Social Science Perspectives on Childbirth and Reproduction

BALOCH MIDWIVES

CONTESTING GLOBAL PERCEPTIONS OF MIDWIFERY IN BALOCHISTAN, PAKISTAN

Fouzieyha Towghi

Baloch Midwives

This book is the first major ethnography of Baloch midwives in Pakistan. Drawing on long-term ethnographic research in Balochistan province, it shows how dhīnabogs/dheenabogs (Baloch midwives ranging in age from about 30 to 80) and their dhīnabogirī (midwifery) aid women and their kin through labor and postpartum recovery.

Its chapters show how Baloch midwives' forms and ethics of care have persisted, despite nearly two centuries of British colonial policies and the subsequent disparaging official views regarding South Asian Indigenous midwives, commonly known as dāīs, in both postcolonial India and Pakistan. Through their continued presence and effective uses of their traditional medicine, Baloch midwives contain, mediate, and offer a powerful critique of women's iatrogenic suffering caused by unnecessary biomedical interventions. Through a nuanced analysis of Baloch midwives' ethical approach to caring for women, and their responses to the exigencies of women's health, this book demonstrates why over a century of state efforts to modernize and biomedicalize childbirth practices have failed to convince the majority of Baloch women in Balochistan to give birth in hospitals. They instead prefer home births and the midwifery care from the dhīnabogs whom they trust.

This book will not only be of interest to scholars and students in anthropology, medical humanities, public health, sociology, gender and women's studies, gender and medical history, South Asia studies, and global health studies, but also to those in the midwifery and the nursing profession. It will also be of interest to non-academic readers wishing to learn about midwives in South Asia and anyone interested in reading about traditional medicine and midwives who practice outside of European and North American cultural contexts.

Fouzieyha Towghi is a medical anthropologist and an honorary academic in the School of Archaeology and Anthropology, Australian National University, and the recipient of the 2015 Rudolph Virchow Professional Award from the Society for Medical Anthropology for her 2014 article, "Normalizing Off-Label Experiments and the Pharmaceuticalization of Homebirths in Pakistan." Drawing from over ten years of ethnographic research, her scholarship has focused on the politics of reproduction, medicine, science, and biomedical technologies and their implications for women's health and lives in South Asia.

Social Science Perspectives on Childbirth and Reproduction
Series editor:
Robbie Davis-Floyd, Rice University, Houston, Texas

This series focuses on issues relating to childbirth and reproduction from social science perspectives. It includes single-authored, co-authored, or edited books concerned both with people's reproductive experiences and with birth practitioners such as midwives (both professional and traditional), obstetricians, nurses, doulas, and others. It seeks to provide new viewpoints on functional and sustainable birth models and the challenges to their creation and maintenance, as well as on obstetric violence, disrespect, and abuse and their root causes. Single-case or comparative ethnographies on birth and other reproductive issues are featured, from high-tech conceptions to normal pregnancy and birth, including reproductive politics and human-rights issues in reproduction worldwide.

Negotiated Breastfeeding
Holistic Postpartum Care and Embodied Parenting
Caroline Chautems

Birth as an American Rite of Passage
Third Edition
Robbie Davis-Floyd

Doulas in Italy
The Emergence of a New Care Profession
Pamela Pasian

Pregnancy and Birth in Russia
The Struggle for "Good Care"
Anna Temkina, Daria Litvina, and Anastasia Novkunskaya

Baloch Midwives
Contesting Global Perceptions of Midwifery in Balochistan, Pakistan
Fouzieyha Towghi

For more information about this series, please visit: www.routledge.com/Social-Science-Perspectives-on-Childbirth-and-Reproduction/book-series/SSPCR

Baloch Midwives

Contesting Global Perceptions of Midwifery in Balochistan, Pakistan

Fouzieyha Towghi

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

First published 2024
by Routledge
605 Third Avenue, New York, NY 10158

and by Routledge
4 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

Library of Congress Cataloging-in-Publication Data
Names: Towghi, Fouzieyha, author.
Title: Baloch midwives : contesting global perceptions of midwifery in Balochistan, Pakistan / Fouzieyha Towghi.
Description: First edition. | New York : Routledge, 2024. | Series: Social science perspectives on childbirth and reproduction ; volume 8 | Includes bibliographical references and index.
Identifiers: LCCN 2023047519 | ISBN 9781032571195 (hbk) | ISBN 9781032571218 (pbk) | ISBN 9781003437895 (ebk)
Subjects: LCSH: Ethnology—Pakistan—Balochistān. | Nursing—Anthropological aspects—Pakistan—Balochistān. | Midwives—Pakistan—Balochistān. | Obstetrics—Pakistan—Balochistān. | Maternal health services—Pakistan—Balochistān.
Classification: LCC GN635.P27 T69 2024 | DDC 618.20095491/5—dc23/eng/20231228
LC record available at https://lccn.loc.gov/2023047519

ISBN: 978-1-032-57119-5 (hbk)
ISBN: 978-1-032-57121-8 (pbk)
ISBN: 978-1-003-43789-5 (ebk)

DOI: 10.4324/9781003437895

Typeset in Sabon
by Apex CoVantage, LLC

I dedicate this book to my mother and father, Hasineh and Malek Towghi, for their unconditional love and for teaching me my mother tongue, Balochi, without which I could not "hear" the Baloch women and midwives to learn of their dignified life and to write this book.

**In memory of Begu, her daughter Mehnaz,
and my late aunt Hoosnia, a Baloch midwife in Sindh.**

Contents

List of Figures *xi*
A Note on Balochi to English Translation and Transliteration *xii*
Abbreviations *xiii*
Acknowledgments *xv*

Introduction 1
My Fieldwork Process: Methods and Materials 6
Dhīnabogs and Their Dhīnabogirī 8
Situating the Dhīnabog vis-à-vis the Dāī/TBA 8
But Who Is the TBA? 10
Baloch Midwives Unsettle the Haunting Expectations of Hospital Births 11
Situating Dhīnabogiri vis-à-vis Anthropology and the Histories of Reproduction 13
The Road to and from Panjgūr (See Figures 0.2 and 0.3) 15
Chapter Descriptions 22

1 Balochistan and the Panjgūr District: Background and Context 30
Panjgūr District 35
The Journey to Panjgūr in Makrān, Balochistan 35
Developing Balochistan Against Maternal Deaths and Tribalism's "Honor Killings" 37
Incorporating Balochistan and Panjgūr 37
Constructing Baloch Culture as the Essence of "Tribalism" 42
Developmentalism to Secure the Nation's Women From Tribalism and From the Sardhāri System 43

Inventing Tribal Misogyny in the Defense of Islam 51
The Colonizing Mentality Rebooted With a Different Face 54
Saving Women Citizens? 57

2 Using Biomedicine to Secure the Maternal Body From Traditional Midwifery 65
On the Use of "Allopathy" 67
Maternal Deaths and the Limits of Facility-Based Births 69
Standard Global Policies vis-à-vis Local Realities 71
Behind the Biological Risk Factors of Maternal Mortality 75
Global MMR Trends, Erasing the Ecologies of Women's Lives, and Local Biologies in Balochistan 78
Curbing Biomedicalization in the "Times of the Lady" 84
The Persistence of Home Births in Panjgūr 86
Local Biologies 87
The Failures of the Biomedical Establishment and of the Legal State 89
Grounding the Orientalist Human Rights Imaginary of the Tribal/Sardhāri System 92

