Biomedical Service Delivery for Women in Northern Pakistan: Ideological Contrasts and Social Resistance

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B.A. (Honours), The University of British Columbia, 2000

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In

THE FACULTY OF GRADUATE STUDIES

(Department of Anthropology)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

August 2002

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Date **August 28/2002**
Abstract

The recent introduction of biomedicine and clinical practice in Northern Pakistan was based upon the assumption that biomedicine would thrive in Northern Pakistan's pluralistic context of traditional medicines. Practitioners envisioned that biomedicine's efficaciousness and secular underpinnings would make it amenable to any ethnic or faith group. While ample studies have indicated that biomedical pharmaceuticals have been adopted with great success despite gender variables (Sweetser, 1993), biomedical clinical practice and its treatment of women in conservative Islamic societies has been more problematic. Despite the best efforts of national and transnational biomedical service initiatives, rural women in Northern Pakistan exhibit some of the developing world's worst indicators for health status, and per capita access and utilization rates of biomedical service delivery. This thesis contends that secular biomedicine's incompatibility with Islamic aspects of socialized gender models has resulted in Sunni Northern Pakistan's preference for the multiplicity of affordable folk and religious healing practices available to them. Professional biomedicine, unlike traditional Islamic therapeutic systems, does not embed or articulate local systems of social relatedness. Because biomedicine neither integrates nor sustains social relatedness and stands outside of the network and norms of social relations, Northern Pakistani society has mobilized women and their access to biomedical service delivery as a point of resistance in their larger efforts to modify unIslamic social interventions.
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Acknowledgements

This graduate thesis arose from my fascination with the problematic confluence of secular, biomedical activities, traditional, Islamic culture and women's lives in Northern Pakistan, a personal and academic interest that developed because of my experiences living and working in this isolated, mountainous region throughout the 1990's. Without the support, guidance, and insight of my supervisor, Dr William H. McKellin (UBC, Anthropology), and the patience and generosity of my committee member, Dr John Barker (UBC, Anthropology), this thesis would not have been made possible. I am particularly grateful for the countless hours of advice, ideas and encouragement that Dr McKellin has provided me throughout my Master's studies in the University of British Columbia's Department of Anthropology. If it were not for Dr McKellin's foresight and good humour, I would have completed neither this thesis nor pursued my Ph.D. career at the University of Toronto.

Additional thanks go to my family; my husband Abdul Wadood Myireh, daughter Kate Reilly, son Abdul Nadeem Myireh, parents, Deborah and Christopher Varley, and brother, Robin Varley. Further, I would like to extend my sincerest thanks to University of British Columbia faculty Dr's Janice Graham, Julie Cruikshank, Alexia Bloch, Ken Bassett and George Povey for having encouraged me along every step of my academic journey in the Anthropology Department's MA programme. Final thanks go to the staff of the Department of Anthropology, whose assistance and kindness made a difficult process easier and far more enjoyable.
1.0 Introduction

The recent introduction of biomedicine and clinical practice in Northern Pakistan was based upon the assumption that biomedicine would thrive in Northern Pakistan's pluralistic context of traditional medicines. Practitioners envisioned that biomedicine’s efficaciousness and secular underpinnings would make it amenable to any ethnic or faith group. However, institutional sensitivity to the complex socio-cultural issues underlying Islamic gender models was inadequately considered in the implementation of biomedical services. While ample studies have indicated that biomedical pharmaceuticals have been adopted with great success despite gender variables (Sweetser, 1993), biomedical clinical practice and its treatment of women in conservative Islamic societies has been far more problematic. Indeed, throughout Northern Pakistan there have been few effective programs successfully amalgamating women's health care needs with the potential benefits and health care improvements proposed by biomedical initiatives. So despite the best efforts of national and transnational biomedical service initiatives, rural women in Northern Pakistan exhibit some of the developing world’s worst indicators for health status, and per capita access and utilization rates of biomedical service delivery. In this respect, women’s lack of service usage exemplifies a clear disjuncture between professional biomedicine’s conceptions of service demand and utilization.

Anthropological reporting maintains that overall resistance to biomedical practice and poor utilization rates results from the costly nature of professional services, low standards and unreliable rates of efficacious treatment in Northern Pakistan (Sweetser, 1993). Yet the underlying tension between traditional faith systems and secular-scientific paradigms characteristic of Western biomedicine, the very way in which traditional, rural peoples perceive of the spiritual geography of health care and its impact on gendered models of social behaviour, remains largely unaddressed. I contend that biomedicine’s failure to integrate Islamic aspects of socialized gender models has resulted in Sunni Northern Pakistan’s preference for the multiplicity of affordable folk and religious healing practices available to them. Professional biomedicine, unlike traditional Islamic therapeutic systems, does not embed or articulate local systems of social relatedness. Because biomedicine neither integrates nor sustains social relatedness and stands outside of the network and norms of social relations, Northern Sunni society has mobilized women’s ability to access biomedicine as a point of resistance in their larger efforts to modify ‘unIslamic’ social interventions such as biomedical initiatives.

Biomedical physicians employ a medical model that conflicts directly with Islamic injunctions prohibiting social interaction between women and non-kin males. Yet even easily accessible, clinical interventions incorporating female physicians still fail to reach conservative target populations. Considering Northern Pakistani women freely receive traditional therapies practiced by
non-kin males, we may inevitably ask why accessing biomedical service delivery has been a problem? What cultural and political complexities shape social resistance to women's usage of clinical services? To answer this, this thesis will explore Western assumptions of secular care as they contrast with those socio-cultural values that Northern, Hanafi-Sunni communities ascribe to unIslamic models of women's biomedical care. Is social avoidance of service delivery more about reifying traditional, Islamic understandings of gender and patient agency than health seeking? Does it represent a clash between biomedical and non-biomedical systems of belief, or between contrasting processes of Islamization and globalization?

The vast majority of developmental literature concerning itself with women's access to health care in the developing world attempts to examine “the situation of women in relation to the health care system, and therefore how they access it” (Puentes-Markides, 1992:619). This research focuses upon “variables such as women's status in the specific culture and society to which they belong” (Puentes-Markides, 1992:619), including their socio-economic situation, position in labour forces and ethnicity, control over decision-making and receipt of social investments. Among conservative, rural Sunni-Islamic populations, any one of these variables is a factor currently affecting women's access to biomedical services. In Northern Pakistan, where governmental and transnational development provides the vast majority of biomedical services, one pivotal feature affecting women’s ability to access service delivery has been largely overlooked. Local notions concerning women's status, roles and their relationship to unIslamic social factors are being connected throughout the Muslim world to an increasingly popular, supranational Islamic dialogue. Just as men's honour has traditionally been gauged in part by women’s status, women are socially perceived as legitimate points of resistance in both formal and informal Islamic campaigns opposing the multiple effects of Westernization, modernization and globalization. This is especially true of socially oriented, development initiatives, of which biomedical service delivery is one facet in a conflict between Islamic and unIslamic social values.

This thesis will examine the immediately visible mechanics underlying unsuccessful women's health projects in Northern Pakistan, and more importantly clarify the socio-cultural significance of family adherence to gender segregation as pivotal features of Islamic identity. Given Northern Pakistan's cultural milieu of Islamic revivalism, growing tribalism and the integration of supranational, conservative Islamic social models with rural life, we may ask if discrepancies in notions of person-hood and social values are responsible for women’s patterns of access to health care services. More than this, the discussion will consider how Western notions of personal autonomy and individuality, inherent features of biomedical models, contrast with Hanafi-Sunni concepts of personal inter-dependence and community. Along with the concrete proxemics of
Islamic models of *pardah*, discrepancies between traditional and biomedical social systems contribute to women's inability to participate in Western-modeled health care schemes.

In order to explain women's poor accessing of biomedical health service delivery, current biomedical paradigms tend to assert that Islamic gender-segregation models that prohibit contact between unrelated males and females present a fundamental and 'problematic' barrier to treatment. From an anthropological perspective, this thesis will attempt to challenge Western biomedical programme's *facile* interpretations regarding lack of service utilization by women in Northern Pakistan, to address a number of more specific and culturally valid issues underpinning local resistance to the specific combination of biomedical practice and women's health. Comparative cultural notions of patient individuality, autonomy, agency and gender relations will figure largely in this discussion. How women access and use clinical biomedical practice is an accurate reflection of not only poor access or the unreliability of services, but of socio-religious models of behaviour involving gendered space and acceptable rates and patterns of accommodation, innovation and social change. Resistance represents the problematic, and socially evolving, co-existence of Islamic and 'unIslamic' social and ideological models, such as those encapsulated by biomedical service delivery. Thus, this thesis will describe how complex, local Islamic models of gender segregation and social mobility are expressed in the hierarchy of pluralistic, medical resort, and confront the forces of globalization and idealized notions of Islamic social life. This will serve to explicate how, through the successes and failures of therapeutically efficacious, but culturally problematic, biomedical service delivery for women, we may examine how biomedicine has become a vehicle for expressing or enacting larger disharmonies between social systems in Northern Pakistan.

After having lived and worked for several years during the late 1990's in various, rural districts of Northern Pakistan, I personally faced the collision and coexistence of Western and Islamically modeled social behaviours with both fascination and trepidation. While living in the Northern Areas, many of my co-workers in rural development were unable to understand how Islamic social models, even when they required barring family members from the potential benefits of 'secular', biomedical care, were considered more important than meeting biomedical expectations of social change and community health promotion. While completing a five-month contract for the Aga Khan Rural Support Programme (Gilgit District Office) examining local socio-economic variations in women's household decision-making abilities, I recognized how difficult it was for Sunni women to access biomedical physicians in a clinical setting. It was only subsequent to my contract, when I married a man from Gilgit District in 1998, and was now subject to the same

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1 Ritual, Islamic female seclusion and segregation that includes veiling (*bijab*).
notions of Islamic identity encircling the women I had previously worked with, that I began to reconsider the seeming simplicity of local resistance to women's biomedical services. I became enmeshed in a fine network of mediated identities, not only between the extremes of Western and Islamic models, but also the deliberate polarization of men and women's social spheres of activities. Prior to marriage, I had assumed, as many do, that this resistance to biomedical services was based merely on a simplistic model of segregation. But in many ways, I was quite wrong. I discovered how fundamentally unaware both I and local development agencies were of the ideological impact of supranational Islamic militancy, and its role in growing characterizations of biomedical initiatives as colonialist interference. This thesis attempts to examine social resistance to clinical services by investigating the local scenario, its history, cultural identities and fears, and how carefully delineated aspirations for an 'authentic' Islamic community and nation contrast with socio-behavioural models advocated by biomedical development.

Localized health care does not exist in isolation. Instead, it operates in conjunction with a varying range of cultural and environmental contexts that must be taken into consideration when explicating the varying levels and usage of local health care systems. This thesis will elucidate a broad range of activities, gender and community relationships and socio-economic elements affecting the health-seeking, decision-making abilities of Northern Pakistanis. In order to delineate the ideological environment affecting women's access to services, the thesis will include a cursory survey of recent developments in Sunni-Islamic conservatism and the revival of more extreme and inflexible models of gender segregation and women's piety (Hoffman-Ladd, 1987). The tenacity with which rural Pakistanis have clung to Islamic models speaks to a larger, global dialogue. This involves the intersection of Western models of governance, program management, concepts of health, social welfare, and women's rights with Islamic models of community reform and acceptable rates and forms of social change. And most importantly, the thesis will situate Muslim women as "bearers of family traditions . . . the intimate links between the political agenda of [Islamic] movements and their views about women's roles" (Jelin, 1995: 41). Women's choice of health care services and use of Western biomedical care is an indicator of the competing influences of secular development agendas and Islamic political movements.

2 Local militancy movements initially organized and gained the vast majority of their current followers during President Zia Ul-Haq's Islamization campaigns of the 1970's and 1980's. Northern Pakistan's Islamic organizations are increasingly representative of supranational political movements advocating shared Islamic identity, and which derive their ideological impetus from common sources (usually Pakistani, Saudi Arabian or Egyptian) and emphasize the reframing of contemporary Islamic society on a global-scale, irrespective of ethnic or cultural variations. This is in marked contrast to national Islamic organizations that had based their sense of communal identity upon localized values, standards and social practices.

2.0 The Local Context (See Map on Page 5)

Northern Pakistan, located at the confluence of the Hindu Kush, Karakoram and Himalayan mountain ranges, is made up of a combination of loosely administered3, boisterously independent tribal zones, former princely states (Swat, Dir, Chitral, Hunza, Puniyal, Nagyr) and semi-autonomous Kashmiri territory (Northern Areas and Azad Kashmir). At the northernmost extreme of Pakistan, bordered to the west by Afghanistan and the Hindu Kush, to the east by India and the Himalayan mountains, and to the north by China and the Karakoram and Pamir ranges, Northern Pakistan is characterized by a diverse series of culture- and language-specific valleys. These exemplify wide variations in ethnicity, inherited and ascribed class, language, religion and socio-economic patterns. However, there are a number of commonalities to which Northerners subscribe. The most of important of which is group adherence to a series of Islamic sectarian schools (Sunni, Shi’a, Ismaili), regardless of ethnic or linguistic variations. Northern Pakistan exemplifies high-altitude, mountainous life; short growing seasons, and a lack of arable land or reliable water supplies, which are largely dependent on warm-season glacial runoff. Until very recently, the majority of Northern Pakistan was completely isolated because of the harshness of terrain and the extremes of weather. No permanent roads reached the Northern Areas until the completion of the Karakoram Highway in 1975, when many northern districts were accessible for the first time by road. There are still no year-round roads to the entirety of the Chitral Valley in the North-West Frontier Province, nor many parts of the Northern Areas, Swat and Dir Districts. The vast majority of Northern Pakistanis are predominantly rural subsistence, cash-crop and livestock farmers, with all civil and economic administration centered in several district, governmental and trade capitals, such as Chitral Town (North West Frontier Province), Gilgit and Skardu (Northern Areas).

