands at the time of marriage, or were promised to receive in the event of divorce (talaq; A) or his death. Meher monies, called zhrap in Shina, were negotiated between the groom, his father, an uncle and the bride’s father, uncle or brother at the time of the nikah (Islamic marriage contract; A). In Gilgit, the sequence preceding a woman’s transition to her husband’s home begins at the time of their engagement (mangini, U; dua, A), which is not legally binding and can be broken prior to the nikah, or formal marriage ceremony.42 The nikah is typically comprised of a small gathering of male relatives and officiated by a mullah, with the bride’s father offering verbal consent for the marriage on his absent daughter’s behalf. Many brides, however, remain living with their parents for several years after the nikah, although their husbands technically enjoy the right to sexual intercourse in the time preceding their

42 The dua (A), an essential element of any Islamic ritual, can also be characterized as supplication.
lavish wedding party (shahdi; U), and her ceremonial departure from her natal home (rukhsati; U) (see Figure 6). The meher was intended to not only alleviate the bride’s family’s marital expenses, but to ‘replace’ the inheritances she would have received from her parents had she remained unmarried. After her marriage, though, a bride rarely enjoyed direct access to the monies, which were almost always managed by their husbands, and were not always recovered by her in the event of a divorce. Some young wives felt their logistical vulnerabilities were offset by higher meher amounts. Among braver women, the meher was sometimes used as a bargaining tool during marital disputes. As is their Islamic right (haq; A), a wife could threaten to demand her meher monies, then and there, unless her husband ‘behaved’ or ‘agreed’ with her. Likewise, the higher their meher, the more some wives felt empowered to negotiate for health access privileges. In line with Islamic dictates, women were also not obligated to expend these monies on the household or to support their husbands.

Even a moderate level of financial independence supported women’s access to more expensive, private health services around Gilgit because they – instead of their husbands – were able to pay for their transport costs and clinical fees. The more money a woman had, the easier it was for her to convince her husband that her visits to local clinics wouldn’t affect the family’s overall well-being. Certainly, the costs of private care in Gilgit were onerous. With the average wage for an agricultural day-labourer being Rs 200 per day (CDN $4.50), the consultancy fee for a private physician ranged between Rs 100 and Rs 500 (CDN $2.30-11.40); this did not include medications or the supplies required for minor procedures or surgeries.

43 Participants noted that sometimes a bride’s family hoped she would become pregnant before the shahdi. Because grooms were eager to avoid the shame that accompanied a baby’s arrival in its mother’s family’s home, a woman’s family could use her pregnancy as a pretext to renegotiate additional meher monies to hasten the shahdi and thereby ‘release’ her to her husband’s home. 44 When a groom failed to advance the meher monies to the bride in the chaotic run-up to the nikah and shahdi, her parents often went to extreme lengths to secure these funds by selling off portions of agricultural land, taking private loans from other neighbours, or taking on additional work for the bride’s new in-laws for various periods of time. In order to avoid such scenarios, many families were, in fact, careful to negotiate for meher advances well before the wedding. These allowed her family to purchase the furniture, clothing and cooking utensils she was expected to take with her at the time of the rukhsati. When Wadood and I had first married, the ‘normal’ amount for a groom’s financial commitment was Rs 10,000 (CDN $350, 1998 dollars). But by the time we returned in 2004, it wasn’t unusual to hear of families demanding upwards of Rs 1 lakh (100,000; CDN $2,380).
Even at the government hospital (DHQ) where all services were technically covered, funding deficits meant that patients were almost always required to purchase bandages, syringes and IV-lines, and bring their own bed linens and food. (Lengthy hospital stays were prohibitively expensive, if not crippling, for poorer families.) Finally, and in the same way that women employed their relationships with neighbours and sympathetic family to strategize around regularly-occurring obstacles to their health service access, they were also known to pool their monies and hire Suzuki vans to take them en masse to visit local clinics or hospitals. I only learned about this as I pored through the In-Patient Register of a local hospital, and noticed that upwards of fifteen women at one time would arrive as patients from outlying villages or specific mohallas. Even while my participant’s husbands protested they wouldn’t allow their wives to ‘loiter’ in the bazaar (a common way to denigrate women’s movement beyond the home), very few actually blocked their wives’ clinic visits, even without his presence, if her earnings paid the fees.

Moreover, the Aga Khan Development Network, regional NGOs and a surprising number of vocal and highly progressive Sunni mullahs had worked hard to teach women’s families about the humanitarian, ethical and even Islamic responsibility of husbands to wholly care for their wives. Additional impetus was provided by Ismaili characterizations of biomedicine as ‘cosmopolitan’, and physicians’ descriptions of traditional herbals as ‘out-dated’ and ‘ineffective’. By using allopathic therapies, many Sunnis felt they

45 The average household income among my informants was Rs 2,500-20,000 (CDN $56.80-45.55) per month, with each household holding an average of ten family members. For Sunnis living in Gilgit Town, land holdings are substantially less than those living in neighbouring villages. As such, their necessary reliance on foodstuffs and household items purchased from the bazaar left them with less money for education and health costs. On the other hand, an overall lack of low-cost transport into Gilgit city effectively inhibited rural residents’ easy access of maternal health services. During my fieldwork, the rate of exchange was Rs 43-44 = CDN $1; at the time of writing, Rs 67 = CDN $1.

46 In the Sunni mohalla where we moved after the 2005 fights began, it was obvious that these efforts had made an impact on how men thought through the social, moral and spiritual costs of deliberately withholding care. In our own neighbourhood mosque, even amid his deep sympathies for the Taliban and active participation with Tablighi Jamaat missions, our local Qari (prayer leader) was firmly in favour of more equitable Islamic marital practices. In stark contrast to the Tablighi Jamaat’s sermons, he argued for returning power to young women to agree to or reject potential suitors, or seek temporary birth control measures should they have ‘too many children.’ These, he said, were truly Islamic practices which had been eroded or subverted by men more interested in power than domestic equanimity. His earnest efforts to rid our Sunni neighbourhood of the ‘unnecessary restrictions’ delimiting women’s everyday lives, and which were endorsed so vehemently by previous mullahs, were met with a combination of surprise, happiness and deep dismay. Many women were understandably grateful for his attentions, though because they were barred from attending mosque, they had only heard about his sermons second-hand.
were participating with a ‘modern’ world. In light of Sunnis’ competitiveness with local Shias and Ismailis, even gentle provocations spurred the majority of Sunni residents in Gilgit Town to wholeheartedly shift women’s care away from village and home-based desi practitioners and toward clinical centers and hospitals. In self-styled ‘progressive’ families, the ‘ethical’ treatment of women was now said to be demonstrated by men’s support for women’s everyday access to biomedical services. This represented a dramatic shift away from emergency-only care as had been the standard practice until thirty-odd years ago, and which was still characteristic of the poorest or rural Sunni households. Notwithstanding the risks posed by unhygienic or improperly supervised clinical settings, hospital deliveries offered conspicuous opportunities for Sunni families to demonstrate their ‘modernity’, while also proving they could prioritize women’s health ahead of pardah, izzat (honour; U) or their financial constraints. Indeed, women’s ability to access biomedical services often deflated Ismaili and Shia criticisms that Sunnis were callously insensitive to women’s needs. In this way, some participants had wondered if by ‘mimicking’ Ismaili gender liberalism and biomedical cosmopolitanism, Sunni women’s use of biomedicine represented a new kind of inter-sectarian competitiveness. By extension, I felt that for religiously moderate families, including a number of my in-laws and neighbours, women’s service use may have also acted as a point of quiet resistance against Wahabbist-politicking and socio-spatial strictures.

Although the Sunni community’s ‘modern’ competitions with Gilgiti Ismailis had led to unexpected benefits for women, these were soon offset by increasing Shia-Sunni ‘tensions.’ The 2004 Nisab Riots, for example, had only served to complicate Sunni women’s access to public and private health services. Because Gilgit Town’s maternity hospitals, and very often the roadways leading to them, were in Shia-dominated mohallas, these clinical spaces became inherently threatening sites during ‘tension times.’ It is worth noting that since the start of sectarian ‘tensions’ in the mid-1970’s (see Sokefeld 1998, 1999) and especially after the Nisab and Zia’u-din’s January 2005 assassination, Gilgit Town’s few remaining mixed-sect mohallas experienced a lessening, if not total departure, of their minority Shia or Sunni residents.
Mohallas were now unified Sunni or Shia blocks which enabled residents to simultaneously increase their sense of personal security and create ‘zones’ of sectarian identity in formerly mixed areas of town.

Moreover, in all areas (including those surrounding local hospitals), visual markers were used more and more often to demonstrate each mohalla’s Shia or Sunni affiliation. For instance, our Shia neighbours in Jutial Mohalla self-identified through the use of black flags, the ‘hand of Abbbas’, or metal lanterns elaborately decorated with the cut-out names of Hazrat Ali and his martyred sons, Hassan and Hussain, raised high above their homes. And on Shia festival nights, men climbed the local mountainsides to light a huge number of bonfires, shaped to write Shia invocations or the names of Imams. While men tended these mountainside bonfires, called čiragaan, women lit large kerosene-soaked piles of sawdust along the roof-edges of their homes, which were then kept alight by their children or servants. From dusk until about 10pm, these fiery, flickering names were visible across town. Depending on where the čiragaan were clustered, such as on the mountainside directly above Gilgit’s District Headquarter Hospital (DHQ) complex, Sunnis could easily see which mohallas were ‘off-limits’ for the duration of these often heavily politicized and increasingly high-risk celebrations.

Because the 2004 Nisab Riots had re-energized Sunni politicization, Gilgiti Sunni women faced an additional set of ‘tension’-related constraints from within their own community. Among my village-based participants, I noticed that mosque-inculcated, quasi-medical notions of behavioral ‘contagion’ intersected with rural Sunni communities’ stridently conservative stance, their sectarian animosities and

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47 By the time we returned in 2004, Sunnis and Shias actively signaled their religious and political affiliations with sectarian-specific clothes, housing styles, language patterns, gender practices and celebratory styles. For instance, heightened emphasis on visible signs of religious affiliation led a number of Sunni householders to hoist white cotton swags, on which ‘Allah’u Akbar’ (God is Great) was written in black paint, on poles above their homes.

48 Many Sunni participants and in-laws argued that while čiragaan shaped out in the name of religious leaders and members of the Prophet’s family were strikingly beautiful, Shia ‘fire writing’ was an idolatrous (shirk; A) act. Both Shia and Sunni Gilgitis suggested that ‘fire writing’ had ‘unIslamic’ roots; many claimed that Ismaili Hunzakuts had imported the tradition to Gilgit. (Gilgiti Ismailis also use čiragaan to mark the birthday and ascension dates of the Aga Khan [‘Hazir Imam’].) Nonetheless, its adoption and use by Gilgiti Shias to mark religious holidays has escalated dramatically in the past thirty years. Importantly, this tradition is practiced by Gilgiti Shias and not by Shias living in adjacent districts.
remembered traumas to impact clinical access. Sunni women were increasingly described by local mullahs and a wide array of Urdu-language Islamiyat materials as simultaneously ‘weak-minded’ (naaqisul aql, ‘imperfect reasoning’; A) and ‘imperfect in their faith’ (naaqisal-e-deen; A), due to their inability to pray during menstruation or after childbirth (see Majlis-Ul-Ulema 2000a: 14). Women were also characterized as being dangerously inclined to unthinkingly emulate their female health providers’ ‘morally unfocussed’ behaviours. To this point, Sunni women physicians working in mixed-gender, mixed-sect hospitals (which were already problematic because of their location in Shia mohallas) represented especially disconcerting, non-normative gender practices. Along with Ismaili and Shia women physicians, Sunni women doctors and nurses, the majority of whom were well-educated and financially independent, with jobs necessitating a more flexible practice of pardah, were often described as ‘morally corrupt’, ‘power-hungry’, ‘man-eaters’ or ‘infidels’ (kufr, non-Muslim; A).

Ultimately, women physicians from all sectarian communities provided awkward proof of alternative gendered existences, and served to pragmatically exacerbate the theoretical frailties of conservative Sunni discourse which claimed that women were inherently incapable of handling so much ‘responsibility.’ In addition, travelling mullahs or lay proselytization groups funded and trained by the Tablighi Jamaat, regularly used their Juma (Friday; A) sermons to argue that secular biomedicine and Family Planning were the product of a corruptive modern condition. Women were now urged to augment their faith, family honour and community integrity through their reliance on home- and mosque-centered Islamic or Prophetic therapies, homeopathy or herbal therapies (desi bilehn; S). To my mind, it seemed as though

49 For example, in Minawar (a Sunni village a fifteen-minute drive to the east of Gilgit Town) I encountered the most heated resistance to Shias as well as Sunni women’s access to Shia mohalla-based clinics. No matter how much I counter-argued against some in-laws’ vilification of Gilgiti Shias, it was impossible to overcome the family’s wounds. During a period of sectarian ‘tension’ in the mid-1990s, Wadood’s 15 year old first-cousin, Pakhtoon, was among 10 Minawar-bound Sunnis shot and killed as they drove through a Shia mohalla; this was only one of the family’s sectarian-related losses since the late 1970s. I found it important, however, to contrast such stories against my own recollections of AKRSP fieldwork interviews with Shia families in Jalalabad in 1998. Sitting in homes where bullet holes were evident in the house’s wood framing, or with bullets still lodged in the trunks of walnut trees in local orchards, women tearfully recounted seeing their husbands gunned down by Sunni marauders during the 1988 massacres.
Gilgiti men and conservative mullahs had externalized and projected their own ambiguities concerning secularism, sectarianism, religiosity and mixed-gender terrains onto women’s practices in the arenas of health, education or social mobility.

**Part V Statistical ‘Silences’ & Sectarian Hesitancies**

Roughly two months before the start of Shia-Sunni fighting and after completing the first stages of community-based research, I began asking local Ismailis, Shias and Sunnis to discuss their everyday and religious differences. By doing so, I hoped to illuminate the role of sectarian affiliation and inter-sectarian uncertainties not only in health service provision, but in how Sunni women’s reproductive practices were understood by their non-Sunni health providers. From my 1998 Internship with the Aga Khan Rural Support Programme (AKRSP), I knew Gilgiti Ismaili narratives were often heavily invested in positively contrasting the Ismaili community against the behaviors, social practices and economic development of the ‘other communities.’ But Ismailis were not alone in this, in that Gilgitis from all sectarian backgrounds described their ‘others’ in less than favourable terms. From many Ismaili and Shia standpoints, Sunnis were characterized as ‘less developed’ and ‘uncivilized.’ Theologically interconnected by a shared lineage of Imams (hereditary religious authorities), Ismailis viewed Shias as a somewhat antiquated and conservative antecedent to their own ‘cosmopolitan’ and thoroughly ‘modern’ lifestyle. Shias and Sunnis alike viewed Ismailis suspiciously, as evidence of both the miracles of socio-economic development and the possible degeneracy associated with ‘progressive’ mixed-gender sociality. Sunnis, in turn, viewed Shias as quasi-Islamic, openly disapproving of the Shias’ preference for religious icons and relics, their *Ashura* rituals (see pages 421-422) and the increased educational attendance by even the most heavily veiled Shia women.

In turn, juxtapositions of sectarian difference corresponded to ethnic identity and socio-economic gradients, all of which were used to justify and explain startling differences in Shia, Sunni and Ismaili women’s access to biomedical services, their use or rejection of Family Planning and their maternal health
Chapter One: Life & Health Between the Nisab Riots & Zia-u’din’s Assassination

practices. In the consensus of the physicians and health support workers I interviewed, Northern Areas Ismaili women’s health fared the best, Sunnis fared the worst, and Shias fell somewhere in-between (see Dr. Sharifa, AKHS,P: January 7, 2005; Gul Naseeba, Zulfiqar Colony: November 9, 2005; Dr. Munab, AKHS,P: November 9, 2005; Dr. Khalthum, DHQ: September 7, 2005). (As Chapter Two will demonstrate, while low service use and high maternal mortality ratios were indeed reflective of rural Sunni communities, clinical providers’ assessments were not entirely accurate for my in-town participants, among whom clinical access and use patterns were frequently as ‘modern’ as those evidenced by Ismailis.) Notwithstanding the correlation between identity and service use, regional health surveys and the Northern Health Project’s baseline survey failed to distinguish between Shia, Sunni and Ismaili patients. Locally-operating federal health services and NGOs were similarly inattentive. Although AKHS,P had conducted community-based surveys in Ismaili and Shia communities, Sunni-specific health statistics were entirely absent. At the Family Health Hospital, an Ismaili community outreach organizer noted:

“...sectarian affiliation is a sensitive issue, and we don’t break down statistics as such, though we might be able to identify [the patient’s] sect by where their alakah [residence; U] is.” (Alairah, FHH: May 12, 2005)

In fact, even before speaking with Alairah I had been trying to ascertain sectarian identity through a patient’s mohalla residence. It was a rough approach but largely reliable; as one physician at the AKHS,P Gilgit Medical Center noted, “How you are doing it is a much more delicate way of finding out” (Dr. Hamza, AKHS,P: August 10, 2005). In order to uphold these mohalla-based inferences, during my fieldwork in local hospitals I also combed through their in-house statistics, Out-Patient and In-Patient Registers, and drew on my own observations of patients’ dress, names and language use, all of which can be suggestive of sectarian affiliation. In this way, it gradually became possible to extrapolate the interrelationship between identity and health outcomes. Hospital-specific statistics offered additional clues; where the 1999 Health Project’s Baseline Survey indicated the regional maternal mortality rate (MMR) was 500 per 100,000 live births (Karim 2004: 11), in 2001, AKHS,P estimated that among their
predominantly Ismaili patient base (with the majority of their clinics and hospitals based in Ismaili-dominated mohallas or Sub-Districts), the MMR was 127 per 100,000 live births (AKHS,P 2002: 21; AKHS,P 2003: 15). By 2003, AKHS,P noted that, among their patients, the MMR rate had dropped even further to 69 per 100,000 live births (AKHS,P 2003: 15).

Despite the importance of these findings, in the early stages of my fieldwork, physicians and health support workers had discouraged my focus on sectarianism, preferring instead to emphasize the commonalities of belief and lifestyle that they said bound each community to the other. And while acknowledging there were indeed significant variations between how Shia, Sunni and Ismaili women accessed clinical services - as well as between their Islamic or desi (traditional; U) health practices - policy analysts, physicians and hospital administrators were equally reluctant to help me address Sunni use patterns. After I had provided the DHQ’s Acting Medical Superintendent with a summary of my research plan, and explained how I hoped to pull into view the demographics underlying Sunni health outcomes, he leaned back in his office chair and, with a bemused look on his face, addressed the junior staff who sat clustered around his desk, “But why just Sunnis?” (DHQ: November 8, 2004) My response - that Gilgit’s Sunni community was facing challenges that were relevant to larger discussions of the multi-sectarian Muslim world - was met with uncomfortable laughter. Clearly, my research had touched a local nerve.

And even after having obtained the support of AKHS,P physicians and support staff who had allowed me to conduct on-site interviews with employees and patients over the preceding ten months, in the late summer of 2005, the Gilgit Medical Center’s Chief Administrator blocked my efforts to secure permission to read or

50 In Ghizer District, AKHS,P operates Primary Health Care modules in Ismaili-dominated Sub-Districts of Puniyal, Iskhomen, Yasin and Gupis. In Gilgit District, Primary Health Care modules operate in Ismaili-dominated Hunza and Gojal Sub-Districts. There is one PHC module in Shia-dominated Nagar District. AKHS,P operates two large hospitals: one in Karimabad, the capital of Hunza Sub-District, and the other in Gilgit Town’s Gilgit Medical Center. It is worth noting that while there are substantial numbers of Sunnis living in Ismaili-dominated Yasin, Gahkuch and Puniyal Sub-Districts (Ghizer District), I was unable to find any official statistics estimating population size, nor health literature discussing how Sunnis in Ghizer District use or access Federal or AKHS,P health services.

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make copies of either public or internal AKHS,P policy documentation.51 I had already received their 2002 and 2003 Northern Areas Annual Reports as a courtesy from AKHS,P’s General Manager, yet the Chief Administrator remained suspicious (Fieldnotes: August 24, 2005). He was even more distressed when I discussed my efforts to tabulate how many of the Gilgit Medical Center’s patients came from Sunni areas in the periods before and after January 8th. After holding a heated meeting with me and the physicians I had interviewed, he finally agreed I could review the hospitals’ 2004 and 2005 Intake Registers. In his efforts to defend my research, the hospital’s anesthesiologist tried to downplay my work’s more awkwardly political elements by citing my marriage to Wadood. “It is a sensitive topic, but if you’re only counting numbers it shouldn’t be a problem, and because of your position, people aren’t confused that you’re affiliated with AKDN [Aga Khan Development Network]” (Dr. Munab, AKHS,P: August 24, 2005). I took this to mean that because of my connections to Gilgit’s Sunni community, no one would mistake me for an AKDN employee.

My Ismaili participants’ initial reluctance to address sectarianism was in some ways a continuation of the ways in which Ismailis distanced themselves from political instability or violence. Conditioned to being caught between warring sects or even the focus of direct violence, it was clear that many Ismailis had become adept at minimizing their presence during times of conflict. Early in 2005, when Shia-Sunni ‘tensions’ were at their peak, one Ismaili physician agreed to discuss the conflict’s impacts for Sunni women’s service use. After a few minutes, it was clear she was nervous, and I paused to ask what was wrong. She quickly responded, saying “I’m not concerned for my personal safety, but for my religion, which is very important to me” (Dr. X: February 9, 2005). Realizing that many non-Sunni health providers initially assumed my marriage to Wadood meant my loyalties were firmly affixed to the Sunni

51 My experience stood in stark contrast to the support offered to Sarah Halvorson, who during her doctoral fieldwork was permitted access to AKHS,P reports, internal communication and documentation by then-General Manager Dr. Zeba Rasmussen (see Halvorson 2000). Hearing of my predicament, AKRSP’s Gilgit District FMU (Field Monitoring Unit) Manager called me the following week and volunteered AKRSP’s Resource Center and office assistants to help with my literature-based research. He professed he didn’t understand AKHS,P’s reluctance to share internal documentation with me, but mused that perhaps my interconnections with the Sunni community might be viewed antagonistically (AKRSP: August 9, 2005).
community, or that I had become antagonistic toward Shias and Ismailis, the doctor seemed comforted to hear I’d worked very happily for AKRSP six years previously, and that during my employment, I had lived with a Shia banker and his Ismaili wife in Shia Khormer Mohalla. She then took the opportunity to discuss how her own Ismaili allegiances inspired her practice of medicine:

“The Sunni community is quite jealous of the Ismaili community, and I do wonder how Wadood’s Sunni family will understand you spending so much time [talking to Ismaili doctors]. They [Sunnis] do not think we are Muslim, but we think we are the best Muslims, because we follow the utmost principles of Islam. For me, it doesn’t matter if the patient is Shia or Sunni. In fact, I don’t recognize what the patient is most of the time. I tell things truthfully, and would not want to say or have anything used to create any sort of problem for my community.” (Dr. X: February 15, 2005)

Not every Ismaili or Shia participant was reluctant to comment on sectarianism. One of my first interviews stands out in my memory, in great part because it spoke so clearly to the ways Ismailis could think about or discursively construct Sunnis. This was especially important because the majority of Gilgit’s health service providers were Ismaili. After hearing I had experienced some difficulties with AKHS,P’s Management at the start of my fieldwork, an acquaintance from my time at AKRSP quickly volunteered her cousin for an interview. Like my friend, Gul Naseeba was an active member of the local Jamaat Khana’s Women’s Council, and had worked for nearly ten years on economic and now health promotion initiatives among her neighbours. Wadood drove me to meet with her at her home on a sunny November day, shortly after Gilgit’s October elections when Sunnis had swept to power.

Annoyed that her local Ismaili candidate had lost to a Sunni, Gul Naseeba moved quickly to question why I had chosen to marry Wadood. Sitting across from me in a rusted garden chair, Gul Naseeba took a sip from her steaming cup of salt chai (tea; U) and looked at me inquisitively. “How could you have married into that community?” she asked, with her niece translating her Burushaski into English. This was not the first time an Ismaili had prodded me to discuss my reasons for marrying Wadood, and joining a community that was roundly dismissed by Ismailis and Shias alike as ‘uncivilized’, ‘degenerate’ and violently ‘jungulee’ (uncultured; U). After professing that ours was a “love marriage”, I asked Gul
Naseeba what she thought of her Sunni neighbours and clientele (Fieldnotes: November 4, 2004). Gul Naseeba started by listing her achievements. For nearly seven years, she had worked as a volunteer community mobilizer for the Aga Khan Health Services (AKHS,P) in Zulfiqar Colony, a mixed Ismaili-Suni mohalla sitting on the southern banks of the Gilgit River. Because she had been a vocal and active participant in Jamaat Khana (Ismaili mosque) women’s organizations and community governance, Gul Naseeba had been elected by AKHS,P to serve as a community advocate. Despite having no formal training in either community health promotion or basic first aid, the AKHS,P had entrusted her with patient monitoring and clinical follow-up. Once a week she met with physicians at the AKHS,P’s Khomer Chowk clinic, where she was given the names and addresses of those patients AKHS,P staff identified as particularly ‘needy,’ or unlikely to return for required medications or care.

“Once a week, the doctors at the AKHS,P center tell me how to care, and who to help. I receive a call once a week from them. I see and meet with the doctors at the clinic and they advise me about health issues that are particular to certain patients, and let me know where they need to go....I help them understand how blood pressure problems affect the kidneys or lungs, I teach them to recognize major diseases. I go throughout one hundred households...at least once a month....Yes, we collect money from all these same residents, and take the money and deposit it with AKHS,P. Typically, we take Rs 5 [CDN $0.80] per person above twenty years of age in each household, but this is not compulsory if they can’t afford to give it. They [AKHS,P] have a system where the money is used. It helps with women who have delivery problems, or blood problems, or transfusions, or whoever is poor - like those people from Darel and Tangir [Diamer District].” (Gul Naseeba, Zulfiqar Colony: November 4, 2004)

For Gul Naseeba, Diameri migrants and their Gilgiti Sunni counterparts were an obvious mismatch with Zulfiqar Colony’s Ismaili community, where women regularly completed high school and many went on to college in Gilgit Town or Pakistan’s urban centers. Her descriptions of her Sunni neighbours provided a typically reductive overview of the perceived differences between Ismailis and Sunnis and exhibited marked similarities to the complaints expressed by my former Ismaili colleagues at AKRSP when they recounted working with local Sunni communities.

“Among my neighbours, the non-Gilgitis [Suni migrants] house condition is not good. People from far-flung areas eat fruit, and then throw away the skins and remnants onto

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the floor where ants eat it. Or, they leave pots with leftover food from meals uncovered, and flies and dust get inside. They don’t fold their *bistra* [bed-mats; U] properly; they are dirty. Women are not ironing their clothes, and their *dupattas* [veils; U] are dirty. Lots of Ismailis equals a good impact on Sunnis, who typically have very dirty homes or clothes. Women even have food on their *dupattas*, and they don’t care about themselves. Now, because of Ismailis, they are shifting to an increased emphasis on cleanliness. I’ve been training [Ismaili] women to grow veggies, but Sunni women remain unable to prepare a proper diet. I encourage them to grow veggies in their home garden so they are not a burden on their husbands, who are required to bring food home from the *bazaar* if it’s not [already] available....If you go to Ismaili houses you see they are more ‘advanced’, but Sunnis are *sada* log [simple people; U]. [Gilgiti] Sunni families see Ismaili women are hardworking, and they realize they should do the same....Sunnis are impressed by Ismailis. One Sunni man calls me the ‘chairman’ of the area! And while Sunni men indicate they want their women to be more like Ismaili women, they say it’s impossible....according to what I’ve seen, Sunni women are able to change, but men don’t give them the opportunity....women say ‘the men won’t let us.’ ....Even after all this, Sunnis feel they are ‘superior’ to Ismailis, and therefore they don’t need to ask us about our Ismaili faith....We hear that they say we [Ismailis] are *kafir* log [unbelievers, non Muslim people; U].” (Gul Naseeba, Zulfiqar Colony: November 4, 2004)

I then asked her if the differences between Sunni and Ismaili women were reflected by their health service use patterns.

“For the women in those [Sunni] communities, the *bazaar* is *dur* [far; U]. For Ismailis, access to health services is not a problem of ‘permission’, but of finance. And unlike Sunnis, Ismailis are forbidden to beg, so instead they try to keep their dignity and place requests with our local *Jamaat Khana* council for funds to cover health services. The council then verifies their poverty and sends a council letter to AKHS,P indicating they will cover the patient’s fees – all this remains confidential. Or, they can go to an AKHS,P health center and request a concession in their fees, once they have spoken to their doctor or the staff.”

(Gul Naseeba, Zulfiqar Colony: November 4, 2004)

Gul Naseeba’s niece Shamsa added that Ismaili women could easily arrange for community financing, transport or even travel alone to AKHS,P’s clinic in the nearby *bazaar* without first asking *ijhaazat* (permission; U) from a husband or male family member. Gul Naseeba then argued that Sunni women rarely left home without a male attendant, even in emergency health situations.

“Sometimes women are ‘copying’ Ismaili women and going alone to clinics, but generally women have someone go with them. Ideally it is better if it is their husband, but sometimes neighbours will go with her too.” (Zulfiqar Colony: November 4, 2004)
Shamsa and Gul Naseeba said that local Sunnis understood Ismaili ‘modernity’ as being the result of cash handouts from the Aga Khan during his annual and bi-annual visits to the Northern Areas. Moreover, they both said that Gilgiti Sunni women were openly envious of Ismaili women’s comparative freedoms. In particular, while Ismaili women were free to attend the Jamaat Khana with Ismaili men, Sunni women were strictly prohibited from entering mosques.

“Sunnis think that when the Aga Khan comes to our area, and we meet with him at deedari [community-level, religious audiences with the Aga Khan; U], he gives us money!...While some Sunnis laugh at Ismailis, and think that the Aga Khan is our Khodai [God; U], some [Sunni] women have said to us that ‘God has given this duniya [world; U, A] for you to enjoy, and the Qaiyamut [afterlife; A] to Sunnis.’” (Shamsa, Zulfiqar Colony: November 4, 2004)

After reflecting on AKHS,P’s community outreach activities, Gul Naseeba affirmed that Ismaili services were theoretically open to all sectarian communities, yet Gilgiti Sunnis had apparently done nothing to return the Ismaili community’s generosities.

[Gul Naseeba, grandmother] “Ismailis wish to interact in a close, peaceful manner, but Sunnis are shaitan [wicked; A]...The government has convened a committee of Sunnis, Shias and Ismailis to work as a catalyst against violence, and generally people in our area try to maintain good relations but...”

[Shamsa, niece] “They don’t have the patience required for successful friendships, they are ready to kill and very close-minded. They’re not ready to accept changes and have no respect for others’ beliefs. Our everyday life shows us why keeping our distance from them [Sunnis] is a good thing.”

[Hanif, grandson] “Sunnis only see our [organizational] systems and don’t understand that these ideas are internalized, with Ismaili beliefs underlying our practice and thought processes.” (Zulfiqar Colony: November 4, 2004)

Questions of progress, advancement, ‘genetic’ predisposition and Sunni obstinacy frequently surfaced in this and many other early interviews with Gilgiti Ismailis. For instance, Shamsa mused that the Sunnis’ unprincipled and unruly nature was “genetically” determined, and laughingly warned me about the future difficulties I might one day face with my half-Gilgiti, Sunni sons (Zulfiqar Colony: November 4, 2004). Shamsa and Gul Naseeba’s sense of Sunni identity as being definitively correlated with conflict was commonplace. In an interview with AKHS,P’s health promotion artist Monir Sadiq, he identified
Sunnis as being inherently dangerous and threatening to Ismailis. “We [Ismailis] don’t like conflicts, and they have guns. We don’t like guns and are unarmed. Our attitude is, ‘If you are good, you will leave us alone with our faith”’ (AKHS,P: August 9, 2005). In a November 2004 interview at AKHS,P’s Khomer Chowk clinic, a staff physician, Dr. Hafiz, argued that Shias and Sunnis were both being held back by religious fanaticism. Over a short break between patients, he described the lamentable efforts Sunni religious organizations had made to improve community health throughout the Northern Areas and the neighbouring Chitral Valley, found at the northernmost edge of Pakistan’s North-West Frontier Province (NWFP).

“Before I was posted to Gilgit, I worked in the northern Chitral Valley…in their Ismaili communities. When I was there, at the request of the local Sunni community in Chitral Town, a Saudi sheikh came to establish a parallel Sunni health center. After a few months and the establishment of just one clinic, he married a pretty girl and left [laughs]….The Sunni community can try to establish efforts like those of the AKHS, but somehow they don’t succeed. Perhaps this is a case of the community’s orientation and attitudes being so starkly different [even] despite having access to the same kinds of services….For people who do have better health, I see a common interest in education and improvements to health standards, hygiene and awareness. Over time and with continuing efforts, those people will become civilized.” (Dr. Hafiz, AKHS,P: November 9, 2004)

Gilgit’s Sunni community was neither immune to, nor unaware of the uncertainties or antipathies local Shia and Ismailis held towards them. In many respects, however unspoken these views were in face-to-face clinical encounters between Ismaili or Shia health providers and Sunni patients, these quiet prejudices played a role in shaping my participants’ preference for certain health centers or physicians. Of course, Sunnis were not exempt from inter-sectarian vulnerability, prejudice or bigotry; I knew first-hand that Sunnis were equally invested in nurturing derogatory stereotypes about their local ‘others’ and had played a heavy role in prior inter-sectarian violences, particularly against Shias. As such, Ismailis were not often wrong in their assumptions of Sunni prejudice. Take for example what one of Wadood’s

52 Over the last twenty-five years, AKHS,P has opened Ismaili-community based Public Welfare Centers and Maternal Child Health centers across the northern half of the Chitral Valley (North-West Frontier Province).
Diameri cousins said to me when he found out I had maintained my friendships with local Ismailis even after marrying into a Sunni family:

“Those people...Mogulai ['Mughal', Ismaili; U] people, will never go to Jennat [Heaven; A] because they don’t say the kalima [Islamic credo; A] properly, nor namaz [pray; A] or roza [fast; A] properly. I think that converting people is paramount, and we will be punished if they refuse! The responsibility is for us to change them! “ (Abid, Gilgit: March 17, 2005)

Part VI Conclusion

Shortly after starting my fieldwork, I realized how difficult it would be to analyse women’s health decision-making, not only because women’s sense of what constituted appropriate care was interwoven with conflictive sectarianism, but because it was also entangled in a web of biomedical, traditional and Islamic health beliefs and etiologies. And in addition to medical pluralism, pardah’s spatial demarcations and mobility-related constraints, women’s health was also shaped by household- (ghar; U), extended family- (khandan; U) and community-specific customs (riwaj; U). For the remaining four chapters in Part One, I address Sunni women’s reproductive and maternal health experiences during times not disrupted by open sectarian conflict. Rather than over-attend to the male-centered hostilities of 2005, I hope to illuminate the everyday battles over identity and ‘body’ navigated by women throughout their reproductive lives. While Chapters Three through Five describe Sunni women’s traditional health practices, Family Planning and the counter-pressures precluding women’s use of contraception, Chapter Two focuses on Gilgit’s biomedical reproductive and maternal health services. Of the more than fifty women I interviewed who came from across the socio-economic spectrum, all had given birth in local clinics or hospitals. (In Gilgit Town, women’s use of hospitals for their deliveries was near total, while in the Sunni villages surrounding town it was less frequent.) Because biomedical service provision played such a regular role in Sunni women’s reproductive and maternal health, I provide an overview of local maternity hospitals and private clinics, the ascendance of biomedicine over traditional therapies over the last thirty years, the gradual disappearance of community-based midwifery, and women’s experience of childbirth, pregnancy and infant loss in clinical centers.
Chapter Two: Gilgit Town’s Maternal Health Services, Private Practice & Personal Loss

Part I Introduction

When we returned to Gilgit in the summer of 2004, my in-town Sunni participants lived within manageable reach of local hospitals, private clinics and pharmaceutical dispensaries and, unlike their rural relatives, faced far fewer obstacles to their uptake of reproductive and maternal health services. Even though Gilgit’s Sunni mohallas evidenced the impacts of increased Pathan, Saudi and Tablighi Jamaat missionization – with masjids (mosque; A) and madrassahs (seminary; A) being built throughout town and more women wearing hijab - intensified conservatism had not completely precluded Sunni women’s uptake of maternal health services. Whether clinical service uptake resulted from genuine efforts to improve women’s well-being, family efforts to ‘modernize’ or sectarian competitiveness, the end result was that very few of my in-town participants had their births attended by traditional midwives (dayahs; U). This was especially true for participants aged thirty-five years and younger, due to their having grown up during the regional explosion in health and socio-economic development (see Hertzman 2001). Indeed, the encroachment of biomedicine into domains of health once dominated by desi bilehn (traditional medicine; S) and desi dayahs (traditional midwives; U), and the subsequent medicalization of women’s reproductive and maternal health occurred more often among in-town residents, and resulted from women’s frequent visits to clinics and dispensaries. After multiple pregnancies and deliveries, many in-town participants felt they could identify biomedicine’s therapeutic scope, etiologies and ‘symptoms.’ In turn, women were adept at deciding which of their reproductive health complaints was best covered by allopathic or desi care.

The Northern Health Project’s 1999 Northern Areas Baseline Survey seems to verify the District-wide shift from desi bilehn (traditional medicine; S) to biomedicine. For instance, 67.8% of women surveyed across Gilgit District had used pre-natal maternal health services (Rahman 1999: 13). Of these, 91.3% received care from hospitals, health centers or clinics, while only 8.7% received pre-natal care from a
traditional birth attendant (TBA) or “non-professional” (Rahman 1999:14).¹ But my in-town research participants’ near-total reliance on clinical childbirth support was not reflected by the same study. Among three-hundred married respondents across Gilgit District, the survey found 42.6% of delivery cases took place in a ‘formal health facility’, while 55% occurred at home (Rahman 1999: 17). After looking more closely at the survey’s methods, I realized because the NHP had focused on rural women living in the villages outside of Gilgit Town (see Rahman 1999: 3, Annexure 1), it failed to account for in-town health practices and service uptake.

At a primary level, this chapter describes the maternity hospitals used by my Sunni participants for pre-natal care, childbirth and pregnancy terminations. However, by foregrounding caregivers’ narratives, this chapter also provides an overview of the wide range of health conditions, ailments and emergencies which were treated by Gilgit’s public and private sector health services. In addition to discussing biomedical maternal health service provision, hospital costs and the ways in which childbirth and pregnancy loss were treated, I briefly describe Gilgit’s pharmaceutical dispensers (comporters; U) and private clinics. (In particular, the section concerning pregnancy and infant loss responds to the “paucity of community-based data on perinatal mortality in Pakistan...[whereby] no method or system for recording miscarriages or stillbirths exists” [Bhutta, Ali, Hyder & Wajid 2003: 22].) Besides offering valuable insights into the subtle ways sectarian affiliation and religious practice occurred in clinical contexts, this chapter may be the first ethnographic exploration of clinical biomedicine in Gilgit Town, and therefore remedy a crucial gap in the literature concerning Northern Areas women’s health.

**Part II: District Headquarter Hospital (DHQ)**

In contrast to the rest of Pakistan where the “private health sector accounts for nearly two-thirds of all health expenditures”, across the Northern Areas the “public health sector is the major health care

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¹ Though the need for traditional dayahs (midwives; U) in Gilgit Town has decreased substantially, organizations like the Family Planning Association of Pakistan had extended their outreach to include Safe Motherhood initiatives in outlying villages throughout Hunza District (FPAP, FHH 2004: 54). These were initiated to help ensure “safe delivery services”, and between the spring of 2003 and autumn 2004, FPAP claimed that 96 deliveries occurred under the supervision of dayahs trained by the project (FPAP, FHH 2004: 54).

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provider with health care facilities of varying levels throughout the region” (AKHS,P 2002:2). Prior to the Karakoram Highways’ completion, and even after the establishment of low-cost non-governmental health clinics, Gilgit Town’s District Headquater Hospital, or DHQ, has served as the primary referral hospital for the entirety of the Northern Areas. Despite considerable clinical insufficiencies, widespread evidence of medical malpractice, chronic under-employment (with thirty revolving staff shifts and nearly one-hundred trained and untrained volunteers covering two hundred and fifty hospital beds [Medical Superintendent, DHQ: November 8, 2004]), the DHQ’s no- or low-cost services were in constant demand. Overall, the DHQ provided more than one-third of the Northern Areas’ “677 hospital beds” (IUCN 2003: 203). Comparated to the smaller District and Civil Hospitals located in each District’s administrative capital, Gilgit Town’s DHQ offers the Northern Areas’ most comprehensive array of diagnostic and therapeutic services. Yet because of the haphazard nature of inter-city transportation (whether by road or plane from Islamabad), DHQ’s medicinal supplies were chronically unpredictable.

After General Pervaiz Musharaff appointed himself President in 1999, he applied considerable energies to improving Gilgit’s hospital facilities, while also placing its Administration under Army-control. An Army Colonel who acted as both Staff Colonel and the District Medical Superintendent (DMS) now supervised the DHQ’s In- and Out-Patient Wards, employees and volunteers. Not without some cynicism or bitterness, staff had nicknamed him “Colonel Sahib” (master; U) due to his autocratic handling of staff complaints. Next in authority was the Northern Areas Director of Health (DOH), who, in 2004, was the Sunni physician Dr. Sher Wali Khan; on January 8th, 2005, he was among the first Sunnis to be killed by Shia assailants. As was the case for all other federally-run Primary, Family and Maternal Health facilities, the DHQ was centrally administered by the Northern Areas Department of Health which, in 1999, included “2,500 medical staff, including 165 doctors” (IUCN 2003: 203).

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2 Because it appeared that hospital volunteers were predominantly men, DHQ volunteers did not play any noticeable role in alleviating staffing shortages at the Family Wing’s In-Patient, Out-Patient and Labour Room.

3 These include DHQs in Skardu (Baltistan), Karimabad (Hunza) and Chilas (Diamer), and Family Welfare (FWC) and Maternal Health Centers (MHC) at Sub-District (tehsil) and village-levels.
In its earliest days, the DHQ’s obstetric services were predominantly emergency-related; patient access was usually constrained by transportation difficulties or family uncertainties about the social consequences stemming from male physicians’ treatment of women. And in the years before governmental agencies like the Family Planning Organization (FPO), the Family Planning Association of Pakistan (FPAP) and the AKHS,P established their in-town clinics, the DHQ had also faced competition from community-based traditional midwives (dayahs; U). But over time, there was a noticeable shift away from dayah-attended home births to hospital deliveries among Gilgit Town’s Ismaili, Shia and Sunni communities. Although my participants visited a number of different health services for their pre-natal and post-partum checkups, roughly 80% said their next delivery would take place at the DHQ. Since its inception in the 1960’s, and even after other maternity hospitals were built in the mid-1980’s, the highest proportion of in-town births have taken place at the DHQ’s women-only Family Wing. According to the Labour Room’s autumn 2004 Intake Register, over seven weeks (September 4 to October 24) there were 520 deliveries (Fieldnotes: August 23, 2005). By contrast, in 2003 AKHS,P’s Gilgit Town Maternity Home handled 648 deliveries over one year (AKHS,P 2003: 5), while at the Family Health Hospital there were 301 births over five years (FPAP, FHH 2004: 13).

Under the direction of the Army Colonel who now supervised the DHQ, in 2000 the old Family Wing block was demolished with the exception of a few rock and timber-framed patient rooms. Officially inaugurated in 2001, a new whitewashed concrete block, two-storey Maternity Block joined a three-storey Out-Patient and administrative ward (see Figure 7). These blocks faced the In-Patient Ward, a bungalow

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4 This varies substantially from both regional and national statistics. As the Gilgit-based Family Health Hospital’s 2004 Progress Report notes, the Northern Health Project’s rural-focused, 1999 Baseline Survey found that “39% of women received assistance from a trained attendant during delivery” (FPAP, FHH 2004: 11). Whereas, “according to the UNICEF, only 19% of deliveries in Pakistan were attended by a trained health personnel during the years 1995-2000” (Bhatta, Jafarey & Midhet 2003: 6); the authors further note that “82 to 89% [of infants were] delivered at home between 1990-7” (Ibid: 6). One conclusion which could be drawn from these statistics (and Gilgit Sunnis’ regular use of hospitals for deliveries), especially in light of the Northern Areas’ MMR rate (500 per 100,000) being higher than the national average (340 per 100,000), is that hospitals and trained birth attendants may make a less than favourable difference to Northern Areas women’s maternal health outcomes (see Rahman 1999 and Bhutta, Jafarey & Midhet 2003: 6). It is also worth noting that the Government of Pakistan’s national health statistics do not take into account, let alone solicit, statistics from the Northern Areas.
reserved for non-obstetric cases. Below the Family Wing’s In-Patient and Labour Room facilities, the Army had constructed a new wing of Out-Patient examination rooms. Comprised of three examination rooms, a separate suite for minor surgical procedures or IUD-insertion and the Family Planning Organization’s primary outreach office, the Family Wing’s Out-Patient (OPD) clinic operated each day between 8am and 2pm, with the exception of Juma (Friday). A small, grassy space beside the Out-Patient Wing was where male attendants waited out delivery cases or physician visits. The OPD clinic was managed by the Family Wing’s two OB-GYNs, one a Sunni living in Sakwar Village and the other a Shia living in Jutial Mohalla, who, with several women GPs, examined roughly one hundred women daily. Because of their Out-Patient duties, physicians and nurses were rarely available to supervise deliveries in the Labour Room; they tended to come only for ‘complicated’ or ‘emergency’ cases. Perhaps because these women physicians were well aware of gossip concerning medical malpractice, they refused to allow me to observe OPD visits. (At the AKHS,P’s Gilgit Medical Center, a ten-minute drive from the DHQ, women physicians reported that among those of their patients who had first visited the DHQ, the majority of women sought help for “common problems affecting menstruation, bleeding irregularities [and] infertility” [Dr. Sharifa, AKHS,P: January 7, 2005].) After reflecting on the number of patients who attended the DHQ’s numerous Out-Patient clinics where only a handful of specialists checked upwards of nine hundred patients each day, one Sunni physician asked “if care was even possible under such circumstances?” (Dr. Yasin, Jutial: November 5, 2004). The Northern Areas’ physician-patient ratios are particularly problematic; in 1995, the
Directorate of Health Services for the Northern Areas estimated that there were approximately 6,660 patients for every doctor, while the Pakistan-wide average was 1,923 patients per physician (Halvorson 2000: 139, Table 4.1). Even with the new Family Wing built to accommodate increased patient numbers, Lady Health Visitors (LHV), the equivalent of a junior nurse-midwife, pointed out how no new staff had been added:

“…three years before the government rebuilt this Family Wing and we have the same staffing as before. Most have been here a long time. One came here in 1998; there are eleven or twelve nurses – Senior Sisters – six LHVs and three Nurses’ Assistants [ayahs] and we have four Senior Sisters in the Labour Room.” (LHV II, DHQ: July 26, 2005)

With upwards of forty delivery cases arriving each day, the Maternity Block’s Labour Room was the busiest of Gilgit’s three hospitals (LHV III, DHQ: July 26, 2005). The Labour Room had three beds, while the Pre- and Post-Partum suites had six beds each. During morning shifts that ended early each afternoon, patients were handled by nurses and LHVs, both of whom were called ‘Sisters’ by staff and patients, and one dayah (trained or lay midwife; U). In the afternoon and evening shifts, one LHV was assisted by two ayahs (U). (Though nurses were technically responsible to provide Labour Room coverage, the majority of their attentions, as noted, were focused instead on the Out-Patient and In-Patient Gynaecological ['Gynae'] Wards.) During their twenty-four shifts, four LHVs managed the Labour Room, with each working day-long shifts once every three days.

“Every week I work two nights, with 24 hours duty. I have 24 hours on, and 24 hours off. I work with one ayah at night. If there are even four to five emergencies, we two can handle it all.” (LHV III, DHQ: August 1, 2005)

Depending on their employment seniority, LHVs’ monthly salaries fluctuated between Rs 5,000 and Rs 8,000 (CDN $113.60-$181.80) (LHV I, DHQ: July 26, 2005). Despite the DHQ Staff Union’s best efforts, their salaries did not come with any additional benefits or subsidized transportation (LHV

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5 At Gilgit Town’s major hospitals, nurses and LHVs were referred to as ‘Sisters.’ Trained and untrained midwives were called dayahs (U), and untrained women orderlies and clinic assistants were called ayahs (U). At the DHQ, dayahs provided a wide array of supportive activities in addition to helping women during the early stages of labour.

6 Before being hired at the DHQ, “dayahs get one year of training at DHQ. Before we had a Midwifery College that was open, but now the health workers are just taking their training from the Sisters who provide the training. We already have a few Sisters who do this. In the afternoons, one Sister [and] a Sister’s assistant are taking care of five wards – we can use a phone to reach her if we need her here, or somewhere else, but all the buildings are interconnected so we can easily reach them ourselves” (LHV, DHQ: July 26, 2005).
II, DHQ: August 1, 2005). The majority of senior Family Wing LHVs and ayahs were Ismaili, and had either been trained in government nursing colleges or by the AKHS,P. Alongside Gilgiti staff, there were also several Punjabi LHVs who were married to Gilgiti men. In its earliest days of operation, the DHQ’s Labour Room was managed by an Afghan dayah named Zarina, who had been assisted by a Sunni Gilgiti dayah named Nargis (LHV III, DHQ: July 26, 2005). Nargis’s younger sister was still employed as a senior LHV at the DHQ where she had worked for twenty-six years. As had been the case for many Gilgiti nurses and LHVs, economic deprivation and more specifically the lack of a father or brother to provide income, necessitated her search for formal employment.

“I’m getting ready for retirement. I’m not sure if I’m going to get a pension or not....I’ve got no formal training, but I learned on the job. I’ve had a lot of experience and seen so many things, what’s the point of training now? [laughs] Allah ne sikhaya [I learned from God; U]! My father died when we were little, and my mother was mujuboorh [lost; U] without him, and said ‘Its better my daughters learn and make money!’ Nargis’s husband died when her children were little, so she had to start work as this.” (LHV, DHQ: August 2, 2005)

Several other now-retired nurses and LHVs continued to work informally and were hired by families for home deliveries, were also Punjabi. Among the most prominent was Sister Sabah, a Khawaja (Karachi Ismaili) who was the Northern Areas first qualified nurse (Sister Sabah: August 29, 2005). Although the Labour Room staff readily admitted they didn’t have as much medical training as Aga Khan Health Service employees, they felt that the Family Wing’s high patient load had helped them refine their skills. “The more you do at DHQ, the more you know - we’re much more experienced than the staff there” (LHV V, DHQ: August 6, 2005).

“I’ve got my Class 9, and got my training for two years at the Public Health School in Peshawar for nursing; I graduated two years ago.” (LHV, DHQ: July 26, 2005)

“I’ve been an LHV [Lady Health Visitor] here since 1990. I got my training as an LHV from an Aga Khan Center in Karimabad, and received two years LHV training in Karachi and graduated in the 1980s. Later, I was with AKHS,P and working throughout the Northern

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7 By 2004, DHQ employees and volunteers had established a Staff Union but it did not collect union dues or carry any effective bargaining power. Instead, the Union’s President and Chairman acted as intermediaries between support staff and DHQ’s Administration and senior physicians. “If we have a problem, we call them and they come, but just to discuss it. Not to take action...we haven’t thought to make our own, female Union of staff from the Family Wing yet” (LHV II, DHQ: August 2, 2005).
Areas, in places like Yasin and Gupis. But after my marriage, my husband didn’t allow me to travel all over the place alone, so he said ‘You should take a government job.’” (LHV, DHQ: August 2, 2005)

“I’ve had my Matriculation [Class 10] and been doing this work for 15 years. My pay now is Rs 7,500 [CDN $174.40] per month8…I had one year’s worth of training, here at the DHQ as a nurse’s aide, then I went to Lady Atchison Hospital for two years training in Lahore as an LHV; after Lahore I came here to start working. I’m from Hunza, near Aliabad, but I married a man from Oshikandass and I live near the Army Cantonment in Jutial.”

(LHV, DHQ: August 1, 2005)

Upon arrival at the Labour Room, maternity patients were registered by attending nurses or LHVs who took the patient’s “name, residence, who they’re married to, whether they were admitted [to the In-Patient Ward] or not, or before; their health status, the timing of things [the birth]…we’ll also write kitney gravida heh [how many children delivered; U]” (LHI, DHQ: August 6, 2005).9 After poring through the Labour Room’s 2004 and 2005 Intake Register, it was clear that LHVs also noted whether medications had been given to hypertensive or eclamptic mothers, and when patients were Hepatitis-positive or had tuberculosis. The baby’s approximate weight (no scale was used in the delivery suite) and Apgar scores were logged; prematurity, stillbirths, infant abnormalities or maternal hemorrhage were also noted. However, records detailing the medications patients were given at the time of delivery, or possible drug allergies were not kept. (DHQ patients were personally responsible for their medical files as the hospital had no facilities for records storage.) Prescriptions were given separately to patients to fill for free at the DHQ Dispensary several blocks away from the Family Wing in the main hospital complex.

Compounding patients’ difficulties, drugs were often unavailable or expired, requiring patients or their families to purchase medications at private dispensaries.

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8 Despite being roughly double or triple the monthly wages earned by agricultural workers, these salaries were still insufficient for a family’s household needs, particularly in nuclear or ‘separated’ families that did not enjoy the collective input of additional salaries. (At the time of my fieldwork, CDN $1=Rs 43, 44.)

9 In 1990, the intake and registration fee was Rs 25 (CDN $ 0.56), and several years later this was increased to Rs 50 (CDN $ 1.13). But as of 2002, the government had eliminated user-fees for all DHQ patients (LHV II, DHQ: July 26, 2007).
Chapter Two: Gilgit Town’s Maternal Health Services, Private Practice & Personal Loss

According to the Labour Room Register, it appeared a substantial number of women arrived nearly or fully dilated, and delivered their infants within an hour of registration (Fieldnotes: August 7, 2005). With physicians and nurses largely preoccupied with heavy patient loads in the Out-Patient and Gynae Wards, LHVs handled the majority of deliveries alone or “khud kiya” (independently, completely, properly done; U) (Fieldnotes: August 1, 2005). (During three weeks of observation, I had only seen physicians intervene for three delivery cases, all of which were obstructed labours requiring C-sections [Fieldnotes: August 1, 2005].) According to one LHV, ‘normal’ first deliveries were up to twenty-fours in length, while subsequent births ranged between twelve to sixteen hours (LHV I, DHQ: August 1, 2005).

When I asked them to summarize the advice they gave delivering mothers, one LHV volunteered her standard ‘patient speech’.

“I make them understand how it will happen, step by step. ‘First you will have a little pain, but don’t push. If you feel less pain you can take a breath, if you feel more pain and the pain is severe, push downwards and out.’ For pushing we tell them to continue pushing until [the pain] finishes. Some patients don’t push hard or long, only for one to two seconds at a time, so we scare them and say, ‘If you don’t push, maybe the child won’t come outside you and will die. You’ve waited nine months, and kept this baby in your tummy. If you’re not pushing now, what was the use of all of that?’ If we see the head is crowning and the birth is near, we’re not giving her a break. If the baby’s head has crowned, but doesn’t move anymore for another ten to fifteen minutes, we’ll call the doctor. (LHV II, DHQ: August 1, 2005)

If time was adequate, many mothers were given enemas upon arrival.\textsuperscript{10} One LHV explained how,

“During labour a lot of women…pass feces during labour, we clean them with cotton, and wash their legs with water [and] we don’t tell them when this happens, it’s normal when the baby’s head is coming out.” (LHV II, DHQ: August 1, 2005) My participants suggested that “chey sharaminder” (women were humiliated; S) at the thought of this happening (Menahsat, Jutial: June 2, 2005). For hospital and home deliveries when women felt the pressure of the baby’s descending head on their rectum, they often leapt up and tried to use the bathroom (ghusl’hana; S), only to be stopped by their more knowledgeable mothers.

\textsuperscript{10} Because enemas were viewed with such distaste by most women, they often fought to avoid them. Rather than battle with agitated patients, DHQ LHVs left this job to ayahs to complete (LHV II, DHQ: August 1, 2005).
or the LHVs (Fieldnotes: June 7, 2005). During labour, LHVs regularly checked women’s blood pressure and used a fetascope to monitor the foetal heartbeat at the end of each contraction (LHV V, DHQ: August 1, 2005). In every one of the ten deliveries I observed, women had their contractions augmented with LHV-administered Oxytocin injections in their buttocks or upper thighs immediately after entering the Labour Room. The effects were instantaneous; where women had once easily breathed through their contractions, they now cried out and complained of the pain’s severity. Shortly after delivering her firstborn at the DHQ, one young Sunni mother described what she felt were the drug’s unpleasant and lasting side effects.

“We went in to the [labour] room and the *dayah* gave me an injection. Afterwards, I felt that all my joints weren’t working properly, and I felt weak, faint and very hot. I was so hot I felt like someone had thrown me into a fire, and I thought I might faint. The *dayah* told me, “Don’t worry, after ten to twenty minutes you will deliver. You are feeling this because of the injection.” In the labour room, I was so hot that when my *Bhabhi* [senior sister-in-law; U] tried to come near me, I told her to go away and not to touch me! [laughs] I threw all my clothes off onto the floor – my slippers, socks, pants – I couldn’t stand it on me because I was so hot. The *dayah* said [again], “We gave you a shot, that’s why you feel this way.” … At home I went straight to bed, and now it’s been fifteen days. Today I’ve come out, but I need forty days ‘on the bed’; people tell me to stay in bed when I try to walk around. I eat in my room, and even now sometime I feel hot, but for two to three days now I’m feeling OK.” (Ruqaiyah, Jutial: August 11, 2005)

For each DHQ delivery I observed, women were lying supine and were discouraged from sitting up; very occasionally, women delivered lying on their sides while a LHV held one leg up. As the babies’ heads crowned, the LHVs poured liquid glycerin from a refillable bottle over the perineum, where they massaged the clean-shaven skin to encourage its elasticity and discourage vaginal tears. However, rarely did first-time mothers emerge from the Labour Room without having had an episiotomy.

According to one LHV:

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11 In recounting her experience of *desi* deliveries twenty years earlier, one woman said, “Some old ladies, or our mother-in-law, will say that if you have to go shit, avoid the bathroom, and stay on the bed...the baby is moving [and] we think the delivery will be soon...in the hospital they give us a chamber pot or an enema” (Madheeya, Jutial: June 2, 2005). When I asked how women reacted if they accidentally ‘shit’ themselves, she said, “Women will be humiliated...if her mother is with her, she can hide it from other people, so other people don’t see it” (Nakeena, Jutial: June 7, 2005). At the DHQ, one LHV described how “some women have given birth in the bathroom. Women come in fully dilated and think they have to take a shit!” (LHV VI, DHQ: July 26, 2005)
“We always do an episiotomy for a first delivery. Here because of the risks of a perineum tear and poor hygiene in the home, we do it so we take proper care and good stitching of the problem.” (LHV II, DHQ: August 4, 2005)

In early August 2005, on a hot and muggy day when load-shedding had left the Labour Ward darkened, still and with no ceiling fans to help move the stagnant air, I observed what the LHV's described was a ‘typical’ delivery. A young Sunni mother had arrived with her aged mother-in-law from Sakarkui, a nearby Sunni village on the north side of the Gilgit River. As she clambered up onto the delivery room table, she told us her husband was absent and had been on-duty with the Army for the last six months. She was already the mother of a two-year-old daughter and from the hallway outside the delivery room her mother-in-law called out she hoped this next baby would be a son.

“Patient about 25 years old, cheeks flushed red, looks around to see who’s in the room, and then down at her lower half. She takes deep breaths and says, ‘Walley, walley, walley’ [come, come, come; S] with the contractions, and ‘Y’Allah’ [Oh God; A] softly under her breath. LHV #1 stands at end of bed…orders LHV #4 to administer more Buscopan [muscle relaxant], who says she’s already given her some and prepares another injection….LHV #3 stands on the side and feels her belly for contractions; belly is bare and her kameez [shirt; U] is pulled up to her breasts, the mother’s hair is tied back with an elastic. LHV #1 feels, using a gloved hand, inside the vagina and tells the mother she is ready to push – moves her hand around the inside of the perineum and stretches it with the index fingers on each hand…They tell her to push, and LHV #3 stands and pushes down gently on the upper fundus [uterus] with her left hand; LHV #1 continues to feel inside…I can see blood and amniotic fluid on the metal tray beneath her buttocks. LHV #3 stands at the side, still a hand on her belly; patient continues pushing, taking perhaps 4 seconds for each push, but the pushes are greater in length and intensity, her face turning red and veins prominent with each push. LHV #1 calls out encouragement to her, and LHV #3 is wearing a pink rubber apron with fresh bloodstains on it...

The birth is imminent, so LHV #1 and LHV #3 stand close, and LHV #3 pushes on the top of the uterus toward the vagina and LHV #1 is stretching hard at the vagina, she cups her left hand on the baby’s head as it emerges with a small gush of water. Very quickly, the rest of the baby - a boy - is delivered as he rotates out of the vagina. The mother takes a deep breath and sighs - the baby has meconium [fecal material] coming out of his rectum. They cut the cord as they hang him upside down – he had let out one quick cry, but his arms hang by his head and he grimaces, lips blue and body pale white with grey overtones. They hold him by his crossed feet, with a receiving blanket around his upper body and partially covering his face, as they tighten the forceps on the cord and then cut it. LHV #1 takes him to the infant table and wipes him brusquely with the same, beige colored light fabric. LHV #4 goes to the door and asks the patient’s mother for the blanket...
they brought with them. LHV #1 returns to the patient and palpitates the uterus; removes the placenta by gently pulling, she lets it slip into the balti [plastic bucket; U] beneath the mother’s buttocks.

The mother rests her arm on her forehead and breathes ‘Shukr hen, skukr hen’ [thanks, thanks; S] when they tell her it’s a boy….They do not check his Apgar scores, nor his heartbeat nor respiration. As I stand by the infant table, I can see blood dropping, drop by drop, from the oilcloth onto the floor from the mother’s vagina….After 40 minutes, they pick up the mother’s shalwar [pants; U] off the floor where she had dropped it, and help her put on knickers [underwear] packed with loose cotton. The back of her kameez is stained with amniotic fluid and blood and she has no dupatta [veil; U]. Her hair is messy and her face quite pale. They help her gingerly off the table, and assist her to the recovery room where she sits cross-legged on the bed and sips the Pepsi and chai [tea; U] I asked the orderly to buy for her from the corner canteen.” (Fieldnotes: August 2, 2005)

When mothers were in obvious distress, LHVs sometimes demonstrated quick breathing techniques. Pharmaceutical pain relief seemed less frequent and was usually provided by injections of Buscopan, an abdominal muscle relaxant (LHV III, DHQ: July 26, 2005) that worked “faster through IV than in tablet form” (LHV II, DHQ: July 26, 2005). Some LHVs described younger or first-time mothers as the most ‘problematic’. “We see with a first baby mothers are mostly crying and anxious, but with second and third babies it’s less so. And some patients can tolerate the pain, while others can’t” (LHV III, DHQ: July 26, 2005). After babies were delivered, mothers were wiped off quickly with damp cotton gauze and if they had vaginal tears or an episiotomy, the LHVs often stitched up the wound without using local anesthetic. Women were allowed to rest on the delivery table for an hour, while the LHVs watched them for potential blood pressure drops and post-partum hemorrhage. They were then walked with assistance to the six-bed postpartum recovery suite across the hall. After complicated births or C-sections, patients were admitted to the crowded eight-bed, obstetric In-Patient Ward (IPD) adjacent to the Labour Ward for one to three days, whereas after uncomplicated vaginal deliveries patients were usually discharged after two to three hours.

After being born, infants had the umbilical quickly clamped and cut, they were wiped off, quickly wrapped and left on side-table where a nurse or LHV tied off the cord stump tightly with long rolled
strips of cotton gauze. Babies were then handed over to a woman’s attendants who were usually waiting anxiously just outside the Labour Room door. Occasionally, breathing problems required that staff use a suction machine and then administer oxygen to the infant; vigorous and sometimes rough handling were used to encourage slow-to-respond newborns to cry. To my eyes, many infants seemed alarmingly small, but I was reassured that the average birth weight in Gilgit was only 2.5 kilograms, or 5.5 pounds.

“A normal weight for new babies here is 2.5 kg, but we don’t take their length measurement here, we have no facilities for measuring. The normal weight range...is between 2.5 and 3.5 kg [7.7 lbs]. Anything more than 3.7 [8.14 lbs] or 3.9 [8.58 lbs] is too big, and 2.2 kg [4.84 lbs] and below is too small. If a baby is too small, we make them warm, and refer them to a Child Specialist for the use of an incubator.” (Nurse II, DHQ: August 1, 2005)

Prematurity was relatively common and often due to untreated or severe maternal urinary tract infections (UTIs), which then caused uterine contractions. There was limited treatment available for such infants and fierce competition for the DHQ’s few incubators which were located three blocks away in the Children’s Ward. Although many delivering mothers were sure of their dates, other mothers arrived uncertain if they were full-term. Nurses and LHV s relied on previous ultrasound reports, if available, or internal examinations to check if the foetus was premature and therefore a ‘high-risk’ case. The majority of births prior to twenty-eight weeks gestation were stillbirths (LHV II, DHQ: August 2, 2005), and there was a shared consensus among both staff and patients that babies born in the seventh month of pregnancy fared better than those born in the eighth, although my participants weren’t sure why this was so (Fieldnotes: August 1, 2005). A nurse and LHV had each described to me the ways Labour Room staff handled premature births and in-utero foetal demise.

Frequent infant maladies included jaundice (kahmul; S), sepsis from infected umbilical cords and pneumonia. Jaundiced infants were more likely to be born to untreated, RH-negative mothers; RH-differences between mother and infant result in hemolytic incompatibility, of which jaundice is symptomatic. Without phototherapy treatment or frequent and consistent breastfeeding, affected infants were lethargic and difficult to feed. This tended to quickly lead to the baby’s overall failure to thrive and sometimes resulted in neonatal death. Gilgit’s high infant mortality rates were often attributable to neonatal tetanus. Women were expected to receive a series of five, preventative tetanus toxoid (‘TT’) injections during pregnancy; these were to help prevent pre-natal and post-partum sepsis (see Bhutta, Jafarey & Midhet 2003: 5; Brabin et al, 2000). Among Gilgit District patients, however, 31.8% of mothers had not received the recommended tetanus immunizations (Rahman 1999: 16) despite ‘TT’ immunizations being offered free of-charge at the DHQ.
“Sometimes it happens that a baby dies during labour. When we use the fetascope, we’ll mistake the uterine sounds for a foetal heartbeat. Or, the mother will have said she’s felt the baby move. If the heartbeat is weak, we’ll send the mother to the OT for a C-section, and women know that less movement is a problem. They know that if there are no movements for 24 hours, it’s a problem. Women will come to us, at all hours and throughout the night, if they’ve noticed a baby is not moving. If there is a heartbeat, we advise them to return in the morning to see a doctor. If there is no heartbeat, the doctor will admit them and advise them; we give them an artificial drip [Oxytocin] and don’t wait for natural labour to start.” (Nurse I, DHQ: August 2, 2005)

“[Premature] babies are often cynos – blue – and have breathing problems. This is the doctor’s work. Generally we know a baby’s age by the size, which we get through PA [pelvic assessment], ultrasounds, check-ups, [but] this is always the Child Specialist’s work, not ours. Some patients have come in, for example, in their seventh month and thought it was their fourth, and said their pains were starting. If it’s in the evening and the birth isn’t imminent, we advise and motivate them to come back the next morning to see the doctor. Or, they can deliver here and we send them to the Child Ward to use the incubator…if they’re not stable, we stabilize them, using oxygen or the suction machine….We tell the mother the risks facing the baby, and the doctors also advise them after they’ve admitted both the mother and baby.” (LHV VI, DHQ: August 2, 2005)

When premature delivery seemed avoidable, staff obstetricians or the nursing staff administered injections of “Besthamethazone, a drip and an IV… and when [the patient is] first stabilized, [they’re] shifted to the ITC Gynae Ward” (LHV IV, DHQ: August 2, 2005). Because Gilgit’s hospitals only owned a few incubators between them, the majority of families were forced to take premature babies home where, in the absence of advanced medical support or the supervision of a pediatrician, many died.13 Because of frequent, in-hospital treatment delays and insufficient surgical support for ectopic pregnancies, eclampsia, uterine sepsis and post-partum hemorrhage, high-risk patients could quickly progress to maternal or infant death. When women or their babies died during or immediately after delivery, the Labour Room staff quickly assigned responsibility to the patient’s family to tell the husband.

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13 One of Wadood’s cousins married during my fieldwork, and after two years his teenage wife gave birth at 7 months to a baby boy. Because there were no incubators available, the doctors had released the baby to his family, who returned to Minawar, where he had died in his mother’s arms after two days. Premature babies often struggled to summon the energy to suckle, and tired quickly even while simply breathing; their underequipped systems and paltry fat reserves were not enough to ensure survival for many.

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This was particularly awkward when a woman was in the final stages of dying; a woman’s dire condition often resulted in her family panicking or raging at attending staff.

“One to two patients have come to us with sepsis, and died. They’ve come from far away, and their chances were very low for survival. We advised the family of the problem. Before they came, they were afraid, but after we explained everything, make them understand about the treatment we’re attempting, they relax. We will tell the relatives to talk to the husband, we don’t do this ourselves, and we tell the mother she’s OK. We’ll tell her, ‘Pray to God that you’ll be OK.’ We can’t tell her the truth. It’s hard for us. And until a doctor comes we do all the work, and [we] keep her company, ourselves. Inside, we’re quite afraid but if we show it, she’ll be worse off. Or, we’ve seen patients with hypertension, and one died on the labour table two years ago. In the first two months of her pregnancy, she had very high blood pressure, and when she was on the labour table she had fits and within half an hour she was dead. She’d gone to the MHC [Maternal Health Center] in her village, and this took too much time....she had twin baby boys, and died right after they were born. When the family came, they were already saying the kalima, and the family took the body directly from here to their village in Hunza.”

(LHV III, DHQ: August 2, 2005)14

Chronic insufficiencies in medical supplies, drugs and equipment made for an austere and sometimes inhospitably unhygienic environment. The Labour Room’s three delivery beds were in poor shape with stirrups either absent or tied onto the bed frame by twine or tape, while the oilcloth that covered each bed was often torn or cut away, revealing blood-soaked foam underneath (see Figure 8). A male ‘sweeper’ cleaned the room once or twice a day, emptying the plastic buckets into which nurses and LHVs dropped placentas and bloody gauze after each delivery.15

Figure 8: DHQ Labour Room (2005).

14 The kalima is the Islamic profession of faith: ‘La’ilaha, il’alahu, Mohammad’ur’rasoolulah’ (There is no God but God, and Mohammed is his Messenger; A). At the time of death, every adult Muslim is expected to recite the kalima in order to gain assured entry into Heaven (jennat, Paradise; A). If individuals are unable to speak, a family member or friend may recite it on their behalf. In fact, Sunni Gilgiti descriptions of a ‘good’ death are largely predicated on an individual’s recitation of the kalima.

15 The IUCN’s 2003 Northern Areas Report specifically noted that women’s maternal health complaints were further exacerbated by the wide range of environmental health issues, including “contaminated water, poor sanitation, air
Beds were quickly wiped off with damp cloths and a loose broom of bundled twigs was swept over the blood-flecked floor. In the summertime heat, the stench could be overwhelming. Between deliveries, the LHVs tended to retreat quickly to their staffroom, and only rarely looked in on labouring patients in the adjacent pre-natal and post-partum suites. Women or their families were left instead to call for help or make their way alone to the delivery room. I often saw trails of blood or amniotic fluid along the building’s hallway, and pools of drying blood on the Labour Room’s one medical stretcher. Because of high rates of infectious disease among their patients, nurses and LHVs often asked women or their attendants if they needed precautions against diseases like Hepatitis. But with the exception of a few senior employees who owned white doctors’ coats, most nurses and LHVs wore ‘everyday’ *shalwar kameez* and protected themselves against blood and fluids with cooking aprons and flimsy, ill-fitting latex gloves. Though the staff’s clinical challenges had not gone unnoticed, they remained largely unmet.

“Two years ago a Major came here and inspected our ward and saw our situation, what we didn’t have - this sort of thing. We had oxygen for the baby, but we didn’t have enough other equipment, like a suction machine, which we [later] got, along with a new vacuum [for deliveries]. The old one was of an *ajaib* [strange; U] style! We got a warmer for the baby, which is a small bed, then we put blankets on and overtop is a light heater. If a baby has jaundice, we don’t have any special phototherapy machines - we just refer to the baby to a Child Specialist. We also now don’t have a special weight [scale] for the mother, but we do have one for the baby; we always weigh the babies when they’re born. But we need a scale to monitor mothers, especially during their pregnancies to see if they’ve gained enough weight.” (LHV I, DHQ: August 1, 2005)

pollution, substandard food, the disposal of untreated sewerage into water bodies, unhygienic and illegal slaughterhouses, and the poor disposal of hospital waste” (IUCN 2003: 191). Labour Room waste, including hazardous biological materials, was first dumped into open trash bins near the Family Wing’s main gate. Hospital waste was taken by tractor to Konodas Mohalla, where it was dumped off the side of the road into a *gulleh* that led into the Gilgit River. “They are dumping this...in Konodas, by the road above the river, and there are dogs and cats coming to eat everything! We joke that during the day, the dogs meet and have a meeting to decide when to go attack the waste! The placentas and all other garbage - needles, waste equipment - is open here at the Family Wing. The cows don’t eat this waste, but at night the dogs come and eat the waste from the bin outside our building. They’ve got a water purification plant right beside this too - can you imagine?” (LHV II, DHQ: July 26, 2005)

16 The DHQ’s ultrasonologist had even begun a pilot study in conjunction with the Aga Khan University Hospital in Karachi, which suggested that the DHQ’s Labour Room was the nexus for rapidly increasing Hepatitis rates across Gilgit Town. The infants who had been exposed to and acquired Hepatitis at delivery faced a much higher risk of the disease turning into hepatocellular cancer in adolescence.

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In recent years, the Labour Room had also received a donated electronic foetal monitoring machine, and while staff had been trained in its use by a consultant from Islamabad, the nurses and LHV's were still uncertain of exactly when its use was medically required (LHV II, DHQ: August 1, 2005). Along with the absence of a working autoclave (sterilizer) and their concerns about inadequate or faulty equipment, Labour Room staff also struggled with a scarcity of even the most basic supplies, some of which were delegated to patients' families to supply at their own cost.

“They give us two cartons of [rolled gauze] cotton a day, but it’s not enough. We give them a list of what we need; if it’s not there, the Administration will simply write ‘Not available’ beside it. Sometimes, patients have to bring such supplies themselves. We have enough IVs, drips, Buscopan in tablets or injections....For infectious patients, like those with Hep B, we don’t have face protection [masks], only the gloves, and we boil the instruments, change the sheets and the plastic [oilcloths overtop foam], or throw them out. Everything is washed in Dettol [antiseptic]...I think boiling is enough to clean the instruments, yes.” (LHV II, DHQ: July 26, 2005)

Because the Family Wing did not have a reliably functioning generator, chronic electricity shortages (which are endemic across the Northern Areas) could lead to delayed surgical procedures, and under-use of the DHQ’s few artificial respirators or suction machines, incubators and phototherapy machines.

During nighttime power outages, Labour Room staff reported delivering babies by candlelight or flashlight. “If the power goes out, I keep my hand in the vagina feeling the baby’s head until we get the light, or until it comes out. We don’t want to have the baby fall in the darkness!” (LHV III, DHQ: August 1, 2005) And throughout Gilgit’s frigid winter months when daytime temperatures often dipped below zero degrees Celsius, LHV’s could be found huddled around a solitary kerosene heater in their staff room, which faced the delivery suite. The hospital’s Administration had provided the Labour Room

17 Because the DHQ was on a grid of electrical supply (or ‘special line’) from which power was available for federal and civil offices, hospital load shedding was never as dire as it was in residential mohallas. “In the winter, the power still goes out sometimes, although it’s always available for the OT [Operating Theater]. We do have bijli [electricity; U] throughout the winter, only with some breaks. It’s not as bad as the rest of Gilgit, with one day on, and one day off” (LHV I, DHQ: August 2, 2005).

18 One LHV discussed her efforts to provide even minimal heating in the wintertime: “We can’t use electric heaters, even those we bring from home, because the Administration comes and says that the electricity is weak, there is load-shedding, and the heater takes too much power. They’ll take the heaters away from us! This is even if we bring

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with two bottles of kerosene per week as well as a warmer for the infant but not the mother. Nurses sometimes complained of having to pay for extra kerosene out of their salaries (FW Head Nurse, DHQ: August 1, 2005), and described their physical pains working in chilly rooms.

“There is no heater for staff on night duty…there is no geyser [boiler] so there is no hot water, there is nothing. I get chilblains in my lower legs and in my hands. My hands hurt from always washing in cold water.” (Nurse II, DHQ: August 1, 2005)

The regularly occurring difficulties in securing after-hours physician coverage at the DHQ Labour Ward were an unsettling component underlying maternal morbidity or mortality, stillbirths and neonatal death.

19 One LHV’s careful explication of the steps required to obtain surgical coverage during the doctor’s on-call hours highlighted how logistical obstacles and heightened risk seemed built into DHQ procedure. Because the Labour Ward had no surgical facilities, Caesarean sections required women be transferred to the DHQ’s Operating Theater (OT) a block away.

“…we don’t do [C-sections] in this building, though we should. When they are shifted, we use an ambulance to take them from this building to there, but many people use a Suzuki [van] instead. Because we only have one ambulance, and there’s many problems with cars for patients. We have only the one, so if there’s an emergency, first someone has to pick up the ambulance driver, who then goes to pick up the doctor, who then comes to get the patient. Sometimes three to four hours can pass before a distressed patient or her baby can be shifted.” (LHV III, DHQ: July 26, 2005)

One nurse quietly clarified that these delays had serious consequences.

“If it’s a serious emergency, we have to call for the doctor, and yes, sometimes the mother or the baby dies. If a mother is hemorrhaging, we do packing [of the birth canal with cotton batting] and are waiting after we’ve contacted the doctor – there’s nothing else we can do.” (Nurse II, DHQ: August 1, 2005)

in a heater with us to warm our hands! There are enough funds that come to us, but because of corruption the money is spent and wasted. It disappears and is eaten” (LHV ‘X’, DHQ: August 13, 2005).

19 According to the Family Health Hospital’s Project Director, among the estimated 500 per 100,000 annual maternal deaths, 30% women died due to post-partum hemorrhage, 15% from eclampsia (or pregnancy-induced hypertension), 10% from obstructed labour, 10% from infections and 10% from unsafe abortions; a further 10% died due to unknown causes (Karim 2002, PowerPoint Presentation: Slide 9). With post-mortems being a rarity even for clinic-based deaths, deaths that occur at home are ‘diagnosed’ using verbal autopsies. Given family members’ tendency to editorialize their health narratives or misunderstand health symptoms, I felt verbal autopsies were a highly unreliable means of determining the cause of death.
And despite the LHV’s overall willingness to train for and practice more advanced surgical methods such as cauterization, forceps and vacuum-suction delivery, or internal stitches if the cervix had been torn during delivery, the DHQ’s administration had enacted job restrictions limiting emergency treatment to physicians. If they transgressed their ‘duties’, the LHV’s faced being temporarily suspended from work or fired. As one LHV recounted:

“If the doctor is at home, we’re not allowed to use the vacuum. And we never use the forceps, but if there is an emergency sometimes the vacuum is used...for D&C’s, forceps and the vacuum, we don’t have the permission to use them; the doctor says these are very sensitive procedures.” (LHV II, DHQ: August 1, 2005)

Because the DHQ’s facilities were spread widely across Bermas Mohalla’s steep hillsides, telephones were the primary means by which LHV’s requested physician coverage or vehicles. This, too, was problematic. Because of the high costs of local telephone lines and profound mistrust between staff, the Labour Ward’s telephone was usually off-limits.20

“Sometimes we have to take the patient by ourselves to the OT, and often times the phone here at our registration [desk] is locked...so we have to go and use a PCO [Public Call Office] here just outside the Family Wing main gate, and use our own money to contact other hospital staff for assistance.” (LHV III, DHQ: August 1, 2005)

Staff efforts to rectify the Family Wing’s more obvious insufficiencies or clinical risks principally relied on formal complaints to DHQ Administration. However, the nurses and LHV’s’ attempts often resulted in threats or disciplinary measures; “The administrators tell us, ‘If you want to leave – go ahead! We can easily find other staff!’” (LHV II, DHQ: August 2, 2005). (Indeed, applicants for formal employment at the DHQ numbered in the hundreds and paid positions were zealously guarded; many applicants waited for paid employment while serving as unpaid hospital volunteers.) Staff discontents carried unavoidable consequences for their treatment of, and interactions with, patients and their families. Several LHV’s discussed feeling depressed by the lack of respect accorded to them by both hospital Administration and

20 Public Call Offices (PCO’s) were found clustered around the DHQ’s two main entrances, the Family Wing and the Operating Theater. In these small stores, the LHV’s were charged Rs 5 (CDN $ 0.11) per call. PCO’s also sold cold drinks, chai (tea) and small food items like samosas or cakes. Because food was not provided to DHQ patients, families had to bring meals for women and their attendants. Similarly, physicians, nurses and LHV’s purchased their lunches or snacks from these shops.
those Gilgitis whose sensibilities were anchored in more traditional notions of midwifery as an ‘impure’ and ‘unclean’ profession (LHVs V & VI, DHQ: August 1, 2005). Across Pakistan, midwives are traditionally given mubaraki (congratulatory; U) gifts by fathers or a woman’s in-laws upon a baby’s successful delivery. In previous generations, the amount of money or the nature of the gift only reflected the baby’s sex, with more money given if it was a boy. In recent years, however, families have tailored mubaraki gifts to also reflect their happiness or dissatisfaction with LHVs’ performance or their sense that LHVs were already ‘rewarded’ by their governmental salaries. When my research assistant, Fazeelat, said she had given three new suits-worth of fabric to the LHVs who had attended her last birth five years earlier, one LHV laughed in surprise.

“A few times we get gifts like Rs 50 or Rs 100 [CDN $1.10-2.25] for chai, or drinks but we never see clothes! Some bring mithaies [sweets; U], but no dupattas [veils; U], nothing like this - never. They used to give us gifts before, but not now. They used to even give gifts for things like checking their blood pressure or heart, but now only a few people give us gifts up to Rs 200 [CDN $4.50]. People were more caring for us then. Now people say, ‘It’s a government hospital, and it’s their farz [duty, obligation; A], they’re earning their salaries, they’re not doing it for free!’” (LHV V, DHQ: August 1, 2005)

There were perhaps other, more disquieting reasons for the LHVs being ‘less rewarded’ for their duties. One LHV explained how physically restraining women was an excusable response to patient noncompliance.

“A patient who is tolerating the pain, and who isn’t abusing or arguing with the staff [we think] is better for them or for us. Some women will even hit the attendant during delivery, and we’ll call their mother or sister to come and hold their hands and legs.” (LHV III, DHQ: July 26, 2005)

After being roughly handled during their deliveries, or after enduring significant pain during exams, some mothers chose to fight back.

“Sometimes the patients hurt us. They’ll hit us with their fists, or grab our arms and pinch us until there is a nishani [bruise; U]. We don’t hit them back, but we’re holding their hands. Some women will say to us, ‘God will kill your parents and you for what you’ve

21 As one LHV noted, “Sometimes I feel depressed, and say to myself that I should stop. When I see a patient again, however, I feel motivated again. I’m not looking for another job, and I’m happy here, but I’m not given any respect, so I’m helpless”. (LHV II, DHQ: August 1, 2005).
done to me!’…Sometimes when we need to do an internal [exam] before the delivery, they’ll say ‘Don’t touch me – it’s hurting me more!’ and close their legs on our hands and arms. Sometimes they’ll open their legs on their own and cooperate, or we have to force their legs open too.” (LHV I, DHQ: August 1, 2005)

The LHVs readily acknowledged that women’s families were sometimes distressed or enraged by the LHVs’ treatment of labouring patients, particularly when nurses or LHVs slapped ‘noisier’ or more ‘rambunctious’ women.

“Sometimes, when we shift a woman to the Labour Room, we won’t allow the family to come in – we’ll close the door on them – but in the Ward afterward we have to deal with them again. Ladies are usually fighting with us more than men, and sometimes three, four or five women will be fighting with us again.” (LHV I, DHQ: August 1, 2005)

In marked contrast to my own childbirth experiences, women at the DHQ labored largely in silence. Women who moaned or called out were often quickly admonished by the LHVs, some of whom were more menacing and told mothers to ‘chup tey bey’ (shut up; S). The nurses’ and LHVs’ sharp admonitions were reflective of local cultural prohibitions against labour-related cries of pain. While women viewed childbirth as a natural and ‘normal’ process, it was also symbolically connected with and seen as evidence of sexuality and sharam (shame). Where a Gilgiti woman’s cries of grief were an essential, performative component of funerary gatherings or reserved for when relatives left for work in Pakistan’s cities, childbirth-related cries of pain were highly stigmatized. In this way, the Labour Room’s enforced quiet represented the extension of women’s traditional (desi; U) childbirth comportment to clinical settings, and the practical convergence of desi and biomedical approaches among hospital staff, patients and their families. As the mother of eight children, the youngest of whom was now seventeen, Madheeya reflected on this silencing as she recounted traditional birthing practices:

“If in labour, a woman should be khamosh [silent; U]. At night especially we have to be quiet, when other people are sleeping and the neighbours could hear. Dayahs [midwives; U] advise us to breathe instead of crying out. They scold us if we make noise, and tell us, ‘Just tolerate it and be quiet!’ They even put their chadors [veils; F] over our mouths, stifling our cries and screams. I never cried or screamed.” (Madheeya, Jutial: June 7, 2005)
Older women, particularly those who had not delivered in many years, tended to foreground their ‘traditional’ strengths and contrast these against the presumed weaknesses of the younger generation. When recalling deliveries twenty years earlier, they described their silence as proof of their comparative hardiness and sometimes mythical forbearance of physical pain; “Bardash tem [we were tolerating it; S]...the pain is already there, how will crying out help?” (Madheeya, Jutial: July 11, 2005) With these nearly unmanageable standards lauded over them, younger women worked hard to maintain traditional expectations, but with limited success. And while most women were coached through their labour pains by other women, it was not unheard of for husbands to be actively involved in assisting their wives up until the actual delivery. In describing her firstborn’s delivery at the DHQ a week before she spoke with me, Ruqaiyah explained how she and her husband had sought privacy in different rooms of an overcrowded family household.

“I couldn’t sleep all night because of the pain, because it was so much. My husband was with me, and I didn’t know it would be alright, but he understood. He told me, ‘Please try to tolerate the pain, and don’t be scared.’ But I was scared, and thought I might die! [laughs] I would put my dupatta [veil; U] in my mouth...to keep the noise quiet, and when I was in severe pain I went into the desi [traditional hearth; U] room, and closed the doors and windows to dampen the noise. Everyone was sleeping, and I didn’t want to wake them up. My husband was in there with me, and he was making me understand, ‘It’s all right, all women go through this.’ It helped me. At 7am I was in severe pain....so I decided it was time to go to the [DHQ] and told [my in-laws]....My sister-in-law, my mother-in-law and my husband went with me, and we took a neighbour’s car without a driver...I controlled myself in the car, but at the hospital gates when we arrived I lost control and began to cry out.” (Ruqaiyah, Jutial: August 11, 2005)

Many women, in fact, were openly confused as to why they weren’t able to withstand the pains with the same fortitude as previous generations. Or they wondered if it was true that in the process of ‘modernizing’, something had happened to weaken them. In the hour immediately following sometimes-traumatic deliveries, very few of the mothers I saw at the DHQ questioned the relative truths of older women’s birth narratives, which female relatives sometimes shared as they stood around the new mother’s patient bed. In these moments, patients roundly affirmed the older generation was tougher and more resilient; I saw this as an obvious effort to appease sometimes disgruntled in-laws, especially if the
newborn was a girl. Conversely, a woman’s inability to control her response to pain was used to symbolize the magnitude of her physical sacrifices not only for the baby, but also her husband and his family; this idea of pain as sacrifice was rooted in Gilgitis’ sense that babies ‘belonged’ to the husband and his family. As such, women’s accounts of their response to labour pain were narratively balanced between emphasizing their fortitude or vulnerability, ‘easy’ or ‘difficult’ labours, familial obligation and personal sacrifice, and pregnancy and birth as women’s choice, or quietly representative of a profound lack of personal control.

Part III The Family Health Hospital

Although my Sunni participants preferred to deliver at the DHQ, and poorer women predominantly relied on the Family Wing’s Out-Patient Department for check-ups, women of greater economic means often chose to visit the Family Planning Association of Pakistan’s Family Health Hospital for their prenatal checks. According to my analysis of the hospital’s In-Patient Register, the hospital - sitting at the periphery of the Army’s Jutial Cantonment – routinely dealt with more than one thousand Out-Patient cases per month, of which approximately 40% were Sunnis (Fieldnotes: September 10, 2005). Established in 1953, the Family Planning Association of Pakistan (FPAP) is Pakistan’s largest non-governmental organization (Acting Project Director, FHH: May 10, 2005). The FPAP has operated in the Northern Areas since July 1986, when they established the Model Clinic in Gilgit’s Kashrote mohalla. The clinic employed a “Lady Doctor [OB/GYN], a Lady Health Visitor, one Aya/Attendant and a Peon …[who] started delivering FP [Family Planning] and MCH [Mother Child Health] services on a very limited scale only in Gilgit town” (FPAP, FHH 2004: 8). In order to identify possible patients and encourage the promotion of FPAP’s low-cost, reproductive and contraceptive services, the clinic’s thirteen community health workers - or ‘Health Guards’- were “paid Rs 10 [CDN $0.20] for each referral case” (Acting Project Director, FHH: May 10, 2005). The FPAP “selected active social workers for positions as ‘Health Guards’… [who were] already well known and liked in their area [and then] trained as Family Planning motivators” (Acting Project Director, FHH: May 10, 2005). Women were chosen from Gilgit, Ghizer, Skardu, Ghanche and

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Hunza, while none were selected from Diamer District (Acting Project Director, FHH: May 10, 2005).

Local antipathies towards women’s formal employment had initially resulted in substantial recruitment difficulties, much in the same way that local schools suffered a dearth of Gilgiti ‘lady’ teachers.

At the time of my fieldwork, FPAP Health Guards were almost always Ismaili. As a result of their in-community allegiances and the recent intensification of sectarian ‘tensions’, many Health Guards preferred to restrict their outreach attentions to Ismaili mohallas and villages. But in recent years, a small but growing number of Health Guards were Shia women who worked in and were from the villages of Danyor and Jalalabad, which are surrounded by the Ismaili villages of Oshikandass and Sultanabad (see Map III). Community outreach wasn’t entirely unproblematic. In Health Guards’ community visits, FPAP IEC (Information, Education and Communication) publications were widely distributed among households, despite the majority of their rural female clientele being illiterate. Many husbands and fathers-in-law were incensed or embarrassed at having to translate ‘women-specific’ health information, particularly when it addressed contraception. Equally problematic were discrepancies between the images, dietary and social practices described or shown in FPAP’s IEC health promotion literature and Gilgiti everyday life. In light of Gilgiti’s disenchantment with the State, the visual prominence of Punjabi diet, dress, family practices and gender roles was, in important ways, reflective of the politically contentious culture-gap between Gilgit and urban Pakistan.

For its first eight years of programming, the Model Clinic’s activities were focused on contraceptive services. In 1987, the Model Clinic initiated a series of mobile health camps in some of the Ismaili-dominated villages surrounding Gilgit, which were also open to Shia and Sunni patients travelling from adjacent villages or Districts. A team of women doctors from Lahore provided surgical sterilization and gynecological, obstetrical and infant check-ups. Surgical sterilization continued to be provided by the
Lahore-based team until 1990 (Karim 2004: 8).\textsuperscript{22} From 1987 onwards, the FPAP expanded their Northern Areas services to include nine Family Health Clinics (FHCs) and mobile units which were staffed by community outreach officers and LHVVs. Thanks to a cadre of visiting male surgeons, the Model Clinic started providing vasectomies in 1993. By 1994 the newly re-named Family Health Hospital’s clinical services began including pregnancy and childbirth. In the years between 1999 and 2003, FPAP clinical services moved from the Model Clinic to another rented premise until the Family Health Hospital was constructed in Jutial Mohalla. By summer 2003, the Family Health Hospital was finally operational and took over services from the FPAP’s older clinic in Kashrote Mohalla.

The ‘new’ hospital was made possible by an October 1998 multi-national funding alliance between the FPAP and the German KfW (\textit{Kreditanstalt fur Wiederaufbau}), when DM 500,000 from the KfW was matched by DM 300,000 from the Lahore-based FPAP (see FPAP, FHH 2004: 2, 9). With its architecture inspired by traditional Hunkazut rock and wood-frame homes, and clinic walls decorated by photographs of Hunza District’s famed Rakaposhi Mountain, the Aga Khan Culture Service-restored Baltit Fort (the former home of the Mir of Hunza), and Ismaili Hunzakut women wearing embroidered pill-box caps and men weaving \textit{sharma} (goat hair; $S$) carpets, the hospital’s décor reflected the synthesis of biomedical modernity, ethnic and sectarian identity (see Figure 9). The prominence of Hunza-related photographs and embroidered wall-hangings were a point of simultaneous admiration and contention among some of the hospitals Shia and Sunni patients and the hospital’s two Sunni female OB-GYNs.

\textsuperscript{22} Depending on the circumstances surrounding women or their family’s desire for surgical sterilization, treatment typically involved tubal ligation. However, if a woman was diagnosed with menorrhagia, chronic anaemia or previous pregnancy-related difficulties, physicians sometimes opted for a full hysterectomy.
The three-floored ‘new’ Family Health Hospital was now the Northern Areas’ largest women’s hospital, with each floor encompassing an average of 6,000 square feet. It was also Gilgit’s only truly ‘women-only’ hospital; two chowkidars (guards; U) kept men from entering the hospital’s Out-Patient Ward on the second floor. Men were directed instead to wait for women patients outside the hospital’s main gates where wooden benches were lined up. Male visitors were only permitted to visit women patients before and after surgery, labour and delivery on the hospital’s third floor, or to visit the first floor administrative offices.

As of 2005, the predominantly male upper-level management supervised Dr. Sunbool and Dr. Latifa, Ismaili and Shia ‘Sisters’ (nurses and LHVs), intake officers, secretaries and receptionists, one pharmacist and two laboratory technicians (male and female). In her early-fifties, Dr. Sunbool proudly told me she was the FPAP’s longest serving Northern Areas physician; “I’ve worked in Gilgit for twenty years, six months...I’m now seeing the children that I delivered during my first year of practice here!” (Dr. Sunbool, FHH: May 11, 2005)

On its upper two stories, the 20-bed In-Patient facility boasted 2 pristine surgical suites, while on the main floor there were four Out-Patient clinical examination rooms which were additionally suitable for smaller surgical procedures (such as IUD insertion), one patient intake and records room, a small pharmacy and laboratory (see Figure 10). The lower floor was made up of administrative and community-outreach offices. Besides offering contraceptive services, the most common in-hospital diagnostic and treatment options included infertility investigations, pre- and post-natal care, lactation and dietary support. Physicians discouraged women from attending the OPD for

Figure 10: Family Health Hospital Labour Room (2005).

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23 Surgical procedures generally included C-sections, laparoscopies and hysteroscopies, surgical sterilization or the use of forceps during delivery.
more mundane health complaints such as fevers or the ‘flu.’ At community-levels, the Family Health Hospital’s most prominent outreach activities included the UNICEF-funded ‘Girl Child Programme’, which was managed by a young Ismaili woman who had moved to Gilgit from Hunza some years previously. Additional programming included ‘Male Youth’ and ‘Women Empowerment’, ‘Advocacy for HIV/AIDS Awareness’, ‘Islam and Family Planning’ and ‘Facts for Life’ (see Karim 2004:12). Each of these outreach programmes was managed and implemented by Shia and Ismaili staff, the majority of whom were men. In fact, the only Sunnis employed by the Family Health Hospital were its two ‘Lady’ physicians and one ayah.

After paying Rs 150 (CDN $3.40), patients were registered and given identity and medical information cards which they kept at home, and were required to bring in for updating with each clinical visit. Women thereafter paid Rs 50 (CDN $1.13) per visit unless they visited the hospital more than once a month, in which case they paid Rs 30 (CDN $0.70) per visit (LHV, FHH: May 12, 2005) The Family Health Hospital tried to keep detailed medical histories for all their patients. As the Acting Project Director described:

“We have rigorous record-keeping, and all patients are provided with serial numbers and report cards, to be brought in at every visit to ensure accuracy of treatment. We can check to see what a woman’s blood pressure was before, all of this! They can also present these at any rural, mobile health clinics as well, or at any FPAP facility in Pakistan, to receive services free-of-cost. We have no computerized system of record keeping as of yet, though this is a future plan of FPAP. So we are unable to co-ordinate the records of women who shift locales, such as from Gilgit to Ghizer.” (Acting Project Director, FHH: May 11, 2005)

Despite their attempts to maintain a ‘modern’ system, it was obvious that in the patient Intake room where two LHV’s weighed women and took their blood pressure, patient records were haphazardly organized. (With a laugh, one LHV admitted they often misplaced patient records and had to “start again” [LHV, FHH: May 11, 2005]. They also admitted many details were erroneous or under-reported.) Because of the familial, cultural and religious problematics associated with women’s use of contraception, Family Health Hospital staff argued they handled registration and Intake information with discretion.
“When visitors come they are handled by a counselor for their specific needs, to ask them if their [contraceptive] program is temporary or permanent, if their husband is there, if they have the husband’s permission – all in total privacy. Counselors are available to men, as well.” (Acting Project Director, FHH: May 11, 2005)

In reality, FPAP notions of ‘patient privacy’ or ‘confidentiality’ were wholly unrealistic. As was the case at the DHQ Family Wing and the AKHS,P’s Gilgit Medical Center, the Family Health Hospital’s women patients were unlikely to visit the hospital without first having explained their need, and then negotiated with their husbands, in-laws, or secured the assistance of their natal family or neighbours. Even before women visited local physicians, a wide array of family and neighbours were well appraised of the nature of her visit. Once at the hospital, it was obvious that a substantial number of women patients knew one another, whether through residence or family connections. Women’s lengthy waits outside the doctors’ examination rooms were filled with discussions of their health complaints, or fielding awkward queries regarding their sexual practices, marital conjugality and religious strictures. To add, some of the LHVs I spoke with enjoyed partaking in the same types of ‘gossip sessions.’ Buoyed up by their in-situ powers over their patients, they were not above pointing out which patient was visiting for an IUD or had had a previous abortion or unwanted pregnancy.

Between 8am and 2pm, six days a week, Doctors Sunbool and Latifa operated the Family Health Hospital’s Out-Patient clinic. Surgeries were scheduled for the afternoon shift which ran until 4 or 5pm; these typically involved tubal ligations, laparoscopic investigations or C-sections. On any given day, upwards of 100 women arrived for care (Dr. Sunbool, FHH: May 12, 2005). Women’s average Out-Patient visit costs could run between Rs 30 and Rs 600 (CDN $0.70-$13.60) depending on how many laboratory tests were ordered. Over two weeks in May 2005, I sat in on nearly one-hundred Out-Patient visits, watching Dr. Sunbool deal with a steady stream of Shia, Ismaili and Sunni women from Gilgit Town, outlying villages and adjacent Districts and Sub-Districts. Women’s ages usually ranged from between their mid-teens to menopause; the majority of patients below the age of thirty-five were pregnant or trying to get pregnant. Very few women asked for contraception, though several did quietly ask for
abortions (see Chapter Five, page 282). Older patients were not uncommon; Dr. Sunbool called her oldest patients “sae Dadi” (real Grandmothers; S) (Fieldnotes: May 14, 2005). From my observations, it seemed peri- or post-menopausal patients usually came for urinary tract infections, prolapsed uterus or incontinence; they were almost always accompanied by their daughters, daughters-in-law or granddaughters. Dr. Sunbool’s patients came from across the socio-economic spectrum; some women wore expensive tailored suits and copious amounts of gold jewelry. Others were draped in heavy black chadors, wearing worn-out slippers or jhootey (plastic shoes, leather sandals; U). Depending on the type of veil women wore and how they wore it, it was often possible to work out each patient’s sectarian affiliation; finding out which mohalla they lived in made this process even easier. It was also clear that patients had come from as far away as Ghizer, Upper Hunza, Diamer and Kohistan (NWFP).

It wasn’t unusual for the door to Dr. Sunbool’s examination room to shake on its hinges from the pressure of women waiting and jostling each other outside in the waiting room. In response, she would open the door, push back at the patients and yell for the ayahs to come and ‘get control’ (‘usko control kuro!’, ‘qabu kuro!’; U). The majority of women were sent after their exams for urinalysis which cost an additional hundred or so rupees; Dr. Sunbool told me she was looking for their sugar levels, if they were pregnant, if they had kidney troubles or signs of infection (Fieldnotes: May 14, 2005). Dr. Sunbool and Dr. Latifa interspersed their patient exams with frequent spells in the ultrasound room across the hall from their offices. A group of perhaps ten women patients, after being examined, would be given a requisition slip and told “paisah jama kuro, jaldi jao” (pay the fee, go quickly!; U) (Fieldnotes: May 14, 2005). (Women were always required to pay for ultrasounds in advance at the cashier’s office beside the Out-Patient clinic’s main entrance.) During ultrasounds, women were often accompanied by deeply curious relatives or neighbours. Dr. Sunbool left her Diameri ayah to instruct patients how far to pull down their shalwar (pants; U), or to push patients back to a supine position if they tried to get up and watch the ultrasound. Dr. Sunbool’s approach to her patients was measured and carefully-paced. Shifting frequently between
Urdu, Shina and Burushaski, she spoke to her patients almost as though they were children. Other times, she was exasperated when patients had not followed previously prescribed therapies, or brought her their doctors’ notes from competing clinics. She was also noticeably amused by her more ‘rustic’ patients, and unabashedly laughed at their somewhat eccentric views on conception, marital conjugality or pregnancy. On one my first days at the Family Health Hospital, I observed a patient exam and ultrasound for a Sunni patient who had come from Diamer District.

“Patient named Gulsumbur aged 20-25, from Tangir [Valley, Diamer District], black chador with neon-colored flower embroidery, plastic shoes, very colorful shalwar kameez with embroidered bodice, wears glass bangles, shiny ribbon band around cuffs and bodice of shirt, dirty hands - lean physique and sharp featured, dark face. Very animated and chatty, speaks Shina. She mentions pain, and Dr. says she has ‘3 live issues, all daughters’ and has had ‘3 abortions’ [miscarriages]. She asks for garmi illaj [humoral medicine, ‘hot medicine’; U], complains about PV [pelvic; vaginal] bleeding, after every 7-8 days the bleeding starts again. Had a miscarriage about one month ago at 3 months gestation, Dr. says she needs an ultrasound to check for retained tissue, and says to LHV ‘jama kurwaiya’ [she’s paid for it; U] and ‘she’ll do it!’ [In the ultrasound room] Gulsumbur escorted in by LHV, takes off plastic shoes, and Dr. says ‘She was not conceiving and I treated her, and she conceived and had three abortions, miscarriages and three live issues – she’s come with bleeding in the last month after the last miscarriage and I think she needs a D&C [dilation and curettage].’ Patient says she doesn’t like Tangir, thinks Gilgit is better and does not want to go back. Dr. says, ‘She has requested me to write that she has to stay here for a few more days. She does not want to go back, and I have agreed!’ Dr. smiles and laughs quietly.

She tells the patient she needs a D&C, and patient gesticulates with an outstretched, wagging hand toward the Dr.’s face, saying ‘Ya Khodai! [Oh God!; A] Not this time, next time!’ Dr. says, ‘Paisah hen, nah?’ [You have money, don’t you; S] and patient just looks at her, head cocked to one side from where she is lying on the table, dupatta still wrapped around her head. Dr. says, ‘You were supposed to come here 2 months back, but she is very late…[looks at ultrasound] she has cystic areas in her kidney – Hai [Oh; U]…’ Woman very chatty, animated, smiling – Dr. says ‘She’s talking against Dr. Khalthum [DHQ OB-GYN], she did her D&C and now she’s saying she’s not OK since then.’ After removing probe from her abdomen, turns to me: ‘Such a dirty abdomen, see?’ Dr. tells patient to drink more milk, woman protests; she is now standing beside ultrasound machine and leans in very close to Dr.’s face with outstretched hand again, to make her case. Orderly is

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24 Gilgit’s health providers referred to both miscarriages and pregnancy terminations as ‘abortions.’ I was left to infer which type of pregnancy loss doctors meant by the circumstances of the case. Failing that, I would ask for clarification.
griping at patient, and Dr. says to her ‘Chup tey bey’ [Leave it, shut up; S], then introduces woman to orderly as being from Darel. Tangir woman says, ‘She’s married from my village, and she’s never given me a gift!’ The orderly laughs, points to me and says ‘Humara humsaihe’ [She is our neighbour, from our area; U]. Tangir woman snippy with orderly and avoids her gaze. Dr. tells patient to eat chota gosht ['small meat', lamb; U], muchlee [fish; U], murghee [chicken; U], kaiey [eat; S]. Tells me patient was with her for 1 hour in her private clinic the day previous, and ‘She won’t leave me alone, see? Bas, nah? [It’s enough now, no?; U]’” (Fieldnotes: May 14, 2005)

Labour and delivery cases were monitored both during Out-Patient clinic hours and while the doctors were ‘on-call’ from early evening until the next morning. ‘Uncomplicated’ nighttime deliveries were sometimes handled only by attending nurses or LHV; if the physicians were unavailable, ‘complicated’ emergency or surgical delivery cases were referred to the DHQ and, less frequently, the Gilgit Medical Center. Despite having the highest Out-Patient attendance rates in Gilgit Town, on-site births occurred so infrequently that in all my visits, I was never able to observe a delivery. According to a 2004 progress report, between January 1999 and September 2004, the hospital handled only 301 deliveries and referred an astounding 1,331 cases to what are described as “higher level health facilities” (FPAP, FHH 2004: 13); in other words, the DHQ or the AKHS,P’s Gilgit Medical Center. Indeed, the DHQ handled the highest numbers of in-town delivery cases; its chief attraction was that Labour Room delivery services were far less expensive than at the Family Health Hospital where complicated childbirth cases started at Rs 2,000 (CDN $45.45). Patients could more easily afford to visit the Family Health Hospital for what they felt were its ‘higher-quality’ pre- and post-natal checkups, despite rumours that patients were routinely misdiagnosed or prescribed the ‘wrong’ medicines. At the DHQ’s Labour Room, several nurses and LHV offered vociferous critiques of the Family Health Hospital’s diagnostic and treatment capabilities. Along

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25 For the very few Gilgitis who were related to Army personnel, their families could sometimes arrange for them to be admitted to the higher-quality Combined Military Hospital (CMH) in Jutial Cantonment. Because the CMH’s unsubsidized services for non-Army dependents were prohibitively expensive, the Military Hospital was used only rarely. Because of its extremely limited contribution to Gilgiti health practices and with none of my participants having used its health services, I chose not to include CMH in my research. As an OB-GYN as the DHQ explained, “…the CMH [is] not for private citizens. They don’t deal with private OT [operations]” (Dr. Khalthum, DHQ: September 7, 2005).

26 In their 2003 report, the IUCN confirmed that at Gilgit’s private hospitals, “specialised medical and surgical treatments [are] very expensive and beyond the reach of the average family” (IUCN 2003: 203).
with staff at clinical centers throughout Gilgit Town, they claimed medical mismanagement, prenatal and postpartum complications forced many of the Family Health Hospital’s patients to come to the DHQ for advanced care. As one DHQ nurse commented, “...[they are only] expert at normal deliveries, in my opinion” (Nurse I, DHQ: August 6, 2005). At the AKHS,P Gilgit Medical Center, staff were similarly confounded by Dr. Sunbool’s popularity among local Sunnis. What DHQ and AKHS,P employees failed to acknowledge was how women’s uptake of Sunni physicians’ services signaled in-community allegiance, which was even more important during the rising sectarian ‘tensions.’

When its in-hospital services were combined with FPAP community outreach, the Family Health Hospital claimed to offer impressive health service coverage. By 2004, an FPAP review estimated that “three-hundred villages of Northern Areas, with an estimated population of 347,381 (42%) were covered under this project” (FPAP, FHH 2004: 12), although the Project Director later conceded that only 63 villages actually “fell under the catchment area of [the] Family Health Hospital and 9 Family Health Clinics” (Acting Project Director, FHH: May 11, 2005). Indeed, it became readily apparent that the Family Health Hospital’s in-house statistics were almost always artificially inflated. In a 2004 FPAP review of the hospital’s performance over a five-year funding cycle (January 1999-September 2004), the Family Health Hospital’s Intake records indicated that a total of “120,307 clients were offered counseling on Reproductive Health (RH), 28,575 were given services/treatment on different components of Reproductive Health and 8,026 complicated cases were referred to nearby higher level facilities” (FPAP, FHH 2004: 13). However, FPAP failed to qualify how the Family Health Hospital’s patient uptake rates were not differentiated between one-time or frequent visitors, or between one or more visits for the same health complaint or pregnancy.

Part IV  The Gilgit Medical Center

Starting from the late-1970’s, economically-, geographically- and culturally- isolated Ismaili communities across the Northern Areas were targeted by Pakistan’s Aga Khan Health Services (AKHS,P) as a key staging ground
for innovative public health measures. According to the staff I interviewed, after building two clinical centers in Gilgit Town and Karimabad (Hunza District) in 1987, the AKHS,P initiated a series of Northern Areas Public Health Centers (PHCs) in Ghizer and Hunza District’s predominantly Ismaili communities. These community-based clinics relied heavily on federal Ministry of Health promotion materials and pre-existing Aga Khan Development Network (AKDN) programming and policy (AKHS,P 2002: 2).

Specifically, AKHS,P programming used pre-existing interlinkages between Aga Khan Rural Support Programme (AKRPS) village-level and women’s organization economic and agricultural projects to introduce basic, preventative, diagnostic and therapeutic services. The majority of AKHS,P’s community health outreach projects in Hunza and Ghizer Districts were, and continue to be, funded by a combination of international funding and locally-generated donations. According to my Ismaili participants, community volunteerism is powerfully exemplified by the huge zakat (annual tithe; A) funds

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27 Beyond acknowledging recent years had been financially “difficult” (AKHS,P 2002: 6; AKHS,P 2003: 1), the AKHS,P 2002 annual review only hesitantly addressed the severity of international funding decreases and subsequent budget cutbacks. According to the physicians I interviewed in spring 2005, AKHS,P had lost significant amounts of funding due to poor project performance indicators among non-Ismaili clientele, in addition to its apparent inability to promulgate ‘self-sustaining’ health programming. Some of my Ismaili participants suggested that AKHS,P’s preference for Ismaili-only, upper level staff and management had been an additional point of contention for external funding reviewers. Despite funding cutbacks, AKHP’s had begun taking steps to ease the resentments of their non-Ismaili clientele and Gilgit District’s Shia and Sunni community leaders. AKHS,P activities now included policy crossover and institutional collaboration with the federal, Ministry of Health; collaborative activities concerned “EPI [Extended Programme on Immunization], [the] outbreak of communicable diseases, [and] National Immunisation Days” (AKHS,P 2002: 3). Their largest inter-institutional co-operation occurred with the Northern Health Project (NHP), “a mega health project... funded by the World Bank, KfW and [the] Government of Pakistan” (AKHS,P 2002: 2). From the NHP’s inception in 1998, AKHS,P had organized “continuing medical education sessions” for DoH physicians, the DoH had “invited eight staff members of AKHS,P,P to training workshops”, and AKHS,P and DoH jointly “trained 289 trained birth attendants” (AKHS,P 2002: 2-3). AKHS,P’s 2002 Annual Review also describes providing annual refresher training for “community based workers and 246 lady health workers (LHWs)” (AKHS,P 2002: 4). AKHS,P’s considerable successes among Ghizer and Hunza’s Ismaili patient populations were envisioned as offering a hopeful precedent for the Department of Health’s (DoH) under-serviced or geographically logistically isolated Shia and Sunni patient populations in Diamer, Baltistan and Astore. But with AKHS,P’s upper-level Administration reluctant to establish Primary or Maternal Health Centers in Gilgit and Diamer’s predominantly Sunni villages, the Northern Health Project was instead charged with the responsibility for these catchment areas. Between July 1998 and September 2002, the NHP unsuccessfully attempted to “replicate the community-based PHC model of AKHS,P (implemented in two districts) to [the] remaining three districts”(AKHS,P 2002: 3). Although the NHP’s “project life...ended in September 2002”, AKHS,P’s 2002 Annual Report noted that they continued to provide technical assistance “on an underfunded basis at the request of [the] DoH” (AKHS,P 2002: 3).
raised by Gilgit Town’s *Jamaat Khana* [Ismaili mosque] Executive Council and then forwarded to the Aga Khan Development Network’s Swiss headquarters for re-distribution. As one Council member explained:

“Donations are voluntary and no set amount is decided, so it can be Rs 5 or Rs 5 *lakh* [500,000]. Projects are announced in the *Jamaat Khana* and certain amounts are fixed for donations from different areas, such as the Northern Areas. The Aga Khan encourages Ismailis to meet their family requirements first before they donate any funds. For the Aga Khan University [Hospital] in Karachi…this project was announced to the global Ismaili community. Rich Canadians offered to donate a large portion of the funds, but the Aga Khan said instead it was better for each community to offer a proportionate share of the expenses so they would all participate in the betterment of the Ismaili population, and their education.” (Ghulmust: November 4, 2004)

This wasn’t to say, however, that AKHS,P’s early clinical outreach efforts, even in Ismaili villages, hadn’t been fraught with difficulty; “It took time for people to acclimatize to our new ideas, as with the AKHS,P Clinical Unit in Gahkuch.²⁸ Locals initially used to spit on AKHS,P vehicles and medical personnel!” (Dr. Hafiz, AKHS,P: November 5, 2004) AKHS,P health workers frequently cited their Ismaili faith as their primary inspiration to continue working amid community antipathies or threats of violence, problems which continue to face medical personnel working in non-Ismaili coverage areas or newly-established clinical units.²⁹ For Ghizer and Hunza Districts’ minority Shia and Sunni communities, health service access and program outreach had been complicated by inter-sectarian animosity and mosque-centered antipathy to AKHS,P’s mixed-gender clinical services. (Notwithstanding staff’s efforts to ease inter-sectarian tensions, non-Ismaili patients were often dismayed to see framed photographs of the Aga Khan hung on the walls of their doctors’ offices.) Though Gilgiti Shias attended AKHS,P’s Gilgit Town services in roughly the same numbers as Ismaili patients, mosque-centered tensions had resulted in AKHS,P being

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²⁸ Gahkuch is the capital of the Ismaili-dominated Puniyal Sub-District, which makes up the central portion of Ghizer District.

²⁹ In order to retain current staff and attract new employees, AKHS,P offers highly competitive salaries; specialist physicians earned upwards of Rs 1 *lakh* (100,000; CDN $ 2,272) per month, while LHV’s were typically paid between Rs 8,000 - Rs 20,000 (CDN $ 182-454) each month.
the least frequently used of Gilgit’s maternity services by Sunni patients, despite AKHS,P boasting the best-trained staff and fewest anecdotal reports of medical malpractice or misdiagnosis.\(^{30}\)

In 2004, AKHS,P’s longest serving obstetrician was Dr. Sharifa; in her late-forties, she was married to another AKHS,P physician and the mother of several young daughters. She had been raised by her grandparents in Hunza after being orphaned after birth, and in a spectacular break even from Ismaili tradition in the 1970’s, was sent to Lahore to train as a physician-specialist. By the time I first spoke with her in January 2005, immediately before Zia-u’din’s assassination, Dr. Sharifa had been employed with AKHS,P for twenty-five years.

“From 1976 to 1978 we operated as a Health Center, providing health education, and we would go to the house for a delivery, if it was a simple vaginal delivery. Older women, dais [midwives], ran our Maternity Center…. [AKHS,P] provided rations of wheat, cooking oil, milk powder for children under five, if the parents could bring them to the Center. In 1993, we made a Maternity Center [in Gilgit] and extended our facility and procedures to include complicated deliveries, miscarriages, and therapeutic D&C’s if they were indicated. (Dr. Sharifa, AKHS,P: January 7, 2005)

When I first lived in Gilgit in 1998, AKHS,P’s Maternity Home was located in the Shia-dominated Khomer Mohalla, sitting alongside the main road that led through Gilgit Town’s eastern neighbourhoods and the Army’s Jutial Cantonment. AKHS,P’s general clinical facility operated across town in Bermas Mohalla in a small, converted office building that overlooked several lumber yards and the Shia Imambaragh’s pastel-hued, cupola-domes, a short walk from the DHQ’s Main Gates. In order to amalgamate their clinical and maternal health operations at one site, in 1999 AKHS,P rented an unused hotel adjacent to the Khomer Mohalla Maternity Home and converted its guest rooms into small surgical suites, Out-Patient examination rooms and In-Patient quarters. The ‘Khomer Chowk’ Clinic’s expanded facilities required AKHS,P hire additional physicians, surgeons and two anesthesiologists, while its clinical operations were

\(^{30}\) The Gilgit Medical Center was, in fact, my own hospital of choice. It was with astonishment that I found the majority of my Sunni participants, even though they lived within easy reach of AKHS,P’s in-town clinic, professed to not know where it was located or had never heard of it. After months of fieldwork, the Gilgit Medical Center was accustomed to my bringing in Wadood’s relatives for pre-natal and infant check-ups, as well as delivery cases.
augmented with new equipment and supplies. And during the summertime months, the clinic hosted visiting Medical Residents from Karachi’s Aga Khan University Hospital.

By 2004, patient demand had pushed AKHS,P management to look for another, larger hospital site. Because of a massive decline in Northern Areas tourism after September 11\textsuperscript{th}, 2001, a variety of unused hotel locations were available for short-term rent or yearly-lease. Facing the glacial-fed Gilgit River and the mountains rising up steeply from Konodas Mohalla, one pristine, colonnaded and vacant three-storey hotel was offered to AKHS,P’s General Manager. By the summer of 2004, the Khomer Chowk staff was preparing to shift to its new River Road location in November. From our home near the new site in Shia-dominated Chenar Bagh Mohalla, we could hear workmen re-equipping the hotel to encompass a new surgical suite, a wheel-chair accessible walkway, a patient registration office and guardroom. On the ground floor was a staffroom, several examination rooms, several Out-Patient clinics, a laboratory, radiology unit and pharmacy, and one surgical suite and a row of In-Patient rooms. The second and third floors consisted of additional In-Patient rooms, and administrative and community outreach offices (see Figure 11). On its western side, the newly named Gilgit Medical Center sat up against Gilgit District’s largest Federal Girls Schools, and beyond that, the Northern Areas headquarters of the Gilgit Scouts. At the hospital’s eastern and southern sides were Shia residences, small agricultural plots, several grocery stores, a ‘canteen’ (restaurant) and a busy snooker club.
The Gilgit Medical Center’s Out-Patient clinics were well attended, with upwards of forty-five patients per day being seen by one or two attending obstetrician-gynecologists between 8am to 2pm.\textsuperscript{31} New patients paid a one-time Rs 100 (CDN $2.27) registration fee and were provided a medical folder for their in-hospital diagnostic, treatment and prescription records. Maternity patients were also provided an Out-Patient card which recorded their weight and blood pressure, along with blood, urine-analysis, ultrasound and basic examination data for each visit. As was also the case at the DHQ, after Out-Patient cards had been filled-in by nurses and physicians, they were returned to the patient and had to be brought in for each subsequent visit. From my own observations, the majority of patients were Ismailis from Gilgit, Ghizer and Hunza, followed by Shia patients from the surrounding Shia mohallas of Chenar Bagh and Domyal, or the nearby villages of Danyor, Sultanabad and Jalalabad. According to the hospital’s October 2004 Intake Register, roughly 5\% of patients came from Sunni dominated mohallas or villages (see Chapter Seven, page 373 for more detail).