3 Searching for the Dāī: Finding Dhīnabogs, Kawwās, and Balluks 106
Blinded by Categories 114
What's in a Name? 118
The Dāī (Daaee) 118
Dhīnabogs, Kawwās, and/or Balluks 121
A Labor of Love 128
Meeting Nāz-Bībī 132
Hidden Knowledges 137
Persisting in the Face of Change 142

4 Haunted by Ingrezī Dhawā 152
The Influences of British Colonial Medicine 152
The Traffic of Ingrezī Dhawā in Panjgūr 155
Methods 159
A Visit to the "Old" Gynecology Ward 161

Infrastructure Matters and the Limits of Biomedicine 171
"Dāīs"/Dhīnabogs in the Broader Context of Women Healthcare Workers 175
"They Don't Call Us!" 179
Disciplining the "Culture" of Home Births, Yet Again, Now With SBAs 183
Who Are the Lady Health Workers (LHWs)? 186
From "TBAs" to "TTBAs" in Panjgūr, or the Unmaking and Remaking of the Dāī 189
The Continued Presence of Traditional Midwives 192

5 Balochī versus Ingrezī Dhawā in the Politics of Births, Babies, and Bad Injections 203
Zar-Bībī's Postpartum Visit 204
Governing Sarkārī Dāīs and Mulkī Dhīnabogs 210
Balochī versus Ingrezī Dhawā 214
Demanding the Injection: Is It Challenging Intergenerational Relations? 217
Hoosnia and Her Mother 222
Peshā "Old/Past" versus Annigān "New/Present" 227
The Meaning of Baloch-ness in Balochī Dhawā 230
Dhuzzay Dhardh/An Herbal Formula for False Labor Pains 231
The Postpartum Chillag 233
The Affective Qualities of Baloch Midwifery and Their Ethics of Care 236
The Realities of Dhīnabogirī versus the Biomedical Establishment's Perceptions of Dāīs 240

6 Un-Enunciated Experiments in the Guise of Humanitarian Care 246
Neym Mardum, Neym Insān (Half Person, Half Human) 246
Medical Relativism as Experiments of Colonial Governmentality 253
Un-Enunciated Experiments From the Clinic to the Home 256
Normalizing Misoprostol and Hysterectomies in the Medical Relativism of Humanitarianism 264

From Pharmaceutical Uterotonics to Biomedical Hysterectomies 266
Structural Inequalities and Dangerous Assumptions 269
The Consequences for Women of the Reign of Biomedical Technologies 275
The Operability of Inoperability 279
The Colonial Ethical "Medical Gaze" Revived 283
Particularizing Rural Bodies to Normalize Hysterectomies, or Recolonizing South Asian Women's Bodies in the Biomedical Way 286
Experimentality and the Thin Line Between Persuasion and Coercion 289

Conclusion: Forms and Ethics of Baloch Midwifery 306

Index *315*

Figures

0.1	Map of Pakistan.	4
0.2	Late 19th century historical map of "Baluchistan" from Gazetteer_V6_pg.336.	15
0.3	District Panjgūr map sketched by Noken Sohb, Social Development Society, Gramkan Panjgūr.	16
1.1	A village in Panjgūr valley.	36
2.1a	Gidhām (traditional housing in some regions of Panjgūr) and a baby camel on the way to Koh-Sabz (Green Mountain).	83
2.1b.	A baby camel.	84
3.1	Approaching a village in Panjgūr.	107
3.2	Grandmother fastening the final knot of the swaddled newborn.	111
3.3	Dhīnabog/Baloch Midwife in her home "clinic."	141
5.1	Maternal grandmother holding the newborn.	205
5.2	A gathering of Baloch midwives in Panjgūr district from different villages of the district.	240

Note: all photographs taken by the author.

A Note on Balochi to English Translation and Transliteration

All translations from Balochi to English and from Urdu to English are mine. On translations and transliteration of Balochi, I also consulted my father, Dr. Malek Towghi, who is a native speaker of Balochi, Urdu, and Farsi and who also has full professional proficiency in Arabic and English. The transliteration system adopted in this book is based on the list of the ALA-LC (American Library Association—Library of Congress) rules. I have done this for Arabic, Balochi, Farsi/Persian, and Urdu words. Historically, Balochistan has been spelled "Baluchistan." However, the Baloch and Baloch scholars consider "Baloch" a more accurate transliteration of the ethnonym, and in 1990, the Balochistan provincial government in Pakistan declared "Baloch" the official English spelling which since has been accepted the standard spelling in Pakistan. I use this spelling in this book. Baloch refers to the people, Balochi to the language, and Balochistan to the region.

Abbreviations

AMTSL	active management of the third stage of labor
BHU	basic health units
CHW	community health worker
CMW	community midwife
DHO	district health officer
DHQH	district headquarter hospital
EmOC	emergency obstetric care
FPHW	family planning healthcare worker/FPHCW in some regions of Pakistan
FIGO	International Federation of Gynecology and Obstetrics
HRC	Human Rights Council
HRW	Human Rights Watch
LHV	lady health visitor
LHW	lady health worker
LMO	lady medical officer
LNHO	League of Nations Health Organization
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCHC	Maternal Child Health Centre
MDG	Millennium Development Goals
MMR	maternal mortality ratio
MS	medical superintendent
NGO	nongovernmental organization
NWHP	National Women's Health Project
PHC	primary healthcare
PPH	postpartum hemorrhage
RHC	rural health center
SBA	skilled birth attendant
SDG	Sustainable Development Goals
TBA	traditional birth attendant
TTBA	trained traditional birth attendant
UN	United Nations

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VFPW	village family planning health worker
WHO	World Health Organization
WHP	Women's Health Project

Acknowledgments

This book would not have been possible without the stories of the Baloch midwives and the time that they took to share them with me. This gift and privilege I can never repay to them, nor to the other Baloch women and men who opened their worlds to me. I thank them for the generosity of their time and their loving welcome (often in their homes) of my interest in their life and work and for sharing their thoughts about the social, economic, and political transformations underway in Balochistan, Pakistan, impacting the lives of the Baloch people and their cherished lifeways. I also want to thank my other interlocutors in Panjgūr and elsewhere in Balochistan and Pakistan, including the medical practitioners, public health professionals, and policymakers whose perspectives enabled me to share this story about birth, midwives, and women's health from a wider angle than only from the views of the Baloch midwives and the women seeking their care.

