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Targeted doctors, missing patients: Obstetric health services and sectarian conflict in Northern Pakistan

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ABSTRACT

The spectre of exclusionary medical service provision, restricted clinic access and physician targeting in sectarian-divided Iraq underscores the crucial and timely need for qualitative research into the inter-relationship between conflict, identity and health. In response, this paper provides a critical ethnography of obstetric service provision and patient access during Shia-Sunni hostilities in Gilgit Town, capital of Pakistan's Northern Areas (2005). I analyse how services were embedded in and constrained by sectarian affiliation in ways that detrimentally impacted Sunni women patients and hospital staff, resulting in profoundly diminished clinic access, reduced physician coverage and a higher observed incidence of maternal morbidity and mortality. The paper first situates obstetric medicine at the interstices of contested sectarian terrain and competing historical projects of sectarian identity. Gilgiti Sunnis' high clinical reliance is argued to be a response to and consequence of, inter-sectarian dissonance and the ascendance of biomedicine during three decades of regional development. In 2005, conflict-incurred service deprivations and the enactment and strategic use of sectarian identity in clinical settings were associated with differential treatment and patient-perceived adverse health outcomes, leading Sunnis to generate alternative sect-specific health services. Obstetric morbidity and mortality during sectarian conflict are analyzed as distinctive manifestations of the wide range of direct harms routinely associated with violence and political strife.

Introduction

The literature explicitly concerned with the effects of 'identity' for clinical services and health outcomes during sectarian or ethnic conflict (e.g. Agadjanian & Prata, 2003) remains insufficient, notwithstanding anthropological studies that foreground the interplay of patients' social, cultural and ethnic identity with health service provision and in-hospital treatment in the developing world (e.g. Andersen, 2004; Oka-Smith, 2009). To some degree, this has been addressed by recent research on reproductive health services in war-torn Sri Lanka (Kottegoda, Samuel, & Emmanuel, 2008), the Occupied Palestinian Territories (Abdul Rahim et al., 2009) and Afghanistan (Williams & McCarthy, 2005). However, few studies qualitatively examine how conflict can exacerbate the identity-related contextual, logistical, and interpersonal forces that then lead to impaired service access (e.g. Bretlinger et al., 2005) and a worsening of hospital-based outcomes. This is especially true for research which elides specific analysis of 'identity' even though it focuses on settings such as Iraq, where sectarian affiliation frequently underlies hospital-based violence or service exclusions (AbuAlRub, Khalifa, & Habbib, 2007; Burnham, Lafta, & Doocy, 2009). (Similarly, the existing literature on obstetric outcomes across Pakistan, when describing medical services in multi-ethnic or sectarian contexts [e.g. Fikree, Ali, Durocher, & Rahbar, 2004], overlooks 'identity' as it can and does intersect with reproductive health practices and outcomes.) As this paper will demonstrate, the interlacing of conflict-incurred, sect-specific clinical access constraints and differential treatment with pre-existing service deficiencies, iatrogenic risk and patient abuse can produce a profoundly more dangerous and symbolically dense set of obstetric risks.

This paper draws on 14 months of ethnographic fieldwork in Gilgit Town (2004–2005), the economic and administrative capital of Pakistan's semi-autonomous, federally neglected Northern Areas (Fig. 1). The Northern Areas was recently renamed 'Gilgit-Baltistan' as part of the Gilgit-Baltistan Empowerment and Self-Governance Order-2009 (Aug 29, 2009). The region is bordered by the North-West Frontier Province, Pakistan-controlled Azad Kashmir, Afghanistan, China and Indian-controlled Jammu and Kashmir. Gilgit's demographic composition is unique to Pakistan;

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Fig. 1. Map of Pakistan. (Map by Carly Murray, Dalhousie University MedIT Computing + Media Services.)

the town is populated by approximately 60,000 evenly divided Shia, Ismaili and Sunni Muslims who are crosscut by socio-economic class, *qom* (clan), ethnicity and language.[1] The town is further sub-divided by sectarian-aligned neighbourhoods (*mohallas*). By focusing on Gilgit's 2005 Shia-Sunni conflicts, known as the 'tension times', this paper qualifies the complex ways sectarian hostilities directly and indirectly constrained Sunnis' obstetric service access and worsened maternal health outcomes. With Gilgit's obstetrical health facilities located in exclusively or predominantly Shia enclaves (Fig. 2), and staffed largely by Ismailis and Shias, Sunni physicians and patients were profoundly impacted. The town's primary government hospital saw an approximately 90% decrease in Sunni maternity patients following the onset of conflict. Despite the scarcity of accurate hospital records or death registration, providers and patients confirmed and corroborated incidents of Sunni maternal morbidity and mortality directly and indirectly incurred by the 'tension times', which were marked by active hostilities, protracted Army curfews, resource shortages and the uneven quality and coverage of obstetric services. Throughout the 2005 conflicts, maternal deaths were neither noted in the District Headquarters Hospital (DHQ) patient register, nor was there official acknowledgement of deaths occurring in non-clinical spaces.

With Sunnis marginalized from clinical settings, the 'tension times' compounded the region's already problematic maternal mortality ratio (MMR).[2] Even prior to the conflicts, providers described a wide range of factors underlying regularly occurring morbidity and mortality, including severe iron deficiency anaemia (see IUCN, 2003: 192), in-utero foetal demise (IUD), pre-eclampsia, ruptured uterus, post-partum haemorrhage (PPH) and, to an alarming degree, sepsis resulting from home-births, hospital deliveries and illegal abortions. In contrast to the national MMR of 276/100,000 live births (NIPS, 2008: 178), in 1999 the Northern Areas' MMR was estimated at 500/100,000 (Rahman, 1999: 12), while a community-based survey in Ghizar District, which neighbours Gilgit District, suggested a much higher MMR of 8.9/1000 (Mushtaq, Shah, Luby, Drago-Johnson, & Wali, 1999: 853).

