Socio-Cultural Discourse on Female Reproductive Rights
(A Case Study of Pothohar Village, District Attock)

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Dedicated to the dreams of my loving father

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ACRONYMS

AAA	American Anthropological Association
BHU	Basic Health Units
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
FPAP	Family Planning Association of Pakistan
FWCW	Fourth World Conference on Women
IUD	Intrauterine Device
ICPD	International Conference on Population and Development
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	The International Covenant on Civil and Political Rights
ICASC	International Campaign on Abortion, Sterilization and Contraception
LHW	Lady Health Workers
LHV	Lady Health Visitor
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
NGO	Non-governmental organization
NIPS	National Institute of Population Studies
PHC	Primary Health Care
PDHS	Pakistan Demographic and Health Surveys
TV	Television
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization
WPPA	World Population Programme of Action.

ABSTRACT

This thesis mainly explores the association between the socio-cultural context and women's perception and practice of their reproductive rights. Meeting reproductive needs of rural women living in a traditional culture of Pakistan is no less than a challenge where sexuality is a taboo subject. There is little known about the sexual and reproductive practices and behaviour of women. The issues pertaining to female's reproductive rights remain unacknowledged at the policy level and lack implementation. Studies that were conducted In Pakistan before had mostly focused on the issues of maternal health from the service delivery aspect and very few attempts have been made to empirically assess linkages between socio-cultural factors and Reproductive Rights.

In order to have a clear picture of the state of females reproductive rights, this study was conducted in village Choha Shah Ghareeb of District Attock, in the Province of Punjab with the prime objective to understand the perception and practices of reproductive rights among females of the reproductive age group (15-49 years). The study employed anthropological methods including participant observation, in-depth interviews, illness narratives to provide a comprehensive analysis of reproductive with an emic perspective. The study explored their participation in Fertility Decision Making and utilization of reproductive health services such as antenatal care, delivery and postnatal care. Furthermore, it investigated those traditional practices which affect female's reproductive rights such as early marriages, inability to access modern health care facilities, nutritional taboos, consequences of infertility, son preferences and unsafe induce abortion etc.

The study elaborated key aspects linked to the notion of female sexuality and fertility. The findings show that socio-cultural norms inhibit discussion related to sexuality and reproductive health and young girls' receive little information about puberty prior to menarche which becomes the foundation for their incapacity to safeguard their future reproductive health. Marriage is considered a religious duty and an inevitable act. Field findings reflect the importance of marriage to protect the honor of women and also for the formation of a family unit. The right to marry and form a family was more recognized

in terms of parental responsibility and obligation to arrange timely marriage of their children. Among married women interviewed in this study, 45% were asked to give their opinion in spouse selection and more than one third of respondents were married to their cousins. Women were also aware of their right to seek divorce yet the majority of them (47%) disagreed and urged the necessity to avoid dissolution of marriage due to the fear of social disgrace, family pressure, being separated from children and due to the limited opportunities to marry again.

Sexuality for married women is an area of compromise, obligation, and lack of control. Sexual obedience is considered an essential characteristic of a good and successful wife. The majority of the respondents agreed that they would never like to refuse their husbands and perceived sex as a 'wife's duty & religious obligation". Furthermore, good women are expected to be ignorant and passive in sexual matters and sexual subservience is used as a strategy to gain love and respect from their husbands and also to secure their present and future well-being.

Women's understanding of their reproductive health comes from their socialization pattern, configuration of gender roles and sense of motherhood and identity based on their norms and traditions. Women placed safe motherhood as an important element of their expressed meaning of reproductive rights and strongly emphasized their right to have good reproductive health care particularly during pregnancy and post-partum period. But practically, the majority of them considered conception and the act of giving birth as 'natural' and received antenatal care mostly in case having some health problem. There was a clear preference for home delivery and hospitals were chosen in case of emergency or health risk or in the absence of family member to assist home delivery.

Women perceived childlessness as a curse because children strengthened the marital bond and raised their status in the family. Having a quick pregnancy meant compliance with social norms and family expectations. Successful childbearing gives them respect and decision making authority in reproductive matters. Women also discussed the deteriorating effect of excessive births for their reproductive health and the majority of

them acknowledged their right to space births and determine family size. Many women mentioned their limited decision making authority with regards to keeping their family size smaller and also accepted the covert use of contraceptives and induced abortion without consent of their husbands in case of having closely spaced pregnancies, health concerns, or under extreme economic misery etc. The majority of women had knowledge of modern contraceptives and apart from them they also knew and practiced traditional methods such as withdrawal. Family planning methods and their perceived viability is at the heart of the discourse surrounding women's fertility control behavior.

The findings demonstrate that women's lower social position and economic dependence on their husbands and families limit their ability to practice their reproductive rights by not allowing them to make independent decisions to regulate their reproductive lives. Fertility decisions are made and experienced within their cultural context whether it is early marriage, compulsory motherhood, home based delivery, lack of fertility control, closely spaced pregnancies, unsafe abortions or utilization of reproductive health care services. The study concludes that women situated their reproductive rights within the broader spectrum of their socio- economic, familial and cultural context. Having a good family life, securing social and economic protection and attaining social respect were key elements of the meaning of reproductive rights for them. Women, in the desire to keep their marriage successful or for the sake of their children, prefer to compromise for the sake of this affiliation, which ultimately provides them socio-economic and emotional support.

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CHAPTER ONE
INTRODUCTION

1.1 Background

The idea of 'reproductive rights' is ideologically embedded in the concept that every individual has the equal rights to enjoy happiness and freedom (Pillai, Vijayan K. Wang, Guang-Zhen Body; 1999). Reproductive health rights are based on the basic principles of human welfare & dignity. They take into account a broad range of economic, social, political, and cultural rights that are recognized at the national and international level. Broadly speaking, they encompass two basic principles: that all individuals must have the right to proper reproductive health care, and the right to be able to make independent decisions regarding their reproductive lives (Benda-Beckmann 1989; Simon and Lynch, 1989; Turner, 1993). Marge Berer (1990) contends that to support reproductive rights is to support the human need and desire to have some measure of control over nature and biology, and over fertility, and to believe that it is ethical to do this.

The movement to ensure commitment towards women's reproductive rights marks a major shift as reflected from the development goals of the 1970s to 80s, which were marked by the structural adjustment programs and other population targets leading towards major cuts in the government budget allocations and spending in the area of health and education. The major international conferences such as the the World Conference on Human Rights (Vienna, 1993); the Cairo International Conference on Population and Development (ICPD: 1994) and the Fourth World Conference on women (that held at Beijing in 1995) all played an influential role in setting up the stage for transforming the agenda of these international declarations of reproductive rights into a practical reality for women living around the globe. Further, by taking up Millennium Development Goals (2000) as priority area, the governments have shown

commitment to address women's reproductive health issues as a key to achieve gender equality (The Center for Reproductive Rights: 2004).The Programme of Action of the International Conference on Population and Development (1994) enshrines an almost-feminist vision of reproductive rights and gender equality in place of the old population control discourse (Petchesky, 1995).

Reproductive rights are considered to embrace certain human rights that are well documented in the national and international human rights treaties and documents. They acknowledge right of all individuals to the right to achieve highest standard of their reproductive health with the capacity to decide freely the number and timing of their children and to have the basic information and means to do so, the right to exercise their reproductive autonomy free of violence, discrimination and coercion (Dawla: 2000).

Many factors influence the perception of reproductive rights, their significance and prioritization. These include among others the race, class, religion, sexuality, nationality, culture and marital status of women (Berer M, 1990). Recent studies and health literature reveals numerous socio-economic antecedents of reproductive health and rights (Fathalla, M. F. 1992; Pappas, G., et al. 1993; Adler et al. 1994; Roberts 1997; Orubuloye et al. 1997; Guang-zhen Wang and Vijayan K. Pillai, 2001). Three main factors, that include gender inequality, women's lower economic position, and the total fertility rate, have been emphasized as most significant in terms of their impact on reproductive health. Women's reproductive freedom influences their mental, sexual and physical health and raising women's status results in the improvement of their overall health (Misra et al. 1995; Elstad J. I. 1996; Defo 1997).

The normative status of reproductive rights is unclear and relative to the circumstances, especially when it comes to their global application. Usually reproductive rights are used primarily to refer to a woman's right to decide whether or not she wants to produce an offspring. While this right clearly includes rights to contraception and abortion, it also covers the right to use modern technology to assist in child bearing such as infertility treatments, artificial insemination and other

reproductive aids with the help of modern bio and gene technology. This also provide women with a choice regarding what kind of offspring they want, by eliminating serious diseases, birth defects and in general undesired genetic conditions. But in the Third World countries the same rights have lot more limited scope. A woman's right to choose her family size is not the right to have as many children as she and her spouse may want as this may not be a locally desirable choice in cultures where children are valued as wealth of the family. Claiming such a right would be irrational in a community in which women and families without children are seen as 'defective' and where women without children may end up in an economically weaker position (Hellsten, 2006).

Women around the world generally excercise less control over their reproductive and sexual lives, their health, and their bodies, and the violations of their reproductive rights is manifested in many ways such as forced and unplanned pregnancies, lack of antenatal care and resulting maternal morbidity and mortality, early marriages, unsafe abortions etc.(Garcia-Moreno and Claro; 1994). In Pakistan alone, 1 in 80 women is at the risk of maternal death.[1] These unfortunate experiences are considered natural, inescapable and customary. This cultural undervalueing of women's undermines their dignity and autonomy related to every aspect of their lives and ultimately results in the violation of their reproductive rights.

The present study focuses on the the cultural framework within which women's reproductive rights are located. To comprehend those ways in which reproductive rights can be opertionalized and practiced within social relations, it is inevitable to focus how the discourse on reproduvtive rights is framed. The study is focused on the cultural paraphernalia attached to the ideologies which represent women's bodies as custodians of motherhood. It analyzes the phenomenon of reproductive rights as constructions, how culture and social norms define and dictate reproductive rights for women.

[1]*See* WHO et al.,Maternal Mortality in 1995:Estimates Developed by WHO, United Nations Children's Fund (UNICEF),UNFPA 45 (2001).

1.2 Defining Key Concepts

a) Socio-cultural Discourse

"Socio-cultural discourse"[2] as applied in this study, mainly refers to the beliefs, ideas, norms, shared values and understandings within a specific community and the subsequent behavior and actions of individuals in that community based on them. Use of socio-cultural discourse is indicative of the basic goal of the discipline of anthropology to understand the connection between specific behaviors or events and the day to day experiences, social pattern, cultural knowledge, and social relationships that make up the contexts in which they take place. In this way, understanding how or why women recognize and practice their reproductive rights and maintain their reproductive health in the way that they do requires an exploration of the social contexts in which reproductive rights are practiced and in which the process of reproduction actually occurs.

Wilson, R. (1997) also explained that the meanings of rights actually come through their use that show how people conceive and in turn practice reproductive rights in their daily lives. The "meaning" that rights embody, has two connotations. In a broader sense, meaning refers to the conventional sense of an expression. The other way to explain meaning is at the individual level; that is a speaker's meaning, or what a person communicates by a statement or expression. It leads towards "socially shared meaning" of reproductive rights.

In the perspective of Corrêa and Carrieri (2004), discourse means a way through which people express their worldview, their subjectivity, which is composed of a set

[2]According to Ellingson (1995:107) discourse analysis is located in a form of debate in which speakers do make struggle with each other in order to create meanings, legitimacy, and to reach a consensus over the principles & course of action among them.

of assumptions that show their conceptions and guide their actions. Therefore, discourse is considered and analyzed as an important part of social relationships. It is viewed as discursive production which includes not only social values, norms, reasoning, explanations, wanted and unwanted behaviour, but also the interpretations, constructed meanings that surround myths, stories and other constructive elements of culture.

The socio-cultural discourse helps to understand how women conceptualize reproductive rights as they discuss its application in real life situations.The socio-cultural norms and values serve as the setting and context for day-to-day living and it represents frames of reference for the individuals to act upon what type of choices to make and actions to be taken with regards to the practice of reproductive rights

b) Sexual and Reproductive Health

Sexual health was defined by the WHO (1974) as *'the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love'* (World Health Organization. 1974).

Reproductive health includes the following key components: (a) all individuals can have the capacity to reproduce as well as to control their reproduction and fertility; (b) that all women can complete their child bearing stages safely and successfully. In addition, couples are able to enjoy sexual activity without fear of procreation and disease (Fathalla, 1988).

The reproductive health framework helps to move birth control from the narrow definition of family planning with their connotations of top-down policy, into the individual reproductive and sexual rights. The World Population Programme of Action (WPPA) adapted this concept in paragraph 7.2 of its final document discussed in Cairo as follows:

> "*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes….."* (WPPA, 1994).

In summary, women's reproductive health includes the ability to have satisfying and safe sex and the freedom to decide if, when, and how to do so.Control over decisions such as marriage, fertility regulation free from dangerous side effects of contraception, and to have access to information on the prevention and treatment of reproductive illnesses. The traditional discourse of reproductive health has its emphasis on the biological capacity of women to give birth to children. It focuses on the natural potential of women to bear and rear children, safe motherhood, fertility control and family planning. It restricts women's health to a narrow focus on reproductive performance without addressing wider issues of women's reproductive rights. The narrow focus on the biomedical aspects of reproduction overshadows the socio-cultural, religious and economic factors surrounding women's health.

Medical anthropology defines reproductive health in terms of an emic perspective regarding issues related to sexuality and reproductive processes and functions (Whittaker, A. 2004). Literature in medical anthropology gives a holistic definition of reproductive health by situating it within the broad economic, socio-familial contexts of the lives of women. It gives much attention to the role of health care culture and social oppression that may constrain women's health.

c) Reproductive Rights

The concept of reproductive rights was first formalized at the women's international tribunal and meeting on reproductive rights convened by the International Campaign on Abortion, Sterilization and Contraception (ICASC) in Amsterdam in July 1984, just before the World Population Conference in Mexico City (Gupta, J. A. 2000).

The definition of reproductive rights is continually shaping and improving and may include the following key areas (R. Petchesky and K. Judd; 1998).

- Effective and well-functioning health care system that offers safe and reliable child and maternal health care services;
- Sufficent nutritional levels and approptiate health conditions, to minimize various risks such as those range from anemia to HIV infections;
- Availability to correct information & counseling cerivices to choose contraceptive methods and to access them;
- Adrequate education in order to be able to read and understand the messages written on clinic wall posters;
- To have employment, financial resources and provision of health insurance, to afford health care services;
- Availability of suitable transportation services to reach the desired health facility;
- To be free from those oppressive traditional values that restraint reproductive choices;
- Protection from domestic or ethnic violence and forced pregnancy that may result through rape and during wars;
- Involvement of women in the activities of NGOs as well as community welfare groups to design policies with regards to reproductive and sexual health at all levels. [3]

1.3 Statement of the Problem

The concept of 'Reproductive Rights' has been used differently by international declarations, women activists, health professionals, social scientists and policy makers. The notion of 'rights' can be phrased in different ways, but what remains obvious is that reproductive rights are constructed and vary from society to society. Contrary to the human rights convention rather it is the local culture and community which defines the nature and extent of reproductive rights given to a man and woman. Thus the notion of reproductive rights must be seen against the background of several societal developments and cultural values. The chief aim of this study was to investigate whether the reproductive rights are actually perceived as such by rural

[3]For details R. Petchesky and K. Judd (eds), Negotiating Reproductive Rights: Womens Perspectives Across Countries and Cultures (London & New York: Zed Books and St. Martin's Press, 1998)

Pakistani women? Do women find themselves in a position where they can claim or access their reproductive rights? This objective was based on the assumption that to be in a position to pursue one's reproductive rights requires relevant information regarding those policies as well as laws that sanction them, along with the existence of those social structures, traditions and cultural values that facilitate their realization. Do women feel themselves entitled for control over reproduction? Their sense of entitlement was reflected in their actions, the way in which they narrated their lives, or simply in their explanations of why they did certain things i-e child spacing, abortion, reproductive decision making etc.

The term 'right' has multiple meanings in itself. It can be interpreted as something granted by law and it is also interpreted as something 'Correct', 'Fair' or 'Just'. Sometimes these two interpretations come into conflict with each other i-e it is well acknowledged as a person's right to decide freely when and with whom to have sex. My question here was to find out how women perceived this right in a culture where refusing sex within marriage is forbidden by religion? Similarly, article 16 of Women's Convention clearly states that women have the right to marry and to found a family without any force and with full consent, including the right to choose their life partner.[4]Age at the time of marriage is one of the most determining factors for the number of children borne by a woman.In Pakistan, 62 percent of women of childbearing age are currently married; one out of six women age 15-19 is already married (PDHS 2006-07). The highest rate of consanguineous marriages have been consistently reported in more traditional rural areas because of the ease of pre nuptial negotiations and optimum level of compatibility between the spouses and families (Afzal et al 1994).The present study investigated how women perceived and practiced their 'right to marry' and 'free choice in marriage' in a culture with this social trend of marrying girls with cousins at a very young age? Didthey feel that their consent matters in spouse selection or it was against tradition to voice one's opinion in this regard? What they thought about appropriate and ideal age at marriage for girls? Did they favour the tradition of cousin marriage or they desired to exercise free will? Did they know their husband before marriage?

[4] (available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article16).

Women's claim and practice of a particular reproductive right may fluctuate, with reference to their social position, status, their economic, social & emotional resources, the cultural space permitted for that claim as well as the social costs entering into divergence with that claim in contrast to those benefits it may likely to bring for them (El Dawla 2000). Access to reproductive health care services is one of the most important reproductive health rights which ensure that all women need to find the reproductive health services available, affordable, and reachable (Committee on Economic, Social and Cultural Rights, 2000). Recent Pakistan Demographic and Health Survey (PDHS, 2012-13) show that 37 percent of women make four or more antenatal care visits during pregnancy. Urban women (62 percent) are more than twice as likely as rural women (26 percent) to have four or more prenatal visits. More than six in ten women have to face a hurdle in seeking health care during sickness. Around 52 percent of deliveries are still home based and only 48 percent of child births take place in a formal health center out of which 15% deliveries are conducted at public facility and 34% are private based.

Previous studies indicate that fragmented health care system and prevailing gender inequalities are central factors that may affect women's utilization of family planning and other reproductive health services (Tian et al, 2007). Article 12 of the Women's Convention ensures health equality by prohibiting any gender discriminatory practices in the provision of health facilities.[5] This study attempted to explore women's perception and practice of their reproductive health care.

My choice to work on women's reproductive rights was based on the fact that current human rights declarations are unsuccessful in addressing reproductive rights violations confronted by women living across cultures. The definition of reproductive health care that emerged from the Cairo conference may not be a true reflection of the wishes and requirements of the local communities. Instead it may advocate the 'worldview' of those planners and activists whose perspective somehow may not be similar to those people that they would like to actually represent (Castle et al 2002). In a country like Pakistan women do not enjoy the same social and legal

[5](/www.unhcr.org/refworld/docid).

status as men and their lower status becomes a primary cause of widespread apathy towards exercising reproductive rights (Hakim and Rukanuddin 2000). The sexual division of power is closely related to the sexual division of labor, where women's economic dependency on men might lead to misuse of power and authority as well as control in relationships (Wingood & DiClemente, 2000). Within the household the ability to make fertility decisions affects other rights such as the right to use contraceptives. The current study investigated foundational principles underlying gender ideologies and values. The study also takes into consideration how masculinities and femininities are constructed and what role they play in shaping women's perception of reproductive rights.

The present research also explored connection between women's decision-making autonomy and reproductive behavior within their specific socio- cultural context. Dixon-Mueller (1993) describes autonomy as the 'degree of access to and control over material resources' while Dyson and Moore (1983) define autonomy as 'the ability (psychological, technical and social) to have knowledge and apply it to make decisions about one's private life and also those concerning one's intimates'. It is obvious that throughout the world, people spend their lives keeping in mind the concerns of others, with obligations and demands, and joys of a peaceful social life (Mumtaz and Salway 2009). Most important research questions were to know how autonomy or freedom is perceived and exercised. How decisions such as decisions about getting married; receiving education, securing employment and receiving proper health care were made? The study attempted to investigate women's control over their own reproductive lives i.e. whom she marries, when she gets pregnant, when to continue and when to end a pregnancy, what kind of contraceptive choices are available to her and other decisions connected to her bodily integrity etc.

There is a two way association between women's reproductive rights and overall culture and both are mutually dependent. Reproductive rights are embedded in culture from where they draw meaning and force. So the main focus of this study was to comprehend reproductive attitude and behavior of women and the state of their reproductive rights in their own socio cultural context to document how these

traditional practices confine women's decision-making options and at the same time they encourage and favor their reproductive role.

1.4. Objectives of the Study:-

Most of the studies of reproductive rights (Petchesky, 1990; Dixon-Mueller, 1993; Fathella, 1990) were undertaken with reference to western cultures and could not analyze the empirical relationship between reproductive rights and social norms prevailing in non-western traditional societies. This study aimed to find out local explanations of the nature and determinants of reproductive rights in a village, Choha Shah Ghareeb. The present study focuses specifically on experiences of reproduction illuminated in the accounts and narrations of women of child bearing age in order to understand how reproductive rights are governed according to social norms. The principal objectives of the study included the following:

1. To document women's knowledge about their reproductive rights and reproductive health care.

The term 'Reproductive Rights' may be alien for the Pakistani rural women as this term is more westernized and coming from International Conventions. I intended to understand this phenomenon within the socio cultural specificity of Rural Pakistan. Rural women do not speak the language of international conventions so my objective was to understand the notion of 'reproductive rights' as understood and perceived by rural women. To better understand women's perception of their reproductive rights I did not use the exact term rather I asked women about specific reproductive rights such as the right to select life partner, the right not to marry too early, the right to choose the number of children, type of contraception, the right to have or not to have an abortion, right to access modern reproductive technologies, right to education and employment etc. The data regarding their knowledge of reproductive health care was collected by probing their views related to pre-natal and post partum care, their knowledge in deciding the place of delivery, their knowledge of contraception.

2. To explore women's perceived importance for each of the specific reproductive rights. Reproductive rights, no matter for whom and where they have been designed reflect basic human needs of protection and self-determination. The study attempted to find out women's sense of entitlement for the following rights in relation to their health: (1) The right to marry and form a family (2) The right to decide the number of children they like to have. (3) The right to choose contraceptives and abortion care services.(4) The right to receive full information concerning their reproductive health. (5) The right to access health services during pregnancy, delivery and confinement. Moreover, I also tried to understand which of these rights have more recognition and how many of them women actually exercised or wished to exercise?

3. To understand the perspectives of women regarding major reproductive health care components such as sexuality/fertility, abortion, family planning and contraceptive use, problems faced in the process of childbearing (pregnancy, delivery and confinement) and related dynamics within marriage.

This objective translated all the reproductive rights into specific points related to the reproductive health care given to women. Women were asked specific questions to narrate their rationale and perceived advantages/disadvantages related to reproductive health care.

4. To examine the extent of women's participation in fertility decision-making and their access to reliable reproductive health services.

This objective was reached by asking questions related to women's autonomy in general matters such as household budgeting, children's schooling, meeting neighbours and relatives etc., to more specific decisions related to fertility regulation such as choosing family planning methods, deciding the number of children, child spacing, etc

5. To explore women's utilization of reproductive health care services and the causes and consequences for using them.

This objective was explored by probing women about their current use of reproductive health services such as access to health facilities such as hospital, dispensary or family planning center: total number of antenatal visits during pregnancy, the nature and extent of post-natal care, place of delivery and the satisfaction from the last experience.

6. To describe power dynamics and authority patterns within the household that effect women's reproductive rights

Women were asked questions to find out their status in their own family to assess the extent to which they exercise authority to go out alone, to argue with her husband, to disobey her husband or in-laws, to have the liberty to use contraception. In addition, they were asked to provide information on what attributes make them powerful or powerless, such as the number of children, particularly the number of sons, educational level, financial status, etc. to find out the factors relationship with reproductive rights

7. To find out those traditional practices which affect female's reproductive rights such as early marriages, inability to access modern health care facilities, nutritional taboos, consequences of infertility and son preferences, induction of abortion by using clandestine methods, etc.

1.5 Locale of the Study

The research was conducted in a Pothowari village Choha Shah Ghareeb located in District Attock, Province of Punjab, Pakistan. In case of present research, the prior knowledge about the culture, familiarity with the local language, and access to reliable key informants, were the main factors taken into consideration for the selection of locale and they proved helpful for gaining acceptance in the research community which was a pre-requiste for in-depth data collection.

1.6 Methodology

Planning the research and finalizing methodological tools before entering into the field is essential. According to Hammersley and Atikinson, ethnographic work cannot be pre-determined but this does not eliminate the need for pre fieldwork preparation. They

consider research design as ‘crucial to ethnography’ and define it in terms of a ‘reflexive process which operates at every stage of the project (2007; 20-21). The ethnographic research for this thesis was conducted in the year 2013 over the course of more than one year. Due to the in-depth nature of anthropological inquiry I prefered to use a case study approach. Case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context (Travers, 2001).The present research is a case study of a Punjabi village Choha Shah Ghareeb, mainly explored through anthropological and qualitative research methods. The purpose of this qualitative study was to gain a deeper understanding and description of problems through gathering and analyzing data.

The present study was conducted in three major phases: 1) the initial introductory phase, which aimed at exploring those social and cultural norms which shape the perception and practice of women’s reproductive rights in the village Choha Shah Ghareeb. The preliminary information obtained from this phase was used to formulate the census forms and interview guide for the respondents. In the second phase (the quantitative phase) a socio-economic survey of the village was conducted in order to obtain demographic information. It provided statistical information regarding family size, number of miscarriages and abortions, utilization of reproductive health services etc, number of currently married and child bearing women etc. This information was utilized for selecting a representative sample for the final phase of qualitative date collection. The last phase (the qualitative phase) employed the technique of focus group discussions (FGDs) and in-depth interviews from the sampled respondents. The use of quantitative methods provided the necessary base line information to select those elements in the sample which were most representative. It was helpful to identify women who were in their child bearing age and had gone through the process of pregnancy and child birth. It gave the opportunity to find out women’s own understanding of their reproductive rights in their specific culture.

The research was planned by carefully choosing several methodological tools to optimize and enhance the credibility of research results.This section presents a discussion about different methodological techniques that were used for data collection.

1.6.1 Introduction and Key-Informant

Rapport building was achieved during the introductory phase, when I firstvisited the locale with the help of one of my female key informants, Sajida[6], who was a village resident and used to work as domestic servant in the city of Wah Cantt. She proved to be a good assistant as she introduced me to the community members as well as helping me to identify other relevant key informants. She was also helpful during the household survey. In the rural set up, outsiders asking questions about household income and wealth are commonly perceived as agents from a government department who collect this kind of information for taxation purpose. The presence of Sajida helped me to gain acceptance in the community and to win the trust of the village residents. Moreover, she also accompanied me to visit a local shrine where I made initial contact with the female visitors and also the shrine care takers who further helped to introduce me to their other family members, relatives, friends and neighbors. This initial phase of rapport establishment helped me to find many good friends and informants who later helped me to understand the prevailing socio cultural norms and practices of the community. It also enabled me to formulate relevant research questions with regards to female reproductive rights and their reproductive health problems and health seeking behavior.

1.6.2 Participant Observation:

After a few days of rapport establishment, I started visiting households for participant observation to obtain in-depth information regarding their reproductive health problems, their perception and practice of reproductive rights, food pattern, marriage system, health care system and health seeking behavior, their daily activities and the general *rusm-o-rewaj* (customs and traditions) of the community. I used to spend time in the homes of my respondents for detailed discussion. It provided me with the opportunity to closely observe them doing various household chores such as cleaning, cooking and distributing food, washing and sewing clothes, looking after livestock, doing embroidery, caring and

[6]A Pseudonym. All names used throughout this dissertation are pseudonym, that I assigned to my respondents to maintain their confidentiality and anonymity.

socializing children etc. I used to observe them performing their duties and participated also wherever it was possible. I asked them questions but did not take notes while we were talking. I used to note down all my conversations and observations after reaching my residence.

Sajida, my key informant, was kind enough to offer me a place to stay in her house. Living at her house as part of her family was really helpful to gain access to the community which is definitely a prerequisite for the success of an anthropological inquiry. I stayed in the village for more than one year and that really helped me to obtain trust and confidence of the people I was studying. Residing with the local family also helped me to achieve the reputation as an ethnographer and distinguish myself from a government agent or a lady doctor or family planning advocate. By becoming an "adopted" member of a local family, I was able to maintain a friendly and good relationship with my respondents. Moreover, speaking the local language and wearing the same dress worn by the local women and respecting the other norms of the village were the strategies that helped me to capture the interest of the people who were kind enough to share their life stories with me.

Through 'participant observation' I was able to directly know their actions, beliefs, or any events that took place in the village. Moreover, 'participant observation' also enabled me to cross check the actual behavior against their reported behavior. For example, observing different family members' roles, their interaction with each other, their contribution to various activities, their role in decision-making, the kind and extent of authority processes in the home, or observing different family members' roles in daily activities, serve as important cross-checks to what people report.

I also participated in various social gatherings such as weddings, funerals, birth ceremonies etc. I also attended events that took place at shrines such as the *Urs* rituals festival held by saints. I visited the government and private hospitals and clinics in District Hassan Abdal, family planning center and Basic Health Units, and homes of traditional birth attendants (*Dai*) and lady health workers to meet female patients who came over there to access reproductive health related information and services. Female patients often used to share their health problems perceiving me as a new lady doctor

who had come from a city, which gave me information about their general reproductive health concerns and problems, but to obtain detailed information about their perception and practices of reproductive health rights I had to conduct in-depth interviews with them

1.6.3 Socio-economic Census Survey

Quantitative and qualitative methods were incorporated into methodology in order to ensure that all aspects related to the research topic are fully covered. As small community was selected with the rationale to gain in-depth information, the initial socio-economic census survey was conducted from the entire village (comprised of eighty six households) in order to discover the most significant features of household composition in the cultural context and to know the common practices surrounding reproductive health and rights.

The census survey also provided useful basic demographic information with regards to the total number of households[7] and the number of family members in each household and their demographic characteristics such as age, education level, income, occupation, residential pattern, family system, household amenities and possessions etc. Moreover, the census survey also incorporated basic questions related to the women reproductive history which included the total number of pregnancies, total number of currently living children, number of still-births, miscarriages and induced abortions, present status (pregnant or not), birth place chosen for last delivery etc. The quantitative data obtained from the census survey was necessary as it was later combined with detailed, thick description with regards to women's lives and their practice of reproductive rights, which strengthend this study by providing a representative sample for detailed interviews.

1.6.4 Semi-structured In-depth interviews

A semi-structured, or open-ended, interview format was chosen for face-to-face interviews. In-depth interviews were conducted with the selected sample of sixty women of reproductive age with the purpose of gathering extensive data with regards to their reproductive health status, health-seeking behavior, and their perception and practice of reproductive rights, their role in reproductive decision making and access to health care

[7]The "household" has been defined and explained to people as a group of people who live and eat together from one kitchen and have a common purse.

services, their social status both in the household and in the community, their attitude towards sexuality, fertility, pregnancy and antenatal care, childbirth and family planning, their control over household resources, freedom of movement etc. According to Silverman (2006) the interview is one of the vitalelements in data collection process especially in the case studies with a qualitative research approach..The use of open-ended questions proved helpful to address the (emic) viewpoint of the respondents. Open-ended questions encouraged respondents to articulate their personal understanding of those factors that they thought enhanced orlimited their ability to exercise their reproductive rights. In essence, questions were focused in order to explore how women perceived their reproductive rights and what obstacles had they faced in accessing health care? How do women negotiate their reproductive choices and what do they believe they should do for themselves to exercise their reproductive rights?

In-depth interviews were chosen to document the lived experiences of married women who were in their reproductive age. Additional information was obtained from local health providers i-e. LHWs, TBAs and village elders (both male and female). The interviews were open-ended and semi-structured, and conducted in the local language. Knowledge and fluency of the local language was helpful to explain and clarify questions and also to understand women's responses as I was able to contextualize their narratives and experiences, having conversed with them.

The flow of conversation depended on the response of the interviewees. During data collection, it was observed that having babies is the ultimate reality of married women in the context of rural culture; motherhood involves more than just the couple themselves. However, women with more years of marriage were found to be more expressive and felt no reservations in sharing their stories of giving birth. They were found more confident and open about discussing issues related to sexuality, pregnancy, birth control and reproductive health as compared to younger women who were a little heseitant in sharing intimate details with regards to their private lives. Some respondents expressed concerns and apprehensions about their personal information being published in the newspaper. They asked me what this information would be used for, and I clarified their misconception and assured them of complete confidentiality. Considering the sensitive nature of questions related to reproduction and sexuality, the questionnaire was not

administered to unmarried girls and women and their views were covered in focus group discussions and group interviews.

1.6.5 Sampling for In-depth Interviews

The in-depth interviews were based on non-probability purposive sampling. It intentionally included women who belonged to different socioeconomic backgrounds representing lower, middle and upper classes e.g from very poor to rich households 2) with both joint and nuclear family structures 3) where women were engaged in some sort of income-generating activities both inside and outside of their households and where women did not work, 4) women with recent history of reproductive illness including infertility and also women who were more vocal and willing to provide information.

My objective was to purposefully select a sample that is most representative of the socio-economic, occupational differences among the population. This selection was based on extensive observation and the opinion of key-informants. To obtain a meaningful sample, women who had experienced reproductive illness or had been part of the birthing and fertility decision making process were selected for in-depth interviews. During rapport building and the socio-economic census survey it was revealed that women found it easier to share what they had already experienced rather than what could happen or should happen.

1.6.6 Narrative Analysis

Among the various methods used for data collection, illness narratives were found most significant due to their potential to analyze the core of most human experiences. Thus narration were used as a kind of interaction that symbolizes the relationship between narrator and culture and that works as a “meaning making process”. Narratives may be in the form of short accounts that emerge during or across turns at ordinary conversations (Gubrium & Holstein 1997: 148).

Narratives can also serve as a form of comprehending, organizing and communicating the human experiences in its psychological as well as social subtleties” (Goodman 2001:169). Medical anthropologists have found narratives to be the most basic way for

humans to understand their social world and as a means to make their experiences transmittable.

According to Good et al (1994:86),

> "*Through narratives, experiences are recounted and represented; in which various life events are presented in a meaningful mannerr; in which activities are stated along with the experiences associated with them and the importance that lends them their sense of the person in*volved…"

In the village, women were connected to each other through shared narratives which proved helpful to understanding cultural specificities involved in shaping their perceptionof reproductive health and rights. Furthermore, narratives were also useful to assess the psychological and socio-cultural dimensions regarding women's reproductive processes. The use of a narrative approach allowed comprehending how individual reproductive experiences communicated through their stories construct shared knowledge of their reproductive rights. It provided a useful framework for understanding why women shared their health experiences with each other to develop an interpretation of the illnesswithin the context of local norms.[8]

The use of narrative approach allowed to better analyze women's experiences of pregnancy and childbirth, fertility and infertility, reproductive health and illness. Women's narrative accounts provided a rich description of the ways they understood and conceptualized their reproductive rights and what linkages existedbetween their reproductive experiences and socio-cultural circumstance in which these rights were actually exercised.The narratives of respondents explained how women constructed reproductive health within their culture and enacted their agency. In what ways socio-

[8]Carla Obermeyer's (2000: 180) also applied a narrative approach to examine the reproductive experiences of Moroccan women where she analyzed knowledge and practice surrounding birth relying on their narratives of recent birth experiences, medical encounters, and views regarding behaviors during pregnancy and the vocabulary used to explain physiological processes. These birth narratives revealed the flexibility and eclecticism that characterized women's reproductive behaviors.

cultural norms influenced their reproductive decision-making and why some women could access reproductive health services, while others did not.

1.6.7 Jottings and Fieldnotes

Jottings and fieldnotes were taken so that they could be used later for the writing up and analysis of this study. It was not an easy task to take jottings or to write fieldnotes. Sometimes it happened that respondents showed reluctance to share their views when they saw a notepad in my hand. They were confused and asked me if I am going to publish this information in the newspaper? I used to write jottings in the local language so that respondents could read (if they wanted) what I have written about them. Many respondents also felt honored when they knew that the information they shared was precious for me. Therefore, I had to rely on my own judgement to decide when to take jottings in the presence of others. Sometimes I had to rely on my memory and at times I used a tape recorder depending on the situation. Then I used to write fieldnotes by the end of a day or the start of the next day. I made various sections mainly comprising the key themes of my study. I tried to arrange fieldnotes in such a way that it proved very useful later on for data analysis.

1.6.8 Data Analysis

Before the commencement of formal fieldwork, I made sure that I had enough information about the village, local terminologies, and the local worldview of reproductive health and rights, required for thesis writing. All the quotations, proverbs, key sentences and local terms used during in-depth interviews and also in the FGDs were translated verbatim into English from the native's Punjabi language. For the purpose of data anaylsis, actual words were considered and have been translated by keeping in mind the socio-cultural content and not the literal meanings. The data was categorised thematically such as marriage, pregnancy, childbirth, post-patrum, family planning, abortion, health seeking behaviour, reproductive health problems etc during the fieldwork with appropriate labellling in the fieldnotes.

1.7 Ethical Considerations

On the other hand, there are certain methodological concerns when carrying out an ethnographic research that demands certain ethical considerations theseincludes issues of informed consent, privacy, bias, appropriate research methods, correct reporting, being honest, and the proper use of information (Patton 1990: 476). Ethical considerations were maintained while carrying out the study and code of ethics as developed by the American Anthropological Association (AAA 1998) was followd to deal with any ethical issue encountered during fieldwork. I attempted to collect data which is ethically and morally valid. According to Wei Li Fang & Ellwein (1990) a more ethical framework for judging fieldwork might be constructed upon respect for individual autonomy based on the fundamental principals that persons always be treated as ends in themselves never merely as means. A framework that strives to preserve individual autonomy (implying authenticity and independence) has to make the interaction between the researcher and the subject its focus. It is the individual actions and the quality of these that must be carefully scrutinized and evaluated throughout the fieldwork.

Keeping this in mind, I tried to establish a truthful relationship with my field respondents and I made all efforts to safeguard their interest throughout my fieldwork. An Informed consent was taken from the respondents and they were also explained the major objectives/purpose of the study and related issues of the research before taking their detailed interviews. They were also informed that their participation in this data collection process is voluntary. The audio and visual privacy of respondents was also maintained. The majority of the female respondents were generally conscious about being photographed so I avoided photography when respondents were not willing.

All the data collected was kept confidential and anonymous. Privacy of the respondents was maintained and pseudonyms were used throughout the thesis. Every society has its own norms and values particularly with regards to gender roles. According to Carl B Warren, *"gender is the key organizing device in all cultures and consequently, male and female researchers will always be treated differently by those they study and thus they will come to know different aspects of the cultures they investigate*" (Warren, 1988). Gender plays an important role in gaining entry into the field. In case of a female

researcher, she might find it easier to elicit information from other women if she is married. She says that *"field workers marital status is of particular significance to anthropological informants since most 'primitive' cultures take kinship bonds as the fundamental source of social structure and social order*" (Warren, 1988).

In traditional rural culture, it is not considered appropriate for anunmarried girl to probe on issues related to sex, contraception and reproduction etc. Being married, I had this advantage to establish a good rapport with my respondents and then probe on sensitive issues concerning their married life, reproduction and sexuality. I assured them that the information they provided will remain confidential. I conducted in-depth interviews with respondents who were currently married women of reproductive age, because of the fact that the main focus of study was to explore their views on reproductive rights but in order to have a representative sample I also incorporated alternate views including their husbands, doctors and other service providers, traditional and spiritual healers, *Moulvis* (clergy) and other concerned persons of the community. It was difficult for me as a female researcher to interview men but I did not take this as an obstacle and managed to interact with men either in the presence of key informants or females of the household.