It is impossible to name and sufficiently thank everyone who was part of my myriad journeys to Balochistan and Pakistan. These were journeys vital toward the writing of this book. In Khuzdār, I thank Nabi Basgh and his family, Zainab and Zainab's family—especially her grandmother Bibi for their unconditional love and generosity during my time in Khuzdār. Learning about Bibi's midwifery planted the seed for me to meet the Baloch midwives of Panjgūr. I am thankful for Gulam Nabi and Shabir, the truck drivers whom I could rely on for my travels in Balochistan, enabling me to witness the majesty of this geography and learn about the lives of the people in Panjgūr and Khuzdār. I also learned a great deal from Gulam Nabi about the landscape and plants of Panjgūr. I especially want to thank my host family in Panjgūr, Mas-Gul and Riaz, and their extended family for their generosity, warmth, and the sustenance and care they provided me throughout my time with them. I wish to express my continued gratitude to them and to the numerous individuals who welcomed me to their homes and aided me with my research in Panjgūr, including Asya and family, Zulaigha and family, the staff of Noken Sohb: Ameen, Kishwar,

Rehana, and their families, Dr. Samad, Dr. Akram, Dr. Wahid, Dr. Amir Gitchki, Mr. Katchkul Ali, and Dr. Bashir. I learned about the history of Panjgūr from Inayattullah Qomi, Haji Fakir Ambar, Fakir Noorjan, and Dr. Gitchki. I am grateful in particular to Fakir Noorjan for her kindness, care, and introducing me to her grandmothers, great-aunts, and the musicians in her family which allowed me to see their treasured nomadic lifeways and deep intergenerational bonds that sustains this life.

In Quetta, I could always count on Zeenat and Sana, who took me in as their sister and intellectual comrade from the outset when I first met them over 20 years ago. I miss our stimulating conversations and debates. I thank them and their beautiful family. My dear friend, the late Begu and her husband, Surat Khan Marri, and their beautiful family made me feel like I was always returning to family in Quetta. They took care of me from the beginning during my repeated visits to Quetta that began in 1991. I am sad that I could not return to meet their loving, highly intelligent daughter Mehnaz, who had become a great Baloch surgeon before her premature death. May she rest in peace with her mother. I thank my father, Malek Towghi, for introducing me to Aga Shahid and the late Nawab Bugti. I want to extend my deepest thanks to Aga Shahid Bugti, Nawab Bugti, and their family. Despite the dangers involved for their family and Nawab Bugti, Aga Shahid made it possible for me to meet and interview Nawab Bugti. It was indeed a privilege and honor to meet Nawab Bugti. I am sorry for his passing and the loss of his other family members in these times of ongoing upheavals in Balochistan. I would also like to thank Abdoulla Baloch for his generous support and his family's hospitality during one of my first visits in Quetta.

In Karachi, I have my aunts Masi Noorjahan, Masi Hoosnia, Baji Zarina, and uncle Akbar and his wife to thank for giving me sustenance and love. Masi Noorjahan also introduced to me many of the *pensārs*/Unani medicine shop owners and herbalists in Karachi. In Islamabad I could count on Farid Midhet to bring me to date on the extant public health policy plans in Pakistan. I would like to thank him, in particular, for inviting me to collaborate with him on the Balochistan Safe Motherhood Initiative (BSMI) project in Khuzdār (1997–1999) that enabled my later journey to Panjgūr. In Islamabad I am grateful for Abida, my friend/sister, and the fact that I could always rely on her love and kindness, our wonderful conversations, and the hospitality of her family.

This book reflects the extensive and thorough training I received from my mentors at University of California, San Francisco and Berkeley. Vincanne Adams, Warwick Anderson, Paola Bacchetta, Adele Clarke, Lawrence Cohen, and the late Sharon Kaufman were instrumental in my development as a medical anthropologist and feminist scholar. I have

been honored and humbled to receive critical intellectual support and guidance from them, for which I am grateful. Their confidence that I would get this book done has sustained my wish to do so. I hope this book is a small way to repay their commitment to my project. They have helped to shape my ongoing scholarship. I am sad that Sharon Kaufman will not see how closely I tried to follow her mantra: "be sure that the ethnography is in the service of your argument." Paola Bacchetta was key to my training as a gender women's studies scholar, modelling and teaching the inseparability of political activism and good scholarship. Vincanne Adams has taught me a great deal about how to think critically about biomedicine with traditional medical practitioners. I can't thank Lawrence Cohen enough for the depth of his support, kindness, and friendship. He has deeply influenced my development as both medical anthropologist and South Asia studies scholar. Adele Clark has been influential in shaping my approach to how I think about women's health issues. I am grateful for her sustained support and in believing in this project. I have also received constant support from Warwick Anderson—who graciously welcomed me in Australia and whose work has profoundly shaped my conscious engagement with the histories of health, medicine, and science. I would also like to thank Donald Moore, Trinh-Minh-ha, and Stefania Pandolfo for inspiring me about my own research through their teaching and scholarship.

This book is also a result of many collaborations and friendships over the years. I have benefited from invaluable comments in the contexts of writing groups, collaborative writing projects, conference presentations, or invited contributions. Many individuals provided intellectual support, personal encouragements, and the sincere wish for my successful completion of this book. Thank you, Huma Dar, Mel Chen, Nancy Chen, Nikita Dhawan, Shalini Randeria, Aditya Bharadwaj. Co-organizing with Kalindi Vora, our Society for Medical Anthropology panel in 2008, then our subsequent co-edited special issue journal on experimentality —Towghi F, Vora K. 2014. "Bodies, Markets, and the Experimental." *Ethnos: Journal of Anthropology*, 79(1): 1–18—was pivotal and informs Chapter 6 of this book. I am grateful to Emma Varely and Saiba Varma for inviting me to contribute to their 2018 special Medical Anthropology issue, "Ghosts in the ward: Health Infrastructures and Their Hauntings," and for their insightful feedback on my contribution—Towghi, F. 2018. "Haunting Expectations of Hospital Births Challenged by Traditional Midwives." *Medical Anthropology* 37 (8):674–687—that would become vital to my arguments in this book. I benefited from the participants in the "Care in Asia—Beyond and Across the Clinic" workshop, organized by Emilija Zabiliute at Nordic Institute of Asian Studies, University of

Copenhagen in 2017. I thank Roger Jeffery for his invitation to present at the 25th European Conference on South Asian Studies in Paris, which led to a writing workshop in Switzerland organized by Clémence Jullien and Roger Jeffery and the subsequent publication of my chapter (Towghi 2021) in their book *Changing Childbirth in 21st Century South Asia*. I thank Luis Angosto Ferrandez for the opportunity to present aspects of research for this book at the University of Sydney anthropology seminar. I am deeply grateful to have met Alison Downham Moore and our mutual interest in critically examining the global proliferation of gynecological surgeries that in part informs Chapter 6 of this book. I also would like to thank my wonderful colleagues in the School of Archaeology and Anthropology, Australian National University, for their kindness and support. Katharine Balolia, Alison Behie, Ashley Carruthers, Simone Dennis, Patrick Guinness, Francesca Merlan, Sverre Molland, Yasmine Musharbash, Nicolas Peterson, Katharyn Robinson, Caroline Schuster, and especially Trang Ta.

A large proportion of the original research for this book, including the archival research, was funded by the University of California Regents, the American Association of University Women, the Woodrow Wilson and Johnson and Johnson Women's Health Fellowship, the American Institute of Pakistan Studies Fellowship Program, and the following from the University of California, Berkeley: the Center for South Asia Studies, the Al-Falah Program Fellowship at the Center for Middle Eastern Studies, and the Gender and Women's Studies Department. I am thankful to them all.

