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A REVIEW OF WOMEN'S HEALTH: THE HEGEMONY OF CASTE, DEVELOPMENT, AND BIOMEDICINE

Jan Brunson

Introduction

There are numerous socially deemed experts on women's health. They come in various forms of 'professionals' – biomedical, family planning, public health, demographic, and governmental – and each professes an expert knowledge on women's health of a slightly different kind. In Nepal, there is a history of those development and health professionals being in positions of power, whether on a global scale such as a member of the global North working in rural Nepal, or on some local social hierarchy such as being high-caste or wealthy. A range of scholarship has provided us with the intellectual tools to deconstruct and analyze the hegemonic production and reproduction of such 'expert knowledge': Foucault in terms of the demographic surveillance of populations (1979) and the medical gaze (1973); Subaltern theorists in terms of the global North's production of expert knowledge about the global South (Spivak 1988), and critical studies of development in the rejection of linear and homogenizing notions of 'progress' (Escobar 1994; Ferguson 1997; Scott 1999). Those on the receiving end of 'expert knowledge' are equally capable of critiquing relations of power; they grapple with inequities in various social statuses on a regular basis. Seira Tamang (2002), for example, describes *janajāti* women's critical responses to high-caste Kathmandu development workers in their village, and in the present article I describe one instance in which a woman with minimal formal education from an agricultural family instructed me, with intentional irony, to use family planning.

Lock and Kaufert (1998) point out that, since the twentieth century, women have experienced an increased appropriation of their bodies for medical practice particularly in relation to pregnancy (and its prevention) and childbirth. I follow their recommendation to begin from the position that "medicalization and power are ideas which must be grounded historically and culturally, as must resistance, agency, and autonomy" (Lock and Kaufert 1998: 1). As a medical anthropologist, in this paper I aim to show the real constraints and consequences of hegemonic systems such as caste,

Studies in Nepali History and Society 18(2): 279–303 December 2013
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development, and biomedicine for women's well-being, but also to narrate the agency and creativity with which humans negotiate such limitations. The intention of this article is to analyze how particular hegemonic discourses on women's health have tangible impacts on the well-being of women of child-bearing age in a semi-urban village located at the edge of the Kathmandu Valley. I utilize a decade of intermittent research in this community to explicate three areas in which dominant discourses about women's well-being have significantly shaped their lived experiences: caste and autonomy, development and fertility, and biomedicine and birth. These examples come from a specific place, between the rural and urban extremes of Nepal, and from a specific group of women, Parbatiya Hindu-caste women. Therefore, in no way can these examples be taken to represent the vast diversity of women who live in Nepal, nor does this paper attempt to review something called 'women's health' throughout the entire country.

Anthropological research on contemporary communities throughout Nepal have demonstrated and celebrated the diversity of women's lived experiences from the classic 1981 series *The Status of Women in Nepal* and Lynn Bennett's *Dangerous Wives and Sacred Sisters* (1983), to more recent additions such as *On the Edge of the Auspicious* (Cameron1998) and *If Each Comes Halfway* (March 2002). The fact that several ethnographies (Ahearn 2001; Justice 1986) deal explicitly with a community's encounters with development projects evidences how pervasive and influential non-governmental organizations (NGOs) and multi-lateral organizations (such as USAID) have been in Nepal. Stacy Pigg (1992) and Seira Tamang (2002) have written influential critiques of development's construction of 'women' and 'the village' in this regard. This paper builds on the insights regarding the diversity of women's experiences as evidenced in the canon on gender in Nepal but it focuses specifically on the ways in which women come to embody[1] the hegemony of global and local discourses on gender and health.

As a review article, the purpose of this paper is to draw connections amongst three related systems of power and women's health – *jāt* (caste[2]),

[1] I use the word 'embody' in its phenomenological sense, as lived experience (see Csordas 1994, 1999).

[2] The English word 'caste' is an inadequate translation of the Nepali word '*jāt*' – see Cameron1998 for a summary explanation. Due to the lack of a better single-word translation, 'caste' is used in this article, though sparingly. I give the Nepali word '*jāt*' primacy in the text as much as possible.

development (*bikās*), and biomedicine[3] – in order to uncover how these dominant discourses shape Nepali Hindu-caste women's understanding and experience of health. I argue that women's health is not a set of facts to be discovered and understood; rather, it is co-produced by historically and culturally situated constructions of biomedical science and development. I use ethnographic examples from a community perched on the rim of the Kathmandu Valley to analyze the impact of dominant discourses on women's health, but I aim to move beyond any one of the examples below to examine their significance in relation to one another, as interrelated parts of a whole. While these three topics are not exhaustive of the variables and structures that impact women's health in this specific context, they are arguably some of the most significant; and when analyzed together rather than individually they provide a fuller picture of the whole of women's well-being. Only when one reaches an understanding of the ways power operates in the lives of women in a particular social context, and how various aspects of their identity intersect to create advantage or disadvantage, can one begin to understand their health.

