That something so preposterous could be happening in modern times at a place barely 100 km from the capital makes it all the more scandalous.

—Times of India, March 5, 2001

In much of rural North India, government and nongovernment health institutions are part of the fabric of everyday life, and their ideals and symbolics are integral to the self-reckonings of the rural poor. But in many spaces, the absence or uncertain presence of official institutions means that, for many, they exist primarily as points of imagination and longing. This is all the more apparent in a context of globalization and structural changes in health care marked by privatization, the “rolling back of the state” (Qadeer et al. 2001:31), reliance on foreign donors and their agendas, and structural orientations toward profit and short-term interventions (Drèze and Sen 2002; Qadeer 2001; Sen 2001). Many rural people seek health care from practitioners who are neither “quacks” nor legitimate doctors but who invent roles for themselves as medical authorities and representatives of development. Self-made medical authority is also common in urban India, but it takes a particular shape in rural areas where it is imbricated with the structure and ethos of development. Lacking official certification, seemingly ersatz doctors cross the permeable boundaries of institutions. Though some include elements of indigenous medicine in their practice, most work in a biomedical frame outside systems such as Ayurveda and Unani. This article addresses the slippery shape of institutional authority in the Sitapur district of Uttar Pradesh, India, where I conducted field research in 2000–2001. Here, I explore the complexities of medical practice in rural locales by considering persons who work on the margins of legitimacy, practicing medicine and health-education, opening clinics, calling themselves “doctors,” claiming the authority of development and medical institutions but without their formal sanction.
Given nearly two decades of change in national policy and international flows of funds, ideology, and regulation through North India, the definition of development is up for grabs at the local level, even as it is, at a more global level, being further constrained within neoliberal visions. As part of the development matrix, medical practice is part of a complex vision of institutionality in rural India, encompassed in the Hindi term *sarkar*. Strictly speaking, *sarkar* is translated into English as “government.” But in North India its practical usage is more complex and contextual (see Guha 1983 for historical aspects of *sarkar*). It can refer specifically to the government of India and its agencies or more broadly to state and nonstate institutions or authority itself. *Sarkar* can be a form of address (most often heard in films, plays, television, and radio) signifying the authority of the addressee and lower status of the speaker and conveying an old-fashioned—sometimes ironic—tone of obsequious self-deprecation. In rural Uttar Pradesh the meanings of *sarkar* point to different valences of institutional authority and power. The term describes something concrete and constraining and also something ineffable and just beyond reach. It is possible to imagine “governmentality” as inherent to its authority—to use Michel Foucault’s term for the ways state forms of power are extended into everyday domains of life, practices that economize life at the level of self-regulation (Foucault 2000). It is also possible to sense in *sarkar* a magical power outside the range of technique, an inscrutable yet palpable essence that, as Michael Taussig suggests, links God, economy, and the state as “abstract entities we credit with Being, species of things awesome with life-force of their own, transcendent over mere mortals” (1997:1).

Or, the use of “*sarkar*” can be considered a moment of myth-making, a “type of speech” that, as Roland Barthes writes (1972:109), conveys taken-for-granted meanings. In myth, Barthes explains, a “concept can spread over a very large expanse of signifier;” likewise, *sarkar*—like development or medicine—extends into other forms of expression and domains of life. As with myth, medical authority provides means for transformation, even “distortion” (1972:121), of the socialities caught up in *sarkar*, forming a point of communication whose “fundamental character ... is to be appropriated” (1972:119).

The structure of formal health care delivery in rural Sitapur is a matter of vacillation between ideals and realities, in the context of global and national changes that have drained a state already “disinvested in health” (Rao 1999; Drèze and Sen 2002). According to Jean Drèze and Amartya Sen, health care in India is marked by low public expenditure, inefficient use of resources, and inequalities in access along lines of class, caste, region, and gender, within a “market system where diagnoses and drugs are treated much like any other commodity” (2002:202). In terms of change, they note the expansion of health services “in quantitative terms” amid “much evidence that their *quality* has deteriorated” (2002:205; see also Das 2002, 2003). These general observations are also true of rural Sitapur: although a skeleton of Primary Health Centres (PHCs) and Subcentres technically exist, “health centres are dilapidated, medicines are not available, doctors are chronically absent, and patients are routinely charged for services that are meant to be free (when they are treated at all)” (Drèze and Sen 2002:205–206). In Sitapur, private medical facilities are also available in larger towns, but their services are
considered by many to be too expensive and potentially threatening. Fear of the hegemonic power of institutional medicine resonates among women in low-caste and low-class communities and for Muslims, given a long history of sterilization and vaccination campaigns they consider (rightly or wrongly) to have been coercive and aimed at eradicating certain groups. As R. S. Khare argues, this broader situation, and what it suggests about transformations in economies and structures of health care, makes close attention to “practiced medicine” a matter of critical importance, particularly in the context of India, where medical systems, structures, and symbolics interweave (Khare 1996).

Yet state and private health services can hardly be considered absent, though they often appear as brief technological or educational “interventions” guided by NGOs. Formal institutional structures take on a range of recognizable forms that demonstrate that medical practice and education are linked components of development bearing a distinct temporal quality. Government programs have, over the decades since independence, placed various figures (such as Assistant Nurse Midwives and Community Health Workers) in rural communities to provide care and educate the public. These workers operate in ever changing capacities (as policy, funding, and government organization fluctuate) alongside more permanent institutions and the stop-and-start workings of NGO and state “schemes.” The line between governmental and nongovernmental agencies is often unclear, and the use of “sarkar” for both calls into question the distinction between them.

“Training” is a key modality of health programs. The state and NGOs train local women to act as institutional agents with responsibilities such as encouraging sterilization and distributing contraception. Similarly, TBA (traditional birth attendant) training is a staple of rural development. In these brief (usually six-day) encounters, village midwives are educated in safe delivery practices and made into representatives of institutions via symbolic objects such as kits and identity cards (Jordan 1993). Through training sessions and activities such as health camps, NGOs attempt to remedy the lacuna of reliable health care facilities in rural areas. In this context, the private health sector is relatively unmonitored (Drèze and Sen 2002:206), although various official programs take advantage of the informal, unregulated quality of medical practice to recruit and establish local networks.

Despite all of the failures, gaps, and “rollbacks” of the state, the spirit of development thrives in everyday encounters outside the range of formal structures through the work of persons we might regard as quacks. This spirit relies very much on the imagination of what institutions—and sarkar—are all about. English terms such as “uplift” and “improvement,” used locally alongside Hindi terms such as *vikas* (development), are part of the world and worldviews of self-made, quasi-institutional practitioners, persons whose work demands consideration of how local practices at once partake of shared imaginations of power and change while also critiquing them. Recent anthropological writing on the state in India has emphasized its everyday, imaginary, and local dimensions, countering homogenizing frameworks that distinguish governance from culture, subjectivity, and the domestic sphere. The state is represented in its immediacy rather than as a set of codes and entities distant from everyday life (Blom Hansen and Stepputat 2001;
Fuller and Bénéti 2001). Drawing on this orientation, I examine the boundaries of legitimacy and forms of authority and bodily practice at once interwoven with institutional models of care and posed in critical opposition to them. The activities of persons who are neither quacks nor doctors complicate the distinction between self and other that underlies the ethos of “uplift,” in particular the view that change comes from somewhere beyond the local. At the same time, they demonstrate that the power of development practices in part lies in the imagination that they do come from an elsewhere, the idea of externality in the face of evidence to the contrary. In what follows, I will trace sarkar and the imagination of institutions in rural India, asking what kinds of socialities emerge from this interplay of presence and lack, the real and the fake.

Pratima Srivastav and the Mishrein

“You must meet Mishrein. She knows so much.” Pushpadevi, a Dalit (formerly “untouchable”) mother of six, told me that while she herself could tell me some things about childbirth, there were certain things I could best learn from a doctor in the nearby village of Devia. Pushpadevi’s sister-in-law agreed with her that Mishrein would be the one “from whom [I] would get my information [jankari].” They looked at each other for a moment, then Pushpadevi leaned forward and said that a month ago Mishrein had “done some work” on her—given her an abortion. She needed to go back, she said; there were complications: “The baby fell, but the road is not clear.”