I thank my editors; I am deeply grateful to Robbie Davis-Floyd for her kind and enthusiastic support. I cannot thank her enough for all her suggestions, her keen editorial eyes, and meticulous editing work. I also cannot imagine a more perfect person and anthropologist to help me get this book published. Robbie has helped me to complete a circle that began in 1986 at Michigan State University with my undergraduate anthropology teacher, the late Brigitte Jordan, who first inspired me to think about midwives and do so with the aid of medical anthropology and anthropology of reproduction. I am deeply grateful to my editor, Meagan Simpson, for believing in this book and its success. It greatly warmed my heart when she conveyed that this book is going to be a "good one." I want to thank my copyeditors.

Finally, I thank family and friends for being in this world during this journey: Especially my parents Hasineh and Malek, to whom this book is dedicated. My brothers Farouk, Nasser (his wife Anya, daughters, Anya-Hasineh and Anya-Zarina), Abu, and Omar and his wife, Vicki, and their children, Trevor and Isabel. Inspiring dialogues with nurturing friends

about midwives, health, love, spirituality, sovereignty, and good food have also sustained my desire to write this book. Thank you, Melanie Brace, Erma Chastine, Jacqueline Georgi, Hedwig Helfenstein, Urs Helfenstein, Jane Hughes, Tamara Sutton, Brigit Zuber. I would not have been able to complete this book without Anju Gurnani, my jivansathi, on my side through and through.

Introduction

> I tell them that Allāh will take care of the birth and bring the child safely into the world. Allāh is the bringer.
>
> —A *dhīnabog* (Balochi midwife)

In Panjgūr, a district of Balochistan, Pakistan, despite the longstanding presence of colonial biomedicine or allopathy,[1] *dhīnabogs/dheenabogs* (Baloch midwives ranging in age from 35 to their 80s) remain vital in pregnancy, childbirth, and the postpartum care of Baloch women. I learned about their distinctive importance in women's lives as I conversed with them in their homes, observing their work and interactions with women and children, accompanied them during their rounds to women's homes, walked with them through towns, fields, and valleys, and climbed the mountains searching for wild herbs and plants. I learned from *dhīnabogs* (and from other Baloch women) about their exceptional techniques of antenatal massage, which they perform to shift and reposition the fetus both before and during delivery to ensure safe births. They discussed with me how they treated and healed childhood and adult ailments with herbs and specific herbal formulas. And I learned about the ways in which they managed reproductive emergencies. I observed the works of *kawwāsi* (expert) *dhīnabogs* whose reputations had travelled far beyond the geographic boundaries of Panjgūr district and Balochistan province, reaching Karachi and other parts of Sindh province, and as far as the Middle Eastern countries of Iran, Dubai, and Bahrain. These and other reputed dhīnabogs prescribed and administered *Balochī dhawā* (Balochi medicine) to aid women to avert immediate and long-term post-delivery reproductive problems. Once, during one of our numerous conversations, typically lasting three hours, one such dhīnabog, Lal-Bībī (all of the names of my interlocutors used throughout this book are pseudonyms), shared that her daughter had died while giving birth to her child under the care of *a lady*—referring to a lady medical officer/doctor (LMO) or a lady health

DOI: 10.4324/9781003437895-1

visitor (LHV)—an auxiliary nurse who has completed an 18-month primary healthcare course in basic nursing and midwifery. During an antenatal visit at the Panjgūr District Headquarters Hospital (DHQH), Lal-Bībī's daughter was diagnosed with high blood pressure and was told to give birth in the hospital/clinic. However, in the private clinic of *a lady*, she was administered the *sūch-chin* (injection or needle)—referring to a uterotonic drug such as Pitocin/syntocinon[2] to speed up and force the labor and delivery of child and the placenta. (A "uterotonic" refers to a drug that stimulates cervical ripening and uterine contractions. "Cervical ripening" is the softening and gradual dilation of the cervical os, which is the opening to the cervix.) Lal-Bībī attributed her daughter's death to the sūch-chin. As with many other dhīnabogs, she was not entirely against the use of such injections in childbirth when necessary, though she and the other dhīnabogs preferred Balochī herbs to facilitate the birth process and to prevent potential complications during delivery and the postpartum period. However, as I met many more dhīnabogs in Panjgūr, they conveyed a consistent concern—a deep worry regarding the near-routine and overuse of uterotonic injections by the *ladyān*, or ladies, being administered to the younger generation of women (in their 20s and 30s). Since Pakistan gained independence from British rule in 1947, the term *lady* remains an official prefix in Pakistan's medical nomenclature. This term refers to different cadres of State-employed women medical workers, including lady medical officers/doctors (LMOs), lady health visitors (LHVs), and lady health workers (LHWs). In Panjgūr, Baloch women and dhīnabogs referred to them as *the lady* or in the plural as *ladyān*. I thus consider these terms to be vernacularized formations, and therefore I have italicized them throughout this book.

The dhīnabogs highlighted the unnecessary and untimely labor inductions that, from their perspective, were compromising the safety of the mother and baby. Over the course of my fieldwork (described in the next section), women and dhīnabogs narrated their observations of the links between the overuse of the sūch-chin in childbirth and the increasing numbers of women with problems unknown in the past, including the problem of unnecessary hysterectomies. Many women lamented, "The time of *balluk* [lit. "grandmother"] is no more; it is now the time of *the lady*."

They wondered why Baloch women in Panjgūr are weaker now and their lives at greater risk around childbirth than they had ever witnessed in previous times, despite the growing use of biomedical technologies intended to support deliveries. As one dhīnabog in Panjgūr explained to me, "Women go to *the lady*, get an injection for the pain, become a little better; then it is back to the same stomach and pain. Then they return to us for care." The injection or the pill, then, rather than easing women's aches and pains, would create more problems, sometimes resulting

in unnecessary drastic medical procedures such as hysterectomies. As my ethnographic research progressed, it became clear that the Baloch women were caught in a triangle of morbidities, infertilities, and hysterectomies that dominated their narratives about the declining Balochī or nomadic lifeways, the simultaneous rise in injection use around birth, and the problematic forces, in their words, of *Ingrezī dhawā* (English medicine, meaning modern/allopathic biomedicine) that some of the women also equated with the sedentary ways of the *shahr* (city).

Baloch women and dhīnabogs spoke with me about how the uterus (*jān*/body; *zahg-dān*/lit. "child's sac") is damaged from the use of hormonal pills and injectable contraceptives, pointing to these drugs and to the excesses of uterotonic injections as contributing to the declining health of Baloch women. While there were women who did request artificial labor inductions to force their labors to begin, there were other women who had *not* asked for the "sūch-chin" before being administered it. Women also spoke of refusing such injections. Some of them purposefully avoided visiting *a lady* because of practitioners' *ādath* (habit) of administering artificial labor inductions and hearing accounts of women being harmed as a consequence. However, in the absence of a dhīnabog in their region, a woman might visit the private clinic of an LMO or LHV late in her pregnancy and end up with a prematurely induced birth, then eventually might find herself farther away in an urban clinic for an emergency attributed to the premature induction. Many of the dhīnabogs expressed dismay over the increasing numbers of women being subjected to labor-inducing injections largely administered by an LMO or LHV. They were also distraught by the pressures exerted on younger women during antenatal visits in the district public hospital to deliver in an LMO's private clinic.