Because of Sunnis' high reliance on their services before and after the start of 2005's conflicts, the DHQ and its provisional 'tension times' offshoot, the 'Sunni Civil Hospital', are the focus of this paper. After briefly discussing the regional ascendance of biomedicine over traditional childbirth practices, and the determinative role of sectarian identity in patients' choice of hospital, the paper summarizes the 'tension times' fallouts for patients, providers and institutions. The paper then details the Sunni community's efforts to navigate around service access barriers with the *ad hoc* establishment of the 'Sunni Civil Hospital'. This is followed by analysis of the enactment of sectarian discord between non-Sunni health providers and Sunni obstetric patients at the DHQ and the contribution of clinical facilities to morbidity and mortality. Data analysis is structured primarily through context-specific attention to the politics of childbirth in conflict (Giacaman et al., 2005; Kanaaneh, 2002). This involves situating maternal health, clinical service provision and patient access amid the cultural, socio-economic and political forces particular to conflicted settings. Critical evaluation of the role of sectarian affiliation in Sunnis' maternal health crises is further predicated on, and expands, anthropological approaches to 'structural violence', typically defined as "increased morbidity and mortality resulting from forms of social organization that frequently lead to groups of individuals being marginalized along social axes", including "economic, racial, and gender inequality" (Keshavjee & Becerra, 2000: 1201). Correspondingly, my discussion of the 'profiling' and 'abuse' of Sunnis in clinical settings draws on the literature examining 'differential treatment' vis-a-vis questions of the rural-urban divide, moral 'deviancy', social status, economic incentives and provider–patient relatedness (Andersen, 2004; Fassin, 2008; Jewkes, Abrahams, & Mvo, 1998; Rivkin-Fish, 2005). By illuminating the "continuation of societal hierarchies, inequality and conflict" into clinical spaces (Van Der Geest & Finkler, 2004: 1998), the hospital-based component of this study complements emerging research on the impacts of sectarian and factional warfare for women's health in Muslim societies (e.g. Devi, 2007), and augments the ethnographic literature concerning South Asian health institutions and their place in local social and cultural 'worlds' (e.g. Unnithan-Kumar, 2004; Van Hollen, 2003).

Methods

This paper is derived from a larger research project conducted in Gilgit Town between August 2004 and September 2005. Fieldwork involved multi-sited participant-observation, interviews, policy and clinic records analysis. Following the onset of Shia-Sunni conflict, and considering the absence of prior sect-specific analysis of Northern Areas' women's clinical access and health outcomes, I sought to demarcate the impact of sectarian affiliation on Sunni women's reproductive and maternal health. Specifically, to render visible the practices and processes that led to starkly impaired clinical service access and adverse maternal health outcomes, and the effectiveness of community-generated measures intended to

[1] Ismailis are a 7th-century offshoot of the Twelver Shia faith. With Ismailis' cultural practices, and site and mode of worship markedly different from Twelver Shias', Gilgiti Ismaili participants predominantly self-identified as 'Ismaili' versus 'Ismaili Shia'. For the purposes of this paper, 'Shias' refers to followers of the Twelver tradition.

[2] MMR is defined as; "death while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (ICD-10 in Bhutta, Jafarey, & Midhet, 2004: 6).

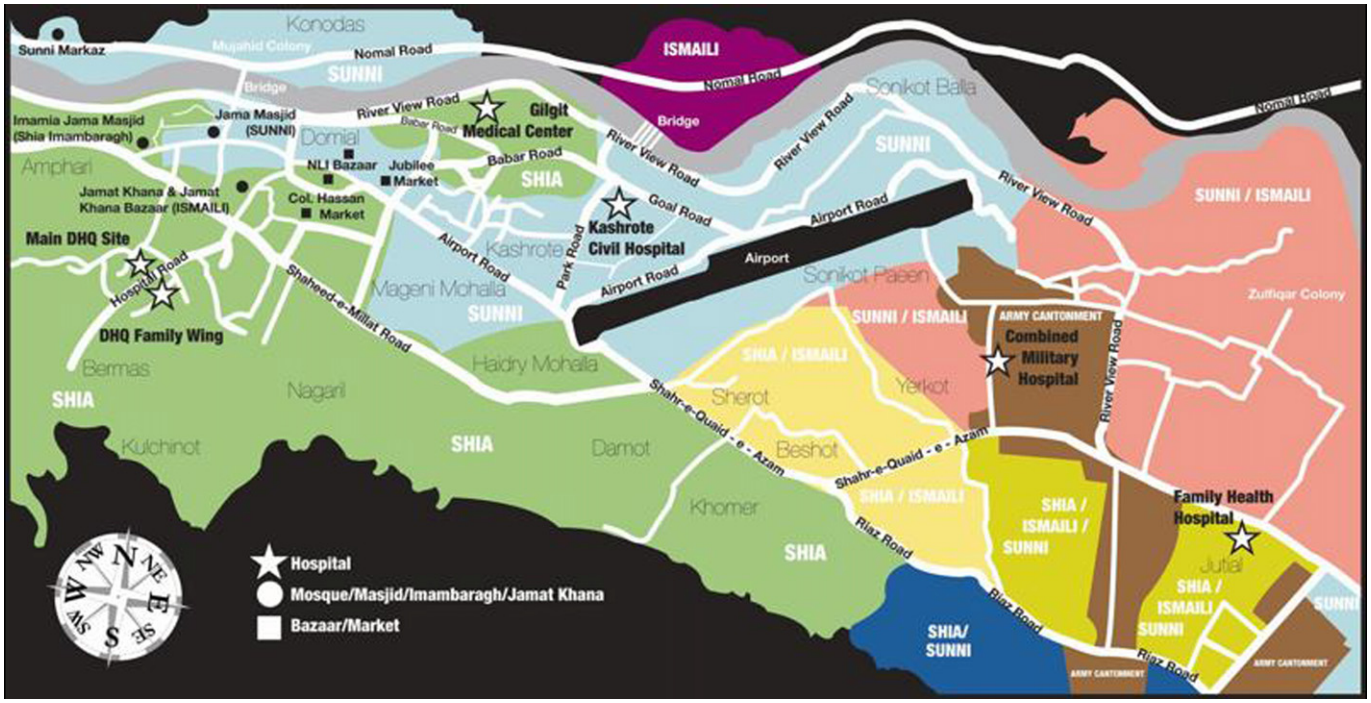

Fig. 2. Gilgit Town *mohallas* and hospital locations. (Map by Carly Murray and Duane Jones, Dalhousie University MedIT Computing + Media Services.)

ameliorate them. Conflictive sectarianism, my status as the wife of a local Sunni and the risks posed by fieldwork in Shia *mohallas* restricted data collection to Gilgit's Sunni community. Civil insecurity, curfews and residents' concerns of surveillance further excluded broad-based quantitative survey methods.

Primary participants were approximately 50 Sunni women of reproductive age (e.g. puberty to menopause). Special attention was paid to women who had been or were pregnant during the 2005 'tension times'. By using neighbourhood-based intermediaries and 'snowball' methods, participants from across the socio-economic spectrum were directly and indirectly recruited from in-town *mohallas* (Amphari, Konodas, Mageni Mohalla, Kashrote, Jutial, Nur and Diamer Colonies), as well as from one Sunni (Minawar) and one Shia-dominated village (Sakwar) at the town's outskirts. This approach permitted longitudinal analysis of commonalities in access constraints and health outcomes across rural-urban and socio-economic divides. Secondary participants included nearly 30 Sunni, Shia and Ismaili biomedical service providers (physicians, nurses, midwives, pharmacists), including all 6 obstetrician-gynaecologists employed at Gilgit's hospitals, as well as 15 homeopathic doctors, traditional herbalists and religious healers. Additional interviews were conducted with 10 governmental- and non-governmental health service administrators and policy developers.