I was told about Mishrein on many occasions by women in Lalpur, the village where I lived (about 80 kilometers from the city of Lucknow) and in Devia. According to these accounts, she performed “ladies’ healing” (ladies ilaz), delivered babies, administered injections, gave abortions, and supplied medicine for “delayed periods” and to “make the dirtiness come out” (gandagi nikalvana) after a delivery. She and her husband ran a clinic out of the front room of their home.

When I asked Mishrein about her work, she said that her main practice was “deliveries.” She was called to homes when a birth was difficult or slow or to turn breech or transverse babies. Had she ever had training? I asked, using the English term that signified formal participation in a state or NGO program. “No,” she said, “I taught myself. But I also watched my husband, who is a doctor.” He too lacked formal training and certification but over years of practice had become a well-respected “doctor” and opened the clinic.

There was a similar figure in Devia, a woman named Pratima Srivastav. Pratima lived in a mud and brick house with her husband and an unmarried daughter and son. Her other daughters were married and in their husband’s homes (sasural) but returned to Devia in advanced stages of their pregnancies so she could deliver their babies. Pratima had begun “delivery and ladies’ healing” (delivery aur ladies ilaz) a decade ago when her children were grown. She was inspired by deep personal interest and by the urging of her husband, who was a certified doctor of naturopathy, an institutionalized form of nonallopathic medicine popular in India. He had attended a prestigious school of naturopathic medicine in eastern Uttar
Pradesh and for a time ran a clinic in a small city 15 kilometers from the village. Just as Mishrein learned her skills from her husband and perfected them through practice, Pratima learned about healing from books supplied by her husband.

In this region of India, home births take place through a categorical division of labor between delivery and postpartum work. The latter includes umbilical cord-cutting, massage, bathing the baby, disposing of the placenta, and cleaning the birth room, all tasks which most women will not perform, even if they deliver babies. Although the delivering of babies is performed by a range of women, often family members of the mother, postpartum work is done by women of “untouchable” communities locally designated for this labor. Although some postpartum workers may also become renowned for their skill in performing deliveries, in most cases delivery and postpartum work are done by different people and under different structures of labor and remuneration. Thus, in Sitapur, where the work of childbirth is generally handled by nonspecialists while specialized work takes place from the point of umbilical cord-cutting onward, it becomes difficult to talk in terms of “traditional midwifery,” though a clearly defined structure of birth-work exists.

But Pratima and Mishrein (both upper caste) regarded their work as operating in a different register from this system (which is dominated by lower-caste, Dalit, and Muslim women), although their personal relationships with both baby deliverers and postpartum workers (dais and dhanuks, respectively) were not antagonistic. Though neither used the terms “modern” or “traditional,” the scientific, educated, and institutional quality of their work set it apart from the tasks of women they considered uneducated and prone to “blind belief” (but experienced). Unlike dais and dhanuks who said they acquired their skills “from God” and through practice (or, “God put the work into my hands”), Pratima described her education as a process of book learning supplemented by practice. Though she denounced the way local women who deliver babies refuse to cut umbilical cords, Pratima did not interfere in the specialized postpartum work of dhanuks: “When I know someone will come to cut [the cord] I leave it, but if it’s the middle of the night, I do it.”

Over the years, Pratima’s renown as a “ladies’ doctor” had spread through Devia and beyond. These days, she told me, she might attend five deliveries in one week and then go through a dry spell with only one in a month. After several years of working in this capacity, she was identified by an NGO/state collaborative project for training as a Community-Based Distributor (CBD) of contraceptives. This project also identified and trained local TBAs (drawing on women identified as postpartum workers and those who delivered babies outside their own households). Though Pratima was a self-defined expert at deliveries, she was selected for the more authoritative, managerial—and paid—position of CBD.

Pratima introduced me to a number of reproductive practitioners in her village, both trained and untrained. I was fascinated and frustrated by the way these encounters became moments in which she enacted what I came to see as a familiar scene of authority. Though educating local women was not part of her responsibilities as CBD, she often played the role of trainer, saying, “Tell her what you learned in the training.” Or “Tell her what I taught you.” She coaxed with cues such as “Remember the Five Laws of Cleanliness.” Or “Tell her how you
measure the umbilical cord before you tie the string." In a conversation with two
baby deliverers I asked, "What work does the placenta do in the body?" While
they began a hesitant response, Pratima cut in: "They don't know this one. It is
the thing that feeds the baby." Then she shifted into a didactic register: "And you
must make sure it comes out right away, or else it becomes poisonous and can kill
the *jacca* [birthing mother]."

In addition to translating my questions into the speech protocols of training,
she interjected questions that mirrored those used by NGO workers to educate and
assess local conditions. These loaded questions were situated at points of praxis
that most concern the medical and public health establishment—pushing on the
stomach during labor, delivery of the placenta, cutting of the cord, and attending to
the stump. She asked postpartum workers how they cut cords and what substances
they use for cleaning (soap versus ash), and she asked baby deliverers how they
decide when to refer women to hospitals and whether they use massage to promote
delivery—all issues dealt with in training sessions.

I accompanied Pratima on several of her weekly visits to clients, when her
tasks as CBD (and the bureaucratic monitoring this role required)—afternoons
spent filling in columns in a ledger) blended with her local role as "ladies' doctor."
Carrying her bag from the NGO, she visited pregnant women and babies she
had recently delivered, and she checked women's bellies to assess how many
months pregnant they were or if they were pregnant at all. She entered unfamiliar
houses and chatted about children and family before remarking that she worked
for "sarkar," which had a new family planning program. She could make certain
measures available to them, she said, and the best one was sterilization (*operation*).
Attempting to dissuade women from rejecting birth control pills on the grounds
that the pills are "hot," Pratima did not dispute hot/cold etiology but said, "So
what's a little heat? Take it at night before you go to bed" (see Nichter 1980 on
"heat" and medical pluralism).

In several instances, Pratima introduced me as "an important doctor from
outside (bahar se)." I protested, saying, "No, no, I'm not. I'm a social scientist
writing a book about medical work (*daktri kam*) and midwifery (*dai ka kam*)."
Between houses, Pratima told me I should not contradict her. It was important that
"these people" think I was a doctor because it would "make them listen" to her, she
said; it would lend legitimacy to her message. It was not just my (false) identity
as a doctor that gave authority to Pratima's mission, but also my being from
"outside" (bahar). Signifying that the authorizing power of institutions comes,
by definition, from somewhere else, the term *bahar* when used in rural settings
denotes foreignness at many levels. In the context of health care, the authority
*bahar* implies is more important than the exact location of the "outside" it signifies.
One who comes from "outside" to reform or to educate bears a familiar sign of
enfranchisement and respectability but is also a locus of suspicion and threat. This
is not only an aspect of development, but is a long-standing theme in the popular
imagination, evident in literature, films, and television programs.

The use of Pratima's first name by men and women in Devia signified outsider
status, even while situating it locally. She was called by name because of her
affiliation with an authorizing structure beyond Devia—the NGO/state project. In
its training sessions and meetings local women were known by their first names, a practice which endowed them with an extravillage identity and, in the eyes of the NGO workers, modernized them. For a woman to be known by her first name in her sasural is radical, making her an outsider in a different way from the married women who are always, to some degree, outsiders in their husband’s home and village. Equally important, use of the first name signified Pratima’s rational refusal of “backward” causalities underlying women’s naming practices—primarily, a concern that harm can be done by using a name in anger or to cast spells. According to some NGO workers, rejection of these causal frames—blind beliefs (andha visvas)—allow women to participate in modernity.

Although it might be possible to imagine Pratima and Mishrein as quacks, few clients described them as such. Some referred to them as “raw” (kacca, implying unofficial), as opposed to the “cooked” (pakka, official or formal) nature of certified doctors, but few questioned their legitimacy. For many, their practice and self-made authority outweighed (or did not contradict) what might elsewhere appear as falsity. However, the implications of unofficial medicine differ across the social hierarchy in rural communities. Caste-Hindu women did not dwell on the fact that Pratima and Mishrein were fake (nakli); however, for the most marginalized women, the difference between real and fake was not only recognized but utilized. In particular, Dalits and Muslims—who fear that hospital needles might contain poison or that they might receive inadequate care or forced sterilizations while in the hospital—described kacca practitioners as offering a safer alternative. Abortions and injections outside of institutions, they felt, entailed less risk than those in official spaces.