Dhīnabogs also spoke with me about the pressures they felt during their homebirth care from some of the birthing women and their kin to administer the labor induction with the sūch-chin. Many said that their local herbs, plants, and herbal formulas have similar functions to facilitate the labor process, but their effects were not harmful like those of the sūch-chin. If needed and available, they would use such herbs. Mostly, they refused to administer injections, though they had access to them through compounders (paramedics with a year of pharmacy training who are trained to administer injections and certain biomedicines, and also serve as vaccinators). During the time of my fieldwork (see next section), all compounders were men, generally young, in their 20s/30s. However, as the dhīnabogs often told me, in refusing to artificially induce labor "before its time," they also risked turning some women away to seek the services of the State-sanctioned workers—the LMOs and LHVs—who would surely administer the sūch-chin to ensure that the birth would occur on site in their private clinics, and not in the district health headquarters (DHQH). For as was

understood by *the ladyān*, when one "catches the live baby," only then could they demand payments from the birthing woman's family. That is, the *ladyān* would only demand a payment if the baby was delivered alive. As is more fully described in Chapter 5, a number of Baloch women said that LMOs would frequently hold back the newborn until they received the full cash payment demanded. As the narratives of Baloch women and dhīnabogs in the succeeding ethnographic chapters illustrate, this link between live births and the demands for cash payments is consistent with *the ladyān's* avoidance or refusal to assist a woman, for example, with a potential stillbirth. They instead referred such women to a tertiary level facility in Quetta or Karachi cities, located, respectively, in the Balochistan and Sindh provinces (see Figure 0.1).

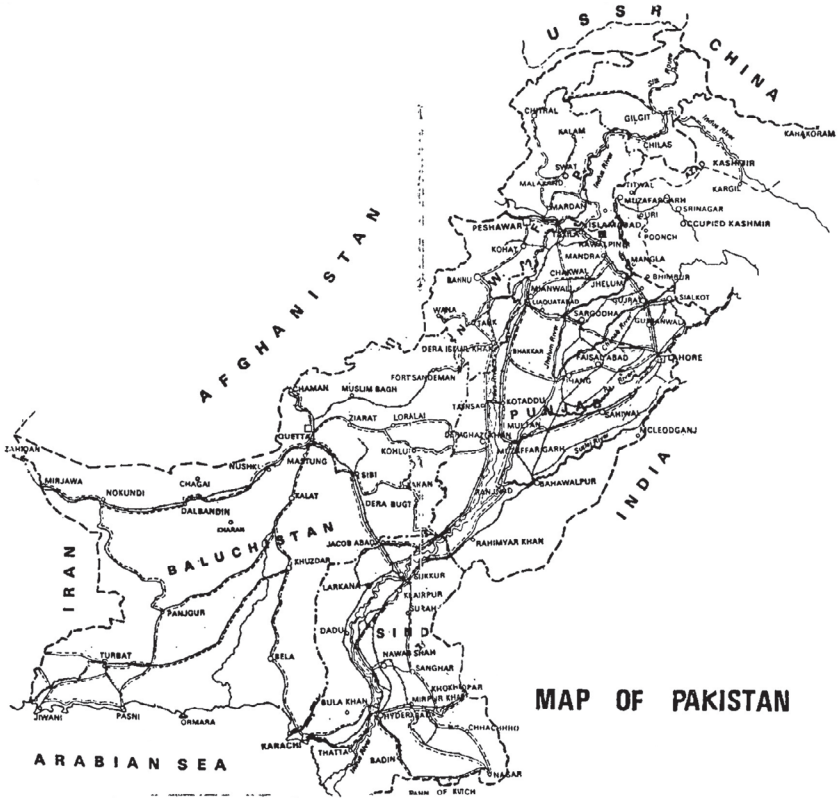

Figure 0.1 Map of Pakistan.

According to my interlocutors, the excesses of uterotonics use were not the only causes of Baloch women's declining health. When dhīnabogs, women, and elders recounted the "better" past versus the present worsening conditions of women's health and childbirth experiences, many also mentioned the social impacts on their *dhīnabogiri* (Baloch midwifery; lit. "the work of dhīnabogs") of the declining access to herbs as well as on the decreasing numbers of expert healers, including dhīnabogs, who would have specialized in myriad Balochī medicinal techniques—a point that I further discuss in Chapters 3 and 5. The ongoing drought that in 2005 had been underway for nearly seven years was also blamed for Baloch women's deteriorating health conditions, weakened bodies, and chronic illnesses. Livestock loss and the declining annual harvests were linked to women's decreasing physical strength, thereby influencing the length of time that women could bear the labor of childbirth and their postpartum recovery, as I further discuss in Chapter 4.

However, despite these shifting environmental and economic contexts, where nature was delivering fewer of some of the essential local plants from which important ingredients of herbal formulas are derived, dhīnabogs continued to search far and wide to secure the necessary ingredients of their most-used herbal formulas, including for example, Bībī-Begum, whom I introduce in Chapter 3, and other dhīnabogs such as Nāz-Bībī (also introduced in Chapter 3) who creatively improvised by capitalizing on their kin connections in Karachi to obtain the essential herbs from the *pensāri* (herbal) shops there.

Another dhīnabog, Bībī-Zarina, told me that no child or mother had ever died in her hands nor in the hands of her great-aunt, who in Bībī-Zarina's view was a "true *kawwās*," referring to an expert and "real" dhīnabog who had taught Bībī-Zarina the craft of *dhīnabogirī*. Here, Bībī-Zarina was not exactly boasting about her aunt's specialized herbal knowledge and the preexisting publicly acknowledged competence of her midwifery—characteristics that also indicated the embodied ethical imperatives of dhīnabogirī; rather she was explicating the unpredictable outcomes of all childbirths in which *khodhrath* ("God's nature" or "the force of God") is viewed to have a central though empirically inexplicable place. This was a recurrent philosophical outlook that many dhīnabogs echoed as they identified their own dignified, assiduous care of women as "a calling"—a vocation guided by Allāh—as well as a work of necessity. Bībī-Zarina continued, "God's nature brings the child to the world. If God might bring death, then there is death [referring to the child's death]. If there is no death, then the child lives." This consciousness about the potentiality of death in and around childbirth, however, did not render dhīnabogs into passive observers of childbirth-related emergencies. These were emergencies that dhīnabogs and Baloch women referred to and linked with the inappropriate administrations of labor

inductions and injections as they narrated to me about women's changing pregnancy, childbirth, and postnatal experiences (see Chapters 5 and 6).