Informed consent was obtained from all participants, and non-English medium interviews were translated from Shina, Burushaski and Urdu. Primary and secondary participants were interviewed multiple times each at a location of their choosing (typically their residence or place of work). Structured, semi-structured and open-ended individual and group-interviews lasted between 1 and 3 h. At institutional levels, fieldwork was conducted at Gilgit's primary hospitals (the Federal District Headquarters Hospital, the Family Planning Association of Pakistan's Family Health Hospital and the Aga Khan Health Service, Pakistan's Gilgit Medical Center), private maternity clinics and governmental- and non-governmental reproductive health centres. (Research did not include Gilgit's Combined Military Hospital, where services are restricted to predominantly ethnic Punjabi and Pashtun Army personnel and their families.) Two months of observation was conducted at In- and Out-patient Departments, Labour and Delivery rooms. Permission for on-site research was granted by individual participants and hospital administrators. Clinic registers, intake ledgers and hospital performance indicators were examined for sect-specific variations in patient service uptake; patients' sectarian affiliation was approximated by place of residence. In 2008, patients' recorded 'domicile' and, thereby, sectarian affiliation were re-analyzed using improved assessments of Gilgit's 2005 demographic composition, permitting greater accuracy in establishing service uptake variations. Research was approved by, and carried out under, the auspices of the University of Toronto's Research Ethics Board (REB #12505).

Available obstetric services

Participants' responses in 2004 indicated that even prior to the 'tension times', Sunni women's reproductive health operated as the arena not only for wellness-seeking and crisis resolution, but also the reflection and enactment of sect-specific cultural beliefs and health practices. These were derived from locally-cultivated, transnationally-nuanced projects of 'modern', 'traditional' and sectarian identity. For example, Gilgiti Sunnis' reliance on obstetric services is a by-product of intensive regional development by the Ismaili, Aga Khan Development Network. Since the mid-1970s, the Aga Khan Health Service, Pakistan (AKHS,P) established over 200 Primary Health Centres across the Northern Areas and upper Chitral Valley (NWFP), marking the start of a "regional health revolution" (Hertzman 2001: 538). The majority of outreach, however, has focused on Ismaili and then Shia districts, sub-districts and villages. The Gilgit Medical Center was the only one of AKHS,P services easily accessible to Sunni communities in Gilgit District. In turn, inter-sectarian antipathies contributed to Sunnis' comprising the least of the Gilgit Medical Center's patients, despite AKHS,P boasting a low patient MMR (69/100,000; AKHS,P, 2003: 15), the

DHQ	Sunni	Shia	Ismaili
Sept 4-Oct 24 (2004) *8 (1.5%) unknown*	~271/521 (52%) (*~155 patients/month*)	~176/521 (33.8%) (*~100 patients/month*)	~66/521 (12.7%) (*~38 patients/month*)
January 5-31 (2005) *4 (4.2%) unknown*	~40/95 (42.1%)	~39/95 (41.1%)	~12/95 (12.6%)
Feb 1-March 5 (2005) *4(4.3%) unknown*	~33/94 (35%)	~42/94 (44.7%)	~15/94 (16%)
March 5-31 (2005)	~16/66 (24.2%)	~38/66 (57.6%)	~12/66 (18.2%)
April 1-30 (2005) *4 (3%) unknown*	~60/132 (45.5%)	~49/132 (37.1%)	~19/132 (14.4%)

Fig. 3. OB-GYN delivery cases (Labour Room, DHQ).

best-trained staff and fewest anecdotal reports of misdiagnosis or medical malpractice. Sunni participants' politically- and religiously-framed concerns regarding non-Sunni providers and sectarian-affiliated services were shared notwithstanding their socio-economic and class-based differences. In some respects, participants viewed the boundary between service use and sectarian identity as permeable and, therefore, a point of community vulnerability.

Although Sunnis used a wide array of biomedical and traditional therapeutic services for their prenatal and post-partum health, approximately 90% of participants, from all socio-economic backgrounds, delivered at the DHQ's no- and low-cost Family Wing.[3] The DHQ is the Northern Areas' primary referral hospital, serving approximately 1.5 million residents and providing one-third of the region's 667 available hospital beds (IUCN, 2003: 203). According to the DHQ Labour Room intake register over 7 weeks in autumn 2004, 521 deliveries were recorded of which 52% were patients from Sunni in-town *mohallas*, villages, sub-districts and districts (Fig. 3). By contrast, the Aga Khan Health Service's hospital, the medium-cost Gilgit Medical Center, handled a total of 648 deliveries in 2003 (AKHS,P, 2003: 5). Despite Sunnis representing the majority of pre-2005 Out-Patient attendees at the Family Planning Association of Pakistan's medium-high cost Family Health Hospital, there were only 301 total, recorded births at the hospital between 1999 and 2004 (FPAP, 2004: 13). Because of the Gilgit Medical Center and Family Health Hospital's nominal roles as sites for Sunni births, this paper provides only a peripheral discussion of their services.

Besides the economic advantage posed by the DHQ's low- and no-cost services, Sunni women's use of the hospital facilitated a multifaceted competitive sectarianism. First, women situated federal health services as the product of the Sunni-dominated State of Pakistan and described how use of the hospital signified Gilgiti Sunnis' solidarity with the national-level Sunni community, while their presence also served to symbolically contest Shias' territorial claims over the *mohalla* in which the DHQ was located. Second, in a town where Ismaili medical and educational 'advancement' posed a sizeable counterbalance to Sunni conservatism, births at the DHQ provided conspicuous opportunities for Sunni families to simultaneously demonstrate their 'modernity' and prove they could prioritize women's health ahead of Islamic strictures. Principally, the ability of Sunni women, with comparatively lower literacy and higher fertility rates, to access obstetric services helped deflect Gilgiti Ismaili and also Shia critiques of Sunnis' purported 'regressive' de-prioritization of women's educational and health requirements in favour of restricted public social mobility and gender segregation. Hospital attendance thereby allowed Sunnis to juxtapose women's health practices against Gilgit's more cosmopolitan Ismaili and Shia communities, for whom biomedical services were a salient marker of 'progress' and 'modernity'. By amplifying the symbolic importance of clinical births, 'modern' competitions reinforced the regional ascendance of biomedicine. Traditional childbirth practices, *dayahs* (midwives) and home-births subsequently diminished in importance. Such shifts ultimately underscored in-town Sunnis' necessary reliance on clinical services. With community-based *dayahs* having retired, died or shifted their practice to local clinical facilities, Sunni women made equally high use of obstetric facilities for childbirth as Shias and Ismailis (Figs. 3, 4). Sunni participants' clinical service uptake stands in stark contrast to regional health indicators and national figures. By comparison, in 1999, 42.6% of surveyed births in rural Gilgit sub-district took place in a health facility, while 67.4% of births in the same study were attended by a doctor, Lady Health Worker (LHW), nurse or trained birth attendant (TBA) (Rahman, 1999: 17–18). In 2006, only 29.7% of women in the North-West Frontier Province and 40.2% of women in semi-urban national settings delivered in a health facility (NIPS, 2008: 113).