At the hospital’s two-bed Out-Patient clinic, nurses or LHV\textsuperscript{s} first checked women’s weight and blood pressure in the examination room’s small antechamber, which doubled as a crowded waiting room for upwards of fifteen patients.\textsuperscript{32} Additional patients sat in chairs or on the grass in the hospital’s courtyard, where they waited to be called. In the summertime, there was an idyllic quality to even lengthy waits, with women and their families enjoying fresh cherries, apricots or cherries from the fruit trees growing in front of the hospital, or \textit{chai} bought at the small canteen beside the main gates. Before seeing the doctor, LHV\textsuperscript{s} routinely sent pregnant patients for urine and blood testing at the hospital’s on-site laboratory.

Routine testing looked for Rhesus-factor (RH), “anemia, albumin or sugar” (Nurse, AKHS,P: November 9, \textsuperscript{31} Between November 2004 and August 2005, I was given permission to ‘sit in’ on nearly one hundred patient visits, and conducted additional interviews with the Gilgit Medical Center’s staff. While Dr. Sharifa had given me permission to observe on-site deliveries, the hospital’s Administrator had taken issue with my research and told me I was prohibited from attending births. By contravening his orders, I would have risked being barred from further fieldwork.
\textsuperscript{32} During my 2004-2005 fieldwork, the Gilgit Medical Center’s Senior Medical Staff were almost exclusively Ismaili, with the exception of a few Shia nurses and LHV\textsuperscript{s} from Nagar District. Trained nurses were occasionally recruited for temporary contracts from among the wives of Gilgit-based, Sunni Punjabi Army officers.
These, in turn, were suggestive of potential pregnancy complications (such as RH-incompatibility, gestational diabetes, hypertension- or eclampsia-related liver or kidney failure) and by relation, foetal morbidity. Physical exams looked for the fundal height, signs of anaemia and weight gain or loss. Internal pelvic exams were commonplace, and when two physicians worked in tandem to deal with a higher-than average patient load, women enjoyed little privacy. After disrobing in front of the doctor, staff and sometimes another patient, women’s naked lower extremities were draped with a sheet and physicians and nurses used flashlights for internal checks.

Given the exam room’s small size, women’s attendants or small children were only very rarely allowed in. The only exceptions were when a condition or prescription needed to be explained to family members, or foetal abnormalities or death had been detected. In such instances, nurses and LHV’s explained that women needed the “extra support” only family could provide (Nurse, AKHS,P: November 9, 2004; Dr. Sharifa, AKHS,P: May 15, 2005). Patient visits were expedient but not rushed. For women who had trouble understanding a diagnosis, or wanted to discuss how emotional, familial or economic worries had precipitated their health complaints, doctors and nurses were patient and directly attentive, holding hands or stroking women’s legs or hair and speaking slowly, in a carefully modulated tone. With more anxious or depressed patients, doctors, nurses and LHV’s were careful to use local honorifics or kinship terminology. Depending on the patient’s age, social status, ethnic or sectarian background, I noted

33 Rh-negative mothers are given injections of Rhogam, a blood product intended to protect mothers and the foetus from Rhesus incompatibility, which leads to fetal hydrops and sometimes intra-uterine death. After a number of pregnancies, some mothers become ‘allergic’ to Rh-positive foetuses and are no longer able to carry pregnancies to-term. Unlike many other medications, Rhogam shots are not provided free-of-charge by the government. Each dose is Rs 5,000 (CDN $ 113.63), with most women requiring one or two doses per pregnancy. If newborns are found to be Rh-negative, then mothers do not require Rhogam following delivery (Dr. Sharifa, AKHS,P: February 9, 2005).

34 Fundal height measures the size of the uterus, from the pubic bone up towards the rib-cage. The height of the fundus is related to gestational size and age.

35 While discussing husbands’ involvement in their wives’ treatment, Dr. Sharifa said, “I will tell a woman exactly what the health issue is, or what she must do, and when to return for a follow-up, and sometimes the woman will ask me to explain to her husband, or the male relative, why follow-up is important, otherwise they might not bring her back. If I have to discuss her health matters, I will do it with her husband but I don’t usually explain these things to the other relatives. I tell her to bring her husband with her the next time” (Dr. Sharifa, AKHS,P: May 12, 2005). My own understanding was that because of the many times women misunderstood their diagnosis, or the doctors prescriptions, or for when husbands were suspicious of what physicians and patients discussed during clinic visits, spousal or family follow-up was extremely helpful.
doctors often called women “Mama” (mother; B), “Bhaji” (older sister; U) or “Kaki” (older sister; S). Burushaski and Khowar were spoken with Hunzakut and Ghizer-District Ismaili patients, and Shina was reserved for Sunnis, Shias and Ismaisls from Gilgit, Diamer, and Astore Districts. Because many of her patients made simultaneous use of Gilgit’s hospitals and clinics for any one health complaint, Dr. Sharifa asked if they were seeing other doctors, and sometimes refused to take on cases already being treated by other physicians.

“People sometimes bring medicines from the DHQ for us to inject them with here at AKHS,P but we won’t do it. It’s a liability issue, and we don’t want to be blamed. Yes, some people make use of multiple practitioners, seeing Dr. Khalthum [OB-GYN] at the DHQ, and then me here, but I want them to stick to one practitioner.” (Dr. Sharifa, AKHS,P: January 7, 2005)36

For additional examinations or diagnosis, the doctors used the clinic’s one ultrasound machine. Ultrasounds were performed on nearly every patient, unless the diagnosis was already clear or women had been referred to the Gilgit Medical Center with recent scan reports from Dr. Shakoor at the DHQ, or the CMH’s ultrasonographer. Despite being briefly trained at the DHQ’s Radiology Unit, Dr. Sharifa readily acknowledged she was mostly self-taught (AKHS,P: May 12, 2005). Yet after years of daily use, and bolstered by frequent corroboration of her reports by Dr. Shakoor or the CMH, she was relatively confident in her use of the machine; “Ninety-percent of the problems I can pick up, such as gross anomalies, amniotic fluid, size of the baby’s head, bones, vertebra, legs, or birth defects” (Dr. Sharifa, AKHS,P: January 7, 2005).

AKHS,P’s pre-natal and ante-natal clinics used short films, educational brochures, seminars and informal counseling to prepare women for impending births, early infant care, breastfeeding and post-partum recovery. During the last trimester of pregnancy, between thirty-two and forty-two weeks gestation, women were “told to bring clothes for their self and the baby to be ready for delivery [and patients were]

36 The Northern Areas Department of Health (DOH) noted that numerous health complications resulted from public-private sector cross-over and women’s erratic uptake of services at multiple locations. For instance, physicians unwittingly over- or mis-prescribed medications to patients who, in turned out, were taking multiple other drugs on another doctor’s orders.
given an orientation [of] the labour room” (Nurse, AKHS,P: November 9, 2004). (At all of Gilgit’s hospitals, women were required to bring blankets and swaddling clothes for their newborns.) In the last few weeks before delivering, women were advised during their bi-weekly and then weekly checkups about those symptoms requiring medical treatment, including their waters breaking, vaginal bleeding or unexplained fevers. On-site deliveries occurred in several converted hospital suites on the ground floor, immediately adjacent to the Out-Patient clinics. Patient rooms were large, with private bathrooms and curtained windows that faced the hospital’s courtyard and gardens. (Though the Gilgit Medical Care offered Gilgit Town’s highest quality services, their clinical facilities and patient rooms were not as clean as the Family Health Hospital, which had a higher-operating budget). Obstetric patients were permitted up to three attendants as long as they didn’t “interfere” with medical procedures or internal exams (LHV, AKHS,P: November 9, 2004). If women had passed their due dates or been diagnosed with potentially life-threatening pre-eclampsia or polyhydramnios, labour was induced through injections or IV doses of Oxytocin, which caused contractions and dilation (Nurse, AKHS,P: November 9, 2004).

Conditioned perhaps by the DHQ’s quick resort to labour augmenting drugs, women were particularly keen to have IVs established as soon as they had been admitted for delivery, and frequently requested ‘glucose’ drips. Throughout Gilgit, ‘glucose’ was equated as a kind of ‘instant energizer’ and a popular, first response to nearly every medical complaint. But for labour cases, women’s interest in IV-glucose was additionally suggestive of the patient and their family’s wish for a convenient, quick childbirth. “They know that when we give them the glucose drip we are going to put injections like Oxytocin in to speed up the delivery...they want the mother to have the baby right away so they can go home, and they just want the baby – the one they’ve been waiting nine months for!” (Dr. Sharifa, AKHS,P: May 15, 2005) Most patients, however, were unfamiliar with Oxytocin’s many associated medical risks, which include uterine rupture, premature separation of the placenta from the uterine wall and postpartum hemorrhage. When doctors chose not to administer an IV-drip, attendants were often angry since an IV was viewed as
synonymous with medical care; “‘Give her a drip, you’re not doing anything, or enough! What is the point of us being here, we could be home!’” (Dr. Sharifa, AKHS,P: May 15, 2005)

Although labouring mothers were not usually provided pain relief, and were encouraged instead to use “breathing exercises to help forget the pain and concentrate on the labour” (Dr. Sharifa, AKHS,P: January 7, 2005), oral dosages, injectible and IV pain medications included the relatively weak “Dactoran, Ponstan and Calpol” (Nurse, AKHS,P: November 9, 2004). “Tamgesic and Socigon” (Dr. Sharifa, AKHS,P: January 7, 2005) were stronger but still only mildly sedating. The strongest pain relief was provided by “Medicom for during labour, after vaginal delivery, or post-surgical, through IV or intramuscular injections” (Dr. Sharifa, AKHS,P: January 7, 2005)37. For in-labour patient monitoring, the nurses and LHV used fetoscopes or stethoscopes to check for “foetal movements and heart sounds [and] women’s blood pressure” (Nurse, AKHS,P: November 9, 2004), while maternal fevers were sometimes suggestive of pre-eclampsia or uterine infections. When cervical dilation was slow or contractions infrequent, women were encouraged to “walk to speed up delivery if in the early stages” (Nurse, AKHS,P: November 9, 2004). And in noticeable contrast to the DHQ, Dr. Sharifa did not discourage her patients from crying out during childbirth.

Unlike traditional deliveries, where Gilgiti women gave birth upright while squatting over an old blanket or sawdust, AKHS,P patients were advised to take a ‘lateral position’, where they sat semi-upright, their knees bent and feet tucked up against their buttocks, or pushing against the bed’s foot-stirrups.

Episiotomies were common, but not nearly as routine as they were for first deliveries at the DHQ (FW Head Nurse, DHQ: August 4, 2005). When completed by a nurse-midwife, uncomplicated deliveries cost Rs 800 [CDN $18.18], while doctor-attended births cost Rs 1,000 [CDN $22.72]. This represented at least half the cost for ‘normal’ deliveries at the Family Health Center. Women were encouraged to stay at the hospital following birth, rather than leave immediately as was the case at the DHQ.

37 All intravenous, oral and injectible medications were detailed on patients’ discharge slips and paid for at the hospital cashier.
“...for a first delivery, women stay at the clinic for twenty-four hours...if it’s not her first delivery, she’s here for at least ten to twelve hours and then she can request to leave and go home early with the doctor’s permission [and] if there are no complications.” (Nurse, AKHS,P: November 9, 2004)

While uncommon, on-site maternal deaths had occurred in recent years.

“It’s very rare, although I can remember one maternal death from PPH [postpartum hemorrhage]. It was not our luck; it was a lady doctor. That was the only casualty that was avoidable that I can think of. We’ve also had one to two deaths from eclampsia, and women arrive here from our rural health centers where they were only able to give them fluids, and Valium. Women arrived here already unconscious, and with seizures. During those episodes, we need medical assistance from our medical personnel; they are the ones who have the responsibility to monitor the patient’s breathing, her seizures. My job is to deliver the baby as quickly as possible. There was also one death from a patient having Hepatitis C. She was full-term, and was advised to deliver early due to medical indicators. She had a vaginal delivery, but unfortunately died two to three days later, her liver was completely destroyed. She was very sick.” (Dr. Sharifa, AKHS,P: May 12, 2005)

After Out-Patient clinic hours, one physician remained on-call. If they weren’t needed in surgery or for emergency coverage, AKHS,P doctors rested in several on-call suites. And because the Gilgit Medical Center had previously been used as a hotel, its staff rooms were already equipped with comfortable beds, sofas or armchairs, bookshelves and well-equipped bathrooms. In the In-Patient Ward, metal-framed chairs and patient cots had replaced hotel furniture. After shifting their operations from the Khomer Chowk site to Chenar Bagh in late November 2004, AKHS,P had renovated the former hotel’s kitchen into an immaculate surgery where C-sections, forceps and vacuum deliveries occurred. But for women with health complaints that contraindicated anesthetic, “such as asthma or allergies, and it is an elective case, first we try to treat the underlying problem then refer them to surgeries [requiring] general anesthetic” (Dr. Sharifa, AKHS,P: May 12, 2005). When the hospital’s anesthesiologist, Dr. Munab, was unavailable, complicated cases were referred to the DHQ and transported either by family vehicle or the Gilgit
Medical Center’s Jeep-ambulance. As was the case at the DHQ’s OT, epidural kits were available but were in any event largely impractical given that, for the duration of a woman’s labour, anesthesiologists were required to stay for monitoring. With only one anesthesiologist on-staff, this would have resulted in uncomfortably long shifts.  

“In 1993...we performed all our operations and procedures under a combination of spinal anesthesia [epidural] and local anesthetic. We would use local anesthetic for draining abscesses, for instance, when we want to numb one particular area. If a spinal was contraindicated, by bleeding or hypertension or blood pressure problems, for example, because the spinal drops the blood pressure anyway, we would refer the C-sections to DHQ. It was our only solution. In ninety-percent of those cases, I would go with the patient and hand them over to the physician there, explaining the case and the patient history. In 1999, we got an anesthesia machine, which has a ventilator, regulates patient breathing and monitors cardiac activity and blood pressure. ...At the Khorom Maternity Home we didn’t have such an anesthesia machine, and for about one year we called an anesthesiologist to come sometimes to monitor such procedures....we no longer use spinal anesthetic anymore, because [of this] requirement....We use a general anesthetic for all C-sections now, for four or five years.” (Dr. Sharifa, AKHS,P: May 12, 2005) 

AKHS,P’s reproductive and maternal health services and outreach programming were interconnected with village-based peripheral health centers (PHC) in Danyor and Oshikandass (see Halvorson 2000), as well as throughout Ghizer and Hunza; many women were referred from these outlying areas for help with complicated pregnancies or deliveries. After births occurred at the Gilgit Medical Center, hospital staff notified AKHS,P field staff to administer the necessary postpartum and infant vaccines, including for Hepatitis and Tetanus Toxoid, or field staff asked women to return to local health centers. For women

39 Prior to AKHS,P reducing their anesthesiology staff to one specialist in 1999, their coverage capabilities and maternity patient services had been more extensive. “We no longer use a spinal anesthetic [epidural] anymore, because of the requirement for constant monitoring. We use an epidural for older men who come in for [short] procedures such as prostate surgery, though. But not for women. We use general anesthetic for all C-sections now, for four to five years now...in general, the post-operative recovery for a spinal was better. The patients are fully alert, less shivering, and blood pressure problems are not so much. But with general anesthetic, sometimes they have a bad reaction and more body temperature shifts” (Dr. Sharifa, AKHS,P: May 12, 2005).

40 Asthma, emphysema, respiratory infections and advanced tuberculosis were some of the primary contraindications to general anesthetic. At the DHQ, one obstetrician remembered a patient death due to TB. “One time a patient was delivering and she had advanced TB. She was bleeding profusely from the mouth, and the anesthetist couldn’t work properly. I delivered twins by operation. One was transverse, and one delivered normally.” (Dr. Khalilum, DHQ: September 7, 2005).

41 Because AKHS,P’s PHCs operated outside of Gilgit Town in non-Sunni communities, they were not included in my research.
living outside AKHS,P coverage areas, patient follow-up was non-existent. Beyond their uptake of the Gilgit Medical Center’s services, Gilgiti Sunnis experienced little in the way of AKHS,P community outreach. When I asked if the nearby villages of Minawar and Sakarkui were covered by AKHS,P activities, AKHS,P’s educational outreach coordinator answered:

“No, they’re not in the AKHS,P plan. Not even Gilgit Town is covered by AKHS,P activities. AKHS,P’s only base in Gilgit is the Gilgit Medical Center. Here we offer children’s immunizations, indoor health education…this is when LHV’s are talking to patients while they wait to see doctors, or they see our posters, or when they are admitted as patients here, or on the request of their doctors. Then they can refer the patient for follow-up to health centers or government health centers. These may not be as good, but it’s all we have to refer them to if they’re not in the AKHS,P coverage area.” (Guhlmayn, AKHS,P: August 24, 2005)

There were attempts, however, to alleviate gaps in service coverage. During my fieldwork, AKHS,P had begun construction on a new hospital site halfway between the villages of Minawar and Sakwar which is proposed to eventually take-over from the Gilgit Medical Center.

Part V In-Clinic, Family Support

The majority of my participants said that they were unable to visit local hospitals without being accompanied by a mehram or wali (close male relative; appointed guardian). At our neighbourhood mosque in Jutial Mohalla, visiting Tablighi Jamaat delegations had argued that close male relatives were the only acceptable attendant for women travelling outside the home. But during my visits to local hospitals, it was obvious that women were not always able to attend local clinics or hospitals with their husbands. Many men worked through the day; others were visibly ‘embarrassed’ in women-dominated settings and reluctant to go to maternity clinics. At the Gilgit Medical Center, I had asked Dr. Sharifa if her Sunni patients always came with their husbands for Out-Patient visits or delivery cases. “No,” she said, “they also come with female relatives or harmsaie [neighbours; U]” (Dr. Sharifa, AKHS,P: May 12, 2005). Indeed, because men were forbidden to go inside the local Labour Rooms, women attendants were the only permissible in-clinic attendant. Though the DHQ’s LHV’s claimed hospital DHQ prohibitions
against male attendants were solely reflective of traditional dictates barring men’s presence during childbirth, it was clear that they shared their patients’ embarrassments.

“Husbands are not allowed to attend, because locals are sensitive in these instances and not interested [because of] cultural ideas and regulations. Also [with] lady staff, it is not appropriate or comfortable for them. If men have questions about the birth, they can approach staff in the clinic, but not come directly to the labour room.” (LHV, AKHS,P: November 9, 2004)

There were exceptions to the rule, however. At the DHQ, one LHV stated:

“Men cannot come into the Labour Room unless it’s an emergency and there are no staff, then we’ll call the men to come and help shift a patient, but this happens not very often...Usually all the men will be here at the hospital, waiting for the female patient, but then when we need them – like for a blood transfusion – we’ll go to look for them, and they’ll be gone, back home or to go get chai [tea; U].” (LHV VI, DHQ: July 26, 2005)

Once a woman had delivered, her husband and close male relatives were allowed to visit her and see the new baby in the Labour Room’s postpartum suite. But for Sunni patients coming to the DHQ from conservative local villages or Diamer District, the Labour Room LHV said women only rarely had women attendants. At the Gilgit Medical Center, Dr. Sumairah noted that “when women from Darel, Tangir or Chilas come they usually come with a father-in-law or a brother-in-law, not their husbands” (Dr. Saadia, AKHS,P: May 12, 2005); her observation was confirmed by the DHQ’s nurses and LHV. Because of my own experiences of conservative Sunni family life, I felt that by deliberately involving other male family members in women’s health service access, Gilgit’s Sunni families often sought to subvert or subdue the emotional intimacies that might interfere with a husband’s primary filial obligations to parents and siblings. (This was particularly true for families from or claiming close connections to Diamer District.) A husband’s involvement in his wife’s care and well being, even in merely logistical ways, was viewed as a potential threat to the love and loyalties that men were expected to hold for their mothers.

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42 In light of men’s anxieties about other men ‘seeing’ their wives or female relatives, during my visits to the DHQ Labour Room I was surprised to discover that a mildly, mentally disabled man and a mute man worked with the LHV to fetch supplies, chai and help to clean the patient rooms.
Mothers-in-law sometimes went to great lengths to stymie and interrupt marital affection. According to my own mother-in-law, husbands were not deemed dispassionate enough observers of their wife’s in-clinic comportment, and were more likely to be swayed by love to do ‘the wrong thing’ (gultee baht; U). (For instance, many mothers-in-law described their sons as ‘complicit’ or ‘disloyal’ when they discovered their daughters-in-law were using contraception.) With their marital role already overburdened by Islamic admonitions that men act as women’s protectors and moral guardians, husbands were thereby expected to solicit family and neighbours to monitor their wives or daughters in community and clinical contexts. A woman’s husband’s sister - loyal to her own mother and brothers’ interests - was one of the more frequent attendants chosen for Sunni maternity patients by their husbands or in-laws.\footnote{Because of the camaraderie and relational equality that could accompany the relationship between the wives of brothers, especially when neither was a blood relative of their in-laws, these types of sisters-in-law were not seen as ‘loyal enough’ to their in-laws’ interests. They were, therefore, not qualified to be ‘good’ attendants.} Her ability to monitor her sister-in-law’s demeanor and requests for help from physicians, nurses or LHVs not only upheld family hierarchies, but valorized her ongoing commitment, indispensability and worth (fayda; U) to her natal family even after marriage. (As I knew to be true among my in-laws, such allegiances partially underlie a woman’s continued ability to ask her natal family for financial or emotional support even after marriage.) Fieldwork interviews, however, showed how a husband’s mother, sisters or even neighbours could intentionally and harmfully distort this information to enhance distrust between spouses and exacerbate a wife’s in-family vulnerabilities, or increase men’s feelings of dependence on their natal family. Not surprisingly, some women quietly described their mother- or sisters-in-law as jasoosee (spies; U). On the other hand, some participants argued that a woman’s emotional investment in her daughter-in-law’s well being and pregnancy-related health was crucial for her own treatment in later years.

“....if the mother-in-law is good, she’ll take care of her daughter-in-law, and thinks of her as her own daughter. Some will even say, ‘If I misbehave with my daughter-in-law, how will my son take care of me later?’ If she is good with her daughter-in-law, she will have no problems with her son.” (Nurse I, DHQ: August 6, 2005)
But a mother-in-laws’ enthusiastic participation with her daughter-in-law’s clinical visit could result in a new set of problems. At the Gilgit Medical Center, one nurse discussed how overly-involved family members frequently impeded a woman’s clinical treatment, especially when births became complicated. Mothers-in-law were often described as “getting in the way,” “too pushy” or “asking too many questions” (Nurse, AKHS,P: November 9, 2004). Even though mothers-in-law often fought against their son’s over-involvement in his wife’s pregnancy and at the time of delivery, in the excitement following the birth of their children, some men wholeheartedly disregarded Islamic, hospital and family prohibitions.

“Hussen’s husband had been in Chilas….He’d telephoned us to ask about Hussen, and we’d said she was in severe pain and had been admitted to DHQ. Within 3 hours he was there. He came to the hospital, reached there, opened his jacket and prayed 2 rakat namaz [prayers; A] on the hospital veranda at the Family Wing….It was very cold [that] February…and he was alone ....They told him he had a baby boy, and he went straight into the labour room to see the baby. He kissed her and cried. His auntie was there, too. We were happy that he was happy. It’s not normal for men here to be so emotional….Hussen’s husband is a tukkudar [contractor; U]. He has his matriculation.” (Madheeya, Jutial: July 11, 2005)

Inspired by the ‘courage’ of those men who dared to transgress this spatial and social gender divide, many younger women discussed their efforts to diminish the social distances between themselves and their husbands when their babies were born. Or, they described men’s interest in childbirth as compelling evidence of marital ‘love’ (ishq, mohabbat, pyar; U). At the age of thirty and the mother of three children, Menahsat was quick to affirm her desire that if she had another baby, she wanted her husband to be with her.

“We want this, but society won’t let us have them there, but we want them there. They are the right person to be with us, and to see what is happening, right? But the Sisters, the doctors, the women with us, our mother-in-law, they won’t let the men in. Our husbands do ask us about our deliveries, though, and what happened and how the baby was born - if we had any trouble or pain.” (Menahsat, Jutial: June 7, 2005)

**Part VI Gilgit’s Private Clinics, Midwives & ‘Comporters’**

Although only a small number of my Sunni participants had delivered their babies at Gilgit Town’s costly private maternity clinics, many women attended these clinics for their pre- and post-natal checkups.
Chapter Two: Gilgit Town’s Maternal Health Services, Private Practice & Personal Loss

According to the Northern Areas Department of Health, the central dilemma with private sector services arose when government hospital physicians opened private ‘after-hours’ clinics; country-wide, Pakistan’s Ministry of Health was aware of the lucrative opportunities posed by private practice (see Thaver et al, 1998). At the DHQ, doctors unhesitatingly referred patients to their private clinics for expensive ‘follow-up’ treatment; in this way, government physicians used the DHQ’s subsidized services as a springboard to private practice profits. In response, the Northern Areas Department of Health and the Ministry of Health enacted legislation prohibiting governmental physicians from referring their patients away from no- or low-cost governmental services; physicians were also officially barred from operating private health clinics during their ‘off-duty’ hours. Yet when faced with the everyday constraints imposed by their low salaries, DHQ’s medical staff disregarded federal rules and have faced few, if any, disciplinary measures or fines.

The Gilgit Medical Center’s Administration, and to some degree that of the Family Health Hospital, had increased their physician salaries as an incentive to keep them from running a private practice. Where DHQ physician salaries were roughly Rs 15,000 (CDN $341) per month, AKHS,P doctors were paid between Rs 70,000 (CDN $1,590) and Rs 1 lakh (100,000; CDN $2,272). Even though she earned a high annual salary, the Family Health Hospital’s Dr. Sunbool owned and operated a highly successful maternity clinic at Majini Mohalla, a short stroll from the Sunni Jama Masjid (mosque). According to Dr. Sunbool, once the Family Health Hospital’s Out-Patient clinical hours were completed by mid-afternoon, “[my] duties cease and we are on-call until the next day. I then go to my private clinic; I estimate that I work an average of sixteen-hours per day” (Dr. Sunbool, FHH: May 11, 2005). The hospital’s Acting Project Director was visibly unsettled when I asked him if Dr. Sunbool’s private clinic and after-hours referrals might present challenges to her patients or represent a financial loss for the FPAP.

“Yes, she has a separate private clinic at which she works when she’s finished her day duties here at 2pm. We won’t lose patients, no...because the services we offer are better, and the quality of care is the same here as what she provides at her private clinic.” (Acting Project Director, FHH: May 11, 2005)
I then discussed how, at the DHQ, many patients were not only dissatisfied with the hospital’s overall lack of equipment. They actually seemed to be more profoundly distressed by how little time they had to talk to their doctors during the morning OPD shift. In response, patients often sought the comparatively expensive “high quality services” (LHV II, DHQ: November 19, 2004) at their physicians’ slower-paced, after-hours clinics. In response, the Acting Project Director tried to deflect my quiet criticism of the Family Health Hospital’s rushed OPD consultations and ultrasound exams.

“Here it is different because the patients see we are very well equipped with the latest technology, and private clinics do not have what we have, and the DHQ doesn’t have it either. Patients come to us from far-flung areas [because] we have a well furnished OT [operating theatre], laboratory, patient rooms.” (Acting Project Director, FHH: May 11, 2005)

Overall, the Family Health Hospital’s Administration was largely reluctant to answer my quietly voiced concerns that their patients used the hospital for medium-cost, high-quality laboratory analysis and a preliminary diagnosis, then visited Dr. Sunbool’s private clinic for the detailed diagnostic or therapeutic advice she didn’t have time to share with them during their rushed, hospital visits. As one Shia homeopathic physician noted:

“In Gilgit there are many such harmful conditions, and at the first level doctors consult at the hospital, where they only have so much time, and so many patients, and they take a small look. Then they tell the patient, ‘There are no resources or materials here at the hospital’ so they refer them to their private clinic where they pay a high fee, Rs 300 to Rs 500 [CDN $6.80-11.40]. They also have their own medical supplies, because of drug shortages at the hospital.” (Dr. Farman, Domyal: August 25, 2005)

Physician-owned pharmaceutical dispensaries allowed doctors to exponentially augment their private practice profits; many physicians had opened dispensaries adjacent to or inside their clinics’ premises. They claimed that because they could supervise the preparation of medications, they offered ‘safer’ prescriptions than those purchased at dispensaries run by untrained comports (dispensers; U), who were widely blamed for frequent drug-related deaths or for selling expired medications (see Sweester 1993).44

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44 One Sunni dispenser shared the story of the man from whom he had bought his pharmacy. “The man who ran this shop before I did...killed a patient right here in this clinic. The man had heart disease, and he gave him Bistrol
This said, private physicians were not exempt from the temptations posed by illicit pharmaceutical sales; expired medications were known to be repackaged in ‘new’ containers, or inexpensive ‘number two’ drugs - illegal knock-offs of the original drug - were substituted instead.

Many of my Jutial Mohalla participants were closely related to their local comporter, a middle-aged man named Mukhtar. He told me he had received two years “training at Islamabad Complex Hospital in 1997” and received a “special diploma for Pharmacies”. After this he had worked with his cousin, Dr. Ahsam-ul-Haq, for “two years and I learned from him which medicines to use for which problems; I also learned how to run the X-ray, lab, check for blood pressure” (Mukhtar, Jutial: August 2, 2005). Because he had been trained to recognize most drugs, their medicinal properties and possible cross-reactions, Mukhtar felt equipped to not only dispense medicines without a prescription, but also comment on the wide range of mis-prescribed medicines given to women by their doctors. To prove his case, Mukhtar showed me a sheaf of doctors’ ‘wrong’ prescriptions which he had collected over the last few years. These, he said, were his record of physicians’ wrongdoings and ‘corruptions’, and his protection against malpractice charges from angry customers.

“I’ll advise my customers if the medicine they request is right or wrong for them, and sometimes the doctor will give them the wrong medicine...One time my wife was sick, and went to Dr. ‘Mohsina’, who said she had jaundice. But I felt she was wrong, so I [went] to the DHQ and saw Dr. ‘Siraj’ and Dr. Khalthum, both of whom said it wasn’t jaundice. Dr. ‘Mohsina’ had advised my wife to take an injection of Diclophanic, which is a muscle relaxant, and also to take Jektopher [sic] which is an iron and copper compound which could have affected her liver. The side effects aren’t helpful! [angry] For the patient on this form [shows me prescription] she had a hernia, where the pain moves across the belly. Her primary problem was this. Dr. ‘Mohsina’ advised her to take Septran, which is a ‘Number 2’ medicine for infections. It’s an antibiotic. Here I sell this medicine for Rs 50 [CDN $1.15], at [her] hospital its Rs 140 [CDN $3.20]!” (Mukhtar, Jutial: August 2, 2005)

tablets and told him to chew them. The [customer] sat on the charpoy [rope bed; U] in the front of the store, ate them and died right in front of us! The comporter was sent to thana [jail; U], and had his licence cancelled, but he got it back again [in] Chilas by paying rishwat [bribes; U]” (Mirfazl, Yadgar Chowk: August 4, 2005).
Many of my Jutial Mohalla participants unhesitatingly consulted with Mukhtar about each of the drugs they were prescribed, or had heard about and wanted to try. Across Pakistan, a doctor’s prescription is not required for pharmaceutical purchases.

“Women will sometimes bring the label of a medicine with them. Many can’t read, and they’ll say because they don’t want to pay the doctors fees...women become experts in demanding special drugs from doctors or clerks.” (Mukhtar, Jutial: August 2, 2005)

And with in-town *dayahs* fast disappearing, dispensers were now taking over some of the responsibilities associated with home-based deliveries or post-partum care. Jutial Mohalla’s foremost *dayah*, Sherafeen, had died several years before my fieldwork, and for the few families that still preferred home deliveries, Mukhtar was requested to come and provide injectible uterine stimulants like Centocine, which he said “makes the delivery easier and faster” (Mukhtar, Jutial: August 3, 2005). Buscopan was used for pain relief, and for women with high blood pressure or who were borderline eclamptic, he administered injections of Valium in order to stabilize them for the shift to the hospital. But too much Valium risked maternity patients becoming unconscious; thereafter, it was “very hard to shift them” (Mukhtar, Jutial: August 3, 2005). After deliveries, *comporters* were often paid to “...provide a drip, or to do a basic check of the mother’s health, but we don’t check the baby’s condition” (Mukhtar, Jutial: August 3, 2005).

Perhaps the most interesting example of a private maternity clinic was the Medicare Maternity Home in Wahadat Colony, a subdivision of Jutial Mohalla. Even with a number of women obstetricians operating in direct competition with his services, the middle-aged Dr. Yasin had recently attempted to extend his eclectic practice of acupuncture and ear, throat and lung medicine to include labour and delivery. On the second-storey above his clinic and a family-owned pharmacy, he had built three patient rooms and one surgical suite where he was occasionally contracted by local families to handle C-sections. But because of gender prohibitions, Dr. Yasin was forced to sub-contract local nurse-midwives and surgeons for uncomplicated deliveries and C-sections. Or he referred patients back to Gilgit’s DHQ, the Gilgit Medical Center or the Family Health Hospital. Against his initial hopes, Sunni loyalties had not extended to
include his treatment of female patients. As a result, he ended up renting out his operating room to physicians and *dayahs* on a case-by-case basis (Dr. Yasin, Wahadat Colony: November 5, 2004).

Indeed, physicians weren’t the only ones hoping to benefit from private practice. After retiring from their duties at the DHQ and Family Health Hospital, several *dayahs* had opened clinics in close proximity to local hospitals. Hospital physicians were generally loathe to critique these poorly-run clinics, out of allegiance to the many years they had worked with *dayahs* like Nargis, who now called herself a ‘doctor’ on her clinic’s signage. (‘Dr.’ Nargis was the elder sister of the DHQ’s longest-serving LHV. Only a handful of my participants had used her clinic for their deliveries; after enduring poorly handled episiotomies under her care, many swore never to return.) With the exception of Dr. Sunbool’s after-hours clinic, Dr. Yasin’s maternity hospital and ‘Dr.’ Nargis’s health center, Gilgit Town’s private maternity clinics were operated by non-Sunnis and were located in Shia and Ismaili mohallas. As such, they made only a nominal contribution to Sunni women’s health episodes or health-seeking. Because Dr. Sunbool’s clinic was located in Sunni-dominated Majini Mohalla, this ensured that her patients faced far fewer of the *izzat*- (honour; U) and sectarian-related concerns. During ‘tension times’ like the 2004 Nisab Riots, these few Sunni-owned, Sunni mohalla-based clinics allowed patients to simultaneously uphold their sectarian allegiances, contribute to the Sunni community’s faltering local economy, avoid the risks posed by Shia mohallas, and receive greater privacy and physician attentions than they would normally have received at busy hospital Out-Patient clinics and Labour Rooms.

**Part VII  Medical Terminations & Infant Loss**

During my fieldwork at Gilgit’s hospitals, I observed a number of complicated obstetric cases and abnormal births. I was also present for a small number of medical terminations, which were relatively common for ‘missed abortions’ (also known as ‘failed miscarriages’, or intra-uterine foetal demise) or foetuses which had been diagnosed with defects through ultrasound.\(^{45}\) The general requirements for a

\(^{45}\) See Hewison et al (2007) for a discussion of Pakistani-British women’s attitudes toward prenatal ultrasound diagnosis, foetal abnormality and the decision to terminate.
 medically-indicated termination included pre-eclampsia or diagnosed foetal abnormalities including inoperable congenital heart defects, microcephaly, anencephaly or hydrocephaly, foetal hydrops or spina bifida. (Mongolism, or Down syndrome, was described as a rarity and harder to diagnose.) The physicians I interviewed were unfamiliar with the nuchal fold marker by which Down syndrome is diagnosed by ultrasound in Canada.) First trimester abortions were recommended after “light bleeding, a missed or threatened abortion, a molar pregnancy...a blighted ovum, or an abnormality if it’s seen in the first three months” (LHV III, DHQ: August 6, 2005). Second- and third-trimester terminations were offered for women with foetal abnormalities, in-utero demise (IUD), intra-uterine growth retardation (IUGR) or polyhydramnios, which results from excessive amniotic fluid. If left untreated, polyhydramnios can cause premature delivery, eclampsia and maternal death (LHV III, DHQ: August 6, 2005). AKHS,P’s procedure for medically-induced terminations was roughly similar to that practiced at the DHQ, the primary difference being that the Gilgit Medical Center’s conditions were more hygienic.

“If the pregnancy is three months or less, we use anaesthetic and remove the foetus through a D&C [dilation and curettage]. If it’s three months and over, we start artificial pains through an IV, and wait for natural expulsion.” (Dr. Sharifa, AKHS,P: January 7, 2005) If in-utero foetal demise had already occurred, most doctors agreed that mothers should be quickly induced, rather than risk delayed childbirth and potential complications like septicaemia.

“In the case of a simple IUD [intra-uterine demise], the woman wants it done as soon as possible, because once it is confirmed the baby is no longer alive it is torture for her to carry it longer, and she will agree for it to be delivered right away, to be taken out. Their husbands will usually agree with the doctor’s opinion.” (Dr. Sharifa, AKHS,P: May 15, 2005) During one of my visits to the DHQ Labour Room, a young woman had come to deliver at five months. A routine ultrasound had shown the foetus ‘expired’ at three months gestation but the woman had failed to miscarry. Because of the increased associated risk for maternal sepsis, blood clots and fever, first trimester

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46 The physicians I interviewed said Down syndrome was extremely rare. At the Gilgit Medical Center, Dr. Sharifa described seeing only two such infants born during her many years of work (Dr. Sharifa, AKHS,P: May 15, 2005).
‘missed abortions’ were described as incredibly ‘khattarnak’ (dangerous; U). After the patient delivered, one LHV summarized her handling of ‘missed abortions’:

It was done and over...in five minutes, very simple. She was admitted two days ago with a missed abortion, and for induction. We gave her a Centro injection, in her drip, for starting her pains. But first we put a hollow pipe into her cervix, then we add sixty CC of water and a balloon expands and dilates the cervix. Then we give her ten to thirty CC of Centro in the injection. The pipe is inserted at 10.30pm or so at night, as for this patient, and then at 6am we start the Centro and the induction....the baby was very blue, we couldn’t see any features on the face, or anything. [grimaces]” (LHV VI, DHQ: July 26, 2005)

At the Gilgit Medical Center, if ultrasound scans indicated a potential abnormality or pregnancy-related health risk Dr. Sharifa referred her patients to Gilgit’s radiologists for confirmation.

“I try to prepare them, to give them some idea and say ‘I have some doubt, and I want to confirm it with another doctor’ and then I will refer them...But if it is a gross abnormality, like hydrocephaly, anencephaly, I do not need to send them for confirmation, I can see it clearly and will go ahead and tell the couple.” (Dr. Sharifa, AKHS,P: May 15, 2005)

When her patients had returned with secondary reports and her findings had been corroborated, Dr. Sharifa asked women’s attendants or husbands to be present for a third ultrasound.

“If a baby is abnormal, especially, we’ll call [the] husband into the room. We try to show him on the ultrasound what is wrong, and we will take the time to explain to them what has happened with their baby. But especially with young women, or those pregnant with their first baby, I will try to show them on the ultrasound...show her the baby’s head, arms, legs.” (Dr. Sharifa, AKHS,P: May 15, 2005)

Doctors noted that without having seen ‘evidence’ of the baby’s abnormality, many husbands balked when they were asked to sign surgical consent papers; the husband’s permission (ijhazaat; U) for medical termination was necessitated by in-clinic policy at the DHQ, Gilgit Medical Center and Family Health

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47 There were only two trained ultrasonologists working in Gilgit, both of whom were male. One worked at the DHQ, while the other worked at the Combined Military Hospital (CMH). Each hospital had a different policy or fee schedule for ultrasounds. Ultrasounds at the DHQ were free, and approximately twenty-five to forty patients were examined each day. Their staff ultrasonographer was Dr. Shakoor, who in his off-duty hours ran a slightly dilapidated private radiology clinic in Kashrote Mohalla. Because “various kinds of [physical] contact between doctors, staff and patients are haram [forbidden]” (Dr. Moin, AKHS,P: November 5, 2004), some women were reluctant to be examined by Dr. Shakoor. Instead, they visited a largely untrained cadre of ‘lady doctors.’ At the Gilgit Medical Center, Dr. Sharifa conceded that because her training was largely ‘on the job’, it was reasonable that AKHS,P did not charge separately for ultrasounds as part of prenatal checks (Dr. Sharifa, AKHS,P: May 12, 2005). At the Family Health Hospital, where Dr. Sunbool and Dr. Latifa were equally untrained, patients were charged Rs 150 (CDN $3.40) per ultrasound.
Hospital. Speaking to me between patients, Dr. Sharifa said that for a termination to proceed there typically had to be a consensus among a woman’s treating specialists, including the Gilgit Medical Center’s staff paediatrician (Dr. Sharifa, AKHS,P: January 7, 2005). Physician-held notions of what constituted an ‘untreatable’ or stigmatizing abnormality, regardless of foetal viability or potential quality of life, figured heavily in the decision-making process to abort.

“I had a case of a five-month pregnancy, and the foetus had short-limbs. My ultrasound was confirmed at the CMH. The baby was useless. It was the mother’s first pregnancy, and I thought it would be a dwarf, though it had normal [size] upper limbs. We terminated.” (Dr. Sharifa, AKHS,P: January 7, 2005)

But when infants were wanted, money was available and pregnancy-related conditions or foetal problems were deemed ‘treatable’, physicians referred women to the Pakistani Institute of Medical Sciences (PIMS) in Islamabad, or Karachi’s Aga Khan University Hospital for advanced medical support or treatment. But because the associated costs and transport difficulties were extreme, the majority of economically disadvantaged patients were forced to complete high-risk pregnancies in Gilgit, where there was no advanced life support for women or their infants. There were also times when a woman’s belief in God’s ability to ‘reverse’ or ‘change’ an abnormal diagnosis endowed her with the emotional stamina to complete a high-risk and often physically painful pregnancy. Among participants who had had ‘abnormal’ babies diagnosed by ultrasound, many harboured the quiet hope that their qismat (fate; A) was alterable, and could be influenced by how they responded to a negative diagnosis. Some felt that their baby could be ‘saved’ through concerted and selfless prayer (namaz, dua; A), by maintaining hope (umeed; U), or by resolving social discord between themselves and family or neighbours. When our second son was diagnosed in 2002 with fatal abnormalities at twenty-seven weeks gestation, Wadood’s response and mine differed in important and hard-to-reconcile ways. Even though the baby was still alive, I mourned immediately for our impending loss. Wadood, in turn, fought against my “indifference,” ”hardness” (sachtee; A) and “lack of hope.” He insisted that if our faith (deen; A) was sufficient, God would more likely assist the baby – and then us - by ‘correcting’ the diagnosis. When the baby was induced, Wadood spent a
desperate few minutes searching for signs of life, despite it being obvious the baby had died several days previously. He was crushed. After hearing my story, Dr. Sharifa recounted a similar case, where a Sunni patient and her husband had come to the Gilgit Medical Center from Astore, a difficult drive of nearly eight hours. (In important ways, hearing these stories helped me to better process and contextualize Wadood’s response to Sikander’s birth.)

“She had a very bad obstetric history, with several neo-natal losses, and she was very happy because she had one son who was born here and was very healthy. She came with her next pregnancy at sixteen weeks, and we diagnosed with anencephaly and advised her for a termination, and she refused, saying ‘Khodai meh mantey heh’ [I trust in God; U] Her brother was with her and said he could not force her to do it. She came to us [at] full-term and delivered. When she saw the baby, she was so upset, and we told her that we had warned her about this, and that was why we had advised her for termination. And this had been confirmed by other radiologists. The woman’s attitude basically was this, ‘Thik thak ho jaega’ [it will be alright; U], because of God.’ But I believe this…that all technology, our brain abilities are God-given, and that God gives us the ability to learn and see - using the technology – the problems so we can solve them.” (Dr. Sharifa, AKHS,P: May 15, 2005)

Among the most common infant abnormalities was spina bifida, where the spinal nerve is left open in a cyst at the base of the back. The nerve is especially vulnerable to trauma during childbirth or early infancy, which then causes paralysis. The condition is a neural-tube defect which is usually due to insufficient folic acid stores in the mother. I knew of at least six Gilgiti mothers who had delivered babies with this condition with none of the infants having survived more than one year. During one visit to the DHQ in late summer 2005, my daughter Kate and I watched as one of Wadood’s cousins delivered her eleventh baby who, to our sadness, had spina bifida.

“As the baby’s body comes out…I look down and see a large bloody cyst on the baby’s lower spine and the Sister says to me in a somber voice ‘Abnormal baby’…the baby is removed and is silent. He has a large, healthy body and a beautiful small-featured face…they clamp and cut the umbilical cord and the dayah carries him to the infant table where she lies him on his side in the chador [veil; F]….As she lifts the baby to wipe him off, I see his legs are motionless, unlike his arms which are flexing. When the baby isn’t crying well initially, and after a few outstretched hands in the dua [supplication; A] position and with ‘Allah Shukr hen’ [thanks to God; S] from the attendant, she goes over to the baby and sees he and the dayah are relatively silent. She hits the dayah’s upper arm lightly several times and puts her arms out in an expression of confusion…the dayah tells her something
is wrong, and the woman looks mournful and puts her hand on her forehead again; the 
dayah turns the baby over as she wraps him to show the attendant what is wrong. I tell the 
attendant there is treatment for the baby, a simple surgery, but the Sister interrupts, saying 
‘They are poor people - paisah nish [no money; $] - and treatment will be difficult for them, 
especially if they have to go to the city.’” (Fieldnotes: August 7, 2005)

Among neural-tube defects, anencephaly was among the most emotionally problematic for new mothers 
and their attendants, and was also among the most common of locally occurring defects (Dr. Sharifa, 
AKHS,P: May 15, 2005). In such cases, the baby’s brain is largely ‘missing’ and the cranium ends in a soft 
flap of skin immediately above the baby’s eyebrows. The rest of the body typically develops normally.

“…with anencephalic babies there is nothing above [the forehead] and they have small 
pointy faces like dogs, with fat hands and feet. We see at least one or two a month, it is 
very common, the most common defect here.” (LHV III, DHQ: August 1, 2005)

Nurses, LHVs and doctors at all hospitals took great care to swaddle such babies so as to minimize the 
abnormality, but also took steps to ensure the mother or her family saw the ‘problem’ so there were no 
remaining doubts about the gravity of the situation. If mothers were in a great deal of distress, hospital 
staff dealt exclusively with the attendants, to whom they gave the baby; “Attendants are usually hesitant 
to show the mother, because of all the pain she has just been through and now she is very upset” (Dr. 
Sharifa, AKHS,P: May 15, 2005). At the DHQ, one LHV told me about the deaths of abnormal infants 
immediately after birth.

“The full term babies sometimes die after delivery, sometimes, usually one hour after birth. 
We keep him on a trolley, and don’t show the mother. We’ll wrap him in a sheet, and 
cover the face as well. They’re only breathing, and we can open the sheet to show the 
attendant. Sometimes the mother asks us, ‘Why isn’t he crying? What happened?’ and 
we’ll say, ‘You should wait, he will cry after some time.’ When the baby dies, we’ll say, 
‘The child was abnormal, and he died. You’re lucky he died, or you have had to spend so 
much money on doctors to care for him, he would have been a burden, and he never 
would have been more than a simple [‘retarded’] child.’ Mothers accept this, and co-
operate, and most give thanks to God and don’t cry. The family’s reaction is usually to say 
that all things are due to God, and they can’t do anything about this....We’ll say to them, 
‘You should thank God you’re alive and OK, even though your baby has died. You and 
the Bap [father] can have another baby!’ We’ll call the husband to the [registration] counter 
and say the same thing to him. We tell him alone, and not when he’s outside or in front of 
other family – in case he’s shy or embarrassed.” (LHV VI, DHQ: August 1, 2005)
For families who opted to terminate fetuses that had been diagnosed as anencephalic, the DHQ’s LHVs were careful to emphasize to the patient that the anencephalic baby had risked her life. Among physicians, however, there was a consensus that such pregnancies rarely caused maternal morbidity or mortality.

“We wait until [the mother] is all cleaned up, and then we’ll tell the attendant and show them the baby – then we tell the mother, ‘If your pregnancy had continued, you would have gotten an infection, then you would have a high fever, and the infection would spread to your blood.’...we’ll say ‘It’s good for your health [to deliver] – you are alive and can give birth again.’” (LVH II, DHQ: August 1, 2005)

There were inevitably times when the more severe the abnormality or ‘odd’ the delivery, the more likely staff or patients responded with fright or even amusement, which in turn compounded the mother’s fear and grief. And regardless of staff protests that they treated the mothers of such infants with sympathy, I had seen the shame experienced by many parents of abnormal children, and could only imagine the stigmas and social distancing they endured. As with infertile women (bhanche, U; shohnee, S), women who had delivered one or more abnormal infants were viewed as spiritually contagious.

“The other day, an anencephalic baby was born. It was dead at birth, and one of the attendants of another woman in labour came over and said ‘jinn payda huaat!’ [a jinn has been born; U] I scolded her, but these are illiterate people, and they were afraid of the baby.48 I told her, ‘He’s a human being, too.’...Most of the anencephalic cases I’ve dealt with are primae cases [first deliveries]. I’ve done three or four such cases as this. I remember one case, it was even in the newspaper, but they mentioned Zarina’s [dayah] name, where the baby was born, but its body was strange. It had no neck, big head, small legs, long arms and a thick torso. When it was born its tongue was wagging back and forth! [laughs] This was perhaps ten to twelve years ago. We were scared and we wrapped up the baby and left it on the side until it died, maybe two hours later. We don’t show such babies to the mother, no.” (Sister Sabah, Kashrote: August 29, 2005)

For ‘abnormal’ babies that survived to birth, or infants who had been irreparably harmed through birth injuries, their lives were often tragically short or characterized by neglect. Much in the way my grandmother recounted farming families in Northern Ireland leaving ‘different’ babies to quietly waste away, poorer Gilgiti families were reticent to face the stigmas, energy and medical costs associated with

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48 According to the Qur’an, jinn are ever-present invisible spirit-beings that are similar to, but not the same as human beings.
even relatively treatable defects like spina bifida. Those babies that did survive usually had initially
hidden disabilities such as mild or moderate mental retardation. These children still faced unpredictable
odds.

“If a baby is born with abnormalities, they are deaf or dumb or have physical abnormalities,
then I think [the family] does not take care of them as if they are healthy. They have no
facilities [here], such as if they are mute or deaf, and I think they neglect them. Some
moderate hydrocephalic cases are born and survive, some with cerebral palsy or birth
hypoxia [insufficient oxygen] survive for a few days, we will intubate and oxygenate
them.” (Dr. Sharifa, AKHS,P: May 15, 2005)

Following ‘abnormal’ deliveries at the Gilgit Medical Center, attention was paid to the infant’s vital signs,
and the mother’s health card noted for follow-up; patient discharge followed soon after. At the ‘high-
tech’ Family Health Hospital, there were very few options available for families coping with an unhealthy
or ‘unusual’ baby. For parents seeking treatment, their best options included visiting the Gilgit Medical
Center’s or DHQ’s pediatricians, or going to the far costlier and less accessible CMH (Nurse I,
DHQ: July 26, 2005). If care was locally unavailable or prohibitively expensive, parents were often
advised to seek advanced care from clinical centers in Pakistan’s urban centers. After asking me to tell her
about my stillbirth experience, my neighbour, Fouzia, shared the story of her firstborn. Her son, Pervaiz,
had been born with spina bifida and hydrocephaly, where the baby’s head is enlarged by cerebral fluid.
With her husband largely disinterested in Pervaiz’s well being, and the extended family unable to afford
corrective surgery in Islamabad, Fouzia nurtured Pervaiz for nine months, even though DHQ doctors had
predicted the baby would die within weeks of his birth.

“For the last month he was alive, there was blood coming from his head, and his hair was
falling out - he was in severe pain. Dr. Hanif advised us to take him to [Rawalpindi] and
perhaps he would survive. I was crying all the last month watching him. He was crying
then only for milk. All the body was very thin, but the head was very big...he had a very
beautiful shakl [face; U] despite the water problem [hydrocephaly]. My husband was
crazy, he was telling me ‘Leave him, some day he’ll die...’ At that time he had no job, and
my brother was helping me...When he died he was at home, at night at one a.m. I was

49 Before being discharged, doctors offered careful warnings to the mother; “After they have lost this baby, we
advise them to use contraceptives for at least six months, and take folic acid for three to four months, assuming this
is the underlying reason” (Dr. Sharifa, AKHS,P: May 15, 2005).
looking at him, and he’d already died, in my room in bed with me. I woke up to check on him because the doctor warned me about his death, and I was waiting. Then I called my mother. From the evening, his face was cold, and he was not breastfeeding. I asked my sister what she thought, and she said ‘Maybe fever...’ She later told me she knew he was dying, because she felt his pulse and it was weak. She knew herself there was a problem...but didn’t want to tell me. I called my mother, and she called some people to come and prepare the baby for burial in the morning. We gave the baby ghusl [ritual purification; A], and I washed the baby myself with my Kagi [big sister; S]. I held him in my arms and washed him carefully, because his head was so big. For two months afterwards I still felt as though he were with me. People told me it was a big sin to cry, and not to cry, but inside I was crying.” (Fouzia, Jutial: June 15, 2005)

Regardless of the cause of its demise, the baby’s body was never left for clinic staff to dispose of; “This is seen as a big gunah [sin; A], so they always take it with them for burial” (LHV III, DHQ: August 2, 2005).

Due to discomforts with the body being ‘mutilated’ after death, post-mortems were extremely rare; almost without exception, the baby’s body was given immediately to the family for burial. At the hospital, first- or second-trimester foetuses were wrapped in white cloth, then taken home and buried in a nearby mosque graveyard or on the family’s property the same day.50 It was only if babies had “died after taking a few breaths, or after taking milk” that families performed the jenaza (funeral prayers) (Shandana, Amphari: August 12, 2005). And as is demonstrated by Fouzia’s narrative, grieving mothers were exhorted to demonstrate their acceptance of God’s will through a calm demeanor; Gilgiti Sunnis describe crying after a relative has passed away as representing anger at God, or a feeling of injustice at a pre-ordained (qismat; A) passing. The naming of the foetus or stillborn infant was viewed as especially crucial for swift passage to Heaven (Jennat; A).

“You’re supposed to [give a name], even if it’s a miscarriage from only three or four months. We wrap these babies in white cloth, too, for burial. Babies need a name for Qaiyaamat, for the Day of Judgment when these babies can help his or her parents. It’s an

50 In Minawar, one woman recounted her own, multiple losses; “I had several miscarriages....One boy died inside at 8 months. One baby girl died at 3 days, and then I made a tawiz [amulet; A] to protect myself. If at 8 months it’s a miscarriage, called shudal zayab [S], which is maybe due to hard, physical work. If people have them at 3 or 4 months, we bury them in a white piece of fabric in kaburistan [cemetery; U]. If at 5 or 6 months we give them a name and use no headstone. Don’t need to wash the baby as it’s chuney [small; S] and goes straight to Allah hookum [Heaven, ‘God’s place’; A]...After a miscarriage, women take ten days rest because they feel stomach pain, are weak, have fevers. Men bury the babies generally, but if it happens at 2 to 3 months women can take the baby to the kaburistan. There is no jenaza namaz [funeral prayers; A] said for these babies” (Pfiffi, Minawar: April 28, 2005).
Islamic concept, in our Hadiths. If the parents have so many sins, the baby can request God to forgive its parents. Even on Judgment Day, these babies can recognize their mother by their smell. Whether [it is] a girl or a boy, these babies can request God to let their parents into Heaven to be with them. They recognize their parents, and want to be with them....The ruuy [spirit; A] goes straight to Heaven after death, it doesn’t stay here in the duniya [earth], because they are beygunah [without sin; U] and are like ferishtey [angels; A].” (Jalili, Amphari: August 12, 2005)

Even when their memories of a baby’s features diminished over time, or in those instances when mothers had never seen their infants, the idea that babies could find their mothers again by smell was poignantly representative of the enduring connections between parents and children. As I had experienced after the births of my five children, newborns are often sweetly scented, so much so that Gilgiti mothers sometimes remarked their newborns were surrounded by khushbool (perfume; U). In more emotionally austere moments, the primary comfort for Fouzia and other bereaved mothers (including myself) was that these lost infants, absent of any earthly sin and unshackled by emotional attachments, immediately ascended to Heaven, where they resided as angels, waiting to plead their parents’ case to God on Judgement Day.

Some women described how particular Hadith and Qur’anic ayats were especially comforting. In one Hadith, the Prophet is recounted counselling recently bereaved parents, of whom he asked, “Would you like to find your child waiting for you at the Gate of Paradise?” (Ul Masabih in Madani 1999: 864)

**Part VIII Conclusion**

The stories of loss, moral meaning and faith foregrounded by women’s in-clinic experiences with loss or in understanding why things ‘went wrong’, naturally drew me away from biomedical settings and toward questions of belief and traditional practices. These issues were not an initial focus of my research; as this chapter attests, I had begun my fieldwork determined to concentrate on biomedical service provision. But because desi practices and Islamic beliefs surfaced so regularly in women’s narratives, it was necessary to also examine the scope and contribution of non-allopathic or religiously-prescribed therapies. And with women’s use of desi bilehn (traditional medicine; S) and Gilther riwaj (Gilgiti customs; S) also interconnected with Islamic doctrine, Sunni ideology and community politics, ethnographic
analysis of desi resort helps explain the ways Sunni women’s health was directed and delimited by questions of faith and tradition. There were a number of other, important reasons to examine desi bilehn. During the 2004 Nisab Riots and the following 2005 ‘tension times’ (see Chapter Six, Seven and Eight), Sunni women were systematically marginalized from maternal health services in Shia mohallas. By extension, and especially when Army curfews precluded women’s ability to leave home for treatment, in-town residents were forced to make greater use of the same home-based desi (traditional; U) therapies and maternal health practices used every day by their village relatives, who were blocked from biomedical services by distance, poverty and Sunni conservatism. But as Chapter Three will demonstrate, this did not mean that in-town residents weren’t already heavily reliant on desi herbals, diets or health practices. Lastly, because Gilgit’s physicians correlated traditional practices with maternal and infant deaths, analysis of women’s desi practices might help explain the Sunni community’s egregious maternal morbidity and mortality ratios (MMR). Following from Rachel Chapman, Chapter Three therefore seeks to “provide an ethnography of pregnancy that contextualizes [traditional] community knowledge, attitudes, beliefs about pregnancy [and] practices related to prenatal health care” (2003: 356), while my work goes one step further to also address childbirth and post-partum care.
Part I  Introduction

While observing hundreds of biomedical clinical exams in Gilgit Town, I noticed in-town Sunni patients often discussed or made reference to their traditional dietary practices or maternal beliefs. Most physicians responded by characterizing women’s use of desi bilehn (traditional medicine; S) as an eccentric holdover from village traditions. Other health service providers described desi remedies not only as dangerously inefficacious, but also reflective of rural Sunni communities’ jungulee (rustic; U) nature.

Biomedical resistance to women’s use of desi bilehn and their home-centered desi practices was common. In mid-February 2005, when his efforts to give me an injection of antibiotics for typhoid were stymied by my over-anxious mother-in-law (who was busy plying me with desi herbals), our Sunni GP-cum-obstetrician Dr. Yasin exclaimed; “Ah...our women! What can I tell you? They’re donkeys!” (February 15, 2005) Four months earlier, the DHQ’s Medical Superintendent had framed women’s domestic practices more delicately:

“We’ve got women washing their clothes in and drinking from the same nullah [river; U], which causes seasonal illnesses, like gastroenteritis, cholera...then there is pneumonia in the winter. People are always expiring [dying]! [laughs]” (Medical Superintendent, DHQ: November 8, 2005)

By focussing on desi bilehn as an outdated and harmful system, Gilgit’s physicians and health support workers underplayed the emotional comforts, spiritual support and relational benefits afforded by desi practices. Nor did health providers acknowledge that women’s reliance on community- or home-centered traditional therapies was partially reflective of the logistical and economic constraints women faced trying to access public sector clinics. Indeed, women’s use of desi bilehn allowed them to work within and not against pardah’s izzat- (honour; U) invested, socio-spatial strictures. And unlike biomedicine, desi therapies integrated Gilgiti notions of sociality, desi riwaj (traditional customs; U) and Islamic prayers to directly redress a wide array of ailments and risks, including health complaints women had learned through experience or been told by their physicians were unaddressed by biomedical etiology. For instance, there were desi bilehn treatments tailored to alleviate the physical discomforts of the
kunooh, an internal organ specific to women’s bodies and associated with reproduction, but which was unrecognized by their biomedical physicians. Or, women amalgamated khorak bilehn (traditional dietary healing; S), malish (hands-on massage; S) and Islamic dhum (blown prayers; A) to help ‘turn’ a breech baby. To this point, my participants’ and local mullahs’ claimed there was no intrinsic incompatibility between women-centered desi practices and Sunni Islam. The two worked interchangeably in women’s pregnancy and childbirth health practices, and afforded women a measure of security against the physical and metaphysical forces surrounding and affecting their reproductive health. As Inhorn aptly notes, Islam is a religion which is conducive to medical pluralism in that it “encourage[s] the use of medicine, biotechnology, and therapeutic negotiation and agency in the face of illness and adversity” (2006: 1).

Finally, it is worth repeating that desi therapies were very often the only available treatment option for rural Sunni women.¹ Notwithstanding the steady growth and popularity of biomedical services among Gilgit Town’s Ismaili, Shia and Sunni communities, in nearby villages like Minawar, Chamughar or Sakarkui, there were still thousands of women who had

¹ The Federal Ministry of Health’s failure to implement village-based primary health care is partially because the majority of government physicians are men. Community discomforts with male doctors treating women’s health complaints, when combined with male physicians’ overall unwillingness to visit or be posted to Sunni villages, has resulted in the paucity of rural women’s primary and maternal health services. Since the late 1970’s, the Pakistani government attempted to actively recruit local ‘Lady Health Workers’ (also called LHWs) who would be trained to perform home-based medical procedures and check-ups, moving on set schedules between villages (Schmidt 1983: 419-420). The programme’s proponents argued that for patients living beyond the reach of local hospitals or clinics or who, for reasons of social seclusion were unable to leave their homes for treatment, trained Lady Health Workers played a vital role in alleviating women’s health complaints. Yet despite government claims that LHWs were present and available to women throughout Gilgit District, during my fieldwork I never saw or even heard of an LHW visit either to Minawar or Gilgit Town’s Sunni mohallas.
either never enjoyed easy or affordable access to Gilgit’s hospitals and clinics; the barriers raised by
distance, inter-sectarian hostility, Islamic conservatism and household poverty were very often
insurmountable. The predominance of desi bilehn in Gilgit District’s village settings as women’s first and
sometimes last resort, underscored the importance of this portion of my ethnographic fieldwork.
Moreover, my examination of women’s desi health practices is perhaps the first effort to qualify rural,
Sunni health practices in the Northern Areas. But my analysis of desi practices was not confined to
village settings (see Figure 12). In addition to women’s everyday reliance on biomedicine, among my
Gilgit Town participants, desi beliefs and practices were thriving and being passed down to the younger
generation, albeit one which was more reliant on biomedicine. Besides conducting fieldwork in Minawar
Village, I also spoke with my in-town neighbours and in-laws, who proved to be immensely
knowledgeable about desi practices and herbal remedies, and offered helpful insights into the changing
scope of Gilgiti therapies amid a steady influx of allopathic pharmaceuticals. Throughout this chapter,
women’s accounts of their ‘traditional’ village-based health practices are therefore interspersed with
narratives collected from women living in Jutial and Amphari Mohalla, many of whose families had
moved to Gilgit Town from Minawar or other outlying villages a generation or so before.

**Part II  Desi Davaie, Desi Bilehn: Traditional Healing**

The first, more formalized type of desi davaie (traditional medicine; U) used medicinal herbs, roots and
humoural dietary supplements imported from across South and Central Asia, with standardized
treatment regimens and dosages prescribed by male specialists working from their in-town offices, or

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2 While AKHS,P has conducted qualitative studied of health among their in-town patients, these were
unavailable to me during my fieldwork. Accordingly, there is very little regional precedent upon which my thesis
Fertility and Childhood in the Northern Areas of Pakistan” (University College London), examined Ismaili fertility
beliefs and infant care practices in Upper Gojal (Hunza Sub-District). In 2000, Sarah Halvorson’s doctoral thesis
(Department of Geography, University of Colorado) analysed the environmental and social dynamics underlying
children’s vulnerability to water-related disease in the Ismaili village of Oshikandass (Gilgit District).

3 For instance, after the Karakoram Highway’s 1975 completion, Gilgit Town’s population tripled in size due to in-
migration from outlying districts. Despite making comparatively greater use of in-town hospitals than their village
relatives, many of these ‘new’ in-town families were still heavily reliant on desi hygiene, dietary and therapeutic
practices.

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from where they worked part-time in local pharmaceutical and herbal dispensaries. The vast majority of treatments drew on Yunani Tibb’s written, systematized diagnostic criteria and formulas. Yunani medicine draws on humoural Ayurvedic remedies and the teachings of Galen, Ibn Sina (Avicenna) and Hippocrates; across Pakistan Yunani is also known as Islami-Tibb, Hakeemi or Hikmat (wisdom; U). In Gilgit, my participants referred to it only as Hikmat, while its practitioners were called hakim. In Pakistan’s urban centers, Hikmat Colleges are commonplace, and hakims are certified and licensed for practice by the Government; there were no such colleges in the Northern Areas. As Sarah Halvorson noted for Oshikandass, Gilgiti hakims were rarely formally schooled. Instead, local practitioners usually came from the ranks of “faith healers, moulvis, sheikhs, khalifas, and pirs (holy men)” (Halvorson 2000: 216). As a direct result, their use of Hikmat was heavily weighted with Islamic measures; “they typically use prayer, water, and auspicious Qur’anic verses in amulets (taveez) in their treatments” (Ibid: 216). In this way, Yunani was regularly synthesized with Prophetic therapies, which are derived from the herbal and ritual healing practices endorsed by the Prophet and described in the Hadith Al-Sunnat (see Al-Jauziyah 2003; Azimabadi 2004; Browne 1921 [2001]; Khan 2004).4 A number of Hikmat and Prophetic medicine providers had opened clinics in Gilgit’s central bazaars, which in structure and operation mimicked professionalized, clinical biomedical practice. At first glance, it was virtually impossible to distinguish Hikmat clinics from biomedical doctors’ offices. Hakims had also begun to rely more on stethoscopes rather than feeling for the patient’s pulse and its ‘weakness’ or ‘strength’, which is a fundamental element of Hikmat diagnoses.

While formalized homeopathy and Prophetic medicine were tethered to transnational, historical textual sources, the second type of traditional medicine - known in Shina as desi bilehn - was specific to the

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4 Prophetic healing was predominantly mosque-centered and male-practiced. Its services were typically provided by both mullahs and laypersons, and involved using Qur’anic ayats (phrases; A), prescribed prayers (namaz, dhum; A), invocation and supplication (dua; A).
Northern Areas. Male and female thabeeb (healers; S) followed desi bilehn’s informal, unwritten therapies and used a regional pharmacopeia. Many medicinal plants grew in close proximity to women’s homes, or could be found in Gilgit Town’s few remaining stands of native trees. Alternately, women asked men relatives to pick up these ingredients or pre-prepared mixtures from local herbalists. Older women were usually adept at preparing herbal therapies for a wide array of reproductive or maternal health complaints. Over time, some women had made desi bilehn a formal home-based practice, treating women from across town and outlying villages for relatively small ‘visit’ fees, perhaps no more than Rs 20 (CDN $0.45) per visit. However, the majority of Gilgiti women herbalists only offered informal home-based support, helping family members and neighbours without payment. Regardless of whether their practice of desi bilehn was formal or informal, women thabeeb generally learned desi remedies from other women, or their husbands or fathers if they were desi thabeeb (Fieldnotes: September 10, 2005). By comparison to most allopathic pharmaceuticals, desi bilehn treatments were frequently more affordable. One provider described the costs associated with a ‘typical’ course of desi ‘medicine’:

“…it’s Rs 200 [CDN $4.50] for forty days worth of pills...if they are very poor, perhaps Rs 100 [CDN $2.30]. Sometimes it’s free and there’s no charge for them.” (Mugehra, Jutial: September 10, 2005)

In their efforts to mimic allopathic pharmaceuticals, local desi practitioners often produced rough pills made from crushed, powdered herbs and roots which were then dyed with synthetic food coloring. (Some desi therapists had also been ‘caught’ using Folic acid or calcium supplements, coloring them with dye and selling them as traditional remedies.) According to Mugehra, a formal desi bilehn thabeeb (traditional medicine healer; S) who worked from her family home in Jutial Mohalla, her female clients’ most frequent complaints included the following:

“…bleeding, back ache, gastric and hair loss problems...women come for too much menses, and for badei [swelling, edema; S] as well [for which] we are giving medicines for two months, the causes are spicy foods, achar [pickles; U], chutney, kuttaah [sour; S] foods. After delivery women come to me too. They come with a lot of bleeding, or safaid pani [‘white

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5 Among my participants, the terms desi davaie and desi bilehn were often used interchangeably, even though they referred to therapeutic systems that were, for the most part, separate and distinct from one another.

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water’, watery vaginal discharge; U] and backache. [For safaid pani; U] the uterus is open, and women have backaches and are weak from too much hard work, so the uterus is open. When she delivers and the baby comes out, the cervix is already open, so wind goes inside. If she’s under a fan, this can happen, and it causes backache. I don’t know why some women have a weak uterus – it’s a common problem we treat....[and] yes, we have a treatment for burning urine.” (Mugehra, Jutial: September 10, 2005)

Desi ingredients or prepared mixtures could also be purchased from a number of large, well-stocked homeopathic dispensaries in Gilgit’s central bazaars. Gilgit’s largest homeopathic dispensary was found just off Phul (Bridge) Road, in the heart of the bustling, Sunni-dominated Kashmir Bazaar, which was comprised of several interconnected shopping plazas beside the Jama Masjid in the center of town. The store was lined with ten foot-high shelves, packed with prepared herbal syrups (sharbat; U), tonics, packaged dry supplements and bottles of ‘pills’ (gollee; U), honey and herbs, roots and minerals. The majority of prepared formulations had been shipped to Gilgit from Pakistan’s formal homeopathic sector, in addition to a number of Iranian tonics and syrups (sharbat; U). Although a number of herbs and roots came from high mountain valleys and forests across the Northern Areas, the North-West Frontier Province (NWFP) and Azad Kashmir, the majority of raw ingredients were imported from India, Iran and Afghanistan (Fieldnotes: August 20, 2005); these were stored in open-topped bins at the front and sides of the store (see Figure 13). A pungent, spicy and slightly perfumed smell suffused the store, which was managed by a man in his late twenties. Arshad described how his clientele purchased raw materials or prepared formulas for a wide array of ‘sicknesses’ (beemari; U), which themselves were tethered to

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biomedical, homeopathic, *Hikmat* and *desi bilehn* etiologies or diagnoses. *Desi bilehn*’s wide therapeutic scope was, in fact, a central component of its popularity.

With most of his day spent busily ‘filling prescriptions’, and mixing raw materials into suitable dosages, Arshad claimed to have gained considerable expertise with herbal ingredients, formulas and medicinal properties. He was able to distinguish between Ayurveda-inclined *desi davaie* and Gilgit-specific *desi bilehn*, and frequently put together treatment regimes even in the absence of formal ‘prescriptions’.

Gilgit’s itinerant and neighbourhood-based herbalists were comparatively less professionalized; their services were restricted to ‘local’ remedies using forest plants from Astore and Diamer District, and from the highest mountain pastures in Upper Gojal (Hunza Sub-District). Gilgit’s *desi* herbals were, for the most part, collected by pastoralists. Carpeted with poppies (*phoonhay*; S) and wildflowers, overshadowed by towering pine, cedar (*deodar*; U) and mulberry (*maroch*; S) stands, the high alpine pastures of local mountains are still frequented during the summers by nomadic Gujurs (gypsies; U) and local shepherds. At several roadside locations near the Sunni *Jama Masjid* and Gilgit’s banking district, itinerant peddlers and roadside vendors sold raw herbs and roots from burlap sacks which lined the curb outside shops or the alleyways snaking off

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6 The well-journeyed mountain passes separating local peaks form traditional trade and migration corridors, and join Gilgit to areas once inaccessible by valley-floor routings or roads; even today, these passes offer ‘short-cuts’ for pastoralists and herders moving goats or sheep from one valley to another. Along windswept mountain pastures, many of which sit astride the mountains which separate Gilgit from neighbouring Districts, seasonal pastoralists from normally inaccessible valleys practice trade and animal husbandry, while preparing *ghee* (clarified butter) and collecting firewood for the impending winter season.
the central road into residential mohallas (see Figure 14). Although a number of ethno-botanical surveys have identified the medicinal and dietary properties of Gilgiti desi bilehn herbals, I was unable to uncover any prior research documenting Gilgitis’ use of desi therapies in home and community settings.7 Moreover, there was little if any recognition of the wide array of hands-on therapies, maternal and infant care practices attendant on desi bilehn, or the supportive role family and neighbours play in women’s reproductive and maternal health. This chapter’s analysis of Gilgit’s women-centered desi practices and therapies, therefore, represents one of only a very few sustained efforts to examine Northern desi bilehn in use.8

**Part III Minawar Family Life**

Over three weeks in April and May 2005, when heavy white blossoms blanketed local orchards like perfumed snowfall and then transformed into leafy copses of fruit trees, I visited with Wadood’s maternal cousins in Minawar – a Sunni village of approximately 200 households, sitting just beyond Gilgit Town’s eastern boundary – to discuss their use of desi bilehn, desi riwaj (traditional customs; U), and in-family pregnancy- and childbirth- support. Because nearly thirty closely related women lived beside each other in one overcrowded, if also picturesque, corner of Minawar, the time I spent with them provided valuable insights into desi bilehn as both a woman- and family-centered practice. Village

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7 In Gilgit Town, one desi thabeeb (traditional healer; S) showed me a worn photocopy of a spreadsheet detailing Northern Areas desi herbals’ origins, medicinal and ‘food’ properties. This information had been gathered by Roland Hansen (MA) as part of the “Pak-German Culture Area Karakorum (CAK)-Project” (date unknown). The thabeeb also kept a loose sheaf of patient testimonials, one of which contained a brief note in English confirming a study on his desi herbals had been done by IUCN Pakistan in Eid Gah, the thabeeb’s hometown in Astore (Fieldnotes: August 20, 2005).

8 Salman Keshavjee’s distinction between ‘popular’ and ‘folk’ medical knowledge in Badakhshan offers a useful parallel to my discussion of desi davaie (U), desi bilehn (S) and ‘Islamic’ therapies. He notes; “The secular folk practices tend to be based on traditions whose roots lie in the integration of Greek and Galenic medicine, with elaborations espoused by Indian, Persian, and Arab physicians, most notable of whom is the physician Abu Ali Ibn Sina [Avicenna]. These traditions of practice, also found to exist in various forms in Iran and Afghanistan, provide a basic structure for popular physiology, illness categories, and therapy (see Burgel 1976; Elgood 1934; Good 1977, 1994; Good 1980, Good and Good 1992; Ibn Sina 1930; Nasr 1968; Pliskin 1987). In addition, in Badakhshan the secular folk tradition involves the use of high-mountain herbal medicines and other local remedies (see Keshavjee 1998; Nuraliev 1981). The sacred folk tradition is based on the cosmology of the Qu’ran and tradition (hadith), and includes religious healers who heal through prayer informally (khalifa or local religious leader) and formally (hakim or tabib, religious healer; Keshavjee 1998; see Good 1977; Good and Good 1992; Olcott 1991; Penkala-Gawecka 1980, 1988)” (Keshavjee 2006: 79).
women’s use of desi bilehn was, in many respects, a product of necessity. As was the case in the vast majority of rural Sunni communities, Minawar had no doctors, clinics or dispensaries. Instead, there was only one small ramshackle roadside stall that sold “Paracetemol and other simple medications” (Phoonurh, Minawar: May 3, 2005). As a result, the majority of pregnancies, births and post-partum recoveries were covered by the services of untrained village-based dayahs, female family members (rishtedharoh; U) or neighbours (humsae; U). Throughout the spring, summer and early autumn, itinerant traders from the high valleys in Astore District plied their wares between households, hawking a wide array of mountain herbals for what Wadood’s cousin, Phoonurh, said women needed most, including “boy babies and good hair” (Phoonurh, Minawar: May 3, 2005). Year-round, there were a few local women who were self-trained desi herbalists and mixed forest plants and roots to treat a variety of problems; the only formal desi davaie clinics were found in Gilgit proper.

Phoonurh’s story provides helpful insights into the conditions of married life, and the social networks surrounding women as they gave birth to, and raised, their children. At thirty-eight, Phoonurh was the eldest of Wadood’s maternal first cousins. With light brown hair, olive green eyes and sharp features, she looked - to my mind - astoundingly healthy and energized for someone who had delivered nine children in sixteen years. Besides managing her unruly brood of often unwashed children, she worked every day in her family’s adjacent fields weeding and watering their wheat, barley and corn crops. She also raised chickens, grew and collected fodder for her goats and milking her cow morning and night. (She proudly told me how the cow had been a recent gift from her younger brother Amir, a China-border trader.) By her own rough estimates, Phoonurh had been married to Wadood’s cousin Shabir Alam since they were both in their late teens. Phoonurh and Shabir were also first cousins. Her father and his mother were siblings, and they had grown up together in an extended family compound. As Phoonurh had experienced in her own married life, there were often intense emotional discomforts and sexual
incompatibilities initially associated with marriages between couples who had been, for the most part, raised to think of each other as siblings. As one young wife in Amphari Mohalla laughingly noted:

“We joke sometimes, first we call men ‘Kaka, kaka’ [big brother; S] then we call him ‘husband’! This isn’t a problem for us, even if it’s a bit strange at first...” (Shehzadi, Amphari: August 12, 2005)

Despite such drawbacks, close family marriages ensured that new brides (dhoolhan; U) shifted to homes immediately next to their parents and siblings and endured far fewer separation anxieties, while also enjoying ready support for pregnancy, childbirth and child-rearing from their natal family and in-laws. Phoonurh, her parents and neighbours argued that the ideal, ‘Islamic’ marriage was between fraternal cousins (chachazad; U) though according to their family histories, maternal cousin (khalazad, U; hourmil, S) marriages were equally common.9 While in-town Sunni families usually waited until their daughters had completed Matriculation (Class 10) or a two-year college degree before arranging their marriages, in Minawar most girls were married at menarche, which was usually between ages fourteen and sixteen. After reaching menarche at sixteen, Phoonurh’s marriage to Shabir had been quickly arranged by her father, Major Mousaf Aziz. The Major was the head of a network of younger siblings, nieces and nephews and now grandchildren who, due to an unhappy series of early deaths, had become entirely dependent on him for financial support and leadership. In order to maintain his authority over more vulnerable junior family members, and to perpetuate his own hold on family-held land-holdings and financial equity, Bura Mamu (Big Uncle; U) had intermarried his children with those of his sisters and two younger brothers, as well as his wife’s nieces and nephews (see Figure 15).

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9 A generation or so before, first-cousin marriages had been standard practice for Sunnis across Gilgit District, irrespective of the rural-urban divide. In Jutial and Amphari Mohallas, more upwardly mobile families now preferred ‘modern’, ‘outsider’ marriages with distant cousins, friends or with the prosperous traders working between China and Rawalpindi. Some families argued they were now aware of the ‘genetic hazards’ of close family marriage. (In one branch of Wadoo’s family, congenital defects, metabolic disorders, poor vision and small stature happened so regularly that doctors had begun urging parents to cease arranging in-family marriages.) And because of their association with germane medical advice, ‘out-marriages’ were viewed as synonymous with higher levels of education and medical awareness.
To Phoonurh’s simultaneous joy and chagrin, Shabir loved her and regularly boasted he would father as many children as her body could bear. Flattered by his attentions to her, and openly grateful that because she had five sons she was far less likely to face the specter of a co-wife, Phoonurh’s marital security was additionally upheld by her parents, who lived in a ‘modern’ cinder-block house immediately beside her desi home and were quick to intervene on her behalf in the majority of marital disputes. When I first interviewed her in April 2005, Phoonurh, her mother, paternal aunts, sisters and sisters-in-law lived in homes that sat beside one another in a semi-circle around an open square of ground that was covered over with *chenar* (maple; U) trees.\(^{10}\) At the end of each working day, the family’s combined wealth was evident by the number of Suzukis, motorcycles and tractors parked haphazardly across the dusty courtyard, with small children darting in and out between the vehicles playing football (soccer). These monies, however, were not reflected in the clothing or health of the women in each household. Unlike their cousins in Gilgit Town’s Jutial and Amphari Mohallas, where women’s health practices were nuanced by non-governmental development, regular schooling and their close proximity to more ‘progressive’ Ismaili families, Phoonurh and her kinswomen had seen their lives more rigorously impacted by the mosque-centered, conservative strictures of the *Tablighi Jamaat* and Saudi missionization which, besides promoting women’s use of *desi bilehn* and Islamic therapies, were also avowedly pronatalist. The physical toll of frequent pregnancies and hard physical labour was obvious. Wadood’s

\(^{10}\) Household sizes were roughly equivalent between Gilgit Town and Minawar, but extended families in-town lived in far more cramped quarters. Though ‘nuclear’ families were fast becoming the new ‘norm’ for in-town residents, the 1999 Northern Health Project survey indicated that 37% of households across Gilgit District had nine or more members, while only 7% were comprised of four or less people (Rahman 1999: 7).
maternal cousins were often missing teeth due to pregnancy-related gum disease and malnutrition, their skin was weathered by agricultural work in the hard sunshine, and their complexions were discolored by brown blotches of cholasma, a hyper-pigmentation of the skin known in Canada as the ‘mask of pregnancy’, and called gup in Shina.

### Part IV Desi Pregnancy Practices

The majority of my participants in Minawar were generally unsure of, or unwilling to discuss how conception occurred. In response to my queries about how pregnancies began, Phoonurh’s sister-in-law, Sohni, simply responded, “Bas [enough; U], if we have no periods we are pregnant and expecting mausoom [children; S]!” (Sohni, Minawar, April 28, 2005) Morning sickness and the absence of a period were the typical ‘first’ signs of pregnancy; at this point, women used the lunar calendar to mark each subsequent month of pregnancy until nine full months (puroh nau mas; S) had passed. They roundly confirmed that this method ensured they knew if the forty gestational weeks had passed before their babies were delivered, although a few women piped up to say they had had pregnancies lasting an impossible thirteen months.11

“I looked at the moon, and saw how many full moons there were between the absence of my menses, counting the days by the moon. I can see if the moon is absent, then [I know] the next month is the start of the Islamic calendar Rabillah. I believe in God, and the chand [moon; U]. If the baby is supposed to be born, though, and God wants it to be born, it will be - no matter whether early or late, so we don’t worry about this too much.” (Dadi, Minawar: April 25, 2005)12

By anchoring their menstrual cycles and pregnancy health to the Islamic calendar, women embedded their health within Islamic celebratory cycles and ritual events. (Though many women never knew the

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11 Miscalculations and uncertainty about the pregnant body’s physiology, regardless of women’s considerable experience with the subject, easily accounted for stranger stories. For instance, one woman told me about her neighbor in Amphari Mohalla, whose pregnancies - she claimed - were routinely longer than one year in length. “All the doctors were worried. Her boy was born after twelve months, and her three daughters were all born after nine months. She was three months pregnant when I was first pregnant...and we had the same due date but she delivered so late. The doctors were telling her, ‘If you’re going to continue, we have to check - if not this month, then the next month we will operate for delivery.’ But instead they would wait for a normal delivery. They were all big babies...her babies arrived at such a big size, when one of the new aunts came to see the baby, they put it in her lap and she said ‘This is not a new baby - bring the new one to me!’” (Mehnasat, Jutial: June 16, 2005)

12 Because women were sometimes confused about their dates, ‘prematurity’ was sometimes incorrectly assigned to full-term infants.
actual date of their babies’ births, they were able to describe their deliveries as having occurred ‘in the
month before Ramazan’ [fasting; A] or ‘at Eid-ul-Adha’.) Despite many mothers-in-law claiming to be the
first to ‘see the signs’, the first person to notice a woman was pregnant was usually the husband. Because
women were not supposed to have sex or pray during their periods, husbands often learned their wife
was expecting when they noticed no monthly break in their sexual relations or saw their wives were still
praying. By extension, by continuing to pray women signaled their pregnancies to the rest of the
household. Without exception, women said they were too ‘shy’ to directly tell their husbands or mothers-
in-law, leaving confirmation of the news for when it became patently obvious over the next few months.
Less frequently, women who had visited in-town clinics for other health complaints had their pregnancies
diagnosed through urine-testing. Generally speaking, women from Minawar went only very occasionally
to see doctors for pre-natal checkups. During one interview, I had asked Phoonurh if she wanted
to see doctors more regularly; in response, Phoonurh claimed her husband and mother-in-law
had to “push” her to see doctors or midwives at the DHQ (Phoonurh, Minawar: May 3, 2005). When she
said this, the few women sitting around her rolled their eyes; one woman commented that neither her
in-laws nor her husband cared if she went at all.

For women who wanted to be pregnant, morning sickness (ulti bin; S) was viewed as a welcome
annoyance. For women whose already arduous daily chores were interrupted by intense nausea or
vomiting, the first three months of pregnancy could be miserable. There were a variety of dietary ‘cures’
for morning sickness, including eating un-ripened apricots, yogurt (daiyee; U) and mint chutney, food
doused with ‘sour’ vinegar (circah; U), sour juices or home-made, pickled cucumber or kale (achar; U)
(Parveen, Jutial: June 15, 2005). More recently, women began taking allopathic pharmaceuticals, though
some of these were loosely associated with a higher-than-normal miscarriage and fetal abnormality rates.

“When I was pregnant with Afsar, I liked the fragrant smell of boiled, dried vegetables, so
much so that when I was cooking I would hold my dupatta up over the steam and then
spend time smelling it afterwards, all day. My mother, with my first [pregnancy] noticed
such things and said ‘Now you are pregnant!’ I was vomiting, sick to my stomach,
Women’s preference or revulsion for certain foods were said to predict the baby’s sex; “when I was having a boy, I was avoiding meat, it had a bad smell and would cause vomiting, but with the girls I could eat anything, despite the nausea” (Shaistah, Jutial: June 3, 2005). Some women even described being disgusted by the smell of their husbands’ bodies, which we joked may have been a clever ruse to avoid sex.

The larger women’s bodies became during pregnancy, the more adeptly women worked to conceal their bellies. For older women, even mentioning pregnancy was seen as deeply embarrassing. When Wadood’s first cousin, Naila, came to visit us one afternoon for chai, it was apparent she was entering the fourth or fifth month of pregnancy. After I casually noted that another family member was “on the way”, my mother-in-law hushed me loudly in obvious dismay. However, I noticed that many of my younger participants in Jutial and Amphari were noticeably less concerned with ‘looking pregnant’. This then prompted lengthy critiques of their immodesty (besharam; U) by their in-laws and older women relatives. After the sixth month had passed, husbands were usually requested to pick up enough fabric from the local bazaar to make two or three new shalwar kameez, which were stitched up with variable seams which could be ‘let out’ the further along a woman was in her pregnancy (Fieldnotes: June 7, 2005). Because shalwar (pants; U) have a drawstring waist, they were easily adjusted to sit below the pregnant belly and be held up by a woman’s hipbones. Women who were more shy, particularly first-time and teenage mothers, also tended to wear their dupattas (veil; U) much lower down on their torso to disguise their enlarged breasts and belly. Many older women described feeling intense embarrassment if their husbands had seen their naked pregnant bodies, or when they were breastfeeding. Zahrima, who had been born and raised in Danyor (a Shia-dominated village across the Gilgit River), helped explain the ‘shames’ associated with pregnant bodies.
“I’m not shy around [my husband] during pregnancy, except when big. At the end of the pregnancy, then I’m a little bit shy, and wear khola [open; U] and loose clothes, and I wear the dupatta low on my body. I’m shy with women, because some tease and say, ‘Look at how big your tummy and buttocks are!’ No, there aren’t any sexual meanings to their jokes...Women with big breasts - maybe they are teased, but I’m small – many feel shy with bigger breasts - but I think bigger breasts look better. Essa [husband] complains that my breasts are too small. But no one encourages me to stay home when I’m big, I’m still going everywhere...[though] I feel shy in front of men.” (Jutial: July 7, 2005)

The more unwieldy women’s movement became as they neared delivery, the more friendly or even caustic jokes were used to discourage them from leaving the home and being ‘seen’ by neighbours and more especially, unrelated men. Some of the more commonly deployed expressions included:

“'Look she walks like a duck!'...or if she has a very fat bottom, like a fat-tailed sheep’s bottom, we call it bosungburee [fat tail, fat ass; S] [laughs], or if a woman is very fat and very wide we call her yeyshunee [yeti-like, stocky; S]!” (Madheeya, Jutial: September 8, 2005)

As their pregnant bellies grew, women had some definitively quirky ideas about the cause of stretch-marks, which are actually ribbon-like breaks in the collagen of deeper layers of skin. Initially purple and later fading to silvery white, stretch-marks are often heralded by intense itchiness in the skin as the tissue begins to rupture. One older married woman in Jutial tried to explain what caused stretch-marks and lamented their deleterious impacts for bodily beauty:

“I think small worms are eating the skin only during pregnancy. We know it’s worms because we want to scratch because it’s so itchy! The worms are bothering us, and are itchy until delivery finishes and they disappear inside. They make our tummy spoilt, and then they leave us!” (Razia, Jutial: June 16, 2005)

At the eighth or ninth month of pregnancy, when women found it hardest to perform household chores, they were advised to do “hulka, hulka kom” (light, light work; S) and avoid heavy lifting, which Phoonurh’s mother said caused “pain in our uterus and upper thighs, which means we are close to delivery” (Pfiffi, Minawar: May 3, 2005) Heavy work was largely defined as “bringing wood, lots of grass, bags of wheat” (Sohni, Minawar: May 3, 2005); this work was quickly taken over by family or neighbours. Women often took up their neighbours’ work for free, under the expectation that the favour would be returned during their next pregnancy. Women were also quick to admit that, in Minawar, they were
advised to stop having sex with their husbands after the fifth or sixth month of pregnancy (although Zahrima said that her former neighbours in Danyor had felt frequent sex during the ninth month helped prepare women for childbirth [Jutial: July 7, 2005]). It wasn’t until much later that women’s fears about sex during pregnancy were at least partially explained to me. Rubeena was in her early twenties and had recently found out she was pregnant with her second child. She lived with her husband and his family in Chilas, a three hour drive to the south of Gilgit Town, but due to homesickness she came back to her parents’ home in Gilgit for extended visits every few weeks. But there were other surprising reasons for her frequent returns.

“We believe that sex in the last month is gunah [a sin; A] and we don’t do it if we can help it. If the husband discharges inside, some could go to the baby’s mouth – and if it’s a daughter, we say it’s like fucking without a nikah. It’s more of a problem with a daughter. My husband had sex with me in the last month before Shafad [was born], but I came right away to Gilgit after that to avoid this happening again! [laughs]” (Rubeena, Jutial: August 13, 2005)

Rubeena’s sense of her expectant body as ‘open’ and permeable was shared by most of my participants, who described their pregnant bodies as more easily susceptible to food, drinks, smells and pain. By extension, women were aware that their pregnant bodies were more likely to gain weight, which led to a whole other host of anxieties. In particular, women worked hard to avoid over-eating and thereby risk an overly large baby and an obstructed delivery. Problem pregnancies were characterized when women either didn’t have enough, or had too much, physical activity.

“…if women are sitting in one place, babies will get too big and delivery will be difficult. If we are moving, working, eating good food it will not affect the baby badly, but if we do a lot of work and don’t have the proper food, it makes a woman’s body kamzor [weak; U] – if a woman feels she has more weight, she is happy because she knows the baby’s health will be good then. If she doesn’t feel much weight, the baby will be weak.” (Phoonurh, Minawar: May 3, 2005)

Phoonurh’s explanation of diet and exercise as being central to infant size and a possible contributor to obstructed childbirth was echoed by other women, none of whom were exactly sure of how food

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13 The nikah is the Islamic marriage contract, after which couples are ‘legally’ allowed to engage in sexual intercourse.
‘reached’ the unborn baby. Regional surveys upheld my observations that while village-based participants did not deliberately restrict their pregnancy diets, they were careful not to add additional or ‘rich’ foods or vitamin supplements.\textsuperscript{14}

“Low food intake during pregnancy is common. Studies have shown that women consume little or no extra food during pregnancy, and may even consciously limit their intake for fear of large fetuses and difficult labour. In one study carried out in the Northern Areas, only 25 per cent of the women surveyed had taken food supplements or otherwise enriched their diets during pregnancy or lactation (Khalil, 2003).” (IUCN 2003: 192)

Pregnancy-related anaemia may have resulted in unusual food cravings among my Minawar participants. Although most of the women sitting with us appeared embarrassed when she told me, Phoonurh’s unmarried younger sister, Safiyya, laughingly described one of the ‘stranger’ (ajaib; U) food cravings among women in late pregnancy and the post-partum period. Running over to the compound wall near the outside summertime cooking hearth, Safiyya pulled a small canvas bag off a hook and opened it to show me a small pile of hardened, light grey colored clay pellets. Phoonurh said they were called mahtee (S). Wadood’s grandmother, Dadi, hooted and took a piece in her hand, crumbling it and saying “We like mud and stones!” My research assistant Fazeelat, who initially thought Safiyya was joking, exclaimed “My God, they do eat rocks!” Catching us by surprise, Phoonurh’s paternal cousin Arjahn walked up to us and, with a look of disgust on his face, said “Our women are so jungulee [rough, uncivilized; U] – put this away, Safiyya! Don’t you have any shame? We tell them not to eat this, but they don’t listen to us...!” The women all chuckled nervously, and Phoonurh told me:

“Some eat this clay-like rock, which we find on the bahar [mountain; U]. Women are attracted to it by its smell and eat it straight – eating and hiding it from their husbands, who scold them. We eat by ourselves so no one tells us not to. We’re also using it for preventing and cleaning the ‘black’ [soot] off our cooking pots.” (Minawar: May 3, 2005)

\textsuperscript{14} Where Minawar women avoided dietary supplements, my in-town participants frequently used vitamins. One of my neighbours not only described how often she visited local clinics during her pregnancy, but also confirmed she used vitamin supplements: “I went to the DHQ and was checked internally, and I went for two injections, TT and Hepatitis B in the seventh and eighth months....I had blood tests for blood group...in the seventh month. At the start, I had a urine test to confirm pregnancy at one month. When I was one month late I went to test...I got advice on multi-vitamins from Dr. Nazia [private physician]. I saw Dr. Sunbool, who referred me to Dr. Latifa [who] told me take something...called Felvolit [iron and vitamin supplement]” (Ruqaiyah, Jutial: July 12, 2005).
Dadi explained how after being soaked in water, the softened clay was used to coat the outsides of cooking pots before they were placed over wood fires. It then hardened and could be chipped off, with more re-applied before the next meal (Dadi, Minawar: May 3, 2005). Rather than simply being an eccentric local food fetish, mahtee seemed to suggest some kind of dietary or vitamin deficiency.\(^{15}\)

Indeed, after my fieldwork I stumbled across several online articles describing profoundly anaemic African-American women in the American south eating clay. This practice, called ‘geophagy’ (‘eating dirt’), actually helped restore their blood iron levels.\(^{16}\)

As women neared their due dates, and particularly when they felt they had ‘complicated’ or ‘difficult’ (mishkeel; U) pregnancies, they sought out the services of local midwives who specialized in pregnancy-related massage (malish; U), dietary remedies (khorak bilehn; S) and even uterine manipulation to turn a breech baby “right side down” (Pfiffi, Minawar: May 3, 2005). As an older Auntie clarified:

“They touch the stomach, but not anywhere else – the woman lies down and they feel her stomach and bachitani [uterus; U] to feel if a problem is in the uterus - zaph tey [they push; S] – she gives us medicine and we feel better. They don’t check our blood pressure, or blood, but they tell us we should take medicines or to go to a doctor.” (Pfiffi, Minawar: May 3, 2005)

For women who wanted to avoid the costs and surgeries associated with breech births (ultah behn; S), desi massage offered a feasible – and sometimes effective - last effort to change the baby’s position. The

\(^{15}\) High fertility rates, with Gilgit District’s crude birth rate being 40 per 1,000 (Rahman 1999: 12), were associated with pregnancy-related anaemia. Chronic anaemia, in turn, resulted in fatigue and a higher risk of maternal and infant mortality (IUCN 2003: 192). While 20% of surveyed mothers with one child were severely anaemic, the number rose to 35% for mothers of five or more (Rahman 1999: 34). According to the IUCN’s 2003 report on the Northern Areas, “The situation is exacerbated by the frequency of childbirth and the early average age (16.3 years) at which women given birth to their first child (AKHSP/FAO, cited in Khalil, 2003). Iron deficiency anaemia is of particular concern because it has a severe impact on women’s reproductive and productive roles….. Because low-income, rural women experience the highest rates of iron deficiency anaemia, and also some of the most physically demanding work responsibilities (including weeding, threshing, pounding, fetching fuel and hauling water), it is probable that anaemia among women accounts for a significant loss of productivity, and therefore, of family welfare (Khalil, 2003)” (IUCN 2003: 192).

\(^{16}\) There is growing ethno-botanical and anthropological evidence that women across the African continent and South Asia eat clay to help reduce morning sickness nausea, or pregnancy-related nutritional deficiencies. Online author Matt Rosenberg notes, “The clay commonly ingested in Africa contains important nutrients such as: phosphorus, potassium, magnesium, copper, zinc, manganese, and iron” (http://geography.about.com/cs/culturalgeography/a/geophagy.htm ; Accessed February 23, 2008).
women I spoke with in Jutial and Amphari admitted that once a breech position was ‘diagnosed’ by their doctor through ultrasound or uterine palpitation, they then often chose to visit desi practitioners living in the villages around Gilgit. Among the most famous was a woman who worked from her in-law’s home in Baseen (Fieldnotes: August 12, 2005), and whose specialty was ‘fixing’ breech cases. When vigorous, directed massage failed, pregnant women were sometimes placed on a large canvas sheet that was held by multiple other women. While the desi woman whispered Islamic prayers and offered invocations (dhum, dua; A) to “affect” the baby’s position, the pregnant client was then tossed into the air, over and over, in the hopes it might dislodge and shift the baby (Shandana, Amphari: August 12, 2005).

Desi practitioners were also the only providers who dealt with and acknowledged the existence of the kunoo (S), which my participants described as an egg-shaped organ of sorts, specific to women’s bodies, and found in variable positions across the lower front torso. Older women described the kunoo as an annoyance, in that it moved around inside the body “disturbing us...it’s just up from our belly button” (Shandana, Amphari: August 12, 2005) During pregnancy and for the first seven days after birth, the kunoo “moves to the front and we can feel it”, whereas immediately after delivery, the kunoo was said to return to its ‘place’ on the left side by the hipbone (Madheeya, Jutial: September 8, 2005).

“My mother says it...sits somewhere on a nerve. When a baby is born, it shifts from its rightful place, it will cause paining here and there, and when a desi doctor or someone puts their hands on you, they can feel it – it’s hard to the touch.” (Gulsoori, Jutial: August 16, 2005)

Women were unsure of its exact purpose and function, but said that eating desi ghee (clarified butter; U) helped return the kunoo to its proper position and reduced its more annoying symptoms (Shandana, Amphari: August 12, 2005). An aged Astori herbalist described having a root called mushkeebalah (S), which was intended for “kunoo pain, for when it moves during pregnancy” (Mohammad Isa, Gilgit: August 20, 2005). And while he described the kunoo as “a pain that moves, and not an actual thing”, he later added that “if the kunoo gets empty or dried in women it causes infertility” (Mohammad Isa, Gilgit: August 20, 2005). Not far from our house in Jutial Mohalla, I had interviewed a Shia woman who
practiced desi bilehn under the supervision of her husband, who she said was a “formally trained” hakim specializing in both desi bilehn and Yunani therapies (Mugehra, Jutial: September 10, 2005). After years of practice, she boasted of being able to prepare multiple, effective remedies for kunooh-related complaints.

“I’m mashing and grinding the materials, and making medicine for [the] kunooh. Yes, I can check and feel for it myself because for the women, I can touch them. The kunooh is in a ball shape, and it’s just above the navel, but women can feel the pain inside, and then it shifts downwards, to below the navel. Women come to me, and I tell my husband their problems and then I tell them [women] the solution. I’m first explaining it to my husband. Women come because of too much bleeding, menses, backaches…the kunooh affects bleeding. Women bleed more if it shifts to the uterus. I am checking them, and if I feel it’s hard in the area, we know it’s there. It’s something like an organ. Women are only feeling it, and getting better after some time. [I then ask Mugehra, ‘Could it just be a feeling, or a sensation then, and not an actual ‘thing’?] If it’s just a feeling, why is it affected by medicine? We use hospital medicine, not [just] desi medicine for this problem. They are gastric pills, but I don’t know their name. The pills come from Pindi or the bazaar, and my husband stores them at the house.” (Mugehra, Jutial: September 10, 2005)

It was only after reading Patricia J. Hammer’s descriptions of traditional Cororo midwifery in the Andes that I realized that what Gilgiti women ‘felt’ inside might actually their abdominal aorta. Hammer had been told about the madri, which was associated with reproductive potential (Hammer 2001: 250). One Cororo midwife showed Hammer where her own madri was by having her lie down and positioning her “hands just below my navel and pressed deeply into [the] abdomen. With her hands held firmly in place, she kept pressure on [the] abdominal aorta until [she]...felt [its] strong, steady pulsation” (Ibid: 249). And in ways that mirror Gilgit women’s descriptions of the kunooh as a shifting organ, Hammer’s participants said their physicians were profoundly unaware of this female-related syndrome.

“They don’t know about how our organs tend to move about the body, following birth…the doctors don’t believe that we must bind our waist post partum so the madri organ won’t ascend the chest and choke us.” (Ibid: 250).

Similarly, none of the doctors I spoke with in Gilgit professed any knowledge of the kunooh, though I sometimes wondered if by disavowing desi beliefs they were attempting to discursively mark themselves as being more ‘modern.’
Part V Desi Childbirth Practices

In villages like Minawar, and for previous generations in Gilgit Town, most firstborns were, and are traditionally delivered at the mother’s natal family home. This was not merely because first-time mothers were seen as needing additional emotional support and help with learning to feed and care for the baby, but because it was an important opportunity for a child’s maternal relatives to cement their connections with the baby and its father’s family. Subsequent births almost always have taken place in the marital home, where there were no ‘special’ rooms designated for childbirth; “We can give birth anywhere, in any room, in our brother’s room, in the main hall, in the kitchen!” (Phoonurh, Minawar: May 3, 2005) Shortly before we returned to Gilgit in July 2004, Phoonurh and Shabir Alam welcomed their ninth child, a baby girl named Sabida. Because Shabir Alam had been working in town when Phoonurh went into labour, she stayed at home and called her mother from next door to assist. Phoonurh’s eldest child, Munafah, was 16 years old at the time, and instructed to look after her younger siblings and keep them away from the hearth room where Phoonurh was giving birth, crouching upright over a pillow covered with wood shavings. As they had done during the final months of her pregnancy, Phoonurh’s unmarried sisters, cousins and female neighbours took responsibility for her fieldwork work and feeding the children.

In the same way that noise during sex was viewed as acutely embarrassing or shameful (besharam; U), Phoonurh was careful that no one would hear her crying out during contractions; Munafah and her brothers “warned people to stay away from the room and house when labour started” (Phoonurh, Minawar: May 3, 2005). Her labour began at 8 am, and Sabida was born at 11 am. Due to shyness,}

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17 In both Minawar and Gilgit Town, many of my participants described themselves as feeling ‘obligated’ to share the details of their pregnancies with their mothers-in-law, although their natural preference was to first seek support and advice from their mothers. And in order to better demonstrate their loyalties to husbands and in-laws, some women chose to deliver at their “mother-in-law’s house, and after forty days...go to their mother’s house. If there is no one at the in-laws’ house to help her, she can leave before forty days to her mother’s house to rest. For a baby’s delivery at a hospital, both the mother and mother-in-law can come with the mother” (Malika, Amphari: August 12, 2005).

18 Women described the typical ‘signs’ of labour starting as the water breaking, or passing the ‘show’ (cervical, mucous discharge) or feeling the overwhelming urge to pass feces (Fieldnotes: June 7, 2005).
Phoonurh forbade her more curious relatives from coming to help. During each contraction, her mother massaged her belly with mustard oil (sarsoh tayl; U), and as with every traditional delivery, the baby was allowed to crown and deliver unaided. During each contraction, her mother massaged her belly with mustard oil (sarsoh tayl; U), and as with every traditional delivery, the baby was allowed to crown and deliver unaided. Women preferred not to touch the baby as it emerged unless absolutely necessary, such as when the baby was stuck or the cord was obviously around the neck; the umbilical cord was tied tightly with string and cut using unsterilized scissors or kitchen knives. Once the placenta was delivered, it was wrapped in newspaper and later buried in a corner of the kitchen garden where house refuse was normally burned. Phoonurh’s mother fetched water to help wash up Phoonurh and the baby, and threw the soiled wood shavings into the bukhari (iron stove; K). When Shabir arrived home an hour later, he whispered the call to prayer (arzan; A) in the baby’s right, then its left ear; this simple and intimate act established Sabida as a member of the Muslim community (umma; A). In comparing Phoonurh’s story with those shared by older in-town participants (women aged forty-five and above), it seemed that very little had changed in the structure of desi home deliveries. Consider Madheeya’s account of her eldest son’s birth thirty years earlier, at her parents’ home:

“I was near to birth and playing with friends and hourmila [maternal cousins; S] in a field, making and eating chapattis [bread; U], but I had to mikki [urinate; S] a lot. I was like a child still, I didn’t have any understanding about these things, you know? I came to my mother and said, ‘I have some pain, and have to go to the bathroom’

19 Dayahs, however, did perform internal exams. Dr. Sharifa explained that for complicated delivery cases arriving at the Gilgit Medical Center from outlying villages, a number of women had been harmed by their dayah’s earnest attempts to speed up the delivery. By manually manipulating open the un-dilated cervix, or by encouraging women to push before they were completely dilated, dayahs put mothers at risk of cervical swelling and then obstructed delivery (Dr. Sharifa, AKHS,P: May 12, 2005).

20 Among Gilgiti families, only the father or another senior male relative is entitled to formalize a baby’s Muslim identity in this way. Within the Sunni Hanafi fiqh, as with all other schools of Sunni jurisprudence, individuals’ spirits are believed to be ‘made’ Muslim from time immemorial. The arzan ritual at birth confirms the baby’s Muslim identity in the material world (duniya; A).

21 Reminded of the three stages of labour in obstetric medicine, I had asked our neighbour Madheeya (who was also Phoonurh’s distant paternal cousin) if Gilgitis marked childbirth in similar ways. “Well, badayi wey badan [bodies swell with water; S] is when the pain starts and it’s not too severe. If the [amniotic] water doesn’t come out right away, the pain is severe. If the water comes out, the pain is not severe and the delivery will be quick…. Dhadcakey shul [severe pain; S] is the last bit of labour and the pushing out of the baby. Khurakoiey nee khattoh [after the severe pain, it comes out; S] is when the baby comes out, Allah ka shukr [thanks to God; A]. Then, khaiy thook bin [placenta comes out; S] is last. We bury the khaiy [placenta; S], the gandagee [filth; U], anywhere, but is far from where we sit or are in the garden or the fields. We bury it, where the dirty things are” (Madheeya, Jutial: May 4, 2005).
and she told me to stay at home and rest, lie down. But then she went out, and I escaped back out to visit my sister’s house, and there I complained about the same problems. She said that my labour was starting, but I only had a little bit of pain. During all this, I was doing lots of jobs – cleaning the house, sweeping. After my sister said this, I went back home and after five minutes there, my son was born. When my sister’s husband heard, he asked [indicates look of surprise], ‘Was she pregnant??’ I had been living after my nikah at my parents’ house….I was my father’s youngest daughter, and he said, ‘We don’t want her to leave us just yet’. I had [my son] 2 to 3 years after my nikah and lived there for 2 more years. At his birth was my mother, a sister and one old lady. There was a traditional house pillar in the room, and I was squatting and holding on to it with both hands, with one lady holding on to my lower back, and one lady holding my shoulders steady. Someone was also massaging my belly with both hands [gestures with downward motions], and holding the underside of my upper thighs. I wore my kameez [shirt; U], and had it spread out over my lap to cover myself – to my knees. One lady was by my feet, and she cut the cord. When I was delivering, they put a cushion, or a mattress, underneath for the baby to fall out by itself on.” (Madheeya, Jutial: June 6, 2005)

Women were clear that the Qur’an and Hadith Al-Sunnat endorsed a variety of prayers specifically to help women during labour. If the pains were severe, the delivering mother or her family could perform “two rakat nufl in namaz [prayer] to help ease the pains” (Dadi, Minawar: April 25, 2005). Women also agreed that there were no desi therapies available to help reduce their labour pains, saying that their only support was God, and pain was inevitable until the baby was born (Madheeya, Jutial: May 4, 2005). The Qari (mullah, prayer leader; A) at our neighbourhood mosque later told me that he was frequently asked to prepare shukr dhum (prayer-laden sugar; A) for delivering mothers at the DHQ, including one instance when his brother’s wife was having twins.

“For an easy delivery, the family comes with water and sugar for me to put a dhum on. Sometimes people are preparing women for a C-section, then [women] will use this and can avoid an operation. In Karachi, three or four times I’ve done this. Last year there were so many numbers in Gilgit. My Bhabhi [elder brother’s wife; U] had a difficult delivery last year and I went into the hospital to see her. I could hear her crying in pain from outside the room, so I asked for water to make a dhum in. There were so many other women in severe pain, and my sister asked for me to do dhum for them as well. All then had an asan [easy; U] delivery. I had been there to support my brother during the difficult delivery,

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22 Rakat nufl (A) are voluntary sets of prayer prostrations which may be done in someone’s name, or on their behalf. (These are different from the rakat [prayer sets, prostrations] that form an obligatory [farz; A] component of the regular namaz.) These prayers are derived from both the Qur’an and Hadith Al-Sunnat. The rakat nufl from the Sunnat were described by Wadood and his family as being more ‘effective’ than those derived from the Qur’an.
because his...children were twins. My sister-in-law was so worried, because the babies were in opposite directions from one another, and all were worried because the karchah [cost; U] would be great for the operation [C-section], so I did a dhum and dua and they both came in the right direction! My cousin joked, “They are the nephews of a mullah, so they have to come in the right direction!” [laughs] (Qari Malik, Jutial: June 12, 2005)

At the DHQ, one Labour Room LHV shared her own, provider-centered analysis of these same practices.

“Yes, women often wear tawiz and they have dhum in pani [water; U] or cheeni [sugar; S]. They’ll get a dhum or tawiz for an easy delivery, and family members will bring it to her if the labour is complicated. An ayah will then bring it to the mother in the Labour Room, even if she’s crying or screaming, we’ll take it and pour it in her mouth! [laughs] Even in the Qur’an, it says for every difficulty, you can do a dhum for a solution. If you believe in it, it works. We’ll also see women with black or white thread tied around their ankles and wrists. We understand what it means culturally, so we don’t have to ask them about it. [Emma: ‘Can you tell me what they mean?’] The black thread is against nazhar ['evil eye'; U], the white thread is…. [looks confused]. If you wear the thread with a dhum on it, it affects you very quickly because it is always with you.” (LHV V, DHQ: August 1, 2005)

And if the labour became complicated, or it was thought that the mother or baby’s life was at risk:

“...we do three times Al’hamdillilah, one time kut walla, one time droodh, do dhum into a glass of water and the laboring mother drinks this – even in the labour room if they let us. If we do the two rakat nufl, God must help us!” (Phoonurh, Minawar: May 3, 2005)²³

In Minawar, Phoonurh described her nine deliveries as ‘easy’ (asan; U) and not overly painful. However, along with her mother and sisters, Phoonurh was well versed in the possible complications of labour and delivery and what to do to assist the mother and baby.

[Phoonurh] “If the cord is around the neck it is like a haloo [pearl necklace, bead necklace; S]. We try to lift it from the neck because the thoon [cord; S] can stop the hawa [breath; U, A]. Most cord problems are not emergencies if the baby is breathing at birth. If the baby is not breathing at birth, we are not cutting the cord right away, and are beating it on the back when it lies on the ground – we cannot do the things they do at hospital, here we don’t know the rules or how it works.”

[Munira] “We are worried when the [amniotic] water has a color, maybe something is wrong. We worry more if there is any color. If the water is the same time as the delivery, this is good because it is an easy delivery, an easy birth. If not at the same time as the birth, it will be a problematic birth. If no water at all, it is very difficult. (Minawar: May 3, 2005)

²³ Alhamdillilah means ‘Praise be to Allah’ (A). Kut walla is also known as Khul‘hu’allah (A), named for a Qur’anic surah (a surah is comprised of four ayat, or phrases); “Say: He is Allah, the One! Allah the eternally Besought of all! He begoteth not nor was begotten. And there is none comparable to Him.” Droodh (A) is a prayer which is read in the name of the Prophet, or on his behalf.
There were inherent truths to their descriptions. The pulsing umbilical cord did have a beaded, ropey appearance, and local doctors claimed there were benefits to waiting to cut the cord when a baby failed to breathe right away. Discolored amniotic fluid was a sign of meconium, which can be indicative of foetal distress, and ‘dry’ births were associated with obstructed or delayed delivery, severe uterine infections, maternal sepsis and infant death. Reflecting on the birth of her fourth child twenty years earlier, Madheeya emphasized the importance of knowledgeable, experienced female relatives when problems arose.

“In olden days, when women’s labour started, they would have to sit or squat and hold onto something, and another woman would hold and support her from behind by holding onto the sides of her buttocks, by her hips. They would be urged to use all their force, and to push. This would make a quick birth. In all labours, mothers would be given a bottle to blow into to aid pushing, or nessoir [snuff; U] would be placed just inside their nostrils to make them sneeze. If the labour was slow, another woman would stand above the mother and push down hard, up and down, violently, on her shoulders….When Hussen was born, her head was in the wrong position, and her neck and the back of her head were showing. I was pushing and pushing, until my eyes and nose were bleeding. My mother pulled my thighs up towards my torso, her hands underneath my thighs, violently many times and shook and shook me. After this Hussen was born. But my eyes were swollen and red, and my face was swollen too.” (Madheeya, Jutial: May 4, 2005)

Because of their experiences with other women, especially during complicated home deliveries, many older women had a keen sense of the internal physiology of the birth canal. To my surprise, especially because of women’s discomfort touching other women’s genitalia during home-deliveries, Madheeya noted that the cervix, softened and enlarged in the months prior to delivery, felt like the “opening of an aie [mouth; S]” while in women who had never been pregnant, it felt “like the underside and very tip of a nose” (Jutial: September 8, 2005). Such descriptions were virtually identical to the ways local obstetricians described the ‘feel’ of women during internal, pelvic exams. Comforted by the knowledge that so many of her sisters and cousins living in nearby villages had delivered ‘successfully’ at-home, I had even overheard our pregnant, impoverished next-door neighbour, Fouzia, nervously ponder if she should have her next baby, her fourth, at home. (She wanted to avoid incurring more debt with her hospital...
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expenses.) In order to dispel her uneasiness, she used her sister’s many apparently safe home-births for inspiration.

“Everyone is advising me to deliver at home - my mother especially. Four of my five sisters all delivered at home. My elder sister gave birth to 10 children - 8 sons and 2 daughters - they were all asan [easy; U], no problems at all. Sometimes she’d give birth in the washroom, in the cow shed! [laughs] All beautiful, healthy, big babies….My sister gave birth alone with all her children. Only with two or three children, my mother or a doctor was called in during her deliveries. She would measure the [umbilical] cord with a stick, tie the cord with thread and cut it with scissors or a razor.” (Fouzia, Jutial: July 7, 2005)

Hearing stories of ‘home-cut’ umbilical cords and deliveries amid dung in the family stable left me surprised that so many babies and mothers had survived home births; sepsis and tetanus from infected umbilical cords or retained placentas were among the most common underlying causes for the deaths of women or their newborn infants (see Rahman 1999). With literally hundreds of pregnancies and deliveries to their credit, the fourteen women I sat and spoke with one spring evening tried to account for why some mothers survived and some died.24 Breech and obstructed births were unanimously described as the most dangerous, and the most likely cause for severe maternal childbirth trauma or death for the partially delivered baby. An elderly mother of seven living adults described having delivered ten full-term babies, three more who died when they were born prematurely, while four of her thirteen total births were breech. She attributed her and her babies’ survival after breech deliveries to being “physically active during my pregnancies, walking, working in the fields, watering, caring for livestock” (Dadi, Minawar: April 25, 2005). Younger women, she said, were much weaker thanks to the recent mechanization of the heaviest agricultural work, such as preparing the fields for planting or harvesting. The younger women who were listening to Dadi’s boasting snickered and giggled, but she turned sharply on them and reminded them of a recent delivery.

“One neighbor just died during a breech birth - they took her to the hospital for the infant’s removal because it wouldn’t come out here. They had to tie the mother’s legs together and covered her up, making a palang [stretcher, bed; U] out of some sticks. There were no cars

24 Each of the older Minawari mothers I spoke with had, on average, delivered between ten and fourteen times by the time they reached menopause.
available, so they walked with her along the highway. The baby’s chin was stuck in the birth canal, and the doctors removed the baby by cutting off its head at the chin and neck.” (Dadi, Minawar: April 25, 2005)

Near the end of my 2005 fieldwork, Nabeela described losing her youngest baby after a traumatic delivery at the DHQ, and her very real fears that she would suffer the same fate as one sister-in-law who had died during childbirth in a mountain village to the south of Gilgit Town. The ghostly images of cousins, sisters and even mothers who had died provided awful accompaniment to, and quietly exacerbated the emotional turmoil surrounding more difficult deliveries. While recounting how she had almost died during her last delivery, Nabeela reflected on the immediacy of maternal loss in her family.

“One of my sisters-in-law died of the same problem [hemorrhage], so I had thought ‘I will die too.’ That had happened five years ago, and I wasn’t there, but I had heard about it. She died in Harbind [Valley], and the baby – a daughter - died with her. She had lots of bleeding, too, and they gave her a glucose drip. They brought a comporter [dispenser; U] from Shatial [town] to give the drip, after she gave birth to the baby girl. It’s Rs 5 [CDN $0.11] kriya [fare; U] from Shatial to where we all live in Harbind. When he came, he gave the drip and she had given birth to the baby. Afterwards, she said ‘I’m dying, so please say the kalima for me’ to the people around her, then she died. The baby died that same time, and was being taken care of by its Grandmother and her sister. They had wrapped the baby up in a chador [sheet, veil; F] and it was on the lap of the sister – and it died there, almost right after it was born. Yes, I know about one or two more ladies who died in childbirth. Sometimes the mother died, but the child is saved. Sometimes the child dies, but the mother is saved. There was one lady who had the same problem [as me], and she died….This was seven or eight years ago, and I heard about it in Harbind.” (Jutial: July 18, 2005)

For complicated delivery cases, Minawar’s dispensers and local dayahs often told women and their families to seek treatment in-town. But even with Gilgit’s major hospitals a mere twenty-minute drive away, men’s everyday absences for work, family impoverishment or a husband’s general antipathy to

25 The kalima is the Arabic language Islamic profession of faith, spiritual self-defense and also conversion; “La’illaha Il’lilahu, Mohammad’ur Rasool’ulalah” (‘There is only one God, and Mohammad is His Prophet’). It is different from the kalima-shahadah, which is contained in the arzan (call to prayer; A); “Eshadua la’illaha, il’lilahu, Mohammad’ur Rasool’ulalah.” (See Chapter Two, page 113, footnote 14 for more detail.) It is worth noting the Sunni kalima-shahadah differs from that recited by Shias; “…the Shi’ah add a phrase to the shahadah, the Muslims’ witness to faith. Following ‘There is no God but Allah and Muhammad is the Messenger of Allah’ it concludes ‘and ‘Ali is the friend (wali) of Allah.’ The focus upon ‘Ali…is the most distinctive mark of the Shi’ah and their chief difference from all other Muslims” (Waines 1995: 171). Moreover, by such differences hospital staff could ‘identify’ a patient’s sectarian affiliation.
mixed-gender health services precluded many women’s ability to reach emergency care. Not surprisingly, Gilgit’s doctors described maternal and infant morbidity and mortality as exponentially higher in outlying villages. In trying to understand the contextual factors implicated in village-based maternal deaths, I turned to a variety of recent studies of Afghan refugees living in rural Pakistan. These offered tangential insights into the possible restrictions facing Sunnis living at the outskirts of Gilgit Town. Among Pakistan-based refugees, for instance, “women who died of maternal causes were more likely to have died either in a health-care facility or on their way to one, suggesting that attempts are made to access health care when complications arise” (Bartlett et al, 2002: 648).