From the perspective of institutions, Pratima’s and Mishrein’s self-made authority and quasi-institutional roles segued unproblematically into legitimate institutional membership. Although the Indian state possesses measures to regulate or prosecute such practitioners, in Sitapur the reverse is often true. Official institutions recruit and officialize them. Pratima was selected by the state-NGO program because of her role as an educated practitioner (even though that status was self-made). And others like her were pointed out to me by official institutional figures—doctors at primary health centers, as well as NGO workers—as beacons of development.

Mishrein and Pratima began their careers by occupying gaps in the fabric of legitimate health care in rural communities. Lacunae in the formal structure take the material form of hospitals with an imposing deadbolt locking the door four days out of seven or with a staff of doctors from Lucknow in attendance only on certain days of the week or private hospitals with fees that are too high. These gaps allow self-made practitioners to institutionalize themselves, to envision professional identities in an entrepreneurial fashion. Many large villages and towns in this region have just such a person, one who can muster whatever “training” has been made available to him or her and who can use his or her association (especially via kinship and marriage) with authorizing agencies (political leaders, legitimate hospitals) to offer his or her services in a medical frame. They range from those like Mishrein with no institutional links to retired ANMs (Auxiliary Nurse Midwives) who open uncertified clinics in their homes. What makes their practice
legitimate and even institution-like—that is, what makes them different from dais, trained or otherwise—is their ability to invoke outside authority and to position themselves in a frame of education and rationality, claims that are not refuted by legitimizing institutions. In this way, imagination becomes a social practice of the most immediate, intimate consequence (Appadurai 1996), and rural women are able to have babies with “doctors” attending, even when none are available, or to have medicalized births in their own homes.

These authorizing forces are as fluid as the practices they endow with meaning. As we shall see, they are based on something other than institutional recognition. For Pratima, having a foot in both worlds allows her to engage the idea of institutions by soliciting and performing the ideas her clients have of institutions and the authority they confer. For practitioners and clients, institutions operate as sites of desire and fear, spaces of not only imagined but real and accessible form of authority. The unquestioned validity of these practitioners demonstrates that, for many rural people, it does not so much matter where medicine and abortions come from, so long as they come in some form. For the most disenfranchised it matters greatly, making kacca (informal) legitimacy preferable to pakka (formal) power.

**Political Leaders and the Educational Mandate**

In Sitapur, I lived with an upper-caste Hindu family that had held significant landowning power over past generations. On weekend nights, the atmosphere in this household was charged with the social traces of this authority. Every Saturday evening Jawahar, one of four brothers, would return from his job on the outskirts of Lucknow. At about 7:30 p.m. the growl of his motorcycle could be heard at the turnoff from the main road, and a few minutes later he would ride into the yard. Several men would be waiting for him on the veranda. Jawahar would greet them and then duck through the doorway into the recesses of the house where someone would bring him a cup of tea. Sometimes he would linger in the courtyard with the women. More often, he would wash the dust from the road from his face, change his pants and button-down shirt for a sarong, and go outside to join the men.

He and his younger brother Raj would sit out late with an ever shifting group of men and a kerosene lamp throwing around them a starkly bounded sphere of light. Conversations would be, as often as not, didactic. Men would come with questions about law, bureaucratic procedures, and agricultural practices, and they would also come for advice on family and property disputes. They would come to listen to news from Lucknow, to what Jawahar would have to say about Uttar Pradesh politics and the styles and trends of the capital. On some occasions, Jawahar would bring newspaper articles; once he read aloud from a magazine about household remedies (gharelu ilaz) and natural (prakritik) alternatives to chemicals used as fertilizers, pesticides, herbicides, and cleansers. The men listened closely, asking for clarification and translation of chemical terms, arguing about the effects of various substances, and laughing when told that the burned residue of a plant could be used in place of chemical dyes to turn graying hair black.
When I asked the elder daughter-in-law why the men would gather every Saturday and Sunday night she laughed. “You think this is bad? You should have been here when Bapu-ji [Jawahar’s father] was alive. Men came in crowds—they came from other villages, day and night, to ask advice on this legal matter, to solve that dispute. Amma couldn’t eat until after he had eaten, so sometimes she waited half the night with an empty stomach.” Bapu-ji had been the political leader (pradhan) of the village for decades. As major landowners, his family had controlled labor patterns in the village for generations until land reform in the 1970s. Jawahar was not in the same position as his father—the official pradhan was now an elected man from a neighboring village (the panchayat [local, elected governing body] served three villages)—and, because Bapu-ji had sold much of the acreage that remained after the end of zamindari rule (i.e., the colonially enforced system of land patronage and taxation), the family no longer controlled agricultural production and work patterns in the village. Jawahar told me that the family had come down in the world in staggering ways over the course of a few decades, and they now struggled to make ends meet, using the income that he and his brothers brought in from their jobs as teachers and as a postmaster to send the children to private schools. But the symbolic signs of their higher status were still intact. As an educated resident of Lucknow and as the most authoritative son in this historically powerful family, Jawahar retained in some respects a similar position of authority that his father had occupied vis-à-vis the community.

As well as being a source of information and authority, Jawahar’s father had also practiced medicine, dispensing prescriptions, injections, and advice. His daughter-in-law told me that “medicine was Bapu-ji’s hobby;” he taught himself bits and pieces and gradually began to practice in the community. Although Jawahar did not practice medicine, he told me that he had taken on the responsibility for the general education and well-being of the community, bringing “a little bit of knowledge” to his village about “modern science and medicine” and the arcane workings of various bureaucratic machines. In remarkable circulations of cultural currencies, it was not exclusively or self-consciously “modern” knowledge that was shared but also a sense of the “traditions” of the rural hinterlands and their translation into a scientific idiom. Jawahar and Raj often explained “scientific reasons” behind various religious and ritual practices, thereby grounding apparently unmodern practices in systems of cause and effect (such as smearing cow dung onto walls and floors as “the Hindu Dettol”—a popular commercial antiseptic, as Raj put it). Likewise, “tradition,” in the form of knowledge about household remedies and “natural” alternatives newly codified and transmitted in magazines, was communicated to villagers both as a novel device and as part of a shared cultural heritage.

The current elected pradhan operated in similar fashion. As bearer of health to his constituency, he was called to homes to prescribe medication and give injections of tetanus toxoid, antibiotics, and synthetic oxytocin, which is a powerful drug used to stimulate uterine contractions. He also educated women in his community about cleanliness: “I tell them, ‘Don’t spread cow dung. Use Dettol, use bleach.’ Now they do this in my village” (cf. Raj’s assertion that cow dung is the “Hindu
Dettol.” He instructed local practitioners to use a “clean blade” instead of an iron sickle to cut umbilical cords, and he taught them that they must wash their hands before attending deliveries. These acts of education were his responsibility, he said, deriving from a desire to serve people, though he was not part of any official health scheme and had never received formal medical education. Rather, his role as political leader put him in a position to serve people by raising their standards of health. Unlike Bapu-ji, whose political authority predated his medical work, this pradhan had begun to practice medicine (daktri) before he entered politics; it had, in fact, been part of his path to authority, creating a relationship with the public from which a political career could be built. The following dialogue illustrates these intersecting trajectories of authority:

Sarah: How did you learn [to give injections]?  
Pradhan: [Holding up his hands to indicate he learned by experience] I was doing my education. I have a B.A. I thought, “I will serve the people.” So I sat in the company of doctors. I learned compounding and then I got the knowledge for how to do injections. Slowly, I began to do the curing for my own family. After this, when people knew “he practices daktri,” patients began to come regularly. Meaning, a relationship with the public was formed. Today, after 20 years I have slowly become experienced. ... I have also read a lot of books. I got information from them as well, what kind of medicine to give for what, what kinds of symptoms there are. Up to now I have never had a patient expire and every patient has benefited [from my treatments]. One woman had a lot of problems when the baby was born. There were so many problems, so I said, come on, let’s go see. I arrived. She was in position. I asked the dai if the baby was straight or in some kind of wrong position. Because if the baby is transverse and you give the oxytocin, the womb can rupture. But the baby was in the right position. I gave the injection and the cervix opened.