The Community Context

The following examples and conclusions come from a decade of intermittent research conducted with Parbatiya Hindu-caste women in a semi-urban village at the edge of the Kathmandu Valley that I call Vishnupura.[4] The stories come from case studies of 28 families selected to represent a range of *jāt*, household structure (nuclear and joint), and socioeconomic status.

During thirteen months of research carried out between 2003 and 2005 I used a mixed method approach that incorporated an initial enumeration of households and a survey of a random sample of households, the selection of thirty case studies representing a range of important cultural and economic factors, interviews and observations at the local sub-health post and the two hospitals utilized by locals, and ongoing participant observation. I fully

[3] I define biomedicine as a system of clinical medicine based on modern Western science that emphasizes technology in diagnosis and treatment.

[4] In compliance with Institutional Review Board requirements, I use pseudonyms for the name of the community and the individuals who shared their stories. In previous publications I used the pseudonym Vishnumati, the name of a well-known river that runs through Kathmandu. I discovered that that name was too distracting to Nepali speakers, so I have changed it to Vishnupura.

immersed myself in family and community life by becoming the paying guest of a local Newar family and participating in daily life and rituals.

In the initial months of the project I mapped and enumerated households (N=794) of the two most populous political sections (wards) of the village and surveyed a random sample of 248 households for basic demographic, household history, and birth information. The number 250 was selected as a number that would result in statistically significant descriptive statistics for the population of households in the two wards.[5] The data gathered in the survey provided information for choosing families for in-depth case studies according to a sampling matrix of the following characteristics: caste, socioeconomic status, education, and age. I had to select additional low-caste (or Dalit) families from the two wards for the case studies to compensate for the small number of them in the population. In addition, there were no low-caste families in my random sample that were in the category of moderate or high socioeconomic status.

Ultimately I selected thirty case studies (with two eventually dropping out at different stages in the interview schedule) that represented de facto joint and nuclear families of each caste and, other than the low-caste families, of middle or low socio economic status. Wealthy Nepali families were few and anomalous in the area, so I excluded them from the case studies. As mentioned previously, I limited my case study households to Parbatiya Hindu-caste Nepalis – a substantial and influential group, yet only one of many diverse cultural groups found in Nepal. We[6] interviewed the married women of reproductive age at each household using a semi-structured, open-ended format an average of five times over the final seven months of my initial research period, and I also had many informal conversations with them

[5] There were two refusals. I excluded households in which one or more spouses were not citizens of Nepal.

[6] My research assistant Meena Manandhar was instrumental to this research in many ways. First, as a woman it would have been culturally inappropriate in this location for me to walk around and call upon families alone. With another woman present, this behavior was fine. Second, though I am conversationally fluent in Nepali, as a native speaker Meena has linguistic grace that I lack as an outsider. Though I was an active participant in the interview sessions, I relied on her to ask most of my questions. I crafted the interview schedule and translated the questions into Nepali and tested them with the help of another research assistant and native Nepali speaker, Manoj K. Shrestha.

along the way.[7] Each interview ranged from thirty minutes to three hours. The topics of interviews were marriage, work, pregnancy, birth and postpartum experiences, and the role of women. The interviews took place alone in the privacy of the women's homes; however some of the most fruitful sessions occurred spontaneously with multiple household members or neighbors present. The first two introductory rounds of household interviews were not taped, but after building rapport I used an audio recorder for the remaining three interviews in the series. Thus, all quotes in the article are direct translations of women's recorded statements, the exceptional result of a painstaking process of translation and transcription. A year later, in 2005, I returned for three months of follow-up research with the same case study families. During the summers of 2009 and 2010 I followed up with the families again, this time including their sons who had come of age and were poised for marriage.

The initial survey I administered in 2003 provides a snapshot of the demographics of the two wards at the beginning of the research period. The average number of years of education was seven for men and four for women. Fifty percent of the families owned their home and the other fifty percent rented. Forty percent of families owned at least one color television. Twenty-one percent owned at least one motorcycle, and three percent owned a car. At that time, the markers of a 'middle class' family typically included a color television, possibly a computer, and a motorcycle. The children typically would have been educated through the School Leaving Certificate (SLC), with young men having more education on average than young women. Behind these averages lies diversity. For example, portions of the community were still quite rural and uneducated, and in the bazaar area unskilled laborers who were new to the area rented single rooms. In small numbers at the other end of the spectrum, a handful of families owned a car or had a child with a master's degree. I excluded from the study a few anomalous, considerably wealthy families such as those who owned car companies and international export businesses.

[7] Originally I intended to interview husbands as well, but after discovering a few women were experiencing marital violence I abandoned the idea. The nature of my interviews could have placed women at further risk had I interviewed their husbands.