Northern Pakistan is characterized, throughout all sub-districts, by a plethora of familial (xandani)4, clan5, kin (qom)6, language (qaban), and sectarian affiliations. In the majority of instances, “all the relations established by religion, descent, kinship...[are] possible bases of community” (Sokefeld,1999:421). Islam is a relatively recent arrival to Northern Pakistan, having only begun to

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3 Due to continuing disagreements over which territories of the former Kingdom of Kashmir belong to Pakistan or India, the Pakistani government reluctantly oversees interim administration of much of Sunni-dominated Northern Pakistan, resulting in a series of marginally autonomous territories with few, if any, electoral privileges, and little nationally funded or supervised educational, medical or civil government infrastructure development.

4 Xandani/Kandban is “derived from ‘family’, but it means not only belonging to a kinship group but also sharing basic traditions and value orientations” (Sokefeld,1999:421).

5 Throughout Northern Pakistan, there are a variety of clans, exemplifying some regional variation, that are subdivisions of individual qom (kinship) groupings.

6 “The meaning of qom is quite broad and ranges from kinship-based groups to the political nation...in the present context it can be translated as ‘quasi-kinship group’” (Sokefeld,1999:417). In Northern Pakistan the primary qom groups are Yeskun (mixed indigenous Gilgit/Hunkazut and Shin from Diamer District), Shin, Chitrali, Hunkazut, Balti and Gujur (who “mainly practice animal husbandry and menial labor...their prestige is quite low” [Sokefeld,1999:420]).
make headway into the area some four hundred years ago (Keiser, 1991:45). Prior to Islam, Northern Pakistan was a bastion of Tibetan-style Buddhism\(^7\), Sikh, some Hindu and moderate indigenous influences\(^8\) (Keiser, 1991:45-47). Influences of each tacitly endure in Northern family structure, household-level rituals and notions of spirituality, language and even children’s games (Staley, 1982; Barth, 1959). Despite multiple contradictions between *riwaj* (local custom) and supranationally informed interpretations of *shari'a* (Islamic law), the majority of Northern Pakistanis choose freely between the two. Except if “forced by an explicit judgment” many will prefer to comply with the “norms of *shari'a*” (Sokefeld, 1999:421).

The Northern Areas, Chitral, Dir and Swat Districts are currently home to a majority, conservative Sunni\(^9\) population, buffeted by minority Shi’a\(^10\) and Ismaili\(^11\) communities. In this thesis, ‘Islamic’ will refer to the global faith system to which Northern Pakistanis, Sunni Muslims claim to subscribe. In particular, Northern Pakistanis are adherents to the school of *Hanafi*-Sunni Islamic theology, which is preeminently practiced among the Northern *ulema*, but is also found widely throughout the Sunni-Muslim world and has historically exhibited a wide range of regional variations in practice. Northern Pakistani *Hanafi*-Sunni society, which had until recently favoured the maintenance of local traditions and value systems, is being increasingly influenced by supranational, *Hanafi* ideological organizations. These orthodox conservative organizations derive their political impetus from the formulation of what proponents identify as purely Islamic models, absent of the vagaries of regional politics and devoid of cultural, ethnic and language specificities.

Supranational *Hanafi* conservatism is radically altering local, and substantially more moderate, Sunni “social organization and culture” (Keiser, 1991:46). This has set in “motion processes of change that ultimately resulted in a new, Kohistani\(^12\) socio-cultural system — a system, however, neither logically consistent, nor tightly structured” which focused on “cultural values, concepts, and

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\(^7\) Evidence of the area’s pre-Islamic, Buddhist heritage is found not only in enduring patterns of Tibetan-style architecture, but a vast assortment of archaeological sites, Buddhist shrines, monasteries and *stupas* throughout all districts. There is a particular concentration found in Swat, Hunza, Gilgit and Diamer Districts.

\(^8\) Several authors have provided cursory explanations of enduring patterns of animism and paganism that survive predominantly in household-level rituals throughout Northern Pakistan (Staley, 1982; Sokefeld, 1999).

\(^9\) The vast majority of Northern Pakistanis subscribe to the *Hanafi* schools of Islamic theology, the most liberally judicious of Sunni sects. *Hanafi*-Sunnis “are followers of the law school (*fiqih*) of Abu Hanifa” (Sokefeld, 1999:421). The *Hanafi*-Sunni school represents the most populous group of Sunni sects worldwide. In an ideological sense, Northern Pakistani society is framed by a highly integrated community (*umma*) of believers, led by an intellectual, religious elite (*ulema*).

\(^10\) Northern Pakistani Shi’ites are, for the most part, *Jafri*, “followers of the *fiqih* of Imam Ja’far as-Sadiq” (Sokefeld, 1999:421).

\(^11\) Northern Pakistani Ismaili communities, latter-day sectarian descendents of Shi’ism, are spiritual followers of the Prince Aga Khan.

\(^12\) Kohistan, both a language and ethnic grouping (*Kobistan*), covers the majority of Diamer, Swat, Hazara and Dir Districts – all of which are located in the southern half of the North-West Frontier Province and the Northern Areas. It is from these areas that the majority of Pathan missionization originated, spreading Pathan social values and Islamic ideals to non-Kohistani, Sunni populations of Northern Pakistan.
ideas so important to organized vengeance” (Keiser, 1991:46-47) in Northern Pakistan. Despite considerable socio-cultural, religious and economic change in the region over the past century, few regional ethnographies have assessed social change, instead concentrating on local culture as a static enterprise. Because Barth’s ethnographic emphasis rested upon the integrity of political organization in Northern Pakistan, he too neglected to fully explicate how shifting “cultural values and configurations of social organization form contexts that affect” (Keiser, 1991: 89) patterns of community and individual decision-making.

It appears likely that immediately after conversion to Islam the core of Kohistani social organization and culture remained generally unchanged. Barth reports as late as 1954 seclusion did not organize women’s lives and that both men and women enjoyed free and open relationships in Kohistani villages in the Swat Valley (Barth, 1956:66). Similarly, informants … stated that the rules of strict purdah now in force are recent, occurring only in the last few decades. (Keiser, 1991:47)

In recent years, Northern Pakistani communities have additionally been plagued and polarized by sectarian violence. Intermarriage, not only along sectarian but also between clan groupings, was a common feature of Northern life. But following the recent expansion of Saudi-funded Sunni zealotry13 and Pathan14 missionization into many rural communities, much of the economic and social intermingling that characterized Northern society has ceased (Sokefeld, 1999:420). It has been replaced by "militant conflict between Shi’ites and Sunnis, with periodically erupting tensions between members of the two groups" (Sokefeld, 1999: 420). Community resettlement resulted in the establishment of 'purely' Sunni or Shi’a villages (Sokefeld, 1999: 420), and commensality between Shi’ites and Sunnis ceased almost completely (Sokefeld, 1999: 420). Religious identity has become overtly defined by opposing sets of values and objectives, and the "value of conforming and being loyal to one’s sect proved irreconcilable with the value" (Sokefeld, 1999: 420) of social relationships between sects.

Processes of secularist, social changes provide an awkward framework for the interplay and expression of community and sectarian tensions. Sunnis often proclaim their virtuousness by describing how they resist secularism in comparison to Shi’a neighbours, whom they regularly decry as kufr (infidels, nonbelievers). Shi’a and Ismaili neighbours point to Sunni avoidance of secular development programs as evidence of their religious backwardness and intolerance. People’s participation with or resistance to secular development - which replaced colonial authority as an

13 A wide variety of mosque (masjid) construction, Islamic school (madressa) funding and maulana (cleric) training have been directly supported by Saudi Arabian Islamic benevolence societies, which funnel funding primarily through Pakistani Islamic organizations, such as the Jamaat-I-Islami.
14 Pathans are predominantly Sunni Muslims, who hail originally from the south and south-easternmost portions of Afghanistan and arrived in northern and western Pakistan for trade in the early 19th century.
imposed source of hegemonic political authority - reflects local concerns with Islamic identity. Sunnis, trapped by their need to act in opposition to more liberal Ismaili and Nurvakshi\textsuperscript{15} Shi'a communities, see little opportunity to partake in ‘unIslamic’ social programmes without forsaking a renewed sense of supranational Islamic identity. This identity is being emphasized by the socio-political machinations of Islamic groups like the Jamaat-I-Islami. Because of these groups, the conservative degree of community Islamization is strengthening. Further, because regional biomedical and socio-economic development is dominated by an Ismaili NGO (Aga Khan Development Network), funded predominantly by Canadian (CIDA), American and Swedish (SIDA) multi-national development organizations, Sunni Islamization has culminated in sizeable social and ideological barriers to Sunni usage of available, Ismaili-endorsed, Western-modeled services.

2.1 Recent Change & Local Islamic Movements

Throughout the twentieth century, Northern Pakistan has witnessed "accelerated rates of change, both economic and social" (Staley 1982:259). The cessation of Northern feudal wars between rival principalities at the turn of the century (especially in Pakistan's Northern Areas and the North-West Frontier Province), "coupled with the new health services introduced by the British, led to a rapid rise in population" (Staley 1982:260). Some surveys confirmed a doubling of Gilgit's population rates since a 1911 census (Staley 1982:270). But population growth, a profound scarcity of agricultural land, negligible hygiene standards and poor water quality has resulted in increased incidence of disease. As one British doctor noted, "every disease flesh is heir to here finds its representative" (Staley 1982:271). Although Pakistan achieved its political independence in 1947, it is characteristic of many developing countries whose “colonial inheritance and...neocolonial situation impose health care modeled after that found in advanced capitalist nations” (Baer et al, 1997:29).

During the last twenty-five years, Pakistan has been a staging ground not only for the contrasting forces of modernization, Westernization and the national revival of Islamic ideals\textsuperscript{16}, but also a variety of innovative rural health promotion projects specifically designed to bridge the distance between Islamic gender segregation (purdah) and Western-modeled biomedical health initiatives and clinical practice. When in the mid-1970's Northern portions of Pakistan were initially opened by year-round land routes and new flight routings (between Islamabad and Gilgit, Peshawar and Chitral), there was tremendous local impetus towards multi-sectoral development.

\textsuperscript{15} Nurvakshi Shi'as, an unusually liberal sub-sect of the Jafri, especially in regards to their treatment of women, are found in isolated pockets throughout the southeastern Northern Areas.
Transnational organizations like the Aga Khan Development Network\textsuperscript{17} took this opportunity to implement a vast network of agricultural (irrigation, crop-industries & fruit/food production), socio-economic (household, community income generation and micro-credit schemes) and biomedical initiatives (vaccinations, primary health care [PHC], and women’s and family health programming). Socio-economic initiatives were devised to encourage local infrastructure development and social change along a continuum that not only ameliorated local concerns, but also matched national markers for socio-economic growth. But following the commencement of the Soviet occupation in Afghanistan, and the evolution of a highly motivated mujahideen\textsuperscript{18} fighting force from within the ranks of Northern Pakistani madrassas\textsuperscript{19} and religiously-mobilized rural, tribal communities, there arose a perceptible backlash against elements of local development which were seen to challenge not only local culture, but potentially threaten its increasingly strengthened sense of participation with a global Islamic community.

The parallel genesis of local religious political parties alongside secular social initiatives provides an uneasy social balance in Northern Pakistan. Particularly for hard-line Hanafi-Sunni communities who welcomed the technological innovations presented by modernization campaigns, but sought to mitigate social innovations introduced by women’s and children’s educational and health programming. Previous research has identified the tremendous influence the Karakoram Highway, AKRSP-link roads, biomedical health services and program initiatives for women, the media, outside visitors, increased education and social mobility have had on the lives of Northern Pakistan’s rural people (Farman Ali, 1997; Warrington & Hemani, 1996; Kuriakose, 1996). Rapid regional socio-economic change has affected the shape, nature and composition of families throughout Northern Pakistan. Not only are men and women inundated with new and vastly different ideas, social norms and values that are imposed from the outside world into the village, but the parallel move of villagers into a cash economy has further changed the shape of their daily lives. The mechanization of labour, larger crops sizes (including a wider variety of cash crops) and male-out migration are direct results of people’s interest and ability to participate in a larger cash-based economy.

Northern Pakistan is a clear example of the growing intersection of Islamic extremism, sectarian disenchantment, and the secular drive to move women beyond traditional, Islamic

\textsuperscript{16} Local Islamic social ideals are most frequently derived from the Hanafi school of Islamic jurisprudence, as embodied in General Zia ul-Haq’s partial implementation of Shariah Law vis-à-vis his Islamization schemes of the early 1980’s.

\textsuperscript{17} Despite their being self-described as an essentially ‘secular’ non-government organization (NGO), the Aga Khan Development Network (AKDN) is actively seen as a religiously grounded, Ismaili organization by Northern Sunnis. To further complicate matters, Northern Sunnis tend to feel that Ismaili-Muslims are not actually Muslims at all, but represent a heretical offshoot of the equally heretical Shi’ite faith.

\textsuperscript{18} Islamic Freedom Fighters.
peripheries of gender segregation and seclusion. The region has seen the implementation of internationally funded health promotion projects for women, and top-down, civil society emphasis upon the notion of women's rights. The parallel resurgence of highly sophisticated, highly mobilized Islamic radical groups and pro-mujahidin movements throughout rural Northern Pakistan speaks to localized fears that Western social development will "begin destroying Islam by annulling its laws and nullifying its traditions" (Esposito, 1999: 66-67). Jamaat-I-Islami (Islamic Society), one of Northern Pakistan's pre-eminent Sunni militant groups has taken great pains to emphasize "Islam's ideological self-sufficiency [and is] less accommodationist, and far more critical of the West" (Esposito, 1999: 67). Jamaat-I-Islami, and its rival organizations (Tablighi-Jamaat, Harkat ul-Ansar, Sipah-e-Saba, Jamaat Ulema-Islam, Harkat ul-Mujahideen, Jamiat Tulba-Islam, Deobandism*) stand in marked opposition to Islamic modernists, who seek to "learn from and emulate the successes of the West" (Esposito, 1999: 67). Instead, they focus on the "failure both the West (capitalism) and the East (Marxism) as models for development in the Muslim world" (Esposito, 1999: 67). The prolific writings of Maulana Mawdudi, Jamaat-I-Islami's spiritual leader, are widely disseminated throughout much of rural Pakistan and provide an extensive, easily understood vision of "Islam as an alternative ideology for state and society. . .as such, for many [Jamaat-I-Islami constitutes] a link between the traditional religious heritage and the realities of modern life" (Esposito, 1999: 67).