S: Can you see if the baby is in the right position or not?  
P: No. These dais, or some woman of the village, they see if the baby is right or transverse. This is not work for gents. I have done about fifty cases. And to this day I give the TTS injection so babies don’t get tetanus. People believe in me....In 1978 or 1979 I got my B.A. After this I felt I would not seek employment, I would serve the people. Consider me a social worker. Then I came into the pradhan line. I got everyone’s cooperation. The people have made me pradhan up to this day. I ran in the first election in 1988, since then I am the permanent pradhan!

Through the interpenetration of medical and political practice, a larger mode of authority is created around social and moral mandates. The knowledge and legitimacy to follow through on those mandates is self-granted, part of ongoing imaginations of identity in relation to legitimizing institutional structures.

Parrots and Mynahs

On the one hand, the pradhan’s development as medical practitioner, like Pratima’s, mirrors the ways local birth experts gain renown—by working within their own families and then gradually, as their reputation grows, beginning to do deliveries in other households. On the other hand, the educational displays of Jawahar, the pradhan, and Bapu-ji are similar in shape and feel to formal training sessions that are a part of NGO and government programs. In taking up an ethos
of improvement they engage a pedagogical mandate in which those in positions of authority also bear a responsibility to serve by educating. Everyday conversations are transformed into didactic encounters, and verandas and courtyards become routinized spaces for transmitting knowledge and performing authority through familiar ways of communicating. While this may involve positioning oneself as a site of authority on institutional matters broadly defined, it can also involve particular ways of communicating—speaking for longer periods of time, shifting into a register of commands and rhetorical questions, or explicitly saying that the listener does not know a certain fact that the speaker will then explain to them. Where health care and bodily practices are concerned, this shift requires situating talk around the same set of discursive figures with which health institutions are concerned, ideas that tend to focus on reproduction: hygiene, vaccinations, family size, and certain practices specific to birth.

A politics of talk is shared by institutional and everyday ways of communicating, through which hierarchies are performed by management of who gets to speak and patterns of exchange. In institutions, these protocols of speech and time are more strictly regulated and recognizable. But as sites for authority overlap, quasi-institutional practitioners can switch back and forth from institutional to noninstitutional identities with a slight shift in language. Patterns of talk allow less-structured conversations to shift into the register of education, even when the conversation has not been overtly designated as a site for learning. The pradhan can, in a chance meeting with an elderly birth-worker, mention that she should use bleach instead of cow dung in her cleaning up duties. During a rambling conversation with village men, Jawahar can read from a magazine brought from the city. Through regulated speech, any place can become institutional, as authoritative—and global—discourses merge with everyday hierarchical relationships.

Because it relies so heavily on training, the enterprise of rural development revolves around talk. This is particularly true in cases when development is concerned with management of the reproductive body and seeks the self-transformation of individuals. The motto of an official family-planning scheme active in this region was “Come and talk” (Ao bate karein). These words were emblazoned on the bags carried by village workers, on banners at rallies, and on ledgers in which records were kept. The program logo showed a parrot and a mynah bird perched on a tree branch talking face-to-face. As I was told by a local supervisor, these creatures were chosen to represent the program because, as two kinds of bird coming together to chat on a tree branch, they are communicating across their differences.

Where development and health care institutions are concerned, the performance of power via talk can, as some NGO workers observed to me, become a pathology. Exaggerated versions of hierarchized talk play out in the space of institutional practice, in interactions between authorities and trainees or recipients, but not in policy discourse and institutional self-representation where hierarchies are often downplayed through assertion of a “participatory approach.” To illustrate, I will describe two instances.

The first example comes from a follow-up meeting at a Lucknow-based NGO, to which nine women trained to serve as Village Health Workers had made long journeys from their communities for “retraining” by a medical doctor. The doctor
introduced the session by joking, “We did not bring you here to listen to me talk. This is a place where you can talk about your problems in the field and share your experiences with each other.” She asked each participant to describe her work and any problems she had encountered. The second woman was midway through her story when the doctor cut in. The doctor then spoke continuously for the next hour and fifteen minutes, going through the agenda of the retraining without acknowledging the tentatively raised hands. After this long discourse, she elicited questions (interrupting the women as they asked them) but never returned to the initial “sharing.” The pattern continued until tea was brought and the meeting was over (at which point the doctor leaned over to talk with me). Later, the NGO director told me he had witnessed similar interactions in field settings with other authority figures. He found this dynamic disturbing but was unsure how to fix it.

The second example comes from another level of development practice, a conference in Delhi on maternal mortality, attended by NGO directors, researchers, policymakers, doctors, and nurses. On one panel, two TBAs from western India were scheduled to speak about their experiences with NGOs. They were placed before the audience not only as successful trainees and active participants in NGO activities in their communities but also because they were vivid embodiments of tradition, and one of the aims of the conference was to celebrate successful efforts to blend “traditional practice” together with “modern science.”

The dais were led onto the stage, where they sat, somewhat awkwardly, at a table with microphones and waited to be told when to speak. The first seemed eager to talk and, when given the go-ahead, described her life and interactions with the NGO. But shortly, a woman in the audience stood and signaled she would like to ask a question. “What I would like to know, Mona, and we are so glad you are here . . . what I would like to know is if you could tell us how you cut the umbilical cord. Do you use a clean blade? How do you measure where to tie the string?” She nodded and gestured to the podium in encouragement. The NGO director nodded supportively at Mona, who looked a bit confused. Mona gave a brief explanation of how she cuts umbilical cords using a “fresh blade.” But soon she was interrupted: “And do you wash your hands? Do you know the Five Cleans?”

The quizzing went on like this through a few exchanges, in which Mona was encouragingly but condescendingly tested on the nature of her practice. As I waited for someone to suggest that Mona be allowed to continue with her story, another woman stood up. “Tell us what kinds of symptoms you see that make you take a woman to the hospital.” When Mona responded correctly, the first questioner smiled and motioned to the audience that we should applaud. “We wholeheartedly support these extraordinary individuals for the learning they have done,” she said. Mona’s own narrative was abandoned, as there was no space for discourse outside the range of “learning” and “receiving” for those in the position of “trainee” and “traditional.” This dynamic echoes a larger theme of the Women in Development (WID) movement, in which tradition operates as an ahistorical “symptom” of female subordination and therefore a hindrance to development (Apffel-Marglin and Simon 1994:32), even in cases where what is deemed “traditional” is also praised on other grounds (Pinto 2003). Regardless of inclusive intentions, when put into practice the categories that development employs become part of the
ways people imagine themselves and their social relations (Pigg 1992:507). Labels such as “traditional” not only reduce sociocultural diversity to a generic category of backwardness (Pigg 1992:504), but they construct a social map that orients everyday encounters (Pigg 1992:492).

These two (somewhat extreme) examples shed light on the power dynamics embedded in structures of training, in which patterns of communication institute hierarchies and remind those involved where they stand in relation to others. In institutional sites as in personal conversations, talk is a site for expressing and performing authority. Unidirectional talk and fulfillment of the educational mandate are enunciations of authority through which subalterns attempting to adopt certain modes of talk are reminded of where power truly lies. Like the frustrated NGO director in Lucknow, there are many trainers, doctors, and administrators who let their interlocutors speak and ask questions, who listen attentively and elicit responses. Such men and women voiced exasperation to me that they or their trainees were silenced by the talk of their superiors. But such critical thoughts were not so readily voiced by those in the position of client or trainee. Either such dynamics were naturalized so as to offer no subject-position from which to voice dissent or the risks of speaking critically were too great.

To return to the pradhan, Jawahar, and Bapu-ji, “uplift” unfolds within and outside of institutions as multiple performances of authority through mimetic speech. Familiar modes of talk allow practitioners to tap into the legitimacy of development and health care institutions; they permit people to partake in institutional authority through a currency of legitimizing signs (Taussig 1992). In these “rehearsals” of power, as in the summoning of the powers of the dead, “What happens...is...an obsession with the rehearsal itself, as if by such means an abstracted authority or meta-authority could be siphoned off” (Taussig 1997:77).