Especially in cases of maternal death, first-level barriers included:

“... [the failure] to recognize the existence of a problem or not deciding to seek health care either because the pregnant woman, her family, or her home birth attendants did not know the normal processes or complications of pregnancy, labor, delivery, or the postpartum period; and a lack of decision-making ability or empowerment once the problem had been recognized. Second-level barriers included unaffordable and inaccessible health care (distance to health care facility or lack of transport). Third-level barriers included not receiving quality and timely treatment once a health care facility had been reached.” (Ibid: 643)

In my fieldwork, I found there were other factors that women and their families took into consideration when deciding whether to have a hospital birth. Over the course of six group interviews, Phoonurh, her sisters, cousins and neighbours were unanimous in preferring hospital births to home deliveries. Because of the association of hospitals with ‘illness’ and ‘crises’, clinical settings allowed women to emphasize birth as a time of intense physical vulnerability and trauma, and upheld their need for post-partum rest. Home deliveries were symbolic of ‘healthy’, ‘normal’ and ‘strong’ (motee, sehatmahn; U) women; these women were less likely to be allowed adequate rest after birth. But women were clearly conflicted in that hospital deliveries also enabled their local ‘enemies’ to characterize them as less robust, feeble or weak (kamzoree;

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26 In their 2004 progress report, the Family Planning Association of Pakistan estimated that Northern Areas rural infant mortality rates were between 70 and 80 per 100,000 live-births (7).

27 In studies of high maternal mortality rates in impoverished, rural Sunni communities in Pakistan’s North-West Frontier Province, a mountainous region to the west of the Northern Areas, there is growing recognition of the role of “peripheral health facilities - which in many cases are the first level of contact for pregnancy women” (Midhet, Becker & Berendes 1998: 1587).
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U), or as a ‘failed’ wife and mother. When I asked Phoonurh what the qualifying criteria should be for a hospital birth, she reflected on her own, nine deliveries.

“I’ve had easy deliveries. If the problems and tukhleef [pain, difficulty; U] are bad, the pains severe, we should have our baby at the hospital. But if the complications happen at home, they will also happen at the hospital – what’s the difference? Sometimes we can’t afford the hospital, or our husbands can’t afford to book a vehicle to take us to the hospital. Or, our husband isn’t home. But if our husband isn’t home a neighbor can help us, provide us a car. We can go alone with a male neighbor, but it’s preferable for ladies to come with us too. We wear pardah when we go, of course. Burqas [large veils; U], kumbuls [blankets; U] – we use the kumbul to completely cover our body on the way. We wear chokothee [traditional cloth menses pads; S] if our water has broken already too.” (Phoonurh, Minawar: May 3, 2005)

Part VI Post-Partum and Infant Care

Following hospital deliveries, babies were only wiped down by the LHV’s and not washed; instead, they were quickly wrapped with the dupattas or silkee blankets (comforters) brought by their mothers specifically for hospital use. Babies delivered at home were almost always immediately bathed by their paternal grandmothers, although some families preferred to wait for auspicious days such as Juma (Friday, Islamic Sabbath; A). During Gilgit’s bitterly cold winters, in-town and rural families sometimes waited up to a week before washing the newborn. After the baby was cleaned, desi ghee (traditional clarified butter; U) was mixed with wheat flour and used as a medicinal paste on the baby’s umbilical cord stump. Using two flannel or cotton cloths, babies were then tightly swaddled, with their arms crossed over their chests, and wrapped around with braided cording. Small squares of embroidered fabric were placed over the baby’s head and held secure by an elasticized fabric band. Following Prophetic tradition, sorma (antimony, kohl; S, U) was daubed onto the baby’s inner eyelids to emphasize their “beautiful almond shape” (Madheeya, Jutial: June 7, 2005), discourage infections and ward off the ‘evil eye’ (nazhar; U, A) of

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28 According to my mother-in-law (who had been born and raised in Minawar’s farming community), ‘weaker’ women feared their husbands were more likely to take a second, ‘stronger’ wife. Women’s anxieties were particularly acute in families that were dependent on women’s agricultural work.

29 One young woman who had recently delivered at one of Gilgit’s hospitals outlined her childbirth expenses; “At the hospital it costs around Rs 1,000 [CDN $22.70] for a delivery, but more for car bookings, buying medication. Maybe Rs 500 [CDN $11.40]. We have to buy the injections, the cotton. A dai [midwife; U] helped me with the deliveries, and we pay them money separately, quietly…we give mubaraki [celebratory; U] money, more for a boy and less for a girl” (Nadia, Minawar: May 3, 2005).
visiting guests or family. (Nazhar was described as an unintentional consequence of strongly directed attentions or emotions, including envy, praise or admiration. In order to ‘break’ or circumvent nazhar, Gilgitis routinely recite ‘Mash’allah’ after offering compliments.30)

“The [newborn] baby wears 1 to 2 loose kurtas [shirts; U], no diapers – just wrapped up with a napkin or cloth between its legs. In the summer we wrap the baby in one chador, and in the winter we use 1 to 2 chadors [sheets] and use a shalwar [pant] string to wrap around the baby – so it doesn’t move, and so it lies properly. All things [legs, arms indicated] are kept in a proper shape. Babies also can’t scare themselves [when] their arms are straight at their sides.” (Madheeya, Jutial: June 6, 2005)

Babies could lie alongside their mothers for the first few days after birth, after which they were tied tightly into traditional Gilgiti cradles called ghorah (S; see Figure 16), their heads placed on pillows filled with rice. (Although the preference for ‘shaped’ heads has decreased in recent generations, some village mothers still described the ‘most beautiful’ adult head as one that had been flattened at the back by months in the ghorah.) Every morning and evening, babies were unwrapped so their paternal grandmothers or aunts could massage (malish; A) the baby thoroughly with mustard oil (sarsoh tayl; U), and then put baby powder on their arms and legs before re-swaddling them. Whenever babies were unwrapped, all nearby fans (punka; U) were turned off for fear the breeze would blow germs (jeraseem; U) or even ‘typhoid’ into the baby’s airway (Fieldnotes: June 7, 2005); understanding this helped explain why the DHQ LHV switched off the Labour Room’s ceiling fan as soon as babies were born. Premature or underweight babies required the most attention in these early days; mothers fed these newborns using spoonfuls of breastmilk and kept them warm

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30 Mash’allah (A) can be translated as ‘May Allah be pleased’.

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by holding them in a *bukhari’s* (iron stove; K) radiant heat. The baby’s breathing was watched carefully, and their tiny hands and feet checked to see if they were cold, which was seen as a sign of possible impending death.

For babies that had colic, cried excessively or had difficulties feeding, new mothers sought out Islamic *tawiz* (amulets; A) from local mullahs. *Tawiz* were made using Qur’anic *ayats* or Prophetic remedies drawn from the Hadith Al-Sunnat, and were either tucked inside the baby’s swaddling cloth or hung above the baby on the *ghorah’s* wooden handle. (*Tawiz* were also sought out to help protect babies against the influence of ‘unIslamic’ spirit entities, including witches [*churriyl*; U, S] and ghosts [*bhud; dakal; U, S*].) The influence of Islamic strictures was more obvious in intergenerational accounts of infant and post-partum recovery; where women had once only rested for seven days after birth, they now rested for the forty advocated by the Qu’ran. Women had once been allowed to whisper the *arzan* into the baby’s ears, but now only men performed this ritual (Dadi, Minawar: April 25, 2005). As one woman speculated, somewhat mournfully, “I know that woman can’t do *arzan* in the mosques, so maybe it’s related” (Mehnasat, Jutial: June 7, 2005).

Among my participants, newborns were apparently all subjected to the same sequence of Islamic measures. These included shaving the newborns ‘dirty’ hair in the first few days after delivery, an Islamically-prescribed ritual called *aqiqa* in Arabic and *jhukorah* in Shina. The baby’s hair was said to be contaminated by amniotic fluid and its contact with the birth canal. As soon as possible after birth, babies were fed honey and pre-chewed dates (*cajoorh*; S) on a pinkie finger by whoever “got to them first” (Fieldnotes: May 4, 2005). There was a friendly rivalry between relatives over who would have the privilege of feeding the baby in this way; according to Prophetic tradition, the baby is said to ‘take on’ the character traits of that person. All these steps were intended to integrate the baby to Islam and family, while also separating the newborn from the mother’s body, its excretions and ritual pollution. In some ways, it also represented the paternal family’s efforts to reduce the mother’s bodily or ‘outsider’ influence.
on the baby. Almost without exception, fathers described babies as ‘theirs’ – saying the mother had only carried the baby, but through blood and ‘flesh’ it belonged to the father, his immediate and extended family (qom, clan; S).

While babies were cleaned thoroughly after being born, women were only allowed a light wash after delivering, and not permitted to get their hair or upper body wet for fear the water would dangerously weaken them by destabilizing their humours (hot, cold; dry, wet).31 For the first seven days after birth, mothers were expected to lie prone and were brought their food and drinks. If they had to use the bathroom, they were helped to walk by their mother- or sisters-in-law. Their dirty hair was tied up in a loose turban, and iron objects (such as farming tools) were hidden under her mattress (bistra; U). These were said to ward off the malevolent attentions of fairies (parri, piran; S), witches or jinn (A). After birth, women were not only physically vulnerable, but in their ritually impure, unwashed state, they were also seen as spiritually vulnerable. More superstitious families kept new mothers awake the entire first night after delivery, telling stories and entertaining visitors, so as to prevent them from being possessed by a hostile entity and possibly killed. (Given the realities of post-partum hemorrhage, women’s fears of a quick death were not unwarranted.) For the first several weeks, women visitors came with their children throughout the day and well into the night, to see the new baby and ask about the delivery. When he was at home, the new father usually sat with male guests in another room or, if the weather permitted, in the garden. Guests were expected to bring small gifts of food, clothing or cash which were given directly to the new mother, the amounts of which varied according to the baby’s sex.

31 Very little is known about women’s post-partum health practices in either Pakistani or Indian contexts. As Maya Unnithan-Kumar notes; “…in its focus on childbirth as central to reproduction, the Indian state is unable fully to acknowledge or address the postpartum risks faced by women who have given birth. The post-partum period has received very little attention in the maternal health planning and policy exercises, despite clear evidence that post-partum deaths in developing countries are more common than deaths during pregnancy and childbirth” (2004: 12-13). Interestingly, the Indian and Pakistani State’s under-attention to post-partum health stands in opposition to the over-attention paid to Gilgiti mothers in the first forty days post-partum by their families, during which time their diet is improved, they are allowed extra rest, social attention and supervision. This represents, in some ways, how the importance of ‘achieved’ motherhood is marked by a correlated increase in ritual and cultural activities and dietary prescriptions.
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"After a baby is born, our relatives come to congratulate us, and to see the new baby. They will come to see the mother and father. These people are friends; one, two, or four will come. The mullah does not usually come. People bring money or cloth for the baby and the mother, or twelve eggs, fruit, candies, cakes...For the first baby, many guests come, regardless of whether the baby is a boy or a girl. If the second is a daughter, only close relatives come." (Mehnasat, Jutial: June 7, 2005)

In the previous generation, for the first forty days after childbirth babies were handled primarily by relatives and neighbours, and only very rarely left for the mother to care for alone. Take, for example, Madheeya’s memories of post-partum recovery and newborn care some three decades earlier:

"Relatives would hold him, and change his cloth and clothes. He slept in a ghorah [traditional cradle; S] and at night when the baby was hungry my mother would bring him to me to feed. I wasn’t socializing or moving around from the house to see relatives during those days. I was only up to use the bathroom. People were with me, and never leaving me alone. Now they leave them more alone – aren’t they lucky?" (Madheeya, Jutial: June 6, 2005)

Confounding local stereotypes and my belief that that conservative Sunni men were vehemently antagonistic to participating in or discussing childbirth, so much so that we joked the ‘feminizing’ qualities of labour stories might emasculate them, my sister-in-law recounted my brother-in-law’s early curiosities about their firstborn’s arrival. Raised in a fiercely conservative Sunni household when my Diameri father-in-law was working as the Qari (mullah, prayer leader; A) for a Sunni mosque in Jutial, to the outside observer, Haleem seemed to be only reluctantly interested in ‘women’s matters’. According to Mayordana, however, his response to their son, Zeeshan’s, birth, when he and Mayordana were still in their mid-teens, offered important insights into men’s private and definitively nurturing character. Barred from accompanying his wife to the hospital by my mother-in-law, Mayordana was taken by Wadood instead. After her return home, Haleem visited once their many mubarakī (celebratory, congratulatory; U) visitors had left, and the rest of the family had fallen asleep.

"Haleem was happy, and looked at the baby, but didn’t hold him. He didn’t hold the baby when he was new! [laughs] When the baby was five to six months old, he would hold him, but before that he was nervous about hurting the baby, or how to hold him. During our first week at home, he would sit with me in our room, when no guests were there...we were shy with each other, shy because it was a new experience with our first child. Yes, he did ask about the baby’s delivery. He would ask, ‘What happened? Was the pain severe?’"
After the delivery, he brought me everything I needed – food, desi ghee [traditional clarified butter; U].” (Mayordana, Sakwar: July 6, 2005)

However, Haleem’s interest in his new son and Mayordana didn’t mean that the majority of men wanted to be present during childbirth. In Minawar, where people were more conservative and less prone to emulate their Ismaili, Shia or ‘progressive’ Sunni counterparts, men unhesitatingly left their homes when their wives or sisters began labour. Wadood’s grandmother joked that in addition to being forbidden from viewing the birth, many men were actively frightened by childbirth, and noticeably intimidated by the hordes of women who bustled in and took over family life for the post-partum period. The traditionally male-defined household morphed into a women-only sanctum, with men being viewed as unwelcome interlopers if they tried to come inside. Banished to their gardens to visit with men over chai, some men tried to stay as far away as possible – “dur bey” (stay far; S) - without also risking censure from their recovering wives should they seem too inattentive. Once their wives had returned home from the hospital, husbands usually spent the first week sleeping in the hearth room (rahkoh ghot, desi ghot; S) with the children or visiting guests, while their mothers and sisters attended to the new mother and baby. But because of women’s efforts to protect, distinguish and segregate gendered realms of knowledge concerning bodily functions, sexuality and reproduction, men were unaware of women’s maternal health.

By guarding their ‘ownership’ over particular spheres of bodily knowledge, it seemed as though mothers-in-law and wives were, in effect, trying to conserve certain kinds of power.

In their early married years, many women were profoundly embarrassed by their mother-in-law aggressively taking responsibility for their personal hygiene or caring for birth injuries. In some ways, this represented the mother-in-law’s earnest attempts to exert control over junior women through forced physical intimacy. But when a woman’s mother provided the same post-partum care, women were far more likely to describe it as an act of love, altruism and deep concern. If women suffered vaginal or perineal tears during delivery, poultices of crushed almonds and apricot oil were applied several times a day directly to the wound. These were said to help relieve itchiness as the skin healed (Fieldnotes: June...
In order to support their slackened stomach muscles, some women lifted up the lower stomach and tied a *chador* tightly around their waist (Madheeya, Jutial: May 4, 2005). To cope with the strong contractions, or ‘after-pains’, that women continued to experience in the first few days after delivery as their uterus contracted to its pre-pregnancy size, some women told me about how in the ‘olden days’ their mothers brought

“...donkey shit and made it *thatoh*, *thatoh* [hot, hot; S] and wrap it in a sheet and wear it between their legs by the vagina, and it would make her feel better. The *thatoh hawa* [hot air; S] would affect the afterpains in the uterus and ease the pain. Now we use modern things like Buscopan or painkillers.” (Madheeya, Jutial: May 4, 2005)

In the first three days after birth, women were traditionally expected not to feed their babies colostrum, the watery, antibody-rich fluid that precedes the arrival of milk. It was not seen as a ‘food’, and it was often described as deleterious for the baby’s health. Under the influence of their doctors, most Gilgiti mothers now breastfed immediately after delivery, but new babies in Minawar were still spoon-fed salt water (*nemakh pani*; U) by their mother or grandmother. (After interviewing women across Gilgit, it soon became clear that salt water was a Minawar-specific custom [*riwaj*; U].) In one way, because breastfeeding was generally thought to deplete the mother’s reserves in the same way as pregnancy, these first few days were thought to help new mothers recuperate their energy stores. Salt water was said to clean and purify the baby’s intestines, and help rid their tiny bodies of meconium (the tarry, fecal material that is produced by the baby while in-utero) (Sohni, Minawar: April 28, 2005). But because the water was often un-boiled and came from contaminated irrigation channels or earthen cisterns (*gulkoh*; S), newborns frequently fell ill and sometimes died in these few short days. If babies were seen as

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32 My assistant Fazeelat confirmed that sheep or donkey ‘shit’ had also been used as a packing material in diapers in the high mountains of Ismaili, upper Gojal and Hunza (Jutial: May 4, 2005). Other women described putting hot ashes into leather bags and then placing these on their stomachs or between their legs as a means to reduce ‘after-pains’ or menstrual cramps (Fouzia, Jutial: July 7, 2005).

33 During interviews with dispensers working at in-town pharmacies, I was told there were homeopathic ‘remedies’ for meconium. According to one dispenser in Jutial, “we have Hamdard Ghulee, which is ‘used to evacuate the bowels of newborn babies and children’” (Mukhtar, Jutial: August 3, 2005); Hamdard is one of Pakistan’s largest producers of homeopathic medicine.

34 When I told a prominent obstetrician about this practice she said (curiously so, given the lack of cultural connectedness between Gilgit and ‘down-country’), “this is a Punjabi belief, that the milk is dirty. I don’t know
particularly feeble, the salt water was supplemented with spoons of desi ghee (clarified butter; U), which Wadood jokingly referred to as the “universal Gilgiti medicine” (Fieldnotes: April 25, 2005). For the mothers of twins, breastfeeding was viewed with trepidation; most women felt their bodies were only capable of producing enough milk for one baby and not two. Because formula - which women jokingly called “cows in a cup” (Ruqaiyah, Jutial: June 16, 2005) - was prohibitively expensive for poorer families, mothers who were weaning their older children were asked if they would help with nursing support for the first year. As Phoonurh explained:

“…normally milk mothers are used when twins are born, and there is not enough milk for both babies, we give our milk to help ease the burden for her. We also believe that milk children will help the milk mother and her family in the future.” Dudh [milk; U] and koon [blood; U] are barabar [equal, the same; U]. (Minawar: May 3, 2005)

Though most women happily volunteered to help, they were often compensated with additional food, clothing or even cash. ‘Milk mothers’ are still a regular phenomenon across the rural Northern Areas, although the practice has lost some of its symbolic resonance and become more pragmatic over time.

When Wadood was born, though his mother had ample breast-milk, women relatives and neighbours competed over who would have the privilege of nursing him, thereby concretizing Wadood’s future financial obligations to them and their children, his milk siblings. Because there were sexual overtones to about the salt water, though...we tell women here that this milk [colostrum] is very powerful, and in older generations they didn’t give the milk but now everyone gives the milk, and we all know that it is very good for the baby. I haven’t seen nemahk pani practices here at our hospital” (Dr. Sharifa, AKHS,P: May 3, 2005). At the DHQ, however, one LHV described seeing women give “salt water to their newborns to drink after delivery, and we urge them that these behaviours are from the past, and we tell them in the Labour Room and Gynae Ward about proper feeding habits” (LHV IV, DHQ: August 1, 2005).

35 One homeopathic doctor I interviewed said desi ghee as far less praise-worthy; “Here a woman can be so weak, with Hepatitis or after delivery – she can have both – [and] they tell her to take desi ghee for 10 to 15 days, or if her bleeding is too much…people take too much of desi ghee, Dalda – bahoot sacht khorak [very hard food; U]!” (Dr. Farman, Domyal: August 25, 2005)

36 Women’s belief that larger breasts were more capable of producing more milk was sometimes upheld by their doctors’ ‘clinical assessments’. During my observation of patient visits to the Family Health Hospital, one young woman came at the urging of her husband, who complained her breasts were “under-developed and didn’t have enough milk” for their three-month-old daughter (Fieldnotes: May 14, 2005). Dr. Sunbool listened carefully to the patient and even after determining the infant was thriving and showed no signs of malnourishment, she reached under the patient’s dupatta (veil) and squeezed the left breast, saying “No breast development! She hasn’t got enough milk for her baby and her husband is saying her breasts should be a little bit bigger! [laughs]” (Dr. Sunbool, FHH: May 14, 2005)
Chapter Three: Desi Bilehn/Traditional Healing & Births at the Hearth

the intimacies associated with breastfeeding and reproduction, women had to ask their husbands for permission to become ‘milk mothers’. And because Islam considers breast-milk a ‘pure’ (pak; A) substance (it is, in reality, a sterile fluid), it was often used as its own desi remedy. “We use it for eye-infections, and it affects well because it’s shaffah [pure; A], it is from God, and when we are sick we can use its healing powers” (Julaika, Jutial: May 4, 2005). There were other surprising and highly strategic uses for breast-milk. In Diamer’s mountain valleys, one means of resolving frequent, violent bouts of inter-familial tensions or protracted blood feuds used to require men to suckle briefly at the breast of their enemy’s wife. This rendered them a ‘milk son’, established the equivalent of parent-child relationality and obligations and nullified any existing vengeances.37

Where their pre-delivery diet was described as “regular” - comprised of salt tea and barley bread in the morning, stewed vegetables (salan; U) and roti (bread; U) at lunch and dinner - Phoonurh’s sister-in-law, Sohni, described women’s diet during the 40 days of post-partum recovery as “proper food...like desi ghee and a special sharbat [drink, syrup; U] made from desi ghee and atah [flour; U] – it’s greasy and rich” (Sohni, Minawar: May 3, 2005).38 Though Wadood could eat it by the spoonful, I found desi ghee one of the more distasteful local food luxuries. Made of the clarified butter of goats or cows, it has a rancid odour and a peculiar, almost gamey flavor. Along with locally-produced almond and apricot oil (tayl; U), it was one of the costliest foods in Gilgit; one pau (1/4 kilogram; U) cost Rs 250 (CDN $5.80). It was also seen as an essential constitutive element of women’s recovery from any pregnancy-related health crises, miscarriage or after delivery. (Because of its exorbitant costs, desi ghee quite literally functioned as a type of

37 See Parkes (2001) discussion of milk fostership as an “alternative kinship structure” (4, 8-13) in Northern Pakistan’s Hindu Kush region (which includes Chitral and Gilgit).
38 During my fieldwork, I noticed that pregnant women were rarely encouraged to change their everyday diet, with the exception of being specifically encouraged to drink milk and eat fruit (Pfiffi, Minawar: May 3, 2005). Meat was eaten only occasionally; families raised chickens, but primarily for their eggs. Cows or goats were slaughtered for special occasions, or shared among family members on a bi-weekly or monthly basis. It wasn’t uncommon for even wealthier families to describe eating meat only several times each month. River trout were available, but not nearly as popular.
conspicuous consumption.) Following childbirth, families that could afford to purchase ghee advised new mothers to eat in the following manner:

“When a woman has delivered her baby, they even make her drink straight, heated desi ghee from a glass or a big bowl - it’s necessary for a first delivery, but not subsequent deliveries - these times a mother dufah ho jae [can go to hell; U] [laughs] For the first one you have to drink it to heal properly - to take care of yourself - it helps the bachitani [uterus; U] heal properly. I don’t know exactly how it works, but our women believe in this. It protects where the placenta came out [detaches], and if you feel pain it relaxes you.” (Shandana, Amphari: August 12, 2005)

“They eat normal food, [except] at nashta [breakfast; U] we eat shorbah soup [S], mohl, gullee [S, S] – this is a pancake made with desi ghee. No, we don’t eat vitamins! [laughs]” (Madheeya, Jutial: June 16, 2005)

For in-town families who weren’t able to produce desi ghee at home, men were sent on excursions to purchase it from shops in the central bazaars, or from relatives living in Gilgit’s outlying villages. Desi ghee was not only a luxury, but envisioned as having particular consequences for a woman’s overall health; “desi ghee helps the bones” (Dadi, Minawar: April 25, 2005). For difficult deliveries, a spoonful of hot desi ghee was even given to women to help ‘lubricate’ the birth canal (Fieldnotes: June 7, 2005). Women were also encouraged to drink lassi (U), “milk with a little salt and sugar in it” (Pfiffi, Minawar: May 3, 2005) but discouraged from eating meat (gosht; U) because it “causes stomach problems and interferes with breastfeeding” (Dadi, Minawar: April 25, 2005). Not every new mother, however, was enamored of her special treatment and the dietary luxuries reserved for her use. Mehnasat had been pushed to consume massive quantities of desi ghee by her mother-in-law, who argued it would help Mehnasat establish a good milk supply.

“She said if you don’t eat enough, or have enough desi ghee, the milk is less. We would eat ten, fifteen, twenty kilograms of desi ghee [over 40 days]. If guests come, we serve them with foods made from desi ghee, because they notice the smell and taste is different if we use other oil. They hate cooking with oil, and [then] say it’s because we’re cheap and don’t give them the honour. I ate less desi ghee with Khadija [daughter], itnay khaya nuhee [didn’t eat that much; U] but much more with the boys. I get headaches when I eat too much desi ghee.” (Mehnasat, Jutial: June 8, 2005)
Most post-partum dietary practices were described in humoural terms, with ‘hot’ and ‘cold’ foods, ‘sour’, ‘spicy’ or ‘sweet’ dishes described as having specific health effects.39 ‘Sour’ or ‘cold’ foods, such as the intensely sour, un-ripened apricots (kuttah mamootee; S) that Gilgitis considered a delicacy in late spring, were said to make the body “sweaty and cause pain, which affects the baby”, whether in-utero or through breast-milk (Sohni, Minawar: May 3, 2005).40 And if women felt their milk supply was inadequate, they were told to eat ‘hot’ foods. “If our milk is less, we eat sugary things, like jhelabis…[or] shukr chai [sugar tea; U], but we don’t add fluids, no” (Madheeya, Jutial: June 16, 2005). Within Gilgit’s humoural schemas, which I found to be virtually identical to the properties associated with Persian cuisine (see Shaida 2002: 287-289), foods were sometimes viewed as the underlying cause for health complaints, with women misreading normal water retention, the edema accompanying pre-eclampsia (toxemia; pregnancy-induced hypertension) or even hydrocephaly in newborn infants as the result of having eaten too much ‘sour’ or ‘spicy’ food during pregnancy; “sometimes the mother will eat things that make her body badei [swell; S] and then baby’s head swells” (Madheeya, Jutial: May 3, 2005).41 There were a variety of

39 Among my participants in Jutial, ‘hot’, spicy, sugary or sour foods were said to produce early menarche in girls. Garam (hot) foods - like eggs, ripened cherries or mangoes, almonds or dates - were often given to boys instead (Madheeya, Jutial: May 4, 2005). Simply put, it wasn’t a social or honor-related dilemma for boys to sexually develop early. Nor was male virginity viewed as a necessary precondition to marriage; “No, it doesn’t matter! What can we do, and how can we know? It doesn’t matter if he is going somewhere before marriage – he can’t get pregnant!” (Madheeya, Jutial: June 22, 2005) On the other hand, if girls had not reached menarche by the time they were sixteen or seventeen their mothers were often concerned and took them to local hospitals or desi bilehn providers for care. As one desi bilehn specialist explained, in the same way that menses could be delayed through diet, it could also be precipitated by food; “...we advise diet changes due to the body temperature. Some girls are hard, and some are soft. A hot body is soft, and it’s from food...if the menses does not come, we don’t have a [desi bilehn] treatment” (Mugehra, Jutial: September 10, 2005).

40 Many of my participants described having a keen preference for the sourness of unripe apricots, which when still green and crunchy were chopped and prepared as a salad that was flavoured with salt and pepper. (Sun-ripened apricots [jharootee; S], on the other hand, were said to be a ‘warm’ food.) ‘Sour’ foods were also said to cause menstrual cramps or add to pregnancy pains. As one young woman from Amphari Mohalla noted, “When I got my period I was told not to eat sour things, like pickles or unripe fruit because it would make pain in my back and could make the cramps worse” (Laiba, Amphari: August 12, 2005). A common dietary remedy for uterine cramping was tumarh (garlic; U) (Fouzia, Jutial: July 7, 2005; Fieldnotes: May 6, 2005). Generally speaking, women mentioned the body’s humoural elements or processes only in passing, or with specific reference to menarche, sexual maturity and reproduction; it was rarely discussed otherwise.

41 Gilgit’s desi practitioners also claimed to have a number of remedies for high blood pressure; “For [pregnancy-related] hypertension we use susr [S] with toomaroo [S]. You make a tea from the two of them and drink it; it makes your blood pressure less. You make a soup from the two of them, and drink it, and add sugar before drinking. The susr cleans the blood, and the toomaroo lowers the pressure. You have to take it until your problem is finished. It’s
diuretic, herbal remedies for edema, which the desi davaie practitioners I interviewed described as being among the most common pregnancy-related complaints.

“You take kashoroguhn [S] and mix it with water and drink it. It’s from Astore. First you heat the mixture a little, then cool it before drinking. Don’t boil it, just heat it a little. You drink it whenever you want, and it makes you pee a lot and get rid of the water and the jeraseem [germs, infection; U].” (Mohammed Isa, Gilgit: August 20, 2005)

Frequent pregnancies and high progesterone levels often resulted in distinctive blotches of hyper-pigmentation around women’s eyes and across their forehead. In Minawar, women viewed these light brown patches of cholasma (gup; S) with considerable distaste as a sign of their ‘farmer’ or ‘villager’ upbringing. Alternatively, cholasma was said to be symptomatic of women’s physical weakness during pregnancy and after birth (Razia, Jutial: June 16, 2005). In order to ‘erase’ these brown markings, many of Wadood’s women cousins in Minawar pleaded with me to bring them Chinese or Punjabi skin bleaching kits from Gilgit’s bazaars. The Pakistani brand, ‘Fair and Lovely’ was heavily advertised on TV and in print media, and although it never had any observable effect, women swore by it and obviously enjoyed participating in what seemed to be modern projects of beauty. In the midst of regular self-sacrifice, deprivation and an overall lack of marital romance, women’s gup-related self-attentions were a luxury.

[Julaika] “The brown spots on our face bother us; we call the brown spots gup. We use chohp [S]; it’s from the dried horn of an ibex and which we make into a powder and then add water, and put this paste onto our face and leave it to dry for 2 days. On the third day we remove it by scratching and pulling it off…. Or when the child is still drinking milk, we take the leftover breast-milk and put it on our hand and apply it to our face.”

[Mehnasat] “But we sisters and our mother never had this problem! All through all my pregnancies I never had it…there is a cream you can use, it’s called ‘Rikko’ cream and it costs Rs 70 [CDN $1.60] and you can buy it from my in-law’s cosmetics store…”

[Malikeen] “You are hiding this cream, and then you are more beautiful than us!” [laughs] (Jutial: May 4, 2005)\textsuperscript{42}

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\textsuperscript{42} My research assistant Fazeelat described another method that involved using a stone to crush certain plants, making a facial mask that was re-applied over forty days, after which time the brown skin was said to simply “peel off” and leave fresh, white skin underneath (Jutial: May 4, 2005). Besides trying to have the ‘clean’ (saf; U) complexions enjoyed by their in-town women relatives, some women in Minawar were also obviously preoccupied
In the same way that women’s bodies were defined by menstruation, pregnancy, childbirth and the wealth of Islamic rituals and prayers associated with each of these events, baby girls’ bodies were ‘treated’ so as to minimize bodily changes in adolescence. While most families avoided circumcising their newborn boys (preferring to wait until their third or fourth year), baby girls were ‘sexed’ in a variety of traditional ways. The majority of women participants claimed to be uncertain if they were Islamic or local in origin. Due to high hormone levels in the baby’s body immediately after delivery, and which are transmitted to the baby from the mother via the placenta, some newborn girls had milk- and menstrual-like discharge. In Jutial, one of Wadood’s cousins described squeezing the hard discharge (honee; S) from baby girls’ nipples in the first month after birth. Citing local customs, she said that if this wasn’t done, girls would get their periods far “too early”, namely, between the ages of ten to fourteen (Madheeya, Jutial: May 4, 2005). In response to Islamic injunctions for women and men to shave their armpits and pubic hair and thereby reduce bodily odour, Gilgiti mothers had concocted a remedy that they claimed prevented the growth of hair at puberty.

“We would take ant eggs when the girl is one year old, and rub them in our hands until they liquefy, and then rub it ‘on there’ to prevent the hair from later coming in, and making it saf sutrah [perfectly clean; U]. I did this on all my daughters and it worked!” (Madheeya, Jutial: May 4, 2005)

Whether menstruating, or dealing with abnormal discharge or post-partum bleeding, women and new mothers were exempt from their prayers (namaz; A) or fasting (roza; A). More devout Sunnis were expected to ‘make up’ these lost days through additional fasting or prayers at another time, but the majority of women were openly grateful for the ‘waqfa’ (break; U). Due to onerous household chores and childrearing, very few women were able to prise enough time out of each day to pray regularly anyway, and had – as local mullahs consistently pointed out – fallen far short in their Islamic obligations (farz; A). Fatawas based on the Hadith Al-Sunnat stipulated that women were ready for intercourse again once their post-partum bleeding had stopped for more than three days; for some mothers, this happened only two

with trying to look as ‘white’ as those naturally fairer Ismaili women who hailed originally from Upper Hunza and Gojal Sub-Districts, where the peoples enjoyed a different ethnic ancestry than the majority of Gilgiti Sunnis.
to three weeks after delivering. But among Gilgitis, the forty days of abstinence called for by the Qur'an were sacrosanct. As one father said, “I have never broken that circle of days” (Hashim Khan, Jutial: May 9, 2005). On the fortieth day after delivering, women were expected to ritually purify themselves in the same way that they did for prayers (namaz wudhu; A); this was different in structure from women’s purification after sex and the end of menstruation (hez ghusl; A). Following their namaz wudhu, and once they had completed their first namaz following delivery, women were expected to willingly resume marital conjugality, despite any lingering discomforts from their still-healing bodies. As one woman joked, “we start our work again!” (Mehnasat, Jutial: June 7, 2005)

For breastfeeding mothers, the weaning period at two years was expected to be quickly followed by another pregnancy; among my in-laws, the ‘waqfa’ (break) between babies was sometimes as little as one year and several months, or as late as three years. Overall, the regular gap between deliveries was two years and one or two months. Among my husband’s siblings and first cousins the two year, two month gap happened with such regularity they joked it was ‘pre-planned’. In reality, it was a reflection of the standard times at which women were expected to begin feeding their babies solid foods. Decreased breastfeeding then resulted in a return to ovulation, and thereafter, pregnancy. Among Minawar and Gilgit Town’s more ‘traditional’ families, openly religious mothers-in-law or grandmothers were disdainful of women who seemed to be trying to delay weaning, and thereby, conception; “Those kind of people can go to Hell! Allah pak hen [God is great; S, A] and wants more of us!” (Dadi, Minawar: April 25, 2005)

Part VII Conclusion

For at least the nine months of pregnancy, and for as long as two and a half years if babies were breastfed, Gilgití women were not expected to become pregnant. If only for a brief spell, women were exempt from the pressure to bear a son, to prove their fertility (and by extension their husbands’), or answer the Tablíghi
Chapter Three: Desi Bilehn/Traditional Healing & Births at the Hearth

Jamaat’s strident calls for Gilgiti families to procreate and strengthen the Muslim umma (community of believers; A). Where Chapter Two looked at biomedical settings and Chapter Three has addressed women’s traditional, home-centered health practices, Chapter Four will analyse the ways in which biomedicine, regional health development and Islamic conservatism focused on family size, Family Planning and women’s marital roles to express divergent projects of identity. The affective roles of sectarian affiliation, religious allegiance and biomedical ‘modernity’ for Sunni women’s reproductive and maternal health are explored. Through the use or non-use of Family Planning, Gilgiti Sunnis from in-town and rural settings sought not only to temporarily participate with local projects of meaning, but to also connect with transnational Islamic discourse by framing their reproductive choices in Hanafi and Wahabbist terms. In this way, Gilgiti women’s experiences were not dissimilar from the health practices described by Tober in multi-sectarian Iran (Tober et al, 2006), where women’s use of Family Planning was predicated on sectarian difference and the “acceptance of fatwas on reproductive technologies” (Inhorn 2004 in Tober et al, 2006: 53).
Part I  Introduction

Before leaving Minawar one evening in early summer, as the chill from the dampened earth rose up to
where we sat on a traditional tukhta bed, I asked Wadood’s cousins if they knew anything about the
pregnancy and childbirth practices of their Ismaili and Shia contemporaries.1 Women looked at each
other with noticeable amusement, and Wadood’s Pfiffi (aunt; U) took my hand and spoke to me almost as
if I was a slightly simple-minded child, and women’s sectarian differences should have been self-evident.

“Shia alak hen, Sunni alak hen, Ismaili alak hen [Shias are separate, Sunnis are separate,
Ismailis are separate; S]... our Sunni mullahs say that we believe in the Qu’ran, God, but
Ismailis and Shias are different. I’m not sure about how Shias are, I can only understand
Sunnis. Ismailis think more about their health, so they are scared of having too many
children. But most Sunnis and Shias believe in the Qur’an and have lots of children.
Although sometimes I think Shias only have three of four children, and no more.” (Pfiffi,
Minawar: May 3, 2005)

With their everyday lives set against conflictive landscapes of sectarian identity, Sunni women’s bodies
acted as a focal point for ‘modern’ secular development, and also intensive family- or mosque-centered
‘Islamic’ pressures to bear more children. In this way, Family Planning was only one of a number of
‘projects’ focused on women’s bodies and fertility in particular; paraphrasing Kanaanah, Gilgit
“discourses on reproduction structure a variety of social conceptions” (2002: 166). And in the same ways
that pardah and veiling, pregnancy and childbirth expressed and enacted values, Family Planning
provided an additional point of contestation, communication and even occasional agreement between
Ismaili, Sunni and Shia perspectives. Using contraception or not, having many children or only a few,
were some of the most visible ways in which Gilgitis, of all sectarian communities, and especially during
Shia-Sunni ‘tensions’, ascribed to contrasting projects of identity. It was also through Family Planning
that Gilgit’s Sunni ulema and secular biomedical proponents spoke most forcefully to one another. In

1 The tukhta (S) is a traditional raised wooden bed, approximately five feet by six feet and surrounded on three sides
by a wooden railing. During the daytime, bistra (bedding; U) is laid out along the sides of the tukhta, and a
dusturkhan (oil-cloth; U) is placed in the center for chai, cookies or meals.
2 Among my in-town participants, Shia neighbours and Ismaili friends, there were few discernable
differences in family size between ‘more educated’ Shia, Sunni and Ismaili families.

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many ways, and even when they disagreed, the polemics used by each camp revolved around the same concerns: women’s bodies, marital sexuality and control over reproduction, socio-economic security, and trusting in the ‘unseen’ - either faith that Allah would provide for a large family, or that smaller families would eventually lead to economic advantages.

This chapter addresses two important aspects of Family Planning programming in Gilgit. Firstly, for my participants, Family Planning advocates, physicians and Gilgit’s Sunni ulema debates concerning the permissibility of women’s use of contraception revolved around one central question: Was it permitted or prohibited by the Qur’an, and if it was permitted, was its use contingent on issues of context, economic ‘need’ or health? Secondly, because Family Planning placed women and their bodies squarely at the heart of contentious regionalized debate between the forces of secularism and Islamism, it was clear that, borrowing from Elora Shehabuddin’s analysis of women and NGOs in Bangladesh, Gilgitis were “being pulled by competing interpretations of modernity, development, Islam and feminism” (2002: 203). As such, I attempt to answer how “different interpretations of Islam may or may not influence reproductive health-related behaviours and how cultural factors influence reproductive strategies” (Tober et al, 2006: 50). Finally, it is important to note that many of the narratives contained in Chapters Four and Five were collected during Shia-Sunni hostilities. However, because I seek to avoid conflating women’s everyday reproductive strategizing and struggles with those specifically related to the 2005 conflicts, in these two chapters I accord ethnographic primacy to the challenges women said they faced regardless of the sectarian ‘tensions.’

Part II Statistical ‘Gaps’

As was described in Chapter One, since the late 1970’s, the Northern Areas has been the scene for concerted efforts to improve health service provision and access. In sometimes uncomfortable ways, women’s maternal health was employed as a point of social experimentation, in that the large number of governmental and non-governmental organizations approached women’s fertility rates as being
indicative of community ‘advancement’, whereby if fertility rates decreased, communities must be thriving. For non-Sunni health providers, Sunni women’s ability to use contraception, to limit family growth or increase birth spacing was highlighted as a point of ‘modernity.’ To this point, one AKHS,P maternity nurse suggested Sunni women’s reluctance to take-up contraception proved they were “not seeing or understanding the benefit of Family Planning; [Ismaili] people in Hunza now see it and appear a generation or two advanced from the Sunni community” (Nurse, AKHS,P: November 9, 2004). After nine months of interviews with AKHS,P staff, I had become conditioned to hearing fertility and birth ratios that I knew stemmed from Ismaili community health status indicators, but which were extended to generalize Northern Areas health ratios. AKHS,P had successfully dominated regional health discourse, so much so that there was little, if any, emphasis on remaining health coverage deficits and access difficulties among non-Ismaili patients. Even in the face of readily-apparent evidence of the region’s health deficiencies (at the DHQ, for instance), visiting scholars often left the Northern Areas touting what many joked was the AKHS,P ‘official party line.’ Consider, for example, Clyde Hertzman, an epidemiologist at the University of British Columbia:

“Two years ago I visited the Gilgit region of Northern Pakistan to learn about the revolution in health that had taken place there over the preceding 15 years. With assistance from the Aga Khan Foundation, a series of new institutions were developed in the region: a woman’s organization for agricultural diversification, economic participation and mutual aid; schooling for girls; a rural sanitation service; and a system of primary health care. The impact of the changes was breathtaking. During this short period the infant mortality rate fell more than four-fifths to approach Western levels. Birth rates were cut in half....The Gilgit region has recapitulated, in 15 short years, a trajectory of health development that took Western societies two centuries to complete. In their transformation the people of Gilgit have made their region a case study in the ‘determinants of health’ – the ways in which the prospects for health and well-being in human societies are embedded in the environments where people grow up, live and learn.” (Hertzman 2001: 1)

Yet the AKDN’s ‘truths’ were not reflective of Northern Areas’ women’s health overall. Instead of Hertzman’s ‘health revolution’, regional indicators describe how Northern Areas women and their children face innumerable, unresolved health risks, many of which were quietly interwoven with
Chapter Four: Family Planning, Islamism & Pronatalism

traditional health and weaning practices or women’s disenfranchisement from clinical care. According to Nayat Karim, Project Director of the Family Health Hospital:

“The women of the region have limited access to social sector facilities. A majority of women in the region do not get/cannot afford any special/supplementary diet during pregnancy… acute respiratory tract infection (ARI) and diarrhea remain the major killers of children, contributing 28 and 14 per cent mortality respectively….more than 47% [of] women had not received antenatal care, and similarly 38.9% have not received Tetanus Toxoid immunization, the number is extremely higher (79.3%) in district Diamer, where over 80% deliveries are taking place at home. Women of the area also suffer a lot due to unspaced and frequent births, which is also one of the major contributing factors among the women of Northern Areas.” (Karim 2004: 5-6)

Motivated by my desire to offset the dominance of AKHS,P discourse, which in many ways inaccurately portrays the Northern Areas as a comprehensively transformed place, and to illuminate the cultural hesitancies which still affect how Sunni women use biomedical reproductive health services, this chapter details my participants’ navigations of Family Planning as concept and practice. Because contraceptive use is still rare in Gilgit District’s outlying Sunni villages, my analysis focuses on Gilgit Town.3

Part III Family Planning Services: FPO, FPAP, AKHS,P & ‘Greenstar’

From the federally-funded, Family Planning Organization’s (FPO) administrative headquarters on the Kashrote Link Road, Sherbaz Ali presided over the Northern Areas Family Planning and Population Control Office. In his late thirties, Sherbaz was an Ismaili Gilgiti, married to a teacher and the father of several children who attended Jutial Mohalla’s Army Public School with my daughter. His sunlight-filled office was dominated by an over-colored, framed portrait of Quaid-e-Azam (the architect of Partition and the State of Pakistan, the tubercular and emaciated Jinnah, astrakhan perched atop his head), and a huge poster of the Northern Areas, with FPO coverage areas traced out in black marker. Officially titled the ‘Population Welfare Programme’, Gilgit’s FPO activities began in 1987 and were administered and

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3 Neither the FPO, FPAP or AKHS,P offered Family Planning outreach in outlying Sunni villages. Because my Minawar participants found it much more difficult to access Gilgit’s health services, and lived under the everyday influence of the Tablighi Jamaat, contraception was rarely used. For the very few Minawari women using contraception, long-term solutions like the IUD were the only feasible option.

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operated through the Directorate of Health Services and the Northern Areas Health Department. Sherbaz had been hired as Deputy Director in 2000, and after substantial lobbying to both the Northern Areas Health Office and the FPO’s Islamabad headquarters, an ‘independent’ FPO office was established along the main road separating the Sunni Kashrote Mohalla from the Shia Chenar Bagh and Domyal Mohallas (see Map IV). When I asked him about the FPO’s primary objectives for Gilgit District, his answer was steeped in development discourse.

“The Population Welfare Programme’s goal is to introduce the small family norm, and to provide the required services to achieve this goal. In the Northern Areas, if we focus on Human Resources Development and government institutions, and community development, the Northern Areas can become a model for the rest of Pakistan. In this context, the population size is still manageable.” (Sherbaz Ali, FPO: July 28, 2005)

From the outset of our first interview, Sherbaz held the Federal government responsible for failing to adequately support regional FPO activities. The FPO’s Kashrote headquarters (as well as their satellite centers throughout Gilgit Town and surrounding mohallas) were crippled by inadequate inter-office communication, which was reflective of the same types of logistical handicaps afflicting all of Gilgit’s government services. In trying to account for the neglects that so obviously impaired safe, hygienic service provision, or answer how underfunding meant the FPO couldn’t extend their services to areas still uncovered by either public or private sector health care, Sherbaz argued that many of their program difficulties were reflective of the Northern Areas’ ambiguous status within the State. As with many local narratives concerning the State, his views reflected Gilgiti assessments of the State as vaguely colonial and suffused with ethnic discrimination towards “non-Punjabis” (Fieldnotes: February 6, 2005), a view

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4 According to the Family Health Hospital’s Chief Administrator, the Government of Pakistan initiated Family Planning services in the Northern Areas in 1994. At that point, the Family Planning Association of Pakistan (FPAP) and the government worked in tandem to provide contraceptive services (including surgical sterilization) (Acting Project Director, FHH: May 10, 2005).

5 Sherbaz Ali disclosed he had heard recent ‘rumours’ that policy analysts at AKRSP and AKHS,P were quietly discussing the need for Northern Areas population growth. Their argument was that the region’s political insecurities and funding deficiencies were a by-product of stymied socio-economic growth, which was in turn tied to a ‘lower than necessary’ population; Sherbaz was unable to clarify what ‘necessary’ population numbers would ideally look like. According to a Marie Stopes Society study (Hamdani, Lee-Jones & Sadler 2006: 1), Pakistan’s population is 158 million.
which had only been exacerbated by the 2004 and 2005 ‘tensions’ and the largely Punjabi, Gilgit-based
Army forces’ apparent neglects of Sunni community security. When I pressed him to tell me more about
how the Northern Areas figured as a ‘half-incorporated’ entity to the Pakistani State, Sherbaz highlighted
an important facet of local health statistics.

“Well, the Northern Areas doesn’t figure into government statistics, really. What I have to
do is take national averages, and add or minus a few points, and make inferences given
our experiences here, but there is really no reliable data reflecting the true numbers of life
here, or contraceptive usage.” (Sherbaz Ali, FPO: July 28, 2005)

Notwithstanding chronic funding insufficiencies and federal neglects, by the end of 2002, Sherbaz was
managing thirteen FPO-funded Family Welfare Centers (FWCs), one contraceptive services Family
Planning office at the DHQ’s Family Wing Outpatient Ward (which was where the majority of my
participants who used contraception had sought care), and two-tiered Reproductive Health Services
(RHS). At one level were those RHS’s directly supervised by the FPO, and at another level were those
private sector health centers providing contraceptive services (IUD, injectibles, Norplant, birth control
tabs, condoms), and surgical sterilization (tubal ligation, hysterectomy, vasectomy) which were paid for
by the FPO.

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6 According to many participants, the Northern Areas wasn’t yet politically important enough to warrant the same
influx of government funding, political attentions and socio-economic development enjoyed by residents of Azad
Kashmir.

7 Prior to November 2005, when the Secretary of Health for the Northern Areas had been re-designated the Secretary
of Health and Population Welfare, Sherbaz had seen his program activities monitored on a near-daily, quasi parent-
child basis by the Islamabad-based Family Planning and Population Control Head Office. Before program
monitoring had been re-assigned to Gilgit, he described having to, “…report to Islamabad, and this was a
cumbersome process, given our telephonic communication problems. I even had to ask Islamabad when I wanted to
take a day’s casual leave! Now, I am required to seek approval from the Secretary for financial and administrative
matters….instead of going back and forth to Islamabad for the correction of some minor problems, I can get things
done quickly, within an hour, or much speedier. The most important thing to know is that before we had no
institutional links with the Northern Areas Administration, and now we have an interface with the local
government. This has enhanced ownership to the local government, and it took Islamabad a long time to realize
this…it was the [Northern Areas] Chief Secretary who enacted this re-designation” (Sherbaz Ali, FPO: July 28, 2005).

8 The FPAP’s Family Health Hospital was the primary recipient of FPO largesse and surgical referrals; their head
offices in Lahore had established this funding partnership with the FPO’s Islamabad headquarters years earlier.
Monies were received after health centers had submitted surgical claims, which were reimbursed directly by the
Northern Areas FPO headquarters. Private sector hospitals secured federal funding by registering first with the
FPO’s federal offices in Islamabad.
“...we have our Family Planning office at DHQ and Reproductive Health Service Centers. There are ‘A’ and ‘B’ centers of these. The ‘A’ centers are established by the programme itself, and it is our own service outlet. The ‘B’ centers are any health center that provides surgeries in the private sector, though we are bearing the costs of these contraceptive cases and pay certain amounts for tubal ligations, or vasectomies. We are planning on adding AKHS to this agreement...They [will] submit claims for these surgeries to us, which we reimburse. They have no additional reporting responsibilities to us, and they register with us at the Federal level through Pakistan, not specifically through our district or provincial-level offices like this one in the Northern Areas. The FPAP of Pakistan, which manages the Family Health Hospital, registers with our Islamabad office, not this Northern Areas office.” (Sherbaz Ali, FPO: July 28, 2005)

In late summer 2005, the FPO had shifted their contraceptive and Out-Patient services from their office at the Family Wing’s Out-Patient Ward (OPD), to a dilapidated house just off Hospital Road, a stone’s throw from the DHQ’s main gates and immediately beside dayah-turned-‘doctor’ Nargis’s maternity clinic. The FPO’s new clinic had been roughly converted to handle a small and rather grotty exam room, which was partitioned off from the wait-room by a rickety metal screen (see Figure 17). The LHV who managed the clinic during its daytime hours (which were the same as the hospital’s 8am-2pm OPD coverage) was a young woman from Ghizer District, Haseena, who had returned to Gilgit after a stint at the Skardu DHQ. She was quick to proclaim the clinic as ‘well-staffed’, with one ‘lady doctor’ who had come from one of their satellite Reproductive Health Services Centers (RHS-C), as well as one “male motivator” who distributed condoms and socialized in the mohallas immediately around the DHQ (Fieldnotes: September, 2005).
7, 2005). The clinic had also hired a “female motivator...one LHV, a chowkidar [male guard], and ayah [woman orderly]”; generally speaking, FPO motivators were expected to “go house-to-house giving education” (Haseena, FPO: September 7, 2005). The clinic did not handle delivery cases, but had increased the scope of its daily operations to now include pre-natal and post-partum checks, which had never occurred at their former site in the female-only Family Wing. (It is worth noting that among those participants who had or were using Family Planning, the majority received contraception from the FPO.)

Over a cup of chai, Haseena summarized the clinic’s services and contraceptive costs, and commented on the FPO’s changing patient base:

“We give injections here, Depo Provera 150mg every three months. And Norgest, 250 mg every two months. At the beginning of their injections, we take Rs 3 [CDN $0.06] to make their [patient] card, and they pay Rs 5 [CDN $0.10] every time they come to see the doctor. We also offer 21 and 28 day pill packs – it’s Rs 3 per pack, per month. Condoms are Rs 1.50 paisa [CDN $0.03] for one; we ask them how many they need! [laughs] They’ll take fifteen, sometimes forty – depending on their need. We do IUCD’s here too. It’s Rs 50 [CDN $1.15]; Rs 20 [CDN $0.45] for insertion, and Rs 20 for removal. Most patients come here for IUCD and injections; one came recently and it was removed after ten years, she had no infection, no problems. Nowadays people come after three or four, or four to five years – before they came after seven or eight kids! [laughs] Now some even come after one or two children...we have Family Planning motivators in the community, and it’s mostly Shias and Sunnis who come in. In Bagrote, they still come after six or seven children!” (Haseena, FPO LHV: September 7, 2005)

Without exception, the most popular contraception was that which required the least amount of daily attention or visibility. Intra-uterine devices (IUD, IUCD) were uniformly cited by the FPO, FPAP and AKHS,P staff as women’s preferred method (see FPAP, FHH 2004: 10; AKHS,P 2002; FPO 2005b, 2005c).

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9 See a 1999 UNESCO publication, entitled “Questions of Intimacy: Rethinking Population Education” for Imtiaz Kamal’s discussion of the early successes of male Health Guards working in Gilgit District (63-71). The study provides some insight into the early efforts of the FPAP to initiate community-based contraceptive outreach, but fails to qualify if the programme’s successes were correlated with the sectarian affiliation of the Health Guard, or their target clientele. It does note, however, that “there were few discouraging problems and few disappointments in these projects to involve men more visibly. There was only mild resistance from certain religious groups in Gilgit” (Kamal 1999: 70). According to Sherbaz Ali, male workers were an essential element for the success of Family Planning initiatives, but “simply motivating ladies does not change the dynamic in a household if the men are rigid and closed-minded.” He also admitted the FPO’s male motivators were a less-than-successful component of Family Planning outreach; “[the] field staff are too shy to discuss issues with [local] men, who are equally reluctant to partake in discussions” (Sherbaz Ali, FPO: November 8, 2004).

10 Bagrote is an isolated Shia village several hours drive from Gilgit Town.
Although most older women were unsure of exactly how they worked, IUDs – also known as the ‘copper T’ - were seen as the closest thing to a ‘permanent solution’ while still being Islamically-permissible. (As this chapter will later discuss, according to Ismaili and more moderate Sunni and Shia interpretations of the Qur’an and Hadith Al-Sunnat, contraception was permitted as long as it was intended only to increase birth spacing, and did not permanently impair a woman’s overall fertility.) Diaphragms, the birth control pill and condoms were all more ‘visible’, required more attention and were described as more likely to ‘fail’ if improperly used.

There were few opportunities for me to identify contraceptive prevalence rates specific to Sunni communities, and I found myself forced to draw inferences from District- or mohalla-specific surveys and statistics. For example, the Northern Health Project’s 1999 Baseline Survey compares contraceptive use between more ‘modern’ mixed-sect Gilgit and more ‘traditional’ Sunni Diamer Districts (Rahman 1999: 20-24). The survey found that among the 28.4% of 289 Gilgiti women and 9.3% of 300 Diameri women using contraception, oral pills were used by 29.3% of Gilgiti respondents, and 42.9% of Diameri respondents. The IUD was used by 23.2% of Gilgiti women, and 35.7% of Diameri women. Injectable contraception - including Depo Provera - accounted for 17.1% of “preferred” contraception in Gilgit District; according to the survey, injectibles were not used by Diameri respondents. At 12.2%, tubal

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11 Given the dearth of Shia community health surveys in Gilgit Town, Tober’s 2006 research may offer helpful insights for in-town Shias’ use of Iranian-derived fatwas to help determine the permissibility of contraception; “Iran’s family-planning programs have been much more successful among [Shia] Iranians than [Sunni] Afghans because, for one, Iranian clerical support for family-planning programs led to a reframing of Shi’a Islamic beliefs that God does not want people to suffer and that a healthy family is more important than a plentiful family” (Tober et al, 2006: 68). Also see Paider (1995: 280-281) and Masud, Messick and Powers’s edited anthology “Islamic Legal Interpretation: Muftis and Their Fatwas” (1996).

12 To my mind, the contraceptive prevalence rates for Gilgit District remain the most problematic because they involve Shia, Sunni and Ismaili populations. As with AKHS,P patient indices, Gilgit District’s Contraceptive Prevalence Rate (CPR) of 28.4% was an unarticulated conflation of strikingly different patient uptake patterns and provided what was - to my mind – an artificial overview of Gilgit health indicators. In 1999, contraceptive prevalence rates indicated that among Ghizer District’s predominantly Ismaili population, contraceptive uptake was 31.9% of identified patients. In Sunni-dominated Diamer District, the figure was markedly lower, at 9.3%. Shia-dominated Skardu and Ghanche Districts, lying to the east of Gilgit District in Baltistan, had prevalence rates of 15% and 18% respectively (FPAP, FHH 2004: 3).

13 Spermicidal foam and Norplant accounted for 6.1% of the contraceptives used by Gilgiti women, and only 3.6% for Diameri women (Rahman 1999: 21).
Contraceptive sterilizations were the fourth most frequent choice for Gilgiti women, while 17.9% of Diameri women had undergone surgical sterilization. Among Gilgiti women using contraception, 11% relied on condoms, and another 1.2% of husbands had had vasectomies. In Diamer District, however, no women reported either condom use or vasectomies (Rahman 1999: 21); rather than represent patient preference, this reflected the local unavailability of male contraception and sterilization. Recent FPAP surveys of Family Health Hospital patients offer similar results, with the exception that oral pills accounted for only 10% of contraceptives used by a total of 26,513 “new acceptors” between 1999 and 2004 (FPAP, FHH 2004: 17). This may reflect the Family Health Hospital’s preference for IUDs as the most reliable, long-term birth control. Indeed, FPAP surveys indicate that among new users, 46% of women had received an IUCD, while 10% of women were receiving Depo Provera injections, another 15% had received Norigest implants, and 8% of women had had tubal ligations (FPAP, FHH 2004: 17). In recent years, the FPO had tried to provide financial incentives to families who ‘signed up’ for Family Planning early on in their reproductive lives. According to Dr. Nagyr Alam, a Sunni surgeon who worked on behalf of the FPO at the Family Health Hospital, the Federal Government offered similar ‘special’ cash bonuses for men or women who chose surgical sterilization, as well as to the hospitals which treated them.

“It’s a matter of RIC – Regional Investment Costs...we pay Rs 700 [CDN $15.90] per vasectomy to [hospitals], and Rs 600 [CDN $13.65] per tubal ligation. Then there’s Rs 300 [CDN $6.80] for me as the surgeon. They give, I think, Rs 75 [CDN $1.70] to the person who refers the patient. But the costs have changed recently. Now it’s Rs 850 [CDN $19.30] for a tubal ligation as the ‘investment’ cost, and [the patient] gets Rs 150 [CDN $3.40]. Then there’s Rs 300 for the surgeon, then Rs 20 [CDN $0.45] OT [Operating Theater] charges, Rs 5 [CDN $0.10] chai, pick and drop money, etcetera. It adds up gradually. The Federal Government also announced special incentives for special clients, like those who have one child. On special days, like International Population Day, or other events, they

14 According the FPAP surveys, 9% of Family Health Hospital clients used condoms, and the hospital reported that 2% of their male patients had received vasectomies; in fact, this was the only service offered by the Family Health Hospital for men (FPAP, FHH 2004: 17).
15 Norigest implants are comprised of three to five small plastic ampoules, or ‘sticks’, which are placed beneath the skin on the inner, upper arm; these provide slow-release hormones, which inhibit ovulation much in the same way as birth control pills. These are generally effective for months to years at a time, depending on how many are used.
are awarded Rs 5 to 7,000 [CDN $114-159] as special cases all throughout the country.” (Dr. Alam, FPO: September 4, 2005)

Cash bonuses for a patient’s ‘contraceptive performance’ were not offered at the Gilgit Medical Center, where Family Planning promotion was quietly interwoven with women’s everyday treatment. Contrary to widespread characterizations that Sunni women were too ‘shy’ (sharam; U) to discuss Family Planning, Dr. Sharifa said her Sunni patients unhesitatingly shared their physical ailments, and lamented the stresses of raising small children. Contraceptive options were weighed up against a woman’s long-term family goals, her husband’s ‘co-operation’, and the number and gender of children already born. (As I will discuss in Chapter Five, when daughters were born, women felt it was harder to justify taking longer breaks between pregnancies.)

“With Family Planning, women will freely express their concerns regarding being continuously pregnant, if they’ve had three or four children in a row and want to stop, for instance. We will discuss the appropriate method for them, such as the ‘ring’ [IUCD], and we will explain the benefits for all methods, and let them decide what is appropriate for them. For instance, with birth controls – if a woman is breastfeeding and the baby is weak, or less than six months or one year – we explain it could affect her milk [production]. If a patient wants a long break between her children, then the IUCD. Women will listen, and then tell us they will discuss the choice with their husbands. If a woman does not understand what we are saying, though this happens rarely, she will have her husband come in and see us, but here there is a question of privacy. We don’t have an extra room, and people are concerned about talking about such matters because the sounds [to the waiting room] just carry across. But I have never refused to talk to a husband about any health issues.” (Dr. Sharifa, AKHS,P: May 15, 2005)

On another occasion, Dr. Sharifa clarified her general approach to patients seeking contraception. Her narrative underscores Family Planning as a family-situated practice and a symbolically overloaded concept.

“We have patients who come in...and talk about withdrawal – in my opinion, this is not many people or couples who practice this – and for others we talk about natural methods of Family Planning, such as the ‘safe period’, which means to avoid the fertile days. For patients with infertility, we provide them the opposite advice – to pay attention and have relations on the fertile days. For some patients who want to avoid conception, I will joke with them that on those fertile days they should ‘Jugurah kuro! Laraiey kuro!’[make a fight, argue; U]. In general, with Family Planning it is a difficult subject, and women might say,
‘Our husbands are not loving us, that’s why they won’t allow us to use it’, or, that it’s a big 
gunah [sin; A] in Islam to avoid conception.” (Dr. Sharifa, AKHS,P: May 12, 2005)

Against Dr. Sharifa’s instincts, I had discovered that a substantial proportion of Sunni families used withdrawal as their primary contraceptive method, in great part because it was one of the few contraceptive measures explicitly approved of by the Hadith Al-Sunnat, where it is referred to as ’azl (see Tober et al, 2006: 52). In Jutial, one mother of nine children described ’azl as a highly-reliable ‘family tradition’ among her in-laws, and mournfully commented she had only learned about it after ‘too many’ pregnancies.

“In Islam this is permitted, we can do it. It’s an easy system to discharge outside, isn’t it? Pfiifi’s [auntie; U] husband Musa uses this method. They have four children, all the family on this side are using this method. My daughters use it, too. My daughter Sarriya is late for her period now, and she and her husband were using this method. Sarriya said to me, ‘Maybe it went inside by mistake?’ For two or two and a half years we’re using this system and then try again. Some try again after four or five years. Lots of women have long gaps now. Before, I didn’t know about this…women didn’t tell me [about withdrawal], and now it’s too late!” (Ghulmana, Jutial: June 7, 2005).

Guided by their physicians’ suggestions, a number of my participants said they were aware of the ‘signs’ of fertility. Even among women who had not spoken to physicians, but who were troubled by the economic and physical hazards of frequent childbearing, some quietly tracked their menstrual cycles and tried to avoid sex on what they felt were their fertile days, with their understanding of conception tied simultaneously to Qur’anic scripture and periodic, doctor-suggested abstinence. “Sometimes we do avoid sex to avoid pregnancy – we are not letting [our husbands] have sex. After safai [‘cleaning’, U; the last day of menses] we will not have sex for one week afterwards then let them have sex” (Nazaish, Jutial: June 2, 2005). Ironically, their misguided sense of timing ensured women resumed intercourse at exactly the most fertile point in their menstrual cycle.

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16 For Iran, Diane Tober notes, “The teachings of the Prophet Mohammad and his direct successors (hadith) were also incorporated to demonstrate that contraception in the form of withdrawal (azl) was also practiced at the time of the Prophet” (Tober et al, 2006: 52).
Contraceptives were also sold at Gilgit’s dispensaries and even at several corner stores. During my 2004-2005 fieldwork, a number of local dispensaries were franchise members of the Greenstar Clinic Project, a national-level NGO that in Pakistan’s urban centers operates independent Family Planning clinics, but in Gilgit was restricted to commission-based, low-cost contraceptive sales; “the Greenstar franchise is a network of more than 12,000 trained private health providers [including] male and female doctors in general practice, chemists and family health visitors” ([italics in original] USAID 2003: 7). Participating Gilgiti businesses displayed the Greenstar logo outside the shop’s front entrance; only condoms and birth control pills were sold in Gilgit, while Greenstar’s urban clinics also offered injectibles and IUDs (Agha, Squire & Ahmed 1997: 3). Both the FPO and FPAP had also made concerted efforts to recruit local dispensers to promote contraception use from their place of business, and act as informal, unpaid ‘Health Guards’ among their neighbours. At a local dispensary in Jutial, a short walk away from the cluster of households where I conducted a large share of my 2005 research, the dispenser Mukhtar showed me a well-worn FPAP booklet that he had been given during a contraception information session, which he had been paid generously to attend.

“I was…a Family Planning member for two years, in 1994 and 1995....With Family Planning, I went to Ghizer for a one-week course, through AKRSP, and there we learned how to give lectures and motivate communities....At the Ghizer course, there were two lady doctors from Karachi, one from the Aga Khan University Hospital, the other from Liaquat Hospital, and I was paid Rs 10,000 [CDN $227] for the ten-day course, plus my karchah [expenses; U] and lodging costs. Sometimes I still meet with other Family Planning members at government offices. The Government writes a letter to me, and other members, and provides a date for lectures and meetings. At the last meeting, there were around four hundred and fifty women and only two men – me included!...Yes, I was a little shy and uncomfortable about being one of the only men there, and giving lectures in front of all the women.” (Mukhtar, Jutial: August 2, 2005)

17 The recent spectre of STIs (sexually transmitted infections) among ‘China traders’ had prompted NGO-level discussions of how Family Planning and HIV/AIDs strategies could be dovetailed. But in the same way that the pressure to build families precluded women’s ability to ask for contraception, condom-use was problematically associated with women being “too knowledgeable” about sexuality, or signalled her mistrust for her husband and his marital fidelity (Blessing Hands: March 10, 2005).
Inspired by his early work, Mukhtar had tried to sell *satthi* (condoms; U), but whether it was due to his clients’ embarrassment at purchasing them from a family member (he was related to many of his Jutiali neighbours) or overall antipathy towards contraception, he had rarely made any sales and now no longer carried them in-stock. This still hadn’t prevented him from displaying a small poster-board in his shop’s front window for several years; it proclaimed ‘*Bucchey Doh Acchey Heh*’ (‘Two Children are Good’; U), and had been given to him during a 2002 ‘Family Planning Meeting’ he attended at the DHQ’s Family Planning Organization clinic. (Due to Mukhtar’s discontent with the poor quality of government-issued birth control pills, alongside his regularly being ridiculed for promoting Family Planning, he had recently removed it.) He kept his one FPAP booklet, entitled “The Concerns and Edicts of the *Ulema* Regarding Family Planning” (“*Islam and Khandanee Mansoobah Bandee Sey Muta’aliq Ulemaie Deen key Ifqar aur Fitawa*”, U; Fulowarwee 1964), inside a small folder underneath his front counter. But Mukhtar described the FPAP’s preoccupation with Islamic edicts as being in some ways misrepresentative of their client’s concerns. He remembered fielding only a very few queries from customers regarding the permissibility of Family Planning; “Maybe one or two people out of a hundred will ask me if *waqfa* [breaks; U] are allowed, and who express some concern to me about this” (Mukhtar, Jutial: August 3, 2005).

At the mosque near our home in Jutial, the Qari was deeply troubled by how often the Qu’ran was incorrectly attributed as the ‘source’ for local antagonism towards contraceptive measures. Against my own expectations, he had begun working to “re-educate” his congregation as to what Islam “actually” said about contraception, and the permissibility of breaks between pregnancies (Fieldnotes: June 12,

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18 After Wadood and I took a quick look, it was immediately clear that the language used by the pamphlet was virtually inaccessible to the average Gilgiti (also see Imran 1998; Urdu language). In their efforts to appease the disgruntlements of Pakistan’s *ulema*, who very often appeal to sophisticated literary genres in their treatises, mosque communiques or *fatwas*, FPAP had utilized ‘high Urdu’, replete with Persian and Arabic words rarely used in everyday conversation or taught in elementary school. The end result was that Mukhtar and Wadood sometimes struggled to decipher the full meaning of many of the arguments FPAP made in favour of contraception as being Islamically permissible.
2005). Notwithstanding his pro-Taliban stance and his ardent calls for the Shariat to be implemented as Pakistan’s primary legal code, the Qari preached that women were entitled to at least four years between pregnancies, an approach which was not far off the advice women received at the DHQ’s FPO office, the Family Health Hospital and the Gilgit Medical Center. The Hadith cited by the Qari to uphold birth spacing were, in fact, the very same Hadith employed by FPAP and FPO health promotion materials. (When I told the Family Health Hospital’s Project Director that the Qari at our local mosque supported birth spacing, he exclaimed; “This is the same, ‘Islamic’ approach we are trying to adopt and promote – the break being a right for women!” [Project Director, FHH: September 2, 2005]) Indeed, for the FPAP or FPO, establishing the Islamic permissibility of various contraceptive measures was seen as crucial for the success of community outreach or their clinical operations. To this point, the FPAP’s own literature demonstrates the calculated interweaving of Family Planning and Islamic discourse.

“After carefully studying the Holy Qur’an, it becomes clear that in the Holy Qur’an there is no text that prohibits people from limiting [stopping] the number of children they have. Even in the Hadith of the Prophet (Peace Be Upon Him), about such things we [may find] some guidance; scholars of the Islamic Shariat also accept [this guidance]. Every once in a while, we come across some Hadith from which we gain [additional] insight into such issues, but most [Islamic] scholars concur that ’azl (the time at which semen is lost ‘coitus interruptus’) is a lawful measure.” (Imran 1988: 1-2; translated from Urdu)

During one interview with the Family Health Hospital’s Acting Project Director, he claimed Qur’anic ayats had ‘proven’ contraception was permissible as long as it was used merely to lengthen the breaks between pregnancies (Fieldnotes: May 10, 2005). The FPAP’s approach was, quite deliberately, only slightly different from the Sunni ulema’s own approach to birth spacing.

19 In some ways, the Qari was co-opting biomedical Family Planning discourse and reframing it in Islamic terms. In other ways, by citing the Qur’an, Hadith Al-Sunnat and a wide range of Hanafi fatawas supporting temporary contraception, his suggestions drew on germane, Islamic edicts and popular tradition. Specifically, more religiously moderate Hanafi dictates argued that men and women were both allowed to use contraception as long as it wasn’t “permanent” (Fieldnotes: June 12, 2005). (While his mosque sermons were heard only by men, his mother actively shared his views during her visits to neighbourhood households.) The Qari’s message was simple, but provided husbands and wives a powerful opportunity to anchor their use of contraception in Islamic dictates, and cite the Qari’s own sermons as evidence that contraception was – at least in certain situations – halal (lawful; A).

Emma Varley
“It is not allowed for a wife to use birth control pills out of dislike for having many children or out of fear of having to support the children. It is permissible to use them to prevent pregnancy due to some illness that may harm the woman if she becomes pregnant or if she cannot give birth in the natural fashion but is in need of a medical operation to give birth. This and other cases are permissible due to necessity...If there is a necessity, there is no harm...This is also the case if she already has many children and it would become a hardship on her to have another one soon, then she may use the birth control pills for a specific amount of time, such as one year or two years, which is amount of time designated for breastfeeding, until she reaches the stage where she would be able to raise the child properly.” (Al-Musnad 1996: 163-164)

In deference to the *ulema’s* restrictions for women’s use of surgical or long-term contraception, the FPO had even begun promoting birth control using the acronym ‘CYP’, which stands for a “couple years of protection” (FPO 2005b: 11-14). But even after borrowing from Sunni *fatawas* to establish the Islamic permissibility of a ‘couple years of protection’, regional Family Planning proponents continued to justify contraception by reaching beyond Islamic doctrine, to appeal to Gilgitis’ ever-expanding family or economic concerns. At the FPO’s Family Planning and Population Control Office, Sherbaz Ali discussed Family Planning as envisioning “the whole family holistically, including with an understanding of children’s well-being, their education. It’s about quality of life, not merely population statistics and numbers” (Sherbaz Ali, FPO: July 28, 2005). This was not dissimilar from the FPAP’s approach, which also included working directly with Gilgit’s Ismaili, Shia and Sunni *ulema*.

“We had to clarify the relationship between Islamic principles and Family Planning, so we met with *ulema* and mohalla, or village-level representatives. These includes Mukkis [Ismaili clergy], Maulanas [Sunni clergy] and Ahol [Shia clergy], and we arranged training for them as well. We prepared workshops on Family Planning, about its benefits, what Islam says about Family Planning, spacing between children, mother’s health, economic challenges to growing families, breastfeeding and then sterilization. Once communities

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20 In fact, it was specifically this *ulema*-sanctioned approach to birth spacing that resulted in the FPO and FPAP’s ‘couple years of protection’ programming. But did ‘couple years of protection’, following in line with Islamic dictates, actually result in decreased birth spacing? From my own observations of village-based participants, breastfeeding mothers almost always enjoyed spaces of two or more years between deliveries. Nor did they claim to practice *'azl* (withdrawal) or any other contraception. As such, it became apparent that however unintentionally, the ovulatory suppression afforded by full-time breastfeeding already provided women with ‘breaks’ between pregnancies. Using contraception for one or two years may not, ultimately, have resulted in any substantial lengthening of birth spacing.
were made aware of Family Planning, people demanded contraceptives, and to know where the services were provided.” (Acting Project Director, FHH: May 10, 2005)

In a subsequent interview the following day, the Family Health Hospital’s Outreach Coordinator explained how the FPAP’s inter-sectarian ‘ulema training workshops’ attempted to:

“...integrate Islamic understandings with Family Planning practices. Family Planning is not just birth control, you know, but total care of a child from birth until the defined age of majority, which in Pakistan is age 18. It also includes a couple’s decision-making process vis-à-vis their child’s care, education and future progress. At another level, it involves a family’s socio-economic status, health and access to health services.” (Majid Hussaini, FHH: May 11, 2005)

According to these broad criteria, anyone raising a child in Gilgit could now be considered a practitioner of Family Planning. (Indeed, in Jutial I was told that a Sunni mullah had been describing his efforts to stop mohalla dispensaries from selling contraceptives as a form of Family Planning.) The FPAP’s careful extension of Family Planning concepts to include questions of family finance, education and well-being worked to simultaneously ‘normalize’ and de-stigmatize the concept. But by inserting the term into the scope of everyday family life, Family Planning organizations had robbed the term of much of its more problematic, political and ideological currency. The concept was now so over-extended that it risked being unassociated with those shifts in family sizing the FPAP and FPO deemed necessary for a family’s economic growth, or gains in women’s health decision-making. As such, the FPAP renewed their efforts to specify the exact benefits afforded by smaller families.

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21 At the Family Health Hospital, the ‘Girl Child Project’ was explicitly focused on involving younger generations of Ismaili women in education projects which supplemented their formal schooling. In turn, these extra-curricular projects were then dovetailed with Family Planning promotion. And as was the case for the majority of regional outreach organizations, the FPAP’s outreach efforts began in more amenable, Ismaili communities. “We selected fifty-eight girls, thirteen to sixteen years old by the project’s definition, to participate in different activities...These youth projects are instrumental to the future success of FPAP and women’s take-up of Family Planning practices. We provide them with Resource Centers, which have newspapers, books, FPAP brochures and indoor games. Through [this] they can read to learn, ‘What is RH [Reproductive Health]?’ Because most of the population thinks that Reproductive Health is a part of illness, rather than it being a normal, health part of life.” (Acting Project Director, FHH: May 11, 2005).
In addition to literature specifically addressing the Islamic permissibility of ‘temporary’ birth control measures, the FPAP had recently published an Urdu-language book, entitled “Anmol Mohtee” (“Pearls of Wisdom”; no date), which cited oft-used Qur’anic ayats, Hadith and more recent fatawas to extol and categorize the qualities of a ‘happy’, ‘successful’ and ‘smaller’ family, which was in turn described as the essential basis for a family’s “sehatmahn masharey” (healthy future; U) (Anmol Mohtee, Introduction: 2-3). Fathers with too many children were described as less likely to provide their wives and children with good nutrition or a proper education, which, in turn, left families vulnerable to poverty and ‘depression.’

Perhaps the most ironic consequence of Gilgit’s Family Planning programming’s emphasis on improved nutrition and increased access to ‘modern’ health services was that the age of menarche has dropped from sixteen to twelve or thirteen. Moreover, for in-town participants of greater economic means, their increasing preference for ‘modern’ bottle-feeding resulted in decreased breastfeeding or weaning and a faster return to ovulation among new mothers. By consequence, many young mothers became pregnant again far more quickly than women had in previous generations. Indeed, a substantial number of my participants claimed that Sunni women’s fertility rates are now higher than they were in the days prior to regional health development. Among my younger participants, birth spacing ranged between 10 months and two and a half years (see Chapter Three, page 202), whereas older women described gaps as long as four years between births, which they attributed to longer breastfeeding practices, and which might also be explained by lower protein- and fat- intake and a higher age of menarche.

Arguments in favour of family planning drew on verses in the Qu’ran that emphasize the importance of maintaining family harmony (Roudi-Fahimi 2005), and that extend the argument that if a family has too many children, tranquility in domestic life will be compromised...because large family size is positively correlated with poverty and high infant and maternal death rates, religious leaders determined family-planning

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22 Perhaps the most ironic consequence of Gilgit’s Family Planning programming’s emphasis on improved nutrition and increased access to ‘modern’ health services was that the age of menarche has dropped from sixteen to twelve or thirteen. Moreover, for in-town participants of greater economic means, their increasing preference for ‘modern’ bottle-feeding resulted in decreased breastfeeding or weaning and a faster return to ovulation among new mothers. By consequence, many young mothers became pregnant again far more quickly than women had in previous generations. Indeed, a substantial number of my participants claimed that Sunni women’s fertility rates are now higher than they were in the days prior to regional health development. Among my younger participants, birth spacing ranged between 10 months and two and a half years (see Chapter Three, page 202), whereas older women described gaps as long as four years between births, which they attributed to longer breastfeeding practices, and which might also be explained by lower protein- and fat- intake and a higher age of menarche.

23 Tober, Taghdisi and Jalili’s 2006 analysis of Family Planning among Shia Iranians and Sunni, Afghan refugees demonstrates important parallels between Pakistan’s Family Planning program and those found in neighbouring Muslim countries. “Arguments in favour of family planning drew on verses in the Qu’ran that emphasize the importance of maintaining family harmony (Roudi-Fahimi 2005), and that extend the argument that if a family has too many children, tranquility in domestic life will be compromised...because large family size is positively correlated with poverty and high infant and maternal death rates, religious leaders determined family-planning

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“I think it’s zulum [sinful; U] to go so fast, and have child after child. If a man’s wages are Rs 3,000 [CDN $68] and he has six children, this is ridiculous. How can he afford to manage school fees, housing, land costs, medical costs on such a small salary?” (Mukhtar, Jutial: August 3, 2005)

Overburdened husbands were described as failing to adhere to Islamic admonitions for wives to be treated equitably, to be allowed sufficient opportunity to breastfeed their children, or to have adequate ‘breaks’ between pregnancies and thereby maintain their overall health (Anmol Mohtee, Introduction: 3).

Indeed, “Anmol Mohtee” carefully highlighted Qur’anic ayats advising men to treat women with respect.

“And they (women) have rights similar to those (of men) over them in kindness.” [from ‘Aur aurotoh kah haq [marotoh pur] vaisah heh heh jaisey dustoorh key muta’biq (marotoh kah haq) autoroh purh heh.’] (Anmol Mohtee, citing Ayat 228, Surah 2 ‘The Cow’, Qur’an)

However, the FPAP’s deployment of Qur’anic ayats was not entirely unproblematic. After turning to the Qur’an to verify the authenticity of these quotes, Wadood quickly pointed how this ayat was not only completely disconnected from any discussion of contraception (the ayat was actually intended as guidance for newly divorced couples), but it had also been carefully editorialized to remove the final few words, which qualified that “men are a degree above them [women]” (Ayat 288, Surah ‘The Cow’, Qu’ran). By changing ayats to suit their own arguments, the FPAP were quickly discredited by Gilgit’s conservative ulema, who argued vociferously against any undue manipulation of the Qur’an or Hadith to suit ‘unIslamic’ purposes (though many of my neighbours quickly noted that the ulema were not above doing the same when the need arose). FPAP and FPO community outreach had also encountered a number of difficulties. According to Sherbaz Ali, the Sunni community’s sensitivities had been irreparably hardened due to the blunderings of several census and health surveys.24 While detailing the

programs were consistent with Islamic principles of promoting a healthy family (Hoodfar 1995; Obermeyer 1994)” (Tober et al, 2006: 52).

24 Despite critiquing the methods used by recent census surveys, Sherbaz Ali was intrigued by the very ‘modern’ benefits of population monitoring. “I had a friend [and] she told me ...that in the UK people are fully documented in real time. You can ascertain the population number at twelve noon, and over the next twenty-four hours you will know exactly how many people have been born, or arrived in the country, or left or died. Everything is properly recorded. Here I can’t begin to plan for this unrecorded, unregistered mob - and can’t prepare services for such a situation” (Sherbaz Ali, FPO: July 28, 2005).
cultural barriers facing FPO health workers, and which sometimes precluded in-community Family Planning discussions, Sherbaz recounted how

“…some people came from the National Institute of Population Studies, and contracted some of our local staff to work with them on a population survey, and they were using a questionnaire which asked about reproductive health, and asked questions of women, such as ‘How does your husband sexually approach you?’ and ‘What contraception does your husband use?’ These are difficult issues to confront, and in areas like Diamer we encountered some resistance.” (FPO: July 28, 2005)

At the Sunni Markaz, such missteps contributed to considerable debates concerning the FPO’s ultimate goals in shifting the nature of Sunni family life and marital conjugality. To the dismay of more conservative Sunni families, it was patently clear that FPAP programming had also associated Family Planning with women’s increased social mobility, education and earning potential. In this way, contraceptive use was symbolically imbricated with a wealth of religiously problematic, and some said ‘unIslamic’, behaviours and gender practices. The Family Health Hospital’s performance reviews, however well intentioned, had also re-framed Gilgiti women in ways that risked raising the ire of local Sunnis. Take for example the following passage drawn from the Family Health Hospital’s 2004 overview of their ‘Empowerment of Adolescents’ project:

“A positive impact was observed in the area where the adolescent girls’ activities were implemented. The parents are now allowing their girls to go for education in the Project-based Home Schools and even permitted them to participate in different social activities. This positive change has been noted even in some areas which were considered more rigid toward social change and the attitude for women and girls, thus the project has been able to shed the local custom of taking veil on going out door to participate in social activities.” (FPAP, FHH 2004: 55)

So in the same way that women’s bodies were marked for change, their comportment and dress were increasingly amalgamated in policy-based discussions of Family Planning. In consequence, this provided additional ammunition for Gilgit’s Sunni ulema who, not without justification, noted that most reproductive health programming was inextricably embedded within social practices foreign to local Sunni tradition, and henceforth antagonistic to those traits or behaviours valorized by Sunnis as essential
markers of sectarian identity. Nancy Cook’s 2006 analysis of Western women aid workers in Gilgit Town seems to validate the *ulema*’s preoccupation with imposed ‘social programming’.

“…in terms of philanthropy, most [come] to instigate socio-cultural reforms by revamping the local education and health system and ‘freeing’ Muslim women from an ostensibly oppressive culture through a transfer of Western expertise.” (Cook 2006: 232)

But while static modern/traditional binaries worked well to justify health program design or *ulema*-level opposition to Family Planning, in actuality, they were a poor reflection of the fluidities and flexibilities of Sunni family life. Rather than identifying Islamic conservatism as hindering their participation with ‘modern’ life, many of my participants described their social, gender and health practices as expressive of both ‘modern’ and ‘traditional’ modalities. During my in-town fieldwork I only very rarely heard a Sunni participant or their family describe Islamic values as antithetical to women’s education or economic empowerment. And as our local Qari’s pro-birth spacing stance demonstrated, not every conservative mullah was against Family Planning or would benefit from FPAP ‘*ulema* training.’

During my interviews with the Family Health Hospital’s Project Managers, they were quick to boast that despite local-level opposition, the hospital had provided “Family Planning counselling” to 35,239 patients, of whom 26,513 had become “new acceptors” (FPAP, FHH 2004: 16). However, the federal FPO’s June 2005 contraceptive performance summary painted a dramatically different picture, which suggests that Gilgiti women used local Family Planning clinics in different ways, or that different clinics attracted different kinds of patients. In June 2005, for the entirety of their Northern Areas operations, the FPO reported only 22 IUD insertions, 14 of which took place in Gilgit Town, while they reported only having a total of 83 ‘new’ and ‘old’ “acceptors” (FPO 2005c: 1). The very fact that the FPO’s numbers were so low (especially given the Northern Areas’ population size, estimates for which range between 800,000 [IUCN 2003: 12-13] and 1.5 million [HRCP 2006: 3]) speaks volumes about issues of access and the overwhelming

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25 In the documents I analyzed, it was unclear if the FPO’s ‘old acceptors’ figures reflected the number of clients who had made use of contraceptive services between January and May 2005, or if these numbers also included contraception clients from previous years.
The FPO’s Northern Areas June 2005 operations included 261 pre-natal and 203 post-natal checks; 851 visits involved treating children for general health problems, and 2,609 visits by adult men and women for their health complaints (FPO 2005a: 1). Similarly, the FPAP’s statistics demonstrated that even in a hospital specifically designated to promote Family Planning, the majority of their services dealt with pregnancy or treating infertility. Between 1999 and 2004, 18,220 patients attended the Hospital for pre-natal care, 2,177 for post-partum checkups, and 1,395 sought treatment for infertility (FPAP, FHH 2004: 13).

Part IV  Risks & Rewards

Despite a multitude of my participants using or having used contraception at some point in their married lives, there were still a wealth of stigmas and inter-generational anxieties associated with women’s use of contraception, particularly because women’s use was associated with sexual dominance rather than the more valued passivity. For instance, some women described how their requests for condom use might signal an ‘unIslamic’ interest in sex without procreation, in other words, sex purely for pleasure - active interest being a liberty only afforded to men. (In fact, it is important to note that men who used condoms rarely faced in-family recrimination or religious reprimands in the same way as their wives.) Given the insidious and punitive nature of neighbourly surveillance and gossip (ghaiebat; S), women often took considerable pains to ‘disguise’ the nature of their visits to the FPO or FPAP. In turn, health service providers accepted that successful service use was predicated on patient privacy and confidentiality. In autumn 2004, Sherbaz Ali discussed his efforts to conceal the types of services offered by the DHQ-based FPO clinic, where their office doors were marked with the FPO logo and the words ‘Family Planning.’ Even those patients attending pre- or post-natal checkups risked rumours that they were instead seeking contraception.

26 The FPO’s Gilgit District coverage also includes Family Welfare Centers in Baseen, a mixed-sect village at the western outskirts of Gilgit Town, Sharoot (a mohalla in the Shia-dominated village of Danyor), Sumair and Minapin (Shia villages in Nagar Sub-District), and the Ismaili-dominated village of Hussainabad in Hunza Sub-District.

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“We are trying to integrate FP [Family Planning] offices into other hospital offices, so people can get more anonymity or confidentiality when they come, so people won’t know if they are there for Paracetemol or the ‘Pill!’” (Sherbaz Ali, FPO: November 8, 2004)

But while the FPO worked to protect their clients from mohalla gossip, at the Family Health Hospital and Gilgit Medical Center, staff worked to protect women against the recriminations of their husband or family. At these two hospitals, administrative staff and physicians emphasized the need for a husband’s involvement in his wife’s health or contraceptive use. “We encourage partner-based decision-making for all reproductive health issues and Family Planning; there is no force on anyone, or from a husband to his wife” (Acting Project Director, FHH: May 11, 2005). By interweaving biomedical coercion with spousal abuse, physicians seemed to be establishing systematic equivalences between family life and medical practice; if spousal force was unacceptable and ‘out-of-place’, so too was medical intimidation.

Conversely, at the FPO’s DHQ-clinic, the LHV in-charge described how they had worked hard to preserve women’s ability to obtain long-term contraception, even in the absence of their husband’s permission.

“...mostly women come – alone - and some women hide from their husbands. I’ve put in IUCD’s so many times with no problems. If they want it for five to ten years, they need permission, but no – we don’t use his signature. I’ll just ask her if he’s accepting this...” (Haseena, FPO LHV: September 7, 2005)

Knowing that the consequences for hiding their use of contraception were often dire, with many women risking physical abuse or being erroneously labelled ‘infertile’ and thereby vulnerable to a polygamous marriage, many of my participants proclaimed they wouldn’t, and couldn’t, keep Family Planning a secret.27 For women who only had one or two children, the pressures were intense to continue having children. In this respect, the demographics underlying contraceptive use are telling; among what the

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27 For example, it wasn’t unusual for younger women to describe breaks between pregnancies that were longer than two years as indicative of infertility. ‘Presumed’ infertility warranted a great deal of public attention to a couple, with husbands and wives being interrogated by close relatives and neighbours about their sexual habits, and husbands sometimes pressured to take another wife. It is important to note that polygamy is gaining in ‘popularity’ among the Sunni middle-class, and can no longer be characterized as a ‘rare’ or infrequent practice. The same can be said for Diamer District, thanks in part to intensified Saudi proselytization.

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Chapter Four: Family Planning, Islamism & Pronatalism

FPAP called their “Family Planning New Acceptors”, 22% of women were the mothers of one or two children, 31% had three or four children, 28% had five or six children, and 19% were already the mothers of seven or more children (FPAP, FHH 2004: 18). Notably, none of their ‘new acceptors’ were childless, which is suggestive of the pressures on newly-married women to avoid delaying childbearing. The majority of their contraceptive clients were between 24 and 34 years of age (48%), while 28% of contraceptive patients were aged 35 and above. Interestingly, an additional 24% of users were between 15 and 24 years, which provides some insight into the number of patients who were already mothers at a young age (FPAP, FHH 2004: 18). At her home in Jutial, Ruqaiyah had only recently delivered her first baby, and was far more reluctant to quietly use Family Planning than one of her senior sisters-in-law, who had already delivered nine children and was noticeably overwhelmed. Moreover, Ruqaiyah framed her reluctance in moral terms, rather than invoking any sense of inherent ‘threat’ or ‘risk’ to her should she go against her husband’s wishes.

“Once my son was born, I said I wanted a two year waqfa [break], but he said he wants me to have another one after a year – year after year, he wants them! [laughs weakly] He wants as many as possible, as quickly as possible. I said, ‘All the pain I’m taking, what is your work except to tell me to make them more quickly?’ [laughs] I can’t use Family Planning secretly, because you should never lie to your husband. I don’t want to do this sort of thing. Men are always in power, you see, and it’s really up to him – not to me. Meh laraie nuhee kur sukhtee huh [I can’t argue]; if he believes I can use Family Planning, OK. Agr woh ismeh nuhee mantey heh [If he doesn’t believe in this], then I can’t.” (Ruqaiyah, Jutial: August 16, 2005)

As Ruqaiyah’s narrative demonstrates, some husbands specifically forbade their wives from using contraception because they wanted more sons. And for those of my participants who had only had daughters, many predicated future contraceptive use on the births of healthy sons (see Chapter Five for more detail). My neighbour Sherbano was pregnant with her fourth child after three daughters, and reflected on her ability to use birth control; “If Allah gives me a boy, I’ll give myself a waqfa [break; U] without asking [my husband]. I can hide it, and I doubt he’d care” (Jutial: June 15, 2005). Sherbano went on to argue that her marital discontents were reason enough to avoid conception.

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“My husband is not like other husbands. He’s not caring, so I don’t want other children with him. I feel more and more weak after all the deliveries, do all the housework, and usually my babies are born during the winters, and I wash all their nappies and my husbands’ clothes during the cold season.” (Jutial: July 7, 2005)

More ominously, one woman in Minawar said that forced sex was sometimes used by husbands against wives they suspected were using, or thinking about using, contraception.

[Naseema] “Rosh bin [they will be angry; S]. Sometimes men are scolding and verbally abusing us – some men beat. Other men, who are jaheel [ignorant, unIslamic; A] are very wild and rough in sex. They are like this before, but not after a woman is pregnant. We can eat medicine [birth control pills] quietly, as long as husbands maharosh ben [don’t know; S].”

[Dadi] “Men are always warriors! [laughs]” (Minawar: May 3, 2005)

For many of my younger participants, there were definite heroisms associated with their decision to fight for contraception, especially when their efforts raised the ire of local hardliners, pitted them against senior sisters-in-law and abundantly fertile relatives, or exacerbated the animosities or power struggles intrinsic to mother-in-law and daughter-in-law relations. In fact, many of my participants made specific reference to their mothers-in-law when we discussed contraception, its permissibility and if they had ever used it. Participants who self-described as ‘modern’ often claimed their mother-in-law was uninvolved with questions of contraception; as Ruqaiyah stated, “this discussion is really kept between [my husband] and me, and it doesn’t involve my Sas [mother-in-law; U]” (Jutial: August 16, 2005). Nonetheless, even more ‘modern’ participants felt there was no easy way to separate their marital sexuality from the interests and sometimes outright voyeurism of over-invested in-laws. When I asked Ruqaiyah who had the biggest influence over her health decision-making, she answered “My husband.” When I then asked her who had the biggest influence over her husband, without a pause she responded, “My mother-in-law” (Ruqaiyah, Jutial: August 16, 2005). Religiously conservative mothers-in-law were often deeply suspicious of the kinds of ‘awareness’ their daughters-in-law might receive from doctors or support staff during even standard Out-Patient visits, especially when they felt their daughters-in-law were interested
in contraception or birth spacing. Yet not all families or mothers-in-law were unsupportive of women’s contraceptive use. In Jutial and Amphari Mohallas, several women from one religiously moderate and relatively prosperous extended family discussed the role of family members in the decision-making process to use contraception.

[Emma] “Did anyone complain to you about using Family Planning?”
[Menahsat] “No, nobody complained. My mother khud khush thee [was happy; U].”
[Naeema] “I have two daughters. The older one is 2 years 8 months, and the younger one is 1 year 5 months. I had wanted a waqfa after the younger one’s birth – I had been feeling very weak, and the children were very difficult – they were crying all day, and all night long. I wanted a break not just for my health and well-being, but for theirs as well. My husband had been happy with my decision [for Family Planning], and supported me totally. There was no signature required for the ring [IUD] insertion, and I went with a small child [from my family] to the [FPO] clinic to get it done.” (Amphari: August 12, 2005)

[Madheeya] “After the last baby, my husband didn’t want me to have anymore…. the baby’s loss [death] had caused me so much pain. Bas, bas, bas [enough, enough, enough; U]! We have more than enough! Sometimes my husband was talking about the tukhleef [difficulty; U] caused by tez [fast; U] deliveries, but he didn’t stop his work! My mother sometimes told me that I needed a break, that I was getting weak, but my mother-in-law never said such a thing; they are not sympathetic with us, only with their own daughters.” (Jutial, June 7, 2005)

Notwithstanding a rising age of first marriage, increased female education and a wealth of locally available health promotion literature lauding the benefits of ‘breaks’ between childbirths, steadily rising in-town and village-based fertility rates can be correlated with improved nutrition, a lowered age of weaning (from two and three years to eighteen-months) and by consequence, reduced birth spacing.\(^\text{29}\)

Ironically, it was because birth spacing had decreased so radically among many in-town residents, some women – and their mothers-in-law - began describing childbearing in onerous terms.\(^\text{30}\) When babies

\(^{28}\) In ways that might have added to religious conservative mothers-in-law’s anxieties, the physicians I interviewed suggested that because of the recent expansion of government and private school curriculum addressing ‘science’ and human biology, their patients already had a good understanding of conception, fertility, pregnancy and infertility, which made physicians’ discussions far less awkward.

\(^{29}\) For most of my participants, this meant they had attended school up until Matriculation, or Class 10; some had even received university graduate degrees.

\(^{30}\) Take for example one woman’s summary of her reproductive history; “I was 13 at the time [of marriage], and I’ve been married now for 17 years. My elder son is fifteen years old and he was born two years after I was married and I
arrived, one after the other and in quick succession, some mothers-in-law complained they were ‘tired’ of helping out.

“...the mother-in-law will often say, ‘Don’t have them too quickly, otherwise who will do the work – with the zamin [land; U], children, animals, cows?’ If we are pregnant too much, they are unhappy. But, if there are two to three years between children, then they are rosh bin [angry; S].” (Madheeya, Jutial: June 2, 2005)

Encouraged by their knowledge that our local Qari favoured more moderate interpretations of the Qur’an and Hadith and supported temporary contraception, a number of my Jutial participants unhesitatingly confirmed they had used contraception at one time or another during their married lives. (It is worth pointing out that each of these women was already the mother of more than three children. Madheeya, for example, had given birth nine times before having a tubal ligation.)

[Ayesha] “I was never band [closed, ‘sterilized’; U], but my husband and I used illaj unkey turuf sey [treatment from his side; U].... I’ve used condoms for three years after [my son] and then had my daughter.” (Jutial: August 16, 2005)

[Madheeya] “I was using the ring [IUD] before, but it didn’t suit me. Then I had a small operation with my bachitani [uterus; U]....[before daughter Hussen] I never used birth control, there was no waqfa for me, I would have sons and daughters year by year. But after Hussen I put a coil in. And after Shailah [and] before Wahab, I had injections every three months.” (Jutial: June 7, 2005)

[Meher] “I took injections, tablets, desi bilehn [traditional medicine; S].” (Jutial: August 18, 2005)

[Mariya] “After Saleema [second child], I had the coil put in – and now [after third child] I have the coil.” (Jutial: June 7, 2005)

[Naeeema] “I used condoms with my husband after the older child was born, and one sister used condoms but it broke! [laughs]” (Amphari: August 12, 2005)

There were other times, however, that I learned it wouldn’t be so easy to accept my participants’ claims of using Family Planning at face-value. Our local dispenser in Jutial was always quick to decry the

have five children. I lost one and now it’s been two years with no more children. I had a boy first, then another boy one year and three months later – then after two years I had a mulai [girl; S] then after a puroh doh sal [two full years; S] another girl, then after one year and some months a boy, then one year and two months later another boy with an operation [C-section], but he died at birth” (Nabeela, Jutial: July 18, 2005). In the thirteen years between her first and last pregnancy, Nabeela delivered on-average every 2.16 years.

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speed with which many of his neighbours had children. He had pointed to himself as an example of the ‘modern’ benefits of deliberate, extended birth spacing.

“In my own family, look, my first child was born and we waited five years before having the second. Then, we waited three years before having the third – my little daughter. What’s the rush?” (Mukhtar, Jutial: August 3, 2005)

In an interview with his wife several weeks later, Noreen provided a very different account.

“One year after marriage, we had a daughter. Three years later, I had a son who died at seven months. One year after my son’s death, my daughter was born but died at two and a half months. One and a half years after my daughter’s death, my youngest daughter was born.” (Jutial: August 16, 2005)

Such examples confirmed that for some Gilgitis, the symbolic salience of Family Planning carried more weight than Family Planning as an actual practice. And in the same ways that Diane Tober’s query, “‘How many children is enough?’” prompted her Iranian and Afghan participants to respond in ways that were more often reflective of “ethnic differences than religious differences” (Tober et al, 2006: 62), my Gilgiti participants’ answers reflected shifting inter-generation values, modern/traditional and urban-rural divides. Take for example, one exchange between Mehnasat, a thirty-year old mother of three, and her mother Madheeya, the mother of eight. While Mehnasat described the “ideal family” as two boys and one girl, her mother countered that “three boys and two girls” was better (Jutial: June 16, 2005). In an earlier interview, Madheeya had noted:

“I think five children is enough, but I’ve had eight. Changes are coming and nowadays people are not having more than five. Eight to ten was normal before, when there was no Family Planning.” (Jutial: June 2, 2005)

To my dismay, even after securing the support or permission of their husbands or in-laws, I found that some of my participants’ efforts to obtain contraception weren’t always well supported by their health providers. In early summer 2005, my brother-in-law, Haleem, asked me to accompany his wife, Mayordana, to the Gilgit Medical Center for an IUD insertion; they were the parents of two small boys, ages 8 and 4, and a daughter who had just turned one year old. (They had lost their second child, a daughter, due to diarrhoea when she was ten months old.) Mayordana had been born and raised in
Diamer District’s fiercely conservative Dudeshal Valley, where allopathic contraceptives were virtually non-existent. After living in Gilgit for ten years, she bemoaned a lack of ‘free time’ to do necessary housework, and cited frequent fatigue as her primary motivation for the IUD. Their decision was well supported by Wadood and I, but vigorously opposed by my mother-in-law, who felt they still hadn’t had enough sons. When Mayordana arrived for her consult during the Out-Patient clinic hours, and even after ascertaining Mayordana would accept an IUD, I was astounded to hear the on-duty OB-GYN tell her to ‘go home, talk to her husband, and think about it’ (Fieldnotes: August 18, 2005). Given how rarely rural Sunni women sought contraceptive services from AKHS,P, I had understood Mayordana’s gesture to be a somewhat heroic one, and was disappointed in the doctor’s initial reticence to reward this bravado with immediate support, especially because my sister-in-law and I had assured her that Haleem had given his consent.

Part V
Surgical Sterilization, Medical Malpractice & Client Dissatisfaction

Because of Sunni and Shia edicts against surgical sterilization, tubal ligations and vasectomies were cautiously implemented by the FPO and FPAP. Mindful of the social risks associated with permanent contraception, AKHS,P had very deliberately avoided including surgical sterilization in their Family Planning services, and focussed their clinical attentions instead on emphasizing ‘healthy pregnancies’ and ‘safe births.’ Like AKHS,P, the Family Planning Organization had opted to sidestep contentious and highly politicized debate on the Islamic permissibility of sterilization, and instead of offering sterilizations

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31 It is worth sharing the end of this story, once the doctor had agreed to help. “Dr. ‘X’ said if Mayordana wanted a longer break – four, five, six years – she should use the IUCD [ring] and it would be inserted and no problem at all for her health, and offer good protection. She asked Mayordana how long a break she wanted and Mayordana said one year, but I reminded her she had said four or five years, and she agreed happily….Dr. ‘X’ said the ring would be best, and told Mayordana to lie down and she would do a PV [pelvic] exam and ultrasound to see if Mayordana was OK for the ring method. I left the room. I stood outside for perhaps 5 minutes, when Dr. ‘X’ called me in to see the [ultrasound]. ‘There’s something here, Emma. I did an examination, and we have found that she is pregnant. There is something else inside, however, that concerns me.’ It was a shadowy portion on the left side of the uterus – beside a 10 week gestation fetus with a beating heart, I could see. She suggested perhaps it was a demised twin. She said, ‘You see, she told me she had her period a week ago, on August 13, but it was bleeding that was lighter than a normal period she said, and it was a threatened abortion – actually. This is why we can’t rely on people’s histories, and must check additionally on our own.’ Dr. ‘X’ laughed and added, ‘Maybe I have wasted my words now on her!’” (Fieldnotes: August 18, 2005)
at their in-town clinics, they had opted to quietly under-write the FPAP’s mobile sterilization camps and surgeries conducted at the Family Health Hospital. But even the FPAP had struggled with widespread social and Islamic resistance to their surgical services. The Family Health Hospital’s Acting Project Director, a Shia from Baltistan, recounted the FPAP’s efforts to introduce sterilization as a viable option for Gilgiti families and the challenges they faced.

“There are definitely limitations in our services, especially with sterilization, where it is absolutely clear that this is not allowed in Islam. The juma [Friday prayer; A] congregation said that sterilization is not permissible in Islam, and it is genocide. But waqfa [breaks; U] between babies are admissible [sic]. Because of all the education materials, services, motivation and outreach, communities have learned enough about contraception and then felt it was worth the risk to have sterilization services for men and women….For our vasectomies, we sent a doctor to China for technical training, where they had strict vasectomy technical criteria and introduced a non-scalpel method of vasectomy.” (Acting Project Director, FHH: May 10, 2005)

Because sterilization had the potential to place women in jeopardy with their in-laws or at risk for divorce - in addition to doctors facing targeted attacks by families caught unaware by the surgery - women’s sterilization cases required a husband’s signed consent. This had not, however, been enough of an obstacle to prevent some women from forging their husband’s signature for a tubal ligation.

“Sometimes men will come in later and ask how the surgery was performed without their permission, saying ‘I can’t even write my name, how can I sign a signature?’ or ‘My wife has done a fraud on me, and now I will divorce her!’ Yes, this has been the basis for several divorces that I know about.” (Dr. Latifa, FHH: May 11, 2005)

Thanks to the FPAP’s annual, mobile surgical sterilization ‘camps’, between “1986 to 2001, the Family Health Hospital has provided contraceptive surgical services [for] 6548 clients (5286 female and 1262 males)” (FPAP, FHH 2004: 8), a figure of which Dr. Latifa was quick to boast in my first meeting with her in the Acting Project Director’s office.32 After she and the Director had lightly grilled me on my own family history as the wife of a Sunni and mother to three children, Dr. Latifa proclaimed, “We’ve performed six-thousand tubal ligations on women in Gilgit since 1986, you know! We’ve had great

32 This statement is somewhat deceptive, in that the Family Health Hospital was opened in August 2003. Instead this refers to the FPAP’s Northern Areas outreach clinics, which between 1986 and 2001 were administered from the Model Clinic.
success in the area, and most of our patients are Sunni. If you’ve only been married for seven years and have three children,” she said with a wink, “you’re a bad example of Family Planning!” (Dr. Latifa, FHH: May 10, 2005)

But in marked contrast to the claims of senior FPO or FPAP Administrators who said Northern Areas Sunnis were comprehensively antagonistic to sterilization, I had learned that surgical sterilization had become increasingly popular among conservative Sunni families, even with Hanafi fatwas specifically prohibiting contraception that irreversibly affected a man or woman’s fertility. (In this way, the FPO and FPAP had failed to distinguish between individual and community-level discourse concerning Family Planning.) For example, and notwithstanding their fierce conservatism, many Diameri patients and their families arrived at the Family Health Hospital well-versed in contraceptive methods, surgical sterilization and the hospital’s maternal health services. Rather than tubal ligations signaling a shift in their social beliefs, or a move away from Islamic strictures towards urban ‘modernity’, an obstetrician who had worked at the Family Health Hospital for nearly a year provided a more pragmatic rationale for Diameri contraceptive use.

“They want permanent, long-term solutions due to the costs of going to and from Gilgit for treatment, or additional Family Planning methods like the Pill or injections, which aren’t feasible due to the distance. Many of them already have many children at a young age, and are positive that they don’t want any more children. If they’ve had four or five children, it is hard to come to Gilgit to deliver subsequent babies, so it is risky. Many women marry at an early age, so by the time they are twenty-five years old, they already have five or more children. Normally, doctors will advise against a tubal ligation...if a woman is thirty years old, she’s too young. But here, they will agree to tubal ligations at a much younger age because of the number of children already born. These women are very forceful, and put great pressure on doctors to achieve results.” (Dr. Sumairah, AKHS,P: April 29, 2005)

But because higher-quality clinical facilities like the Gilgit Medical Center refused to provide surgical sterilization, Sunni families seeking safe and carefully managed sterilization had nowhere else to turn but the FPAP’s Family Health Hospital. As a direct result of several, well-publicized deaths at FPAP mobile health camps, my participants were sometimes hesitant to use their services. Doctors’ accounts and my
participants’ personal recollections of botched surgeries provided disturbing evidence of the role of improper surgical techniques and insufficient hygiene in maternal morbidity and mortality rates.

“I remember they [FPAP] used to have rural clinics where once in Singal [Ghizer District] in 1993, I witnessed them conducting forty to fifty tubal ligations in one day. They would lie one woman down, perform it under local, and then lift her up and the next lady would lie down. At this clinic, a team from Pindi came, there were maybe three doctors, and they would wear three or four surgical gloves at one time. After one surgery, they would peel off the top one and use the one underneath....two to three years ago several women died post-operatively from tubal ligations. I’m not exactly sure how it happened, but you should check their record of operations and post-operative figures.” (Dr. Sharifa, AKHS,P: May 12, 2005)

“...the union council chairman [in Ghizer] told me about 2 women who died after a tubal ligation camp, and one woman was 20 years old and left behind 2 children.” (Dr. Farman, Domyal: September 4, 2005)

“...they [FPAP] said they would operate on me for not having more babies. In the operating room, they opened up the woman on the bed next to me, and the doctor saw there was a baby of 4 months inside, and they scolded the mother and father for coming in when there was a pregnancy, so they sewed her back up again – I saw this with my own, big eyes! This woman had 4 girls and 5 boys but no periods for two to three years. She [had] thought, ‘Now we should operate because my periods are not coming.’ At that time the baby was surviving, but I don’t know what happened in the end. She was on the other bed, and I saw this myself!” (Zeenat, Jutial: July 11, 2005)

In two separate interviews, it was quickly apparent that IUDs were also responsible for a host of preventable health complaints, which had then irreparably harmed women’s faith not only in contraception, but also their physicians. Although they were generally inexpensive to purchase and have inserted (at the Family Health Hospital, LHVs estimated the device and insertion cost to be Rs 300 [CDN $7]), unless women could prove the IUD’s failure or associated problems resulted from a doctor’s mistake, improperly ‘placed’ IUDs cost substantial amounts in order to have them removed. In our more cynical moments, my participants and I mused that contraceptive ‘malpractice’ may have accounted for substantial hospital or private physician revenues.

[Shabnum, sister] “You should talk to my sister – she is pregnant again, even after using Family Planning!” [Laughs, and points to her sister who has just come in the room.]
[Naeema, sister] “I got pregnant even after they inserted the ring at the [FPO Office] DHQ – after one year I got pregnant although the ring was still inside. I hadn’t been having my periods for a while, and I went to the hospital for a check-up. They said, ‘You’re weak, that’s why you’re not having your menses’ and they told me that if my periods stopped, it wasn’t a problem, but it was a problem if I was bleeding too much. But then I went for an ultrasound at Dr. Shakoor’s office, and he said I was already five months pregnant! Dr. Khalthum had referred me to see Dr. Shakoor. I did a blood test too at DHQ, and they said I was already 5 months – I had gone there to be checked and they sent me to Dr. Khalthum, who looked at my reports and told me to go to Shakoor. I went back later to complain to the Sisters who inserted the ring – one said she had done a course in Karachi – but the Sister who did mine wasn’t there. On the ultrasound, when he checked, Shakoor said the ring had come out by itself – nazhar nuhee aayah [he couldn’t see it; U] – and the baby was 6 months, and totally thik thak [OK; U]. I didn’t notice it come out by itself, though. I had wanted a waqfa [break; U] of maybe five or six years – the doctor told me that if you’re very weak, sometimes the ring comes out by itself. At the Family Planning office, many women were coming to complain of problems just like mine – other women were there for injections. Many said their ring had come out. There are only 2 nurses working there – no doctors.” (Amphari, August 12, 2005)

[Mehnasat, daughter] “After I had the coil put in, I had bleeding problems for ten months. For a few days I would be pak [ritually pure, clean; A] for namaz, and then maybe sometimes a week, then the bleeding would start again.33 Dr. Sunbool had put the coil in, and I felt kidney pain afterwards. I had gone to Dr. Yasin and he scolded me, saying ‘Don’t do this, you are very young – and it affects your kidneys – you are the wrong age!’ I had put the coil in at the Family Health Hospital, and Dr. Sunbool said it was in its proper place, and she would charge me Rs 1,200 [CDN $27] for its removal. She said it was in its proper place, and the problem was with my kidneys so she would not remove it. …but later Dr. Latifa, the Medical Officer, said it wasn’t in its proper place and the uterus had turned blue, so she removed it. I had been going every week before that because of the bleeding, and Dr. Sunbool would charge me and give me medicines for my kidneys, and then change the medications. But the medications didn’t work. For the whole ten months I was going every one to two weeks to see her, and she’d change the medications but to no effect. The bleeding was light, and during that time I was restless.”

[Madheeya, mother] “One Bhabhi [sister-in-law; U] had a coil put in, and after seven months the baby was born with the coil stuck in his face, and at the same time the baby died.” (Jutial: June 7, 2005)

Despite my having spoken to a number of women who said their IUD’s had been improperly inserted or ‘lost’, the LHV in-charge of the Family Planning Organization’s primary clinic beside the DHQ instead

33 Participants described IUD-related breakthrough bleeding as particularly bothersome because it prevented women from engaging in either namaz (prayer; A) or sex.
claimed, “In one hundred [patients], perhaps one or two ‘fall out’ by themselves if they’re not put in properly by the LHV; if it’s put in carefully, it stays” (Haseena, FPO LHV: September 7, 2005). To add, very few women were warned about the IUD’s side effects, which include missing up to three menstrual periods. As a result, a number of women falsely believed they had become pregnant even after receiving the IUD. Injectable contraception (such as Depo Provera) was associated with a much wider range of problematic side effects than the IUD; these included prolonged menstruation and frequent breakthrough bleeding, which was sometimes severe enough to cause anaemia (Fieldnotes: August 12, 2005). Women also worried that using birth control pills would irreversibly weaken them, and prevent them from doing household chores or having more children. Prompted by the sermonizing of local Tablighi Jamaat members, one domineering mother-in-law in Minawar said she’d warned her now-infertile daughter-in-law about using contraception; “if you eat medicines, you’ll get weaker and be unable to eat or work - they will make you sick and you’ll be unable to have children later, see?” (Mia Begum, Minawar: April 28, 2005; also see Winkvist & Akhtar 2000: 77) From his dispensary, Mukhtar confirmed that because of his clientele’s regular complaints about condoms failing, or problematic side-effects from the birth control pill (many government-provided pills were ‘high dose’ and more likely to cause nausea for the first few months of use), he eventually discontinued contraceptive sales.

“They [FPO] didn’t give us good quality medicines and 90% of people complained, while 10% were OK….even educated people, men and women, came to complain about the medicines, saying ‘We’ve used the Family Planning, but we’ve become weak, our digestion is a problem, we have breathing and lung problems, vomiting’ - all these were side effects of the pills, so they would discontinue the pills, and we would give them intramuscular injections of ‘Heepotirt’, which stops children for three months at a time….some women have kidney problems if they take the injections. From the DHQ office we are advised about the Family Planning medications, and we specifically asked their distributor there about side effects with the injectibles and pills, and later we said ‘No more!’ to the distributor because of the problems. They [had] told us there were absolutely no side effects from the injectibles, and only some minor and temporary ones from the pills. One female cousin in our own family experienced side effects from the drugs, some
of our customers’ side effects automatically went away after several months, but some side effects remained... No one came to get additional medications, because they weren’t satisfied. Here only one company makes birth control pills – Wyeth – and another kind of pill is made here in Pakistan under a U.S. licence. We’ve received no complaints about the Wyeth pills; ‘Orale’ were OK. The Pakistan government makes birth control pills, but we don’t sell them here. We had them before but not now because they failed; they were Rs 8 [CDN $0.18] but there was no quality; one woman was taking them but now she’s eight months pregnant, so you can see what happened! [laughs]” (Mukhtar, Jutial: August 3, 2005)

During a group interview in Amphari Mohalla, participants who had once used contraception were quick to attribute poor contraceptive quality as the primary reason they discontinued using Family Planning.

“Nowadays, all things – even Family Planning – are of Number Two quality. Look at my ‘ring’ [IUD] – it didn’t work!” (Naeema, Amphari: August 12, 2005) It had hardly helped that the FPO had begun providing free, high-quality intrauterine ‘copper coils’ (IUDs) to an untrained dayah who had recently established an NGO in an Ismaili-dominated mohalla.

“Well, Shubahz runs a multi-purpose center...she came to me recently for 50 copper-T rings the other day, and I gave them to her. She does IUCD [and] I understand she does deliveries and post and antenatal care – she worked at Family Health Hospital before.” (Dr. ‘X’: September 4, 2005)

With Shubahz Dayah’s practice said to be rife with medical ‘accidents’, I wondered how many women might have been injured in the process of obtaining contraception. To my amazement, especially because IUDs are not intended for more than five years worth of use, one of Shubahz’s assistants described how

“We get assistance from Family Planning and other associations. Shubahz has some of the latest coils and rings – there is no chance to get pregnant...With ours, you can keep it in for even 15-20 years! Some weak [women] have it removed after 20 weeks.” (Zeenat, Dumoni Health Trust [pseudonym]: September 8, 2005)

Even condoms were discussed as having problematic health consequences for women, so much so that one participant exclaimed, “It’s bad for women, isn’t it!” (Hussen, Jutial: August 11, 2005) One middle-aged woman in Upper Jutial readily admitted her husband used condoms for at least part of their married life. But she was quick to blame condoms for a bevy of gynaecological ailments which ensued each time they had used them. As much as it initially sounded like an unlikely scenario, Gulsoori’s
explanations soon seemed entirely plausible. Many wives were hesitant to urinate and ghushl (ritually purify; A) after night-time intercourse because the sounds of washing might awaken the rest of a crowded extended family household, who would then know what ‘had happened.’ (During occasional visits to my in-laws’ home, Wadood always discouraged me from washing except during ‘normal’ morning hours, in part because he was trying to avoid the shames that would accompany my usual preference for early evening baths.) But by avoiding ghushl after sex, women left themselves vulnerable to urinary tract infections, which if untreated, sometimes progressed to kidney infections.

“We stopped using [condoms] because I was getting sick, and having pain in my sides, and blood in my urine, and burning when I mikki [urinate; S]. Dr. Latifa told me I had ‘rubbish’ and jeraseem [germs; U] in my kidneys. When we started to use the condoms, I got sick, and took so many medicines, pills, capsules. I saw so many doctors for this. I wanted a coil [IUD, ‘ring’] and injections from the doctors….but the doctor told me it would make my infection even worse and it could become cancer. Dr. Sunbool at the Family Health told me. Poor Sunbool and Latifa – they did so much for me but weren’t able to fix my problems.” (Ayesha, Jutial: August 16, 2005)

As much as doctors found this type of attitude ‘quaint’ and ‘uneducated’, I soon found there may have been an association between previous contraceptive use and secondary infertility.34 Many younger women had heard stories that secondary infertility was a frequent complaint among women who used the IUD. The same was said for injectibles, including Depo-Provera. One of my neighbours, the mother of two small girls and desperately tired of being pregnant, said to me that her primary fear of contraception was its rumored potential to cause infertility. “I’m a bit scared. I know someone who had a boy, then a

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34 Regional health surveys fail to account for women’s fears that contraception would fail or irreparably harm their health, or discuss in-family pressures against Family Planning. Instead, the Northern Health Project survey found that, across Gilgit District, 23.2% of 100 married women wanted more children, while 41.5% were not using contraception because they were already pregnant or breastfeeding; only 6.3% of women indicated that their husbands’ objections underlie non-use (Rahman 1999: 23). To add, 3.4% of Gilgiti women answered that they avoided using contraception due to health concerns. Interestingly, in Sunni-dominated Diamer District – where many of my participants had said women would be comparatively more interested in having children than their Gilgiti relatives - only 15.8% of 100 women indicated they wanted more children. Moreover, 1.1% of Diameri women indicated their husbands were the reason they were not using Family Planning. In a separate portion of the same survey, women (including those who were, and were not using contraception) were asked if they would use Family Planning at any point in the future; in Gilgit District, 69.2% of 289 respondents answered ‘yes’, while only 22.3% of 300 Diameri respondents answered affirmatively (Rahman 1999: 24).
Chapter Four: Family Planning, Islamism & Pronatalism

girl, then used [hormone] injections and now can’t get pregnant again” (Fouzia, Jutial: June 15, 2005).