Northern Pakistan's religious parties, including Jamaat-I-Islami, constitute the "primary locus of the 'Islamic movement' which is the grassroots alternative to the government controlled establishment of Islam" (Hoffman-Ladd, 1987:29). The party-supported sermonizing of these groups – frequently partnered and sponsored by local mullabs - has provided by far the most ideologically sophisticated articulations of women's place not only in relation to local society, but also to processes of globalization. Despite local mullabs often having been "the subject of criticism

19 Islamic schools.

20 The genesis of mujahidin movements originally began in order to provide anti-Communist, covert forces operating in Afghanistan during the Russian occupation, but has more recently evolved into a fighting force of volunteers for the Kashmiri separatist movements (e.g. Harkat ul-Mujahideen) operating across the border in Northern India.

21 Tablighi "are the followers of the Tablighi Jamaat, a lay missionary movement founded in the 1920's in northern India that aims to bring Muslims back to the right path, that is, to the prescribed observances such as daily prayer" (Sokefeld,1999:421; Ahmad, 1991 in Sokefeld,1999:421).

22 Jamaat-Ulema-Islam (JUI) was started by radical Deobandis in the early 1940's, but flourished as a political party following Partition in 1947. JUI has repeatedly endorsed an anti-military, anti-American and anti-imperialist stance in all party propaganda, particularly since the early mid 1970's when General Zia Ul-Haq's Islamization schemes permitted JUI to mass-construct madrassas throughout Northern Pakistan. As "Pakistan's state-run educational system steadily collapsed, these madrasas became the only avenue for boys from poor families to receive the semblance of an education" (Rashid,2000:89). The more extremist JUI party has been embroiled in bitter power-struggles with its nearest political competitor, the Jamaat-I-Islami, since Pakistan's 1970 elections.

23 Deobandism represents "the followers of the famous North Indian Islamic seminary at Deoband, which propagates an orthodox version of Sunni Islam ... most Sunni ulema [formal religious communities] in the present-day Northern Area belong to the Deoband school" (Sokefeld,1999:421).

24 Muslim clerics.
[with little] arbitration or assessment powers in the village” (Kurin, 1985:858), the weight and import of recent Islamic fundamentalism is endowing mullahs with far greater power than they have previously enjoyed in Northern communities. In spite of the historical ambivalence of their position in rural communities, mullahs now function as primary, social vehicles for the articulation of globally informed ideals of Islamic social relations and women’s behaviours. Ultimately, mullahs provide the most cogent local connection to a larger dialogue on Islamic fundamentalism, social values and women’s roles. Because of the global emphasis of their studies, many madrassa educated mullahs barely know their own country or history (Rashid, 2000:23). Instead, they learn “about the ideal Islamic society created by the Prophet Mohammed 1,400 years ago” (Rashid, 2000:23) and this is what they purport to emulate. Despite their more progressive counterparts in urban centres, rural Islamic movements make few efforts to adopt social agendas inclusive of “women’s education and participation in social life” (Rashid, 2000:86).

2.2 Northern Women’s Household Roles

The household activities of families throughout rural Northern Pakistan focus on the upkeep of family members and home, livestock and agriculture. The daily, working life of rural women is arduous and physically intensive, with almost all activities centering on hard manual labour. Northern women are responsible for a vast array of tasks in the household or domestic economy, specifically in agricultural, poultry and dairy production and informal, household-to-household sales. The amount of housework a woman does depends on the number of males and females present in a household. In families with more than one female, as in a joint family household where daughters-in-law, sisters and daughters reside with a senior female, women are individually responsible for certain tasks. The workload for women in joint family households is somewhat alleviated. Throughout the Northern Areas, if two or three women reside in a household, one usually performs tasks associated with livestock, one with fieldwork, and one with housework (cooking, cleaning, childcare, etc). The increasing nucleation of households results frequently in only one woman managing a household, occasionally with the help of a daughter-in-law.

The situation is made more dramatic with male-out migration (Varley, 1998:8; Kuriakose, 1996; Sales, 1999:411), when women are left alone to deal with the full range of household activities, regardless of the task’s previous division of labour by gender. Women with absent husbands were completely responsible for the growth, harvest, processing and sometimes sale of wheat, barley and maize crops - a task otherwise done by men. Women with small children carry a heavier burden of household responsibilities than women with older sons who are able to take over a range of tasks left behind by fathers who had migrated out of the village for work (Varley, 1998:7).
Occasionally brothers-in-law or fathers-in-law, as is the case of joint households, are able to also fulfill these responsibilities. If women have enough financial resources, they can hire seasonal labour to help out in busy times, such as harvesting (Varley, 1998:8).

While they may not actually receive funds in-hand for the production of cash crops and activities, women's physical labour is pivotal to a household's asset creation (Varley, 1998:7). In Pakistan's Northern Areas, women perform a wide array of activities complimenting a household's earning potential besides formal income generating projects. The household budget is usually comprised of money generated from a husband's employment outside the village, while cash crops and small-scale enterprise activities also compliment a household’s finances. A male authority regularly controls the general household budget (Sales, 1999:411; Varley, 1998:). The household budget is regularly expended on household necessities, children’s educational costs, and individual contributions to either savings accounts or village organization holdings (Varley, 1998: 3,12). Women play an active role in the generation of funds for the household budget, complimenting their husband’s contribution if he is employed.

In many parts of the Northern Areas, women work hand-in-hand with men in farming activities, or take sole responsibility for these tasks, yet have no decision making power over, or access to, the funds generated (Varley, 1999:13). Instead, they tend to have control only over those limited funds generated from traditionally female tasks or 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). Traditionally, many women's personal assets are limited only to their amount of their dowry (mehr)²⁵, which is usually under the authority of their husbands, and may not always be recovered by women in the event of a divorce (talaq).

2.3 Decision-Making

In my previous research for the Aga Khan Rural Support Programme (1998), I interviewed women throughout the Northern Areas (Puniyal, Ghizer, Nagyr, Hunza & Gilgit Districts) to report on their daily household-level activities, decision-making abilities, and for comparative purposes, their perceptions of their husband’s responsibilities. Subsequent to my fieldwork and marriage, I had the opportunity to informally assess the multiple factors shaping household decision-making for women. Decision-making within the household reflects an interweaving of social relationships, and more importantly emphasizes traditional male and female gender roles and responsibilities.

²⁵ Northern Pakistanis, for the most part, still provide brides with their portion of the family inheritance upon marriage. In addition, husbands and their family are expected to provide a dowry fund (mehr), the amount of which is negotiated between families and is provided to the bride either during the marriage or in the event of a divorce (talaq).
The domestic sphere in Northern Pakistan is fundamentally defined by kinship groupings (qom). Each qom is individually characterized by patrilineal and patrilocal patterns of lineage endogamy. The qom’s communal domestic sphere is also a territorially defined, household unit that is off-limits to unrelated male, and in which related men and women enjoy unrestrained social mobility and interaction. Given the ideological confines of gender segregation, the only acceptable place for women to socially operate without adhering to seclusionary measures (such as wearing the veil [pardah, hijab]) is the territorial component of the domestic sphere. Within the domestic sphere, men are identified as the primary decision-makers for major financial or familial issues, the education and marriage of children, designating household tasks among other men and bestowing the authority to do the same among women to a senior female (Varley, 1998:11-13). While men control dominant decision-making in several areas (e.g. land sale/purchase, children’s marriage), women and men are responsible, in varied ways, for decision-making within their respective gendered spheres of activity. Women’s decision-making is unrestrained as long as she is not co-opting decision-making that is traditionally designated to males, or involves her movement or social interaction beyond the domestic/household sphere (Varley, 1998:13).

Men are especially entitled to decision-making over women in their qom when the issue-at-hand necessitates women’s mobility or social interaction beyond the territorial and ideological proxemics of the domestic sphere (Varley, 1998:13; Sales, 1999:411). Women’s ability to relate to unrelated women depends upon the communal or individual orientation of male qom members towards the qom of other women. In this respect, while women may personally decide they require specific services (e.g. health) located beyond the domestic sphere, the ultimate authority to decide whether she may travel from the household to service delivery rests with her husband or another senior, qom male.

Increases in individual decision-making are usually associated with variables in status (whether ascribed or achieved through merit, experience, age and/or marriage). But because of high levels of regional unemployment, men are often forced to leave the village to seek more gainful, year-round or seasonal employment in major cities to the south. Women receive only minimal

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26 Northern Pakistani architecture demonstrates the domestic separation of unrelated men and women’s worlds through rooms or facilities for each gender. Men’s accommodations (mardana) and women’s accommodations (zenana) are constructed alongside one another, but physically separated by walls, gates or gardens. Related men and women associate freely within the zenana, while the mardana is usually reserved for unrelated male guests or male social gatherings. Unrelated female guests are welcomed into either a guesthouse, which is separate from both the mardana and zenana, or visit in the zenana after special warnings are paid to males from the household to avoid this area for the duration of the visit.

27 A large number of Northern men frequently work as contract labourers for construction projects in Pakistan’s major cities (Peshawar, Islamabad/Rawalpindi, Lahore and Karachi), or as seasonal farm hands in more prosperous districts of the Northern provinces (Baluchistan, parts of the North West Frontier Province, the northern Punjab). More
advice from their husbands on how to school their children, plant certain crops or whom to go to in
the village when they require additional information or help (Sales, 1999:411-412; Varley, 1998:8). As an unintended result, women are left very much to their own devices when it comes to the management of their households in the absence of their husbands. Although previous Aga Khan Rural Support Programme reports indicated that “women are rarely left to head a household alone” and that there has been no significant increase in their decision-making power in the process of male-out migration (Kuriakose, 1996), evidence I gathered from across the Northern Areas suggested that the opposite is occurring. Because of male-out migration and women’s income generation profits, women reported that major decision-making power is being more readily accorded them because they are in possession of enough funds to financially contribute to major household issues. However, due to issues inhibiting women’s ability to further increase their capital generation (e.g. marketing problems, religious conservatism and/or regional traditions, the small-scale nature of income generation activities) women remain unable to financially participate in a household’s large fiscal decision-making (Varley, 1998:33).

Indeed, there have been substantial social efforts, driven by internationally-funded rural Islamization campaigns and Sunni madrassas (Islamic schools), countering increases not only in women’s decision-making abilities and their freedom to achieve education and health care, but also community integration between Sunni, Shi’a and Ismaili factions. The clear disjuncture is that despite their vast contribution to the welfare of a household, even in fiscal terms, women enjoy considerably less decision-making authority (in education, health care, children’s education, household budgeting and expenses) than their husbands, whose work is more seasonally and situationally intensive than women’s. This reflects, in many ways, Islamic notions of household decision-making and gendered ideals of personal agency. It also reaffirms that household authority is not based primarily on economic contribution, but on other ideological factors.

What are more general attitudes towards decision-making, identity, individuality, community and nation? Especially in how they contrast to biomedical emphasis upon the patient as ‘autonomous individuals’? How might this affect health seeking behaviours? While biomedical health surveys routinely focus on individual access and usage of biomedical services, it is recognized that in Pakistan “community level differences in access to resources, including access to health care, influence” (Agha, 2000:200) the ability of individuals to provide health care for themselves of their family. In contrast to Western models which place emphasis upon the individual, Fredrik Barth 28

infrequently, adolescent Northern boys work as hired hands or household servants (domestics) in wealthier Northern homes.

28 Barth conducted extensive ethnographic research among the Swat Pathans of Northern Pakistan in the late 1950’s.
succinctly described Northern society as constituted predominantly by acephalous political systems, characterized most frequently by unilineal descent groups where group solidarity is derived from shared degrees of ‘likeness’ (Barth, 1959: 5). Sunni communities, organizing themselves along lines of patrilineal descent, typically feel that “all males [and also women] descended through men from a common ancestor are brothers in a sense, and unified as a group against outsiders” (Keiser, 1991:75).

While descent groups motivate much of corporate and political allegiances, the fusion of interests between individuals or groups is frequently situational (Barth, 1959: 6). Charter groups “in the political system are formed by the strategic choices on the part of participants, and do not emerge by virtue of a mechanical solidarity deriving from likeness” (Barth, 1959: 7). Pivotaly, Barth’s assessment of personal agency among Swat Pathans carries important implications for decision-making within the available hierarchy of medical resort. Specifically, Barth indicated that the “recruitment of corporate political units depends on the exercise of individual choices between alternative allegiances….thus descent charters do not unequivocally define corporate units; these charters are made relevant to political action indirectly through their strategic implications for the choices of individuals” (Barth, 1959: 5).

2.4 Women in Northern Pakistani Communities

Northern Pakistan embodies some of the Islamic world’s most stringent seclusionary measures. Despite national trends towards increased education, access to health services, a higher age at marriage and increases in personal decision-making, rural women in Northern Pakistan remain relatively untouched by national and transnational campaigns directed at alleviating some of the starker and more austere aspects of their existence. Hanafi-Sunnī models are increasingly representative of extreme, Taliban-style gender seclusion throughout much of the North West Frontier Province, Diamer and Gilgit Districts in the Northern Areas. Pathan populations throughout the North represent the most stringent of seclusionary measures regarding women. While the situation for women in non-Pathan portions of Northern Pakistan is not quite so staunchly segregated, Chitrali and Gilgiti majority populations still take a certain amount of pride in their preservation of the most conservative aspects of gender segregation. By comparison, Ismaili interpretations of female behaviour and social mobility are remarkably liberal.