My Fieldwork Process: Methods and Materials

My analyses in this book are informed by over two years (2004–2006) of ethnographic research in Pakistan, archival research at the WHO and the United Nations headquarters in Geneva, and at the British and Wellcome-Trust libraries in London, subsequent ongoing communications and follow-up visits in Pakistan with some of my interlocutors (2010–2019), and the review of governmental and nongovernmental reports and policy documents. I also draw from my intermittent journeys in Pakistan from 1992 to 1999 and in 2003, which entailed public health work and research. A significant proportion of my ethnographic research—over 15 months—took place in Panjgūr; during this time, my field research in Pakistan also took me to the cities and towns of Khuzdār, Quetta, Karachi, Hub, Dera Bugti, Gwadar, Turbat, Peshawar, and Islamabad. My research in Panjgūr involved participant observation in hospital wards and in the contexts of midwives' work in home, community, and hospital settings and in-depth individual and group interviews and conversations with 86 midwives, approximately 200 women, four *hakīms* (physicians of Unani medicine; see next section), and a range of allopathic practitioners: women and men medical doctors, lady health visitors (LHVs), lady health workers (LHWs), and compounders; local artists, historians, politicians, government officials, social justice activists, *pensārs* (herb gatherers/sellers; pharmacists/herbalists), shop owners, and *badhoks* (herb carriers/gatherers/traveling herbalists).

I began my fieldwork to identify the implications of reproductive health and development policies and the associated national program interventions for traditional midwives and women's health in Balochistan, Pakistan. I wished to explore four interconnecting aspects: (1) How local midwives and reproductive women were negotiating the healthcare system in the context of the global safe-motherhood paradigm that viewed all births as "risky" with the intended objective of normalizing hospital births, (2) the physical and social contingencies of rural life, (3) the bioscientific rationales underlying the policies to modernize midwifery and reproductive healthcare practices, and (4) the implications of the increasing biomedicalization of childbirth for women's health and of local forms of women's reproductive health care.

My research interests took me to Panjgūr, Balochistan, because the "*dāīs*" (the most commonly used term for traditional midwives in both India and Pakistan) there had a reputation for excellent and skillful use of medicinal plants and herbal remedies that I had learned of during my prior public health work in numerous districts of Balochistan, including Khuzdār, where

from 1997 to 1999 I worked as the co-investigator and project coordinator of the US National Institutes of Health (NIH)-funded Balochistan Safe Motherhood Initiative (BSMI) maternal-health intervention project (Towghi et al. 2000). In Khuzdār, I met two Khuzdāri Baloch midwives who told me that herbal uses for *janenī bīmārī* (women's sicknesses) were more common in Panjgūr than in Khuzdār. They both had family ties in Panjgūr, though they lived in Khuzdār and continued what I subsequently learned to be their "dhīnabogirī" work, entailing extensive uses of herbs for variety of women's and children's health ailments. One of them, affectionately called Bībī, was over 80 years of age and had practiced for most of her life in Panjgūr before she and her family moved to Khuzdār. Ironically, during that time I did not learn about the category of "dhīnabog," as I still thought that I was looking for "dāīs." Bībī's granddaughter had worked with me on the BSMI project. The granddaughter's uncle—a biomedical doctor—also had contacts with district officials in Panjgūr. Through them, I made my initial contacts with the local people in Panjgūr.

Of course, other factors also led me to do fieldwork in Panjgūr. These included my proficiency in and knowledge of the Balochī language spoken in Panjgūr and my network of contacts such as friends, family friends, and extended family members in Balochistan, Karachi, and Islamabad that enabled me to do the research despite the post–September 11, 2001, safety concerns regarding travel and research in Pakistan.

Given my prior time and work in Balochistan, I was aware that for internal travel in Panjgūr, it is crucial to hire a vehicle and a local driver who has an organic knowledge of the roads and villages situated—in some cases hidden—in the valleys or on the sides of the mountain ranges of the vast span of the Panjgūr district. I, therefore, organized a preliminary visit to Panjgūr in 2004 to set up the infrastructure of the research. I looked for a place to stay, hired a local driver, and identified a woman research assistant—an elder who would be able to accompany me in my travels across the district during my fieldwork process. I visited Islamabad, Karachi, Khuzdār, and also the Balochistan provincial headquarters of various health offices in Quetta. In Islamabad, Karachi, and Quetta, I contacted government and nongovernmental officials and policymakers involved in reproductive health care and in the promotion of the Safe Motherhood Initiative in Pakistan. While in Islamabad, I arranged interviews with officials from UNFPA, UNICEF, WHO, the Population Council, and sought permission to review archival materials that were housed in their regional offices in Pakistan. I also contacted and interviewed members of the National Safe Motherhood Alliance and the National Commission for Human Development (NCHD), which, in May 2003, had finally undertaken the task of developing a national program for training and deploying 15,000 "community" midwives (CMWs), also known as SBAs (skilled birth attendants)—a strategy that had been approved

by the Prime Minister and the Federal Health Minister. In Chapter 4, I discuss the outcomes and implications of this program initiative for maternal health—an initiative that had not yet reached Panjgūr during the time of my fieldwork. Due to the political situation and to the events that were unfolding in Balochistan that had started in 2003 leading to the intensification of the links among military activities, foreign development aid, and large-scale government-funded development activities, including the Gwadar seaport project (described later), I decided to also interview a number of prominent Baloch political leaders, including Akbar Khan Bugti, who at the time was the *Tumandar* or *Sardhār* (head) of the Bugti tribe of Baloch people and who also served as the Governor of Balochistan province, to understand their views on the increasing role of the Pakistani military in the "development" of Balochistan.

Dhīnabogs and Their Dhīnabogirī

Drawing on my ethnographic research in Balochistan, Pakistan, as described previously, in this book, I show how dhīnabogs and their dhīnabogirī aid women and their kin to remedy and resist the injuries of biomedicalized obstetrics. Dhīnabogs' mediations and interruptions of the increasing "iatrogenic"[3] effects of biomedical interventions experienced by Baloch women in rural Balochistan signify the embodied forms and ethics of dhīnabogirī, which has persisted despite nearly two centuries of disparaging policy constructions of South Asian Indigenous midwives, commonly known as *dāīs* (Lal 1994; Ram 1998; Rozario 1998; Jeffery et al. 1989; Van Hollen 2003; Towghi 2004; Pinto 2008). British colonial and postcolonial Pakistani policy assumptions regarding the South Asian dāī's character and work, which have been largely negative, are the antitheses to the forms and ethics of Baloch midwifery in Panjgūr. Dhīnabogs' approaches to the care of mother and child are inscribed in the very meanings of the Balochī vernacular categories: *dhīnabogs*, *kawwās*, and *balluk* as detailed in Chapter 3. The ideals of dhīnabogirī are also reflected in the ways in which Baloch women and dhīnabogs constitute a *mulkī* (of one's country) *dhīnabog* versus a *sarkārī* (government) dāī, as further elaborated in the succeeding pages of this Introduction and in Chapter 5. In short, "dhīnabog" is a Balochī word meaning one who assists, facilitates, and supports the woman in the labor, delivery, and postpartum process.

Situating the Dhīnabog vis-à-vis the Dāī/TBA

Indigenous midwives all around the world were designated the category of "traditional birth attendants" or just "TBAs" due to a World Health

Organization (WHO 1978, 1979) decision in the 1970s to promote their training and incorporation into the biomedical system in order to advance primary health care (PHC). The WHO defined a "TBA" as a traditional practitioner who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship with other TBAs. (This was a joint WHO/UNFPA/UNICEF statement in which a TBA could also be a family TBA "designated by an extended family to attend births in that family" [WHO 1992: 4]).