Several physicians were aware of the possible correlation between contraceptive use and primary or secondary infertility. They were also concerned that when women used Family Planning prior to having their first child, women’s subsequent infertility might be unduly blamed on contraceptives. When I had asked Dr. Sharifa and Dr. Sumairah what methods they suggested for young couples, they both answered:

“...condoms, pills, injections...but I think that these are not good in early marriage. Every method has its side effects. Sometimes after using Family Planning for two to three years they come in and we diagnose infertility issues, although they may not be connected directly to the Family Planning methods. If the woman and man have a family who are present, and able to help them care for the baby, I advise them not to wait too long.” (Dr. Sumairah, AKHS,P: April 29, 2005)

“We urge them to have their husband’s consent first, and for 90% of them we advise them to use condoms rather than pills or injections. We do this so if there are any future infertility issues, where mothers-in-law might blame a couple or a woman for using Family Planning, people cannot say it was because of the pills or injections.” (Dr. Sharifa, AKHS,P: May 3, 2005)

Disappointed by contraceptive quality or failure, some women had begun turning to desi bilehn for birth control. Women’s quiet efforts to prevent conception included water or goat’s milk douches after sex, or making cloth ‘diaphragms’ and surreptitiously inserting these prior to intercourse. Mohammad Isa, an Astori herbalist who sold his wares across from Gilgit’s main banks, showed me a small bag filled with dried flowers, still attached to their stems.

“You take this for ten days with dudh [milk; U]. You see, it looks like an empty bachitani [uterus; U]. The woman eats it at night, and she has to avoid the bistrah [bed; U] with her husband for the days she is taking it. This is called dareiy [S], and you can have it with kacheel [S] and sher [S]. You take a pinch-full every night, and you must take this – and all other [desi] medicines – after taking food. It costs Rs 50 [CDN $1.13] for about ten days worth. It works rozana [all the time; U], one-hundred percent! And she’s band humesha key liyeh [closed forever; U]. It’s from Astore, from high upon the mountain off a tall tree. There are no side effects, none, from desi davaie! I have only this one medicine for Family Planning.” (Mohammad Isa, Gilgit: August 20, 2005)

And women weren’t the only ones who felt contraceptive use or surgical sterilization could incur significant, lasting health harms. While women felt that tubal ligations were responsible for a wide array
of abdominal pains, which they blamed specifically on the surgery’s effects for the uterus or ovaries, many husbands were deeply hesitant to have vasectomies because they were rumoured to make men weak. “Some husbands have done a surgery [vasectomy], but my husband is scared. He is already sick and weak, and is the only son in a family of eighteen people” (Gulsoori, Jutial: August 16, 2005).

Importantly, men’s fears drew on Islamic discussions that argued the ‘proper’ ejaculation of sperm was essential for balanced health; condom-use and vasectomies both impaired ‘full’ ejaculation and resulted in a ‘harmful’ build-up of sperm. Take for example, the following passage from an Islamiyaat book concerning Prophetic medicine:

“The best doctors state that sex is one of the best methods to preserve good health. Galinus [Galen] said, ‘The essence of the sperm consists of heat and air, and it is hot and wet because it is produced from the pure blood that feeds the essential organs.’...When sperm is congested in the body, it will cause certain ailments, such as obsession, madness and epilepsy. Discarding it, on the other hand, helps cure many of these elements. When the sperm is kept in the body for a long time, it becomes spoiled and turns into a toxic material that can cause certain ailments.” (Al-Jauziyah 2003: 222)

I had also wondered if men feared that after being sterilized, they would be vulnerable to being labelled with the same derogatory or stigmatizing terms usually reserved for the infertile or childless (bhanche, U; shohnee; S) (see Chapter Five, page 297), whereby infertile men were not only seen as ‘weakened’, but also vaguely emasculated. Women were more accustomed to being described as kamzoree (weak; U), and faced far less social stigma than men should they be seen as physically frail or ‘delicate,’ in part because such qualities appealed to the stereotypical, valorized dimension of ‘feminine’ traits, bodies or behaviours.

**Part VI ‘Failed Uptake’: Islamist Pressures, Fertility and Pronatalism**

In order to better continue my discussion of the counter-pressures impinging on women’s contraceptive use, or to explain women’s preference for more children, the remainder of this chapter focuses on the effects of Islamic conservatism, and the ‘modern’ co-opting of marital sexuality and reproduction by even ‘liberal’ elements of Islamic discourse. Even though many prominent members of Gilgit’s ulema had established the Islamic legitimacy of temporary birth spacing, mullahs based at the Sunni Markaz and
conservative mosque-complexes across Gilgit Town, remained vehemently antagonistic to any form of contraception. Gilgit’s anti-Family Planning  ulema shared their views through masjid sermons and fatwas, conservative Islamic periodicals or at political rallies. Whether Shia or Sunni, the  ulema described Family Planning as being among a number of ‘threats’ to religious identity; these included ‘secularism’, women’s education initiatives and Pakistan’s failure to fully implement the Shariat. Their arguments were carefully tailored to respond to Family Planning discourse, and indeed, often mimicked the discursive structure of Family Planning health promotion. Where FPAP and FPO materials argued temporary contraception was not explicitly disallowed by the Qur’an, conservative mullahs counter-argued that nowhere in the Qur’an was contraception explicitly sanctioned. And while the FPO and FPAP relied largely on specific Hadith in favour of ‘azl, conservative  ulema argued that the Muslim individual’s responsibility (zimwaree; U) was to prioritize Qur’anic stricture ahead of secondary sources, including even the cherished Hadith Al-Sunnat.35

The  ulema’s vocal protests against Family Planning’s ‘unIslamic‘ influence on marital sexuality, reproduction and childbearing provided beleaguered Family Planning advocates yet another opportunity to characterize the Sunni community as ‘regressive’ or resistant to ‘modernity.’ In trying to explain why Sunnis ‘failed’ to use contraception (an approach whereby women were often characterized as either recalcitrant, slightly obtuse or overpowered in their reproductive decision-making), the vast majority of physicians and nurses predicated non-use on the harshly ‘uncaring’ and ‘inequitable’ polemics of Sunni conservatism, a view that was shared by a number of more moderate Gilgiti Sunnis (Fieldnotes: July 28, 2005; September 4, 2005). Moreover, biomedical personnel located women’s use or non-use of Family Planning within traditional/modern - and more problematically, Sunni/Ismaili or Sunni/Shia - binaries. To this point, Dr. Sharifa noted:

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35 Ironically, and even despite their admonitions for husbands and wives to prioritize the Qur’an against Hadith supporting temporary contraception, the  ulema’s sermons and Islamiyaat anti-Family Planning literature were usually anchored in and ‘legitimated’ by Hadith.
“...the [Shia] shaykhs are against Family Planning; they say how many children you have is God’s concern, not yours. Men hear such messages at mosque, but it is difficult to translate what the mullah says to daily life and its needs. Women want less children, as do men, but [Sunni] mullahs and [Shia] shaykhs say Family Planning is gunah [a sin; A, U].” (Dr. Sharifa, AKHS,P: January 7, 2005)

According to one dispenser, a number of colleagues working in other stores had discontinued contraceptive sales after facing covert or direct intimidation from ‘local Sunni militants’ or fundamentalist-inclined mosques (Waris Khan, Yadgar Chowk: August 2, 2005). In light of the tacit threats or social antipathy surrounding Family Planning, more religiously-observant participants were largely reluctant to answer questions concerning Family Planning, and deferred instead to religious discourse. For example, during one interview with a homeopathic physician, he refused to discuss Family Planning, preferring instead to emphasize his sectarian identity and loyalties.

[Emma] “Can you tell me about Family Planning, if patients come to you for that?”

[Dr. Farman] “I’m Shia, you know, and we obey first the Hazrat Imam Ali....” (Domyal: August 24, 2005)

Many participants declared that the Tablighi Jamaat in particular had added intense pronatalist pressures to married life. In Minawar, Wadood’s cousin Phoonurh described how, at the local mosque

“...mullahs say you should believe only in Islam, and you can only stop having babies after twenty to twenty-five children. The child you avoid conceiving could be a big mullah one day, they say, and you are also stopping all their future generations from being born. All Tablighi people are saying this, preaching this, mohalla dawat [instruction for the area; U]. They also are khalee namaz dawat din [only giving prayer instruction; S], preaching in the mosques. Our husbands hear this and come home and tell us, and tell us not to stop our pregnancies. We are helpless in this; we are afraid of God, and our husbands.” (Minawar: May 3, 2005)

Tablighi took particular pains to emphasize the potential ‘unborn’ as both male and pious. The idea of another son was almost always appealing because of the material and emotional benefits accompanying the birth of boys. But because their lives had been so seriously compressed by male-dominated conservatism, many of my Minawar participants were far less interested in the idea of one day having a mullah in their
immediate family. Among more religiously progressive or educated families in Jutial Mohalla, women were sometimes openly antagonistic to Tablighi sermonizing. 

“It’s really none of their business, and the men and mullahs don’t understand all the trouble, suffering and work women endure to be mothers – being pregnant, payda huoa heh [giving birth; U], breastfeeding, caring for them, and all the other housework related to married life. It’s not their business if women stop their pregnancies or not, awah nay [right, no; S]?” (Samina, Jutial: May 4, 2005)

Yet despite their vocal protests against increased pronatalism, many of Jutial families continued having babies regularly, apparently without using contraception for breaks between pregnancies. In the midst of women’s dissatisfactions with the misunderstandings and emotional oversights endemic to male-female relations, perhaps the fear of God and sin or the competitive value of sons remained.

Motivated in part by their efforts to either legitimate ‘larger families’ or safeguard themselves against in-family fights over their use of contraception, a number of participants were increasingly reliant on a wide array of situation- and context-specific fatwas to help clarify Islamic positions on contraception, girls’ education and pardah. Some of these fatwas were prepared by Pakistan’s top clerics, as well as by prominent mullahs at Gilgit’s Sunni Markaz and its massive madrassah complex, the Jamiat Nasrat’ul Islam. Visiting seminarians to the Markaz from across Pakistan, South Asia and Saudi Arabia presented Juma sermons that placed a heavy emphasis on the role of Islamiyaat materials in everyday family life; foremost among these were the “Tafsil Qu’ran” (“Clarification of the Qur’an”), “Riyadh us Salieen” (“Gardens of the Faithful”), the “Tablighi Nisab” (“The Syllabus of the Tablighi”), and the revered Sahih Al-Bukhari (see Khan 1996, English translation). Moreover, there were a wide variety of Urdu-language manuals specifically intended to answer or resolve issues related to piety, prayer, bodily comportment and veiling, as well as married life and conjugality. In many respects, these Islamiyaat materials represented the efforts of Pakistan’s Sunni ulema to co-opt and ‘Islamize’ discourse it viewed as ‘modern’

36Among my Sunni participants and in-laws, the Sahih Al-Bukhari was the most popular compilation and commentary on the Hadith Al-Sunnat. See Chapter One, page 72 for a discussion of the Islamiyaat texts used by Gilgiti members of the Tablighi Jamaat.
or potentially threatening to Sunni precepts. Evidence of this is provided by the number of books or pamphlets extolling the benefits of love in married life, affirming women’s spiritual equality or advocating women’s ‘Islamic right’ to education. These messages ran in stark contrast to the Gilgiti ulema’s past conservatisms, whereby even forcibly arranged marriages were characterized as adhering to an Islamic ‘norm’, where love between spouses was a socially disruptive force, and women’s education was tantamount to heresy. These tensions only served to reaffirm the existence of ideological and religious dissonance not only between Sunnis and non-Sunnis, but also between conservative and moderate, regional and national, and national and supranational forces.

There were also an increasing number of ‘question and answer’ Hanbali- and Hanafi-Sunni Urdu-language texts specifically addressing questions women had concerning reproduction, women’s physiology and fertility.37 Besides being popular among women in-town participants, Wadood said these were also widely read by Sunni men. The sum effect was that because of Family Planning-focused Sunni proselytization, mosque attendance, rallies and the wide array of Islamic literature synthesizing ‘scientific’ and ‘Islamic’ discourse concerning marital sexuality, fertility and reproduction, Gilgiti men were able to claim a much greater awareness of women’s ‘issues’ than the previous generation. By consequence, whatever knowledge-based and practical authorities women had once enjoyed over issues of their body or reproduction were now being invaded by the subtle pressures and educational efforts of Sunni missionization. A number of conservative mullahs - especially those who sermonized from the Sunni Markaz in Konodas Mohalla - were increasingly concerned that health promotion campaigns were teaching women how to monitor and manage their fertility. In response, Sunni men were urged to pay closer attention to their wives’ menstrual cycles in order to counter-act whatever covert measures women might be taking to avoid conception, such as abstaining from intercourse during ‘fertile days.’ This led to

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37 The Hanbali-Sunni fiqh predominates in Saudi Arabia, while the majority of Pakistani Sunnis adhere to the Hanafi-Sunni fiqh. Generally speaking, Hanafi-Sunnis will only turn to Hanbali-Sunni dictates should the Hanafi fiqh fail to answer their concerns or provide advice for specific situations.

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men gaining knowledge of women’s health in ways that had once been traditionally stigmatized, or accessible only to a woman’s mother-in-law, mother or sisters.

“Sometimes when I’m asking a woman what her LMP [last menstrual period] was, she’d even go outside and ask her husband – who will know. Or, women will bring in a slip of paper with her last menstrual date written on it; her husband will have written this.” (Dr. Sharifa, AKHS.P: May 12, 2005)

Dr. Sharifa’s observances powerfully contradicted widespread assumptions among health policy proponents that religiously conservative Sunni couples refrained from sharing more ‘intimate’ details with one another, or deferred to the traditional boundaries between men and women’s bodily knowledge. (It even contradicted the responses of some of my male Sunni participants.) Among recently written Islamiyaat manuals, many acted as the contemporary extension of the Deoband movement’s careful, 19th-century extrication of ‘unIslamic’ customs (riwaj; U) from women’s lives (see Chapter One, pages 71-74).

But while the Deoband’s primary women-directed manifesto, the “Beheshti Zevar” (“Ornaments of Heaven”, English translation; Thanawi 1997), directly named, described and then condemned a wide range of South Asian cultural traditions and health practices as being unIslamic, contemporary social manuals inferred what was unIslamic by not addressing it at all (see Majeed 2005; Majid 2006). But because many contemporary Islamiyaat manuals represented extraordinarily weak scholarship, or were bound up with competitions between Saudi-styled Wahabbist strictures (derived from the Hanbali fiqh) and Pakistan’s Hanafi-Sunni Tablighi Jamaat, the potential for misinterpretation or multiple interpretations on any one Qur’anic ayat or Hadith was enormous. In Wadood’s extended family there were regular in-
family and inter-generational debates or conflicts concerning which Gilgiti *rīwāj* or in-family practices constituted germane and verifiably Islamic practices.

An example of the ways in which even clearly promulgated Sunni tracts were misrepresented or deliberately misinterpreted to suit Gilgiti traditions was evidenced by some of my participants’ discussions of breastfeeding practices. Among Gilgiti women living in Jutial, there were heated arguments about when a woman should wean infants. Some women felt that continued breastfeeding was necessary up until two years so as to prevent them from becoming pregnant again “too quickly” (Fieldnotes: June 16, 2005), while others felt that, depending on the baby’s gender, women could feed for less than the Qur’ānically endorsed two years. In a discussion with me and her nephew’s pregnant wife Ruqaiyah, Razia, the peri-menopausal mother of nine children, took time to clarify what she thought were Islamic stipulations concerning weaning.

[Razia] “For girls we’re told to breastfeed for one and a half years. For boys it’s two years. It’s an Islamic requirement. It’s in the *Tafsil Qur’an*, in this book. We didn’t see it with our own eyes, but the *ulema* tells us, and we accept their words.”

[Ruqaiyah] “It’s in the second part of the Qur’an, and in a book called ‘Beheshti Zevar’ which means ‘Heaven’s Jewelry’ – that’s us, women…it’s a book for women in Urdu and I’m completely literate so I can read it all. If we don’t understand something, we can go and ask our elders.”

[Razia] “I don’t know why boys get more milk, it’s just that Islam says they should, and ordered us only to do this.” (Jutial: June 16, 2005)

After carefully combing through the Qur’an and an English translation of the Urdu-language “*Beheshti Zevar*,” it was apparent that there was, in fact, no ‘Islamic’ differentiation between how boys and girls should be breastfed or for how long. My participants’ creative fusion of local beliefs, Qur’ānic *ayats* and contemporary Islamiyaat manuals demonstrated women’s careful efforts to legitimize the attentions they lavished on infant sons. Shorter feeding periods for baby girls, and women’s own awareness that pregnancy often followed quickly on the heels of weaning, were also evidence of women’s desire to try to the other, but...scholars are by no means infallible, inviolable, or...always in agreement with each other; they are judged by their practice as well as their knowledge, whereas the texts themselves are indisputable” (26).
conceive sons as quickly as possible after the birth of a daughter. But this superimposition of local preferences to Islamiyaat materials was also a tactic wholeheartedly embraced by many of my participants’ husbands and fathers. During my interviews with Wadood’s women cousins, three generations of women took time to debate the permissibility of contraception within Islam.

[Phoonurh, niece] “Islam says it is a big sin to stop having pregnancies. That is why I’m afraid and haven’t stopped having children.”  
[Nadia, aunt] “Having three or four children is enough already!”  
[Phoonurh, niece] “My father was reading the Qu’ran the day before, and he said that even a short break between babies is gunah [a sin; A]!”  
[Nadia, aunt] “God doesn’t want you to suffer with too many pregnancies, though!”  
[Phoonurh, niece] “Then why have I had nine children?”  
[Dadi, grandmother] “Men are the problem here. Trchekay [look; S]...after 40 days [post-partum recovery] they go right back to sex. Only if a man leaves can a woman stop having babies.” (Minawar: May 3, 2005)

Unlike my Minawar participants, the majority of whom were illiterate or could only read Arabic, most in-town participants could also read and write Urdu. Even if they were ultimately unable to change their family’s minds about contraception, they derived obvious satisfaction from being able to easily ‘check’ the Qur’an or Islamiyaat sources to see if the fatwas, ayats or Hadith used against them by their husbands or families were authentic. Over the past decade, and especially in families aligned with the Tablighi Jamaat, Gilgiti brides were regularly given a set of Urdu-language Islamiyaat books intended to help guide young wives through the tumultuous first years of married life, adjust to their in-laws and even co-wives, and cope with homesickness. Our neighbour, Faridah, had married her first cousin after completing Matriculation when she was seventeen. Her husband, Iqbal, was in his mid-twenties and delighted to marry the prettiest of his maternal first cousins. Because her mother had only shared a set of

41 When Wadood asked Phoonurh’s father to identify this particular passage in the Qur’an, her father (who is also Wadood’s maternal Uncle) grew visibly agitated and argued back that by questioning him, Wadood was questioning Islam. He refused to admit that there was, in fact, no such ayat.
42 Many men in Minawar, although they were uncertain about ‘secular’ education initiatives for girls, took great pride in their daughters being able to read and recite the Qur’an in Arabic. In Minawar and Sakwar’s Sunni communities, several girls-only madrassahs have been opened specifically to train girls to become a Qur’an Hafiz (someone who has memorized the Qur’an; A).
43 In my in-town participants’ homes, I noticed families often possessed an Urdu translation of the Arabic Qu’ran, unlike Minawar families, who tended instead to own Arabic-only Qur’ans.
fairly confusing allusions to what ‘sex’ entailed, Faridah was left instead to intuit the forthcoming ‘trial’ by thinking of how animals mated. She found this a terrifying prospect, and for the first few weeks after their nikah and shahdi (wedding party; U), she remembered lying stiff as a board and completely unresponsive beside Iqbal.

“I didn’t know about sex when I got married, not really...my husband said to me, ‘Look, you’re such an educated girl and you don’t know about these things?’ He gave me a book, ‘Nikah Ka Tohfa’ ['Marriage Gift'; U] to read and learn from, and in the book it tells you how to do everything! Like...[laughs] those things! About ghusl [ritual washing; S]...I was kafee chotee [quite young, small; U] and scared. I didn’t know about sex before the wedding, and thought we were only supposed to sleep together on the same palang [bed; U]. For the first week after our marriage he didn’t touch me, then he explained it to me and gave me the book, and I read it to learn what is supposed to happen. I was scared about it. I was in Class 5 when we had our dua [were engaged; A], and for the whole next nine years I hid from him...After the shahdi [wedding party; U] there is no privacy....of course we’re shy, because they are small houses, with so many people. We’re even avoiding to sit alone in a room with our husbands.” (Faridah, Jutial: June 8, 2005)

After talking with Faridah that day in June, I’d asked Wadood to drive me to Gilgit’s largest Sunni religious bookstore, ‘Harooni Comunications.’ Excited and encouraged by Faridah’s suggestion that there was, in fact, an Islamic book that described sex and helped prepare brides for marital conjugalitly, I bought a stack of the ‘most popular’ women’s books and periodicals (Fieldnotes: June 8, 2005) To my dismay, they were tepid treatises on the spiritual merits of being a good mother, a good wife, a good daughter-in-law. But because many of their ‘lessons’ were anchored in stories from the Qur’an and Hadith Al-Sunnat, books such as “Kitabun Nikah” (“The Islamic Marriage”; Ragie 1994), “Tohfa-e-Khawateen” (“A Gift for Muslim Women”; Madani 1999) or “Tohfa-e-Dulhan” (“A Gift for Muslim Bride”; Majeed 2005) represented the continued efforts of political Islam, working under the guise of benevolent sermonizing, to shape and Islamize the most mundane or intimate of everyday practices. There was little apparent differentiation in the advice provided to men and

44 While Shias valorize the life and practices of the Prophet’s daughter Fatima (the wife of the fourth Caliph Ali, the Shia community’s spiritual progenitor), Sunni treatises praise the behaviour and piety of the Prophet’s favourite wife Ayesha (who was the daughter of the first Caliph Abu Bakr). She is attributed as the primary source for
women, except men’s manuals were shorter and filled with admonitions to treat co-wives equitably in polygamous marriages, while also emphasizing men’s intellectual and ritual supremacy. Women’s books placed a heavy emphasis on chastity, wives’ obligations to serve their in-laws and to maintain their attractiveness and sexual availability to their husbands in case his ‘glance’ might stray to another woman. And rather than directly address questions of contraception or birth spacing, which then risked mullahs having to discuss ayats affirming temporary contraception, the ulema’s pronatalist position instead emphasized questions of marital sexuality and physical affection, and advised women how to improve their attractiveness to their husbands.

“A woman should regularly apply perfume that her husband likes because perfume makes her more attractive and enhances their love…it creates a sense of vigour and it is also pleasing to the angels. Just as the eyes are messengers to the heart…the nose also shares this privilege.” (Majeed 2005: 356-358)

In a continuation of male/active and female/passive binaries, the intensity of men’s attentions to the smell, sight or feeling of women’s bodies was not supposed to be reciprocated. The Islamiyaat literature describes women’s bodies as inherently sensual, submissively receptive objects. Gilgiti men and women were quick to recite a well–known Hadith as proof of women’s marital obligations to provide sexual satisfaction for their husbands; “’When the husband calls his wife to bed and [she] refuses, thus causing him to sleep displeased (with her), the Mala-ikah [Archangel Michael; angels] curse her until morning’” (Hadith Bukhari quoted in Majlisul Ulama 2000: 23). The only exceptions were if a woman was menstruating, whereupon sex was described as a deviant act and religiously impure.45 To this point, women were often warned that because of the temporary inability to have sex, they risked losing their

hundreds of Hadith, many of which are regularly invoked by mosque discourse as evidence of women’s capacity for patience (sabr; A), virtue, bravery and modesty.

45 While Gilgits roundly described the menstruating body as ritually polluted (jehnabat; A), my participants agreed that women were not to be held responsible in any negative sense for their bodies being off-limits and unproductive. My participants said because menstruation was ordained by God, it was a ‘deficit’ for which women would be forgiven. Yet women were still admonished to reduce their ‘unattractiveness’ during menses, and disguise the ‘smell’ of their menstruating bodies with musk or perfume.
husband’s ‘attentions.’

According to “Tohfa-e-Dulhan” (Majeed 2005), with its advice largely reliant on the Hadith of the Prophet’s wife Ayesha, menstruating wives were encouraged to foster other kinds of marital intimacy.

“When Hazrat A’isha was experiencing her menstrual cycle...he [the Prophet] would lean his head into her room...so that she could wash and comb his hair....It is therefore wise for a woman to sometimes apply perfume to her husband’s body and clothing...she will also be rewarded for practicing Sunnah [Prophetic traditions; A] if she combs him.” (Majeed 2005: 358-359)

Some texts had even begun advocating new couples, particularly after arranged marriages, be sent on (sometimes forced) honeymoons, to become better acquainted and help dispel any of the sexual anxieties that accompanied marriage between strangers (Majeed 2005: 359-361). The primary objective was to avoid a miserably unhappy Chand Rat (‘Moon Night’, first intercourse; U), an experience typically associated with arranged marriages.

“My mother didn’t really tell me about it [sex] - khas nish [no news; S]. I knew a little bit on my own. But at the time, my whole body was tense and I was sweating. I was so nervous! I was scratching at him till blood was running! [laughs] Now sometimes he teases me, saying ‘Remember you said, ‘Why have you married me, mother and father? This is your fault!’” (Rubeena, Jutial: August 18, 2005)

In more moderately well off, ‘modern’ Sunni families, honeymoons were optimistically viewed as a crucial first opportunity for couples to become acquainted, and enjoy sex without being spied on by younger family members. Some brides described hoping that they would conceive their first child during this time, which would concretize the marital bonds and, by proving their fertility, demonstrate they were worthy of their in-laws’ choice for their son. This pressure to conceive was noticed by local physicians; “Women think they should be pregnant as early as possible after marriage - two to three months after their shahdi” (Dr. Sumairah, AKHS,P: April 29, 2005). Indeed, in their efforts to deflect attention away from the few Qur’anic ayats and Hadith that permitted temporary contraception, or long-

46 It was not uncommon to hear religiously conservative men in Wadood’s family cite menses as one of the reasons why men were ‘compelled’ to take another wife. Pronatalist mullahs took this a step further, to specifically argue that a husband should enjoy the opportunity, and in fact had the right (denoted by the Arabic word ‘haq’) to ‘sire offspring’ as often as possible.
term contraception under specific circumstances, conservatists had foregrounded the much larger
time and Hadith lauding childbearing and motherhood. Prominent among these is one Hadith
collected by Ibn Hibban; “Marry the child-bearing, loving woman for I shall outnumber the peoples by
interesting was that even though Pakistan’s conservative ulema had once argued that marital ‘love’ was
an invention of the over-sexed Western world, Urdu-language Islamiyat texts and pamphlets now
declared ‘love’ (ishq, mohabbat, pyar; U) was an essential ingredient for happy, Muslim spouses. Books
such as the “Az-Zaujaus Salih” (“The Pious Husband”; see Majlis-Ul-Ulema 2000a) or “Al-Mar’atus
Salihah” (“The Pious Woman”; see Majlis-Ul-Ulema 2000b) used various Hadith as evidence of the
‘Islamic’ importance of marital love, and to encourage physical intimacy, foreplay and affection between
a bride and groom.

“‘Allah loves a man who caresses his wife. Both of them are awarded Thawaab [God’s
acceptance of their repentance; A] because of his loving attitude and their Rizq [earning; A]
is increased.’” (Hazrat Abu Hurairah quoted in Majlis-Ul-Ulema 2000a: 83)

“When a husband clasps the hand of his wife with love their sins fall from the gaps
between their clasped fingers.” (Majlis-Ul-Ulema 2000a: 83)

“According to Rasulullah (Sallallahu Alahi Wasalaam) [the Prophet; A], the rahmat (mercy) of
Allah Ta’ala cascades on a couple when the husband glances at his wife with love and
pleasure and she returns his glance with love and pleasure.” (Majlis-Ul-Ulema 2000a: 83)

Even though women’s ‘bridal manuals’ referred to conjugality only by polite inference, there were a
variety of books that were far more explicit. With their advice (naseehat, U; see Majlis-Ul-Ulema 2000b)
derived from the Hadith, and their remedies integrative of humoural medicine and diet, Prophetic
medicine texts valorized the ‘healing’ or ‘pathologic’ properties of marital sex. They also provide
important insights into the ways desire, sexuality and reproductive potential were intertwined.

“One should avoid having sex with an old woman, the very young who are not ready yet
for sex or do not desire it, an ailing woman, a woman who isn’t comely or a hated
woman....Having sex with a woman who is having her period is not allowed in the
religion and by the nature of things, as it is very harmful and the doctors warn against it.
Furthermore, we should state that the best sexual position is for the man to get on top of
his wife after having fondled and kissed her….The worst sexual position is for the woman to get on top of the man during sex, because it is against the natural way that Allah has created….In this case, the man will not be able to ejaculate all of the semen and whatever remains will get soiled and harm his body. Also, this position might allow some harmful moisture to descend from the woman’s sexual organ to the penis. Also, the womb will not be able to hold on to the semen in this position and thus conception will be more difficult. Further, the woman is and should be the receiving party and when this position is turned around and she becomes the giver, the act will go against the natural way.” (Al-Jauziyah 2003: 226-228)

And in ways that continued from men’s ‘Islamic’ fears that condom use or sexual positions might hinder ejaculation and thereby unbalance their bodily humours, Imam Ibn Qayyim Al-Jauziyah (2003) specifically added that intercourse between loving spouses was ‘healthier’.

“Having sex with a woman that one loves will not weaken the body and will expel the semen more effectively. Having sex with a woman that one does not like will weaken his strength and will not expel sufficient amounts of the semen congested in his body.” (Al-Jauziyah 2003: 227)

One of the key problematics stemming from Islamic pronatalism and religious agendas that framed marital conjugality and reproduction as a primary means to remedy the Gilgiti Sunnis’ demographic and economic disadvantages, was that discourse advocating that a wife’s ‘natural’ right to sexual pleasure ran counter to Gilgiti women’s own sensibilities. With certain exceptions - namely if infertile women were trying to become pregnant or women were trying to recapture their husband’s interest - many of my participants equated sexual interest with ‘seduction.’ In turn, seduction was associated with the desire for pleasure. There was intense hostility directed towards women who were thought to ‘enjoy’ sex - which women routinely referred to as kacho kom (bad work; S) (Fieldnotes: September 8, 2005) - so much so that they were likened to ‘whores’ (cunjuree; U) (Madheeya, Jutial: May 3, 2005). One of the central exemplars of a Gilgiti woman’s modesty, piety, family subservience and marital submission was her sexual chastity; for men, one of the primary attractions of marital intercourse (if also frustrating at times) was their wives’ earnest plays at avoiding sex. But if women were encouraged, as the Islamists suggested, to actively take pleasure in their sexuality, this unsettled the passive-dominant binary on which

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'successful' Gilgit married life was predicated. During a fairly heated discussion between mothers in Jutial, one middle-aged mother emphasized, and not without considerable pride:

“Women don’t start or initiate sex with their husbands here – they wait for their husbands to start it. For so many years, I’ve never felt pleasure, I’ve never tried to initiate sex. I have so many children, but still my husband wants sex. He complains that ‘You are a woman, you should be garam [warm, hot; U], and if you don’t want it you are cold, and you should go back to your own [parents’] house!’ If we eat light foods, cold foods, this means we want sex less. If we eat warm or garam cheez [hot things; U], then we will want sex. Because of this we give our daughters no eggs or kebabs so they are not hot. I am one of seven sisters, and we are all the same; we are not hot with our husbands. We are thinking that women who have not had hot things at a young age, before menses, they will not feel pleasure with their husbands. Women who feel pleasure with their husbands, their character is not good. They are like a prostitute; cool sexual temperament is better. My buree mulaie [big girl, eldest daughter; U] has told me that she has never felt pleasure with her husband. [smiles] During intercourse, women should keep quiet, because the husband is the right one to feel pleasure, not us.” (Musama, Jutial: May 3, 2005) 

Although in this quote, Madheeya acknowledged sexual desire was an unavoidable aspect of women’s adult lives, controlling it and channelling sexual energies towards housework and childrearing, or sublimating it through diet, were the preferred coping measures. Instead of exhibiting sheepish naiveté, my Sunni women participants frequently talked, joked and gossiped about sex. As Madheeya recounted, “Yes, [women] do discuss sex with each other, and with details – yes, we joke about it too – give details – how long it lasts, how often – I don’t know about more than this” (Jutial: June 2, 2005). But I soon realized the only acceptable discussion among women was one affirming their repugnance for sex, how it afforded them no pleasure, how women who showed pleasure were essentially no better than prostitutes, or how women were impatient for their aging husbands to lose sexual interest or ability. Women deliberately shared in this discourse of ‘disinterest’, one that reflected their ambivalence about female sexuality or the awkwardness of marriage to close relatives. Only a few women clarified how, whether feigned or real, such disinterest was an intrinsic element of foreplay or gendered sexual agency.

47 Other women were more vehemently antagonistic to women’s sexuality; “If my daughter told me she enjoyed sex, I’d tell her dufah jao [go to Hell; U]! I will scold her, saying ‘Look what you say! I’ve come to hate you because of it!’” (Raheema, Jutial: September 8, 2005)
In trying to understand why women’s pleasure was viewed – at least publicly – in such negative terms, particularly in light of Qur’anic admonitions for men to engage in foreplay and ‘prepare’ their wives for intercourse, I talked at length with Wadood about men’s own perspectives on sex. He said that in traditional beliefs, if a man climaxed, his partner would by consequence climax at the same time. Moreover, when a woman attained orgasm, desi beliefs suggested that vaginal discharge during intercourse was analogous to semen (mahnee, pani; U) and facilitated conception. With this in mind, I realized women’s avoidance of pleasure might also be an attempt to avoid pregnancy. Moreover, there were other ways women tried to prevent pregnancy. While observing patient visits to the Family Health Hospital, I noticed several women ask Dr. Sunbool and Dr. Latifa to help reduce their husband’s sexual appetite. Although I was unable to follow-up with these patients, I wondered if besides reflecting Gilgiti women’s traditional appeals to sexual ‘modesty’, this wasn’t also a quiet attempt to decrease the frequency of intercourse and avoid conception.

“...some women will tell me that their husbands have too much sexual desire, or interest in sex – and they will ask me if I have anything, any medication, that they can give their husbands. This hasn’t happened very much here in the office; one lady, in particular, asked me this by telephone. But they [women] say this is a big problem for them. The men here are too frustrated, and have no other outlets...so they use their wives. It’s not like in other cities [with prostitution]. One lady asked for this medicine to lessen her husband’s desire, and I consulted with Dr. Waseem to see if anything was possible. And he said ‘No, not unless we give him steroids!’ But then, what do we do when the husband comes in to see us and says, ‘What have you done to me?’ How do we do this without his permission?”

(Dr. Latifa, FHH: May 13, 2005)

None of this meant that Gilgiti men weren’t also unsettled by the expectations they felt surrounded sexuality, desire or lack of desire. A multitude of Islamiyaat texts used Hadith to ‘prove’ that husbands were obligated to satisfy their wives through foreplay and also ejaculation (see Al-Jauziyah 2003: 225).

(Besides being characterized as a pak [pure; A] fluid, semen was also described as a source of sexual
pleasure for women. By extension, men were increasingly unsettled by the expectations they felt surrounded their own sexuality, desire or lack of desire. Where women turned to ‘cold’ foods to reduce their sexual desire, men turned to ‘hot’ foods to augment their sexual drive. Gilgiti men’s sexual ‘remedies’ included fried eggs, sugary drinks, meats, as well as Viagra or desi bilehn therapies. At the Kashmir Bazaar Homeopathic dispensary, I was shown a number of sharbat (tonics; U) and supplements intended to remedy ‘insufficient erections’ or arousal, or to enable men to have intercourse multiple times in a row. Some of these aptly-named therapies included ‘Fulnight Tonic’ and ‘Testovit Supertonic’ and ‘Safoof Mughalaz: A Powerful Sexual Tonic’ (Fieldnotes: September 1, 2005). (The Urdu word mughalaz can be translated to mean ‘hard’, ‘vigorouos’ or ‘severe.’) I was also told about a desi bilehn remedy to ‘gain sexual power’ called selahjeet, or shargaey (S). When I worked for AKRSP in 1998, I learned that Shia women collected this for sale from the mountainsides in Nagar District; it was variously described as guano, a mold or an indeterminate substance ‘produced by birds.’ It may be eaten raw or processed into syrup, and was among the most expensive desi remedies.

**Part VII Conclusion**

This chapter has explored the complex ways that Gilgiti Sunnis’ interpretations of the Qur’an, Islamiyaat materials and ‘modern’ Muslim discourse on sexuality were shaped by local-level, political-, inter-sectarian and cultural forces. As such, this portion of my thesis adds to ethnographies of the practice of Islam which, as Magnus Marsden notes, were once dominated by the notion that “because Islam is a religion of submission...there is little place for the expression of individual creativity in the living of a...

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48 Women’s vaginal discharge, on the other hand, is described is ‘impure.’ It is worth noting that the only pak fluid produced by women’s bodies is breastmilk (Al-Musnad 1996: 72-73). To my mind, this can be interpreted to mean that breastmilk is made pak by its association with childbearing and motherhood, while semen is made pak by its’ association with procreation.

49 Forcibly arranged marriages between unwilling partners posed perhaps the greatest challenge to a husband’s ‘Islamic’ obligation to satisfy his wife. Some men described their early married years with wives they found profoundly unattractive as having been emotionally traumatic.

50 At one of Gilgit’s largest pharmacies, five tablets of Viagra were available for Rs 2,500 (CDN $57).

51 Men were hardly comforted by Hadith which recounted the Prophet’s ability to have intercourse with seven or eight wives over the course of one night (see Al-Jauziyah 2003: 225).

52 Selahjeet can also be used by women, and is prescribed by desi bilehn thabeeb as a general ‘cure’ for ‘weakness.’
Muslim life, and that morality in Muslim societies is a ready-made and uncontested category simply deriving of a single set of scriptural codes” (2005: 8). In order to redress such assumptions, Michael Lambek adds:

“…[while Islamic] texts by themselves are silent; they become socially relevant through their enunciation, through citation, through acts of reading, reference and interpretation. Therefore, we need to examine how texts are being used and by whom, when recourse is made to textual authority, and what kinds of entailments such actions bring.” (1990: 23)

When critically considering the overall failure of regional Family Planning campaigns to effectively reduce Northern birth rates, it is important to reiterate that - as with many health-planning initiatives - program failure or low contraceptive prevalence rates are not necessarily indicative of any lack of need or interest from women themselves. Indeed, a large number of my Sunni participants said they wanted more *merzee* (choice; U) and *faisalah* (decisions; U) over the number of children they had and when they had them. To my mind, however, debates between women and their families, health providers and Gilgit’s ulema concerning the permissibility of contraception were still secondary to, or under-appreciative of, the immense advantages presented by multiple pregnancies and ‘large families.’

Notwithstanding a wide array of research specifically addressing the ‘failures’ of Pakistan’s Family Planning programs, few studies qualitatively examine the wide range of counter-pressures restricting women’s use of contraception, or the many other ‘traditional’ ways women attempt to space births or avoid conception.

Nor has prior research critically deconstructed how Pakistan’s Family Planning proponents and the Sunni ulema both, to quote from Heather Paxson’s analysis of Greek Family Planning programs, advocate ‘moral objects of sex’ that encompass “the creation of ethical, and gendered, subjects” (2005: 96). Where Gilgit’s Family Planning proponents argued for contraception in favour of a seemingly ‘liberalist’, women-

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53 Moreover, because even my self-styled, ‘modern’ participants preferred larger families, it was clear women only occasionally associated family sizing with traditional/modern binaries. As Kanaaneh notes for Palestinian women living in Israel, the modern/traditional, or “modern/backward reproductive opposition draws into its vortex an incredible array of social life and ‘nearly every possible social and personal characteristic becomes associated with one side of the discourses’ dichotomy’” (Khazoom 1999: 8 in Kanaaneh 2002: 166), even to the point where participants claimed both concepts for the same practice or experience.

centered and health oriented agenda, the conservative ulema’s arguments were steeped in what Paxson calls “an ethic of service [where this] moral object of sex is directed at realizing social expectations within patriarchal modes of family and nation” (Ibid: 96).55

Where Gilgit’s Sunni ulema purposefully negated the salience of reproductive control for women and families who aspired to ‘modern’ standards, or who were driven to desperation by family impoverishment, Family Planning proponents avoided acknowledging the symbolic, material and religious salience of reproduction, pregnancy and the birth of sons. These were the pressures which drove a number of women to ‘choose’ to continue having, or want, more children notwithstanding poverty, decreasing agricultural properties and high unemployment. Chapter Five therefore addresses the wealth of women- and family-centered counter-pressures inhibiting women’s use of Family Planning. Specifically, Gilgit Town’s Family Planning proponents failed to acknowledge the ways that childlessness or having ‘too few’ children enacted heavier consequences than having ‘many children.’ Indeed, the anxieties and reduced agencies endured by women who ‘suffered’ in the absence of a son or a living child accorded additional symbolic freight to, and upheld the overall importance of pregnancy and reproduction for my participants. Pregnancy afforded Gilgiti women and their families an undeniable abundance of material, faith-based and relational benefits. And in the same ways that women’s reproductive ailments, pains or fears allowed them to ventriloquize social discord, spiritual imbalance or their socio-economic deprivations, pregnancy’s positive correlations - with improved status and gains in in-family hierarchy, in concretizing marital relationships or with sons enabling their future economic security - minimized any of the presumed benefits afforded by ‘smaller families.’

55 See Imam (2000) for a discussion of the ways “Muslim discourses of sexuality vary not only by community, but over time” (124-134).
Part I  Introduction

What were those pressures that precluded Sunni women’s use of contraceptives, and which were unacknowledged by Northern Areas survey results or only lightly alluded to by women’s physicians? Where the Northern Areas Health Project’s 1999 Baseline Survey had subsumed women’s preference for ‘more children’ under religious factors, I found that there were – in addition to Islam - a variety of pragmatic, economic and symbolic pressures women and their families were unable to easily ignore.

Besides disregarding the contributions of medical malpractice, contraceptive failure, in-family and inter-generational power struggles and Islamic conservatism with respect to women’s reluctance to limit family size, regional Family Planning proponents neglected the importance of sons, or the challenges facing women who are unable to conceive or carry a child to term. The births of daughters, or more specifically the absence of sons, infertility or pregnancy loss imperilled women’s social, marital and familial security, and interrupted what many described as their Islamic obligation (farz; A) to provide heirs and guarantee patrilineal descendants for their husbands. During the ‘tension times’, these reproductive pressures were intensified by conflict-attenuated Islamic pronatalism and discussions of ‘sons’ as future combatants.

But there were serious consequences for women’s preoccupation with pregnancy and their overall inability to access reliable contraception. To my mind, this was most poignantly evidenced by women’s anguish and desperation with unwanted pregnancies. As much as they employed pregnancy to ‘speak’ on their behalf or signal sectarian identity, pregnancies did not always come at opportune times, and the often dangerous steps women took to end unwanted pregnancies presented far greater risks than either childlessness or the stigmas associated with Family Planning. Unlike my analysis of Family Planning in Chapter Four, wherein women’s contraceptive use was correlated with Gilgit District’s rural-urban divide, this chapter examines the concerns, fears and practices shared or experienced by all my participants, regardless of where they had grown up or now lived as married women and mothers.

According to Winkvist and Akhtar, “little is known about Pakistani women's own perceptions of child-
bears and health. Studies documenting women’s own thoughts about their lives and health have only recently begun to emerge from developing countries (e.g., Gittelsohn et al., 1994)” (Winkvist & Akhtar 2000: 74). And in their examination of low-income infertility patients in Karachi, Bhatti, Fikhree and Khan note “there is a dearth of knowledge regarding Pakistani women’s perceptions and treatment seeking behaviour for infertility” (1999: 637; see Shaw 2004). My analysis, therefore, is among only a handful of Pakistan-based, women-centered studies addressing infertility and miscarriage, as well as unwanted pregnancies and abortion (see Sathar, Singh & Fikree 2007; Singh 2006).

**Part II ‘She Could Only Make Daughters...’**

After nearly twenty years of Shia-Sunni unrest, high unemployment and rural poverty, there could never be ‘too many sons’ for Gilgiti Sunnis. My own experiences as the mother of two half-Giligiti boys had helped me understand the ways sons concretized their mother’s in-family seniority and marital security, and were envisioned as their parents’ and siblings’ future caretakers and economic support. And for Gilgiti families that enjoyed strong ethnic- and cultural-ties to Diamer District, the eldest son was envisioned in quasi-warrior terms, as both protector and guardian of his brothers, their wives and children, and defender of his sisters’ izzat (honour; U) even after marriage. As a young mother in Amphari noted, “they say sons will take the place of the father, and care for the family. They say it will be due to him that the family will be bigger one day” (Malika, Amphari: August 12, 2005). Put simply, a son allowed his parents to achieve a status, security and relational connectedness that was unmatched by a daughter.

Sons also allowed Gilgiti women to become, to their simultaneous delight and consternation, a point for neighbourly envy, or to inspire the frustrated anxieties of an antagonistic sister- or mother-in-law. Once a son was born, less supportive mothers-in-law often felt they’d lost the chance to encourage their sons to divorce or re-marry; my own mother-in-law greeted the news of our sons’ births with an obvious mix of joy and dismay. (Because Wadood’s ex-wife had four daughters, his family assumed he had divorced her
in order to try for sons with another wife. After we had our two boys, many of my in-laws suggested Wadood would never divorce me because I had provided him ‘sons and security’.) Moreover, a son guaranteed his mother’s future ascendance over her own mother-in-law. By the time her sons gained family decision-making authority in their mid- to late-teens, women were able to shift their allegiances away from their mother-in-law and, with their sons’ support, become more overtly ‘self-interested.’ During an interview with my key participant, Madheeya was extraordinarily clear on the parameters of meaning and logistical benefit afforded by sons.

[Emma] “What if your sons are not able to have any sons of their own?”

[Madheeya] “Bas, duao dishto ney bin – moh tokh hen [enough, we are making a space – it needs to be done; S]. We need sons. If our daughters all marry other men, they do good things for that family, for their husband’s mother, but they are useless for us. Our sons can do everything, even pray for us – the house that is without a son, is not a house. A home without a son isn’t complete…. A mother who has sons is a complete wife and mother. A woman without sons is not complete. She depends on her husband. If he is good, he can tolerate daughters and wait. If the husband is not good, he will try for a second marriage.”

(Jutial: June 22, 2005)

Only the children of sons were counted towards a family’s future descendants; a son’s children were also described as physiologically ‘belonging’ more to their paternal than maternal grandparents and kin.

“There is more love with a son’s children because they are always [living] with us, because our sons’ children are like our bones. But my daughter’s children are not our own because their father is an outsider and not our own. If my daughters’ husband is from my brother’s family, there is puro khushwaqt ben, row khush barabar hen [much love, and our happiness is the same; S]…if my sister’s son is my daughter’s husband, bas [enough; U]! My brother’s children and sons are closer to us, more special to us….I have no grandsons from my sons yet, so there is no such difference. If there are sons, they will be like our bones so we should love our own more. [And] I’m closer to my brother’s daughter than my sister’s daughter. And I’m closer to my son’s daughter than my daughter’s daughter…but between our son’s son and our daughter’s son, when her husband is my brother’s son, there is no difference.” (Madheeya, Jutial: June 22, 2005)

In light of the Family Planning Organization’s push for a ‘two-child family’, which they typically promoted as being with one son and one daughter, I asked several women to describe their ‘ideal’ family size. In her answer, Madheeya was careful to explain why sons mattered even more in smaller families.

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“An ideal family is two boys and one girl, or three boys and two girls. If there are two to three sons, you are OK. A brother can help manage all the other family as well, parents, siblings, in-laws. If there is only one son, we feel sorry for them, because it’s only his responsibility in caring for everyone and the load is on his shoulders, with no one to help him. Look at Neemat – his wife has only one daughter who is fifteen years old, and they have no other children...this is very mishkil [difficult; U].” (Jutial: June 8, 2005)

There were undeniably very few options available for women with no sons. At the Gilgit Medical Center, Dr. Sharifa pointed out that women who had only had daughters were unable to live with a daughter and son-in-law after being widowed; “Women don’t like their sons-in-law, and they say [his] house is not their house. Their daughter’s house belongs to her in-law’s family” (Dr. Sharifa, AKHS,P: May 15, 2005).

My participants understood certain body or personality types to be more likely to produce sons. Moreover, there were a wide variety of desi physical, behavioral and humoral markers that women drew on to ‘diagnose’ if an expectant mother was carrying a son or daughter. My participants intense interest in ‘reading’ their bodies for signs of a boy mirrored the many worries and hopes associated with the liminal nine months between conception and delivery.¹

“If a woman’s eyes are shining, it’s a boy. If she’s ugly, and has a thin face, she’s giving birth to a girl. If when she’s pregnant, her stomach is loose, it’s a girl. If her stomach is tight, it’s a boy. And if a woman eats different kinds of food, some people say it means she’s having a boy, or a girl. Or, her khawab [dreams; U] might tell her. If there are guns, pistols, white shalwar kameez in her dreams, she’s having a boy. Or a gold angouti [women’s ring; S]. If she sees fruit, bangles, frocks, it’s a girl. If she sees anar [pomegranate; U], cucumber, apples or a rose it’s a boy. If she sees peaches or jharotee [ripe apricots; S] it’s a girl.” (Uzma, Amphari: August 12, 2005)

“There are lots of myths about whether you’re going to have a boy or a girl. They say that if a woman puts a white cloth on her head, and a man comes first to her, she’ll have a son. If a woman comes first to her, she’ll have a daughter. Or, when she’s pregnant she can try to express some milk onto a spoon and if the milk spreads the spoon, it’s a girl. If it stays in

¹ In their study of Punjabi women in Lahore, Winkvist and Akhtar discuss that “…about half of the women in both city and village reported that they had felt well throughout their pregnancies and had been happy each time they discovered that they were pregnant. A few mothers of daughters qualified that they felt happy because they hoped that they would bear a son…whereas another woman explained that she knew all throughout her pregnancy that it would be a daughter and worried about the girl’s future” (Winkvist & Akhtar 2000: 77).
one place, it’s a boy. Our Bhabhi can tell by looking at us what we’re having and she’s usually right!” (Shafqat, Amphari: August 12, 2005)

“They say if you hate meat in the first months, if your mood is not OK, and if you fight with your husband and don’t want to have sex with him, it’s a girl....if it’s a boy, you’ll want achar [sour pickles; U], meat, spicy things, [but] I don’t know about sex! [laughs]” (Madheeya, Jutial: August 11, 2005)

I sometimes wondered if women’s fear of childbirth was related to the intense disappointments women endured when daughters were born. For the births I observed, the room was sometimes fraught by palpable tension. Women and their families knew that should a daughter be delivered, she would be vulnerable not only to the profound disappointments of their husbands and in-laws, but also abuse, divorce or their husbands taking a second wife. One LHV at the DHQ described how Sunni mothers typically reacted to news of their baby’s sex:

“Mostly parents are giving their thanks for having a boy, our whole riwaj [culture; U] is doing this. Some women will say, ‘My family is disturbing me because I’ve only had girls, and even my husband disturbs me, but today – Allah ka shukr heh [thanks to God; U], now I’m the mother of a son!’ Even if it’s a first baby, and a daughter, we see a difference. Sometimes with a girl the patient and her attendant will become pale and behosht ho guya [faint; U], especially if it’s another girl. We, however, are giving them mubarak [congratulations; U] for having daughters; for both boys and girls we do this. Even if it’s another daughter after three or four daughters, we’ll say ‘You should give your thanks to God you’re both healthy’ but the woman will say, ‘What can I do? God is not co-operating with me, maybe now my husband will marry again or divorce me!’ We’ll say to them, ‘Don’t worry, both boys and girls are the same and barabar [equal; U]. You are lucky, because girls are easier to handle than boys!’ But the mothers keep quiet when we say these things.” (LHV IV, DHQ: August 1, 2005)

In her discussion of Sunni mothers’ treatment of newborn daughters in the DHQ Family Wing’s postpartum recovery suite, one LHV remarked that childbirth presented mothers-in-law with a unique, almost performative opportunity to either display their open animosities for a daughter-in-law, or to demonstrate their religious sensibilities or ‘Islamic’ comportment through compassion and patience.

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2 This LHV’s sense of gender ‘equality’ or ‘sameness’ stemmed specifically from Islamic emphasis on men’s and women’s spiritual equality ‘before God.’
“If a daughter-in-law has a daughter, she won’t even ask about the mother’s condition. Or, if it’s a boy they’ll just take the boy and ignore the mother. When it’s a baby girl, I’ve seen that the mother-in-law’s face can be awful, she will be so cold with her daughter-in-law, and some won’t even look at the baby. But some are very good, and giving their thanks to God whether it’s a boy or a girl, and kissing the mother’s face. If the family are Chilasis, they’ll blame God for the baby being a girl...some actually tell us this when they’re here.” (LHV II, DHQ: August 6, 2005)

At the DHQ, several non-Gilgiti LHVs argued that the local preference for sons was even stronger than they had witnessed in Pakistan’s southern urban centers.

“In the Northern Areas, I’ve noticed a big preference for boys. There’s often a very bad reaction when the girl is born, and the families are upset and not happy.... If she’s had many daughters, sometimes she’s even afraid to leave the Labour Room and face her in-laws, and I’ll see that they seem angry with the patient.” (LHV VII, DHQ: August 4, 2005)  

The most upsetting cases, according to several DHQ LHVs, were when twin daughters were born. Each month, two or three sets of twins were born in their Labour Room; the LHVs commonly overheard families discussing such arrivals as, “'khambuket doh doh lurkiyon aa ruhee heh’, meaning ‘bad luck is coming with two girls’” (LHV IV, DHQ: August 1, 2005). The challenges facing new mothers didn’t end at the hospital. One of Wadood’s cousins sorrowfully recounted how her neighbour was beaten by her husband after delivering a fourth daughter. “Her husband said, ‘Give it to me, and I’ll shove it back in there again!’ Sometimes he was beating her, but now she’s had three sons so he’s happy with her now” (Tajahour, Jutial: August 18, 2005). In Jutial, my neighbour, Fouzia, had two daughters after the death of her firstborn son. Her husband Ahmad was employed as a peon at the Konodas Courts;

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3 There were times when non-Gilgiti LHVs’ privileging of Punjabi family practices was unsettled by participants’ own experiences of life ‘down-country.’ Zaitoon was in her early forties, the mother of three daughters and had been married for ten years. Her maternal uncle had arranged her marriage to a Punjabi Army officer who had been stationed in Gilgit Town, and she now lived outside Multan. When I spoke to Zaitoon, she discussed the pressures she and her husband faced from his Punjabi family to have a son; “I want a son, though – both my husband and I want a son. The girls are going to go to someone else one day, and we have too much land and need to have a son to give it to. If I have only one boy, bas [enough] – this is all I need.... I’m scared of my in-laws if I don’t have a son. In the Punjab there is a lot of emphasis on having a son, and they are very upset if you don’t have one. My husband is good, but..... It’s their village custom to have a son. People tease us, saying ‘Look, you only have daughters and no son!’ Both my husband and I are teased, and I’ll say, ‘Look, God is happy!’ But otherwise I’m chup [quiet, silent; U]” (Zaitoon, Jutial: August 17, 2005).
he had moved to Gilgit from Gas, an isolated village in Diamer District, six years earlier when he married Fouzia. After the birth of their second daughter, Fouzia remembered that

“…when Sulwah was born, he said ‘Next time you have another daughter, I’ll take another wife!’ As soon as Sulwah reached home from the hospital, he threatened me like this. With Noorzadi [first daughter] he was OK, happy. I was quiet when he had said this, but worried, and then forgot about it and said, “God gave this, what can I do?” Khodai pak hen [God is great, pure; S]...men determine the sex of the baby. And I [had] said, ‘I will do another marriage if you marry again!’ and he said to me, ‘You can’t do this – you’re just a woman, just sit down and be quiet!”’ (Fouzia, Jutial: July 7, 2005)

And it wasn’t only the sex of surviving infants that mattered. For instance, when miscarriages occurred in clinical settings, after the foetus was delivered and passed to a woman’s family for burial, many mothers-in-law and attendants took time to carefully examine the tissue looking for the baby’s sex (Fieldnotes: April 28, 2005). The young mother of a one-year-old daughter had recently been diagnosed with a ‘missed abortion’ during a first-trimester ultrasound, and had received a D&C when she failed to miscarry. With her mother-in-law still frustrated by the birth of Samina’s daughter the year before, Samina noted that her in-laws had spent considerable time trying to poke through the foetal tissue to find the sex.

“My mother-in-law looked at it after the operation [D&C]. They gave it to us and she opened it, and under three pardey [veils, covers; U] there was a tiny nishan [human form; U], with eyes, legs and everything was there....my mother-in-law looked at the baby they took from inside, and said she saw it and it was a lurka [boy; U]. I didn’t see if it was a boy or a girl, but we saw [the body] with our own eyes!” (Samina, Jutial: August 4, 2005)

The irony of Samina’s story was that her mother-in-law’s preoccupation with ‘boys’ was enough for her to claim the miscarriage had been with a boy, even though Samina’s mother insisted she had, in fact, seen “nothing” after Samina passed the blighted ovum, a condition whereby the placenta develops but there is no foetus (Fieldnotes: August 7, 2005). Among my participants, ‘lost’ baby boys were counted and actively remembered, but women were less likely to discuss the daughters they had lost during pregnancy or at birth. Moreover, burials were not differentiated by sex, nor were funerary prayers
required for stillborn babies or miscarriages, yet a baby’s sex provided evidence of a mother’s “capacity” for either sons or daughters (Fieldnotes: August 4, 2005).4

Some participants discussed their belief that a woman’s outright rejection of a newborn daughter might, in some ways, invoke or contribute to continued ‘bahd qismat’ (U) - literally, bad destiny - with future deliveries. Wadood suggested that the more a woman resented a daughter, God might continue to ‘reward’ her with more girls. Indeed, when one neighbour delivered a firstborn son, her in-laws suggested it was her reward for having wanted and accepted the idea of a daughter during her pregnancy. Several weeks before her baby’s arrival, Ruqaiyah had conceded that by wishing for a girl she was seen as somewhat ajaib (U), or ‘strange’.

“I want a daughter, but people are scolding me, like my Bhabhis [senior sisters-in-law; U], mother and my mother-in-law, they’re in-charge! [laughs] I love girls, but people in Gilther [Gilgit; S] want sons...all people think this way, a daughter goes to another house, but a son is there in our old age to help us, he is like a stick to hold onto - he can do everything!” (Ruqaiyah, Jutial: July 12, 2005)

By extension, several women said their husbands were unconcerned with a baby’s sex, arguing instead “it’s just our culture which is concerned with sons” (Malika, Amphari: August 12, 2005). Indeed, despite the social importance of sons, the mothers of daughters often protested they were ‘fine’ with only daughters. Malika’s sister, for example, lamented how throughout Gilgit’s Sunni mohallas “…all people want sons, society makes us crazy for boys. Look, I have two daughters and this is more than

4 While the sex of live infants was recorded at the DHQ’s Labour Room Register, the sex of stillborn or miscarried foetuses was not noted (Labour Room Register, DHQ: August 24, 2005).
enough for me, but society puts pressure on us to have sons” (Jalili, Amphari: August 12, 2005).

Among participants who only had daughters, they claimed their typical retort to a husband’s threat to remarry was, “Go to Hell...go ahead!” (Khala, Jutial: June 15, 2005) But this was a brave cover for women’s intense social and marital vulnerability. Inevitably during these same conversations women recounted the perils and inequities of polygamous marriage, especially when one wife had sons and the other only daughters.

Gilgiti women’s fetishization of sons did not mean, however, that once the traumas of a daughter’s arrival had subsided, that daughters were necessarily loved any less than sons. A daughter’s place in the family birth order carried important consequences for her welfare. If daughters’ arrivals were interspaced by the arrival of sons, I rarely overheard mothers discuss their daughters as being a ‘problem.’ Moreover, once sons had been born, a woman’s desperation about her inherent failure to ‘carry boys’ was substantially relaxed. When women enjoyed the local privilege of having borne multiple boys, a daughter’s arrival was often viewed as completing the family, and mothers joyfully discussed having someone to ‘help’ her with housework, and keep her company. However, daughters were still described by their mothers as ‘transient’ to family life, and affording few - if any - future material or economic securities, or social respect for their aging parents. The emotional comforts that daughters were routinely praised for offering family and neighbours were rarely a direct topic of conversation, unless women sought to unfavourably compare their son’s lacklustre filial devotions to those of a loyal daughter, or to valorize the importance of daughters when no son had been born.

“Now in Gilgit, people are educating their daughters more, and they can see their sons are just [loitering] in the bazaar, so they are recognizing the value of their daughters

5 What distinguishes Gilgiti son preference from son preference in other parts of Pakistan is that in Northern Areas Sunni communities, a bride’s family is not expected to provide a dowry to the groom and his family. Instead, families adhere to Qur’anic and Hadith Al-Sunnat dictates whereby women receive a cash or gold equivalent of their inheritance from their parents, while it is the groom who provides a negotiated dowry (mehar; A) to the bride and her family. Because of this, my participants never described their daughters as incurring the same, onerous financial obligations normally associated with wedding expenses in urban Pakistan (see Winkvist & Akhtar 2000: 80).
more….but the pressure for sons is still there, in all types of families, even the educated ones.” (Dr. Sharifa, AKHS,P: May 15, 2005)

Not every mother-in-law was antagonistic to her daughter-in-law when only girls had been born. Many mothers-in-law were aware of the emotional trials endured by daughters-in-law who had not yet borne sons.

“Just because God didn’t give her [sons], this is not her fault. I’d feel embarrassed [if a second wife was taken] of course - this is a very difficult situation. And more educated, more good families will adopt rather than resort to a second wife, they will try to avoid a second marriage.”6 (Madheeya, Jutial: June 16, 2005)

For Sunni women who had only borne daughters, they often mourned the loss of the traditional celebrations (khushey key marabur, mubaraki; U) and gifts that accompany a son’s arrival.7 Such celebrations are even more dramatic when a son is born after “many daughters”, which many participants qualified as being after “three or more daughters in a row” (Fieldnotes: July 16, 2005). For families living immediately outside of Gilgit Town’s civic boundaries (inside of which shootings were regularly investigated by the Frontier Constabulary’s forces [FCNA]), a son’s arrival was typically marked by bursts of pistol, rifle or semi-automatic gunfire.8 The mubaraki parties I attended for newborn boys - where family, friends and neighbours crowded around the new mother and infant - reminded me of a queen holding court. In many ways, new mothers seemed delighted to be the focus of their neighbours’ envies, which paradoxically upheld the importance of a son (see Figure 19). If daughters were born, it was a slightly mournful affair, replete with onlookers who had come to see how upset the mother

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6 Because of Hanafi-Sunni fiqih emphasis on the importance of blood kinship and its relation to inheritance rights and Abrahamic admonitions to procreate, adoption was exceptionally rare among Gilgiti Sunnis.
7 During her fieldwork among Paxtun women in Pakistan’s North-West Frontier Province, Benedicte Grima noted the embarrassment and sorrow experienced by women who had delivered daughters; “Neelum…already had one son and this was her second child…Neelum received far fewer visitors, and the atmosphere in her house was quiet and somber. She kept the infant covered next to her on the bed…but visitors did not ask to see the child…[she] was so distressed over bearing a girl that it aroused anger in other women who spoke about her. Comments included: ‘What right does she have to be angry and depressed? The child came from God. Is she not grateful for what God gives her?’ It was as though the community expected and vicariously lived out her disappointment but would not tolerate it if she carried it ‘too far’” (2004: 65).
8 Because they couldn’t fire celebratory shots in-town, families often telephoned or relayed messages to close relatives living in outlying villages where the news was celebrated with gunfire, which women took great delight listening to over a crackling telephone line (Mayordana, Sakwar: July 6, 2005).
was, or add to her distress through pointed comments or by musing that divorce might soon follow if there were many other girls. The envies between sisters-in-law when one had borne sons and the other only daughters, made for deeply emotional mubaraki celebrations. When my sister-in-law Mayordana delivered her second son, Arsalan, her older sister-in-law was already the mother of four small girls. With some pain, Mayordana noted differences in how the children’s arrivals had been marked;

“People came to give [me] mubarak [congratulations; U], but her family didn’t come [for her babies]. She was depressed and afsoos hen [had regrets; S] that all her children were daughters...[she said] ‘My qismat is not good, I only had daughters!’ Bhabhi and my mother-in-law, but not my father-in-law, were concerned with the gender. With Zeeshan she was jealous, she already had three daughters and then I had two sons...At Arsalan’s [second son’s] birth, she came to visit, but she was a little bit rude, and changed her attitude at the beginning.” (Mayordana, Sakwar: July 6, 2005)

In Minawar, Waddood’s maternal cousins were openly distressed by their husbands’ general inattention to newborn girls (this despite women being equally distraught by their daughter’s arrival). Marked differences between mubaraki celebrations for boys and girls were sometimes described by the mothers of baby girls as a kind of injustice (zulum; A), sin, or demonstrating their husband and in-laws’ ingratitude to God. Women’s lamentations and angers were not simply reflective of the imbalance in attentions paid to their new baby. Women’s upsets, to my mind, also reflected their inability to ritually mark and celebrate their safe transition through childbirth, or to accord social importance to their sacrifices and wifely contributions.

“My husband brings food and desi ghee for the celebration meals. We eat the desi ghee with wheat flour. If boys are born, he gives big meals to all the relatives. If it is a girl, he does nothing. I wondered why he does this only for boys and not for girls, and I asked him to celebrate the girl’s birth too, but he said he’ll only do it for boys.” (Phoonurh, Minawar: May 3, 2005)

A baby’s sex also carried important consequences for women’s treatment during the first forty days after childbirth. When sons were born, a new mother’s interactions with guests were carefully monitored by her in-laws out of fear that ‘envious’ or upset visitors might try to hide an amulet (tawiz; A) against the new mother or infant somewhere in the family house. But for the mothers of newborn daughters, they
were almost always pushed to return to ‘normal’ life and take up their domestic responsibilities far more quickly, thus compounding the difficulties of post-partum recovery. Making matters worse, women’s in-laws sometimes used daughters as an excuse to harshly criticize women and their natal families, or instigate a divorce. In light of the multiple potential, or fully realized, shames experienced by women during their reproductive life, some mothers professed not wanting daughters because they feared for her future life as a wife and mother.

“I don’t want a daughter, you never know what her qismat [fate; A] will be, and you can’t control that after she’s married...whether he’s good with her or not, if he’s a nashah [drug addict; U], or his family treats her badly.” (Hussen, Jutil: August 11, 2005)

Narratives assigning ‘blame’ to a woman’s body, however, were being increasingly challenged by emphasis on biomedical ‘science’ and Qur’anic ayats that attribute a baby’s sex to men. (Herein was the delicate synthesis of “Islamiyyat aur science” (Islamic doctrine and science; U) pushed by local Sunni mullahs, who argued that Qur’anic scripture had been ‘proven’ by biology [Fieldnotes: February 5, 2005].) This notion that the male body carried responsibility for the baby’s sex was even used to help comfort distraught mothers at the DHQ: “If [the mother] is crying a lot, I might call her husband in and say, in front of his wife, ‘It’s your body that decides the baby’s gender, not hers!’ and he’ll say nothing.” (Nurse, DHQ: August 1, 2005) While some men readily internalized the belief that ‘Islamic science’ had proven a baby’s sex was determined by semen, they were profoundly unsettled when daughters were born, and their considerably relieved wives ‘blamed’ the baby’s sex on them. While describing her three children’s deliveries, Mehnasat remembered her husband’s simultaneous surprise and disappointment at their daughter’s birth.

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9 Conscious of these complaints and risks, a woman’s family sometimes tried to disassociate themselves from her if she had only borne girls, due in part to their very real fears that her ‘deficiency’ might be held against them. This quiet distancing was additionally upheld by their economic insecurities. The more a woman’s family defended her when she gave birth to daughters, the more her in-laws could argue they were returning her - through divorce - to a loving and economically-supportive family. In fact, it was only with extreme reluctance that a woman’s family, especially when they were impoverished, took her back into the extended household if she had been divorced.
“When Ehsan was born, I was very happy despite eight tangkah [stitches; U]! [laughs] My mother-in-law and in-laws were all very, very happy [and] more than anyone else was my husband, who was thinking ‘My seed did this!’ [laughs] Before Khadija was born, he had been thinking, ‘If I could make one son, why can’t I make another one?’ And he was upset when she was born.” (Mehnasat, Jutial: June 8, 2005)

A father’s treatment of his newborn daughter, even if initially marked with inequity and unhappiness, was expected to resolve itself over time. Many women described a ‘good father’ vis-à-vis his treatment of daughters, whether wanted or unwanted. Living in a small enclave of Sunni households in Shia-dominated Amphari Mohalla, Malika was in her mid-twenties and the mother of three young daughters. With her youngest still only one year old, Malika was five-months pregnant with her fourth child. She quietly conceded she faced considerable pressures to have a son, and was reticent to discuss the possibility that the next baby might be yet another daughter. Later in our conversation, she more light-heartedly discussed how the “abundance” of girls in her extended family resulted from their quasi-genetic disposition towards daughters (Malika, Amphari: August 12, 2005). She said her husband’s even-handed treatment of their daughters exemplified his equitable and “Islamic” nature. Indeed, more progressive mullahs and Sunni physicians described a “true Islamic” man as one who equitably welcomed sons and daughters (Qari Malik, Jutial: February 5, 2005; Dr. Khalthum, DHQ: September 7, 2005).

“He is a good husband. At night when the girls cry, he gets up with them, and prepares bottles for them at night. When he’s fahrik [free, unoccupied; U], he’s taking care of them and carrying them with him. No one makes fun of him for being like this in our family. Both he and his younger brother are helpful with their wives.” (Malika, Amphari: August 12, 2005)

Malika argued that her husband was deliberately contradicting inequitable, desi Gilgiti notions of ‘masculine’ behaviour, whereby the fathers of daughters infrequently pay sustained attention to their daughters, nor took them with them during social visits outside the house or to local bazaars for shopping. By doing so, Malika seemed to suggest that her husband was not only inverting Gilgiti concepts of gendered parenting, but also taking on more ‘modern’ Islamic practices. Regardless of men’s nurturance
of daughters, if his wife was unable to ‘produce’ a son, husbands were advised by men and women alike to marry again. Many older participants, such as those who were nearing or had reached menopause, expressed little sympathy for the predicaments facing younger wives who had only delivered daughters and were vehemently opposed to polygamy. (As one young wife said, “It’s very wrong to do [polygamy], just for a son!” [Jalili, Amphari: August 12, 2005]) Nor were older women in favour of husbands granting their first wives a divorce in such instances. “He should not give her a divorce, but he should manage both [wives] equally” (Uzma, Amphari: August 12, 2005).10 Added to this was a perceptible sympathy among older women for the husband’s plight, principally because he was viewed as somewhat incomplete in the absence of a male successor; “Boys, boys, boys – men need a boy, what can you do? This is his haq [right; A]!” (Uzma, Amphari: August 12, 2005)11 In an interview with Uzma and her adult daughters Jalili and Malika at their home in Amphari Mohalla, their debates offered important insights into women’s notions of marital justice (insaaf; U), emotional security and children’s loyalties to their mothers and stepmothers.12

[Jalili, daughter] “He should let [the wives] live alak [separately; U], they can’t live in one house together! This is very unfair and difficult for women.”

[Uzma, mother] “But here, there are too many wives that live together, very happily, like mother and daughter. In some families, the children like their stepmother more than their real mother!”


10 Two middle-aged Sunni wives took some time to clarify the qualities made evident in an ‘equitable’ polygamous marriage. One argued, “He should give them the same clothes, food and give them sex in the same way and amount. One time with each of them, taking turns. If he’s not doing this, he goes straight to Jahnam [Hell; A]!” Her sister-in-law added, “There should be separate residences, but treatment should remain the same. If separate it is better, in the same house there is jealousy, conflicts, quarrels” (Khala & Chachee, Jutial: June 15, 2005).

11 Wadood explained that some extended families were unwilling to subject women to the presumed injustices of such a marriage. In other families, polygamy was a regularly anticipated feature of a man’s older years, especially if his first wife had failed to have any - or ‘enough’ - sons or no longer provided sexual satisfaction.

12 It is worth noting that, for the case of Chitral, “The children of first wives – both boys and girls – in polygamous marriages are frequently said to live disturbed emotional lives. These children are not said to have received sufficient levels of love from their father, being sidelined in favour of his second wife’s children” (Marsden 2007: 96).
Chapter Five: Wanted Sons, Unwanted Babies & Empty Wombs

If a woman’s family enjoyed close economic and business dealings with her husband and his in-laws, or when spouses were close cousins, it was often possible for her parents or brothers to discourage her husband from remarrying for many years.

“In his first marriage [our cousin] had two daughters, and after twenty-three years he married again for a son. He and his first wife tried, for so long, and with so many methods, to have more children but she couldn’t get pregnant again. His second wife is maybe twenty or twenty-two years old, he’s more than forty years of age. His new wife is from Ghizer [District] and she still lives with her parents, but now that she’s delivered a son he wants to bring her to Gilgit. His job means that he’s sometimes here, but sometimes on-duty [in Ghizer]. Every week he goes to visit her, but he’s always with his first wife. He only makes weekly visits to his second wife. His first wife is very, very disturbed about the situation. Nobody likes to share their husband. She’s only acting like she’s happy on the outside that he had a son. His daughters were crying before, and told him he didn’t have their permission *ijhaazat* [permission; U] to bring the wife near them, but now with the arrival of a son they’re a little bit happy, and say he can bring them to Gilgit. (Malika, Amphari: August 12, 2005)

For the second or third wives of husbands who had already fathered multiple daughters and no sons, women’s stresses were alleviated somewhat by her knowledge that if she had a daughter, locals would invariably attribute the ‘fault’ to her husband. After having daughters with two wives, it was now more likely he was ‘responsible.’13 Women took particular pains to mock men who had made “fools” of themselves by trying so often, and for so long, to have a boy (Fieldnotes: June 22, 2005). In some ways, this reflected women’s empathy for the trials endured by wives as they were pressured time and again to bear a son, and offered implicit commentary on their own marital insecurities, whether they had been resolved by the birth of a boy or not.

[Hussen, daughter] “In Chilas, a man married and first had five daughters. With his second wife he had five girls, and with his third wife he had one daughter. Then he went and killed himself. He was a neighbour [of mine], and he desperately wanted a son. I’m not sure how old he was.”

13 Using the locally famous example of Mullah Nasrat’ullah (one of Gilgit District’s foremost Sunni clerics) as precedent, two young mothers in Amphari Mohalla commented, “Some women can have both boys and girls, while others can only have boys, or only have girls. Look at Mullah Nasrat’ul – he married again after having nine daughters, and now with his second wife he’s had two daughters. You can’t force God you know! At times like this, it’s clear it’s the man’s fault he’s only having daughters” (Malika, Amphari: August 12, 2005).
Mindful of the emotional hazards and economic inequities associated with polygamy, Sunni women often discussed seeking both Islamic and magical recourse ‘against’ daughters, or to produce sons. Their efforts and expenditures were especially intensive after several girls had already been born. Among the most common forms of spiritual intercession was women’s recitation of the Qur’an’s Surah Yasin, which mullahs said provided protection against spiritual imbalance, or the harms women felt were caused by ‘evil forces.’ There were also a wide array of Islamic prayers (namaz; A), invocations (dua; A) and amulets (tawiz; A) specifically tailored for ‘sons’, all of which were drawn from Hanafi-Sunni rulings (fatawas; A) and the Hadith. In addition to telling women to eat specific foods in carefully staggered sequences, or imbibe drinks onto which invocations had been blown (dhum; A), some Sunni mullahs were famous for making ‘effective’ tawiz for sons. These either had to be worn by women prior to conception or women were advised to use them in the first month after conception and before the foetus’s sex had been established.14 Some women, however, expressed quiet concerns that because they weren’t allowed to wear the tawiz during intercourse - due to sex’s polluting qualities for the Qur’anic ayat contained inside - these remedies might not always work (Fieldnotes: August 12, 2005).15

“People said for a boy, after my two daughters, I should have used a tawiz but you have to use it in the first month, and wear it around your stomach, or before you’re pregnant, but I found out too late with this [pregnancy]. You can get these types of tawiz from the mullah. He makes these tawiz using a Qur’anic ayat, and he usually charges Rs 500 for a tawiz like this.” (Malika, Amphari: August 12, 2005)

In addition to Sunni clergy, there were a number of female diviners who worked to diagnose a woman’s inability to carry sons as resulting from medical ‘defects’, Islamic sorcery (as’Sihr; A) ‘black magic’ (kala

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14 Generally speaking, women agreed that the foetal genitalia was visible at four months gestation, while limbs could be seen by three months (Madheeya, Jutial: June 22, 2005).

15 Mullahs could circumvent the problems associated with tawiz that were intended to be worn even during intercourse by using codes and ciphers instead of actual ayats from the Qur’an. Each symbol employed in the tawiz corresponded, in turn, to an Arabic letter from a larger Qur’anic ayat or surah.
jatu; U), or the capricious or malicious intervention of Islamic spirit-entities called jinn (A). Because diviners professed to be able to communicate not only with jinn but also fairies (parri, piran; S), women felt their services would address and alleviate the widest possible array of spiritual components underlying the births of daughters.

[Saba] “My husband’s sister’s daughter made tawiz from this lady after she had seven daughters….After six daughters she went [to a mullah] for a tawiz, paid Rs 500 [CDN $11], but she had another daughter afterwards.”

[Uzma] “There is a lady in Jutial who makes tawiz for boys. I went there for a tawiz for a son after my other daughter had four daughters, and she told me to bring Rs 500 and some sheep’s desi ghee, and told me it would be a boy. But she gave birth to another daughter, so she must be a fraud….a person’s ability is proven by the effect of their tawiz!” (Amphari: August 12, 2005)

[Mayordana] “My Bhabhi [sister-in-law; U] Sohrana had given Rs 5,000 [CDN $114] for a tawiz for a boy [and got it] from a mullah in Amphari. This was after three daughters….My mother-in-law was so angry when Aqleema [the fourth daughter] was born. She said, ‘We wasted all that money on the tawiz!’ …Sohrana was depressed and sorry that all her children were daughters, asfós hén [had regrets; S].” (Mayordana, Sakwar: July 6, 2005)

Gilgit’s traditional herbalists (desi bilehn; S) sold relatively inexpensive supplements for women who wanted sons or to ‘block’ daughters (Fieldnotes: August 20, 2005). One young wife, who was the mother of three small girls, recounted how she had been told to eat “certain desi roots before you’re pregnant [so] you can have a boy…these come from the jungul [forest; U]” (Arriba, Amphari: August 12, 2005).

“If you have too many daughters, and you need sons, this is kinisheekee [S]. You use it before you’re pregnant, of course! The woman eats it for ten days, with milk every night after she’s finished the course then she can sleep with her husband. It always works; it’s one-hundred percent! But she definitely has to avoid sex [first] - what’s the point of using it once you’re already pregnant? [laughs] It’s from Astore…high on a mountain….You grind it, make a powder and take it, a thumb-full at a time. A ten day course is Rs 60 [CDN $1.40].” (Mohammad Isa: August 20, 2005; see Figure 20)

Figure 20: Kinisheekee (2005).
At Gilgit Town’s largest homeopathic dispensary, I had asked if their desi davaie (inclusive of Ayurveda and Yunani Tibb) products, herbs or roots included similar ‘remedies’ for daughters.

“I know of this type of thing, but I haven’t been able to find it yet. I don’t carry things like this in the store. It comes from the forests. I’ve read about it, and heard about it, but don’t have it.” (Arshad, Kashmir Bazaar: August 20, 2005)

Despite the popularity of desi remedies, one participant in Jutial Mohalla derided her neighbours when they visited the local herbalist, a Shia woman who assisted her husband with his home-based desi bilehn practice. Arguing against her daughter’s claims that herbal remedies worked, Madheeya said:

“There is no desi davaie to make a boy or a girl, it will not [have any] effect. Whatever it is, it is – from the beginning! I don’t believe in these things. Those with only sons, will wish for daughters. And those with only daughters...” (Madheeya, Jutial: June 22, 2005)

Indeed, a number of women believed that desi and spiritual remedies were to no avail; “You can’t force God to do what He doesn’t want to do...it’s really all up to God what the baby is going to be” (Jalili, Amphari: August 12, 2005). Even though desi remedies offered unlikely resolution, obstetric ultrasounds presented women with new sex-determination opportunities (see Miller 2001, Unnithan-Kumar 2004b). During my time watching patients receive ultrasounds at the Gilgit Medical Center, Dr. Sharifa and Dr. Sumairah routinely discouraged women from asking about their baby’s sex. Dr. Sharifa quietly suggested that many of the women who found out the foetus was a girl would eventually try to abort, notwithstanding how far along they were in the pregnancy.16 Indeed, many doctors were poignantly aware of the family pressures facing women patients, and refused to oblige women’s curiosities. Take for example the reaction of the DHQ’s ultrasonologist when one of his Sunni clients asked for the baby’s sex:

“When I went to Dr. Shakoor for my ultrasound, my sister asked him if the baby was a boy or a girl, but he got so rosh [angry; S] with us and scolded us, saying ‘It’s because of this attitude the men in Gilgit are so proud, and only want boys, boys, boys!’ He wouldn’t tell us what the baby was.” (Malika, Amphari: August 12, 2005)

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16 One Aga Khan Education Services (AKES) study described how “the higher levels [of] disadvantage for [Northern] women are highlighted by the fact that only 48% of the school age population is female, despite the natural advantage of girls” (AKES 1996 in Sales 1999: 409). While the study did not explain which factors accounted for the Northern Areas’ sex-ratio imbalance, future research should be attentive to the role of foetal sex determination, elective ‘illegal’ terminations and women’s use of abortificients in regional demographics.

Emma Varley
At the Family Health Hospital, the OB-GYNs also claimed to only share the baby’s sex after the twenty-fourth week of pregnancy, when it was too late to seek a medical termination, and women were far less likely to find a dayah willing to complete an ‘illegal’ second-trimester abortion (Fieldnotes: May 13, 2005). But after twenty-four weeks, Dr. Sunbool said she was a harsh realist, unwilling to ‘hide’ the facts from her patients.

“I will tell the sex after twenty four weeks, and some will cry because they don’t want the issue [baby]. If they ask, I don’t hide anything from them, even if the woman already has four daughters and is expecting another one.” (Dr. Sunbool, FHH: May 13, 2005)

Yet an hour later, Dr. Sunbool reversed her position on sex disclosure:

“If I see it’s a female, I make so many lame excuses, such as ‘Come next time, I can’t see today’ or, ‘The image from the machine isn’t clear’ [because] if they know it’s a girl, they will deliver [abort] early.” (Dr. Sunbool, FHH: May 13, 2005)

And when I sat observing another ultrasound scan later that same day, Dr. Sunbool’s colleague, Dr. Latifa, admitted looking for a baby’s sex as early as fourteen weeks gestation, even though “it’s very difficult for us to tell at that time” (Dr. Latifa: May 13, 2005). One of my most uncomfortable moments observing clinic visits came when a pregnant patient, only two months away from her due date, became visibly agitated both during and after her ultrasound with Dr. Sunbool. After clambering onto the examination table, the patient quickly sat back up again, straining to see the ultrasound images once Dr. Sunbool began measuring the foetus’s head circumference and thighbone length, checking for its gestational age and development. After a female orderly pushed her back down, the patient began pestering Dr. Sunbool to tell her if the baby was a “di” (daughter; S) or a “puch” (son; S) while the doctor replied she couldn’t see the foetus properly. Looking over her shoulder at me where I sat in the corner of the room, and speaking quietly in English, Dr. Sunbool said:

“I’m afraid to tell her, because she has already taken an abortion medication...she has taken a medication we use for amenorrhea [absence of menstruation] and an anti-malarial, and she has told us this already. If it’s a girl, she’ll abort. She will go to a dayah to abort, who will induce her for premature delivery. If the baby is early, they will not care for it after delivery, they will not feed it.” (Dr. Sunbool, FHH: May 13, 2005)
After completing the ultrasound, Dr. Sunbool left the room to speak with Dr. Latifa in an adjacent room, and I was left alone with the woman who, after tying up her shalwar (pants; U) and straightening her dupatta, came and stood over me. I was sitting busily writing up fieldnotes before the next patient came into the room; she put a hand over mine as I wrote and firmly pulled up my chin so we were looking eye-to-eye. Uncertain and caught off-guard, I whispered “Sapoie mubarak [pregnancy congratulations; S].” She leaned in closer, and in a deeply inquisitive and strained voice, asked “Puch [son; S]?” I clarified my congratulations were for the pregnancy, and I didn’t know the baby’s sex, though my nervousness was telling. Moving in even more closely, the woman grabbed one shoulder tightly and asked again, “Puch?” She then pushed a small pile of pharmaceutical prescriptions and exam records for me to look at, presumably so I could see if the baby’s sex had been noted during the ultrasound. My heart thudding in my chest, I whispered in Shina “Bushtey” (I don’t know; S). She asked again. Once more I repeated, but this time in Urdu, “Maloom nuhee” (it isn’t known to me; U). The door opened, and an orderly, startled to see me held in the woman’s grip, came and pulled her away from me and pushed her out of the room.

The intensity of the patient’s fears, her desperation and her obviously harmful intent towards an unborn daughter were overwhelming (Fieldnotes: May 13, 2005). In light of such moments, it was clear that the doctors’ highly variable position on foetal sex determination was suggestive not merely of the lucrative benefits afforded by ultrasound, but also the necessary differences in physician approach to patients who posed, or did not pose, a risk toward their unborn babies.

Women sometimes debated if by using tawiz, desi ‘remedies’ or ultrasound to divine, change or check for foetal sex, their efforts weren’t also suggestive of their ingratitude to God. By extension, some women suggested that a woman’s piety, or lack thereof, might encourage God to ‘turn a girl baby’ into a boy, or vice versa, notwithstanding prior ultrasound confirmation of the sex (Fieldnotes: August 12, 2005). In this way, women’s narratives emphasized how moral comportment and ‘deservedness’ were causative forces.
underlying ‘good’ or ‘bad’ events. At the Gilgit Medical Center, Dr. Sharifa was sympathetic to the trials endured by Sunni women without sons. Yet she also seemed vaguely repulsed by women’s fervent fixation on sons and their sometimes-obvious, wholehearted desire to terminate a healthy pregnancy with a female foetus. Dr. Sharifa was, however, careful to acknowledge how women’s in-laws’ and husbands’ disappointments had pushed many expectant mothers to take significant risks with their health.

“I had one patient who had a son…and after that had five daughters and was seven months pregnant again. She requested me to check for the sex, and said ‘If it’s a girl, I will terminate.’ When I asked why, she said ‘If it’s another daughter [my in-laws] won’t allow me to use Family Planning, and I will have to keep getting pregnant until I have a son!’ So the pressure was from the in-laws.” (Dr. Sharifa, AKHS,P: May 15, 2005)

And while it happened only rarely, a number of women had reportedly committed suicide after delivering another daughter. According to one Gilgit-based NGO, such women were ‘driven’ to suicide by their in-laws or out of fear of divorce, after which time women almost always lost custody of their children (Blessing Hands Funding Application [EU]: September 2003).

While Dr. Sunbool and Dr. Latifa were both unmarried and childless, curiously nearly every other prominent ‘lady doctor’, alongside a bevy of LHV, LHWs and dayahs, had only daughters and no sons. For those Sunni participants who used a baby’s sex as a point for moral commentary (whereby daughters were viewed as ‘punishments’ and sons as ‘gifts’), this dearth of sons was looked on as God’s punishment women who had shirked traditional social strictures in favour of education and paid employment. Health workers, conversely, re-imagined their circumstances as a deliberate ‘message’ from God. If a mother of daughters could succeed and provide her children with a far more comfortable life than those Gilgitis who had sons (and failed to educate them), perhaps their patients would be more accepting of female offspring.

17 It was not uncommon for women to ponder if their obviously unwanted daughters were tangential by-products of their spiritual transgressions, or the result of interpersonal enmities and ‘black magic’ (kala jadu; U). Just as importantly, women envisioned the births of sons or of healthy infants after loss as rewards for their moral righteousness.

Emma Varley
“In Saudi Arabia they accept daughters, but not in Sakwar [Village]! Here people have been affected by Hindu elements....Who is happy with girls here? Even our Prophet stood for his own daughter when she arrived!...What are the sons giving, my goodness. I was the seventh daughter of ten. My mother was *pugulee* [crazy; U] for sons, though finally she had four sons. We’ll take better care of a mother, as compared to boys!” (Dr. Khalthum, DHQ: September 7, 2005)

“In such cases, I use my own example – that I have three daughters and don’t get pressure from my in-laws, and don’t try to have more children. But some ladies will say, ‘But you are a doctor, you are educated, nobody can say anything to you!’ In this respect, I think women should be powerful, in terms of their education, in economic issues, so they can manage these issues and pressures.” (Dr. Sharifa, AKHS,P: May 15, 2005)

Yet Dr. Sharifa, not unlike the Sunni Dr. Khalthum at the DHQ, was not completely exempt from the pressure to have a son – this despite her Ismaili identity, the Ismaili community’s overall support for ‘gender equality’ and her own economic independence. As repayment to the Aunt and Uncle who had raised her and her older brother after their parents had died, Dr. Sharifa’s brother had married their daughter – his first cousin. Fifteen years later he had fathered four daughters, while Dr. Sharifa had borne three daughters.

“My [foster mother; Aunt] cried every time a grand-daughter was born, and yet my daughters have never missed having a brother, but my nieces were waiting for the last baby to be a boy, because their Dadi [grandmother; U] had told them it would be a *lurka* [boy; U]. They still feel something is missing from their family, and I explained it [to my brother’s] mother-in-law by saying ‘The same God who gave you two sons, gave me three daughters, so do you want to *jugurah* [have a fight; U] with God?’” (Dr. Sharifa, AKHS,P: May 15, 2005)

Although Ismaili physicians admitted that ‘boy fever’ also featured in Ismaili community life, they derided the festishizing of sons as reflecting the individual, rather than the community’s, inability to ‘advance’ or incorporate Ismaili ‘gender equality’ with family-level practices. Even after detailing her four daughters’ multiple educational and employment accomplishments, the DHQ’s Dr. Khalthum laughingly conceded that her Sunni family was dissatisfied with her decision to stop trying for a son. Her situation had also effected how she shared her own experience with patients; “I don’t emphasize that I have only
daughters when I talk to other people about my family, otherwise I’ll get advice about how I need sons!”
(Dr. Khalthum, DHQ: September 7, 2005)

**Part III Unwanted Pregnancies**

An important consequence of the unavailability or impermissibility of contraception, in addition to the push for more sons, was unwanted pregnancies. Gilgiti women frequently felt that pregnancy and birth were in some sense pre-ordained and therefore beyond the scope of their or their husband’s control (Sherbaz Ali, FPO: July 28, 2005). Their beliefs in the spiritual elements inherent in conception did not, however, stop women from experiencing genuine anguish when they dealt with unexpected or unwanted pregnancies. Women’s distress was especially great when their family faced significant economic deprivations, or they were left alone with other small children while their husbands were on-duty with the Army or working ‘down-country.’ At the DHQ’s Family Wing, the Labour Room nurses, LHVs and attending physicians confirmed they were not allowed to provide elective terminations, illegal in Pakistan. Elective abortions were defined as resulting from a mother’s desire to end an unwanted pregnancy, avoid economic difficulties if many children had already been born, or to abort a female foetus. At the Gilgit Medical Center:

“…patients request but can’t [receive] illegal abortions…these women frequently go to a dai [midwife] in Zulfiqar Colony. Medically and ethically, AKHS,P cannot provide abortions on-demand, even if the patient is unmarried or has many children.” (Dr. Sharifa, AKHS,P: January 7, 2005)

The procedure’s illegality within Pakistan, however, was not based completely on Islamic precepts. Indeed, women, their families and a number of mullahs asserted that under certain circumstances, namely fear for the mother’s health or severe impoverishment, abortion was ‘permissible,’ but only until the foetus ‘quickened’ at around four months.

“We are helpless, because our bodies are not so strong, and we will suffer if we have another baby. Some husbands don’t like this, so we don’t discuss these things with them. It’s OK to do it in the first two months, but after that it’s a big gunah [sin; U]. After two months, it has a body, a nishan [human form; A], but before this it’s just blood, so what’s
the sin? My daughter had an abortion at four months. She said she was fed up, and went to the... hospital for an abortion. I’m not sure who the doctor was...she paid Rs 4,000 [CDN $91] and her husband gave his permission. Well, [actually] she told him after the D&C, but he understood their youngest daughter was so young, and wasn’t angry.” (Khala, Jutial: August 18, 2005)

During my observations of nearly one hundred patient visits to the Family Health Hospital’s Out-Patient clinic, it was not uncommon to see women devastated to find out they were pregnant. During one such visit, a young woman leaned across the desk and in a heavy whisper began pleading with Dr. Sunbool in Shina. Dr. Sunbool leaned back in her office chair and in a loud voice, and to the obvious embarrassment of her patient, explained in Urdu:

“This is an unwanted child, and she is trying to convince me to give her an abortion. But I have said that the excess hormones that pregnant women have will help to make her uterus a little relaxed and it will be beneficial to her to be pregnant.” (Dr. Sunbool, FHH: May 14, 2005)

In the Out-Patient visits I observed in local hospitals, physicians were noticeably uncomfortable with, and routinely refused such requests. But in early spring 2005, I began hearing rumours that one local OB-GYN – referred to hereafter as ‘Dr. X’ - regularly provided ‘illegal’ and also very expensive abortions.18 (On the one hand, I was somewhat relieved to know that women seeking to end their pregnancies weren’t forced to rely only on the services of dayahs. On the other hand, this particular physician charged exorbitant rates for her services, especially when women were unmarried.19) It wasn’t until a LHV working at another clinical center recounted her own experience that any of my remaining doubts were laid to rest.

18 ‘Dr. X’ was reportedly well aware that medical misdiagnoses, botched terminations or post-abortion complications were regularly attributed to her work. One DHQ LHV described being confronted by ‘Dr. X’; “I was at a workshop with her, last year perhaps, she said to me and some other people, ‘I hear you people are making bad rumours about me, let’s just see who is doing this!’ I responded and said, ‘I see your bad prescriptions, all this shows up at the DHQ, so we know the truth.’ She was angry, and said, “We’ll see who it is, let them stand up and I’ll face them!’” (LHV, DHQ: August 6, 2005)

19 With the exception of ‘Dr. X’, the health providers I interviewed roundly denied Gilgit’s other OB-GYNs provided ‘illegal’ elective abortions. Their claims were upheld, in many respects, by the fact that such rumours did not surround the work of any of the other physicians I interviewed.
“She did my own termination! I was pregnant a few years ago, it was summertime and the nausea and vomiting, along with the heat, were making me pugul [crazy; U], so I went to her for an abortion, to buchhey ruhhtey hey [leave the baby, take it; U]. I went for a D&C and she charged me Rs 4,000 [CDN $91]. We’re in the same profession, and even attended the same workshops and training seminars, and I had thought she’d give me a discount...Look, she’s made herself very rich from this work...I had asked for a concession, but she just said ‘Afsoos’ [regrets; U]. Her D&C work is very, very perfect. We don’t see any complications from her D&Cs [at this hospital]. She’ll normally charge Rs 8,000 - 10,000 [CDN $181-227] for a termination, but if it’s an ‘illegal’ [extra marital] case, she’ll ask for much more, up to Rs 20,000 [CDN $454].” (Sister, Hospital X: August 19, 2005)

Biomedical technologies had added new complications to the local practice of abortion. Counteracting women’s notions that the foetus was ‘unformed’ until ‘quickening’ (usually after fourteen weeks gestation), ultrasounds proved that even an unfelt eight-week foetus was ‘active’ and ‘alive’ (zinda; U).20 Yet foetal quickening remained a key diagnostic point for how dayahs handled prenatal care, and now ‘illegal’ abortions.21 For instance, at her midwifery practice in mixed-sect Diamer Colony, the Shia Dayah Ambreen was said to have set the ‘cut-off’ for terminations at quickening. One of her ayahs (assistants; U) confided how, “Ambreen will give a drip of medicine to the mothers [but] when movement has started [is noticed] she won’t do abortions” (Sabrilah, Diamer Colony: September 11, 2005). Yet even though ultrasounds and biomedical emphasis on the foetus as a ‘baby’ had added new moral discomforts for women seeking even pre-‘quickening’ terminations, financial and family-based pressures led to a steadily rising abortion rate.22 Rather than pointing to ‘Dr. X’, Dr. Sharifa blamed the growing business in ‘illegal’

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20 During an early second-trimester obstetric ultrasound at the Family Health Hospital, Dr. Sunbool’s laughing commentary on the foetus’ movements exemplified this ‘humanizing’ of the unborn; “I love babies this size! Look, a total baby! Like a little monkey! See it kicking and stretching, it’s happy!” (Dr. Sunbool, FHH: May 14, 2005)
21 In some instances, health providers’ and women participants’ descriptions of ‘illegal’ abortion were synonymous with ‘illegal’ pregnancies, in that the pregnancy and abortion were the result of an ‘illegal’ (pre- or extra-marital) relationship. In other instances, participants’ referred only to the procedure’s illegality within Pakistani law.
22 One recent FPAP health survey suggests that upwards of 10% of maternal deaths are due to ‘unsafe abortions’ (Karim 2004, PowerPoint Presentation: Slide 9); to my knowledge, there are no other available health statistics concerning abortion for the Northern Areas. I relied instead on health service providers’ anecdotal observations that higher numbers of their patients had either solicited or claimed to have received elective ‘illegal’ abortions, or sought help for post-abortion complications. The medical terminology employed by health providers to describe pregnancy terminations in hospital Intake Registers made it impossible to distinguish between ‘illegal’ or therapeutic cases; both were referred to as ‘missed abortions.’ This term applies equally to improperly handled ‘illegal’ terminations (where there is an incomplete removal of the foetus), the failure of a miscarried foetus to be
abortions on *dayahs* like Ambreen, who were dangerously exploiting new segments of the local health ‘market.’ As I discussed in Chapter Two (see page 150), after retiring from active service at the DHQ or Family Health Hospital, several prominent *dayahs* started their own private clinics, self-styling as trained nurses or even ‘doctors.’ Although their work focused predominantly on informal pregnancy and childbirth support, and included massage, homeopathic therapies for morning sickness and joint pain, or pre-natal breech birth manipulation, ‘illegal’ practices were – by far – the most lucrative component of their clinic-based work.

“We often see the mismanagement of labours by *dais [dayahs]*. There has been a shift in the services that they provide. Now their business has shifted to high paying abortions, which require a lot less work and monitoring than labours, which can go on for hours and hours and their pay is much less...it will be at least Rs 3,000 [CDN $68] for an abortion. But they don’t do a complete job, and only interfere with the pregnancy. This is why the women come to us afterward and need us to complete the process once it has been interfered with. Women will not be honest with me about what has happened, and it is only after I ask question after question that they will admit to me what they have done; they tell me that they have promised the *dais* not to give their names to anyone. In the last few years, women would come to see Dr. Sabriqilah and say to her, ‘First I will go to see [the *dayahs*], then I will come to you and you will finish [the abortion]!’ Even very educated women, after they come to us and we will not do an abortion, they will go to the *dais*, knowing the risk!” (Dr. Sharifa, AKHS,P: May 12, 2005)

In one hurried interview, two of Ambreen *Dayah’s* three women assistants discussed the clinic’s services while Ambreen shopped unaware in a local *bazaar*. The elder of the two women, Shabnum, described how women came throughout the day or arrived under the cloak of nighttime darkness to ensure their privacy.

“Usually lots of women come, at least one to two times a day, sometimes too many are coming [uses her fingers to indicate ten]...Ambreen worked alone before, but now there are three of us girls working too. When patients come and see us there, they get scared and sometimes leave.” (Shabnum, Diamer Colony: September 11, 2005)
According to the other assistant, if terminations were deemed a ‘medical necessity’, and cases were referred to Ambreen Dayah by local physicians, first-trimester abortions cost “Rs 2,500 [CDN $57] for Shias, because [Ambreen] is a Shia, and Rs 3,300 [CDN $75] for Sunnis and Ismailis” (Sabrilah, Diamer Colony: September 11, 2005). Regardless of a woman’s sectarian affiliation, ‘illegal’ terminations were equally expensive; ‘simple’, or uncomplicated procedures cost Rs 5,000 (CDN $114). One of her assistants declared Ambreen Dayah’s technical work was “A-1!”, while the other added that Ambreen “generously” returned funds each year to the Shia community out of her earnings as zakat (tithe; A) (Shabnum & Sabrilah, Diamer Colony: September 11, 2005). And though the health providers I spoke with said Ambreen was a relatively effective practitioner of first-trimester abortions, they pointed out how the overall lack of hygiene at her clinic often led to serious consequences. At the DHQ, Family Wing LHV’s had provided emergency treatment for many of Ambreen’s patients after they developed post-procedure complications.

“She’s bilkul [completely; U] untrained and uses a suction machine for terminations….first she gives them an injection of Heparin [blood thinner] and of Cintocene [uterine stimulant] before the surgery, using an IV line. She used dilation and then suction. This method only works well until two months, it’s a very gandagee [dirty; U] method [and] she charges Rs 5 to 6,000 [CDN $114-136] per case. After two months, she has to use another method.” (LHV, DHQ: August 6, 2005)

Some nurses willingly discussed their efforts to ‘find out’ who had caused the women damage, although they denied women had died due to abortion complications, or from blood infections like septicemia.

“We see women come in with infections following illegal abortions, but none have died with us. These patients are secretive at first with us, but then they’ll share the news with us. We’ll discuss it with them, and force them to tell us the truth. They’ll then tell us where they went, who did it, how they did it, how much it cost. Everything….One patient was here and told us she had an abortion at one, two or three months. We dilate the cervix for an induction, like at full-term. Some come out after the dilation. When the baby hasn’t come out, or it’s an incomplete D&C and they’re still bleeding…. But I don’t know how they do such abortions.” (Nurse II: July 26, 2005)

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23 After reflecting on my interviews with the Family Wing’s LHV’s, I found their naïveté regarding abortion techniques largely unbelievable. Nurses, LHV’s and ayahs routinely prepared women for medically necessary
It also became increasingly clear that a number of local LHV\'s had been trained under ‘Dr. X’ and had gained an intimate knowledge of abortion techniques while observing her practice. As one local LHV, who worked in a local clinic, noted:

‘Dr. X’ gives abortions [and] she charges Rs 10,000 [CDN $227] even if people are poor! ‘Dr. X’ itna zulum heh, lekin kam saey heh [is that much of a sinner, but her work is perfect]…I worked with ‘Dr. X’ before. (LHV, Clinic X: August 19, 2005)

For the families unable to afford ‘Dr. X’\’s services, they could contract off-duty or retired nurses, LHV\’s or dayahs to provide abortions in the privacy of their homes.

“There was one time, with an illegal case…[when] the mother came to me and begged for my help, saying, ‘If she has the baby, it will ruin her chances for marriage!’ There are many problems for such women, and I said I would help her, but she had to pay some money to cover my costs. I took only Rs 500 [CDN $11.30], but she gave Rs 3,000 [CDN $68], which covered the medicines [and] the supplies.” (Sister X: August 27, 2005)

Given how frequently women faced life-threatening infections after these ‘illegal’ procedures, I had asked Dr. Sharifa if she felt that – in light of the proven and ongoing demand for terminations – abortion should be in some way legalized. Her answer surprised me, in that it de-prioritized the risks facing women, and instead foregrounded the ways men could manipulate the medical system to their advantage.

“I don’t know, but I think that maybe if it’s made legal men will be able to put much more pressure on women to have abortions, for instance, if it is their third or fourth child and unwanted, or if it’s an ‘illegal’ [extra-marital] pregnancy. It might encourage these kinds of situations, you know?” (Dr. Sharifa, AKHS,P: May 12, 2005)

‘Illegal’ abortions were not only the result of women\’s impoverishment, the pressures of raising many small children at any one time, marital instability or pre-marital sexual relations. Pregnancy and childbirth was often defined as being more ‘appropriate’ for younger women. By the time women were in their mid-thirties they were described by their family and physicians as ‘too old’ to have more children.

Among the health providers I interviewed, most agreed that pregnancy past the age of thirty was more...
likely to result in obstructed deliveries, postpartum hemorrhage and maternal death, or an undersized or weak (*kamzor*; U) baby (LHV III, DHQ: August 1, 2005). (Conversely, pregnancies that happened ‘too early’, when girls had not yet fully developed, were viewed as equally *khattarnak* [dangerous; U].)

And by the time many women were in their mid-thirties, their first grandchildren were being born. The interconnections between women’s sexuality and pregnancy were now far more problematic and embarrassing. The shames experienced by a woman’s adult children were cited as reason enough for older mothers to seek an illegal abortion. At the Gilgit Medical Center, Dr. Sharifa had treated several such cases, and knew of at least two suicides of women who were unexpectedly pregnant again in their early forties. Several months before I first interviewed Dr. Sharifa, one of her patients had killed herself in the first months of an unplanned, ‘late life’ pregnancy.

> “Her son was very upset and embarrassed by his mother’s pregnancy and disturbed her quite a bit, saying ‘You’re too old to be having children again! This is not your business!’ She was very upset and took an overdose of pills and died, because of her son disturbing and humiliating her about this pregnancy.” (Dr. Sharifa, AKHS,P: May 3, 2005)

Other older women were driven to seek abortions from untrained *dayahs*. Over the past decade, Dr. Sharifa had seen a number of such women arrive for emergency treatment after developing serious, post-abortion complications.

> “Another older patient was five months pregnant, and her eldest son was twenty years old, and she had four or five other children. She found herself pregnant and said that she wanted to have an abortion, against the wishes of her husband, who had a *jugurah* [fight; U] with her about this saying ‘This is a legal pregnancy, why should we be embarrassed, or hide it, or finish it?’ But she persisted and he agreed to an abortion. They came…to a clinic where she had a procedure done, and she was told it was complete…but the next morning, she developed severe stomach pains and then she came into AKHS…she was blood pressure-less, and pulse-less, but still talking! Her abdomen was very tender and she was in septic shock. She wouldn’t admit to interfering with the pregnancy, and we weren’t sure of the diagnosis because upon a vaginal exam we couldn’t feel anything, the uterus [felt] empty….I went to ask the woman what she’d done, and told her we needed to know in order to help her. The woman admitted to going to the clinic…we opened her up to see what had happened, and maybe also save her. In those days we didn’t have an anesthesia machine, and we had only spinal anesthetic, and local anesthetic. We used a local anesthetic, and she was still unconscious from Ketamine…we found the uterus was

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perforated and the baby and placenta were lying on top of the intestines. We operated at four or five in the morning and by that evening she had died. She never regained consciousness.” (Dr. Sharifa, AKHS,P: May 3, 2005)

Women driven to desperation by rapid pregnancies, poor health or poverty, but for reasons of finance or fear avoided seeking abortions at Gilgit’s hospitals or with dayahs, frequently turned to pharmacological and herbal abortifacients. After speaking with comporters in several of Gilgit Town’s biomedical dispensaries, I learned there were a number of relatively inexpensive drugs women used to cause miscarriages or foetal demise. Dr. Sharifa confirmed that anti-malarial quinine was among the most commonly used, although profoundly ineffective.

“Usually women will take these tablets – anti-malarial, Paracetemol – to try to self-abort. They try to overdose and cause an abortion. The anti-malarial is quinine, but it doesn’t work, and they come to us afterwards asking for help. If the foetus is still alive, we don’t tell her to terminate, because we’re not sure if any abnormalities are present, or what drugs she used. If the foetus has died, or the condition is bad of the mother, we will perform a procedure.” (Dr. Sharifa, AKHS,P: May 3, 2005)

The Karakoram Dispensary sat along the main road leading through Gilgit’s eastern mohallas, and was surrounded by a mixed Sunni-Ismaili neighbourhood. It was run by a Shia veterinarian who felt pharmaceutical sales would be far more lucrative than his less prestigious dungur daktar (animal doctor; U) duties. Because his store was in close proximity to the Family Health Hospital, Alamgir had seen his business profits increase dramatically with the sale of contraceptives (including condoms, otherwise a rarity in most Gilgiti pharmacies) and pharmaceutical remedies for ‘too much’, ‘too little’ or ‘absent’ menstruation (Fieldnotes: August 26, 2005). He quickly confirmed that local women and their families regularly sought his help for unwanted or ‘illegal’ pregnancies.

“If children are young, under a certain age, and [women are] pregnant again, it’s very hard for a woman if she has two small children! Then mostly men, but some women will come...Some women know when it’s their menses time, so they come within a week or so after they’re late to get something to end the pregnancy. Others aren’t so sure, and come later, sometimes one month later. This [Gynaecosid] is Rs 27 [CDN $0.60; see Figure 21] for

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24 See Santow, Hull & Hull, Johnston (2001) for ethnographic research on menstruation, emmenagoges and abortifacients.
two tablets, and you use them *subah-sham* [morning-night; U] in one day. 25 This works when a woman is one week late. Otherwise we have Argit capsules which are Rs 30 [CDN 0.70] for one, and you take these two times a day for three days. It creates bleeding and finishes the pregnancy. You use with Duoton capsules, you use them together. You take these two times for one day. And more than one month? Then women have to use injections. We have Oxytocin, which is Rs 5 [CDN $0.10] for 1 milliliter, this is the last option! [laughs] Other people go to *dayahs* like Ambreen, who lives and works in Diamer Colony...but you see, most people come here just with the name of the medicine and no discussion.” (Alamgir, Karakoram Dispensary: August 26, 2005)26

At Gilgit Town’s homeopathic and herbal dispensaries, store clerks said they were adept at concocting treatments for a number of reproductive or maternal health complaints, as well as unwanted or ‘illegal’ (pre- or extra-marital) pregnancies.27 (Desi specialists also confirmed that men came as often as women to purchase the herbs and roots reputed to cause miscarriage.) In order to prepare these ‘remedies’, clerks frequently worked from previously filled prescriptions, which were kept on-record along with the complaints for which they were used. And from the roadside where he sold *desi bilehn* ingredients, one itinerant Sunni herbalist described having

“...a root called *fotoh* [S], but you can’t use it too much or it will make you sick. Dangerous stuff this is! The [pregnant] woman has to take it with warm milk, in powder form, and she only needs to take it once, and after five minutes there is a discharge... We advise people to use it before two months, because then it’s just blood. Even when you use a little, it destroys the baby – it’s very dangerous! This is *shaitan-e-kissim* [a wicked thing; F].” (Ubaid Darwush, Gilgit: August 20, 2005; see Figure 22)

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25 On the warning label for the Gynaecosid tablets Alamgir showed me, it was clearly stated that the pills were for “secondary amenorrhea and not to be used if pregnancy exists or is suspected” (Fieldnotes: August 26, 2005).
26 In important ways, women’s use of *desi* and allopathic abortifacients illustrates the collapse of the boundary normally separating contraception from abortion. Women’s home-based abortive measures did seem to hedge up against mainstream Family Planning precepts, which Heather Paxson defines as “the calculated use of contraceptives to achieve desired family size” (2005: 95).
27 The physicians I interviewed never discussed if their patients had used *desi bilehn* for abortions.
In the absence of store-bought herbal remedies, Sunni women relied on home-prepared abortifacients, although their efficacy was uncertain.

“In this area, women take a stick from the *chokinaar* [peach; U] tree and beat it to a pulp. If your period is four or five days late, you insert this into your vagina, and the next morning you will have your bleeding start. There is also a root in the mountain forests, like a grass, and we grind it, boil it, and drink it. There is also *gurrh shukr* [unrefined, raw sugar; U] which we mash, put in to soak with water, and then the next morning we drink the water.” (Abidah, Jutial: August 18, 2005)

In the village of Sakwar, which sits at Gilgit Town’s eastern boundary, Abidah’s cousin, Nadia, confirmed that unrefined brown sugar, which was said to have ‘hot’ humoural properties, was among the most easily accessible and commonly used abortifacients.

“My sister had a one year old son – this is very recent – and she found herself pregnant again quickly, so to stop the pregnancy she ate *gurrh* [sugar; U], which is sometimes mixed with walnuts or almonds inside, and she was breastfeeding. Then her son got sick, and her husband, who is a mullah, threatened her saying, ‘If this boy dies, you watch what I’ll do to you!’ Our relatives took the child, hid him and took him to the hospital for treatment. The mullah did not know his wife was pregnant, and she did miscarry, and she’s hiding this from him too.” (Nadia, Sakwar: May 3, 2005)

Because home-made measures utilized locally available ingredients or inexpensive herbal ingredients, they could be produced at little- to no-cost, although some women debated if they were as ‘safe’ or ‘effective’ as formal *desi bilehn* or allopathic pharmaceuticals. For women who were unable to procure surgical terminations, or pharmaceutical or *desi* abortifacients, carrying on with the pregnancy until delivery was the only choice. But married women weren’t the only ones facing ‘unwanted’ pregnancies. When unmarried pregnant women failed to obtain surgical, pharmacological or *desi* terminations, the only remaining options were hiding the pregnancy and then killing or abandoning the infant.
Part IV Abandoned Babies

When unwed mothers sought help ‘too late’ for a medical termination, such as after foetal quickening, dayahs, ayahs and ‘Dr. X’ were all reported as refusing to proceed with an abortion (Fieldnotes: September 11, 2005). At Ambreen Dayah’s Diamer Colony clinic, her assistants confirmed she advised such clients to return again after their seventh month of pregnancy for induction and delivery, and thereby avoid the risk of ‘honour killings’ that came with their increasingly noticeable size (Shabnum, Diamer Colony: September 11, 2005). And while I’d heard frequent rumours Ambreen Dayah also quietly ran an orphanage, the physicians I interviewed protested they knew nothing of it. Once again, it was left to a ‘Sister’ to quietly confirm the local gossip.

“She got all her experience through ‘Dr. X’, and she’s even now keeping abandoned babies at her home. She has a big car, too, and has the support of ‘Dr. X’ because of her work with the abandoned children. There’s also some NGO from abroad which sends money to her.” (Sister X: August 13, 2005)

Once I had been told about the wider scope of Ambreen Dayah’s practice, such claims were quickly corroborated by other Gilgitis. Even my own brother-in-law, a part-time taxi driver, confirmed he’d twice been hired by a couple from Oshikandass to pick up a baby from Ambreen Dayah’s clinic. When the first baby had died, they returned again for a second infant. One LHV at the DHQ confirmed Ambreen’s clinic was one of the only safe places for women to deliver their ‘illegal’ or hidden pregnancies. “People know that if the woman is eight months pregnant, they can go to her and they know [she] will take care of the baby….There are so many babies in her house” (LHV IV, DHQ: August 27, 2005). While ‘legal’ deliveries were routinely charged between Rs 1,500 and Rs 2,000 (CDN $34-45), late second- or third-trimester ‘illegal’ deliveries ranged between Rs 9,000 and Rs 10,000 (CDN $204-227) (Shabnum, Diamer Colony: September 11, 2005). The day we visited Ambreen Dayah’s clinic, her ayahs told me about two teenage Sunni sisters who had arrived the previous week to deliver their ‘illegal’ pregnancies, after which the babies had been quickly adopted by local families. Adding to the drama, the
babies had been fathered by the same male relative. Whether through sheer ignorance or genuine naivety, the girls’ parents hadn’t noticed the pregnancies until one of the girls asked for medical treatment.

“The reason the [girls] had come in was that one of the girls was complaining of pain in her kidney, and her father brought her in....he brought them for a medical check, and after a urine test we found one girl was seven months pregnant!...She was a student of Class 9, perhaps fifteen or sixteen. [The babies’ father] came, you know, and we scolded him, but he just laughed and clapped his hands, saying ‘You don’t just clap with one hand!’28 He is young, about twenty-eight, and a Sunni....He is a relative of theirs who was living in the same house. He was an uncle-type figure to them...the girls’ father brought him and he had found out and was so angry! The boy didn’t come [at first] and the [girls’] father sent Police for the boy. Their father told him he was responsible for the fees, but the boy refused to pay....The boy wanted to do a *nikah* with the sisters, but [they] refused. Now, how can this kind of thing happen in Islam?” (Sabrilah, Diamer Colony: September 11, 2005)

It is worth pointing out that Sabrilah’s astonishment was multi-layered; she was not merely addressing the ‘illegality’ of the man’s relations with the two young girls or their subsequent pregnancies. In light of Qur’anic prohibitions against a man being married to two sisters at the same time, she was equally appalled by his offer. Sabrilah and Shabnum then explained how ‘illegal’ pregnancies sometimes resulted from other kinds of forbidden relationships. Given increasing antipathies between Gilgit’s sectarian communities, mixed-sect couples were roundly prevented from marrying, even in the instance of an unplanned pregnancy. As Shabnum recounted:

“One lady came here two days before for an ‘illegal’ delivery. She was a Sunni, and from the lower royal family, and the [father] was an Ismaili – she had a baby boy, a very pretty baby boy!” (Shabnum, Diamer Colony: September 11, 2005)

Although many such delivering mothers were discouraged from going to the DHQ where patients’ names and residence were recorded in the Intake Register, ‘illegal’ cases still occasionally appeared at the Labour Room. There, the nurses, LHV’s and the Family Ward’s Head OB-GYN said the patient’s emotional state was usually the first sign something was amiss.

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28 This common Gilgiti expression is roughly analogous to ‘It takes two to tango.’
“There have been one or two times I can think of, mostly when I’m on duty, where we think maybe it’s ‘illegal’, because the woman can’t talk to us and the family stays close to them. And they are confused, and say the wrong things or give different stories about the same patient….With ‘illegal’ cases, women are not thinking that they’re a mother. They’re concerned about society and the consequences they face...” (Nurse I, DHQ: August 6, 2005)

At a primary level, fear displaced maternal obligation and love. The potential punishments women faced ranged from social isolation, forced marriage to the baby’s father (who might even have been a relative or her rapist), or being murdered by her father, her brother or an uncle. Although doctors routinely refused (or claimed to refuse) assisting with abortions, they were often willing to help women in the final stages of a hidden pregnancy. Physicians frequently took extraordinary and courageous steps to protect women with ‘illegal’ pregnancies, and thereby save women from public shame, police involvement and ‘honour killings.’ Indeed, both rape and pre-marital sex had been criminalized by Pakistan’s Hudood Ordinance; men or women found ‘guilty’ of extra- or pre-marital sex (zina; A) faced time in jail (see Khan 2006). At one local hospital, an OB-GYN described taking careful measures to protect such cases in the patient’s case file.

“For illegal cases, I give full protection to the ladies. If I see them early in pregnancy, I advise them that I’ll help them. It’s their headache, but I’ve protected these ladies. I use ‘ovarian cysts’ as my code word on medical forms [laughs] but the babies are born safely. I operated on one such case here, and another doctor insisted the police come. I said, ‘They are not involved in sex issues!’ And I took the [hospital administrator] into my confidence, saying ‘Men can marry after, why can’t women?’...Many cases for [illegal] delivery have [come] here. I tell them to say the doctor advised the patient to rest, and to say it’s ‘gas’ - this kind of thing.” (‘Dr. Sudasha’, Hospital X: September 1, 2005)

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29 In his ethnography of an Ismaili-Sunni village in the Chitral Valley (NWFP), Magnus Marsden notes similar occurrences; “Chitralis talk about illicit sexual encounters, and the illegitimate children (zharioli) who occasionally result. On some occasions the woman, having given birth, was quickly married to a different man from another village. In other incidences they were married immediately to the man purported to have brought ‘shame’ on the family. More rarely, abortions were carried out in local hospitals; a bribe was paid to the doctor who then carried out the abortion without filing a fornication (zina) case with the local police” (2007: 97). Given the number of abortions, ‘quiet’ deliveries and abandoned infants in Gilgit Town, and the apparently minimal role of ‘forced’ or rushed marriages, my research points to a number of possible differences from Marsden’s findings, all of which would benefit from future research.