The *burqa* (an all enveloping, head-to-toe veil with lattice-work facial covering) is traditional garb for Pathan women, who are valued throughout Sunni portions of the Northern Areas as potential brides based on their extremely limited access to the world beyond the domestic sphere.
Beyond their seclusion in the domestic sphere, Pakistani social models forbid women from engaging in a comprehensive range of socio-economic behaviours. Community standards of moral behaviour have inevitably, and increasingly, focused on the social control of women. Such standards are informed by supranational ideologies promoting women's adherence to conservative models of Hanafi-Sunni gender segregation, and represent less of the accommodationist and more moderate trends of the recent past. Through the increasingly conservative preaching and admonishments of local religious clergy, men are repeatedly urged to “control their women” (Keiser, 1991:42). Piety, familial honour and chastity are highly valued feminine traits. In rural Hanafi-Sunni communities, the “notion that woman’s chastity is man’s responsibility” (Hoffman-Ladd, 1987:37) forms the axis for traditional, male-dominative decision-making, family structure and political organization. Pious women must demonstrate their faith not only through the clothes they wear (Hoffman-Ladd, 1987:31), but also through their adherence to Islamic models of seclusion and mobility. In many respects, Islamic notions reflect how, as Strathern described amongst Melanesian women, “femaleness emerges ultimately from the artifacts, ideas, values, and symbols associated with women” (Strathern, 1980:16). Much of the conservative propaganda countering women’s social mobility reaffirms that anything that “causes [women] to leave the natural place for which she was created – the house” (Hoffman-Ladd, 1987:35), and “exposes her to mixing with men ... may [also] expose her to moral corruption or the vulnerability of religion and honor” (Al-Sadawi in Hoffman-Ladd, 1987:35). Northern Pakistani communities prefer to adhere to rigorously conservative standards, in which women are discouraged from leaving the domestic home under any circumstances, including schooling past puberty, for routine and sometimes emergency medical treatment, and most certainly for employment. On the other hand, in more moderate, predominantly urban Hanafi-Sunni communities throughout Pakistan, veiling alone affords “women the possibility of upholding traditional ideals and sexual values at the same time as they move into the educational system and work force” (Hoffman-Ladd, 1987:40). While there are certainly notable exceptions to this rule in many Sunni communities, these exceptions are fewer and farther between as the reach of Islamic conservatism affects individual ability to challenge community norms.

In many conservative communities, people “think about the quality of social relations in terms of contrasting concepts ... of these, enmity/amity, bad/good, enemy/ally, and distrust/suspicion/trust most typify how people think” (Keiser, 1991:18). The social principles that underlie, and regulate, relations between members of the opposite sex are represented by gendered polarization of equality/inequality, aggregation/segregation, trust and mistrust. Despite such polarization, most individuals “interact neither as allies or enemies” (Keiser, 1991:18). Instead, “these relationships pose the greatest danger because of their fluidity – they can unexpectedly
change to relationships of alliance or enmity at any moment” (Keiser, 1991:18). Because of the unpredictability of people’s relationships with one another, “neither trust not distrust but guarded suspicion structures behaviour between most men” (Keiser, 1991:19). As such, unrelated community members will often avoid one another rather than provide opportunities for the social wrongs than can arise from interaction, no matter how mundane. In his ethnography, “Friend by Day, Enemy By Night: Organized Vengeance in a Kohistani Community” (1991), Keiser30 was himself witness to a number of village encounters in which friends would seemingly morph into blood enemies, capable of murder over what appeared to be the least provocative of issues. Social infractions concerning pardah and moral propriety are considered among the most inarguable reasons for extreme vengeance behaviours, widely known as ‘honor killings’.

The consequences for sexual improprieties are grave. Both parties may be expelled from their home and community, a serious consequence in traditional society where women have few, if any, opportunities for socio-economic independence, particularly in rural areas with high male unemployment. In the most severe of cases, both parties are killed, although throughout Pakistan, women are killed more often than men. This reflects local, Islamic notions that sexual impropriety between men and unrelated women results from women’s embodiment of sexuality, and her ability to incite sexual behaviour; women are the primary cause, and therefore should be blamed, for men’s sexual misbehaviour. In many parts of the North, honour killings are idealized in Sunni communities as enacting public standards, especially those concerning family [male] control over female relatives. Many religious clergy praise them as inhibitory measures countering future infractions. Because biomedical services provide grounds for both distrust and vengeance (e.g. physical contact between male physicians and female patients), it is obvious that in communities where conservatism and tribalism prevail, women’s medical services remain a near-impossibility. Even when women treat women, the highly sexualized nature of women’s bodies and their purportedly ‘weak’ psychology are deemed to leave them susceptible to moral corruption by secular, ‘liberated’, ‘Western-style’ and unIslamic female physicians and clinical practitioners who are peripheral to the society.

2.5 Hanafi-Sunni Theories of ‘Femaleness’

Thus, local attitudes to women’s roles and place in society, while taking many of their cultural cues from regional approaches to gender issues, are increasingly determined by larger, Islamic models. In order to explicate community-based resistance to biomedical service delivery for

30 Keiser conducted ethnographic fieldwork in Dir-Bajaur District of the North-West Frontier Province, a district to the northeast of Swat where Barth had worked 25 years previously. Keiser's research concentrated on clarifying ritual and revenge among Kohistani and Pathan populations.
women, it is necessary to provide a cursory analysis of the socio-religious frameworks underlying women’s social mobility. In many traditional Islamic societies, the veil and women’s spatial relegation to the private sphere reflects “the appropriateness of her invisibility and nonparticipation in public life” (Hoffmann-Ladd, 1987:23). Veiling and segregation are perceived as effective social tools countering mafatīn (beauty), “loci of fitna”, emphasizing that the beauty of women holds a danger for men...this aspect of female sexuality...implies that women are a discordant element that must be controlled and separated from men to allow society to function properly” (Hoffman-Ladd, 1987:28). In Northern Pakistan, men are repeatedly exhorted to maintain economic and moral control over women; “men’s minds are more perfect; men are more far-sighted, more resolute, and stronger...they are, no doubt, better able to face life and its difficulties and many various problems” (Musa in Hoffman-Ladd, 1987:37). If men “are not in charge of women, women will lose sight of all human values and the family will disintegrate” (Hoffman-Ladd, 1987:34). Spatial and sexual dynamics, inherent in Muslim social organization, lie most noticeably at the confluence of domestic and public domains of activity and interaction.

Because Hanafi-Sunni notions of sexuality are territorial, “regulatory mechanisms consist primarily in a strict allocation of space to each sex and an elaborate ritual for resolving the contradictions arising from the inevitable intersections of spaces” (Mernissi,1975:137). Supranational Sunni ideologies promote that for the smooth functioning of Islamic society there must be “no accepted patterns for interactions between unrelated men and women” (Mernissi,1975:137), apart from “ritualized trespasses of women into public spaces (which are, by definition, male spaces)” (Mernissi,1975:137). Such supranational views doubly complement and compound pre-existing, localized notions of the importance of gender seclusion.

The symbolism of sexual patterns certainly seems to reflect society’s hierarchy and power allocation in the Muslim order. Strict space boundaries divide Muslim society into two sub-universes: the universe (the umma, the world religion and power) and the universe of women, the domestic world of sexuality and the family. The spatial division according to sex reflects the division between those who hold spiritual powers and those who do not. The division is based on the physical separation of the umma (the public sphere) from the domestic universe. These two universes of social interaction are regulated by antithetical concepts of human relations; one based on community, the other on conflict. (Mernissi,1975:138)

In contrast to Islamic and unIslamic societies where groups enforce respect of “sexual rules by a ‘strong internalization of sexual prohibitions during the socialization process’”, conservative Sunni communities, such as those in Northern Pakistan, tend to place additional emphasis upon “external

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31 Social disorder or chaos.
precautionary safeguards such as avoidance rules” (Murdock in Mernissi, 1975:30). Quranic scholars have clarified this by adding “the difference between these two kinds of societies resides not so much in their mechanisms of internalization as in their concept of female sexuality” (Mernissi, 1975:30). In Islamic culture, female sexuality has historically been defined as active, while their behaviour is passive. Islamic liberalists, such as the 19th century Egyptian scholar Qasim Amin, have frequently claimed, “women are better able to control their sexual impulses than men and that consequently sexual segregation is a device to protect men, not women” (Mernissi, 1975:31). Given this, Amin asks us to consider “who fears what in such societies?” (Mernissi, 1975:31).

For rural Northern communities, seclusionary measures symbolize the social containment of women’s potential for wreaking *fitna* through her embodied, active sexuality (versus passive social behaviour). Active sexuality incites men to promiscuity or misbehaviour, and results in shame (*sharam*) being brought upon male family’s *ghrairat* (personal integrity). *Jamaat-I-Islami* literature makes this connection between women’s embodied sexuality and shame more cogent and globally applicable; “the entire body of a woman (except her face and hands)\(^{32}\) is to be treated as pudenda; it is a vulnerable, weak object that must be covered to avoid embarrassment and shame…even the voice of a woman…should not be heard” (Hoffman-Ladd, 1987:43). Because women’s appearance is seen to cause social “*fitna*…she must be covered for the protection of men” (Hoffman-Ladd, 1987:43). Fatima Mernissi, a Quranic scholar and specialist in supranational trends in Hanafi-Islamic theology, clarifies the theoretical complexity of explicit and implicit theories of female sexuality that abound not only in Islamic literature, but in community interactions. Tension between these theories produces “a double theory of sexual dynamics” (Mernissi, 1975:32).

The explicit theory is in the prevailing contemporary belief that men are aggressive in their interaction with women, and women are passive. The implicit theory, driven further into the Muslim unconscious, is epitomized in Imam Ghazali’s classical work [which] sees civilization as struggling to contain women’s destructive, all-absorbing power. Women must be controlled to prevent men from being distracted from their social and religious duties. Society can survive only by creating institutions that foster male dominance through sexual segregation and polygamy for believers.” (Mernissi, 1975:32)

Social and sexual segregation deeply typify traditional Islamic beliefs in women’s *qaid* (“the power to deceive and defeat men, not by force, but by cunning and intrigue” [Mernissi, 1975:33]). As such, “the whole Muslim organization of social interaction and spatial configuration can be understood in terms of women’s *qaid* power…the social order then appears as an attempt to

\(^{32}\) This is based upon a “modesty code that interprets the Quranic passages on *zina* (sexual immorality) to mean that all of the woman should be hidden from view, except her face and hands” (Hoffman-Ladd, 1987:43; Mernissi, 1975:59).
subjugate her power and neutralize its disruptive effects” (Mernissi, 1975:33). Northern Pakistani women, whose “existence outside [the domestic] sphere is considered an anomaly, a transgression – are subordinate to men, who (unlike their women) also possess a second nationality, one that grants them membership of the public sphere, the domain of religion and politics, the domain of power, of the management of the affairs of the umma” (Mernissi, 1975:139). Indeed, in Northern Hanafi communities,

Male and female worlds . . . are clearly demarcated and hierarchically ranked. The lines between them can be crossed only with great difficulty, if at all. Kohistani women do not own animals, and cannot herd them; they do not own guns, and cannot fight. They cannot enter mosques, and cannot hold positions of political authority. . . women’s behaviour becomes a matter of male Muslim identity because the way women act directly impacts on ghara'a, men’s gift of personal integrity from God. Women must never walk outside their husband’s (or father’s) house without proper escort . . . women must never speak to an unrelated man. No man’s direct gaze should fall on another’s wife or daughter. Women (men too, but especially women) must not sing or dance, particularly at weddings. Finally, women should always comport themselves with modesty to protect their shame (sharam) – hiding, controlling, minimizing, and denying their sexuality completely if possible. Men who allow their women freedom become baghraithat (‘men without possible integrity’). So do those who refuse to retaliate violently against anyone purposely threatening their women’s shame. (Keiser, 1991:42)

3.0 Health Service Delivery

Northern Pakistan exemplifies a wide range of rural health care options – home-based, community, and professional. Local patterns of health seeking behavior cogently echo Arthur Kleinman’s tripartite system of medical services and classification in informal home and community care, traditional (folk providers) and professional (biomedical) communities. Kleinman’s tripartite system, which sets the parameters for client-practitioner interrelationships and intersectoral tensions, and between informal and professionalized systems of available medical resort, provides an appropriate framework for discussing the role of biomedical therapies in Northern Pakistan systems of medical resort. Within rural Northern Pakistan, the pluralistic hierarchy of available medical resort includes popular healing, Islamic (or Prophetic) medicine, Yunani Tibb and Western-modeled biomedicine. Prior to the introduction of professional biomedical care, the traditional hierarchy of medical resort was based upon informal and unprofessionalized, yet ideologically sophisticated, Islamic systems of prophetic and folk healing.

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33 Kleinman’s model, however, does not account for the socioeconomic and political dynamics that I am examining. It merely provides theoretical scaffolding in order to relate existing services to one another.

34 Anne Sweetser’s research of biomedical, Prophetic and folk therapies in the Kaghan Valley (found in Mansehra District, immediately to the south of Diamer District) indicates that the vast majority of traditional medicines and treatments are frequently inefficacious (Sweetser, 1993).
Decisions regarding treatment for illness episodes are both practical and deeply symbolic. They reflect not only a person's highly individualistic physical and spiritual needs. More importantly, they signify individual, family and community allegiance to sectarian standards of appropriate patient behaviours. Patient behaviours are further constrained by local social and gendered models of mobility and seclusion. Generally, individuals or families do not seek the treatment of one practitioner exclusively. They tend to seek "help from practitioners of several different types of therapy simultaneously or serially" (Sweetser 1993:46). This is done to maximize the possibility of "obtaining the appropriate countermeasure which will result in immediate relief" (Sweetser 1993:55). Research in rural Baluchistan (a Northern Pakistani province found immediately to the south of the North-West Frontier Province on the border with Afghanistan) indicated that the majority of cases obtained treatment simultaneously from different medical systems (Sultana & Hunte, 1992:1395), with interests in medications taking precedence over practitioners (Sultana & Hunte, 1992:1390). While people tend to choose health-care strategies that are immediately appropriate to the shifting nature of their economic status (while the very poorest have little choice but for traditional therapies), there are recent, unmistakable trends towards the avoidance of biomedical clinical interventions for women (Agha, 2000; Carbonu & Soares, 1995; Ahmed, Shah & Luby, 1998; Sweetser, 1993).