1.8 Justification and Significance of the Study

Pakistan became 6th most populous country in the world by the year 2013 with its population of 184.5 million. It is projected that it will reach the 5th most populous by the year 2050 if it continues to increase its population with the current population growth rate of two percent (Government of Pakistan, 2013).

The socio-cultural setup of the country encourages early childbearing and 15 percent of reproductive aged women start giving birth by the age of 18 years, and 32 percent by the age of 20 years. That means eight percent of young adolescent women (those in the age group of 15-19 years) are already mothers or expecting their first baby. Pakistan's total fertility rate is still 3.8 births per woman with an ideal family size of having more than four children as desired by men and women(Pakistan Demographic and Health Survey (PHDS), 2012-13). It is obvious that women reproductive health issues and problems

remain most important cause of their poor health and high mortality in Pakistan especially in case of rural women who have more chances to undergo mistimed and unwanted pregnancies, experience gender-based violence, maternal deaths and disability, sexually transmitted infections, and other reproductive health related illnesses (PDHS, 2012-13).

The above mentioned statistics from PDHS (2012-13) indicate that the state of women's reproductive rights is dismal. The prevalence of women's reproductive rights not only indicates their health status in general but also the quality of health care services in particular. When women enjoy their reproductive rights it means that they have achieved the optimal level of health care. Erikkson, M. K. (2000:166) stressed that it is the basic human right to have the liberty to decide about procreation as it is essentially what constitutes a free individual. Protecting and ensuring reproductive rights is crucial as it makes women capable of exercising other choices. The present study aimed to understand women's perception of their reproductive rights which can be an important step towards establishing reproductive health programs in line with women's needs and demands. In addition, by focusing on women's reproductive health care and by understanding their perception towards their reproductive rights might be the most vital step in setting up health priorities and future health agenda for the policy makers to come up with culturally appropriate health interventions.

The fundamental importance of reproductive rights for human welfare is often unrecognized for several reasons. First, the concept of reproductive rights remains defined and articulated in egoistic terms. Second, the social and cultural factors which shape the extent of rights remain unspecified at the theoretical and policy levels. Third, the human meaning and definition of reproductive rights tend to be value and cultural specific. For these reasons, empirical research on reproductive rights may invoke fears of conflict between the values of the investigator and the values pertaining to the reproductive rights of the local people (Dixon-Mueller, 1993). Most of the studies done in Pakistan have focused on the state of reproductive health in the context of health services provision. However, these studies were unsuccessful to explore women's awareness of their reproductive rights while obtaining the reproductive health services.

Therefore, this study can be a modest contribution to add significant information to the existing literature in the context of Pakistani society, which can be useful in building future health programs based on women's needs and rights.

This study provides useful data pertaining to key reproductive health issues such as spousal communication, family planning, pre-natal and post-natal care, safe child birth etc which act as foundation of basic reproductive rights. Research work, on women's reproductive rights is limited and calls for more in-depth studies to bring women's needs on national health agenda which should be further utilized while setting up future health projects and population policies. No health policy can achieve desired objectives unless it is designed and implemented in accordance with the ground realities. Understanding the state of women's reproductive rights is a precondition for implementing reproductive health projects successfully. The World Summit (2005) also acknowledged this need to integrate availability of reproductive health facilities in the national agenda to achieve Millennium Development Goals (MDGs). However, reproductive health illnesses still exist as a major cause of morbidities and mortality among women of child-bearing age. Caldwell et al (1998) also suggested that culture has a substantial impact on determining health-related behavior and it may be helpful in designing health projects and policies.

It is expected that this work will benefit health planners, government and non-organizations and donors and other stake holders working in the area of health in Pakistan to incorporate this information when planning projects intended to improve health status of the Pakistani women by acknowledging the rights that they themselves consider essential for their reproductive health. Paul emphasized the importance of understanding social context for designing community welfare programme. He said

> *If you wish to help a community improve its health, you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform, and what they mean to those who practice them (Paul 1955 cited in Scrimshaw 2001:53).*

Pakistan is among those developing countries with a high mortality rate for women. According to the estimates of World Health Organization (2005) the ratio of maternal deaths is 320 per 100,000 women (PDHS: 2006-07). National Institute of Population Studies, Islamabad, Pakistan).There is a strong need to identify all those factors which contribute towards morbidity and mortality among reproductive-age women. It is expected that the present study would be a pioneering effort for highlighting women's health requirements to design interventions in order to improve effective reproductive health care programs. The present study will contribute to the reproductive rights knowledge in two ways. First, it will add to a comprehensive knowledge of the ground realities and underlying socio-cultural norms which shape women's perception and ideals of their reproductive rights and their reproductive behaviour and second, on the applied side, it provides an in-depth understanding of the strengths and weaknesses of the reproductive health services available to the target population.

1.9 Overview of the Historical Development of Reproductive Rights

1.9.1 Global Situation

The history of reproductive rights can be traced from the late 1960s, when the First International Human Rights Conference, that held in Tehran (Iran) documented that all persons have this basic right to choose freely their family size, the timing and spacing between children and the right to have information and knwoeldge to do so. It was urged that all individuals must attain reproductive autonomy and self determination. The recognition of reproductive rights preceded with more steps and at the occasion of international population conference that held in Mexico in 1984 redefined the concept of reproductive rights with the addition that couples must have the right to attain education and information for reproductive decision making.[1]

Reproductive rights were further recognized and emphasized at the International Conference on Population and Development (ICPD) in Mexico, and by the CEDAW[9]. It proved to be major step towards the recognition of women's decision-making authority in

[9]Convention on the Elimination of All Forms of Discrimination Against Women, (CEDAW) is a major international human rights instrument that has explicitly emphasized and referred to reproductive rights and it binds state parties to ensure the stipulated rights.

fertility related matters. Strengthening of reproductive rights and debates on women's reproductive health care issues continued at the international level. The outcome of these efforts became particularly apparent in the UN Conference on Environment and Development, in 1992, which re-emphasized the need for government bodies to provide appropriate health services which are affordable and accessible for everyone. Another encouraging step in this regard was World Conference on Human Rights held in Vienna that reaffirmed women right to health on the basis of equality to ensure the widest range of fertility control methods, as well as equal access to education.[10]

The International Conference on Population and Development (ICPD) that was held in Cairo, Egypt, in 1994 proved to be a major turning point in contributing to the first most comprehensive definition of reproductive health. It is considered unprecedented with regards to the concept of reproductive health which it broadened to add reproductive rights based on the principals of certain human rights which include the right to make reproductive choices free of coercion, discrimination, and violence, as mentioned in the international human rights charter[11]. Furthermore, the ICPD Programme of Action also directed state parties to ensure gender equity and to address discriminatory customs and negative social attitudes and practices that result in limited power for the women to exercise control over their reproductive lives.[12] Although Cairo was considered as a 'sea change' with regards to the propagation of reproductive rights however scholars such as Cook and Fathalla (1996) highlighted their concern that the Cairo Programme of Action still hasa weak apparatus to legally bind governments to honor their commitments. This deficiency of enforcement is especially apparent due to the non-legal status of consensus documents.[13] The struggle for reproductive rights till ICPD has been viewed from many angles. Most of the scholars appraised these or dismayed that the governments were

[10]Vienna Declaration and Programme of Action, World Conference on Human Rights, Austria,
[11]Para. 7.3. of the "Programme of Action of the International Conference on Population and Development (ICPD)," Cairo, Egypt,1994
[12]*Supra* note 197, para. 7.3
[13]Different societies and cultures deal with reproduction in their own ways and so there is yet not a uniform practice that can be considered as general, and consistent to all cultures that can constitute a 'general practice' that can be regarded as legal binding for all countries.. For a practice to become an international custom, international law requires that it has to be *general, consistently applicable to* all societies.

somehow diffident to adopt even a non-legally binding document until the chapteron principles (Chapter II) was included which acknowledged the sovereign right of all countries to follow the recommendations in accordance with local laws and with full consideration and respect for different religious, ethical and cultural values of its people (McIntosh and Finkle, 1995).[14] However, the Cairo event was a major step in explaining the concept of reproductive rights and highlighting this fact that the issue of population must be addressed with a particular focus on the needs of individual men and women instead of just meeting demographic targets.

Another milestone concerning women's reproductive rights happened in 1995 at the Fourth World Conference on Women (FWCW) that was held in Beijing, and that contributed the Beijing Declaration. The Beijing Platform of Action also acknowledged and spelled out women's right to decide matters with regards to their sexuality and to have control over their own bodies, fertility and reproductive health behavior[15]. It proved to be a major milestone in the construction of women sexual rights as human rights and it put forward the ground-breaking conception that women cannot comprehend their other human rights unless they have control over their sexuality. It further operationalized the recommendations made in Cairo conference, where reproductive rights were defined.[16] In the Beijing conference, governments had a consensus to take appropriate action to ensure reproductive rights as fundamental human rights (Dunlop et al. 1996: 163).

International human rights law contains several instruments that safeguard reproductive rights. Since these instruments are of universal application and first instrument that bears upon the discussion of women's reproductive rights in general international human rights law is the ICESCR. The International Covenant on Economic, Social and Cultural Rights (ICESCR) protects the right to health. Article 12 (1) provides for the right of everyone to enjoy the highest level of physical, sexual and mental well-being and health. Article

[14]Wang, Guang-Zhen and Pilliai, Vijayan K. (2001). Also emphasized legal approach to address social vulnerabilities which entails that the state must be obligated to play a significant role for the promotion of reproductive rights by responding to the political pressures by those women who introduce new reproductive rights moves.

[15]Para. 96. of the Beijing Platform of Action, Fourth World Conference on Women, Beijing, China
[16]Para. 23. of the Beijing Platform of Action, Fourth World Conference on Women, Beijing, China

12(2) stipulates steps to be taken by states to ensure the realization of the rights stipulated in Article 12(1).[17] Article 12(2) (a) imposes an obligation to states to guarantee family planning services to prevent such deaths and ill health. The ICESCR also protects *the right to decide the number and spacing o f children.* This is because the general health of the woman is dependent upon many factors, one of which is the number and the manner with which her children are spaced. Further to this, the ICESCR protects *the right to family planning information and service* (Cook, R., 1993**).**To concludes the discussion of the ICESCR, it is argued that this instrument is significant to reproductive rights. It protects the right of women to decide their family size and gap between their children, accessibility to family planning information and services, enjoyment of the good health, and the right to form family life.

The International Covenant on Civil and Political Rights (ICCPR) is another important international human rights instrument that protects reproductive rights. It protects the rights to have a family, decide the total number of one's children, control of one's own body and accessibility to family planning information. There is a consensus at the international level that all interventions made with a purpose to regulate fertility should not be with the sole objective of population control. Individuals should not be forced against their will to limit their family size just to achieve demographic goals. In other words, these interventions should not be coercive and should not force people to limit their family size against their will only for demographic purposes.[18]Women's own individual needs must be considered, preceded by an adequate and an appropriate counseling that details the implications of the choice being made.[19]

[17]Article 12(2)(a) of the ICESCR
[18]ICPD Programme of Action, Principle 8
[19]ICPD, Principle 7.2. Also, Article 16 of the CEDAW

1.9.2 National Laws & Policies and the status of reproductive rights in Pakistan

Reproductive rights for women in Pakistan require favorable laws and policies as well as a conducive political environment to ensure the successful implementation of reproductive rights. International recommendation make governments liable to eliminate all legal barriers to ensure the provision of reproductive rights and if a country fails to incorporate and implement internationally agreed principles into its national health policies and laws, reproductive rights of women will remain unacknowledged and inaccessible.

Despite the fact that Pakistan is among those 179 countries of the world who are signatory to the International Conference on Population and Development Programme of Action (ICPD PoA) and CEDAW yet the situation of Sexual and Reproductive Rights in the country is not very satisfactory. There is still lot to be done at the policy level and in terms of service delivery as well.[20]

The federal government of Pakistan has taken the responsibility to formulate national health policies.[21]The first health policy of the country was designed in 1988. Until now, the health policies framework is mainly based on the ninth Five Year Plan and the National Health Policy, as formulated by the Health Ministry in 2001.[22] The vision of National Health Policy is based on the approach "health for all". The Government of Pakistan attempted to address issues related to reproductive health and rights through various policies with the prime objective to improve the state of reproductive rights within its socio-cultural and religious boundaries. [23]

Overall vision, objectives and principles of the policy put great emphasis to ensure reproductive rights. The policy also highlights barriers involved in the improvement of reproductive health services and the most important among them is the low social status

[20]Population Reference Bureau.(2007). World Population Datasheet.

[22]Statistics Division, 2000. Federal Bureau of Statistics, Government of Pakistan.
[23]Ministry of Health, Government of Pakistan, National Health Policy 2001,at 4 (2001).

of Pakistani women, which calls for serious steps to improve social condition of women in Pakistan.[24] The major objectives of the policy are the following:

- Provision of reproductive health care services across age and genders;
- Equitable health services in terms of access and affordability with a focus on vulnerable populations:
- Awareness raising and dissemination of information with regards to reproductive health services;
- Provision of reproductive rights for everyone.[25]

The policy envisions improvement in those conditions which are significant to create a conducive environment required for its successful implementation. It suggests increased financial investment in the area of health and related sectors; cooperation among various government bodies, to repeal discriminatory laws against women; universal access to primary education; monitor progress to ensure successful implementation of the policy and to promote and encourage the role of the private sector including NGOs and civil society. The policy also mentioned five basic principles as a pre-requisite for the execution of the policy. They include,

- To ensure that the reproductive needs of people of all ages are well identified
- Information dissemination for the availability of reproductive rights, including the "right to decide and choose";
- Women's empowerment and reproductive decision-making autonomy;
- Sensitization of men with regards to women's reproductive rights;
- To end coercion and violence against women.[26]

The main goal of Pakistan's National Health Policy is to achieve and promote gender equality in the area of health. It describes the following strategies to achieve its goals and targets.

[24]Planning and Development Division, Government of Pakistan, National Reproductive Health Policy (2000).
[25]ibid
[26]ibid

- To ensure that reproductive health care is available to every woman of childbearing age at their doorsteps;
- Improve and expand health services through community-based lady health workers;
- The establishment of "women-friendly hospitals" to provide emergency obstetric care covered ib the Women Health Project and also to start a referral system in the villages and health facilities at the district level ;and
- To increase the registration and enrollment of midwives, lady health workers, and nurses[27]

The National Maternal, Neonatal and Child Health (MNCH) was also launched by the Federal Ministry of Health in April 2005 with the purpose of ensuring universal maternal and child health.[28] Further development in this regard was the presentation of the Reproductive Healthcare and Rights Bill in the National Assembly in 2009 to provide professional reproductive health care services but the bill was opposed and rejected by the Senate.[29] Again in 2013, the reproductive health care and rights act was collectively passed by the national assembly to implement international recommendations for the promotion of reproductive health care.[30] Pakistan has also developed a National Reproductive Health Package which aims to provide quality family planning information and services, abortion care and treatment for complications, treatment of infertility and other RH problems etc.

Despite government's efforts to improve its overall health system, the status of reproductive rights still has not reached the expected level. Pakistan is labeled as one of the countries with the highest mortality rates in Asia. The magnitude of the higher maternal mortality ratio in Pakistan reflects the dismal state of reproductive rights and indicates a violation of women's basic right to life, safe and healthy pregnancy, and childbirth.

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[27]National Health Policy, *supra* note 169,§ 4.1,at 12.
[28]Provincial Reproductive Health and Maternal and Child Health Project in Khyber Pakhtunkhwa. Dailypaperpk.blogspot.com. Retrieved March 5, 2014 from http://dailypaperpkads.blogspot.com/2014/01/reproductive-health-andmaternal-child.html
[29] (2012, Feb 9). Bill to facilitate reproductive health introduced in NA. The Associated Press of Pakistan.
[30] (2013, April 18). Pakistan passes Reproductive Health and Rights Act 2013. Reproductive Health Matters.

Although reproductive health and rights policies have been launched across the country, yet their effective implementation is lacking and the desired outcomes have yet to be achieved.

1.10 Organization of the Thesis

The first chapter presents an overview of the topic, key concepts, research questions and major objectives of the study. It also contains the methodological approach of the study and the description of the methods and techniques used for data collection and analysis. It further discusses the historical development of reproductive rights at the global level as well as relevant policy developments in Pakistan.

Chapter 2 presents the theoretical framework along with the literature review articulating various cross-cultural studies that assist in understanding various socio-cultural determinants that influence the knowledge and practice of reproductive rights. Chapter 3 entails detailed description of the study area that includes its historical and geographical background, demographic composition, social and economic organization and family and kinship structure of the village.

The next five chapters present the findings of this research. Chapter 4 discusses the overall marriage pattern that includes how marriages were arranged, the timing and age at first marriage, criteria for spouse selection, an individual‘s right to marry and divorce. Chapter 5 focuses on socially constructed taboos and myths that influence women’s understanding of menstruation and the socio-biological changes accompanied with it. It further sheds light on how married women perceived sexuality, the notions of their right to have or not to have sex, sexual subservience and coercion. Chapter 6 highlights discourses around motherhood and reproduction discussed under the sub-themes of women’s right to give birth and meeting social expectations through successful reproduction and motherhood. It further unpacks the social significance of having children and the dilemmas associated with infertility.

Chapter 7 contextualizes those socio-cultural traditions, norms and factors that shape women's reproductive lives and facilitate or hinder their right to reproductive health care during pregnancy, delivery &in the post-patrum period. Chapter 8 focuses on women right to fertility regulation, providing a discussion on various strategies women employ to control their fertility through induced abortion and family planning. The chapter reveals their level of participation in fertility decision-making and the way they negotiated their fertility preferences in the context of their traditions and culture. Chapter 9 discusses the key research findings within the broader theoretical framework guided by critical medical anthropology and situates my work within the relevant literature and finally presents the conclusion.

CHAPTER NO 2

LITERATURE REVIEW & THEORETICAL FRAMEWORK

This section presents review of literature showing key aspects related to my topic through which research questions were developed. It highlights major themes of work that constitute the focus of this research. It further discusses the theoretical framework used for this study by analyzing various theoretical approaches within medical anthropology.

2.1 What Do Reproductive Rights Encompass?

Different scholars define reproductive rights differently. However Petchesky (1990) considers the concept of reproductive rights as too narrow. She prefers the concept of reproductive freedom to reproductive rights. In her opinion, the concept of reproductive rights limits the women's liberation problems to those related to reproduction, as if women were wombs on two legs. The concept of reproductive freedom provides a broader understanding of rights, which includes not only reproductive rights but also freedom from social and economic barriers. It takes into account factors such as education, the availability of child care centers, and active men's participation in child rearing which broaden the choices women can have in reproductive decision making. The concept of reproductive freedom also emphasizes economic and political power essential to force women's issues into the forefront of public issues. The availability of realistic choices with regard to reproduction is more likely to place the decision to have children in the hands of women than in the hands of men. The concept of reproductive rights encompasses three major thematc categories as suggested by Cook (1992);

- Right to be free from all forms of discrimination.
- Right to marry and form a family, liberty and security, information and education.
- Right to access health care and avail the benefits of scientific progress.

The present section discusses previous studies done to explain the phenomenon of reproductive rights at the global and national level. It highlights how reproductive rightsare interpreted and applied across cultures and what consequences their denial can bring for the women living in different parts of the world.

a. Right to Freedom from all Forms of Discrimination

Ensuring women empowerment, gender equality and equity has always been at the core of international declarations particularly those dealing with population and development programs (United Nations, 1994; ICPD, 1994).[31] Charlesworth (1995) noted biases that exist in human rights against women. He explained that women experience mistreatment and discrimination within families but human rights are ensured for men who play a role in the economy with active participation in public sphere. Family is regarded as a private sphere which is not the area for making intervention by the human rights groups and activists. Socio-cultural beliefs that shape gender roles often re-enforces gender inequities. Various studies at the international and national level have depicted women's lack of autonomy. In a developed country such as the United Kingdom, social exclusion of women and poor economic conditions remains most essential factor in determining their reproductive rights (Acheson:1998). Pakistan was ranked 99th among 109 countries in terms of gender and development index in the year 2009 (UNDP 2009) it was the 146th number among 186 countries in the Human Development Index (UNDP, 2013).

Several studies indicate that gender discrimination can cause poor health outcomes for the women (Krieger et al, 1993). Gender inequality can have a significant impact on women's ability to decide their family size. According to Kritz and Gurak (1989), wives fertiltiy behavior may be influenced by their husbands in a number of ways i.e. they are less motivated to reduce family size given the fact that they receive benefit from the labour of more children but bear less costs of their rearing. On the contrary, gender equality in family relationships empowers women to make decisions independently with respect to theformation, spacing, and completing their family (Pillai and Wang, 1999).

Patriarchal cultures give women less control over those conditions in which they live (Dixon-Mueller, 1993). Mason and Palan (1981) defined the patriarchal system as a set of social institutions that limit women's opportunities by making them more dependent on their males for the survival. Patriarchal control has direct impact on women's

reproductive decision-making. Patriarchy ensures that women do not have the freedom and courage to go against the institutions or traditions that subordinate them. This ideology is further reinforced through socialization which proscribes roles, behaviors, expectations based upon gender (Brock- Utne, 1985).

Patriarchy deprives women of control over their reproductive behavior. Patriarchy influences women's reproductive rights in many ways. First, it rigidly defines women's reproductive role as bearing and rearing children. Second, it values children, especially male children, as positive economic and spiritual assets. Finally, reproductive decision making is controlled by males of the family or community rather than by the women. Egalitarian relationships between women and men provide women with the ability and the power to obtain reproductive freedom (Pillai and Wang, 1999). In patriarchal societies male descendents, in particular, are highly valued. Patriarchal ideology restricts womens right of reproductive decision making and their reproductive behavior is often controlled by the older members and the males in the family, who impose family-level fertility expectations on women (Keyfitz, 1986). Jejeebhoy and Sathar (2001) also mentioned that in patriarchal contexts, strictcontrol is exerted on women's ability, participation in family's decision, their economic empowerment as well as their spousal relationship.

Gender inequality has a direct bearing on the practice of reproductive rights. This is because cultural beliefs, religious justifications and gender role socialization in Pakistan, all reveal beliefs about men's dominance and superiority over women (Ali, 1994; Mumtaz & Shaheed, 1987; Shaheed, 1991; Winkvist & Akhtar, 2000). Pakistan is considered having an unequal society with the cultural ideology and values that produce and reinforce inflexible gender restrictions and hierarchies (Mumtaz, Salway, Shanner, Bhatti, & Laing, 2011; Easterly, 2001). Most Pakistanis consider the birth of a female as "liability and a social burden" and woman's assets revolve around her reproductive capabilities and as an object of sexual service. Their reproductive role makes them a form of commodity that is owned by the husband (Mumtaz & Shaheed, 1987).

South Asian women's sexuality and their reproductive roles are generally seen as central to their role at home and in the society at large (Abraham, 1999; Lateef, 1999; Shah;

1997). According to Preisser (1999) South Asian woman are expected to be self-sacrificing, obedient to their husbands and to their elders, to be loyal to the family and kin, and to uphold values of familial integrity. Gillian Walker and Virginia Goldner (1995) stated that womenwho challenge these social prescriptions or live a life style that is against the prescriptions, are considered threatening and are castigated by society.

Discrimination against girls and women in food allocation and neglect of other reproductive health care within families is major problem confronted by most South Asian women (Cain, 1982). The discrimination against females continues throughout their lives. The nutritional status of females is compromised because of their unequal access to food, by heavy workload, and by special nutritional needs (for example, iron; women are particularly susceptible to anemia).

Women's roles are confined to domestic work and they are discouraged to work outside. It is considered a females duty to do all household chores, look after family members, and give birth to a male child who gives her respect in the family. There is discrimination against daughters often manifested in poor food allocation and restricted access to health services. As a result, they suffer a high mortality rate, especially in the first four years of their lives. The obvious outcome of son preference is female aggravation over males' supermacy. Women generally feel frustrated and inferior compared to privileged men (Hussain, Fikree, & Berendes, 2000). Women's lack of authority has been cited as the major cause underlying their poor health status among most Islamic societies (Caldwell 1986). In Pakistan alone a widespread strong desire to have atleast two sons contributes to a continuing high fertility (Saeed. S 2012; Ali, 1989; Chowdhury, 1994).

Pakistani culture is predominately patriarchal in nature with clear gender differentials in access to opportunities and resources of all types (Durrant and Sathar, 2000). The gender construction considers men as earners and sole decision makers, while women as economically dependants and housewives. The social demarcation of males and females roles is further exacerbated by the notion of *purdah* closely linked to the concept of male *izzat* or honour (Khan 1999). Marriages are generally arranged within the blood relatives,

and reproduction of the patrilineal lineage is mendatory for the women to achieve status and security in their marital homes (Winkvist and Akhtar 2000).

Pakistan is one of those Third World countries where males take all the chief decisions making imvolvement of women at any level of household decision making very low (Sathar,& Kazi, 1990). Jejeebhoy and Sathar (2001) in their study conducted in Punjab, Pakistan concluded that women have little say in their family decisions, their access and control over resources is also limited. Pakistani wives are subordinate at all levels of society, and they are subject to their husband's rule, particularly in contraceptive use (Manzoor, 1991; Zafar, 1993). The Commission on the Status of Women of the United Nations (1995) reported that the burden of the family and the absence or insufficient sharing of family responsibilities by men and society can affect women's freedom to make choices. Regarding the relationship between women's access to economic resources and fertility, the literature suggests that women's economic dependence actually reduces the economic bargaining power of individual women within the family, thus making it possible for husbands to impose their own family size decisions on wives (Folbre, Nancy. 2002). Blumberg (1991) argues that control over economic resources is the major (though not the sole) correlate of gender equality. There are three major dimensions that are closely related to gender equality: (1) Equal access to resources including education, employment, and health care; (2) Autonomy, that is, the freedom to make decisions on every aspect of life choices; and (3) Power that is, equal participation and ability in the making of decisions (Agassi, 1989; Ferree and Hall, 1996). Basu (1992) also reported that women who worked outside their homes had more say in household decision-making and a higher status within the family than women who were engaged in irregular income-generating activities inside their homes.

Women's economic independence is a way to enhance their reproductive autonomy. According to Caldwell (1982), women's ability to challenge patriarchal norms with regards to their reproductive decision-making is increased when they are able to contribute to the household economy (Oppenheimer, 1997; Crenshaw & Ameen, 1993). Women's involvement in productive activities also provides opportunities for women to exercise more autonomy and enhance their participation in decision-making, including the limiting or spacing of births (Hadi, 2001). Women's economic independence is likely

to change the nature of the relationship with their husbands, and women might have more equality in their conjugal relationship and, as a result, may exercise more control over fertility decisions (UN, 1985).

In South Asia, men are considered breadwinners and women are supposed to carry out household chores. In these societies, women are not much encouraged to participate actively in economic activities. For example, in Pakistan, women's participation in the labor market is not more than 15 percent due to the prevailing gender inequalities and low literacy levels. Moreover, women's work outside home is also viewed with suspicion and mistrust (Sathar and Casterline 1998). Consequently, women have limited control over economic resources (Sathar and Casterline 1998; Jejeebhoy and Sathar 2001). The unequal role allocation in different spheres of life gives unequal power to men, and women hold lower positions which not only affects their routine decisions but also decisions regarding fertility. As a patriarchal society, Pakistani women have restricted participation in some areas. The disproportionate opportunities available to men and women in many spheres of life reveal that gender inequalities exist in Pakistan (Sathar and Casterline 1998).

In short, gender discrimination undermines women's status and power within the family which ultimately reduces their ability to safeguard their existing rights and to demand new rights (Hartmann 1995). In fact, reproductive rights cannot be exercised until the patriarchal economic, social and political conditions under which most women live are radically changed. So the struggle for reproductive rights needs to be located in the broader struggle for their political, economic and social freedom (Harper, Gil: 1995).

b. The right to life and survival

Childbearing can be the greatest health risk for many women living in the world's poorest regions. Morbidity and mortality related to pregnancy and childbirth complications are inherently greater for women who have children at young ages, women who have too many pregnancies, women with too closely spaced pregnancies, and women who continue to have children at older ages (Mbugua 1997).Although over recent decades, maternal mortality and child mortality rates have fallen, yet they still remain remarkably high. Every year around 600,000 reproductive aged women die due to complications

related to pregnancy and most of these deaths occur in developing countries (WHO, 1999).

As far as situation in Pakistan is concerned, its Constitution ensures Right to Life in Article35 with the pledge by the State to *"protect the family ,mother and child".* But so far it has failed to show substantial improvement in the area of women's health due to high maternal morbidity, greater reproductive health burden, low contraceptive prevalence rate, and lower nutritional status and life expectancy ratio (Ahmad, 2012). There was one doctor for the 1,432 patients compared to the 390 patients per doctor in the United States. Inaddition, 45 percent of Pakistani women are iron deficient resulting in poor reproductive outcomes such as stillbirths, mental retardation and infant mortality. Hemorrhage, infections, hypertension, unsafe abortion, and prolonged labour are illnesses causing higher mortality among rural women (Aslam, et al; 2005). Nearly 20% of all these maternal deaths in Pakistan are associated with pregnancy and complications related to childbirth and insufficient gap in pregnancies results in low survival rates among newborns (NIPS *et al* 2008; Maitra and Pal 2008).

Maternal mortality among women of reproductive age mostly occurs due to preventable causes, particularly in developing countries. The majority of the women in developing countries are low users of maternal health care and their poor health can be improved if the reproductive health care services (such as prenatal and delivery care) are available and accessible to them (Center for Population and Family Health, 1992; Ronsmans &Graham, 2006). Lack of family planning facilities was also found as direct factor that cause death in many recent studies that were conducted in different settings (Nwogu-Ikojo & Ezegwui, 2007; Ramos et al, 2007).

Violence against women is another serious phenomenon that can have detrimental impact on women's reproductive health. It is reported that around thirty two percent of women living in developing countries undergo some form of violence during their pregnancy (Glasier et al., 2006). According to PDHS 2012-13, one out of ten women experienced violence during pregnancy and its ratio is twelve percent among rural women, which is higher as compared to urban women that are eight percent. Overall estimates suggest that

a total of thirty nine percent married women of reproductive age have experienced emotional & physical violence from their husbands.

Right to liberty for women transcends their right to safeguard and recognizes their health and life, reproductive choices as part of her personal autonomy and integrity. Autonomy is defined as a person's capability to manipulate one's personal environment (Hindin 2000). Moreover, Jejeebhoy and Sathar (2001) explained the concept of 'autonomy'as technical, social, and psychological ability to control oneself, including reproductive life (Jejeebhoy and Sathar 2001). They are empowered to control material and other resources and are able to develop and enjoy equitable power relationships within their families.

Moreover, reproductive autonomy also entails access to the knowledge and information and also health care services that make choices possible for women. Thus autonomy takes into account a set of other rights for women as an individual. It is concluded that Reproductive health is not just a biological condition; rather it is shaped by social forces, power relationships and other real life situations that may range from family to the level of international institutions (Obermeyer, 1994). Responsibilities associated with child bearing and rearing are believed to be the primary causes that restraint women's ability togain and exercise herindependent reproductive autonomy (Ware, 1993). Motherhood may restrict their mobility as well asother opportunities to participate in other social activities which can further reduce their personal autonomy (Sogner, 1993).

Another feature of women's liberty is related to their ability to control their lives. In South Asian cultures, women have limited decision-making power in the household and ineffective communication with their husbands (Sathar and Casterline 1998). Participation in household decisions is limited in making decisions about clothing, food, recreation, education and treatment of children when they are sick as well as decisions concerning their reproduction. The participation or control over such decisions gives a woman authoritative power and raises her status in the household (Hindin 2000). Hadi (2001) stated that women's position in reproductive decision-making has remained poor in most developing countries. Dyson and Moore (1983) explain that women paritipation in household decision making is not much encouraged and their personal decisions are

influenced and constrained by kinship, family, and marriage relationship. They are socialized to believe that their own wishes and interests are subordinate to those of the family. Therefore they mostly forego their personal health in repeated child-bearing. National data on Pakistan shows that 38 percent of married women can jointly participate with their spouses in matters such as visiting family and relatives, major household purchases, and their own health care needs (PDHS 2012-13).

c. The Right to Liberty and Security

The Political Covenant article 9 (1) ensures the right to personal liberty and security.With regard to the Constitution of Pakistan, Article 9(Chapter 1), states "*No person shall bedeprived of life or liberty save in accordance with law"*(Government of Pakistan 2009). Reproductive autonomy is compulsory aspect of reproductive rights that gives individuals the right to engage in wanted sexuality and also to be free from coerced sexuality, abuse and violence (Helmut 2004). So far, there is no policy in Pakistan, that exlusively deals with the freedom to control one's sexual and reproductive life. There are no specific laws that govern individual's sexual rights according to their free will. Sexual behavior of couples is mainly treated as 'private affair' that requires no public or legal intervention.

Women's liberty in the context of making independent choices to have or not to have children is influenced by their unmet need of family planning. According to the estimates, worldwide around 123 million women, mostly from developing countries, are unable to use birth control methods in spite of having an expressed desire for family limitation (WHO 2004). As an outcome, 38 percent of the total pregnancies worldwide are estimated to be unwanted, around 6 out of 10 of such unplanned conception turn into induced abortion. In Pakistan, married women bear on average one child more than their desired number of children. This shows women's dire need to access family planning services as survey data reveals that nine percent of married women have an unmet need for child spacing and eleven percent of them still have an unmet need for child limiting (PDHS 2012-13).

Casterline and Sathar (2001) argued that the discrepancy between women's stated fertility preferences and actual contraceptive behavior indicates their latent demand for

contraception. It further reflects women's inability, hesitation and equivocation to achieve their reproductive goals (Bhatti, F. 2014). The main reasons behind this persistent gap in Pakistan are powerful and deep-seated social and cultural obstacles against the use of birth control methods. One of the most crucial rights for women is to give them liberty to choose the size of their family and the number of children to bear as this would be the most influential determinant of their health and well-being.

d. The right to marry and to found a family

It is the right of all individuals to marry and form a family with their peronal choice.[32]The institution of marriage is seen as central to the functioning of society. Marriage is not just seen as a social norm but the most desirable and inevitable act for all Muslim adults and is considered a part of every Muslim's religious practice (Hassouneh-Phillips, 2001). In addition to the cultural mandates, marriage is also believed to be a social and religious obligation **o**f all Muslims (Sherif, B. 1999). In Pakistan, like other South Asian cultures, marriage is seen to bring families together and strengthen them as groups (Korson &Sabzwari, 1984). Marriage is the only socially and religiously approved avenue for sexual union and intimacy between individuals and the only desirable context for procreation (Hassouneh-Phillips, 2001; Sherif, B. 1999). While premarital sex is prohibited and dating and courtship are socially disapproved, celibacy is also discouraged for both men and women (Sherif, B.1999).In Pakistan,the minimum legal age at marriage is 16 years for girls and 18 years for males. The event of marriage provides women with legally acceptable ways to initiate child bearing and the age at which women first marry determines the reproductive span of women lives in which they are exposed to the risk of pregnancy (PDHS, 2012-13).

Previous studies suggest that most Asian cultures value the interest of the family or group over the interests of individuals (Ho, 1990; Shon & Ja, 1982) where conformity and interdependence is encouraged and where individuals are expected to prioritize their family's interests before their own (Preisser, 1999; Segal, 1991). Although women have the right to decide the time and the person to marry, still many girls have to marry young at the minimum legal age or even below that due to the fact that they lack other life

opportunities (Cook, 1993). Despite the legislation to eliminate the practice of early marriage, still many girls throughout the world marry right after puberty and are expected to have children quickly which may result in risky pregnancies and other complications (UNFPA- safe motherhood, 2004). A study based on forty demographic and health surveys concluded that, in many countries, girls still get marrried at a very young age, as around 20-50% of them marry by the age of eighteen years and 40-70% of women get married by the age of twenty years (Singh & Renee, 1996). The situation of women living in Pakistani is very similar. They initiate childbearing early as a national survey shows themedian age at first marriage among women is 19.5 years and 15 percent of them give birth by the age of 18, and 32 percent by the age of 20 years. More interestingly, eight percent of adolescent girls (15-19 years) are already mothers or pregnant with their first baby (PDHS 2012-2013). A recent study conducted in Punjab, Pakistan, shows that parents are really anxious to marry their daughters as the older their age at marriage, the greater the risks to their chastity and honour. Marriages are mostly endogamous with the clear preference for first cousins due to its perceived benefits in strengthening family ties (Bhatti, 2014).

The tradition of marrying early might negatively affect women's liberty as well as position in thefamily, more specifically in case of a large spousal age gap (Sathar et al. 1998). Early child bearing also results in reduced educational and economical opportunities for the young mothers (UNFPA-safe motherhood, 2004).It also deprives them from receiving higher education and pursuing good careers which ultimately lowers their social position.

Indeed, where births are confined to marriage only, an increase in women's age at marriage can be a major factor in fertility decline, as early marriage increase the period of exposure to the risk of pregnancies in the absence of fertility control (Sathar et al. 1998; Sathar and Casterline 1998). Thus, as the literature suggests, the increase in marriage age can significantly reduce fertility in countries where births occur only within marriage. This argument is supported by Abeykoon (2000) who found in Sri Lanka, increased age at first marriage among women proved to be a significant factor that facilitated the onset of fertility decline.

In Pakistan, a high percentage of women is married with a first cousin. Rafat Hussain (2005) explains that the endogamous unions are prefered due to the presence of common characteristics that may include religious, ethnic, and clan affiliation. Many studies have shown that women in consanguineous marriages tend to marry early, are less interested to use modernbirth control methods and have more pregnancies and child deaths (Hussain and Bittles, 1999).

e. Right to Recieve Information and Education

The right to receive information and education is one of the basic human rights and can play a vital role in improving the reproductive health status of women.[33]The absence of sexual and reproductive health information and education among women and men is likely to have significant impact on their practice of reproductive rights.

According to Correa (1994) the reproductive rights ideology is brought about by women, for women and through education. In order to improve the reproductive health status of women they should be given the right to receive appropriate health related information & education and to be in a position to comprehend and utlize this information (Lee & Garvin, 2003). Research suggests that lack of education among women restricts their access to information and services. It further limits their mobility to look for better health care services and their involvment in social affairs that are likely to empower them (Leach, 1998).Due to the lack of health related awareness and limited access to information on available health care services women face many impediments to take advantage from qualified health providers (Ensor &Cooper, 2004).

In Pakistan, the survey indicated that women having secondary education start childbearing 3 years later than uneducated women and sixty eight percent of women did not discuss the issue of family planning during field visit by a provider or at a health facility, highlighting missed opportunities that could have been used to inform and educate women about birth control and fertility regulation (PDHS, 2012-13). The

findings of the study conducted by Jejeebhoy and Sathar (2001) in Punjab, Pakistan, revealed older or educated women had more say in their own lives as compared to uneducated. Several other studies in Pakistan show the significant impact of education on women's fertility behavior, their contraceptive use, greater reproductive autonomy and status in family (Gangadharan & Maitra 2003; Fikree *et al* 2001; Mahmood and Khan 1985; Durr-e-Nayab 1999; Faizunnisa and Ul Haque, 2003).

Educated women are likely to be more aware of their rights. According to Pillai and Wang (1999) education helps to enable women to make use of various ideas and values for their personal development and provides them with opportuties to organize themselves as a social group to alter their socio-economic conditions. The relationship between education and personal autonomy has been the subject of extensive research. Education beyond primary school is often associated with adoption of innovative ideas (Dixon- Mueller, 1993). Similarly, Correa (1994) also highlighted the several advantages of women's education. In her opinion, education as a human resource may give women confidence that help them challenge traditional values and intensify the motivation to demand equality.