The 'tension times'

By 2004, Gilgitis had endured three decades of accelerating sectarian violence, strongly influenced by Iranian Shia politicization and Saudi-funded Sunni proselytization. Although Sunni, Shia and Ismaili research participants frequently claimed mixed-sectarian and ethnic ancestry, they indicated that by the mid-1970's intersectarian commensality and marriage had largely ceased. Sectarian polarizations were initially rooted in land tenure disputes (Sokefeld, 1997) and Sunni contestation of Shia claims of ethnic 'ownership' over Gilgit Town. Following from the 1979 Shia, Iranian Revolution, regional Ismaili non-governmental department, and the national rise of Sunni Islamization, Saudi-funded *jihadi* militancy and the Taliban throughout the 1980's and 1990's, Gilgiti society was marked by substantial ideological and doctrinal cleavages. This led to differential emphasis on education, literacy, health and community welfare, notwithstanding similarities in

[3] In addition to visiting in-town hospitals and private clinics, participants' prenatal and post-partum health needs were supported by homeopaths, herbalists and Islamic therapeutic resort. Besides offering recourse for a wide array of culture- and faith-based health complaints and etiologies, traditional therapies were a valuable concession to conservative Islamist emphasis on 'Muslim' healing practices such as Prophetic Medicine and Hikmat. Because they were viewed as being largely synonymous with Sunni identity or Islamic conservatism, traditional practices allowed women to pragmatically and politically engage with sect-specific healers, ideologies and textual sources, family- and community-bound practices.

Family Health Hospital	Sunni	Shia	Ismaili
Nov 24-Dec 24 (2004) *4 (0.2%) unknown*	~ 661/1631 (40.5%)	~ 513/1631 (31.5%)	~ 453/1631 (27.8%)
Jan 1-Feb 1 (2005)	~ 204/585 (34.9%)	~ 216/585 (36.9%)	~ 165/585 (28.2%)
Gilgit Medical Center	**Sunni**	**Shia**	**Ismaili**
October 1-31 (2004) *15 (3%) unknown*	~ 77/510 (15.1%)	~ 218/510 (42.7%)	~ 200/510 (39.2%)
January 1-31 (2005) *4 (1.88%) unknown*	~ 25/213 (11.74%)	~ 74/213 (34.74%)	~ 110/213 (51.64%)

Fig. 4. OB-GYN out-patient attendance.

economic standing across communities. By 1988, sectarian 'tensions' had escalated precipitously. A militia of fundamentalist Sunnis from southern Gilgit District, neighbouring Diamer and Kohistan Districts, massacred 200 Shias in the nearby villages of Jalalabad and Danyor (see Ali, 2009). Regional Shia and Sunni militancy thereafter involved escalating political activism, weaponization and targeted attacks, while Northern Areas Ismailis adhered to pacifism despite being a frequent target for Sunni and, less frequently, Shia prejudice and violence.

The January 2005 Sunni-orchestrated killing of Syed Agha Zia'u'din Rizvi, leader to Northern Areas Shias, was the flashpoint for longstanding sectarian, political, and economic rivalries. In 2004, Zia'u'din had been at the forefront of extensive, sometimes violent *Nisab* (Curriculum) Protests, centering on Shia opposition to the Sunni tone of the Federal Education Syllabus. Immediately following Zia'u'din's January 8th shooting, gunmen shot and killed a number of Sunni government employees, while civil and federal offices and Sunni-owned businesses were attacked by arsonists. In ways that amplified Sunnis' anxieties about hospital settings over the ensuing ten-months of fighting, the District Headquarters Hospital, where Zia'u'din was initially taken for emergency treatment, was the scene for attacks directed at Sunnis. Male patients were rumoured to have been shot in their beds, and one Sunni victim's family confirmed he had been killed while receiving treatment for gunshot injuries received earlier that day. While gunmen threatened to kill Zia'u'din's attending Sunni physicians should he not survive his injuries, the DHQ's 'women only' Labour Room was forcibly searched for Sunni male attendants. The Sunni, Northern Areas Department of Health Director was shot and killed as he attempted to leave the DHQ. (A large number of DHQ patients and staff were rescued by family or non-Sunni colleagues, while others were unable to escape for several days because of the density of Shia homes surrounding the hospital.) By day's end, approximately 17 Sunnis and one Ismaili died. The 2005 'tensions' were unprecedented in their scope and intensity. By October 2005, nearly 100 Sunnis and Shias had been killed, while Ismailis remained politically neutral observers to the hostilities.

After the Pakistan Army's January 8th takeover of Gilgit's civil administration, issues related to health service provision, physician safety and patient access were under-prioritized, with civil security measures centered on government offices, banks, tourist centres and the homes of prominent businessmen, politicians and Army officers. During this time, the DHQ remained open albeit understaffed. For several weeks following the initial hostilities and thereafter during subsequent periods of 'tension', the Gilgit Medical Center and Family Health Hospital were forced to close due to a lack of security for patients and staff; obstetrical emergencies were referred either to the DHQ or the Combined Military Hospital, which provided sporadic coverage in January and early February. Curfews and roadblocks within Gilgit Town and along the Karakoram Highway (KKH) throughout 2005 restricted supply shipments of tetanus toxoid, Rhogam vaccines (for Rh-negative mothers) and infant immunizations, as well as the medications required to treat eclampsia and post-partum haemorrhage. Impaired service access and ambulatory coverage meant fewer women received emergency care; it was also increasingly difficult for Sunni patients to hire taxis to transport them through 'high risk' Shia *mohallas* to the DHQ. Because of Gilgit Town's isolation, few women were able to make the costly 16-h journey to Islamabad for advanced care.

The subsequent 10 months were marked by frequent low- and high-intensity armed conflict, mortar attacks and bombings, Army curfews and weapons sweeps, school closures, police surveillance, and media and telecommunications blackouts. Exclusionary measures were deployed vis-a-vis Sunni business strikes, Shia and Sunni attacks and counter-attacks. Sunni officials, including physicians, were frequently targeted for violence. The names of 2 DHQ physicians appeared on a Shia *Imambaragh* (mosque)-issued edict listing alleged 'involved' Sunni parties to Zia'u'din's killing, locally referred to as a 'hit list' (Markazi Anjuman-e-Imamia, 2005). The targeting of Sunni physicians echoed and inverted the killings of 60 Shia physicians by Sunni militants in Karachi between 1991 and 2001 (Ali, 2001), as well as the sectarian-motivated assassinations of Iraqi doctors following the 2003 U.S.-led invasion (Burnham et al., 2009; Jalili, 2007). Many Sunni private physicians subsequently abandoned their in-town practices, fleeing to the comparative safety of Islamabad where they established new clinics. Even though the Department of Health Director was killed at the DHQ, Sunni staff was not regularly provided secure transport to and from the hospital. Staff sometimes refused, or were unable, to attend emergencies – obstetric or otherwise – or avoided their duties on days of 'tension'. Though the DHQ's Labour Room remained open during a month-long total, then partial, curfew between January and early February, obstetric coverage was infrequent. The DHQ's 1 Sunni OB-GYN had gone on-leave, while the hospital's lone ultrasonologist, a Sunni, maintained that, as the rumoured target for future strikes, he was frequently compelled to avoid his hospital duties. With physicians apparently identified by militants as sources of political or economic power for the Sunni community, participants argued physicians' relocation or death prised new spaces for Shia advancement.