Roland Barthes has written, “For while I don’t know whether, as the saying goes, ‘things which are repeated are pleasing,’ my belief is that they are significant” (1972:12). Undoubtedly, in this case things repeated are both pleasing (for some) and significant. For Jawahar, quasi-institutional authority—while also a burden that kept him from his wife and dinner—was visibly pleasurable, as he sat on a small mat warming his feet near a fire of dried leaves, caressing the lump of betel in his cheek. Other sites of desire might include the pleasure of talking authoritatively, giving advice, being called upon to administer a treatment, performing a service (seva), executing social mandates (Žiţek1997:51), or being part of something larger than oneself, something that confers legitimacy. This is the pleasure of “becoming an identifiable and legible word in a social language, of being inscribed in a symbolic order that has neither owner nor author” (de Certeau 1984:140).

The mimetic acts of development that enable persons to become recognizable within an “anonymous text” bespeak the magical power of institutions to endow authority, to enable those beyond their official realm to draw from a well of legitimacy and become institutional. In the context of childbirth education, it has been suggested that education is the site for the transmission of legitimacy via communication of biomedical knowledge and the transformation of women into “modern pregnant subjects” (Ketler 2000:142). But in these cases, education does not necessarily
confer legitimacy or transform subjects into legitimate modern ones. Rather, it provides a site for enacting authority; the *performance* of education accomplishes a transformation of subjects. The law—in this case, the legitimizing rules of development—is “grounded only in its own act of enunciation” (Žižek 1997:78).

But who is transformed? Less the subaltern men and women who “learn” from these figures and become and remain “trainees” than educators themselves, who become agents of authority and participants in development. This transformation cannot come from nowhere, however, for while mimetic acts bestow legitimacy, they also require that legitimacy already exists. The pradhan could best serve in this capacity because he already had power and authority through the institutions of democracy, land-ownership, and high-caste status. At the same time, he explained, it was the authority of medical practice that set him on a political path.

Mimesis occurs at several levels and in several directions. When everyday people mimic the patterns of training sessions to engage their forms of authority, they pattern themselves on institutions that are themselves inherently mimetic (Langford 1999). The halls of biomedical and development institutions are also sites of mimesis through patterns of talk and performances of authority. In the case of agencies actively involved in reproductive health in rural Uttar Pradesh, key icons drive home this fact of training and illustrate the mutuality of mimesis: there is no original songbird, but two inherently mimetic birds chirping back and forth, mimicking and transforming and mimicking again across a divide of essentialized difference. Local people mimic the speech of formal trainings. And, in spite of assertions to the contrary (“come and talk,” “we have a participatory approach”), institutions such as NGOs mimic patterns of talk of everyday people in everyday encounters, in which hierarchy is performed through economies of speech, in which the powerful speak and subordinates listen.

“Visiting doctors,” or trainers brought in for a few days or NGO workers who live for part of the week in “the field” and the other part at home in the city, appear like iconic outsiders familiar on the Indian educational and political landscape or, like Pratima, come to appear so through the performance of authoritative speech. At the same time, the practices of institutional training closely resemble the patterns and projects of knowledge control and dissemination characteristic of rural patterns of authority and older systems of governance and power. To be sure, the way Bapu-ji was sought for information and authority predated the presence of institutional training in Sitapur. According to his family, his practice of administering injections did not predate those trainings but remained on a continuum of similar acts that were the perquisites of authority. His household was chosen as the site for a government hand pump and the post office (both in the outer yard but behind a wall and gate that were locked at night) and a program (now defunct) to supply oral rehydration salts. These activities demonstrated that certain kinds of power trump institutional boundaries—such as walls and gates—and obscure distinctions between real and ersatz medical practice.

When there is no source or origin for mimesis, development practices are shown to hinge less on contests of knowledge than on a series of performances, rehearsed acts with immediate recognizability regardless of the knowledge they convey or contest. Stephen Marglin (1990) understands development processes by
way of a distinction between *episteme* and *techne*—that is, between universalized, formal knowledge systems and practical knowledge or practice itself. He argues that these categories of knowledge are universal, as are the conflicts they produce. Frederique Apffel-Marglin challenges this view, arguing that epistemic ways of knowing arise from a Western European historical and cultural context (1996). The suggestion of their universal applicability, she asserts, is imbricated with contests of power and, in particular, colonial domination. Thinking about people like the pradhan leads me to suggest that the architecture of “uplift” at once institutes a distinction between episteme and technē, and at the same time stakes a claim to episteme, leaving technē for the “traditional” others upon whom will be delegated the project of teaching epistemic knowledge. Thus, the idea that development practices are primarily contests of knowledge is true insofar as knowledge is part of the way development *practices* take shape and part of the way ideologies and structures of “improvement” are imagined. But quasi-institutional practitioners and everyday encounters show that development is itself a technē, a series of local acts.

Just as medicine in the postcolonial world is situated at a tension between the universality and particularity of scientific practice, so too does it live in a space between neutrality and power. This is as much a matter of process—the ways by which science and medicine become authoritative—as it is of episteme. As Gyan Prakash writes of colonial science, “On the one hand, science was projected as a universal sign of modernity and progress, unaffected by its historical and cultural locations; on the other hand, science could establish its universality only in its particular history as imperial knowledge” (1999:71). Although it is through this projection of medicine as a universal sign that medicine is able to command authority, the opposite is also true when it comes to everyday mingling of medical practice and power: to gain access to universal realities (and their legitimizing force), one must already be in a position of recognized authority.

**Injecting Power**

To pursue the power dynamics that make the ersatz both legitimate and necessary, I turn to another act through which legitimacy is borrowed from institutions: giving injections. In the rural homes in which men and women practice as “doctors,” giving injections is a way to demonstrate technical ability, biomedical knowledge, and access to institutions. This is especially true during childbirth, for which the use of injectable oxytocin to stimulate labor is delinked from (official) hospitals and clinics through its widespread availability from rural pharmacists. In hospitals, oxytocin is most commonly administered intravenously (although in some rural hospitals it may also be given by injection). When administered improperly, it may cause the uterus to rupture. Although needles and drugs are available to anyone who can pay for them, individuals who are institutionally sanctioned and trained to administer such drugs are notably *un*available to the rural poor, and thus giving injections is a key means by which people carve out niches as medical practitioners. Although injection giving is more often performed by men than by women, many women have also taken up this practice. I have mentioned
that Bapu-ji and the pradhan were called upon to administer oxytocin (Bapu-ji injected his daughters-in-law during their births in his home). Although Pratima did not give injections, Mishrein did, as did practitioners in nearby villages. Several ANMs, though they were not supposed to give oxytocin, did so and some ANMs' opened clinics after their retirement from government posts.

Other kinds of injections, primarily tetanus toxoid and antibiotics, are also administered by village practitioners. However, while the deinstitutionalized use of these medicines is seldom rendered a social problem, the unregulated use of oxytocin by injection has become a scandal in urban centers as a marker of the chaos of rural ways in locales that are thereby represented as beyond the reach of law and rationality. For this reason, there is a careful politics of revelation in the ways practitioners spoke of this practice. An upper-caste wife of a political leader—a former ANM with a clinic in her home in which, according to local women, she gave oxytocin—denied this practice, suggesting it was dangerous and unscrupulous. In contrast, Bapu-ji’s family considered this activity part of his service to the community, and the pradhan enacted a critical turning of scandal back onto institutions:

Doctors take plenty of money [for injections]. This ANM, she takes 500 rupees. Hey! What's a needle? Fifty rupees. Meaning, it's her job! I think that [it should be reimbursed] according to one's abilities, that if a person is in a weak condition, meaning they can only give ten rupees, then... But [it should be from a] good company. Here people give the one for animals. Antocin. To make the buffalo milk come in. This is wrong. But I do the right kind of work [sahi kam]. Here people take 100 rupees for an 80-rupee injection. Society's well-wishers [sarcastically].