The attainment of the same level of education with men is a precondition to women's autonomy (Julemont, 1993). Educated women make use of opportunities in the labor market, which is likely to introduce new forms of authority, and challenges traditional power relations within the family. Education facilitates women to broaden social networks, and prepare women to gain benefits from opportunities in the public spheres. Women's education is likely to increase their reproductive rights and level of gender equality (Pillai and Wang, 1999).

There is a positive relationaship between education of women and their use of maternal health care services. Education enables them to decide freely about their health, it also increases demand for modern health care services (Jejeebhoy, 1995; Celik and Hotchkiss, 2000). Education creates awareness and gives ability to woman to make reproductive choices (Mahmood, 2002).

Hall (1992) viewed education as a form of cognitive empowerment that enables women to understand those conditions which cause them vulnerabilities. This realization helps

them to make choices that may go against cultural and social expectations. Brown (1990) also noted that education helps women to spend less time in household and non-market activities'. It increases their mobility and participation in the labour market which enhances their role in decision-making within the family, which ultimately leads towards women's equality and empowerment.

The low educational level amongst South Asian women contributes to their lack of knowledge on safe childbearing practices. Increase in the educational status of women helps to reduce maternal mortality rate (Rahim,Shafqat & Faiz 2006). According to a study, in Pakistan, mothers and grandmothers are the main providers of basic health education to young girls. They are considered major transmitters of knowledge on issues related to menstruation and sexuality. Pregnant women receive advice from elderly women (Mumtaz & Rauf 1996). In Pakistan, a study done by Mahmood (1992) reveals women's lack of spousal communication and knowledge about contraceptives. Her study suggests that women did not practice family planning due to antagonism from the spouse and the fear that using contraception would predict an intention to avoid having children on their part, which carries social consequences. However, what women perceive to be the irrefutable consequence of using contraception is not always the reality because when questioned by Mahmood (1992), many husbands denied having negative views about birth control.Moreover, lack of reproductive counseling and fear of harmful side effects are factors that influence use of contraception (Manzoor, 1991). Although awareness about the importance of having pre-natal care is a precondition of its usestill, due to the cultural context of Pakistani society, knowledge related to sexuality and reproductive is considered 'shameful' and a 'culture of silence' prevails around these matters (Khawer and Rauf 1997).

f. Right to Reproductive Health Care

One of the most essential reproductive rights is to provide women with relevant reproductive health care services. It requires that every woman must find reproductive affordable health care services available, and accessable (CESCR Committee, 2000).[34]

[34]Women's right to access reproductive health care services has been acknowledged by many international treaties and conventions sych as emphasized by the CEDAWArticle 12(2) and Beijing Platform for Action Paragraph 92.

Complications related to pregnancy and childbirth tend to a death toll of around 529,000 women and most of these deaths occur in developing countries (UNICEF, 2004). Effective maternal healthcare services hardly exist in developing countries (Cleland J et al., 2006; Merali, 2000). According to the estimates, about one third of women receive no anti natal care at all during pregnancy, and almost 60% of the deliveries take place under unsafe conditions (Cleland J et al., 2006). Less than 30% of women receive postpartum care, while in developed countries over 90% receive this service (Merali, 2000). Over one fourth of the women suffer from short- or long-term reproduction-related problems (Merali, 2000), and nearly 200 million women in developing countries suffer from life-threatening complications related to pregnancies (Cleland J et al., 2006). Further studies reveal that most of the maternal deaths occur due to unskilled care at the time of delivery still, each year around sixty million deliveries are home based throughout the world, without the help of any skilled person (Yasir et al., 2009).

The reproductive health of women is explained in terms of their ability to go through their reproductive span and beyond with choice, respect, and to be free from the dangers of gynecological problems and risks (Zurayk, Younis, and Khattab 1994).

Although the main objective of Pakistan's National Health Policy (2009) is to advance health of people through effective health care programs/projects that aim to enhance equity and efficiency in the area of health including safe motherhood and provision of reproductive health services with the help of a life cycle approach (Ministry of Health, 2009). The Constitution of Pakistan also guarantees women's health and its Article 34 states that appropriate steps shall be taken in order to ensure full participation of women in every sphere of national life (Government of Pakistan, 1973). It has made significant efforts to meet the Millennium Development Goal 5 (MDG5), by proiding and improving district health services. It is expected that these efforts will lead to the provision of an optimal level of health care services at every level (Government of Pakistan, 2006) but despite the increase in health services, inequities are also widening in its utilization between the rich and poor (Mahmood, 2010) as national data suggest that 84% of non-

rural women actually sought delivery care from the public sector (Mahmood & Bashir, 2012). Despite persistent efforts for the improvement of maternal healthcare services, concerns still remain regarding the low uptake among the poorer stratas (Mahmood, 2010). Women find less time for seeking health services due to their domestic workload; the role of mothers particulary, gives them a greater reproductive burden than men in the family (Maya Unnithan-Kumar, 1999).

The maternal health status of Pakistani women and their uptake of health services are not encouraging.The estimated maternal mortality rate is near 500 per 100,000 live births (WHO 2004) which males Pakistan one among six countries which contribute to more than half maternal mortality rate throughout the world (Hogan et al., 2010). Statistics from PDHS 2012-13 reveal that more than half (52 percent) deliveries take place at home. Facility based delivery is more common among urban mothers. Numerous studies indicate that prevailing gender inequalities and a fragmented health care system negatively influence women's access to reproductive health services including family planning (Tian et al, 2007). In Pakistan, women mentioned different obstacles in seeking health care during sickness. Forty percent of women cited the issue of transportation and 37% mentioned the long distance from a health facility as an obstacle.While 30 percent financial constraint for seeking medical advice or treatment. Only 18 percent women cited the issue of having permission for visiting health facility as a problem (PDHS, 2012-13).Various studies show the distance to a health facility as a problem in utilization of health services. A study conducted in Punjab, Pakistan, found that the longer the travel needed to reach a family planning center, the less likely women are of availing a family planning method service (Population Council, 1997). The state of health services is not satisfactory and there is s shortage of female medical staff, and one-third of government based health facilities lack female staff. Morover, most of the female physicians are placed in urban areas (Anne G.Tinker, 1998 quoted in The Center for Reproductive Rights).

The lowly position of women within their families has been found to be an imporant factor that limits their access to prenatal healthcare (Winkvist and Akhter 1997). Furthermore, cultural values with regards to women's mobility through the restriction of

purdah prevent them of availing healthcare services outside home (Rashid et all. 2001). The norm of *purdah* restricts women's access to health care services by dictating that they can only be examined by female physician (Winkvist and Akhter 1997, Tinker 1998). Women's constrained mobility is one of the most prominent aspects of *purdah* in Pakistani culture (Khan 1999, Sathar and Kazi 1997; Mumtaz, Z. and Salway, S., 2005).

Another important social barrier is that majority of the women are not independent to make decisions concerning their health. Women's low participation in fertility decision-making is found to have an impeding impact in previous reproductive health studies in Pakistan (Sathar and Kazi 1997, Fikree *et al.* 2001). Li (1993) argued that social pressure, limited resources and inaccessible health care, in some of the developing countries significant factors that cause lack of decision-making power and increase in reproductive complications among women. This is particularly important in many South Asian cultures where the mother-in-law holds decision making authority related to pregnancy and childbirth. The decision to deliver at home or at any health facility primarily depends on the wishes and beliefs of the mother-in-law (Piet-Pelon et al. 1999). Opposition and the unsupportive attitude of the family members can put women in a fragile situation where they find it hard to make decisions on their own, even in a state of emergency. They may not be able to use family planning methods even if they wish to do so (Kadir, Fikree, Khan and Sajan, 2003). Pregnancy and decisions related to it (such as whether or not to seek anti natal care, place of childbirth or the type of attendant to assist in childbirth) is normatively in the discretion of the older women in the family who are considered *siyarni* (wise and experienced) and their decisions have binding effect. The expecting mother is not supposed to make personal choices and the opinions as all her health care requirements are considered the responsibility of her mother-in-law (Mumtaz, Z. and Salway, S., 2007). Women who cousult their mother-in-law in family planning matters were found more inclined towards adopting modern contraceptives (Fikree et al., 2001). Findings of different studies suggest that in Pakistan, decision making authority mainly rests with the males and elderly women (Matsumura & Gubhaju, 2001).

This literature shows that the birthing process in South Asia has largely been considered as a woman's affair (Unnithan-Kumar 2002; Jeffery *et al.*2002,). In many developing countries, women are more vulnerable to poor-health, have poor access to health services

and health promoting resources which makes them disadvantaged in the healthcare system (Okojie 1994, Vlasoff 1994). One qualitative study based on the evaluation of women's contentment regarding receiving health care services concluded that women acknowledge and desire easy access to a heath care facility, and holistic medical care. They desire well coordinated physical as well as sexual health, family health and social functioning (Anderson et al, 2001).

g. The right to the Benefits of Scientific Progress

The right to enjoy the benefits of scientific progress and its applications has been recognized by the Economic, Social, and Cultural Rights Covenant Article 15 (1) as well as the Vienna Declaration, Paragraph 11. Sen (1994) argued that often socio-political forces undermine options for women. Paternalistic control of women's fertility behavior is well reflected in reproductiuve laws and policies. For example, in some developing countries voluntary sterilization services depends on the number of caesarian sections a woman has gone through.

In the developing countries, bearing children is perceived as major factor to achieve social status, respect and acceptance in the community (Hollos, 2003). Women are desperate to have children and they are willing to spend significant amounts of their meager household income in consulting medical professionals and gynecologists. Reproductive technologies that promise to overcome the difficulties in bearing and having children primarily enable women and men to counter social stigma and to regain a sense of self and personhood. To counter the social pressure and criticism associated with their childlessness, infertile women often consult spiritual healers for a sacred solution to their barreness and to resume their worth as women (Unnithan-Kumar, 2010).

Similarly, it is the basic health right of every pregnant woman that she must not to be forced to do any undesirable procedure during pregnancy. Many times women's choices are constrained by ignorance, personal or religious beliefs that preclude certain decisions through socio-psychological pressures (Flagler et al, 1997). Therefore, women need to be well informed about all the different possibilities while providing them pre-natal health care (Johnson, 1987).

Many studies highlighted poor public health services and the high cost involved in consulting a health specialist makes health care services inaccessible for them. Tarafder (2013) study conducted in Bangladesh found that rural women rely more on traditional or spiritual healers for being cost efficient and accessible despite having knowledge of the importance of consulting a doctor. Family elders may not be able to interpret the medical care required during pregnancy and this can be life threatening. Thus adherence to the decision of family elders may not allow women to consult qualified health professionals.

The scenario of women reproductive health services in Pakistan is quite similar to Bangladesh. In Pakistan, underutilization of health care facilities is attributed to the lack of female health professionals, poor quality of health facilities and inconvenient location of Primary Health Care (PHC) units (Government of Pakistan 2000). Even basic health facilities often have restricted hours of operation and approximately only 25% of Basic Health Units (BHU) has qualified female doctors (Islam and Tahir 2002).

Reproduction and serving the family are the main tasks assigned to women throughout their life cycle. A study conducted by Sathar and Kazi (1997) in rural Punjab, Pakistan, revealed that womens mobility and their access to health is constrainted by social norms and only 43 percent of women in their study was allowed to visit nearby fields alone, and approximately 28 percent could visit unescorted to a health facility.

Issues of reproductive health and rights need to be located within a wider context of gendered inequalities occurring in women's everyday lives. Social exclusion of women together with gender discrimination limits women ability to maintain their health. Khan (1999) reports from her study in rural Punjab, Pakistan that concepts of honour and the practice of gender segregation restricts women's access to health services.

2.2 Anthropology and issue of 'Rights'

Anthropologist's definitions of human rights puts greater emphasis on cultural differences and more specific focus on safeguarding the rights of traditional communities. Anthropologists are against the nature of universal nature of rights. Empirically, they

oppose the rights of individual as self-evident universals. The Statement on Human Rights as given by the American Anthropological Association (AAA) emphasized that "standards and values are relative to the culture from which they are deriven" (American Anthropological Association Executive Board 1947 cited in Washburn, W. E. 1987) and many Asian and African anthropologists also reject the notion of "individual rights" as ethnocentrically western (Legesse 1980:123).

Although the International Conference on Population and Development (ICPD) was participated by the Delegations from 179 States which took part in negotiations to finalize a Programme of Action on population and development for the next 20 years still this could not be implemented in its true spirit. One of the major criticisms of the international human rights framework is their lack of concern for the social differences between women living around the world. There islittle attention paid to understand the socio cultural context in which reproductive processes take place. Many scholars have argued that the concept of 'Reproductive Rights' is based on the western concept of individualism and ownership of one's body which does not take into account the subjugated position of many women in reproductive matters and their interdependence in sexual and reproductive relations. It suggests that culture specific-approaches to human rights in general and reproductive rights in particular must be endorsed instead of adopting narrower definitions given by universal human rights declarations. Reproductive rights for the people living in a culturally diverse world can only be formulated, implemented, and protected through their cultural understanding. This call for in-depth anthropological inquiries to find out the areas where local cultural values and practices edorse or oppose international norms of reproductive rights and motherhood. Anthropological analysis of rights with reference to diverse culture is needed to find out gaps and negotiate the differences between cultural versus "universal" interpretations of rights.

Reproductive rights are not an isolated issue and are intrinsically linked with culture. Some progressive human rights scholars assert that human rights entitlements are not just morally defined in the abstract, but must be grounded in cultural, political and social conditions (Correa& Petchesky, 1994; Petchesky & Judd, 1998; Ferguson, 1999). It is significant to include woman's lived experiences in order to comprehend how meanings

are constructed and identities are negotiated within their own context. The use of a culture centered approach allows culture to be treated as constitutive space where unheard voices of the marginalized people can participate in knowledge construction (Dutta & Basnyat, 2006;Bell,2002).

Anthropologists can make significant contributions by analyzing the concept of 'rights' in culture-specific contexts, by making effective human rights educational materials to combine sentiment with human rights reasoning. Anthropologists can also help to shape human rights and entitlements rhetoric and instruments through the analyses of "rights" and "duties" across cultures. They are able to better understand human beings as a member of a society and group. This process can organize and advance discussions of rights conceptualized, assumed, or abrogated at various societal levels or by different social institutions (Messer 1997). Participants of the Women's Global Network for reproductive rights (1993) also concluded that larger social conditions cannot be ignored as they often determine which choices are available to women. Rights on their own without attention to the context has no value. Thus the present study aims to differentiate between international appropriation of reproductive rights language and its relevance within the Pakistani cultural context.

2.3 Theoretical Framework

The present research is situated within medical anthropology following the theoretical framework of interpretivism, critical medical anthropology and social constructionist approach.

The following theoretical approaches were found relevant to address the broader socio-cultural, religious and economic conditions and factors which contextualize women perception and practice of reproductive rights. Contributions from these theoretical approaches highlight various aspects that link together cultural forces and processes that influence their reproductive health as well as act upon shaping individuals perception and practice of reproductive rights.

1. Theories of Social Construction

The basic premises of social constructionist theory is that all knowledge and social realities are contingent upon human practices, being constructed through interaction between humans and their world, and developed and transmitted within a social context (Crotty,1998).

Constructionists approaches suggests that knowledge is constructed through individuals interaction with their own world (or experiences) as well as by interacting with other individuals within a specific social community. For them, "There is no reality out there" rather, every phenomenon is assigned meaning through human conversation and cultural process, or it is constructed. This implies that knowledge construction is the byproduct of cognitive and social processes and it further expands through sharing of experiences or ideas with others (Gergen, 2008). The basic argument of the constructionist approach is that reality is socially constructed by and between the individuals who experience it (Gergen, 1999). Also emphasizing the importance of social world to human behaviors, Gubrium & Holstein (1997:54) argued,

> *"Social worlds are constructed through interactions. The kind of statuses we obtain, the positions we take up, and the situations in which we do participate all are consequence of what we say and do with one another."*

Berger and Luckman (1966) expressed similar views that individuals socially construct realities through communication of their agreed and shared meanings. That's the way beliefs about the world are socially invented. Bell (1993) also stated that people are well connected with their culture and social values that are likely to influence their thoughts and actions.

Thus, a social constructionist approach mainly emphasizes the significance of shared meanings that are connected with social norms and values, beliefs, behavior, attitude and actions that to be communicated symbolically in a society. These social ideas and attitudes are constructed over time within a specific social and community context. It is an outcome of the context in which actions occurs and is shaped by the cultural,

historical, political, and social norms and values prevailing within that context and time (Gergen 2003; Gergen, 1999).

The meanings which surround reproduction and reproductive rights are also culturally constructed, so they vary according to the social context in which they are found. Many studies have been conducted to examine the relationships between people's health related decision-making behavior and the context or social settings in which individuals live. For this purpose, Browner selected three Latin American contexts to examine the ways "conjugal dynamics," or the amount of power men exert on their wives, shapes women's reproductive decisions. Her findings reveal how reproductive choices are shaped by the socio-cultural and structural factors present in specific physical and social contexts. It increases our knowledge of the concept of "health" by putting it in the context of the individual to include their lived experiences and by recognizing that socially constructed cultural, economic and gendered factors crosscut and shape health behavior (Browner 2000).

Anthropologists Clellan Ford and Frank Beach (1951) explained that sexual customs and practices and expressions would vary cross-culturally, as they are likely to be influenced by gender identity, reproductive capacities, individual needs and desires etc. According to social constructionist view, there are no universals and they focus more on cultural influences as the most significant in understanding human sexuality and reproduction. They argue that the meanings of sexual and reproductive behavior and potentials are to be found in social relationships and through various forms of social organization. It is socially learned, through a variety of discourses which are embedded in norms, values, laws, religious strictures, social practices, socialization pattern and other cultural influences.

The present research relies on the basic assumption of social constructivism that the perception of reproductive rights is not objective rather it emerges out of individuals interaction with each other, through the process and pattern of their socialization, negotiations and strategies they use while living in their particular context.

2. Interpretive Paradigm

The interpretive approach, mainly emerged with the foundational work by Arthur Kleinman(1988), focused on the explanatory models of illness that emphasize the significance of incorporating 'native's point of view'. This perspective brought a major shift in understanding the linkages between the cultural domain and the domain of disease. Kleinman emphasized that disease is just not an entity rather an explanatory model that belongs to culture which is not just a way to represent illness but is also crucial to its composition as a human reality. For Kleinman, it is not correct that disease is absolutely natural and therefore above or beyond culture (Kleinman 1977 quoted by Good 1994:53). This stance became the foundation for theorizing in an interpretive tradition.

Baer *et al* (1997) and Good (1994) argued that the interpretive tradition in medical anthropology examines how interpretations are constructed in various social contexts. It provides an understanding of how meanings and interpretive practices conect with socio-psychological and physiological processes to result in different forms of illness and illness trajectories. According to the stance of Good, sickness is manifested through interpretive activities that involve interaction of one's biology, the societal practices and cultural meanings that help to construct clinical realities. However, the major flaw of this approach is its failure to give a critical view that became the basis for the formulation of the 'critical approach'. It lacked inclusion of unequal power relations in constructing clinical realities and it paid less attention to social and structural determinants of the experiences and their interpretations. The interpretive approach views illness as an interpreted and subjective experience but the critical point emphasizes the role of societal forces and structural factors.

The interpretive approach is meaning-centered and considers social processes and constructs behind disease and illness. Thus the use of social interpretive approach is

relevant to the study of reproductive rights as it acknowledges the significance of understanding social and cultural context to ascertain the local worldview of reproductive rights and from the perspective of those who practice them.

3. Critical Medical Anthropology

Anthropologists in general, and medical anthropologists in particular, have shown their interestin issues related to maternal health and reproduction, health care system, health seeking behavior, illness and diseases. The anthropological literature reveals how anthropologists have been investigating women subordination because of social emphasis and pressure on their reproductive roles and capacities and control over when and how they reproduce. Some of the key issues that have characterized in this study include the women's perception of the reproductive processes, their reproductive health and rights and the role of cultural norms and values in shaping reproductive experiences of them.

Medical anthropology applies anthropological theories, knowledge, and techniques to address issues related to health, disease, sickness, medicine, and healing (Brown 1998). However it pays further attention to issues related to power relationships, stuructural inequalities, and social hurdles (Baer 1990; Singer and Baer 1995). Critical medical anthropology emphasizes fostering connections that exist between social groups and the political institutions of the community at large. It focuses on the pattern of interaction that shapes and determines human behavior, attitude, belief system, and emotions (Singer 2004:24). At the micro-level, critical medical anthropology is concerned with individuals, social expectations, and at the macro-level, it contextualizes health seeking behavior of people in the context of broader historical, political and economic context with the aim to acknowledge the significance of culture centered approach within the complex issues of control, power and resistance, as they are linked with the notion of health (Singer 2004).

The critical medical approach emerged as a criticism of the interpretive stance. It attempted to shift focus of medical anthropology towards social factors. This approach is associated with Soheir Morsy (1979:356), which aimed to incorporate a political economy of health into the broader anthropological stance. According to his argument,

> *"The relationship that exists between individual actions and social determinants is indicative of the fact that individual actions are culturally informed interactions taking place between human actors and their economic and political relationships. Thus, culture is understood in the critical approach in relation to issues of power, control, and resistance that revolve around health, sickness, and healing."*

The critical stance also stresses a 'local worldview' which implies that individuals are not passive objects, rather they act in response to the material environment created through the arrangement of social relations (Baer, 1997). Critical approach while considering interpretive understanding of illness also goes beyond and takes into account those power relationships in which interactions and experiences take place. These theoretical dimensions are relevant to the study of reproductive rights as they draw a connection between social context and individual subjective experiences. The theory of critical medical anthropology integrates the macro level dimension of the political economy of health with individual experiences and agency. This dual attention is relevant to my study as it aims to explore those connections that exist between women's understanding of their reproductive health and their social practices.

Hence, this research is informed by Critical Medical Anthropology which, according to Hans Baer *et al* (2003) explores the extent to which issues of inequality, power and oppression shape human well-being and illness behavior. However, the study remains focused heavily on local socio-cultural dynamics, that sideline of global power politics. This framework is relevant to the present study as it examined the power dynamics that existed in marital relationships and between families, the resistance of women to obtain reproductive health services, and how all these issues are perceived within the normative structure of the community. Individuals make their own reproductive decisionsbut their perception of their reproductive rights is influenced by the aforementioned, invisible social and cultural forces. What kind of health consequences it brings for the individual or the community is what makes this entire study worth investigating.

CHAPTER No 3

VILLAGE PROFILE

The study was conducted with the major objective to understand how female reproductive rights are percieved and practiced in a given culture. Therefore, obtaining in-depth information was necessary with regards to the socio-cultural norms, values and beliefs in the selected locale that influence, guide or control the practice of reproductive rights among married women in their everyday lives. Understanding the cultural context in which reproductive rights are excercised is significant to know the reproductive health behaviour of women. Kunitz (1990:126) highlights this phenomenon as

> *To better comprehend the prevalence, distribution, as well as prevention of these health problems requires in-depth understanding of the people concerned in their cultural setting. It calls for a different kind of science thatfocuses on local worldview, beliefs, norms, attitude, behavioural pattern and social organization rather than simply attaining universal knowledge of the viruses and GNP per capita.*

The present study mainly focuses on village Choha Shah Ghareeb, Tehsil Hassan Abdal, District Attock, situated in Potohar- a plateau area of 500 square miles comprising of the districts Islamabad, Rawalpindi, Attock, Jehlum and Chakwal. This chapter provides the historical and socio-cultural context of the community and area where this study was conducted, considering it helpful in analysing the socially constructed meanings related to female's reproductive rights. It presents inter-linkages among reproductive behaviour and other material and non-material aspects of the culture. The information in this chapter comprises information collected through participant's observation and other research techniques.

3.1 Area and Location

The village Choha Shah Ghareeb was choosen to examine the perception and practice of reproductives rights of rual women in the Potohar area located in the Provnce of Punjab, Pakistan.

3.1.1 The Pothohar Area

The Pothohar Plateau is densely populated area of Pakistan which contains the historical city of Rāwalpindi and the Capital City, Islamabad. Pothohar is an extension of the Siwalik Hills, in the North of Punjab. It is an elevated plain, a plateau, situated between the rivers Indus to its North and Northwest, the Jhelum to its east and southeast. Its north is squeezed between North Himalayan mountain ranges of Muree-Abbottabad with lesser the Margala Hills, with the height of 1200 meters. Its south is bordered by the SaltRange with major heights of 1054 meters near Pai Khel and 1522 meters at Sakesar with gradual decrease towards east (Ahmed, 2014).

3.1.2 District Attock

History and Location: Attock district, located in Pothohar area, derives its name from the famous Attock Fort that was assigned its name by Mughal Emperor Akbar The Great. Attock was accorded the present administrative status of a district in the year 1904. The district has Swabi and Haripur districts of Khyber Pukhtunkha, on the north, Chakwal district on the south, Rawalpindi on the east, Mianwali district on the south-west, Kohat district on the west and Nowshera district of Khyber Pukhtunkha on the north-west (Planning Report – Hassanabdal, 2008).

The total area of the Attock district is 6,857 square kilometer and its density according to the population Census of 1998 is about 1186 per square kilometer. In the year 1951, the population of the district Attock was 486 thousand, which increased to 1275 thousand by 1998, and the growth was about four and half times in the past 47 years. There are 6 Tehsils in the district and 78.7 percent of its population is living in rural area settled in total 349 villages (Directorate of Industries, Punjab. 2012).

The population of Attock is not evenly distributed among its different Tehsils. Jand Tehsil is the largest with 29.8 percent of the total area and inhabited by 17.91 percent of the total population of the district. Pindigheb Teshil stands at the top on the basis of land with 27.2 percent with 15.35 percent of the total population. Fateh Jang Tehsil area wise is 18.2 percent of the total with 16.81 percent of the population. The area of Attock

Tehsil is 19.7 percent of the land and population share of 39.29 percent. The Hasan Abdal Tehsil is smallest in terms of total area which is 5.1 percent of the land with a total population of 10.66 percent. The population density of Hasan Abdal tehsil is comparatively more, which is 388 persons per sq. Km (ibid).

3.1.3 Tehsil Hassan Abdal

Hassan Abdal is a historic town in Northern Punjab. Hassanabdal lies on the main Grand Trunk (GT) Road – N-5. It is close to Wah Cantonment and at the distance of 71km away from Capital City, Islamabad and also well connected to other famous cites including Rawalpindi, Kamra, Peshawar, Mansehra and Abbotabad etc. (as per DCR 1998).

Historical Background of Hassan Abdal

The term came into being in the beginning of the fifteenth century when, during the reign of Mirza Shah Rukh (son of Amir Timur), a saint Sayyid Baba Hassan Abdal known as Wali Kandhari came to this place and settled here. Since then this valley began to be called Hassan Abdal after his name. It is difficult to establish that the name of some habitat changed to Hassan Abdal or that it was a new colony. Genral Cunningham in this regards states:

> *"The old name of the town id Harrow. Most probably it is correct since the river that flows three miles away from the Hassan Abdal is called Haro. A sadho (Priest) told me that the place was called Batkar. It reflects that the Muslim consequence who called Hindu Mandir (temple). Butjada termed the name Butkh and because of the temple the traces of which have since been found on the second mound to the north-east of sarrow garden." (Archeological Survey of India; 1871-2:33*retrieved from *http://asi.nic.in/)*

Many Moghal emperors also visited this area. First the Mughal emperor Akbar visited the area from 1581 to 1592. The Mughal emperor Jahangir visited this place six times and mentions in his Tuzk-e-Jahangiri this town by the name of Baba Hasan Abdal where he stayed for three days. Some historical places of the Mughal period are Wah Garden, Saraey which is called "Andaroon Mohala" and the Tomb of Cypress (Soroo Wala Maqbara of Lala Rukh). The area of Hassan Abdal remained under Sikh rule from 1813

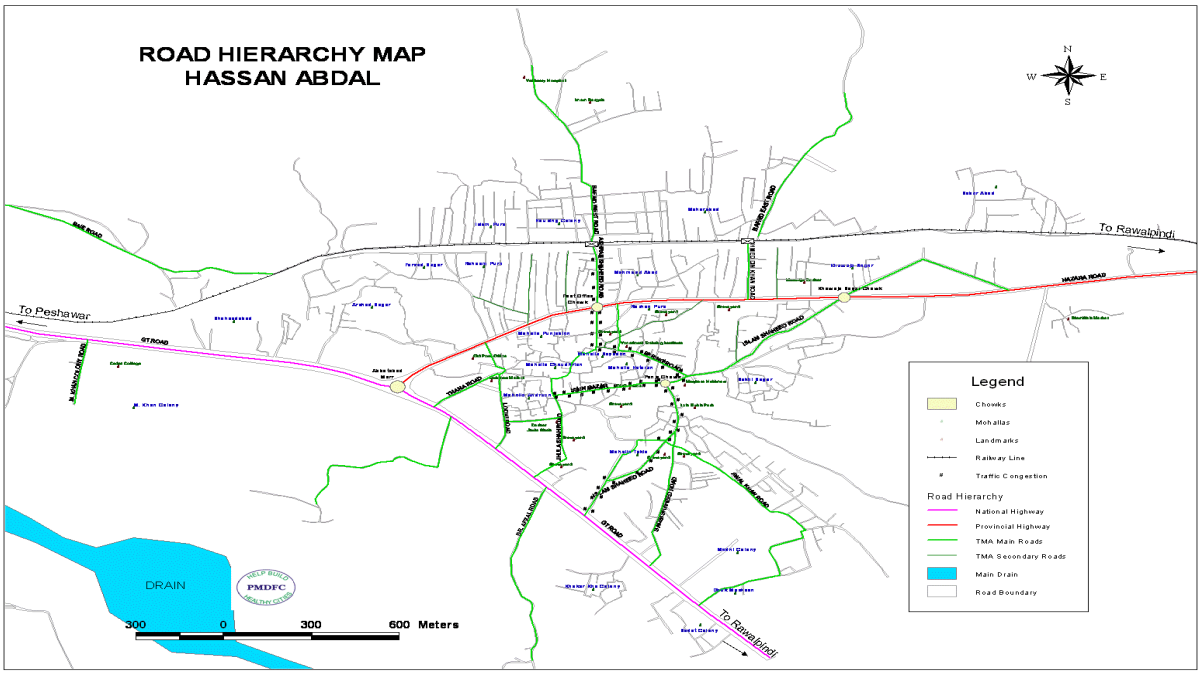
to 1849. Hassan Abdal has a Sikh temple (Gurdwara) known as Punja Sahib[35]. Hasan Abdal is also known as a 'holy city' since it houses the Gurudwara of Punja Sahib.Twice a year Sikh pilgrims visit the Gurdwara from all over the world. (http://myattockcity.com/index.php/2013-03-03-02-02-14/hassan-abdal-information).

As far as the health facilities are concerned, Hassan Abdal has almost all the facilities including a Government run Tehsil Headquarter Hospital and Private hospital, the Hassan Abdal Surgical Complex, and various privately owned clinics, pharmacies, quacks and homepaths in and around the city. Most of the hospitals and the clinic are located nearby Wah Cantt and Rawalpindi. It has a government primary and high school upto secondary level for boys and girls, a higher secondary school each for boys and girls and a degree college for women. To cater to the educational requirements of the population, it has also many privately run schools as well. Hassan Abdal has a famous Cadet College established by the government of Punjab which is one of the finest institutes of Pakistan. It is considered an honour for Hassan Abdal that the first Cadet College of the country was established here in 1954.

Major industries and factories in Hassan Abdal include the Askari Cement Factory, the Gunj Glass Factory, the Ali Glass Industries, the Neelam Glass Industries,the City Flour and General Mill, the Chanab Flour Mills, the Taxila Cotton Mills, the Al-Wakeel Oil and Ghee Industries. The town has many hotels and restaurants including the Punjab Hotel, the Start Hotel, the Blue Lugoon, the River View Hotel, the Al-Aroos wedding

[35] In Punjabi language, punja means hand or impression of five fingers. A sacred rock in that is believed to contain the hand print of Guru Nanak who is the founder of the Sikh faith.

Hall.



Source: http://www.hassanabdal.com/map

3.1.4 The Village Choha Shah Ghareeb

Choha Shah Ghareeb is a village approximately 3km away from Tehsil Hassan Abdal. It is located on the right side of the Grand Trunk Road near Burhan Interchange. It comes under the Union Council of Jullo. In Punjabi language "*choha*" refers to "spring", and the village Shah Ghareeb derives its name from a saint/pir whose shrine is famous for a natural spring.

As far as the history of the village is concerned, there are no written records available but according to the oral tradition village Choha Shah Ghareeb is more than one hundred years old and before the partition of indo-pak, followers of different religion including Hindus, Christian, Sikh and Muslims used to live here. The Muslim Sufi Saint Baba Shah Ghareeb came from Swan and settled here. He was herdsman and used to look after the herd of one family. Baba Shah Ghareeb was famous for his spirituality and miracles. Once a calf was lost and eaten by a Jackal. Then Baba Shah Ghareeb called the name of

that calf and the calf came back alive. Another miracle associated with Baba Shah Ghareeb is that once a thirsty person came to him and asked for water. He hit the ground with his stick and then awater gushed forth like a spring. Baba Shah Ghareeb declared this water as holy and benefitial and to this day people of the area believe that it helps to recover from various medical problems.

3.2 Religion

The people of the village are Muslims by faith and all of them belong to the Sunni sect. religious education is emphasized and even many illiterate people have learnt to recite the Quran. There is a mosque in the village, where males belonging to different age groups get together, offer prayers and discuss their various issues. The Imam (Islamic preacher/cleric) conducts five prayers a day, and on Fridays there is a regular religious sermon called a*khutba* that is attended by the men of the village. The children also come to mosque for *Nazra-e-Qu*ran[36] and take their daily lessons from the Imam.

Belief in the supernatural, evil eye, evil possession and magic is quite common in the village. People do believe in spiritual healing as a solution to their various problems. Apart from the shrine of Choha Shah Ghareeb, villagers also visit other shrines, *pirs* (saint) and *maulvis*[37] around the area to find out cures for various medical, social, economic and other problems.

3.2.1 The Shrine of Choha Shah Ghareeb.

According to the locals, the Tomb of Baba Shah Ghareeb is on the right side of the grand trunk road where he is buried and where the ceremony of the annual *urs* (Death anniversary of a saint) takes place. The shrine inside the village was the *bethak* (sitting place) of Baba Shah Ghareeb where he used to sit for prayers and mediation. Not only residents of the Choha Shah Ghareeb but also people outside the village strongly believe that the water of this spring has healing powers as if it can relieve them from various

[36]Nazra is to read the Holy Quran verbally, without learning its translation and memorization by heart
[37] Maulvi is a term used among Muslims for a person who is an expert on Islamic law

health problems particularly different skin diseases/infections so people often visit this shrine to bath in that holy water.

As such there is no '*gaddi'* (hereditary decendent of the shrine), elderly women from five families are taking care of the shrine. One female care-taker sits there for a week and then gives a turn to another care-taker. They sweap the shrine, guide the visitors and also collect the donations left by them. The shrine of Choha Shah Ghareeb is beautifully decorated with mirror work. The son of Amma Jee, one of the shrine's care takers, works in Saudia Arabia as an expert of mirrors work. He collected donations from the whole village and then brought mirror of good quality from Pakistan and used his skill to decorate this shrine with a fascinating glass mosaic. The shrine has one room where the Sufi saint used to sit for prayers. It has a big yard outside with a boundary wall. Moreover, it has two washrooms for both males and females. After taking a shower, women particularly those suffering from infertility and *purchawan* (evil shadow) leave their old clothes and accossries over there. According to the care-takers, these clothes are distributed among the poor people as *sadqa* (alms). With the blessings of the saint, skin diseases which are considered contagious are not transferred to other persons. Menstruating women who are impure are not permitted to take a bath at the shrine unless they regain their state of purity. It is considered irreverent and disrespectful towards the shrine.

Visitors fetch water with the help of small cans attached with a rope from the spring to take a bath. They also bring plastic bottles and cans with them to bring this sacred water for the patient at home. There is a hawker who sits close to shrine and sells plastic bottles for ten rupees. People from far away places, including neighbouring villages, Wah Cantt, Rawalpindi and Islamabad come over there and take this miraculous water along with them in the strong belief that this water has the power to heal various diseases.

The shrine is thronged by visitors particularly on Thursdays and Fridays. Many people informed me that there are different types of illnesses and it is not possible that all of them can be cured with medical treatment. It depends on the nature of the diseases and the factors which cause that disease. Certain types of illnesses can only be recovered by

spiritual healing. Many childless women are seen at the shrine of Choha Shah Ghareen, who squat inside the shrine for hours, sweap its yard, take a shower with the majestic water, offer prayers, make a *mannat* and give alms etc. Women suffering from misscarriages also visit the shrine. According to one of the shrines care-taker's who my key informant was as well, to have a successful pregnancy and healthy baby, a total of seven consecutive visits to the shrine are recommended. Women aiming to have a child usually visit early in the morning on every Thursday. On the last visit, they pray and make a *mannat* (wish) to conceive and if their wish is fulfilled they come along with new-born for the seventh and last visit to express their gratitude and acknowledgement. For skin allergies, people visit the shrine for atleast three consecutive weekends. The number of visits can increase upto seven times maximum. People with skin diseases such as *phubehri* (Leucoderma), allergies, rashes, pigmentation, pimples and abcess and other types of problems such as depression, to ward off the ill effects of the evil eye or magic, high blood presuure, diabetes, or paralysis visit the shrine seeking a cure. Moreover, people also take children who are weak and ill. There are clay lamps which visitors lightfor making a wish any day, but the maximum number of people gathers on Thursday. The oil of these clay lamps is used for healing different skin diseases particularly for *khujli* (itching) and body aches. People also take ashes and salt from the shrine to be healed from various illnesses. Small stones at the shrine are also considered sacred and many people can be observed rubbing them on the infected parts of their bodies. People also tie a thread, iron lock or piece of clothes at the window of shrine and make a vow. Upon the fulfillment of vow, they visit the shrine again and open the knot. They believe that tying of thread/cloth or iron lock as a mark of their vow makes the saint obliged to mediate with God to grant their wish.

For amulets, women visit other shrines, i.e. the Shrine of Mallo, or the Shrine of Gham Mit, Shrine in Burhan located in the nearby villages. People who visit the shrine of Choha Shah Ghareeb also make offerings known as *nazrana* (gift) which may include flowers, cardamom pods, fruits, and cash money, which is used for the decoration of the shrine.

In short, the village Choha Shah Ghareeb is famous due to this shrine and its contributions in resolving socio medical problems of the people. Out of respect, the villagers even do not turn their feet towards shrine while sleeping.

Source: Retrieved from Google Maps

3.3 Roads and streets

The village Choha Shah Ghareeb is connected with the main G. T. road through a metalled road. But the situation within the village is different. Some of the streets within village are *katcha* (muddy) and some are paved with baked clay bricks. This area has a rough terrain and the streets are bumpy because there are layers of rocks below the ground. The streets have an open drain running on one side of it and some of them have a drain in the middle. When it is blocked, due to rain or pebbles or plastic bags or other sorts of garbage, then the whole village stinks due to over-flowing dirty water and a breeding ground for flies and mosquitoes. During rains, people of the village suffer a lot of difficulties due to mud in the streets.

3.4 Transportation

A paved road connects the village with the main G.T. road where the local transport is available to take passengers to the main Bus Terminal of Hassan Abdal which is approximately three kilometers away, where one can find vans, buses, Suzukis, auto rickshaw/*chingchi*[38], private taxis and cars a round the clock.