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This same physician was quick to attribute her ‘leniency’ toward these women and their families as being the product of Islamic strictures. Seeing my confusion, she cited a Hadith to illustrate her point:

“I remember Islam and the good sayings of our Prophet Mohammad, Peace Be upon Him, when I deal with such cases. One lady came to him and she was pregnant, and asked him for her punishment [death]. Because she didn’t want to go to Hell after she died, you see? He told her to finish the pregnancy first, and then come back to him. She returned after the birth, and said ‘Punish me now so I can go to Heaven!’ The Prophet told her to wean the baby first and come back after two years. She returned to him after two years, and asked for her punishment, and the Prophet said he had to ask first in the Majlis [prayer congregation; A] if anyone could care for the baby – sabak raheem [lesson of mercy; A] – and one man stood up and said he could care for the baby. The Prophet was not happy, but he was [then] forced to punish this lady, and after the Majlis-e-Sahabah [the Prophet’s congregation, companions; A] asked the man, ‘Why did you offer to care for the baby? Didn’t you see the Prophet wanted to give the lady raheem [mercy, forgiveness; A] if no one could take her baby?’ So, why should we hide, why should we call the police?” (‘Dr. Sudasha’, Hospital X: September 1, 2005)

As was the case at Ambreen Dayah’s orphanage, many of the ‘illegal’ infants born in local hospitals were quickly adopted by childless couples who had asked nurses, LHVs or physicians to be on the ‘look-out’ for foundlings. More rarely, infertile staff adopted the infants themselves (Madheeya, Jutial: June 22, 2005). Not all adoptive parents were infertile, though, in that some sought to remedy their ‘lack’ of a son. And in families with only boys, some participants openly entertained the adopting a daughter (Shailah, Jutial: June 16, 2005). When infants were abandoned at the DHQ, staff contacted the Gilgit Police, who in turn had working relationships with several locally owned and operated orphanages.30

Until it lost a large share of its international financing in autumn 2004, the Sahara Orphanage, a Saudi-funded home and madrassah that cared for infants and younger children, had operated from the heart of Sunni-dominated Konodas Mohalla. Stepping up to fill the gap in service coverage was the CEENA Welfare Services, an NGO established in 1997. At CEENA’s orphanage in Lower Jutial Mohalla, four full-

30 According to CEENA Welfare Society staff, their Chief Administrator regularly paid for the transportation and interim care of abandoned infants, while also offering small financial incentives and ‘rewards’ to government employees, civil servants and local politicians to ‘save’ at-risk infants, or help ease the constraints that impeded women’s ability to more safely abandon their infants, and ensure the baby’s survival (Fieldnotes: May 5, 2005).
time women employees and a bevy of community volunteers helped care for up to fifteen infants at any one time.\footnote{CEENA also managed a hostel for upwards of thirty children who had been orphaned or abandoned by their impoverished parents (Neelum, CEENA: May 5, 2005).} When I first visited in May 2005, five infants were being cared for in a small house set in the midst of an apple orchard. Inside, just off from a well-stocked kitchen and heated in the evening chill by a small charcoal brazier, was a small room filled with traditional wooden cradles (ghorah; S), into which infants were snugly tied with flannel cording. Volunteers described these babies as ‘lucky’ to be alive.

“One mother...gave birth and buried her baby near the road under sand. A passerby found the baby still alive, then police contacted CEENA. Our officials begged them to keep the baby alive, and offered to pay all the associated costs to bring the baby to the center. The baby is now alive and well! Within the last month, another baby was found half eaten by dogs, near where it was left outside our front gate. Another baby was found dead in a [plastic bag] in a nearby field a week ago. Babies are often wrapped completely in [plastic bags] and discarded on roadsides, or in fields, or along water channels. Many are found dead...just as many are found alive as dead, with many more cases unreported or undiscovered. Another infant was found with its throat slashed. One woman...gave birth to a baby, placed it afterwards in a freezer and when the baby was completely frozen, took it and left the body at the Gilgit Airport.” (Haijeri, CEENA: May 5, 2005)

After recounting many more of these sad stories, CEENA staff added that many babies were also left at local Shia Imambaragh, Sunni mosques and Ismaili Jamaat Khana. (One CEENA employee mused this provided evidence not only of a baby’s sectarian ‘parentage’, but also acted as compelling proof of the failure of Shia and Sunni religious conservatism or Ismaili ‘advancement’ to thwart pre-marital sex and pregnancy [Fieldnotes: May 5, 2005].) The majority of CEENA employees were Ismaili; a number of nurses and LHV from the Gilgit Medical Center also volunteered at CEENA during their off-duty hours. The orphanage had recently begun to receive funding from the British NGO ActionAid, whose staff in Islamabad incorrectly described CEENA as a “home for unwed mothers” (Nazish Brohi, ActionAid: April 2, 2005). Back in Gilgit, Dr. Sharifa was horrified that this was how the home was being described, and protested that CEENA only cared for “foundlings and older orphans” (Dr. Sharifa, AKHS: May 3, 2005).

The consequences of such a rumour, in fact, risked CEENA being forcibly closed or subject to arson.

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\textit{Chapter Five: Wanted Sons, Unwanted Babies & Empty Wombs}
“Our [Gilgit Medical Center] lab technician’s mother works there, and there are many lovely babies there. Some are very new and very small. They make sure to adopt and place them all with families though, most of the families are from Canada. When they come to get the babies, and the adoption papers are completed, they have a big function for the families when they take the children. I cry every time I go there, when I see the children in such difficult circumstances.” (Dr. Sharifa, AKHS,P: May 3, 2005)

Because CEENA was managed and funded primarily by Gilgit’s Ismaili community, their adoptive services were highly unusual. In line with Hanafi-Sunni dictates (see Inhorn 2006), the Government of Pakistan had prohibited legal adoptions regardless of the circumstances. Fostering children was legally permitted, but only if the child kept its father’s name and retained the right to inheritance from its paternal family. But in an apparent concession to the special challenges facing Ismailis as a minority community, the State allowed abandoned Gilgiti infants to be adopted by urban Pakistani and Canadian and American Ismailis. In some ways, regardless of their original sectarian or ethnic background, orphans were ‘made’ Ismailis through CEENA’s institutional, sectarian-aligned ‘parentage.’ (As was the case at the Gilgit Medical Center, portraits of the Aga Khan were hung in many rooms, while female staff members wore his gold-framed photo on necklaces.) Whether this was known to those parents who had chosen to leave their babies at CEENA remained unclear; Wadood commented that if Sunni or Shia parents knew the children would be raised as Ismailis, they might have preferred to kill them instead (Fieldnotes: July 16, 2005). In 2003, seven abandoned babies were found and brought to CEENA (CEENA 2003: 6-11); one volunteer estimated the number to have risen to nearly forty by 2005 (Fieldnotes: May 5, 2005). Moreover, girl and boy babies were rescued in roughly the same numbers, and baby girls were apparently not any more or less likely than baby boys to be killed at birth. During subsequent interviews with women participants, I heard many other accounts of babies being found alive and dead in Gilgit’s Sunni mohallas. I also learned that not every ‘illegal’ baby was aborted, abandoned or killed. One quiet ‘adoption’ in an in-town Sunni mohalla proved how, if only sometimes, families worked within themselves to secure alternate, middle-ground solutions to unanticipated pregnancies.
“My husband’s sister’s son, he was married and had one daughter, then after so many years and no more children, he was having relations [sex] with a police lady. She got pregnant and gave birth to a baby boy, and sent this baby with a Suzuki wallah [taxi driver; U] to his house in the middle of the night. The driver gave him the baby, after dhuk dhuk [knocking] on the door. After one week she [the mother] came to claim all her expenses for the pregnancy and delivery. People had asked the man where the baby came from, and he said that he had been going through Chamughar and a poor, sick woman was dying and gave the baby to him. Some people believed him, some didn’t. This happened here! Just a while ago, maybe a week or two ago, the mother was driving down ‘X’ Road and saw her baby, and kissed him on both cheeks and went away afterwards. She saw the baby as she sat in her car. Sub jantey heh [everyone knows; U] this happened!” (Bushra, X Mohalla: June 22, 2005)

Part V Infertility, Miscarriage and Social Loss

Besides women’s struggles to produce sons, or their desperate efforts to end or avoid unwanted pregnancies, I felt the saddest and least hopeful community was women dealing with infertility. The Shina word used to describe an infertile woman is ‘shohnee’ (masculine ‘shohnoh’; S), meaning ‘barren.’ However, ‘shohnee’ applies equally to “someone without children” (Latifa, Minawar: April 28, 2005), inclusive of unmarried men and women, or those who have not yet had their first child. It wasn’t an inherently derogatory term, but acquired additional, negative freight the longer a married man or woman were childless. The term also applies to women who have only had miscarriages or stillbirths, and less frequently to women who have only delivered daughters or for older widows who do not have any sons to provide a home for them. Among Gilgiti Sunnis, for women and their husbands, unresolved infertility was described as a definitive and virtually insurmountable loss. Many men and women characterized infertility, in fact, as a symbolic, economic and social form of death (maut; U). Infertility was not merely equated with the absence of future, socio-economic support from adult children - sons, in particular – but more fundamentally, it represented a man or woman’s inability to become parents, and fulfill the one function through which husbands and wives could achieve full decision-making authority, social standing and in-family status.
Although most participants were uncertain of infertility’s etiological underpinnings, they unhesitatingly described infertility as the ‘fault’ of one partner and not the other. Infertility – like the births of daughters - was usually blamed on women; moreover, my participants never entertained the idea that it might be an issue ‘caused’ by both partners.\footnote{The only exceptions were when men admitted to impotency or had failed to have children with a second wife. I was told of one young cousin in Diamer District, who had been married in his late teens to his first cousin. But because of brain damage from epileptic seizures, he was unable to maintain an erection. After one year, his wife used this as a reason to ask for a divorce, and his family quickly consented. The young woman remarried within a year, and soon had children of her own.} With adoption prohibited by the Hanafi-Sunni fiqh, and with childlessness an unacceptable long-term solution, the answer to infertility was generally divorce if the husband was at fault, or the husband remarrying if his wife was deemed ‘responsible.’ The irony of modern ‘love marriages’ was that husbands were loath to divorce much beloved infertile spouses, particular in the first happy years of a marriage. In turn, wives were deeply reluctant to ‘share’ their husbands with a new bride (habaynee, ‘co-wife’; S). In many ways, such scenarios reified the fears of the older generation that ‘love’ could form an insurmountable obstacle to successful family building. The majority of in-laws only allowed their daughters-in-law one or two years of desi, then biomedical, then surgical therapies before pushing their sons to remarry. Ironically, biomedical technologies, surgeries and pharmaceuticals enabled frustrated in-laws to engage in far more invasive and harmful interventions than had been possible in generations prior.

The tensions placed on women who failed to conceive were enormous; I only have to think back on own desperation trying to get pregnant after marrying Wadood. For month after month, Wadood and I waited and waited. And so did his family. For the first two years of our marriage, Wadood and I were referred to doctors, desi specialists and mullahs for a cure to my apparent infertility. After enduring countless humiliating discussions with doctors about my menstrual cycles and our sexual habits, and often with visibly bemused male and female members listening in on the conversation, I would weep in frustration and embarrassment. For the wife of a family’s only, or eldest son – as I am - the pressures to
conceive and bear sons within the first two years were especially intense (Fieldnotes: May 13, 2005; Fieldnotes: April 28, 2005). Among the new brides I spoke to, they uniformly agreed they were expected to deliver their firstborn by the first wedding anniversary; anything later indicated a ‘problem.’ As I had myself experienced, participants often complained that after only two months of marriage their mothers-in-law had pestered them to discuss whether sexual intercourse happened often enough, or asked if they were trying to ‘prevent’ conception. Several young wives recounted their Sas (mother-in-law; U) asking about menstruation, vaginal discharge and its consistency, if husbands ejaculated inside or if women washed semen away while ritually purifying after sex (hez ghusl; A). At a first level, women and their families sought fertility medications and then specialist care from local hospitals. When I first spoke to Ruqaiyah, a neighbour in Jutial, she was eight-months pregnant with her first child and mournfully shared the story of one of her nieces in Amphari, who had been married at the same time as Ruqaiyah.

[Emma] How many months after you got married were you pregnant?
[Ruqaiyah] About one and a half months after our marriage. There was no pressure to get pregnant. Bas [enough, OK; U]...if we get late people say maybe there are some problems, and make rumours. My sister-in-law’s daughter got married at the same time as I did, now it’s nearly 1 year later and she’s not pregnant and people think something is wrong, and ask, ‘Why isn’t she pregnant?’ We say to them, wait two to three years and she will be pregnant, and we’re telling her not to worry – it’s just been one year. But I’m close to delivering my first child and she still is not pregnant, so people talk to her and she’s become worried, and she’s only 20 or 21 years old. (Jutial: July 12, 2005)

In Minawar, Zarina had married her first cousin Rahim in 1995. After their nikah, they lived with his parents and siblings in an extended family complex. For the first year, Zarina had failed to become pregnant. This then caused considerable panic for her mother-in-law, who only had two sons among seven daughters and was desperate for her daughter-in-law to produce grandsons and ‘correct’ the

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33 Between a mother-in-law and her son’s wife, the drive towards conception raised many of the same awkward intimacies that were foregrounded by traditional childbirth practices, whereby a mother-in-law was the only in-law permitted to handle a young wife’s near-naked body or her breasts during infant feedings immediately after childbirth, or even apply herbal poultices to perineal and vaginal tears after delivery (see page 194).
family’s gender imbalance. When I asked her if the push to conceive quickly had caused her any anxiety, Zarina said that the everyday emotional disquiets that came with shifting to a new home with new family rules had actually been more upsetting. At the same time Zarina was forced by her mother-in-law to visit a series of doctors and desi practitioners, her family comforted her, saying that her situation was entirely ‘normal’ and some women took several years to have their first baby. Adding to her mother-in-law’s consternation was the fact that Zarina was only ‘able’ to have sex with Rahim for one or two weeks during each menstrual cycle.

From the middle of the cycle until her period, Zarina had copious black discharge, which made her ‘impure’ for both intercourse and prayer. Her desi practitioner said the discharge signified a uterine ‘blockage’, though her doctor said the discharge did not signify any specific diagnosis or pathology. After nine months, Zarina was given a matchbox full of small black desi bilehn pills, which she said “had a smell like black salt, and inside was brown crystalline powder” (Minawar: April 28, 2005). She was told to take it for one month, and again the next month if she still wasn’t pregnant. After two months, Zarina became pregnant with her daughter, Shamila. But because the baby was a girl, her mother-in-law put intense pressure on her to wean Shamila early and conceive again. Once again, Zarina ate the desi pills, which she said allowed her to become pregnant with her first son, Manzoor, who died of pneumonia when he was two months old. Zarina had delivered another daughter the year after Manzoor died, and then three years later gave birth to her son Qadeer, the first surviving grandson. But even after his birth, Zarina was not yet exempt from her mother-in-law’s desire for more grandsons.34 As one of her in-laws noted, “A woman will get pressure from her in-laws and from her husband. If she is not pregnant, she will get

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34 Rahim’s younger brother had married in the autumn of 2004, and even by early 2005 his mother was agitating for his teenage bride Bilqees to receive fertility treatments. By spring 2005 she was taken, somewhat reluctantly, by his parents to the Aga Khan University Hospital in Karachi, as well as a number of other hospitals and private clinics. Bilqees was quickly diagnosed with ovarian cysts, and was treated for the next year. Bilqees delivered a son in spring 2006, after having her labour induced at seven months due to polyhydramnios (excessive amniotic fluid), but the baby died after only a few days. In the following summer of 2007, she delivered a daughter, to the intense dismay of her in-laws and husband (who called us in Canada to complain).
pressure from her mother-in-law, or pressure for a second son if she only has one” (Suhaila, Jutial: June 3, 2005).

Infertility’s underlying causes were often linked to chronic dietary deprivations and malnutrition, not only during Gilgiti women’s childhood and adolescence, but into adulthood and married life.

For women who were frequently pregnant, pregnancy and post-partum dietary restrictions were correlated with ‘small-for-size’ infants, breastfeeding difficulties or mastitis (infection of the milk-ducts), as well as pitting and decalcification of the pelvic bone, which was then associated with obstructed deliveries in subsequent pregnancies. Infertility also resulted from untreated sexually transmitted infections, such as pelvic inflammatory disease (PID), which leads to scarring in the Fallopian tubes and a higher risk of ectopic pregnancies and maternal mortality. At the DHQ, Dr. Khalthum described infertility as one of the most unwieldy health challenges facing Gilgiti women.

“Infertility is a vast topic...It’s very common here, and many couples come - women have menses problems, amenorrhea [and] after 2 years I start an investigation. I’ll do a routine exam, and take a history....I see a lot of cases of secondary infertility due to tubal closures - blocked tubes – this can be from any infection, even appendicitis. Ectopic pregnancies, then, are common. We can’t open tubes here, and only a few staff can do fluoroscopy...We see congenital abnormalities and blocks. We refer them down-country, but this is very expensive....If women are infertile, they’re often divorced. Very good women will find a second wife for their husband for children.” (DHQ: September 7, 2005)

Due to Gilgit’s limited surgical and laboratory facilities, infertility diagnoses and treatment regimes were restricted to blood analysis, occasional laparascopic diagnosis and pharmaceutical drugs. Despite the wide array of etiologies associated with male and female infertility, treatments were typically restricted to the female body, while my participants reported that private physicians were more likely to encourage aggressive, long-term and expensive treatments that carried multiple, painful side effects. In the absence of drugs treating male-factor infertility, inclusive of sperm motility or morphology problems, doctors

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35 Pelvic inflammatory disease (PID) and endometriosis are associated with a wide array of gynaecological problems; “Inadequately treated, acute PID, leading to hydrosalpinges, pelvic adhesions, tubo-ovarian abscesses, and anatomical distortion, is one of the major causes of infertility throughout the world” (Kennedy & Parkes 1997: 455-456). PID is frequently associated with chronic or repeated, asymptomatic chlamydia infections (Ibid: 456).
worked instead to heighten a woman’s reproductive potential and thereby increase the chance for even ‘weak’ sperm to impregnate her. At the DHQ and Gilgit Medical Center, the course of therapy for infertility was roughly similar, notwithstanding differences in hygiene, pharmaceutical costs and service quality. During my visits to Out-Patient clinics at the Gilgit Medical Center and the Family Health Hospital, I noticed that in their initial visits to physicians, women who had failed to conceive over a one to two year period were typically advised to eat nutritious food (khorak; S), take Folic acid supplements in advance of conception (to reduce the associated risk of congenital defects, such as spina bifida), and increase the frequency of sexual intercourse. On occasion, doctors suggested that infertility could be related to women’s misunderstandings of fertility and conception.

“...they don’t usually know about the physiology of conception, or the time of the month for getting pregnant. If they’re experiencing infertility, we will explain the main times for conception during their cycle, if they’re uneducated. But women are getting more educated...In areas where women are unaware of their health, they always think they are the ones who are responsible. Men, their husbands, will take them to health centers or to the hospital or dispenser, and say [the wife] should be checked and get medicine. Now, many people are more educated and accept the idea that it can be his responsibility, too. Until we check the husband, we will do nothing invasive to the wife - not laparoscopies, or anything such as this. I’ve noticed that most of the people who come here are actually not infertile. It’s just that maybe their husbands are in the Army, or away working somewhere else, and they come at the wrong time, or they don’t come here long enough for their wives to get pregnant.” (Dr. Sharifa, AKHS, P: May 3, 2005)

In the same ways that my participants used biomedicine to achieve temporary breaks from pregnancy, women turned to biomedicine to help them conceive, or conceive ‘faster’, even in the absence of proven infertility or any underlying pathology. Ovulatory stimulants like Clomid (clomiphene citrate) were

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36 The Family Health Hospital, Gilgit Medical Center and DHQ all offered more advanced diagnostic procedures and surgical treatments, including laparotomies, laparoscopies and hysteroscopies.

37 Increased frequency sometimes exacerbated the situation; some types of male factor infertility, such as low sperm count or poor morphology, are paradoxically worsened by regular intercourse.

38 Many of the physicians and nurse-midwives I spoke with suggested that in previous generations, ‘infertility’ had been due men’s seasonal absences for hunting expeditions (shikari; S), timber cutting in high-altitude mountain forests (jungul; U), summertime shepherding on mountain pastures, or trade trips to Iran, Afghanistan and Pakistan’s urban centers. With the steady urbanization of Gilgit Town, and increases in formal education and non-agricultural employment, trade trips were no longer necessary.
described as offering women a helpful means to become more easily pregnant during their husband’s brief visits home. During one visit to the Gilgit Medical Center, I had seen Dr. Sharifa prescribe Clomid to a patient who was anxious to conceive during her husband’s six-week, annual visit home. Fertility drugs were also used to increase the likelihood of conception between unhappily married couples, for whom intercourse was infrequent. After extended marital absences, some women were said to use ‘old fashioned’ methods to entice their emotionally distant husbands to have sex; the drive to conception afforded women one of the only opportunities to actively pursue their husbands.

“...in the olden days when a woman’s husband went far from home for a long time to work, she would bring an axe, a rope, and a large stone to keep by their bed. When he would come back he would be sacht [hard, tough, distant; U] with her, and she would show him all these things and say, ‘You can do whatever you want with me to make me soft again for you’ and he would become passionate.” (Mehnasat, Jutial: June 2, 2005)

Doctors were also aware of the role of marital conjugality and emotional distance as factors in infertility.

“... we will raise the issue of sexual intercourse when we are concerned with Family Planning or infertility, when we try to find out what are the hindrances, then the discussion of the husband will come up, and we will discuss his beliefs, his attitudes – will he allow Family Planning, or does he engage in regular intercourse? But we don’t discuss this as a matter of sexual desire; instead it is a matter of ‘behaviours.’” (Dr. Sharifa, AKHS,P: May 15, 2005)

At the Family Health Hospital, Dr. Sunbool carefully questioned her patients, working to uncover the sexual incompatibilities she claimed were most often responsible for infertility. When one young wife...
came for help, Dr. Sunbool quickly ‘diagnosed’ that the woman’s presumed infertility resulted from marital ‘disharmony.’ With her strawberry-blonde hair partially covered by a cherry-red dupatta, the patient was in her early twenties and had been married for nearly two years. Prompted by Dr. Sunbool’s congenial and slow-paced chit-chat, she soon confessed she felt no sexual attraction to her husband, who she disdainfully noted had only obtained Class 8 while she had graduated from Class 12. While writing her a prescription for Viagra, Dr. Sunbool gently asked her to discuss the marriage.

“’Taleem koi cheez nuhee [Being a student isn’t important; U], if he is good! Is he good?’ Dr. Sunbool asks. The woman nods her head ‘yes.’ The doctor asks, ‘Do you want children?’ The woman nods ‘yes.’ ‘Does your husband want children?’ the doctor continues. The patient nods ‘yes’ again. Dr. Sunbool pauses; ‘Was this a love marriage?’ The patient shakes her head ‘no.’ ‘Are you scared of him?’ Sunbool asks. The patient shakes her head ‘no’; ‘Sirf dil nuhee lagta heh [it’s only that he doesn’t strike (affect) my heart; U]. The woman says her husband is an auto-electrician, and the doctor asks, ‘Bucchay nuhee chahiye? [don’t you need children?; U] The patient answers quietly, ‘Chahiye’ [we need them; U]. The doctor writes a prescription; ‘Nashita key bat use kurna’ [use it after breakfast; U] and sharbat [vitamin syrup; U]. If you don’t conceive in one month, use it again another month. If the medication isn’t here, you can get it at my private clinic. It would be better to bring your husband to my private clinic. For one medication, eat it two to three hours before sleeping, rozana [always; U]. The days between eleven and eighteen [in the menstrual cycle] are good for conception, aap ka shuhor sey zaya nikal [your husband should not lose this opening, chance; U].’” (Fieldnotes: May 14, 2005)

A short excerpt from my observation of a Sunni woman’s visit to the Family Health Hospital for secondary infertility illuminates the delicate synthesis between a woman’s emotional state, her fertility and conception.

“Dr. Latifa sits and reads through a patient file, which includes a normal semen analysis, and the case concerns secondary infertility, with one child born fifteen years ago when the patient was seventeen. She’s now thirty-two; her file is huge, and complete with many records, X-rays, coming from multiple hospitals, labs and clinics. Karachi, Islamabad, Gilgit…are mentioned. Many tests done; thyroid, blood sugar, rubella - IGP positive. I could see one paper said ‘referral to physiotherapy’ from the DHQ. The woman lies on the table, the dupatta over her head and the sheet pulled down to her pubic line. Dr. Sunbool comes in to room, after an orderly fetched her, and they are consulting on uterus [ultrasound] images, looking for cervix and vaginal canal; woman in pain when probe applied. Dr. Sunbool suggests it’s a retroverted uterus, asks if PV [pelvic, vaginal] exam
done, Dr. Latifa says ‘No, she’s in second day of menses.’ Dr. Sunbool draws a line diagram in front of the patient to demonstrate how a… uterus should look. ‘Here is the endometrium, the attachments…’ Patient has one fifteen year old son, Dr. Sunbool says ‘Thik thak ho guya’ [it was OK, it went well; U]. Ovaries normal, semen analysis normal, Dr. Latifa asks aloud, ‘Why she’s not conceiving?’

Patient gets up when ultrasound complete and rushes to the bathroom, eyes wide and sighing loudly. Doctor writes up notes [as] unexplained infertility…‘For one year now, I think she has given up, but the last fourteen years she was going here and there, from Karachi to Islamabad, looking for treatment. She is only thirty-two years old, she is too young to stop trying, but in this case I can’t give medication to induce her menses, her cycles are normal. She is a bit depressed, and this may affect her fertility. The message comes from the brain. She should eat, relax, drink more, take Vitamin E – I’m giving her this because Vitamin E deficiencies are related to infertility. I don’t want to give her anti-anxieties because she might get addicted. She is a working woman. I will advise her to stop trying to conceive, under these worries I think she cannot conceive.’ The woman returns from the bathroom, and stands at the door to the room. Dr. Latifa says, among other advice, ‘Agr zehen free rukho, conception ho jaega.’ [if your mind stays free, conception is going to happen; U] She tells her to come back after one month.” (Fieldnotes: May 13, 2005)

In some ways, by addressing women’s fear that their emotional and psychological constitution could be the cause for infertility, it seemed Dr. Latifa was reinforcing the same beliefs she sought to unsettle and disempower. In order to avoid an overanxious or compulsively worried temperament harming fertility, women were instructed not to think about getting pregnant. But this new type of ‘mindfulness’ could become an obsession of its own, especially when family fears and concerns remained an ever-present factor in everyday life or social visits.

Mishandled childbirth cases or traumatic deliveries were also suspected culprits for secondary infertility.

During my fieldwork, one of Wadood’s distant cousins from the Harbind Valley (a four hour drive to the south near Chilas) had moved with his family to live in Ismaili-dominated Sonikot Mohalla. After hearing I was a ‘lady doctor’, Akbar brought his anemic, sharp-featured and slightly wizened wife to see us.

While Akbar sat in our garden, shaded by the branches of a plum tree, morosely staring at the grass and chain-smoking cigarettes, Nabeela pleaded with me for help. She had lost her youngest child, a baby boy,
during an emergency C-section at the DHQ three years previously, and had been unable to conceive again. I clarified I wasn’t a medical doctor, but agreed to look through her English-language medical records which she kept in a shiny blue folder, to see if I could determine what her diagnosis was. She had been to doctors at every maternity clinic in Gilgit, then ventured as far south as Islamabad and Karachi for X-rays, blood tests and specialist treatment. The expenses detailed on each clinic receipt were enormous, and added up to hundreds of thousands of rupees. Akbar was not wealthy, and had sold his inherited farmland in Harbind to pay for her care, even though they already had three living sons and two daughters. Though she said it was unlikely, Nabeela’s overwhelming fear was that Akbar would marry again for more sons. Because family size in Harbind regularly exceeded ten children, five children was not nearly enough. Deeply uncertain about her future should she fail to have any more children, Nabeela still praised her husband as attentive and loving. His continued search for medical treatment was unusual for Harbind, where other men would have quickly resorted to a second marriage. In the meantime, Akbar and Nabeela’s family nursed some fairly eccentric ideas about possible therapies.

“Akbar says ‘If I have a lot of money, I can take you to a good hospital down-country and get you a new uterus!’ One of my sisters’ husbands says that in one hospital there, if they give you an injection in your right thigh, your uterus comes out, and then if they give you an injection in your left thigh, your uterus goes back in!” (Nabeela, Jutial: July 18, 2005)

Indeed, prolapsed uteruses were a frequent complication of recurrent pregnancies, a primary cause for secondary infertility and only remedied by surgery. In Minawar, and with her daughters-in-law sitting within earshot, Wadood’s aging auntie offered her own carefully tailored views on the consequences of infertility for wives.

“If a woman is not able to provide more grandchildren, her son might take another wife. The first wife will stay on like a servant, with no sex from her husband, but he will enjoy this with his second wife. But mothers-in-law do not encourage this; it is up to the men to decide on their own. But men want to make their parents and mother happy.” (Pfiffi, Minawar: April 28, 2005)
And while in outlying villages like Minawar many women claimed “people never think it’s the man’s fault” (Sohni, Minawar: April 28, 2005), increased emphasis on Islamic ‘science’ and biology had integrated the notion that men were often equally responsible for infertility. Male infertility was ‘traditionally’ proven by his inability to produce children after two marriages, a scenario which provoked considerable angst for each wife and risked humiliation for the husband. Before marrying again, an increasing number of men looked for treatment at Gilgit’s hospitals, where semen analysis was a relatively new addition to local medical services. This did not mean, however, that men were entirely willing or cooperative patients. Physicians claimed that men’s overall hesitancy to talk to their physicians was due to the stigmas surrounding male infertility; “Men don’t want to know if they’re responsible…” (Dr. Sharifa, AKHS,P: May 3, 2005).

“One Minawar couple weren’t able to conceive, so the husband went to Karachi for treatment and was told to avoid his wife for three months, now people are saying it’s time for her to go to him in Karachi to try to get pregnant. If a man can’t impregnate his first or second wife, people will make fun of him and say, ‘Why does he keep our daughters when he can’t do anything with them?’” (Sohni, Minawar: April 28, 2005)

Although men whose wives failed conceive were encouraged to marry again to sire children, women married to infertile men generally had a much harder time. Even though there are a variety of steps women can take to petition for a divorce within the Hanafi fiqh, the majority of my participants believed

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41 There were other, less desirable options for the wives of infertile men. With a husband’s permission or encouragement, some wives sought out other men to impregnate them. According to Wadood, a school friend had been the product of just such a union, and one of many siblings born to his mother, all of whom were rumoured to be fathered by one or more neighbours. After reaching adulthood, and plagued by the stories surrounding his apparent conception, he became emotionally unbalanced. Armed with a loaded pistol, he finally confronted his mother. Enraged, he demanded she tell him who his real father was, and when she refused, he pointed the gun at her. Though neighbours had long claimed his biological father was a neighbour, who was already married and the father of many children, his mother refused to admit to anything. She pleaded with her son not to approach this particular neighbour, and ruin his reputation and also hers’ and her husband’s. Wadood’s friend then pointed the gun to his head and shot himself. His suicide sent shock waves through the local community. But his neighbours didn’t seem to be as distressed by the circumstances of his birth, as they were appalled that he was unable to turn to his ‘true’ father for the material, economic and emotional support his ‘adoptive’ father had failed to provide him. Sunni community discourse characterized the ‘illegal’ offspring of these relationships as being adrift, unable to claim their inheritance or their father’s name. By consequence, they were likened to non-persons and associated only with their mothers’ family; an anathema.
that Sunni women are comprehensively prohibited from seeking divorce against their husbands.\footnote{As one young wife explained to me, “No conditions are allowed on the wife’s part...women are never allowed to get or ask for a divorce” (Mehnasat, Jutial: June 15, 2005). Some women were able to broker a divorce by placating their husband and his family with large sums of cash. By doing so, women and their families hoped to avoid the shame that accompanied public divorce negotiations in the Legal Courts operating in Sunni-dominated Konodas Mohalla. “If a woman goes to court, her family fears for her reputation and will say ‘no’ [to this]. The parents of [one girl] said to the man, ‘We’ll give you money if you divorce her’ and he answered, ‘You can give me the whole world, but I won’t divorce her.’ He wants her to suffer.” (Madheeya, Jutial: June 15, 2005).} As one Sunni mullah explained:

“If it’s the man’s fault, and he doesn’t want to give a divorce, the woman can’t divorce him. This is our way, unless it is written in the \textit{nikah} contract. Islam gives women some freedoms, for instance if a man is ‘not sincere’ [commits fraud] she can go to the courts to petition for divorce. Women should also have some \textit{haq} [rights; A].” (Qari Malik, Jutial: June 12, 2005)

However, \textit{nikah} negotiations on the bride’s part, whereby a clause could be inserted allowing for her right to divorce if her husband was infertile, were seen an inherently disloyal position towards her husband and his family and were typically avoided. Even when women technically enjoyed the right of divorce, they were deeply hesitant to face the gossip surrounding a woman’s desire to end a marriage. In such cases, divorces were frequently misconstrued as evidencing women’s prioritization of sexual ‘need’ over her obligations to her ‘vulnerable’ husband. Unwilling to debate the more awkward or ‘emasculating’ details surrounding questions of infertility in Gilgit Town’s courts, many wives found themselves trapped. By the time many women managed to obtain a divorce, or their husbands had died, they were past childbearing.

“My Kaki [older sister; S] got married a long time ago, but didn’t have any children – her husband died and then my sister married again and had no children. But her second husband already has ten children – eight boys and two girls – with his first wife. Dr. Khalthum [DHQ] did a small operation on her, but still no babies. Her husband is trying his best, and taking her to doctors and hospitals for checks and \textit{illaj} [treatment, medicine; U]. Dr. Khalthum was saying, ‘After this operation you will get pregnant!’ But she’s been eating medicines and there’s no effect. She had the operation just after last \textit{Ramazan}....With the first husband, the mullah saw it was the husband’s fault in an [Islamic] book, and told them about this....The husband was checked, and both doctors and the mullah said it was his problem. Then after his death we gave her to her second husband....She had also [done] \textit{desi davai} but it had no effect. (Gulnar, Jutial: July 18, 2005)
There were a variety of desi remedies women could turn to when they failed to conceive; women also described themselves as adept at ‘reading’ their menstrual patterns and vaginal discharge for signs of either ‘fertility’ or uterine ‘sickness’. Among the most commonly-cited ‘symptoms’ of infertility was safaid pani (white water; U). Among Gilgitis, and across Pakistan in general, watery vaginal discharge is said to be a side-effect of uterine weakness or ‘fatness’ (Mohammad Isa, Gilgit: August 20, 2005), which women said caused pain, menstrual irregularities, infertility and miscarriage. Biomedical physicians clarified safaid pani was not associated with any underlying pathology, but instead signaled healthy reproductive function or the fertile days in each menstrual cycle. The FPAP had even gone so far as to publish a pamphlet addressing women’s misconceptions of safaid pani, which physicians refer to as leucorrhoea.

At the Kashmir Bazaar Homeopathic dispensary, I was shown a number of prepared desi bilehn, Hikmat and Ayurvedic supplements for safaid pani and other reproductive ‘problems.’ Among these was ‘Safoof Harmoons’ (‘Power Hormones’; U) for women (with a stylized image of an egg in the process of being fertilized on the box) and ‘Safoof Mughalaz’ for men, which carried the image of a cowboy riding a bucking horse.

“For women’s infertility, we have supari pak, mucharas, kamarkaz [U], all are from India, and putter lakh. You mix them all, grind them and take it subah-sham [morning-evening; U] after food. You make it like a flour and have it with milk, you put it in your mouth first and then drink it down. It’s for a bachitani kamzor [weak uterus; U]….For men with infertility

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43 Not all clinical health providers agreed with physicians’ assessments. While I observed patient visits and deliveries at a local hospital, one LHV took time to explain how, in her opinion, ‘safaid pani’ signaled physical weakness and deprivation; “Women who have this problem complain a lot of lower abdominal pain, it’s a very khattarnak [dangerous; U] discharge, and is the result of diet deficiency. Women do all the fieldwork, do all the work in general! [laughs] People who are pregnant think leucorrhoea is a problem….they think the discharge is a zehar [poison; U] to the pregnancy. Women complain a lot….and [when] they have discharge they complain of severe back pain. We give them vitamin capsules, antibiotics, and capsules they put inside [the vagina] for yeast infections” (LHV, Kashrote Civil Hospital: September 3, 2005).

44 In June 2005, the FPAP published an Urdu-language pamphlet entitled “Aurutoh Pani kee Shikayaat” (“Complaints About Women’s Discharge”; U). This attempted to correct women’s belief that clear or white-coloured safaid pani weakened them, or that such discharge signalled sickness (beemari; U). The FPAP asserted that safaid pani was normal bodily discharge, not unlike saliva or tears, and necessary for successful intercourse and conception. The FPAP associated vaginal discharge with uterine infections if it had a foul smell, was yellow-coloured, if it was associated with discomfort or itchiness, or if women noticed it had an unusual odour during intercourse. Only in these instances was discharge related to infertility, lower back or hip pain, or impending miscarriage.

45 See Chapter Four, page 256 for additional uses of ‘Safoof Mughalaz.’
we have this [gutted, mummified lizard]; it’s called *reghme* [S], and it’s a lizard which lives in the sand. This is from India. You take this with *muslee safaid* [root; U], *tahl makanah* [Indian seed; U] and *magzibinolah* [similar to cotton-tree seed; U] and make it in powder form, and have one time before *nashta* [breakfast; U] with honey or milk, *subah-sham* [morning-evening; U], and you first finish a forty day course. If it doesn’t work, you take it for three months regularly, *lazmee baht* [it’s a necessary thing; U].” (Arshad, Kashmir Dispensary: August 20, 2005; see Figure 23)

“There are sixteen different kinds of remedies for this one problem [male infertility]. This happens when older men lose the power that young men have [laughs]. One indication of this is if a man is peeing outside on the ground, if his pee doesn’t make a hole in the dirt he has no pressures and is infertile.” (Mohammad Isa, Gilgit: August 20, 2005) 46

There were a number of other, costly herbal remedies, syrups and even desiccated animal organs used specifically for infertility. At the Kashmir Dispensary, Arshad handed me a small, heavily perfumed, waxy and leather-like pouch which he claimed was the stomach of a local animal called a *herahn* (S), which is similar to the endangered mountain ibex.

“...this is its *nafs* [stomach; U]. It is a cure for infertility in general, *aulad key liyeh* [for children; U], and does not make boys or girls. It is Rs 12 to 13,000 [CDN $273-295]...” (Arshad, Kashmir Dispensary: September 2, 2005)

For couples that were unable to find resolve through biomedicine or *desi bilehn*, there were innumerable Qur’anic ayats, Hadith and *fatawas* which stipulated a husband wait two years before divorcing a childless wife or taking a second wife. In Jutial Mohalla, I had asked our Qari how long the Hanafi fiqh required

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46 In the same way that *desi* herbalist Mohammad Isa suggested male infertility could be diagnosed by a ‘weak’ stream of urine, some men and women described pregnancy as occurring when semen (*pani; U*) was forcibly ‘shot’ into the uterus. According to local beliefs, infertile men – too weak to impregnate a woman’s passive, docile body – were then viewed as socially weak, or as effeminate. Conversely, infertile women were sometimes described as ‘too strong’ to be impregnated, and therefore characterized as more ‘active’ and spiritually harmful. In some ways, infertility resulted in an inversion of the social and behavioral traits normally assigned to fertile men and women.
husbands to wait before second marriages became ‘necessary’ or were viewed as legitimate recourse.

Sitting with me one hot, still summer afternoon as I picked through and cleaned a tray of fresh mulberries, the Qari took some time to explain infertility’s underlying causes and his own approach to infertile couples:

“...In the Qur’an and various books it advises people to wait until four years has passed, not to worry until then. Many are so young when they are married, and aren’t ready. They are tanda [cool; U] – in cold areas, women are fertile later, and their menses comes later. In garam alakah [warm areas; U] people are mature and sexual earlier...Men never come [for infertility], if they are kamzor [weak; U] they want to hide it, it’s a matter of honour and pride. I can ask women directly about infertility, maybe they’ll tell me but they won’t bring it up with me [by themselves]...Most people don’t know about this four year requirement, and mothers-in-law are mostly upset about this lack of children. But I advise men and women to check with a doctor, for medicine and treatment. If they want children, and both are OK, then they should wait until four years. If a woman still has a problem after this, then a second marriage is permissible, but because of the costs and difficulties affording medications and treatment, or to go to Karachi or Islamabad for these things...most people are poor, and prefer a second marriage to medical care. It’s easier and sometimes cheaper.” (Qari Malik, Jutial: June 12, 2005)

I was openly surprised by this four year rule, which was the first time I had heard there might be an Islamic precedent for waiting so long. The Qari said that in his opinion, Qur’anic rules were always ‘just’ and his job was to carefully root out more ‘harmful’ Gilgiti beliefs or practices (including those which relied on what he termed ‘unnecessarily harsh’ fatawas) and replace these with more equitable or ‘fair’ Islamic approaches. In this way, our local mullah conscientiously bypassed Hadith and fatawas advising men to wait only two years before re-marrying, and relied instead on more liberal Islamic interpretations recommending, but not demanding, that husbands support an infertile wife for four years. Qari Malik’s quiet efforts to protect brides during the first, vulnerable years of married life represented an earnest attempt to salvage fragile spousal relationships, and stave off the interventions associated with over-anxious mothers-in-law, family or neighbours.
To my mind, the symbolic and actual connections between a woman’s emotional state, her piety and its health effects – positive or negative – were more powerfully demonstrated by recurrent miscarriages or secondary infertility. Here women had proven their ability to conceive which represented half the battle won, but due to ‘worries’ or ‘nervousness’ (parashanee zyada; U) they may have inadvertently precipitated “uterine weakness” and foetal loss (Fieldnotes: May 14, 2005). Among participants who had miscarried multiple times, they described their uteruses as ‘weak’ (kamzor; U); pregnancy loss was also said to be caused by overwork, jumping, carrying heavy loads, not enough rest or ‘rough’ sex. The primary symptom of an imminent miscarriage was vaginal bleeding. In fact, many women saw any irregular bleeding during pregnancy as a sign the foetus had died. Our neighbour’s eldest daughter had been three months pregnant with her third child when she started bleeding; even though she hadn’t passed any tissue with the blood her mother-in-law quickly pronounced she’d lost the baby. She was immediately ordered to take ten days of bed-rest, which is the ‘normal’ Islamic recourse for recovery from a miscarriage. She then resumed her normal daily activities and caring for her two older children. But one month later, at the end of Ramazan, she was startled by a change in her body.

“I woke up for sehri [pre-fasting breakfast; A] and was hungry and felt my stomach, and it was sach [hard; U]. I also felt something moving. I told my mother-in-law, but she said, ‘You have lost the baby already and you are just weak.’ But a neighbour lady came and said, ‘No, this is a normal four month pregnancy!’ I went with my husband for an ultrasound with Dr. Shakoor. He said it was a normal pregnancy, everything was there, arms, legs, everything, and he advised me to rest, and said ‘Maybe it will be a miscarriage, so to prevent it you should take bed-rest’ but I kept working anyway. My sister-in-law was getting married, and I was the eldest [sister] there, so if I asked for rest from my in-laws they might get angry. I was scared of losing the baby, and my husband advised me to rest, but I refused….Allah’u Akbar [God is great; A] and very merciful.” (Mehnasat, Jutial: June 8, 2005)

47 Women’s recovery was often marred by the comments offered by less sympathetic women visitors; “Some [women] come for teasing. Close relatives will come and say ‘How sad…’ and try to make the mother more sad. Some will even say it’s the mother’s fault” (Razia, Jutial: June 16, 2005).
Bed rest and reduced workloads, or the cessation of breastfeeding if the youngest child still hadn’t been weaned, were described as the most effective prevention against a ‘threatened abortion.’ There were also desi herbals that women used to stop bleeding during pregnancy, even though women weren’t entirely sure of exactly how they worked.

“There are some methods to prevent miscarriage. We might bring golahmee [a cow’s fat; S], and some roots from the forest – like artiskurth, chimurghoozoo [S]- these are homeopathic roots. They crush the roots with the mortar and then the woman eats it on an empty stomach in the morning until the bleeding stops. They are also giving this to infertile women, fahrik [it works; U]! This practice is common now, and was used in the old days when no other medicines were available. To get these roots, we go to a famous store – Sardar Khan’s – in the bazaar. People say you can even find a sparrow’s milk there! [laughs] One man once asked Sardar Khan, ‘You have everything here, how about jharee chey sheekee [old lady’s shit; S]?’ [laughs]” (Madheeya, Jutial: June 3, 2005)

While two to three miscarriages over a woman’s total reproductive life were viewed as ‘normal’ events, having more than five was viewed as ‘too much’, and signaled cosmological imbalance or the machinations wrought by ‘black magic’ (kala jadu; U). For mothers who began having miscarriages after successfully delivering other children, her friends and family attributed her problems to a traumatic birth, or a ‘tired’ and ‘weak’ body. But recurrent miscarriage in the absence of any surviving children was viewed as profoundly bad luck (bahd qismat; U) and potentially ‘infective’ to other women.

“…if a woman is first married and has this problem she is very unlucky and brings bad luck for the family – she is called a di puch kahn [daughter son eater, ‘child-eater’; S] and like with other women who can’t get pregnant, we call her shoneh [alone, barren; S]. If she can’t give birth to children, she must do all the work at home. She is only there for manual labour, free work.” (Mehnasat, Jutial: June 3, 2005)

When after desi and biomedical treatments had failed, women remained unable to conceive or carry a child to term, their qismat (fate; A) and lives were described in sympathetic but also deeply tragic terms.

While there were never any direct efforts to prohibit infertile women from attending reproductively symbolic events, such as engagement parties (mangini; U), weddings (shahdi; U) or mubaraki celebrations

48 Among Gilgiti participants and in local medical parlance, ‘abortion’ and ‘miscarriage’ were used to describe the same process, namely, the premature and naturally occurring expulsion of the foetus.

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for newborn babies, some participants described their uncertainties about what these women’s presence might mean for socially, physically and spiritually ‘vulnerable’ women, such as those entering married life or recovering from childbirth. (The same sets of uncertainties and fears were not applied to infertile men, who instead of being socially distanced or viewed as spiritually ‘harmful’, were characterized as being essentially emasculated and harmless.) When I asked our local Qari if there were any spiritual rewards accorded to women who suffered miscarriages, and which might help offset the stigmatizing qualities Gilgitis applied to these women, he said that Islamic discourse envisioned events like infant death or miscarriage as spiritually ‘positive’ events.

“A woman who dies during childbirth obtains the rank of Shaheed (martyr) [while] a woman who exercises Sabr [patience] when her child dies, will enter Jannat [Heaven] immediately…. (Miscarriage, too, is a blessing for a Muslim woman. Difficulties and calamities should not, therefore, lead to impatience, frustration and ingratitude).” (Majlis-Ul-Ulema 2000b: 63)

These were small comforts, however, in light of the ways infertile women were disenfranchised by their in-laws and neighbours. And even if they did manage to give birth but the infants were daughters, they were in the long term as helpless as women who had no children at all. The socio-economic securities and the family supports associated with sons still remained beyond their grasp.

**Part VI Conclusion**

Women’s efforts to have babies - or, women’s posturing as ‘wanting’ babies - allowed them to claim some sense of ownership over pregnancy, whereby children represented women’s deliberate contribution to husbands, family and community life. To my mind, and in comparison to the agency or communicative modes available to women when they weren’t pregnant, it was through their drive to have sons, to protect themselves against miscarriage and infertility, or by resolving health complaints or coping with unwanted pregnancies, that women’s agency or sense of ‘control’ over her marital sexuality, health and well-being and future economic security was most forcefully enacted, or imagined to exist. However, it was also apparent that very few women enjoyed the option to refuse marital intercourse and thereby
avoid conception. This was where, in unsettling and also dangerous ways, abortion played such an important, albeit quiet, role in ‘remedying’ pregnancies women had been powerless to prevent.

It also seemed that women used the tensions surrounding fertility and reproduction to articulate and illuminate the insecurities inherent in family-building. But this ability to use reproductive health to ‘speak’ for larger domestic and community-bound issues was constrained by a baby’s sex or the nature of a woman’s health complaint. For example, women who had only delivered daughters or were struggling with infertility or miscarriage were less likely to receive adequate nutrition, in-family support and access to medical care than the mothers of sons. As the previous five chapters have demonstrated, there is an undeniable intensity and wide variability to pregnancy as a physiological, symbolic, religious and socio-economic experience. In addition, Gilgiti Sunni women’s pregnancy and childbirth practices demonstrated conspicuously divergent projects of identity, which allowed women to temporarily ascribe to and participate in different belief or value systems. These experiences, in turn, enabled women to vocalize ‘self’, sectarian affiliation and in-family loyalty in a myriad of important ways. The next four chapters examine how the ‘everyday’ tensions, meanings and risks associated with childbearing were amplified and exacerbated by Gilgit’s Shia-Sunni conflicts, and the in-community enmities and shadowy battles that all the while plagued women’s interpersonal relations and sense of well-being.
Part Two: Extraordinary Fights
Chapter Six: ‘Tension Times’ Part I (January 2005 Fieldnotes)

Part I Introduction: ‘Tension Times’ Fieldnotes

Each day after interviews and fieldwork visits, I would go home and transcribe my notes to the computer. Looking back at my fieldnotes from January 8th, which had been the second day of my on-site research at the Gilgit Medical Center, I found one sentence, written in shaky handwriting across the top of a page of notes:

“(hear machine gun fire from area by NA Scouts)”¹

This small note marked the beginning of the troubled days when Sunni women’s health access was stymied and blocked by Shia-Sunni conflicts and Army curfews and which, for obvious reasons, competed with women’s health for my fieldwork attentions. In order to foreground the intensity and complexity of Gilgit’s sectarian strife, and the important ways the conflicts impacted every aspect of daily life, and women’s health service access in particular, I’ve chosen to present a selection of my fieldnotes from the ‘tension times’ of the winter, spring and summer of 2005.² In many respects, this Chapter, and its second half in Chapter Eight, are inspired by Peter Gottschalk’s brave ethnography of one Northern Indian village where he examined the currents of hatred, animosity and occasional bloody violence that marred local Hindu-Muslim relations (2001). Besides keeping Robert Fisk’s “Pity the Nation” (2002) and Gottschalk’s “Beyond Hindu and Muslim” close at hand during my fieldwork, I also read M.J. Akbar’s detailed reports of brutal caste and communal violence in India (1998). By traveling from conflict-zone to conflict-zone over ten years, Akbar’s newspaper articles offered compelling insights into the genesis and practice of violence between neighbours, families and friends. His first-hand accounts transmit the feeling and mood of conflict far better than any academic analysis I have ever read. Indeed, an increasing number of anthropologists temporarily set aside theory in order to share conflicts’ emotional, physical

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¹ The Northern Areas Scouts headquarters was a quarter kilometre west past our Chenar Bagh Mohalla home.
² My fieldnotes have been lightly editorialized for style and grammar, and the removal of details which present risks to research participants, Wadood’s family, friends and me.
and sensorial hues (see Bourgois 2001; Danner 1993; Das 2007; Sachs 2000; Suarez-Orozco 1987; Krog 1999; Swedenburg 1995).

But unlike the aforementioned authors, who are fully equipped to infuse critical theory and ethnographic analysis into their discussions of conflict or war, the ability to interweave embattled life with theory is quite simply beyond me at this point. Academic writing can, if handled indelicately, rob a situation of its nuance and emotion. As often as I’ve tried to recapture the feeling of conflict in previous academic writing (see Varley 2008a, 2008b), my authorial skills are simply not developed enough to express things as they were - multi-dimensional, frightening, enlivening. The downside to foregrounding fieldnotes instead of analysis is that my writing is sometimes too intimately entangled with my own interests, thoughts and interpretations. To this point, Doug Henry paraphrases Feldman to argue that:

“...in trying to explain violent events [we] inevitably impose a kind of narrative order about them...[which speaks] more of our own specific, cultural imaginary.” (Feldman 1995 in Henry 2006: 381)

In many respects, I agree. On many the summer day, when the popping of distant pistol fire punctuated our meal-time chats or interrupted the children’s naptimes, I morbidly hauled out Robert Fisk’s “Pity the Nation” (2002) to review the death tactics and strategizing of war-torn Lebanon. In my own way, I was trying to prepare myself for the wider scope of carnage in which Gilgit might soon be immersed. And the book worked to re-vitalize my own terrors concerning how much further, and horrifically, Gilgit’s conflicts could go. For me, the peculiarly ‘present’ and minutely-detailed nightmares involved with imagining death or violence, were quite the opposite of what Feldman describes as “cultural anesthesia” (2004: 208). Instead of Feldman’s sense of Westerners being conditioned or inured to “generalities of bodies – dead [or] wounded” (Feldman 2004: 208), in some ways I was more highly strung and frightened than my neighbours, many of whom were unaware of wider histories of inflicted, geopolitical horror.

After reading through Fisk’s ‘in-the-moment’ accounts of atrocities, it was clear that Gilgit’s hostilities, though bloody and imbued with tension, were not as bad as it could get. For Gilgitis, however, the sectarian fighting was the worst it had ever been, and yet it still seemed emotionally and strategically
manageable. Such hardy optimism ultimately fanned the flames of violence that gripped Gilgit for nearly a year.

Because Feldman speaks against academia’s “banishment of [the] disconcerting [and] discordant” presences that “undermine the normalizing and often silent premises of everyday life” (Feldman 1994: 405 in Henry 2006: 381), my notes show my efforts to understand how discord and fear, alongside mundane and joyous moments, suffused and defined everyday Gilgiti life. I have also tried to answer Doug Henry’s call for anthropologists working in embattled contexts to acknowledge “how violence pervades their field relations and the modifications made in their own lives as well as the lives around them” (Henry 2006: 381). For these types of field sites, Doug Henry further comments that “a reflexive awareness of personal position and context [becomes] crucial in mitigating self-risks” (Ibid: 381), though I found such surveillance was emotionally and intellectually depleting; it was physically exhausting to be afraid so often, and to be on-guard for so long. Moreover, by their very nature conflictive settings require flexible methodologies and rapid responses to “the shifting social complexities unique to unstable field sites” (Kovats-Bernat 2002: 211 in Henry 2006: 381). To this point, my fieldnotes provide some explanation of the ways we chose to protect ourselves, or failed to protect ourselves enough. And during those days that Sunni women were unable to reach local hospitals, I too was bound to our home out of fears for my safety. The fights that restricted life and health access for my participants, posed the same hazards and constraints for Wadood, my children and me.

Finally, although I was diligently attentive to recording the events unfolding around and to me, my fieldnotes cannot be read as a journalistic account, in that there was - and is - no way to verify many of the things that happened. Because of government-enforced media ‘blackouts’ and Army curfews, there was very little documentation of Gilgit’s ‘tension times.’ Despite this, my fieldnotes offer important snapshots of the stresses and anxieties affecting my Sunni participants, local physicians and hospital
administrators. Indeed, the fights of January 2005 and those that followed through the spring, summer and autumn, were the backdrop to the narratives and health crises I describe in Chapter Seven.

Part II January 2005

January 8, 2005

Dr. Sher Wali Khan, Director of the Northern Areas Health Services, has been gunned down en route to his home, we’ve heard, and his driver was injured.

Kate, Nadeem, Imran [my children, then aged 13, 4 and 11 months] and I were sitting in our sunroom firing up the bukhari [stove; S]; it was a cloudy day and cold. Wadood had gone to get groceries, newspapers and pay our rent to the land-lady. While he was gone, we heard scattered gunfire to the upper part away from our house, and I had thought that it might be for an official event at the Northern Areas Scouts headquarters, or celebratory shots fired for a wedding or birth. Due to the number of shots being fired, Kate commented that, “It must be a rich person’s wedding!” I had just put Imran down for his nap; he was wrapped up in woollen blankets, asleep on the bistra [bed mat; U] along the wall. I was putting more bunni [holly wood; S] and jhuke [kindling; S] into the angeti [stove; S]...and then heard a heavy ‘rrrrrat!’ of machine gun fire (an LMG or Kalashnikov?). I looked up at Kate, who stared back at me, slightly wide-eyed. I remember thinking, ‘Do I show her that this is a bit unnerving? That I also recognize something is different about this?’ Then we heard it again, and this time it was loud enough to waken Imran. After five minutes, Wadood came in and said “There’s been fighting – an important Shia was killed.” He said it was chaotic in town; he had been in a workshop with our Suzuki and the shop-keeper in the workyard pulled him inside the shop and told him to stay. Wadood fought to leave, saying he had go home because we were alone, yet they tried to keep him there and said it was too dangerous to leave. On the way back, he said there were four lanes of traffic exiting town towards Airport Chowk. Some Suzukis couldn’t turn around, so they were driving in reverse; people were on foot leaving, and he took a shortcut through Kashrote Mohalla and got home. Our Shia neighbours said, “Go in the house and lock the doors and gate.” Kate was terrified. We packed and told them we were going to Minawar. Wadood was saying, ‘If we don’t leave now, we won’t be able to leave later!’ We threw our stuff together – forgot the camera and my gold bangles – all with the idea we might lose the house to arson. Wadood brought the rifle out of the house and left it in the back of the car – the licence for it had Abu’s [father-in-law] and Wadood’s names. Haleem [brother-in-law] arrived and said taking a gun could cause a problem – I didn’t understand at first, and Wadood said later that at a checkpoint, the police might think we were going to join the fight; there being serious consequences for having a gun.
We drove out of the property, although the neighbour was saying “I believe you should stay” - we drove along River View Road up past the Army [flower] nurseries to the Heliport, then turned left and headed up into Jutial toward the Serena Hotel, which we preferred to going to Minawar.\(^3\) After checking in, we had lunch with Haleem [my brother-in-law] and I called Ferdost [an Ismaili friend]. He said he didn’t know how he’d done it, but he had made it home while they were announcing the curfew. At the time I spoke with him, the curfew was 400 meters short of the Ramazan Hotel. The Serena restaurant manager said they had tried to burn down the Chief Secretary’s Office, that Gilgit’s Civil Administration had given up trying to contain the violence, and the Army was going to start the curfew around 2pm. Wadood called [his relatives in] Minawar after lunch, and they said that they had heard three or four Sunni doctors had been killed. They reported that one doctor’s body had already been brought home, and passed Minawar along the KKH, for burial near Jaglote. They were angrily asking Wadood why he was “out and about” – and saying he is a target because of his perceived influence.\(^4\) Bura Mamu [Big Uncle] said everyone was at home, and it was “good what Sunnis had done”, while Wadood protested that innocent people would suffer. Bura Mamu dismissed this as “Canadian thinking” and said that this approach won’t work in this part of the world.

By mid-afternoon, we truly knew that it was Agha Zia-u’din who had been shot. Besides being the Khateeb for Gilgit Town’s primary Imambaragh, leader to Northern Areas Shia communities and the Imamia Students Organization, he is also the elder brother of Razi-u’din Rizvi, who unsuccessfully ran for a seat in the Northern Areas Legislature in the October elections. Our land-lady’s maternal uncle is the Home Secretary, and on the radio he was reported saying, “This is terrorism, not sectarianism.” Wadood then called Ikramullah Changezi [Shia friend] who said the curfew hadn’t happened yet in Nagaril Mohalla, and he said, “Wadood, you’re not from Gilgit anymore – and you’re not in Canada – so you’re an in-between, and should stay away from the problems.” Wadood urged Ikramullah to stay safe too. It was when we watched GEO-TV that it was confirmed that “reknowned scholar Agha Zia-u’din has been injured and two [with him] killed.” When we spoke to Ferdost again later, he said a relative had been shot in the head near the Co-Operative Bank because he had helped four Chilasis to his home for safety; they had been working with him in his nearby office. Shia gunmen followed them in and killed all the Chilasis – at 7pm the bodies were still in the house – and no one could get them out. The cousin was now

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\(^3\)Our preference for a local hotel was based on my own, deep concerns for my family’s health. While Minawar is a scenically beautifully village, and Wadood’s family welcoming and congenial hosts, problems obtaining clean drinking water often led to my family and me falling ill. To add, a variety of Wadood’s cousins were receiving treatment for TB during my fieldwork, and we were hesitant to share communal sleeping rooms with people who were still coughing and actively infectious.

\(^4\)Wadood’s immigration to Canada had led a substantial number of family, neighbours and friends to assume he was now wealthy, and as such, capable of influencing family matters as well as local politics.
in critical condition at the DHQ. We then heard the doctors were killed treating Agha at the DHQ when gunmen came to the hospital to finish him off. Later we heard Dr. Sher Wali had been killed as he was at or near the hospital. Haleem had been driving his taxi through the bazaar, and saw people were throwing stones to break out the windows of passing Suzukis….Wadood spoke with Ferdost again later in the night and gave his afsoos [regrets; U] on his relative being shot. Ferdost then said that he had heard “one hundred had died.” Wadood answered by saying, “If this number is true, then it’s going to be as bad as the ’88 riots.”5 Later, the restaurant manager corrected us and said it was “11 killed” and the news had been announced on GEO-TV.

Wadood called [his friend] Omar at the Ramazan Hotel, and he said they were stuck at the hotel – which was now all closed up, but they could hear scattered gunfire still at 7pm and the curfew hadn’t yet reached the hotel. He said businesses were being burned, and they could still see smoke rising above town. He also told Wadood about Sunnis trapped in the Co-Operative Bank near the Polo Ground, between the Shia and Sunni mosques. He had heard ugly rumours that Shia gunmen had set fires around the building and were demanding that the Sunnis come out, one by one, to be shot; he also heard the police had shot these Shia gunmen and rescued the Sunnis. Perhaps this could account for some of the deaths? At dinner, Wadood told me that Zia’-udin was “not a good guy” and was vehemently anti-Suni. Perhaps then this was a retaliatory crime for his involvement in the assassination of Sipah-e-Sahabah’s [Maulana] Azam Tarik last year in Islamabad. Wadood said behind the killings are a myriad of motives; jealousy, sectarian rivalry, professional and political competition, personal enmity.

When I asked Wadood if we could escape to stay in Hunza till it calms down, he was mystified by my naïveté; “Emma, we can’t go through Danyor because it’s 95% Shia and 5% Ismaili at its edge, by Oshikandass – there are very few Sunnis. Even after that, we’d still have to drive through [Shia] Nagar District. If they recognize us, people might shoot us because they don’t want anyone coming in who could make a problem.” Danyor isn’t yet under curfew, but tonight we’re hearing reports of cars being burned and the curfew being imposed. At dusk, Wadood walked to the end of the Serena Hotel’s driveway so he could look down to the road. He came back and reported having seen, “one hundred men running up the road from the corner intersection where some shops and a PCO [Public Call Office] are – they told me they were there talking, shopping and the Army came and told them they had ’5 seconds to leave or you will be shot!’ They’re dummies.”

5 See Chapter One, pages 56-57 for more detail.
At 11.30pm, Ferdost called and told us the story of his relative’s death; it’s now official. Ferdost said
that after Zia-u’din’s shooting, Shia gunmen were out looking for “religious types” – such as [Sunni] men
with long beards. Hence the Sunni doctors were targeted on their way home from work. He said the
people from Diamer had requested protection from his relative, who took them in and they were all
sitting around the stove, drinking chai, waiting out the fighting. Shia neighbours – or someone – noticed
them go into the house, and then Shia gunmen arrived, masked and with Kalashnikovs, on two
motorcycles. They banged on his front gate, and asked him to turn over the Sunnis; he pretended they
weren’t there. They kicked down the gate, and went in and shot them all inside the room – Ferdost said
there were five or six of them, not four. They killed all of them, and knocked over the bukhari, which caused a
fire and destroyed the room. Ferdost said, “They feared my relative, who is a government officer, would
recognize them so they shot him with a pistol in the head; he died on the way to the hospital. His
daughter, who saw her father shot along with her handicapped brother, had trouble summoning help
after the shooting, and the bodies were not removed for some time.”

Ferdost said the risk was high to us, and not to go home to Chenar Bagh Mohalla because it is “Shia
territory.” He said we could go and stay with his parents in Sonikot, but not to tell anyone (Wadood
is telling everyone where we are!) and perhaps we could get a police escort, or go to Sakwar or Minawar,
but it is “Wadood’s decision where to go.” From his house in Majini Mohalla, Ferdost said that the gunfire
continued all day until evening time. Just before calling us, he had left his house to see if he could buy
milk; shops were opening surreptitiously to help offload foods that would spoil. While outside, he had
seen Army and police vehicles patrolling. When they passed, people on the street tried to hide
themselves. He told me that if people are caught, the Army punishes them in awful ways. For example,
officers spit on the ground and tell people to lick it up, or they forcefully rub people’s noses on the
ground. (At that point, Ferdost said the Hazir Imam [Aga Khan] urges Ismailis to be peaceful and to have
“good relations with both communities.” He told me that Ismailis aren’t directly threatened, but they do
suffer the consequences of fighting – such as lost business or school days.)

January 10, 2005

No break in curfew today – for second day in a row. A fellow from Skardu was in the dining-room last
night...[he] told us that Agha Zia-u’din Rizvi was “not behind the assassination of Azam Tariq” in
October, 2003. Somehow, when he told me this I disbelieved him. Here, I tend to disbelieve any quantitatively
whole statements either for or against a certain idea. I’m also learning about the powers of
exaggeration. Ferdost, for instance, told us 100 had died the first day - then on the 9th he reported a bus
had been completely shot up in Kohistan (we heard from the Balti it was a bus accident, in which one
passenger – or perhaps the driver – had died, and that it was dangerous to spread such gossip....who’s to know what is gossip and what isn’t?). The Balti told us that the body of one of Zia-u’din’s attackers was in the DHQ Mortuary, and he was not a local - he was an “outsider.” He claimed that part of the rage of the Shias following the attack, especially towards the Sunnis, was because the surviving attacker fled towards Baseen, a Sunni area where they feel that he must have had support or a hiding spot. We saw a picture in Al-Jazeera of Zia-u’din’s blue Pajero, which had bullet holes in the windscreen. Two of his three bodyguards were killed. One survived, and drove the Pajero directly to DHQ on the rims of the tires, which had been shot out by the attackers. The Balti also said that he had heard there was a signal shot fired from Konodas Mohalla (a mixed neighbourhood...where the Sunnis are very conservatively Sunni) when Agha Zia-u’din left his house to go to mosque. (Can they actually see his Amphari Mohalla house from Konodas?) Then the assailants were ready and awaiting his arrival in Gilgit. (We also overheard him telling another diner that he felt it was Al Qaeda....something which I balk at. It’s too easy a catch-word now, and too quickly bandied about, despite the advantage of very quickly communicating an idea that can be discussed and debated, and which requires far less explanation than saying... Sipah-e-Sahabah, or Jamaat-Ulema-Islami. It [also] assumes a unity among Sunnis – ethnic, social, economic, political, ideological – which only rarely exists.)

Al-Jazeera erroneously reported that Gilgit is 240 km to the north of Islamabad, and then reported how in Karimabad [Hunza District] there were angry mobs setting local government offices on fire. In Skardu, angry youths set up road-blocks and burned tyres on the road. On the one hand, these youth appear to have enough funds to buy them motorcycles [Rs 25,000-50,000; CDN $568-1,140] and Kalashnikovs [Rs 25,000-35,000; CDN $568-795], so they can’t be the very lowest socio-economic stratum in Gilgit. But then people argue that the sons of better-off families are more likely to be educated, and less prone to violence. Inbound NATCO drivers have also reported that there are road-blocks in Jaglote, Chilas and Kohistan. This may stem from the local angry that accompanied the burial of the Chilasis, whose bodies were returned home yesterday. Ikramullah, Wadood’s Shia friend who lives in Nagaril Mohalla, just called to offer us assistance from the AC (Assistant Commissioner) in getting home to Chenar Bagh today. Ikramullah said that one of his relatives was killed, and they were busy all of yesterday until the evening preparing the body and then having the Jenaza and burial. The relative evidently died when his car was set on fire...but the details are still unclear.

We called our land-lady’s mother last night too to ask her about our neighbours in Chenar Bagh. She said her daughter, son-in-law and their children had lived in that house, surrounded by only Shia neighbours, for 8 years and through countless curfews, and had never had one single problem or
incident. She said she could “guarantee” the quality and peacefulness of our neighbours, but couldn’t guarantee – as with any area – the quality of interlopers or people who were coming in deliberately to create problems. She said she had been trying to phone us continually since the incidents started, and was a little alarmed that we weren’t answering the phone. She said that her brother is the Home Secretary here, and he was in Islamabad when the riot began. A “crowd of Shias” went up to his house to get him and found his wife and children alone. They didn’t [hurt] her, but they pushed his cars out of the house and burned them on the street. It’s interesting how psychological trauma, or women’s fear at losing male relatives, doesn’t figure into how people describe the issues affecting women. It’s only physical violence that is described as ‘disturbing’ or ‘hurting’ an individual, or their families. Only Ferdost has been more likely to allude to the emotional [and] psychological pain caused to bystanders [of violence]. I had no idea that the fighting had so quickly extended from near the main Imambaragh, past the Co-Operative Bank to the Ramazan Hotel. It surprises me that the gunmen also managed to move past the NLI [Northern Light Infantry] Bazaar. It also astounds me how very quickly people were prepared to fight. Masked gunmen appeared right away on motorcycles – Kalashnikovs armed and ready. So far, the majority of the fourteen killed have been Sunnis. About three to four were Shia, one was definitely an Ismaili, and the rest Sunnis – five at least being from Diamer District. How unfortunate, because of its implications for ongoing and extended ‘tension.’ Wadood said that what he found most interesting about all of this was that Kashrote Mohalla – which contains by far the most well-armed and organized Sunni community in Gilgit - hasn’t added anything to the violence against Shias.

Whenever Wadood talks to people, he says “Halaat kaisey heh?” [how is the situation; U] At lunchtime on the 8th, the restaurant manager said that the “halaat bahoot kharab heh” [the situation is very bad; U] – and he then described a mob attempting to set fire to the Chief Secretary’s office, and the other killings.

Wadood also said that he thinks the reason the Shias kicked down the gate of the Ismaili man’s house was because they “knew he wouldn’t fight back” or “be armed” (Ismailis generally don’t keep any weapons at their homes). He said it would be a rare occurrence for a Shia or Sunni to kick down the door of the house of each other, because of how often the people inside are well armed. He also said that because of his family’s [tribal] connections to Darel [Diamer District], Shias would expect us to be heavily armed, even though all we actually own is an antiquated, Lee-Enfield bolt-action rifle and a cloth bag with “rusty bullets, and one .32 mm pistol with one bullet. Wadood is hoping to borrow a Kalashnikov and bring it from his Bura Mamu’s place in Minawar – for personal protection. He’s also affirmed – yet again – how he has to maintain a low profile and stay home after dark. Bura Mamu had to leave today for Rawalpindi, where he’s due to depart on the 15th for his six week Hajj in Saudi Arabia. He’s going by their dubbah
[small van; U] to Jaglote, where he’ll arrange private transport to Pindi. The buses are not a safe option, given people still aren’t clear if the last bus incident on the KKH was an accident, a shooting or both.

For the last two days, Haleem has walked to the hotel from Sakwar [where Wadood’s parents, siblings and children live]. It’s about forty minutes across the rocky hillside above the road between each area. He also can avoid the road-blocks (there is, evidently, barbed wire across the road and major barricades across the road at Khomer Chowk, which is an area that is presumably experiencing great ‘tension’). He’s had to leave our car in Sakwar, where Wadood asked him to take it. Still can’t figure out why Wadood did this, unless it was a way to get his Dad’s ancient rifle and ammunition to Sakwar where they might need it. Haleem had said we can’t be found to have a weapon with us, regardless of whether there is a license or not, because the police or Army will assume that it will be used to add to increasing ‘tension’ or battles. Haleem at this point also can’t bring our car back into Gilgit – no one is allowed to move their vehicles into town. So if we were to go home, we’d have to have the Army or FC [Frontier Constabulary] take us, and then to leave, we’d have to arrange a Suzuki hire.

Evidently, Zia-u’din is being treated at CMH [Combined Military Hospital] in Rawalpindi for his wounds. Everyone is saying that if he dies, things will get much worse. Yesterday around noon a camouflage-colored military helicopter flew very low past the hotel. People are saying it came to collect him to transport him to hospital down country – the road being a far, far too dangerous way to move him around. The DHQ is also a problem. Omar, Wadood’s friend who works at the Ramazan Hotel, has said that the greatest areas of ‘tension’ – including Hospital Road and Amphari Mohalla – were the last to be secured under curfew on the 8th and 9th because the Army was short-staffed and unable to get in with the proper number of troops to secure the area. So, Shia gunmen were able to “have the run of the place” for an extended period of time. (But it’s still not anywhere like ’88, when it took over a week for the civil government to be able to call in the Army to secure Gilgit, Jalalabad, Sakwar, Minawar.) Omar said that some of his Sunni relatives work at DHQ, and they had been “chased” by armed Shias through the hospital as they tried to leave, and while they tried to hide on the hospital’s extensive grounds. They managed to get into a room or building and lock it from the inside, and waited until the gunmen had left - after which they miraculously escaped unharmed.

Ferdost had offered yesterday for all of us to go and stay at his parent’s family home in Sonikot - but I could sense he was hesitant about having Wadood go there to stay. I’ve learned not to take it

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6 Sonikot is set on the northern side of the main road leading through Gilgit Town at its eastern edge. Here, homes lead all the way down to the Gilgit River; the majority of households are Ismaili, alongside smaller numbers of Sunni and Shia households.
personally, even when he jokes about Wadood’s irreversibly “dangerous, Diameri genetics”.7 He cautioned us not to tell anyone if we were going there. He mentioned that his mother was able to get a local inspector to assist a relative to shift from to a new house elsewhere in Gilgit. Today he offered again to help, but I thanked him, and said it would be wiser that Wadood go to Minawar or Sakwar, and not impose on his parents, given that the consequences of his being found might be too terrible to imagine. He seemed grateful that I understood the implications, and affirmed Wadood should not go back to Chenar Bagh – it’s too risky. When I had first tried calling him today he was out buying food; some people had opened their stores for a spell, despite the curfew, and he said that things were getting more “open” in town. I asked about Chenar Bagh, and he said he had heard of no problems whatsoever. But hearing that people are moving about with relative ease, even if there might be police patrols, unsettled me. Domyal sits immediately above our house, and is a Shia mohalla. It wouldn’t be hard for people to scoot down the hill to Chenar Bagh and our home. From our rooftop, I have seen that there are numerous short cuts all across the hillside separating Domyal and Chenar Bagh. Wadood mentioned too that we might want to go to Islamabad for a while. He said he could call ahead to his family in Diamer and Kohistan, past Jaglote, and they would be there to accompany us on the drive and make sure we’re not stopped or harmed by anyone looking for Shias. I’m not sure if people know you’re Shia by your name, your appearance, your home village, or if your sect is written on your Shinakhati card. (Wadood said that generally men with longer beards [it’s supposed to be a fist length from the chin] are Sunni, and beards that are cut close to the jaw-line are Shia, while Ismailis are often clean-shaven.) It’s quite terrifying, hence the Shia Balti who had planned on going back to Skardu, revised his plans and is staying here for a while. The Sunni-controlled roads between Gilgit and the junction leading to Baltistan are too dangerous.

Here in Gilgit, and in Pakistan overall, it’s hard to comprehensively dismiss or discard the rumours people feed to you, no matter how outlandish they may initially seem. There’s always a kernel of ‘something’ in what they say, or why they say it, and it’s being attuned to that – and also being conscious of the nuances of ‘truth’ - that makes this work maddening. I’m also aware of how little I’m able to transmit or capture, using words alone. For instance, curfew means utter silence. (A car engine can be heard from a very long way away indeed. It starts as a lonely and threatening rumble which gradually articulates itself as the distance lessens; people then begin to panic as to what it is – a tractor? A police or Army wagon? Private car? Suzuki?) Earlier this afternoon, as Wadood and I stood along the hotel’s garden wall, I was conscious of how little noise there was. Just felt the cool mountain breeze, heard the ripple of political flags from

7 Many Gilgitis – Ismailis, Shias and Sunnis alike – frequently described violence in Diamer District as being the result of Diameris’ ‘inherited disposition’ for conflict.
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atop nearby stores. Occasionally we could hear children shouting from a distance, or the low bellow of a cow or the crow of a chicken, but very rarely. The unnatural quiet is both a welcome break and an unhappy omen of troubled times. Knowing it’s only the curfew that keeps the madness from spilling onto the streets is not comforting.

Throughout all of this, I was reminded that Gilgiti women’s health-decision making is a multi-dimensional, responsive process. Responsive to the ways people want to think about themselves, the immediacy of their need, and also - as the ‘tensions’ illustrate - the local context and Shia-Sunni antipathies. Health decisions are inextricably interwoven with and reflective of the ways Gilgitis choose their neighbours, schools, jobs or servants. All this, in turn, is nuanced or exacerbated by inter-sectarian ‘tensions’ and the nature of each particular health crisis. AKHS,P reports and many other studies have failed to elaborate on this. To add, all these ‘tensions’ are recent memories, which are not displaced from the decision-making process by a generation or a decade, but by a matter of months and now days. Children attending the Army Public School relay how many days they’ve lost in the last year to elections, curfews - 70! The two government high schools (Numbers 1 and 2) have been closed since June because of ‘tensions’ between Shia and Sunni students. The Sunni and Shia mosques, as well as side streets between Airport Chowk and Nagaril, Kashrote and Domyal Mohallas are barricaded off by police during Juma prayers every Friday. How do families actually keep their angers at bay?

The hotel staff wanted to purchase food from the market today, and even the Army was unable to assist them getting there. There are evidently too many road-blocks in between for them to get there and back easily. The KKH has road blocks along it in Jaglote, Chilas and perhaps even Shatial (this part is rumour), and one of Wadood’s relatives has said they’re letting people down-country, but not back into the Northern Areas. Just before dinner, we heard that Agha Zia-u’din has died in Pindi, and that this news was “confidential” and had just been received by hotel staff from Army officials. The waiter even intimated, which is not surprising, that the fellow had died before his body left Gilgit - but the Army were saving the news for when they had established curfew throughout town. The restaurant manager said that the Army is bringing in two more units tomorrow to help manage the town - this probably being in reaction to the death, and the return of this fellow’s body to Gilgit for burial. Evidently, people have been coming down the KKH from Nagar [District] to fight, but because the Army has control of the two bridges leading into Gilgit Town which we can see from our hotel room - one the rickety suspension bridge and the other built by the Chinese - they can’t get across. The waiter said that undoubtedly people would want to come up from Diamer as well to fight, and that they “had this right” because they had lost so many innocent people in the initial blood-shed. Rights have little to do with this...
really – it’s all blind, misapplied justice at this point. The Army does not want this news to spread until they have firm control, so we’re not sharing it with anyone for any reason. I don’t need to have the concept of rioting anywhere on my conscience, even if my contribution is miniscule or unintentional.

The waiter said that Zia-u’din had returned to Gilgit from Iran 10 days ago – probably a religious or scholarly or political trip of some sort, there being intense relationships between Gilgit’s Shias and Iran. He had also been in jail for a month following the last major riots, concerning the Nisab which had so infuriated the Shia population. The Army is saying there will be a two-hour break in curfew tomorrow sometime, and we will be speaking to Azam or a Colonel Masood from the FC about securing safe transport for us to get into Chenar Bagh to get some of our things, and get out to Minawar for a spell. It’s just a matter of finding a quiet corner for ourselves in Minawar where we can keep the kids safe, healthy and warm. Some rooms are free, but they’re very cold and have no bukhari. The house in Sakwar is overly crowded already – Haleem, Zeeshan, Omi, Abu, Munir, Shaheen, Neelum and Wadood’s paternal first-cousin Abid already sleeping in a room about 10 by 10 feet, with an angeti smack in the middle of the room used for cooking.

January 12, 2005

On the 11th, mid-morning, there were rumours that the curfew would break between 2-4pm and we would all have a chance to either a) escape to our respective homes, b) run to local transport to leave town, or c) go to the bazaar to collect food-stuffs and necessary items (get firewood for the bukhari, have a shave, get bread from the bakery, refill gas canisters) and go to a relative’s house, or d) leave in order to get out of an area in which individuals had been trapped during the fighting. About 1:50pm, it was confirmed that there would be a break in the curfew until 4pm, and there was a hustle in the lobby of the hotel as [several tourists] signed off on their hotel bills. They were heading down to the adha [bus station; U] on the main road outside of town in a hotel mini-van, where they would transfer to another bus to take them the rest of the way down the KKH to Islamabad. At 2:15pm, we decided to take the children with us in case we found it was safe enough to stay the night at home in Chenar Bagh, or we could leave for Minawar directly from there. We drove down the road, past the Jutial Public School, the PTV station and the Jutial Sub-Than [jail; U], going very quickly along the main road and right past the Helicopter Chowk, into the Ismaili areas and then down along the river towards Chenar Bagh.8 We saw a few armed guards and regular chowkidars [guards; U] loitering in the Vision International parking lot – the hospital being shuttered up – and a few minutes past this, encountered the Army and Gilgit Scout’s

8 The jail was where Shia prisoners, who had participated in the Nisab Riots led by Agha Zia-u’din, had been imprisoned since summer 2004.
checkpoints and barricades at the two suspension bridges over the Gilgit River. In the line-up of cars in front of us, there was a Datsun Hi-Ace with about ten men sitting in the back. The Army had all of them disembark to be searched – with several guards at the ready with machine guns aimed at the group. Each man was patted down for weapons, and an older gentleman with a beard kept an eye on us in the meantime. The police often look to see if they can recognize people passing through the checkpoints, not merely to prevent anyone doing anything, but in order to invoke shared or dissimilar mohalla, village, caste connections. These relationships are just as valid – if not more so – during times like this, and are brought into the forefront to identify, assist, constrain or facilitate with check-point procedures.

We told them where we were going, to our house just past the VIP Guesthouse, and were allowed to drive past them and zig-zag slowly past a small maze of barbed wire barricades. On the right side of the road, immediately after the bridge entrance/exit, was another police/Army checkpoint where people leaving Chenar Bagh, or entering or exiting the bridge, were being similarly checked; men spilling out of vehicles onto the road to be patted down – it all appeared peaceful and co-operative. There was also a small sand-bag bunker being constructed immediately opposite the bridge entrance, in which I assume machine-guns would be placed. As we exited Chenar Bagh an hour later, I saw several Datsun Hi-Ace’s, Army green, passing us with armed soldiers, each with a machine gun, and a central soldier standing behind a rudimentary, make-shift mobile machine-gun post, which was put together with string, heavy duct-tape and a stick, with the large calibre machine gun placed on top and aiming out front towards the road.

We hurried towards home – I having heard from a staff member that there was a large number of police and Army encamped at Chenar Bagh and the NA Legislative Assembly building. As we drove past, I noted, with great disappointment, the presence of perhaps three soldiers or police by the main buildings. I was quite nervous about our stopping at the lane gate to unlock it and let the car in – Wadood dashed out and unlocked the gate as quickly as possible, leaving it open behind him. I noticed a few men gathering outside the local store, across from the open-air snooker club on the riverside, and was nervous that perhaps these might be people monitoring for our arrival in order to attack. But it was more likely local residents taking the break to stretch their legs, reconnect with neighbours, pick up supplies (did not see many women on the roads at all, unless it appeared that they were with men leaving town and heading towards the adha) and to collect the news and gossip. However, they did notice us.

Kate, Imran and I went immediately over to greet the neighbours and inquire as to their well being. It was only our neighbour’s daughters and some granddaughters who were at the house – I didn’t see either the
mother or the father and brothers. The sisters were in good form and told me that there had been no problems in Chenar Bagh, and it was “only in the bazaar” where the problems had occurred. They asked me when we were coming back, and I said “perhaps after two to three days.” At the house, Wadood pulled out a suitcase and I packed some clothes for him and the children. Wadood finally got a proper pair of shoes. He had worn his purple socks and plastic chapels for the entire first three days – he had forgotten to pack either shoes or clothes as we dashed out of the house! We back out through Gilgit Town and off to Minawar. Along the road we noticed the *adha* was full of outgoing passengers. Along the road many single men, who looked like Gilgitis but Wadood said might be Pathans or Baltis working in Gilgit without their families and were heading home alone; everyone was streaming towards the *adha* with bags and suitcases in tow. Several families, women included, were also on the way. I noticed that women often waited, in full *pardah*, with their children, behind a small rock wall across from the road from the *adha*, where the men arranged transport and bus tickets.

There were perhaps three or four large buses being loaded up with bags, burlap sacks, propane gas cylinders and put atop the bus – with passengers milling about. Just before the *adha*, an Army official asked us to drive down into the *adha* parking lot to register our car as we left. We pulled in front of the buses, and Wadood gave his name – and they asked who he was the “son of” as well. Then they let us go and we drove back up onto the road. At the checkpoint just before Sakwar there was a small machine gun post set up behind sandbags. We drove past a large Army truck and out along the road past the mosque at the western, Sunni side of the village. (The Shia area of Sakwar is the eastern three-quarters of the village.) At the far end of the village, past another Army check-point, were several Bedford trucks full of large logs of *bunni* (holly wood; S), with drivers clearly from Chilas. Wadood said if it weren’t for the checkpoint it would be an incredibly dangerous place for Sunni drivers to wait. It was more evidence that the Army aren’t letting much into town; the lumber-yards are closed in Nagaril and Kashrote Mohallas.

With some difficulty we drove off the KKH and into Minawar, our axle grinding on a pile of sand, and then up along the narrow road past Wadood’s old primary school and then into the heart of lower Minawar. The old village is a much harder drive uphill from further along the KKH. The road towards the family compound is very narrow, with a rock wall leaning threateningly close to the side of the car, and Wadood admitted he “hates Minawar” and there are too many people. In the empty field just past Chota Mamu’s house, we saw a small hoard of boys playing in the dust, and we pulled the car into the main enclosure between Bura [big; U] and Chota Mamu’s [little maternal uncle; U] houses to be greeted by Chota Mamu, Rizwan and Shabir Alam. Everyone was pleased to see us, but was curious as to why we’d not come earlier. We came out of the car, and I shook hands with as many of the men and woman as I
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easily recognized. Nadeem was ready to bolt off to play with the boys. It was only with some difficulty we restrained him. We heard that Dadi [grandmother; U] was resting in Bura Mamu’s house, recuperating from her small outpatient procedure three weeks ago and now taking desi-davaie (traditional medicine).

Wadood suggested we go to “visit some people” before settling down for the night. So, off we went to Chota Mamu’s [little maternal uncle; U] house, where his wife Mami [maternal aunt; U] greeted us all very affectionately. We went into the traditional hearth of the home - a large room about twenty by twenty with a central hearth area. Here the angeti [stove; S] is secured onto a base of cement that is surrounded by a wooden frame. Outside the angeti’s main door there is a small depression in the cement - which is all very carefully swept clean, or dampened down and washed every few days. This is for embers, or to rest the ends of wood pieces that are too long to fit inside the angeti as it burns. The room was marked with four main posts, with some – not overly elaborate – carvings in the wood. It was all painted over with medium brown, glossy paint. The angeti sits at the lowest level in the room, and there is one level up in the floor, perhaps ½ foot up, from around the angeti. At the end of the angeti, from where the stove-pipe rises up, there were floor cushions placed for people to sit comfortably while food is cooking, or to warm themselves in the winter chill.

Directly above the angeti is a small smoke-hole – a square in the overlapping timber work that is the roof - perhaps one foot square, which lets in a surprising amount of light when the power or lights are out. The lights streams downwards to light the faces of those sitting immediately around the angeti, while the rest of the room remains in semi-darkness. On one side of the room were wooden shelves with all the family’s dishes, glasses, tea-cups and saucers, tea canisters, some ghee [clarified butter; U] canisters, Chinese tin plates with stencilled-designs, metal cups and some spoons. Long bistra, pastel coloured kilims [hand-woven carpets; S] and velveteen covered, burgundy designed busks are arranged around the angeti and along the far walls of the house for guests to sit on. The family’s blankets and pillows are kept folded and covered by a sheet in the corner of the room; the blankets are unfolded every night when the family sleeps. As we hunkered down around the angeti, Mami placed a very large kitilee [kettle; S] - which must hold at least 8 litres of water - on the smaller pot lid closest to the angeti’s pipe. (This being the cooler of the two ‘elements.’ The forward ‘element’ is larger, and used to cook items at higher temperatures. The majority of firewood burns underneath this larger, outer lid.) The kitilee warms water for drinking or washing hands. Wadood said that male guests are given the seat closest to the angeti pipe with their back to the wall, facing the room entrance. Women guests, or the women of the house (so to speak) who are given the right to serve food or expected to do so, have the seat immediately opposite this.

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Chapter Six: ‘Tension Times’ Part I (January 2005 Fieldnotes)

Wadood’s cousin Safiyya cooked a chicken that Rizwan slaughtered for dinner, and Mami was already making a dhal dish and rice for dinner. Shabir Alam also came to visit, and most of the family sat with their bare feet on the edge of the angeti stand, hands and toes pointing towards the open angeti door, enjoying the heat, and all were fairly quiet. There were general discussions of what was going on in Gilgit, and Shabir Alam affirmed that our area – Chenar Bagh – was not a good area for us to be in at this particular time. No one had been in the bazaar when the fighting started, which we were collectively grateful for, and most of the conversation questioned the motives of the Shias in hunting down so many Sunnis from Diamer and Kohistan. Most of us had sugar chai and ate our cookies off the dusturkhan [oil-cloth; U] spread on the floor up behind the angeti. Others drank their neemak chai [salt tea; U] from small bowls. Wadood later told me that the chicken was a treat – they don’t usually eat meat more than once a week. The bijli [electricity; U] came and went during the afternoon, and disappeared again just before dinner; we ended up eating by the light of a gas cylinder. Just before dinner, Chota Mamu brought out a camouflage rifle case and unzipped it to reveal a Kalashnikov. With a smile, Wadood asked me, “Do you want a picture of your son with a Kalashnikov?” The Kalashnikov was surprisingly light and had a curved magazine for the bullets, one of which Chota Mamu showed me while saying that each kartous [cartridge; U] costs Rs 25 [CDN $0.60]. This isn’t a huge amount of money, but it’s enough to seriously set back a poor farmer. The Kalashnikov itself was Rs 32,000 [CDN $800] – some can be bought for as little as Rs 25,000 [CDN $568]. Wadood said that he had bought one many years before; a “beautiful one that folded in half for easy packing” for Rs 38,000 [CDN $864]. One day he had come home after work and found it missing. His father had exchanged it as payment for some of the many, many debts he had incurred.

The next morning the baby woke up at 6.30am, happy and calling for Wadood. They brought us fried eggs, paratha [fried bread; U] and hot water, yet I could barely eat from the stress. Everyone kept commenting how “kamzor” [weak; U] I had become. Shabir Alam had stopped by to sit with me and Wadood and offer his advice that if we weren’t going to permanently shift to live in Minawar, we should stay for at least three to four days and could use one section of his house; one half being very old and traditional, the other new and spotlessly clean and beautiful. Shabir Alam asked us to follow him over to visit Dadi, and then his wife Phoonurh and their children at his house – just behind Tehsildar Mamu’s house, and adjacent to a huge, empty rocky field from which there are tremendous views to Gilgit Town. We then headed out to the main garden, where Pfiffi (Bura Mamu’s wife) was collecting twigs from off the ground and held in a fold of her voluminous dupatta. We went in to see Dadi, who was sitting by the angeti, along with Sohni’s brother and her mother. Dadi looked frail and fragile, thinner and weaker. She told Wadood that for 10 days she had been eating nothing but noodles on the advice of the desi-
[traditional medicine; U] doctor. I urged her to eat regular food, in whatever quantity she could, because I openly doubted how dietary changes could affect her diseased uterus. She seemed to understand, but said that her underlying problems had been improved by the diet change.

Bura Mamu’s portion of the house is much like Chota Mamu’s, only older and dirtier. Mint green paint had been slopped over the windowsills, and dirty pieces of white cloth – embroidered with flowers and traditional designs – lay across the window-ledge, and were draped over the top of small tables and wall shelves. The windows facing outside were painted over, and the smoke hole had a small piece of plastic over it to keep out the draft. At one point, Safiyya climbed up onto the roof to clean out the pipe. She began by putting a piece of reed matting over the smoke hole and shaking the pipe and brushing the exit out – so the small pieces of debris wouldn’t fall into the room inside. There was no electricity that morning, and in the down-light from the smoke hole small pieces of ash from the *angeti* breezed around like snowflakes. Dadi sat at the pipe-end of the *angeti* to get warm, and urged Kate and I to sit close as well. Sitting beside Dadi, and with her back to the *angeti*'s pipe, Phoonurh caught my attention, and pointed over her shoulder at three of her sons, who were sitting at the back of the room; “Look at my Army!” she said proudly. (Their eldest son Hameed is away studying at a militant Sunni *madressah* in Pindi. In his school identification card photo, he wears a black and white striped turban wrapped overttop a mirrored Sindhi cap.) Also in the shadows at the side of the room was a traditional cradle – called a *ghorah* – in which Khadija, Fida’s six-month-old daughter slept. Hejira, his wife, arrived when the baby woke up; she is Amir, Phoonurh and Safiyya’s older sister. (During this time, Wadood called Ferdost quickly to tell him where we were, and that we were planning to escape back into Gilgit again should there be a break in the curfew. Ferdost said there was aerial firing in the Amphari side of town for about five minutes the night before. Later we learned it was aerial firing from the Army warning people to keep inside their homes – perhaps people were coming outside.)

At about 1pm, we strolled across to Shabir Alam’s house for lunch. Phoonurh was already sitting at the hearth, and had rice cooking on the *angeti* while a chicken dish was cooking on a gas range against the far wall of the room. The hearth room is in the oldest part of the house – the lintels and support beams are very old and blackened by smoke. Shabir Alam admitted that he was going to rebuild this portion of the house, and tear all the old woodwork out – the front, wooden door did look particularly ratty and spare, with a screen separating the interior of the room from the open front door. Their youngest baby, Sabida, was asleep in the traditional cradle on a far side of the room, covered over with a sheet and two small woolen blankets. Phoonurh’s toddler son sat with her, warmly dressed in used clothing but new boots. Their hearth room was in a slightly worse condition than the other two houses. During the course of her
cooking, quite a few children showed up to sit around the aneti; Shabir Alam’s younger sisters, Mussrat and Bulbul, came with their children. Safiyya also came by to help Phoonurh, who is her eldest sister, and Phoonurh’s 16-year old daughter, Munafa, made the rice for the lunch.

Mussrat’s children ate from a shared plate, perched on the end of the cement hearth base, once we had finished our dishes. Phoonurh then used the sauce from the chicken dish and put it into a large shallow pan, into which she placed ripped up pieces of chappati for the youngest children to eat once they were softened by the broth. Vitamin deficiencies are evident with the babies and women. Sabida had large red blemishes – recovering boils - on her face. Phoonurh also complained about having had them at various times all over her face, and showed me some angry active boils on the wrist and forearm of her right arm. I thought they might be related to poor nutrition, but the babies are fat and active. Hejira then arrived with her baby, Khadija (her husband Fida having left on an in-town errand with Rizwan). Khadija, according to Phoonurh, is 40 days older than Sabida and smaller than her as well – friendly competition between mothers over the size and abilities of their babies being well in evidence. Many of the babies wore multiple layers of clothing with knitted caps with long ear muffs, hanging well below their shoulders, which I think could be tied under their chin to keep them extra warm. But I’ve also noticed a lot of babies wear long socks with long tops and sweaters overtop, and no diapers. Some babies smell quite strongly of old urine, while others are kept very clean and changed frequently, or their bedding is washed daily.

Catching my eye as I looked over the room, Shabir Alam repeated several times “Hum gharib log” [we are poor people; U] and because of that that their house is desi, it’s “not good.” I commented that I found the traditional house designs to be warmer, and more effective and useful than the modern designs which are sterile and easy to clean, but far less comfortable, especially in wintertime because the cement walls do not retain any of the bukhari’s heat. The desi homes are easier to warm - they are wooden-beamed, with dirt-covered roofs and rock or wattle-and-daub walls. After lunch, Shabir Alam asked his son, Wahab, to bring his two rifles over to him, along with a long shoelace that had a small lead-looking piece hanging at the end of it. (This is used to clean the rifle barrel.) Shabir Alam removed the bullet cartridges from the chamber of these bolt-action rifles, and held them up against the smoke-hole light to check the inside of the barrel for dirt. After inspecting each one, Zia tied the cleaning device back around the trigger piece of one of the rifles and leaned them back up against the wall by the cradle where Sabida had slept. They were both unloaded.
As the children ate, their mothers and older sisters were knitting sweaters and booties for the babies. Once the lunch was finished, Wadood went back to Bura Mamu’s house to check to see if Ferdost had called with information about the *waqfa* – curfew break. Shortly after two, Kate hurried back to tell me that Wadood was in the car waiting for me, and wanted me to collect his *choga* [traditional men’s woollen cloak; S] and find Nadeem. He had found the home phone was unattached to the car battery, which they use to power the line during load-shedding. Rizwan had taken the battery to run the *dubba* [Suzuki van; U] and drive Fida to the edge of town. With the phone out of commission, Ferdost would have been unable to call. I walked into Bura Mamu’s garden, where Wadood had started the car, and then we heard a motorcycle drive up. I walked with Pfiffi through the garden gate, and saw the local Imam, wearing a *pakhol* overtop a Palestinian style head-scarf, black and white in design, and with lots of *sorma* [kohl; U], getting off a motorcycle. He had just arrived from Gilgit Town, and told us a break had been announced. Despite his requests for us to stay, we left, but not before first promising not to go back to Chenar Bagh.

We drove back down through the village to the main road, and sped as quickly as we could back towards Gilgit. At the base of Sakwar, where the Chilasi drivers were still trapped with their loads of firewood, there was an Army checkpoint for incoming traffic. The Army captain asked us where we were going, for Wadood’s name and his *Shinakhati* card. A late middle-aged female police officer, wearing a heavy cable cord sweater over a *shalwar kameez*, with her *dupatta* pinned lightly over her head, came to the back door where I was sitting. As I opened my door, she barked said “Utoh” (get up; U) – I did and she patted me down a little bit before starting to dig around in the mess of our belongings in the back seat. At this point, an Army officer with a Scouts uniform recognized Wadood, and while the back trunk was being searched, the fellow assured his supervisor that “*Woh humara ghao sey heh*” [they are from our home, community; U], and the fellow said “Bas, thik heh” [enough, OK; U] and had to ask the female officer several times to stop digging around before she somewhat unhappily backed away. As I got back into the car, I heard someone comment about us being “*ungrez*” [English; U]. There were two thoughts in my head as they stopped the search. First, I was grateful we hadn’t brought a Kalashnikov with us, as Wadood had considered doing. Secondly, it was frightening to think a minimal village connection could stop a search for weapons in the car of a man whose family is from Diamer District.

After this we drove with ease to the Sunni end of Sakwar, where we saw a small impromptu camp across from the police post, in the small glade of trees behind the rock wall. There, more soldiers were living in tents and using small cleared out cooking spaces. Pots and bread pans hung from branches in the trees. There were more zig-zag obstacle courses of barbed wire and the usual speed-bumps, and an Army
captain in a khaki suit with a metal hat covered with what looked like fishing net asked us where we were going and where Wadood’s Shinakhati card was. As was expected, there was far more traffic on the other side of the barrier to leave Gilgit than to enter it, and enough police officers to try to process as many of the drivers, trucks, cars, Suzukis, dabbas and buses as possible. We drove straight through to the Serena Hotel. There were substantial barbed wire barricades at the foot of the hill on the main road. We had our usual dinner last night, and noticed more load shedding than usual – the hotel’s diesel generator and town power lines frequently interchanging. When we came in yesterday, they told us that there had been skirmishes in Amphari and Baseen, but nothing in any other area, and that Zia-u’din had truly died and the news was just spreading throughout Gilgit.

January 13, 2005

National-level responses to Gilgit’s plight demonstrated conspicuous uncertainty regarding how exactly to respond to the specter of sectarian violence. Immediately after Zia-u’din’s shooting, Information Minister Sheikh Rashid Ahmed declared the “incident was an act of the enemies of Pakistan”, unhelpfully adding that “those responsible for all this are neither Muslims nor Pakistanis” (Dawn: January 8, 2005). After Zia-u’din’s January 12th death, Senator Nisar Ahmed Memon (Pakistan Muslim League Additional Joint Secretary) opined that the problem wasn’t necessarily sectarianism, but that “anti-state elements were bent upon destabilizing the country and targeting the ‘soft valley’ of the Northern Areas to hinder the economic and political reforms introduced by the government there” (Dawn: January 11, 2005). While Memon’s refrain was echoed many times over by Pakistani officials, Gilgitis protested that his was a highly unlikely explanation, and hardly accounted for post-1988 increases in local, Shia-Sunni militarization, community segregation and the ongoing exclusion of Gilgit from state-level governance. Furthering on Memon’s rationale, KANA Minister Makhdoom Shah Faisal Saleh Hayat offered an even more insubstantial articulation of post-January 8th events, saying that if Zia-u’din’s death and the subsequent shootings “were purely an act of sectarianism, the other sect [Sunnis] would have reacted but this was not the case” (Dawn: January 11, 2005).

Sectarian responses were equally unfocussed. Throughout Pakistan, Shia members ISO party advanced a sometimes contradictory set of theories to explain why Zia-u’din had been killed. Javaid Haider, president of the Imamia Student Organization’s (ISO) Karachi chapter, stated that Zia-u’din’s shooting resulted from American political interference. Specially, that “the United States was trying to turn Pakistan into a secular state by targeting [the] Ulema and intellectuals to destroy religious harmony in the country” (Dawn: January 9, 2005). Another Shia politician, Agha Aftab Haider, suggested Zia-u’din’s death was “the outcome of his successful resistance movement against [the] secularization of [the] education syllabus.” Haider cast the net further to describe January 8th as a “conspiracy…to fan sectarian riots before the month of Moharram to divert attention of Pakistani Muslims from the problems of Muslims all over the world” (Dawn: January 9, 2005). Others were more likely to assign blame to local and national sources. Speaking anonymously to reporters, one Gilgiti Shia stated, “Mr Rizvi in his last Friday sermon had criticized the government for not resolving the curriculum issue [and] had warned the government of resuming the protest campaign” (Dawn: January 9, 2005). Gilgiti members of the separatist Baloristan Research Forum “held the local administration responsible”, and “termed [Zia-u’din’s death] a work of agencies” (Dawn: January 9, 2005).
Gilgiti Sunnis vigorously discounted state-held assumptions that Zia-u’din’s death was entirely political, and pointed to a lengthy, local history of sectarian conflict as proof. Yet by citing the Sunni community’s lack of preparedness for Shia violence, they simultaneously contested any notion of local involvement in planning January 8th. Conspiracy theorists maintained that Zia-u’din was killed on the orders of Shia supporters of his political rival, Syed Allama Naqvi. But the majority of Sunnis, like most Shias, felt Zia-u’din’s death probably resulted from the Federal Government’s concerns with growing political influence and militancy among Gilgiti Shias. January 8th was thereby described by many of my participants as the product of Pakistani security concerns, while subsequent conflicts were fuelled by a unique conflation of Gilgiti and Iranian interests.9

Today everyone is waiting for Zia-u’din’s body to be returned by helicopter to Gilgit – it’s supposed to arrive at 4pm. It’s 3.45pm right now, but the weather is bad and it’s quite cloudy. We’ve just been told they can’t bring the body up by helicopter today – a trip that takes about 2 hours. They might try again tomorrow. But once again, the Army won’t allow a curfew break out of fears of the public’s reaction to his Jenaza and burial. We met a Canadian trekker at dinner tonight; the Army had brought him to the Serena from the Medina Hotel in central Gilgit Town, where he had heard quite a few small gun and machine gun fights over the days that he was stuck there. He had arrived in Gilgit on the 7th, and on the 8th he hiked up to Kargah to see the Buddha. On the way back through Baseen he was stopped and told there was fighting in Gilgit. He kept going and noticed several Hi-Ace’s full of anxious passengers speeding out of town and away from the action. Having a full beard might have made him somewhat of a target, and quite a few locals offered to keep him for chai (and possible longer stays in their houses) en route. At one point, and it’s not quite clear where, he was stuck in a small pharmacy-PCO until about 5pm. This was near a fast-rushing part of the river that cuts through Baseen, and here he noticed that the frail bridge crossing the river was either out of commission or not passable by foot passengers due to the traffic. One man had taken several inflated inner tubes, and overlaid them with two-by-fours and plywood to create a precarious raft; he was ferrying people two to three at a time across the river. The tourist noticed there was a substantial crowd on the Gilgit side of the river, trying desperately to get across. He said even after the sun had gone down, there were still groups of people crossing by flashlight and propane cylinder light. He had heard rumours that a Sunni from Peshawar had killed Zia-u’din, and then he heard conflicting reports that Zia was killed as the result of rivalry or enmity between two Shia clerics. The resulting massacre of Sunnis might have been a means to distract attention away from the Shia community’s responsibility.

9 It later took the Army to organize and return by helicopter a number of “top officials of the local administration who [had] been absent from the area for about a month”; sources stating “military authorities had expressed displeasure over their absence” (Dawn: January 9, 2005) at such a critical juncture. By January 13, Pakistan Muslim League (PML-NA) Chief Organizer, and Northern Areas Legislative member Hafiz-ur-Rehman “demanded [the] imposition of martial law in the region until the situation had improved” (Dawn: January 13, 2005).
Today, the hotel General Manager told me that he had spoken to the fellow conducting the post-mortem on the assassin, who had been shot multiple times. In fact, he had been shot by one of Zia-u’din’s bodyguards before the bodyguards were killed, and then Zia mortally wounded. The pathologist had described the Sunni as powerfully muscled, and quite young – perhaps 26 years old. Later, Wadood told me that before the police were able to shift his body to DHQ’s mortuary, “Shias managed to cut off his nose and remove his eyes”, which infuriated the police and led them to temporarily “accuse the Shias of committing a sacrilege” (actually a profanity according to Islam, which prohibits mutilation of corpses). Others argued that this was intended to conceal the assassin’s identity, and reduce any connections between him and the local Shia community. Wadood and I had spent much of the day discussing how very quickly members of the Shia community responded with violence toward local Sunnis. Amir’s uncle, who manages the Sunni Co-Operative Bank by the Polo Ground, halfway between the Shia and Sunni mosques, said that as soon as he heard the firing only a hundred or two hundred yards from his office, he told his driver and bodyguard to get him out of the bank immediately. They left right away, and as they were driving away there already were gunmen following and firing on his Jeep. Wadood has told me that he suspects there will be a huge cache of weapons and ammunition in the Shia mosque, and that Zia was responsible for militarizing the local Shia population, hoping perhaps, he says, for an Iranian style revolution, or at least strict adherence in the Nisab and Pakistani law for Shia customs and religious law. He was also described by some here as having pushed the Shia community towards its current dressing styles, which very closely mirror – especially in the case of women – the chador style of Iranian Shia woman. I’ve also been told that after the ’88 riots, in which many Shia were killed by Sunnis, that the Shia community made efforts to “train its women”, although the total implications of this statement are not entirely clear; for example, does this imply weapons training?

Wadood told me how when the ’88 lashkar arrived from Diamer and Kohistan, Shias living at the lower, roadside edges of Minawar ran up the rocky hillside where his uncles then lived, calling for help and refuge. His uncle offered them complete protection, and for upwards of a month almost a hundred Shias – complete families – stayed in the family compound. Many of Wadood’s relatives from Diamer who had come up on the KKH, ostensibly to injure or even kill Shias, had stopped first at the Minawar family’s house, where they were quickly convinced by the uncle to assist in protecting the Shia families. Wadood relayed, not without some emotion, that how after one month they were able to return to their homes in the same village with no risk, where they have remained to this day. He also added that later, many of those same Shias had turned and blamed Wadood’s family for being some of the instigators of the ’88 riots. These accusations devastated Wadood’s family and led to many of his Minawar cousins
arguing Shias could not be rehabilitated, even by kindness. Wadood also says that many of his Diamer relatives truly believed, and may still do, that they would be able to convert many of the local Shia to Sunni Islam by force.

Wadood says that Sunnis in Diamer District and Kohistan are waiting to come up to join the fight, and it would only take one phone call from the Sunni Markaz for them to get into vehicle convoys and come up, as they did in ’88 when Zia ul-Haq supported the massacre because - in a sick way - it affirmed Sunni Islamic unity between the Army and local peoples throughout Northern Areas and Sarhad [NWFP]. At the end of the day, I had overheard various tidbits from senior Army officers who sat at the table beside ours, and were meeting at the Serena to discuss their strategy. It seems that 16,000 additional troops were brought in by the Army by road and transport plane to help control the situation. The town’s population can’t be more than 60,000, so this number is astounding when one adds this to the troops already here and on the Army base in Jutial Cantonment. This new push is being called ‘Operation Cleanup’ – a name which has already been deployed in Waziristan, where the Army’s ‘Operation Cleanup’, or Wana Operations, are striking at the Taliban and tribal jihadis. The ISI [Inter-Services Intelligence] and Army are coming into Gilgit by C-130 transport over the next few days. The ISI’s role is to collect local information and police reports, which will be used as the basis for targeted raids into local mohallas, to seize weapons caches or jail the perpetrators.

For Zia’s Namaz-e-Jenaza [funeral prayers; U], the Army is arranging crowd control, though the Shias are citing Army involvement in his death. (After Zia had returned from Iran ten days ago, rumours have it that he was warned by the ISI to desist from future Iranian missions, or risk his life. There are also stories that Zia’s brother tried to see him at the CMH in Pindi, but he was prevented from viewing the body.) Wadood also gleaned from a casual chat with an Officer in the front foyer that there was shooting in Amphari before, but that the Army had gone in to beat up the shooters. (Ferdost called after dinner to tell us he’d heard that Shias living in Domyal last night were shooting across the River at Konodas, and also neighbouring Kashrote.) The hotel manager sat with me for a few moments, looking glum. He said that Kalashnikovs were easily available now, thanks to the intense flow of money and weapons into Afghanistan during and after the Soviet occupation. He also critiqued Pakistan’s inability to make a claim for Kashmir when it can barely manage law and order in the Northern Areas, and predicted the Army would do whatever it could to quash the story of Gilgit’s current problems, because this

10 The Sunni Markaz is the formal headquarters for Gilgit Town’s Sunni ulema; the largest Sunni mosque complex in Gilgit District. It is surrounded by an extensive madrassah complex and large fields, which are used for outdoor prayers on Eid-ul-Fitr, Eid-ul-Adha and Eid-ul-Nabi.

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complicates their claims for Kashmir. He also remarked, and not without obvious sadness, that Shia-Sunni strife was inevitable: “In Zia’s time, they planted the seeds, and now the plants are flowering.”

Most alarmingly, we heard that two Sunni men from Jaglote had been killed on River View Road on the 8th – about 100 yards past the Gilgit Medical Center, towards the suspension bridge leading to Konodas. This absolutely complicates our return to Chenar Bagh; these men were supposedly hunted down and killed by Domyal residents as they tried to escape. (Were these the shots we heard so close to our house, and which woke Imran?) After dinner, Wadood received a call from a cousin in Jutial and groaned at the news. His cousin’s husband Liaquat, a civil servant, had been killed in his office on Hospital Road where he worked. He had been caught by the rioters as they set the government buildings around him ablaze. Reports now suggest that between fifteen and twenty-seven have been killed; two Shias were killed in Chilas, and Sunni drivers have been killed and assaulted in Soust, Hunza and Nagar. One of Wadood’s former colleagues from NATCO [Northern Areas Transport Corporation] was said to have been beaten up and robbed by Shia youth as he tried to speed through Nagar District in his transport rig.

**January 14, 2005**

Agha Zia-u’din’s body was unable to arrive in Gilgit yesterday because of problematic weather both here and in the mountains between Gilgit and Islamabad. Wadood has told me that the government has offered Rs 3 lakh [CDN $7'142] in compensation to the families of those Sunni men killed in the initial clashes on the 8th and perhaps also the 9th. He said that such a speedy compensation package is a new means to resolve sectarian ‘tensions’ in the Northern Areas. We were discussing yesterday how the Sunnis in Diamer District might be called up by the *Markaz* here, and proceed up in convoys toward Gilgit – where the Army is expected to hold them back at numerous checkpoints en route. Wadood said the Army’s sympathies, despite their need for control, very clearly tend to lie with Gilgiti Sunnis. Yet in light of the sheer amount of men who might come to fight, it could be impossible to hold them back. As in Zia’s day, there was concerted pressure for it to appear that Pakistan’s Sunni *ulema* and local Sunni communities were in allegiance. The Army was one such mechanism for evidencing support of national Sunni *ummah* [community; A] towards its brothers in conflict.

At the hotel today, a prominent Ismaili businessman was talking about the “foolish Shia community” and their apparent inability to see the consequences of their actions. He described them as a minority community, isolated in a variety of ways, in neighbourhoods that are separated from one another by Sunni and Ismaili boroughs, or by rivers and valleys. He commented that Shias can’t possibly hope to be able to launch a successful war against the Sunnis, who, contrary to their overall reputation as ignorant
fighters, are being described by many of the Isma’ils I’ve spoken to as being remarkably, admirably restrained in not fighting back. The Ismaili gentleman said that Gilgit Shias are equating the murder of Zia with the martyrdom of Hazrat Imam Hussain, and that they are saying “for every one Shia killed, we are willing to strike at ten!” He described the “Shia mafia in Gilgit, and how they bring goods in from China by force” through Soust. Trade items are then brought to Gilgit, whereupon they’re sold or shipped down-country – invariably using Sunni drivers in Bedford transport trucks. I had said I was mystified why the Shia community was deliberately striking at people from Diamer, because this would make it nearly impossible for Shias to travel safely through Diamer and Kohistan en route to Pakistan’s cities. Flights from Gilgit are expensive and unpredictable.

After breakfast, we had heard rumours that they would try to bring Zia-u’din’s body back again today – preferably in the morning for a quick burial – but then someone said he might have his body taken first to Skardu to show the Shias there. It seemed an odd idea, but the fellow working at the hotel who told Wadood assured him it was “confirmed” information. But on the 1pm ARY news broadcast, the reporter said that the body was due to immediately leave the Rawalpindi air-field by military chopper, with 21 people accompanying the body along with Syed Ali Naqvi, the head of the Pakistani Shias (the Ehle-Tashee [Ahle-Tashe] are Shia, Ehle-Sunnat [Ahle-Sunnat] are Sunnis). The reporter said that they had prepared two burial places (kubur) for Zia-u’din and one of his deceased bodyguards, and that only his family and immediate neighbours and friends from around his house in Amphari would be allowed to attend the Namaz-e-Jenaza. The burial spot would be inside the grounds of the Shia mosque, which is evidently quite unusual. I guessed that perhaps it would become a sort of shrine, and a place for people to renew their faith, their commitment or their angers. Earlier in the day, we called Wadood’s Pfiffi in Minawar, and she said that they had heard a rumour that Zia’s body was already in Gilgit and being buried quietly by the Army; however, because nothing had come up by road, everyone in Minawar was saying that his body had never left Gilgit at all – it was all part of an elaborate Army hoax. Seemed possible – but then conspiracy theories breed well in environments with little effective media or refuting evidence, and where stories and half-truths are the medium for communication.

ARY news said that Zia’s body and that of his bodyguard would arrive in Gilgit, if weather allowed, around 4pm. Shortly after 4pm I could feel the vibrations from the incoming helicopter. I went out onto the room balcony just in time to see the camouflaged military helicopter arriving in low over Gilgit to land at the heliport near Kate’s Army Public School. We realized his body had finally come back to Gilgit, and another process of mourning could begin. Many of the staff had assembled on the lower gardens to see the body arrive, and quietly filed back into the hotel once the helicopter engines fell silent. Wadood
called Ferdost at 4.30pm to ask him if he could hear anything from his house in Majini Mohalla. Ferdost said the Army was right outside his door, not allowing him to leave at all this time (there were minimal patrols prior to this), but he could hear Arabic prayers in the distance. He said that these were the it’tharawat, where a portion of the Qur’an - which may be used to describe the deceased’s personality or devotion - is used as the primary prayer for their soul’s rapid ascendance to Jennat [Heaven; A]. There were no sounds of gunfire. Staff at the hotel reported that last night was the first quiet night, the first without gunfire or violent incidents since Zia’s shooting.

After talking to Ferdost, Wadood turned to me; “At this point, much of the information we’re receiving is either the same, or versions of the same stories. Many people are saying that once the burial occurs it will be easier for people to reconcile, and yet many Shias are evidently in town for his burial – from villages like Nomal, Jalalabad, Minawar or Nagar [District]. How did they get here with the curfew? Where is the Army support for them and how did they get across the river?” The 16,000 additional troops are supposed to have arrived by road, although we’ve seen no evidence of an increased Army presence.

What I’ve been thinking about is the processing of terror and fear, distrust and mistrust in Gilgit. It seems in Gilgit almost like there are concentric layers of fear and violence that radiate outwards from an event, through and over certain neighbourhoods which are either immune or implicated, depending on the balance of Shia and Sunni interests and population in each mohalla. It’s also made me reassess why AKRSP and the Serena prefer to hire Ismailis over the other sects. The potential for security risks by having the Shias and Sunnis working together at hotels or offices at times like this could be incredibly difficult to manage. Preferential treatment and narcissism may also function as a discrete survival tactic.

We heard that the curfew has spread as far as Skardu now. Ferdost said that his niece had called from a hotel in Karachi Company in Islamabad once she heard that Agha Zia-u’din had died, and she had said that hundreds, if not thousands of Shia students had come into the streets to protest and were openly weeping.11

11 The following commentary by Ahsan Wali Khan was taken from Pakistan’s “Dawn Online Newspaper”, January 14, 2005; “Gilgit is once again bleeding. The situation turned ugly on January 8 when Agha Ziauddin Rizvi, a prominent religious leader, was injured in an attack; he succumbed to his injuries on Thursday. This incident angered the supporters of Mr Rizvi, and they unleashed a spree of killing and violence. The mob, spearheaded by weapon-brandishing youths, killed 12 people while property worth millions, including dozens of vehicles, was damaged and burned. Curfew was imposed and the military was called out to help the administration restore order. The situation remains tense and the people are living in a state of fear and panic. Many, including women and children, are stranded at different places. They have no contact with their families and little hope of reaching [their] homes owing to the curfew. The shortage of food items and fuel for cooking and heating purposes in the harsh, cold weather is yet another problem the people have to face, not to mention the suffering of the sick, who have no way of reaching a doctor or procuring medicine. The government has completely failed to protect the life and property of the citizens. It has not learnt from the experience of June 2004 when a weeklong curfew was imposed after bloody
January 15, 2005

There is no curfew relaxation for the third day in a row. At 10am this morning, we watched the military helicopter – which had brought up Zia’s body – flying down-valley towards Minawar, and beyond. The weather is considerably sunnier today, with clouds only on the tops of the mountains, and the sunshine radiant on their snowy flanks. Syed Ali Naqvi has arrived to stay in Gilgit for several days in order to broach a ‘truth and reconciliation’ approach to harmonizing relations between the Shia and Sunni communities. Wadood has said that the Sunni Markaz will be meeting with Naqvi today, and I noticed Mir Ghazanfar Ali of Hunza in the restaurant – red haired, blue eyed – emanating a lengthy trail of expensive cologne. The Mir is the Deputy Chief of the Northern Areas Legislative, and he is staying in-town to attend these meetings.

Last night, around 8.30pm, I went up to the hotel’s Business Center to send some emails. In the hotel lobby I spotted Fida Zara, a friend of Wadood’s from their school days. He had come to drop off some papers for a work colleague ‘hiding’ in the hotel, and looked very pale. I’d asked how he and his family were doing. He began by saying that he had been on Hospital Road at the heart of the riot, when the attacks began. He said that he was still shaky talking about it now, a week after it took place, and that “Al-Hamdillilah” his family had survived, although his father and a young brother had been in the bazaar nearby. Fida said that his family owns several homes along Hospital Road, and that he was heading home from giving dua at a friend’s mother or grandmother’s Jenaza near Baseen when he passed the DHQ entrance and saw a blue Pajero – riddled with Kalashnikov fire on all sides, the windshield shot to pieces as well – and individuals carrying a body from the car into the Emergency Ward. He said that he recognized the Pajero as belonging to Agha Zia-u’din and remarked to himself, “This is a very bad day for the Northern Areas.” As several car loads full of gunmen, along with men on motorcycles, arrived at the DHQ, he overheard one of them shout, “Take him [Zia] to the operation theatre and then go and…” Here, he indicated an arm up-raised, a trigger finger pulling. Immediately after they carried Zia in to the

clashes erupted over the issue of the Islamiat syllabus, and has not put in place any contingency plan to deal with such kinds of eventualities. Disregarding the inconvenience to the people, and instead of cracking down on the troublemakers, the Gilgit administration’s routine method of handling similar crises is to impose a curfew in the area. This has become the way of governance. The administration should ensure the writ of law, instead of following a policy that is tantamount to one of appeasement. Miscreants and criminals must be nabbed and punished, and the victims appropriately compensated. The military/civil administration that has an effective monitoring role in the Northern Areas, must be held accountable, and heads should roll for not ensuring security in the sensitive region. All efforts must be made to apprehend the attackers and pinpoint the reasons behind the assassination attempt. Likewise, nobody should be allowed to get away by giving the pretext of being caught up in the mob violence. What must also be eliminated is the dangerous trend of well-organized teenagers armed with lethal weapons carrying out executions behind the smokescreen of mob violence....”