Women's Autonomy and *Jāt*: The Limited Explanatory Power of 'Autonomy'

As all of the examples in this paper are drawn from research with Parbatiya Hindu-caste women, it is appropriate to begin with an analysis of the ways in which caste and gender intersected in Vishnupura women's lives and affected their well-being. Due to the history of Nepal's unification as a state and the consolidation of political power in Kathmandu, high-caste Hindu Nepalis became the political and cultural elite. Tamang describes how this high-caste hegemony was perpetuated by the development industry – even as *janajāti* activism was growing – through constructing an image of 'the Nepali citizen' as Hindu, and 'Nepali women' as "uniformly poor, illiterate and choked by Hindu patriarchal domination" (2002: 165). Rather than generalize erroneously the results of my research with Parbatiya Hindu-caste women to 'Nepali women,' I examine how different axes of power and gender intersect within this very specific sub-group of the Nepali population. The ways caste, class, and gender intersect within the Parbatiya group is relevant to maternal health because those intersections create different sets of structural limits on behaviors and thus shape the landscape of suffering for women. I argue that a commonly used measure of women's well-being, autonomy, is inadequate because it obscures the ways caste, class, and gender interact and differentially affect women's health during and after pregnancy.

In her study of gender and caste in far western Nepal in the late 1980s, Mary Cameron (1998) investigated the lives of low-caste women in order to articulate the ways their lives differed from the dominant discourse on gender and high-caste women. Cameron thus began the project of investigating the particulars of caste relations and gender, a project that I pick up again in a more urban location. Cameron demonstrated that although low-caste women are ritually impure according to the high-caste perspective, a different set of ideals superseded the purity/pollution ideology of caste for low-caste women. Their contribution to subsistence and wage-earning activities allowed them a social autonomy and relative economic power that most high-caste women did not have. The economic necessity for women to be engaged in labor related to agricultural work or other small-scale earning activities ultimately freed them from some of the patriarchal restrictions on mobility and interactions outside of the home. Although Cameron argued for a more nuanced reading of low-caste women's autonomy than the simple claim that low-caste women have more freedom and autonomy than women of high-

caste, she concluded that low-caste women's income and the social benefits of their labor give them more leverage than upper-caste women who depend on honor for their ideological power.

Women in Vishnupura disagreed on the implications of *jāt* for contemporary Nepali women. Some said that it depended on the individual, their education, their economic status, or whether they had adopted an urban lifestyle. Regarding how life differs for low and high-caste women, one woman replied, "Well, it depends on the actual life conditions of the people, how can we say?" Some high-caste women expressed the opinion that low-caste members did not have to be as respectful in the forms of speech that they use, such as using the *timī* form of address with individuals of higher status. Other women were hesitant to answer, but made general statements like, "People say that the life of low-caste women is freer than the life of high-caste women. For example the low-caste can do any job and go anywhere."

The experiences of low-caste, low-class women in Vishnupura bear out Cameron's findings on low-caste women's rejection of high-caste gender rules. In this sub-group of families, women did not have to show as much deference to their husbands through respectful forms of prescribed speech and behavior. All of these five women were engaged in wage-earning labor. Their families were concentrated in the bazaar area, and all were nuclear families with the husbands currently living in the households. They were renters, not landowners, and were not involved in the agricultural sector like many of the high-caste land-owning families. Three women worked as tailors in family-owned businesses and operated one-room shops. The women managed all aspects of the businesses: taking orders, sewing, and negotiating prices. Another woman, significantly more destitute than the others, managed her own fruit shop, selling whatever was in season at her roadside stall. She also handled all management aspects of the small business, traveling an hour's distance to the market where she purchased her fruit and setting and negotiating prices according to various market influences. These women were small-scale entrepreneurs who appeared to act mostly independently of male involvement.

Radha, the remaining example of a low-caste, low-class woman from my case studies, worked as a janitor in a hospital. The nature of her work was less entrepreneurial than the former examples but it resulted in similar exposure to people beyond her community. She had to travel by bus to reach her place of employment and she received a set wage for her work. Radha was often

present in the bazaar; I ran into her in public spaces frequently whereas with all the other women (high- and low-caste) I saw them on the streets perhaps once or not at all. She was the victim of gossip amongst locals because she worked the evening shift cleaning a hospital and had to return home late in the night. Noticing this, people gossiped about the possibility of her being a prostitute. Her freedom of movement, especially at night, had consequences in the eyes of the public.

Radha's case draws attention to some of the nuances and complexities of the interaction of gender and caste for low-caste women. If viewing gender norms from a low-caste perspective, low-caste women do have more autonomy in matters such as getting a job as a janitor and independently traveling to and from that post. But in the views and reactions of the larger community, and from the socially dominant perspective, this woman's transgression of the dominant (read high-caste) perspective on gender roles resulted in a backlash from members of the community speaking against her moral character. It is clear from these public expressions of disapproval that, from the dominant perspective, women should not be working in this fashion. Thus, to say that low-caste women are exempt from the gender rules of the dominant/high castes fails to take into account the social disapproval that is expressed from the larger community or society. Regarding gendered restrictions on mobility, one low-caste woman said,

> Society wants a woman to stay inside the house and not speak with anyone, otherwise they start backbiting you. Even if we wear nice clothing they will talk about us and start commenting that so-and-so's daughter-in-law is behaving like this and that. We can't speak with outsiders…

Such a statement would be characteristic of high-caste women who face greater gender restrictions, but these came from a low-caste woman. Going out, wearing nice clothing without any special occasion,[8] and speaking with non-family members are all acts of immodesty and may bring social scorn upon a woman. The distinction of the experience of gender for low-caste

[8] Being critiqued for wearing nice clothing (with the exception of special occasions) is likely to be related to class as well as caste. See Pravina Shukla 2008 for an analysis of dressing above one's class in India. I owe thanks to an anonymous reviewer for making this point. In Nepal, Mark Liechty (2003) addresses in detail the desire amongst the middle class in Kathmandu to dress fashionably, while limiting the extent to which one does so in order to maintain one's moral standing.

women, then, is their partial rejection of dominant society's gender roles while, at the same time, they are looked down upon for doing so by the larger society.[9] They operate within two disparate sets of gender dictates for they cannot escape the dominant society's perspective even while rejecting it.