In the village, very few people have their own private cars. Some people do have motorbikes and cycles which are traditional means of transportation. In the village, people do help each other by offering a ride to reach either the main road or the nearest bus station in a situation of emergency. People have to visit the city to fulfill their various needs such as shopping, visiting hospital, attending an educational institution or for the purpose of employment. Due to this daily inflow and outflow of the population, the traffic is increasing on roads day by day. Traveling for women is difficult because the public transport is over-crowded. When women are ill and they have children with them, then this problem is multiplied. Women usually cover their entire face except their eyes when they are traveling by public transport to cope with the stares of men. Pregnant women are rushed to the hospital by asking someone for a lift or by public transport. The transport problem is one of the biggest hurdles for women in getting an education and seeking health care.

3.5 Climate

The village has five distinct seasons in a year including the summer season (from May to September) which is characterized by hot and dry weather, autumn (from October to November) which is characterized by pleasant and dry weather. The winter season (from the end of November to mid of the March) is cool but the temperature rarely falls below the freezing point. The pleasant spring weather starts from the mid of March and it starts becoming warmer and drier towards the end of April. In April, the temperature starts rising up to the end of June, when the monsoon rains start, which continue untill the mid of the August. The monsoon season is really hot and humid.

[38] Auto rickshaw or chingchi is three wheel cycle driven by one person, having a back seat meant for two persons but sometimes four to five persons alongwith the driver travel together.

3.6 Demographic Characteristics of the Village

Tehsil Hassan Abdal comprises 350 square kilometers with a population of 135, 856. The annual average growth rate of the Tehsil is 2.00 whereas the urban population is 37, 976 as per the 1998 census (Planning Report – Hassanabdal, 2008).

Table 3.1Demographic Details of Tehsils in District Attock

Tehsils	Number of Union Councils			Population (Thousand Persons)						1998 Urban Population %
	Urban	Rural	Total	As Per 1998 Censes			Estimated on 31-12-2013			
				Rural	Urban	Total	Rural	Urban	Total	
Attock	3	8	11	144	118	262	194	151	345	45%
Fateh Jang	2	12	14	188	26	214	239	33	272	12.1%
Hassan Abdal	2	6	8	98	38	136	125	49	174	27.9%
Hazro	2	11	14	197	42	239	261	54	315	17.6%
Jand	1	11	12	211	17	228	262	22	284	7.5%
Pindi Gheb	2	11	13	166	30	196	202	38	240	15.3%
Total	12	59	72	1004	271	1275	1283	247	1630	21.3%

Source: *Planning Report – Hassanabdal, 2008*

The census survey of village Choha Shah Ghareeb that has been conducted as part of this study presents the following demographic details.

Table 3.2.Sex Wise Division of Population

S.No.	Gender	Number	%
1	Male	297	45.48
2	Female	356	54.51
	Total	653	100

The total sample population for this study included sixty women in reproductive age (15-49) which were chosen through nonprobability purposive sampling. The table below presents the age distribution of those women who were selected for in-debth interviews.

Table 3.3. Age-Wise Distribution of Selected Respondents

Age of respondents		No of Respondents	Percentage
Age of respondent	20 – 24	5	8.33
	25 – 29	15	25
	30 – 34	19	31.66
	35 – 39	15	25
	40 – 44	6	10
	Percent	60	100.0

3.7 Food Patterns

The food consumption of the villagers is quite simple, and food is eaten three times a day starting with the morning breakfast. For breakfast, mostly people have tea with *paratha* (fried flour bread) with fried egg or left-over curry. Some people also take *lussi* and homemade butter for breakfast. Lunch is simple since most men are not present for this meal as they are out for work. Usually left-over curry is used for lunch and a fresh meal is cooked for dinner to serve the men of the household. Dinner comprises of vegetables and pulses as meat, chicken and rice are expensive and are eaten a few times in a month. The price of mutton is highest, six hundred rupees per kg, which is not affordable for poor peopleand it is mostly eaten on special occasion. Farm chicken is used more as it is less expensive than meat. A lot of spices and oil are used in curry. Curry is eaten with *roti* (homemade bread) made with flour. They are cooked in a *tandoor* (big earthen oven) or *tawa* (hot iron plate). Rotis are thick and big in size so they are consumed less in numbers and also reduce the work of women.

Guests are served with special dishes such as *pulao* (rice cooked in meat broth), *desi murghi* (home bred chicken), *gosht* (meat), *zarda* (traditional orange colored sweet dish made with rice, nuts and raisins) etc. In summers guests are served with *sharbat* or *rooh afza* (an eastern drink) and in winters *doodhpatti* (tea) is served.

Villagers do follow certain food taboos and they avoid eating hot and cold food together. Certain combinations of food are avoided as villagers believe that food imbalance can cause them ill health. For example, milk is not used with fish, spinach or melon. Certain food restrictions are followed during pregnancy and hot food is avoided as it is believed that heat producing foods cause harm to the fetus and may cause miscarriage. *Desi ghee* (home made butter oil) and milk is considered beneficial for women during pregnancy, post-partum and lactation. Special foods are prepared and given to women after child-birth to help them regain their lost energy.

3.8 Dress Pattern and Body Adornment

'Shalwar kameez' (loose pants and trouser) is common dress for males and females.Young men also wear trouser and shirt.Men also wear small piece of unstitched cloth called *parna* with them. During summer season, men usually cover their head with *parna* while going outside to protect them from the heat of scorching sun. During winters, men wear sweaters and woolen shawls to protect themselves from cold. Men's footwear consist of pothohari *chappal* (slipper) called *kheri*. Clothes worn by villagers are most simple and a pair of clothes lasts for few days before it is changed. Dark and bright colors like red, orange, blue, green are preferred by women. Women also like too wear floral designs instead of wearing clothes in plain colors. For them, dark and bright colors make women look more attractive and the dust and stains are not much visible on them. Men like to wear light colors like white and off-white. Bridal dress is mostly made in red or maroon color as it symbolizes happiness and fertility.

Clothes are mostly sewn by women themselves and most of the women do have sewing machine at homes. There are also women who do ladies tailoring in the village to earn their livelihoods. Many women know embroidery or needle work which mostly women do to enhance the beauty of their dresses.

Most of the women do not comb and braid their hair daily. Mustard oil is used for head massage. Cleaning of teeth is also not done on daily basis and people use tooth paste as

well as *dandaasa*[39] for this purpose. Women also blacken their eyes with *surma* (traditional name for kohl mostly used as eye cosmetics) to enhance their beauty. Small children and older ladies also use *surma* with the belief that it sharpens he vision.

Women also do make-up on special occasions such as weddings and Eid[40]. Any kind of *khushboo* (fragrance) is not recommended for women as it may attract males. But women do use fragrant talcum powder and hair oil. *Mehndi* (hina) is also used by women to color their hands and feet. Older women also apply hina on their grey hairs to color them. Women all agreed that young unmarried girls should avoid make-up. When I asked what would happen if they also do make up, they explained that 'people will talk that she is trying to look older and may be she is looking for a husband'.

In the village women also like to wear jewelley. *Chooriyan* (glass bangles) are worn by both married women and unmarried girls. Married women are recognized mostly by the jewellery they wear which is mostly in gold but due to the increased rate of gold these days most of the married females do not have gold bangles so they wear artificial bangles and wear ear rings, rings and nose pin of gold all the time. Women who cannot afford buying gold have adopted an economical way to adorn themselves and now days even brides do not mind wearing artificial jewellry matching with their dress.

3.8.1 *Purdah*

Purdah is strictly observed and women keep their heads covered with *dupatta* (diaphanous veil) even within their houses. The newly wed brides also cover their heads in front of their in-laws. *Dupatta* is considered compulsory part of females dress. For going outside home, a big *chaadar*[41] is worn which is more than four yards to covers the whole body upto legs. Many women cover their faces full or half while going outside the village so they cannot be recognized by the strangers. It is compulsory for women to

[39] *Dandasa* is a Peel from the walnut tree which is used for teeth whitening.
[40] Two Muslim festivals, one at the end of the fasting month of Ramadan (*Eid-ul-fiatr*) the other celebrated in the Islamic month of *Zilhajj* to commemorate Abraham's willingness to sacrifice his own son to God (*Eid-ul-adha*).

[41] Loose veil which drapes over the body upto knees or heels

maintain *purdah* from men not belonging to their family. Men also lower their gaze or look away when they talk to stranger women. Women agreed that they should cover their bodies particularly when they move outside their homes in order to protect their bodies from the gaze and attention of stranger men.[42]

A pregnant woman wears loose clothes to hide her pregnancy. Women feel very shy when they become visibly pregnant. Pregnant women preferably cover themselves with big veil through the village and even or even within their own homes when men and ederly ladies are present. Women also mentioned that their pregnant body also becomes a constraint to acess health care services. Husband often do not allow pregnant wives to visit hospitals for check ups or ultrasound because pregnant body sumbolizes sexuality and they feel embarrassed to expose it to stranger men.[43]

3.9 Death Rituals

In the village, the event of *fotgi* (death) is considered most tragic and every known and unknown is encouraged to attend this. The entire village immediately reaches the house of the deceased and the preparation of the burial of the *mayyat* (dead body) starts. The

[42]Purdah refers to seclusion of women to saregaurd their modesty (Monsoor, 1999). Malik's (2000) study revealed that women in Pakistan are expected to lives under the constraint of *purdah*. Due to different spheres for men and women, mostly women are confined physically within their homes and seldom get a chance to move outside and that too for only serious and approved reasons. In most parts of the country, except few wealthier cities such as Islamabad, Lahore and Karachi people would perceive a woman and her family to be shameless because of no restrictions on her mobility.

Similarly, Tahrunnesa and Zeidenstein discussed the outcomes of of purdah said, that strict observance of *purdah* in villages shows that a family is of high social, economic and/or religious rank. Socially, it is a tribute to a male's honor which is vested in the behavior of family women and to his ability to protect and provide for them. Patricia Jefferey (2000, p23) while analyzing cutom of purdah for women explained women are considere custodian of family honor and their vulnerability to assault by other outside males necessitates constant watch on their virtue. It requires bodily concealment, virtuous behavior, which includes averting the eyes and no conversation with strangers.The extent to which women follow rules of segregation will determines pride and status of men. A non-conformist woman endangers family pride which may cause humiliation for its male members (Shaukat, 1975, p167-168).

[43] Malik (2000) reported the impact of purdah on women's health and reported that consulting male doctors is a significant social barrier for women in Pakistan because of the custom of *purdah* due to whih either they would delay their consultations or they seek health care at the stage when they become serious.Furthermore, maternal mortality rate is alarmingly high because manywomen cannot benefit from the health care system as their mobility is very closely related to the *izzat* (honor)of malemembers of her family.

dead body is kept on the *charpai* (traditional cot) inside the house and a *phoori*[44] is laid for the women who come for mourning. The arrangement for men is done separately usually outside the house either in the street or in the open ground.

The dead body is given bath according to the prescribed Islamic rules. It is recommended to perform the funeral as soon as possible and before the sunset but it can be postponed for some hours if any close family member or relative is awaited. N*amaaz-e-janaaza* (Funeral prayer) is only attended by males.For the following three days, people come for *faateha* (praying for the deceased) and condolence to the family. On the third day, the ceremony of *qul*is performed. After the burial, there is no cooking at the deceased home and the relatives and neighbours arrange food for the deceased family and their visitors. The mourning continues for forty days and then *chaliyan* or *chaleeswan*[45] is celebrated and meal is served to all those who come for condolence and prayer. At this occasion, people want to give good food as it is a matter of prestige for them.

In the village, pregnant women are forbidden to visit the house of the deceased until the fortieth day has passed. It is believed that the house where death has taken place is crowded and the expecting woman may get *purchawan* (shadow) of those women who have experienced pregnancy loss and miscarriages.

3.10 Civic Amenities in the village

3.10.1 Graveyard

There is one graveyard situated on the village corner. Some of the graves are concrete marked with tomb stones while the rest of the graves are only made of mud. People prefer to bury their family members next to each other but no distinct areas are demarcated for each family. People visit the graveyards mostly on Thursday and also on other special occasions (during months of *Muharram*[46]and *Ramazan*[47]) to lit *agar batti* (scented-wick) and offer *fatiha*[48] for the deceased people.

[44] Rug usually made with leaves of date tree
[45] fortieth day after the death
[46]*Muharram* is thr first month of the Islamic calendar

3.10.2 Water and Sanitation

People in the village have boring at their homes which they use to take out water at any time. They also use hand pumps or wells and natural spring as a source of water. The sanitary conditions in the village are not satisfactory. There is no proper drainage system and water used in the houses flows outside in the streets. During rainy season, small puddles of water are formed everywhere and form a breeding space for flies and mosquitoes.

3.10.3 Electricity

Every household of the village now have separate electricity connection which made it possible for the villagers to use electric appliances like iron, fans, washing machines, televisions, refrigerators, computers, motors, juicers and blenders etc. Due to the problem of load shedding in the village, those who can afford do have UPS (Urgent Power Supply) in their homes. Mechanical generators are also used on ceremonial occasions such as wedding, funeral etc to counter the breakage of power supply.

3.10.4 Market and Shopping Facility

There is a small*karyane ki dukaan (*grocery shop) where items of daily use such as sweets, toffee, biscuits, soft drinks, milk packs, tea, flour bags etc are available. But to buy good quality items people go to the city. The main bazaar of Hassan Abdal is quite near where almost everything is available. Women reported that to buy sanitary products such as disposable sanitary pads, and undergarments for adolescent girls they go to the main bazaar of Hassan Abdal and Wah Cantt where female sales girls sell these products. Mostly mothers go and purchase these items for their daughters in secrecy, as according to the village norms it is not regarded as a good practice to buy such items openly which denote female sexuality. However to do shopping for different occasions and ceremonies like weddings and Eid, many women and girls prefer to visit big markets in the city. In

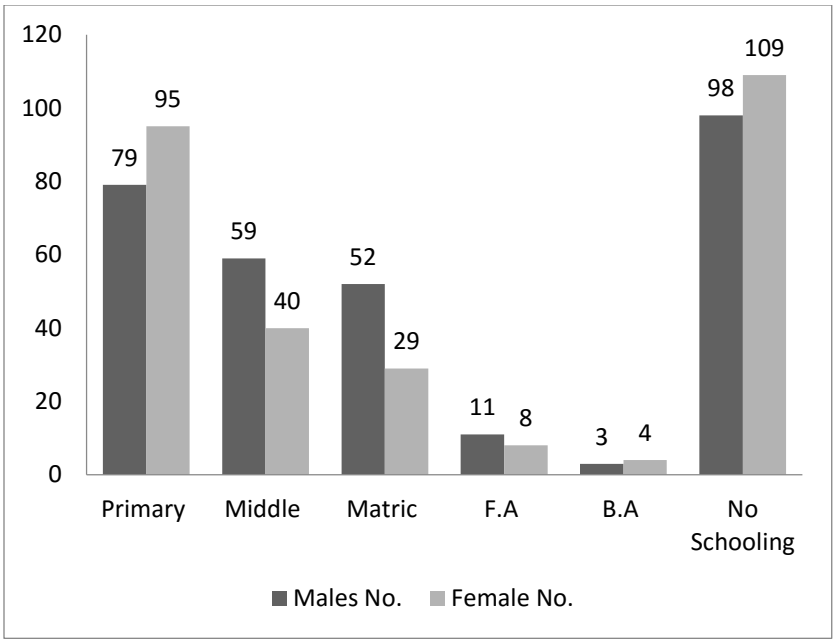
[47] *Ramazan* is the Ninth month of the Islamic calendar; fasting month
[48] Prayer and condolence for the deceased

recent years many new shopping plazas have opened in Hassan Abdal where good quality items are available to fulfill their shopping requirements.

3.10.5 Education Facility

Women's access to educational opportunities is increasing day by day, but sill they lag far behind. There is one government primary schools for boys and girls located in the village. Three female teachers serve at the school and the building of the school is very old and it lacks the basic furniture to cater for the proper seating of the teachers as well as students. There is no facility for secondary and higher education in the village. Those who wish to study beyond primary level travel to the city every day where high schools and colleges are located. Many students in Choha Shah Ghareeb travel to Hassan Abdal and Wah Cantt every day and study in different educational institutions there. Girls are also getting education, after completing primary education from the village school; they go to Hassan Abdal for secondary education. Even the girls, who are lucky enough in getting their parents permission, are in most of the cases, seldom able to acquire education beyond primary level, because it entails going out of the village for attending school. The figure 3.1 shows the level of education among the village population beyond the age of five years.

Figure 3.1 Level of Education Among Village Population (Beyond 5 years)



The above mentioned illustration shows that girls outnumber boys at the primary level but their educational attainment gradually decreases ahead. Most of the girls do not continue their education after matric and their number is smaller than boys in acquisition of higher education. There are number of reasons why girl's higher education is not given priority. Moreover, people in the village bad-mouth girls who travel to the city even in the pursuit of education. They criticize girls who travel in local vans and Suzuki pick-ups and even scandalize them with drivers and conductors. They circulate rumors that girls do not go to colleges rather they run affairs in the city and become shameless. Many women also complained that they are afraid to send their daughters to city for higher education because of the fear of village boys who destroy their reputation by writing their names on the walls with chalk. This brings shame and dishonor to the family these girls belong to. People start doing gossip about these girls and assassinate their character. Parents want to avoid this situation so that there are no questions about their daughter's morality. For marriage, modest girls are selected and so in the culture of village a slight rumor about a daughter's character can ruin her future prospect for winning good proposals. It is a fact that parents would not like to marry their son to a woman who was the center of gossip and did not meet their standards of being a "good and modest woman." Several girls want to procure further education but unable to do so due to transposrt problems, purdah restrictions and financial constraint. On the contrary boys are encouraged to study as they

can easily travel by public transport. Parents wish more to educate their sons as males are expected to earn for their family and these days due to the lesser availability of agricultural land for all sons it becomes necessary for boys to persue their studies to have a good job or acquire some skill to run their own business. Despite positive attitude of parents towards the education of sons, many boys quit their studies after matric and intermediate level.

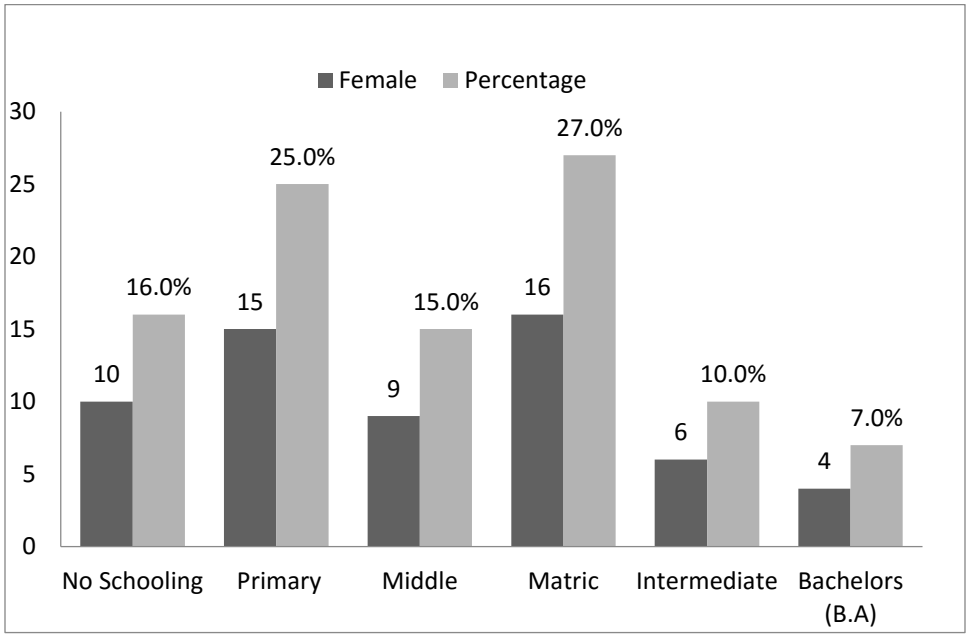
Many people particularly, older generation believe that higher education makes women disobedient, arrogant and argumentative and keeps them away from modest conduct.They think that a girl, on acquiring higher education and knowledge, becomes hard to deal with, and also fails to prove herself as a good wife and daughter-in-law, because such a wife would very frequently enter into arguments over petty matters, pick quarrels and threaten to earn her bread herself. Villagers also have this fear that more educated women may not become good and responsible wives as education makes them more liberal and dominating. It becomes very difficult to find a suitable match for a girl with education higher than the one which normally the boys in the surroundings or from her relatives have. On the other hand, the girl would not readily agree to marry a person with lower education. Above all, people would also hesitate to request for the girl's hand, fearing a rejection or even an insulting response.

Girl's education has no utility for their parents as the benefits will go to her husband with whom she is married. There is no tradition of women working outside their homes. That is why sending daughters to college and university is considered useless as they are not supposed to do jobs like men. So basic education upto matric level and the knowledge of Quran and *Namaz*[49] are considered enough qualification for girls. Other practical reasons were also mentioned such as the long distancefrom the school. Parent's excuse for not sending their daughters to high school and college is that they are located in Hassan Abdal and they need private transport to reach school which is expensive and not

[49] The ritual prayers prescribed by Islam to be observed five times a day.

affordable for everyone. Figure 3.2 shows that percentage of women with regards to their level of education.

Figure 3.2. Level of Education Among Respondents



3.11 Family Structure and Household

Family structure in the village is based on patriarchy where male dominance is visible in almost every decision of the household. Men are considered the head of the household and the authority is in the hands of males. The residence pattern is patrilocal i.e after marriage, the couple lives with the parents of the husband and later on they may form a separate household. The decent is traced patrilinealy and the consanguinal marriages are common and mostly preference within the lineage of father. It creates a social environment in which men are more authoritative and females have to forego many of their rights.

The people in the village mostly live in joint/extended families. When children grow up and start getting married, a separate *kotha* (room) is built for the newly wed couple within the compound of the extended house. In the village, many families demand that this newly built *kotha* must be written as the bride's property in the *nikah naama* (marriage

agreement). That's how a separate household is established. When siblings are few, the married son along with his wife and children resides in the household of his parents. Husband, wife and children live in one room. Ahmad Akbar S. Ahmad (1980) has also described three types of family structures among patrilocal families (1) The nuclear family comprising parents and their offspring (2) The compound family in which a patriarch and/or his sons and their wives live together and share expenses (3) The joint family system in which the nuclear families living in a compound, consisting of married brothers, keep their independent budgets. The joint family system is most common and the preferred form of family system in the village. They use the word *'akhathe'* (jointness) to explain their loyalty to the family. In this way, married brothers and their families enjoy intimate interaction and at the same time remain economically independent.[50]

In the village, the old construction of houses is *'katcha pakka'* (bricked as well as mud plastered). The newer one are bricked and cemented. The houses are usually built in a straight horizontal line with a common bathroom at the end. Almost every household has two types of kitchen. One is constructed at the one corner of the courtyard and *tandoor* (earthen stove)and *katcha chulla* (mud stove) are usually placed in this outdoor kitchen. In addition to this kitchen, a small room also serves as kitchen cum pantry. During the rainy season, people use this indoor kitchen. The newly constructed houses now have a different pattern and they are compact with one or two bed rooms, a drawing room, kitchen and wash room. A boundary wall surrounds the house with an entrance gate fixed in it. Having a nice home is considered a matter of great prestige and it was interesting to note that people in the village do hang old and rough shoes on the top of a newly construct house to save it from the bad effects of the evil eye and to keep the evil spirits away from home.

[50]García-Moreno C et al (2005) argued that due to the common prevalence of the Joint family system in Pakistan, women's chances suffering from emotional, verbal and physical abuse by in-laws are higher as compared to countries where the nuclear family system is more common and culturally accepted.

Table No 3.4 Family Types

S.No	Family Type	No. of H.H	%
1	Nuclear family	42	48.83
2	Joint family	31	36.04
3	Extended family	13	15.11
	Total	**86**	**100**

3.12 The Village Economy

All the families of the village do not own agricultural land. Those who own land are called *zameendars* (landlords) and those who do not own land, work as share-croppers or tenants who either receive wages or share in agricultural yield. In the village, few households are dependent on agriculture for subsistence while other people are engaged in non-agricultural activities. The major crops grown in the area are wheat and maize. *Kanak* (Wheat) is grown in October or November and it is harvested in April. After the harvest the grain is thrashed and stored in large metalled drums called *parulla*. Then women clean, wash and dry them as per need and then they are taken to the city for grinding purpose.*Mak*(Maize) is also grown but in small quantities as its consumption is less. It is sown in June and harvested in September. Women separate the corn from the cobs and then dry it under the sun. Then the grain is separated and stored in bags that are sent for grinding as per requirement. *Khal* (hay) obtained from the crops is also not wasted and is used as fodder for the animals. *Saryun* (mustard) is also sown as a subsidiary crop and its soft leaves are used as *saag* (cooked vegetable) which is a very popular dish among villagers.

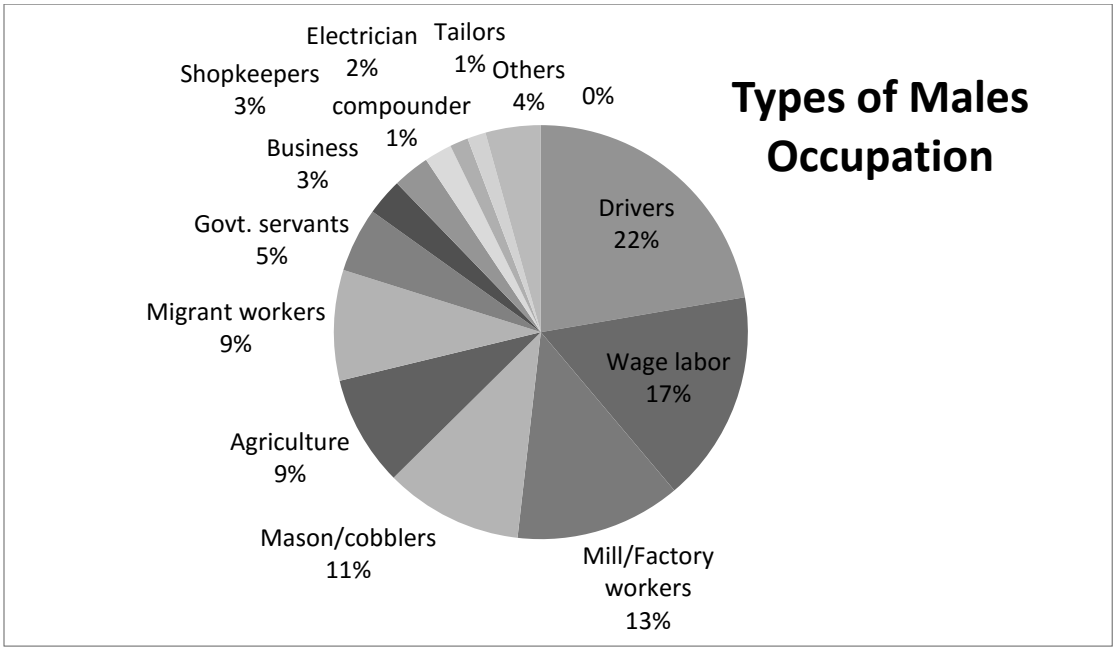
With the passage of time the economic needs of people have increased and they started opting for jobs other than agriculture. A change in the economy took place with the construction of various industries[51] which have provided opportunities for a paid job. Many men from the village work in these factories and earn rupees 8000 to 15,000 per

[51] Major industries and factories of Hassan Abdal include Askari Cement Factory, Gunj Glass Factory, Ali Glass Industries, Neelam Glass Industries, City Flour and General Mill, Chanab Flour Mills, Taxila Cotton Mills, Al-Wakeel Oil and Ghee Industries etc.

month. The other occupations for men are as drivers, mechanics, wage laborers, masons, carpenters, electricians, tailors and shopkeepers. Some people also have their own business and they have shops. Men's routine is to leave the house in the morning and then return by late evening. All day long men are not available at home except those who are either old or are too young to work. Even the young unemployed men stay outside the house during the day. They believe that it is against a man's prestige to stay at home during the day. They consider it woman's way to live as being confined within the four walls of home which is considered a feminine virtue.

Men from this village also migrated abroad in search of employment. Twelve men are working in the Middle East (Dubai, Abu Dhabi, Saudia Arabia and Qatar). Most of themare working as drivers and laborers. They send remittances to their family left behind in the village and this plays a major role in the changing economic status of the family. The families of migrants have a passion to use this remittance money for home constructions.

Figure 3.3. Types of Males Occupation



3.12.1 Female Employment.

The International Conference on Population and Development (1994) has focused on women's employment as a significant means to empower them and to bring a change in women's reproductive behavior in developing countries. Women's employment is an important indicator of their reproductive rights. Women's participation in economically productive activities is vital to bring a change in desired family size, as it decreases their dependency on their husbands. Moreover, it provides opportunities for women to exercise more autonomy and enhances their participation in decision-making, including the limiting or spacing of births (Lightboume 1985, Hadi 2001). In Pakistan, women's work outside the home is viewed with suspicion and mistrust which consequently decreases their control over economic resources (Sathar and Casterline 1998; Jejeebhoy and Sathar 2001).

The division of labor in the village, like the rest of Pakistani society, is mainly gendered. Women are kept inside the house with the expectation to fulfill the responsibilities of child bearing and housekeeping. On the other hand, men are the breadwinners and assigned duties outside the house to earn the livelihood for their families. Mullana Maududi, a famous religious scholar, attributes this gender division of labor to nature. He considers man the active and woman the passive partner in the system of nature; because of the man's natural qualities of dominance, power and authority, he is superior to passivity (Maududi 1979). These religious interpretations and cultural practices have kept women in seclusion (*pardah*) and discouraged them from joining the labour force.

According to the norms of village, good and chaste women confine themselves to their household and they are not seen by stranger males outside their homes. Home is considered the safest place for women but due to financial crises, if they have to work outside to support their families, their work is not much appreciated by the community. Bano expressed her views regarding females who go to cities to work as maids. According to her,

> *"Aye bari mundi gal hay banda fazri uthay tay ghair bandya day boway ja barey. Tay apnay marad kaar deeknay rowan. Aye uj kal na fashion bunr gya hay karoo baar julna. Jay zanani chungi hoye tay thora bota jo wi labbay*

guzara kray na kay gher murdan day moon luggay. Baar na mahool khraab hay, so gul ho sakni hay. aurta ich sharam honi chai ni hay."

It's a bad practice that one wakes up in the morning and goes to the house of stranger people and our men (referring to husbands) keep waiting at home. It has become a fashion these days to go outside home (for work). If a woman is good she should be contented with available resources instead of interacting with stranger men. Outside environment is awful, many things can happen.

Another respondent put it in this way,

"Mardan aastay nokri sakhulli tay zananiyan aastay okhi."
Employment is easy for men and hard for women.

However there were women who wanted to work outside the village to help their husbands and to increase their family size but their husbands raised concerns and were reluctant to allow their wives to work by saying that it is not known what type of environment is out there. Men considered it their duty to safeguard their wives from nasty characters. As Qudsia says, *"Men can go out and work anywhere they want but they do not let us go. I have seen the examples of a few women who earned money by working as maids in the nearby cities but I am not allowed. My husbands says that people are not trustworthy these days and so I just stay at home and do household work."*

a) Household Work.

The majority of women in village Choha Shah Ghareeb, consider themselves to be housekeepers with a primary responsibility to perform household chores. Right from the childhood, girls start helping mothers in various household tasks such as cleaning the house, washing clothes, taking care of younger siblings, or fetching things for the mother while she cooks etc.

Women in the village get up early in the morning and then keep busy in various household activities during the whole day. Women spend most of their daily time on cooking three meals which include *nashta* (breakfast), lunch, evening tea and dinner, cleaning the home, washing dishes and clothes etc. In a joint/extended family, these household chores are assigned to many females, but in cases of nuclear families a mother has to perform all the duties by herself with the possibility to receive assistance in case of

having an older helper, usually a daughter who can clean the house while the mother is preparing food. In cases of a daughter-in-law, most of the work is done by her and the mother-in-law performs small tasks but the main household duties are handed over to the daughter-in-law.

The observational data suggests that woman may have a few hours to rest during mid-day, but they spend it in activities such as sewing and repairing clothes, doing embroidery and crocheting, organizing household things or visiting neighbors.

b) Women's Income-Generating Activities.

Only a small number of women were engaged in various types of income-generating activities both inside and outside their homes. These women belonged to the poorer economic strata and started working after their marriage to support their families. Women's informal income-generating activities include crocheting, sewing clothes, embroidery etc. The other professions in which women were engaged include working as house-maid in the city, or a *dai* (Traditional Birth Attendant), or a LHV[52] at the Family Planning Center.

Women mentioned that either their husbands were not working at all or they were earning meager incomes not sufficient to meet their family expenses. Women reported that they spend a major portion of their income to meet basic requirements, such as food, clothes and the health care of their children. Those women who work inside their homes do not have any specific hours to work. They can do embroidery, crocheting and sewing whenever they find free time. Women earned a small amount of money from these activities. For example, for sewing one ladies suit, they get 200 rupees only, and it takes atleast three to four hours to stitch one *shalwar qameez.*.

Women usually used this little amount for their own personal purchases, such as buying clothes or any household item such as utensils/bed sheets etc, rather than contributing directly to the household economy.

[52] Ladies Health Visitor (A women trained in biomedicine to provide health services for women.

c) Women's Contribution to the Household Budget

Women also highlighted their role in managing the household budget (either pooled income or husband's income alone). Women married to the husbands working as daily wage laborers received daily money, depending on the possible income of their husbands each day.

Wage laborers or *dehari daar mazdoor* leave homes in the morning in search of work such as a mason, carpenter, white washer, loader, etc, and return home late in evening. Sometimes they get work and sometimes they return without earning a single rupee. Wage laborers generally give their wives a small amount daily to buy food items vegetables, flour, oil, rice, spices, etc. Women married to factory workers receive a fixed amount of income from their husbands to manage the household budget, usually in the beginning of each month when they get their salaries. In case of a joint or extended family, the senior female controls the budget which is mostly used to manage the kitchen-related expenditures. The wife is given asmall amount for her personal use and to be used for her children like, buying snacks, medicines, clothes, etc.

Women make sure that they do not spend the entire received amount. They try to save some money for a rainy day such as when any family member is sick or to clear the family's debt. Some women also try to enhance their income through working informally at home by doing embroidery or crocheting etc. The money earned by women themselves and also the money saved from the daily expenditures become the woman's money, and she has full control over its use.

d) *Kamaittee* (Rotating Credit Association)

*Kamaittee*is a revolving saving fund system in the village which is organized by the women themselves. The participants of the *kamaittee* funds are eitherrelatives, neighbors, or friends. The number of *kamaittee* members is not fixed. One woman volunteers herself to manage the *kamaittee*. She invites all the *kamaittee* participants to her home where they deposit an equal share of money on a monthly basis. If any participant is unable to pay the *kamaittee's* fixed amount then there is a provision that two females can share one *kamaitee* and pay half the amount each. At the end of each month, one name is chosen through a lottery and the winner takes that month's total collected amount. The first

kamaitte always belong to the one who takes the responsibility to collect it. This continues until everyone has received one round of money. Many women said that they do not inform their husbands about their *kamaittee* as the money they contribute is secret money which is either saved from the household expenditure or from their personal income-generating activities. Women mostly use that to collect dowry items for their daughters, to buy gold jewellery or to spend on occasions such as the marriage of any relatives or in case any other family member is sick..Women who join *kamaittees* in consultation with their husbands receive extra money from them to pay off the *kamaittee.*

3.13 Women and Inheritance:

The women-folk of this village do get a share in the inheritance but they are seldom enabled to exercise control over that property or use it according to their own will. They cannot dispose off the property without obtaining explicit consent from the male co-sharers. Another factual position is that at the time of one's marriage, the girl has to give away her share in inheritance in favor of her brothers. In case she does not, under some influence or her own desire, the brothers will threaten that they would not take care of her in future in case she needs their help. The females are bound by the age-long traditions of withdrawing from their legal rights of inheritance. Though the religion and family laws allow women to inherit their share of property, yet most women willingly concede their shareofthe inheritance to please their natal family.

3.14 Mobility

A woman is expected to safeguard her *izzat* (honor) which is done by restricting her mobility. She does not venture outside home without taking permission from her parents or husband. Failure to do so becomes a cause of strife and conflict within the family. A woman who is frequently seen outside her home is severely chastised and is suspected of having a *chakkar* (extra-marital affair). Suspicion of adultery is a great dishonor not only for the husband but also for the entire community as a married woman is a custodian of not only her husband's honor but also that of the whole village. She is considered, *"pind di noo"* (The village's daughter-in-law).

The mobility of unmarried girlsis strictly monitored by the elders in the family. Girls experience more restrictions as compared to boys, reflecting the traditional values of the village. The onset of menarche is consideration an indication of growing up *(jawan hona)* and the end of childhood andfreedom. A *jawan larki*(adult girl) is supposed to observe *purdah*. Their interaction is really watched with scrutiny. Parents make sure that girls are not defaming them before they are married because even a false rumor about their conduct can bring shame to their family. That is why the transition to adulthood begins an era of confinement.

The major reason for putting restriction on the mobility of unmarried girls, as reported by the majority of the parents was, they perceived the village atmosphere insecure for young girls to move out freely. The other factor causing restricted girl's mobility is the common practice of young boys and even some men to play in the streets. They are often in the habit of staring at the girls and women who pass by them. Such behavior when brought to the notice of the family infuriates the elders who may reprimand the ruffian or even beat them to teach them a good lesson. All this would lead further to the estrangement of the village-folk and may turn into hostile enmity. To escape all this it is always considered better to keep the girls confined to the house.

Women's social participation is ceremonies are fully controlled by men. Visiting neighbors or friends without permission from husband and in-laws is considered bad and strictly condemned. A modest and virtuous daughter-in-law is one who does not venture outside her home aimlessly and prefers to spend her time inside the four walls of the house. A woman who goes out too frequently is considered "*awaara*" (a wanderer) and accused by people of having a bad character. Men try to protect their *izzat* (as represented by his wife, sister or daughter) by keeping her confined to the house as far as possible. By restricting women's mobility they ensure their respect and reputation.[53]Women's social

[53] In a patriarchal society, woman cannot control their own sexuality. Rather it is considered a familial property. Fears of pre-marital sexual relations and the young woman falling in love become major concerns for the family members who are held accountable socially to protect and control a woman's sexuality (ICRW, 2003). Sathar and Kazi (p47) explaining the impact of restricted mobility of women on their health described that majority of women women in Pakistan experience restricted mobility because of their observance of *purdah* that creates hurdles for women to avail even nearby family planning facility . In case,

participation after marriage is subjected to the approval and desire of her husband and in-laws. She cannot attend a ceremony unless she is allowed by her in-laws. Women's social interaction is fully controlled by men irrespective of their own willingness.

One of the respondents mentioned that her husband's large joint family did not like going outside home so she had to restrict her mobility to obey the family norms and rarely left thehome even on errands or just to visit friends or relatives. Women are expected to confine themselves within the four walls of home. If they are going out some male member or an elderly woman must accompany them as women who go outside unaccompanied are likely to face indignities and harassment because of the lack of respect for their autonomy.Howoever, older females have less restrictions on their mobility, rather they represent their families on the various social occasions and ceremonies such as birth, marriage and death. They may also visit other villages and cities for shopping.

no health facility exists (as in the majority of the rural areas) then the possibilities for women to access health care services are even more limited.

CHAPTER NO 4

RIGHT TO MARRIAGE& DECISION MAKING

Marriage is considered the only socially acceptable way for childbearing in Pakistan. It is a valued social institution which is considered crucial for a woman's security and well being.In the village, arranging daughter's marriage is crucial and perceived as "*furz poora kerna"* (complete the duty) or *siroon paar lana*(remove the burden from the head).