Northern Pakistanis can be generalized as behaving according to two basic patterns: illness specific, in which they seek out different kinds of therapy for different disorders, and multiple use, in which assistance is sought from a variety of different medical resources during a single episode of illness. Northern communities evidence overlapping, albeit under-investigated, illness classification systems and tremendous variation in local understandings of illness causation and severity (Schmidt, 1983; Sweetser, 1993; Staley, 1982). Because ethnographic material presenting Northern illness classifications is extremely limited, I may make only cursory statements concerning how people use and think about illness and health service delivery. Members of many households scale illness by degrees of severity (whether it is perceived as life-threatening or not, infectious or not, etc), treatment by the status or occupation of the ill individual, how much therapies cost (biomedicine requires cash funds, but prophetic healing does not), how accessible various forms of treatment are, the ideologies and cultural patterns represented by different therapies, gender (if the patient is a

35 The Baluchistani context, as described in a 1992 study examining maternal and child health-seeking behaviours, tends to reaffirm general concerns on the part of biomedical development planners, that while Northern Pakistani families are not intrinsically opposed to the notion of women's health maintenance, they prefer medications to practitioners. This is reflected by the local preference to first treat women at home with pharmaceuticals before moving from the traditional female domain (the home) when seeking practitioner intervention in a male-dominated domain (public space). While this does not necessarily preclude women seeking practitioner care, it does mean that the hierarchy of medical resort is linked explicitly to socio-cultural needs within the larger community.
female, because of *pardah* she is less likely taken from the home for treatment), and age (if it were a very elderly individual, treatment is generally less rigorous) (Sweetser, 1993).

Community treatment is usually chosen first, as it allows the individual to recover amongst family and - especially in the instance of senior male and female family members - permits them to continue to supervise familial activities from the sickbed. Further, by utilizing traditional therapies, individuals reaffirm and reinforce not only their faith in and relationship with God, but also their social relationships in the village vis-à-vis village healers. If biomedicine is deemed a necessary compliment to traditional therapies, male family members will purchase various medications in town and bring them back to the home to be administered, rather than disturb the sanctity of the home's healing environment.

In order to permit women access to unrelated, male community and folk practitioners, Northern Pakistanis have made extensive and liberal usage of *xandán, qom,* community and religious classifications (Sokefeld, 1999:419-422), within which it is possible to construct situationally-appropriate relationships. Individuals from different *xandán* may find acceptable interrelatedness at the *qom* level, and if not there, at the community or even sectarian level. The more distant the point of relationship from the *xandán* and *qom,* the more permissible and necessary fictive kinships become because they enable individuals to perpetuate acceptable socio-cultural standards while seeking health service delivery. But the common interest always remains in overall recognition and deference paid to Islam as a unifying social and healing force. Secondary to this is the pivotal importance of maintaining, through community and folk therapy models, local socio-cultural systems of gender seclusion and social interaction.

### 3.1 Islamic Medical Therapies

In order to adequately emphasize the social, and gendered tension between traditional culture and biomedical initiatives, it is necessary to briefly outline the traditional, pluralistic hierarchy of medical resort (Romanucci-Ross, 1969) which predominantly meets meeting women's health care needs in rural Northern Pakistan. Despite biomedicine's emergence as a "global medical system, indigenous healers reportedly continue to function as the major health care providers for about 90% of the world's rural population" (Bastien, 1992 in Baer et al, 1997:219). Northern Pakistan, where the belief in religious healing is ubiquitous, is clearly no exception. In Muslim villages throughout Northern Pakistan, people tend to view the world from a "predominantly religio-moral as opposed to secular-scientific perspective" (Sweetser 1993:43). In direct contrast to public health promotion

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*Research has typically been constrained because of the overall inaccessibility of the domestic sphere to outsiders.*
emphasis on clinical biomedical services, rural notions of 'wellness' are more holistic, "including emotional and spiritual as well as physical dimensions, their search for treatment is ultimately a search for contact with healing powers conceived primarily in Islamic terms and understood through reference to the hierarchical structures they experience in a society" (Sweetser 1993:43). Few villagers would question the idea "that birth and death are the responsibility of Allah, and many assume that much of what occurs during life is predetermined" (Sweetser 1993:53). Under the rubric of Northern Pakistan's religious healing is a heavy reliance upon prayer, prophetic medicine and numerous forms of popular practice. Biomedicine, on the other hand, is "commonly regarded as non-religious and impure and thus denigrated in comparison with religious healing" (Sweetser 1993:54).

Islamic medicine, known in Pakistan more generally as Prophetic healing, is a somewhat ambiguous and misleading term describing a body of medical and bodily knowledge that relies heavily "on Greek, Persian and Indian medicine, but especially on the Greek, so much so that historians of science barely incorporate it in their otherwise comprehensive works of world history of medicine" (Abdalla, 1997:27). Prophetic healing is a complex and sophisticated synthesis of more ancient Galenic healing traditions, known as Yunani Tibb, and those healing practices recommended by the Prophet in the Hadiths. Prophetic healers utilize therapeutic remedies from the "al-Qabyb fu al-Tibb" (Canon of Medicine), "written by the Persian, Ibn-Sina (Avicenna) during the 13th century" (Sweetser 1993:51). Individual health is generally conceptualized as a "proper balance among the humors" (Sweetser 1993:51) and diagnosis is performed through an examination of "mental function, pulse and respiration, stools and urine, and the appearance of every part of the body including tongue, skin, hair, eyes, etc" (Sweetser 1993:52).

Classical Islamic medicine, popularly and professionally practiced in many of Pakistan's urban centres, is characterized by highly "developed theoretical structures, differentiated professionalizations and their transferable and transmittable written knowledge" (Abdalla, 1997:24). In its professional form, Islamic medicine may be identified alongside the other "greater systematizers" (Abdalla, 1997:24), Ayurveda, Yunani and Chinese medicines. However, the notable distinction is that Northern Pakistani Islamic medicine is an informal, thoroughly unprofessionalized practice. The informal practice of Prophetic medicine in Northern Pakistan is far less comprehensive than its professional counterparts in urban centres throughout Pakistan. Biomedical classifications of Prophetic medicine mistakenly identify it as a professional "medical system' in [an area] where in fact only impulsive and non-coherent notions about disease and cure exist" (Abdalla, 1997:24).
Prophetic medicine, in its purest and most identifiably Islamic form, originates with “some 300 or so hadiths or traditions and anecdotes attributed” (Abdalla, 1997:53) to the Prophet Mohammed which deal with medicine and health-related subjects. However, the Prophet “was not considered a practitioner, and his medical advice, exhortations, or recommendations were not regarded as part of medicine ... nevertheless, the ‘medicine of the prophet’ or what is believed to be his, was destined to have a great influence” (Abdalla, 1997:53) on Islamic medical traditions. It has been this aspect of Islamic medicine that predominates and flourishes throughout rural communities in Northern Pakistan. Northern practitioners rely on these hadiths (traditions) and a varying array of locally available, indigenous herbal remedies. These remedies are acceptable largely because they are unaccompanied by theoretical belief systems which conflict with Islamic suppositions of health and healing. Prophetic medicine’s ability to intersect with indigenous therapeutic systems (which abound in Northern Pakistan, but have been unexplored) reflects its ability to “blend with the other facets of the communities” (Abdalla, 1997:25) in which it is practiced. Further, it articulates “disease, misfortune, and cure in culturally meaningful idioms, and [is] handed down from generation to generation” (Abdalla, 1997:25).

Non-professional Prophetic healers, known as hakims, are motivated to service through human sympathy (hamdardi) and accept no payment for their services, although they may charge nominal sums for their herbal remedies (Sweetser 1993:49-52). Their social value rests upon their stressing treatment of the whole physiological, mental and spiritual person. In essence, they offer intensely personalized treatment. This conflicts with local conceptions not only of disease causation, embodiment and notions of effective cure, but also with the fundamental belief that the body embodies cultural ideals and values. Culture, therefore, cannot be separated from the body.

The increasing popularity of hakims in rural Pakistan is testament to a time when "religious consciousness and awareness of dangerous side effects of (often misprescribed) biomedicine's are both increasing" (Sweetser 1993:53). Because popular and folk practitioners of traditional medicine are frequently associated with religious organizations or institutions, there has been less local interest “in acquiring new skills and [using] certain biomedical-like treatments or technologies in their own work” (Baer et al, 1997:215). Instead, there has arisen a vast network of quasi-biomedical practitioners who supplant the authority and practice of formal physicians, and provide the greatest regional competition for the supply of medical resources. By confining biomedical care (usually pharmaceutical products) to home-based therapies, this blending of products and systems, through
the integration of non-invasive herbal and biomedical pharmaceuticals, permits spirituality and the cultural context to be preserved by the dominance of Islamic therapies.

3.2 Biomedical Service Delivery in Northern Pakistan

Since 1978, when the World Health Organization and the United Nations International Children's Emergency Fund called for urgent action by all governments to provide appropriate health care for the underprivileged, Pakistan has attempted to implement comprehensive, rural-based primary health care strategies (Hezekiah, 1993:493). Yet Pakistan, with a population of 130 million people, remains a primary example of developing countries where the rural population lacks appropriate and accessible health services (Hezekiah, 1993:493-495). Because Pakistan has historically supported little socio-economic and health services infrastructure throughout Northern Pakistan, biomedical development has been random and unreliable. There are nationally-funded district hospitals found throughout Northern Pakistan, and annual mobile health clinics held in more rural regions, but the majority of local health care - especially following the 1975 completion of the Karakoram Highway - has been implemented by transnational, non-governmental organizations (NGOs). While the previous locus for biomedical care was the district hospital, the rapid proliferation of low-fee, small-scale, non-governmental regional health clinics and service delivery centers is alleviating local dependence upon ineffectually run, and inaccessible, government hospitals for the majority of biomedical diagnosis and treatment. In Chitral District and the Northern Areas, the Aga Khan Health Services Pakistan (AKHS, P) has,

... been implementing the Northern Pakistan Primary Health Care Programme since 1987. Working in partnership with local communities, the government, and other AKDN institutions, like the Aga Khan Rural Support Programme, the goal has been to find sustainable ways of financing and delivering primary health care in the high-mountain valleys. This has led to a village-based approach -- the designation of community health workers by the local village organization, the training of these workers in community-based disease prevention, and the reorientation of health professionals (government and private) to primary health care. The programme serves 575,000 people. Since it began, AKHS,P has trained close to 400 community health workers and over 200 traditional birth attendants in the Northern Areas and Chitral. In the Northern Areas, AKHS runs 29 health centres, a medical centre and a maternity home. In Chitral, AKHA runs 24 health centres, four dispensaries and a maternity home.

(www.akdn.org/agency/akhswork.html#pakistan:2002)

While this processing of biomedicine on indigenous terms has the potential to result in a highly efficacious blend with traditional therapeutic knowledge, it more often represents ineffective dosages for misdiagnosed conditions, and simple illnesses progressing to medical crises where women are either left at home to die or rushed to hospital for belated emergency treatment.
Prior to AKHS,P's efforts, the Government of Pakistan has implemented, since the late 1970’s, a series of Basic Health Units (BHUs), Regional Health Centres (RHCs), and Tehsil\textsuperscript{38} (THQs) and District Headquarters (DHQs) throughout all districts of Northern Pakistan. Each health center is designed to provide enough pharmaceutical dispensaries, a minimum of surgical coverage, physicians and drug dispensers to meet local health service needs along a continuum of minimum to maximum health coverage, with service fees scaled according to individual, user-pay ability. Because of the unavailability of trained health personnel, there is a heavy reliance on civil dispensaries (run by paramedical staff) in order to provide both health coverage and “life-saving drugs to the people of remote areas” (Dawn, April 28: 2002). Despite concerted efforts to recruit both locally and nationally trained doctors, specialists, drug inspectors, and Executive Health Officers, a substantial number of Basic Health Units\textsuperscript{39} “are without doctors, showing district and provincial governments’ neglect towards the public health sector” (Dawn, April 28:2002)\textsuperscript{40}. The Pakistani Government has begun, since mid-2001, “changing the eligibility criteria of new medical graduates to ensure the doctors worked in rural areas … under the new rules, graduates must complete 1-year service in a rural area to be eligible for registration with the Pakistan Medical and Dental Council (PDMC)” (Ahmad,2001:2036). Despite their best efforts, there is “only one doctor for every 6600 people” (Sales,1999:409) in Northern Pakistan.

Because physician-coverage and utilization rates are low, the national provision of medical facilities to rural areas remains a high priority. In their efforts to complement the lackluster provision of physicians and biomedical specialists, the Pakistani government has undertaken comprehensive programs to train and deploy auxiliary health workers throughout rural areas (Schmidt, 1983:419). When neither auxiliary health workers nor government-physicians are accessible, affordable or offer appropriate services, the next step of resort lies in the flourishing trade of private health care. As a direct result of the inadequacy of public health care throughout Northern Pakistan, for-profit private health care is flourishing in the majority of rural tehsils.

\textsuperscript{38} Tehsils are regional wards that fall under the local jurisdiction of government districts, all of which are centrally administered by provincial capitals. In the instance of Chitral District, Peshawar is the governmental and administrative capital. Gilgit functions as the administrative and medical headquarters for the Northern Areas (Gilgit & Baltistan Districts).

\textsuperscript{39} Basic Health Units provide the majority of care in those outlying districts that do not fall under the coverage of regional (RHCs), Tehsil (THQ) and district headquarters hospitals (DHQs).