Amongst my case studies it was high-caste women who were restricted the most in their behavior, such as leaving the home, speaking excessively with family members or gossiping with neighbors, appearing 'over-smart' in dress or speech, and touching certain religious or food items while menstruating.[10] Ganga, a soft-spoken, young Chhetri woman, confided that she felt a little confined within the home of her husband's large joint family. The family did not like for her to go outside so she rarely left the home even on errands and never left to just walk around (*ghumna jāne*). Another woman around the same age, a Brahman woman, explained that women should behave in this way:

> Women have to be a little bit down. They don't like women to speak like they are important. Women have to mind others and elders. We have to obey the husband. We have to endure, to mind whatever is said, no?

High-caste women were expected to express the most deference toward their husbands and husbands' families.

I also found contradictions to such generalizations about high-caste women. Through comparing low and middle class families within each caste, it became clear that poor high-caste women were not bound by the same rules. Out of economic necessity some high-caste women of lower socio-economic status worked as laborers in the fields or assisted with household tasks such as large-scale food preparation for special occasions for other wealthier locals. These high-caste women who regularly engaged in agricultural work were the most difficult women to meet for interviews. They always seemed to be out planting rice in this neighbor's field, or hoeing a plot of land for that person's corn. Thus, being confined to the home was hardly a restriction faced by this group of high-caste women; in fact they were rarely at home, especially during peak agricultural seasons.

[9] The low-caste women in my case studies were proud of their entrepreneurial work, and they occasionally dismissed or mocked the stereotypical gender restrictions associated with high-caste women. Therefore I was not inclined to think that they experienced their activities as shameful or degrading.

[10] This is more true for extended family households than nuclear.

The significance of class for high-caste women can be observed within the walls of a single building in Vishnupura. The large, rectangular, three-story building is owned by the family of Ganga, the Chhetri daughter-in-law mentioned above. Four generations of her husband's family live in the building on the second and third floors. Most of the first floor is rented to other families. In one corner of the first floor is an informal tea stall where locals often gathered for a meal during breaks in the agricultural workday. Ganga rarely left the top stories of the building, spending most of her time involved in food preparation for the family. A Brahman woman, Devi, a few years Ganga's senior, lived downstairs with her husband and their two boys in two rooms that they rented on the ground floor. In contrast to Ganga, Devi was rarely at home. She worked as an agricultural laborer in order to earn money to help pay for clothes and school fees for her two boys. Her husband was a teacher, but his income was not enough to support even their meager existence. The only times she was at home were at dawn and again in the evenings after dark. She had taught her young sons how to cook because of her regular absence.

The economic necessity for her to work outside of the home set in motion a series of consequences that disrupted gender roles and restrictions for high-caste women. First, allowing her boys to shoulder some of the responsibility of food preparation defied one of women's most symbolic and time-consuming responsibilities, cooking for the family. Of further interest, the sex composition of her children demanded that sons, not daughters, take on that responsibility. Second, her work for various local land-holding families required that she interact regularly with men and women from the community and those nearby. She also occasionally traveled to nearby towns when news spread that they needed extra hands. Although Devi may have taken care to maintain a sense of modesty throughout such interactions, her mobility and public presence threatened the traditional gender expectations so readily visible in the behavior of the Chhetri family upstairs.

This example begs the question of whether the low-class Brahman woman has greater autonomy than her Chhetri neighbor, and raises a much larger issue of the extent to which autonomy and other aspects of women's well-being may be in conflict. The Brahman woman had few restrictions on her movements outside the home and was a valued source of income for her family, but she had little leisure time, engaged in demanding physical labor, and was separated from her family. Women who move about alone in public

also may face indignities while working outside because they are less protected and easier targets for harassment. The Chhetri woman had less autonomy, but she had a more comfortable life in terms of her basic needs, such as adequate food and shelter. She had the luxury of only doing light housework and having more leisure time, but she rarely left home. It was clear from our conversations that she longed for more social contact. As I argue more extensively elsewhere (Brunson n.d.), in this social context, poverty acts as a leveling mechanism between high- and low-caste women, making it impossible for either to live by the dominant set of high-caste gender ideals.