Age at marriage is one of the most important demographic variables that contribute the fertility transition from high to low population growth. According to Pakistan Demographic and Health Survey (2012-2013) the median age at first birth for women (age 25-49) is 22.2 years. A higher median age at first birth is observed in urban areas (23.0 years) than in rural areas (21.8 years).

Although women in Pakistan have the right to decide the time and the person to marry still many of them marry at a very young age which may affect their reproductive health. The present chapter highlights how women's autonomy in choosing their spouses is difficult in a culture that values the interests of the family over the interests of the individual, where marriages are arranged by families, where young girls are expected to prioritize their family's interests before their own. The present chapter elucidates religious and cultural traditions that promote early marriages, considering the fact that the longer a woman stays unmarried the higher the possibility of her chastity and honor being at risk and what kind of impact it causes on her reproductive autonomy.

4.1 Right to Marry

Informal interviews and focus group discussion with women revealed that women understood and recognized what are now called 'reproductive rights'.Women expressed the view that many times they were aware of their rights but in their context they were not able to exercise them. For example, due to growing awareness through electronic

media women and girls knew that it is their right to marry the person of their choice and they also expressed the wish not to marry too early but they felt reluctant to claim that right thinking that they will get into conflict with their family's norms as it is against their tradition. Before claiming that right women weight the social costs of entering into conflict against the benefits it was expected to bring. If the cost was higher than the benefits then they considered it rational to forgo that right in order to maintain **t**hei**r** respect and honor in the surroundings as well as to continue receiving protection from their families.

A marriage in the village is considered to be a social contract that involves two families rather than solely the bride and groom. That is why decisions with regard to marriage were beyond the discretion of the bride and groom. Therefore, family-centered decisions have priority over individual preferences. One of the young girls commented,

> *'Jo larkiyan apnay waldain ke marzi ke khilaaf jati hain wo be-ghairat hoti hain. Jo apnay rasam riwaj ka lihaz he na keray wo be hadaita hay."*
>
> Girls who go against the wishes of their parents are honor-less. Women who disrespect their traditions are immoral.

When I asked her what she meant by being immoral? She replied

> *"Buzargo kay faislay ka lehaz na kerna, apni marzian kerna, unki marzi kay baghair shadi or ishq-mashooqi waghaira' aisi larkiyan apnay kertootu se khud to badnaam hoti he hain uss gher ki baqi aurto ka bhi aitabar khatam ho jata hay."*
>
> Disobeying an elder's decision, exercising one's own will, getting married without their (elders) will or falling in love, etc. These type of girls not only defame themselves with their misconduct, the rest of the women from their family also loose their trust.

The above statement shows that in order to protect the family's honour girls prefer to let their parents decide for them. The decision when and with whom a woman should marry is entrusted to the family. The consent of the parents is what matters most. Jameela stated, *"assan na rawaj hay kay jo kuj kerna krana hoy maa baap hi karsun"*(it is our tradition that parents do whatever has to be done). This kind of statement reflects parental authority over their children's marital decision-making. The majority of the respondents

were married to a relative and he too was selected by their parents. They accepted their parent's choice as their own choice. As Najma stated,

Waldain di marzi hi assan ni marzi hay
(Our) parents wish is our wish

Women expressed the view that parents always decide wisely and they always take good decisions which are favorable for them as daughters. Women use their agency to choose life partners was guided by being submissive in a culturally accepted manner.Women's acceptance of their parents choices as their own continued to legitimize and reinforce the norm that parents have the ultimate decision-making authority, making it hard for others to challenge it.

> *"Meri phuppi humarey gher ayi aur apnay betay kay liye jo gher zimadaar aur berozgaar tha mera rishta manga. Mera baap razi ho gya or ussay han ker di. Mujhay kamray main bulaya aur phir uss nay 500 rupya mujhay de dia. Uss waqt mujhay apna aap be bus mehsoos hoa. Main uss bunday ko janti thi kionkay wo mera phuppi zaad tha, laiken meray abu kafi ghussay walay hain or wo jo chahtay hain wohi kuch gher main hota hay. Main durr kay maray inkaar nahi ker saki laiken baad me main nay apni bari behan jo shadi shuda hay ko bataya kay mujhay larka pasand nahi. Uss nay meri ammi aur dadi ko bataya aur phir dadi nay mujhay mara aur meri ammi ko laan taan ki jiss nay mujhay cable pe dramay dikha dikha kay kharab ker diya."*
>
> My father's sister came to our home and proposed me for her son who was irresponsible and unemployed. My father agreed and said yes to her. I wascalled into the room and then she (father's sister) gave me 500 rupees. At that time I felt helpless. I knew the guy as he was my cousin, but my father is quite arrogant and whatever he wants happens at home. I could not say No out of fear but later on I told my elder sister who is already married that I dislike the boy. She informed my mother and grand-mother and then I was beaten by my grand-mother who also scolded my mother who (according to her) spoiled me by showing me dramas on Cable TV.

Uzma did not challenge her father's authority in a public way. However, even when she expressed her wish indirectly in private, she got a violent reaction and was forced into submission. Her "right to marry" was compromised by the family's greater need to shape her response to be better aligned with village traditions.Women are expected to uphold their family's honor by keeping their

parents‟ happiness above their own. Challenging parents decision and undermining their authority is considered bad.

One of the young girls gave her opinion as,

> *“Jo aurtain ghero se bhaagti hain unki mian or susraal walo ki nazar main koi izzat nahi hoti. Wo apni qadar ganwati hain or koi bhi unka etabar nahi kerrta. Ye kiss tarah ho sakta hay kay jo larki apnay maa baap jo paal poss kay jawan kerain unke saath mukhlis na ho eik emaandaar biwi ho gi? Maa baap hamesha apnay bacho kay saath mukhlis hotay hain aur hamesha wohi faisla kertay hain jo unkay bacho kay haq main behtar ho. Larkiyon ko apnay gher walo ki beizzati nahi kerwani chahey.Aisi larkiyan museebat main phuns jati hain or unhain doosro ki tanqeed aur nafrat ka samna kerna perta hay.”*
>
> Women who elope have no respect in the eyes of husband and in-laws. They lose their worth and no-body ever trusts them. How come it possible that a girl who is not faithful to her parents who brought her up will be an honest wife? Parents are always sincere with their children and they always decide what is best for their children. Girls are not supposed to bring shame to their family. Such girls get into trouble and face criticism and hatred from others.

Traditionally, there is a strong emphasis to make daughters submissive. It is believed that the upbringing of the natal family is well reflected in the behavior of girls. That is why mothers always teach their daughters not to speak much, especially to argue with elders and to be an expert in household chores,especially cooking and cleaning. They stress the reality that the ideal woman is the one who abides by all the traditions. Saleema, mother of three daughters said,

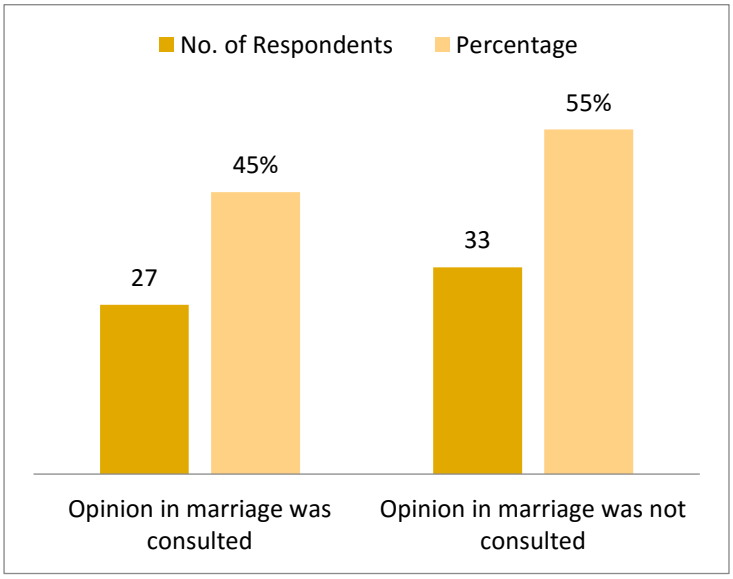
> *“Acha jee aap ko ilm hay kay badshah ko bhi betiyan byahni perti hain. Koi bhi unhain hamesha nahin rukh sakta. Ye tu qaraz hay jo maa baap ko asal mailk yani mian kay hawalay kerna perta hay. main apni larkiyon ko yehi batati hoon kay ager wo mian aur susraal walo se zaban chalayen gi tu tasur tu mera he kharab ho ga. Wo shikayat karain gay kay main nay betyon ko tameez tareeqa nahi sikhaya. Meri tarbiyat pe sawal uthain gay jo main bilkul nahi chahti. Sabar aur farmabardari jaisi bunyadi khoobiyan chahye hoti hain shadi ki kamyabi kay liye. Kapatti biwi koi bardasht nahi kerta aur aisiyon kay khawund unhain chor detay hain.”*
>
> Well. You know even a king has to marry off his daughters. No one keeps them (the daughters) forever. They are just like a deposit which parents are supposed to handover to its real owner, the husband. I tell my daughters that if they will argue with their husbands and in-laws then it will reflect badly on me. They will complain that I did not teach my daughters how to behave. My upbringing will be questioned which I really don’t want. Patience and

obedience are the main qualities needed for a successful married life. Nobody tolerates a quarrelling wife and they are abandoned by their husbands.

The subservient character of women mentioned by Saleema was endorsed by many other women, who highlighted the importance of obeying their future husbands to avoid the consequences of divorce. They understood that women have to sacrifice a lot to make their homes. They knew the fragility of marriage and the ease of remarriage for a man in society in case he is not happy with the first wife.

In the matter of spouse selection, the parents, particularly the father's decision, is regarded as most wise and also final. At the time of the*nikah*, the groom has to loudly announce his consent trice for accepting the particular girl in his *nikah* against a specified sum or h*aq mehr* (antimony). After the consent of the groom, two males called *Vakils* (lawyers) along with two *Gawah's* (witnesses) with the prior permission of the father go to the bride and ask thrice her *marzi* (consent) about the acceptance of the groom. The girl already knows the views of her parents and cannot even entertain the very idea of announcing her 'No' in the presence of relatives, neighbors, friends and other guests. She expresses her *haan* or 'yes' by slight nodding of head and many times her silence or shedding of the tears is perceived as her *haan* (yes). Thus the consent of the girl is obtained just as an unnecessary formality.

Figure 4.1 Women's Response to Right to Marry



The above mentioned figures show that only 45% respondents actually participated in the decision to choose their life partner and their opinions were consulted in this regard. The right to marry and form a family was not much recognized as a right rather it was perceived more in terms of a parent's prime duty and obligation to decide in the best interest of her or his children.Women emphasized the role of traditions and the pattern of their socialization which taught them to accept their parent's wish as their own wish. They reported that family elders do consider the compatibility of the *rishta* (marriage proposal) before finalizing it and in case girls feel that it is not suitable then they convey their reservations to mothers through the help of elder sisters or sisters-in-law. The notion of having a right to veto parent's decision about spouse selection was not well recognized.

4.2 Criteria for Spouse Selection

It is also clear among the women that their identity and respect is embedded in their success in marriage. People are concerned about who marries their daughters. **W**omen were asked about the criteria of spouse selection. There are several considerations kept in mind while selecting a daughter-in-law. According to one of the respondents,

> *"Shadi kay liye wo larki munasib hoti hay jo gher kay kaam kaaj main mahir ho, purdah karey, aadat ki achi ho, ziada fashion na karay, maskeen si ho aur kam uz kam punjwi paas ho, chitti unparh na ho."*
>
> A suitable girl (to be selected) for marriage is the one who is expert in doing household chores, observes veiling, has nice habits, must not be too fashionable, humble and must have passed at least primary level education, must not be illiterate.

Another respondent described the traits of an ideal woman as,

> *"Larki farmabardar honi chaheyi, laraki na ho. susraal walo ki khidmat karay, shakal surat ki bhi achi ho. Sughar ho aur gher bananey wali ho."*
>
> A girl should be obedient, not argumentative. (Should) serve (her) in-laws. (Must be) nice looking. (She is) fine fingered and a home maker.

In-depth interviews with respondents reveal that chastity and obedience are the qualities which are at the top of the wish list followed for selecting an ideal *bahu* (daughter-in-law). Similarly, certain qualities are also considered most desirable for selecting a boy.

One of the respondents explained it in this way,

> *"Larka charsi podri na ho, azad ya lofer na ho. Kum rozgaar laga ho, jara apnay biwi bachay sambhaalan joga hoey."*
>
> The boy should not be a drug addict, should not be spoiled. Must be working, in a position to support his wife and children.

The fieldwork findings reveal this trend that spouse selection is mainly driven by female hypergamy and the parents try their best to at least maintain the current living standard of their daughters.

Women also explained that due to the preference of endogamous marriages, girls are engaged early but married later within their family. They do have an idea about the personality of the person they are to be married with. One respondent said,

> *"Hun kuriyan wekhdian nay kay munda kaala hay kay chitta, naal tukna hay kay nahi tukna?"*
>
> Now girls see whether the boy is having a dark or light complexion and he seems to be a good match or not?

4.3 Age at Marriage

In Pakistani culture in general and rural settings in particular, marriages are a universal phenomenon (Shah, 1986: 347). In this study, the majority of the respondents agreed that getting married was a bigger priority for them than any other thing. It is perceived as a huge responsibility on the shoulders of parents which they must fulfill before they leave this world. This reflects the norms of the community that prefer early marriages considering the fact that the longer a woman stayed unmarried the higher the possibility of her chastity being at risk. Women themselves shared accounts of the emotional stress and anxiety associated with puberty and virginity and its accompanied restrictions on their mobility. Although the legal minimum age of marriage is 18 for boys and 16 for girls in Pakistan, as national identity cards are not issued until the age of 18, many respondents reported that parents in the village overstate their daughters age at the time of marriage.

The majority of the respondents still believe that the appropriate marriage age particularly for girls is to be the onset of puberty. Marriage age for men should be low as well, as long as they are able to work and support their family. Preference for early marriages is

based on religious and cultural traditions. Many respondents referred to traditions (*Ahadees)* of the Prophet (PBUH). The onset of puberty among young boys and girls is considered to be an appropriate time for initiating a marriage because delaying past puberty can give them the opportunity to develop immoral impulses which may lead to *zina* or premarital sex which is strictly forbidden in Islam.

Women also mentioned that the age of puberty varies from girl to girl and these days girls even become *jawan* (reach menarche) at the age of 11 and 12 years when they are not mature, still studying and have no sense of marriage and the responsibilities associated with it. A very young girl is not even capable of taking care of herself. They emphasized the necessity of girls being mature enough to fulfill the responsibilities of her husband and in-laws, manage household affairs, complete schooling, and to deliver a healthy child without any risk to her health.In their opinion, the ideal age at marriage for girls should be changed from the age of pubertyto "as soon as possible".

Women also emphasized early marriage to ensure healthy reproduction. The majority believed that women whomarry later are more likely to experience problems during pregnancy and childbirth**.** The LHV explained a similar opinion,

> *"Baray operation ki sub se bari waja larkiyo ki bari umer ki shadi hay. Pachis saal ki larki bhi badair hoti hay aur hadian pakki ho jati hain jiski waja sey aksar normal delivery nahi ho sakti. Choti umer ki larki ho to na sirf hamla jaldi hoti hay bulkay hamal main maslay msayl bhi kum hotay hain"*
>
> Late marriage of girls is the biggest reason for a cesarean section. A 25 years old girl is also mature and her bones become hard which mostly makes normal delivery impossible. A young girl not only becomes pregnant quickly but also experiences less problems during pregnancy.

Late marriage is not appreciated as if a girl's marriage is not arranged at the appropriate age and she becomes older, then it becomes really hard for the family to find a good and suitable *rishta* (match) for her. That's why girls need to be married not late than 20 years old. Most parents were fine with the first appropriate match that came for their daughters as they find no logic in delaying a girl's marriage. Mothers often despair at the continuously increasing delay in marriages occurring due to socio economic factors.

One of the respondents said

> *"Ye to sharam ki aur fikar wali baat hay jis tarah jawan larkey larkiyan shadi kay intizaar main apnay maa baap kay gher main umer gwa rahay hain. Humara mazhab tu iss baat pe zor deta hay kay jub aulad jawani ko ponhchay tu maa baap ka ye faraz hay kay unn kay liye acha bur dhoondain. Ye tu baray gunah ki baat hay kay larki jawan ho jaye aur uski shadi na kurao, jitni dafa mahwaari aye maa baap kay sir charti hay. Aajkal behayai aam honey ki bari waja ye der se shadiya kerna hay jiski Allah aur uska Rasool ijazat nahi detay".*
>
> It is a matter of shame and grave concern how adult (*jawan*) girls and boys are growing old in their parent's house waiting for their marriage. Our religion emphasizes that it is the duty of parents to search a good match as soon as children enter in the phase of their 'adulthood' (*jawani*). It is a great sin if daughters are kept unmarried once they have reached puberty and parents will be held accountable for their every menstruation. Late marriages are a major reason for spreading immoral activities these days which is disapproved of by Allah and His Prophet (P.B.U.H).

4.4 Social and religious significance of marriage.

Women shared their opinion about marriage and said that it is an inevitable act. The importance of marriage to protect the honor of women and also for the formation of a family unit, leads to a great pressure on women to get married soon and also stay married. In the village, married women have higher social status than single persons (spinsters) whose marriage could not be arranged on time, which is considered unfortunate. Married woman is called *suhagun*. Women frequently mention,

> *'Jawan larki ager kunwari murr jaye tu uska janaza bhi halal nahi hota"*
>
> The funeral of an adult woman who died unmarried is not permissible (in Islam)

It is the great wish of parents to see their children married and settled in their life time. Traditionally, girls are taught that their real home is where they go as a bride and are expected to leave that house in a coffin. Previous studies have also found that married women may have greater status than unmarried ones, mothers may have greater power and status than childless women, and mothers of sons have greater status than mothers who have borne daughters only (Lateef, 1999; Winkvist & Akhter, 2000). Beside the cultural significance of marriage, religious teachings also reinforce and strongly

recommend marriage for men and women. In Islam, marriage is considered among the signs of God's power and blessings. The Qur'an says,

> *"And among His signs is that He has created for you spouses from among yourselves so that you may live in tranquillity with them; and He has created love and mercy between you. Verily, in that are signs for those who reflect." (30:21)*

Bahira Sherif also described marriage as a social and religious obligation of all Muslims throughout the Islamic world. Marriage is the heart of social and religious life. In the Muslim tradition, celibacy is also discouraged for both men and women (Sherif, 1999). Marriage is the only socially and religiously approved avenue for sexual union and procreation. It is not just a cultural norm, but the most desirable and religious practice for all Muslim adults (Sherif, 1999; Hassouneh-Phillips, 2001).

Islam has encouraged marriage for those who have reached physical and psychological maturity. It should not be delayed unnecessarily if one can afford the means to establish a family. A marital relationship in Islam has been described as one of Allah's wonders. In the Qur'an Allah says:

> *'And among His wonders is this: He creates for you mates out of your own nature so that you may incline towards them, and He engenders love and tenderness between you. In this, behold, there are signs indeed for people who think."* (Qur'an 30:21)

The Prophet (peace be upon him) said:

> "You have seen nothing like marriage for increasing the love of two people." (Hadith from Ibn Majah.)

Even though religion and the constitution allow the dissolution of marriages, the occurrence of divorce is uncommon and extremely stigmatizing to the individuals and families involved. The practice is typically discouraged by family elders as it is likely to bring dishonor and shame to the family. Consequently, women choose to keep their marriages intact as they have been taught to make sacrifices and play their role to keep family together. Women said that the option of being single or divorced is highly condemned and socially disapproved of. Beside social pressure, there is the religious

assertion that the wife must obey her husband, stay married and keep the family together. Divorce is highly disliked in Islam, and the Prophet (Peace be upon him) said:

> *"Of all the things Allah has made lawful, what He most hates is divorce."*
>
> (Hadith from Abu Dawud).

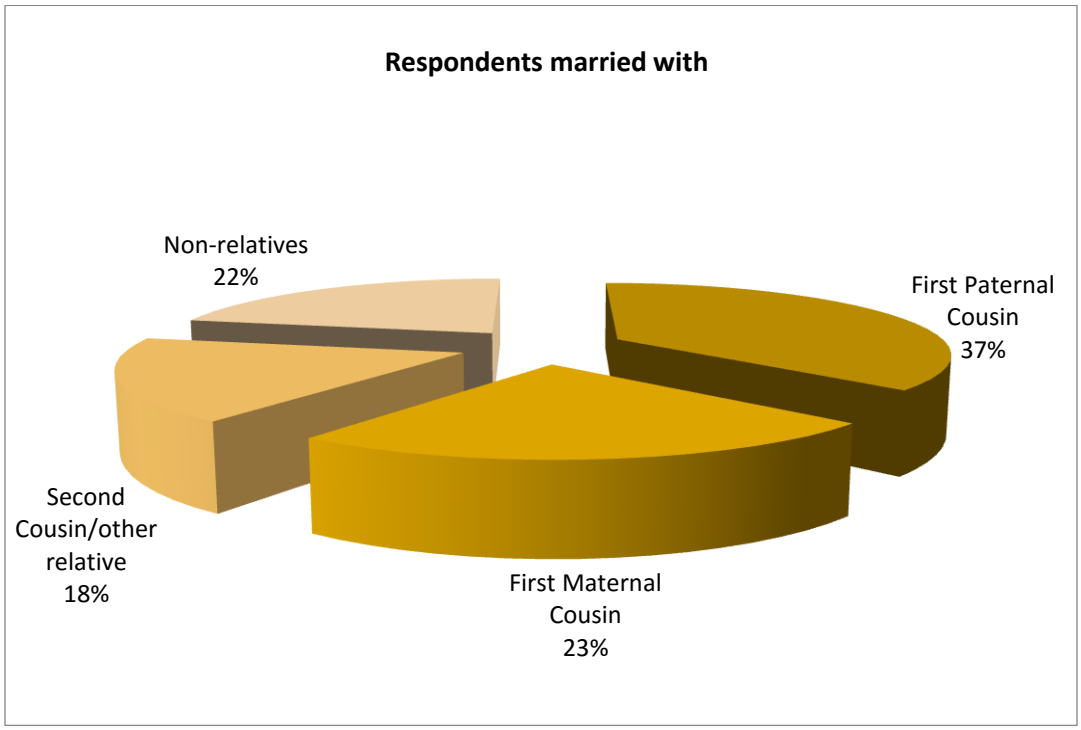
The Prophet (Peace be upon him) is also reported to have said:

> *"If a woman asks her husband for divorce without some strong reason, the scent of paradise will be forbidden to her."*
>
> (Hadith from Ahmad, Tirmidhi, Abu Dawud, Ibn Majah)

4.5 Marriage Patterns

The tradition of endogamous marriages serves key cultural functions in the community and is still a popular custom. Village residents, particularly elderly women were found to be great supporters of endogamous marriages because they arranged suitable and familiar matches within the family while providing the new couple with family support and marital security. Usually, it is preferred to find a match from the village or relatives living outside the village. But in case no suitable match is found, then a proposal from outside the village and family is accepted. Many families prefer to marry their children to members of their own extended family; thus marriages between cousins are common. Cousin marriages are preferred as they keep the family united by increasing the solidarity among them. Many respondents shared their opinions that they would prefer marrying their children within the *biraderi* (which is known as *'apno main shadi*') because of prior familiarity, mutual understanding, and ease in making marital arrangements due to low chances of deceit. Moreover, it is also believed that the behaviour of the husband and his family depends on his '*khoon'* (blood). Blood has characteristics and people belonging to same blood do care for each other. The figure below illustrates clear preference for an endoganous marriage pattern, with more than one third respondents married with their cousin or *biraderi* member.

Figure 4.2. Marriage Trends



Although polygyny is permissible but the actual occurrence of multiple marriages is not common. In Islam, polygyny is allowed, upto four wives at any one time, but with the specific condition to be able to treat all of them equally. Allah says in Quran,

> *"... Then marry such women as seem good to you two, three or four. But if you fear that you will not do justice between your wives, then marry only one..." (4:3)*

Cultural norms make polygyny contingent upon particular conditions as explained by one respondent,

> *"Asal shadi tu pehli shadi he hoti hay. Shadiyan kerna konsa sokha hay. Aajkal tu eik biwi aur bacho ki roti poori kerna mushkil hay.Do do biwyan kon paal sakta hay. Laiken baaz dafa halaat aisay ho jatey hain kay doosri shadi kerni perti hay. Jaisay ager kisi ki pehli biwi beemar ho jaye, ya phir maa baap kay gher naraz ho kay beth jaye, pehli biwi banjh ho ya phir larkiyan he larkiyan hoon aur pehli biwi se mazeed bacho ki umeed na ho, pehli biwi kisi kay sath kharab ho, ya nafarmaan ho, ya phir kisi ki pehli biwi mur jaye aur peechay chotay chotay bachay sambhalney wala koi na ho."*

> Real marriage is the 'first marriage'. It is not easy to arrange marriages. These days it is difficult to feed one wife and children.Who can afford having two wives? But sometimes there are circumstances in which a second marriage becomes indispensable. For instance, if someone's first wife is sick, or start staying at her parents home in annoyance, the first wife is barren or in case of only female children with no hope of further children from the first wife, the first wife's extramarital relations with someone, or her being disobedient, or in case someone's first wife is dead, and there is no one to look after the little kids left behind.

4.6 The Outcome of a Marriage is Determined by Fate

Women in the village strongly believed that fate or *muqaddar* plays a significant role in every aspect of their lives. Nowhere is it more evident than in matters related to matrimony. According to the respondents, marriage is predetermined by fate. It is immutable and cannot be changed. A woman said,

> *"Shadi naseeb se hoti hay aur jorey aasmano per bantay hain. Hur larki ka muqaddar uskay saath hota hay acha ho ya bura. Baribari achi shaklo wali bhi rul jati hain ager muqaddar main khushi na ho. Ye larki ka apna naseeb hota hay kay ussay acha banda millay. Maa baap jahez to de saktay hain laiken jo muddar main likha hay usko nahi badal saktay."*
>
> Marriage is determined by fate and couples are decided in heaven. Every girl has her own fate (*muqaddar*) be it good or bad. Pretty looking girls may be detested if they do not have happiness in their fate. It is written in a girl's own destiny to have a nice husband. Parents can give dowry but they cannot change whatever is written in fate.

If a woman's marriage is successful and happy, then she is thankful for her good Fate. If not, then she is patient for it is her *kismat* (fate). She should bear whatever hardships come her way and pass her days in silence. During in-depth interviews, it was revealed that women blame their fate for their childlessness and unhappy marital relationships. Phrases like *"Jo Kismet muqaddar"* (Whatever the fate), "*Jo muqaddar Allah likh day badal nai sakda.*" (Whatever fate Allah writes cannot be altered), *"khaid muqaddaran di"*(Game of Fate), *honda ohi hay jara muqaddar which hooway.*" (Whatever, the Fate decrees has to happen) show that women have strong convictions on fate.

Since it is the girl's destiny that determines her married life, an option of divorce and re-marriage is not considered on the grounds that if a woman's fate was good, she would

have had a successful married life. It would not matter how many times she remarries- she will remain unfortunate and discontented as her own fate is *kharab* (bad).

A man may divorce his wife on various grounds which may range from childlessness, deviance from normative behavior or suspicious of adultery. Receiving a divorce from the husband is dishonorable for the woman and her family, in particular her father whose *izzat* (honor) she represents. It is he who loses face in the society. Consequently, a woman never contemplates a divorce, no matter how miserable she is.

Married women are not expected to leave their husband's home other than in the event of death. It is considered disgraceful for her to even return to her *maikay* (natal home) after having a fight with her husband. Koser was advised by her parents at the time of her marriage as

> *"Ujj to susraal hi tera sub kuj hay. Paway kuj wi howay tu russ kay na aanwi."*
>
> From today your marital home is your everything. No matter what happens, never return here angry.

Married women are advised to live her days with her husband, even in the most adverse circumstances. The women are told that it is always better to spend the days rather than to return to the parent's house.

> *"Zananiyan noo waqt langana chaida hay paaway marad jinna wi paira howay."*
>
> Women should bear with the husband, no matter how bad he is.

In the event of the dissolution of a marriage, the blame always rests upon the woman. A divorce implies that there must be some flaws in the woman that she could adjust and that she has failed to meet the requirements of her husband. Divorced women have to hear comments such as,

> *"Jay tu aidi changi biwi hondi tay fair agla talaaqa tay na denda."*
>
> 'If you were a good wife then why did he divorce you?'

A woman who retaliates and seeks divorce is considered unchaste and suspected to be interested in someone else. A patient and noble wife is always contented with her husband, no matter how he is, and would not even think of leaving him.

4.7 Right of Divorce

Since divorce[54] is considered a shameful act, a woman should just be patient and pass the time. Seeking a divorce is a "*mandi gal*" (bad deed). Such women are not considered honorable as they not only defame themselves but also bring shame to their family. One of the respondents said,

> *"Jeerian aurta likhat karadian nay ona nu koi changian nai akhda, na unna da chal chalan theek honda ae"*
>
> Women who get divorced are not appreciated by others and they are not of good character.

Divorce is discouraged as the honour of the woman is at stake. Women who get divorce are suspected to be involved with someone else. Women are expected to safeguard their honour by keeping their marriage intact.[55]Once a woman is married, she should get along with her husband through thick and thin. Even if she is not happy with her married life, she should never contemplate returning to her parents house or requesting a divorce. Socio cultural norms expect women to be responsible for the success of their marriage. If she gets a divorce, she loses face in the village. The status of a divorced woman is low which is evident from the fact that the participation of divorced women at the occasion of marriage is avoided and they are not allowed to place *hina*or *mehndi* on the bride's hand

[54]Divorce among Muslims is governed by Muslim personal law. *Talaq* refers to the right of Muslim male to unilaterally rebut the marriage contract without giving any cause (A Handbook on Family Law in Pakistan, *supra* note 483, at 43). On the other hand, in *Khula it* is wife who initiates the process of marriage dissolution by giving a justification behind her demand of divorce and she is required to forego her dower and other material things received from her husband at the time of marriage (Shaheen Sardar Ali & Rukhshanda Naz, *supra* note 520,at 120). In case spouses have agreement on *khula*, then the marriage is dissolved without interference of the court but in case the husband is unwilling then the court may declare the termination of the marriage if it is convinced with the argument given by wife (Muslim Family Laws Ordinance, No.VIII,1961,§ 7(6) (Pak.);A Handbook on Family Law in Pakistan, *supra* note 483,at 45.)

[55]The rates of divorce is (0.5%) and separation is (1.0%) which are considerably low among women aged 15-49 in Pakistan (NIPS *et al* 2008).

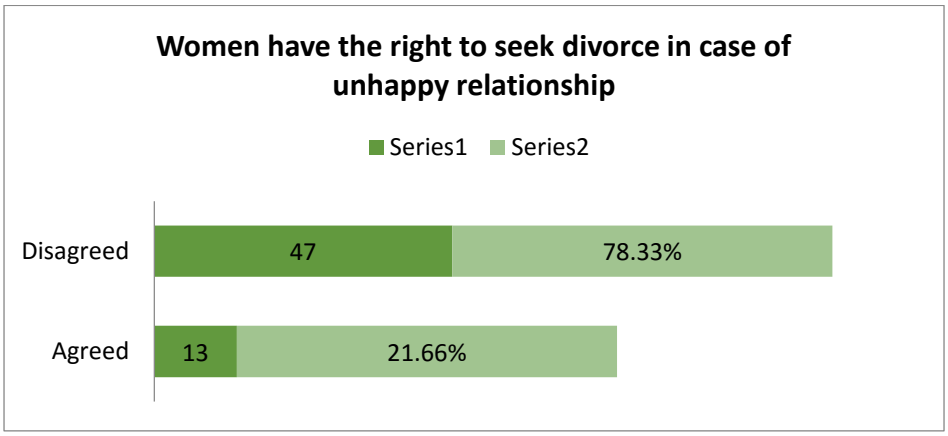
due to the fear of transferring bad luck. That is why women are socialized that they must endure and resist domestic violence. One of the respondents said,

> *"Talaq wali aurat ki zindagi aur okhi ho jati hay jab wo maikay aa kay beth jaye.Bhabhiyan zindagi azab ker deti hain. Gher waley tanay detay hain kay ager achi hoti to khwand kay gher main bus kay dikhat, bajaye iss kay kay wo baap kay booway pay wapis ati."*
>
> The life of a divorced woman becomes harder when she returns to her natal home. (Her) sisters-in-law make her life hell. Family members ridicule her that if she would have been good she would have adjusted herself in husband's home instead of returning back to her father's home.

The chances of remarriage of a divorced woman are limited and even if she is successful in finding a second husband, her husband and in-laws will tease her with reference to her previous unsuccessful marriage. In the women's opinion it is far better to keep staying with a violent husband instead of hearing *tanay* (taunts) from others.

Women themselves believed that they would not get anything in return if they dare to go against their family's norms and social expectations.Women must recognize their role as an obedient and sacrificing wife to maintain their homes.Similarly, women were also aware of their right to seek divorce and they knew that it is permissible by religion and law. Despite the awareness of this right, women urged the necessity to avoid the dissolution of marriages even in the cases of unhappy marital unions due to the fear of social disgrace, family pressure, being separated from children and due to the limited opportunities to marry again.

Figure 4.3.Women's Response to Right to Diovorce



When respondents were asked whether it was their right to seek divorce if they were living a happily married life then the majority of them (78.33%) disagreed. In their opinion, divorce is considered highly undesirable and they should *guzara* (manage) with their husbands no matter how hard they are. Women should refrain from seeking divorce in order to retain the social acceptance and support that they also require. This reveals that women may not be willing to exercise any right due to cultural opposition despite the fact that they have access to this right. Thus woman may not be open about certain rights, but by virtue of being a rights-holder, they have access to them and they may exercise the right whenever they think it is indispensible for them.

4.8 Marriage Ceremonies

When a suitable match is found, a proposal is sent through a close male relative and it might take several trips beforethe proposal is finalized and accepted. A meeting is held between the two father-in-laws and other family elders and a mutually convenient date is fixed for the marriage. If the wedding is postponed for some reason then a *mungni* (engagement ceremony) is held. The family of the boy alongwith some close relatives and friends visit the bride's house. They take gifts of cloth for the bride and a gold ring depending on their financial position and this gift giving is called *shagun dalna.* After this, the girl staying with her natal family is considered a guest who is expected to marry

soon and move to her groom's house. The boy's family is greeted well by the bride's family, relatives and friends, and are usually entertained with sweets and a meal.

Weddings are afestive occasion that can last up to three days or more depending upon the family's means. A son's wedding is celebrated more enthusiastically than a daughter's wedding as marrying off a daughter is considered losinga family member. The bride's new home is typically in her father-in-law's residence where an additionalroom (*kotha*) is built to accommodate her dowry. Many women informed me that their parents made sure *kotha* (where their daughter is going to live) is given in the legal possessions of the bride and it is written in the *nikahnaama* (marital agreement). It is considered a strategy to secure the marriage. One of the respondents said,

"Likhtaan kernay naal pair pakkay ho janday nay".
A written guarantee ensures (marital) security.

Another respondent said,

"Ghiaro main likhat parhat ziada hoti hay"
A written guarantee is more in practice in case of marrying non-relatives.

On the day of the marriage, the groom alongwith his family, friends, and relatives depart to the bride's home and this wedding procession is called*janj* or *baaraat*. New and fancy clothes are generally worn by all the attendees of the ceremony.

The bride's family and relatives welcome the *janj*. Special food is served on the occasion of a marriage. A '*Katwa'* dish is cooked which is made from beef. *Katwa* is a kind of big mud pot which is filled with beef and oil and all the spices and then it is cooked over-night. One '*katwa'* is enough for forty persons and then it is served in a small mud vessel called '*dugga'*. One '*dugga'* is served to four persons. *Katwa* is relatively an expensive dish and mostly made at the occasion of a boy's marriage and in case of a girl's wedding preferably rice and chicken is cooked.

A *nikahkhwan* (one who recites the sermon of *nikah*) asks the consent of the bride and groom. The *gwah* (legal witnesses) from both the parties also sign the *nikah nama* (marriage contract). Once the nikah is done, small packets of sweets brought by the

groom's family known as *bid* are distributed among all the guests. Then the groom goes to the female's side where he sits next to the bride who is dressed up in bridal costume which is mostly red in color. The bride's sisters and other female cousins perform some traditional customs on this occasion. For example, they do not let the groom sit next to his bride unless he gives them a requested amount of money called '*Laag*[56] *laina".* They also offer milk or sweets to the groom and sometimes hide the shoes of the groom and ask for some cash in order to return the shoes to him.

There are certain Islamic months in which weddings or any such ceremonies of happiness are not organized like *Muharram* whichis considered a month of sorrow, so in this monthpeople do not play music or sing songs. Similarly, the fasting month, *Ramazan*, is not considered appropraite because people fast for the whole month. Many women also informed me that they avoid arranging weddings of their children between Eid-ul-Azha and Eid-ur-Fitar as it may bring misfortune to the new couple.

[56] Special cash on a ritual occasion

CHAPTER NO 5

SOCIAL CONSTRUCTION OF MENSTRUATION & SEXULAITY

The onset of menstruation brings a major shift in a girl's life which turns her into a sexualized woman from a child. This chapter provides an overview of personal experiences, knowledge and perspectives of women with regards to menstruation and sexuality. It also highlights how socially constructed taboos and myths influence women's opinions and attitude towards menstruation and sexual behaviour. Women themselves shared accounts of the biological and social changes associated with puberty and its accompanied restrictions on their mobility, *purdah*, education, etc.

In the cultural context of the village, unmarried girls understood talking about sexuality and asking questions about married life as shamelessness *(be hayai)* and such girls are perceived as 'bold'. Socio-cultural norms inhibit the discussion around the issues of sexuality and reproductive health which may help young girls to be informed about their body and physical anatomy. This chapter highlights why addressing socio-cultural norms related to menstruation and sexuality are important as they expect women to be submissive right from childhood which becomes the foundation for the lack of control over their future reproductive health and incapacity to make decisions about themselves.

5.1 Initiation of Menarche *(Jawan Hona)*

Women informed me that in the village, girls usually reached menarche, their first menstrual period, at the average age of 11 to 13 years.Women informed me that now the girls in the village reach menarche earlier as compared to the older days. Earlier women used to havethat period on average between 13 to 15 years old. Sakeena shared her concerns regarding the girls young age of menarche these days as

> *"Aajkal larkiya jaldi jawan hoti hain abhi wo chothi panjhwee class main perh rehi hoti hain. Wo apnay under ki iss tabdeeli se pareshaan ho jati hain. Itni choti umer main to unn main itni samajh hi nahi hoti kay apnay apko mahwari kay dino main sambhalain. Buhat sari maen tu mahwari kay pehlay din larkiyan school hi nahin bhejti kionkay khoon pehlay din mahwari tez hoti hay or darr hi laga rehta hay kay beihtiyati ki waja se kahin peechay dagh hi na lag jaye or tamasha ban jaye. Larkiyan murghi or unday khati*

hain jo buhat garam hotay hain or phir unhain mahwari jaldi ana shuru ho jati hay."

These days' girls become adult at a very young age when they are in 4th or 5th class. They become anxious with this change in them. They are so young that they do not know how to manage themselves during menstruation. Many mothers do not send their daughters to school on the first day of their menstruation when the flow of blood is high for fear that due to their carelessness they might stain behind and be made fun of at school. Girls eat chicken and eggs which is very hot and induces early menstruation.