Given the frequency of regularly occurring pregnancy- and childbirth-complications and high pre-conflict service uptake levels, physicians were preoccupied by the toll hospital closures, police checkpoints, total and partial Army curfews had taken on service access and, thereafter, health outcomes. Besides failing to

provide adequate security for hospital staff and community-based health workers, the Federal Government – through the auspices of the Army – and Gilgit's civil administration had neglected to ensure safe patient access routes through Shia *mohallas* to local hospitals. Although Army curfews in January and February, and from mid-March to mid-April 2005 had also enacted logistical constraints for Shia and Ismaili maternity patients, the 'tension times' posed a fundamentally greater challenge for Sunni women. By their own accounts, Ismailis and Shias did not face the same degree of overall access restrictions. While Shia *mohalla*-based hospitals benefitted Shia patients, Ismailis' access was enabled by their political neutrality, theological interconnectedness with Shias and progressive community standards concerning women's mobility, enabling women patients to travel without male attendants. By summer 2005, thousands of Sunni women had been blocked from service access by curfews, roadblocks or, as was more often the case, by family members unwilling to accompany them.

Service declines were not due to any inherent, direct threat to women. Instead, women's ability to access care was linked to men's inability to accompany them. *Pardah* strictures which, by definition, entail women's veiling and gender segregation, also required Sunni women patients travel with closely-related male attendants who were now the targets for Shia attacks. Sunni women were thereby forced to measure their maternal health risks against the possibility of husbands or male relatives being injured or killed while accompanying them to hospitals in Shia *mohallas*. As one physician noted, "For the last 2 or 3 months, women who are pregnant have been a source of great worry [for] their families" (April 29, 2005). Concerned that male attendants, described by providers and patients as 'security', were armed, the Gilgit Medical Center, for example, occasionally prohibited them from entering the hospital grounds. Fearful of the threats posed to male attendants from the surrounding Shia *mohalla*, Sunni women patients typically left local hospitals against their doctor's orders immediately after delivering. Four months after Zia'u'din's assassination, Sunni women's clinic visits remained substantively altered and physician supervision dangerously diminished.

> Women were pressurized to leave quickly by the men with them, who stayed [outside]. We avoided investigations that could be postponed, such as blood testing…haemoglobin, urine. (Dr 'Sumairah', AKHS,P:April 29, 2005).

Meanwhile, hospital administrators and physicians struggled to manage the ways stringent community allegiance undermined the ethical imperative to serve patients regardless of sectarian affiliation, as was confirmed by the Family Health Hospital's Shia, Acting Project Director;

> At a staff meeting, I indicated…that the definition of a hospital is to serve humans, and we can't discriminate between the patients by sect or community. All services will be provided regardless of differences, and regularly. I acknowledge that there is patient insecurity about the sectarian identity of physicians and staff at the hospital, because this is an intersect make-up hospital. I also recognize patient insecurities about attending the DHQ, and the impact this might have on our patients, their concerns and fears regarding preferential treatment. (May 11, 2005)

At the DHQ, the Sunni OB-GYN described how, "The Sunnis complain…[and] my family and friends are not happy with me working here" (September 7, 2005). The initial 'tensions' had so interfered with her sense of security that she had taken an extensive Medical Leave. Months later, she noted; "We are working in a war situation, but it's hard to give treatment under gunfire, with gunmen standing nearby…This is a battle zone, and unpredictable" (September 7, 2005). Correspondingly, several Sunni participants argued the DHQ ultrasonologist's practice of medicine, normally held in high regard, had been compromised by 'tension times' stresses.

> We met one woman at the DHQ… [where] she had gone for five different ultrasounds and was given five different reports on her pregnancy. Which one can we believe when it works this way? I don't think Dr 'X' is in his right mind these days. The Shia-Sunni 'tensions' are disturbing him too much and he's fearful. Look at my report; he got my name and age wrong, everything is wrong! ('Samina': August 4, 2005)

Curfews, telecommunications 'blackouts' and *mohalla-by-mohalla* weapons sweeps further worsened access to services. During a week-long curfew in April 2005 several participants, unable to leave their homes, or, contact the Army, police, hospitals, family or neighbours for assistance, were forced to give birth unattended. And as the 'tensions' continued into summer, the number of Sunni participants denied transport assistance by Army personnel through Shia *mohallas* increased, especially during regularly occurring Shia religious events and political rallies. Only rarely were Sunni families able to contract and afford off-duty government nurses or Lady Health Workers to attend home-births.

At all local hospitals and the DHQ in particular, service disruptions, on-site insecurities and chronic instability produced dramatic shifts in patient attendance rates (Figs. 3, 4). DHQ Labour Room records indicate a roughly 79% decrease in Sunni patients between autumn 2004 and February 2005. Following intensive fighting and poor civil security in March 2005, Sunni patient numbers dropped 90% from 2004 levels. Additional curfews, weapons sweeps and security measures in April led to Sunni patient increases, yet patient levels still stood in stark contrast to the roughly 155 Sunnis who delivered at the DHQ each month prior to the 'tensions'. Nor did this mean that Shia and Ismaili patient levels hadn't also dropped. Between January 5–31 (2005), Shia patient numbers dropped 61% from 2004 levels. However, by March 2005 Shias' overall hospital presence had increased from 34% of patients in autumn 2004 to approximately 58%, whereas Sunnis made up only 24% of delivery cases for the same period. Because the DHQ is a referral hospital, many missing obstetric patients were rural women. Sunni, Shia and Ismaili patients traveling from regional villages, sub-districts and districts were routinely stopped, held up or turned back from Army checkpoints surrounding the town, a move intended to prevent militants from entering Gilgit. In-town and rural Shia and Ismaili women, however, were largely able to turn to *mohalla*- and village-based health workers, government Maternal Child Health centres, as well as AKHS,P's Gilgit Medical Center and satellite clinics. In rural Shia communities, a steadily growing number of women's health clinics have been established by charity, non-governmental and *Imambaragh* organizations (see Gloekler 1998). Despite petitions from district representatives for increased area coverage, the dearth of reproductive and maternal health services in Sunni *mohallas* and rural communities is the partial result of vociferous *ulema* (religious clergy) opposition to services that are sectarian-aligned, mixed-gender or incorporate 'Family Planning'.