\textsuperscript{40} In Chitral District, there are 21 BHUs, three RHCs, three tehsil headquarters hospitals (THQs), and 22 civil dispensaries apart from the District Headquarters Hospital (DHQ), which is located in the region's administrative capital, Chitral Town. As of April 2002, 13 out of 21 Basic Health Units were without attending physicians; “X-ray and other basic laboratory test facilities are non-existent in all the RHCs; the BHUs are being run in the far-flung areas which are, in most cases, more than 80km away from the District Headquarters Hospital” (Dawn, April 28:2002).
Private health care, despite its considerable cost, is seen to provide "better and more flexible access, shorter waiting, greater confidentiality, and greater sensitivity to user needs" (Zwi, Brugha & Smith, 2001:463). Despite this, "the quality of care offered by many private providers is poor. . .[and] poor people spend a greater proportion of their income on health care. . .often using less qualified or totally untrained private providers" (Zwi, Brugha & Smith, 2001:463). The Pakistani Government has suggested implementing "accreditation schemes. . .[to] monitor the services offered by providers against agreed quality standards, in exchange for which such services are promoted to potential service users” (Zwi, Brugha & Smith, 2001:463). However, as an inadvertent consequence of their dual interest in promoting both physician recruitment and private service usage, on February 12, 2002, the “government of Pakistan’s North West Frontier Province (NWFP) announced that it had banned private practice by doctors working in public hospitals, but said it would allow ‘institutionalized private practice’ under which doctors could do private work in public hospitals after completing their shift” (Ahmad, 2002:685). Private work is a direct consequence of low governmental pay scales, resulting in an alarming number of physicians who “examine and treat patients who paid a consultation fee in the government-run hospital….as a result, poorer patients no matter how needy or seriously ill are refused public hospital beds, which are taken by wealthier patients” (Ahmad, 2002:685).

If poorer patients need surgery and are unable to raise the fee for private treatment, they are operated on mostly by junior doctors, leading to, in some departments, alarmingly high complication and mortality rates. In some cases patients who have not paid a fee but who are seen by consultants have complained that doctors were unkind and disrespectful. (Ahmad, 2002:685)

Yet despite the proliferation of private services, recent health surveys and maternal mortality estimates (Ahmad, 2002; Sales, 1999; Agha, 2000) indicate that women, and children, continue to remain isolated from all forms of service delivery.

Moreover, much as how local variations of illness causation, severity and classification systems have been under-explored, there is an insufficiency of research clarifying the diversity of available biomedical practices, practitioner approach and institutional assumptions. Understanding this diversity would serve to explain regional interpretations of practitioner acceptability, and the potential, and practical, compatibility of certain practice-specific aspects of local biomedical service delivery to local standards concerning women. For instance, in a Hanafi-Sunni village lying immediately to the south of Gilgit Town, I was aware of one local physician who had made substantial efforts to modify his private clinic in an Islamic fashion. This included the construction of a separate entrance, waiting area and examining room for women and children, and a special
lattice-work screen, which ran along the centre of the clinic’s examining room, through which the doctor could address female patients in a manner that fulfilled many *pardah* requirements. Although this did not satisfy all *pardah* advocates (many locals oppose any social contact, including speech, between unrelated men and women), a growing number of patients and their families found the clinic more accessible.

3.3 Women’s Biomedical Service Delivery & Barriers to Treatment in Northern Pakistan

Northern projects focus overwhelmingly on obstetrics and gynecology, with a lesser emphasis on tuberculosis, parasites, malnutrition, respiratory ailments and degenerative eye conditions (e.g. trachoma, cataract). Until Zia’s Islamization schemes and subsequent backlash from conservative religious organizations, family planning once held a pivotal place in rural community and women’s health schemes. Historically, biomedical development in Northern Pakistan has identified women’s health needs as “almost exclusively related to their reproductive roles or their need [has been] defined in male terms, without considering and integrating their own experiences of health and illness, so that the health system is able to respond in a culturally appropriate and gender sensitive manner” (Puentes-Markides, 1992:620).

A plethora of recent medical surveys focusing on women’s health in Northern Pakistan describe a depressing range of treatable, yet untreated, medical conditions. These include anemia (which affects nearly 40% of pregnant women [UN Wire, July 28/1999]) and obstetric emergencies (Ahmed, Shah, Luby et al, 1999). Northern Pakistan has one of Asia’s highest maternal mortality rates, nearing 340 per 100,000 (UN Wire, July 28/1999). Women and infants in Northern Pakistan are approximately “1.6 times as likely to die” (Agha, 2000:203) as Punjabis, who enjoy far greater access to biomedical services based on their comparative availability and a higher urban proportion of the population. The rural-urban divide in Pakistan poignantly represents wide variations in educational and socio-economic status experienced by women. In Northern Pakistan, “the higher levels for disadvantage for 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 “66% of urban births were to mothers who had no education, compared to 92% of rural mothers with no education. . . births in rural areas occur to younger mothers: 16% of births in rural areas occur to mothers aged below 20 years compared with 14% in urban areas” (Agha, 2000:203). In both rural and urban areas “24% of births occur within 18 months of the last birth” (Agha, 2000:203). In rural Northern Pakistan, 25% of infants are born underweight, and “70% of women receive no antenatal care during pregnancy” (Agha, 2000:203).
A definitive hindrance to health initiatives rests in that the vast majority of government physicians are men, inevitably leading to a substantial void concerning women’s primary and maternal health care services. Since the late 1970’s, the Pakistani government has attempted to counter this absence of physicians by actively sponsoring and recruiting ‘Lady Health Visitors’ (LHV’s)\textsuperscript{41}, to perform home-based medical procedures and check-ups, moving on a set schedule and route between villages. Over the last two decades, the Pakistani Government has developed extensive Basic Health Programs (BHPs) to train auxiliary health workers and to establish rural health facilities networks throughout the country. Nationally-sponsored programs to train lady health visitors, dispensers and sanitary inspectors, have now been in operation for decades and are generally quite successful, albeit less so in more conservative areas of Pakistan (Schmidt, 1983:419-420). For those rural women who live beyond the reach of institutional biomedical care (such as in hospitals or local clinics), or for reasons of social seclusion are unable to leave their homes for treatment, the Lady Health Visitor is the first and last resort beyond traditional therapies.

Northern Pakistan suffers under an extraordinarily high burden of maternal mortality. Recent estimates have suggested “the maternal mortality ration [to] range between 300 and 700 per 100'000 live births” (WHO, 1991 in Midhet, Becker & Berendes,1998:1587). In light of these staggering figures, “medical causes and associated risk factors of maternal mortality have been extensively studied”, leading to an increased understanding of the “role of health care systems in the causation of maternal mortality” (Midhet, Becker & Berendes, 1998:1587). Recent studies are indicating that “women who died of maternal causes were more likely have died either in a health-care facility or one their way to one, suggesting that attempts are made to access health care when complications arise” (Bartlett et al, 2002:648; Midhet, Becker & Berendes, 1998:1587). This also suggests that hospital treatment may be locally regarded as more of a ‘last resort’\textsuperscript{42} than as reasonable recourse in instances requiring medical attention. Growing recognition is being made 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). In particular, “access to primary-level health care may influence pregnant women’s behaviour regarding utilization of modern health services” (Midhet, Becker & Berendes,1998:1587). Expanding understandings of the “role of contextual determinants of maternal mortality” are elucidating “interactions between determinants at multiple levels” (Midhet, Becker & Berendes,1998:1587).

\textsuperscript{41} Lady Health Visitors (LHVs) are predominantly independent, unmarried Pakistani women, usually from the Punjab. Countering local angers at the notion of Muslim women working unaccompanied in rural communities, the Pakistani Government has made concerted efforts to hire Christians, who they perceive as ‘free’ from local strictures concerning mobility and social access.
3.4 Women’s Access & Usage of Biomedical Service Delivery

Among barriers at the first level to women’s treatment is a general failure, especially in the instance of maternal health,

... 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. (Bartlett, Jamieson, Kahn, Sultana, Wilson & Duerr, 2002:643)

As a first-level barrier to treatment, women’s seclusionary measures have had demonstrable impact on women’s health status and their ability to access biomedical service delivery. High infant mortality rates are frequently attributed to Pakistani 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). Despite this, there is little awareness among biomedical specialists that these same stresses may also impede women’s ability to provide care for themselves. The vast majority of medical surveys in Northern Pakistan concentrate on women’s health care issues as a subset of maternal and child welfare, and as a result, developmental research has been unable to clarify how women’s access issues are very different, and far more complex, than children’s. Women enjoy health care needs that extend far beyond pregnancy and childbirth, despite regular assertions in biomedical literature that the “low social, economic and legal status of women is intimately tied to the well-being of their children” (Agha,2000:199).

Other first-level barriers to treatment include distance to treatment, the costs associated with travel and treatment, and appropriate supervision of female patients while outside of the home. In Northern studies reviewing the success of tuberculosis management programs, many researchers stated that women were overwhelmingly the largest proportion of program defaulters; “rural women were particularly disadvantaged by problems associated with travel: all 9 rural women respondents named duration/cost of travel and being unable to travel alone as factors contributing to default” (Khan, 2000:252). Additionally emphasizing local beliefs that biomedical services are inappropriate for women is how, as with the case of tuberculosis treatment, “patients were subjected to long waiting times, given little education. . .and often not provided the drugs they required for treatment”

42 Throughout much of rural Northern Pakistan, there is the notion that the hospital is where you go to die. This view is not entirely unreasonable, either, considering the lack of adequately trained physicians and hospital supplies.
Even when medical treatment is accompanied by biomedical literature, in rural areas male literacy rates are approximately 15% and women's 4% ([1987 estimate] Sales, 1999:409).

Among recent surveys of biomedical service delivery in the Northern Areas is one describing "the incidence of specific...emergencies in a mountainous rural community in the Northern Areas of Pakistan and [assesses] use of existing health services, and outcomes related to acute surgical illness events" (Shah et al, 1998:846). Women's risk of maternal morbidity is highest between the ages of 25-35 years old, and is attributed to the high pregnancy rate in this age bracket (Shah et al, 1998:854). The study clarifies how vast proportions (85%) of patients across the Northern Areas are initially managed at home or close to home in a health centre, dispensary or civil hospital. Only 32% eventually sought specialist care (Shah et al, 1998:856). This was especially true in the instance of females requiring surgical interventions, and although largely unexplored by the authors, represents a facet of social life that can be attributed in great part to local norms of female seclusion and purdah.

Northern women from Sunni communities find their access to medical resources, whether public or private, especially complicated. Access to health care is limited due to “standards of family honour and economic constraints...purdah places constraints on interaction between women and caregivers” (Sweetser, 1993:57). Because of routine physical examinations, clinical biomedicine is incompatible with the strict physical segregation that purdah dictates between unrelated men and women. If a woman has a health complaint of a more ‘private’ nature (gynecological), it is seen as too personal a health-crisis to be addressed, let alone discussed, by either those healers who are viewed as extended members of the family or biomedical practitioners. This is exacerbated because there are few female physicians in the region. Instances like this require that a woman’s husband, father or brother, armed with a cursory and often vague list of symptoms, seek advice from a discrete distance. However, many men appeared unconcerned about the possibilities that women may suffer from certain conditions that they are unable to speak freely about.

The premature deaths of many rural women exemplify how often it is “apparent that special help is required, far too late for minimally comfortable travel of successful treatment, and only if the family can afford to arrange and pay for the trip, will the woman be seen by competent medical personnel” (Sweetser, 1993:60). But the issue of service usage is complicated by more than finance. In more conservative communities, it was not uncommon to hear men say they would rather see

43 The authors' methodology was comprehensive, including a cross-sectional population-based survey, conducted throughout 18 villages in the study area (population 100,000), selected from a random sample from a total of 9900 households with interviews focusing on the oldest pre-menopausal female member (n = 836) (Shah et al, 1998:846-848). Questions focused on injury, acute abdomen, and/or maternal morbidity occurring in the previous year. Mortality from a wide range of surgical emergencies was also elicited based on the respondent's lifetime knowledge of the household (Shah et al, 1998:850). Study results, while providing concrete data regarding the high level of incidence rates
their wives ‘die’ than see them be treated by a biomedical physician. Their rationale was seemingly simple. Contact with a biomedical physician would result in lost honour (izgat/ghrairat). But it also signals women’s social entrée into a world that does not protect or affirm their place within a recognizably Islamic context. This has the potential to do more than eradicate family honour; it could undermine the social fabric of Northern life.

When women are permitted to seek outside biomedical services, male and female members of their family often accompany them. For routine visits to surgical outpatient clinics or hospital dispensaries, I frequently observed that women often ended up waiting outside in hired jeeps or vans while their husbands when in to see whether or not a physician, or female nurse, was available to come out to check her. In those rare instances when hospitalization is deemed a greater necessity than maintaining the strictures of purdah, women are only able to stay overnight should a male or senior female member of the family be able or willing to stay with them at all times. Men never face this same concern regarding family guardianship when seeking biomedical care beyond the domestic sphere.

Family supervision is an essential aspect of any clinical interaction. Doctors, because of their insistence on physical contact during examinations, are seen as morally ‘suspect’. My husband related one particular story where a male friend physically assaulted a physician at the District Hospital. The gentleman had been told by his sister, who had recently visited the hospital, that the doctor had touched her wrist to check her pulse and asked ‘private’ questions. Equally suspect are female nurses. Despite the government’s precautions in hiring Christian nurses, I was told on many occasions while living in Gilgit and Chitral that all nurses were ‘randy’ (sexually promiscuous). It was not uncommon that female nurses had professional chaperones (chowkidars) hired to accompany them back and forth from work, because of the considerable sexual harassment they suffered from local men. There were even widespread rumors in Gilgit that nurses regularly performed in ‘blue prints’ (pornographic films).

3.5 Women’s Attitudes to Service Usage

Biomedical research highlights the ultimate inadequacy and outreach of surgical services in the Northern Pakistan, particularly for women whose health care needs remain largely unmet. However, when critically considering the overall failure of national women’s health service, such as the family planning programmes of the 1970’s, it is important to reiterate that health service failures do not necessarily indicate a lack of need, or interest, from women themselves.

(1531/100000 persons per year for injuries; 1364/100000 for acute abdomen) indicate problematic rates for maternal morbidity (16462/100000).
The frustrating part of the experience is that there does seem to be an unmet need for family planning. Many women do indicate a desire to avoid further births and to learn more about contraception. Yet this need has never been converted into effective contraceptive usage. Supply inadequacies certainly continue to exist. But the family dynamics in a male-dominated society such as Pakistan may also be part of the problem. The women, who bear the ‘costs’ (and only some of the benefits) of children may want fewer children; whereas men, who derive most of the benefits, may want more. If the man makes the decision, the result is clear. (Robinson, Shah & Shah, 1981:91)

When biomedical development considers women’s own attitudes to health service delivery, it confronts a substantial paucity of either qualitative or quantitative evidence. Because of the substantial limits that have been historically placed on their ability to organize and politically self-represent, rural women are largely unable to “to identify the health and human rights problems they have experienced in recent years…and to convey their attitudes regarding women’s human rights” (Rasekh et al, 1998:453). However, recent research dealing with the effects of conservatism on women’s own perception of health has clearly indicated that women are generally unhappy with their health status vis-à-vis Sunni models, and “strongly support…women’s human rights…suggesting that [local] rejections of international norms of human rights [are] incommensurate with the interests and needs of…women” (Rasekh et al,1998:453).