These examples illustrate that while at the aggregate level *jāt* is correlated with opportunities in life such as education and wealth, at the individual level there are exceptions. Micro-level analysis reveals that among the higher castes as well as the low, women's capacity to earn is recognized and utilized by families of lower socioeconomic status. As a result, gender restrictions such as the control of women's movements and communication with others were loosened in these families.[11] I argue that low-caste women's autonomy should be understood in the context of their economic status – historically low – and not solely their ritual status. The pragmatics of survival among impoverished people, coupled with hopes of enabling economic mobility for their children, precluded adherence to strict gender norms that limit female participation in productive work.

Social scientists have postulated that an increase in women's autonomy is associated with better maternal health (Bloom et al. 2001; Das Gupta 1995), lowered fertility (Das Gupta 1995; Mason 2001; Morgan and Niraula 1995; Vlassof 1991), and other improvements in women's well-being. While several studies have questioned the validity of various measures of autonomy (Ghuman et al. 2006; Mumtaz and Salway 2009), I challenge the use of autonomy on a different front: according to the ethnographic examples described above, in situations where women have greater autonomy vis-à-vis men, they are likely to be in more dire socioeconomic circumstances as well. What are the implications of arguing that poor high-caste women and low-caste women have more autonomy, while as a result of their poverty, they engage in physically demanding labor or have difficulty obtaining and

[11] See Des Chene 1998 for an in-depth look at a similar phenomenon in a Gurung family.

consuming nutritious foods? Amongst the women who were engaged in agricultural labor, stories abounded of working while pregnant past the point of exhaustion and not eating due to being unable to access foods that did not cause nausea. Low-caste women's high autonomy is often overshadowed by the negative aspects of their low economic status such as lack of nutritious food or control over physical exertion and rest. Similarly, low-class but high-caste women's autonomy – though it may appear greater if they are engaged in work outside the home out of economic necessity – is also often trumped by the same negative aspects of low economic status. To consider autonomy as a primary indicator of women's well-being, then, would be to miss the effects of poverty on women's overall health. When talking about women's autonomy, other measures of discrepancies in power and social hierarchies must also be invoked, and attention paid to how they interact.

Development and Fertility: The Local Negotiation of Global Discourses on Procreation

With the second and third ethnographic examples in this paper, I broaden the perspective from local hierarchies of caste, class, and gender, and analyze the impacts of global discourses on procreation and maternal health. Discourses, or dominant sets of ideas about how life ought to be lived, are as likely to hail from distant locations as local ones in an age of globalization. I define a discourse as a system of ways of thinking, speaking, and acting, always imbued with power. Some take the form of official discourses, such as the one on family planning espoused by organizations like USAID and International Planned Parenthood Federation. This transnational discourse is slightly altered to fit various social contexts in the global South, but overall, underlying themes such as lowered fertility as a fundamental aspect of modernization or development are consistent (Greenhalgh1995; Sharpless 1995). This discourse gains power at the local level in places like Nepal through its association with the economic supremacy of the North, complex bilateral relations between nations, notions of modernity, and as demonstrated by Pigg (1992), local understandings of *bikās* (development). It also gains power through the money that is transmitted along with the themes or messages – aid is provided to supply family planning services, medical devices and equipment, and advertisements promoting smaller families.

Although some discourses may be dominant, all people exist in fields of multiple discourses, and typically many of them conflict. A local discourse

on the importance of sons amongst Hindu groups in Nepal, for example, conflicts with the one described previously of family planning programs promoting a small family (meaning two-child, replacement level fertility), for not every family will have the requisite son within two births (Brunson 2010b). Women thus come to embody, in Csordas's (1990, 1999) sense of the word, these conflicting discourses and processes of social change through the practices of procreating and avoiding pregnancy.

This discourse of replacement level fertility can be traced to the United States (U.S.) in the 1950s and '60s. Reviving Malthusian logic and explaining scarce global resources and poverty in terms of an unchecked human population 'explosion' (Ehrlich 1968), intellectuals and political leaders in the U.S. began to develop programs aimed at reducing what were considered to be high fertility rates in the global South. Historian Thomas Robertson (2012) describes how the two key organizations in global efforts at fertility reduction, the Population Council and International Planned Parenthood Federation, were created by individuals who had a mixture of motivations and concerns: global overpopulation and its impacts on the political security and natural resources of the U.S., women's right to contraception, and also some lingering eugenic motivations towards societies and segments of society deemed inferior. In these initial stages of the population control movement, population and development planners equated women in the global South with fertility itself: as something that had to be controlled. In the 1980s and '90s, the discourse amongst the international development community on women in the global South shifted towards one of women's empowerment and right to contraception. Despite the official change in discourse from population control to women's reproductive health, the control of population growth and fertility remained the underlying objective; the hegemonic aspiration of lowering fertility continued to drive population policy and funding.