The pradhan's “right work” is, according to him, an antidote for corruption and faulty science. Not only does he repeat institutional practices, but by deriving power through mimesis of key acts, he offers a corrective to what he sees to be improper and immoral institutional functioning. Several articles “exposing” the practice of oxytocin injecting in Sitapur appeared in the newspaper during my stay. One particularly vitriolic article was headlined, “Daais-in-hurry inject death to rural women” (Mishra 2001). It began with a story of a “23-year-old illiterate housewife” from “a small hamlet in Sitapur.” She received a hysterectomy at a hospital after being administered an incorrect dose of oxytocin (the article does not say by whom). The headline turns a common critique of biomedical handling of birth (that doctors are too hasty in giving drugs to speed up labor) onto arguably disempowered rural, mostly low-caste and elderly women. Mapping rationality in terms of space, time, and governance, the article quotes a doctor as saying, “That something so preposterous could be happening in modern times at a place barely 100 km from the capital makes it all the more scandalous.” Although the article places much of the blame upon daais, it also states, “The culprit in almost all cases is the wrongly administered oxytocin injection given by either the auxiliary midwife-nurses (ANM) or the local daais.” However, in the concluding section of the article, attention returns to the original case of the “illiterate housewife;” in which, as it turns out, her oxytocin was administered by an ANM. Whereas much is made of “daais-in-hurry,” nothing is said...
about the regulation or surveillance of government employees. Indeed, whenever ANMs are mentioned, attention shifts elsewhere—to dais and rural women “too poor and ignorant to lodge a formal complaint.”

If the administering of injections is controlled by persons in positions of authority even as it remains scandalous in some quarters, to what extent is it deinstitutionalized? In public health and popular media, those not in positions of power (dais, rural women) are blamed for this practice. However, those who control the informal economy of needles are educated people in positions of power defined by political status, caste, and landownership. Or they are associated with institutions, either as government employees, or by virtue of their having received training, or by establishing institutional identities of their own. Although some dais may give injections, it is important to note that they are not alone. Impugning their practice alone obscures the shared dynamics of power that ground quasi-institutional and medically mimetic practices. Placing the burden of scandal upon them reminds us that certain figures must always remain “the problem.” The needle, like certain kinds of talk, provides entry into legitimizing structures for those who administer it and a social map for those who are scandalized by it. For those who receive it, it injects power into the body, establishing another site in which those in positions of authority perform hierarchy and borrow from the legitimacy of institutional forms—the work of doctors and the stuff of hospitals.

While quasi-institutional authority through talk requires locating certain subjects always in the position of trainee (or recipient), the practice of giving injections shifts the conversation to the body. Legitimacy and power take shape through embodied exchange, as well as through a metaconversation about who does and does not give injections as well as who does and does not receive them. In other words, it is not through the bastardizing of legitimate practice that social hierarchies emerge. Rather, hierarchy is reasserted through the very crafting of legitimacy. What remains to be asked is not just how and on what basis legitimacy is made but in opposition to whom is it crafted? Whom do its framings exclude?

Institutional Letdowns

My final story of sarkar considers a single person, Preethi, and a series of failures—in this case, failures to enter legitimate, seemingly egalitarian structures. Preethi lived in Lalpur and was of the “untouchable” and stigmatized Pasi community, a group or caste locally stereotyped for what were imagined to be dirty and transgressive ways. When I met Preethi she was just beginning to serve as a Community Based Distributor (CBD), the same post held by Pratima. During our first encounter, she hovered in my doorway, making confusing small talk and drawing attention to her role of CBD by carefully exposing the NGO satchel hanging from her shoulder. She had taken on this job when the original worker, a young woman of an upper-caste family, was convinced to quit on grounds that this was inappropriate work for an unmarried girl. As she had undergone training separately from the other women in her group, who were monitored and assisted by a single supervisor, Preethi came into the structure as already an outsider.
She was stigmatized in other ways as well. Men of her family had been arrested for a murder and robbery in a nearby town. Women gossiped that she was a prostitute for police officers in a nearby station; the fact that she had divorced her first husband and was now in a second marriage only seemed to verify rumors of her sexual escapades. For many village women, her reputation as a loose woman (as one woman described her, one who “changes husbands the way some women change blouses”) was underscored by her participation in the family planning project and other institutional schemes that had come down the road. Her current work required her to move from house to house and village to village, beyond the spheres of both her natal village (maike) and her marital village (sasural), and beyond the acceptable movements between home, bazaar, and temple. According to one woman, “She should walk with purpose and intention directly to her destination. Instead, she stops in the road to talk to people; she goes slowly; she lingers here and there.” Women in my house teased me about my “new friend” and wrinkled their noses when they heard I had been at her house. They warned that I should not let her into my room, as she might be eyeing my possessions to plot a theft. The caste of which Preethi was a member was, as a whole, associated with criminality and promiscuity.

A few years earlier, a self-improvement banking scheme had been introduced in the village. The committee of local officials (nine men and Preethi) met in the outer yard of my household in the evenings. Village women did not let this fact go unnoticed. “Picture this,” one said, “She sat out in the yard with all those men and her—nine men and ‘Madam.’” Eventually Preethi left the committee, but her family continued to commemorate her participation by including in their yearly Karva Chauth painting a man in a suit, carrying a briefcase.

As CBD she attempted to garner new clients by going house-to-house in neighboring villages. With stigmas of sexuality and thievery attached to her name, it was no surprise that Preethi had difficulty in acquiring clients. Most were from her own neighborhood. Other CBDs in her group spoke disparagingly of her, as did the local ANM. “Who will let her into their house when they know she will be laying her eye on everything?” Pasis are known to be thieves, the local ANM agreed, and she could not understand why the NGO had trained her. The NGO supervisor shushed them but also agreed that “her work is strange.” At meetings at the NGO field office, Preethi was publicly chastised by the field director for not having enough clients and failing to work hard enough to get them. He threatened expulsion from NGO work if she did not have better results by the next month and set her as a negative example for other CBDs. Underscoring these failures, Preethi was sarcastically referred to as “Madam” by many non-Pasi women and children in the village. This practice made a mockery of her attempts to acquire social legitimacy through institutional structures, reminding her that for her obtaining authority—the ability to be called “Madam” in seriousness—would remain out of reach.

Not long after the arrests of men from her family, Preethi came by to confer with Jawahar. Her distress was evident in the tears welling up in her eyes and the way she grabbed my hand with a painful grip as she explained her situation. “People are talking. They are saying it was my husband who did these things; they
are damaging our name. I am worried about this infamy.” She told me that rumors about her husband were untrue, but because the arrested men were his brothers their crime had damaged her own reputation. “How am I supposed to carry out my work under these conditions? Bhaiya [Jawahar] will offer relief, he will have something to say.” But Jawahar, who professed to being less caste-ist than his brother, was in Lucknow. So Preethi told Jawahar’s brother Sunderlal what she had told me. Without giving concrete advice, he assured, “Everything will be okay.” Then he turned to me and laughed, “Her whole family are thieves, they are *thieves*!” But Preethi seemed satisfied and left the courtyard. Outside, she told me that in the evenings she took walks to clear her mind. She had headaches, she said, from the tension, and sometimes she needed to leave the atmosphere in her house to walk on the paths through the fields. This kind of activity was not one any self-respecting women did alone, or even in groups, in the case of the upper-caste women in my household who were bound by strict adherence to the rules of purdah.

A few evenings later I walked into the outer yard, where some men were discussing local elections. Preethi was seated just beyond the edge of the circle. She leaned forward on her chair, as though she might be straining to hear, her social position underscored by her location just beyond the range of lamplight.

**Imagination and Institutional Authority**

What is it about medical and development practices—especially those related to reproduction—that allows them to be transmitted outside formal institutional structures but only to certain persons? The situations I have described suggest that it is at once the structures and techniques of institutions (their mimetic quality), the quality of development as an ethos (in which medicine is both pedagogical and technical), and the gendering and moral weight of things associated with fertility that allows these practices to retain validity outside their legitimated sites.

The articulation of medical practice and political authority has a long history in India. In the colonially encouraged *zamindari* system of land-ownership, patronage, and taxation prevalent in this part of Uttar Pradesh, the responsibility of indigenous landowners for the well-being of their subjects was encouraged by colonial authorities and this often took the form of sponsorship of hospitals and other health care institutions (Pati and Harrison 2001). Imperial medicine articulated with power more generally and was “integral to colonialism’s political concerns, its economic interests, and its cultural preoccupations” (Arnold 1993:8). This self-consciousness of medicine as science was a source of its power, a mechanism by which colonial intervention was authorized and distinctions were enforced between colonizers and indigenous people (Arnold 1993:18).