By catapulting in-town Sunni women into the same types of service deprivations that caused rural women to die in such high numbers, the paucity of 'tension times' service alternatives to the DHQ ensured Sunni women faced greater, sustained health risks. Between January and September 2005, providers attributed a number of otherwise-preventable maternal deaths – from botched home-deliveries, missed abortions and sepsis – to conflict-

related access constraints for Sunni physicians and patients. In response, by late January 2005 Sunni politicians, in conjunction with Sunni physicians and support staff displaced from their DHQ duties, proposed the *ad hoc* establishment of the no- and low-cost Kashrote Civil Hospital, or, 'Sunni Hospital'. An unused building in a Sunni-dominated *mohalla* was purchased using community donations and converted into a rough surgery, Labour Room and cramped In-patient and Out-patient Wards. By spring, the facility was enlarged to 40-beds with the addition of a 20-bed Patient Wing. There were, however, no on-site facilities for X-rays, ultrasound and most laboratory tests, which required Sunni patients to attend the DHQ or costly private clinics. High patient loads overwhelmed hospital staff, many of whom were unpaid. In February 2005, upwards of 1500 patients, some coming from as far as 250 km away, visited the site daily. Hospital intake records indicated that 281 babies were delivered at the site between March 3 and September 3, 2005.

By summer, the facility was in disarray; electricity and running water were infrequent, and medicinal and cleaning supplies were in short supply. The 2-bed Labour Room was supervised by a retired Ismaili nurse, whose duties were supported by several Ismaili LHWs and an untrained Sunni *dayah*. There were no facilities for C-sections, and pain relief and anaesthetic were not normally provided for D&Cs or labouring mothers. Surgical and examination equipment was routinely unsterilized between patients. In order to compensate for the associated risk of infection, before being discharged (typically 1 h after delivery) obstetric patients were given a prescription for antibiotics, which provided a poor measure of safety given the high regional prevalence of Hepatitis B and C (Alam & Naeem 2007). For complicated deliveries, obstetrical procedures were limited first by the degree of missing resources and then, later in 2005, the absence of specialists and support staff, many of whom had been forced by financial pressures to return to their DHQ postings. Complicated cases were routinely sent back to the DHQ; on rare occasions, patients were referred to the Gilgit Medical Center, the Family Health Hospital or to hospitals in Islamabad. The DHQ's OB-GYN confirmed the multiple constraints posed by conflict had undermined her practice of medicine at the 'Sunni Hospital';

> I've seen a lot of cases of foetal distress and IUD [in-utero demise]…I've done emergency cases under local anaesthetic and sedation [because] we [had] no specialists available for epidurals. I had to do this once…because a patient was dying and I was afraid to [go] to the DHQ. It was a case of placental abruption and impending [uterine] rupture from obstructed labour and eclampsia…We're seeing patients who've had strokes from eclampsia; I've treated many cases…. (September 7, 2005)

Sunni participants frequently framed their hospital attendance as a point of community loyalty, and described having to prioritize symbolic allegiance to the at siege local and global Sunni community (*ummah*) ahead of individual needs. Such reconfigurations of practice and meaning were articulated not only as a by-product of Shia 'aggressions', but also intensified regional Sunni militancy following September 11 (2001) and the U.S.-led invasions of Afghanistan and Iraq. The DHQ's OB-GYN's interpretation was less political; "The Kashrote Hospital has no facilities, but people are forced to go there. They're not going willingly" (September 7, 2005). While the Federal Government had initially promised funds to further develop the site, by the end of 2005 the promised monies had not materialized, ostensibly because the sect-specific hospital would have contravened the government's 'equitable', 'non-discriminatory' provision of health services. Despite the cessation of active hostilities by winter 2005, 'tension times' changes to obstetric service provision and clinic access remain in-effect; the Kashrote Civil Hospital's presence a testament to the pervasive frictions and periodic killings that continue to separate Sunnis from Shias.

Patient 'profiling'

According to Sunni participants, the 'Sunni Hospital's' necessity was underscored by their perception of the DHQ's Labour Room as a site of differential treatment. To an increasing degree during the 'tensions', participants claimed neglect or physical and verbal abuse by non-Sunni DHQ nurses not only signalled everyday patient-provider power imbalances, but the deliberate misuse of authority against vulnerable Sunni patients. Divided into Labour, In-patient and Out-patient Departments, the DHQ's 'women only' Family Wing was supervised by two, Sunni and Shia women obstetrician-gynaecologists who provided intermittent delivery coverage between 8am and 2pm and were on-call overnight. As a result, Labour Room services were managed primarily by Ismaili, Shia and only a few Sunni nurses ('Sisters'), with additional support from trained and lay-midwives (*dayahs*). Participants who had recently delivered at the DHQ alleged that non-Sunni nurses' attention to, and negative comments about, their bodies, health practices and comportment provided compelling, additional proof of the Sunni community's 'tension times' targeting and differential treatment.

A number of nurses shared their belief with me and, more importantly, with labouring patients, that Sunnis were recognizable by their 'recalcitrant', 'difficult' and 'uneducated' disposition or health practices. Rural patients especially were described as 'oppressed, 'ignorant', 'dirty' and 'smelly'. While delivering, Sunni women were observed being chastised for their clothing or hygiene, or, lightly mocked for their presumed religious conservatism, which staff claimed was evident by the degree to which women veiled. Indeed, Sunnis, particularly those from Diamer District, which had played a pivotal role in the 1988 Shia massacres, were frequently characterized as 'inflexible', inherently 'dangerous' religious fundamentalists, or, 'extremists'. Nurses appeared to disregard women's vocal protests that they were too poor to afford soap, new clothing, or, that girls' schools were neither accessible nor affordable. Some women's attempts to deliver in a traditional squatting position, versus the clinic-preferred supine, Sunnis' 'uncultured' (*jungulee*) or 'bestial' (*janwar*) nature. To this point, the DHQ's Sunni nurses, some of whom were self-described 'modern', ethnic Punjabis participated in patient critiques to the same degree as their Ismaili and Shia colleagues, whereby differential treatment stemmed at-once from biomedical discourse critical of 'dangerous' traditional practices, and sectarian and ethnic 'difference'. Several Ismaili nurses appeared particularly invested in noting sectarian dissimilarity. Shia and Sunni patients' 'misbehaviour' or 'callousness' comparatively upheld their self-held notions of Ismaili 'civility' and 'neutrality', concepts that had acquired additional resonance during the 'tension times'.

> We're Ismaili, and we're looking at [Sunnis and Shias] differently, curiously. They'll be in the same [delivery] room, experiencing the same thing, but they make a distance between themselves, and won't talk or discuss. There's no friendliness. They will say to us, 'Look, she's a Shia!', or, 'Look, she's a Sunni!' and we reply that we could care less…. (Senior Sister: August 1, 2005; Varley 2008: 67)

Patient 'profiling' and commentary enabled 'modern-traditional' binaries, regularly invoked by Gilgitis to explain inter-sectarian difference in socio-economic domains, to be projected onto bodies and health practices as a form of boundary marking. By focusing on women's bodies, religiosity and 'backwardness', non-Sunni providers discursively side-stepped more unwieldy political discussions of

sectarian religious and cultural difference. In-clinic observations confirmed sectarian 'profiling' built on discordant sectarian relationality that, for the most part, pre-dated the onset of conflict.