The hegemony of population control funding and programs may have originated in the global North in many cases but local governments and policy makers bought into the idea that lowering fertility rates would result in economic growth. Historically in Nepal the acceptability of limiting family size was driven by a dramatic expansion of the role of the state into everyday affairs, in particular into Nepalis' reproductive lives. This began in 1959 with the establishment of the first family planning service organization, the Family Planning Association of Nepal (FPAN). The following year FPAN became an

associate member of International Planned Parenthood Federation. Around the same time, the government of Nepal began to associate the role of family planning with national development and family welfare. The government concluded that reducing the national fertility rate would help maintain a balance between population growth and economic growth, and it adopted a family planning policy in 1965. Subsequent development plans dealt with population processes from both a policy and programmatic point of view. From 1985–1990, population policies and programs not only emphasized family planning issues in the short term, but also focused on long-term concerns such as encouraging the small family norm through education and employment programs that aimed to raise women's status and decrease infant mortality. The government altered its position from encouraging family planning through sterilization to promoting temporary methods. The Eighth Plan (1992–1997) continued the strategy to create a favorable atmosphere for the small family norm of two children through economic and development programs and improve the scope and quality of family planning services offered throughout the country, but it also established a new emphasis on the concept of birth spacing and the use of temporary birth control methods (National Planning Commission 1992: 350). The Ninth Plan (1997–2002) promoted a "Small Family for Happy Family" to the rural populace and aimed to reduce population growth through improvement in the health of women and children (National Planning Commission 1997: 635).

The women in the case study families were familiar with the 'happy family,' two-child model that was commonly promoted on radio, television, and even in school books. It is a slogan used around the world in an effort to lower fertility rates. And indeed, women talked about two, otherwise three, children being enough. Yet there is a problem with the 'happy family' representation, an inherent contradiction that is apparent in the very logo of the Family Planning Association of Nepal: the image of two parents with two children, one daughter and one son. I found that the presence of one son remained crucial in this context (Brunson 2010b; for an overview of son preference see Croll 2000). How can a family ensure such a perfect composition of offspring as in the logo (Figure 1)? Only roughly 50 percent of couples would produce the sex composition of the children in the FPAN logo, one girl and one boy. Another 25 percent would produce two boys, and the remaining 25 percent would produce two girls. Thus, many contemporary young mothers were faced with conflicting discourses: produce a son, but only have two children.

Figure 1: The logo of the Family Planning Association of Nepal, depicting the 'small, happy family' with one son and one daughter

Despite social and familial pressures to have a son, most of the young mothers in the case studies who had only daughters declared that their daughters were adequate, perhaps better, due to daughters' good behavior and caring attitudes towards their mothers. But ultimately they could not escape the fact that daughters were lost to other families at the time of marriage. In contrast, a son would bring a daughter-in-law into the household. In a lively discussion of gender roles on the front porch of a large joint family of the Chhetri *jāt*, the mother-in-law from the neighboring house summed up the role of daughters. She joked loudly to the group, "The daughter runs off – if she is given away (in an arranged marriage), she goes; if she isn't given away, she goes. If there is a son, he will care for [the parents]." She was making the point that whether a woman elopes or her marriage is arranged, eventually she "runs off" (*bhāgcha*), leaving her parents' household. Everyone recognized the truth of that statement. Sons, on the other hand, remain with their families and care for their parents as they age. Jethi (the most senior daughter-in-law of the family) added:

> After one becomes old, parents, we old people, won't be able to work. [We] can't do fieldwork, can't care for livestock. For that a son is needed. After a son is born, a daughter-in-law will come. After the *buhārī* comes, they will manage things and do the fieldwork. They will have babies. And for these things isn't a family necessary? Without a son, where does a *buhārī* come from?

Much later in the conversation, the focus shifted to my situation at that time as an unmarried woman. Jethi teased me by saying that I should have two children and then do family planning. This was a brilliant ironic application of the family planning message promoted by the government and international

non-governmental organizations alike, that 'a small family is a happy family,' and one should have two children and then 'do family planning.' Instead of an INGO or bilateral organization funded and often run by predominantly white Americans or Europeans telling Nepali women how to manage their sex lives and procreation, a Nepali woman with only an elementary-school level of education turned the power hierarchy upside down by teasing a young, white American researcher that she should have two children and then use family planning. It was one of the highlights of my decade of research in this community.

In sum, young mothers in this research were caught between conflicting discourses on procreation: produce a son, but limit the number offspring to two. Although women and girls were viewed as more capable and valuable than ever before, and Hindu prescriptions about the need for a son were fading, young mothers described how they were unable to escape the practical aspects of producing a son in this patrilocal context. Producing a son was the best chance at securing assistance in the household as one grows older, for a son will bring a daughter-in-law into the home. There was no guarantee that this scenario would play out so neatly, as women themselves recognized (see Brunson n.d.), yet it seemed like the best option for those caught between the ideals of lowered fertility and having a son. In these examples, it is clear how the modern project of fertility reduction in the global South impacts the reproductive health of married women in Vishnupura. They negotiate conflicting local and global discourses by striving to limit their family size through using contraceptive technologies while, at the same time, attempting to produce a son.

Biomedicine and Birth: The Mixed Results of the Medicalization of Birth

The hegemony of biomedicine and its effects on women, maternal health, and birth seem less ominous and problematic than the racist and eugenic roots of the population movement. The Safe Motherhood Initiative, now consolidated under the Partnership for Maternal and Child Health, certainly had a more faultless history and a nobler goal – the improvement of maternal health – than the population movement. But the expansion of biomedicine as the dominant system of health and healing around the world and its appropriation of birth as a medical event have resulted in the surveillance and monitoring of women's bodies in the global South all the same.