Like their historical predecessors, the practices described in this article highlight the fluidity of institutional authority as a site of imagination and practice. These structures of knowledge confer legitimacy in ersatz ways that both affirm and rebuke the authority of institutions. While they disseminate the ethos of development, their illegitimacy draws attention to failures of state health structures. As such, this form of biopower operates alongside other sites of (more legitimate) governance, engaging surface qualities and tropes and tapping into near
magical authority, but without the concern for surveillance that often characterizes biopower (especially in rural India, see Gupta 2001).

Michel Foucault’s concept of governmentality describes a dispersed form of governance, regulation, and surveillance, the means by which disciplinary power is extended into everyday life and socialities (2000). With the regulation of life (biopower) as its primary modality, governmentality functions by transforming subjects and by opening up an intimate domain for policing the self. As Akhil Gupta argues, in this concept “Foucault is interested in mechanisms of government that are found within state institutions and outside them, that in fact cut across domains that one would regard as separate: the state, civil society, the family, down to the intimate details of what we would regard as personal life” (2001:111). Governmentality takes on particular meaning and urgency in the case of health care in India. In recent work on medical services in Delhi, Veena Das (2002, 2003) focuses on a particular aspect of governmentality: exclusion. Noting that the use of biomedical services is high among the urban poor while the quality of care is notably low, Das traces the shape of exclusion as an aspect of the forms of biopower emergent from national and global demands and constraints on health care (2002).

Quacks are an integral part of this process, even as they aim their work toward service (seva) to fill the gaps left by legitimate institutions. Two issues are important to consider: the means by which quasi-institutional practitioners acquire legitimacy and the global and national conditions that make such work necessary, inevitable, and exclusionary. Borrowing legitimacy through the back door, so to speak, from institutions, quasi-institutional practitioners engage in repeated moments of myth-making in the sense Roland Barthes described—as a moment of communication (1972:25). What lends these acts potency is their “intelligibility,” their familiarity (Barthes 1972:25). But also granting a mythical air is their frozen quality—when speech “turns away and assumes the look of a generality: it stiffens, it makes itself look neutral and innocent” (Barthes 1972:125). In other words, because claims to knowledge and legitimacy are made at seemingly natural points of authorization, and as part of the production of a familiar form of neutrality, they are not undermined by their inventedness.

In her description of a spurious Ayurvedic practitioner in New Delhi, Jean M. Langford argues that through a series of legitimizing practices the “fake” practitioner reveals the inherently mimetic qualities of biomedicine, “troubling the binary of truth and falsehood that is a foundation of scientific knowledge” (1999:24). Following Homi Bhabha’s (1994) writing on mimesis and parody in postcolonial literature, Langford suggests that mimesis enacts a (sometimes subtle) parody of the original, while also engaging “legitimating signs” (1999:33), disrupting colonial projects by emptying them of meaning. What might be interpreted as hybridity in the case of Ayurvedic quacks is “actually a particular moment in an ongoing intercultural mimetic and countermimetic reverberation” (Langford 1999:33).

But for all their imitation, the work of Sitapur’s quacks is subtly different from that described by Langford in that, rather than (or more than) parodying the original, this ersatz medical practice is part of the very fabric of legitimacy,
integral to the survival of “development” in rural areas—and, indeed, to survival itself. While they may at times mock development, such practices also enable development to remain a naturalized zone in the rural imagination. According to Barthes (1972), it is the appearance of neutrality (in other words, at once the claim to neutrality and the falsity of that claim) which determines who may and may not partake of a myth. Preethi’s failures demonstrate that while the source of legitimacy lies in this neutrality, there are many underlying contingencies and partialities. These are perhaps the very things from which mythical speech “turns away”—long-standing symbolics of “uplift” that designate who may partake of authority and upon whom authority is imposed as the condition of its existence.

Preethi’s story might suggest that the legitimacy of development practice is indeed available to all, provided that “nonmodern” peoples abandon their prejudices (in this case, caste-ism). But the complex and very modern stigmas of caste demonstrate that certain prejudices are integral to the amalgam of education and health care that is development. The imagination of development itself requires that certain persons remain in the category of recipients, and thus they cannot be purveyors of the magic (Escobar 1995; Pigg 1992, 1997). Those, against whom the educated and rational self is defined, must present themselves as always in the realm of the uneducated (even if with an occasional wink). While Preethi was undeniably stigmatized by her community, her treatment within institutional structures was also demeaning on the same, though subtly transformed, basis as her community’s prejudices. In such engagements, “untouchability” is effaced as an overt category and replaced with notions of immorality, laziness, criminality, and ignorance (borne out of a lack of education), or it slips into the discourse on hygiene. The effect of such institutional practices (and their ersatz correlates) is that caste- and class-based forms of discrimination are performed in a context that erases caste (and sometimes class) as explicit signifiers.

Medical interventions may depoliticize social problems by offering technical solutions (Ferguson 1994), but their use as a point of reference is often in the service of political relations. Rayna Rapp (1988) suggests that “communication” does not always suffice to promote changes in behavior, especially when there is a difference in power between health care personnel and clients. Likewise, Cecilia Van Hollen (2003) argues that in Tamil Nadu the symbolic content of health-related messages is less important than the social hierarchies such messages reassert. In Sitapur, while both observations are true, communication (training or talk) also resituate power relationships (such as those based on caste or land-ownership) on new ground that is ostensibly free of power. This shift transforms hierarchical relationships into a narrative in which progress is constituted on the basis of ideals of equality and availability to all.

Should the wrong people attempt to carry off mimesis, their failures reveal inconsistencies that are, at their strongest, articles of bad faith. The first of these deceits is the idea that universal knowledge (of medicine and development) precedes power and legitimacy, and that power (economic, political, self-mastery) and authority in a modernizing world come from correct understanding instead
of being mutually constitutive (Dirks 1994). In these cases, the performance of correct understanding as legitimizing, and natural truth is what constitutes power. The second set of deceits concerns the bundling of education and equality. This includes the notions that medicine and development embrace a politics that is separate from the interests of particular groups or individuals, as is asserted in global health policy (Adams 1998); that the legitimacy of development is available to all who enter into certain universalized ways of knowing by participation in authorizing structures; and that universal knowledge manifests itself in the same way and is equally available to all who seek it out. These deceits are cousins of the bad faith underlying the colonial venture, in which performance of Enlightenment-based political models in the service of colonial rule reveals the instability of those models at their source (Bhabha 1994; Prakash 1999). Or, the matter of hidden contradictions can be seen as a problem inherent to ideologies more generally, such that the “materialization of ideology” reveals “antagonisms” that “the explicit formulation of ideology cannot afford to acknowledge” (Žižek 1997:4). Either way, in Sitapur, when models of equality based on education, medicine, and “uplift” are put into practice, equality for all is precluded and what remains is equality for some.

Particular to public health, there is a tension between universal availability and emphasis on a single population, a tension we might see as being expressed in these moments of bad faith. On the one hand, it could be suggested that references to equality and universality are ultimately only teleological, as health care development is, like social medicine, explicitly (not just from the perspective of its critics) about the welfare of a certain class of people—the poor—rather than aimed at all classes. But on the other hand, missionary medicine in the late 19th century created inroads into local communities precisely because of its claims of availability for all (Fitzgerald 2001:113). The “penetrating power” of medicine into all levels of society enabled it to be part of the matrix of a colonial hegemony that was integral to the assertion of European superiority over indigenous populations (Arnold 1993).

Ultimately, regardless of their general or specific intent, development and institutional programs are always negotiated in terms of local political relations (Adams 1998; Ferguson 1994). But the everyday practices of those on the margins of institutions demand that we shift attention away from the separation of local politics from institutional ones. On the one hand, these practices suggest, at least for this part of India, a complicity of institutional forms of legitimacy with the hierarchies of political power, control over resources, and symbolic stigmatization that characterize so much of rural life. But on the other hand, the fact that these are the practices to which many turn for health care shows that familiarity is part of the power of ersatz medicine. What disappears is a distinction between center and periphery as the breach between a home ground of modernity and its points of insertion. Quasi-institutional practitioners are not “merely” mimetic or even “quasi” to development. They are part of the grand, inspiring, and desire-provoking myth that is social improvement, mythical in the sense Roland Barthes intended—not as a falsehood, but as a narrative site of power that has become naturalized as real and inevitable. The mimetic performance is part of the original—perhaps
the very part that keeps it going in spaces from which it always threatens to disappear.