'Profiling' occurred alongside obstetric patients frequently being pinched, slapped or, more rarely, punched by nurses and *dayahs*. Conversely, it was evident providers were sometimes reciprocating Sunnis' insults or physical abuse. Nurses recounted being struck by distressed patients or family members, or, overhearing Sunnis describe Shia ritual observances as idolatry (*shirk*), or, Ismailis as a 'corrupted' variant of Islam. Although participants protested that abuse was a direct consequence of sectarian affiliation, in actuality such deprivations and harms were nearly impossible to disentangle from regularly occurring abusive practices, which nurses justified were acceptable responses to patient 'non-compliance' or 'shameful' noisiness, and established authority over patients from comparable socio-economic and educational backgrounds. Notably, participants did not associate physician-patient encounters with the same degree of perceived harm or inter-sectarian discord, a view that was upheld by physicians, who argued "sectarian identity is never an issue in practice" (September 7, 2009). This did not mean, however, that sectarianism and abuse between patients and physicians did not occur. Rather, DHQ patients' privileging of their physicians was a dual reflection of OB-GYN's infrequent Labour Room attendance and, compared to nurses' professional disposition, their relatively more 'cordial' or 'parental' approach to patients.

As Van Hollen reasons for abusive obstetric practices in Tamil Nadu, DHQ nurses' abuse of patients "stemmed from issues of professional hierarchy and were sociological in nature" (2003: 130). Low salaries, poor working conditions, rigid in-hospital hierarchies and administrative restrictions placed on their treatment of obstetrical complications placed nurses at the behest of, and accountable to, hospital administrators, attending physicians, and patients and their families. Nurses recounted being threatened with dismissal on account of formal complaints when women died, irrespective of the role of inadequate physician coverage, insufficient blood plasma supplies or patient delays in seeking care. In turn, nurses strategically transferred their frustration and insecurity to patients perceived to be less likely to incur professional disciplining or same-sect community sanctions. Despite abusive practices being observed directed at Shia and Ismaili patients, Sunni patients were especially disadvantaged by Sunnis' reduced 'tension times' political strengths and diminished presence as clinicians and hospital supervisors. Conversely, 'tension times' service gaps and access difficulties had over-sensitized Sunnis to the existence of inter-sectarian targeting, leading participants to sometimes inaccurately forecast prejudice in clinical encounters. In order to help construct a stronger rationale for providers' moral 'corruption' and thereafter DHQ service avoidance, it was also apparent that women and their families deliberately overlooked abuse or prejudicial commentary occurring at the Kashrote Civil Hospital. DHQ patients' concerted 'tension times' focus on abuse also precluded acknowledgement of nurses' kindness or resourcefulness during obstetric emergencies.

Nonetheless, apparently clear examples of sectarian targeting at the DHQ were widely shared among participants, their family and neighbours, furthering Sunnis' concerns for 'non-Sunni' hospital sites and providers. For example, one participant recounted watching as her daughter, a first time mother from Sunni-dominated Chilas (Diamer District), struggled through a difficult delivery;

> Ajmah was in severe pain…and screamed and cried. [She] was in the DHQ, on her hands and knees on the bed crying out, and the nurse and *dayah* were beating her and saying, 'Is this how you Chilasis do this?' ('Nasreen': June 7, 2005)

More ominously, when perceived maltreatment occurred alongside medical malpractice, and with non-Sunni providers increasingly characterized as the agents of conflictive sectarianism, Sunni maternal deaths under non-Sunni care were sometimes re-cast as 'murder'. Documented 'tension times' maternal deaths were instead the complex product of conflict constraints, pre-existing service deficiencies, irregular or absent prenatal care, the patient's age, maternal health status and previous foetal loss; delayed emergency obstetric care, iatrogenic risk and medical 'accidents'. As Andersen confirms for Ghanaian hospitals, in addition to providers' mismanagement or neglect of specific 'types' of patients, "serious resource deficiencies…are important and obvious catalysts of malpractice" (2004:2003). Sunnis assigned DHQ staff responsibility for harms that were the collective outgrowth of sustained, systemic failures at public and private levels. Even in times of relative peace, the Labour Room's services were impaired by inadequate physician coverage, staff shortages, faulty or absent equipment and supplies (respirators, blood pressure cuffs, surgical gloves and soap, autoclaves), and surgical delays, with only female physicians permitted to conduct C-sections. Hospital staff confirmed the DHQ's pharmaceutical supplies were in short supply, absent or expired, forcing patients to rely instead on higher-cost, frequently counterfeit medications from private dispensaries (see Morris & Stevens, 2006: 3).

Institutional deficiencies posed significant maternal health risks and led DHQ patients to occasionally self-refer, against doctors' orders, to other hospitals. All documented DHQ-based maternal deaths occurred during the overnight shift, when in-town roadblocks and inadequate hospital transport meant on-call OB-GYNs were often more than an hour away from the Labour Room. Service gaps were especially acute on nights of heightened 'tensions' and thus more likely to affect Sunni, Shia and Ismaili patients equally. For one Shia patient, the 2-h wait before an OB-GYN arrived was too long; she died of post-partum haemorrhage minutes after being shifted to the Operating Theatre for an emergency C-section. In an inversion of Sunnis' claims of 'obstetric murder', Sunni physicians were distinctly anxious about such scenarios.

> I am a Sunni doctor and I treat Shia patients – I treat them well, to end their problems…. On the day the 'tensions' began, I was treating one Shia…patient, who was stuck in my [private] clinic. For 3 to 4 hours I had to do uterine massage by hand to control her post-partum haemorrhage. I had no drugs to treat this in my clinic….I was afraid that if she died, they would blame me, a Sunni, for her death. (September 7, 2005; Varley, 2008: 60)

The DHQ's Sunni OB-GYN was sympathetic to her Shia patients' plight. Following her posting to the 'Sunni Hospital' after January 8th, she reported, "One [Shia] patient cried because another doctor operated on her during my absence and the baby died, and she said, 'Why weren't you here?'" (September 7, 2005).

Case example

The story of one maternal death at the 'Sunni Hospital' illustrates the intersecting 'tensions', clinical insufficiencies and pervasive fears within which obstetric service provision and patient access were embedded. In mid August 2005, a young Sunni mother, in the final month of a pregnancy with twins, was taken by her husband to the DHQ Labour Room due to unexplained vaginal bleeding. Although she was not experiencing contractions, the attending nurses had admitted her for observation with the expectation they could summon the on-call OB-GYN should complications develop. The nurses had left the patient resting in the prenatal suite, where they had checked on her periodically. They had not, however, taken her medical history, which would have alerted them to a pre-existing cardiac condition, which carries a significant risk of maternal morbidity and mortality, especially in

childbirth. Later that night, one of the nurses had looked in on the patient and found her bed empty.