12 National leader of Pakistani Shias.

Emma Varley
hospital, young gunmen with Kalashnikovs slung over their shoulders, their faces covered by black chadors, began to fire on immediately available Sunni targets, or grab nearby Sunnis and shoot them with pistols (from his hand gestures, it appeared that they might be shooting them in the head). From what he told me, it sounds as though these killings occurred with very little distance between the assailant and victim. I asked if they just left the bodies where they fell, and he said yes. I also asked him if he looked when they were killing people, and it wasn’t clear, even after talking for some time, if he had seen the actual killing, but he said he saw them “preparing to do it.” I wonder if he had purposefully averted his eyes.

At this point in the story, almost as a confidential aside, he tells me that he’s Sunni. I’ve noticed many people indicate their sectarian identity in this way, almost as though it’s a bit of a ‘secret.’ I blurted out that he was very lucky not to have worn a beard, or have the assailants recognize him as a local Sunni. (I also confessed that prior to this, because he was clean-shaven, I had thought he was an Ismaili.) He said yes, that this had made it easier for him in a sense that day, although he still admitted saying to himself, “This is perhaps my last day on earth.” I asked, “Was your heart in your throat, and did you run?” He said he didn’t run, but acted “confident”, walking as calmly and ‘normally’ as possible. He did confess to being terrified, and said he tried not to look directly at either the gunmen, or the Sunnis being killed. He said running would have probably resulted in his being shot and killed on the spot.

He told me about a relative working at the DHQ who claimed to have heard “with his own ears” the gunmen saying to one another, “Go kill any Sunnis you can find - man, woman or child.” [Stories were shared very quickly, and also changed in the process. A number of accounts were second, third and fourth-hand by the time we heard them. Fida’s was then the only first-hand, eye-witness narrative I heard.] Fida’s relative evidently told him that several Sunnis were wounded or shot and killed in their hospital beds at DHQ, and that the gunmen acted like “mental patients.” Fida remarked that the ISO (Islamic Students Organization) which had been headed by Zia-u’din, had all been detailed ahead of time as to exactly what to do should an event like this occur, and were extensively trained. With great vehemence, and thrusting his hand away from his face in a gesture of disgust, Fida said, “You can’t trust these people!”

When I discussed the rumours I’d heard that Zia-u’din may have died as the result of a Shia-Shia fight, with the subsequent killings of Sunnis being meant to distract from the truth, he said that there was one thing that pointed definitively away from this. Namely, that the assassin was a Sunni Pathan, and it was improbable a Shia would have been able to contract him for the killing from a conservative Sunni
mosque, as the newspapers have reported. Fida then surprised me by saying that he felt Zia and Gilgit Shias were “right to have done what they did” during the Nisab Riots. This awoke me to the chord of sympathy that some Gilgit Sunnis feel for the Shias’ struggles for recognition, which are not entirely dissimilar from Sunnis’ own efforts to be heard by the Federal Government. I asked if he had seen the Sunni-managed Co-Operative Bank surrounded by fires, and he said no – it hadn’t been burned, though adjacent Sunni businesses were. He also said that a petrol bomb had been used on the room in the Ismaili’s house where the men from Diamer died. This is where the stories begin to cross-cut, as with another rumour I’d heard that the Ismaili family had been “burned alive” in the house, while Ferdost said the angeeti or something had been knocked over and the room had burned out.

Fida said that his father had been working at the family’s shop, where his little brother had gone to find him and to tell him what was happening. In that area, gunmen in a Suzuki dubba came to shoot at his father and brother, who crouched along the inside of the store and escaped injury. Another man and his small son who were standing beside them, however, were injured and the child died after being shot multiple times across the upper torso by machine gun fire. I asked Fida if he had weapons in his house and he said no, “just several TT pistols”, and if he had a Kalashnikov he would be “much safer.” Later that night, after the family had managed to congregate at their home, surrounded on all sides by Shia homes, Fida recounted how a cousin and his wife had been preparing to leave the house and drive back towards Baseen. Fida pleaded with him not to leave the house, warning him that Hospital Road had been blocked off at this point, and Shias were catching and killing Sunnis as they tried to leave the area by car. Shortly after, his relative from the DHQ arrived with two patients, who they took in for their own protection; they were afraid they would be murdered if they stayed in the hospital.

He said that they have another relative who is a police driver. Once the curfew was established across town, he was able to bring a vehicle and two officers at 4am on the morning of the 9th to shift the entire family to an uncle’s house in Kashrote Mohalla, where they are now all living. He said they had to leave without using any lights, or making any noise and get into the vehicle and leave as quickly as possible – not knowing who in the neighbourhood would be watching to kill them as they left. I can’t imagine how fear permeates and saturates a location after something like this, and how the notion of personal space can be irrevocably tainted for someone who has lived in a house for many years. I asked what his plans were in the future, and he said that they will have to “abandon the property”, “rent it out to another family” and find a new home for themselves in another location. This idea did not seem upsetting to him; he said he wanted to relocate to Zulfiqarabad, an Ismaili-dominated mohalla. He said anywhere there are Sunnis and Ismailis “there is aman [peace; U]” (here he sat back in the chair and said the word slowly and
calmly, while pushing each hand out in a vertical direction away from the center of his chest, as though indicating a long horizon with his hands).

**January 16, 2005**

Today is the third day after Zia’s burial, which in Shia Islam requires a meal of some sorts. The 3rd, 7th and 14th days after death are marked by gatherings - called jalsas, or jaloos - prayers and meals. Sunnis, on the other hand, mark it on the 3rd, 10th and 40th days after burial. People at the hotel were saying today would definitely be a curfew too, but now the hotel manager is saying there is a curfew break for 4 hours from 2-6pm. I can’t imagine how continuing to trap Sunni and Ismaili populations in their homes - without access to food, medicines, supplies - in order to accommodate Shia mourning will result in faster resolution of sectarian enmity. At a personal level, and bound up by inconvenience, deprivation and fear, might not Sunnis and Ismailis resent the Shias even more?

Wadood spent a lot of time last night talking with Fida, who came to meet us for chai and relayed additional stories. Fida said that the night of the 8th, when he and his family were all safely inside their house, there was a loud banging on their gate. His mother went outside and called to ask who it was, and received no answer. At this point, his little brother went quietly up to the main gate and looked out to see if it was anyone they knew. There he saw two masked gunmen standing just outside the gate, their faces concealed by wrapped-around chadors. Then mother and son quickly retreated back into the house and nothing more happened. (Could the gunmen have been unwilling to kick down the gate because they were unsure if there were weapons and ammunition inside?) A friend of Fida’s from Jaglote said he saw the people who shot Zia-u’din - he relayed this in a phone call. Four men had been in a Jeep and stopped Zia’s Pajero with their vehicle. Three men then jumped out and started shooting at the Pajero and Zia-u’din, while also shooting out the Pajero’s front tires. The Pajero’s driver tried to turn the car toward the DHQ, and one of the assailants ran and shot directly into Zia-u’din, and then he was shot, in turn, by one of the bodyguards and died there. The driver at this point was driving on the car’s rims to the DHQ. While the Pathan was killed, the other three managed to drive away and escape to Baseen.

During his visit, Fida mentioned that the gunmen he saw were predominantly between 16 and 18 years old. Furthermore, he added that the gunmen immediately went into offices along Hospital Road and removed and executed prominent Sunnis – including a “well decorated civil servant”, and then of course Dr. Sher Wali Khan – “an important man in our community.” How were these young men to know who these individuals were, where to find them and what they meant to the Sunni community? Fida said that the Shia youth were, in his opinion, ISO members. He said that many of them receive military training in an area in Nagar, and that they receive ideological and religious training, as well as the details required
in case an attack against their leaders occurs, from the Shia Imambaragh in Gilgit Town. He also said that Zia-u’din was a “bloody man” and “the real terrorist” – a troublemaker who might have also been the victim of personal enmity between himself and two other Shias, one being a cleric and the other a local politician, who had evidently told Zia-u’din during a very recent fight, “You stick to the mosque, to your prayers, or I will kill you.” When we talked about the immediacy of the plan and attack against the Sunnis, Fida said that he felt and was convinced it was “pre-planned”, which led him to ponder some difficult questions. One concerned thinking through the ISO’s ability to isolate and kill so many important Sunnis, so quickly. And why people in the hospital, and the Director of Health Services for the Northern Areas? Also, how were they so well equipped so quickly even at the start of the fight, with ammunition, heavy weapons and even petrol bombs? He also wanted to know why the Pathan assailant’s face was disfigured by members of Zia’s “team”. Not only were his nose and eyes removed, but the skin on his face was also apparently stripped off. I relayed the story Wadood had told me, that the Army was “furious” at the body being mutilated, and had accused the Shias of trying to “hide something.” Fida agreed with this interpretation, and said – with his finger pointing dramatically down at the desk – that this is a “big question which the Army must pay attention to.”

Later, as we were drifting off to sleep, Wadood remembered to tell me that – like residents in Diamer were doing – Gilgiti Shias were volunteering their Eid qurbani funds for ammunition and weapon purchases. I also heard from Wadood that Diamer residents had managed to raise das lakh [1 million rupees; U] in compensation funds for the Ismaili fellow who was killed protecting his Chilasi colleagues.

Evidently Syed Ali Naqvi met with Qazi Nisar at the Sunni Markaz yesterday. The Sunni community in Diamer and Kohistan has put in a demand to Naqvi that the Shia community here agrees, in a formal contract, not to “hit” any of their Sunni leaders, Qazi Nisar being foremost among them. They must do this by Eid-ul-Adha - in 4-5 days time - or the Sunnis are prepared to do something about the situation, and may come up to Gilgit to fight. This is ominous news, and I’m not sure if Naqvi has the power to assure the Sunnis, or to convince the Shias that it’s in their best interest to agree. Yet even this might be

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13 Leader of the Northern Areas Sunni ulema.
fraught with difficulty. How many fractures and divisions are there among local Shias, or between Gilgiti, Nagari and Balti Shias? Evidently, an Army Colonel had gone to Diamer a few days ago to try to negotiate some kind of truce, or receive Diameri’s assurance that there would be no retaliation from the Sunnis there. A Diameri cousin bragged to Wadood that they had “kicked him out”, and wanted a promise of peace directly from Gilgiti Shias and not brokered through the Army. People at the hotel are also nervously talking about Ashura and Moharram, which are also impending in the next month (see Figure 24). Neighbours commented that we’ve already experienced one Ashura and now have to face another one.

January 21-23, 2005

We made the shift from the house in Chenar Bagh on January 23rd – we were anxious, harried and paranoid while rolling up carpets, pulling down curtains, and sorting out furniture and garden tools. We had actually left the hotel on Eid-ul-Adha – January 21st - a day which felt less than auspicious given that the previous night, Haleem had been arrested while walking along the highway in Sakwar, along with several other young men, as they went to buy two goats for Eid’s qurbani [sacrifice; A]. Wadood had received a phone call at the hotel from the City Thana [jail; U] at dinner-time, and was less than pleased. Given curfew had already started, there was nothing we could do that night. The next morning we drove first to the Thana and arranged for Haleem to be released.

On Eid morning we tried to leave when curfew came up at 8 or 9am (to start again at 1pm), but were prevented from driving along the road and up past the General’s mess in Upper Jutial by Army sergeants, who made several calls on their mobile sets to confirm we were not permitted to drive along the road. We were told that vehicles were prohibited from driving along the main road because the Army generals were having their Eid prayers at the Army mosque just up from the Heliport. We finally got back down to our house in Chenar Bagh where Wadood and Nadeem left Kate, Imran and me off for the night. We planned to watch and “assess” the risk situation at the house, and if we felt uneasy, to then start packing up our belongings. I felt frightened and harried, and as we drove in through the house’s main drive I urged Wadood to drop us off and leave as quickly as possible. His presence made me feel that things could happen, and I worried that people might be waiting for him.

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14 The following article was taken from Pakistan’s “Dawn Online Newspaper”, January 18, 2005; “GILGIT: The federal government on Tuesday set up a tribunal to probe the incident of January 8 in Gilgit, said a press note issued by the District Magistrate of Gilgit, Sajid Baloch. Chairman of the Chief Court, Raja Jalaluddin, would head the tribunal, said the press note. The situation in Gilgit district remained peaceful on Tuesday, it added. The press note said that curfew break would be extended from 7am to 1pm on Wednesday. Moreover, PIA would also resume its flights on Wednesday. AFP ADDS: Local police chief Sakhiullah Tareen said that six men were taken into custody for their suspected involvement in the January 8 riots in Gilgit.”

15 See Chapter Eight, pages 421-422 for a brief discussion of Ashura.
Chapter Six: ‘Tension Times’ Part I (January 2005 Fieldnotes)

Once inside the house, I got the angeti started and began to arrange the room so that Kate and Imran could be comfortable. I did as much cleaning as I could. We had absolutely no power – not a flicker on either line – for the duration of the night. Kate and I read by candlelight after dinner. Imran went to sleep unusually early; he was probably confused and felt it was later due to the darkness. We had the angeti stocked up for a good night in a warm room, but I slept uneasily because of all the noise of the loud-speakers on the road outside – trucks or Jeeps driving by with loud-speakers speaking in an Urdu which echoed off the rock walls of the adjacent mountains. Kate and I managed to translate that residents were being urged not to use their weapons, and warned not to leave their house or face severe punishments. In a sleep-addled state, I then noticed that the Konodas mosque was broadcasting their arzan [call to prayer] exceptionally loudly. The reverberations of the Imam’s voice reached us in a warped way, slightly before the words did, and even then, the familiar words of the kalima-shahadah were vague and hard to decipher amidst waves of rolling sound. At times, it sounded like children singing- voices echoing, and then deepening and shifting. The effect was eerie, and Kate was noticeably unsettled. We wondered if the mosque was trying to get the ‘message’ of faith out to Sunni residents throughout Gilgit city in the wake of the 8th’s carnage.

The next morning, I awoke to find the room exceptionally cold. When I went into the kitchen to start boiling water, I noticed snow on the branches of the fig tree outside the window. It was astonishing. At least one inch worth; it was the first snowfall inside town for many, many years. We could see the snow heavy on the outstretched branches of the huge chenar [maple] trees by the ibex monument. Quite remarkable and heart-warming, at least once the fire inside was going strong. Wadood arrived when the curfew broke, and said that at the Shia mosque near his parents place, he could hear them mourning and wailing and sermonizing for most of the night previous. He said that the Shia community had asked for 40 nights of mourning for Zia-u’ddin. He said that things would inevitably get worse during Ashura and the 10 days of Moharram, when Shias are said to whip themselves into a frenzy (literally), and mosque sermonizing becomes much more hostile against Sunni neighbours. (My fear is pushing me to speak in ways that sound sacrilegious or disrespectful. I’m not sure what to make of myself.) Against my protests, Wadood insisted on staying with us that night. Throughout the night, we were frequently awakened by the sounds of Army and police vehicles doing the rounds in our neighbourhood and across the river in Konodas. In a whisper, Wadood translated their messages; they were announcing next days’ curfew break (8am-5pm then), and asking people to co-operate with the government and not to carry weapons anymore into the bazaar, as well as urging young men not to wear large winter chadors, as these are how people conceal firearms as substantial as a Kalashnikov. The next morning we awoke and prepared.
Chapter Six: ‘Tension Times’ Part I (January 2005 Fieldnotes)

to move to our new rental in Jutial Mohalla. In Chenar Bagh, Kate and I disassembled the cooling angeti and I cleaned out the stove, the pipes and the metal tray. Finally got up to the new house just before curfew at 5pm, and the snow was falling lightly again on the garden there. (Wadood’s relative Ghazanfar came from his house and told us that the power for Jutial used to be five days on, one day off. Now it is two days off, one day on. After the 8th, the Shia residents of Guruh - where the main power supply station operates - had switched off the power to Gilgit Town because of their upsets with the Sunnis.) Once the furniture was inside and out from the falling snow, we agreed that we would set up the hearth area first. I was inundated with mental images of a cosy, desi kumrah [traditional room; U] and a roaring fire. Romantic notions abounded. Due to a lack of firewood, we froze anyway.

January 23-25, 2005

On the morning of the 23rd, we met Dr. Sharifa by accident at the Army-owned Askari Bakery. She was there with several nurses from AKHS, in the Gilgit Medical Center’s Jeep, to buy groceries for hospital staff. I told her how, after I had finished interviewing her at 11.15am on the 8th, I had gone straight home and heard the gunfire begin shortly afterward. She remarked that they had heard the news at 1pm, and immediately closed the hospital. I can only wonder what happened to the woman who was there in the early stages of labour while I talked to Dr. Sharifa. I was obviously happy to see Dr. Sharifa well and unharmed, and told her how much I’d worried about her during the worst of the fighting. She said that the hospital had been re-opened for two days now, but today was the 25th, and the Aga Khan’s birthday - the hospital GM [General Manager] had decided to shut down all “inside operations” indefinitely because of the risks to staff and patients. I’m not sure what this means for community-based health services though.

On the 24th, Ferdost came with his younger children to have chai with us, and to formally congratulate us on the new house. Over slices of walnut cake, he commented that “moderate Sunnis like Wadood may be able to make changes to their communities”. He also said, several times, that he “finds it hard to believe that Wadood is a Sunni” - which we took as a typically Ismaili, ‘sideways’ compliment, hued by a slightly piquant edge. Prompted by Kate’s offering afsoos [regrets; U] on his relative’s murder, Ferdost’s daughter, Nasirah, told us he’d actually been shot “in front of his daughter and mentally handicapped son” and that the girl had begged for her father’s life – “in the name of Allah and the Rasool” [Prophet; A]. The killers hadn’t hesitated to shoot him anyway. The daughter had gone screaming, hysterical to their neighbours to try to get help moving her father to the DHQ – just up the hill from their home - but no one was initially willing or able to assist. By now, Diameri Sunnis had managed to raise Rs 16 lakh [CDN $36,300] in memorium and compensation funds for the Ismaili’s surviving family, a gesture which Ferdost says
has deeply touched Gilgit’s Ismaili community. With tears in his eyes, he moved on to discuss how one of the Home Secretary’s guards had been killed when mobs pushed the Secretary’s private vehicles into the street and burned them. And to my surprise, Ferdost noted that the Northern Areas’ entire annual budget would have to be diverted to pay for the Army and troops that would stay here “indefinitely”, or “at least until the end of Moharram.” (Evidently, communities are expected to pay for their own defence when the fights are “their fault.”)

One of Ferdost’s neighbours is a senior Medical Officer at the DHQ. He had told Ferdost that on the 8th the Army had taken the “unusual decision” to keep Zia’s condition secret from his compadres and ISO guards, though he did initially exhibit some signs of life. The Army had reassured his people that he would pull through, and quickly shifted him to the CMH in Pindi. This was thought to protect against further killings, in that it allowed the Army valuable time to move in troops and establish the curfew. It also saved the lives of Sunni staff and patients at the DHQ; Ferdost had also heard about Shia teenagers running around the DHQ complex with guns on January 8th, with some as young as 12 or 14. And from a Shia friend in Nagaril Mohalla, Wadood was told that “Shia mothers were the first to push their sons out the door to punish the Sunnis.” While he and his children went to sleep the night before, Ferdost reported hearing more “firing coming from Baseen”, whereafter an Ismaili relative called at 2am to ask about the noise. The next morning, they heard that the police had moved into Baseen to “capture some of the terrorists” and there had been a firefight, from which the police had “run away.” There were also rumours that Shaiykhs at the main Imambaragh had urged Shias to shoot at any police who were coming into their mohallas to arrest possible culprits from the 8th’s violence. (Is this a quiet admission of ‘guilt’ or involvement by the Imambaragh’s Executive Council? Are these police raids part of the ongoing ‘Operation Cleanup’?)

Ghazanfar and his brother Ahmad Khan came at the end of chai for gup-shup [chats; U], and said that a few days ago their cousins had heard it was “confirmed” that Shias were planning on killing “at least five-hundred Sunnis in retaliation for Zia-u’din’s murder.” They also showed us a photograph of the Pathan assassin that was in the local “K2” newspaper. The same page showed a picture of Zia-u’din’s velvet cloaked coffin in the main Imambaragh, attended by Shaiyk Naqvi and other dignitaries. There is a perceptible ramping-up of Shia sentiments across Gilgit town. I’ve noticed a vast proliferation of black, sometimes silver-edged or silver embossed triangular black flags – some with Ya’Ali [oh Ali; A] written across them – flying and flapping on bamboo and wooden poles high above Shia homes and businesses. They have appeared very quickly, and are obviously meant to demarcate mohalla boundaries, and which
streets, homes or shops are Shia; Wadood emphasizes this is a form of self-protection, too. (“Please don’t burn this house!”)

On the 25th, Wadood felt confident enough to drive us back into the town’s central bazaars to look around. At the main Imambaragh, we could see there are now three immense black flags above each of the three main cupola domes - they weren’t there before - and a massive flag raised above one corner of the mosque compound. This, evidently, is where Zia is buried. Ten to fifteen Sunni-owned shops are burned in a solid corridor in the narrow gullee [road; U] that interlinks the Shia Imambaragh with the Polo Grounds, and the nearby Sunni Jama Masjid. Roofs missing, a charred orange metal desk sitting desolate and lonely in one store closest to the bank. It’s amazing that the bank remained untouched. Further up Hospital Road, as it winds up toward the DHQ, the gas store where we used to take our cylinders to be filled, had also been struck by arsonists. The metal shutters covering the front windows are curled up by the heat, or torn away. (The interior is completely gutted, and I can only wonder what became of the Sunnis working in the stores.) A few days after Eid-ul-Adha, I was quietly relieved to see a number of Army- and police-manned barricades re-appear on the main roads throughout town. They had been there for the first week after the 8th, and I’d been frightened when they were first dismantled. There are a few barricades that never came down; at the chowk joining the main road with Shaheed-e-Millat Road and Nagaril Mohalla, and at the Army Public School. At the corner of Hospital and Shaheed-e-Millat Roads there are still men hunkered down behind sandbags, while guards are posted at various locations and intersections along the main bazaar. In Nagaril, we also saw men in sandbag bunkers - machine guns pointing out - atop some shop roofs. The feeling of security and surveillance is much more intense there than anywhere else in Gilgit. Periodically, Army vehicles and truck convoys pass by – in the open cab of rented Datsun Hi-Lux’s, soldiers stand aiming LMGs out to the road ahead.

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The curfews last each day now between 6pm and 6am. Around fifteen minutes before curfew begins, an Army vehicle drives through the mohalla, announcing by loudspeaker that the curfew is impending, to go inside, and notes the following day’s curfew break. The streets are nearly deserted at this point; shops close down, the metal rollers clanging shut over their front doors. There have been no eggs for the last few days, and it’s only in the last few days that tomatoes and other fresh foods have reappeared. For the longest while, it was only potatoes, carrots and a leafy green that someone calls saag [spinach; U] but which looks more like a type of kale. Four days ago, Wadood bumped into his old Ustad [teacher; U] from his days driving buses with NATCO [Northern Areas Transport Corporation]. Hajji Tufail [Sunni from Azad Kashmir, a friend and former NATCO colleague of Wadood’s] had been pulled from his NATCO
office duties in Mansehra to drive buses between Pindi and Gilgit again. Shia drivers were both unwilling and unable to traverse the entirety of the KKH, especially past Sunni strongholds like Besham. Tufail wasn’t pleased with his return to driving, but sympathized with the Shia drivers who had fled “their down-country duties” after the 8th. He also told us he heard there was a rally planned by Sunnis in Chilas for the next day; we fed him chai and cookies, and dropped him off at the bus adha by 2pm.

The following morning, Wadood took Nadeem with him into the bazaar for groceries. He had first headed down through [Shia] Khomer Mohalla, but was stopped and turned back by Shia relatives not far from home. They said there were further troubles in the bazaar, and people were escaping again by foot and in vehicles. We spent the next twenty minutes listening for gunfire over our garden walls, but didn’t hear anything. Haleem arrived an hour later, and reported that nothing had really happened. This was supposed to be the day Sunnis in Chilas and Gilgit planned to coincide their rallies, but the Army had prevented a riot by turning people back from the bazaar, and forcibly stopped the crowd already there from becoming even more unwieldy or violent. Driving through the main bazaar two days ago, we spotted a distant cousin chatting with an older gentleman on the side of the road, where shopkeepers usually gather to sip small cups of chai and gossip. At our invitation, he got into the car with us and came shopping. We stopped at some point to talk about the present problem, and in rapid-fire Urdu he said, “Insh’allah, Shia log khatum ho jaega” [if God wills, Shia people will be finished; U]. Deeply saddened and exasperated by the intensity if his animosity, all I could do was ask, “Kyo?” [why; U] He explained that his extended family lives in several homes across Sakwar. One house is located in the older, Shia part of the village up towards the nullah; it was burned and partially destroyed by Shias following the 8th. Sakwar Shias claimed it was Minawar Shias who came and did the damage, and he is deeply distrustful of all of them.
Chapter Seven: ‘Halaat Kharab/Tension Times’

Part I

Introduction

This chapter draws on interviews with Sunni women and their families, as well as Sunni, Shia and Ismaili health service providers, to analyse the social and territorial forces underlying conflict, identity and women’s health in Gilgit Town between January and September 2005. For Gilgiti Sunnis, the 2004 Nisab crisis and 2005’s sectarian conflicts marked one of the rare times when women could legitimately assign direct blame for their health problems to factors outside the Sunni community. In the quieter spaces between bouts of fighting, women were still forced to navigate the ‘usual’ array of in-community obstacles, such as pardah, intergenerational struggles and financial constraints. And in addition to the logistical impediments associated with the ‘tension times’, the Shia-Sunni conflicts produced numerous ideological ‘barriers’ to service access. I uncovered multiple instances when clinically preventable maternal deaths were connected to Sunnis’ Shia-mohalla vulnerabilities, in-community allegiance and the often dangerous practice of medicine at Gilgit’s rudimentary ‘Sunni Hospital’, a provisional alternative to Shia mohalla-based clinics. Conflict, and the anxieties endured by families as they attempted to transport maternity patients across numerous Army checkpoints, only exacerbated Sunni conservatists’ pre-existing uneasiness concerning women’s visits to mixed-gender, secular or faith-based health services, such as the Family Health Hospital or AKHS,P’s Gilgit Medical Center (see Figure 25).

1 My fieldwork followed the health practices of a defined number of participants. After the 2005 conflicts began, security risks and increased in-community hesitancies to talk to ‘outsiders’ made it virtually impossible to seek out additional pregnancy and birth narratives. Because only a small number of my participants delivered during the conflicts, Gilgit’s health service personnel provided the most comprehensive overview of ‘tension times’ clinical operations, women’s service use and maternal deaths.
By clarifying the crucial relationship between Gilgit’s 2005 conflicts, identity, neighbourhood spaces and diminished health access, this chapter may also remedy a gap in the social geography, development and humanitarianism literature. Notwithstanding growing recognition of the correlation between sectarianism and deliberately impeded service throughout Afghanistan and Iraq’s Sunni and Shia communities (Murphy 2008; Olson 2006), “the possibility that people whose health is already compromised might be actively placed into deprivation is rarely entertained” by social geographers of health (Smith & Easterlow 2005:177). In this respect, the conflict-related impacts of sectarian identity for clinical services are emerging as a pivotal, albeit under-explored component of international health studies. And while some social geographers claim networked social relations regularly supercede a neighbourhood’s territorial dynamics in terms of their health impacts (see Diez-Roux 2004; Easterlow & Smith 2005), Gilgit’s 2005 conflicts may demonstrate the reverse. Namely, that the Shia-Sunni hostilities exacerbated the proximal boundaries and logistical limitations inherent in neighbourhood life, wherein the strategic value of relational interconnectedness or socio-economic status was minimized. For embattled settings like Gilgit, where personal safety, community loyalty and service access or provision were affected by identity, exclusion and neighbourhood social spaces, frictions of distance and finance combined with neighbourhood-centered ‘frictions of affiliation’ to imperil women’s health.

**Part II Hospital Closures & Health Fallouts**

Zia-u’din, along with two of his three bodyguards, was shot multiple times in his Pajero Jeep on the chilly morning of January 8th. Immediately after he was mortally wounded, his surviving bodyguards retaliated, killing one assailant while two accomplices fled towards Baseen Mohalla and evaded capture. Witnesses reported that within fifteen minutes of the initial attack, Shia gunmen armed with Kalashnikovs and pistols took to the streets. The gunmen, who some onlookers identified as being members of the Imamia Student Organization’s (ISO) youth wing, spent the next few chaotic hours moving through government offices along Bank and Hospital Roads (both of which began from beside the Imambaragh, then led upwards through residential portions of Bermas Mohalla towards the DHQ).
Gunmen searched carefully through each office building to find and then shoot a number of Sunni businessmen and civil servants. Among these early victims was Wadood’s cousin, Liaquat, the middle-aged husband and father of six. In another incident, Shia gunman arrived at the home of Ismaili Forestry Officer, Taighun Nabi, near the main Imambaragh, and killed the six Sunni Chilasi colleagues he had taken in and hidden for their protection. In apparent retribution for his having aided the ISO’s ‘enemies’, the gunmen shot Taighun in front of his children as they left the home. His murder was viewed as especially tragic and cold-blooded because Ismailis living in and around Gilgit make a concerted and very public point of not carrying or owning weapons.

As Zia-u’din’s body was shifted to the DHQ’s Operation Theater (OT) for surgery, gunmen moved throughout the hospital’s premises, searching for more Sunni physicians and patients. Indeed, by nature of the DHQ’s location in an all-Shia mohalla, its close proximity to the Imambaragh, and because Zia-u’din was receiving emergency treatment at the OT, the hospital was the scene for a number of violent attacks. Many Sunni staff survived only after hiding in unused offices or being concealed by colleagues. (One of our Jutiali neighbours was saved only because a Shia hospital janitor agreed to lock him inside an empty, darkened office.) Many others - like Dr. Sher Wali Khan, the Northern Areas Health Director - were either unable to leave or had been caught and killed by ISO gunmen. One of the Gilgit Medical Center’s physicians later recalled hearing how the DHQ’s anaesthetist had only narrowly escaped death as he struggled to save Zia-u’din’s life:

“When Zia-u’din was in surgery at the DHQ, the anaesthesiologist had intubated him and resuscitated him. There was cardiac activity, but bad bleeding and a bullet in his brain. Then gunmen with Kalashnikovs had walked into the surgery and pointed a gun at [the anaesthetist’s head] saying, ‘If he dies, then all will die.’ They pointed to the 4 or 5 Sunni surgeons who were present…” (Dr. ‘X’, AKHS,P: February 11, 2005)

At the same time, ISO members roamed the hospital grounds, and a number of Sunni patients and their families tried desperately to hide or escape. While a large number of patients were rescued by quick-acting family members as well as by Shia and Ismaili patients’ family members, some were cut off from
Chapter Seven: ‘Halaat Kharab/Tension Times’

escape because of the density of Shia homes surrounding the DHQ, and were forced to quickly devise interim ‘hideouts’. At the DHQ’s Family Wing, two LHVs described the flurry of activity as Sunni men came and hid throughout the usually all-female premises.

“At around 12 or 12:30 on the 8th, we heard a lot of shooting at this chowk [intersection; U], and we heard that Zia-u’din had been shot and was wounded and in the OT. We heard gunfire throughout the afternoon, until around 4pm when the Army arrived, and everyone had come in here, but no terrorists came into this area here. But there were so many people here that there was no space. The men were hiding here because they knew that no men could come in and get them. The patients and their families were here, as well as other people. At the time, we had one policeman doing duty at [this] hospital, but he only had a baton so when the shooting began he ran away...Sunni men, with beards, came into the Labour Room and hid in...the bathroom and our staff washroom. They were begging us to save their lives. If the terrorists had come in and started shooting and killed them, what could we have done to help them?...We’re all Ismaili [LHVs] here. I was living here near the hospital, and was serving food and chai to the people stuck here. I was bringing it for...the Sunni patients and staff. This was going on until evening when they could leave. The police came and, one by one, took them to their homes....It was for another 3 or 4 days that patients’ relatives were contacting the thana [jail; U] to ask the police to collect their relatives, patients at DHQ, and escort them home.” (LHV, DHQ: August 1, 2005)

“I was off-duty that night [January 8th], but another Sister was on-duty with a dayah. Some Sunni brothers came in and hid in the Labour Room bathroom....they locked themselves in and were in there chupaya [quietly; U]. They were Sunni men with beards, and they stayed in there until 3am, then we were able to get them a police escort out of the hospital and home. Yes, Shia gunmen – maybe 5 or 6 of them – had come in wearing chadors around their faces, and asked the Sisters if any Sunnis were here, but she said, ‘This place is for ladies only, why are you asking me this question? There are no men here!’ Afterwards they left, and the Sister had just been sitting here on this bed [in staff-room]. We’re Ismaili, and not interested in this type of thing, you know? We’re not like this.” (LHV, DHQ: July 26, 2005)

At the Gilgit Medical Center, Dr. Sharifa had been busy checking maternity cases during the Out-Patient Clinic’s morning hours and was only alerted to the violence by her patients’ family members, who came in a panic to take the women back home. Although her husband had asked her to leave the premises right away, she stayed until mid-afternoon to supervise women who were already in labour and could not be moved, as well as several emergency obstetric cases. Because of the fights, it had been extremely difficult to arrange for secure patient transport from the Gilgit Medical Center to any other local hospital,
including the Combined Military Hospital, where Dr. Sharifa had heard that maternity patients were forced to sleep in hospital corridors due to a lack of available beds.

“On the 8th of January, a patient’s father came at around 1pm to ask if his daughter – an obstetric patient – could be transferred to the CMH in order to continue her treatment. He was, I think, a retired Army officer. At the time, I had another patient in the hospital for a scheduled induction, she was due to deliver the following day, and she was also shifted to the CMH. My husband wanted me to go home quickly, but I took nearly a half an hour to ready myself and make sure my patients were shifted properly to the CMH. But, you know, thinking about all the untreated patients with emergencies concerned me deeply.”
(Dr. Sharifa, AKHS,P: February 9, 2005)

Throughout the afternoon and early evening of January 8th, and while physicians throughout town scrambled to arrange patient transport or complete delivery cases, ISO gunmen and Shia protestors continued to wreak havoc on local government offices and banks, Sunni-owned businesses and commercial bazaars. Very much as they had during the 2004 Nisab protests, rioters set alight the Pakistan Water Development (PWD) offices, the Civic Water Authority, the Northern Areas Health Directorate and the Chief Executive’s office, along with private and official vehicles at his Gilgit residence. The Sunni Chief Executive’s life was spared only because he was in Islamabad at the time. In the shadow of the main Imambaragh’s cream-colored cupola domes, along a narrow road linking Shia Bermas Mohalla with the main bazaar, two-dozen Sunni-owned businesses were completely gutted by fire. Suzuki dubbás (mini-vans) loaded with gunmen continued to roam Gilgit’s central bazaars, shooting at Sunni businesses and killing a total of eighteen innocent bystanders, including at least one child, although some local politicians had estimated the death toll as being nearly double this number. In private clinics throughout town, patients and physicians were trapped for hours, and sometimes days. One Sunni physician recounted her efforts to save a Shia maternity patient in the chaotic hours after Zia-u’din’s shooting:

“I am a Sunni doctor, and I treat Shia patients - I treat them well, to end their problems. On the day the tensions began, I was treating one [Shia] Nagar patient, who was stuck in my [private] clinic. For 3-4 hours I had to do uterine massage by hand to control her post-partum haemorrhage - I had no drugs to treat this in my clinic. My arm was absolutely aching for the next few days because of this, but I was afraid that if she died they would blame me - a Sunni - for her death.”
(Dr. Ghazaleen, Nur Colony: September 13, 2005)
It wasn’t until early September 2005 that I was finally able to speak with Dr. Khalthum, the DHQ’s Sunni OB-GYN, about her experiences on January 8th. Even nine months later, she was wary to speak, and cried frequently during the interview.

“This is very hard to talk about, and I don’t want to talk about it too much, alright? [cries] I was on-duty, and suddenly there was a lot of shooting and smoke and fires, people running here and there. It was a big disaster. People from the Shia community took us doctors to [their] houses, and from there, relatives sent vehicles to come and get us. A Shia driver took us to [his] house.... When Sunnis were killed, there was a lot of tension. I did a C-section on a [Shia] Nagar patient. There were more than 70 patients. I operated on all communities doing C-sections. My patients are very satisfied with me...sectarian identity is never an issue in practice. One [Shia] patient cried because another doctor operated on her during my absence, and the baby died, and she said, ‘Why weren’t you here?’ I can’t discuss [January 8th] security – it’s too hard to remember.” (Dr. Khalthum, DHQ: September 7, 2005)

It was only a few hours after Zia-u’din had been shot that Gilgit’s Civil Administration, unable to curb the spreading violence, finally capitulated and formally requested that the Pakistani Army establish a ceasefire and curfew. Once the January 8th curfew was firmly established, the normally bustling city fell silent. Vehicles no longer traversed the roads, children no longer played on side streets and all businesses were closed. Army vehicles did rounds of each neighbourhood with messages eerily reverberating through loudspeakers, urging people to lay down their weapons, and to remain indoors or risk being shot-on-sight. The January 8th-initiated curfew, which fluctuated between total and partial restrictions, lasted nearly three weeks. In the subsequent nine months of my fieldwork, the Army enforced an estimated eight curfews. Some were city wide while others were limited to specific localities during Army-conducted weapons searches, or in response to localized violence. Between January 8th and the early spring of 2006, contingents from the Northern Light Infantry (NLI), Frontier Constabulary (FC-Northern Areas), Gilgit Scouts and Army Rangers maintained a firm grip on Gilgit’s Civil Administration, and were responsible for temporary roadblocks throughout Gilgit’s bazaars and conflict-prone mohallas.

During the first few weeks of the January curfews, and with physicians no longer able to refer complicated obstetric cases to the DHQ, the Pakistan Army’s Combined Military Hospital (CMH; Chapter 360, Emma Varley)
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Two, page 129, footnote 25) agreed to continue treating patients from all across Gilgit Town. Because all three of Gilgit’s other hospitals were frequently closed during the spring of 2005 (due to physician and patient security concerns, Shia religious events, Sunni political rallies or Army curfews), the CMH remained the only consistently open and functioning hospital in Gilgit Town. It was also the primary service provider for politically sensitive cases, offering advanced medical support and on-site security for the victims of targeted sectarian attacks. At the AKHS,P, physicians routinely sent complicated and emergency obstetric cases to the CMH, where they felt patients faced fewer mohalla-related threats. CMH doctors, however, were soon overburdened by the deluge of new patients. “At the CMH there was only one OB-GYN on duty for the first days of the ‘tension’. In one day they handled four C-sections!” (Dr. Sharifa, AKHS,P: February 9, 2005)

During times of increased risk, or ‘tension times’, Shia mohallas became ‘no-go’ zones for more cautious Sunnis. Conversely, the Sunni villages around Gilgit, and between Gilgit and Islamabad, were increasingly dangerous for Shias. In mid-summer 2005 in Parri, a Sunni village a forty-minute drive south of Gilgit Town along the KKH, several Shias were pulled from an inter-city bus and killed. One Sunni neighbour suggested that Sipah-e-Sahabah members had advised the killers to identify Shia men by self-flagellation scars on their back, which acted as telltale signifiers of their participation in Ashura mourning festivals.

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Unfortunately for Gilgiti Sunnis, those mohallas in which Gilgit’s primary health facilities operated were now distinctive zones of Shia sectarian allegiance (see Map IV). While the sprawling DHQ complex sat at the heart of Shia Bermas Mohalla, in December 2004, the AKHS,P had moved their in-town clinic from one Shia enclave, Komer, to another, Chenar Bagh. The Family Health Hospital was located at the crossroads of sizeable Ismaili, Shia and Sunni communities, and was only accessible to Sunnis depending on which roads were safely passable during peace or the ‘tensions’. The Family Health Hospital’s primary advantage was its close proximity to the massive Jutial Cantonment, which extends a

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3 In the days immediately following periods of sectarian violence, it was common to see tractor-loads of furniture shifting families and households between Gilgit Town’s Shia and Sunni mohallas. As previously mixed neighbourhoods transformed into unified Sunni or Shia blocks, residents changed their habits of movement, business and education. Distinctive corridors of ‘safe’ travel and business emerged for members of either community, most obviously during times of high tension. At the same time, Shias used huge triangular black flags, edged with silver, often emblazoned with the names of the Prophet’s Family, while many Sunnis used the JUI’s (Jamaat-Ulema-Islam party) square black and white striped flags; these hung from bamboo poles above Shia and Sunni households throughout Gilgit Town and neighbouring villages. Wadood commented that ‘Shia’ or ‘Sunni’ flags were used so rioters, vandals and arsonists could now identify which ‘side’ each business was on.

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sense of ‘control’ to its immediate environs. (Further into the Jutial Cantonment was the Combined Military Hospital.) Moreover, because of the high costs associated with hiring private security guards, or the difficulties obtaining police or Army guards, many of Gilgit Town’s private clinics closed. Numerous physicians relocated with their families to live and work in Pakistan’s urban centers. But even at the Family Health Hospital, Gilgit’s largest maternity hospital, the administration was unable to finance clinical operations during the January curfews. According to the hospital’s Intake Register, the hospital was closed between the 8th and 24th of January and then re-opened, only to close again for January 26th and 30th (Fieldnotes: September 10, 2005).

“For 4 or 5 days we remained closed in critical days. There were security concerns for physicians and the inability of doctors to make it to work due to total curfew....[The] Islamabad and Lahore [Family Planning Association of Pakistan] offices said to close down the hospital, but I said that under my leadership, I could make the decision to run a functional hospital to meet the community’s needs, and because due to terrorism activities at the DHQ, people were unable to go there – it is a terrorism zone....We already had appointed security, but I wrote to the FCNA [Frontier Constabulary Northern Areas] Commander requesting them to patrol and ensure security from the FCNA [area] to the hospital, but I was told it would be a huge cost, covering salary and overtime for all required personnel. The Army was already charging the Civil Administration for such services and couldn’t provide additional security without payments...because of this huge cost, we had to excuse ourselves from our request.” (Family Health Hospital Administrator, Gilgit: May 11, 2005)

The situation at the Gilgit Medical Center had been no easier. By mid-January, the hospital’s General Manager had withdrawn AKHS,P fieldworkers from their mohalla- and village-level duties, and decided to close the Gilgit Medical Center and re-locate its physicians to ‘safer’ Ismaili community-based AKHS,P facilities in Ghizer District and Hunza Sub-District. When Dr. Sharifa spoke to me on February 9th, the Gilgit Medical Center had been open again for just over two weeks.

“This is the third week now the [Gilgit Medical Center] has been open for Out-Patients, [and] now In-Patient facilities are open. But our field staff are not working....The hospital was closed for 15 days during the worst of the curfews. Drs. Munab and Hafiz stayed with the few patients who could not, for whatever reason, be shifted until January 11th. Even during the curfew, once we partially re-opened the hospital, some patients managed to come in...and had been allowed through police checkpoints. On the 24th of January, we started clinical work again at the Gilgit Medical Center. We had Out-Patient hours only for two days, and our General Manager fretted and worried about our security and said it was...
unsafe to open [completely], so he planned to send me and Dr. Hafiz to Hunza to work with patients there, and Dr. Munab to Singal. On the 26th, Dr. Hafiz and I were readying to go to Hunza, but patients began arriving and Dr. Munab said, ‘We must stay here, if they are coming in to us, in order to help alleviate the local need.’ Together with me, we urged the General Manager to open the hospital, more than just the Out-Patient duties, and to have one doctor on-call at night for patients who cannot stay....During our 15 days of closure, I received regular calls at home from patients asking, ‘What do we do?’ I would apologize, saying I was sorry about the political problems and was unable to come in....The AKHS offices are still closed, with only the Accounts office open for urgent work. The General Manager has not returned to work, and Dr. Munab and I had to fight to get the clinical unit open again. It was the issue of women facing critical care needs that compelled me to stay in Gilgit and provide care. The GM was nervous that should we open to patients again, Sunni and Shia patients would start fighting with each other in the front [garden], and we do not have the facilities to deal with this type of situation.” (Dr. Sharifa, AKHS,P: February 9, 2005)

Because of the dangers associated with hospital locations and inadequate security measures during periods of increased tension, conflict and curfews, a large number of Sunni women who would have ordinarily delivered at Gilgit’s larger, low or no-cost health centers ended up giving birth unattended at home. As a result, governmental and non-governmental health fieldworkers reported substantial increases in post-natal complications, and maternal and infant deaths following home deliveries. Only when complications arose and safe passage was assured, did women and their attendants travel to deliver at Gilgit’s few Sunni-operated, costly private clinics, and this was if they were even open. The only exceptions were rare instances when off-duty government nurses, LHVs or dayahs were contacted and able to travel to the woman’s home to assist for a fixed fee.

“During the curfew, I went on the roads [to a delivery] and an Army man from Punjab asked me where my duty was. I said, ‘The hospital!’ and he said, ‘What’s in your [medical] bag?’ I said, ‘A Kalashnikov, pistol, and my lunch!’ He laughed and let me go, and they didn’t disturb me again. I was going for home deliveries in Kashrote before the Sunni Hospital was established. They were all normal deliveries, and if the patients asked for an injection, I said ‘No, if you want an injection, go to the hospital!’ [laughs] If we deal by the

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4 At no time during or since my fieldwork have these losses been formally quantified or publicized. The fieldworkers who provided anecdotal assessments of increased maternal and infant morbidity and mortality included Lady Health Visitors (LHVs), Lady Health Workers (LHWs) and Family Planning Motivators, working on behalf of the non-governmental Family Planning Association of Pakistan and the Pakistan’s federally funded Family Planning Organization.

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heart, and we want things to be normal for the patient, God assists those in those times.”
(Sister Sabah, Kashrote: August 29, 2005)

Speaking to me in late summer 2005, the Family Planning Organization’s Northern Areas Deputy
Director looked back on what he felt were the special risks faced by civil servants in the first few months
after Zia-u’din’s assassination:

“...government offices were at a standstill between January and March, and we were unable
to do anything....No, we weren’t closed. Our programme is directed by, but not directly
tied to, the Northern Areas Administration. We are directly sponsored by the Federal
Government, who expected us to keep going. We started our services again on January
19th, but I kept our [outside gate] locked...because it was a serious issue and we are
operating in Kashrote [Sunni mohalla]. Most of the casualties on the 8th were Sunnis, and
of those most were government servants. There were only two murders on the roads, one
was Sher Wali Khan and the other was a clerk near the hospital. Then there was the
murder of the Ismaili Forestry Officer, who provided safety for his colleagues. Many died
in [his] house, but two or three escaped by hiding in a bathroom, I think.” (Sherbaz Ali,
FPO: July 28, 2005)

Even after the curfew had been partially relaxed in late January, the DHQ, Gilgit Medical Center and
Family Health Hospital were still referring a number of their patients to the Combined Military Hospital,
which reflected physicians’, hospital staff and patients’ ongoing security concerns. (In important ways,
many participants claimed the government’s overall neglect of the Northern Areas was proven by the
Army’s failure to prioritize local health above their everyday protection of banks, the Jutial Cantonment
and the homes of Northern Areas Legislature Members.) And in early February, just before the start of
Shia Ashura events, Dr. Sharifa said that miscommunication between AKHS,P administrators, hospital
employees and field-staff concerning the Gilgit Medical Center’s ‘tension time’ hours and clinical services
led a number of nurses and fieldworkers to believe the hospital was still closed, even three weeks after
Zia-u’din’s death. Dr. Sharifa went on to describe how, believing the Gilgit Medical Center was closed,
one AKHS,P nurse’s late-January attempt to find treatment for a pregnant relative at the CMH

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5 Sherbaz Ali’s discussion of the civil servants killed on January 8th was difficult to interpret. In the absence of
additional clarification, I was unsure if he meant to suggest that the ISO had targeted Gilgitis employed by the State,
or simply Sunnis who happened to be working near where Zia-u’din was shot.
demonstrated that even there, the Army’s Medical Officers remained ill-prepared to handle the many patients who were too frightened, or unable, to visit Gilgit’s other hospitals.

“On January 26th, one of the AKHS nurses had taken an OB-GYN patient, who was a relative of hers, to the CMH because she thought AKHS was closed and I was still in Hunza. The patient had primae [first delivery] breech, but the CMH staff were overwhelmed and pointed out to the nurse all the other patients lying on makeshift beds and mattresses on the floor, and said they could only accept critical patients, and this woman hadn’t yet started active labour. They told her to take the patient to the DHQ, where the OB-GYN was not there, but the nurses said they were confident they could handle the delivery. At the DHQ, the nurse found another woman who had absent membranes for 2 to 3 days, no fever yet, and the nurses were giving her pain killers for the minor contractions she was feeling. She was aged 19 or 20 and it was a prima gravida [first pregnancy].” (Dr. Sharifa, AKHS,P: February 9, 2005)

Because the ‘tensions’ continued well into late autumn 2005, women’s health access remained unavoidably and consistently interwoven with their families’ fears of ‘khattarnak’ (dangerous; U) Shia mohallas. Speaking to me nine months after the conflicts began, Dr. Khalthum and the DHQ Labour Room LHVs confirmed the Shia-Sunni ‘tensions’ still determined how and when Sunni women accessed DHQ services. They also confirmed that the Army had started providing armed escorts for physicians as they travelled to and from work.

“Kohistanis [Sunnis] aren’t coming anymore. One gynaecologist is doing C-sections in Chilas now, Dr. Zohra, I hear she’s from Astore. Otherwise people are going to Abbottabad.6 If the situation in the city is bad, they’re not coming. It’s [only] one quarter of our patients [who are] coming now – patients have died at home during the curfew. They’re not getting proper treatment just because of sectarian division. The most important thing [for you] to focus on [are] sectarian problems, please highlight this!.... Right now, I have [Army or police] escorts during times of bad ‘tension’ to the hospital. Two days ago one Sunni was killed, and 2 injured in a Suzuki shooting. There was great ‘tension’ in the city, those victims were treated here. We are giving cover in a war camp, essentially. Look, I have [siblings] in the U.S., Australia...but if I leave this place, my people will suffer. If I go to the Sunni community, people here [Shia-dominated Bermas mohalla] will suffer too. In my opinion, uneducated criminals are creating this situation...For emergency cover, police come in the ambulance during tension times.” (Dr. Khalthum, DHQ: September 9, 2005)

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6 Abbottabad is a 13-hour drive south of Gilgit Town, in the North-West Frontier Province.
“Before the ‘tension’, we would have between 12 or 15, and 32 or 38 deliveries a day. This was a lot. And sometimes there would be three ladies at the same time in the Labour Room....Now deliveries are bahoot kam [very little; U]. Perhaps 8, 9 or 10 deliveries a day after the ‘tensions.’ Yes, it’s mostly Shias who come to us now. They are mostly from this [Bermas] neighbourhood, which is all Shia. The length of their stay depends on their conditions....but now [Sunni] people try to come and go quickly. Our Sunni brothers go to Kashrote and the Sunni Hospital there, although yesterday we had two [Sunni] patients come. They had tried to deliver at Kashrote, but they were hypertensive and brought here for C-sections once we had them stabilized. They were unstable there...” (LHV III, DHQ: July 26, 2005)

“We have mostly Shia patients now; we know that if a patient comes from Sakwar, Sakwar is saree Shia heh [all Shia; U]. Or Bermas, the area around the hospital, saree Shia heh, aur Minawar saree Sunni heh [is all Shia, and Minawar is all Sunni; U]. This is how we’re able to identify which community a patient belongs to.” (LHV VI, DHQ: August 6, 2005)

During increased ‘tensions’, women’s maternity clinic visits or post-partum hospital stays were cut short by family members anxious to return to the safety of home. Speaking to me four months after Zia-u’din’s assassination, the Gilgit Medical Center’s OB-GYNs described how the hostilities, and fear in particular, continued to shape women’s use of maternity services:

“Both Shia and Sunni communities with patients wanted treatment and discharge early and fast in the day so they could be home by dark – they were concerned about the location and issues of personal safety. Post-January 8th, Sunni families would come with security – male family members – who were not allowed onto the premises of the hospital, so women would come in to deliver their babies with a female companion, and then leave right away, versus staying for 1 to 2 days recovery. They would leave against doctor’s orders, and were afraid for the safety of the men standing guard outside.” (Dr. Sharifa, AKHS,P: April 29, 2005; see Figure 26)
Patients bring more people, and will often try to request a private room right away for their attendants. We have a few extra rooms so we let them do this, if they want. Both men and women attendants come, and there have been no open displays of weapons. Women were pressurized to leave quickly by the men with them, who stayed in the yard. We avoided investigations that could be postponed, such as blood testing for pregnant women – haemoglobin, urine. But we did all operations and sent them early to their homes. For the last two to three months, women who are pregnant have been a source of great worry to their family. The whole house is in tension.” (Dr. Sumairah, AKHS,P: April 29, 2005).

At the DHQ and the Gilgit Medical Center, physicians assumed that most male attendants were carrying concealed weapons. Consequently, hospital security was tightened due to fears that sectarian fighting would break out between maternity patients’ male attendants. As one doctor stated, “We have been concerned about so many attendants coming because we don’t want the two communities to quarrel…while waiting” (Dr. Hafiz, AKHS,P: May 3, 2005). For AKHS,P the risks must have seemed particularly acute; in early 2005, Sunni gunmen had attacked one of their health centers in Chitral, and several hospital security guards were killed. As such, it was clear that the fears endured by Sunni patients were akin to the worries and vulnerabilities experienced by AKHS,P’s Ismaili providers and staff.

And by nature of the DHQ’s location and the number of deaths which had taken place on and immediately around its premises on the 8th, the LHV’s described their situation as similarly ‘insecure’ (see Figure 27). For example, in late July, one Ismaili Labour Room LHV discussed the many difficulties she faced both at the Family Wing, and while trying to reach the hospital for work each day:

“We have one chowkidar [guard; U] now, but between January and March, we had 3 to 4 Fauji [Army] with us, and local police. But now there’s absolutely koi security nuhee [no security at all; U]. No pick or drop, or additional safety and security for night duties. I come here through [Shia] Danyor, and worked all through the curfew. I have had to use

![Figure 27: Concrete bunker and sandbags (Army post; R) at DHQ Main Entrance, Bermas Mohalla (2005).](image)

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private Suzukis, and have to change vehicles 3 or 4 times before I reach the hospital. The government can’t do anything, and never listens to us. We’ve given them so many applications and met with the Chief Secretary, for pick and drop, and we told them, ‘You can even cut the cost from our salary!’ but I still have to come along, and leave my husband and children at home.” (LHV II, DHQ: July 26, 2005)7

Not surprisingly, at all local hospitals, health service personnel were preoccupied with territoriality and religious identity.

“I’ve noticed that my female patients are dressing differently since tensions began in January. Women, particularly from Nagaril [Shia enclave] wear long black burqas, which are also worn by the relatives I see coming to visit women after they’ve given birth at the [Gilgit Medical Center]. Maybe this is to identify themselves more as Shias, I’m not quite sure what their reasons are. Otherwise, I can’t tell them apart by looking.” (Dr. Sumairah, AKHS,P: May 3, 2005)

“If we see a big beard on the men in the family, we’ll assume they’re Sunni. If they’re from a place like Chamughar or Darel, we know they’re Sunni. If they’re from Nagar, they’re Shia. Or, during their pains, the Shia patients will cry out, ‘Y’Ali!’ We have also noticed that Shia women are using black burqas more now than before, much more. Sunni women cover their faces more...when they’re outside, and some wear long coats that cover their bodies down to their feet.” (LHV, DHQ: August 1, 2005)8

“We’re Ismaili, and we’re looking at [Sunnis and Shias] differently, curiously. They’ll be in the same [delivery] room, experiencing the same thing, but they make a distance between themselves, and won’t talk or discuss – there’s no friendliness. They will say to us, ‘Look, she’s a Shia!’ or ‘Look, she’s a Sunni!’ And we reply that we could care less, it doesn’t matter in the least to us.” (LHV, DHQ: August 1, 2005)

Even I was not exempt from the identity-related curiosities of my Sunni, Shia and Ismaili participants. At the DHQ, the Family Wing’s Shia In-Charge Officer, a brusque man in his early fifties was in the middle of repairing the Labour Room’s blood pressure cuff when he spotted me interviewing two Ismaili

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7 A few days later, another DHQ nurse reported how “during the ‘tension time’ and curfew, people worked so much extra time and they allocated extra money to us for our overtime, but the money never came to us. We haven’t seen it. We complain and complain, through our Union, the Paramedic Staff, but they waste our time with excuses and false promises [like], ‘It will come next month!’” (Nurse I, DHQ: August 1, 2005)

8 Following Zia-u’din’s death there was an especially impressive uptake in the chador by local Shia women, with schoolgirls as young as five seen wearing tailored black chadors en route to local schools. One Shia neighbour said she felt obliged to honour Zia-u’din’s memory by being more vigilant and observant of Shia dictates, particularly those Zia-u’din had promulgated for Northern Areas Shias. In fact, Zia-u’din’s edicts concerning marriage, meher (dowry; A, U) and zakat (tithes; A) were also followed more dutifully in the months following his assassination.

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LHVs. He wiped the sweat off his brow and came and sat with us, and quickly offered his own slightly disjointed perspectives on faith and conflict (which the LHVs seemed to find somewhat amusing).

“Are you Muslim? If your husband is from Darel, how can you sit with your hair uncovered with me?...We Shias, you know, we believe in Imam Mehdi. Christians are the same.9 They love aman [peace; U] and are never interested in causing problems for other people or other Muslims. They don’t call other people – like the Sunnis do – kafir [unbeliever; A]. Insh’allah [if God wills; A], the war Saddar [President; U] Bush plans on Iran nuheeo ho jae [will not happen; U]. They can’t see how much Shias stress harmoniousness in their beliefs. The ulema are creating the major problems here. Right, my Ismaili sisters?” (In-Charge Officer, DHQ: August 23, 2005)

In the same ways that patients and their families were unnerved by high-risk hospital locations, a number of participants began to question if conflict had impacted their doctors’ ability to practice medicine. Dr. Shakoor worked during the days at the DHQ, and shifted to his private practice in Kashrote Mohalla by mid-afternoon. On Shia celebratory days, or when rumours were rife that another ‘hit’ could be expected, he avoided his DHQ duties completely and without giving notice. After visiting him at his private clinic for an obstetric ultrasound, our neighbour Samina felt his nervousness had gotten the better of him.

“We met one woman at the [DHQ] OPD [outpatient] Ward – she had gone for five different ultrasounds and was given five different reports on her pregnancy. Which one can we believe when it works this way? I don’t think Dr. Shakoor is in his right mind these days. The Shia-Sunni ‘tensions’ are disturbing him too much and he’s fearful. Look at my report – he got my name and age wrong, everything is wrong!” (Samina, Jutial: August 4, 2005)

At the DHQ, Dr. Khalthum was quick to admit that the ‘tensions’ had so seriously interfered with her own sense of security that, nervous and overwrought, she had been forced to take an extensive Medical Leave.

“After the 8th of January, I didn’t come. I was sick, and didn’t understand the situation, you know? In my heart, it is my intent to see patients whether they are Shia, Sunni, Sikh, Hindu…I [went] to Pindi, and came back and didn’t go back to Kashrote [Sunni Hospital]. They planned to take me back during my absence, but I was in a miserable condition….I came back [to the DHQ] in April. For two to three months we didn’t know what was

9 The In-Charge Officer was referring to the ‘vanished’ twelfth Imam Mehdi (also spelled as Mahdi), who was believed to have disappeared from the earth in the 7th century, and awaits his return to the world on Judgment Day. Gilgiti Shias who belong to the ‘Twelver’ sect, the majority community in Shia Islam, believe the Imam Medhi’s return will be heralded by Hazrat Isa (Jesus), who will warn Muslims and non-Muslims alike to embrace the Imam and Shia Islam prior to the end of the world (also see Waines 1995: 163-169).
Some people said I was forced [to return] by the government due to shortages....it’s true. Recruiting new physicians is very difficult....We are working in a war situation, but it’s hard to give treatment under gunfire, with gunmen standing nearby. And there are such blocks between Shias and Sunnis! I had to go on Medical Rest after the curfew time....Even though I was sick, I heard there were problems and went to the Kashroote Hospital. I was myself in a tense community.” (Dr. Khalthum, DHQ: September 7, 2005)

Other Sunni physicians described how they faced threats to their safety even after returning home each day. At the Gilgit Medical Center, Dr. Sumairah (the Sunni OB-GYN who had moved to Gilgit the year previously) described how her life amid Karachi’s ethnic and sectarian strife had not been enough to prepare her for the hazards posed by Gilgiti sectarianism. Even seven months after the ‘tensions’ had started, she remained uncertain about how best to navigate the risks she and her family faced as Sunnis.

“I live by the FCNA HQ [Frontier Constabulary Northern Areas Headquarters], just up from the Sunni [Army] mosque, and our immediate neighbours are Shias. You know, I have found my telephone line cut on more than one occasion. It’s quite regular, and happens in the morning or evening, and the [Shia] neighbours tell us it’s because [the wire] is low-hanging, and it’s cut by animals passing, or by rubbing on the stone wall, though we think this is unlikely. My husband is in the Northern Areas Scouts, and he has talked with some of the young boys living around us, and said if it continues to happen he’ll see this as suspicious and launch an investigation....I’m often alone at home with the children when my husband is on-duty. We’ve been thinking of moving down to [Ismaili-Sunnii] Zulfiqar Colony, where a lot of Northern Areas Scouts families are living, because of the fears we have in Jutial.” (Dr. Sumairah, AKHS,P: July 28, 2005)

It wasn’t only Sunnis who found their practice of medicine or access to local clinics compromised. While Ismailis had only been the focus of violence on rare occasions, the January 8th murder of Taighun Nabi caused a number of prominent Ismaili health service personnel to feel far more vulnerable. Even as late as July 2005, the Family Planning Organization’s Deputy Director confirmed that clinical operations, outreach services and his own sense of safety had been seriously interrupted by the continued ‘tensions’.

“Yes, I’m Ismaili, but I’m not sure how safe that is anymore either. You never know when they [Shias and Sunnis] are going to target someone to start blaming things on another community, you know? When I opened up this office, a few [Sunni] individuals from here in Kashroote came and said, ‘Don’t worry about opening up again, we are here to support you and your work, but we are on a strike from [our] government duties until better security is offered to all of us.’ These individuals came and visited me here in my office.
We had intermittent breaks in our services after January, as with Ashura and Moharram, but things have been basically fine since April.” (Sherbaz Ali, FPO: July 28, 2005)

His experiences and vulnerabilities were not dissimilar from the insecurities and fears facing Sister Sabah, an Ismaili nurse who had come out of retirement to work at the interim ‘Sunni Hospital’ in Kashrote Mohalla.

“I’m proud to be an Aga Khani [and] of our community. We don’t believe in weapons, or this violence....My son, Subhan Hussain, if he’s traveling on the road and [Sunnis] hear a name like his, they think he’s a Shia....My granddaughter in the Punjab is worried about me, and she wants us to come and live with her. She’s five years old, and when we speak on the phone she asks me when I’m coming because she knows about the ‘tensions’! [laughs] Dr. Latif now only has a private practice [for security], but it’s very expensive for people to use private practices.” (Sister Sabah, Kashrote: August 29, 2005)

Similarly, the Family Planning Organization’s Deputy Director had decided in mid-summer 2005 to move their organizational headquarters from Kashrote Mohalla (where the office sat along the link road separating the then at-siege Shia Domyal and Sunni Kashrote Mohallas) to Ismaili-dominated Sonikot Mohalla.

“We shifted...not because of any incidents or problems, but because of staff concerns that should things happen in the city proper, such as where we were, they would be stuck or unable to get out. Whereas this area, Sonikot, is still in the city proper [and] a safer locale, where I don’t think anything bad has or will happen.” (Sherbaz Ali, FPO: September 2, 2005)

At the DHQ, Dr. Khalthum appeared to be deeply frustrated by the Army’s apparent inability to stymie the influx of weapons, or to end the conflicts that would continue to erupt throughout 2005. As with the narratives offered by many of my participants during the ‘tension times’, Dr. Khalthum’s discussion shifted between angrily castigating local military forces and police for failing to adequately threaten and then punish the ‘terrorists’, whether Shia or Sunni, and then emphasizing the importance of peace.

“I’m not satisfied with the Army and police up until now..... if there’s one firing [shooting] the Army go after 24 hours, and the criminal people stay there! If I was a General, I would threaten the mohalla, ‘If you don’t give us the person who did this, I will destroy the area!’ The most important thing is peace, you know, and these problems have been brought from the outside to the inside. The first thing is peace. We’re all Muslims, with minor

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differences. Even Hindu and Sikh should live peacefully.” (Dr. Khalthum, DHQ: September 7, 2005)

Physician insecurities, patient fears, and the dangers inextricably associated with Shia mohallas, ensured that health service provision was frequently impaired, if not stopped altogether. They also resulted in a substantial proportion of Sunni maternity patients and their families feeling that home-deliveries were less risky than attending Shia mohalla-based hospitals. Accordingly, local obstetricians, gynaecologists, LHVs, LHWs and *dayahs* estimated that hundreds, if not thousands, of women who would have ordinarily delivered in hospital settings were either denied access to appropriate services by the Army during periods of curfew, or by family members who were hesitant or completely unwilling to accompany females to seek treatment in, or accessed through, Shia-dominated areas. Hospital Intake records provide some sense of the decreasing patient numbers and Sunni patients in particular.

Such was the case at the DHQ, where the Family Wing’s Labour Room saw an approximately 39% decrease in Sunni patients between late 2004 and early 2005 (Fieldnotes: August 12 & 26, 2005). For example, over seven weeks in autumn 2004 (September 4th to October 24th), 44% (229) of 521 delivery cases at the DHQ came from Sunni mohallas or villages. But between February 1st and March 5th (2005), only 27% (25) of 94 DHQ delivery cases were from Sunni areas. At the Family Health Hospital, which was located in a comparatively safer area of Gilgit Town, Sunni patients made up roughly 34% (191) of 564 patients noted in the Intake Register between January 1st and February 1st (2005) (Fieldnotes: September 10, 2005). This represented a 20% decrease in patient attendance rates since late 2004; between November 24th and December 24th (2004), the Family Health Hospital’s Intake Register notes that 43% (709) of their 1,631 patients came from identifiably Sunni mohallas or villages.

The vast majority of these ‘missing’ patients turned either to neighbourhood *dayahs* for pregnancy and childbirth-support or attended the

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11 In November and December of 2004, the Family Health Hospital notes 1’171 and 1’183 respectively visited the hospital. But for January through April of 2005, the hospital treated far fewer patients. 564 patients were recorded for January 2005, 686 were noted for February, 772 in March and 916 in April (Fieldnotes: September 10, 2005).
provisional ‘Sunni Hospital’, which was established by physicians and hospital support staff too frightened to return to their work at the DHQ.

Not all hospitals saw drops in Sunni attendance. At the Gilgit Medical Center, I was permitted to view the hospital’s autumn 2004 and winter 2005 Intake Registers (Fieldnotes: August 26, 2005). Between October 1-31 (2004) at the Khomeer Clinic location there were 958 patients; 48 male and female patients came from Sunni-dominated areas (including in-town mohallas and outlying villages), 179 patients came from mixed Ismaili-Sunni mohallas and villages, 51 patients came from Shia-Sunni mohallas, and 147 came from in-town, mixed-sect mohallas. Of these, 492 women patients were noted as receiving OB-GYN treatment and there were 51 deliveries. Between January 1st and 31st (2005) the hospital treated a total of 358 male and female patients, with 25 patients coming from Sunni-dominated areas (including in-town mohallas and outlying villages), 58 patients coming from mixed Ismaili-Sunni mohallas and villages, 28 patients coming from Shia-Sunni mohallas, and 63 patients from Shia, Sunni and Ismaili in-town mohallas. Of the Gilgit Medical Center’s January 2005 patients, there were apparently only 12 delivery cases among 202 registered OB-GYN visits. While in October 2004, only 5.32% of AKHS,P patients came from exclusively Sunni areas, the number rose slightly in January 2005 to 6.98%.12 Due to my inability to check Intake records at the FPO’s in-town clinics, I was unable to quantify either service provision or use before and after January 8th. Instead, I was left to ask the FPO’s Deputy Director if the demand for contraception had changed since January 8th.

“I’ve actually been wondering this myself, and yesterday asked a staff member to compile a survey and data analysis if the consumption has gone up or down, declined…and they are looking at the period between July and December 2004, and January to June this year. I don’t know if there have been changes, maybe women’s mobility has been restricted to Health Centers...maybe if a Shia woman, for instance, was coming to our Kashrote center before, now she may not feel as safe to come, or her husband or family may not allow her. But we don’t ask what community people are from, so we don’t have any statistics that can break down who shows up at the centers.” (Sherbaz Ali, FPO: July 28, 2005)

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12 At the Gilgit Medical Center’s weekly infant vaccination clinic, the situation was not as hopeful. During my February 2005 observation of one full day of vaccinations, only one infant out of a total of thirty-four came from an identifiably Sunni mohalla. The remainder came from Shia- and Ismaili-dominated mohallas.
This confirmed not only that he knew conflict had interrupted women’s access to services, but that Shia women may have faced barriers to FPO’s Kashrote services that were similar to those experienced by Sunnis in Shia mohallas. It remained, however, that Shia women were still able to turn to Gilgit’s three, other maternity hospitals.

**Part III  Sunni Civil Hospital**

At government, *ulema* and community-levels, the Sunni community was not oblivious to the risks facing Sunni patients.13 Within weeks of the DHQ’s January closures, and the proven dangers for Sunni physicians and support staff working there, prominent community members proposed the establishment of a ‘Sunni Hospital’ in Kashrote. (Sunni-dominated Kashrote Mohalla sits above the Gilgit River, and is buffered on one side by Shia Domyal Mohalla, and on the other by mixed, Ismaili-Sunny Zulfiqar and Sonikot Mohallas.) Using community donations, an unused building and adjacent property straddling the boundary separating Kashrote from Shia Danyor and Chenar Bagh Mohallas were quickly purchased. This was soon followed by a tentative promise for additional funds from the federal government once a permanent hospital site was under development.

“The government has promised money, and they’ve explained to the leaders that we’ll establish a...facility, but they’re not giving us the money until we have actual hospital plans. The hospital needs papers, and right now there’s no design or plan. These should be ready this September or October [2005]. Now everything is paid for by self-donation.”

(Sister Sabah, Kashrote: August 29, 2005)14

The new hospital was set along a quiet, tree-lined side street, surrounded by a high concrete block wall. Inside, a ramshackle assortment of abandoned office buildings had been haphazardly converted to handle patient beds and a rough surgical suite. The property sat in the shadow of the Aga Khan

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13 Only very rarely did I uncover national media coverage of women’s, curfew-related health costs. One example is the Dawn Newspaper’s June 6 (2004) reporting of the *Nisab* Riots and Army-enforced curfews, where “sources said that a young woman died on Sunday in the Jutyal area of Gilgit as she could not be taken to hospital because of curfew.” This young woman had been the wife of one of our neighbours in Jutial; she was also the sister-in-law of Liaquat, the Sunni civil servant shot by Shias in the first hours after Zia-u’din’s shooting. She had been diagnosed with throat cancer in the weeks after her first child’s birth and had been preparing to shift to Islamabad for treatment when the *Nisab* Riots, and then the Army curfews, prevented her and her husband from traveling south.

14 According to local officials, the Federal Ministry of Health was hesitant to fund the ‘Sunni Hospital’ because sectarian-specific services ran counter to the Ministry’s secularly-styled approach to service provision.
Education Services’ (AKES) Northern Areas headquarters; the hospital’s front entrance overlooked family-owned agricultural properties and the Gilgit River.

“The hospital opened in January, fifteen days or so after [January 8th]. On the 20th or 22nd it started [again]. All members of the Sunni community decided to establish this, because Sher Wali was murdered along with so many other people – even Aga Khanis [Ismailis] – they thought it was better that this hospital should start, and this was decided by doctors and elected members of government. There were four male doctors, including a Child Specialist, DM and Dental. They wanted this and shifted their work here, because of personal fears at the DHQ.” (Sister Sabah, Kashrote: August 29, 2005)

Within a month of the opening, Northern Areas Home Secretary, Hafiz-ur-Rehman, himself a resident of Kashrote, personally funded the construction of a 12-bed In-Patient Women’s Ward (see Figure 28). In the earliest months of operation, the Labour Room was managed by two Sunni OB-GYNs. Dr. Shagufta had been forced to leave her Shia mohalla-based private clinic, while Dr. Khalthum was one of the DHQ Family Wing’s two OB-GYNs. Providing additional supervision and ‘childbirth duties’ was Sister Sabah, a retired DHQ Family Wing employee. When I first attended the hospital to observe deliveries in August and September, Sister Sabah’s assistant, an Ismaili LHV named Nahilah (who was, to my enduring confusion, paid three times as much as the better-trained Sister Sabah), described how three women worked full-time in the Labour Room and Out-Patient women’s clinics:

“We have one LHV, one Motivator, and one qualified Nurse working here, on three alternating days, for 24 hour shifts. Our LHV works daily here from 8 or 8.30am until 2.30pm when she goes home. I went to Peshawar, to the Public Health School for two and a half years. One year in Public Health, and one year midwifery. The government gives me Rs 6,000 [CDN $136.36] per month.” (Nahilah, Kashrote Civil Hospital: September 3, 2005)
But because the two-room ‘women’s clinic’ was so heavily inundated with Sunni patients desperate to avoid the DHQ, the majority of OB-GYN services were left to relatively untrained LHVs and dayahs to handle. As Sister Sabah recounted:

“I’m paid Rs 2,500 [CDN $56.81] a month to work 24 hour shifts every three days. Before it was every two days, and I had no time to sleep, [and] with my home duties on top! [laughs] It was onerous, and too much work for me.” (Sister Sabah, Kashrote: August 29, 2005)

Moreover, I had noticed the majority of the hospital’s Labour Room patient records for March 2005 were written by Khaldiyum, who, according to Sister Sabah, was a “Family Planning Motivator, and deals with pills, IUCD, injections, condoms. She has no midwifery training” (Kashrote Civil Hospital: September 3, 2005). Indeed, Khaldiyum’s poor handling of labour and delivery cases, and her failure to properly suction infants’ airways at birth, was said by other nurses to have contributed to higher-than-normal rates of pneumonia and death in newborns. After hearing all of this, I had been deeply concerned about the lack of training, and was not much reassured by Sister Sabah’s protests that the hospital’s elderly dayah and Khaldiyum were adequately educated.

“She [dayah] had three months training at the DHQ. Whenever a lady wants to learn privately, she can arrange this training herself, or if she’s employed from the government to learn, she trains formally at the DHQ. Or if she wants to learn privately she arranges [it] herself and watches in the Labour Room at the DHQ as an apprentice. It’s informal training.” (Kashrote Civil Hospital: September 3, 2005)

During the initial months of its operation the majority of Kashrote Civil Hospital employees were unpaid, which forced several doctors and staff to return to their paid postings at the DHQ once the January ‘tensions’ subsided. Service fees, however, were maintained as low- or no-cost, while supplementary zakat-style donations were solicited from incoming patients and their families at the hospital entrance. This did not mean, however, that the hospital’s services were inexpensive. During one visit to the Labour Room, I watched as a young woman was referred to the hospital lab by Sister Sabah for a pregnancy test. Upon her return, she tried to pass over the glass vial to Nahilah, the LHV, to be checked. Nahilah, in turn, sharply reprimanded the woman for expecting them to have the facilities for even sada (simple;
tests, and suggested that a “private urine test” would cost Rs 60 (CDN $1.35). (This service was free at the DHQ.) And according to one participant who had a therapeutic abortion at the Kashrote Civil Hospital, the procedure’s costs were comparable to, if not more, than that of the ‘high-end’ Family Health Hospital. “It cost us Rs 2,000 [CDN $45.45] today at the Kashrote Hospital; we had to pay to bring the IV-line, the glucose, for some injections and the procedure” (Shandana, Jutial: August 4, 2005). According to the obstetric service charges quoted by the hospital’s Head Nurse, the ‘Sunni Hospital’ was in many instances exponentially more expensive than the DHQ (where Intake fees had been dropped in 2004).

“The government fee is Rs 200 [CDN $4.55] per delivery, and a D&C in the OT [Operating Theater] is Rs 500 [CDN $11.35]. If [the D&C] is done here in the [labour] room we take Rs 200.” (Sister Sabah, Kashrote: August 29, 2005)

Prior to my September 2005 departure, there were discussions that the Federal Government had agreed to either shift the DHQ’s location to one more suitable for multi-community use, or would funnel appropriate funds to further develop the Kashrote location. One doctor poignantly remarked that regardless of the severity of future sectarian tensions, it would still take at least ten years to establish an effective running hospital in Kashrote (Dr. Bilal, Kashrote Civil Hospital: August 29, 2005). Several of the ‘Sunni’ Hospital’s Sunni employees described their work as proof of their community allegiance, while the hospital’s Ismaili maternity nurses argued their efforts were evidence of inter-sectarian camaraderie. Others, however, suggested that their duties were more forced than voluntary:

“I was posted [to Kashrote] for one month, on public demand, but not [by] hospital administration order. If I hadn’t gone, my community might be against me.” (Dr. Khalthum, DHQ: September 7, 2005)

Notwithstanding the Sunni community’s best efforts, the Kashrote Civil Hospital faced significant shortfalls in trained staff, medical and cleaning supplies, electricity, water and patient beds. Nor did they possess a fully functioning laboratory, reliable sterilization equipment, X-ray or ultrasound facilities, or regular surgical and emergency room coverage; such services were referred to other hospitals or farmed out to private labs and diagnostic facilities. (When medication, facilities or surgery were unavailable and treatment could be delayed, women were advised to reach Islamabad for treatment. The trip by road was
ordinarily sixteen to twenty hours, and prohibitively expensive for poorer patients and their families.)

Overwhelming patient loads additionally complicated the Kashrote Civil Hospital’s performance, given that the vast majority of Sunnis from across the Northern Areas and the NWFP shifted from the DHQ to this much smaller, less equipped facility. One delivery room nurse estimated the ‘Sunni Hospital’ handled up to 1,500 patients per day in its initial month of operation (February 2005) (Fieldnotes: September 3, 2005). Patient attendance fluctuated over the next eight months of my research, mirroring periods of relative stability or increased sectarian tensions. According to the Labour Room records, 281 babies were delivered at the Kashrote Civil Hospital between March 3rd and September 3rd (2005) (Fieldnotes: September 3, 2005; see Figure 29).

[Emma] “Where do your patients come from mostly?”

[Sister Sabah] “From Ghizer, Jaglote, Chilas, Parri, Minawar, Tangir...Chilas! Yes, many come from Diamer....Even Army people come here, though they usually go to the CMH. But it’s very expensive there, and friends and family can use it but it’s not for outside people, except during ‘tension times’. You have to have an Army ID card to use the services there....the hospital formally opened on February 1st [and] people came as an emergency. All the patients had been going previously to the DHQ. Dr. Khalthum was hardly here two to three months when she shifted back to the DHQ. During the ‘tensions’ all the Sunni doctors came here. Even [Shia] Dr. Shehazeen came here once or twice to help from the DHQ.” (Kashrote Civil Hospital: September 3, 2005)

The Sunni physicians working at the Kashrote site were deeply distressed by the hospital’s limitations, and the dangers this then posed for patient well-being. These risks, in fact, were part of the reason Dr.
Khalthum had eventually ‘discharged’ herself from her Kashrote Civil Hospital duties and returned to the DHQ.

“I’ve done emergency cases under local anaesthetic and sedation [using] Valium, Lajoctil [sic], Pathodine – this combination in particular. We have no specialists available for epidurals. I had to do this particular drug combo once because a patient was dying and I was afraid to come to the DHQ. It was a case of placental abruption and impending rupture, from obstructed labour and eclampsia. Yes, we’re seeing patients who’ve had strokes from eclampsia. I’ve treated many cases here. They come in fits, and they have operations. They are pre-operatively sedated with Valium, and we deliver the baby if they’re in labour. One woman was behosht [unconscious; U] for 5 or 6 days, but awoke and recovered. Magnesium sulphate [for eclampsia] is not available...” (Dr. Khalthum, DHQ: September 7, 2005)

The dangers facing Sunni patients at the overwhelmed Kashrote facility had not gone unnoticed by Dr. Khalthum’s Shia colleague, Dr. Shehazeen. In early August 2005, she had been the first to tell me about the Kashrote Civil Hospital obstetric patient who had been debilitated for days by eclampsia:

“One week before, on a very busy day, we had a primae patient arrive with fits [seizures], but we gave her very good management and she recovered. For five days she had been unconscious at the Kashrote Hospital after fits, and Dr. Khalthum had brought her here from there. It took her days to become fully conscious. She slowly returned to her senses while we kept her in the ITC Ward. She would recognize people, and start to speak, and remember where she was. The baby was OK.” (Dr. Shehazeen, DHQ: August 4, 2005)

It wasn’t until September 2005 that I was able to attend births at the Kashrote Civil Hospital. Women endured episiotomies and stitching without local anaesthetic, used syringes were left lying on patient beds and there was no running water to help clean labour patients, or the delivery room. Sister Sabah insisted that their instruments were sterilized “daily” (which in and of itself was already deeply problematic) and, to my horror, it soon became apparent that the Labour Room’s speculum, scissors and forceps were not sterilized between cases (Fieldnotes: September 3, 2005). Instead, obstetric patients were routinely given prescriptions for antibiotics when they were discharged. The Labour Room was a cramped and thoroughly dingy room with two patient beds. Its windows were painted shut and it was set off from another small room which was used for patient check-ups, and where families waited for delivering mothers. I had worked hard not to show my disgust at the conditions, and tried to be as...
supportive as possible for the nurses, LHV’s and dayahs working there. These women, I knew, had little or no power to change the hospital’s conditions. But once I returned home to Jutial Mohalla, I had warned many of my pregnant neighbours to avoid using the hospital for any type of invasive procedure.

Madheeya’s daughter, Samina, had been referred for a therapeutic D&C in late summer 2005 and, despite my heated protests, her mother and mother-in-law insisted she have the procedure done at the ‘Sunni Hospital’. When I went to visit her at her parents’ home two days after she returned home, I found her lying in a side-room, feverish and weeping.

“My husband came and brought the taxi this morning at quarter to six, and we drove down to the Kashrote Hospital for me to be admitted by 6.30am. I saw how awful it was, tay saeey rahn [you spoke truthfully; S] about how dirty it is there. I asked them for a ‘Special Ward’, no matter what the costs, and they looked at me and said, ‘Special Ward? We don’t have a Special Ward!’ They put an IV-line in my arm with a glucose drip and I started to cry, because I was afraid and remembered what you said. I said, ‘Please let me go and I’m going to the Aga Khan Hospital instead!’ but they told me, ‘You can’t go now, we’re already got the IV-line in you.’ So they took me to do the procedure, and I was done by about twelve noon. It hurt so much, like when I was delivering Neelum. And when I was crying because of the pain, the doctor told me ‘Khamosh!’ [silence; U]. They gave me some pain medication, but it wasn’t enough. You were right about all of that. They were scraping at my insides with something, I didn’t want to look because I was scared, and the pain was so bad.” (Samina, Jutial: August 4, 2005)

In the weeks following her visit to the Kashrote Civil Hospital, Samina’s bleeding continued unabated. Wadood and I finally took her for an ultrasound at the Gilgit Medical Center, where Dr. Sharifa discovered the D&C was incomplete and Samina was suffering from the early stages of sepsis. Adding to the dangers facing obstetric and maternity patients, by the time we were preparing to leave Gilgit Town in September 2005, the Kashrote ‘Sunni Hospital’ suffered from inadequate physician coverage for its Out-Patient Clinics and In-Patient Ward. Dr. Khalthum had returned to her DHQ duties, and Dr. Shagufta’s surgical skills were widely disparaged by her patients. Sister Sabah, the Khawaja Ismaili obstetric nurse who had been among the first hired employees at the Kashrote site, was given greater
responsibility for complicated and uncomplicated delivery cases. After reflecting back on her extensive experiences as a maternity nurse in Libya, Egypt and Lebanon, before she had moved to Gilgit Town with her family and started work at the DHQ, Sister Sabah acknowledged that the hospital’s overall lack of facilities made recruiting a new OB-GYN, let alone hospital volunteers, nearly impossible.

“We need a residence, a room, for staff and a doctor on-call space, [where] they can be available twenty-four hours. I went to Dr. Fida [Interim Administrator] to talk to him after my duty finished this morning, and said, ‘I have to come here, because you don’t have time in the hospital for us.’ I told him to start giving the sweepers their [money], or the hospital will be like a kuchurah ghar [slum dwelling; U]. He agreed....We need an OB-GYN too, but [they are] not available. Dr. Shagufta, who is a DMO [District Medical Officer] is working until 2pm most days, but what about coverage at night? She lives in Baseen, and by the time we can get the doctor for an emergency, the patient will have given their salaams [greetings; A] to Allah. It was difficult even for me to get here – I used to walk here daily. [Points to legs] This is my car! [laughs] If they were able to take land for the hospital, why can’t they get an ambulance as well? We first offer to transfer patients to the DHQ, but if they don’t want to go, then we send them to AKHS. Long ago, Sunnis wouldn’t even eat from an Aga Khani [Ismaili] plate, so why would they want to take their services? But if ‘these people’ [Shias] want to murder people, why not first choose to take [Ismaili] services?” (Kashrote: August 29, 2005)

Besides the many iatrogenic and hygiene-related risks facing pregnant or delivering patients, there were a number of women who identified their attendance at the hospital as exemplifying their loyalty and commitment to the Sunni community’s cause, no matter how faulty or ineffective the services. For other participants, their continued and largely unavoidable reliance on the Kashrote Civil Hospital caused a number of women and their families to discuss Gilgiti Shias’ apparent callousness for local Sunnis’ health needs. Even despite her loyalties to the beleaguered Sunni community, the DHQ’s Sunni OB-GYN had worked hard to navigate around the hazards presented by the Kashrote Civil Hospital location. Her fears for patient safety then affected where she referred her maternity patients.

“Always at my [private] clinic, I refer and admit patients to the DHQ. I can’t take the responsibility to send them to Kashrote. It’s not my area, and I’ve seen lots of cases of foetal distress and IUD [intra-uterine demise] there.” (Dr. Kalthum, DHQ: September 7, 2005)

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15 The largest community of Pakistani Khawaja Ismailis (ethnic Sindhi or Punjabi) is in Karachi.
Dr. Khalthum’s preference to direct more complicated cases to the DHQ, or to DHQ physicians working in their private clinics, was similar to the approach taken by “Sabah and Nahilah, the on-duty LHV, at the Kashrote Civil Hospital. I watched as Nahilah conducted an internal examination on a young patient complaining of early pregnancy bleeding; on the other examination table, Sister Sabah injected an older patient with Profasi, a progesterone supplement intended to help reduce the risk of miscarriage. As Nahilah and Sister Sabah worked, they chatted. Their exchange demonstrated how thoroughly interconnected the Kashrote Civil Hospital’s services were with Gilgit Town’s other, clinical settings and service providers.

[Nahilah] “She is complaining of PV [vaginal] bleeding, and she is two months pregnant.”
[Sister Sabah] “The doctor is absent today, and Nahilah is taking the OPD [Out-Patient Department] duties in the Labour Room.”
[Nahilah] “Her cervix is not opened, but she’s bleeding a little bit. I’m advising her to go to Dr. Khalthum for an ultrasound in the evening, and she needs bed-rest and to avoid lifting...”
[Sister Sabah] “This woman has two boxes of 500 IUI Profasi injections. It’s Rs 657 [CDN $14.93] for two vials. The woman had three previous miscarriages and is now two months pregnant and the doctor advises her to use this. This patient is from Kashrote. Dr. Shagufta, from the Hidayat Memorial Hospital [Shia Khomer Mohalla] had given her a parchi [prescription; U] and sent her here to get the injection after purchasing the medication.”
[Nahilah] [To patient] “Go and get an ultrasound from Dr. Khalthum [private clinic], or Dr. Shakoor, it’s your choice. Dr. Shagufta [Suni OB-GYN] hasn’t got an ultrasound machine.”
[Sister Sabah] “I’m advising her to get an ultrasound from Dr. Khalthum at her private clinic. [To patient] The dayah is going to shift from here to work with her there at 3pm, and you can wait here till then and go with her? [To Nahilah] The patient has a case of threatened abortion [miscarriage]....One patient came to me with leaking [amniotic] membranes, and I referred her to Dr. Khalthum at her private clinic, where she was checked and then went to the DHQ for an operation and had a C-section.” (Kashrote Civil Hospital: September 3, 2005)

During my final interview with Sister Sabah in early September 2005, she was uncertain of what the future held for the hospital, its staff and patients. Despite her doubts, she was working to implement a DHQ-style approach to patient records and managing their pharmaceutical supplies. On the last day I spoke with her, Sister Sabah and Nahilah were being feted by a pharmaceutical representative, who plied them with boxes of free vitamins and pain relievers. Speaking to me a few days later from her office at the
DHQ, Dr. Khalthum was hopeful that the Kashrote Civil Hospital location could grow and extend its services to Shias and Ismailis. “When this condition is finished, this hospital should progress with [its] facilities, and everyone should go to any hospital regardless of sect.” (Dr. Khalthum, DHQ: September 7, 2005).

**Part IV Maternal Deaths, Malpractice & Insurgent Reproduction**

Because Sunni women’s ‘tension times’ health risks could be correlated with Shia, Sunni and Ismaili mohalla-boundaries, health service access and identity, sectarian affiliation was unavoidably implicated with increased maternal morbidity and mortality. For example, at the Gilgit Medical Center, which also acted as AKHS,P’s Northern Areas headquarters, the General Manager’s very real concerns for the dangers associated with Shia or Sunni neighbourhoods led to AKHS,P health workers being withdrawn from their field postings for nearly a month following January 8th. (This despite the majority of AHKS,P LHVs being Ismaili, and therefore less likely to be affected by violence.) Consequently, there were far fewer trained and semi-trained health workers offering home-based, childbirth support or post-natal follow-up visits. And because Gilgit District has some of Pakistan’s highest fertility, infant and maternal mortality and morbidity rates, it was more than reasonable to expect that there were, in fact, a troubling number of women who died as a direct result of neighbourhood tensions or Army curfews (see Figure 30). To date, there are no official estimates of the possible loss of mother and infants’ lives, notwithstanding the haphazard collection of verbal autopsies by AKHS,P health workers following Zia’s death, or anecdotal accounts provided by physicians who were friends or relatives with the deceased.

Emma Varley
“Five women in our own family died during the curfew, you know? I know of 6 or 7 [other] women who’ve died as a result of the ‘tension.’ This is a battle zone, and unpredictable.” (Dr. Khalthum, DHQ: September 7, 2005)

It wasn’t hard to see how the conflicts had worsened women’s maternal morbidity and mortality even in clinical spaces. I learned of a number of clinically preventable maternal deaths where the loss was directly attributable to on-site curfew or safety-based constraints on movement for both patient and physician, or to security concerns for male attendants of the delivering mother. This was most obviously the case at the DHQ. In late August, I came to the Family Wing in the morning and found the two, on-duty LHVs exhausted, silent and grim, sitting side by side in the staff-room. They had spent several hours the previous night trying to save a dying obstetric patient.

“I called the doctor at 11.40pm, and she arrived at 1am. We shifted the patient to the Operating Theater at 1am and she died at 1.30am - right away. Before this we had given her a glucose drip, and we had passed a cannula for this with great difficulty. We gave her ‘Centrol’ after the delivery because there was a little bit of bleeding, but when she was in the recovery room she was sitting up, drinking water and talking with us, her husband and her daughters. They were there with her….she was very happy about the delivery. It was a boy, and [he came] after maybe ten years of trying. The delivery was at 11pm...the baby was OK, no problems with him. After thirty or forty minutes they were packing and getting ready to go home. The husband was trying to get a car for them to leave, but she had a little bleeding, no pain. We did uterine massage and then we decided we needed the doctor, but because the phone was locked and the PCO’s closed, and we couldn't leave the [Family] Wing because of the curfew....so we sent a written note with a dayah to the DMO [District Medical Officer] to send a driver and car to get the doctor….The Rangers had stopped the dayah on the way, and asked where she was going. They said she couldn’t go across the road [to the main DHQ Offices] because there was a curfew that night, from around 11pm-2am...but she told him it was an emergency, and he let her go and take the message. During this time, we sent the patient’s husband to go and get blood from the labwallah [lab man; U], and he told the husband he [couldn’t give] the blood because [her] volume was 9.4, and normally they wait until it is 6 or 7. So they sent him back to us, saying ‘Only come back when it’s an emergency!’ But she was bleeding, and the blood loss happens so fast when this kind of case happens...by then she was pale, anaemic, dizzy, her blood pressure had dropped too. At the end we couldn’t detect a blood pressure or pulse, but she was still hosht [conscious; U]...The doctor arrived at 1am, and we shifted her at the same time. But she died at 1.30am.” (LHV II, DHQ: August 23, 2005)

And because the ‘tensions’ continued well into late autumn 2005, the families of Sunni maternity patients remained vigilant to the possibility of danger while visiting the DHQ, even during periods without...
fighting. Over the spring and summer months, a number of delivering mothers had been admitted, and then forcibly withdrawn from treatment by male family members frightened for their own security in the all-Shia neighbourhood. Indeed, Bermas had witnessed the worst of the 2005 attacks on Sunnis. (And after the murder of Gilgit’s Shia Pakistan People’s Party [PPP] leader, Ramzan Ali Danish, on September 8th [Dawn Newspaper: September 11, 2005], Bermas was the launching grounds for nighttime mortar attacks on adjacent Sunni mohallas.) In late summer 2005, I was told about an obstetric patient who died after being shifted from the DHQ to the ‘Sunni Hospital’.

“The woman came on a Saturday night with her husband. She had no pain, but a little bleeding – she was full-term, so we admitted her for observation. Later that night we went to check on her and her bed was empty. Her husband had taken her, secretly, without talking to us first. I suppose he got scared, or nervous or something. No, there weren’t any particular problems or tensions that night, so I’m not sure what motivated him. He took her straight to Kashrote...we heard Monday morning that she had died there without having delivered....the staff there are not prepared for such emergencies, really not.” (LHV II, DHQ: August 23, 2005)

“One man, who was afraid of his own death, took his wife, who didn’t matter, from here [the DHQ] and he lost her and the babies....This issue, too, is very important and I hope that you address it. The services are there, but the main thing is peace.” (Dr. Khalthum, DHQ: September 7, 2005)

“Yes, a patient died here at Kashrote a few days back. She went first to DHQ, they told her to stay until morning but she ran away to Kashrote for delivery. She was a cardiac case, and there was no delivery. I was on duty when people from her family came, and they said we weren’t checking her blood pressure. They were talking too much, and I said, ‘First, tell me what they did at DHQ! You’re involved in this, and that was an established hospital! Why did your family bring her here?’ It was a young mother who died.” (Sister Sabah, Kashrote Civil Hospital: August 29, 2005)

The Kashrote Civil Hospital’s insufficiencies were frequently discussed by DHQ and AKHS,P employees, who learned about botched surgeries, and maternal or infant deaths when emergency cases were referred to them by the ‘Sunni Hospital’s’ panicked staff. One DHQ LHV had heard that D&C’s had been conducted by a volunteer LHV (LHV VI, DHQ: August 23, 2005). In my own visits to the ‘Sunni Hospital’, I had found this to be true. There, Sister Sabah was quick to decry the LHV’s technical skills, but argued that high patient numbers had forced them to take unusual measures. In
another example, AKHS,P health workers recounted how a labouring Sunni woman, frightened by the Kashrote Civil Hospital’s austere and unhygienic conditions, fled on foot to the nearby Gilgit Medical Center (Nurse, AKHS,P: May 3, 2005). But even after maternity cases were referred to the DHQ by the Kashrote Civil Hospital, women faced ever-present and largely unavoidable health dangers. In mid-August 2005, the Gilgit Medical Center’s General Manager told me about yet another maternal death at the DHQ’s Labour Room.

“I live in Zulfiqar Colony, and one of my neighbours a few nights ago was a woman who died because one of those untrained dayahs at the government hospital [DHQ] gave her an injection of Oxytocin and her uterus ruptured...this was one of my neighbours, you know? I woke up in the morning, at about 6am and heard a terrible noise and people crying from near my house. I went out to inquire as to what had happened, and the woman’s husband told me everything. About how she had died, and they had brought her home from the hospital at around three in the morning. I asked him, ‘Why didn’t you bring her to us at AKHS? We have the staff, we have surgeons, we have the facilities!’ He said that when her labour began, at perhaps 11pm at night, he had wanted to bring her to our medical center, but his wife insisted they go to the government hospital, because she was friends with or knew one of the dayahs working there in the Labour Room. When she was there, they gave her Oxytocin and she suffered a uterine rupture and died at perhaps one in the morning.”

(General Manager, AKHS,P: August 10, 2005)

These deaths demonstrated how easily the boundary between conflict-related constraints and medical malpractice collapsed. The tragedy of maternal deaths also required I think through the inter-relationship between loss and martyrdom (shaheed; A), especially because women’s reproductive roles became more intimately tied up with issues of community struggle, Sunni political identity and the perceived ‘victimization’ of the Sunni community. After speaking further with Fazeelat, my research assistant, I became aware that because of Shias’ veneration of the Prophet’s daughter, Fatima, and the tragic stories of family loss surrounding her life - with her husband, the Caliph Ali, and sons murdered (see Waines 1995) - Shia women were permitted powerfully expressive vehicles and symbolic precedent for their protests of Zia-ud-din’s death, and their subsequent roles as the ‘mothers of martyrs’. Sunni women, though largely aware of the many accounts lauding feminine strength and autonomy available to them through the Hanafi fiqh, nonetheless found their ability to publicly voice community suffering vis-a-vis
personal experience severely constrained by local culture and Wahabbist-influenced dictates. These customarily emphasized self-sacrifice and stressed the public absence of women’s identity as individual, emotive social actors. Sunni women restricted their participation in the ongoing tensions to their encouragement of male family members and neighbours in planning household and community-level defensive measures, and in maintaining family life on a day-to-day basis.

For instance, despite the political power inherent to their public visibility as widows, bereaved mothers or as victims themselves, I noticed that there was little, if any, social space provided for Sunni women to protest current events or vocalize their own losses. Rather than harness the politics inherent in ‘tension times’ maternal deaths, women’s health experiences were marginalized amid overall efforts to masculinize and militarize community response. So while Shia women marched in protest against the deaths of Shias or the lack of arrests in the Zia-u’din case, Sunni women remained conspicuously absent from the public domain.16 In fact, the purposeful restriction of women to the household stemmed from the same top-down, patriarchal power dynamics and political processes that ensured Gilgit’s Sunni community continued to lag behind both the Shia and Ismaili communities in female literacy and school attendance.

Despite Shia and Sunni women being publicly portrayed as the ‘mothers of martyrs’, or very occasionally as political ‘martyrs’ (such as when several Shia women were reportedly shot and killed in spring and fall 2005 after throwing rocks at soldiers during Army weapons sweeps), women’s roles as ‘health martyrs’ remained markedly absent from community narratives of victimhood. Because of the wide range of

16 By my own observations, Sunni women were now subject to more stringent gender segregation practices than before the conflicts. They were also unable to attend public demonstrations or protests. Many of my Sunni women neighbours argued that Shia women’s political participation confirmed how ‘Shias have no honour or shame.’ As such, it often seemed as though Sunnis’ pardah practices were part of community efforts to positively contrast Sunni ‘piety’ against Shias’ at-conflict, gender behaviours. In contrast to Shia women’s active role in marches and rallies, Sunni women found other ways to protest not only the ‘tensions’, but the conservative restrictions being placed on them from within the Sunni community. An obvious example was women’s deliberately defiant movements during Army curfews. When fears of arrest confined men to the home, groups of women boldly crossed checkpoints to visit grieving widows, to sit with new mothers or assist in deliveries (see Chapter Eight, page 429). Such visits acted as protests against Shias and the Army, but also subversively counter-balanced increased, in-community conservatism by temporarily suspending pardah’s otherwise intractable boundaries.
regular risks accompanying home deliveries, domestic maternal deaths were described as normative events and not interpreted as being ‘shaheed’ in any overtly political sense.17 And like many aspects of women’s home life, these losses remained invisible to the community-at-large. But hospital-based births evoked a different sense of risk. Maternal deaths at Gilgit’s health centers evoked an ominous sense of failed responsibilities on the part of non-Sunny physicians and hospital staff. Embedded within sectarian tensions and set against conspiracy theories, Sunnis’ narratives of Sunni deaths at Shia mohalla-based clinics were often suggestive of discriminatory treatment or criminal neglect by Shia health workers. Only in these moments were Sunni maternal deaths discursively integrated with martyrdom paradigms.18

Conflict had also affected the way women, their families and the Sunni community thought about reproduction. Conflict theoreticians assert that the causes of war are often essentialized as being “inherent to particular cultures and regions, rendering them inexorable and unavoidable” (Huntington 1998 in Giles & Hyndman 2004: 17). In a similar vein, if conflict is often described in essentialized terms, its solutions are often as reductive and naturalized. Gilgiti women’s post-January 8th reproduction narratives and the Sunni community’s own efforts evidenced just such a ‘naturalized’ response, whereby Gilgiti Sunnis sought to displace their sectarian insecurities through hastily arranged marriages, and by placing renewed emphasis on the importance of pregnancy, and sons in particular. Motivated by women’s fervent desire to effect change in hostile landscapes, narratives foregrounded what I called ‘insurgent reproduction.’ At its simplest level, this meant that frequent pregnancies would produce necessary future combatants. In Gilgit, any ‘insurgent’ credo of women’s symbolic and actual reproduction of the Sunni

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17 This being said, Wadood clarified that even ‘normal’ maternal deaths met shaheed ‘standards’, in that women were perceived to have died as an outcome of their religious obligation to reproduce.

18 There were a number of ways that Gilgiti Shias and Sunnis distinguished between women’s deaths as either ‘normal’ loss or martyrdom. For example, there were the reported deaths of Shia women who had purposefully “gotten in the way” of Army operations during especially chaotic spells (Fieldnotes: March 12, 2005). Their participation and sacrifices were glorified among the Shia community, and they were given public burials where substantial numbers of male and female mourners were permitted official passage (notwithstanding citywide curfews) to attend the funeral. However, the most vulnerable victims of sectarian tensions, such as women and infants dying during the prenatal and post-partum periods, or during childbirth because of treatment unavailability or denied access to service centers, were largely ignored at the community-level or by local politicians. Herein lay the critical distinction between the valorization of women’s political deaths, and the less noteworthy specter of maternal deaths.
body politic depended, however, on the basic hope that each pregnancy would produce a son. (As was the case before the ‘tension times’, daughters were described as holding only peripheral value in sectarian, inter-personal or inter-familial conflict, barring, of course, their own ability to produce sons at a later stage.) The tandem development of ‘reproduction’ and ‘conflict’ concepts among Gilgiti Sunnis drew some of its vitriol from neighbouring Diamer District. There, the birth of sons was customarily envisaged as an essential component in the socio-economic repair of a region debilitated by tribal enmities and murder. Daughters born to Diamer families living in Gilgit were rarely welcomed.

“If the family are Chilasis...they’ll tell us they need more boys against their enemies. Some actually say this to us when they’re here - the preference in that area is for boys only.” (LHV VI, DHQ: August 6, 2005)

“Then, you have Chilasi women who often say they need more sons to replace those lost to [clan] fighting!” (Dr. Sharifa, AKHS,P: January 7, 2005)

This idealization of infant sons as warriors coalesced neatly with the material and economic underpinnings for Gilgiti son preference. Sons not only enabled protection and retribution, but their ‘maleness’ symbolized the Sunni community’s future economic restoration. Local clerics helped cultivate women’s sense that their pregnancies and childbirth experiences were part of a larger Sunni insurgency. Militantly conservative mullahs in Minawar, for instance, sermonized that women’s producing bodies were fields of promise, providing a harvest of nurtured vengeance. Women were told that for every missed conception, they were as guilty as if they had killed twenty people. Non-pregnancy was now equated with greater carnage than Gilgit’s one-on-one fighting (Fieldnotes: April 28, 2005).

[Phoonurh, daughter-in-law] “My mother-in-law has told me that I have to produce more sons in order to protect the women, the family, and the village from Shias.”

[Pfiffi, mother-in-law] “The Minawar mullah has told women that for every one pregnancy they avoid, it is equivalent to killing ten people. So, for two avoided conceptions you have killed 20 people - God will be very angry if you stop having babies!” (Minawar: April 28, 2005)

In Jutial, my participants debated the consequences of conflict and at-risk mohalla spaces for women’s emotional well being. Terror’s physiological consequences for women’s maternal well being and, by

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extension, infant health, were frequently discussed. After one night of intense fighting in our mohalla, my neighbour described her efforts to reduce the transference of her fears to her unborn baby.

“We did a dhum [prayer; A] for the baby. When they did the fires [arson attacks on Shia stores following a local Sunni’s murder] at the chowk [intersection; U], I was so scared and frightened, and when he was born, my fear shifted to him - all the nervousness went to him, so my father-in-law did a dhum for him.” (Ruqaiyah, Jutial: August 11, 2005)

As 2005 progressed, there were more and more bittersweet celebrations at the births of babies born to fathers who had died in sectarian conflict. Our neighbour, Liaquat, a Sunni civil servant, had been shot and killed on January 8th, and it was with fanfare and some tears that his son’s birth was announced, house-by-house, six months later. Not unlike many Pakistanis, Gilgitis perceived the arrival of a child after its father’s death as a happy and fortuitous event. Each birth was described as a small triumph, as the ability of a ‘martyred’ father to continue to exist through his child, particularly if the baby was a boy. Moreover, some of my Jutiali neighbours envisioned the newborn sons of slain fathers as future stalwart defenders not only of family honour (izzat; U), but sons obliged to later seek revenge (badal; U) against their fathers’ killers. To this point, I return to what my neighbour, Fouzia, said in the aftermath of our neighbour being shot by Shias (see Introduction, page 6), when she ardently emphasized the increased importance of early marriage and childbearing during conflict.

“He [the victim] was a Sunni, bas [enough; U]! What more do Shias need! See, this is why you should get married quickly and have children, so you have a son to live for your name, to keep it open against your enemies, and do revenge for you when he’s grown!” (Fouzia, Jutial: July 20, 2005)

There were a variety of ways in which my participants could directly connect their pregnancy health complaints or childbirth experiences to the Shia-Sunni hostilities or exclusionary practices. Immediately after January 8th, Gilgitis from all sectarian communities had been able to request Army vehicles to escort emergency and delivering patients to local hospitals. Yet for nearly a week in early April 2005, the Army enforced a total curfew and telecommunications blackout during mohalla-by-mohalla searches for

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19 By the end of my fieldwork, I had noticed how an increasing number of my Sunni in-laws were giving their newborn sons traditionally Shia names, such as ‘Ali’ and ‘Hussain’. Wadood said this was the purposeful co-opting and ‘Sunni-fication’ of what locals normally identified as “Shia culture” (Fieldnotes: September 12, 2005).
unregistered weapons and arms caches (Dawn Newspaper: April 3, 2005). Locked inside their homes, women and their families were unable to contact the Army, other relatives or neighbours for assistance transporting maternity patients to hospital. In the predominantly Shia mohalla of Amphari, home-births were the only available option. Army personnel refused to permit safe passage for labouring Sunni women to local hospitals, or to allow *dayahs* to pass checkpoints for home deliveries. In an interview with the BBC, Kashmir and Northern Areas (KANA) Minister, Syed Faisal Saleh Hayat, had described April’s ‘Operation Clean-Up’ as a means to “purge” and “de-weaponize the city”, and that all entry points to “the region had been blocked to check [the] supply of illegal weapons” (Dawn Newspaper: April 3, 2005).

By the fourth day of curfews and searches, regardless of the cost to community health, the tally of recovered illegal weapons stood at a mere 37 weapons (Dawn Newspaper: April 5, 2005) (see Chapter Eight, page 440, footnote 8). As the ‘tensions’ continued into summer 2005, the Army showed less interest in ensuring Sunni women’s health service access, and the number of maternity patients being denied assistance by Army personnel increased. This coincided with the Sunni community’s deeply held belief that they were a community under-siege, and spurred considerable gossip concerning the Army’s fragile working relationship with Gilgit’s predominantly Shia police force. Many women and their families argued that Sunni Army Officers were too ‘frightened’ to upset the local Shia police.

“I assisted my sister-in-law when she gave birth to her last baby in Amphari during the ‘tension.’ Police wouldn’t give us a car, and there was no driver. The pain started at 11pm and she delivered at 2am. We telephoned DHQ, the police, the *thana* [jail; U], and the police department said it was impossible to take her to the hospital. My brother-in-law tried his best to find someone to take her, but he couldn’t….At her delivery it was me and my mother-in-law helping her. She was crouching on the floor, holding onto something to keep her upright, and after 2 minutes she delivered. We found a *dusturkhan* [tablecloth; U] to put underneath her – it was an emergency, what could we do? We have to do such things at times like this. We cut the cord ourselves. We did it properly, with scissors. No, we didn’t wash [the scissors]. We tied the cord with bandage-like material. Her water broke at 11pm, when the pain started. We knew the delivery was impending; she had gone pee, and then the water broke.” (Emun, Jutial: June 7, 2005)
Women who emerged relatively unscathed from their home or hospital birthing experiences described themselves as ‘victorious’ participants in the Sunni community’s ongoing struggles. But for respondents who miscarried, many ascribed their losses to emotional turmoil during violent ‘tension times’.

“For two weeks [since a cousin’s killing], we’ve been seeing doctor after doctor. I’d been bleeding on and off since the night of Shakeel’s shooting. We saw Dr. Khalthum at the [DHQ’s] OPD [Out-Patient] Ward and she said the baby was finished. She told me I needed a D&C and advised me to come and get it done at the Kashrote Hospital where they would admit me for half a day.” (Samina, Jutial: August 3, 2005)

All the while, women’s health service access remained entangled with local calendars of religious belief and expression. Embedded in Gilgit’s ongoing tensions were regularly occurring Shia religious festivals, Nisab protests and men’s and women’s religious meetings (jalsa; F). On religious holidays, the mountainsides surrounding Gilgit were alight with čiragaan; huge bonfires shaped to spell out the names of Shia Imams (Ya’Ali, Ya’Hussain, Ya’Mehdi) and invocations (Ya’Noor), or signify political allegiance (‘ISO’) (see Figure 31). Following January 8th, however, these evenings took on more ominous overtones for us. Where Shia festivals once held a feeling of joviality and camaraderie, with many Sunnis...

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20 Sunni women’s health access difficulties could also be attributed to the resurgence of local Sunni politicization. Perhaps the most conspicuous political display of post-January 8th Sunni unity occurred with the Tablighi Jamaat’s annual Ishtemah (gathering), which was held at Konodas Mohalla’s Sunni Markaz (May 12 – 15, 2005). In Juma (Friday) sermons prior to the event, Markaz clergy claimed the Tablighi Jamaat had strategically selected Gilgit to affirm national support for the local community’s sectarian struggles. Gilgiti Sunnis and local branches of the Tablighi Jamaat and anti-Shia Sipah-e-Sahabah were delighted. While the majority of Ishtemah participants were Gilgitis, attendees also came from across Northern Pakistan and the Punjab. Gilgit’s Chief Secretary announced the final, full day of Ishtemah (May 14) was a local holiday, and Sunni physicians and support staff from Gilgit’s hospitals, private clinics and dispensaries stopped working in order to attend. The DHQ, in fact, was closed completely for May 14th. At the Family Health Hospital, Dr. Sunbool worked alone because Dr. Latifa had been prevented by the crowds from leaving her home in Konodas Mohalla. At her morning Out-Patient clinic, I overheard vociferous complaints from Dr. Latifa’s patients, who complained that in addition to being excluded from the Ishtemah’s male-dominated events, they now they had to cope with additional treatment delays (Fieldnotes: May 14, 2005).
preparing special meals which they shared with Shia family and friends, they were now transformed into highly political events. With Army contingents guarding the roadways leading into Sunni mohallas, Shia celebrants marched in heavy numbers with flaming torches held aloft, through Sunni enclaves en route to jaloos (rallies; F) at local Imambaraghs. For the evening’s duration, transport in or out of Sunni mohallas was either off-limits or strictly regulated; adding to many Sunnis’ resentments, women’s ability to reach private clinics or hospitals was obviously affected. Because conflictive sectarianism infused and altered social terrains and clinical spaces, this required my carefully re-thinking the ways Gilgit Town’s neighbourhood spaces and boundaries were impacted by questions of identity and affiliation. By amplifying the dangers (actual or imagined) associated with religious identity in social spaces rife with flux, turmoil and interpersonal threat, and conflict-related “neighbourhood effects” (Smith & Easterlow 2005: 175) magnified Sunni women’s individual health risks. Specifically, this concept from the social geography of health literature posits that health behaviours are constrained and enabled by neighbourhood spaces, which “add their own contribution to patterns of health variation” (Mitchell et al, 1998 in Smith & Easterlow 2005: 175).21

Part V Voices and Counter-Voices: Patient ‘Bravery’ & Physician Discontent

During my research at the Kashrote Civil Hospital’s Delivery Room, it seemed as though many maternity patients and their families were prepared to handle any in-hospital discomfort or risk death, provided overall family security and in-community allegiance remained assured. But when asked if their use of the

21 In contrast to my ethnographic fieldwork, which relied on participant-observation, open-ended interviews and narrative analysis, most social geographers investigate ‘neighbourhood effects’ through “multilevel theories and sophisticated statistical models” (Oakes 2003: 1929), though the theory’s strongest proponent, J. Michael Oakes, argues they almost always “fail to confront the enormous methodological problems associated with causal inference” (Ibid: 1929). Oakes suggests the central weakness of ‘neighbourhood effects’ approaches stems from social geographers’ frequent inability to distinguish the affective and causal role of neighbourhood characteristics in highly variable, individual health practices or outcomes. To this end, social geographers of health often argue that all contexts are “reducible to the attributes of individuals” (Diez Roux 2004: 1957), thereby invalidating “the notion of ‘neighbourhood effects’ (and in the extreme, even social effects) altogether” (Ibid: 1957). Instead, Gilgit’s 2005 Shia-Sunni hostilities clearly demonstrate how conflict can concretize the interrelationship between ‘neighbourhood effects’ and individual health. Gilgit’s neighbourhood spaces were unavoidably implicated with maternal morbidity and mortality, in that Sunni women’s ‘tension time’ health risks were so clearly related to mohalla- boundaries and the hazards posed by sectarian affiliation.

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Sunni Hospital represented a preference for Sunni over Shia physicians or support staff, the majority of female patients answered in the negative. Many protested that the sectarian identity of their service provider didn’t matter to them, saying, “A doctor is a doctor, what does it matter?” (Sushilah, Jutial: August 16, 2005) Nor were many respondents outwardly concerned with their personal safety, being relatively confident that women were not targets of sectarian violence. One nurse went so far as to say, “It’s the men who were and are scared to come, not the women!” (Nurse I, DHQ: August 6, 2005) In fact, many of my participants were quick to argue that sectarianism played no role in their health decisions, even though this ran completely counter to my own understanding of the ‘tensions’. Indeed, I found that a certain sense of bravado was cultivated by Sunni women and their families in their discussion of health service access. Not uncommonly, women proclaimed that “Shias don’t frighten me – they can’t hurt me!” (Saadia, Amphari: June 7, 2005) Or, “Shias don’t own this place - how can they stop me?” (Lailah, Jutial: August 3, 2005) Yet contradictions and narrative ruptures soon began appearing in women’s accounts. For example, some women said they were unafraid of the Shias living around the DHQ and Gilgit Medical Center although, according to their own narratives, many were obviously still preoccupied with Shia mohalla risks.

[Emma] “Does the area where the doctor works matter, for instance if in Nagaril or Bermas Mohallas?”

[Gulsoori] “No, the area doesn’t matter...I don’t care about this, and am not afraid. But I do prefer the Family Health [Hospital] not only because it’s close, but because of the [mixed Sunni, Ismaili, Shia] area, especially during ‘tension times’. But even if it’s a problematic area, I’ll go wherever I need to.” (Jutial: August 16, 2005)

However, women’s service use belied their fears and inter-sectarian hesitancies. Despite women’s regularly asserted invulnerability to sectarian violence, massive Sunni patient shifts away from the DHQ illuminated the community’s awareness of the dangers facing them. For example, the Kashrote Civil Hospital’s establishment powerfully exemplified the Sunni community’s inability to remedy their circumstances.

Dr. Khalthum, who had worked for two or three months at the ‘Sunni Hospital’ in early spring 2005, confirmed that her Kashrote maternity patients had few available treatment options:
“The Kashrote Hospital has no facilities, but people are forced to go there. They’re not going willingly.” (Dr. Khalthum, DHQ: September 7, 2005)

As such, women’s use of the hospital was largely unavoidable. Moreover, the regular perils of female self-sacrifice ensured women’s maternal health needs were de-prioritized in the service of overall family security and in-community allegiance. Women’s constructed braveries required that I carefully think through women’s objectives when they shared their health-experiences. Although a number of women admitted being anxious during increased ‘tension times’, most energetically disavowed Shias as ineffective combatants, too loudly proclaimed themselves absent of fear or said their lives were unaffected by the hostilities. And even amid the obvious limitations imposed by conflict, Sunnis carefully re-described their failure to access clinical centers as a deliberate ‘choice’. Through this narrative turn, the under-siege Sunni community shirked self-identification as the ‘victims’ of Shia militancy, thereby unbalancing notions of perpetrator and power, victim and diminished agency. Such reconfigurations of action and meaning resembled what Wardlow terms “retrospective agency” (Wardlow 2006: 163), whereby the inability to reach health services, whether by stymied access or fear, was later reconstituted to emphasize purposeful choice. In reflecting on her own work among women in Papua New Guinea, Wardlow cautions ethnographers to remain vigilant to the “motivated, constructed, and partial nature of retrospective narratives” (Ibid: 158). For instance, these occur when individuals compensate for a “lack of agency” by narrating “their lives in a triumphalist language of self-determination” (Ibid: 158). In other ways, women’s accounts acted as what Feldman calls “‘counter-labyrinths’ of coping, and ‘counter-memories’ against fear” (Feldman 1995 in Henry 2006: 392).

In marked contrast to women’s retrospective agencies, health service personnel were far more willing to discuss the fears and insecurities attendant on their medical practice or office work. For example, some Sunni doctors voiced their concerns about the potential threats posed by Shia co-workers:

“I was speaking with a Shia colleague a while back, and both of us were being forcefully positive about the [sectarian] situation. But I knew inside that this colleague was involved.”

(Dr. Nikallum, Majini Mohalla: July 1, 2005)
Chapter Seven: ‘Halaat Kharab/Tension Times’

In turn, Dr. Nikallum’s concerns were mirrored by, and also offered important contrasts to, the concerns expressed by Ismaili health providers, such as Sister Sabah at the Kashrote ‘Sunni Hospital’ and Sherbaz Ali, the Family Planning Organization’s regional Deputy Director:

“I never ask if a patient is Sunni or Shia. First, humanity is the major issue. Look at DH [District Health Officer] Behram, who was transferred to Ghizer and protected by Shias. [Holds up palm of hand to my face] See, these five fingers are not equal. Some [Shias] are terrorists, while others are wanting peace. In Danyor, a man [Ismaili-turned-Sunni Dr. Ayoub] was killed, and they hid his body behind a rock and others found his body later. There is no guarantee here...We have to ask, why and how are they fighting? Areas in Gilgit are the problem. We can wait for changes in the next generation. For example, now many Sunnis are more open to Ismailis. In 1985, I remember asking a member of the [DHQ] staff to slaughter a chicken for my food, and he asked if I would eat the food if he did it. I asked him, ‘You’re saying takbir [sacrificial prayer; A] for the slaughter - Sunnis are saying it, why can’t I eat it?’ From 1985 till now it was quite open, but now it’s changing again. Extremist people are not allowing their children to meet with kids from other areas or communities.” (Sister Sabah, Kashrote Civil Hospital: September 3, 2005)

“We have employees from all three communities here. Some of our Shias employees had concerns about working here, but all were supported here by their fellow employees, and everyone was positive. I emphasized to them, ‘We’re all from one society, despite our other differences, and we can’t hide or take refuge from one another.’ It’s not an option.” (Sherbaz Ali, FPO: July 28, 2005)

Later in this same interview, Sherbaz offered an important insight into the confusing nature of the hostilities, whereby targeted killings were not always the product of religious difference. “We have to remember there are other personal problems and rivalries behind the violence” (FPO: July 28, 2005).22

Other physicians felt that by publicizing the conflicts, the Pakistani Government would be more likely to intervene and end the hostilities. But as one senior-level public sector employee noted, by sharing his experiences with the media he risked significant backlash from the federal government. In early January, when the Army had established their initial curfews, he had been approached by an international journalist as he tried to return to Gilgit Town after a working visit to Diamer District.