Anthropologists, however, have long since recognized the inadequacy and narrowness of this definition, which has discursively configured and reified TBAs as possessing similar skills, functions, and statuses within and across communities to justify a standardized maternal child health or safe-motherhood development policy. For example, Stacey L. Pigg (1995) showed how the production of acronyms in health development discourses results in a specific form of violence, erasing in the process the variety and range of midwives and their functions in Nepal. And Brigitte Jordan (1989) observed the transformations generated by foreign-funded national TBA training programs in Mexico in the relationships between traditional midwives and the women seeking their care (see also Chawla 1994; Davis-Floyd and Sargent 1997). These anthropologists and many others have compellingly shown how the globalized usage of the term "TBA" has produced a generic, universal figure to serve the shifting requirements of national healthcare goals, thereby occluding the heterogeneity of traditional or Indigenous midwives' medicinal work within and across nations (Towghi 2004). Often blamed for the risks experienced by women in and around modern childbirth, the heterogeneity of "TBAs" continues to elude or to "haunt" the persistent health development efforts to homogenize and instrumentally use or altogether replace them with a "new" cadre of women healthcare workers (Towghi 2018). Yet such processes of reduction or categorization are by definition incomplete and are not internalized by midwives themselves, as evidenced in this book's ethnographic Chapters 3 to 6. Where TBAs have been blamed for problematic maternal health outcomes, in reality poverty, malnutrition, and other socio-structural factors are implicated in creating the risks that can result in maternal deaths and morbidities, as I discuss in the succeeding pages. In this context, where also healthcare facilities are often inaccessible, "dāīs/TBAs" actually save lives and support women's future well-being. In Chapter 5, I discuss dhīnabogs' crucial roles in averting the deaths of mothers and babies in obstetric emergencies experienced by women when allopathic doctors refuse to touch the case and instead refer women to tertiary hospitals in Quetta or Karachi. Janet Chawla (2006) also observed in India the essential roles of dāīs in saving the lives of women experiencing obstetric emergencies.

But Who Is the TBA?

Whereas anthropologists have effectively deconstructed the homogenizing impacts of the category "TBA" (see for examples Davis-Floyd et al. 2001), less or no attention has been given in the literature to how the dominant South Asia category "dāī" is constructed as the universal category of the South Asian traditional midwife as in India, Pakistan, and Bangladesh. Little attention has also been given to how such categorical homogenization might obfuscate the diversity of local traditional midwives as well as the significance of their preventive and lifesaving work in and around childbirth. During my fieldwork, however, rather than finding "dāīs," I met dhīnabogs, kawwās, and balluks, who had escaped the reifying effects of categories, acronyms, and discursive effacements (Pigg 1995), given the general absence of references to them as dāīs or as TBAs among the Baloch women in Panjgūr. I met profoundly complex subjects who were serenely enacting their understated distinct expertise and unstated ethics of care, as exemplified by Khatija and by many other dhīnabogs introduced in the succeeding pages and in Chapters 3, 5, and 6. Just like the designation "TBA," the category of "dāī" has functioned to efface vernacular identities and a complex of local therapeutics associated with women's medicinal work in South Asia. As I elaborate in Chapter 3, instead of the "dāī," I discovered a *mulkī* (of one's country or region) dhīnabog who is not called a "dāī." Nor do biomedical practitioners know the "dhīnabogs," as they referred to them as dāīs or as TBAs. Thus, glossed over as a dāī/TBA, the dhīnabog's vernacular identity is written away in colonial and postcolonial maternal child health discourses. This epistemic erasure has made her presence uncertain but has also sustained her, which is precisely why I too at first, though only for a short time, could not locate the Baloch midwife—the "dhīnabog." In Panjgūr, dhīnabogs remain present in women's lives, mediating and offering powerful critiques of women's iatrogenic sufferings. The dynamics of the care that they provide to women challenge the reductive and disparaging representations of dāīs/TBAs and home births, as I discuss in Chapter 4. Their philosophical outlooks and practical responses to the exigencies of childbirth and to the iatrogenic emergencies confronting Baloch women, emanating from their allopathic clinical encounters and from their subjection to biomedical technologies, counter trends in global health development interventions over the past three decades that have revived an aspect of colonial discourse that had explicitly viewed traditional midwives as "mother killers," and the home as a site of dirt and death. On the proliferation of these views about local midwives in Asia, Africa, and Latin America, see Lefeber and Voorhoeve (1998). These authors also point to the popular belief in Indonesia of

midwives as native "death angels" and to the view of traditional midwives as directly responsible for infant and maternal deaths in India.

In contrast, I learned about the enduring trust and respect that dhīnabogs have among their people in the 21st century because of their dhīnabogirī skills; many are considered kawwās (experts) in their craft, highly experienced in their dhīnabogirī, including herbalism. They are also regarded with esteem for their postpartum care of mother and child and for consciously avoiding unnecessary vaginal examinations. Women and their kin turn to them in search of good and dignified care. As communicated to me, a dhīnabog lacking the expected dhīnabogiri skills cannot be respected; she therefore cannot be entrusted with one's body (or the care of one's daughter, granddaughter, daughter-in-law, or niece in and around childbirth); if she cannot be entrusted, then she is not a "dhīnabog." This social position of dhīnabogs demands a certain ethical mode of relating to women and to one's dhīnabogirī. As understood by Baloch women and men in Panjgūr, a dhīnabog is involved in assisting women with the intimate and most private of bodily matters; this aspect of her work is further elaborated upon in Chapter 3, where I present some of the profound parallels between what I learned about the Baloch midwives in Panjgūr and the Muslim midwives of the premodern Middle East, including their consistent invocations of Allāh in and about their dhīnabogirī practices, their view of this work as a "gift from Allāh," and the fact that for many of them, there is no boundary between the care of women in and around childbirth and the care of a deceased woman's body.

Baloch Midwives Unsettle the Haunting Expectations of Hospital Births

Throughout this book, I contrast the colonial and postcolonial discourses regarding South Asian traditional midwives to delineate how Pakistan's health and social development policies—embedded as these are in a global universalized biomedical and human rights framework—render Baloch persons, practices, and regions as "traditional," "rural," and "tribal" in their connotations as "backward/outdated," "underdeveloped," and perpetually "anti-modern." Aided by scholarship on hauntology, ruination, and affective infrastructure, I trace the contested "governmentality" of women and dhīnabogs (Foucault 1979; Derrida 1994; Thrift 2007; Stoler 2008; Street 2012). I argue that Baloch midwives' approaches to their dhīnabogirī go against the grain of the historical and contemporary production of knowledge about South Asian Indigenous midwives and Baloch women. In meditating on colonial ruination, the feminist theorist and anthropologist of coloniality/colonial governance Anne Stoler (2008:

194) described the persistence of "imperial formations through material debris," or the remnants of colonial governance and discourses that continue to degrade the material environments in which people live and their sensible and moral experiences of the world. I extend these ideas to consider the postcolonial continuity and ramifications of the "colonial debris"—the copresence of biomedicine (hospitals/clinics, personnel, injections) and the enduring or "haunting" powers of State and transnational institutional discourses about people such as the dāīs/TBAs—and Baloch women's and dhīnabogs' affective responses to the increasing push toward hospital births and to the iatrogenic injuries caused by inappropriate and unnecessary biomedical interventions.