Afghani women, participating in qualitative studies44 investigating individual attitudes towards human rights, have voiced their desire to see that “women should have equal access to education, equal work opportunities, freedom of expression, freedom of association, freedom of movement, control over number and spacing of children, legal protection for women’s human rights, and participation in government” (Rasekh et al, 1998:453). This suggests, in no small part, that local dissatisfaction with biomedical service delivery rests not so much with women, but with men and/or community leaders who see concepts of ‘equality’ and ‘freedom of movement and expression’ as directly contradicting Islamic models of male-centered governance and decision-making. Research on the inter-relationship between seclusion and sickness in rural Northern Afghanistan indicated that,

...women complained of backaches, lack of energy and many other ailments...and said that sometimes their husbands would not let them go to a doctor. Some women complained specifically about their seclusion, which they called qeit, or confinement,

44 A variety of recent biomedical studies (Raschh et al,1998; Ahmad,2001; Assefa et al,2001; Bartlett et al,2002) have concentrated on the particular intersection of Islamic extremism (e.g. the Taliban), women’s health and biomedical service delivery in Afghanistan and among Afghani refugees living in Northern Pakistan. Much of this research corroborates and supports inferences regarding contextual determinants affecting women’s ability to access and utilize health service delivery in Northern Pakistan, where the climate of Islamic extremism, the general unavailability of consistent governmental health service facilities and stringent local ideals of women’s social mobility are remarkably similar.
imprisonment... *purdah* was not simply about being segregated and veiled; it meant that men had complete control over the movements of their women, giving them ultimate power. [The researcher] also describes the 'deep anxiety women experienced over illness'. She writes: 'As mothers and nurturers of the family they had a vital responsibility, and yet their and their children were especially vulnerable since they depended upon their husbands for money for cures. It was iniquitous but true that men could deny women and children recourse to medical help, and it was no wonder that women placed importance upon methods such as divination or diet, which were at least accessible and within their control. (Moghadam, 1994:87-88)

Unlike their Afghani counterparts, it remains unclear how Northern Pakistani women feel about their health status, and their status as persons on a continuum of unIslamic social development. But it is not unreasonable to assume that Northern women, coming from nearly identical socio-cultural and religious environments, feel similarly to Afghani women. My understanding of women’s own perceptions of when they required care were mixed. Many women whom I spoke with informally in Northern Pakistan were responsible for the care and upkeep of not only a large house, but also of the people who lived in it. Consequently, they rarely found the opportunity to adopt a 'sick role'. Their services were required on an hourly, highly demanding basis. Husbands, not responsible for cooking or basic child-care, seemed to find ample time to seek treatment or rest. Their wives, however, continued to cook and clean under the assumption that no one would eat or have clean clothes to wear if she took time out for herself.

### 3.6 Social Interconnectedness & Viable Therapies

In contrast to their halting efforts to access biomedical service delivery, Northern women remain free to access the therapeutic services of a wide array of non-professional community and folk practitioners, some of whom are actually unrelated males. This is simply because community and folk systems of health seeking and services embed and reify local, but also supranational concepts, of Islamic gender models and social relatedness. The survival of community and folk therapies depends upon its ability to reaffirm localized and supranational notions of gendered and Sunni-Muslim social relatedness. Traditional therapies emphasize not only existing hierarchies of decision-making, medical resort and gender relations, but confine treatment to the domestic sphere, preserving the cultural context and familial integrity, especially for female patients. Unprofessional community and folk services are frequently unpaid, voluntary and private, thereby preserving the culture context and appropriate standards of gender and social relatedness. Conversely, biomedicine resists reflecting localized socio-cultural or religious models through service delivery models, especially those concerning women’s health.
Social inter-relatedness in Northern Pakistan deeply contradicts the transactional nature of human interconnectedness proposed by biomedical models. Tremendous social value is placed upon those relationships that carry the potential for cultural reaffirmation, corporate or individual benefit. In contrast to secular-biomedical frameworks that place fundamental emphasis on individual autonomy, Northern Pakistanis identify “self as a system, patterned by the interrelationships among its various identities” (Keiser, 1991: 33). This forms a powerful contrast, and highly articulated social response, to biomedical models advocating increases in women’s personal mobility and autonomy. It also expresses how fundamentally Northern Pakistanis see themselves as individuals existing within, and dependent upon, larger networks of social relatedness and responsibility. Given Northern Pakistani patterns of individual and community decision-making, descent group, corporate and ward political allegiance, it is apparent that communities are capable of taking vigorous stance in the protection of both group and individual interests. In this respect, resistance or reluctance to utilize women’s biomedical service delivery represents community interest in maintaining traditional interests, values and the integrity social relations.

Instead of reaffirming the social interconnectedness underlying their practice, biomedical physicians insist, “their domain is distinct from morality … and from religion, politics, and social organization” (Hahn & Kleinman, 1983:306). Professional biomedicine is a far more ‘discrete’ system than community or folk medical models, which “discern interconnections between these domains … which practitioners usually ignore or deny” (Hahn & Kleinman,1983:306). In essence, then, local resistance “attests to the powers of biomedicine as a sociocultural system” (Hahn & Kleinman, 1983:305). As such, biomedical development relies not only upon active efforts to propagate biomedical technologies and products. Professional success is contingent upon programme ability to insert self-sustaining systems of biomedical beliefs and appropriate standards of patient behaviour into rural attitudes towards health, illness and healing. Indeed, “for these measures to succeed, transformation of the social structure may be a precondition” (Velimirovic, 1990 in Baer et al, 1997:220). But social transformation in Northern Pakistan, especially where it concerns women, is clearly problematic.

The conundrum remains that, because of biomedicine’s insistence on employing few considerations of local belief systems and cultural practices, it has negated its potential as an acceptable social force in rural, Islamic communities. Even more damagingly, professional biomedicine in Northern Pakistan highlights Islamic sexual segregation as the basis the “horrendous plight of women and children and their exposure to all sorts of discrimination, abuse and

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45 ‘Benefit’ being defined by a much broader spectrum of advantage than merely improvements in health, but also including social relatedness, prestige and/or status.
exploitation” (Santos-Ocampo, 1999:337). These ‘wrongs’ have been “sustained by cultural and social norms and by structures of political and economic inequality” (Santos-Ocampo, 1999:337). Project initiatives continue to depend on the assertion that “sustainable progress will be achieved when women are finally empowered to make free, informed and responsible choices, and assert themselves as leaders in their own right within their societies … women’s health is the surest road to health for all” (4th World Conference on Women, Beijing, China, 4-15 September, 1995 in Santos-Ocampo, 1999:337). Afghani research corroborates how conservative Hanafi-Sunni communities see such biomedical development ideology as irrelevant and potentially harmful to “their culture and Islamic law” (Rasekh et al, 1998: 455).

International measures which “provide the principle of equality between men and women and for express protection of women against discriminatory rules and treatment” (Rasekh et al, 1998:455) are deemed highly offensive in a climate where these ‘discriminatory rules’ are conversely understood as evidencing authentic adherence to Islam. Instead of representing change which in no way carries the potential to adversely affect local value systems, especially those concerning gender, biomedical development is deeply interested in challenging and changing gender value systems. In response, religious opponents see biomedical development as a viable target in their efforts to block developmental forays of any kind into community life. Describing the rationales underlying religious opposition may also serve to answer why Northern women participated with such vigor and interest in economic initiatives but were unable, or unwilling, to participate in biomedical initiatives designed – at a bare minimum – to maintain basic health.

Lack of service usage may also be explained, in some ways, by looking to those institutional misunderstandings that have historically characterized much of biomedical planning throughout rural areas. The evolution of women’s biomedical service delivery in Northern Pakistan was initially predicated — however inappropriately - upon the comprehensive participation, of both men and women in transnational economic initiatives^46. The vast scale of women’s participation in economic incentives had truly caught many developmental planners by surprise. Because of women’s

^46 The Aga Khan Rural Support Programmes (AKRSP), the largest provider of income-generation programmes for women and their families, “typically link elements such as rural savings and credit, natural resource management, productive infrastructure development, increased agricultural productivity and human skills development with a central concern for community-level participation and decision-making… Social capital built at the local level provides a supportive environment for enlarging the economic assets of a community and for harnessing individual self-interest to generate income growth in an equitable and sustainable manner. Assets are typically built through community management of natural resources - water storage, irrigation infrastructure, soil conservation or forestry - or the construction of basic economic infrastructure, such as rural roads or agricultural storage facilities. Income growth is promoted by increasing agricultural productivity through improved farming methods, input supply, marketing, land development and management reform or by increasing off-farm incomes and supporting enterprise development.” (www.akdn.org/agency/akf_concerns.html#rural:2002)
remarkable foray into the field of economic development (agricultural, small-scale poultry and dairy production, for instance) throughout Hanafi-Sunni communities in Northern Pakistan, institutional assumptions that rural women in modern Muslim societies are “trapped inside rigid gender roles and cultural identities” (Bessant, 1998:396) appeared inaccurate. In fact, many early schemes were successful simply because they enhanced and replicated the domestic economy.

Yet armed with their misinterpretation of women’s participatory abilities, development planners assumed that because “women have in many instances moved back and forth between local and outsiders’ cultures. . . their prominent role in this cross-cultural traffic [allows] women to participate in defining the boundary between ‘us’ and ‘them’” (Bessant, 1998:396). Further, planners asserted that these same women, “even if the movement occurred through acts of consumption or marketing – [would take] the opportunities provided by new circumstances and situations to redefine some roles and, in some cases, to devise entirely new roles” (Bessant, 1998: 396). But this was clearly an underestimation of the barriers facing social innovation and its ability to succeed amidst a traditional, Islamic context.

4.0 Critical Discussion of Issues
4.1 Rational Choice, Passive or Active Resistance?

In considering why biomedical services remain generally inaccessible for women, we may ask whether or not lack of service usage indicates rational choice, passive or active resistance? If we are to reflect on the generally impoverished and inefficacious nature of Northern Pakistan’s health care system, people’s traditional preference for self-medication appears a rational choice. In view of the inviolate nature of male-female segregation in conservative Northern Hanafi-Sunni communities, we may describe lack of usage as a form of passive resistance. But if we are to also consider how predominantly women remain isolated from not only biomedical services, but also many other secular initiatives extending beyond the domestic economy in Northern Pakistan (such as education, employment, business or entrepreneurial activities), the issue becomes more complicated. We may then infer that that there are mechanisms of social resistance at work, purposefully targeting and affecting one segment of the local population. The primary mechanism for active, community resistance to secular initiatives has been social mobilization through Islamic ideals. This raises a pivotal question regarding biomedical service delivery and inadequate service usage in Northern Pakistan. Have national and supranational Islamic social movements, arguably the most powerful
socio-political factor currently mobilizing Pakistani society, been adequately considered given their impact on access and resistance to unIslamic health service delivery?

Active resistance to biomedical health schemes began most noticeably with family planning programmes that began in Northern Pakistan in the late 1970's. During the height of Zia's Islamization schemes, the family planning programme in Pakistan stumbled and has yet to recover what early momentum it had gained prior to Islamic opposition. My husband describes numerous instances when family planning campaigners were chased out of villages, followed by threats of death or violent retaliation should they return. During my research for the Aga Khan Rural Support Programme, I was frequently told how mullahs devoted considerable energies to describing the hell-bounded penalties for those who indulged in Western birth control (Varley, 1998:19). The more closely biomedical programming targeted women or the domestic sphere, the more enraged local Islamic proponents appeared to become. Not surprisingly, biomedical insiders predicated programme failure not only upon people not having access "to services of even minimal quality" (Shelton et al, 1999:192). More importantly, they directly "attributed poor performance to an intrinsic resistance...related to cultural conservatism, religious influences and the low status of women" (Shelton et al, 1999:192). Unfortunately, beyond research focussing on the poor outcomes of family planning initiatives, there have been few sustained efforts at investigating how issues concerning gender, status and religion perpetuate programme failure in other arenas of biomedical service delivery for Sunni women.

The failed legacy of family planning campaigns continues to deeply affect the current scope and success of women's health services. Women's health clinics are discouraged, because they are seen as covert 'fronts' for health programming that may provide women with ideals and values contradictory to local, Islamically-oriented ones. The only routinely permissible women's service delivery has been the maternity hospital, which also suffers from lack of usage and poor service provisal. In rural, Northern communities mullahs often make concerted efforts to block women's health campaigns unless they are specifically approved by local, Islamic committees. Increasingly, Islamic committees are finding supranational legitimation supporting their resistance to unIslamic social processes, such as those exemplified by biomedical service delivery.

4.2 Regional Examples of Islamic Resistance

In neighbouring Afghanistan, the Taliban regime (1993-2001) provided recent evidence of Hanafi-Sunni radicalism's loathing for biomedical models of service delivery. When the United Nations protested the Taliban's closure of all medical service provision for women in Kabul in 1996, the Taliban countered by stating that, as with educational services for girls, the UN wanted "a big
infidel policy which gives such obscene freedom to women which would lead to adultery and herald the destruction of Islam” (Rashid, 2000:111). While the Taliban’s preoccupation with adultery was more indicative of Pathan values concerning women’s behaviour and sexual impropriety, their dismissal of women’s health services as a social necessity indicates several things. Firstly, that the need for Islamic segregation was paramount to individual health concerns. Secondly, their extreme version of Sunni Islam cogently connected their anti-Westernization, anti-globalization agenda with biomedical service provision. Thirdly, the Taliban articulated active, and legislated, resistance to services that were seen to fall beyond the fray of Islamic social values.