Sakeena's views reflect the mindset of many other women in the village who believe that highly nutritious food such as chicken, eggs, meat, ghee etc are 'hot' and cause early menstruation. The menarche requires a change in behaviour and because girls are so young that is why their mothers remain worried whether their daughters will be able to manage it. The same point has been highlighted by Britton (1996) describing that, *'the menarche is a significant marker of the life cycle of women that may mark the physical transition of becoming a woman - as a rite of passage - and yet it occurs at a time when a girl still feels like a child and may resent the transition to womanhood. A girl who experiences menarche must confront the notion that she is now a woman capable of reproduction, but still too young according to society to engage in reproductive behavior."* Menarche is the confirmation of fertility and womanhood and their delay also causes concerns and anxiety among mothers. Naeema mentioned

"Main pundra saal kithi jab pehli dafa period hoey. Mujhay yaad hay meri maa mujhay dacturni kay paas le ker gayi or bataney lagi kay merey saath ki tu sari larkiyon ko period hotay hain or merey ander shayd koi nuqas hay jiski waja se abhi tak nahi hoye. Meri maa bari pareshaan thi or kehti thi periods na honey ka matlab hay kay main zanana nahi hoon aur ager doosro ko pata chaley ga to koi mujh se shadi nahi kare ga. Dacterni nay laal sharbat dia or kaha kay mujhay khoon ki kammi hay iss kay ilawa koi nuqas nahi. Do maheenay main nay sharbat pia or phir ussi saal mujhay period ho gaye."

I was 15 years old when I got my period for the first time. I remember my mother took me to a lady doctor explaining to her that all the girls of my age have their periods and I may have some defect that caused this delay. My mother was really worried and she said that having no period means that I am not feminine and no one will marry me if this becomes known to others. The Lady Doctor gave a red syrup and said that I have a blood deficiency and no

other defect. For two months I used that syrup and then the same year I got my period.

5.2 Knowledge of Menstruation

Girls are not expected to discuss anything related to sexuality until they are married. They do receive any information about puberty prior to the onset of menstruation. It is not considered appropriate that girls know these things before time. At the onset of menstruation, girls tend to consult their mothers or elder sister or friends who explain to them how to handle the bleeding and to wash their dirty clothes away from the eyes of others. Young girls felt severely inhibited about asking questions about physical changes occurred in their body and they realize that keeping silent on women's health issuesis also expected from a grown-up woman. They were just told that menstruation is just a normal part of growing up. Women said that giving this kind of information to their young daughters in advance will spoil their innocence. They said that nobody disclosed this information to them when they were young and so they do not feel the need to discuss such things with their daughters before puberty. The rationale given is that "it is not our tradition" *(ye humara riwaj nahi).*

Women mentioned that within the cultural spectrum of village, the most important source of information regarding menstruation and its management is a girl's mother, with elder sisters and same-age peers close behind. However, in the village, it is not considered appropriate to expose girls to TV advertisements showing menstrual materials such as popular sanitary pads known as "Always". Women said that they advise girls not to watch TV along with male family members due to the advertisements of sanitary napkins and contraceptives. One of the woman commented,

> *"Aurat ki sharam hi uska sab kuch hay. Drama dekhan azab ho gya hay. Waqfay main ganday ganday ishtihar deihatey hain. Larkyon kay pad dikhatay hain. Ye to purday wali cheez hay TV per ishtihar laganey ka kia maqsad hay. Wo aurtain jo bazaar ja kay mardo se ye cheezain (pads) kharidti hain wo bhi be sharam hain. Inn nangay ishtiharo ki waja se hum mardo ka saath beth k larkion ko TV nahin dekhnay detay. Larkiyon ki massomiat hi khtama ho jati hay. Wo zaroorta se ziada or waqat se pehlay hushyar ho jati hain."*

> A woman's shame is her everything. It has become difficult to watch drama. Dirty TV advertisements are shown during intervals. They show girls (sanitary) pads. This is something which must be kept hidden, what is the point to advertise on TV. Those women who buy this kind of stuff (pads) from men are also shameless. We do not let our girls watch TV while sitting among men. Girls lose their innocence. They become over clever before time.

Women or mothers brief their daughters that menstruating is a normal process that starts when girls are grown up. Not knowing the scientific explanation of the release of pubertal hormones, they explained *mahwari* (menses) as a normal occurrence that all women will eventually partake in. They tend to reassure their daughters that the onset of menstruation is the indication of her transition from a girl child to an adult woman. One of the respondents said,

> *"Jab meri dono betiyo ko pehli pehli dafa kapray aye to main nay unhain bilkul wohi bataya jo kai saal pehlay meri amma nay mujhay bataya tha kionkay ye mamla to sari aurto kay sath hota hay. Main nay unko bataya kay fikar wali koi baat nahi ye koi bemari shimari nahi. Ye to aam si baat hay jiss se pata chal jata hay kay ub tum jawan ho gayi ho or iss liye ab tumhain doosri bari aurto ki tarah uthna bethna chahiye. Jawan aurat purdah kerti hay, apnay aap ko dhak kay rukhti hay, akiali bahir nai jati, mardo kay sath nahi milti julti aur apnay aap ko sambhal kay rukhti hay aur sharafat kay saath rehti hay jab tak apnay gher kina ho jaye."*
>
> I said to my two daughters at the time of their first menstruation exactly the same thing that I was told by my own mothermany years back because this matter is common to all women. I told them that there is nothing to worry about since it is not a disease. It is just a normal occurrence that shows that you have become an adult which requires that they should start behaving like other mature women. An adult woman observes purdah, covers herself properly, does not go outside unaccompanied, does not interact with males and must carry themselves well and must remain chaste till the time she goes to her own (husband's) home.

The same finding has been reported by another study which describes that mothers choose this time to discuss the meaning of womanhood with their daughters, which often includes raising a guard around boys, dressing like a lady, refraining from rough play, and other things that ladies "do" and "don't" do (Britton 1996).

5.3 Management of Menstruation

Women informed me that the menstruation is a mark of femininity and womanhood. When girls reach the menarche, they are explained how to manage this. Menstrual blood is considered highly impure (*paleed*) and girls are taught how to make sanitary napkins at home. Women informed me that ready-made pads are not used as they are expensive and difficult to purchase and then dispose off. In the village, cloth pads are used which are made from old and used cotton cloths locally called as *taaki* or *leerain* (rag). Women used these cloths and then washed them separately as they were considered impure. After wash, they are dried either in any corner of the courtyard or any place where they cannot be noticed by others, particularly males. Sanitary cloths are required to be kept in '*purdah'* as they indicate the fertility of women. After drying, these cloths are kept for reuse. Women kept using the same cloths till they became too old to be used further. Women also said that these cloths are washed with washing soap but still after frequent use it becomes difficult to get stains from them. Once they become old and dingy, they were burnt for permanent disposal. It is considered sinful if they are thrown in the garbage to be seen by others. Some older women also mentioned that the menstrual blood can also be used by someone for doing magic for any ill purpose. Nazneen explained the etiquette of the disposal of menstrual products as,

> *"Aajkal bane banaye pads marketo se mil jate hain laiken inko istimaal kerna bari be hayai hay. Madren aurtain to yehi banay banaye pad istimaal kerti hain or phir kooray main phenk deti hain apnay mahwaari kay khoon samiat. Ab jo banda bhi koora uthaye ga wo usko dekhay ga. Jo koi bhi inn khoon se bharey pedon ko dekhay ga wo uss aurat pe lanat bhejay ga jiss kay wo hain. Ye to bara gunah hay kionkay qiamat kay din yehi pad inn aurton kay moon main nichoray jaye gain, yehi waja hay gaon main aurtain purani leerain istimaal kerti hain or phir dho dha kay saara khoon bahir nikaal deti hain."*
>
> These days' ready-made (sanitary) pads are available in the markets but it is immoral to use them. Modern women use these ready-made pads and then throw them away in the garbage with their menstrual blood inside them. It (the pad) must be witnessed by the person who collects the garbage. Whoever will see these blood filled pads will castigate the woman they belong to. It is a big sin because at the Day of Judgment these (blood filled) pads will be squeezed in their mouth. That is the reason women in the village use old cloths and then wash them to drain out the blood.

In the beginning, girls experienced difficulty in keeping these pads inside their underwear. They remained conscious that the cloth pad may seep out and make their clothes dirty.

Normally one pad is used for the entire day but in case of heavy bleeding more than one pad is used. The women did not relate the concept of hygiene with the frequent change of pads. For them, the only purpose of the clothwas to absorb the menstrual blood. Girls were advised to wash their pads immediately after use and everybody washes pads herself unless a woman is too sick to do that like after childbirth, the mother or *dai* washes. Socio-cultural norms concerning the use and disposal of menstrual materials expected women to keep their menstrual state secret, and people around should never see any evidence of sanitary products, blood stain on cloths, or be able to detect the menstrual scent.

6.4 Taboos Regarding Mentruation

Menstmal blood is believed to be dirty (*ganda*) and impure (*napaak*) and in Islam it is *najis* (Arabic: نجس) which means ritually unclean.Traditionally, mothers oriented their daughters to the menstrual cycle in much thesame way their own mothers did with them. The information with regards to the use and disposal of sanitary products and taboos related to the functioning of the menstrual cycle passed on from one generation to the other. Women refrained from participating in certain activities while they are menstruating, for example menstruating women do not pray or touch any sacred object like the Quran and praying carpet (*jae namaz*). They did not participate in holy activities such as *Meelad* (Religious gathering to celebrate the birth of Holy Prophet Muhammad (Peace Be Upon Him). Menstruating women did not fast during the holy month of Ramadan but they pretended to be fasting and woke up early in the morning to prepare *sehri*[57]and also *Iftari* (sunset meal to end fasting). The cultural norms expected from women to conceal their state of menstruation.That is why non-fasting menstruating girls and women also behaved like they were fasting too. Women said that if they eat openly during the time of fast, other people (males) will get to know that they are menstruating and its like advertising one's feminine secret.

[57]Morning meal before fasting, especially in the month of *Ramazan*. See also *Suhoor*

Women believed that menstruation is a time of vulnerability for women as they had to follow many restrictions. Certain activities which females normally do in routine days wereabandoned during menstruation. For example,it is regarded unsafe and harmful to take a bath during menstruation. Taking a bath is thought to stop the menstrual blood flow; the air may enter into the body and may cause swelling *(jisam phulna).* Taking a bath is restricted till bleeding stops. Women believed that it is really important to have a substantial blood flow *(mahwari khul kay ana)* because if the blood flow is scanty then it is likely to cause many gynecological problems. It is likely to cause trouble in the reproductive system.

Similarly, it was also believed that during menstruation females should restrict themselves from participating in various physical activities such as doing heavy physical work, lifting weights, skipping; and using cold water for washing utensils and clothes. The menstruating body must be kept warm as much as possible. With the passage of time, girls learn how to adapt to their menstrual cycle. They were told right from the beginning that this is something which occurs every month on almost the same dates. Girls and women worry about their expected date of menstruation, particularly school-going girls to avoid embarrassment which can be caused by staining their clothes with spots of menstrual blood while they were in school. One of the girls shared her experience as,

> *"Mujay cheyvee jamat main pehli baar kapray aye. Mujhay iska pata nahi tha. Miss ko meri qameez pe lagey khoon kay dagh nazar aa gaye aur unho nay mujhay siraf gher wapis jaa kay kapray badalnay kay liye kaha. Main to pareshaan hi ho gayi kay pata nahi kiss na maloom waja se mujhay gher wapis bheja hay. Meri class main eik larki thi jisko shayd pata tha mujhay samjhaya kay sab larkiyon kay saath ye hota hay laiken uss waqat mujhay kuch samjh nahi lagi kay wo mujhay kia samjha rahi hay. Jab main gher wapis ayi to phir meri ami nay mujhay samjhaya mahwari kay baray main or mujhay underwear or uss main rukhnay kay liye kapra dia. Unho nay mujhay samjhaya kay main apni mahwari ki baat kisi kay agay na keroon, school main kisi saheli se bhi nahi aur ye bhi kay ye buhat zaroori hay kay larkiyan apnay mahwari kay khoon aur iskay kapro ko chupa luka kay rukhain. Unhon nay mujhay kaha, "tu ab jawan ho gayi hay koi bachi nahi rahi isliye tujhay pata hona chahiye kay apnay app ko kis tarah sambhalna hay."*
>
> I was in class six when I had my first menstruation. I did not know about that the teacher saw blood stains on my shirt and only asked me to go back home and change clothes. This made me worriedwhy she sent me back home for an

> unknown reason. One of my class fellows who was perhaps aware tried to explain me that this happens to every girl but at that time I did not get what she was trying to explain me. Then I returned home and my mother explained about menstruation and also gave me underwear and a piece of cloth to keep in it. She (her mother) explained to me not to discuss my menstruation with anyone, even any friend at school and that it is really important for a girl to hide her menstrual blood and pads. She said, "*You are grown up and no more a child and you must know how to carry yourself*."

Many women mentioned menstruation as a time of irritation as they had to follow certain restrictions. Among others, there are also food taboos which young girls weretold of. For example, they should refrain from eating spicy food such as pickle. They should also avoid cold food such as yogurt, water melon, cantaloupe, ice cream; rather they should eat hot food such as boiled eggs to augment the blood flow. Similarly, soft drinks and *lassi* (curd milk) should be avoided as being cold and hot drinks such as green tea are considered good during menstruation. Sadia described her precautions during menstruation as,

> *"Mahwari ka tame tu okha hi hota hay banday ko bari ehtiyaat kerni chahye taa kay muslay na hoon. Main tu mahwari kay pehlay paanch din thanda paani nahi peeti chahey sakhat garmiyan hi kion na ho na hi main apnay haath per thanday pani main geelay honey deti hoon. Meri maa ne sikhaya tha kay doodh chwarey peena mahwari kay darddo kay liye accha hota hay aur iss se mahwari bhi khul kay ati hay. Ager khoon ruk ruk kay aye tu barey masley hotay hain jaisay wazan burhna shuru ho jata hay or phir beemar bhi asani se nahi hota."*
>
> Menstruation is a time of vulnerability so one must be very careful to avoid any complication. I do not drink cold water during the first five days of menstruation even in a hot summer and I don't wet my hands and feet in cold water. I try not to wash clothes during these days. My mother taught me that drinking "*doodh chuhara*" (a concoction made with milk boiled with dried dates) is good for the cure of menstrual cramps and it also enhances the bleeding. In case of scanty bleeding, women may have complications like gaining weight, having difficulty to conceive etc.

Apart from the above-mentioned taboos associated with menstruation, women also mentioned magic practices relating to the use of menstrual blood. To capture love and obedience of a husband, women wash their underwear with blood stain and add few drops of their blood in their husband tea or any other drink. It requires no other ritual,

prayer, or invocation. Women believed in its efficacy completely but they agreed that such a practice is immoral as menstrual blood is highly impure. They just mentioned it but no one admitted to trying it herself.

5.5 Menstruation and Change in Girl's Behaviour

Women agreed that with the onset of menstruation they started perceiving girls as women because the menarche is the confirmation that a girl's body is able to reproduce. Women also commonly agreed that these days girls reach to puberty at an early age of 11 years or 12 years thatis problematic as they can be treated neither as a fully-developed woman nor as a child because her state of existence lies somewhere in between. Women understood well the relationship between menstruation and the ability to get pregnant which made them more worried and protective about girls. They cited Islamic teachings that encourage early marriages for girl.

Women informed me that it is a parent's duty to marry off their daughters once they start menstruating at home. It is a sin to keep a '*jawan'* grown up girl at home. One of the women mentioned,

> *"Jab betiyan jawan ho jaen to maa baap ki neend haram ho jati hay. Unko apni ankhain khuli rukhni perti hain taa kay wo apni betiyon ki izzat ki rukhwali ker sakhain jab tak unki shadi na ho jaye. Ye koi asaan kaam nahi. Ye to Allah ka bara Karam hota hay ager jawan hotay saath he kisi ki beti apnay gher ki ho jaye. Jo maa baapiss mamlay main be fikray hotay hain wo gunahgaar hain. Unki ibadatain qabool nahi hoti."*
>
> Parents cannot sleep when their daughters reach puberty. They must keep their eyes open to safeguard the chastity of their daughters till they are married. It is not an easy task. It is the blessing of Allah if one's daughters go to their (marital) home soon after they reach puberty. Parents who remain unconcerned with this matter are sinful. Their prayers are not accepted.

The narration shows that the puberty of girls add to a parent's responsibilities. Although menarche itself did not observably change a girl's body,it definitely changed parents perception of her as a sexual being that must be protected. Women also said that it was not uncommon that young girls may develop an attraction towards opposite sex at this age. That is why mothers worried about their daughters arriving at menarche and start looking for a marriage proposal. They also imposed restrictions on girl's mobility and did not allow them to play with boys like they used to play before. One of the women said,

"Jab larki ko kapray aa jayein to uska kaam hay kay wo sakkay peo se or pra se bhi fasla rukhay, sir pe chaddar rukhay or apna poora jisam dhamp kay rukhay. Jawan larki kay jisam pe baap ki bhi nazar nahi perhni chahiye."

When a girl reaches menarche she should maintain a distance even from a real father and brother. She should cover her head with cloth and cover her entire body. Even a father should avoid gazing at the body of a young girl (daughter).

Another woman said,

"Jawani main to khoti bhi khoobsurat hoti hay. Larki jawan ho to pata chalta hay, uskey qad kath se, jisam se. Larkoyon ki iss umer main rakhi kerni perhti hay. Jawan larki badnaam ho jaye to pooray khandaan ki izzat barbaad ho jati hay."

Even a female donkey (jenny) turns beautiful in youth. When a girl reaches puberty, it is seen, from her height, from her body. Girls must be monitored at this age. The defamation of a young girl can destroy the honor of the whole family.

Many girls found this new state very irritating due to these social restrictions posed on them. They experienced different physiological changes in their bodies such as weight and height gain that occurred with puberty; breast enlargement and growth of axillary and pubic hair but they remained poorly informed regarding the exact nature of these changes.

5.6 Menstrual Disorders

During menstruation, women mentioned complaints like irritability, headache, malaise, backache and tiredness. Menstrual pain or cramps (Dysmenorrhea) and discharge were most commonly reported problems. These cramps range from a dull pain (*muthi dard*) that simply irritates, to a more acute pain. The intensity of pain varied from woman to woman and some women did not even mention it at all. Women associated this intensity of pain with their reproductive health. Sidra mentioned the story of her friend who remained childless because of her persistent menstrual cramps.

"Sadia ko mahwari main sakhat takleef hoti thi. Uski takleef tu bus bardasht se bahir hoti thi jo marzi totka ker lo gher pe faraq nahi perta tha jab tak kay ussay husptal na leke jao dard khatam kraney ka teeka lagwaney kay liye. Uski shadi 10 saal pehlay hoi thi apnay chacha zad se or kabhi uski god hari nahi hoi. Uski saas her waqat ussay batain sunati hay kay uss main tu ye

nuqas shadi se pehlay ka hay or iski maa nay dhoka dia hay iss niqas kay barey main unko na bata kay. Kionkay ye to sub jantey hain kay jin larkiyon ki mahwari itni takleef se ho unn main maa bannay kay barey muslay hotay hain. Sadia ki saas ussay bura bhala kehti hay kay wo apnay muslay ka pehlay ilaj kerwati warna ussay shadi nai kerni chahye thi bachay na paida ker kay ussay apnay mian ki zindagi berbaad nahi kerni chahiye thi."

"Sadia used to have acute pain during menstruation. Her pain was simply unbearable and would not be cured from any thing at home unless she was taken to hospital to have an injection of pain killer. She was married to her cousin 10 years ago and she never got pregnant. Her mother-in-law keeps scolding her all the time saying that she had this defect before marriage and her mother committed a fraud by not telling them about this defect. Because it is understood that girls who have severe pain have problems to become mothers. Sadia's mother-in-law condemns her that she should have sought treatment of her problem otherwise she should have not married and spoiled her husband's life by not giving him children."

The above mentioned narrative explains that a menstrual problem is understood as a key factor that causes reproductive health problems, particularly infertility. Women also mentioned other types of menstrual irregularities such as hypomenorhea whichmeans light or scanty menstrual periods and locally called *mahwari khul kay na ana* or *mahwari znormal se kum ana*. Hypomenorhea, is a matter of great concern as the majority of the women believed that the female body is producing small amount of eggs that are necessary for conception. For maintaining a good reproductive health, it is significant that girls should have a sufficient amount of menstrual blood. Women and girls having less than three days bleeding do get worried. It is widely believed that less menstruation causes various problems. Women also acknowledged variation in the length and flow of menstruation. One woman remarked,

"Kisi ko kapray ziada atey hain or kisi ko thoray. Apna apna hisaab hota hay. Meri maa ko chay chay din kaprey atay thay or mujhay kabhi chaar din se ziada nahi aye."

Some (women) have heavy menstruation and some have scanty. It varies from person to person. My mother used to have menstruation for six days but I never have it beyond four days.

Women also mentioned excessive bleeding (menorrhagia) which is locally called *Kapray ziada ana.* Women considered the average duration of 3 to 6 days bleeding as normal. They also said that the blood flow is heavy during first three days and then it gradually

reduces. If the bleeding continues beyond six days it indicates an abnormality or problem. Generally older women have more complaints of excessive bleeding and many women blamed *rasoli* or fibroid or use of modern birth control methods particularly intrauterine device (IUD) and uterus prolapse as the major causes of prolonged bleeding. According to cultural norms, menstrual problems were not openly discussed particularly when faced by unmarried girls for fear that it may add difficulties in arranging their marriages. Married women also tried to seek various kinds of herbal treatments at home unless their problem was aggravated and got worst. Women reported that in cases of backache, menstrual cramps and light bleeding, green tea (*sabaz paati ka qahwa*) is considered good with the addition of a small and big cardamom. Women also boil a pinch of *ajwain* (Carom seeds) in water and drink it to augment the menstrual blood flow. To be relieved from menstrual pain, a panadol tablet is also used. Women also tried to hot compress their back with a warm brick as a pain relief strategy. Women believed that menstrual irregularities hint at underlying reproductive issues that were supposed tobe hidden. Women took precautions such as avoiding drinking cold beverages and walking on the cold floor barefoot, as the cold can stop menstrual bleeding and can make the cramps worse. They even do not take a bath or wash their vagina for fear that it may damage their reproductive system. This shows that personal cleanliness and hygienic practices were almost non-existent, as far as bath taking or regular changing of sanitary pads are concerned.

5.7 Menopause:

Nafisa Shah (1997), with reference to her discussion of women in the rural Sindh, Pakistan, argued that menopause among women indicates a “termination of womanhood” which results in less emphasis on segregation and seclusion of older women. The control of women’s sexuality and mobility through notions of *purdah* thereby becomes flexible when women reach the menopause. Post menopause is the time when women have more freedom of movement and they achieve the status of “honorary males”.

5.8 Women's Right to Sex

Women said that they were informed about sex just one night before marriage. Usually the mother feels shy to explain 'sex' to their daughters so a married sister or cousin is a source of information for the bride becoming somebody's wife. This information is limited to the sexual activity and knowledge about child spacing and contraceptives is not included.

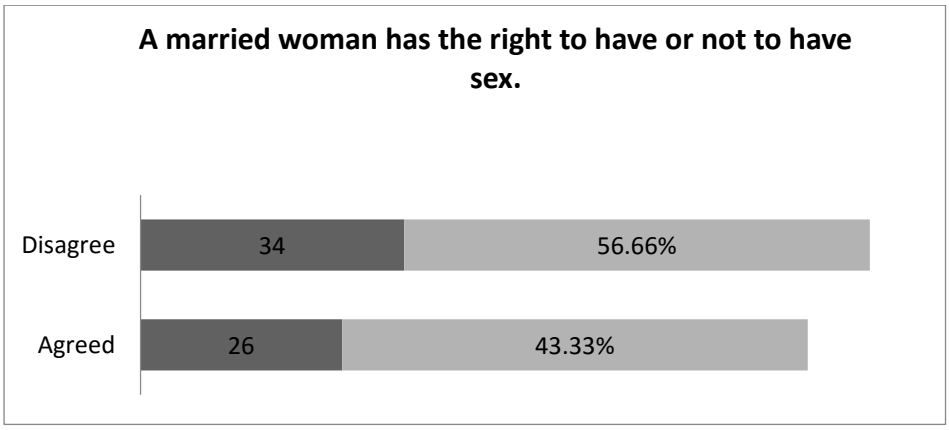
Women in Choha Shah Ghareeb find absolute value and pride in their ability to reproduce and provide heirs to the husbands. Women had a clear sense of what is expected from a Muslim wife. Many women mentioned that Islam has forbidden wives to reject or decline the sexual advances of their husbands.

As Nasra explained,

> *"Shadi ka asal maqsad he yehi hay ka jawan marad aur aurat ko apni khawhish deeni tareeqay say poori kernay ka moqa muhayya karey. Iss se wo gunah se buch saktay hain."*
>
> The real purpose of marriage is to provide adult men and women with the opprotunity to satisfy their (sexual) desires in a religiously approved way. It can protect them from sin.

Women said that it is mandatory for them to fulfill their husband's desires. They were shy when I asked them about having pleasure in sexual interaction. They believed that 'pleasure' is the male's domain and women must seek 'satisfaction' in making the husband happy. Women believed that a man's place in Islam is superior. Men are the breadwinners and so they are entitled to make all decisions regarding family and kin.

Figure 5.1 Women's Response to Right to Sex



Many women during interviews expressed their wish to live up a way that they feel comfortable. They (43.33%) wanted to have this right to avoid coercion in their relationships and wished not to have sex with their husbands unless they also wanted this. Women complained that sometimes they may not be willing due to fatigue, illness, workload or any other reason and in that case they should not be forced. Women also mentioned that in their social context these expectation are hard to achieve and women are not generally able to live up to these aspirations. Rather, they have to shape their lives according to the social expectations, for attaing respect and social protection. On the other hand, 56.66 women disagreed with the idea that it is a right of a married woman to have or not to have sex with her husband. They perceived sex as 'wife's duty & obligation" and a necessary requirement of married life. In their opinion to demand sex is a husband's right and to satisfy his desire is a wife's duty. Saying 'No' to a husband is a great sin and it makes the marital bond weak.

Women were least aware of the notion of personal ownership of their bodies and their statements revealed that they considerd their bodies as a commodity which is owned by their families. The way they perceived their bodies, and the social values they followed in shaping that perception, was not considered as an encroachment on the self. Rather it was so deep-rooted in their socialization pattern that it seemed to be an integral part of their psychological make-up. However, women's claims to a particular right depended on their social status and position in the family and many other cultural, emotional, cognitive, social and economic factors.

Women strongly emphasized religious teachings which highlighted their sexual obligation towards their husbands. They cited that refusing a husband's sexual demands is *haraam* (forbidden) and a great sin. A wife cannot refuse sexual intercourse unless she has a valid reason such as menstruation, obligatory fasting, sickness etc. A popular saying of Prophet (PBUH) frequently mentioned in this regard is given

It was narrated that Abu Hurayrah (may Allaah be pleased with him) said:

> *"The Messenger of Allah (PBUH) said: "When a man calls his wife to his bed and she refuses, and he went to sleep angry with her, the angels will curse her until morning."* (Narrated by al-Bukhaari, 3065; Muslim, 1436)

Therefore a wife who fulfills the sexual requirements of her husband within the framework of marriage not only pleases her husband but also pleases Allah. Women had a strong belief that the ideal wife according to the religion is cooperative with her husband who tries her best to fulfill her duties and obligations by seeing to the welfare and happiness of her husband and children as her first priority after her duty to Allah.

5.8.1 Sexual Coercion and Non Consensual Sex

Women shared their apprehensions that they had to bear threatening consequences in case of saying "No" to a husband on having sex. These consequences may range from verbal abuse, anger, suspicion to more severe reactions such as beating and forced sex. They also reported that men cannot control their sexual desires and refusing them can lead to their negative reaction as they seldom understand the reasons for which sex was refused. Kalsoom said,

> *"Ager marad aurat kay paas ana chor de to aurat samajh jati hay kay iss say koi ghalti hoi hay aur iska marad iss se khafa hay. Phir wo marad ko razi kernay kay liye maafi mangti hay."*
>
> If a man (husband) stops sleeping with his wife then the woman (wife) understands that she has committed some mistake and her man (husband) is annoyed with her. Then she has to apologise in order to make her man (husband) happy.

For some women, the uncaring attitude of their partner made them unresponsive towards having sexual contact. As Sabreen reported,

> *"Mera khawund mujhay pasand nahi kerta. Aisa lagta hay k us nay sirf apnay maa baap ki waja se mujh se shadi ki. Meri koi koji to nahi laiken wo her waqat he mere andar nuqas nikalta hay. Wo jumlay kasta hay kay," tu kali hay. Teri to chati hi nahi. Tere under koi khubsoorati nahi." Wo mujhay zehni azyat deta hay. Ye mere samajh se bahir hay kay main ager itni hi koji hoon to phir haftay main do teen dafa mere sath milnay ki khawhish kion hoti hay. Kitni dafa mera dil kerta hay kay main iski baat na mano kionkay mere dil main ab iske liye kuch nahi hay laiken mujhay pata hay kay biwi ka kia faraz hay. Main isko inkar ker kay apnay liye gunah nahi khatna chahti."*

> My husband does not like me. It seems he just married me for the sake of his parents. I am not ugly looking but he always finds flaws in my personality. He taunts me saying, *"You have a dark complexion. You have small breasts. You have no beauty at all."* He gives me big mental torture. I fail to understand why he expects me to have sex two three times a week if I look that bad? Many times I just want to avoid his demands as I have nothing left for him in my heart but being a wife I remember my duty. I don't want to earn sin for me by refusing him.

Many women acknowledged this fact that to have unconsensual sex is not something uncommon in marriage. One of the young women, Mubeena, put it in this way,

> *"Mere kum umri ki shadi thi, shayed 16 saal kithi. Ye to mujhay pata tha kay mian biwi main koi jismani taluq hota hay laiken sahi nai pata tha k kiss kisam ka taluq hota hay. Meri khala ki beti nay shadi se eik raat pehlay mian biwi key milap ka bataya. Sath ye bhi k thora buhat dard bhi hoga laiken main shorna machao. Main darr gaye kionkay usne kaha kay khoon bhi nikalta hota hay. Shadi ki raat khawund shuru ho gaya. Main thaki hoi thi or khofzada bhi tu isi liye main nay uski minnat ki wo baqi kal ler lay laiken wo ghussay main agaya or bola, "ager ye sub kuch nahi kerna tha to phir shadi hi kion ki? Ager tum nay meri baat nahin maan rehi ho to phir behtar hota apnay maa baap kay pass hi bethi rehti. Ab tum meri biwi ho aur jo main kehta hoon wo tum kero. Mere oper hukam na chalao."*

> I got married at a very young age, perhaps 16 years and I knew that there is some physical contact between husband and wife but I was completely unaware about the nature of that contact. My cousin briefly told me about sex just one night prior to marriage. She told me it is going to be a little painful but I should not make any noise. I got scared when she told me about expected bleeding. Then, on my wedding night, my husband started doing it. I was really tired and afraid and so I requested him to postpone it to the next day but he got angry and said,*"If you can't do this then why did you get*

married? If you are not willing to obey me then it would be better for you to stay with your parents. Now you are my wife and do what I say. Don't give me orders."

Many other women just like Mubeena were over-powered by men in sexual matters. During in-depth interviews, it was reported by many women that tedious household chores made them so exhausted that they just wanted to have a rest to recover their energy for the next hectic day. In this situation, with a fatigued body having sex on husband's demand is just like another task rather than having intimate pleasure. Women also mentioned other reasons for declining sex such as lack of privacy in joint family households. Most of the houses in the village were small not having more than two or three rooms. The wash room is built at the corner of the courtyard and as such there was no facility of having an attached wash room with every room. Sex is termed as "*akhtay hona*" or "*mian biwi ka mi*lna". According to the norms of the village, the sexual routine of a couple is kept secret. The other family members should not know when and how many times a couple had sex. Women said that sexual intercourse made them highly impure and they were supposed to take a ritual purifying bath right after having sex as prescribed by the religion. When women tooka shower at during mid-night then there was a possibility that someone may come to use washroom and find it occupied. Women said that they had to do it quickly specially when they were living in an extended family system or even if they were living in a nuclear family, the presence of grown up children is a constant threat for them. Due to limited space, when children grew up women started sleeping with their daughters and the husband slept with the boys. Not all married couples have their seperate bed-rooms. In this kind of situation, it is not desirable for them to have frequent sex because tt becomes really hard to maintain privacy at times, but men did not understand these issues and expected that their wives must be willing to have sex whenever they desired. Another theme that emerged during in-depth interviews was sex during pregnancy. Generally, many husbands compromised on their sexual needs while their wives were pregnant but a few women reported that their husbands forced them to have sex during pregnancy and the postpartum period when bleeding stops. They said that their husbands could not control their sexual drive and simply cited an excuse "*hum se paal perhaiz nahi hoti"* (we cannot observe sexual abstinence). However, no

woman reported sex during menstruation as it was well understood by men that it is prohibited in Islam and also for the reason that the impure blood can harm their sexual organ.

Many women expressed greater need for privacy with regards to the sexual activities of married couples. For instance, Nasra voiced against her mother-in-law"s monitoring of her sexual contact with her husband. She mentioned that her mother-in-law used to notice her frequency of taking a *ghussal* (shower) which is mandatory after having sex. Nasra complained that she tried her best to take a shower early in the morning but her mother-in-law would see her wet hair and then she would presume she had made sexual encounter with her husband. Nasra expressed greater need for privacy and respect from her mother-in-law towards her sexual life.

Women also mentioned that fulfilling a man's sexual desires somehow made them dependent on their wives. It kept husband and wife closely intimate with each other. On the contrary, if a man is not satisfied with his wife then his unfulfilled sexual desires will get manifested in misunderstandings, suspicions, verbal abuse, separation and even abandonment. Shamsa told how her husband reacted to her refusal of sex,

> *"Ussay her waqt ussi kaam ki pari hoti hay. Wo raat ko bhi kai kai dafa kerta hay or yhan tak k din k waqat bhi jab her koi jag raha hota hay. Usme sharm he koi nahi. Milaap ki ziadati ki waja se main buhat kamzor ho gai. Mere paanch bachay hain or teen zaya bhi hoye. Mera jisam bilkul sookh gaya aur saheliyan kehti hain kay main dhancha lagti hoon. Usse meri sehat ki koi parwa nahi. Jab wo mujh se ikathay honey ka kahey or main inkar ker do to larai shuru ker deta hay. Wo baat cheet band ker deta hay jab tak k main uss se mafi na mang loon. Eik dafa isko chot lagi or haftay k liye husptal dakhil hoa. Wo itna kala per gya kay usne mujhay majboor ker dia kay main wahi bath room main he shuru ho jao. Jab bhi main nay zor dene ki koshish kroon, wo doosri bevi laney ki dhamki deta hay jo zayada jawan ho or uske saath chal sakey."*
>
> He (her husband) is sexually demanding. He wants to have it many times not only during the night and even also during the day when everybody is awake. He does not feel ashamed. Due to excessive sex, I became very weak. I had five children and three miscarriages. My body has become so thin and my friends say that I just look like a skeleton. My husband is least concerned for my health. Whenever I say no to sex on demand he starts fighting with me. He also stops talking to me till the time I apologize him. Once he got injured and admitted to hospital for a week. He became so desperate that he

forced me to have sex with him in the bathroom over there. Whenever I try to be more assertive, he threatrens to bring another wife who is young and can coordinate with him.

According to the norms of the village, sexual matters should remain between husband and wife. The family members were not expected to intervene in the personal matters of married couple. Women accepted nonconsensual sex considering it as their 'obligation' and also to avoid worse consequences such as abuse, conflict and divorce. Due to social taboo on discussing sexual matters women had the apprehension that negotiating sex may lead to misunderstandings and they might even be suspected of infidelity.

5.8.2 Refusal to Have Sex with the Husband

Women informed that males, by nature, are sexually aggressive with a strong libido. The wife is supposed to satisfy his sexual demands any time he desires.

> *"Marad tay koray wango honda hay. Jay zanani na puchay tay unnay tay moon marna he hay."*
>
> A man is like a horse. In case (his) wife does not attend to his desires then he is likely to develop extra marital relations.

Many women said that if they refuse their husband and argue with them then it provides justifiable grounds for the husband to do *zabardasti* (coercive sex) with her.

> *"Mardan nay apni marzi kerni hondi hay, jay na manno tay fair zabardasti he karni hai."*
>
> Men do what they want, in case of refusal (they) do it by force.

It is believed that the husband has complete sexual rights over the wife and it is the prime duty of wife to satisfy her husband at any time he wishes. When Sakeena refused her husband, while she was pregnant, he said that, *"mai teray naal wia isi kam wastay keeta hai. Beemar honey da ae matlab te nai kay zanani no meenay khawand nu puchay he na"* (I married you for this purpose. Being pregnant does not mean wife does not attend to her husbands for nine months).

In-depth interviews also reveal that women did not refuse their husbands due to the fear of being suspected to be involved with someone else. The in-laws and husband also

condemn and accuse the woman saying, *"haq na daindi ai."* (She does not give him his rights). Furthermore, it is also considered *"Sakht gunna" (*a great sin) to refuse the husband when he calls his wife for this purpose.

> *"Ager mard aurat ko haath na lagaye aur mian biwi ikathay na ho to iska matlab hay kay wo kisi aur aurat kay sath hay kion kay mardo ko iss ka chaska hota hay aur wo iss kaam kay baghair reh hi nahi saktay."*
>
> If a man (husband) does not touch the woman (wife) and husband and wife do not have sex then it means that he (husband) is associating with some other woman because men are obsessed with it (sex) and they cannot refrain from this activity.

One of the respondents said that she felt obligated to have sex with her husband although she was advised by the doctor to avoid it. Many women also mentioned that they would return to their natal family to avoid the sexual advances of their husbands. Particularly in the post-patrum period when they needed rest they preferably stayed with their mothers. Refusing a husband who wants sex becomes difficult whie sleeping together in one room. Women said that shifting of spaces creates a change in womens role from a sexually active wife to asexual daughter without offending husbands. Married women sought sexual refuge at their parental homes or in some cases requested their mothers, sisters or any other female relatives to stay with them.Thatrequired husbands to sleep elsewhere. But not all women had to move to the parental house in order to abstain from sex. Ruqayya explained that she went through sterilization and doctor advised her to avoid husband for atleast three months. She said,*"He was very supportive and caring. He brought fruits and chicken for me. He did not come closeor demanded sex."*

Mehreen explained that, "*I just cannot say 'no' to my husband as he gets annoyed and then he goes to the roof and sleeps alone. His anger makes me more distressed. I find it easier to fullfill his desire than to calm down his anger. Sometimes I am tired and just not in mood to have sex but I hide my feelings as my objective is to avoid conflict and maintain harmony."*

5.9Male Sexuality is Expressive and Female Sexuality is Repressive

It is an impression that women who talk about sex openly are considered bold (*be khof*) and shameless (*be sharam*).Male sexuality is active and expressive. Women said that

males by nature are sexually aggressive. The male's libido is something that is bragged about. It is neceassry for a male to remain sexually active otherwise he will develop "*garmaish"* (heat) inside. On the contrary, females displayed a passive sexuality. In sexual matters, it is always the husband who takes the initiative and calls the wife and not the other way round. Women thought that their husbands may not like if they invited them for sex. A woman who always wanted to be with her husband was not spoken of in good terms. Women are supposed to be shy and it is a male's prevogative to invite his wife for sex whenever he desires. Women are the passive partners and a woman with an aggressive sexual appetite is considered *"be sharam"* (immoral) and not having a good character. Shameem mentioned that she was reluctant to protest against her husband's frequent and coercive sex because she was afraid to be accused to want all this herself. People would say, *"Too app ae kuj lorni hai".* No woman wanted to be labeled as sexually demanding.