“A representative of Al Jazeera TV met with me at Sakwar at the check-post on January 9th. I was coming back from Chilas and was stopped at Sakwar by the Army. [The journalist] couldn’t reach the city because the Army didn’t allow him past. He asked me about the

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22 See Chapter Eight, page 420.
situation in the city, and if he could call me once I had gotten home. I gave him my number, and he returned to Jaglote. He called me later, but because of the curfew I hadn’t been out, didn’t know what was going on, and couldn’t share anything with him....I refused to speak with him on the phone about the details. We are government servants, and were on the [ISO hit] list...[but] I was afraid more from the bureaucracy and the problems I could face from them.” (‘Muhammad’, Kashrote: September 11, 2005)

Other Sunni physicians said they were intent on publicizing the consequences of conflict for Gilgiti Sunnis, and were far less concerned by the potential fallouts from ‘information sharing’. (These were those participants who urged me to use their real names in my thesis and related writing, but for whom I still decided to use pseudonyms.)

[Emma] “I want to assure you that I’ll give you full anonymity in my report....”
[Dr. ‘X’] “I don’t need anonymity. Look, I speak openly with intelligence officials, including Major Generals, in the evening during my spare hours in Kashrote. I tell them what I know of the situation, and of various peoples’ involvement.” (Majini Mohalla: July 1, 2005)

The majority of Sunni physicians and health workers were deeply troubled by the implications of sectarianism on health service coverage, and their ability to practice medicine. At the DHQ, Dr. Khalthum framed her obligations to continue working at both the Kashrote and DHQ sites in religious terms. “Till my own death, I will give cover to my patients. This, you know, is jihad” (Dr. Khalthum, DHQ: September 7, 2005). At the Family Health Hospital, the Shia Acting Project Director proved that Shias were equally likely to discuss their ‘moral responsibility’ to offer health services regardless of sectarian affiliation.

“At a staff meeting, I indicated to all our staff that the definition of a hospital is to serve humans, and we can’t discriminate between the patients by sect or community. All services will be provided regardless of differences, and regularly. I acknowledge that there is patient insecurity about the sectarian identity of physicians and staff at the hospital, because this is an intersect make-up hospital. I also recognize patient insecurities about attending the DHQ, and the impact this might have on our patients, their concerns and fears regarding preferential treatment.” (Acting Project Director, FHH: May 11, 2005)

In many respects, the conflicts provided physicians and health service personnel crucial opportunities to discuss their ‘others’. For instance, when Shias killed the Ismaili Forestry Officer Taighun Nabi on January 8th because he had protected Sunni colleagues from the bloodshed, Ismaili narratives began
emphasizing their political unity with the Sunni community, and vociferously contested the ritual and doctrinal commonalities shared by Ismailis and Shias. At the DHQ, I overheard Ismaili nurses referring to Sunni men as “our Sunni brothers” (Nurses II & III, DHQ: July 26, 2005).23 Meanwhile, some physicians were distressed by the changes conflict had wrought on their own community. Dr. Khalthum was appalled by heightened attentiveness to sectarian identity, and in-community demands that she limit her practice to Sunni patients. In response to her angers, and instead of moving deeper into her fears and frustrations, she focused again on the morality inherent to her practice of medicine, and described how she had proposed a series of peace-oriented ‘health camps’.

“Things remain very much tense [for me], because my family and friends are not happy with me working here [at the DHQ]. If I’m killed, it’s for a good cause. Maybe some will hate me, because a few in each community created this disaster. In the Shia community, many are good...during these times many Shias saved the lives of Sunnis....After the curfew, I asked my colleagues here to start medical camps in Bermas - named ‘Sher Wali’ camps - and another camp should be started in Kashrote called ‘Zia-u’din’. Yes, I thought this would be a wonderful step towards peace, you know? But they said it was a critical time, not a good time for such a thing. Who knows, maybe when things get better. What agencies and departments can fix this situation, I don’t know....I pray to God never to have a moment where I want to kill someone...in my community, Sunnis are happy if a Shia dies. And if a Sunni dies, Shias are happy. [cries] I hate murder, I hate this thing.” (Dr. Khalthum, DHQ: September 7, 2005)

Another Sunni OB-GYN was quick to blame the federal government for ‘forgetting’ Northern Areas Sunni patients, and pointed out how Sunni physicians’ avoidance of their DHQ duties had also imperilled Shia patients.

“Look, more than nine months has passed and the government is not paying attention. I’m very upset about the Shia population, too – Sunni doctors are not going [to the DHQ] during ‘tensions’!” (Dr. Ghazaleen, Nur Colony: September 13, 2005)
The long-standing neighbourhood and family connections between Shias and Sunnis formed an undeniable counter-balance to Sunni angers at Shia aggressions. In the same way that many of our Shia neighbours in Jutial were Wadood’s maternal cousins, many of Gilgit’s more prominent Sunni

23 In another example, a prominent Ismaili woman politician confirmed that in addition to their ethnic Hunzakut heritage, many Gilgiti Ismailis could trace their ancestry to Sunni-dominated Diamer District (Gulnizari, Domyal: March 16, 2005).
physicians counted Shias among their close relatives. They also argued that Sunnis - like Shias - were entitled to claim Gilgit Town, and even present-day Shia mohallas, as part of their ancestral ‘homelands’.

“Many of my own relatives are Shia, and we see each other as enemies. What about love, and affection, and tolerance? I leave all these things to the Almighty. Life is very short...”
(Dr. Khalthum, DHQ: September 7, 2005)

“Most families here are mixed [sect]...so how can they be enemies with one another?” (Sister Sabah, Kashrote Civil Hospital: September 3, 2005)

“Sunnis have been living in Kashrote, and on Hospital Road, and in Amphari for the last two hundred years, and those people [Shias] are avoiding coming to Diamer [District] and our people. We [all] know each other very well. [laughs bitterly]” (Dr. Nagyr Alam, Yerkot: September 15, 2005)

A wide array of resentments and confusion accompanied my Sunni participants’ experience of health service marginalization. As the ‘tensions’ continued, Sunni women’s frustrations grew and their patience with the Sunni community’s strategic weaknesses wore thin. An increasing number of Sunni women began to angrily discuss the constraints placed on them, now and in the past, by Gilgit sectarianism. The apparent failure of their Shia relatives and neighbours to help them during health emergencies also caused some women and their families to bitterly recall the many other ‘tension times’ when they had fought to protect these same Shia kin and neighbours. Speaking to me in mid-summer 2005, one middle-aged ‘auntie’ wept as she recounted her elder daughter’s inability to deliver her baby at the DHQ, and her fears for male family members travelling in and around Gilgit Town. Her worries then

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24 In addition to their exclusions from hospital services, schools and in-town Shia bazaars, many families were increasingly angered by their inability to safely host guests or hold family events like weddings. For instance, in May 2005, Wadood and I were invited to attend a wedding in Amphari Mohalla, but we were warned not to go because of the possibility of more strikes against local Sunnis. A few nights earlier, several Shia boys had been caught by the Rangers as they prepared to shoot guests arriving at a pre-wedding dinner in Amphari.

25 What was particularly telling was that despite enduring life-threatening pregnancy health conditions, such as pre-eclampsia or eclampsia, expectant mothers more often emphasized how their greatest anxieties arose when male family members left the home for shopping, work or school in Gilgit’s mixed- or Shia-only mohallas. As the household’s breadwinner, family leader and primary decision-maker, a man’s loss had the potential to devastate the family, whereas wives were sometimes described as ‘replaceable’. And for Sunni women, widowhood carried enduring, stigmatizing associations, in that widows were often symbolically applied with responsibility for their husband’s demise, regardless of the circumstances. Quite unsympathetically, widows were sometimes described as ‘ruiy’ (witches; S), or ‘man-eaters’. More harmfully, the female relatives of men seeking to marry a widow often suggested that her misfortune or poor destiny might somehow infect the fate (qismat; A) and well being of her next husband.
transitioned to her recollections of the 1988 ‘tensions’ when she, her son and brother-in-law had risked their lives to save two Shias from the Sunni lashkar.

“During the ‘tension times’ in ‘88, Zafar [son] and I were going with Khalid [brother-in-law] in a Suzuki to Jaglote, and on the way we saw many, many people coming up in cars and vans from Jaglote and Chilas, Darel and Tangir. All [the] people were from Diamer. This was near Parri, just outside Jaglote. The Suzuki driver and conductor were Shias, and all the people coming up were going to join the lashkar that was attacking Jalalabad since the night before – this was the next morning after the attack had begun. The driver and conductor were terrified. And Zafar wanted to hide them in a family member’s house. We got off the road and went there, and when my brother-in-law went back to check on the driver and conductor, they were already gone. People had taken them to the river to be killed, and then stolen their Suzuki and gone back to bring more Sunnis up [from Diamer] to fight....Khalid took a gun from the house, and went down to get the men, and the Sunnis there fought so much with him, so much, saying, ‘Why do you want to save these people?’ He held the driver and conductor very close to him in each arm, so tightly that his arms were aching from pain, and they were holding him back hard, and were afraid they would be pulled from him and killed. [crying] He told the men there, ‘Until you kill me and all my family, you can’t kill them!’ They fought with him, but he managed to save them, and sent them back … with Zafar and another relative. How can we all be total enemies to one another? My family is not puroh [all; S] Sunni. My aji aji [mother’s mother; S] was from Sakwar and a Shia, and my [Shia and Sunni] family is everywhere – Majini Mohalla, Amphari, Minawar. I’m not only a Sunni, and am part Shia too.” (Shailah, Jutial: July 20, 2005)

Later on the same day that Shailah spoke to me about the ’88 ‘tensions’, our neighbour and her relative, Shakeel, was mortally wounded by three Shia gunmen. I was deeply unsettled to see the same women neighbours who only a few hours earlier wept over the ‘tensions’, now urge their husbands and sons to ‘kill the Shias’. To this point, feminist analysis often characterizes women as being anti-war (see Giles & Hyndman 2004), and rarely gives a voice to the antagonism, rage and grief that results from profound insecurity and pervasive fear. In the wake of Shakeel’s death, ‘striking out’, ‘living with open hearts’, ‘digging a hole for our enemies’, or ‘burning’ were some of the metaphors angrily deployed by my women in-laws and neighbours as they agitated for Shia deaths as a response not only to men’s deaths, but also their miscarriages, pregnancy trials, traumatic births and domestic insecurities (Fieldnotes: July 22, 2005).
Chapter Seven: ‘Halaat Kharab/Tension Times’

Whether it was because they were wary of local-level fallout from talking to me, or due to Qazi Nisar’s heated admonitions to refrain from the same invective or violence as their Shia ‘aggressors’, the Sunni physicians I interviewed rarely directly voiced their feelings for Shia or Ismaili sociality and religious practice. Instead, participants preferred to speak around the ‘tensions’ by emphasizing their deep disappointment, and also incredulity, at the failure of family relationships and neighbourhood friendships to stymie the ongoing conflicts. But unlike the DHQ’s Dr. Khalthum, who mourned the ‘tension time’ severing of her family’s relations with Shia relatives, Dr. ‘Mehmood’ (a Sunni physician who treated many of my participants’ non-pregnancy-related complaints) deliberately avoided acknowledging his multiple family connections with local Shias. The relationship between the doctor’s family and his Shia relatives had been troubled in recent years. In the early spring of 2002, distant relatives had come to fight with his cousin, Sadiq, over land and water rights. (Throughout Gilgit, disputes over rotating water supplies and agricultural properties were common and sometimes resulted in bloodshed.) According to Dr. ‘Mehmood’, his Shia relatives had first ascertained that the doctor and his eldest brother were at work before ‘striking’ at Sadiq, who was alone at their shared, extended family compound. By using their water disputes as a segueway to his discussions of Shia “fanaticism”, his narrative invoked the violence and relational complexities of Gilgiti sectarianism:

“Sadiq…is a big man…and he managed to get a weapon away from one of them and [shot] them. Then many people from my [Sunni] family, they were [living] all around us, came and asked ‘What happened?’ Sadiq called the police, who came and asked the same thing, and they saw one man from this community lying on the ground, and he had a bullet through here [the buttock] and there was blood everywhere, and [the police] asked me, ‘Do these people want to attack you and your brother?’ And I said, ‘How can I say? I don’t know for sure…’ These are how these people [can be]. They [can be] very fanatical and close-minded, and extremists.” (Dr. ‘Mehmood’, Sherot: May 18, 2005)

When I spoke with Dr. ‘Mehmood’ in early summer 2005, he was preparing to shift his family to Rawalpindi, where he wanted to open a private clinic and live more safely; he was well-aware that prominent Gilgiti Sunni doctors were being targeted by the ISO (see pages 369, 397 and 428 for more

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Angered that they were being pressured or forced to abandon their Gilgit Town practices, several Sunni physicians were, at least post-January 8th, more willing to directly invoke the more impolite aspects of sectarianism. Their interviews provided valuable insights into the conflict-fuelled ways some Sunnis discursively constructed their Shia ‘others’. Sitting in the sun-bathed, rose-filled garden behind his dusty and slightly unkempt house, Dr. ‘Naeem’ quickly launched into analysis of the differences between Sunnis and Shias. (Throughout our conversation, Dr. ‘Naeem’ insisted on referring to Shias either by one of their formal names, Ahle-Tashee, or as “the other community”. This was the one and only time during my fieldwork I had heard Shias described in this way by Sunnis.)

“This other community, these other people here...you know? They are very extremist and backward thinking, very dirty in their hearts and minds, and they don’t care whether I help people or not, they just say ‘Oh, he’s a Sunni!’ and ‘Oh, he is a doctor!’ and they want to hurt us....My home is a nice place, we are educated people, and we are trying to bring education into our families, our people. These other people, though, they are not putting their energies into helping their communities to develop, to get better; only to fighting and making trouble....I was taught, by medicine and by my people, to respect and help people of all communities...Ismaili, Shia....and I have never discriminated against anyone in my medical practice, or in how I help people. Medicine teaches us this thing, to help anyone and everyone. And my culture tells me to support everyone, and my family which is everything to me. Our people here, the Sunni people, we are helping one another - this entire area is all our peoples’ and the shops of this place are in our people’s hands...And from Khunjerab Top [Pakistan-China border] down to Karachi, it is all almost Sunnis, but these other people - the Ehl-e-Tashiri people - they think they can push us away. We grew up feeling that we are not the only people here. There are Shia people here, Ismaili people here, and we need to help each other even if we are different. But those other people are not like this, can you see, my sister?” (Dr. ‘Naeem’: May 18, 2005)

One Sunni, non-governmental community health administrator shared his own, less confrontational views regarding Gilgiti Shias, while also alluding to the vulnerabilities he faced by continuing to work in a mixed-sect office.

“People here orally endorse peaceful dialogue, but internally all are deeply involved. The actual problems in Gilgit are imported. Zia had one billion rupees in his account when he died, and I’d like to ask where this money came from? I know that when I talk to some of my co-workers who are Shia, they all talk about peace and ending the conflict, but I know
that they are involved and interested parties as well.” (‘Abdullah’, Konodas: August 22, 2005)

But in ways that were markedly similar to Sunni physicians’ claims that they were morally obligated to serve the Sunni community, and drew their inspiration from Sunni *fatawas*, *Markaz* dictates and the Hadith Al-Sunnat, Shia health providers were equally likely to interweave their discussions of ‘duty’ and medical efficacy with *Imambars* directives and Iranian-styled jurisprudence. For instance, a regionally-renowned homeopathic physician carefully emphasized the importance of Shia doctrine and prayer for his practice of medicine. Interestingly, the spiritual measures he suggested for his clientele, such as the *Naad’Ali*, were incompatible with Sunni patients’ beliefs.

“...[Hazrat Ali] believed in good justice, good governance. The UN and other major governments use Hazrat Ali’s methods, you know? We use the ‘Najabul-Alakah’. It’s a very famous book, dealing with government problems, issues of politics, conflict resolution, *insaaf* [justice; U]. He had a strong discipline; he was the Prophet Mohammed’s, Peace Be Upon Him, [son-in-law] and Hussain [and] Hassan’s....father. We believe in the Prophet Mohammed as our last prophet, you know? When I have a patient, I teach them to do the *Naad’Ali* prayer. I instruct them to do this *dua* with their *davaie* [medicine; U]: it leads to seventy percent beneficial results. There is also [the] *Surey Rahman*. You do this with full *akayda* – honest intention – from your heart when you do these things and you can see results. After *namaz* – for the first prayer – I say for one week to do their *namaz* and then afterwards do the *Naad’Ali* or the *Surey Rahman*, and do a *dhum* on a glass of water. You do this *rozana* [non-stop; U] for one week, and *wudhu hona chahiye* [need to do your *wudhu*; U]. This is very important. There is the ‘*Najabur-Balaqa*’, which instructs us to speak the truth, to recognize wrongdoings and prevent them, to move forward well with other *imamdari log* [believers, believing people; U] and to have personal trust in God.... It is my *massiya* [religious duty; U] to treat patients, and God gives me help in all these things I do. In my hands is *shifa* [healing; A]. If I treat with *akayda* [faith, conviction; U] all things are seventy to eighty percent curable.” (Dr. Farman, Domyal: August 25, 2005)

Dr. Farman then moved to invoke a pivotal moment in Shia history, when Arab Sunni fighters loyal to the first Caliphs had attacked and killed a number of the Prophet’s family in Karbala; these were those early Muslims who had placed their allegiances with the Prophet’s son-in-law, Ali. Dr. Farman’s descriptions of the Karbala massacres served as a potent analogy to the current Shia-Sunni conflicts from a Shia perspective.
“...If we look back in history we see Muawiyya and his son, and they were major dictators in Islam’s early history after our last Prophet, Peace Be Upon Him, died. [Muawiyya] stole the power from Ali, who wasn’t interested in power like these men were. In Karbala, these young men were massacred, were *qurban* [sacrifices; A]. In those days even a small baby of 4 months old, when its parent put water before it to drink, was shot in the neck with an arrow. Can you imagine what kind of people do such a thing? [cries] In those times, *sub kuch qurban heh* [everything is a sacrifice; U]. Hussain and Hassan looked at these people, and said ‘My grandfather didn’t teach me that this is our *deen* [faith; A]!’ Even now, our people do *jaloos kurtey* [do rallies; U] all over the world, in the pursuit of education, understanding and *aman* [peace; U].” (Dr. Farman, Domyal: August 25, 2005)

At the same time that Sunnis and Shias alike elided their communities’ active involvement in the hostilities, physicians, health support personnel and Sunni women only very occasionally discussed the possibility of Shia-Sunni reconciliation. During my final September 2005 interview with Sherbaz Ali at the Family Planning Organization’s headquarters, he took time to discuss the importance of optimism in resolving the ‘tensions’. He also added discrete commentary on the number of Sunni physicians, like Dr. ‘Mehmood,’ who had chosen to leave Gilgit Town to work in Islamabad, Rawalpindi, Lahore and Karachi after January 8th:

“Unless people focus on the positive, and don’t discuss how much worse things can get, Gilgit might just continue to devolve into further fighting. People have to become fed up with the fighting and make decisive efforts to continue living and working together....In my village, Sultanabad, Ismailis and Sunnis live together. About one hundred Sunni households are among a majority of Ismailis, and all these homes are surrounded by Shia communities. But gradually [Sunni] people are coming back to their homes, and being more optimistic about the possibilities of living together again....In times of ‘tension’, such as this, it is very important for people to continue to remain connected to the Northern Areas. It’s nearly impossible for us to separate ourselves from our community, our families, our culture, and join with the rest of Pakistan....” (Sherbaz Ali, FPO: September 2, 2005)

In contrast to Sherbaz Ali, who argued that identity and cultural autonomy specific to the Northern Areas was central to inter-sectarian reconciliation, Dr. ‘Naeem’ reflected on what he felt was Gilgitis’ ingratitude for low-cost Ministry of Health services, and lamented the lack of political connectedness between Northern Areas residents and the State. Moreover, he characterized Shia Gilgitis as being unpatriotic, disloyal and committed to violent intrigue.
“We [Sunnis] are people who should be thankful to Pakistan. We don’t pay one rupee to the state [in personal taxes], but Pakistan provides everything to us free, and we should be thankful and proud to be part of Pakistan. And these other people the [government] takes things to…they are only thankful to Iran, who gives them lots, lots of money and they use this money not for good things, but weapons.” (Dr. ‘Naeem’: May 18, 2005)

Despite Gilgit Sunnis’ overall bitterness concerning the government, and notwithstanding the Federal Government’s obvious neglects for Northern Areas infrastructure and civil security, it appeared Dr. ‘Naeem’ was trying to tap into the types of allegiances he felt Gilgit Sunnis should feel for the Sunni-dominated State. In fact, in the months before I spoke with him, Dr. ‘Naeem’ had been openly critical of Gilgit Sunnis who agitated for increased political recognition and regional autonomy. For some participants, enhancing the community’s political alliances with the State were the last, best opportunity for Northern Areas Sunnis to secure community support, or bolster regional federal funding in exchange for their national loyalties.

Part VI  Sunni Bodies

Even with Ismaili Nurse-Midwives genuinely sympathetic to the trials endured by their ‘Sunni brothers and sisters’, and Sunni physicians deeply disturbed by the conflict’s health impacts, the inter-sectarian prejudices that preceded the ‘tension times’ continued to surface in and taint Sunni women’s clinic visits. At all of Gilgit’s primary maternity health centers – the DHQ, Family Health Hospital and Gilgit Medical Center – Sunni patient comportment, practice and social behaviours seemed a point of fascination and curiosity for Ismaili and Shia staff. More distressingly, some biomedical providers and health workers unabashedly projected derogatory assumptions about the Sunni community’s ‘backwardness’ onto the bodies of their Sunni women patients; Diameri women, in particular, offered a conveniently displaced focus for local acrimony and inter-sectarian competitiveness. Hospital nurses often mocked Sunni women’s use of tawiz or the black dhum-‘infused’ threads tied around their ankles or wrists (Fieldnotes: May 12, 2005). Or, they offered arch commentary on how women’s domestic oppression and their jungulee (uncultured; U) disposition, were evident in stomach muscles slack from frequent pregnancies, the many agricultural and moxibustion scars on their hands and arms, or fingers nearly tattooed from
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sooty implements and cooking pots. Physicians, nurses and LHVs even suggested they could identify Sunni patients by their bodily cleanliness, or lack thereof. One common ‘marker’ cited by hospital staff as evidence of Sunni women’s inadequate personal hygiene concerned pubic hair. (According to Islamic dictates, women should shave off their pubic hair once every twenty-one days, or immediately after menses ends. Men and women believed pubic and armpit hair stored both odour and germs.) In contrast to Sunni women coming from outlying villages, Dr. Sharifa described how her predominantly Shia and Ismaili patients arrived ‘prepared’ for internal exams:

“I would say that 98% of local women are clean…I’ve noticed that when they know they’re coming here for an exam, they’re clean and ready for a PV [pelvic exam], but if they’re from far-flung areas, by the look of it, they’re not clean.” (Dr. Sharifa, AKHS,P: May 3, 2005)

Even the newly-hired Dr. Sumairah found rural Sunni women’s avoidance of shaving genuinely curious:

“Hair removal is a problem with women, because sometimes they say their husbands won’t allow it, although it is Islamic to remove it! I asked one woman, ‘Why haven’t you removed the hair from there, you are very dirty!’ The woman responded, ‘We barely have money for food, how can we afford soap!’” (Dr. Sumairah, AKHS,P: April 29, 2005)

Similarly, when I asked them to account for the more obvious cultural differences between themselves and their Diameri patients, the DHQ’s Ismaili maternity nurses focused on issues of hygiene.

“Well, with patients from Chilas, Darel or Tangir we see…differences. The women from these areas are very dirty, and are smelly. They don’t take baths, and aren’t shaving [their genitals] – if they have their menses, they don’t wear pads, so we have to clean them ourselves with soap and water. If they have their periods, they’ll wear two to three shalwar [pants; U], and we are helping them to clean themselves, but here a body bath is not possible. When we ask them why their hygiene is so poor, they’ll say ‘In our area, we live on the baharh [mountainside; U] and we use wood always in an open fire. We don’t have angetis or bukharis [iron stoves; S, K] to heat water like you [Gilgitis] have, and all the smoke comes onto us and our bodies, making us dirty. We can’t help this situation!’ Their whole body is usually dirty, and I’ve noticed that they make many, many small braids in their hair and will leave it this way for months without washing it. I’ve noticed lice on them sometimes, too. Their clothing is also different. They wear their sleeves very long, to their fingertips sometimes, and their kameez [shirts] have different styles. Some are very open, like Kohistani kameez, and they decorate them with big buttons. On the Chilas-side, the patients are a little clean, and have nicer clothes. Change has come there very recently. But on the Darel and Tangir side, they are very dirty.” (Nurse II, DHQ: August 1, 2005)
“Patients from places like Chilas, their hygiene is very poor, and there are jerieem [germs; U] on everything! They don’t care. We had one female patient from Chilas and she delivered and the doctor noticed the smell from [her] was terrible. And when [she] got off the delivery table it was so filthy underneath...we had to use perfume and spray so many times in that room for two to three days to get rid of the smell, but it still remained! Chilasi women patients are very smelly, some are educated, yes I know, but many are very dirty. We notice that their clothes, their hands are covered in filth. When we have to put a cannula in their hand, and we clean the place with cotton, the cotton pads turn black! When we ask them why they don’t wash, they say ‘We’re junglee [uncultured, forest dwellers; U] people, we live in the forest, we’re uneducated, and we have no money for soap or such things.’ We’ll even joke with them, ‘You’re having sex with your husband and not washing afterwards?’ They say they don’t.” (LHV II, DHQ: July 26, 2005)

Embedded within doctors’ and nurses’ generally un-reflexive accounts of patient incivility and rural ‘primitivisms’, it was clear that many Diameri Sunni maternity patients had internalized the rhetoric deployed against them. But it is also worth adding that Shias hailing from rural areas of Nagar or Skardu Sub-Districts were not exempt from the antipathies of one Ismaili Maternity Nurse at the DHQ, which raises an additional set of research problematics. (Such Shia women, however, had not suffered the same service exclusions and deprivations as Sunni patients.)

“They [Diameri] have ajaib kuprey [strange clothing; U]. Suits with long tops, not like ours, and dirty hands and feet, and they don’t comb their hair. They’ll put their food on the floor to eat, when they come with a patient, or if there is blood or stuff on the bed-sheets, they’ll put their roti [bread; U] straight on this to eat! They also spit nessor [snuff; U] on the floor, and make the place so dirty....But we see that Hunza patients are very clean, and one patient will only come with one attendant – they’re very neat. But patients from Nagar, Astore, Chilas and other remote areas around Skardu – eww. They’re not clean like this.” (LHV IV, DHQ: July 26, 2005)

On the upside, AKHS,P’s Dr. Sumairah remarked that many of her Diameri patients had made conspicuous efforts to ‘dress up’ for their clinic checkups, and perhaps more excitingly, their first visit to Gilgit Town:

“...they use this big occasion to dress up, wash with baths, even if they’re here for [just] a health issue! They see the lady doctors, the nurses, and other patients and their dress, and want to appear similarly.” (Dr. Sumairah, AKHS,P: April 29, 2005)

Even while lauding their Diameri patients’ kindesses, many obstetricians – Sunnis included – never failed to comment on the more ‘amusing’ cultural differences between Gilgit and Diamer. More
disturbingly, it soon became apparent that even Gilgiti Sunni physicians denigrated Diameri traits, if only to amplify their comparative ‘advancement’.

“The Diamer traditions, such as their welcomes, are very good. The Ismaili and Shia doctors who’ve been posted to Chilas have been given great respect. They are a very sada ['simple, 'innocent'; U] people. One Darel lady came to the clinic with a full bladder, and I asked her if she wanted to pass urine. She said ‘Yes’, and asked if it was alright to do it. I said ‘Yes’, and she went ahead and peed on the table, and all over the floor! I said, ‘You’ve ruined my Rs 5,000 carpet!’ Yes, they’ve sometimes used rocks to clean themselves here at the DHQ!26 [laughs] Hygiene is a big problem there, they are not making themselves clean. I’m asking ladies why they don’t take a bath, because they are so dirty?....It’s a lack of education.” (Dr. Khalthum, DHQ: September 7, 2005)

One woman’s recollections served to powerfully illuminate the ways in which prejudices could be enacted in the course of medical treatment. Ajmah came from a middle-class family, and had been born and raised in Jutial Mohalla’s Sunni enclave. She had received her Bachelor’s degree several years earlier, and then married a civil servant from Chilas. After their wedding, she had shifted to live with her husband and his family in Chilas and, not unlike many first-time mothers, she had returned to Gilgit Town to give birth, and then be cared for by her mother and sisters. Her childbirth experience at the DHQ provided important clarification of the ways ethnic and sectarian affiliation could be used against maternity patients. After noting that Ajmah had written down Chilas as her marital residence in the Intake Register, two of the Labour Room’s Ismaili LHVs mocked her ‘poor’ handling of childbirth pains as being indicative of her ‘ethnic’ and also Sunni, Chilasi identity. Prohibited from entering the Labour Room, Ajmah’s mother, Nasreen, had been forced to stand instead at the delivery suite door, unable to intervene on her daughter’s behalf, and watch as Ajmah struggled through the final stages of childbirth.

“Ajmah was in severe pain with her son, and screamed and cried...[she] was in the DHQ here, on her hands and knees on the bed crying out, and the nurse and dayah were beating her and saying, ‘Is this how you Chilasis do this?’” (Nasreen, Jutial: June 7, 2005)

26 One maternity nurse confirmed that a Diameri patient had used rocks to clean herself after a bowel movement, and consequently destroyed the plumbing in the Labour Room toilet when she tried to flush them. In rural areas, both men and women commonly use small, smooth stones to clean themselves after urinating or having a bowel movement.
Once babies had been born, nurses were often highly critical of the dingy, or thoroughly worn-out swaddling fabric that many poorer mothers brought to wrap their newborns in. After observing a birth in late summer 2005, I saw several DHQ LHVs laughingly point out a Sunni mother’s use of an old *dupatta* for her newborn baby. The mother’s shame was palpable, and I quietly paid an orderly to purchase some simple cotton cloth from a local shop. In many ways, by focusing on women’s bodies, Sunni religiosity and Diameri ‘backwardness’, non-Sunni personnel were able to discursively side-step more unwieldy discussions of socio-economic impoverishment, and the failure of faith-based humanitarian agencies like the AKHS,P to address or remedy the Sunni community’s peace-time or ‘tension time’ health crises. And even as apolitical as their discussions of Sunni patients and sociality seemed to be, after living in Gilgit for two years, I knew that many of these stereotypes supplanted deeply political conversations of religious and ritual difference. In many ways, it also seemed in-town Sunnis were paying a high price for the legacy of violent tribal conflict characteristic instead of Sunni communities in neighbouring Diamer District and the North-West Frontier Province.

### Part VII Sunni Exclusions?

In the wake of Zia-u’din’s death, there was no longer any debate over whether Gilgiti Sunni women faced the District’s highest reproductive health risks. But the more I spoke with health providers about Gilgiti sectarianism, the more it appeared that besides facing in-community and conflict-related constraints to their health service access, Sunnis had been, in multiple discomforting ways, historically disenfranchised from Gilgit’s public and private health services by their sectarian ‘others’. In marked contrast to Ismaili and Shia health workers’ descriptions of Sunni women’s poor health status as stemming solely from family intervention and religious conservatism, I now understood the situation to be far more complex. The Shia-Sunni conflicts had established that Sunni women’s unmet health needs could also be the product of sectarian exclusions and inter-community antagonisms. By extension, could these same ‘tensions’ have contributed to deliberate neglects by locally-managed governmental and non-governmental agencies? In order to better understand the Sunni community’s claims that they were
deliberately excluded from programming benefits, I looked to the available health and policy literature, and returned to re-interview hospital administrators and community outreach directors. With very few exceptions, and quite understandably, Gilgit’s health professionals were reluctant to directly address the question of intentional neglects. But in September 2005, I was contacted by a Sunni physician who wanted to share his insights into exclusionary service provision and policy. Dr. Nagyr Alam had worked for over twenty years in Gilgit District as a senior-level health policy analyst, and was a former consultant to the FPAP. He argued that the Sunni community’s impoverishment and ‘backwardness’ was a partial by-product of Ismaili and Shia bias. Specifically, he said that sectarian prejudices had contributed to a profound absence of effective clinical outreach in Gilgit District’s Sunni villages and Diamer District.

“Fifty percent of the [Northern Areas] population is totally neglected, and not covered, especially in the Sunni community. The whole of Diamer District has no Family Planning [Organization] office. From Darel up until Boonji is the area included here, and yet in Astore there are four Family Welfare Centers, with three in Astore Valley and one at the DHQ in Chilas. The population of these areas is more than three lakh [300,000]…. Parri has a population of four to five thousand, but there are no Family Planning services, not even from NGOs or the private sector. Chamughar is purely Sunni, but there are no services. There are no services in Minawar despite interest from the people there. Yes! They’re interested, and they know about Family Planning, but there is nothing from the government side for the people there. I’ve served all over the Northern Areas, but basically I’m from Chilas. I’ve done a lot recently, and am doing the best I can for our

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27 Sunnis’ frequent claims they were bypassed for health outreach activities were borne out in the available health literature. At the Family Health Hospital, senior-level Ismaili and Shia employees decided the scope and location of FPAP’s community outreach and mobile health unit activities. Five of the nine FPAP outlets operated in Shia-dominated Baltistan (Skardu and Ghanche Districts), three outlets were found in Ismaili-dominated Ghizer District and Gilgit District’s Hunza Sub-District; Sunnis being a minority population in Ghizer. Only one service center - the Family Health Hospital - provided coverage for local Sunnis, as well as for patients making the laborious and expensive journey to Gilgit from Sunni-dominated Diamer District (see FPAP, FHH II 2004: 13). The Federally-funded Family Planning Organization (FPO) ran seventeen Family Welfare Center’s (FWCs) across the Northern Areas. Ten were in Shia-dominated areas throughout Skardu District and Nagar Sub-District, two operated from Shia communities in and around Gilgit Town, while five were located in Ismaili-dominated Hunza Sub-District and Ghizer District. Of the remaining five FWCs, two were found in mixed Sunni-Ismaili communities in Astore District, while two FWCs operated from mixed Shia-Sunni mohallas in Gilgit, and were accessible to Sunni patients. The FPO’s remaining FWC was located in Sunni-dominated Chilas (Diamer District), where its services were integrated with the local government hospital. Similarly, AKHS,P’s Public Health Care (PHC) coverage was focused first on Ismaili-dominated Puniyal and Ishkoman, Yasin and Gupis Sub-Districts (Ghizer District); Ismaili-dominated Hunza Sub-District (Gojal, Gilgit District), and Shia-dominated Nagar Sub-District (Gilgit District). As was noted in Chapter One, only the Gilgit Medical Center offered coverage for Sunnis living in Gilgit District (AKHS,P 2002: 7).
community. There was one FWC [Family Welfare Center] in Gilgit, in the last six to eight years, and it was closer to the DHQ [in Shia Bermas Mohalla], but now because of [Sunnis’] influence, it [has] been moved closer to the Sunni community. Take Konodas, for example, there is no satellite center there. And in Sakarkui there are no services. I’ve been here for the last three years, and in this department the higher authorities keep us in the dark.….[Health units are] essential to moving [Diamer District] forward, but there seems to be an interest in holding it back. Even here, my duties [were] purposefully limited and stunted by senior office officials, who aren’t Sunni. I’m a trained physician, one of the rare ones from Chilas too. What [was] I doing analyzing numbers?" (Dr. Nagyr Alam, Yerkot: September 15, 2005)

After this listing of the Sunni mohallas and outlying villages that remained uncovered by public service coverage, and describing the ineptitude and inadequacy of Federal funding allocations, Dr. Alam moved quickly to discuss AKHS,P preference for Ismaili or Shia employees as partial evidence of the strategic marginalization of Northern Areas Sunnis. From Dr. Alam’s perspective, Ismailis appeared interested in keeping Sunnis at a particular socio-economic disadvantage, in that Sunni deprivations upheld the Ismailis’ comparative advancements and modernization.

“The international community is not bringing changes, even if they can, because they are going [first] through the Ismaili community, which will not want the change, and they keep the funds separate [for themselves]. There is money direct for Diamer from Islamabad, but rather than coming [to them] it’s funnelled through Gilgit. If donations come, then we need them sometime for the area, to motivate people, but [funds] are not coming. We can groom people and train them. It’s just a matter of education and health projects, and of appropriate design. If we involved the locals as employees, they [could] motivate their relatives much more easily. This is all the fault of…Managers here and their interests and prejudices. This is why [the Federal Family Planning] program is a total failure in the Northern Areas. If stabilization can occur, then we can proceed. Look, I’m a religious man but I choose to have only three children! The Chief Secretary of the Northern Areas visited Diamer one time in one year, and I took to him a letter about the weaknesses of [federal Family Planning services] in the Sunni community, and I’m still awaiting a response. The regional system here has totally failed. Now, we can talk about the private sectors and the NGOs and how they are controlled by one [sectarian] community, but we can’t even complain about our [Federal] system and its multiple weaknesses. My letter was about the projects and programmes in Chilas….the [government] keep multiple issues alive here to confuse us – sectarian, political, economic – to keep us from focusing on our own issues. Look at how they talk about Palestine and Iraq, so we forget about our own health problems. We can’t even take care of ourselves, let alone a distant neighbour!” (Dr. Nagyr Alam, Yerkot: September 15, 2005)
Dr. Alam held little optimism that these organizational inattentions would be remedied. Many of his own policy recommendations, which were structurally similar to AKHS,P’s community outreach programming, had been ‘ignored’ by his superiors. Marginalization such as this had also contributed to many members of the Gilgiti Sunni community – including prominent mullahs - to view Ismaili- and Shia-managed projects as deliberately neglectful of Sunni health deficits.

“There are no facilities or experts for complicated deliveries [in Darel and Tangir Valleys], and they have to come to Gilgit. My proposals dealt with how there is no LMO [Lady Medical Officer] available, and how we should offer Rs 60,000 to 80,000 [CDN $1,363-1,818] per month for a doctor, and Rs 15,000 to 20,000 [CDN $340-454] for an LHV [Lady Health Visitor] as incentives for people to go and work there. Because of the lack of facilities, and the difficulties of the area, it would take as much as this to encourage people to go, and then once things begin to improve it would not be so hard to attract out of staff area, or by then we’d have locals working. Even the private sector in [Ismaili] Ghulmit offers wage incentives!” (Dr. Nagyr Alam, Yerkot: September 15, 2005)

When I had asked AKHS,P and FPAP administrators about the lack of service provision in Sunni-dominated areas, they explained that their efforts had been thwarted by the frequent challenges mobile health workers faced when they tried to work in more conservative Sunni communities. According to the Family Health Hospital’s Acting Project Director, FPAP Health Guards were often asked “so many questions, such as ‘Who are you? Are you an agent for America?’” (Acting Project Director, FHH: May 10, 2005) During my interview with the Gilgit Medical Center’s General Manager, he qualified how Sunni patient hesitancies were the product of inter-sectarian prejudices:

“The [Sunni] men all know where we are, but the women don’t...the men are concerned perhaps about the area we’re in, or they believe somehow that the medicines we give will affect them. Yes, actually this is true - people in extremist communities used to say that in our vaccines there might be medicine to ‘make people Ismaili’! It’s absurd, but this is what they feared.” (General Manager, AKHS,P: August 10, 2005)

AKHS,P’s health promotion artist, Monir Sadiq, was equally concerned with the perils of presumed, political affiliation for AKHS,P community outreach. Many of his posters took the form of ‘before-and-after’ or ‘storyboard’ images, all of which were attentive to Gilgit and Hunzakut culture, dress and
architecture. Guided by the Gilgit Medical Center’s General Manager and senior administrative staff, Monir had carefully crafted each poster to minimize religious and political backlash.

“I think of the ulema in each area [sectarian community; region], and what they will allow or permit. Many mullahs are upset about human images, and most of the extremist mullahs are from Diamer. Even the government wants to crush these mullahs, and get them out of their way – people don’t like the mullahs but they can’t do anything. At AKHS they’ve received letters of complaint from such mullahs, who are afraid of Ismailis because they think American policies, and those of other countries are being diverted through Ismailis to them. Our work isn’t American, or from the EU [European Union] – it’s humanitarian. Our programmes focus on community demands….Our work is for all communities, and all come freely. It’s very difficult for us to start and open these areas. The [Diamer] government requests us through their elected officials to present our information, and these people know about our services.” (Monir Sadiq, AKHS,P: August 9, 2005)

In addition to their discussions of Diamer District, other AKHS,P employees were quick to attribute Sunni under-usage of the Gilgit Medical Center to Sunni hostility towards Ismailis. Or, they described how the religiously conservative mullahs’ anti-Family Planning stance proved that Sunni communities were still unsuitable for outreach initiatives. Dr. Alam had a different opinion.

“Eight years before, AKHS came to Chilas with five billion rupees. This resulted in…[a project under] IFAD, which they started through the Aga Khan Foundation [AKF] and the locals cooperated with them. All the intellectuals, they agreed with the project. Two to three months later, AKF [Aga Khan Foundation] said that [Sunni] mullahs were not accepting [of the project], and this was not true. And their appointments came from the outside [non-Sunni communities], despite manpower being available in Chilas. During the interviews they asked for experience, and they were using this to avoid local appointments. They take all the benefits they [accrue] from international experience, and keep [Sunnis] away from the money and the benefits, portraying them as terrorists and extremists. Family Planning is a small component of health, but many are exploiting this in a large way to develop irritations about other projects and issues of community interaction. The largest and most successful aspect of our work is the MCH [Maternal Child Health] centers. This is a huge, very successful service. But they are exploiting the name of Family Planning in front of mullahs. I’m very upset about this! Why are they not in Diamer? Managers will give long briefings about religious reservations to Family Planning, but why aren’t they emphasizing [Maternal Child Health] instead? It’s far less irritating and upsetting, and deals with Family Planning as a facet. This reaches the whole

Chapter Seven: ‘Halaat Kharab/Tension Times’

community, and before we try only Family Planning programmes we can show them how we can help through MCH. Why expose a minor, irritating point? But then they’re saying, ‘They’re refusing us, and resist implementation to our projects!’ [This is] an excuse to international donors...Nomal [Shia Village, Gilgit District] has just been awarded another [Family Planning Organization] FCH [Family Child Health] center, and a MCH, and AKHS are already there, but what about Diamer? Many other areas, like [Shia] Nomal, are saturated! In the last twenty to twenty-five years, the private and public companies have worked there on Family Planning and there is ninety-nine percent awareness. They don’t need the motivation, versus an area where fifty percent of the population doesn’t know about Family Planning.” (Dr. Nagyr Alam, Yerkot: September 15, 2005)

Ironically, the Family Health Hospital’s Project Director confirmed Dr. Alam’s claims that the majority of Sunni communities were genuinely interested in receiving care, and were not unfamiliar with the range of clinical services offered by both the FPO and FPAP.

“...even among the poor [and] uneducated in remote areas, where you [would] think people have no awareness, they know everything about Family Planning and need no motivation. During 18 years work with the FPAP.... I haven’t myself seen any religious opposition to our work...[I’ve] not seen opposition anywhere. Even very religious people have come to discuss the issues with me, but not in an adversarial way.” (Project Director, FPAP: September 10, 2005)

In late summer 2005, AKHS,P’s General Manager confirmed that he too had received a formal request for community health support from Diamer’s elected officials.

“They had complained to me that they have a huge, unmet need for Maternal and Child Health [MCH] service units, and although they have a number of MCH centers that are newly constructed throughout Diamer District, they remain unstaffed and unequipped. My response was that, despite our current budget crisis, we might – if in a partnership with the government – provide funding for the building or maintenance of these MCH units.” (General Manager, AKHS,P: August 10, 2005)

From my reviews of patient Intake records, regional health surveys and physicians’ anecdotal observations of patient practices, it was hard to disagree with doctors’ assessments that “maternal mortality rates [were] vastly different in the most extreme way between Ismailis in Hunza and Sunnis in Gilgit and Diamer” (Dr. Hafiz, AKHS,P: November 5, 2004). In particular, AKHS,P doctors described maternity cases from Diamer District as “the worst kind of patient...because women were brought too late

29 According to former research participants in Gilgit, in the three years since I last spoke with AKHS,P’s General Manager, no inter-agency or governmental progress has been made with regard to Diamer’s MCH units.
for treatment” (Dr. Hafiz, AKHS,P: November 5, 2004). But by focusing on religiosity, gender practices
and community eccentricity as the source for Diameri women’s ailments, such views failed to account for
the distance- and economic-related constraints facing Diameri maternity patients and their families. Such
restrictions, however, had not gone completely unnoticed. After starting work at the Gilgit Medical
Center, Dr. Sumairah (the Sunni OB-GYN from Karachi) noted how, among her patients,

“Gilgiti women are educated...Gilgit is like a city, whereas Diamer is like a village. I have
not seen such places, but I am interested to go one day. I have dealt with many patients
coming from Diamer. I face the problem of translation, because I cannot speak Shina, so I
rely heavily on my nurses to translate the patients’ histories. Some women don’t speak
Urdu, so their husbands have to sit in on the patient history with these women to
translate. The women are not shy...they know they have come after a long journey, so they
give the whole story and all the details, related or irrelevant. Some have to stay at a great
expense, in local hotels, buying food. Both husbands and wives are anxious for us to
accurately diagnose and treat the woman’s problems. Some women think they have gynae
problems, but after examinations we find it is something else, like TB [tuberculosis],
Hepatitis. Anemia and malnutrition are frequent problems, and a general lack of meat and
dairy.” (Dr. Sumairah, AKHS,P: April 29, 2005)

Moreover, non-Sunni health policy developers, hospital administrators and non-governmental personnel
failed to explain why outlying Shia communities, which very often evidenced extremes of poverty,
distance, religious conservatism and political zealotry comparable to those found in Diamer, had been
targeted for health outreach, while Sunni communities had not. During a November 2004 interview at the
‘old’ Khomer Clinic, Dr. Hafiz confirmed that the AKHS,P had similar difficulties targeting Shia clientele,
although apparently this had not stymied AKHS,P outreach in rural Shia communities.30

30 A number of AKRSP internal policy and assessment documents confirm that AKDN initiatives faced significant
challenges in Northern Shia communities. In her analysis of “emerging social sector institutions” across the
Northern Areas, AKRSP Field Operations Consultant, Aalya Gloekler, noted that because “Nagar is a politically
volatile and culturally conservative area, extreme care should be taken in regard to the role of [AKRSP’s] recently
established women’s resource centre” (1998: 35). In many respects, the difficulties faced by AKRSP offer insights
into local-level hesitancies concerning AKHS,P service provision. With regard to the slow progress of AKRSP’s
Village and Women Organization (VO, WO) in non-Ismaili areas, Gloekler commented: “It is unfortunate that after
almost 15 years of the programme’s existence, sectarianism has still prevented many from taking part in the process
of development. This of course again raises the question of whether VO or WO really is the kind of structure that
is/was required at the village level, or does the problem lie elsewhere? What has gone wrong in the propagation of
AKRSP’s objectives to make sectarian groups in some areas suspicious of the programme? It could also be that some
groups such as Sunnis in Gupis and Puniyal areas are late settlers, and hence have not been properly incorporated
into the social system. Linked to this is the idea that, the AKRSP is seen by them as serving the interests of only one
Chapter Seven: ‘Halaat Kharab/Tension Times’

“To the north of Gilgit District, in Nagar District, there is an area called Hispar which is Shia. There, child and maternal mortality were sky-high. …And in Hispar they are building a large Imambaragh, people have studied at Tehran and have a lot of Islamic education. But still people in these areas prefer religion over health development. Contrast this to the [Ismaili] Shimshal…area, where there was a Jeep-able road, and people were well aware of maternal risks despite being severely isolated for more than 6 months of every year. The road is blocked for part of the winter due to snow. This is because of community voluntarism among Ismailis, and the leadership of His Highness [the Aga Khan] as a guiding factor.” (Dr. Hafiz, AKHS,P: November 9, 2004)

This portion of my fieldwork established that Gilgiti Sunnis’ fears were not mere suspicion, but based on an extensive understanding and experience of the prejudices held against them by their local ‘others’. (And to be fair, in the same ways my Sunni participants were certain of the ‘mistruths’ nurtured against them, they were equally certain to nurture ‘mistruths’ about their Ismaili and Shia neighbours.) A number of Sunni participants, in addition to their antipathy, envy and occasional admiration for Ismailis’ economic successes and gender liberalism, were now convinced they had been deliberately excluded from AKHS,P benefits. Sunnis also forecast prejudice to exist in ways that were obviously overblown. For instance, some participants argued (albeit profoundly unjustly) that Gilgiti Sunnis’ overall marginalization from Aga Khan Development Network activities provided evidence of the AKDN’s collusion with the U.S. government which, during my fieldwork, was entangled in military offensives against tribal Sunni militants in Pakistan’s Waziristan District, or in bombing Pakistani and Afghan communities suspected of harbouring the Taliban. But even if my Gilgiti participants were to accept that discursive ‘other-ing’ was an unintentional element of AKHS,P policy or clinical service provision, and not also a deliberate force underlying policy and service provision, Sunni women’s health deprivations remained the same. With a type of quiet distancing underlying service provision and sometimes also...
women’s in-clinic treatment, this may help explain why many Gilgiti Sunnis hesitated to use sectarian-affiliated services such as those offered by the AKHS,P. At the Gilgit Medical Center, for instance, Dr. Sharifa recounted a substantial number of her Sunni patients asking if AKHS,P’s services were “for everyone, or only for your own [Ismaili] people?” (Dr. Sharifa, AKHS,P: May 15, 2005).

Part VIII  Conclusion

Set against the spectre of sectarian conflict, pregnancy affirmed women’s belonging to a community that self-defined through pronatalist attitudes, larger families and sons as combatants. As such, pregnancy was interwoven with the enhancement of community affiliations, and ideological, identity and spatial demarcations. Because conflict renewed community emphasis on sons as a solution both for future ‘tensions’ and the Sunni community’s current demographic and political insecurities, I worried that Gilgit’s religious conservatives had harnessed yet another rationalization for their ongoing struggles to undermine Family Planning campaigns. Without any corresponding improvement in Gilgit’s maternal health services, Sunni religiosity and pronatalism can only serve to worsen the region’s lamentable maternal morbidity and mortality risks. Not unlike the pronatalist pressures placed on Palestinian women during the *Intifada*, Gilgiti women may be facing a long-term “festishization of fertility”, in which women are targets of sectarian rhetoric that “deeply politicizes their reproduction” (Kanaaneh 2002: 65). And by occurring at the core of community life and providing powerful symbolic reinforcement of the Sunni community’s vulnerabilities and sacrifices, the ‘tension times’ struggles of women, their families, nurses and physicians to access or provide care tangentially illuminated the fragilities of Gilgitis’ uncertain citizenship.

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been easily manipulated at the local level” (Ibid: 137). In her critique of the ways ‘biased’ or inequitably implemented projects are perceived by local communities, Everett goes on to say; “I argue it is not through mystifying development as a science that power is achieved, but rather through the implementation of projects that suit the interests of state or local actors, and through the resistance to such projects on the part of the target groups. In other words, those who push for development programs and strategies (especially national elites) may seek to present them as neutral, scientific, and outside of political conflicts, but few people will actually perceive them as such” (Ibid: 140).
Indeed, Gilgiti Sunnis’ viewed their logistical vulnerabilities as not only stemming from Shia ‘intrigue’, but also from the Federal Government’s lack of interest in the Northern Areas. For example, by arguing that the Northern Areas “was not Pakistan” and Gilgitis were “not Punjabis” (Fieldnotes: February 6, 2005; see page 422), my Sunni participants purposefully distinguished themselves and their children as ethnic Gilgitis rather than Pakistani citizens. Such attitudes complemented and upheld the growing presence of separatist, Northern Areas projects of identity, which were themselves cultivated and nuanced by sectarian discord and political alienation. Over the long term, women’s health crises and community pronatalism may play a significant role in the home-as-battlefront approaches emphasized by Northern Areas Independence movements such as the Balawaristan National Front (BNF), which drew their impetus from Gilgiti disenchantment with the State.

Ultimately, non-Sunni health providers’ discriminatory or insensitive handling of Sunni women patients, as well as the deliberate exclusions Sunni physicians and community members felt were demonstrated by selective service provision and outreach, only served to further legitimate Sunnis’ belief that they were intentionally disenfranchised at local and national levels. Overall, the inter-relationship between sectarian conflict and intentional health deprivation requires urgent additional research. Very rarely does the available literature examine the ways Muslim communities, through the medium of biomedical service provision, apply prejudice or restrict access to their local ‘others.’ This, despite multiple recent incidents in Iraq and Afghanistan where Sunni or Shia patients and doctors have been killed while working at, or receiving treatment in, clinics affiliated with Sunni or Shia faith-based humanitarian organizations (see Murphy 2008 and Olson 2006).
Chapter Eight: ‘Tension Times’ Part II (February-July 2005 Fieldnotes)

Part I February 2005

Even though the worst of the hospital closures was now over, Gilgit remained a ‘tense’ and sometimes terrifying place. On days of high ‘tension’, when neighbourhood life was wracked by paranoia and insecurity, it was easy to see why Sunni women and their families felt it was impossible to go through Shia mohallas to reach local hospitals, regardless of the magnitude of their health problems. Or why Sunni physicians continued to avoid their duties at the DHQ or those in-town clinics that were located in Shia mohallas. Once again, I have edited my fieldnotes for grammar and style, and provided pseudonyms for all my formal research participants. These selections represent only a portion of the fieldnotes written during the ‘tension times.’

February 4, 2005

Awoke at ten this morning to more slate grey skies and a deep chill in the air. As Wadood pulled the covers off my inert body, he told me that a Shia had been shot and killed in Amphari the night or day previously, and that he “wasn’t surprised.” He disclosed that before the shops were burned in the corridor between the Co-Operative Bank and the Shia Imambaragh, the Shias “stole” the produce and supplies. One of Wadood’s friends had recently bought Rs 26 lakh (CDN $59,000) worth of loose tea from China, Iran and across Pakistan. Wadood suggested that with all the monies lost, some businessmen might be driven to want to retaliate violently. Just before lunch, Wadood’s ‘auntie’ came from her house up the road. She knocked on our garden gate, and when Wadood answered, she warned him to “stay indoors” with the children and me. She had heard vague reports of impending trouble.

Wadood called for Ferdost this morning, who told us that “2 Shias had been killed in Amphari.” This meant that Sunnis were trying to “strike back”, and this was more easily accomplished in closely-packed neighbourhoods like Amphari, with its many hiding places and vantage points. Ferdost called later and confirmed the deaths, which he said were Shias shooting at Pathans living in Amphari, because a Pathan was the assassin who fired the fatal shots at Zia-u’din. (Later, Wadood’s Shia Mol [Uncle; S], who is a retired policeman, clarified the shooting concerned water access rights, and there had not been any fatalities.) After lunch, Wadood called his cousin Amir to ask about – and in a disturbingly happy, go-lucky voice, no less – a “No 1 Kalashnikov” (evidently there are badly made copy versions, like there are “No 2 ‘illegitimate’ cars with no registration papers). After coming over for a cup of chai, the mullah at our neighbourhood mosque told Wadood that, in Amphari, Shia households were supposedly collecting money for ISO members. And in preparation for future fighting, Amphari Shias had made sure that upwards of 200 death certificates were ready, and these grim papers were being used as the basis for an extended money drive among Gilgit Shias. ISO members are supposedly arguing that they are ready to die “serving the community and the cause.”
As dusk was falling today, a hard rapping on our outside door brought Wadood out to greet an ancient fellow with dark lashed, green eyes, a large nose and teeth destroyed by gum disease and heavily stained by tea and a lifetime of smoking. He came into the house reticently as I was sitting at the angeti, holding Imran who had just fallen asleep. As he had come into the room, he had held onto Wadood’s arm and pointed to himself saying “Dada, Dada” (Grandfather). I welcomed him, and he sat by us and ate the food gratefully. He spoke Shina very quickly and sometimes with great emotion, his eyes welling up with tears that didn’t spill. I heard him say that the situation (halaat) was bad, and he talked rapid-fire about how his family (rishtedar; meh rishtedar hehn – “my family”) were in Minawar, and how he had long-standing connections with them. Evidently his Shia father was from Haramosh - his mother and Wadood’s Dadi [grandmother] were first cousins. Mol didn’t seem too obviously disturbed by Zia-u’din’s death. He preferred instead to spend a great deal of time recollecting the “better days” pre-1988, when the Shias and Sunnis living in Minawar and Sakwar were “one people.” He talked a great deal about his extensive family connections in Minawar and, in particular, with Dadi [grandmother; U] and Bura Mamu [big uncle; U]. He often looked as though he would break down talking about this. Mol attributed the latest issues to not only the machinations of “outsiders” but also those Shias who had relocated to Gilgit from outlying and hard-hit areas following the ’88 riots – namely Jalalabad, Jaglote, Minawar. His implication was that “real” Gilgitis wouldn’t have participated in such issues because of their long-standing traditions of living amicably with one another. He affirmed that in the past, Shia and Sunnis lived in much more ‘mixed’ communities, were intermarried with great frequency, and were socially open and amenable to each other’s customs and religious traditions. After Mol left, I started making dinner, and then Wadood’s cousin Amjad arrived from Minawar. He told us that his second son had been born on the 21st of January. I asked Amjad if his wife, Lalzahoor, (another first cousin for both Amjad and Wadood) had the baby at home, and he said “yes.” The labour had started the day after Eid in the late evening, and the baby was born around midnight – it was a fast and uncomplicated delivery. He said that the curfew had affected their options, as getting her to DHQ from Minawar would have taken too much time, and they would have had to stop and explain their story to Army and police officers all along the way.

Wadood says that the curfew is supposed to be all day tomorrow or the following day, as the Army and police are doing “Clean-Up” in our neighbourhood, and will keep tight control over local homes so that people can’t slip out and away, or move their guns. When we were in town for firewood yesterday, I saw that the Army and police have set up an interim ‘camp’ in the partially-built Shaheeno Hotel, the front entrance for which is now guarded by sandbag bunkers about 5 ft high, with machine gun tips pointing out from them. We also found the newly built link-road connecting Nagaril and Kashrote still closed by
two rolls of barbed wire, and several checkpoints manned by heavily-armed police and Army. On the roof of the Sunni Jama Masjid, we spied several more of the sandbag huts with machine guns pointing out. There are three or four more of these sandbag ‘way-stations’ along the main road that connects the airport and Ramazan Hotel. Wadood said that a day or so earlier, Sunni leaders had met in the Tangir Valley [Diamer District] to discuss what to do with the Shias in Gilgit, and amongst other things, had agreed that if they have to come up this time, they’ll be killing Sunnis as well as punishment for their evident “stupidity”. I asked Wadood what he meant, and he said that the Tangir Sunnis are frustrated with Gilgiti Sunnis consistently resuming business, familial and social relationships with “enemy” Shias following each period or incident of tension.

**February 6, 2005**

Another grey day, with misty snow-laden clouds hovering over and enveloping the local mountains. Wadood commented that he’d never seen so much snow, nor so low on the hillside, in his life. Wadood went to Maghrib prayers tonight at the masjid, and spent an incredibly long time getting back to us. We had sat in the dark waiting because tonight is our bijli nish [no electricity; S] night. When he came back he said that there had been a community discussion about how to best protect Qazi Nisar Ahmad, leader for Gilgit and the Northern Areas Sunnis. Locals are evidently talking about how to prepare – emotionally, politically, tactically – for Ashura, when many Shia men gather on the roads to move en masse, while self-flagellating or beating at their chests (until their knuckles and breastbones are raw and bloody), reliving their grief about the deaths in Karbala.¹ The ritual is said to become increasingly more intense as the Ashura march progresses through town.² Some Sunnis show extreme distaste for this practice; it was just outside the main Sunni mosque downtown where a number of Shias were shot during an Ashura procession in the early 1990s. Many Sunnis had requested them on numerous occasions not to march down past the Sunni mosque, as the ritual’s bloodier aspects are “upsetting” to them. They often grimace and shake their heads when they discuss it, saying that in no way does Islam call for or condone such self-injurious actions.

¹ Benedicte Grima provides crucial insights into Ashura rituals; “Byron Good and Mary-Jo DelVecchio-Good...[focused] on the Shi’ite popular passion play of ‘Ashura, the public ‘ritual drama’ commemorating and re-enacting the Imam Hussein’s death at the hands of the Sunnites. Participants who are actors by nature of the drama, are stimulated to identify with the event and mourn the historical as well as the present social injustice. Vernon Schubel takes a more synchronic approach to looking at the role of grief and tragedy in the Shi’ite passion play in Pakistan (1985; forthcoming). There, he suggests, the reader of the legends in responsible for evoking grief and tears from the audience. Weeping for Hussein is perceived as a sign of Muslim sincerity, and the emotional experience marks the height of Shi’ite practice” (Grima 2004: 145).

Tonight’s discussion at the mosque supposedly included brief debates about retaliation during Ashura – Shias’ “weaker time”, some said, when they have sharpened, double-edged knives on chains instead of guns in their hands. One or two men wanted to go and meet with Qazi Nisar to ask his opinion on this matter, though they were ultimately and roundly discouraged by all the others. I’m not clear how much of this was about ‘striking’ back, or ‘pre-emptive defence’ should Shia emotions become “dangerously” re-inflamed during Moharram [the mourning month]. I also wasn’t sure whose idea this meeting was, or if it had been called for by members of the Sunni Markaz. It’s obvious, however, that the Markaz plays a role in shaping some of the responses and actions of the various community mosques that are under its influence, although it remains unclear whether these are formal or informal relationships. Before dinner, Gibreel [Wadood’s paternal cousin] is on-duty with the Fauji [Army] guarding the National Bank on Hospital Road. He called to tell us to avoid coming into town today because there was a “huge crowd” of Shia women demonstrating on the road by the main Shia Imambaragh. He estimated it was upwards of 500 women. From his posting across from the DHQ entrance, Gibreel confirmed that the hospital complex is a veritable ghost town, not necessarily because the physicians aren’t there, but people are “afraid” to be back up at the site.

We were at Ghazanfar’s house yesterday for chai and sat with his parents, siblings and in-laws around the angeti in their traditional room, with its layered smoke-hole, which is itself protected by a small, glass-roofed metal-framed house, to keep falling rain or snow from coming inside. Ghazanfar was accompanied by two cousins who came from across town. One said there is “no future” for them at all in Gilgit, and they are actively contemplating ways “to leave and escape this for other places and chances.” I told them I could empathize with the everyday struggles facing Northern Areas peoples, and acknowledged that the Pakistani government seems to do very little to assist the area to develop its resources. Both young men and Ghazanfar said that “this is not Pakistan” and the people here are “not Punjabis.” They also talked briefly about the Shias and the difficulties of this situation, and how sectarian ‘tensions’ impede business or their study plans. Ghazanfar’s cousin added that “even Ismailis, after this incident, are beginning to think of many Shias as unpredictable and dangerous” (in great part because of the murder of the Ismaili gentleman in front of his children). (I had heard this opinion voiced by multiple Ismaili friends, and healthcare providers working in local hospitals.) The younger cousin then said, “We Sunnis are peace-loving people, and would not do this sort of thing” – in contrast to some of tonight’s discussion at the masjid, as well as to Gilgiti Sunnis’ undeniable involvement in other bouts of sectarian strife and discord.
February 9, 2005

Some say today is the first day of Ashura, while Wadood’s Shia friend Mujeeb says it will start on the 11th. Mujeeb has said that during Ashura it is his understanding that the Shias will “strike at the Sunnis” and he is trying to find a way to leave Gilgit, but there are no flights due to the cloudy weather and he cannot travel by road down to Islamabad. He also reports hearing rumours that Shias will strike following Ashura, in the same way they did during the Nisab Riots, in protest for the education syllabus and to demand that the government locate and punish the killers of Zia-u’din. Ferdost called this morning and told Wadood that there had been a gunshot, or shots, fired from around the Park Hotel last night. As we drove back from the hospital through [Suni] Kashrote Mohalla at noon, we saw a large number of young men, many wearing Western clothes (tight jeans, light Chinese jackets, and shirts with sweaters or turtle necks and those big, quasi-Army fashion boots; the older men seemed more often to wear shalwar kameez, chadors or Chinese-made jackets with pakhols). They were standing along the road, or walking towards the main chowk, and crowding the small gullee [alleys; U] that wind off Kashrote Link Road to small houses, packed tightly together. A few soldiers stood at the end of these gullee, watching in towards the houses and glancing back to monitor the traffic, with machine guns at the ready. At this time, the Army was evidently conducting weapons sweeps through local houses.

February 11, 2005

There is a large ISO banner by the Shia mosque nearest to our our house. It is black with white Arabic lettering; it marks Ashura and memorializes Karbala. Today is the first day of Moharram and it has been announced on TV and the local radio stations. There are black, fabric swags tied

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3 In his discussion of British colonial efforts in Yaghestan (the area now known as Darel, Tangir and Thor in Diamer District), Northern Areas scholar Martin Sokefeld describes how ‘rumour’ is sometimes used as an “instrument of terror” (2002: 301). His analysis is worth quoting at some length here, as not only it provides cogent insights into the ways rumour impeded everyday Gilgiti sociality, but also because it helps explain the role of ‘rumour’ in my fieldnotes (see Chapters Six and Eight): “‘Rumours are weapons that spread terror by working as predictions of violence. Rumours are like the spirits sent to cause harm in that they appear to come from nowhere. Rumours fly around like the evil spirits’ (Perice 1997: 2). Perice emphasizes that rumours are not simply imperfect accounts about real events, but that they are effective, generative productions. This is an important point because it questions the distinction between information and ‘just rumours’ which is drawn in every-day discourse. Gregory Bateson’s famous definition of information as a ‘difference that makes a difference’ (Bateson 1987: 381) applies to rumours as well. Rumours definitely make a difference. The distinction between both kinds of communication cannot be made entirely on the basis of a knowledge whether a given rumour/information is true or not: ‘Rumours become information when they are believed to be true’ (Perice 1997: 3). The most important thing about rumours is not the question whether they are right or wrong, but that people deem them important enough to tell other people about them, writes Kapferer (1996: 24). This draws attention to the manner in which rumours spread in a society. Although rumours are certainly told and retold, it appears that they disseminate by themselves, like contagious diseases. Accordingly, disease metaphors have been employed to describe the life-cycle of rumours (Morin 1971). Rumours do not depend on authorial positions (Perice 1997: 8) but roam about in a network-like fashion” (Sokefeld 2002: 301).
to the side-mirrors of all Suzuki taxis and Shia-owned private cars. Haleem noticed that taxi drivers were playing religious tapes and the sermons of Shia Imams concerning *Moharram*.

**February 11-20, 2005**

Typhoid from the 11th onwards. I recovered by the night of the 20th, which was when *Ashura* finally ended, as did the electricity – which the Army ensured was on constant supply for the entire festival.⁴

*On those nights when fevers left me wasted and nonsensical, the disembodied, undulating and angry sermons emanating from the nearby Imambaragh were truly terrifying. I slept wrecked by nightmares that militants were creeping up the hill toward our little azure-blue house, overshadowed by the skeletal, reaching branches of our apricot and apples trees.*

While I recovered, Gilgit’s Ismaili, Shia and Sunni leaders tried to work out peace agreements. Since January 8th, their efforts had included jirgas, Legislative memorandums and religious pacts. On February 18 Gilgit’s Tanzim Ahle Sunnah Wal Jama’at (Sunni) and the Central Anjuman-I-Imamia (Shia) approved what was described as a landmark peace treaty (*Dawn: February 18, 2005*). Within weeks, and the resumption of targeted killings, it failed.

**February 25, 2005**

Imran has had typhoid now for four days. Today one Wadood’s distant cousins arrived mid-way through the afternoon to see us. Over a cup of *chai*, he told us that the Shias in Sakwar had cut down fifty to sixty fruit trees belonging to an absentee Sunni landlord. He’s anxious for the Shias “to be finished” and talked about having “people come up from Chilas to do the job.” Coincidentally, there were three or four Hi-Aces full of Chilasis who arrived in Gilgit last night to stay at the Park Hotel. We drove through the *bazaar* in the evening with Imran and saw police wagons clustered on the road-side across from the Park Hotel, and noticed a number of Chilasis with longer beards talking fairly amiably with the police. This afternoon, at around 3.30pm, there was intense firing between Kashrote Sunnis and the Army when the Kashrote residents tried to block the main road and conduct private weapons inspections of passing vehicles (which Shias have been doing at the western, Shia end of Gilgit Town, after Amphari Shias had started searching Sunni-owned vehicles for at least a few days). The Army ordered them to stop, and

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⁴ The following article is taken from Pakistan’s “Dawn Online Newspaper”, February 13, 2005; “GILGIT: Army and paramilitary forces will stay in the city and its suburbs till the end of Muharram, Northern Areas police chief said. The security forces were deployed in the capital city of Northern Areas on January 8 to quell violence and maintain order. Speaking at a press conference here on Sunday, IGP Sakhiullah Tareen said police personnel have been deployed at 836 imambargahs in northern areas for Muharram and 1,184 are active in major towns to keep order apart from other security forces. He said the police department is beset with an acute shortage of personnel and that is why they faced problems in reaching the trouble spots. He said a ‘quick response force’, headed by IG police was being formed to ensure brisk movement of police in the trouble areas. …The heavy snowfall coupled with torrential rains in the region has also blocked the Karakoram Highway for the last one week at different spots which had created shortage of food and fuel in the region and hundreds of passengers are stranded in Gilgit and Rawalpindi as the region has lost aerial and road link over the last one week. The PIA also suspended its flights to the region due to bad weather and local banks are running out of cash as they transport currency by air only.”

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fired into the air, at which point several Kashrotis shot directly at the Army; several individuals on both sides were seriously injured. Ferdost reported hearing fifteen minutes of gunfights; from the Ramazan Hotel, Omar said the bazaar was now completely closed, and the hotel closed due to spreading fights. (And this after the bazaar had begun opening up again. For three days after Ashura rituals finished, the bazaar was unusually quiet. Many stores were boarded up and closed, and Wadood attributed this to Shia exhaustion following the rituals, and peoples’ general fear of being in-town.)

Rumour today that two Shias were kidnapped from Baseen and taken to be killed, which may lie at the core of recent, increasing tensions. In Sakwar, Wadood’s mother heard the nearby Shia Imambargah announce that the deadline for local Sunnis to leave Sakwar had passed yesterday. The deadline was imposed by a Shia cleric four days ago when Shias were prohibited from marching through the Sunni area of the village by the Army. At dusk, Wadood’s mother and sisters congregate with neighbouring women and cousins to sleep in a common house, while the men take turns “doing duty” throughout the night. On the 11th, Haleem had even gone so far as to drive down - through snow and Army barriers - to his father-in-law’s home in Dudeshal [Diamer] to fetch four-hundred rounds of ammunition and two Kalashnikovs. We’re still unable to get a reliable new weapon into the house due to police checks and road-blocks.

At 7.30pm we left the house to take Imran for his final injection of antibiotics at the Gilgit Medical Center. Just as we were leaving, Gibreel called and said that if we weren’t home in an hour, he would try to secure an Army escort to move us from wherever we were “stuck.” At the bottom of the road, we were stopped at the first police checkpoint, which was alight with bonfires and the police turning back any cars trying to come into town. They waved us through. In Zulfiqar Colony tonight there is no bijli [electricity; U], as it’s Jutial Mohalla’s turn. We passed a dimly-lit police check on Shaheed Naveed Road, beside the Heliport, and drove down around the bend onto River View Road, covered over by a canopy of naked tree branches, through which the moonlight created dappled patterns on the road. Past the Eye Hospital, we turned a sharp corner and nearly drove into the hundreds of large boulders that had been strewn across the road - there was nearly thirty feet worth of these, with a small trail made through them for motorcycles. In horror, Wadood slammed on the brakes and tried to reverse as quickly as possible - the car stalled for one scary minute, the re-started. We drove quickly back up the police check we had just passed. The officers there had no idea about the road closure, and we were all unsure if it was Shias or Sunnis who had blocked the road, though one soldier commented this was “to trap people from leaving the area.”
They suggested we try the CMH [Combined Military Hospital], but once at the gates we were told to “go away” and that “there are no doctors present, they are all gone for their evening meal.” Frustrated and afraid now for Imran, we drove back up the road to Khomer Chowk, only to be told it was “impossible to go into the bazaar as it is band” [closed; U]. There were four police officers who checked our trunk for weapons, and asked us what we were doing. Wadood told them our “bal” [son; S] is sick and we needed his injections at AKHS. They asked if we could wait until morning, and we said no. One of the Policemen went to his commander in the sand-bag unit, sandwiched between two shops, and came back giving us permission to go to the next checkpoint at the Minar-e-Pakistan monument. The road was very dark and very empty in between; we were stopped at the next check by Army and police, who asked us again what we were doing. They advised us we needed Fauji [Army] permission to go into the main bazaar - problems had occurred around the Park Hotel, and it was tricky getting in and out of the area.

Wadood went and spoke with a senior officer in both Shina and Urdu. One of his fellow officers tried speaking to Wadood in Burushaski, to which Wadood apologized saying “I’m not from Hunza.” (The officer expressed his surprise, saying “But you have the face of a Hunzakut!”) After nearly an hour, they gave us permission to go and sent an Army officer with us. He and Wadood spoke about how “kharab” (bad; U) the situation was. In the bazaar there were only a few police, some stray dogs. There were armed soldiers guarding the generator room of the Park Hotel. All along Kashrote Link Road we could see several scorched or dusty patches where there had been road-blocks and fires, and the main alleyway leading into Kashrote was completely sealed off by piles of rubble and boulders. Wadood said this might be an attempt by residents to stop further Army weapons searches. Chenar Bagh was eerily, unnaturally quiet; at the Gilgit Medical Center’s main gate, an armed guard opened a side door. The hospital was alright, and a fair number of patients and family attendants were milling about on the main floor veranda. I knocked on the nurses’ staffroom, and [Nurse] Sakina came out to give Imran his injection. A warm, nighttime spring wind was whipping through the hospital courtyard and raising trails of dust. She whispered that the “halaat bahoot kharab” [the situation is very bad; U]. As soon as she was done, she urged us to leave immediately. We drove home very quickly and were recognized at all the checks, where they let us pass easily.

**Part II  March 2005**

**March 6, 2005**

The roadblocks have, for the most part, disappeared since the worst of things right after the gun battle between Kashrotis and the Army. There is a checkpoint at Khomer Chowk for people leaving Gilgit, and
another at the Minar-e-Pakistan for people going into Gilgit. The roadblock at the Army Public School is no longer there, but the Army is still somewhat in evidence with a few sandbags near the school and just past Askari Bakery. There is another area, at the foot of the road up to the Serena Hotel, where both the Army and police have check posts and occasionally pull out the barbed wire to stop traffic either incoming or outgoing.5

March 8, 2005

Exactly two months have passed since Zia’s death. This morning we went and picked Fazeelat [research assistant] up at 10am to go for interviews. In Minawar, the sun was shining and the almond blossoms were heavy on the trees. Dadi [Wadood’s grandmother; U] said the cherry blossoms will come later this month and the fruit will follow in June and July. Apple blossoms will start in early May. The village fields are starting to look slightly green, though still dusty. There was a major rainstorm four nights ago. Inside Bura Mamu’s house, the traditional room was unlit (no bijli [electricity; U]) and the angeti fire was out, but the sun shone in both from the upper smoke hole and a side window facing to the west of the house. Fazeelat looked around the room and joked about the number of children present, and of babies who keep appearing, brought by younger family members, to be breastfed by their mothers in the room. The women quickly ask about birth control, and Fazeelat spends some time discussing its necessity (this caught me by surprise, as I’d asked her to start by talking about post-partum dietary practices!). Fazeelat said that after having her three sons — “kafee hen” [quite a lot; S] — she and her husband chose to stop having children. Phoonurh turns to me and asks, “Have you brought any birth control pills with you — and if you haven’t, can you the next time you come?”

A male teenage cousin soon burst into the room and says there is a “halaat kharab” [bad situation; U] developing in Gilgit, as a Sunni doctor named Ayoub had just been killed in Danyor; he was the personal assistant to the Chief Secretary. (They say he’s from Darel at this point, but that night Ferdost called and explained the victim was actually an Ismaili who had long ago converted to Sunni Islam.) He had been

5 The following article was taken from Pakistan’s “Dawn Online Newspaper”, March 6, 2005; “GILGIT: The Northern Areas administration has asked all government employees to resume their duties on Monday for which security guards and buses have been arranged to pick and drop them, official sources said. The offices, hospitals and educational institutions have been empty since the violence in Gilgit on Jan 8 in which 17 people including top Shia scholar Agha Ziauddin Rizvi were killed. The sources said that it was not clear if the orders are applicable to the schools and colleges which were not opened after the winter vacations for the fear of fresh violence. They said that the decision to open the schools would remain pending until a permanent solution is found to resolve the curriculum issue in the region which is reportedly a major factor behind the current unrest. According to a report the new Shia leader and the successor to the late Agha Rizvi, Syed Rahat Hussain Al-Hussaini, has renewed the long standing demand of finding a solution to the school curriculum otherwise they would never allow their followers to attend the schools which are closed for the last two months including the newly established Karakuram International University. - Correspondent”

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shot while walking near a main chowk with a relative, who was also shot and is seriously wounded.

Against the protests of the cousins, who urge us to sit down and “chai pi” [drink tea; S], we agree to leave right away. We explain that our children are alone at home, and we have to leave if the situation is bad – Wadood is sitting outside the room eating cake and drinking chai. We all then head out to the car, all the women requesting us to “Wa, wa” [come, come; S] back as soon as possible. We promise, in response, that if the situation improves we’ll come again the next morning. At the first major intersection in town, at Serena Chowk and the Sunni masjid, there are large boulders, burning tyres and barbed wire everywhere. Even more rocks have obviously been cleared from the road, and we can see the police and Fauji – in camouflage, holding their rifles high against their chests – are still working to clear the road. After being initially told to drive back to Minawar, Wadood makes a “special request” that we be allowed to go home. After eyeing us over, one officer tells us we can proceed. We were fifth in a line of perhaps twenty cars, tractors and passenger wagons heading into town.

March 10, 2005

There were important exceptions to Shia and Sunni weaponization. Northern Areas Home Secretary Hafiz-ur-Rehman, an elected Sunni official from Hulka 2 and prominent spokesperson for Sunnis in upper Diamer District and lower Gilgit District, initiated and led several business strikes by Gilgiti Sunnis following targeted attacks on their community. Among the most prominent was a three-day total strike by Sunni businesses following the March 8th killing of Education Officer Dr. Ayoub in the neighbouring, Shia mohalla of Danyor. These strikes brought Gilgit to a standstill and dramatically displayed the economic clout of local Sunnis, who owned an estimated eighty percent of commercial business in Gilgit Town. There were also several mixed-sect rallies and jirgas where members of the Northern Areas Legislative Assembly protested the violence and sought peaceful resolutions to Gilgit’s crisis (Dawn: May 2, 2005). Delegates included renowned Hunzakut mountaineer and Northern Areas Legislative member Nazir Sabir, Northern Areas PPP leaders and local journalists.

Dr. Ayoub, an Ismaili who had converted to Sunni Islam, was among the seven or eight Sunni families who had refused to leave Danyor, despite open threats against them, after Zia’s death. His death was the first of a series of planned reprisal killings by the Shia community following Zia’s assassination. There had been calls, including those published in an open letter from Gilgit Town’s Main Imambaragh (‘Kharardadh’ [dispute; U], January 26, 2008), to kill a Sunni on the 8th of every month in which those responsible for Zia’s death had not yet been apprehended. The January ‘Kharardadh’, which contained the names of fifty-four ‘involved’ Sunnis, was what Gilgiti Sunnis ominously referred to as the Shia ‘hit list.’ On this list were the names of a number of physicians, including Dr. Shakoor, the DHQ’s staff ultrasonologist.

It is the second day of the Sunni business strike honouring Dr. Ayoub. We drove up to the main Airport Road, and noticed all the shops were closed en route. From Airport Chowk to Hajji Ramazan’s Hotel – which was open, “people have to eat” – and then past that into NLI Bazaar. The police or Army won’t let you in unless you’re “buying something”, so to pass, we pretend to drive into a side market, which wasn’t great today because everything except for some Ismaili cloth shops, were closed. We continued on
through the main bazaar and towards the Jama Masjid. Even the Ismaili-owned Soneri Bank had its metal shutters rolled down; by my own estimates, it appeared 85-90% of in-town stores were closed. Wadood and I agreed it’s a much more peaceable way to respond to Dr. Ayoub’s death, notwithstanding a tremendous loss of monies for the Sunni community. Wadood then added that he heard that Sunni business owners were being threatened. If anyone opened their shops, other Sunnis would “burn it down.” Unity is everything right now. Wadood seemed upset to see the Ismaili stores opened. He said, “They should also be pressured to close”, though I reminded him this would effectively be “taking sides.” As Ferdost said, local Ismailis prefer in almost every way to remain “neutral.”

Looking past the Sunni Jama Masjid toward the Imambaragh, we could see several Shia businesses open, but the majority were closed – including the subzi [vegetable] corner just past the Imambaragh. I could see the Co-Operative Bank, and the massive armored vehicle parked on that corner chowk at Kazana [Bank] Road. We then turned back around past the entrance to Kashmiri Bazaar and the chowk leading to the bridge to Konodas, and drove through to Jamaat Khana Bazaar, where various shops were opened, but this is an Ismaili business area so it was no surprise. Further on, near the Kabuli Hotel, a Pathan gentleman sat outside an open clothing store. Wadood commented that by tomorrow Sunni leaders may “be much stricter with Sunnis who have kept their businesses open”, and there is a rally later today where this issue may be discussed or dealt with. The larger pharmacies, ‘Zeeshan’ and ‘Punjab Medical Store’, were closed. Wadood suggested that Sunnis may be the business class in Gilgit, and while many of the storeowners are local, an increasing number of Sunni Pathans and Swatis are coming from “down country” to sell their goods.

Among our neighbours, I’ve noticed that Wadood’s cousin, Adam Khan, who is a top advocate in Gilgit’s High Court, has been assigned a police detail to protect him on his way to and from work each day. Prominent Sunnis are being targeted, and Wadood wonders aloud if the Shias could even “find Qazi Nisar these days.” I suggest maybe the Shias know it will be outright warfare if Nisar is killed, so they’re striking at more ‘ordinary, special people’ in the meantime. We had also heard yesterday that upwards of 2,000 Shias have proclaimed their willingness to “die in the cause of the Nisab” – ridiculous, and a sign of economic insecurity, under-employment, and no immediate prospects rather than people who have forsaken a good, normal life in order to pursue a religious cause. Gibreel had told us about a week ago that when he accompanied an Army convoy into Amphari to look for weapons, some Shia women had come out on to the road and started throwing rocks on the soldiers, and when the vehicles slowed, the women ran up to hit them and even bite the arms of soldiers trying to fend them off.
March 12, 2005

After waking, Wadood and I convinced ourselves today was the day to go and try to fetch a weapon either from Minawar or to borrow one of the two brought from Dudeshal. (They had brought up weapons covered up by dupattas, buried amid a stack of of jhuke [firewood; S] in the back of the Suzuki wagon.)

After breakfast, Wadood was gone for 40 minutes, and came back with a ten to twelve page photostat of a Shia “hit list” that was put out by the main Imambaragh, and had been ‘leaked’ to a neighbour. It has the names of approximately fifty prominent Gilgiti Sunnis on it, including Sher Mian Jan, the director of the Co-Operative Bank, who is Wadood’s cousin’s maternal uncle. SHO’s, the DHQ’s radiologist...you name them, they were there. From what Wadood translated, it is evident the Shia community identifies them as being implicated, however implausibly, in “Shaheed [martyr; A] Agha Syed Zia-u-din’s murder”, which was described as a “huge loss to Pakistan.” The neighbour said that the list was shared with him by a “sympathetic party” in the Shia community. By the phone numbers at the top of the document, we could see it had originally been FAXed out. (After scanning the list, Wadood notes that one individual - Education Officer Dr. Ayoub - has already been killed.) Moreover, the document infers that on the 8th of every month, a sombre anniversary of sorts, another prominent Sunni will be killed. (As of the 13th, some Shias also tried to hit another Sunni on the list who lives in Amphari - Saki’ullah Tareen, Inspector General for the Northern Areas’ police. This supposedly happened on Sunday, and may have precipitated major fighting that night.) The list ended up being reassuring in certain respects. It was clear that ‘ordinary Sunnis’ were not targets.

Once we’d arrived in Minawar, and were ensconced in Rizwan and his new bride’s ornately decorated wedding suite, still festooned with silk flowers, and with a rifle hung on the wall. Shabir Alam asked about our safety, and reminded us he and Amir were “ready” to come and fight for us. I had thought that Wadood was interested in the Kalashnikov which Rizwan was showing us, but it turns out this was Rizwan’s own gun, and as we left, Rizwan and another relative went in his dubba [van; U] ahead of us.

I asked Wadood where the Kalashnikov he wanted was, and he said it was supposed to already be in Jutial with another individual. Fida and Rizwan were going to pick it up for us, and then bring it to show us after an hour or so. We ended up coming late, and found Rizwan’s dubba parked by our door, and Rizwan and Fida sitting on our front steps waiting for us. We hurriedly opened up the front door and let them in (we lock it from the outside). I went in the house to put Imran down for Kate to watch, and when I looked back out the

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6 In early April 2005, IGP Sakhi’ullah Tareen was killed, and several family members seriously wounded, in a planned ambush while he drove in a police-escorted convoy through Shia-dominated Nagar District, en route to an official event in Karimabad (Hunza Sub-District).
door, Fida was bringing in a Kalashnikov partially wrapped in a dark-coloured woman’s chador. He and Wadood sat with Rizwan, a neighbour’s son and Abid in our garden, and carefully examined the Kalashnikov, its magazine and bullets [see Figure 32]. Wadood then came into our room, where he told me that Fida was selling it for Rs 35,000 [CDN $795], along with 50 bullets at Rs 27 [CDN $0.60] each, which is less than the store price of Rs 30 [CDN $0.70] each. Given our household budget, the weapon was too expensive.

The men spent about 45 minutes in the garden before leaving for Minawar. As darkness set in, Abid and Wadood began to ready for their “night duty.” This essentially consisted of finding suitable areas of the garden to sit in and monitor the property. We had Mohammad and our tenant also “doing duty”, and Nasser later came to help us out. The men had arranged for multiple shifts of two hours each. From 8-10pm, 10pm-midnight, midnight-2am, 2-4am and then it would be finished as dawn approached and the risk of violence diminished. Wadood says the “worst time” is between midnight and 2am. There were also two other people in our garden – one by the water-tower side of the house, and one sitting in the garden watching the top of the wall. It was a night with no power, so we used candles in our bedroom. That night, we felt badly underprepared, with only Wadood’s pistol and the Lee-Enfield [rifle], plus our new Chilasi tenant with his pistol, and our neighbour Mohammad with his Kalashnikov; Mohammad spent his time watching from our wall towards his home’s front gate.

March 13, 2005

Sunday morning began with sunny skies, and more blossoms on the apricot tree outside. Our apple tree is almost in total bloom now. We could hear the flights for PIA taking off in the morning rounds, and we ate breakfast while sitting in the garden. We had visitors from very early in the morning, male relatives from around Jutial and men from immediately neighbouring families, coming to ask us about how “duty” went the night before. On the 12th, Wadood had requested the mullah to put out a call for

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men to meet at the mosque after *Maghrib* prayers that night to talk about the issues facing them with possible attacks. The mullah said that he didn’t want to do it that day, but would wait for the next day (the 13th) to put out a call in which “community leaders” would meet at the mosque after evening prayers to discuss community security. After having lunch with Afghan friends in Kashrote Mohalla in the early afternoon, we stopped at a small shop for juice. The owner knew Wadood well from sometime long ago. He told us that the police, after they had arrested some local boys from Kashrote for the earlier fights at the Park Hotel, had beaten the boys so badly that they had to be taken to the DHQ for emergency treatment. He also said that within the local police departments, the officers and staff are deeply split along sectarian lines. What’s ironic about the recent ‘tensions’ is how much these events have solidified trust between Sunnis and Ismailis, whereas before the frictions and suspicion between these communities was much more pronounced. As we drove home from Kashrote, I noticed how many men seemed – to my mind – to be looking intensely into each car, scanning the faces of people walking past. The air had the feeling of a space in which a bomb is about to explode.

Once we got home, the day was still sunny and lovely, so I went into the garden. I was just looking up to the Ismaili monument (*Mogulai Taj* [Ismaili King], as the Sunnis call it) when I heard, over the regular noise of the neighbourhood, the pop-pop-pop of what seemed like machine gun fire from the far west of town. It was distant, and went on for about 5 minutes; the noise was interspersed with the sounds of firewood being chopped, children calling, the wind and bird-song. But once the daily flood of irrigation water came spilling down the water channel that runs outside our garden wall, I couldn’t hear the noise anymore. I thought about telling Wadood, but was hesitant to mention it in case it wasn’t true. At 4.30 or 4.40pm, the sun began to set behind the mountains, and evening shadows crept across the lawn. The sun had just about set when Wadood got a phone call from Gibreel at his posting on Hospital Road, who told us there was major fighting in Amphari. At the same moment, someone began banging on our front gate, and I quickly confessed to hearing gunfire an hour or so earlier. I retreated to the bedroom, where Abid came to me and said, “*Ha, awaz zyada heh – dhuk dhuk*” [Yes, the noise is more – ‘pop’ ‘pop’; U] and pointed behind him towards the center of town. We listened, and could then hear pistols and machine guns being fired – very clearly – in Gilgit’s central *bazaars* and mohallas, but there was no noise closer than that.

At some point, we all began to panic. Wadood and Abid burst into the kitchen, and although there was *bijli* that night, we had only lit candles and the gas lamp so as to deflect attention from the house. Abid had a plastic bag full of bullets which he was pushing, one by one, into the magazine of his Kalashnikov, while Wadood was doing the same with the Lee-Enfield. Under his breath, Wadood
muttered, over and over, “We have to get ready, it’s starting.” Kate and Imran went into the middle room, and I had left a window open under a curtain. About two minutes later, Kate came running back out of the room, a startled Imran on her hip, saying she thought that a ‘Shia was hiding in the room’. She had mistaken the curtains, moving in the breeze, for a person hiding in the corner. It took a while to calm both her and the baby, and to relieve her of the shame she subsequently felt from fearing Shias in this way.

The neighbourhood was by now black and silent; I was very upset, and pleading with Wadood to tell me what to do. He was firm and short with me, saying he had to keep his mind clear and there might be a “big fight.” He instructed us to “stay away from open windows, keep lights to a bare minimum, keep below the firing line through windows or doorways, be aware of sight lines into the house from all possible directions.” He then told me he’d show me how to operate the Lee-Enfield and his .32 mm as soon as he had a chance. Around the same time I began to calm myself down, our regular “duty team” had shown up, and I saw there was real terror among them too. Anxious discussions, loud whispering, and men moving quickly through our yard to find sight lines to protect their homes, which surrounded ours. I told our tenant, Ahmad, to bring his wife, Fouzia, and their daughters into our house for the night. She trooped in with the girls, quietly in the darkness and with blankets in tow. Sulwah was sleepy and Noozad quiet. Fouzia took them into our guest room where Kate and Nadeem were watching movies quietly, the volume low and with a single candle. While I was on the phone with Mum, Fouzia crept into our room. Once the call was finished, she told me about a Shia who had been caught on the roof of her cousins’ house in Danyor, and talked about her own fears; “I am taiyar [ready; U] and will use a chakhu [knife; U] to defend myself!” Wadood meanwhile was coming in and out of the room, asking how I was doing. I could hear his mouth was dry from fear.

Throughout the evening, the phone rang and rang – people were checking for information, confirming news, asking for assistance, sharing stories, offering advice, describing local fights. At one point, Haleem called from Sakwar, his voice softer than usual. He asked me how I was, and I said in a shaky voice, “Fighting zyada heh, bhai – hum parashan heh!” [there is a lot of fighting, brother – we’re worried; U] He urged me to calmly tell Wadood not to leave the house, under any circumstance: “Ghar sey nuhee nikaltay heh.” [he shouldn’t come out from the house; U] I promised, and then crept outside to tell Wadood to come in and talk to Haleem. Things were quiet in Sakwar. An hour later, Bura Mamu and Rizwan called from Minawar, saying “the men in Minawar are ready to come to Gilgit and join the fight.” There was no discussion of jihad in any of this. Wadood and our ‘duty team’ simply kept repeating what the local Qari had been saying, that the Sunni community should “not be acting like terrorists, and only protect
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themselves defensively.” Bura Mamu asked if we needed anyone right then, or more weapons, but Wadood only said he would call “when the time comes.”

After bringing chai to the “duty” team, I took a few minutes to sit with Wadood in the darkness underneath our apple trees. He now confessed that for the first hour he felt panic and fear, and the second hour involved mentally strategizing how to prepare for Shias breaking into the property. A few minutes later, he and Mohammad crept down to the corner of our alley where it meets the road. Hiding in the shadows behind a stone wall, and with only one stone each, they threw rocks up and broke out the bulbs that had been strung along the roadway to increase security during Ashura. They saw, in turn, Shias doing the same immediately down the road – not more than a block away. We’re told that ten men are guarding the masjid, and another few are staying with the Qari and his family in the house by the cemetery. Someone with a rifle is watching our home’s rear wall, and Mohammad stands on a ladder to watch into the alley, a Kalashnikov slung over his shoulder. The front gate was kept open only a very small amount, so that people could see if anyone was coming up or down the street, or near our front stairs. Men in the neighbourhood were using whistles to communicate. After listening hard, we could all hear that the Shias down the road were using hoots and rough hollers to do the same. There was generally a heavy silence in the yard – people standing at the edge of the wall, Kalashnikovs at the ready – total silence from all adjoining households, deep whispers from the men which turned into voices when the need arose or someone came into the house from outside (from Ghazanfar’s house, to discuss security or something that had happened, or a game plan). The air was thick with tension and fear, and the sky past our house lit up by the few neighbouring homes that had their lights on. The majority of families kept their lights off, perhaps to minimize attention from Shias, or to allow people to more easily move in and out, unseen, between properties.

At 10pm, we heard distant gunshot blasts and people yelling; the fear rose up again in my belly. Wadood remarked, with a light laugh, that in all his years growing up in Jutial Mohalla they had never so much heard a shot in anger – ever. No one had heard gunfights go on for so long, and certainly this had never happened in Gilgit Town. It was only after two and half hours that silence settled over the town. At 10pm, Gibreel called and in a hoarse voice, told me that he was preparing to go with a convoy into Amphari, and to pray for him. At 11.30pm he called, his voice shaking and distant, and said he had seen horrible things. He said his commander was nearby, and he couldn’t talk. (In fact, he never did share what he saw.) For the rest of the night, I slept only fitfully. Kate was up often to check out the door or window for me if there was noise, talking or to see why our dog Saffy was barking. We even had someone watching from the roof at one point. I put my bed and the baby’s by the back of our angeti, while
Kate and Nadeem slept in front of it. Wadood came in around 3.30am, and only slept when there was complete silence across town. Just before I drifted off to sleep, Ferdost called and said that if, by tomorrow morning, there was no curfew it meant that the Army had been able to “establish control of Gilgit” and this was a positive sign. He wistfully added, “This is a crucial night, I think....”

March 14, 2005

Gibreel had his day-off from Fauji [Army] duty today, and spent the greater part of the day napping in our guest-room. After waking, having chai and lunch, he told us what he knew about the 13th, and perhaps offered some insights into what Army convoys had experienced - or were responsible for - as they tried to stop the fighting [see Figure 33]. He told us that one Shia woman had been shot by the Army as they “did operations... She died of her injuries today, and a soldier was injured around the same time.

She had come out of her house to throw rocks on the patrol.”

Shortly after lunch, Mian Jaan came to see us; he had left his car at a local workshop to have it fixed. With his home near to Danyor, he tells me that because of the ‘tensions’, he has sent his mother, his wife and their youngest children to live in the family’s house in upper Hunza.

He owns multiple businesses, of which the Army are his regular patrons. He is a helpful source for incoming news, and though we’re often initially doubtful as to the veracity of his more outrageous accounts, the vast majority of his stories end up being factually correct. Today, Mian Jaan tells us that Qari Ashfaq, head of the Kohistani Sunnis, was in Chilas to talk to the community there for their March 11 juma prayers. Qari Ashfaq was reported to have said, “We are going to protect the Ismailis, but the Shias are going to be killed.” He was also quoted as saying if a Kohistani lashkar came to Gilgit, they intended to “capture Jalalabad, because Chamughar [Sunni village] is immediately after Jalalabad on the road to Bagrote. And if they don’t stop killing our people, we will take Jalalabad completely.” I was
unclear as to how Qari Ashfaq relates to the Sunni Markaz here, and Mian Jaan said that Ashfaq works under the guidance of Qazi Nisar, who is the “Ameer Ehl-e-Sunnat wa’Jamaat”, and “big leader of the Jamaat ul-Dawat ul-Islam.” In his sermon, Ashfaq was also supposed to have claimed that the ISO’s leader lives in Danyor, along with “other terrorists and community leaders.”

Mian Jaan suggested that the “bad leaders” in Shia areas, particularly in Nagar District, are “pushing just a political agenda with an emphasis on Shaheed and the wrong agenda” He said that he, along with other Ismailis, think that “Shias are coming to their last day” and are “not the majority in the Northern Areas or in Gilgit District - Sunnis are, even if only by a narrow margin.” Deeply curious, I pushed him to tell me what he knew about Zia-u’din. Without pausing, he answered, “He’s a man of blood! This man encouraged extreme, extreme anti-Sunni sentiment among his followers, and there appear to be a growing number of Shias following his martyrdom.” He also said there had been fighting again in Amphar this morning, he heard it at about 10am and came straight to our house from the bazaar because he doesn’t want to get caught in the workshop. After talking with so many friends, and former colleagues, it seems as if Ismailis want to distance themselves, ideologically, theologically, and in terms of overall identity from Shias in the most complete way. Those we know have ceased discussing how they share any beliefs, or their role as a sub-sect of Shia Islam.

March 15, 2005

A Pathan street vendor was shot by Shias as he hawked his wares in a central bazaar, or selling things house-to-house, we’re not quite certain. Musa, who is Afghan and lives in Kashrote Mohalla, tells us that the man was at the DHQ receiving treatment. There, the hospital staff told Musa that this fellow - the Pathan - had been shot and injured when he heard a knocking at his front gate, and answered it without checking. Later today in the afternoon, a Chilasi was shot and killed outside the Soneri Bank opposite the Jama Masjid, but according to police, he was murdered by another Sunni Chilasi, who “was using this opportunity to ‘hit’ an enemy and have the Shias get blamed.” Wadood offered his own opinion that “the Chilasis may be trying to instigate a larger fight between Sunnis and Shias.” Ferdost and Mian Jaan both called at separate times to tell us they’d heard two Shias were killed in Bargo yesterday, but “khas confirm nish” [the news is not confirmed; S]. The Army has taken careful steps to restrict the release of all such information, whether through the media, radio or through Army channels. Today there was supposed to be meeting, held in Islamabad, between Alims from across the Northern Areas. Alims are members of District Councils; they talked with the President, Prime Minister and Minister for KANA (Kashmir and Northern Areas). We heard the Shia component of the regional MMA-NA (Mutahida Majlis-e-Amal Northern Areas) has refused to participate in any talks until the Nisab issues are resolved. The
Sunni contingent has seized this space to send their Alims from Diamer and Gilgit Districts. In the meantime, Qazi Hussain Ahmad (leader of the Jamaat-e-Islami) has said from his headquarters ‘down-country’, “We will not support the Nisab demands or interfere, but we will support other issues. Only the Shias can resolve the Nisab.”

March 16, 2005

Ferdost called to tell us that some “terrorists on motorcycles” drove through Jamaat Khana Bazaar, and began shooting their weapons into the air as they passed Pathan-owned businesses, in “order to scare away the people.” I asked him to explain what he meant. “Shias here don’t want anyone doing business in Gilgit who isn’t from here.” I then asked him, “You mean, anyone who isn’t a Shia Gilgit?” He paused before answering. “Yes, you’re right – because Shias here believe that they are the ancient peoples from Gilgit, and everyone who is here has come from another district. Sunnis have come from Diamer, and Ismailis have come from Diamer and Hunza Districts.” Knowing how convoluted Wadood’s own ancestral connections are to Gilgit District, I pushed Ferdost for more. “But didn’t the Shias come from Nagar District?” “No,” he said. “They were probably here first.”

March 17, 2005

Mian Jaan returned again in the late afternoon, carrying a bottle of fresh lassi [yogurt drink; U] and qeema-filled [ground beef; U] fried bread. He owns a shop in the central bazaar, and overheard senior Fauji officers come in today to discuss recent happenings around town. There are more FC [Frontier Constabulary] and Army troops being brought to Gilgit in preparation for the next Nisab protests. (A relative in Minawar called to tell us the troops had passed Jaglote early this afternoon, and will arrive in Gilgit by late afternoon or early evening.) By March 21st, the Shia community has a complete strike planned for this next round of the Nisab. Morbid details abound; Shias are supposedly bringing in huge amounts of fabric (white for men, black for women) called kuffar, which is burial cloth. As Mian Jaan opined, “they are ready to die for the Nisab if the Government of Pakistan does not accept their demands.”

Since January 8th, thirty-two people are said to have been killed. Twenty-two Sunnis, eight Shias and two Ismailis, some in their homes and others in the bazaars. Ismailis, because of the actions of Taighun Nabi [Ferdost’s relative] on the 8th are now described by some Shias as “supporters of Sunnis” and have been listed as targets, for the first time in living memory! Twenty-five people have now been arrested in connection with Dr. Ayoub’s death in Danyor on March 8th. While he was over for chai yesterday, Ferdost told me about meeting a Shia Engineer on the way home from a meeting. On the way, Ferdost asked him why the Shias
had killed his relative and the man responded, “Because he had refused to hand over the Sunnis! Those people are nothing more than animals, so why did he do such a foolish thing?” Quietly enraged, Ferdost countered by asking, “Under similar circumstances, wouldn’t you do the same thing for your colleagues?” The man hesitated, but said “Yes.” The alignments between Sunnis and Ismailis are growing stronger as some Shias continue to act in threatening ways. The second Ismaili death apparently occurred a few days ago. According to Mian Jaan, an Ismaili came across some Shia men “wall chalking” (writing graffiti) in a residential neighbourhood in Karimabad [Hunza District]. The men were writing about the Nisab, and the Ismaili reprimanded them for writing “such stuff in our neighbourhood” and a fight ensued. Two days later, several Shias came back to his house and called him out to talk. His mother and brothers waited for him, and when he didn’t return they searched for him. His body was found in a field adjacent to their house.

Yesterday, the Sunni owner of the Punjab Medical Store was shot by some men who drove past his shop in Landcruisers. According to Mian Jaan “there was no assistance from the FC, Army or police who were watching.” Mian Jaan’s wife’s cousin owns a small hotel in the Jamaat Khana Bazaar, and he – along with other shopkeepers – was arrested by the police. He was kept in custody overnight so he could “describe the shooting” in as much detail as possible, though it seemed more like a punishment. Wadood and his cousins were debating the meaning in this shift from ethnic Gilgiti to non-Gilgiti targets. Rumours and brief newspaper reports abound concerning the supposed corruptions of the largely Shia Gilgit police force. One senior police officer has been caught sending guns and rounds to Gilgit from Gupis on a truck, which had been searched and the driver arrested. Most of the top police officers are Shia, whom Sunnis fear are “monitoring Sunnis and communicating this information to the ISO and Anjuman [Imambaragh Council] group.” (In response, we’ve heard that some senior, Sunni police have been brought in from Diamer to help “balance out” the force.) The Shia Anjuman Imamia is supposedly financed by Iran and its business and financial ventures inside Pakistan - hotels and shops in urban centers - as well as trade with China. It is the umbrella organization, financial sponsor and ideological guide for violently anti-Sunni sub-groups, including the ISO and Sipah-e-Mohammed. On the Sunni side, the Jamaat-Ulema-Islam heads a myriad of other parties, including Jamiat-Tulba-Islam, Harkat-ul-Mujahideen, and the Sipah-e-Sahabah, which since being officially banned, is now re-named the Jamaat Dawat’ul Islam.

Stepped-up Sunni politicization enabled the resurgence of local divisions of the Sipah-e-Sahabah, who were seen as defending the rights of Sunnis to continue living in increasingly Shia-only villages, and as the only locally available (and slightly unprepared) match for highly militant branches of the ISO.7

7 Among Sunnis who were sympathetic to, but not always in league with, the Sipah-e-Sahabah, some complained that because of fighting internal to the Sunni community and an overall lack of preparedness and planning, Gilgit’s Sunni

Emma Varley
After coming back from an afternoon visit to his cousins in Minawar - where curious relatives from Diamer have been coming to stay, and learn more about the current ‘tensions’ - Wadood sat with me on our front veranda and looked out onto the northern mountains. “Many Sunnis are keeping quiet,” he said. “They’re waiting now for the snow to melt in the mountain passes between Diamer and Gilgit. Only then could people from Diamer and Kohistan come.” As he continued, the sky over town was darkening with incoming rain clouds. “The rain will help the snow to melt much faster. Some say it’s on Sunnis’ side now.” (I’d often noticed Sunni neighbours ‘reading’ the mausum [weather; U] as if it signals divine intervention. For example, snow helps block the roads and protects Shias from a Sunni lashkar [see Figure 34].) I asked Wadood how long it would take for the lashkar to arrive; “It’s only three hours on foot by Kargah, Sakwar and Minawar Nalals.

Within ten hours, all can be here. Many Shias are doing what they can now, I think, before the Diameris can arrive.”

**March 19, 2005**

During Saturday prayers at 4.30am, Sunnis were said to have fired at a Shia mosque in Sonikot Mohalla. Two were seriously injured and one man from Nagar [Sub-District] died. In Minawar, Amir’s cousin Muzaffar said it was Shias shooting at other Shias – though this is certainly more Sunni gossip.

In late March 2005, and after our children began suffering stress-induced nightmares, Wadood and I sought several weeks respite in Islamabad. While attending a workshop on Islamic conservatism in Northern Pakistan, I met up with old friends who were now based in Islamabad. My friend and former colleague, Aimon, is married to the Pakistan correspondent of an international newspaper. During the birthday party they hosted for me in early April, Doulat was alarmed to hear of the intensity of the conflicts, and confirmed that very little information had been relayed through the press. Intrigued by our tales of extremists were unable to offer comprehensive protection or pre-emptive ‘strikes’ on Shia ‘terrorists’. Instead, Sipah-e-Sahabah measures were limited to uncoordinated responses to sectarian attacks against Sunnis.

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nighttime gunfights, and Gilgit’s socio-sectarian spatial divides, he soon asked us to help provide information for a possible newspaper article, and to appear on television to discuss the hostilities. Deeply alarmed by the potential implications, specifically because I thought Wadood would now be an obvious retaliatory target for Shias, we quickly back-pedaled, and distanced ourselves from journalists, research cells and governmental acquaintances. Such measures may have ultimately saved my work.

Part III

April 2005

For one week in early April, we were unable to telephone our relatives and friends in Gilgit because the General in-command of local security had commenced yet another, more comprehensive ‘Operation Clean-Up’. Telephone lines, satellite and internet communication were all ‘disabled’ for the duration of these mohalla-by-mohalla weapons sweeps. Worried that we would lose our firearms and few bullets, we had sent word – via a friend working on the NATCO inter-city bus – to a relative to try and hide everything. Ironically, at the last moment, just before Army officers had begun dismantling the lock on our front gate, Wadood’s cousin Gibreel, himself an Army officer, reassured them that we were “only Canadians” and were “not violent.” They then decided to bypass searching our house. We returned to Gilgit by the middle of April.

April 27, 2005

Eid-e-Millat celebrations were tonight. Many bonfires and lights on the mountainsides, which were reshaped around already-written words such as the whitewashed boulders written out to spell ‘Ya Noor’, Ya’Ali’ and ‘ISO’.

On top of the Mugalai Taj, a huge fire burned, starting from twilight. I climbed up against our rock wall and could see fires were also on the Konodas-side mountains. From our house, I could see and counted twelve large čiragaan [celebratory bonfires; S]. The water channel was also alight with small bonfires, all along the south-west side of Gilgit Town. Wadood had said that he’d heard čiragaan were ‘forbidden’ by the government, but the government and Army are either powerless to stop them, or afraid to intervene. Looking up behind our house, I could see small, moving lights on the mountainside directly above Jutial; young men must have been up there with torches, lighting and re-lighting the names. Wadood said perhaps there were “hundreds of Shia men” on the mountainside, and they would be coming down later for a jaloos (meeting; F) at all local Imambaraghs, including the one nearby.

Our power had been out for most of the late afternoon, and it was about 9.30pm when we heard “Ali, Ali...murtabad...murtabad!” [death to...death to; U] being yelled by a large group of young men coming down from the mountainside for their jaloos. Haleem, Sadiq, Wadood, Kate and I went down to

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8 The following article was taken from Pakistan’s “Dawn Online Newspaper” on April 5, 2005; “GILGIT: Law-enforcing agencies recovered at least 91 weapons as a search operation for illegal weapons continued in Gilgit for the fourth day on Tuesday. Northern Areas Chief Secretary Manzoor Nadeem told a press briefing here that out of 91 weapons, 54 were licensed and 37 weapons and 720 rounds of ammunition were illegal. About the nature of seized weapons, he said that the cache included three Kalashnikovs and some pistols and pledged that they would continue the search operation till restoration of peace in the city.—Correspondent”

9 The Eid-e-Millat-e-Nabi is the Prophet’s birthday, and celebrated by both Sunnis and Shias. But in the wake of Ziau’din’s January death, Shias marked these shared, ritual events much more animatedly – and politically – than Sunnis.
our front gate to see what was happening, and I climbed on the metal ladder to look over the wall towards the road. I could see several men and small children coming from further up along our alley to watch the procession heading towards the Imambaragh along the road. First, an armed Policeman came and stood in our alley entrance, and I could see the lights of flaming torches casting quickly shifting shadows while Shia men, about fifty to seventy of them, came down shouting slogans. It was less than I’d thought. They were followed by two police wagons full of armed police, in their black and slate grey uniforms. The excitement was short-lived, and Uzma and her cousin peeped out from the front gate of the neighbour’s house next door. I asked Wadood what the marchers had been saying, and he said “We want a Revolution! We will make the Revolution happen!” Just after the men passed, the power came back on at our house, lighting up the front lamps over the entrance way and illuminating my gawking face.

April 28, 2005

Today there were long sermons broadcast from the Imambaraghs at Khomer Chowk and the one near our house. It started after lunchtime and continued throughout the early afternoon. This was followed by lengthy broadcast prayers at the evening namaz. Ferdost called and said it’s a Nabi celebration today, following Eid-e-Millat. The sounds of prayers and fervent, heated sermonizing left me feeling unsettled, and reminded me of March 21st, just before we left for Islamabad, when at exactly 9.15pm we heard loud chants radiating up towards our house: “Allah’u Akbar, Allah’u Akbar, Ya’Ali, Ya’Ali!” It lasted for upwards of ten minutes, and none of our frightened Sunni neighbours knew what was happening, or what it meant. And at precisely the same moment it began in Jutial, our phone rang and it was my terrified sister-in-law calling from Sakwar, saying “Bhabhi, bhai ko bulao!” [sister, call brother; U] At precisely 9.15pm, Sakwar’s Shia jaloos there had co-ordinated their chants to start at the same time from beside the Sunni masjid, along the KKH. Meanwhile, at our house in Jutial, Omi [mother-in-law], Kate and I cowered in our bedroom beside the angeti; Omi kept saying, over and over, “Shia, Shia!” She told me that in good times, she and her Shia cousins are “khandan” [family; U], but with the bad times, the ‘tension times’ come, and the relationship is severed. She demonstrated this by chopping one hand into the open palm of her other hand. Naveed and Rizwan had come to stay with us from Minawar that night, entirely by coincidence, and each had a Kalashnikov. They told me not to worry. “Aram kuro, Bhabhi, kot fikhr nuhee, [relax, sister, it’s nothing; U]” one said. “Some Shias make noise like that, to disturb their neighbours.” My teeth were literally chattering with fear.
May 8, 2005

Today is the four month anniversary date of Zia-u’din’s shooting, and in the last two months, Sunnis have been assassinated. March 8th was Dr. Ayoub in Danyor, and then April 8th it was a Class 9 Sunni student, male, who had gone to Danyor to take his annual exam. We had planned all week to stay close to home, and off the roads. We woke up this morning after a night alone, without family to do ‘duty’ with us. I had a fitful sleep the night previous; there had been a slight wind through the night that picked up toward 2am and banged the doors in Kate’s bathroom and bedroom, and then the unlocked window in our room. Wadood woke up to correct the problem by re-latching the doors, and I scared us both by asking, “Someone hit our window, was it you?” So we spent another half-hour prowling the house making sure nothing was amiss, and relying heavily on our dog, Saffy, to bark if there was a problem. Shaheen, Kate and I heard stones being thrown at the house again two days ago. We found several two to three inch sized stones, some very sharp with flint-like edges, around the base of the largest apricot tree that evening.

Between March and late May, Wadood and I began experiencing a phenomenon that was unique to the ‘tension times’, whereby Sunni antagonists used the hostilities as a cover for their own acts of revenge against fellow Sunnis. For several nights, and even during nights of open fighting across town, Wadood’s ex-wife and her family had used the hostilities to their advantage, and used slingshots to hurl volley after volley of stones at our home’s corrugated tin roof. It wasn’t until several months later we found out who our nighttime antagonists were; many of the Sunnis who engaged in these covert battles assumed their victims would naturally blame local Shias for whatever harms or frights they experienced.

One of our neighbours traded his old firearm for a ‘new’ one about a week ago. A cousin closed the door to the main hall so the gun dealer could be brought through the side door into the house. I didn’t see him at all.

The new firearm has a lighter-weight body, is reddish wood and it can be dipped into water to cool it down if it overheats or over-fires, although apparently it would take more than 1,000 rounds for this to happen. Some neighbours report having bullets ‘hidden’ all over their homes in odd locations; wrapped in shopper bags and hidden among shampoo bottles in the toiletries cupboard, or even in small tea-cups in the kitchen cupboard.

May 9, 2005

Hashim Khan told us yesterday that a Sunni from Jaglote was grabbed, and hit in the head with an axe by two Shias bent on “revenge”. He said that the man sustained injuries along the side of his face. He was struck from behind, according to him, but the assailants ran away and he wasn’t sure what the man’s condition is now. The two Shias, evidently, were arrested and are now in thana [jail; U]. Someone told Wadood there was a skirmish at the DHQ today between a group of Shia teenagers and one or more
Sunnis. The [Army] Rangers were called in and they broke up the fight and took the Shia youth away. There are, evidently, Fauji [Army] Rangers stationed in each ward. Someone said one to two for each patient ward, and by the Operation Theatre. I would like to check if this is the same for the Family Wing. People are still unhappy about using services there.

May 12, 2005

Brilliant, sunny day with a few clouds. Today is the start of the annual Ishtemah, the main Tablighi Jamaat meeting for all Pakistanis, which is held once each year in different cities. On the roads coming into town are many Kohistani and Diameri faces, black turbans, pakhols - there are estimates of upwards of a half a million people expected here, and the Sunni Markaz have spent three to four days preparing for this, making sure washrooms are ready, and securing space for seminars for Tablighi Jamaat leaders coming from Raiwind. Wadood says this is truly a chance in a lifetime for those local Sunnis who are too poor to afford transportation to the regular Raiwind meetings. Wadood says there will be very little sleeping, that things will continue until midnight and then re-commence at first prayer in the morning. I wonder if the meeting is being held as an irritant to the Shias, or when exactly the Tablighi Jamaat made the decision to bring the main meeting here. Wadood wants to go to the meeting tonight from Maghrib to Asr prayers (roughly 5pm until 7.30-8pm) and tape-record the conferences. I’ve asked him to pay attention to meetings that concern women or family life. Wadood says security is tight, but I’m still concerned.

For Gilgit’s Sunni ulema, increased emphasis on jirgas as a means of conflict resolution represented the conflation of ethnic and religious identity. First, by drawing on jirgas - a characteristically Pakhtun model of tribal judiciary - Sunni Gilgitis sought to reinforce their political alliances with the Mutahida-Majlis-e-Amal (MMA), a multi-sectarian coalition which had recently taken control of the Pakhtun-dominated NWFP. Second, jirgas allowed Gilgit Sunni to build stronger political connections between the Gilgit Town Sunni Markaz and Markazi in Diamer District and Kohistan (NWFP). For example, the invitation by Gilgit’s Maulana Qazi Nisar Ahmed for Qari Ashfaq (regional leader of Kohistani Sunnis) to participate in local peace jirgas, represented a significant advancement in the integration of Sarhad and Northern Areas Sunni communities, and the merging of their respective ethnic, political and ideological differences. It also allowed Gilgit’s ulema to foreground their desire for MMA-style governance. Indeed, there was increased co-operation and ideological symmetry between Gilgit’s MMA Chief Secretary and Qazi Nisar in all ulema-level responses to the violence.

At the same time that the Sunni Markaz looked to the MMA for additional political support, local Tablighi Jamaat members began using the MMA’s NWFP-based recruitment and ‘community’ monitoring techniques. In Jutial Mohalla, Tablighi Jamaat members traveled door-to-door immediately prior to prayer times, telling men to go to mosque. During mosque sermons, tablighis advised male community members to make monthly visits to Gilgit’s Jama Masjid and the Sunni Markaz for Friday prayers (Juma namaz). Immediately before leaving Gilgit in

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10 Qazi Nisar, as he was called by Gilgiti Sunnis, is formally titled ‘Amir of Tanzeem Ahle-Sunnah Wal Jama’at, Northern Areas and Kohistan.’
September 2005, a neighbour returned after a 6-month Tablighi mission in Peshawar. He soon began taking daily prayer attendance at our local mosque. While this aroused the ire of some community members, many others felt that this would strengthen the Sunni community’s internal allegiances and moral piety. MMA-style recruitment was not limited to adult men; Tablighi members pressured poorer families to send their children to Gilgit Town’s largest madressah. They also urged older boys and young men to attend Tablighi Jamaat missions, which last between three days and six months, and visit mosques throughout Gilgit District, the Northern Areas and the NWFP. Whenever possible, Tablighi members advised that girls’ education be limited to an Islamiyaat curriculum, and that Sunni women make a regular practice of adopting the Afghan-style burqa or total hijab – a hitherto unpopular practice, even in Gilgit’s most staunchly conservative households.11

Part V  

July 2005

Wadood’s cousin Shakeel – our next-door neighbour - was shot at his house by Shias. We heard the shots when it happened. The Army has flown him to Rawalpindi for treatment.13

July 21, 2005

As the Army left last night after establishing the curfew, another group of police in their black tops and khaki pants came into the alley, and a head officer was with them. He saw Wadood, Fouzia and I sitting

11 There were, however, varying manifestations of the Tablighi Jamaat throughout Gilgit, each evidencing either firebrand conservatism or, to paraphrase then-President Musharaff, ‘enlightened Islamic moderation.’ With regards to their doctrinal orientation on women, individual mosque communities tended to be either reactionary or moderate Deoband; the former having staunchly conservative cultural ties with Diamer and Kohistan (NWFP), the latter with more progressive religious movements in Pakistan’s urban centers. While each approach draws on imported materials shaped by the Hanbali-Sunni fiqh (particular to Saudi Arabic and parts of the Middle East), they make principal use of a vast Urdu-language, Pakistan-published Hanafi-Sunni Islamiyaat literature. Moreover, the proliferation of home-grown, Northern Areas’ Deoband madrassahs shows how the political revitalization of Sunni Gilgiti identity occurs in ways that remain firmly anchored to local culture. Community-level mosques, often in competition with one another while simultaneously dependent on Gilgit’s main Sunni Markaz for financial and administrative support, responded to one another not only through juma sermonizing, but also through their differential responses to Shia-Sunni ‘tension.’ This sense of ideological ‘other-ing’ and ‘distancing’ between Sunnis has contributed not only to the development and expression of community-based Sunni identity. It has also pushed gender debates – ‘women’ being a particularly evocative symbol for community or group identity – to the forefront of Gilgit’s Sunni political mobilization.