Many biomedical advances save women's lives during obstetric emergencies through managing obstructed labor, hemorrhaging, eclampsia, and postpartum infection. By examining the hegemonic aspects of biomedicine and birth, I do not intend to downplay its potential to reduce mortality and morbidity. At the same time, the history of the medicalization of birth and the rise of obstetrics contains many troublesome chapters, including the professionalization of delivering normal births and the outlawing of midwifery, the use of (unknowingly) harmful medicinal and technological interventions in birth, and the failure to recognize the importance of the social or environmental aspects of a successful birth such as physical and emotional support for the laboring woman (Bell 2009; Cheyney 2010; Davis-Floyd et al. 2009).

Beginning with Jordan's *Birth in Four Cultures* (1993) anthropologists joined other social scientists in recognizing and defending the value of local practices of birth such as active labor and multiple laboring positions that were superior to the supine position required in hospitals. Davis-Floyd and Sargent (1997) expressly critique the 'authoritative knowledge' of biomedicine as it related to women and childbearing, calling for a woman-centered approach to birth. In addition, anthropologists have documented how moving birth out of the home and into the hospital resulted in a sharp increase in the number of medical interventions in birth, many of which are questionable in their benefit to women and newborns, and some, such as the excessive use of Pitocin and cesarean sections, are rejected outright (Davis-Floyd et al. 2009). Such historical missteps made in the U.S. can be avoided in countries of the global South in which medical systems are currently expanding their coverage of the population.

Other anthropologists have documented how birthing women may be abused verbally or even physically in hospital settings, particularly when a large gap in social standing (due to wealth, education, or ethnicity) exists between practitioner and patient (Smith-Oka 2012). While most women in my research did not speak poorly of the hospitals or treatment they received there, a couple of women had minor complaints about the long lines and wait time and the attitudes of the nurses or doctors. Anjala, a woman in her twenties who went to regular antenatal checkups and gave birth in the nearby hospital, commented on how the "nurses used to scold me and say, 'Why is such a small girl going to give birth so early?'" She laughed, explaining that they must have thought that she was young – when she was actually twenty-

two at the time of her first birth – because she happened to be petite and look younger than her age. This misguided admonishment by the nurses hints at the possibility of mistreatment by hospital staff but nevertheless Anjala reported that her experiences at the hospitals were good.

In sum, scholars of maternal health have turned away from the once-standard practice of institutionalized delivery and extreme versions of medicalized birth that are expert-centered rather than woman-centered (Lyerly et al. 2007). At the other end of the spectrum, idealized notions of 'natural birth' are deemed to be equally problematic for a variety of reasons (Kukla et al. 2009). A balanced approach is needed in which healthy pregnancies are delivered at home with a trained practitioner and high-risk pregnancies at a hospital or birthing center (Murray and Pearson 2006). This requires a well-functioning referral system that can identify high-risk pregnancies and also ensure that women who suffer obstetric emergencies are identified and transported to a medical center or hospital (Koblinsky and Cambell 2003; Rath et al. 2007).

In Vishnupura, I encountered several obstacles to a referral system working properly (Brunson 2010a). First, I was surprised to learn from women that knowledge about birth was not passed down from elder women in the family or community to women of the next generation. Since the average number of years of education in the two wards of the study area was seven for men and four for women, they also were not receiving information about birth in school. A couple of women directly attributed the delay in being taken to the hospital during prolonged labor to their lack of knowledge. One young Dalit woman, the mother of one son who lived in a rented room with her husband, explained that she did not have very much experience at that point in her life (she was nineteen during her first pregnancy and had only two years of formal schooling) and did not go for antenatal check-ups out of shyness. When it came time for her to give birth at home, she remained in labor for four days. She said, "On the fifth day, I could not tolerate it anymore and I went to the hospital. For four days I had been in labor, and on the fifth day everyone scolded me and I went to the hospital for admission."

Second, no form of birth attendant was assisting the births happening at home. Several women in their forties described giving birth alone but younger women reported that their mother-in-law or other female relative was present for at least the final stages of labor. As a result of their isolation and low social standing, there were several scenarios in which women who were

undergoing birth complications that warranted hospitalization were not in a position to decide it was time to be transported to a hospital. Anjala, mentioned above, described how when she was experiencing prolonged labor her husband's elder brother was the one who finally insisted that she be taken to the hospital. As a new wife in the joint family, she was not socially in a favorable position to make decisions regarding a medical emergency (though her mother-in-law had been notably supportive of her care throughout pregnancy). Another high-caste woman, Shanta, explained she was not able to make such a decision in her case because of her physical condition. When her body did not expel the placenta after the birth of her son, she was in and out of consciousness. She happened to be a community health volunteer, so although she might have realized the gravity of her situation, she was physically unable to assess the situation and assert her desire to be transported to a hospital. Men still viewed birth as the domain of women and remained mostly uninvolved until the situation became so critical that it warranted a husband or father-in-law stepping in, making a decision, and seeking biomedical intervention. This creates ample opportunity for life-threatening delays in transporting women to a hospital (Brunson 2010a). Added to this is men's general lack of knowledge regarding matters of birth; they find themselves in the awkward position of evaluating situations and making decisions to act regarding matters about which they know little (Mullany 2006). Neither men nor women were in a position to act in an obstetric emergency at home.