An aggressive male sexuality is countered by a passive female one. A woman who openly expressed her sexual appetite was considered bad. Women said that they should not ask fot sex. They should repress their sexual desires and wait for the call of their husband. Women were of the opinion that *"aurat di izzat oday tikar hondi hai."* (A woman is responsible for her own honour). Husbands do not respect wives if they display sexual initiative. They may suspect their wives of sexual promiscuity. "*Jinna nu lut laggi hoey oh fir ek tu nai rajdian.*"- (women who are fond of (sex) do not get satisfaction from single person.)

5.9.1 Male Impotence is concealed.

Male impotence is a source of great *beizzti* (shame) for the man. Consequently, it is concealed and not freely discussed. *Izzat* (honor) belongs to the man and it is represented by the female and defined in terms of her sexuality.

A good and chaste wife would always safeguard her husband's honor. She never reveals any of her husband's weaknesses to anyone. Many women quoted a famous story in which a wife who remained childless in her whole life due to her husband impotence but did not disclose to anyone about her husband's fault. Everybody blamed her for being infertile, particularly her in-laws, but she remained patient and took the blame on herself

to protect the honorof her husband. When she died and her dead body was taken to the graveyard for burrial, people gathered for her funeral felt a strange fragrance and saw the rose petals falling on her grave. Then people asked her husband about the special quality she possessed for which she was rewarded after death? Then her husband revealed that he was impotent but his wife always kept his secret of impotence and did not tell anyone. Everybody blamed her for being infertile and barren but she remained patient. Although this story has no reference in the religious text books, it is widely believed and shared among women in the village. It is expected from a wife to protect her husband's honor. If she advertises his faults he will be *beizzat* (dishonored) and in turn she too will be *beizzat*.

Zareena said that her cousin returned to her natal family and told her parents that she wanted a divorce. Her husband along with his family elders came to convince her and she revealed in the presence of all family members that her husband is a "*khusra*" (impotent).

Her husband divorced her right there as she had disgraced him in front of everyone. According to Zareena, it's been five years and nobody married her considering that she is a bold and shameless woman. If she were a chaste woman she would not revealed her husband's weakness in public. She herself is not a modest woman. *"Nazran chon gir gai hai"* (She lost face).

Men are considered superior and so their aurthority is not questioned. Husbands in particular are religiously superior to the women. Nasreen, says that no matter how cruel the husband gets, *"mard di izzat kerna aurat da faraz hay"* (it is obligatory on a woman to respect her husband). This is justified on the grounds that he is *"mijazi khuda"* (He is God in earthly form). The wife is ordered to prostrate before her husband, after God.

5.9.2 Home Remedies to Increase Virility and Sexual Appetite

Women also mentioned the use of certain foods, which were considered beneficial to naturally enhance sex drive and libido. *Khushak maiway* (Dry nuts) particularly pistachio, dried dates, w*alnuts*s and cashew nuts are considered to increase the sexual powers of males. Moreover, increasing the use of ginger and garlic is also considered a good source to boost the male libido. Milk and dairy products like *makhan* (home made butter),

paneer (cheese) and *lassi* (curd water) are considered good to improve virility. In addition, women also mentioned the use of special oils by men that can enable perfect erection and increase the duration of sex.

CHAPTER NO 6

MOTHERHOOD & REPRODUCTION

Reproduction and motherhood have always been central to women throughout history. In the village, susseccful reproduction and motherhood are seen as normative steps in women's lives. There are strong cultural expectation that women should get married, bear and rear children and become good mothers and wives. Motherhood helps women to gain acceptance and appreciation from her husband and in-laws and from the overall community in general.

This chapter explains cultural representations of mothering and discusses how women are socialized to believe that motherhood is natural and inevitable, and one of the most valuable social roles for them to fulfill. It further explains how motherhood and having children gives them a sense of achievement, satisfaction, and pride, and makes them feel empowerd, secure and accomplished. Being mother gives women a status and a unique identity.

In the village, women were not sole decision makers in their fertility related matters and the decision regarding when and how many children to have is often situational and determined by a number of socio-cultural factors. Given such pervasive social pressure upon women to have children, particularly sons, women feel obliged to meet their reproductive targets as set by the community, failing which may have detrimental effects on their respect, status and marital stability.

Because of the immense value associated with reproduction, barrenness is not only intolerable; it is unacceptable and percieved as a failure to adhere to traditional values and norms (Hampshire KR et al, 2012). In this context, infertility is disastrous with the negative outcomes and social cost such as depression and shame, criticism, exclusion, condemnation, hostility and fear of husband's remarriage and concerns over their deteriorated health conditions.The present chapter also highlights the plight of infertile women and various treatment options they sought for the cure of infertility.

6.1 Traditional wisdom about becoming a mother

Becoming pregnant is perhaps the biggest responsibility expected from a new wife. Married women explained that soon after marriage people start inquiring *koi khuskhabri* (any good news), *kuj hay* (are you expecting), *koi aas hay* (any hope) and if a woman is unable to conceive immediately after marriage, gossip will start in the community and the family members particularly, a mother-in-law will start interrogating to know what is wrong with the new bride. A woman is highly treasured within the *ghar* (marital home) for her potential to produce children for the family. While pregnancy is eagerly anticipated within the family, at the same time it is a matter that needs to be kept in *purdah* (not a topic that should be discussed openly).

Women mentioned that they felt shy to announcing one's pregnancy either to one's husband or other family members. Women also pointed out that missing a menstruation is considered an obvious sign of pregnancy and it is known as *din uttay charna* (periods overdue).

Pregnancy is called *hamal tehrna* or *bacha pait payna* and a pregnant woman is referred to as *bemar aurat*. Women also mentioned that they had difficulty in cooking certain foods like meat curries because of their smell and then they got to know that they became pregnant.

Women in the village emphasized the importance of becoming a mother (*ma banna*). This is the most important goal in a married woman's life. Women unable to achieve this goal are seriously afflicted in terms of their worth and respect in the family. A married woman has no justification if she does not conceive immediately after marriage. Sumera told me that two years back she was married to a migrant who works in Bahrain. He left her two months after the wedding and the company allows him to visit his home country once in three years and that too only for two months. She said that her husband works as a laborer and cannot afford to travel frequently even if he wishes to. Sumera reported facing criticism and public gossip for not sharing the good news. According to her experience even the wife of a migrant husband has no leverage to make excuses about why she had not yet become a mother. She quoted her mother-in-law who said,

> *"Jab hamal hona ho to eik raat may he ho jata hay. Mera beta to do mahenay reh key gya hay. Terey main koi nuqas hay warna tu bhi koi khuskhabri sunati. Main khud to shadi ke baad pehlay haftay main he pait se ho gayi thi. Laiken meray beaty ko tu nay koi khushi nahi di. Namurad he perdes chala gya."*
>
> A woman can conceive over night if the conception has to take place. My son stayed for two months. You (daughter-in-law) must have some kind of defect otherwise you could have disclosed the good news. I got pregnant in the first week after my wedding but you (daughter-in-law) did not make my son happy and he left discontented.

These sentiments were shared by a woman who could not prove her worth by having a quick pregnancy and who has to deal with the effects of her husband's migration. The failure to conceive can create an intricate family environment and have negative consequences for a new wife in her *sasural.* In conversations with her and many other women in the village, I found that the significance of becoming a mother is best understood within the complex of social relationships that includes members of the extended family, friends, neighbors, relatives and the community at large.

The pressure to can could vary significantly depending upon the structure of the family. In the case of a joint family, the couple is likely to experience more pressure to "oblige" their family members with a child. It has been observed that it is not only the couple's or a husband or wife's desire for a child that is important, but also the desire of the entire family, with the influential role of the mother-in-law shaping this desire.

Women reported that in the case of not becoming a mother, people around them start offering suggestions about the possible ways of dealing with childlessness. Rashdia, a mother of four children, described how after marriage she did not conceive in the first year. Six months passed and her mother-in-law started scolding her. She called in a Midwife to check her who gave a satisfactory report. Then she (the mother-in-law) took her to the nearest shrine which is known for the cures against infertility. Her husband never asked her anything but her *saas* (mother-in-law) started practicing all possible strategies in the pursuit of grand-children.

Women are expected to become pregnant within the first couple of months regardless of the age theywere getting married at. Bearing and rearing children are central to a woman's prestige, power andwellbeing in the rural socio-cultural context and

reproduction brings in real joys and benefits for women in their relationship with their spouses and their families. In women's understanding, reproduction constituted with their bodies and they are made for this purpose. Women realize that their reproductive capacity becomes a source of power. Zareena explained this fact as

> *"Meri shadi 16 saal ki umer main apnay cousin se hoi thi. Meri khala saas buhat bemar thi or meri shadi unki darkhast per bari jaldi main hoi. Main kum umer or kamzoor thi laiken phir bhi sab gher walo nay yehi mashwara dia kay jaldi jaldi bacha paida kero. Meri bari behnain or cousins nay bhi yehi naseehat ki kay mian kay saath her mamlay main taawun kero, ussay khush rukho or jaldi se bacha paida kero ager main nay ghar ka hissa banna hay, unki manzoori laini hay or taika banana hay."*
>
> I got married at the age of 16 with my cousin. My mother-in-law who is also my aunt (*khala*) was very sick and my marriage was arranged as an emergency at her request. I was very young and weak but still everyone in the family was suggesting to me to have a child as soon as possible. My elder sistersand cousins also advised me to cooperate with my husband in every matter, please him (the husband) and have a child soon if I want to be part of the family, be fully accepted and have a say.

Similarly Shagufta reported that one week after her marriage, her mother-in-law stopped her from drinking green tea when she suffered from flu saying '*mattay Allah karam keray*" mean May God bless you. By that she referred to becoming pregnant as according to the health beliefs of most of the rural women hot drinks may cause bleeding. She hoped that Shagufta might have conceived and if she drinks *qahwa* (green tea) that may lead to an abortion.

The above-mentioned statements refer to the cultural norms that create expectations from women to become an early mother as entering into motherhood provides them with an opportunity to negotiate their identities and find a place in their social and familial context. Though women may feel pressured to initiate a family early, women understand well what it means for her to comply, to prove her worth, to attain value and define her place withinthat cultural setting. As the women note, culture shapes the women's understanding of motherhood.

Acceptance and being part of the family in the cultural setting of Choha Shah Ghareeb means the participation in family decision-making. Culturally, when one has the leverage to participate in the decision-making, women are also trusted and given the right to make

decision about themselves and emphasize their choices including in the realm of their reproductive health. Though apparently it seems that these family expectations may constrain women's control over their bodies, women comprehend well the power they gain to negotiate their surroundings oncethey become a mother. Women in the village describe motherhood as an entry point for voicing their opinions with regards to reproductive health rights. Once a woman hasbecome a mother she is able to assert preferences about her reproductive health. Motherhood is the source for women to attain, value and social recognition within their cultural space. Agency, therefore, is how women reconstruct social norms within their cultural context to create legitimacy for themselves.

6.2 Women's Right to Give Birth

Women knew well that they have been assigned the duty of reproduction to ensure the continuity of their family's lineage. They wished to havea healthy and risk-free reproductive life. They recognize the significance of fertility control and they knew how child spacing was beneficial for them.[58] Women's right to reproductive health was explored and their responses revealed that their understanding of the concept of 'Reproduction' was found closer to the definition of the WHO which they explained in terms of having healthy bodies (women particularly refered to healthy uterus), bodies free from morbidity *(kumzori ya bemari na ho*) in order to ensure healthy reproduction and to be able to pass safely throughout their reproductive span.

Safe motherhood was found to be as an important component of their expressed meaning of reproductive rights.[59]They also identified good diet, particularly during pregnancy and post-partum, access to health care facilities, antenatal care, free mobility and having assistance in performing household chores as important rights women must be

[58]The traditional approach for studying reproductive health is mainly focused on healthy childbearing without considering the broader issues with regards to women's reproductive rights and women's perspectives (Zurayk, 2001).

[59]Petchesky and Judd (1998), in a cross-cultural comparison of how women understand reproductive rights, argued that the main justification women give behind their sense of reproductive entitlements is motherhood. They have to go through pain and suffering throughout pregnancy, childbearing, and childrearing which seem to be a form of currency they have to pay out of their bodies. (p. 302).

given.Having the ability to become pregnant without any medical intervention is considered both vital and desirable.

Women in joint families contextualized the right to give birth and decide their family size within the larger socio-cultural setting. They considered the wishes and expectations of various family members, especially parents-in-law, and thinking how an inability to fulfill familial wishes may result in conflicts and discord in relationships.Women prefered not to confront others particularly husbands with regards to reproduction. Instead they had internalized the importance of their existence in terms of their reproductive performance. The majority agreed that a woman has no better place than by herhusband's side. In the minds of women, a husband's place in religion is superior. In their prescribed roles, women believed they had to uphold Islamic tradition through which men are entitled to make decisions regarding family and kin.

Women talked about the importance of having children in terms of their own security. Saima described the utility of having children in this way:

> *"Shadi kay shuru main humaray barey rolay thay. Laiken jab mera pehla bacha hoa to merey husband nay mujhay thori tawajja deni shuru ki. Aulad shadi ko mazboot kerti hay. Jab mera doosra bacha hoa tu merey husband ka pyar ziada ho gya. Meri khala ki beti ki shadi mere se do maheenay pehlay hoi liken badkismati se wo maa na bani. Uske husband ne usko maa kegher chor diya or khud doosri aurat se shadi ker li. Mujhay yaqeen hay ager mere bachay na hotay to mera bhi yehi haal hota. Bacho se hi aurat ki qadar hoti hay. Bacho se zimadarian berhti hain or mian ko kahi or dekhnay ka moqa hi nahi milta".*
>
> We had great conflicts in the beginning of our marriage. But after my first baby was born, my husband started giving mesome attention. Children make married life more cemented. After having a second child (son) my husband started loving me a little more. My cousin who married two months before my wedding unfortunately could not become a mother. Her husband sent her back to her natal family and married another woman. I believe, the same could have happened to me if I were childless. A woman is valued for her children. Children increase responsibilities and leave no chance for husbands to look anywhere else.

Thus having children is perceived as a curb on a man's potentially threatening sexuality, and it reduces his probability of polygamy because it is unlikely that a man would upset his relationship with his children.

Nadia, a mother of five daughters, said that she was the person most disappointed when she gave birth to her fifth daughter. Although her husband and parents-in-law did not blame her for giving birth to five daughters, she herself internalized the necessity of having atleast one son. She knew that she has no control to determine the sex of her children, but despite that she felt the disappointment of not being blessed with a boy. The other women who visited her consoled (*afsos*) her instead of congratulating (*mubarak*) her. Becoming a mother of a fifth daughter turned into an occasion of grief. Referring to the social pity, she said that many women suggested she try again and also contact a spiritual healer (*pir*) who could help her in the pursuit of a son. She had an incomplete family and it was something that everyone understood.

Kiran reported that after giving birth to a third daughter her husband became more aggressive. She and her husband fought from time to time. She was worried about his insulting behavior. Her husband's younger brother (*dewer*) had two sons. Other women that came to her house told her that they wanted to see one from her. She commented,

> *"Main bari dukhi hoti hoon jis tarah ka salook wo kertay hain line se larkiyan paida kernay ki waja se. Maa ko to takleef aik hi jaisi hoti hay chahay larki ho ya larka. Mera dil bura hota hay jab khalayen behnain meri teesri bachi ki pedaish pe kehti thi kay kia acha hota ager iski jaga beta ho jata. Log bhi apni jaga ghalat nahin hain kionkay larkiyan achi to hoti hain laiken unki shadi ho jati hay jabkay larkay maa baap kay saath rehtay or unka khiyal rukhtay sambhaltay hain. Mere mian sakhat ho gya hay or kehta hay k mera koi waris nahi. Main majboor hoon kionkay mera kismet pe koi zor nahi. Main apnay mian ki khidmat kerti hoon or uskay saray hukam manti hoon. Main apna ghar nahi khrab kerna chahti laiken koi guarantee nahi kay wo khamosh rehay or doosri bivi na laye."*
>
> It is painful to see how people around you behave when you give birth to a series of daughters. A mother bears similar hardship irrespective of the sex of a child. I really felt disheartened when auntees and sisters commented on my third daughter that it would have been so nice if she had been a son. People are also not wrong in their opinion as daughters are good but they are married off, whereas the sons stay and look after the old parents. My husband has become so rude and says that he has no heir. I am helpless as I have no control over my destiny. I try to serve my husband and obey all his orders. I

don't want to destroy my home but there is no guarantee that he will stay quiet and would not bring another wife.

Kiran's statement summarized the opinions of several other women who feel vulnerable for not having a son. Women admit this reality that successful reproduction and especially the number of sons produced is the most important feature of their lives that makes them feel secure. Women believed that they are constrained to marriages for many reasons. They are not financially independent and cannot survive on their own. They need to compromise for the sake of their children, for the sake of their respect and what remains a sheer reality is that they have no other place to go. Many women said that wives should not argue with their husbands in any matter because respect of a married woman lies in her companionship with her husband. One respondent said,

"Aurat ki shan uske mard se hoti hay. Mard bura bhi ho tab bhi wo aurat ka aasra hota hay. Shadi kay baad na maa baap poochtay hain na behan bhai. Aqalmand aurat apna gher bachati hay."

A woman's worth is with her husband. A man (husband) is a shield for a woman even if he is bad. After marriage, neither the parentsbother nor sisters and brothers. A wise woman saves her home.

Women mentioned long-term benefits of having children. Women understand that motherhood creates space for the couple to become independent in a separate household. Even if they choose to live with the extended family, motherhood creates opportunities for them for independent decision making.

Parveen, a wife of the migrant husband articulates this point as,

"Mera miyan dubai main kaam kerta hay. Shadi kay baad main susral may rehti thi jo mujhay koi kharcha nahi detay thay. Gher wala sare paisay apnay baap ko bhejta tha. Jab meray bachay ho gaye tab mujhay sirf unke paisay miltay thay jo main school ki fees waghera deti thi laiken baqi sara paisa wo khud rukhtay tay. Paisay western union kay daftar atay thay jo shanakhti card ki copy bhi rukhtay hain. Gaon ka riwaj nahin kay aurtain aisay daftro main jaien iss liye kabhi sussar or kabhi jaith paisay wasool kerta tha. Laiken jab mera baita 18 saal ka hogya or uska shanakhti card ban gya to ab paisay uske naam pe atay hain. Dair se hi sahi laiken meray betay ki waja se meri zindagi main khushali ayi hay. Ab main susraal walo ka mun nahin dekhti or na hi choti choti cheezon kay liye kisi kay agay haath phailana

perta hay. Ab main alag ghar main rehti hoon. Such he kaha hay beto se khushhali aati hay."

My husband works in Dubai. After marriage, I lived with my in-laws who gave me no money. My husband used to send remittance money to his father. After having children, they released funds only for the payment of their school fee etc but kept rest of the money by themselves. Remittance can be collected from the office of the western union with the requirement to submit a copy of the identity card (of the receiver). It is against the tradition of the village that women visit such offices, for that reason, either father-in-law or husband's elder brother will receive remittance. But my son started receiving money when he turned 18 years old and got his Identity card. Though late, but my son brought prosperity in my life. Now I do not look at the faces of my in-laws neither I need to beg from others for petty things. It is a true saying that sons bring prosperity.

After marriage a woman becomes part of her husband's family and often the husband's family is involved in decision making.Women in the village expressed strong acceptance for ultimate powerful authority ascribed to the husband and the supreme reverence associated with parents-in-law. Many narratives of elderly women reflect their disappointment with the news trends, especially with respect to women's roles and attitudes. Older women with married children described their daughters and daughters-in-law to be irreverent of their role in the family, often disliking women raising a voice to their husbands, being unable to serve the family and to bear more children. one of the elderly woman in my study said:

"Main hamesha apnay khawaund ki marzi pe chali, uski khushi ka khyal kia. Uske waldain ki sari umer khidmat ki. Log meri misaal detay hain. Meray saas nay mujhay kaha tha, 'aurat ki qadro keemat uskay beto se hoti hay". Mujhay chay betay hoey. Log kehtay hain, 'main barey naseeb wali hoon" eik bahu roti pakati hay to doosri kapray istri kerti hay. Laiken inn sab kay peechay meri bari mehnat hay. Aaj kal ki nasal wo sakhti bardasht nahi ker sakti jo hum nay ki. Ye to khawaund se zaban chalati hain. Apni marzian kerti hain. Unko naam se bulati hain. Bachay bhi ziada paida nahi kerti."

I always acted as my husband desired. I considered his happiness. I served my parents-in-law throughout my life. People quote my example. My mother-in-law told me 'a woman finds her worth through her sons'. I gave birth to six boys. People say 'I am very fortunate'. One daughter-in-law cooks for me and the other irons my clothes. But there is my huge struggle behind all this. The new generation (of daughters-in-law) cannot bear those hardships, the ones we did. They (the daughters-in-law) argue with their

husbands. Do what they want. They call their (husbands) names. They do not reproduce many children.

The above mentioned narrative demonstrates the fact that the older generation of women valued culturally defined gender roles and kept on asserting them for the maintenance of their culture. They recognized their role as 'reproducers' and felt pride in serving the family. Referring to the new generation, they felt annoyed by young women who do not stick to the traditions as they are supposed to.

6.3 Reasons for having children

Another significant theme which emerged during the course of in-depth discussions surrounding marriage and procreation was the question of a woman's status and position if she is not able to make her husband happy by providing him with healthy children specifically, sons.

The majority of participants agreed that a woman has no better place than her husband's home and that ultimate happiness comes when a woman is married in a timely way to a person who is loyal to her, who protects her from all possible dangers and with whom she can have children. One of the respondents describes her feelings after 30 years of marriage:

> *"Meri shadi pundra saal ki umer main apnay chachazad se hoi. Hum nay uthais se ziada saal ikathay guzarey. Hum nay har eik doosray ko sari khushyan di aur tawun kia. Wo eik acha sathi sabit hoa. Meri shadeed khahish aur koshish kay bawjood main koi bacha paida na ker saki. Meray susraliyo ko napasund tha kay wo be naam he reh jaye. Main nay bari duayen ki kionkay mujhay banjh honey ki waja se her kisi se tanay sunnay pertay thay. Meray mian kay sath bhi yehi hisaab kitab tha wo bhi tano ka nishana banta laiken uss nay mujhay kabhi ussay waris na dene ki waja se laan taan nahi ki. Main nay apnay mian ki shadi apni door pray ki rishtay daar se karwa di aur ub humarey chaar bachay hain. Main nay wohi kia jo eik achi biwi ko kerna chahoye tha. Meray apnay bachay to na hoye laiken main nay apni taraf se wo kia jiss say usko wo khushi milay jo ussay milni chahiye. Aurat ki izzat uskay shoher aur uskay gher se hoti hay. Issi izzat ki khatir main nay doosri aurat bardasht ki aur apni shadi ko bhi bachaya. Mera janaza bhi meray shoher kay gher se niklay ga."*

> I got married with my cousin at the age of 15 years. We have been together for more than 28 years. We have given each other all kinds of happiness and support. He proved to be a good '*sathi'* (companion). Despite my strong desire and effort, I could not bear any child. My in-laws despaired that he

(her husband) would die name-less. I prayed a lot as I had to hear lamenting remarks from everyone for being barren. The same happened with my husband who was also a prey to social criticism but he never scolded me for not giving him a '*waris'* (heir). I arranged my husband's marriage with one of my distant relative and now we have 4 children. I did what is expected from a good wife. I failed to bear any child and I have done my part to finally bring him the happiness which he deserves. A woman's respect is with her husband and home. Just for the sake of this respect, I tolerated another woman and also saved my marriage. My dead body will leave my husband's home.

6.3.1 Children and Social Status

Almeida & Dolan-Delvecchio (1999) noted that in South Asian families, a man's loyalty to his parents, especially his mother and other kin members, may supercede his loyalty to his spouse, on the other hand, the wife's significant relationships tend to be with her children. In this study, it emerged as a major fact that a woman's status and position in the family is significantly raised by giving birth to children, specifically sons. This study also found that sons were considered a big asset for the mothers as they yielded greater power with them. Bearing sons brings greater prestige for a woman in South Asian cultures (Lateef, 1999; Shah, 1997; Winkvist & Akhtar, 2000).Malik's (2000) study with reference to Pakistani society argued that if a woman does not conceive, various cultural explanations are givenand usually the blame is put on the women. A barren woman is often amarginalized figure and seen as someone both personally unfulfilled and sociallyincomplete.

6.3.2 Reproduction to Ensure Marital Security

Women reported that children are considered '*zanjeerain'* (chains) that tie a couple together. Many women reported that they compromise (*samjhota*) with the harsh behavior of their partners just for the sake of children. Sana puts it in this way,

> *"Mera gher wala mujhay gali galoch kerta hay. Mujhay zaleel kerna uski aadut hay. Laiken meray chaar bachay hain or wo mere bacho ka baap hay. Ye bachay mere pairo ki zanjeer hain. Inki waja se main apni zillat bardasht kerti hoon. Ye bachay na hotay to main eik din bhi iss aadmi kay saath guzara na kerti."*
>
> My husband abuses (verbal) me. Scolding me is his habit. But I have four children and he is father of my children. These children are chain on my feet.

> I tolerate my insult just because of them. I would have not lived for a single day with this man if I had no children.

Women perceived motherhood as a source for gaining position and prestige in their *susraal* (husband's home). Having *aulad* (children), especially sons, brings marital security for them. Failing to become a mother weakens the woman's marital ties and she has to face a constant threat of being abandoned by the husband and possibly returned to her natal family if not divorced. Women understood it well that if they are not capable of producing children, it means they have no utility as a woman and their dedication to their husband and their commitment to keep their *gher* (home) secure requires that they must allow their husbands to remarry and they must agree to live with the *sokan* (husband's second wife) in a polygamous marriage under the same roof. However, in the same situation, women's remarriage was not considered as an option.

Women mentioned the fear of polygyny resulting from their inability to give birth to children. One woman said:

> *"Chay saal ho gaye hain or mera koi bacha nahi. Mere teen bachay zaya hoe aur ub meri saas kehti hay kay mere undar koi nuqas hay. Uskay betay ko aur shadi ker layni chahiye takay doosri aurat se aulad ho jaye. Laiken mera bunda inkar kerta hay. Main iski taya zad hoon liken usko iss baat ki koi purwah nahi. Main sub kuch burdaasht ker sakti hoon laiken mera dil doosri aurat qabool nhi kerta. Ye kaisi azmaish hay. Agar mera eik bacha bhi hota tu gher main ye pareshani na hoti. Mujhay apnay khawund ki doosri shadi ka khouf na hota."*
>
> It's been six years and I have no child. I had three miscarriages and now, my mother-in-law says that I do have some faulty inside. Her son should remarry so that another wife can have offspring. But my husband says no. I am his cousin, but still she (the mother-in-law)doesn't care about that. I can tolerate everything, but my heart does not accept another woman. What kind of a trial this is! Even if I have a single child, there will be no tension at home. I will have no fear of my husband's second marriage.

The above mentioned narration exemplifies how children are expected to increase marital harmony and how the existence of even one child can safeguard a childless woman from the fear of being discarded.

Having one's own biological children (*aapnay tido jammay bachay*) has been reported by women as a necessary obligation for a wife which gives herthe opportunity to prove her womanhood and justify her place in the family.Women believed that bearing children quickly to fulfill the desires of the husband and his family actually 'solidifies' a marriage. Children make a marital bond stronger. Children act like a bridge between a husband and wife who try to minimize their differences for the welfare of their children.

Newly married wives are often given advice by older married females to 'obey' the husband and follow his wishes. They believed that husband become closer to their wives if she is also a mother of his children. Once a child, especially a son, is born married life becomes easier and smoother. Children, particularly sons, gives women more confidence as it raises their status in the family and they have more say after giving birth to sons.

6.3.3 Children as Wealth

Children are considered a great treasure and precious commodity. Women frequently highlighted that people who are rich have their wealth in terms of money, land and gold, while for poor people children are everything. As one of the respondents, a mother of six children said,

> *"Main chota se ghar main rehti hoon jis main sarey ghar walo kay liye bhi jaga kaafi nahi. Kabhi kabhi to hum bijli ka bill bhi nahi bhertay or humari bijli bhi cut jati hay. Laikin main hosla nahi harti kionkay mujhay pata hay mere charo betay eik din barey ho jaye gain or mere pooray gher main chanun ker dain gain. Meri bahuwain ghar sajayen sanwarain gi or mera khyal keray gi aur mujhay koi kaam nahi kernay dain gi. Maon ki qurbani to ussi waqat tak hoti hay jab bachay chotay hon. Mujhat pata hay jab mere bachay barey hon gay or kaam kaaj pe lag jaye gain to meri sari pareshaniyan khatam ho jaye gi. Such hi hay, bachay hi asal dolat khazana hain."*
>
> I am living in a small house not having sufficient place for my family. Sometimes we don't pay the electricity bills and our electricity is disconnected.. But I do not get discouraged as I know my four sons will ultimately grow up and they will illuminate my entire house. My daughters-in-law will decorate the house and they will take care of me and will not let me do anything. Mothers sacrifice only while their children are younger. I know all my worries will be over when my children will grow up and start working. It is true, children are the real wealth.

6.3.4 Children as source of personal pleasure

This notion of reproducing for happiness and pleasure is quite well established in the village. Children are a big emotional support for married women and without children; women described their daily routines as dull and unexciting.

A childless woman explained it in this way,

> *"Aurto ko to khushi milti hay apnay bacho kay chotay chotay kaam ker kay. Bachay poora din musroof rukhtay hain. Main bari budnaseeb hoon kionkay mere paas faarigh waqt main kernay kay liye ziada kuch nahi. Mere apnay bachay nahi hain aur main apnay dil ki tassuli kay liye doosro kay bacho ki taraf dekhti hoon jaisay jaith aur dewar kay bachay. Doosru kay bacho kay saath main waqat tu guzar sakti hoon laiken mera koi huq nahi kay main unki purwarish main koi mudakhlut karoon kionkay main unki maa to nahi."*
>
> Women find pleasure in doing little things for their children. Children keep them busy all day. I am very unfortunate as I do not have much to do during my free time. I do not have my own children and for the satisfaction of my heart I look towards the children of others like the children of my husband's elder and younger brothers. Although I can spend time with others children, but I do not have a right to interfere in their upbringing as I am not their mother.

The above mentioned statement stresses the importance of children for personal happiness and joy. The lack of children is also perceived as thelack of a reason to be. In the village, girls are socialized according to clearly established gender roles. Married women are expected to become mothers and look after their children. Childless women find their life boring as they do not have this opportunity to invest their time and efforts in child rearing activities.

6.3.5 Children as old age security

In the village, old age support is an important incentive for parents to have children. Parents expect to rely on their sons for financial support in their old age. According to the village norms, elderly parents are also expected to receive health care from their children especially when they are sick and in poor health. According to one respondent,

> *"Jub maa baap boorhay ho jain tu unka khyal rukhnay kay liye koi tu hona chahiye. Boorhay log luggay tu nahi choray ja saktay. Jub waldain kumzor*

or charpai se lagey hon tu unko poochnay wala koi nahi hota, sirf unkay apnay bachay hi khidmat kertay hain."

When parents become old, there must be someone to look after them. Elderly people cannot be left unattended. When parents are weak and bedridden, then there is no one else to take care; only their own children take care of them.

The provision of old age support provides a rationale for son preference who can co-reside with parents and look after them. Thus, women find more value and utility in having particularly male children to ensure that there are multiple breadwinners for the family. Moreover, children are also seen as a support system if the male head of the household dies. Widows in the community experience this suffering differently if they have a son who is expected to look after them as soon as he is able. Widows with female children are more likely to be compelled to marry their brother-in-law because a family's honor is threatened if the widow remarries and a stranger (*ghair*) is responsible for raising another man's daughters. The same phenomenon has been reported by Dyson and Moore (1983) that women are confronted with an insecure future which probably becomes more unstable when her husband dies. A woman undoubtedly sees children, especially sons, as a potential source of security.

6.3.6 Children as Way to Heaven

According to a famous saying of the Prophet (peace be upon him):

"Paradise is the reward of a wife who pleases her husband until death."

(Hadith from Ibn Majah).

In the village, women were well aware of the notion of the honor of mothers by Allah. Islam has acknowledged the significance of this role and status of mother. She is given respect, appreciation for her life long struggle and for the hardships she experiences and the sacrifices she makes for the welfare of her children. Women knew well that heaven lies at their feet.

The prophet is reported to have said:

"Paradise lies at the feet of mothers" (Hadith from Nasai and Ibn Majah).

Respondents shared their feelings that all hardships they suffer with regards to pregnancy/gestation, childbirth and rearing of children bring great rewards for the

women. Child bearing and rearing is perceived as spiritual acts and an opportunity to obtain Allah‘s blessings.Many women also mentioned that religion encourages un-controlled reproduction as it is going to increase the number of Muslims.

6.3.7 Fear of high infant mortality

A high infant mortality rate is also one of the reasons that women want to have more than desired number of children. Women said that one or two of their children may die because of any disease or any supernatural cause like the evil eye or *jadoo* (magic) so it is better to have substantial number of children so in case of death of a child still they would have enough number of surviving children.

6.4 Infertility

In the village, the notion of infertility is perceived in different ways. Mostly it refers to those women who never conceive a child after marriage, or women who conceive but miscarry and never give birth to a living child. Sometimesinfertility may be understood ashaving only daughters and no sons.[60]

Women in Choha Shah Gharreeb agreed to the fact that childlessness makes the lives of women quite unstable. In a study done in Karachi, Pakistan also reported negative consequences of childlessness for women in the form of emotional, mental and physical abuse from their husbands and in-laws, threat of divorce or second marriage by their husband, and expulsion from their husband’s home.Women also reported psycho-social repercussions in the form of depression, unhappiness, dejection and suicidal ideas (Sami N, Ali TS, 2006).

6.4.1 Infertility as a Social Stigma

Inhorn‘s (1996) ethnographic study on poor, infertile Muslim women explains how women’s role is confined to reproduction, in the patriarchal structure of Egyptian society

[60]Greil‘s (1991: 6) analysis of infertility in the social context explained the difference between infertility as medically diagnosed “reproductive impairment”, and infertility as a “socially constructed reality” experienced by the couple. He suggested that medical technology, purpose of marriage, the traditional gender role expectations, and the advantages of having one’s own children play a major role in determining infertility experiences.

intensifies the problem. Her work explains how childless women were subjected to domination and socially most disadvantaged as they experienced triple social stigma: femaleness, poorness, and barrenness.

Similarly, field findings of the present study describe also that local attitudes which mostly appear in the form of gossip (*galbaat*) sympathy (*hamdardi*) or ostracism (*tana*) contribute much greater propinquity and motivation in the pursuit of children. Gossip and lamenting attitude of people who had not experienced infertility themselves is an important source that forms the social pressure in which infertility is perceived and experienced. Women suffering from infertility felt this pain in common and said that people around ask about their children, without thinking whether or not they should probe.

Women shared different terms that are used in the village to describe infertility and infertile women. The term *banjhpan or beauladi* ismost commonly used to refer to infertility. Interestingly, the word *banjh or banjer* (Barren) is only used for women not for men. There are other terms used to indicate infertile women such as *Shund* (local word for sterile), *Khusri* (eunuch) and *Mushtandi* (a woman who moves freely and carelessly). These terms are derogatory and indicate the helplessness and incapacity of women to produce children. Childless couples and a ones having no sons are known as *oternikhater*, the ones without a heir to carry their name after them (Sultana and Hafeez, 2014).

In-depth interviews revealed that infertile women are objects of pity, disdain, criticism, curiosity, exclusion and even condemnation.Women described their humiliation in many different ways. In the village, *Banjh*or infertile women are not welcomed to certain activities and ceremonies, particularly, life affirming occasions such as weddings and the occasion of child-birth.Women who have never conceived face more restrictions. At weddings, infertile women were openly debarred from taking part in various weddingrituals, for example, such as .they were prohibited to place *mehndi* on the palm of the bride. Moreover, they were also discouraged to assist deliveries of other female relatives.At the occasion of childbirth, they were not supposed to touch the new-born as infertile women were feared to cast a '*burasaya'* (bad shadow) on it. Newly married

women and pregnant women were also advised to avoid contact with infertile women due to their *purchawan* (evil shadow) which can cause them same problem. Infertile women are socially perceived as being '*manhoos'* (bearers of misfortune) and also thought capable inflicting their ill fortune on other women just like a contagious disease. Although the fertile women well understood how bad infertile women feel, they justified this practice, considering it a taboo that needs to be respected. These cultural rules make infertile women emotionally distressed and socially handicapped by virtue of their childlessness.

6.4.2 Infertility and women's position in the household

In the village, bearing progeny is considered as part and parcel of a stable married life. Women achieve status and prestige through becoming mothers. The theme that emerged from discussion with the women is the role of children in fostering harmonious relationships with the husband and his family. Sabreen, explaining the attitude of her father-in-law said,

> *"Mere susar mujhay banjar daraky kehtain hain aur wo darakht jo phal na de usko jar se wadna chahiye. Gher walo kay main kisi kaam ki nahi isi liye wo apnay betay ko kehtay hain k wo mujhay choar kay or shadi ker lay. Wo baap ki nahi suntan. Laiken mujhay baro pareshani thi. Phir usne mujhay ye kaha, "isse kehne do jo iska dil kere. Ziada na mehsoos kero. Main tumhain kabhi nahi choroon ga. Ager meray muqadar main aulad likhi hay to tere se hi ho jae gi."*
>
> My father-in-law says that I am a barren tree and a fruitless tree must be cut from the roots. I have no utility for the family so they asked their son (her husband) to leave me and get married again. He did not argue with his father. So I became worried. Then he said, *"Let him say whatever he feels. Do not take him seriously. I will never leave you. If I have children in my destiny, I will get them from you."*

Sabreen and the narratives of many other women indicate that people around and particularly parents-in-lawfeel no reluctance to suggest that a man should remarry to resolve the problem of not having childrenirrespective of which partner is actually clinically infertile. Women also cited examples from many TV serials in which men remarried for the sake of children. With these examples, they emphasize that it is customary and acceptable to remarry incase a first wife has not given birth to children.

One of the childless women described it in this way,

> *"Main nay her heela kia kay mere under ka nuqas sahi ho jaye 10 saal tak banjhpan kay ilaj kay liye mukhtalif kisam kay tareeqay istimal kiye. Akhirkar main naumeed ho gayi. Mujhay maloom hogya k ab mere bachay nahi hongay. Meray (khawund) nay kabhi mujhay banjh honey ki tohmat nahi di. Jahan jahan main nay ilaj kerwaney ke liye kaha wo wahan mujhay lay kay gaya. Main uski qurbani nahi bhool sakti. Issi liye main nay faisla kia k main isko bachay se mahroom na rukhoon or wahid heela yahi that kay wo kisi or se shadi ker lay. Issi liye main nay uski shadi apni masairi se kra di. Ub uskay teen bachay hain. Wo mujhay bari ami kehtay hain. Or hum eik chat k neechay khushi se rehtay hain."*
>
> I made every effort to rectify the defects in my body and I tried various methods to cure infertility for up to ten years. At last I became hopeless. I knew that I will not have children. He (husband) never accused me for being infertile. For so many years I received his protection. He gave me everything that I needed. He took me wherever I asked him to accompany for the treatment. I cannot forget his sacrifice. So I decided not to deprive him of a child and the only way was that he gets married to someone else. That is why, I arranged his marriage with one of my cousins. Now he has three children and they call me 'elder mom'. We live happily under one roof."