Jacques Derrida (1994) introduced "hauntology" as a punning contrast to "ontology" to describe how contemporary discourses, institutions, and cultural meanings are always already haunted by past structures of meaning and material presences as if they were "ghosts" from other times and lives (Till 2005). For Baloch women, colonial medicine is not merely a ghost of the past, but a presence that is experientially part of their daily realities. As such, biomedical technologies are not only the material remnants or "imperial debris" of colonial medicine, but also persist in their postcolonial allopathic/biomedical face and legal State backing that authorize biomedical practitioners to enact unwanted, often risky medical interventions in the guise of "care" (Stoler 2008). In postcolonial studies, "hauntings" are read as presences of the past that are less about a terrifying memory or a ghost, and more about a disquieting condition that impels one into political action, or to an affective response to unjust conditions or social processes (Gordon 2008; Lincoln and Lincoln 2015). "Affect" is a form of consciousness that "primes us for action" (Thrift 2007: 221). This affective formation is produced by encounters between persons and between persons and things. Dhīnabogs' affective responses—the urgency in their caregiving dispositions—were not only shaped by encountering women's recurring iatrogenic ailments, but also were primed by their own dhīnabogiri experiences and by those of their foremothers of having successfully averted and managed complicated cases with Balochī dhawā, as dhīnabog Murād-Bībī described to me and as when, in Chapter 5, Fatima's mother rhetorically proclaimed, "Where were the doctors and training then?" They understood, for instance, that pharmaceutical labor induction modifies women's physiological status differently than when "safer" Balochī herbs are administered to assist the birth process if needed. They reached this understanding from direct observations and from the accounts of childbirths and dhīnabogirī that were often re-narrated in social gatherings such as the *shashigan*. The "shashigan" is the sixth postpartum day public community gathering to celebrate the formation and well-being of the *zāg-o-māṡ* (child-mother)

dyad, during which stories are told about childbirths and about the skillful work of dhīnabogs, past and present.

However, as Street (2012: 53) noted following Stoler (2008), the "affective qualities of 'imperial debris'" are not the same as the colonial nostalgia that can be brought about by colonial graveyards or by the abandoned remains of dead civilizations. The ethnography in Chapter 5 reveals that, unlike the nostalgic memory of the 80-year-old compounder (Raheem) and the 60-year-old biomedical Doctor G about the "well-functioning" British colonial medical system, Baloch women (like Zeenat) and the dhīnabogs had a different perspective on allopathy and on the "Ingrezī" (English) hospitals. Given their experiences with biomedicine, women such as Zeenat and dhīnabogs like Mah-jān and Murād-Bībī did not consider allopathy to be beneficial or see the hospital as the ideal location for births. Their views are consistent with recent social science research on women's negative experiences of the increasing facility-based birthing in the Global South that I detail in Chapters 2 and 4. Contrary to Raheem's and Dr. G's sentimental appreciations of British allopathy and its "remnants" (Stoler 2008), Baloch women's iatrogenic experiences with Ingrezī dhawā have only reinforced their perceptions of the value of their traditional Balochī medicines.

Situating Dhīnabogiri vis-à-vis Anthropology and the Histories of Reproduction

Anthropological studies of reproduction and maternity, and historical studies of colonial medicine, have examined the embodied consequences of healthcare policies and practices experienced by women and by their traditional or Indigenous midwives. Scholars have also noted how spaces of modern reproduction are increasingly manifesting not only as "zones of iatrogenesis" (see e.g. Towghi 2018: 675) but also as zones of "obstetric violence" and terror for childbearing women around the world (Sen et al. 2018; Castro and Savage 2019; Smith-Oka 2022).[4] This trend is echoed in the narratives of Baloch women and midwives in this book as well as confirmed in studies outlining the global escalation of unnecessary interventions during pregnancy, birth, and the early weeks of life, "risking iatrogenic harm to women and newborns" (Renfrew et al. 2014: 1129). Anthropologists have also cautioned against romanticizing TBAs (Jeffery et al. 1989; Rozario 1998). Baloch midwives in Panjgūr, however, criticized the misuses of injections in and around childbirth by *the lady* (referring to an LMO or LHV) in their private clinics along with mismanaged births by inexperienced "dāīs" who, they suggested, are not dhīnabogs, insofar as they qualified the role and its attendant expertise and practices, as is evident in the ethnographies in Chapters 3 and 5. The local narratives about the work of the dhīnabogs also pointed to the distinctions between "good" dhīnabogs, balluks, or kawwāsi dhīnabogs and an

elder woman who might occasionally assist with births. This differentiation is consistent with the status of various women who might have been involved in assisting childbirths in the premodern Middle East (discussed in Chapter 3). Baloch women's and men's narratives made it clear that it would be difficult, and against the grain of dhīnabogs' dignity and social ethics, for an unqualified "dāī" to claim herself as a dhīnabog merely by having attended the first ever and foreign-funded government TBA training program that had been initiated in Panjgūr only in 2004 (as discussed in Chapter 4). As such, then, there would be no guarantee that as a "trained TBA," she would be accepted as a dhīnabog or asked to assist women in childbirth, and even much less to provide postpartum care, as in the example of Rabia in Chapter 3. Baloch women and dhīnabogs' experiences present views that radically diverge from government and global health policy assumptions over the past three decades that have implicated the absence of hospital births and/or skilled birth attendants (SBAs)—referring to a doctor, nurse, lady health visitor (LHV/auxiliary nurse)—to be chiefly responsible for maternal mortality, leading then to the disparagement of home births and TBAs.

As the ethnography in Chapter 4 shows, Baloch women were clear about wanting to give birth at home assisted by a dhīnabog, but they were not against seeking biomedicine in cases of complications and to receive the antenatal tetanus toxoid vaccine. Antenatal visits were occasions for LMOs (lady medical officers/doctors) to pressure pregnant women to give birth in their private clinics with verbal and physical tactics of control, including premature labor inductions (Towghi 2018: 679–82). In this and other ways, Baloch women in Panjgūr are haunted by a "colonial governmentality" (Scott 1995) marked not only by postcolonial allopathic injunctions to avoid home births and the State-imagined "dāīs," but also by the pervading structural inequalities, differentiated medical infrastructures, poor quality of care, and public-private asymmetries comprised of incomplete and ineffective public hospitals and the unaffordable private medical market (see Chapter 4). In Chapter 6, I engage with Scott's (1995) idea of colonial governmentality in the European colonies. Following Foucault (1979), Scott considered colonial governmentality to be undergirded by a modern political rationality distinctive from the political rationales underlying European governance in Europe. I connect this point to analyze the racialized biomedical rationales behind the justifications for the global advocacy of the universal use of misoprostol for postpartum hemorrhage (PPH) prevention in the Global South in home or community settings—meaning outside the hospital/clinic setting where one would expect a backup system to respond to an emergency caused by the biomedical intervention itself, whereas the advocacy of such a policy in North America and Europe would be considered highly risky. As Prakash (2000: 192) showed, as in Europe, governmentality in British India also developed in response to the outbreaks of epidemics and famines, representing an effort to act on