12 See pages 1-6 for more detail.

13 The following article was taken from Pakistan’s “Dawn Online Newspaper”, July 20, 2005; “GILGIT: Tension and panic heightened in Gilgit and suburbs on Wednesday when unidentified gunmen shot dead three people, including a union council chairman, taking the toll of the fresh spate of violence to eight. Police said Rajab Ali, 55, chairman of Nagar Union Council, was shot dead by unknown assailants at Babar Road. A taxi driver, Habibur Rahman, resident of Sonikote, was found murdered in his taxi in Didingdas, 15km east of Gilgit. The news spread in the city, triggering fresh clashes in Sonikote and a 22-year-old young man, Arif Hussain, resident of Nagar valley, was sprayed with bullets by unknown assailants when he was taking rest near the bank of Gilgit River. The clashes forced shopkeepers and businessmen to shut down their shops and within no time the city wore a deserted look....Police said another pedestrian from Nagar valley was fired upon and injured by unknown miscreants on the River View Road soon after clashes occurred in Sonikote....Huge contingents of police and rangers have been dispatched to the troubled areas of Sonikote and Kashroot to quell unrest, the sources said. Gilgit plunged into fresh chaos following the murder of four passengers on Sunday night in Gonar Farm while travelling on the Karakoram Highway. Nobody has been arrested in connection with the incident.”
on our front steps, and they called Wadood down to talk to them, saying “Bhai” [brother; U]. I was scared we would be in trouble for being out on the road, but the officer, an older gentleman of about 55 years, with dyed, light brown wavy hair, asked him gently what happened. Wadood went and they spoke about fifteen feet up the alley from our front gate, just as another man came down from Shakeel’s house. It was his cousin Sharif, who spoke angrily to the police, telling them “Go, we don’t need police protection for the night!” I was astonished. Wadood explained, “They don’t want their hands tied, because if the police are there, and the Shias come back, they can’t do anything...” We went back into our houses, and were inside for perhaps twenty minutes, when Wadood suggested we walk to Badriya’s house [Shakeel’s first cousin] to see what was happening. I wasn’t sure where Badriya lived, but Wadood still pressed Fouzia and me to “go up the hill and see what’s happening.” Because the Army were stationed with two to three men on every alley corner along the main road, men wouldn’t be allowed to pass. So, a gang of us - including Shimaah, one of her small nephews, her daughter Faridah, Fouzia, Kulsoom, Saira, Sushilah, Tamana and I - headed off down to the corner, passed the Army officers, and walked directly up to the alley above our house. We could see police wagons and emergency response vehicles parked by the smoldering shops at the chowk, and as we went into the darkened alley past four officers, they asked us in Urdu where we were going. Shimaah answered, “We’re going to see a relative – a woman.” They let us pass. As we walked along in the darkness, heading towards the lights of Badriya’s house, I could see men trapped inside their homes, spying out in the alley to watch us and the police on the corner. We reached the house and went inside the main gate. There was plastic matting set all across the ground in the main courtyard. Here, Shakeel’s mother sat weeping, surrounded by women, in the middle of the ground, calling out his name and “Y’Allah!” [Oh God; A] I went and sat behind her, but two women came and pulled me up off the ground, saying “Bhabhi, please don’t sit here – come inside with us.” I followed them somewhat reluctantly, and heard women whispering, “There’s Wadood’s jamaat!” [wife; S] as I passed them. We went into Badriya’s room, which opened directly onto the courtyard. Three small children were sleeping on the bed, the tube lights on, and a curtain separated her bedroom from the bathroom. I asked Badriya where her own baby was, and she said she’d given him to her niece to hold because all the crying and screaming had frightened her. Outside, it was now relatively calm, save for crying among Shakeel’s mother and sisters. Badriya was calm, and another woman came and sat beside me, kissing my hands, and told of how Shakeel had been shot. There was an animated conversation between them both, and Badriya clarified that he hadn’t been in his garden at all, he was only shot once, and he was attacked outside his front gate on the road, not inside his property, as we’d first been told. Some Shia boys he knew had come to the house to call him out; his father had been concerned due to the late hour and the other killings that day, and went with him to the gate. The boys tried to walk with Shakeel away from
Chapter Eight: ‘Tension Times’ Part II (February-July 2005 Fieldnotes)

the gate, but the father went with them and noticed one of the boys holding a pistol, so he grabbed the boy and fought with him. Shakeel ran back inside the house, grabbed his Kalashnikov, jumped off the low house roof into road, and was then shot by the Shias, who at the same time whistled loudly to a group of other boys, perhaps ten of them, who were waiting just up the road, and they then all ran away into the darkness. The Sunnis came pouring out of their houses within a minute of the shooting, so their window for escape was narrow.

Only at that moment, I noticed that two of Shakeel’s sisters and Badriya still had blood on their arms from when they had helped lift his body into Badriya’s husband’s car, which had then taken him to the CMH. From where we sat inside, I could see another sister standing beside the house gate, opposite Badriya’s bedroom door, moaning and crying, “Y’Allah … mera bhai! Kya ho jaegeh!” [Oh God … my brother! What will happen; U] I walked over, rubbed her back, and gave my afsoos [regrets; U]. She turned to me, saying “Bhaji, dekho [sister, look; U], we people would never do this to anyone else; what did my brother do to anyone? He is a good man, his heart is saf [clean; U], and they hit him like this? What can we do? This is from God!” Later, as the sun began to rise, Haleem offered a slightly different appraisal of his injured cousin; “He was a fighter and shararattee [wilful, naughty; U]. He was strong-minded and strongly Sunni.”

July 22, 2005

I was woken up very early by Wadood, eyes filling with tears, telling me “He has died, I just heard the news – they’re bringing his body today from Pindi.” He then left the house for about an hour. Kate and I got up, made breakfast and cleaned the house. Initially, it was a bright sunny day, with only traces of clouds. The weather changed completely when Shakeel’s body arrived at his house at around 1pm…they had earlier said his body would arrive at 9 or 10am. The mood was very somber throughout the morning. Before we had eaten breakfast, Ghazanfar came into the garden with Wadood, his eyes red and puffy, and sat with his back to our veranda having a cigarette with Wadood. When I sat down to talk with him, Ghazanfar obviously needed to vent; “Look, what can we do? This comes from God…what can we do with this situation? [hand gesturing toward lower Jutial’s Shia homes]. We’re trying our best not to do anything to provoke anyone, and this never happened before in Jutial.” Ghazanfar said a [Shia] chowkidar from ‘X’ Hospital was involved, and that neither he nor anyone in his immediate family had been seen since the incident, nor had approached the family to offer their sympathies and state their being uninvolved, a common pattern among Shias who are living nearby, are relatives or who are innocent and don’t want any retribution taken out on them. Ghazanfar said he was desperately upset about the killing, in great part because Shakeel was so javan [young; U]. Wadood said that in Rawalpindi, they had first
taken Shakeel’s body to Dr. Yasin’s house, where it was kept prior to them bringing the body up by rented van to Gilgit. They reported that “rain had followed us the entire drive up to Gilgit.”

At 11.30, there was a fair bit of commotion and a vehicle drove up past our house; Fouzia came over quickly to ask me if it was the body. We could hear the women at Shakeel’s house start screaming and lamenting as the car arrived, but Kulsoom ran out to check with the men passing our house along the road, and they said that the body was in Jaglote, but these were just relatives arriving to grieve. Kulsoom and her daughters then went back into their house to wait until the body arrived. The body arrived at around 1pm, and as it did, fat drops of rain began to fall, heralding a brief rainstorm, with thunder rumbling and reverberating off Gilgit’s mountainsides. Wadood said weather like this was the sign of a martyr’s passing. There was then a brisk wind which wildly rustled the leaves on the fruit trees, and slammed shut all the open windows throughout the house. It was only after the Jenaza that the weather returned to being warm, sunny, and still. As the body passed our house, and the van parked in front of the house (his body was in an open wooden casket, tied to the van’s roof rack), I heard the Qari’s voice on the masjid loudspeaker:

“Shakeel Ahmad, Shaheed [martyr; A], has come home – please go to see the family at their home and mourn the passing of this man.” From Kareem’s roof, we saw the women were on one side of the house garden, with a shamiana [fabric; U] tent set up in a square for his body near the front gate. I watched as six or seven young men helped untie the casket from the roof-rack, while the women were howling, screaming. A man stood nearby, fiercely waving a heavy stick to keep the women from completely knocking down the shamiana tent on its left side. The noise was tremendous [see Figure 35]. Kareem’s daughter, Sushilah, was on the roof beside me, straddling a neighbour’s baby on one hip and with her own small children standing quietly beside her, holding onto the edge of her dupatta. Sushilah was crying, howling: “Afsoos, afsoos – qurban, qurban!” [regrets, regrets...sacrifice, sacrifice; U]
and yelling hoarsely at the house, “My poor cousin, my poor boy!” She was inconsolable, her hair and clothes in disarray, her cheeks shiny with tears, completely focused on the spectacle. From where we stood, we could see women and children coming up to Shakeel’s house from adjacent fields, guests climbing over the rock walls separating properties to join the mourners. I noticed police walking up the alley towards the house, and saw Khumain [Shia neighbour] open his gate briefly, and then look out and close it again. He looked quite disconsolate and uncertain, as though he wanted to join, but couldn’t. As the body was put into the main *shamiana* tent to be viewed by the closest family members, I heard a commotion in the alley and saw Adam Khan and two police officers running down the alley, with Adam Khan shouting after two other men ahead of him, “Wazir! Wazir! Miskeen!” Sushilah yelled, “Someone must have hit or killed someone!” so we ran off the roof, down to the steps to see the commotion. At the corner of the alley just up from our house, a group of perhaps eight police officers, with Ghazanfar standing to one side, surrounded Wazir [Shakeel’s uncle], and Shakeel’s teenage cousin Miskeen, both of whom were crying and in loud voices saying they wanted to kill someone, to let them go into the mohalla to kill someone. They had seen Shakeel’s wounded body and lost control. It took about five minutes before they were calm enough to be walked back up to the Jenaza.

The namaz began at 1.45pm, the Jenaza was broadcast starting at 2pm, and they began the procession down to the cemetery at 2.10pm. The Jenaza was full of, “Y’Allah…make us peaceful people, who live with mohabbat [love; U]. Y’Allah, give us the sabr [patience; U] to survive the plans of others….Y’Allah….” At 1.45 they had attended namaz there, then went up to collect the body from where it was being attended by the women. With Shakeel’s open-topped casket, draped over with blue cloth [see Figure 36], they walked back down again and began putting him into the ground by 2.15pm. I had watched them as they passed our house, leaning over our garden wall, cloaked by the leaves of our apples trees. The open-topped casket was covered with
a blue cloth. When Fouzia came to get her daughters, she said she had seen Shakeel’s face from a profile angle, and he had a *zukhmi* [wound; U] on his chin. His mother, she said, had just sat beside her son’s body, softly repeating his name over and over. At night, just after sundown, and the sky full of clouds, we drove up and through Salar Chowk to get fresh *nan* [bread; U] from a nearby *tandoor* [bread ovens; U]; at our own corner, the *tandoor* and restaurant were still intact, but closed by police. However, the whole right side of this small commercial market had been burned. The Shia-owned shops were completely gutted and missing their roofs. Wadood said Sunnis had broken into the cylinder store and put cylinders in different stores, then set them alight - they soon exploded, and destroyed the buildings. As we drove past, Wadood said sadly, “The next time this happens, they’ll run down to the Shia shops below our area and set them on fire too. You watch.”
Chapter Nine: Kala Jadu/Black Magic & Deliberate Harms

Part I  Introduction

This final chapter examines how, while overshadowed by the Sunni community’s intense attentions to the Shia-Sunni hostilities, Sunni women waged wars of their own against one another. By early spring of 2005, after having conducted interviews with mothers in Gilgit Town and the outlying Sunni villages of Minawar and Sakwar, it became apparent that, despite poverty, nutritional deficiencies and even medical mismanagement being the primary factors undermining women’s health, women preferred to emphasize the role played by interpersonal enmity, ‘malevolent magic’ and abusive domestic conditions in their lives. Women even alluded to poisonings during pregnancy, and being intentionally deprived of food during their post-partum recovery. Indeed, as much as I had encouraged women to discuss how the Shia-Sunni conflicts had shaped patient-physician interactions or interfered with their access to health centers in Shia mohallas, women pushed back to prioritize how intra-community discord and mal-intent presented equally, if not more unwieldy threats, and caused many of their health complaints and crises.

While the 2004 Nisab Riots and 2005 Shia ‘strikes’ had provided a useful distraction from Sunni community in-fighting, it had not precluded my participants’ regular engagement in household quarrels, interpersonal vengeance and neighbourhood battles.

The badal (vengeance; U) paradigms that resided at the heart of, and structured, my participants’ interpersonal enmities and attacks, were a central component of Northern Areas politics and culture, of which Gilgit’s Shia-Sunni hostilities were a dramatic refraction. The other side of badal, or revenge, was its deployment in what Gilgitis described as the ‘safest’ social relationships, such as those within families and between women. On one level, women’s relationships were truly harmonious and congenial, and I benefited greatly from my neighbours’ empathy and many acts of generosity. On another level, women’s relationships could be riddled with insecurity and competitiveness, and often culminated in chronically antagonistic relationships. The compacted quality of mohalla-life hardly helped; in Jutial Mohalla, local homes banked steeply against one another and up into the hillsides. It often felt as though emotional instability, voyeurism and inequity were fundamental elements of these neighbourhood spaces. For
women living amid circuitous mazes of family properties and alleyways - in small homes where tiny rooms branched off from other tiny rooms - life was described as an ever-vigilant attempt to self-monitor against offensive magic, harmful gossip and the surveillance of less-than-friendly in-laws, neighbours or even their natal family (see Figure 37).

According to my participants, women were always working to defend themselves against their domestic or community rivals which included in-laws, co-wives (habaynee; S) and neighbours (humsaie; U) (see Halvorson 2000: 310-312). Because of widespread economic deprivation and driven by the spatial frictions of overcrowded households, these women competed over resources and the financial and emotional support provided by adult males, whether sons, brothers, husbands or fathers. Domestic clashes were the most protracted and multi-faceted, driven by the tensions accompanying arranged marriages between unwilling partners, young brides working under the supervision of a dictatorial mother-in-law, or the frictions of overcrowded households. For the women I worked with, animosity and competition underpinned many of their social interactions and conversations, and motivated the strategic acquisition of personal information, which could in turn be used for material, emotional, social or cosmological ‘gain’. In some respects, the economic and inter-relational underpinnings of women’s battles were not entirely dissimilar from the bitter, community-based tensions fuelling Gilgit’s sectarian hostilities. As Galina Lindquist notes in her discussion of the effervescence of ‘magic’ amid post-Soviet Russia’s instability and flux:
“...[an] aspect of epistemological value in the studies of magic is its obvious connection with the structures of power. Magic practices thrive where power is brutal and overwhelming, where the rational channels of agency are insufficient or of limited value, and where the uncertainty of life calls for methods of existential reassurance and control that rational and technical means cannot offer...the ideas and instrumentalities of magic, seen as ‘practices of consciousness and self’ (Kapferer 1997)...secure agency and [also] define the boundaries of the self.” (2006: 2-3)

This component of my research highlighted how very different were the fights of men and women. Wadood joked that men dispensed with their anger through fights, hard agricultural labour or armed conflict.

Women, on the other hand - living socially compressed lives, physically encircled by high-walled gardens and family compounds - nurtured their enmities, and sometimes worked for years to perfect revenge projects. Largely because of local antipathy towards women’s public confrontation of their rivals or enemies, women resorted to sorcery or ‘black magic’ – which Lindquist argues acts as an “instantiation of power” (2006: 18) - to seek covert redress for emotional, economic, social and material imbalances between themselves and other women. As such, these quietly conducted battles permitted women a forceful and far-reaching sense of personal agency, ironic insofar as it arose from a lack of agency.

Part II Nefarious Etiologies: Nazhar (Evil Eye) & Kala Jadu (Black Magic)

The vast majority of my Sunni women participants claimed that their fertility, pregnancies and infants were targeted for kala jadu (black magic; U) by ‘jultee’ (jealous) co-wives, neighbours or the wives of their husband’s financial competitors. Because Gilgiti women’s social and familial status was inextricably dependent on marriage and childbearing, and with bodies already over-determined by Islamic honour (izzat) concepts, their fertility provided a strategic target for symbolic vengeances or direct interference by members of their family and neighbours. (Indeed, women, local jadugar [sorcerer;

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1 Men were not unaware of these shadow battles. They often paid for women’s trips to local healers, provided money for the tawiz (amulets; A) required to block ‘magic’, or bought the herbal remedies required to soothe women’s fears. But rather than engage in these struggles, many men simply deferred to local mullahs to communicate the Islamic or unIslamic nature of their acts to women, or to resolve the afflictions women claimed were caused by their ‘others’. When women claimed their ‘enemies’ were among a man’s own natal kin, men’s directly addressing these frictions risked extended family break-ups, or their being pushed by their mother and sisters - who were often the very same women being accused of ‘black magic’ - to divorce their ‘disloyal’ and ‘bitter’ wives. Men’s enduringly quiet role is confirmed by their overall absence in women’s narratives of either interpersonal enmity or malicious ‘magic’.
Chapter Nine: Kala Jadu/Black Magic & Deliberate Harms

‘magician’, U] and Sunni mullahs routinely confirmed that the largest share of ‘black magic’, counter-magic and ‘spirit attacks’ centered on reproduction.) What better way to cripple your rival or enemy than through sexual dysfunction, infertility, the birth of daughters or persistent menstrual difficulties – in other words, her ‘womanhood’? Moreover, each of these outcomes was considered a pre-condition for divorce (talaq; A) which, like infertility or the absence of sons, was characterized by my participants as a type of social ‘death’. Punitive measures and retributive acts were tailored to cause maximum gender-specific damage, and clearly demonstrated that Gilgiti women were socially constituted through their bodies, and more specifically, reproduction. Moreover, the enduring correspondence between conflict-grounded pronatalism and women’s enmity resided in a prolonged focus on fertility and the birth of sons.

Almost without exception, my participants took careful, everyday steps to spiritually safeguard their fertility and pregnancies, or covertly and preemptively disable their domestic ‘enemies’ (dushmani; U) through formal prayer, as well as Islamic sorcery (as’Sihr; A) and the darker forces associated with ‘black magic’ (kala jadu; U). Less frequently, women suggested that male and female spirit diviners could be paid to invoke attacks by jinn (Islamic spirit entities; A), witches (churriyl; S), fairies (parri; S) or even ghost-like apparitions (bhud; S). Other methods were said to be unintentional, such as the ‘evil eye’ (nazhar; U), yet were still grounded in palpable acrimony. More problematically, enmity was said to also involve women being covertly fed inappropriate medications, bodily substances (rumored as spit, pieces of hair, fingernails or even menstrual blood) (see Buckley & Gottlieb 1988, Meyer 2005), homeopathic therapies, herbs, intoxicants or even poisons. In turn, I found women’s accounts were upheld by more ‘objective’ accounts, such as physician’s accounts of their obstetric patients’ obvious use of tawiz (amulets; A). And during my research into women’s use of abortifacients, several desi bilehn (traditional healing; S) purveyors claimed to be able to concoct poisons (zeher; U) for paying clients. Seen in this way, the local Sunni community’s high maternal morbidity and mortality rates may be understood to reflect conflictive
sociality not only between sectarian communities, but also within them. Because Sunni women often prioritized the physical symptoms they felt resulted from *kala jadu* (black magic; U) ahead of the dangers associated with domestic abuse, pregnancy-related malnutrition or the Shia-Sunni hostilities, their narratives poignantly illuminated how sectarian conflict was not the most important or salient constraint women felt they faced with their everyday health.

Besides indexing women’s vulnerability to unseen forces, somatic complaints vocalized and called attention to unresolved family discord and women’s socio-economic vulnerability. My own difficulties navigating covert, women-centered battles proved how incredibly adversarial women’s social lives were. In the first year after I married Wadood, the Canadian High Commission in Islamabad warned me about two credible death threats. We ultimately discovered that both originated from Wadood’s ex-wife, her mother and sisters. But besides the risk of physical violence, my in-laws later suggested I was also the focus of ‘black magic’ (*kala jadu*).² Confirmation of sorts came six years later, on a languid spring evening in 2005. Because one of Wadood’s relatives had found quick resolution to her menopausal woes through Islamic prayers and later divination, she urged me to share my own litany of ‘female’ complaints with our local mosque’s Qari, who was one of the few unrelated men entitled to hear such intimacies.

Chatting in a quiet corner of my house, he confided that since 1998, there had been countless times when women (many of whom were now my neighbours) had tried to procure costly and laborious spells and amulets against me, the majority of which were intended to prevent me from having sons, and thereby ruin my marriage. He suggested my problems now might have their origins in these simmering fixations. Not only was I caught off guard, I was frightened and confused by the immensity of antagonism towards me, and quickly awakened to a whole new level of ethnographic discovery. A month later, I was regaled with grim stories of a suitcase full of *tawiz*, *jadu*-infused *dupattas* and scraps of my stolen clothing.


*Emma Varley*
which had been discovered in the possession of Wadood’s ex-wife. (My father-in-law, a mullah, had
opened several tawiz and deciphered the texts as being intended to make Wadood divorce me and render
me infertile.) Wadood’s ex-wife’s and her family’s angers stemmed largely from their perceptions of our
supposed ‘wealth’ and frustrations that, because we had two sons, Wadood was seen as inextricably
bound to me and therefore, less available to his own family and his four daughters from the first
marriage. But even before I had learned about sorcery, witches or fairies, during the tumultuous first year
after our marriage, I was regularly admonished to be wary of the ‘evil eye.’ Nazhar was described as the
consequence of any strong emotion, and said to be among the most common sources for women’s health
complaints. As one older ‘auntie’ in Jutial noted:

“Anyone can give nazhar. Some can kill by even one look if they are very dangerous. Some
people, at the same time they give nazhar, can give an immediate effect. Others, the effect
appears after a long time. Nazhar is an unintentional, natural thing....[even] good people
can make sacht [hard; U] nazhar. Only bad people can make bad and dangerous nazhar. We
try to avoid people we know are like this, but it’s not easy because we have many guests,
and we can’t tell them to leave or not to come.” (Shailah, Jutial: August 18, 2005)

In Minawar, Sohni said new mothers were told to protect themselves and their newborns using threads
onto which prayers or dua had been ‘blown’, a process called dhum (A).

“...black threads on both wrists and ankles and around the neck, to protect against nazhar.
We do it right away after birth. Guests and relatives will admire the baby, and maybe give
nazhar, though this is unintentional....It can come too from jealousy. You can tell the baby
has been affected because it might cry all day, have a fever. If a child dies from sickness, we
might say it is from nazhar, or if a child dies suddenly. We try to guess where the nazhar
comes from, and might try to avoid this person in future. But if when the next baby is
born, that person wants to come and visit, we can’t stop them. We can only try to protect
the baby using thread. We use tawiz against nazhar [and] mullahs make it up for the
baby....I’ve gone many times myself for my children.” (Sohni, Minawar: April 28, 2005)

In Jutial, Najma acknowledged some people were aware of their capacity for nazhar.

“My older brother-in-law has a very bad nazhar, and when he gives it, for example when
he’s admiring a fat baby and doesn’t say ‘Ma’shallah!’ within one minute, the baby will be

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3 See Mohsiniff Hazrat Sheikh Abu Ala’abaz Ahmad Bin Ali Boni’s Urdu-language ‘guide’ to making tawiz
(“Shamsul Maroof: Waliteeful Auroof”, 1992), which includes step-by-step instructions for creating and interpreting
the codes, ciphers and images used in both protective and harmful tawiz.
sick! I don’t believe it’s affecting me during pregnancy, because I do dua and so I feel comfortable and not affected.” (Najma, Jutial: July 12, 2005)

But where nazhar was a largely accidental by-product of emotion, kala jadu (black magic; U) was deliberate and carefully crafted. Unlike Islamic as’Sihr, which was bound to Qur’anic and Prophetic sources, kala jadu drew on and bridged a more extensive arsenal of materials, rituals and local beliefs. In fact, jadu refracted and re-used the same devices as Islamic therapies, such as amulets (tawiz; A), invocations (dua; A), ‘blown’ and hands-on remedies (dhum, A; malish; U). Jadu typically involved spoken spells and amulets, whereby ‘magicians’ re-ordered and inverted Qur’anic ayats, which acted to negate the healing benefits associated with certain phrases.4 (For example, an ayat normally used in amulets to help women conceive could be re-written to cause infertility.) Bodily substances were also placed in food, drinks or on clothing to permeate and unsettle women’s bodily processes or temperament. Not unlike Islamic dictates and social precepts, jadu focused on social relationships, marital practice, religious obligations and questions of cause and effect.5 In this way, women’s spiritual measures were not dissimilar from Csordas’ description of charismatic healing where

“...within ritual acts...healing includes a repertoire of discrete acts [which] can be understood as...‘saying something’ or ‘doing something’.” (1994: 43)

While Islamic sorcery was mosque-centered and male-dominated, home-based kala jadu was predominantly women-centered. Indeed, because it maintained women’s adherence to pardah strictures, home-centered kala jadu was more accessible and used far more often than as’Sihr (Islamic sorcery; A); my analysis therefore focuses on the role of jadu in women’s health complaints. Many participants claimed the victims of jadu were most often women between menstruation and menopause, with women’s fertility being a primary focus. Antagonists, on the other hand, lived at all points across the

4 Kapferer argues that magical practices “constitute metacosmologies, that is, methods of patterning or bringing together acts, events or practices that may normally be expected to exist in different or separate cosmological frames” (Kapferer 2003: 20). ‘Cosmology’, in turn, can be defined as “a process whereby events, objects and practices are brought into a compositional unity, are conceived and patterned as existing together, and are in mutual relation” (Ibid: 20).

5 Harmful jadu was also described as being directed to injure or ‘impair’ those people women loved the most or were dependant on.
lifespan; reproductive ability was not a precondition to acting on acrimony or enmity. In addition to their fervently held belief that moral righteousness was in itself a ‘protection’ against malicious intercession, women quickly took preventative measures if they discerned interpersonal ambiguity or animosity.

Defensive remedies, curative measures or counter-attacks first employed Islamic tenets (adab, amal; A), prayers (namaz, dua, dhun; A) and amulets (tawiz) (see also Werbner 2003: 223-224). When enmities became public and lines of social allegiance were openly drawn, it was strategically important for victims to take the moral ‘high-road’, which entailed conspicuously resorting to mainstream Islamic therapies and divination (see Figure 38). But just as frequently, if the measures against them were known, women were quietly advised to repel future attacks and nullify current complaints through the same systems employed by their antagonists, regardless of the spiritual repercussions arising from ‘unIslamic’ or ‘unethical’ measures like kala jadu.

In Jutial Mohalla, three of my immediate neighbours (two men and one woman) were said to have been ‘formally trained’ jadugar (magicians; U) who provided their services for set fees. Many more women neighbours were said to have learned about jadu by experience, or been ‘apprenticed’ during their adolescence by mothers or female relatives who were themselves informal practitioners. But there were other, more disconcerting sources of jadu expertise.  

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6 Jadugar were not the same as desi (traditional) healers, such as diviners, desi bilehn providers and even mullahs. Although there were rumours these individuals’ services could occasionally be procured to cause harm, by definition they worked exclusively to ‘block’, ‘fix’ or ‘turn back’ the spiritual forces directed against women. Jadugar, on the other hand, were said to generate harm as often, if not more often, than they remedied social discord or produced counter-magic.

7 One neighbourhood dispenser claimed the man who had previously owned his shop was a jadugar (magician; U). Interestingly, the dispenser’s account began by first establishing the former owner’s criminality in other contexts; “Shahidullah did a big fraud on me. He was selling his store here to me, and while we were negotiating the contract he drugged my chai, and did a fraud on me for Rs 150,000 [CDN $3,409]? When I woke up the next morning he had emptied the store of the medications I had bought, and changed the stamp on the contract, which I had signed while
One older woman who was well beyond her more spiritually vulnerable childbearing years, cautioned that the mullah providing a protective tawiz one day was the same mullah aiding an envious relative with jadu the next.8

People and mullahs do kala jadu [black magic; U] for money. Mullahs and jadugar [magicians; U] will do these things; they will do jadu for talaq [divorce; A], infertility. They might take the hair of the wife, put it in a hole in a kabur [grave; U] before the first arzan [call to prayer; A], and if hot smoke comes out, people say it will have worked. A woman I know did this; she wanted her son to divorce his wife. (Khala, Jutial: June 3, 2005)

I was startled by how often retributive acts occurred against close relatives, especially because women’s fights and their fears of family members and neighbours stood in stark contrast to Islamic credos and Gilgiti cultural emphasis on women respecting and supporting their kin.

“...some people make jadu [magic; U], such as enemies. Most people are upset about some arranged marriages, and will do jadu. For jadu, people will write a Qur’an ayat [phrase; A] in the wrong way to create a problem.” (Fazeelat, Jutial: June 3, 2005)

“If a daughter is proposed to, jealous families may try to break the dua (engagement, ‘ritual’; A), or to end the marriage, or to make her infertile.” (Qari Malik, Jutial: June 12, 2005)

While the mullahs I interviewed never admitted making ‘negative’ tawiz or sorcery, they readily acknowledged being solicited, sometimes through intermediaries (such as neighbours or the mullah’s own family), to cause harm between family members.

“I see a lot of jadu work in this area, to make husbands and wives fight, to cause sicknesses... In the last year a woman came [to me]. Her son was married first and then

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8 One Shia woman shared a particularly troubling story, which destabilizes the boundary between mullahs as healers, or the perpetrators of ‘unIslamic’ harm: “Here is a true story I heard from my auntie who is from Nagaril. One day a relative of hers lost a young child, a little boy who was maybe one or two years old. They had gone to the kaburistan [cemetery; U] to bury the child, and then the next morning before arzan they returned to the kubur [grave; U] to say prayers for the little boy – and they were carrying lanterns with them because it was still dark. They came to the kubur and saw the mullah, the one who had performed the jenaza [funeral prayers; A] sitting on top of the fresh grave, the earth had been disturbed, holding the [amputated] arm of the child. As they saw this, he fell before them, ‘Forgive me, please forgive me – I had to do this for jadu – I had to do it!’ Someone had paid him to make jadu for them. After one week, this mullah died in a horrible way, horrible. This is not just a story, you know. This is something my aunt actually knows about and witnessed. These people [mullahs] are the most corrupt, the most awful. They will do anything for money” (Bibi Hoorilah, Jutial: June 1, 2005).
married a second wife, but she thought the first wife was better, and the second wife not so good to her. She first talked to my mother, then I talked to her and said that maybe before the second nikah I could have helped her, [and increased] love for the first wife from the son, but now it’s too late, and to go against an Islamic nikah would be bad. I asked her not to be angry with me [but] Islam doesn’t give permission for me to do such a thing. She had wanted me to make a tawiz or dhum to cause the son to end his marriage to the second wife...[and] to love the first wife and to leave the new one. I’m against this after the nikah, but told her, ‘I can make a tawiz that both your son and his second wife will live happily with you. I can only make tawiz for positive things.’ I relayed this message to the woman through my mother, who gave this lecture to the woman, who said ‘Thanks God, he is a good mullah!’ when she heard what I had to say. Jadu is usually from relatives. We can do an investigation [to] find out which enemies are making jadu. People come from behind you, or [those] people acting so free and loving and open are the worst. They want your hair, or thread from the fabric of your shirt or dupatta to use, they use this for jadu.”

(Qari Saimullah, Sonikot: June 17, 2005)

At a primary level, women said jadu’s somatic effects included backaches (derh shilahn; S), headaches (shish shilahn; S), uterine ‘weakness’ (bachitani kamzoree hen; S) and menstrual irregularities. It was quickly apparent that these ailments coincided with the most common, body-anchored points for women’s expression of unhappiness (gham; U) or emotional turmoil. Jadu’s symptoms also included menstrual pain, prolonged bleeding, seizures, pain, dizziness, insomnia, nausea, fetal abnormalities and death, unexplained emotional instability and infant distress. Overall, women said that enmity-related complaints included’

“...unexplained health problems, infertility, chronic illnesses that may be the result of jadu. Or, if your daughters are spinsters, and can’t find a spouse, or for infants who are ill in some way – they can’t walk, or talk, or eat properly.” (Fazeelat, Jutial: July 7, 2005)

Women’s sense of their bodies’ permeability was also extended to their discussions of the safety or vulnerability of ‘home’. My participants cautioned me that harmful tawiz could be buried in the ground beneath my feet, or the leaves of our fruit trees laden with dhum (blown prayers or ‘spells’). Whenever Wadood felt that we were particularly susceptible to his ex-wife’s or our
neighbours’ animosity or jealousy, at sunset he would circle our house while reciting the protective Surah Yaseen. He also scoured the nooks and crannies of the stone garden wall for hidden tawiz, and looked through the flowerbeds for hair or toenail clippings that might have been thrown over the wall during the night. In my own search for mischievous magic, I once found a weathered paper tawiz nailed to the branch of our cypress tree. I had asked my brother-in-law, Haleem, to take it to the local jadugar (magician; U), who opened it, and after ‘deciphering’ the symbols inside, said it was to ‘gain wealth’ (Fieldnotes: April 28, 2005; see page 455, footnote 3) (see Figure 39). And in the uppermost branches of a pomegranate tree of our home in Chenar Bagh Mohalla, I had found a rolled ball of dark hair; Wadood and his family were unsure if it was a protective or afflictive measure. Even hospital locations were said to be vulnerable to such forces, which in some ways reflected the anxieties experienced by women who faced delivering there. In the same way that jadu-imbued domestic spaces symbolized women’s apprehension of deliberate intra-familial harms, sites like the DHQ’s Family Wing may have been superimposed by women’s quiet fears of maternal mortality, medical ‘accidents’ or physician negligence.

[Emma] “Do you want to give birth at home?”
[Emma] “Khodai sey mangtey [God will help me; U]. I don’t know what would keep me at home to give birth...my mother-in-law will go with me. My husband too. I’m scared to go to the DHQ [because] it’s a bad and dangerous place. I’m scared of the room with the dead bodies at the back of the Family Wing. I used to go to school there, near the entrance of the Family Wing, and I knew there were dead bodies there, Allah tobah! [God forbid; U]...I have a fear of [the] DHQ because I have fears of jinn, and people told me there were jinn there. My sister’s husband was telling me that someone in his family was admitted there to the hospital, and he went there to see them. It was late at night when he arrived, and the gate was locked, so he climbed in over the gate and while looking for the relative, he went into a room full of light, and people all dressed in white. After, he went into a patient’s room and asked the chowkidar [guard; U] there, ‘Who are the people in that room?’ The chowkidar said, ‘You’re lucky, because they left you [alone]...many dead people were brought here today!’ My brother-in-law went back to that room to see for himself after, and it was empty.” (Jutial: July 12, 2005)

Given my own experiences, it wasn’t hard to see how overwhelmed women could be by the enormous scope of afflictive and remedial measures. After sharing my fears for my spiritual well-being and my ability to safely carry my youngest child (with whom I was pregnant at the end of my fieldwork), one
neighbour discussed how jadu and enmity had affected her sense of physical well-being, domestic security and social space:

“A mullah had told me that a dushman [enemy; U] made jadu [magic; U] against me, after I told him how sick and weak I am [after a stillbirth], and that the medicines were not working….In a book he had, it said someone did jadu. I’ve been to so many different mullahs for tawiz, but they don’t work. I wear them when I’m at home, but not when I go outside. I feel so sick and such pain when I’m at home, but not so much when I leave the house….I was with the mullah when he looked at a book. I went because my husband’s sister was married to my brother, and my brother did a second marriage, and maybe his wife’s mother-in-law is doing jadu against me because of this? In the start of my marriage, I was so thin and sickly, and not eating. My mother-in-law was very angry, and my brother made so many tawiz for me to fix this. This was in the time before my first baby was born. They and I were afraid that my husband would divorce me and marry again, so my brother made me a tawiz. We also found a tawiz against me, and the mullah looked at it, it was a big paper with writing on it. It smelled awful, like kerosene oil – it had a bad smell, and on it they had written for my husband and me to separate or divorce. My brother found it in a box at home, and burned it….I asked the name of the person who made the tawiz, but the mullah said he wouldn’t tell, so I wouldn’t go and make a fight with that person. But every mullah we’ve gone to has said, ‘Someone has made jadu against you, this has resulted in bad health effects.’…but he wouldn’t say who or which woman had made it, so we wouldn’t fight. He only advised us to throw it in the water, saying ‘It’s not good for you!’ But my brother took it and burned it in a lantern.” (Nabeela, Jutial: July 18, 2005)

In contrast to my own feelings that women’s fear of jadu was more predominant than actual attacks, women claimed they had copious, direct evidence of kala jadu. As proof, women pointed to the sizeable number of tawiz that they said they had found - some of which they showed me, or which I myself saw ‘materialize’ during divination sessions (Fieldnotes: July 25, 2005). These recovered tawiz employed symbols or formulaic sets of numbers or Arabic letters. Some were written in Urdu and used the names of the victims, or they contained crudely-drawn pictures of people, which are called naqshah (A, U). In light of stringent Islamic prohibitions concerning the use of human imagery, naqshah were described by mullahs and community members alike as proof of jadu’s inherently unIslamic, shirk (idolatrous, heretical; A) nature. And though women were always quick to blame other women for practicing jadu,
none of my participants admitted to being the instigator, the aggressor, or to taking offensive measures. In light of the stigmas, social distancing and occasional violence experienced by people who had been ‘caught’ practicing jadu, women’s hesitancies made perfect sense. In Jutial Mohalla, where we lived for most of 2005, and where I conducted the bulk of my interviews, magicians (jadugar; U) and their clients were described by local mullahs and our neighbours in harsh terms.

“They are the worst people, who are out of Islam! These people go into graveyards, or to stay alone in the forest; they make jadu there in horrible scary places, they do jadu alone.”

(Qari Malik, Jutial: June 12, 2005)

Even after finding these tawiz, women argued that jadu relied on shared belief to work; most participants emphatically cautioned me that if you began to believe in magic, even for the briefest moment, you were susceptible. (When my neighbours discovered I was pregnant again, they urged me to quickly take precautions - “Khabardar, Emma!” [be careful; U]) Moreover, women were exhorted to never admit to or share their vulnerability, fear or insecurities with anyone they suspected of harbouring ‘bad’ (kharab; U) or envious (jultee; U) feelings toward them. As such, even obviously depressed women took pains to publicly emphasize their happiness (khushwaqt; U) and contentment. And while women and their families were aware of the potential for malfeasance from neighbours and guests who came when babies had been born, they recognized there was little they could do to block such celebratory visits. Equally interestingly, there seemed to be a variety of ways in which a new mother’s spiritual integrity could offset her ‘enemies’ inflicted harms or malicious thoughts. Despite women’s ritual impurity during post-partum bleeding, new mothers’ dua (invocations; A) - especially in the first forty days after delivery - were viewed as influential.

9 The ‘quietness’ surrounding women’s presumed practice of jadu may be likened to Veena Das’s phenomenological analysis of the ‘rumors’ (Das 2007:117) surrounding communal violence. Das describes rumour as the process by which, “propelled into public spaces...negative and hateful images of self and other slowly seeped into the understandings of many people” (Das 2007: 117). My re-reading of Das suggests that rumor – while acting as social discourse, propelling and mobilizing sometimes egregious acts - also functions to ‘mask’ and distance individuals from their actions. Specifically, by qualifying the harmful stories surrounding them and their actions as ‘rumour’ or ‘gossip’, individuals attempted to protect themselves from the harsh realities of familial or community stigma, punishment or ‘revenge’.
[Madheeya, mother] "At both the time of our nikah and a baby's birth our dua are powerful, at these times - because at the time of birth, a new mother is giving life to a human being - God says to her, 'For this, what you wish I can give to you.' At the nikah time, both husbands and wives are close to God and their dua are listened to."

[Hussen, daughter] "Anybody can come to us during those times, even enemies! Our husbands are also close to God at those times, such as the time of birth, and can do dua then too." (Jutial: June 7, 2005)

Moreover, jadu was said to be proven by, or the product of, changing or worsening in-family or marital relationships. Take, for example, one exchange between myself, a woman named Zeenat and her adult daughter Noor:

[Emma] "I've heard that you and your husband were very happy when you were married. What reactions did this elicit from neighbours and family?"

[Zeenat, mother] "In the start, we were so young and not thinking about if people hated us, or were jealous. Later we understood that they were, and kept our distance. I was happy and satisfied with my marriage, but others were unhappy at my being lucky, although they never behaved that way in front of me. We lived in a joint family, and some of my sisters-in-law would notice that I was playing with my children, and make comments like, ‘It looks like she’s not working - she just spends time with her children!’ and they were jealous. Mir Zaibul [husband’s brother’s wife] was like this. She was using sihr and jadu against her enemies and people she was jealous of. If you are a sincere person, sihr will not affect you, but you still have to be careful. But with people like this, the hole they dig for you, they will also fall in themselves! We used to say the [Surah] Yasin and do a dhum in water for ourselves to drink every day."

[Emma] "Did Mir Zaibul ever try to do jadu against you?"

[Zeenat, mother] "I was in Konodas and she was here in Jutial. She had been married to a man from here, from Gilgit, for one to two years then divorced him, then she married my husband’s brother. She made a big jadu after this, and there was a fight in [our family] home. My father-in-law and in-laws were all listening to Mir Zaibul against me. My father-in-law gave all the property, all the money - not even a chamuch [spoon; U] for us - to her and her children. He favours her and them. She made jadu so that my father-in-law would love her children and not my children...."

[Noor, daughter] "Now all are coming, begging for forgiveness [hands together in prayer position, on knees with face lowered and hands outstretched toward Zeenat’s feet] from my mother because they now realize she was right, and Mir Zaibul was wrong - she is our real auntie, you know? She competes with our mother for and about everything."

[Emma] "Did Mir Zaibul ever do jadu against your health, or that of your children?"

[Zeenat, mother] "I’m never scared and am so bold. No matter how hard she tried I was never frightened or believed it could affect me. Nazhar and jadu will not work if you are

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10 In this context, Noor emphasized that because Mir Zaibul was the wife of a blood uncle, and not merely a distant relative or fictive ‘auntie’, her competitiveness and presumed use of jadu were even more reprehensible.

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very sincere. God is great with you...Islam never says that jadu will work, all things come from God. Now people feel she did jadu on my father-in-law and brother-in-law, and now realize this, and feel badly for that and are apologizing.” (Jutiwal: June 6, 2005)

Ruqaiyah, a young mother who as a teenager had attended a madrassah in Amphari Mohalla for several years, unhesitatingly said jadu had no ‘power’, but then mused on its rumoured effects for her mother-in-law:

“I have belief in Allah Tallah, not jadu. I’ve heard about jadu in this area, but not seen it with my own eyes. Some people say that because my Sas’ [mother-in-law’s; U] health and habits are different at different times, someone has done jadu, but I don’t think her problems come from jadu. I don’t know anyone who does this sort of thing. Though people say it might be from that...” (Ruqaiyah, Jutiwal: July 12, 2005)

In Jutiwal Mohalla, the Qari at our local masjid and a middle-aged neighbour separately suggested jadu was actualized most often by the fears of its victims, and carefully explained how prayers worked to displace the emotional insecurities incurred by jadu’s powers. As such, a woman’s state of mind was an essential element of personal defense.

“The remedy for jadu is that you are firm with your deen [belief; A], you pray and do additional dua [invocations; A] regularly with your daily namaz [prayers; A]...then nothing can touch you. You don’t need amulets or spoken prayers to protect you if you have this. The less you do, the more prone you’ll be to the effects of jadu. The more nervous and anxious you are, the weaker you are too.” (Qari Malik, Jutiwal: June 2, 2005)

“...we believe that if you are sincere, and a good person, then jadu cannot do anything. [It] will not affect you. But we can do things like say the [Surah] Yasin and walk around our homes every morning to see if anything has been placed inside our property for jadu. If you find anything, Emma, you don’t touch it - use a stick to move it - and throw it into water, and it will finish the jadu right away. If you don’t believe in these things, if you are bold, they will not affect you. Personally I don’t believe in these things. If you are afraid, and believe that they will work, then it may affect you.” (Haleema, Jutiwal: June 2, 2005)

Even while tacitly admitting to jadu’s contagious properties, many women fervently argued that because jadu was not described by the Qur’an or Hadith Al-Sunnat, its powers existed only in women’s imaginations or were a by-product of chronic fear.11

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11 And though more ‘modern’ husbands often downplayed the existence of supernatural entities or jadu, almost without exception my participants’ husbands and male family members described taking measures to protect
Part III Diagnosing Ill-Intent

Formally diagnosing and remedying the harms associated with enmity, magical intercession and spirit attacks involved a vast series of inter-related practices; many of these were much more costly and laborious than Gilgit’s allopathic services. In Gilgit’s Sunni bookstores, a wide variety of Islamiyaat books and pamphlets detailed prescriptions, counter-spells, and amulet-based prescriptions offsetting magical intervention. Knowing I was the target for a host of angers from Wadood’s family, our local Qari often brought me Urdu- and English-language pamphlets describing prayers intended to alleviate family complaints or interpersonal discord. Some were focused on as’Sihr and jadu, which was a topic the Qari found particularly enlivening.

“I have a book called ‘Jadugar ka Hookam’ ['Order of the Magician'; U] which is concerned with matters of as’Sihr…Sihr concerning mahabbat [love, affection; U] between a husband and wife, or a mother and child. Or, to cause a man to have and suffer from bad khawab [dreams; U]. The book explains how jadu is done and then gives basic advice on how to control the shyateen [devils; A] or jinn involved. The book explains which ayats were used in making jadu, and gives advice on lamba illaj [extended treatments; U], dhum walley ['blown' prayer; U] and which surat sunti [Qur’anic chapter to listen to; U].” (Qari Malik, Jutial: August 15, 2005) 12

I soon discovered that for each one of women’s fears, there were never-ending steps they could take to protect themselves or their loved ones from obvious enmities or antagonism. In the same way that Wadood believed that by praying his way around our domestic space he was safeguarding us, many of my participants procured pre-emptive, protective or counter-active tawiz. These were then placed into the branches of trees described within Islam as embodying heavenly properties, such as figs, apricots or pomegranates. Or they were buried on the pathway of a known antagonist, burned in strategically themselves against these same risks. And while my participants admitted that men were not often the target of reproduction-centered harms, male infertility and impotence were sometimes attributed to jadu.

12 Although the Qari’s conflation of as’Sihr and jadu suggests they were one and the same practice, the vast majority of my participants argued they were, in fact, distinctly separate systems. As I describe at the beginning of this chapter, the boundary between as’Sihr and jadu was demonstrated by differences in their practice, afflictive and remedial scope. Wadood had grown up privy to numerous consultations between his father (a mullah) and jadu-affected neighbours. He clarified that the ‘transmission’ of as’Sihr, and its somatic symptoms, were different from those associated with jadu. As’Sihr was described as arising specifically from intense fright or ‘shock’, whereby an individual’s emotional or spiritual composure were momentarily breached, thereby allowing as’Sihr to infiltrate and effect their system.
placed kerosene lanterns or cast-iron stoves, nailed on a door lintel or hidden under mattresses. (In essence, it appeared that protective amulets were deployed in the same places women felt injurious *tawiz* were likely to be hidden.) One of the most common diagnostic measures involved a mullah taking an article of women’s clothing, which had to have been worn for at least twenty-four hours and carefully measuring it at all angles. He then blew a *dhum* (prayer; A) across the clothing, and re-measured the clothing. For increases in size, it was viewed as indicative of *jadu*; for shrinking clothes, the Islamic effect of capricious *jinn*. If the measurements remained the same, the cause was said to be within the natural realm, and women were sent to their doctors. *Tawiz* countering *jadu* or *jinn* were made to be worn in a woman’s hair, around her neck, on red or black strings around her waist or pinned to the top of her pants to rest atop the womb; in short, any part of their bodies women felt were affected or vulnerable (see Figure 40). Alternately, women placed them into water, almond or apricot oil, honey or milk and with the dissolving of the inky spell, drank it while whispering invocations and prescribed prayers, or offering supplication.

Women and mullahs argued that the most effective *tawiz* against *jadu* or *supian* used costly saffron (*zafraan*; U, F) from Spain or Iran. The costs for *zafraan tawiz* ranged between Rs 500 and Rs 1,000 (CDN $11.36-22.72), while ‘normal’ *tawiz* cost from Rs 50 to Rs 100 (CDN $1.13-2.27) (Phoonurh, Minawar: May 3, 2005). *Zafraan* was said to speed up the amulet’s efficacy, with efficacy being proven by the *tawiz*’s end results. In many instances, mullahs described their services as being analogous to those offered by biomedical physicians:

“If there are bigger symptoms, if people are going to the doctor and eating medicine and it’s not effective, then we’re sure it’s another problem.....We try our best to help the patient, we try every diagnosis. We will use *dhum* in water, or in sugar which the person eats as a cure....One time someone came, and I did *dhum, dua* and made *tawiz* for them to take – but I didn’t know who came to me – I was new in this area and not familiar with everyone, but I asked them to return if there was no effect, and they didn’t come back.
I asked for a report either way, like a medical check-up, and if the doctors give medicine and it doesn’t work, then the patient returns for a new treatment, these people should do likewise with me, and I can advise them what to avoid, or change the dhum. I’m only advising [women] as to the limit of how to use something. If it’s not effective then I can change [it]. There are so many things to choose from. We have special books made for tawiz, specialties inside are for children, women’s health – head to toe! Some we know from experience, from our elders and teachers - and we get advice from them on it. There are different names for such books - one is ‘Ain-e-Amilayaat’ – har maraz ke puranu [the history of every sickness; U] – different authors, the greatest mullahs – it’s like a dictionary! If a subject is not in one book then you can find it in another book, check in another one. For one disease there are five to six kinds of treatment.” (Qari Malik, Jutial: August 15, 2005)

In addition to Sunni clergy, there were a small number of female diviners who worked at the blurred boundary between Islam and indigenous beliefs to ‘diagnose’ kala jadu and make protective tawiz.

Working from their family home, diviners charged fees that were roughly equivalent to those paid to mullahs for tawiz. Women diviners - who came from Gilgit’s Ismaili, Shia and Sunni communities - communicated both with Islamic spirits, such as jinn, and Gilgiti cosmological beings, such as fairies (parri, piran; S). As one woman recounted:

“This woman speaks to the parri [fairies; S] and she goes behosht [unconscious; U] when they are talking to her, and her head shakes back and forth….She sings, and speaks about where people have hidden tawiz against you, how they’re hidden somewhere. She’s from Domyal [Shia Mohalla], but she lives and works in Jutial - she works there, takes money and speaks with the fairies, our neighbours told us about her. Another lady in Yasin Colony, she can [find and make appear] the tawiz. My husband’s sister’s daughter got tawiz from this lady after she had seven daughters, and yes, she had some abnormal daughters.” (Saba, Amphari: August 12, 2005)

Some of my participants acknowledged that diviners might be ‘frauds’, or described how the diviner’s claims were erratic and untrustworthy. After visiting a woman diviner in Jutial Mohalla, the mother-in-law of one of my Amphari Mohalla participants disparagingly noted how “for some people [the diviner]”

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13 Over two days in July 2005, I visited a Sunni woman diviner at her home, an hour drive south of Gilgit Town. After a local mullah had ‘diagnosed’ me as being affected by jadu, he had encouraged me to visit this woman, who he claimed possessed the ability to communicate with a family of jinn (a father and his two adult daughters). The jinn, in turn, would help the diviner locate and materialize the tawiz, charms or objects made against me. After watching the diviner mysteriously produce items for a number of women, it was my turn. For several minutes, she spoke with the jinn in trance, then plucked a gate lock (talah; U) from the air in front of me, and handed it to me as ‘proof’ of another woman’s efforts to lock my heart against Wadood.

Emma Varley
says the right thing, but for others she says the wrong thing, she gets it wrong” (Shaheela, Amphari: August 12, 2005). Or, they admitted that the tawiz could have been made by the diviner prior to the session, and cleverly produced during the session. The most conclusive proof of kala jadu, they said, came from divination sessions conducted on-site at women’s homes. Between her rounds at a local hospital, an Ismaili LHV sat down to talk to me about her own experience navigating intra-family enmity, marital discontent and a diviner’s ability to ‘locate’, remove and remedy her woes:

“I am from a valley in Upper Ghizer District, and when I married Saleem for the first year we lived with his grandparents in a family house in Sultanabad. People were not happy, it seems, that he married me and not someone locally. After a year of marriage, before the birth of our first son, we were fighting very much. My husband and I hated each other, and couldn’t even stand to be in the same room together. When he came home from work he would go and sit in another room, and we didn’t speak; we were fighting so much, and it all started for no particular reason. One day, a local woman came and asked me what was wrong, and I insisted there were no problems. The woman persisted, and I admitted I was bored, and my husband didn’t like me and wasn’t happy with me. The woman said maybe someone had done jadu against us, and suggested a man in Danyor for my husband and me to go to regarding how to find out if jadu or tawiz had been done against [us]. I told Saleem, who initially dismissed it, but I countered him by saying, ‘Look, we were so happy before with each other, then something changed – what was it? It can’t hurt for us to see this person and try to find out...’ So we drove to Danyor and the diviner looked at my palm and said it was jadu and there was a big tawiz near their house. He then suggested a man from Jalalabad who could find the tawiz and open it, destroy it. That night at 1am we brought this second diviner from Jalalabad...once at the house [he] requested a branch from a chilree [cypress tree], which is usually found up high on the mountain. He then smelled it, and went into a kind of trance, during which time he walked around the house, and through the guidance of jinn...then found a spot in the garden near their bedroom window and started digging. The first diviner had mentioned something about a dhum being done on sona [gold; U] and thrown near their place. I saw him remove a box from the ground and inside was a big tawiz on paper, with writing I couldn’t decipher, plus a human bone, hair and fingernail clippings. As well there was a stone and several other articles [and] he told us to destroy the box and throw its contents into clean water, and made me and Saleem tawiz to wear. Since then we’ve had no problems [or] misunderstandings and we shifted from that house to Zulfiqar Colony, where we lived for 5 years. It was only in the last year we were given 2 kanals [acres; U] of land in Sultanabad and we’ve moved back and built our own home.” (LHV, Hospital X: August 21, 2005)
When amulets were materialized, women were advised to destroy them in fire or throw them into clean water and dispel the magic. In remedying a health problem’s underlying cause, women diviners typically followed the maxim ‘like versus like’. Clients were told to counter ‘spells’ that had been cast through similar systems of sorcery, magic or Islamic prayer. This was in contrast to mullahs, who warned women to restrict their use of prescribed remedies to Islamic sources. Clients either praised the diviner’s abilities or derided her ‘strangeness’; many professed being frightened by the divination process. Yet it was only through working in the shadow of male-centered ritual practice that women gained the leverage to navigate the widest range of health concerns, or preserve their sense of safety and well being. The downside, however, was that diviners and their clients were easily characterized as duplicitous, fearful, anxious and unIslamic.

To this point, women-centered practices were increasingly opposed by strict, Saudi-funded Wahabbist Islamic organizations. Wahabbist-inclined mullahs, who were deeply antagonistic to the agencies inherent in women’s practice of ‘magic’ and sorcery, cited the Hadith Al-Sunnat to describe kala jadu and divination as antithetical to Islam, and its practitioners subject to the death penalty. As I discussed in Chapter Four (see page 246), South Asian women-centered practices had already been the focus of Deoband efforts to purge Islam of ‘unIslamic’ elements. Specifically because jadu was a women-centered variation of male-dominated Islamic sorcery, mullahs’ present-day efforts to disrupt the paradigmatic connections between jadu, as’Sihr and Islam represented very real resentments towards women-dominated agentive practices, which were construed as actively threatening the male-dominated integrity of mosque-centered community life. So if male-dominated as’Sihr was a ‘quiet’ practice, women-centered jadu now had to be even ‘quieter’. But in spite of conservative mullahs’ antagonisms and the ascendance of Wahabbist approaches in mosque sermons, kala jadu and divination remained widespread.

14 It’s worth noting that Wahabbism also views tawiz as antithetical to Islamic practice. Its proponents routinely exhort Muslims to place their faith directly in Allah, rather than in written words or worn amulets.
15 Although Sunni mullahs regularly protested that women’s use of jadu enjoys no precedent in Islam, there is a considerable, Islamic literature affirming women’s historical use of similar systems of ‘magical’ resort (see Azimabadi 2004, Duomato 2000, Sakr 2001).
because their practitioners promised women they could directly locate the source of enmity, and thereby
counter-act and alleviate a wider array of spiritual and social factors than was remedied by Islam
alone. Women’s practice of, and belief in, jadu illustrated how ‘magic’ was and could become “the
religion of the other” (Chireau 2003: 3).

Because rigidly austere Sunni proselytization actively worked to sever the ideological and practical inter-
linkages between jadu and Islam, women’s discussions of jadu were often fraught with tension. But
women were themselves already uncomfortable, in that their jadu narratives raised problematic and
sometimes contradictory discussions of the supremacy and practical powers of Allah (God), magicians
and nazhar. In sum, women always affirmed Allah held ultimate authority for any occurrence or action,
the majority of which was pre-destined (qismat, fate; A). Magic or sorcery could only work if Allah
allowed it to work. But on the shadow side of these discussions were women’s intimation that no matter
what Allah intended, jadu could sometimes trump God’s
benevolent powers. Explicating this belief was nearly impossible;
discussing how Allah or qismat could be ‘beaten’ by jadu’s dark
forces verged on heresy. Only in private, protected conversational
spaces, and after vigorously saying ‘tobah, tobah’ [forbid; U] while
they tugged at each earlobe, did women share their thoughts
about the darker and more obscure powers affecting their lives.

Lastly, and perhaps most curiously, diviners and the diagnostic
and curative benefits they supposedly offered their clients were
also being challenged by health outreach programmes, which
characterized divination as dangerous recourse for easily remedied
medical complaints. At the Gilgit Medical Center, AKHS,P’s in-house health promotion artist showed me
a number of paintings he had prepared for AKHS,P outreach activities in Ghizer, Hunza and Nagar

Figure 41: AKHS,P ‘anti-divination’
health promotion material (2005).
Districts (see Figure 41); these were part of community story-boards, which were used to show how women’s resort to desi bilehn, Islamic prayers or diviners only delayed necessary allopathic treatment. By restricting women’s ‘magic’, the unusual alliance of Gilgit Town’s conservative Sunni ulema and health outreach proponents sought to reduce the gendered agency accompanying jadu or as’Sihr, and minimize the wide range of practices operating at the periphery of formal Islam, and out of the control of Gilgit’s Sunni ulema or women’s treating physicians.

Part IV  Supian, Churriyl (Witches), Parri (Fairies) & Jins

Women’s fears for their marital, reproductive and maternal well-being were not restricted to nazhar and kala jadu. Many women also described how their nightmares were a vivid precursor to the birth of an abnormal infant, or the unexpected loss of an infant during its first year of life. Specifically, women recounted dreams where they were attacked by animal-faced women either during their pregnancy or the day prior to their child’s death. This vague and quasi-human entity – which was also viewed as a sickness – was called supian (S). Like churriyl (witches; S), jinn and piran (fairies; S), the supian manifested women’s phenomenological or emotional engagement with specific social realities or metaphysical entities. Over a series of interviews, my assistant Fazeelat and two of Wadood’s cousins discussed the supian’s multiple, interchangeable modalities:

“Some say it is a wind, or a sickness. A dangerous supian…can even kill a child of two to three years. The sacht [hard; U] ones do this; a woman with supian can transfer it to another woman’s baby if she gives her milk to it, or touches parts of the baby’s body. Some afflicted women will take an article of your clothing, like your veil, and wipe it on their body secretly and make sure you wear it, and transfer it in this way. Supian are cats, dogs, cows – they have the face of a cat sometimes. If she wants to affect a woman, she takes the form of a cat that the woman sees in her dream, and this means the supian wants to attack her.” (Khala, Jutial: August 18, 2005)

“Supian happens more with boys than girls…perhaps because when jealousy exists, or that people might then wish ill on others’ pregnancies or future prosperity. People use tawiz for treatment of supian, regardless of their overall fatalism.” (Fazeelat, Jutial: April 25, 2005)

“The way Jehan got it was ‘genetic.’ [Her] mother…had 1 child, then lost 7 children. The supian paladhee [shifted; S] from the mother to the daughter. It is like nazhar in how it shifts, and that is mostly unintentional. It is from God. Both good and bad things come from God.
Chapter Nine: Kala Jadu/Black Magic & Deliberate Harms

– happiness, sadness, pain, tukhleef [difficulty; U] – all comes from God.” (Azeelah, Jutial: May 4, 2005)

According to Sunni women, the supian was a ‘being’ restricted to Gilgiti cosmology, but local mullahs had begun working to apply supian with Islamic parlance, and thereby co-opt and control its associated practices. One mullah described supian as having its basic roots in Gilgiti cosmological systems, but said it was also reflective of Islamic discourse. He said the concept actually originated from the Arabic expression umm os’subian, which means “the child’s mother” (Qari Malik, Jutial: August 15, 2005).

Overall, mullahs argued that supian experiences were real, but women had misunderstood that these entities were actually Islamic jinn, human-like creatures, both good and bad, which live in divine spheres parallel to ours. Literate women who were better versed in the Qur’an, or who had been schooled in local madrassahs, were equally unconvinced the supian was ‘Islamic’.

“In the Qur’an and Hadith, it’s not mentioned. In Surah Abu’Hayab, it mentions one Hadith and tawiz…only jadu is mentioned in the Qur’an Sharif [Noble Qur’an; A], when people write a Qur’an ayat wrong, for instance.” (Ruqaiyah, Jutial: July 12, 2008)

Once ‘infected’ by a malevolent jinn, the Qari described how pregnant women carried the supian - or ‘sickness’ (beemari; U) - through their veins to the unborn baby:

“It will go to the uterus and push with its foot on the baby and kill it; you’ll zaya [lose; S] the baby. For women who are totally infertile, the jinn who comes from supian pushes on a particular vein and causes abnormal bleeding, and you can’t get pregnant, or the jinn will be attacking the baby in the early months, or it can kill the baby in later months by pushing on its neck and strangling it….It is a marasz [sickness; S] which [can] come from jadu and the jinn is the source of the supian. Women are confusing two separate things in one effect here. The jinn can come in either a man or a woman’s shape, and jadu can summon the jinn to do this work. If women come to me, asking for a tawiz for supian, I don’t explain the difference to them.” (Qari Malik, Jutial: August 15, 2005)

Other women described deformed infants as the physical manifestation of the supian:

“Sabreena’s sister had a daughter with deformities – I saw the baby girl once after birth – its face was blank and there were horns on the back of the upper head. There was one eye in the middle of the forehead, and sign of a mouth…it only lived for two days. The supian came and appeared in its real shape!” (Madheeya, Jutial: June 2, 2005)
While some women’s descriptions of the *supian* harkened at mysterious ailments, other times it was a mask for entirely natural causes, including tetanus-related seizures, the traumas of obstructed childbirth, or congenital birth defects. One woman noted that

“…sometimes babies are born with blue spots, bruises all over the body. Or some babies have clenched mouths and teeth and then they die. In dreams, their mothers see the *supian.*” (Khala, Jutial: June 2, 2005)

The mythical quality of these deaths only partially obscured the neglects associated with unhygienic births, or the harmful interventions of untrained midwives, and women’s inability to directly blame their family or doctors for the loss. For women who had lost multiple infants to the *supian*, prescribed ritual responses were arduous and emotionally taxing, deeply symbolic of women’s social liminality in the absence of surviving children. One mother recalled how when her first surviving baby was born

“…for three days they hid him from me, moving him from the room I was in - I couldn’t see ‘it’ [actual words]. When they brought him to me, first I looked at the Qur’an, then looked a plate of flour which I mixed with my breast-milk, then they made a dough which they threw for the dogs to eat. Then they put the baby on my lap, and I put a drop of breast-milk in his right nostril, then looked at the baby. I was so scared the baby would die - I kept the baby close to my chest, tight in my arms for fear he would die, all night, afraid he would die in the morning, waiting for him to die at night, not thinking about him living.” (Khala, Jutial: June 2, 2005)

In this way, the *supian*-affected baby became a screen for women’s unsettled, projected anxieties - for her marital and economic security, the moral messages implied by infant loss, punishment and retribution, jealousy and unresolved enmity. One woman had lost her first six infants, one after the other, and said how

“…all [through each] pregnancy, I would be afraid I would lose the baby. In dreams, many women came and sat around me, and then I was sure my baby would die. They were touching, stroking my belly; they were different characters in each dream…. I even gave my milk to a donkey when the babies were born, so the *supian* shifts to the donkey!” (Pfifi, Jutial: June 2, 2005)

But babies were not the only ones vulnerable to spiritual entities; many women described themselves as being intensely susceptible to spiritual forces in the forty days after delivering. In trying to account for their post-partum ailments or health crises, many women claimed that the same male and female spirit
diviners, whose services they often recruited to rid them of kala jadu, could also be paid by their ‘enemies’ to invoke attacks against them by Islamic spirit entities called jinn, or witches (churriyl; U).16 This said, these forces were also described as free-roaming and uncontained, affecting women at-will.

Witches were universally characterized as a negative force. Churriyl were described as human-like, but not explicitly human. Like jinn, they were a natural part of God’s order (hookum; U) and could be Muslim, non-Muslim or “the kind of person who doesn’t pray for at least 40 days” (Hussen, Jutial: August 18, 2005). They were always women and were occasionally described as “drinking blood” (Nurse I, DHQ: August 23, 2005). For women who could ill afford to directly assign blame to their female enemies, witches provided a helpfully differentiated symbolic focus for the harms affecting them or their newborn infants. To my mind, because witches were usually qualified as being older women, they provided a narrative substitute for women’s acrimonious mothers-in-law. One young cousin, clearly exhausted by daily battles with her mother-in-law, described witch attacks as covert and ‘unIslamic’.

“Three days after I delivered Shafi, I was sleeping and my mother was with me. In the middle of the night, I awoke and saw the door opening slowly by itself, and heard small, light footsteps coming across the room to me. Then I felt and saw small, soft hands massaging my arms. I was so frightened, and started to say the kalima and it made them angry. I heard a voice telling me not to say the kalima, but then I said the Qur’anic Ayat al’Kursi and they ran away….in the morning I told my mother, and after that she took extra care of me, and would stay up at night watching me.” (Muneeza, Minawar: August 18, 2005)17

In turn, Muneeza’s mother recounted being ‘attacked’ some twenty-odd years earlier, when Muneeza herself had been born.

16 As our neighbourhood Qari explained, “Jinns are just like people. They originate from Heaven, but some are borey [bad; S], shararatee [naughty, mischievous; U] some are kafiroh [non-Muslim; A]” (Qari Malik, Jutial: August 15, 2005).

17 The Ayat al’Kursi is a small section of Chapter Three in the Qu’ran, ‘Thilqur’Rasool’ (‘The Cow’): “Allah! There is no God save Him, the Alive, the Eternal. Neither slumber nor sleep overtake Him. Unto Him belongeth whatsoever is in the heavens and whatsoever is in the earth. Who is he that intercedeth with Him save by His leave? He knoweth that which is in front of them and that which is behind them while they encompass nothing of His knowledge save what He will. His knowledge save what He will. His throne includeth the heavens and the earth, and He is never weary of preserving them. He is the Sublime, the Tremendous.”
“Here...people think witches can come, and it’s bad to leave a new mother alone. We don’t believe this thing about piran [fairies; S], which we believe are good. With Muneeza, after her birth, I was sleeping at night and all night I was crying. A witch came and was trying to kill me - it came and was pulling me [indicates pulling at breasts, clothes, hair]. I was not in my senses, [but] it wasn’t happening in my dream. I just wasn’t in my senses. Elders had told me about this kind of thing happening before Muneeza’s birth, and they diagnosed it and told me what was happening. In the 40 days after a baby is born, the graveyard’s mouth is open for a new mother - she is vulnerable to physical and supernatural forces.” (Safia, Jutial: June 6, 2005)

In light of Safia’s and Muneeza’s accounts, and with so many maternal deaths caused by post-partum hemorrhage, this ‘watching over’ of women in the first day after delivery was entirely pragmatic, and may have saved a considerable number of lives. Older women also described how there had been more churriyl in previous generations:

“Long ago, there were so many churriyl in Jutial. When people died, the churriyl would get together around the dead body. One man who lived here made tawiz [and] the people went to him and asked him to make the witches leave. So he went to that place and did dhum and dua for them to leave but it didn’t work [completely], so he went back to the people and asked them to give food, a goat or something, in God’s name as qurbani [sacrifice; A] to get rid of them, and they did. It worked. The churriyl were keeping the spirit of the body to eat, you see. I saw churriyl with my own naked eyes.” (Khala, Jutial: August 18, 2005)

When I asked where witches could be found, one elderly ‘auntie’ shared a story from her early married years in Jutial Mohalla:

“They make a certain noise at night, and you can hear their awaz [voices, sounds; U]. Sometimes we could hear so many voices, it was like they were having a big party....we could hear them in a big garden with a lot of trees.” (Khala, Jutial: August 18, 2005)\textsuperscript{18}

I found something quite evocative about this auntie’s story, of a neighbourhood alive at night with the sounds of women’s other-worlds, their spiritual other halves; of a darker, parallel universe inhabited by women unconstrained by Islam’s ritual strictures, unburdened by husbands or children.

\textsuperscript{18}Fazeelat described how among the trees, the churriyl was not alone. The “chenar [maple; U] tree is where jinn and fairies like to stay...you have to avoid such trees at evening time” (Fieldnotes: August 16, 2005). Fazeelat had earlier described how, “...my mother and elders always warned me to stay away from tall trees, and bright flowers, because fairies like those places, and will see you and pusund [like you; U] and take you, marrying you!” (Fazeelat, Jutial: July 12, 2005)
Pregnant women suffering eclamptic, hypertensive seizures were sometimes ‘diagnosed’ by their families or mullahs as being possessed by *jinn*. Rather than going to hospital for emergency treatment, their families sought care first from Islamic clergy, herbalists or spirit diviners. Such delays carried undeniable consequences, including death. While seizing, eclamptic women were sometimes beaten by family or mullahs to rid them of the invading *jinn*; DHQ staff had mentioned seeing several pregnant women arrive unconscious and covered with bruises. There were other, less violent means to resolve women’s possession episodes. Our local Qari recounted treating one such case in Minawar several years earlier:

“I had just come back from Pindi and was visiting my brother in Minawar when he said there was a woman who had *jinn* coming to her. I went to the *mulaie* [young woman; S] and had her sit in a chair across from me. I didn’t touch her myself, as she was not a little girl and therefore not *meharam* [permissible; A] to me. But her uncle and brother sat beside her chair and held her thumbs and big toes tightly in their fingers, because *jinn* enter and exit the body through these points….At times we take branches from a tree we call *phak* [fig; A]...and do a *dhum* on the branches. If the person doesn’t answer us, or lies to us - and is really a *jinn* - we strike them very lightly on their knuckles or elbows. If it’s a *jinn*, they’ll scream in pain. We can also check to see if the individual is playing with us, and this isn’t a real case of *jinn*. If there is no one available to hold a woman’s thumbs, I can do it myself - and if there’s no one beside myself to hold her toes, we’ll tie the first two big toes tightly together so the *jinn* can’t come out. I then read the *Ayat al’Kursi* and did a *dhum* on her and asked her - the *jinn* - the specified questions. [If] there’s no answer, we’ll keep repeating the *Ayat al’Kursi* until they respond. If the *jinn* lies, then you can use the branches of the *phak* tree20…..Sometimes when we know a *jinn* is coming to afflict an individual, we can make *tawiz* for the person to wear to stop the *jinn* from coming back to them. Sometimes when we are talking to the *jinn*, they are frightened or scared of us, and refuse to co-operate or talk, or give us lies for answers. It depends on the nature of the *jinn*, but some can be very difficult to communicate with us and it takes a half hour or so of pushing before they respond to us. Or, they’ll use a different language to communicate.”

(Qari Malik, Jutial: August 15, 2005)

Unlike *churriyl* and *jinn*, fairies (*parri*; S) were described as having oddly positive qualities. The fairy’s primary crime was to fall in love with humans, put them into trance and steal them away to their mountainside homes. If expectant women and new mothers suddenly became dizzy (*chukur*; U) or fell

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19 See Lambek (1990) for a discussion of the role of Islamic clerics in alleviating or diagnosing spirit possession episodes in Mayotte.

20 After one interview, Fazeelat explained how “the fig tree [along] with the *anar* [pomegranate; U] tree is considered a tree and fruit of Heaven” (Fieldnotes: August 16, 2005).
unconscious (behosht: U), or were seen as acutely emotionally or mentally unstable, they were sometimes viewed as being held in the grips of a fairy’s ‘spell’, and vulnerable to ‘running away’ or ‘disappearing’.21 (The primary sign of an actual ‘attack’ by fairies was said to be an unexplained seizure.) One of my participants in Jutial even recounted how her elder sister had been kidnapped by fairies shortly after the birth of her fifth child:

“Before her marriage, she had problems. She would scream and say a fairy was attacking her, strangling her and giving her problems breathing, and trying to snatch her away. After some time, she married and had 5 daughters; 4 are alive now, and 1 is dead. She was 14 at the time of her marriage, and after 14 years of marriage, she had a 3 months old baby girl and was holding her in her lap, feeding her and sitting in the small lawn in front of their house. Suddenly, she disappeared! The baby was still there, in the garden where the mother had been – she wouldn’t have left such a little baby alone like that on purpose! That night, some people from her husband’s family came to our house, and asked where she was, but we didn’t know where. My brothers and the husband’s family searched for 3 months for her - on the mountains, along the river – we didn’t even find a dead body! Before her marriage, she had gone to a mullah for a special tawiz, and he said ‘Don’t open this, and you must always wear it!’ as protection against the parri [fairies; S]. Then she didn’t have any more problems like before. After marriage, she had some of the same feelings again, and with her husband she went to a Konodas mullah, who made a new tawiz and advised them to throw the old one in the river. She went with her husband to do this. On the second day after this, she disappeared and the fairies took her. Another relative...had the same problems with fairies, and she came to us. We asked her, ‘Where is our sister?’ and she told us, ‘She is with the fairies, but she wants to go to her parents again. But the fairies tell her, if you go, we’ll kill you!’ The fairies live in some high mountain areas – koiy khaat [high mountain, pasture; S]. I’m not sure where, but it’s near running water....My relatives said that fairies only come in front of very lucky people, and they come in the shape and appearance of a tube [fluorescent] light. I don’t know what stole her....Her youngest baby died because people were not able to care for her properly, and she missed her mother so much.” (Ruqaiyah, Jutial: July 12, 2005)

The strongest possible Islamic recourse to kala jadu, afflictive Islamic jinn, supian, churriyl (witches) or piran (fairies) was to ‘bounce it back’ at the perpetrator or its original source through concerted spiritual meditation, prayer counts (tasbih; A), fasting (roza; A) and social isolation. Prominent among prayers was

21 Several months after we left Gilgit Town to return to Canada, a distant relative and former research participant called and told us that her husband of thirty years had ‘disappeared’ (jhagoh; S). While some speculated that he might have killed himself in the Gilgit River (a frequent location for suicides), many more suggested he had been taken by fairies. Even until the time of writing in 2008, there has been no trace of his whereabouts.

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the Manzil, which when read was said to be “extremely effective for protection against the evil influence of Jinn, Sih’r” (Ali 2006: 3-4). Handicapped by household duties or childcare, most women were unable to do this for themselves, so their husbands contracted mullahs to pray on their behalf. Such recourse was called ‘cutting chillah’, and was described by Fazeelat as a process used by both Shias and Sunnis.

“You go to a mullah...he sits in a room for 40 days reading the Qur’an, doing prayers...After 40 days, you can check with him and he will tell you how many tasbih [prayer counts; A] he did for you. If your problem is solved, you pay more money... now it’s more than Rs 5,000 [CDN $114]...even if people are very poor, they’ll find the money no matter what, arrange a loan, anything!” (Fazeelat, Jutial: July 7, 2005)

Sometimes, cutting chillah necessitated that mullahs inhabit the same spaces used by black magicians, and which were also said to abound with jinn and fairies.

“...chillah means a ‘lonely place’ with no noise or disturbances. Some can go to a secluded place, like forests or pastures, with no disturbances. To cut chillah they might use a special book, like one used for cutting jadu or nazhar ['evil eye'; U], and they are reading this for all the 40 days.” (Fazeelat, Jutial: July 7, 2005)

In some ways, ‘cutting chillah’ was analogous to a vision quest. After reflecting on the numerous times his father had been contracted to conduct chillah on a neighbour or mosque congregation member’s behalf, Wadood explained how chillah practitioners were advised to

“...go to a small place with water flowing and coming from both sides. During their 40 days, they experience many different things, and have to stand up to these challenges for it to be all done properly. They might see snakes, or things that aren’t really there. To become a professional Islamiyaat expert...he will face all things.” (Jutial: July 7, 2005)

Last but not least, women used biomedical drugs for enmity’s ‘symptoms’, including those associated with ‘black magic’. As with eclamptic seizures, which could also be ‘diagnosed’ as spirit possession,

22 The Manzil is comprised of a set of carefully organized ayat, which could be recited along with “other Du'as and formulas for protection. It was customary to make special arrangements for children...to commit this ‘Manzil’ to memory....there are thirty-three Ayaat which ward off the effects of Sih’r (witchcraft), and that they are a protection against the Shayaateen (devils), thieves and harmful wild beasts....if one suspects anyone to be afflicted by the evil effects of the jinn, then these Ayaat should be written and made up as a Ta'weez (square with number & word) and then hung on the victims neck, so that the Ta'weez [be] in place of a pendant, near the heart. These Ayaat should be read and infused into the water by blowing thereon, and subsequently sprinkled on the victim. If the ill effect is in a house, then this water may be sprinkled inside and outside the four corners of the house....It should be considered and borne in mind that the effectiveness of the recital of these Ayaat and Du’as as a formula for specific purposes depends [on] sincerity, undisturbed and earnest devotion of the reader. The effectiveness of the response to Du’as is relative to the determination of one’s conviction” (Kandhlavi 1981 in Eliasi 2006: 4-5).
many reproductive and maternal health complaints were simultaneously covered by allopathic, Islamic and desi etiologies and therapeutic recourse. Because they often made concurrent, expensive and erratic use of competing medical systems, women risked misdiagnosis, delayed service uptake, over-medication or cross-medication. However, the wide range of resulting side effects and health harms were poorly understood by local physicians. Self-medicating against the anxieties and unhappiness accompanying relational turbulence was also quite normal. Besides anti-anxiety medications like Valium or muscle relaxants like Buscopan (which were easily purchased without a doctor’s prescription), many women routinely used a local beverage called ‘pong-makhotee’.23 When I was sick with typhoid, my use of antibiotics was supplemented with this amber-coloured brew of saffron (zafaraan; F), a local herb (pong; S) and makhooti, which women described as a ‘mountain flower.’ The raw ingredients were brought in twisted plastic bags, carried in the folded-over corners of dupattas and given to Wadood each evening by concerned female neighbours. While the saffron was Iranian and bought in Gilgit’s main bazaar, and pong grew wild in local gardens, the makhooti was purchased from the aged Astori peddler who passed through our neighbourhood every few weeks during the summer. (This same drink was also described as a calming ‘tonic’ of sorts, and had been occasionally offered to me after in-family arguments [see Varley 2008b: 148].) Pleased by its calming effects, I had finally asked to see the raw ingredients, and quickly wondered if it was actually an opiate tea brewed from mountain poppies, called makhooti in Shina (Varley 2008b: 148). But in contrast to my participants’ use of desi bilehn (traditional medicine; S) for jadu’s somatic effects, the desi specialists I interviewed said jadu and desi bilehn were mutually exclusive systems, whereby desi remedies could not alleviate jadu’s effects. In Jutial, the Shia woman who

23 In his analysis of drug addiction in Afghanistan, David Macdonald notes similar patterns of drug use among women; “A study of 50 Afghan refugee women polydrug users in Pakistan found that many were first introduced to drugs like Valium by visiting a doctor for a range of medical conditions such as body ache, sleep disorders, headaches and psychiatric problems. As the report says, ‘Once they understood and had ‘learned’ the effects of these drugs, they were able, if they wanted to or when they needed, to simply buy them to self-medicate whenever they chose.’ Others learned of these drugs through neighbours and friends….A qualitative study of women in southern Afghanistan conducted between 1998 and 2001 also showed that women increasingly turned to pharmaceutical drugs to relieve stress and tension….At the same time, as they had done for centuries, women also used ‘poppy water’ (opium extracted from poppy pods by boiling) to tranquilise babies or young children who were irritable or could not sleep” (Macdonald 2007: 216-217).
prepared and sold *desi* remedies confirmed how, “…women don’t come for the effects of 
*jadu*, I don’t believe in it! Maybe they’ve gone to the mullah for this, but not to us” (Mugehra, Jutial: September 10, 2005).

In addition to *desi bilehn* or pharmaceuticals, there were other ways women tried to preserve or salvage their peace-of-mind. When my participants and I were especially weary of the everyday travails of family life, group interview sessions carried an undeniably therapeutic quality. Women’s *gup shup* (conversations; U) provided helpful opportunities to flush out our angers and process the meanings and motivations behind rivalry or hatred. But there were limits to women’s ability to express or share their discontent or fear. Narratively balanced between a litany of physical ailments and interpersonal frictions, women’s ‘self’-centered complaints were only socially acceptable when they foregrounded concerns with fertility and family well-being, or the health of the unborn. Indeed, when unconnected with their health issues, Gilgiti women’s subjective voicing of ‘selfhood’ or unhappiness was routinely viewed with suspicion, as narcissism or as a potential threat to family or marital integrity. By talking ‘too much’, for instance, women risked being characterized as ‘trouble-makers’.

*Emma* “Do women make gossip about other women’s reproductive lives?”

*Najma* “Yes, they make a lot of gossip and *gup shup* [idle chat; U]. If a woman is pregnant or not…I’m not going out, and usually don’t like to sit with women who talk like this.”

*Emma* “Do you know women who make trouble like this?”

*Najma* “It’s usually old ladies, who have too much free time, and don’t have any work. In every community there are people like this. In Amphari, it’s a big neighbours ‘colony’, and more women are roaming the streets, watching and making trouble….After our *shahdi* [wedding party; U], my husband [was] not allowing me to go to the neighbours’ houses. Only to my sister-in-law’s house and with my husband’s permission…I don’t like people so much, and neither does my husband.” (Jutial: July 10, 2005)

Listening to gossip, or partaking in it, invoked the same types of cosmological vulnerability accompanying ‘magic’. Women often cautioned me, saying “If you believe in it, it will happen to you!” or, “If you listen to your enemies’ gossip about you, you’ll fall into the hole that they have dug for you!” (Fieldnotes: August 17, 2005) In this way, my afternoon visits to women neighbours, ostensibly to comb
through our families’ happenings over several cups of tea, illuminated the infectious qualities shared by gossip (ghaiebat; S) and ‘black magic.’

It was nearly impossible to extricate myself from the vigorous, ongoing mindfulness and self-surveillance necessitated by ‘magic’ and gossip, and which paralleled in many ways the routine self-monitoring required by pardah (veiling, gender segregation; U) and other practices of Islamic comportment such as prayer (namaz; A) and ritual purification (wudhu; A) (see Burton 1988). As was the case for our everyday negotiation of gossip, jadu required that we think through, re-imagine and predict our family and community relationships from our enemies’ standpoints. To the dismay of women’s more ‘visible’ antagonists or rivals, these family- and neighbourhood-based efforts to address women’s interpersonal or health complaints through discussions of ‘magic’, paradoxically reinforced the same marital ties, intra-familial and neighbourly affections targeted by jadu. Because a woman’s shared accounts and protective measures involved local mullahs, family and friends, they allowed her to re-define, re-new and strengthen her relationships with more supportive in-laws and neighbours.

**Part V: Deliberate Harms**

The harms perpetrated by women against other women were not only hypothetical. At the end of my fieldwork, I began hearing about a number of intentional offenses, which involved women being surreptitiously fed, or dosed with, inappropriate medications, herbs or poisons. During my research into women’s use of abortifacients, for example, I discovered that some pharmaceutical dispensers had concocted ‘poisons’ for paying clients. (Because I was pregnant with my daughter Sofia for the last four

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24 Where Nancy Tapper describes how narratives, “gossip and gifts between [Afghan] women demarcate a ‘sub-society’ serving as a psychological...outlet in situations of male domination” (Tapper 1978: 395 in Ahmed 2006: 11), in Gilgiti parlance ‘gossip’ (ghaiebat, choogulee; S) carries deeply negative connotations. Such terms are predominantly applied to conversations that are specifically tailored to instigate social discord. More neutrally, women’s conversations are characterized as ‘discussions’ (gup shup, batey kurte heh; U) or ‘stories’ (kahanay; U), whereas folktales are described as ‘qissa’ (myth, fable; F). By anchoring their health stories to ‘kachi-mish’ formats, women used narrative structures to “draw attention to a separate [expressive] women’s culture” (Grima 1992:6). As such, Gilgiti women’s narratives occur among, and reflect larger distinctions between ‘public’ and ‘private’, ‘hostile’ or ‘friendly’, male or female social spaces. Women’s decisions whether to narrate ‘themselves’ and their innermost thought’s requires continual awareness that “the revealed information may be held against oneself” (Grima 1992:3). Similarly, Marsden writes that in neighbouring Chitral, “not all thought...is vocal and part of the sociable exchange of ideas and viewpoints; thought may also be concealed” (Marsden 2005:22). Pardah, too, was “as much about concealing thoughts and emotions as it [was] about covering heads and bodies” (Marsden 2005:22).
months of fieldwork, these confessions certainly impacted the way I thought about gifts of food from our neighbours or less friendly in-laws.) For women who had delivered only daughters, and who knew through ultrasound they were expecting yet another, some were supposedly deliberately overdosed with anti-malarials which cause premature delivery and infant death. At one Sunni mohalla pharmacy, the dispenser described how clients sometimes purchased vials of injectible Oxytocin, a uterine stimulant that, if over-prescribed, caused miscarriage, early delivery or uterine rupture (Usama, Jutial: August 8, 2005).

Usama suggested that if local rumours were correct, Oxytocin vials were – if only exceptionally rarely - disguised as ‘vitamin shots’ and administered to unsuspecting women by their mothers or sister-in-law or by their pressurized husbands. (Hearing this, Wadood commented that there was no way to know the motivations underlying such actions, but suggested that ‘inflicted’ abortions were most likely the result of impoverishment or frictions between mothers-in-law and junior wives.) And in obvious contrast to Gilgit homeopathic practitioners’ claims that traditional herbals could “do no harm,” the desi bilehn purveyors I interviewed conceded that desi remedies could be “improperly” used (Fieldnotes: July 17, 2005). In one of Gilgit’s larger homeopathic dispensaries, the dispenser confirmed misused ingredients could cause permanent damage or death, and that women made up the bulk of his customers.

“…we have something which causes humuhl giranah [miscarriage; U] until three months...it’s called haloo [S], and you have it with thatoh ghee [hot butter; S]. It’s a seed from a big tree, the seed comes out of a fruit, and you take one small spoonful first...it always works, although it’s gunah sacht [a hard sin; U]...One day, someone came begging down at my feet, offering me Rs 50,000 [CDN $1,140] but I refused to give it to them...they could be tricking someone to eat it without their knowledge...Then there is shingiriff [S]...rhong sey atah heh [it comes from the mountains; U]. If prepared as a zeher [poison; U] it eats your bones from the inside out, making a hole in them. It’s a very complicated
process to mix, *yaar* [friend; U]...you take an egg yolk and mix it with the material and store it for forty days, [and] then you use it by applying it to the skin.” (Imtiyaaz, Dispensary X: August 11, 2005; see Figure 42)

At the same clinic, the dispenser also showed us bottles of liquid mercury, which he claimed women put into their enemy’s shampoo or food. *Desi bilehn* also included remedies to protect women against these same kinds of harm.

Speaking to me from the roadside where he sold *desi* herbs from burlap sacks, Mohammad Isa showed me a variety of stone charms made from the aptly-named *zehermura* (U), a jade-like material that was supposed to ward off the evil eye (see Figure 43). In powder form, though, it was said to act as an antidote to poison (*zeher*; U) (Mohammad Isa, Gilgit: August 20, 2005). *Desi* providers’ accounts weren’t merely about male anxiety about women’s domestic machinations; indeed, these products were also sold to and used by men against women. On several occasions, I was told about incidents when husbands had killed their wives under the guise of ‘honour killings’. Moreover, some men showed no compunctions about killing their wives even when they were pregnant or had just given birth, in order to secure a second marriage. In the early spring of 2005, our neighbour, Fouzia, shared her deep fears for her teenage niece who was being pursued by an already-married man from Diamer District. Fouzia’s family was vehemently opposed to the marriage, but

25 *Zeher Mura* is also the name of a medicinal herb collected from high mountain forests across Northern Pakistan.

26 I learned of at least fifteen ‘honour killings’ that occurred among Wadood’s extended family and friends over the period of my fieldwork; such deaths do not typically result in murder charges. For the most part, my participants did not feel that the men committing these acts should be punished unless they had ‘faked’ the underlying cause for the death. For example, I was told of one man who had invited a friend for dinner, and then shot and killed both his wife and the guest. He then told police that he had ‘caught’ them together and was therefore justified in killing them in order to avenge his lost izzat (honour; U). When he later confessed he had killed his wife in order to secure another marriage, locals were outraged and quickly called for him to be jailed (Fieldnotes: June 12, 2005). Such stories were corroborated and upheld by ‘Blessing Hands’, a Sunni-operated NGO based in Gilgit Town; “In most cases the motive for these forced killings...are i) to cover rape cases, ii) marriage without the consent of parents or brothers, and iii) extra-marital relations [and] honour killing” (Blessing Hands Funding Application [EU]: September 2003).
the prospective groom, who was in his mid-forties and already the father of many children, had threatened to kill the niece and family unless they relented. The girl’s family’s chief concern had been that she would be part of an inequitable polygamous marriage and, despite the threats, they withheld their permission. Several weeks later, the man’s wife died, shortly after delivering another baby. My fieldnotes recount one of Fouzia’s frantic visits to Wadood, as she tried to secure additional help in delaying the marriage.

“Her niece…is 18 years old and currently attending a madrassah where she lives and studies. She is the daughter of a…man from Darel who was murdered by Shias some years back [and] she was small when her father was killed, and [then] promised to a relative of his family in marriage. [Her] marriage has already been agreed to, but another man from Darel…asked for her hand in marriage, and her family refused…The man’s family said that if he couldn’t have her, they would kill whoever tried to keep her from him, or kidnap her and bring her to Darel for marriage. The family continued to protest, but then two weeks ago…his wife died by vomiting up copious amounts of blood, and Fouzia’s family suspects she was poisoned. Seven days after the wife’s death, the man and his supporting family arrived here in Gilgit to claim her for his wife. Fouzia’s family is desperate to avoid any conflicts, but didn’t want to hand her over, so Fouzia came to ask what they could do to ‘hide her’…The Darel man then threatened to kill anyone who tried to hide the girl from him. Fouzia told us today…that the family has agreed to send her for marriage to this man in order to save the lives of other men in the family, as he has indicated nothing will deter him.” (Fieldnotes: April 27, 2005)

The harms directed at women weren’t always pharmacological or as dramatic. For many Sunni mothers, their Islamically-endorsed restriction to bed-rest and light housework for the first 40 days after delivering was viewed as one of the only protective and nurturing spaces they enjoyed in a life dominated by arduous housework. For some women, their postpartum fragilities were intentionally exacerbated by restrictive diets, which were not reflective of Islamic or Gilgiti dietary rules, but derived instead from family and household-level practices meant to intensify women’s suffering, weakness, social isolation and distress. This, conversely, amplified the robust health and authorities enjoyed by their female in-laws. In early August, one of my neighbours had just delivered her first child. After three weeks we found her severely weakened by the diet imposed on her by her mother-in-law, who one year earlier had rejected
Ruqaiyah as her son’s choice for a bride. Fazeelat was appalled, and angrily rebuked the mother-in-law.

Restricted to a liquid diet of yekhnee (broth; U), Ruqaiyah described how

“My mother-in-law says I can’t have normal foods because the baby’s stomach will be bad. I can’t drink water, and can’t even use water to brush my teeth…She is telling my husband to watch me and make sure I don’t have water.” (Ruqaiyah, Jutial: August 11, 2005)

It was because of the harms directed at them through such ‘do-good’ measures that many women were summoned to their natal home for the postpartum period, especially if daughters had been born and the new mother was viewed as a more likely target. The mothers of daughters were almost always pushed to take up difficult domestic work more quickly. When combined with harsh dietary restrictions, this affected women’s recovery and breastfeeding; this, in turn, led to malnourished newborns and sometimes early infant death.

**Part VI Conclusion**

While pregnancy-related health complaints functioned as one of the only ways women could publicly mediate or reconcile issues of marital or intra-familial neglect, emotional or material deprivation or interpersonal discord, young mother’s accounts of being possessed or kidnapped by capricious spirits provided dramatic, discursive representation of the cosmological forces encircling and endangering their childbearing years. In many ways, women’s enmities mirrored Akbar Ahmed’s description of Pakistani society as “Kalashnikov culture”, or as he mused:

“…’dodgem car culture’; it implies more than just the collapse of law and order: you may be hit in any place, sideways, from the back, from the front, by anyone at anytime, anywhere. You will be hit for any reason however irrational or illogical.” (Ahmed 1997: 216)

*Kala jadu* narratives first worked to confirm women’s perceptions of ill-intent and then their actual practices. Secondly, *jadu* practices, beliefs and related narratives acted as “metaphor[s]…or cultural idiom[s] for distress” (Scheper-Hughes & Lock 1987:24), thereby enabling women to account for misfortune (*gham*; U), trauma and injustice (*zulm*; U). Other anthropologists have identified witchcraft accusations “as a symptom of envy among the less powerful” (Foster 1972 in Scheper-Hughes & Lock 1987:24) – although in Gilgit, it seemed very much the reverse - or the “inchoate expression of resistance
to the erosion of traditional social values based on reciprocity, sharing, and family and community loyalty” (Mullings in Schep-Hughes & Lock 1987:24). The closest Pakistani examples can be found, oddly enough, in ethnographic accounts of prostitution (Brown 2006; Saeed 2002), wherein ‘black magic’ and sorcery were employed to help procure long-term, financially-lucrative client relationships. More helpfully for the purposes of this chapter, Chireau’s analysis of African-American ‘conjure’ traditions characterizes malevolent ‘magic’ as a vehicle of conflict (2003). An important distinguishing feature of ‘magic’ is its creative incorporation of “a dynamic of negation” (Kapferer 2003:21); “magical practice and sorcery are major sites of invention...[which] attack the very ways in which human beings routinely are seen or conceived to construct their realities” (Kapferer 2003:21). Women’s interpersonal battles and *kala jadu* thereby involved the alienation, dislocation and forcible disintegration of ‘normative’ Islamic concepts of identity, boundaries and belonging. *Jadu*’s disruptive nature also contradicted the Sunni community’s responses to sectarian conflict, which prioritized community reintegration and the enhancement, affiliation and demarcation of ideological, identity and community-based boundaries. By relation, pregnancy affirmed women’s belonging to a community which defined itself by pronatalist attitudes, larger families and sons as combatants. And because the 2005 ‘tension times’ placed additional symbolic and economic value on reproduction, Gilgit’s Shia-Sunni conflicts paradoxically reinforced the local importance of pregnancy as a target for women’s enmities and fear.

There were two fundamental communicative elements associated with the occult forces affecting and afflicting Gilgit women. At a primary level, the profound insecurities inherent in women’s accounts of lives interrupted by unseen or unwieldy forces mirrored the uncertainties, powerlessness, emotional and physical servitudes entailed by everyday life. The violence of these ‘magical’ or ‘supernatural’ events offered women a powerfully evocative, alternate means by which to address the ‘real world’ harms they experienced in the course of married and family life. A woman’s engagement to an unseen, potentially harmful suitor (*mangethur; U*), her sudden departure from hearth and home at the time of marriage, her
death during childbirth due to doctors’ or dayahs’ neglects or mistakes, or her abuse and killing at the hands of people who were supposed to cherish her - such events were symptomatic of the uncontrollability and risk that women were raised to expect, which their parents and siblings feared, and which sometimes drove the most profoundly marginalized or abused Gilgiti women - wives and mothers - to suicide in higher and higher numbers (Blessing Home for Women: March 12, 2005).\(^{27}\) It is worth returning to what Hussen, the mother of two little boys, said to me one month before we left Gilgit:

“I don’t want a daughter, you never know what her qismat [fate; A] will be, and you can’t control that after she’s married...whether he’s good with her or not, if he’s a nashah [drug addict; U], or his family treats her badly.” (Hussen, Jutial: August 11, 2005)\(^{28}\)

Secondly, even when simple biomedical rationales could explain a woman’s health complaint, allopathic explanations reduced women’s opportunity to express ‘Self’, comment on family or neighbourhood discord, or enact personal agency. Understanding this helps explain why women routinely refused routine and germane allopathic diagnoses, or found them insufficient. Ultimately, kala jadu, Islamic divination and, by association, Islamic and desi counter-measures, were the primary means by which women felt they could directly or indirectly ‘blame’ their families or neighbours for unmet responsibilities, or the failure to protect them from inflicted harms, domestic abuse or purposeful deprivations, address the vulnerable, permeable and mortal ‘self’, and reckon with their fears for infant loss and economic security. By interweaving cosmological beliefs with their physical symptoms, women achieved far-reaching commentary on their insecurities and enmities. By extension, they demonstrated their moral disposition through the therapies they chose, despite the very real danger that, by prioritizing this vocalization of discord ahead of the need for urgent biomedical treatment, these choices could lead to death.

\(^{27}\) According to one Gilgit-based NGO; “In the absence of any survey or research, the exact status of affected women could not be ascertained. Local newspapers reported that 26 women committed ‘suicide’ in 2002 in one district (Ghizer) alone... This information could be retrieved because news reporters from the district were sensitized enough to report these...acts, while in other districts due to conservative traditions, ethnic, sectarian and other ignorant attitudes, these cases are seldom reported in the press or registered with police stations” (Blessing Hands Funding Application [EU]: September 2003).

\(^{28}\) See Chapter Five, page 270.
Part I Thesis Summary

In my ethnography of Gilgiti health practices, I have attempted to show how Gilgiti Sunni women’s pregnancy and childbirth experiences are inextricably embedded in Gilgiti ‘customs’ (riwaj; U), biomedical notions of ‘progress’ and ‘safe motherhood’, Islamic strictures at the home- and mosque-levels, and occult or ‘magical’ forces.

Part One of the thesis explores how, for women who were fertile, pregnancies came frequently and were welcomed by families more aggressively oriented towards size as an affirmation of their religious values. And while women described themselves as ‘enduring’ pregnancies, they also prayed to become pregnant. Moreover, pregnancy’s forty weeks offers the most vulnerable women the chance to dream of what could be. Along with relatives and neighbours, women offer supplications for the arrival of a healthy child– such children being envisioned in adulthood as prosperous and loyal to their mothers’ interests. In Chapter Five, we see the trials endured by women without sons, who read their expectant bodies anxiously for ‘signs’ of a boy, and quietly prepare themselves for divorce if another daughter is born. In many ways, their fears and insecurities are similar to those experienced by women who are infertile. For the mothers of unhealthy infants, or those who had experienced miscarriages or stillbirths, subsequent pregnancies entail fearful hopes for a child that would survive. For women who try to find a resolution for unwanted pregnancies, or who are plagued by the discomforts of their expectant and recovering bodies, pregnancy confirms their beliefs in marital and maternal ‘sacrifice’ (qurban; A).

But for women struggling to remedy irregular menstrual cycles and erratic fertility, pregnancy provides a brief opportunity to rest assured of their ability to function at a woman’s most basic, most important level. It also temporarily deflates their harshest critics, who look to the long spaces between pregnancies as signs of witchcraft (jadu; U), the evil eye (nazhar; A), jealous jinn, fairies or an enemy’s ‘black magic’. If the remedies of their physicians, desi bilehm’s healers (thabeeb; S), neighbourhood mullahs, ‘magicians’ (jadhugar; U) or diviners fail to end women’s problems with fertility, pregnancy, or the un-ending production of...
daughters, they resort to the herbal remedies sold by the itinerant salesmen who arrive in Gilgit Town each summer. These tradesmen prepare herbal therapies for pregnancies - wanted or unwanted - sons or ‘too many daughters’.

Childbirth is marked by Islamic prayers and family traditions meant to ensure a baby’s safe arrival and a mother’s survival. I heard women of all generations and backgrounds discuss childbirth in tragic terms, but for different reasons. Women who were older, or those who still lived beyond the reach of medical services, bore their children in smoky, darkened rooms, over floors spread thick with sawdust or rags. They morbidly described a graveyard’s mouth hungrily yawning open for the new mother’s soul in the first forty days after childbirth. Not without justification, they reveled in their proven ability to survive, and used their own partially-imagined reproductive histories to set sometimes harshly competitive and unrealistic standards for their daughters-in-law or other women. But younger women face a new set of risks and dangers other than those associated with home-births and traditional midwifery. My in-town participants talked of miscarriages predicted weeks in advance by ultrasound, of birth defects for which there was no remedy save for a late-trimester induction, of post-partum hemorrhage caused by overdoses of Oxytocin, of hospital blood banks absent of plasma, and of surgeries and abortions botched by OB-GYNs or ‘rustic’ midwives (dayas; U). They talked about Labour Rooms as a possible source for disease, and explained how their desi attempts to turn breech babies “head-way down” not only represented their efforts to save themselves the high cost of a C-section, but also helped them to avoid the sad likelihood of a post-operative infection.¹

Part Two of the thesis examines how women’s fertility features as a core physical, social and symbolic experience, around which the conceptual apparatuses enacted by Shia-Sunni warring and enmity oscillated. Alongside women’s own deployment of their bodies as a means of social expression, health service proponents, family, community and Sunni clergy harnessed the symbolic importance of women’s pregnant bodies as “a locus for contested control, and a target to be edited and narrated by others” (Henry 2006: 380).

¹ See Chapter Two, page 114, footnote 16.
As Rhoda Kanaaneh’s 2002 work attests, war’s strategic targets very often concern identity, self and personhood, as well as women’s physical bodies. Borrowing from Salman Keshavjee, the ways Shia and Sunni communities fought and symbolically deployed women’s maternal health practices as “‘essential marks of cultural identity” (Keshavjee 2006: 80) represented creative modifications on historical patterns of conflict, religious identity and gendered sociality and practice. A narrow reading of Gilgit’s 2005 ‘tensions’ assumes that because the conflicts resulted in logistical impediments to health services, they represented spaces bereft of the opportunity for women’s agency. But because the rigid conservatisms of local Sunni practice afforded women few means of expressing ‘public’ agency, the surreptitious and indirect agency afforded by ‘magical’ resort was imagined to be an even more important avenue for change or resolution.

This point, in particular, is useful in unsettling monochromatic portraits of Muslim women as being wholly deprived of agency. The available South Asian literature often overlooks the primary importance of women’s narratives, health seeking or their use of the cosmological in everyday relationships as sources for social leverage and power. I contend that if Gilgiti Sunni women’s health narratives are not only meant to illustrate or share personal experiences, but that women also mediate or seek recourse through them for their unmet health, emotional or material needs, then health-seeking and narratives may be thought of as agency.

By extension, women’s offensive or defensive engagement with ‘unIslamic’ forces can be re-interpreted to represent not only health seeking, but also women’s resistance to the restrictions placed on them by Wahabbism, the Tablighi Jamaat and even biomedicine. In this way, Gilgiti women’s use of divination and ‘black magic’ could be described as ‘actively’ mediating and counteracting women’s ascribed, bodily and social ‘docility’. And by unsettling any notion that women’s domains are amicably coherent, Chapter Nine attempts to complicate research that describes women’s interests as being aligned, while women and men work against each other. Simply put, women’s interests do not always – or ‘naturally’ - benefit other women. As Heba El Kholy noted for her women research participants in Cairo, in Gilgit’s insecure or embattled domestic spaces “the ‘enemy’ who women should resist is not always clear, and it is not always
men” (El Kholy 2002: 25). Like El Kholy, I prefer to emphasize that because women “operate within the same socioeconomic and cultural context...this aspect of ‘togetherness’ gives the gender conflict some very special characteristics” (Sen 1990: 47 in El Kholy 2002: 27).

While my participants demonstrated remarkable resolve to comment on the traditions, ideologies and practices encircling and restricting their lives, and thereby, their health, they remained “constrained in the kinds of social action they [could] exert” (Wardlow 2006: 14). As with El Kholy’s participants, external constraints included “fear of physical violence, the inability to generate an income, or the difficulty in accessing social security benefits” (El Kholy 2002: 218). In such contexts, “women’s resistance is likely to take covert, non-confrontational and momentary forms” (El Kholy 2002: 25). Alternately, women respond to constraints through “strategic trade-offs”, in which they deal with the contradictory demands placed on them by their health and need “to retain their respectability and central identity as [Muslim] wives and mothers” (El Kholy 2002: 224). As such, my views coincide with Kanaaneh’s identification of Palestinian women as “active participants (in delimited ways)” (Kanaaneh 2002: 66). I employ Kanaaneh and El Kholy’s work with a caveat, however. Because their work focuses on women’s ‘visible’ social negotiations, they overlook how cosmological realms provide a plethora of women-centered modes of antagonistic response.

With regards to Gilgiti Sunni women’s use of Islamic prayers, Prophetic medicine and divination, the work of Azam Torab (1996), Mary Elaine Hegland (2002) and Saba Mahmood (2005), which examine Shia and Sunni women’s strategic use of religious piety to symbolize subjectivity and agency, may offer useful insights.

Part II Final Thoughts

My goal during my fieldwork and thesis writing was to provide as detailed an ethnography as possible on a profoundly under-serviced, under-researched and misunderstood community. My hope was not merely to remedy a gap in the Northern Areas literature, but to add to research on women’s reproductive health.
Thesis Conclusion

outcomes as a product of innumerable complex factors. As Chapman comments in her analysis of prenatal health practices in war-torn Mozambique:

“Until recently, few studies focused on local experiences of reproductive vulnerability and specifically addressed prenatal care strategies of women in developing countries from an ethnographic perspective (Adetunji, 1996). The processes by which poor women in developing countries make reproductive health care choices during pregnancy have been largely unexamined (Chapman, 1998). In spite of the dearth of information about pregnancy management strategies of poor women, the standard discourse on maternal mortality in developing countries often reveals underlying assumptions that poor women are incompetent, and somehow undeserving health ‘consumers’ (Marshall, 1988). Such assumptions inform attitudes prevalent among biomedical health workers, health policy makers, and international aid donor agencies.” (Chapman 2003: 356-357)

After looking back over the ways women’s health illuminated their socio-economic and political, community and domestic vulnerabilities, the common thread to each chapter in my thesis is ‘communication’. Whether women struggled with infertility, difficult pregnancies, or painful post-partum recovery, their health concerns were used to demonstrate the conditions of family-building, marital conjugality and the growth of the Sunni community. And by drawing attention to the ‘self’ vis-à-vis reproduction, women attempted to hold their in-laws accountable for their ailments, anxieties and the failure to protect them from perceived harm. And if such dilemmas remained unresolved at the marital or family-level, women’s narratives were quietly extended to involve the local ‘court of public opinion’, with the expectation that neighbours, extended family or religious clergy might intervene on a woman’s behalf. Ultimately, the harms described by my participants allowed women to articulate and hence to ‘see’ their vulnerabilities, to anchor their fears to social and material contexts, to project their marital and family-based anxieties into compressed and seemingly more manageable arenas of sociality and action, and to diagnose and attempt to remedy a long list of generally unavoidable reproductive health hazards.

But simply being pregnant was no guarantee that women would receive adequate attention or support. As such, health complaints or pain (whether actual or somatic) were crucial co-ingredients for ‘reproductive communication’. Women strategically employed their health concerns as symbolic substitutes for direct

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commentary on their unmet needs, deprivation or instability, fear and anticipated loss. Even among the most technically ‘healthy’ patients, women routinely narrated a long list of emotional fragilities and somatic pains, all of which were used as the starting points for further inquiry into the state of their lives. As Dr. Sharifa noted during my second interview with her:

“Some women get less attention and are neglected, even though they are often pregnant. They use sickness as a tool to describe pregnancy as a problem, and then their attitude to pregnancy is that it is a ‘disease’. Women come in with aches, pains, morning sickness - they are all physiologically normal, but if their attitude to the pregnancy is negative, or if they feel neglected, they use pregnancy as a tool to communicate their needs. They expect the doctors to tell her husband, who will then take her back to clinics where doctors can see her, hear her, and assess her mindset and attitudes.” (Dr. Sharifa, AKHS,P: January 8, 2005)

In some respects, my approach to women’s health-seeking, reproductive practices and narratives as a vehicle for recognition and possible change is paralleled by James Wilce’s discussion of illness narratives in Bangladesh, where he noted; “…illness interactions…are often adversarial [because] patients’ talk disturbs and moves others. It may point to conflict external to the ‘medical situation’ as much as it points to ‘symptoms’” (1995: 927). But looking back, I can recall only a very few occasions when health providers described themselves as being moved or challenged by their patients’ experiences. It was true that some physicians, like Doctor Sharifa, routinely empathized with the women who sought their help. And as the quote above illustrates, she was deeply aware that health-seeking was very often a call for other kinds of help or recognitions. The majority of health providers (for reasons that should be examined in future research), however, seemed unreceptive to the communicative elements inherent in health-seeking.

Take, for example, Sister Sabah’s reaction to a newly-delivered mother at the Sunni Kashrote Hospital:

“Woman comes complaining of leucorrhea, back and ovary pain, discharge. She’s forty days post-partum...had four boys and five daughters, and points to her swelling feet [after] removing them from her plastic slippers, and says she’s weak. Sister Sabah points to her and whispers to me, ‘Psychiatric patient! After so many deliveries she is depressed, and all the time she is talking for nothing. All the time complaining for this or that pain.’ The woman starts talking about wudhu [ritual washing; A] with cold water, and says drinking it causes her problems with beshap [defecation; S]. Sister Sabah says, ‘She’s come three times already and I refer her to the doctor; she doesn’t want Family Planning!’ [laughs] Nahilah gives her a prescription and tells her to go.” (Fieldnotes: September 3, 2005)
By this, we can see that attention-seeking only worked in certain contexts and with certain kinds of health providers. Where mullahs and desi healers listened, biomedical providers were more likely to pathologize or medicate, or they used women’s practices to point out and mark the differences between themselves and their patients. Sister Sabah’s reaction is not dissimilar from the reactions of biomedical providers to women’s health complaints described for other parts of South Asia. In his anthropological and semantic analysis of Bangladeshi illness narratives as a form of meta-communication, James Wilce noted:

“‘If a baby does not cry, it won’t get any milk.’ This Bengali proverb recognizes the occasional need for self-assertion by complaining, although on the other hand superfluous complaining is criticized as alakshmi (inauspicious).” (1995: 932)

Gilgiti women’s need for vocalization was made all the more important because of women’s overall inability to directly confront their life circumstances. Especially in the first years of married life, Gilgiti women face the stressed erasure of their individual personae and needs. But in contrast to Grima’s discussions of Paxto women in the North-West Frontier Province, where she observed that “the more emotion is culturally molded to fit a norm, and the fewer the opportunities that are provided for personal expression, the more the personal is suppressed and becomes undefinable, even by the individual” (Grima 1992: 3), I felt that by mediating ‘self’ through the body and health seeking, narratives, somatic complaints and their fears of spiritual imbalance or entanglement with ‘black magic’ (kala jadu; U), Gilgiti women navigated around many of the cultural antagonisms concerning self-expression. In ways that might, in future, be loosely doubled back to not only reconsider spirit ‘attacks,’ jinn or fairy possession and ‘magic,’ but also Gilgiti women’s use of health to illustrate the forces impinging on their lives, Janice Boddy notes:

“…as both possession and performance…[zar] is a powerful medium for unchaining thought from the fetters of hegemonic cultural constructs and, to paraphrase Ricoeur (1976), for opening it up to difference and possibly illuminating directions.” (Boddy 1988: 23)

Thinking of pregnancy as perhaps the most expansive symbolic communicative device available to women may also help explain why many women ardently refused Family Planning and continued having babies. In the absence of other more effective communicative modes or agencies, I feel that non-pregnancy was
equated with a type of social silence, whereby women’s bodies are less able to metaphorically ventriloquize a wide array of health, interpersonal and emotional complaints. (At the other end of the spectrum, post-menopausal women enjoyed an ‘earned’ freedom of subjectivity, self-expression and social commentary. As such, they were less inclined to involve ‘female’ complaints to convey discord.) But being pregnant also attracts the nefarious attentions of other women, occult forces and metaphysical other-worlds, and these threats were the ones foregrounded by my participants. Indeed, although ‘tension times’ service constraints and access difficulties represented ‘extraordinary’ disruptions, they were not as vociferously protested, not only because of the pressure placed on women to ‘silence’ their complaints during times of conflict, but also because, according to my participants, these problems paled in comparison to the wide array of other struggles and unmet needs women experienced in their everyday life.

Part III Future Research

While we know Pakistani women make simultaneous and serial use of multiple practitioners, anthropology needs to better account for the context-specific, contrastive ideologies underlying everyday health practices and their consequences for women’s well being or sense of efficacy. However unintentionally, arms-length discussions of Sunni Muslim women’s lives reduce them to caricatures within larger Islamic ‘scapes,’ rather than illuminate how women blend their own beliefs and gendered cosmologies with the core conservatisms of Sunni Islamic practice. To this point, there is also an urgency to anthropology that attends to the myriad of cultures, ethnicities, languages and diverse social practices subsumed by global discourse on a poorly differentiated Islam, discussions of which have been additionally shaped to respond to the non-Muslim world’s projected fears. To add, the existing literature concerning Muslim health practices is overly reliant on biomedical ‘speak’, biotechnologies or pharmacological practices. Apart from the Palestinian-based work of Julie Peteet (2002) and Rhoda Kanaaneh (2002), or Janice Boddy’s analysis of Sudanese spirit possession and female circumcision (see 1988, 1989), relatively few medical anthropologists research the symbolic and experiential minutiae of Muslim reproduction and infant care practices during conflict or intense political
instability, especially where they intersect with gender inequity or contested practices, service uptake and health outcomes. Alternately, researchers often underplay Muslim women as decisive health actors, who achieve locally understood empowerment and decision-making by quietly circumventing their religious and socio-economic compression. Rectifying scholarly gaps requires our embeddedness in women’s everyday worlds.

In a variety of ways, my thesis acts as a stepping stone to additional, Northern Areas-based research and theorizing on women’s embodiment of social and political life (Scheper-Hughes & Lock 1987), or the “contested nature of the body and bodily illness during...social and political violence” (Henry 2006: 380). In particular, my discussions of women’s health practices during conflict augment the ethnographic literature on trauma and loss (Caruth 1995; Eng & Kazanjian 2003; Kannabiran & Kannabiran 2002), sectarianism and civil hostilities (Aretxaga 1995; Das 2007; Ismail 2005; Giles & Hyndman 2004; Gottschalk 2001; Sokefeld 1998, 1999, 2005; Spencer 1990), memory (Malkki 1995), and somatization and the experience of violence (Csordas 1993, 1994; Feldman 2005; Henry 2006; Khan 2006). And in ways that move well beyond Pakistan, Gilgiti women’s embattled health practices may shed invaluable light on women’s health in war-torn, sectarian divided Afghanistan and Iraq, Sunni health service uptake in Shia-dominated Iran, or be extended to encompass ethnic difference, conflict and women’s health in Sri Lanka, or Islamic fundamentalism and women’s health development in Bangladesh. Indeed, my thesis adds to the qualitative literature on maternal health practices amid unrest (Bretlinger et al, 2005; Palmer et al, 1999; Pedersen 2002; Scheper-Hughes 1992), and the consequences of Pakistani conflict, structural violence and militarism for gendered identity (De Mel 2003; Chaudhry 2004; Chenoy 2002; Gul Khattak 2002a, 2002b; Khan 2002; Saigol 2000).

And by better balancing analysis of Pakistani women’s cosmological terrains to include more of the ‘objective’ factors contributing to women’s health crises, future research might address and counter biomedical assumptions that magic, sorcery and Islamic therapies occur at the periphery of clinical biomedicine. (Indeed, Gilgiti women consistently interwove their beliefs in Islam and the occult with their
discussions of ailments or health events that, in other contexts, are encompassed by ‘biomedical’ etiologies. Women also brought such beliefs to bear on how they used allopathic pharmaceuticals or when they sought medical care.) For North American and European contexts, my thesis may also help illuminate South Asian women’s use of homeopathic, herbal and Islamic therapies during pregnancy. Because we are still in the early stages of this branch of South and Central Asian research, the enormous scholarly and applied potential of this work remains intact. Overall, and in no small or easy way, my thesis has addressed Gilgiti women’s culturally-, religiously- and politically-attenuated experience and use of their own bodies, and the crucial importance of pregnancy and childbirth to women’s social standing, sense of well-being and identity.
Thesis Appendix

Anthropology Department
University of Toronto
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Toronto, Ontario (M5G 3G3) CANADA

Research Information
“Women’s Health in Northern Pakistan”

Dear [--------],

You are being invited to participate in my study examining women’s health in the Northern Pakistani city of Gilgit.

My name is Emma Varley, and I am a doctoral student at the University of Toronto’s Anthropology Department. I will be living in Pakistan from August 2004 until December 2005. My Ph.D. research explores the reproductive and maternal health behaviours of women living in Gilgit and its immediate environs (including Jutial, Donyal, Khomer and Chenar Bagh boroughs). These health behaviours include issues related to pregnancy, childbirth and breast-feeding. I am interested in understanding how religious, ethnic and gendered identity effect Gilgiti women’s health behaviours. But I am also interested in understanding how women use available health care services.

I am asking Gilgiti women, between the ages of twelve and fifty-five, to discuss their reproductive and maternal health issues. I will also be talking to family members (with your permission, if they are related to you), local health practitioners [bakims/doctors] and non-governmental development organizations about women’s health issues.

My research involves informal discussions with you about Gilgiti women’s health needs and experiences seeking treatment. You may participate with a minimum of one informal discussion [interviews], or as many times as you would like or are able to meet with me. These informal discussions [interviews] will not last more than two (2) hours at any one time. They will take place at your convenience, and at a location of your choosing. I will take notes of your responses to my questions, and will only audio record your responses with your consent. I will use a translator to help me to better understand your responses.

Your responses to my questions will be kept confidential, and your identity will remain anonymous. I will not use your real name, and I will provide false names [pseudonyms] for you in my research. However, you may request that I use your real identity if you feel that it benefits you as a participant.

I will not share your identity, or discuss your participation with my research, with anyone without your permission. I will be the only one to have access to your responses to my research questions. You may request copies of the notes or audio recording transcripts I make of our discussions [interviews].

Your participation in this study is voluntary and unpaid. You may refuse to participate, or withdraw from the study at any time, without negative consequences. You may also decline at any time to answer any question, or ask me not to observe or participate with any aspect of your daily life.

Emma Varley

“Women’s Health in Northern Pakistan”
Emma Varley (Researcher)
It is my intention that my research results contribute to better non-governmental or state health policies concerning Gilgit women's health. In order to accomplish this, I may provide a summary of my research to non-governmental or health advocacy organizations working in Pakistan and internationally. However, I am unable to financially assist individual subjects/informants in obtaining health services.

I will produce a doctoral thesis [academic book required for a Ph.D. degree] using research results. Research results may also appear in magazine [journal] article/s and/or book/s available to the public. Please note that unless you grant me permission to do otherwise, I will not use your real name, or disclose any personal information that could be used by others to identify you, in my doctoral thesis or in any articles or books I publish. You may request to receive a copy of the books or articles I produce from this research. Following my return to Canada, you may direct your requests to me care of:

[Address]

I will be returning to discuss your participation in one week [insert date]. Please feel free to contact me before or after that date, care of:

Phone: (5811) 53133

If you have any questions concerning my conduct, or this study, you may contact my academic supervisor at the University of Toronto.

[Dr. Michael J. Lambe]

Thank you for your time and consideration,

Emma Varley
Researcher


Emma Varley


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