Notes

Acknowledgments. Research for this article was funded by an International Dissertation Research Fellowship from the Social Science Research Council (2001). I am grateful for the assistance in India of Anindita Baidya, Deepak Singh, Naval Pant, Tony Castleman, Ram Advani, and Manoj Srivastav. A number of people provided insight, advice, and thoughtful readings of this article: João Biehl, Isabelle Clark-Deces, Emily Martin, James Boon, Carol Greenhouse, Susanna Trnka, Rachel Newcomb, Kenneth Croes, Kavita Misra, Ramnarayan Rawat, Craig Jeffrey, Janet Chawla, and Kanwarjit Chawla.

1. Imrana Qadeer notes that in recent years a series of UN conferences placed “a moratorium...on any debate on the nature and direction of development...[such that] issues of health and population had to be debated in the overall framework of structural adjustment” (2001:121).

2. An underreported aspect of health care in both state and private institutions is the abuse—physical and verbal—that many women fear and experience at the hands of doctors, nurses, and administrators (a problem with global dimensions) (Pires et al. 2002).

3. The title “Mishrein” is the female form of the surname and upper-caste appellation Mishra. Like many women, the Mishrein was not known by her first name; but was widely identified by caste and gender.

4. I use the phrases baby-delivering and baby-deliverers deliberately as opposed to “midwife” or “midwifery.” The idea of “the dai” as the “Indian midwife” is one that suits public health needs and global medical discourses, but it does not “fit” the local context; however, when it is used by others to misidentify local circumstances, as in the news article I describe below, I retain it with that meaning.

5. Dais deliver babies but refuse to cut the cords for reasons that have to do with pollution and the symbols of cord-cutting, and dhanuks usually do not deliver babies outside their own families, but it is their work to cut the cord.

6. A common belief held by medical personnel (and reflected in colonial documents) is that dais smear the umbilical stump with cow dung (gobar)—a depiction used to emphasize the purportedly unclean and barbaric character of traditional practitioners. This imagined practice is a familiar trope in urban discourse about rural birth.

7. In fact, a longstanding component of dai training involves encouraging trained dais to establish clinics in their homes in which they will conduct prenatal visits, assess the need for referrals, and perform deliveries.

8. The context of Sitapur and its complexities in terms of the medicalization of birth reiterates Mark Nichter’s argument that “medicalization is not just the prerogative of the medical (psychological and medico-legal) professions and it is engaged for reasons other than social control. It is embraced by people for a variety of reasons” (1998:327). At the same time, this context also emphasizes the ways in which social control can emerge through forms of medicalization delinked from formal institutions and the hegemonic structures they are taken to confer.

9. Mimesis characterizes not only the symbolic and ritualized performances of talk in present-day medical and development practice, but also to the medical practices of India’s colonial history. In particular, there is a striking resemblance between the development of missionary medicine in the 19th century and current medical practices in the hinterlands. For European missionaries the 19th century was a time when interest in medicine was growing out of a desire to “open up” previously resistant regions and to preserve their
own health in missionary outposts (Fitzgerald 2001). Before qualified medical practitioners became part of their groups, missionaries often acquired medical knowledge in a "haphazard, fragmentary" fashion—attending a lecture here, watching patient treatment there (Fitzgerald 2001:104). When it came to treatment, they did not "confine their forays into the medical realm solely to self-treatment," especially as medical work became intrinsic to evangelical activity (Fitzgerald 2001:104) and, according to some reports, lent missionaries greater authority among indigenous populations (Fitzgerald 2001:105).

10. The demand for oxytocin has several sources. In particular, Cecilia Van Hollen notes the association of pain and exertion with delivery in South India, such that while labor-inducing drugs are felt to enhance the proper unfolding of delivery, pain-relieving medication is viewed as counterintuitive and thus seldom used (2003). I have noted a similar phenomenon in Uttar Pradesh (Pinto 2003)—in particular, in the ways women use the symbol of “needles” (sui) to locate the female working/birthing body as an index of subaltern identity. In this context, differentiation between labor-inducing and pain-relieving drugs is ambiguous; many women (especially lower-caste and lower-class) say that they don’t require “needles” to give birth. While these women use rejection of “needles” as a mark of identity (and sign of disenfranchisement), their higher-caste and higher-class counterparts render oxytocin injection during home birth a symbol of affiliation with the ethos of progress and institutional legitimacy (even when they have made clear decisions not to give birth in a hospital) (Pinto 2003).

11. A fairly large literature on the administration of injections in developing countries has focused on vaccination campaigns and the symbolics of injections more broadly; injections are shown to occupy a zone in which the power and fear of biomedicine are linked (Bierlich 2000), because injections are especially iconic of biomedicine (Whyte and Van der Geest 1994). Vaccination campaigns in particular have been closely examined for elements of coercion they may encourage (Greenough 1995) and for the relationship between health-seeking ideologies, local visions of illness, and acceptance or rejection of vaccines (Nichter 1990, 1995). Mark Nichter notes that, “Vaccination programs have... provided an opportunity for political commentary as well as the articulation of collective anxieties” (1995:618). Cecilia Van Hollen has addressed the symbolics of oxytocin injections in her work on South India (2003).

12. Needles are also part of other kinds of plays of authority: Jawahar’s three-year-old son enjoyed playing doctor, over and over again. He pushed a wooden toy with wheels—his “motorcycle”—and then strutted over to his grandmother (who often complained of aches and pains). “Amma, are you sick? I will give an injection.” Screwing up his face to show the pain of an injection, he said with a curt tone, “Don’t cry. It’s okay.” Then he gave Amma a handful of imaginary pills, saying, “Eat these.”

13. The author of the newspaper article uses a different form of transliteration than the one I have used in this paper, hence the difference between “daais” and “dais.” Likewise, the pluralizing of this Hindi term reflects the way the term has come into English usage.

14. Karva Chauth is a holiday on which women fast for the well-being of husbands, and celebrations include the painting of elaborate wall pictures.

15. This current formulation undoubtedly relates to British origins of social medicine described by Foucault, in which state medical structures were aimed explicitly at ensuring the well-being of the poor and maintaining the laboring class (2000).

References Cited

Adams, Vincanne
Apffel-Marglin, Frederique

Apffel-Marglin, Frederique, and Suzanne Simon

Appadurai, Arjun

Arnold, David

Barthes, Roland

Bhabha, Homi

Bierlich, Bernhard

Blom Hansen, Thomas, and Finn Stepputat, eds.

Das, Veena


de Certeau, Michel

Dirks, Nicholas B.

Drèze, Jean, and Amartya Sen

Escobar, Arturo

Ferguson, James

Fitzgerald, Rosemary

Foucault, Michel
Fuller, Christopher J., and Veronique Bénéfi, eds.  
Greenough, Paul  
Guha, Ranajit  
Gupta, Akhil  
Jordan, Brigitte  
1993 Birth in Four Cultures. Prospect Heights, IL: Waveland Press.  
Ketler, Suzanne  
Khare, R. S.  
Langford, Jean M.  
Marglin, Stephen  
Mishra, Manjari  
Nichter, Mark  
Pati, Biswamoy, and Mark Harrison  
Pigg, Stacey Leigh  
ABSTRACT In north India, unregulated medical practice is considered by many to be a sign of the failure of institutional rationality and “backward” quality of rural life. However, the work of self-made doctors can also be seen to engage key elements of institutional rationality as it is interwoven with the structure and ethos of development. This article explores what these practitioners and their work suggest about the imagination of institutions in rural India and the kinds of power
this invokes. Through mimesis of key practices (namely, forms of talk and use of injections), self-made doctors tap into the authority of legitimate institutions to occupy lacunae in state health structures and redress (even as they reproduce) effects of privatization and repeated temporary health measures. At the same time, everyday elements of these practices demonstrate that institutional legitimacy can only be borrowed by those already in positions of authority (on the basis of caste status and political leadership), challenging ideals of equality that underlie health-related development efforts. [medical practice, quacks, development, reproduction, India]