Further complicating the situation was the fact that only one family had ever used the Skilled Birth Attendants (SBA) available just a few kilometers down the road at the sub-Health Post. Shanta's family, because of her relationship with the sub-Health Post as a community health volunteer, called one of the SBAs to remove the placenta. Her case was the exception. No one had an explanation for why the SBAs were not being used; local families skipped over this middle level of care and went to one of the hospitals in Kathmandu. Implementing the usage of an effective birth attendant would appear to be critical for improving the referral system but the individual would need sufficient cultural capital and good relations with community members so that s/he would be utilized and his or her recommendation to transport respected. Such an individual could effectively support the continuation of the predominant practice of giving birth at home while mitigating the risks of doing so. Identifying who is a good candidate for a

skilled birth attendant has proven to be extremely challenging, however (Justice 1986; Pigg 1997; Berry 2006), and the debate over the role of traditional birth attendants continues (Kruske and Barclay 2004). Recent research in the Kathmandu Valley also suggests that involving husbands more in matters of pregnancy and birth could help solve some of the problems surrounding maternal health, whether women deliver at home or a hospital (Brunson 2010a; Mullany 2006).

In order to work towards a balanced approach to birth that supports healthy births at home as well as adequate identification and treatment for high-risk pregnancies and obstetric emergencies, a better understanding of why skilled birth attendants are underutilized is needed. Without this important link in the chain, the referral system as currently conceptualized in the maternal health literature cannot function properly. The potential exists in this setting for nurturing an existing practice of birthing at home along with a support system of biomedical practitioners and technologies that avoids the extremes of the medicalization of birth reached in countries like the United States.

Conclusion

Improving women's health, according to dominant development and biomedical discourses, involves controlling procreation through family planning and the active management of birth. Reducing mortality and morbidity is part of the project of modernity and adopting the tools and perspectives of reproductive health is tied to the state management of citizens and the governance of self (Foucault 1978; Pigg and Adams 2005). Ideally, such surveillance of citizens and bodies and the resulting social and biomedical interventions serve to alleviate suffering; in practice the process is more complicated, no less so because biomedical knowledge, 'expert' and authoritative as it may seem, is constantly being disproven, discarded, discovered, and refined.

A gendered approach to health requires a consideration of intersectionality (Crenshaw 1989), or all the ways in which the lives of Nepali women differ depending on their positions on various social hierarchies of power and the ways those statuses interact or bolster one another. This paper has briefly summarized several of the areas in which Nepali Hindu-caste women's health is impacted by global and local discourses on procreation and birth. Gender, *jāt*, and socioeconomic status combine in the examples presented here in

particular ways that amplify or diminish the power of these discourses. The section on autonomy emphasized the multiple ways poverty can affect women's well-being: low socioeconomic status loosens some of the traditional high-caste gender norms, but concurrently it can sacrifice women's ability to maintain good health. From the section on family planning, it becomes apparent how the modern project of fertility reduction in the global South has impacted the lives of women who strive to limit their family size through contraceptive technologies while still producing a son. The final section on biomedicine and birth suggests that rather than follow some of the missteps of biomedical system in the global North, Nepal is well-positioned to capitalize on the existing practice of birth at home as long as women receive adequate support during delivery and a functioning referral system is in place.

There is an inherent danger of reifying the tendency to equate 'women's health' solely with matters of reproduction, or essentialize women as procreators, by focusing on family planning and maternal health. Nonetheless, these are major sources of morbidity and mortality for Nepali women, as well as the main ways that biomedicine and development affect their embodied experience. While these important lines of research should not be abandoned, areas of women's health not related to procreation deserve exploration. In addition, the binary quality of gender goes unquestioned in this paper, and future research will do well to move beyond binary and heteronormative assumptions about the gendered aspects of health. Last, the meaning of *jāt* is not static, and future studies of gender and caste need to redefine it according to how it exists in praxis. Understanding better the ways that women's multiple socially constructed identities – such as *jāt*, ethnicity, class, education, and sexuality – interact and combine are essential to improving 'women's health' in the future.

Acknowledgements

I would like to acknowledge funding for this research from a Fulbright-Hays Doctoral Dissertation Research Award, Brown University's Andrew Mellon Program in Anthropological Demography at the Population Studies and Training Center, and Bowdoin College's Fletcher Award to support faculty research. I owe much gratitude to Meena Manandhar and Manoj K. Shrestha for their assistance with my research in Nepal over the years. I would also like to thank Barbara Grossman-Thompson for inviting me to participate in this special issue and for significantly improving this article through her

substantive comments and editing. Likewise, I thank the anonymous reviewers for their contributions.

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