It is important to note that the Taliban grew into an ideological force from Northern Pakistani origins. Their political and cultural aspirations, including those concerning women, were drawn from radical Deobandi organizations and madrasas throughout Pakistan. Following the original exodus of Afghan refugees to Northern Pakistan in the mid-1970’s, the Jamaat-Ulema-Islam (JUI) undertook the construction of radical Islamic training camps throughout Pakistan (Rashid, 2000:91-93). These were designed specifically to develop a force of Islamic freedom fighters to overthrow Russian-occupied Afghanistan, but also to transform relatively secular Pakistan into a pure Islamic state. JUI camps were instrumental in developing an ideological and political elite for the Taliban government, many of whose officials were raised and educated in Pakistan. While the Taliban have “clearly debased the Deobandi tradition of learning and reform” (Rashid, 2000:93), the ties between the Taliban and Pakistan’s extreme Deobandi groups “are solid because of the common [ethnic] ground they share...[and] both are united in their vehement opposition to the Shi’a sect and Iran” (Rashid, 2000:93). While other Islamic organizations are not generally adverse to modernization, the Taliban and extreme Deobandis “are vehemently opposed to modernism and have no desire to understand or adopt modern ideas of progress of economic development” (Rashid, 2000:93). In fact, Taliban followers in Pakistan created immense social repercussions. This included the closure of various maternity hospitals and women’s clinics throughout the North-West Frontier Province’s tribal districts and the southern Chitral Valley in 1997, during my time living in Northern Pakistan.

By 1998, the Pakistan Taliban groups were banning TV and videos in towns along the Pashtun belt, imposing Shari’a punishments such as stoning and amputation in defiance of the legal system, killing Pakistani Shi’a and forcing people, particularly women to adapt to the Taliban dress code and way of life. . . . The Taliban and their supporters present the Muslim world and the West with a new style of Islamic extremism, which rejects all accommodation with Muslim moderation and the West. . . . the Taliban have given Islamic fundamentalism a new face and a new identity for the next millennium — one that refuses to accept any compromise or political system except their own. (Rashid, 2000:93-94)
Northern Pakistan’s neo-Taliban groups, which include the JUI and increasingly the Jamaat-I-Islami, represent a synthesis that draws its roots alternately from Egypt’s turn-of-the-century Muslim Brotherhood (Ikhwan-ul-Muslimeen), and Northern India’s original Deobandi seminaries. In “opposition to the traditional mullahs these Islamicists refused to compromise with the indigenous neo-colonial elite and wanted radical political change, which would create a true Islamic society. . . . in favour of a new Muslim internationalism which would reunite the Muslim world” (Rashid, 2000: 86). In addition, as with many radical movements in the Middle East and North Africa, Islamic authenticity is contingent upon agendas endorsing anti-Westernization, anti-modernization and women’s seclusion to the domestic sphere. Therefore, as a social phenomena active conservatism “can be interpreted by some as a ‘response to efforts to deal with contradictions within social systems and to struggles among the state, economy, family, and religion to control their efforts’” (Fields, 1991 in Billings & Scott, 1994: 22).

4.3 Regional & Supranational Resistance to Globalization Processes

The social impact of globalization and modernization processes on Northern Pakistan is undeniable; each demands response, whether based on relationship or resistance. More than representing the incongruency of clinical practice and local social models advocating women’s segregation, the problem of women’s service usage speaks to the supranational problematization of interactions between Western, secular and Islamic social approaches. It is from this understanding that we may set clinical awkwardness against a changing socio-political, religiously mobilized, and globally affected context. Western versus Islamic globalization, the legitimacy of religious opposition, and Islamization campaigns all provide incentive and initiative for people to reject multiple facets of unIslamic social models. Biomedicine is but one feature of this larger – and flexible - rejection of ideas, values, products and models of socio-political development.

Biomedical development in Northern Pakistan, often integrated with national and transnational drives for secular education and employment, has been identified by supranational Hanafi-Sunni conservatism as a problematic component of the globalization process. Globalization, for the purposes of this paper, can be described as not only the movement of people, but of “information, symbols, capital and commodities in global and transnational spaces” (Kearney, 1995). And in every respect, biomedical development embodies not only the transfer of medical capital and commodities, but also the dynamic transference and exchange of ideas, social and cultural values. One of the most problematic features of transnational, biomedical development initiatives has been its inherent inter-relationship with unIslamic processes of globalization, both economic and social. These processes have “become a major determinant of national, social and economic policies”;
“thus, although responsibility for healthcare and the public health system remains with national governments, the fundamental social, economic, and environmental determinants of population health are becoming increasingly supranational” (McMichael & Beaglehole, 2000:497).

If we consider Pakistani biomedical development as a by-product of such processes, it is possible to analyze local resistance to services by also investigating resistance to globalization and modernization. While empirical evidence supporting this interconnection is incomplete, it is a reasonable hypothesis given how well documented active, regional resistance to other secular initiatives has been. Instead of only representing local adversity to women’s access of health services, resistance to biomedical service delivery can be seen as also representing supranational, Hanafi-Sunni discontent with the problematic, social consequences of international development, women’s health and human rights. Afghanistan’s Taliban Government, with its rigorous prohibition of women’s ability to access not only biomedical care but all aspects of public, social life, is perhaps the most poignant and extreme example of this phenomena (Rasekh et al, 1998:449-450; Rashid, 2000).

Interestingly, recent research has aptly described that although Taliban regulations represent “a striking departure from the past religious and cultural practices of Afghanistan” (Rasekh et al, 1998:450), social modifications constraining women’s access to services typify powerful innovations in Hanafi-Sunni conservatism throughout Central and South Asia. In these areas, the imposition of Islamic models of gender segregation is part of the larger mobilization of Muslim communities in their political, ideological and social opposition to processes of globalization and modernization. Many Northern Pakistani religious organizations, deriving their stimulus from supranational foundations, envision an “insidious plague of hedonistic perversion and display [as] no chance by-product of the transition to a new social and economic order; it is rather, in the view of some of the Islamic associations, a deliberate plot to destroy Muslim society by undermining its feminine foundation” (Hoffman-Ladd, 1987:31). Community adherence to gender segregation and spatial seclusion models is not simply the "survival of tradition; [it is] more the 'reinvention' of tradition when modernity and progress destabilize or challenge strongholds of power" (Jelin, 1995: 41).

As with Hanafi-Sunni dominated Egypt, where “the disintegrating impact of Western culture in Egypt’s modernization process and the consequent feelings of anomie and cultural disorientation” (Hoffman-Ladd, 1987:38), more conservative supranational Hanafi-Sunni organizations continue to focus on the “importance of cultural authenticity, not at the expense of modernization, but

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*Footnote: Informal, Northern Pakistani attitudes towards women’s accessing of biomedical service delivery are not at all unlike Taliban edicts (fatawa) directives that forbid “women, except for those working in the health care professions, from working outside the home, attend school, or leave their homes unless accompanied by a husband, father, brother or son” (Rasekh et al, 1998: 449-450). Indeed, much of the ideological impetus for Taliban directives was directly derived...*
subordinating social change to . . . authentic, cultural values. . . . Islam is a prime component of this authenticity” (Hoffman-Ladd, 1987:38). Instead of promoting a ‘modernity’ that transgresses the traditional boundaries of social behaviours, these supranational Islamists envision women’s adherence to Islamic values as her ‘protection’ against the transitional difficulties of integration to male-dominated public life. Veiling, seclusionary measures (pardah) and reliance upon a male authority are all endorsed by JUI and supranational Jamaat-I-Islami literature as ensuring a “greater degree of dignity and self-esteem than Western culture offers”48 (Hoffman-Ladd, 1987:40).

Supranational Sunni conservatism has permitted Northern society to connect women’s social innovation, and participation with unIslamic elements, to the very destruction of the family, the core Islamic social unit. In this respect, it is not only biomedicine that is rejected, but also innovations in social behaviour and women’s mobility necessitated by access and usage. Efforts to modify local gender models are radically interpreted by some as “imperialist plots to destroy Islamic society by ‘liberating’ women in Western fashion” (Hoffman-Ladd, 1987:28). Beyond the contrasting, socio-cultural tenets expounded by social and biomedical development, the recent genesis of Sunni-Muslim identity throughout the North relies heavily upon the notion that ‘authentic’ Islamic values will be undermined, if not destroyed, by localized acquiescence to the vagaries of Western globalization.

What had merely been passive resistance to women’s participation with biomedical service delivery in Northern Pakistan is now taking on a particularly active and supranational importance. Northern Pakistani communities, like Hanafi-Sunni communities throughout South Asia and the Middle East, are successfully creating new “identities for themselves and their families by playing gender and culture off each other” (Bessant, 1998:396). By further exploring this social phenomenon, anthropological research will establish the increasing relevancy of the study of gender relations and health care in conservative, Islamic societies against the backdrop of globalization.

5.0 Conclusion

Despite qualitative efforts to identify the pluralistic relationship between professional, popular and folk medical systems, and to emphasize the notion of health, illness and sickness as social and cultural processes, biomedical facilitators in Northern Pakistan pay infrequent attention to the broad range of cultural mechanics underlying refusal or avoidance of their services for women.

from the madrassas of Northern Pakistan. Within the realm of biomedical practice, as with every other sector of society, Taliban rules were implemented to substantively prohibit contact between unrelated males and females.

48 Indeed, the negative picture that is painted of Western women doubly supports local conceptions of the protective nature of Islamic social models.
Northern biomedical initiatives are generally characterized by an express desire to evaluate cultural impediments to program implementation in traditional societies that are seen as 'resistant' to change. However, there are few indications that cultural awareness has resulted, vis-à-vis program design, in a substantial increase in either access or usage of clinical services by rural women in Northern Pakistan. Because the majority of broad-range, longitudinal studies of Pakistani health care are conducted with the sole purpose of implementing rural medical clinics, there has been little biomedical research directed at understanding exactly how systems of social life or belief - beyond the parameters of biomedical paradigms - are incompatible with project design. While this does not mean that biomedical facilitators are unaware of the cultural component, it continues to appear that health promotion programmes are neglecting to appreciate that health and illness in Northern Pakistan are essentially social, cultural and gendered activities.

Increasingly development planners recognize that international development has been “unable to question its own categories and moral assumptions, leaving little room for dissent” (Benthall, 1995:19). As Marilyn Strathern begs us to consider, anthropologists and social planners must critically “identify the inevitable sources of bias in our models” (Strathern, 1980:14). But socio-cultural discord between biomedical and local systems does not always rest on “mistaken interpretations” (Strathern, 1980:14) of women’s roles in Northern Pakistan. Biomedical planners are not ‘wrong’ when they see *pardah* as a cultural constraint to health services usage; nor are they ‘wrong’ when they identify that within the local, Islamic context women are seldom afforded decision-making opportunities concerning their own health. Instead, the institutional blindness that characterizes much of biomedical development has more to do with development’s underestimation of the vast assortment of culturally and religiously fixed rationalizations for non-usage of health service delivery in transnational, biomedical developmental models.

Social resistance to biomedical service usage frequently focuses on Islamic identity. As is characteristic of the region, identity and status is predicated upon women's social status, lack of social mobility and segregation from non-kin males and public, male-dominated spheres of life. Although Northern men appear able to accommodate their intrinsic identities as Muslims with their usage of biomedical clinical services, women remain inextricably identified with 'traditional' Islam. Hence, their ability to re-configure, manipulate or forsake Islamic ideals of 'womanliness' within the larger social spectrum - and access public, biomedical services that are predominantly offered by male physicians - is weakened. Despite assertions by biomedical development planners that “politically neutral health schemes” (Ahmed, 1982:3) represent international development’s best hope for community enhancement, continual efforts to encourage women’s participation with biomedical schemas hardly depicts development as functioning “irrespective of political position”
Instead, it is clear that development continues to embody fundamentally un-Islamic concepts of person-hood.

Women's attempts to re-evaluate and re-shape her socio-economic existence in Northern Pakistan are resisted by a Muslim, male elite striving for the propagation of more conservative, male dominated social models. The axis of this pressure rests upon sexual segregation, a corollary of which is "a fundamental belief in distinct differences in the composition of the male and female personalities that entail different social roles and functions. . . .in fact, if the sexes are integrated, especially by the entry of women into...public, it is feared that these sex differences will disappear" (Hoffman-Ladd, 1987:33). In direct response to processes of economic, political, educational and biomedical globalization, resistance to biomedical services for women represents in some ways the reassertion of the power of the local - in essence, the "residual importance of localities [and] national differences" (Abu-Lughod, 1998: 240). The structured proxemics of Islamic militancy provides Northerners with a framework for resisting processes of 'Westernization' in their educational and administrative systems. Thus, we may infer that local resistance to biomedicine rests on social inconsistencies between ideological approaches. This ideological gap concerns Islamic gendered identity, firmly rooted within both a community and supranational context, and biomedical emphasis upon human equality and universal access to health services. In this respect, local resistance to biomedicine rests as much on social inconsistencies between ideological approaches as it does the poor quality and quantity of service delivery.

Biomedical development embodies not only competition between culturally located belief systems, biomedical and traditional practices of health service delivery, theories of the body, disease causation and cure. More fundamentally, it represents a poignant contrast with Hanafi-Sunni values as they are exemplified by appropriate social behaviours, gender segregation, and local hierarchies of social mobility and personal agency. Because of its transactional, economic, and ideologically discrete nature, biomedicine dislocates itself from the local context, impairing its ability to be recognized and utilized by local communities in ways that sustain and support traditional socio-cultural models, especially those concerning gender. The mistake of most biomedical programming has been to assume that the primary issue underlying lack of service usage is cost, or that the simple incorporation of indigenous healers into biomedical service delivery (Velimirovic, 1990 in Baer et al, 1997:220) will render biomedicine comprehensively amenable for local access and usage. In fact, it is the overall incompatibility of secular biomedicine and Islamic models of decision-making, patient autonomy, individual agency, gender and faith that render this inter-relationship a horrid fantasy for vast portions of conservative Hanafi-Sunni South and Central Asia.
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