Without having notified staff, her husband had taken her "secretly" from the DHQ to the 'Sunni Civil Hospital' even though, as one nurse commented, "There weren't any particular problems or 'tensions' that night" (August 23, 2005). At the 'Sunni Hospital', the mother was admitted once again for observation but was not seen by a physician, nor was her blood pressure taken. She was put under the supervision of an unqualified Family Planning 'motivator', who had been hired because of the dearth of trained nurses willing to work at the Kashrote site. By the following morning, the patient died without having delivered. The 'Sunni Hospital' and DHQ staff quickly displaced their clinical failures by framing the husband's actions as irresponsible. By doing so, they denied voice to the manner in which sustained and legitimate fears for personal safety drove him to remove his wife from care at the DHQ. However, in their accounts of the death, and even while tacitly acknowledging their services were inadequate, 'Sunni Hospital' staff suggested the onus of blame also rested with the DHQ's Labour Room staff for having failed to initially recognize the gravity of the patient's situation.

At one level, this death demonstrated the collapse of the boundary between conflict-related constraints and medical malpractice. But rather than identify the critical role played by inter-sectarian hostilities not only in guiding patients' choice of hospital but also in guaranteeing the 'Sunni Hospital's' ongoing necessity, health providers – Sunni, Shia and Ismaili alike – promulgated a 'geography of blame' (Farmer 1992) in which women's families, more than service providers or ill-equipped clinical settings, bore the burden of responsibility. The DHQ's OB-GYN, for instance, commented that, "one man, who was afraid for his own death, took his wife, who didn't matter, from [the DHQ] and he lost her and the babies" (September 7, 2005). Yet she was also cognizant of the 'Sunni Hospital's' share of liability. By late spring 2005, despite her early role in establishing the hospital, she withdrew from active service at the Kashrote Hospital, citing deep concerns for on-site hygiene and resource insufficiencies. By autumn 2005, she refused to even refer Sunni patients there from the DHQ during Shia-Sunni 'tensions'. According to her, the risks associated with deliveries at the 'Sunni Hospital' now outweighed the risks posed by the DHQ Labour Room and the Shia *mohalla* surrounding it. Otherwise-preventable maternal deaths confirmed that obstetric service access alone could not avert morbidity or mortality.

Discussion

The story of Gilgit exemplifies the myriad fallouts that occur within the realm of reproductive health in settings where "the politics of identity is a symptom and cause of conflict" (Van Beek, 2000: 550), and medical practice and discourse become capable of signalling community and contestation. The DHQ and 'Sunni Hospital', in particular, acted as microcosms of the same types of political, socio-economic and faith-based schisms that led Iraqi Shia and Sunni patients, physicians and support staff to be excluded, targeted and killed in government hospitals and sectarian-affiliated clinics (IRIN, 2007). Gilgiti Sunnis' maternal health risks were not effectively mediated by the availability of emergency obstetric facilities; morbidity and mortality were the outgrowth of pre-existing, conflict-exacerbated institutional deficiencies and discordant inter-sectarian patient–provider interactions. Such findings correspond with health surveys of northern Pakistan that point to the "role of health services in the causation of maternal mortality" (Midhet, Becker, & Berendes, 1998: 1587; see Jabeen, Gul, & Rehman, 2005), and enlarge analysis of the scope of 'differential treatment', ordinarily characterized by socio-economic inequality, resource expenditures and "attentive kindness and respect" (Andersen, 2004: 2005). By extension, the sectarian 'profiling' and maltreatment of obstetric patients coincides with studies demonstrating that health providers' abusive "attitudes and practices cannot solely be attributed to or excused by their working environment" (Jewkes et al., 1998: 1792). Given the thousands of Sunni obstetric patients missing from local hospitals in 2005, the risks associated with the Kashrote Civil Hospital and already high maternal mortality ratios, it is possible that maternal deaths outnumbered the deaths of men during conflict. No less importantly, Sunni physicians' alienation from the DHQ inevitably led to collateral health repercussions for Shia and Ismaili women.

As prior research has shown for Palestinian women's childbirth practices during "states of siege" in the Occupied Palestinian Territories (Giacaman et al., 2005:130), and indigenous women's access to clinical facilities during intra-community conflict in Mexico's Chiapas State (Bretlinger et al., 2005), Army curfews, roadblocks and the logistical insecurities of obstetric facilities in Gilgit's Shia *mohallas* ensured that, for Sunnis, "the place of birth had to be remapped and reconsidered [by] health providers and women" (Giacaman et al., 2005: 136). Unlike Palestinian women, however, Gilgitis went without the "new childbirth networks [and] birth assistants…arising by virtue of crisis" (Ibid: 136). In the event of conflict, Pakistan's regional and national-level politicians must demand legislated exceptions to curfews and roadblocks for women in-labour, and mandate hospitals and their access routes as fundamental priorities for civil security efforts. Recommendations for enhanced obstetric service access and provision should additionally include emergency preparedness training, hospital infrastructure and staffing improvements, 24-h in-clinic physician coverage, extended ambulatory services, and renewed efforts to recruit Sunni physicians, support staff and community-based Lady Health Workers. Mobile birthing clinics, telephone-networks to guide family members through deliveries, coupled with the distribution of home-birth 'kits', will further reduce conflict-related morbidity and mortality (see Abdul Rahim et al., 2009). Regular clinical service quality audits, resource management and performance reviews, and the effective gathering, storage and analysis of medical records, birth and death registration (see Ali & Kuroiwa, 2007) will thereafter determine the success of local initiatives.

Reproductive health interventions and policy designed for conflict will benefit from evidence-based analysis of the wide affective scope of sectarian hostilities, fallouts of which may include differential health service provision, access and sect-specific maternal health risks. Future research should attend to the complex ways in which 'affiliation' and 'identity' can act as determinants of health during ethnic- or sectarian-hostilities, or, evaluate how sectarian affiliation shapes pathways to care during conflict. Qualitative analysis of 'identity', health and conflicted terrains will lead to a better understanding of how a patient, provider and hospital's 'affiliation' may combine to worsen maternal health outcomes. This may be especially true when one community is able to deploy direct or indirect exclusionary mechanisms to marginalize another community from care, or in settings where conflictive sectarianism and the geographic distribution of health resources result in additional barriers to service use. Further research on this subject is urgently needed not only in the Northern Areas but across northern Pakistan, where the 'Talibanization' of obstetric service provision (Lamb & Shehzad 2003), religious extremism, and factional and sectarian hostilities in the North-West Frontier Province and FATA (Federally Administered Tribal Areas) are actively undermining reproductive health service access and outcomes. Given that hostilities have spilled over into the Punjab, Sindh and Baluchistan, the necessity of such research cannot be overstated.

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