Infertile women also experience emotional harassment and hurtful remarks from their in-laws. Childless women are considered worthless and they have to make more effort to keep their in-laws happy if they are unsuccessful in giving them *aulad*. Aliya shared the story of her friend,

> *"Jab bhi main uske ghar jaon wo agay kaam main masroof hoti hay kabhi eik kaam or kabhi doosra. Uskay saath nokro jaisa salook hota hay. Uska gunah itna hay k wo maa nahi bani halankay uski reportay theek hain. Uska miyan apni maa k darr se apna test nahi krata. Eik dafa usne mujh se kaha, "aisa lagta hay k main aurat nahin hoon. Her waqat meri saas yehi sunati rehti hay k main to zanani hi nahi." Wo tokain sunti hay, her eik ki khidmatain kernay kay bawjood bhi ussay manta koi nahi. Kitni dafa to ussay uskay maikay wapis bhej dia sirf iss liye k wo bacha paida nahi ker saki. Miyan or susraal waley uss se jaan churana chahtay hain. Ab wo na agay ki or na peechay ki."*
>
> 'Whenever I visit her home, I find her busy in doing this thing and that thing. She is treated like a servant. Her sin is that she did not become a mother although all her medical reports are correct. Her husband is not willing to have his (semen) tested as he is afraid of his mother. Once she said to me, *"it seems that I am not a woman. I relentlessly hear this from my mother-in-law that I am not a woman."* She faces criticism, she serves

everyone even then she is unacceptable. Many times she is sent back to her parents' home just because she could not give birth to children. Her husband and marital family want to get rid of her. She has no place in her marital family nor at her natal home."

Similarly, another respondent shared the attitude of her mother-in-law;

"Her banda mujh se eik hi sawal poochta hay k meri noo kab khushkhabri sunaye gi. Meri tu hasrat hi reh gayi potray khilaney ki. Bachay to nal o nal hi honey chahiyen shadi k. pata nahi kion tere jaisi banjh aurat hi meray betay k mathay lagi. Poora din khati hay or muj ban gayi hay laiken faida koi nahi. Log sahi kehtay hain k phuddar muj kasai jogi. Main bhi yehi keroon gi. Kuch saal dekhoon gi or phir bhi tujhay bachay na hoye to apna rasta napoo. Meray betay ko zananiyon ki kami koi nahi."

Everybody asks me the same question when is my daughter-in-law going to share good news. I just have this unfulfilled desire to play with my grandsons. Children are expected immediately after marriage. I do not know why a barren woman like you was destined to be in my son's life. All day she keeps eating and becomes a buffalo and the output is nothing. People are right to say that a barren buffalo should be handed over to the butcher. I will do the same. I will wait for a few years and if you fail to provide us with children then find your way. My son has no shortage of girls.

The above mentioned narration reveals that infertile women fail to achieve status and respect in their marital homes. As a result of their childlessness, they serve the householdbeyond normal expectations to compensate for their incapacityto be as mother. Others, particularly mothers-in-law make them feel worthless and lacking womanhood, not being able to fulfill the actual purpose of their existence.[61]

6.5 Perceived causes of infertility

Women mentioned several reasons for their reproductive failure such as *naqas khoraak* (abortive food), *zanana masayl* (gynecological problems) such as *mahwari ka masla* or *mahwari agey peechay hona* (menstrual irregularity), *choti bachadani* (small size of uterus), *bachadani pe soj* (swelling in the uterus), *bachadani ka moon band hona*

[61] Although Pakistan is known for high population growth rate, still infertility remains a major reproductive health issue with estimates that range from 15% to 22% (Hardee K, Leahy E., 2008).

(blockage of the outlet of the uterus), *bachadani ka sookhna* (shrinking of the uterus), *naloon main masla* (problem in the fallopian tubes) to supernatural causes such as *parchawa* (evil shadow) of other infertile women and evil eye, *kala amal* (black magic) *taweez dhaga* (amulets) or curses and the breach of cultural values. Women in the village also described various causes of infertility ranging from *taqdeer ka likha or Allah ki Marzi* (destiny or God's will) to supernatural causes. However, many women also cited some health related issues such as *jisam ki churbi* (body fat), *kamzori* (weakness), *khoon ki kami* (anemia).

Women mentioned all the problem referring to some kind of *nuqas* (defect) in their bodies but they did not discuss anything with reference to men. This reveals that women have internalized that reproductive failure is their own responsibility. Women somehow feel reluctant to acknowledge the possibility of male infertility. The social norms expect women not to say anything bad about their husbands. Shamsa describing the characteristics of a good wife said,

> *"Achi aurat wo hay jo khud bhi apnay mard ki izzat kray or doosro se bhi kerwaye. Apnay mard ka purdah rukhey. Issi main aurat ki apni izzat hay. Meri khala ki beti kehti thi kay uska mian kay under bachay paida kernay waley jaraseem hi koi nai. Chaar saal uss nay dactri ilaj kraya. Dam darood kraya or akhirkar uski god bhar gayi. Ab poora gaon mazaq urata hay ka ye bacha kahan se aa gya. Uss nay apni badnaami khud krayi. "*
>
> A good woman is the one who respects her husband and also makes others to same. She must keep her husband's secrets. A woman's own respect lies in this. My cousin used to say about her husband that he has no sperms. She relied on allopathic and spiritual treatment for four years and finally she conceived. Now the entire village mock her saying, where has this child come from? She is responsible for her denouncement.

Depending on the reason, different medical, ritualistic, and spiritual treatment methods were selected to cure infertility. One of the women said,

> *"Apni sakki aulad ni khawhish boo zalim honi hay. Maa pagal ker choryas. Mere daron meray wadday dushman wi aulad maron na tarsan. Main bachiyan ni umeed lay kay dacter, hakeem, daiyan, piran kol turni rahi haan tay sehat tabah gawai. Bachay Allah na tohfa honay unn tay ae o khazana hay jara banda lakha kharach ker kay wi nai labna. Hun main humdardi tay tanz karen wastay ek cheez han. Inj lagna hay jis tarah sarey rishtaydaar mere mernay nay intizaar hich bethay hun taa kay o meri zameen qaboo karan kionkay meri jaidaad na koi waris nai."*

> The desire to have one's own biological children is irresistible. It made me crazy. I wish even my worse enemies do not yearn for children.. I went to doctors, herbal doctors, traditional birth attendants, saints, in the hope of children and lost my health. Children are a gift of God and a treasure that cannot be acquired even if you have millions to pay. Now I am an object of sympathy and vilification. It seems that my relatives are waiting for my death so that they can get hold of my land as I have no heir to inherit my property.

6.6 Treatment of Infertility

Women reported different opinions about their practice of healing in the pursuit of motherhood. They vehemently argued that childlessness makes them so desperate that they opt for different physicians (gynecologists, LHW and Traditional Birth Attendants (*dais*). as well as visiting shrines and spiritual healers either simultaneously or one after the other to achieve their reproductive goals. Their decision to seek a cure and the choice of a particular provider was based on recommendations given by their mother-in-laws, their mothers, friends and other social contacts who have already visited hose providers for the cure of primary or secondary infertility or for any problem.

In the village, women prefer to visit the *dai* first since she lives inside the village and does not charge much. One of the women told that her mother-in-law took her to the*dai* just two months after her wedding. The*dai* gave her *puryan (paper wrapped* sachets of powders) prepared with a mixture of j*ari bootyan* (roots and herbs). She instructed her to take one *puri* (sachet) daily and continue this oral medication for forty days. She was also advised to have intercourse daily. She conceived before the completion of the forty day time period. According to the *dai,* she uses various methods depending on the nature of a problem. For example, in the case of *bachadani ka moon band hona, the* blockage of the the opening of uterus or *bachadani ka moon phirna,* the displacement of the opening of the uterus, she would place her hand inside for examination and then use a stick to make the uterus correct. In case of swelling *(soj or waram)* and infection of the uterus (*bachadani)* orf allopian tubes (*nullain*), the *dai* keeps cotton swabs (*rui ka bura*) inside the uterus soaked with orange colored medicine with a thread which is pulled out for taking out an inserted swab. Moreover, the*dai* also uses injections and pills for different purposes. The technique of abdominal massage is also used. The choice of method varies from case to case. The excesses of women's health risk was particularly pronounced in

cases where the *dai* (Traditional Birth Attendant) was consulted. They use various traditional methods such as insertion of *phitakri* (A white transparent solid crystal), *jaiphal* (nutmeg), *kastoori* (Curcuma aromatica or fragrant plant) inside the uterus with the help of a cotton swab to remove swelling, fat and heat (*garmi*) from the uterus which are the common causes of infertility. The quest for procreation compels women to even accept clandestine and painful methods of *dais* such as opening of the uterus with a long sewing needle (*soowan*) or sharp edged sticks (*teelay*). Women who sought treatment of infertility from the*dai* mentioned various problems such as *mahwari ka dard/masla* (dysmenorrheal/menstrual cramps), *nuloon ka dard* (pelvic pain) and *reham pe zakham* (perineal wounds) which they developed as result of their treatment.

Childless women or those having difficulty to conceive again become desperate to conceive as soon as possible. They opt for various methods simultaneously and also are quick in changing treatment options. Fear of social stigma, loneliness and marital instability persuade women to seek multiple and novel ways to acquire progeny. In addition to spiritual healing, they also relied on biomedical treatment (*dactriilaj*) considering that it can assist them to cure infertility. For women, *ilaj*, is a broad category that encompasses all the efforts women could use to seek a cure and that includes visiting various practitioners, to get tests done, to receive any sort of treatment, take medicines, to use sacred amulets (*taveez*) and so on. '*Ilaj kerwana'*(to seek treatment) is the top-most priority of childless women regardless of its success.

They consulted various doctors from the city Wah Cantt and Hassan Abdal, being nearest to the village. By 'doctor' women generally refer to any person that can practice not just biomedical treatment but also those giving homeopathic medicines are also considered doctors. Moreover, technicians, compounders, nurse or a LHV who can conduct exams like ultrasound scans and X-rays, blood & urine tests, and who prescribe medicines that consist of tablets, injections, or drips and who can perform dilation and curettage (D&C) are also perceived as doctors. Women maintained a record of their reproductive profiles including the results of tests, ultrasound reports, prescribed medicines, receipts of doctors etc, as an evidence of all the efforts made on their part. These documents are visual proof that to have children, they tried different options which were within their limits and if they were not successful in becoming mothers, it was not their fault.

Rasheeda's comment explains how embarrassed she felt while going through a vaginal examination by a lady doctor

> *"Apni sharamgah nangi kerna chahey kisi aurat kay samney he kion na ho bari takleefdeh baat hay. Jab doctor mujhay check kerti thi to main sharam kay marey apni ankhain band ker liati thi. Ye mere liye kisi azmaish se kum nahi. Aisay ilaj ka kia faida jo banday ko nanga ker day. Ye to bara he behaya tareeqa hay. Laikin meri majboori hay. Mujhay krana perta hay ye sub."*
>
> To expose ones vagina, even to another female is a painful thing. When the (lady) doctor examines me, I keep my eyes closed out of embarrassment. For me it is no less than an ordeal. What is the advantage of this kind of treatment which makes a person naked? It is such a shameful procedure. But I am helpless. I have to undergo all this.

She further complained about the cost of the allopathic treatment and said,

> *"Ye doctor to lalchi hotay hain. Inko pata hay kay majboor logo ki jaib se paisa kaisay khechna hay. Banjh aurtain to inki kamai ka buhat acha zariya hain. Main jab bhi gayi, lady doctor sahiba nay pehla kaam hi ye kia k mukhtalif kisam kay laboratory waley test, khoon test, peeshap test waghera mujhay likh k pakra diye.. Usne to mere mian ko bhi kaha ko wo bhi mardana jarseemo wala test kra le laiken usne aya gya ker dia. Laiken main nay bacho ki khatir ye sarey likhay test kerwaye. Jab main doobara testo ki reportain check kerwaney gayi tu uss nay phir mujh se check kernay ki 1000 rupya fees bator lee. Meray sare test theek thay. Phir usne mujhay eik or tubain check kernay kay liye test likh kay dia. Phir main lady doctor k pass gayi report dikhaney kay liye jo taqreeban theek thi. Usne meri tuboon kay under spray kia or kaha kay tubain theek hain unda bachadani main bhejnay kay liye. Uss nay khali mujhay taqat ki goliya day di. Jab jab main ne uss semashwara kia, uss ney mujhay umeed dilai, yehi bataya ka main bilkul theek hoon. Ager main theek thi to phir mujhay itney chakkar kion lagwai. Ab main roohani ilaj kerwa rehi hoon or mujhay yaqeen hay kay Allah karam karey ga."*
>
> Doctors are greedy. They just know how to grab money from the pocket of a helpless person. Infertile women are a good source of earning for them. Whenever I went, the first thing the gyneocologist did was to write a list of various laboratory tests, blood tests, urine test, etc. she also asked my husband to go for a semen test but he did not take it seriously. But I had all these prescribes tests done in the quest for children and when I visited her again to discuss my reports she again received her consultation fee which is 1000 rupees. All my test results were ok. Then she prescribed me another fallopian potency test. Again, I visited gynecologist to show her the report which she found almost ok. She sprayed inside the tubes and said that the tubes are ok to transport ovum to the uterus. She just gave me multivitamins. Whenever I consulted her, she gives me hopes and tells that I am fine. If I was fine then why she called me so many times? Now I have started taking

spiritual treatment to be sure to receive God's blessings.

Women expressed their disappointment about money spent, medicine taken, and distances traveled, to no avail. Women who sought infertility treatment from biomedical clinics expressed a diverse range of emotions, which varied from depression and shame to concerns over deteriorated health conditions. They mentioned that biomedical treatment of childlessness is a long process with a series of investigations and treatment. Women strongly argued that doctors exploit childless women and try to take advantage from their desperation. Some women who were undergoing infertility treatments for many years particularly denounced its saying that it made them worse. Frequently mentioned side effects of hormonal drugs include weight gain, backache, weakness, anemia etc. Their belief is that any kind of pill burns the blood and makes a body weak and swollen. In fact women due to their reproductive biology become a focus of infertility treatment which involves using hormonal drugs, continuous monitoring of ovarian follicles etc. It involves greater health risks for those undergoing treatment.

Women also informed me that their plight is exacerbated where they have to bear the brunt for their partner's infertility. Men are less questioned and stigmatized as compared to them and due to this they take less interest in infertility treatments. And they also run the risk of having their fertility status known to others. One of the respondents said,

> *"Mere marad ki jurseeman na nuqas dasya hay per o dactran na aakha nai sunrna hay. O aakhna hay kay o jawan tay sehat mund banda hay ussa kissay ilaj nilor nai. Usnay agay lambi zindagi pai hay tay kuj saal intazaar kerna ussa qabool hay."*
>
> My husband has been diagnosed with a sperm defect but he does not follow the doctor's recommendation. He says that he is a young and healthy person and does not require any treatment. He has his long life ahead and waiting for some years is acceptable for him.

One of the woman reported that despite insistence, her husband never agreed to medical tests because men do not want to be exposed due to fear of shame and guilt. Another woman said that her in-laws kept her ignorant about her husband's defect (*nuqas*) but unfortunately she was treated for her husband's infertility for thirty years. She became sick for trying several types of treatments. Eventually she had to remove her uterus due to fibroids (*rasoli*) and it was at this stage she got to know that it was her husband who was

defective and needed treatment. Similarly, Uzma consulted many gynecologists in the quest for children and all her tests were found correct. She was advised to get her husband tested as well but she could not convince him due to his mother's opposition. According to Uzma, her mother-in-law said,

> *"Mera putar changa pulla hay, uss na eda wajood hay. Ussa ilaja ni koi lor nai."*
>
> My son is alright (referring to good health), he is muscular. He does not need any treatment.

The majority of the respondents could not differentiate between the male sexual performance and his potential to impregnate a wife. They believed that a man who has erection power is sexually fit and he has the power of reproducing. Although biomedical perceptions of infertility consider men as potentially equal contributors to childlessness, the majority of the wives blamed themselves for not having children.

6.6.1 Hakims

Women also informed me that they visited practitioners of Unani medicine known as *hakeems* for herbal medicine. In their views, mostly men are more inclined to consult *hakeems* as they develop *garmaish* (heat) inside their bodies and herbal medicines are good to cure that. Hakeems also give different tablets, syrups and *puryan* (sachet). Their medicines are considered less harmful. Hakeems are known to suggest less medicines and their focus is more or *paalperhaiz* (precaution). For example, they ask you not to eat spicy food, eat raw vegetables, refrain from intercourse etc. Women also said that generally men consult *hakeems* for various sexual problems (*jinsi maslay*) like premature ejaculation (*jaldi farigh hona),* sexual weakness *(jinsi kamzori*) etc. they also give herbal oils for applying to the male organ.

6.6.2 Spiritual Healers

Out of desperation to become mothers, women also visited shrines to seek treatment from spiritual healers. Many women said that health practitioners do not inform them of the actual cause of their infertility and so they assume that it may not be a physical defect but just a delay from God. The *pirs* or saints, therefore, are believed to be closer to God.

They act as spiritual healers who are able to treat infertility when its etiology isbeyond the expertise of*dais*or doctors.

Women informed that in the pursuit of children not only the village residents but also many other women from far away places come to visit the shrine of Choha Shah Ghareeb to take a bath from the holy water for six consecutive weekends. On the last visit, they pray and make a wish (*mannat*) to conceive and if their wish is fulfilled they come along with the child for the seventh and last visit to show obedience and thankfulness. They give alms and say prayers. Women also reported the use of holy water for drinking and/or vaginal douching.

Childless women also visit other shrines like the Shrine of Mallo, the Shrine of Gham Mit both located in the surrounding areas which are specially known for the cure of infertility. They take *taveez* (amulets) from there with religious verses or numerological formulas inscribed on pieces of paper. They are used for drinking purposes and also tucked inside leather covering to be worn by infertile women around the neck or lower abdomen, which is, the place of the uterus. Women also make offerings at the *mazaar* (grave of a Muslim holy person or *pir*). The offerings are known as *nazrana* (gift). Women offer cotton or silk sheets (*chaadar)* preferably in black or green colorwhich is embroidered with shiny silk thread, flowers, cardamom pods, and cash money which is used for the decoration of the shrine and also for preparing *langer* (sacred food).

The in-depth interviews with infertile women revealed their willingness and motivation to go to any length to have children. Further, most agreed that women should not restrict themselves to any single mode of treatment in seeking a solution for their childlessness. They narrated examples from other women stories to quote all the possible ways of dealing with infertility. Religion was found to be a common element among infertile women to encourage them to keep living without children. They often mentioned that it is God who gives children to whoever He wants. Human beings can only make efforts and pray for the success. This belief serves as a source of contentment in the period of suffering and trial. A popular construction is

Aulad ki kami buhat bari azamish hay

Childlessness is a big ordeal.

Women also tie a thread or make a knot with the piece of cloth of any colour or size to a window or other sacred object. They make their wish or vow, promising to return to untie the thread or piece of cloth and make a special offering if their wish is fulfilled. Women believe that a knot remains a burden on the *pir* or saint unless it is fulfilled. The shrine of Choha Shah Ghareeb is one of the famous shrines women like to visit in the hope of blessings needed to obtain a child.

Religion offers a plethora of ways for expressing limited human control on the outcome of their efforts. The statement such as *ager aulad qismat main hoi to mil jae gi* (will be blessed with the children if they are written in the destiny) *Allah kay gher main dair hay per undher nahi* (In God's home, there is delay but no denial.) *aulad dena Allah jee ka kaam hay* (It is God who gives children) *qismat per zor nahi* (destiny is pre-determined) *Allah kay khazanay main koi kami nahi* (There is no shortage in God's treasure) I*nshallah* (God-willing). These statements which are used in daily conversations indicate fatalism and hope to achieve desired reproductive goals in future. Oscillations between sorrow and optimism, disappointment and desires for the future were evident in women's stories of their treatment.

In short, religion, the husband's behaviour and access to financial resources played a major role in determining options that women could pursue to bear children. Childless women explained how their infertility makes them suffer a lot not just because they can not fulfill the real purpose of marriage, but also an enending series of negative consequences that socio-cultural context of these infertile and childless women brings for them.

The Case Study of Shakeela

Shakeela stressed that childlessness is undoubtedly a big tragedy in her life as she could not become a mother by giving birth to children but also failed to prove her worth as a good *bahu* (daughter-in-law) and an ideal wife by fulfilling her prime obligation of producing heirs who could continue family line.Shakeela got married 13 years earlier at the age of 19, but never conceived a child. According to her,

> *"Having one's own children is a necessary condition to achieve respect in the susraal (in-laws). A bahu (daughter-in-law) is only considered a valuable member of the family when she becomes a mother and brings offspring, only through the children does a married woman receive respect and recognition meaning that their opinions are not taken into consideration in deciding household matters. I try to serve everyone at home, keep myself busy in household chores during the whole day and even then my in-laws do not seem happy. My father-in-law always complains and often expresses his anger that his son will remain la-waris (heirless) and it is so unfortunate to be married with a barren woman."*

Shakeela's statement explains how children, particularly sons become a source of honor for a married woman. Additionally, she also described the importance of continuing the family line by having a male child. Continuation of the family lineage is considered the prime contribution and responsibility of a wife and daughter-in-law and so a childless woman is accused of being responsible for discontinuing the family line.

Shakeela said that she really wanted her own children and for that purpose she started her *ilaaj* (treatment) within one year of her marriage to achieve a successful pregnancy. She visited various practitioners and tried various types of *ilaaj and all* her reports were normal. She could not convince her husband to get tested and so she is not sure if her husband had some problem or if the *nuqas* (fault) is inside her. Her story highlights the lack of cooperation from husbands who very often do not want to undergo any infertility tests.

Shakeela explained how she kept visiting doctors and spent a huge amount of money in the hope to have children. Eventually, she was disappointed regarding the various biomedical treatments which did not work out in her case. The inefficacy of the treatment method and cost it involved made her switch to other options and so she started

consulting local *dai* in the village who prescribed her various *desi nuskhas* (traditional herbal medicine) for eating in order to regulate her menstruation. Moreover, the *dai* also diagnosed her swelling inside the uterus and as a remedy she introduced medicines inside that actually worsened her problem. Despite several visits to a *dai*, neither her menses regularized nor did she become pregnant. Shakeela did not loose patience and kept visiting the shrines in the quest of children. She visited a shrine of Burhan located in the neighboring village for seven weeks on every Thursday and then the pir gave her hope that she will become pregnant soon but she did not. She also visited shrine located in village Mullo where the *pir* gave her amulet to wear with the hope of becoming mother soon but no miracle happened. Shakeela said that she had tried almost everything and is now just praying to Allah with the hope that one day she will concieve on its own.

Shakeela‘s story portrays the importance of having children and the necessity of receiving various treatments felt the childless women to make conception possible. She does not want to be blamed for her childlessness as she did everything that was possible for her. In her views, her childlessness is not due to a lack of initiative, but it is her destiny and Allah‘s will.

CHAPTER NO 7

RIGHT TO REPRODUCTIVEHEALTH CARE

(Pregnancy, Antenatal, Delivery, Post-Patrum)

Reproductive rights include the right of all women to have unrestricted access to the full range of appropriate health care services and options that enable them to go through the process of child bearing safely and to ensures safe pregnancy and delivery to have healthy childrens (WHO, 2012). When a woman conceives, what is done next depends on several factors other than her health beliefs, motivation, resources, capacity to act, etc. To a greater extent it depends on her family, as well as the community where she lives. Health facilities, economic conditions as well as norms associated with health and gender establish the major domain that helps to conceptualize pregnancy and the entire process of child birth. This chapter illuminates how socio-cultural traditions and religious beliefs shape women's realization of their reproductive needs and their capacity to choose and access available health care services.

The chapter elucidates how women perceive their reproductive health and illnesses and to what extent contextual factors such as women's status in the household, the role of family in reproductive decision-making, son preference, norms regarding women's reproductive autonomy, social exclusion and their access to modern health care facilities, lack of health information, norms related to *purdah* that may inhibit women from consulting qualified health professionals, poverty and inability to pay, etc, influence women reproductive health behavior. It highlights how socio-cultural norms and traditions still exert greatinfluence on reproductive health care practices especially in relation to pregnancy, delivery and post partum.

7.1 Pregnancy and Antenatal Care

Essential antenatal care provides an opportunity to diagnose and monitor conditions that may endanger the health of a mother or fetus (Corroli et al. 2001; McDonagh 1996). These routine antenatal check ups during pregnancy can make women aware about dangers signs and where to seek treatment in case of any complication. This is particularly significant in case of rural women with least information and low levels of education (WHO 1999).

Socio-cultural norms shape womens health seeking behaviorin such a way that they gives priority to the health of the family over their own health, and seek medical consultation when they are seriously ill and seeking medical treatment becomes imperative. Women continue doing daily work during pregnancy which makes it very difficult for them to take 'time out' to visit the hospital.

Women considered conception and the act of giving birthas'natural'not requiring medical interventions. As Noureen mentioned

> *"Mujhay nahin pata tha kay jab pait se ho tu kis maheenay main husptal check up kay liye jatay hain. Meray ghar main tu ye kuch kisi nay nahi kiya. Hamal to qudarti amal hay or iss kay liye to kissi duwai daru ki zaroorat nahi. Main to gher pe khayal rukhti hoon or yehi humara tor tareeqa hay. Husptal janye ki zaroorat to nahin hoti per aurtain ye kuch ker kay apnay bando ko nakhra dekhati hain. Her aurat ye kaam kerti hay. Hum nay aisi aurton ki kahaniyan bhi sun rukhi hain jinho nay khaito main bachay paida kiye. Banday ko sirf or sirf himat pakarni chahiye."*

> I did not know in which month of pregnancy one should go to the hospital for a check-up. In my family, no one had done this. Pregnancy is a natural process and medication has nothing to do with it. I take care at home that is what we do. Going to hospitals is not required but women do it to exhibit coquetry in front of their husbands. All women do that. We have heard stories of women who have given birth in fields. One should build her courage and that's it.

Noureen constructs her meanings of becoming a mother through other women around her. Her reference to "that's what we do" (*humara tor tareeqa)* is how women follow traditional practices within the realm of their reproductive health. Having seen for

generations what women around them have done successfully creates a shared cultural understanding of birthing. Women rely on stories of other women to make decisions with regards to their own reproductive health.

Women also argued that visiting formal health care systems consumes time that is taken away from their domestic responsibilities like doing household chores or attending to their children and other family members. In addition, women expressed their doubts regarding the side effects of western medicines affecting their health negatively. Like Sonya who described her views regarding the utilization of antenatal care from hospital as,

> *"Golyan to garam hi hoti hain or ye dacterniya dwayo ki lambi chori list pakrati hain. Wo ye kehti hain kay ye maa or bachay donokay liye achi hain. Main nay bhi iron ki goliya khai thi laiken un se to mujhay qabaz ho gayi or wo to hamal main achi nahi hoti. Bari booriyan tu mana keri hain kay koi garam cheez na khao jaisay goliyan. Iska faida kum or nuqsaan ziada hay. Wo vitamin ki goliyan bhi likh k daytji hain laiken wo zara mehngi hoti hain or banda unhain rozana khana bhi bhool jata hay. Iskay ilawa wo aapko her maheenay chakar lagwati hain or her bari fees batorti hain. Jab bhi jao wo eik hi baat batati hain k "sub kuch theek hay or taqat ki goliyan lazmi khao." Ooper se husptal bhi door hi hay or local garyon pe jao to kum uz kum do ghantay to lug jatey hain. Or phir subah kay waqt gher pe bhi itnay dher kaam hotay hain issi liye check up kay liye time nikalna zara mushkil hota hay. Mere khayal main to kraya or dactron ki feesay bhernay kay bajaye banda phal waghera kharid lay or jaan banaye."*
>
> Pills are supposed to be hot and these gynecologists prescribe you a long list of medicines. They say it is good for the baby as well as mother. I have taken iron pills but it constipated me and that is not good during pregnancy. Older ladies suggest not eating anything hot like pills. It has more harm than benefit. They also prescribe you vitamin tablets but again they are bit expensive and one forgets taking them as regularly. Beside that, they want you to keep visiting them every month and charge you a fee on each visit. Every time you visit them they make similar remarks that "*everything is ok and you must take energy tablets*". Moreover, the hospital is bit far and it takes at least two hours to reach there on local transportation. In addition, I have a lot of work to do at home in the morning and for that reason it is difficult to spare time for check-ups. I think, instead of wasting money on travel expenditure and doctors fees one can buy fruits, etc. and improve one's health.

Women understood pregnancy as a natural phenomenon and emphasized having good diet instead of relying on medicine. Many women highlighted the notion that they need to visit a gynecologist in case of any problem which require treatment. As Nasreen explains,

> *"Hamal to eik qudarti baat hay ab kia tuk banti hay banda husptalo kay hi chakar lagata rahay baghair kisi muslay kay. Koi bhi mujhay husptal nahi lay kay giya tha chaar maheenay tak laiken jab mujhay khun chut pera tu main nay apni saas ko bataya uss nay yehi samjha kay mera larka ho ga. Kehnay lagi, "khoon un aurton ko parta hay jinkay pait main larka ho. Tu mere per gayi hay. Mujhay bhi larko ki dafa daagh lagta tha. Ye apnay kaamo se jaan churaney kay bahaney hain aaj kal ki larkiyon kay " Laiken phir khoon ziada ana shuru ho gya or kamar main bhi sakhat takleef shuru ho gayi. Main tu darr gayi kay bacha he na zaya ho jaye. Tab ja ker gher walo nay kuch pareshani ki or mujhay dactarni kay pass lay kay gaye jis nay do teekay lagay sath main aram ki takeedain kee."*
>
> Being pregnant is a natural phenomenon and it makes no sense to keep visiting the hospital unless you have a problem. Like nobody took me to hospital untill after four months but when I started bleeding I told my mother-in-law who perceived it as a sign of a baby boy. She said, *"Bleeding mostly occur to those ladies who have a boy inside womb. Your case is similar to me. I also had spotting at the time of boys. These are just excuses of these days girls who want to get away with their work".* But my bleeding became heavier and I have severe backache. I was afraid to miscarry. Then my family took it seriously and took me to a gynecologist who gave me two injections and recommended the rest.

Nasreen's views shed light on the fact that antenatal care is not considered essential and women and people around them seek medical interventions with some reason like as Nasreen pointed out *"unless you have a problem".* There has to be a firm reason that can establish that a medical consultation is necessary and imperative. Customarily, it is expected that pregnant women should continue with their family responsibilities and seek formal care when deem this as the only resort.

Women also cited various obstacles that hinder their access to antenatal care most importantly restrictions imposed by the family where she lives. Rukhsana illustrates how her husband's opposition stopped her from seeking anti-natal care,

> *"Mera khawand pasand nahi kerta k main gher se bahir jaon chahey husptal he kion na jana ho. Main to peeshaap test k liye bhi nahi gayi hamal ka pata laganey. Jab kapray nahi aye to main sajh gayi k bacha honey wala hay. Mujhay koi dactor k pass nahi lay k jata or sarey bachay mere ghar*

main dai k hatho hoye. Wo kehta hay k jo aurtain besharam hain jo lamkay tid ghair mardon ko dikhati hain. Aisay mard bhi beghairat hotay hain jin se apni zananiyan control nahi hoti. Wo kehta hay, "mujhay pata hay husptalo main kya kya hota hay aurtain jati hain or tid nangay ker kay ghair mard ko dikhati hain."

My husband does not like it if I go outside our home even in case of visiting a hospital. I never went for a urine test to confirm my pregnancy. When I missed my period I understood that I was pregnant. I was not taken to any doctor and all my children were born at home with the assistance of a midwife. He says women who show their hanging tummy to stranger men are shameless. Men who allow their wives to reveal their pregnancy are pride-less who cannot control their wives. He said, *"I know well what is happening in hospitals. Women go there and show their naked belly to a stranger man (referring to ultra sound)."*

Rukhsana's comments demonstrate the reality that women's health cannot be separated from their contexts. Unequal power relations between spouses can curb their ability to make independent health decisions. People around women may not understand their health needs as experienced by them. Women do not want to disturb the peaceful environment of their home and their relationship with husband. For them, meeting the husband's and family expectations is a priority. A good woman should not make her husband angry and she should think about him before she thinks of herself.[62]

7.1.1 Food during Pregnancy

Most women reported eating no special food during pregnancy. They eat whatever is available in the household and the same food which is prepared for the rest of the family.

[62] Mumtaz and Salway (2005) also concluded from their study in Pakistan that pregnancy is an obvious outcome of sexual activity.That is why it is considered a matter of shame (*sharam*) which needs to be kept hidden especially from males. Therefore women restrict their mobility and prefer to avoid going outside the home to access services in order not to reveal their pregnancy to others. Other evidence from this study suggests that male figures play a key role in the uptake of reproductive health services. In particular, men who were educated at secondary and higher levels were more likely to have spouses utilizing antenatal check ups and tetanus toxoid immunizations. This is similar to the data from another study in Pakistan which noted that providing information to husbands on safe motherhood and family planning increased women antenatal care and handling obstetric complications through hospitals (Midhet and Becker 2010). A separate study in India found the estimated risk of maternal death to be three times higher among women whose husbands were uneducated compared to women whose husbands were college educated (Ganatra 1998).

It also depends on the affordability of things like meat and chicken which are costly as compared to pulses and vegetables. Women did not report consuming any special nutritional food supplements during pregnancy.

The weakness and pain as reported by women can be a result of their under-nourishment due to little attention to the quantity and nature of the food intake of mothers during pregnancy and afterwards. Women in the village eat the same food they eat during normal days. This means they would have a cup of *chai* (tea) or a glass of l*ussi* (Curd Milk) in the morning, approximately one to two *rotis* or *parathas* with one *'katori'* (small bowl) of *salan* (Curry) usually left over from last night is dinner. Then they take the same *roti* and *salam* which may be cooked vegetables or *daal (*pulses) or sometimes meat or chicken at mid-day and the same at night. It is also a popular belief that women during pregnancy like to eat food with a sour taste like *acchar* (pickle), lemon, oranges and *pakoras, imli* (tamarind), *tatri* (Citric Acid) etc. Most women do not add any supplementary food to their meals. Some women reported that they craved for *koila* (Coal), *kachay chawal* (uncooked rice), *gaachi* (mud), *hooka* (hubble-bubble) etc but they were unable to explain any reason for these food cravings.

A few women mentioned that eating *naryal* (coconut) makes the child beautiful and they also recommended eating fish for the same purpose. Some women also mentioned that eating cabbage will increase the probability of having a baby boy. Traditionally, they start taking one glass of hot fresh milk with *desi ghee* or castor oil orsesame seed oil in the eighth month as these are good *'chiknai'* (lubricating) foods which make the inside greasy which helps the baby to be delivered quickly.

Many women reported different food cravings during pregnancy and this is sometimes linked with the sex of the baby. For example, many women mentioned that if a pregnant woman primarily craves for more sweet things such as *mithai*, *kheer*, *revriyan*[63] etc, it is assumed that she will have a girl. On the contrary, if a pregnancy woman craves for more sour, salty and spicy food it is thought that she is going to have a baby boy.

[63] Local sweets

7.1.2 Restrictions during pregnancy

There are certain restrictions which expecting women have to follow during pregnancy. Pregnant women do not visit a house where there is some disease, especially tuberculosis and chicken pox etc. They are also advised not to visit a woman who has recently suffered from an abortion or still-birth due to the fear of getting *purchawan* (transmission by intangible agent). Similarly, pregnant women do not attend any funeral or visit the house of the deceased for the same reason of getting *purchawan*.

During lunar eclipse, pregnant women are asked to walk continuously. If a pregnant woman remains seated in one position during the lunar eclipse, her child will be born dead in that position. During a lunar eclipse, pregnant women avoid cutting anything with scissors or knife. If they do so, the lips of the baby will be scarred when he/she is born.

It is also believed that if a pregnant woman frequently drinks tea during pregnancy, the heart of the baby stops functioning and it will be born dead. Similarly, other food items which are considered 'hot' in content like beef are also considered harmful for the baby and eating such hot food is likely to cause jaundice and even still birth.

Many women also mentioned certain restrictions with regards to access to modern reproductive technology and said that their husbands and mothers-in-law did not like if they expressed their desire for having an ultra sound scan during pregnancy. One of the respondents quoted her mother-in-law who said,

> *"Bacha purda mangda hay. Mardo se machinay lagwa lagwa kay check kerwana be sharmi hay."*
>
> (Unborn) baby needs to be concealed. It is shameful to be examined by (ultra sound scan) machines by males.

Another respondent mentioned a similar statement of her mother-in-law's who did not allow her to have an ultra sound scan during pregnancy and expressed her mistrust on doctors to detect the gender of the unborn child.

> *"Bacha thappa thuppia hona hay. Husptaal alay wi undaaza landay nay."*
>
> Baby (inside womb) is wrapped. (Doctors at) hospitals just make guesses (about gender).

7.1.3 Pregnancy & Workload

As far as workload is concerned, for many women it remains the same during pregnancy. Many womensaid they performed the same tasks during pregnancy as they usually did. Most explained their continuation of physical work in terms of necessity. One respondent explained

> *"Pait se honey se koi roz kay kaam kaaj ki chutti nahi ho jati. Main kaam na keroo to phir kon kere ga. Mere bacho nay roti khani hay. Mere gher ki safai honi hay. Mujhay roz kay roz kapray dhoney hotay hain aur aisay buhat se doosray kam. Moqa milay tu main aram ker laiti hoon or ager na milay tu banda phir kia karay? Bacha jamnay se koi main apni zimadaryan se to farigh nai na ho jati. Meri saas mujhay yehi sunati hay kay bara main nay koi navekla kaam nai kia. Sari aurtain bachay jamti hain aur ye qudarti amal hay."*
>
> Being pregnant does not exempt women from routine work. Who would do the work if I didn't do it? My children need food. My house needs to be cleaned. I have to wash clothes daily and many other similar tasks. If I get a chance I will rest, if not –what to do? Pregnancy does not entitle me to be free of my duties. My mother-in-law reminded me that I did not need to do anything new. All women give birth to children and it is natural phenomena.

Senturia (1997), in her study of pregnant women in Albania, found that women doing strenuous work like lifting heavy weights were more likely to experience a miscarriage and they were at higher risk for preterm deliveries and low birth weight than employed women who had help at home. In the present atudy, many women highlightedthe inverse relationship between doing work and reduced labor while giving birth. They believed that women who remain active thought-out their pregnancy have quicker deliveries. One married woman said while narrating her experience of giving birth as

> *"Ager aglay din mera bacha honay wala hota to main ajj poora din gher kay kaam kaaj aam dino ki tarah kerti. Banda hamal main warzish wala kaam karay tu phir akhir main bacha paida kernay main asaani hoti hay. Mere pehlay bachay ki dafa main nay do charpaia khud dhoi thi. Meri shadi shuda behan mere gher ayi hoi thi uss nay mujhay kaha bhi kay wo madad kay liye mere gher ruk jati hay kionkay mere pooray din thay laiken main nay uss se kaha kay main theek hoon. Charpai dhonay kay baad main nay gher walo kay liye khana banaya or phir dai ko bulaya kionkay mujhay dardain mehssos hona shuru ho gayi. Ghantay main hi mera bacha ho gaya. Sara kuch asan aur jadli ho gaya aur iss tarah mera bacha hoa jistarah banda bara peeshap karay."*

> If tomorrow I was to give birth, up until today I would be doing all the household work as per routine. Physical work during pregnancy makes child birth easier. At the time of my first delivery, I washed two *charpais* (cots) myself. My married sister came to my home and offered to stay in my house for assistance as I was on full term but I said that I am fine. After washing the *charpais* I cooked food for the family and then called the *dai* (traditional birth attendant) as I felt labor pains. I delivered my baby within an hour. It was easy and quick and I gave birth like defecating.

These comments reveal that birth is not something about which one should be worried and make a fuss. Some women also reported the attitude of the husband's and other family members became considerate during pregnancy and they were advised not to carry heavy weights or wash clothes. They were also provided with rich foods like milk, ghee, meat and fruits to improve their health and gain energy (*taqat*) but such examples were exceptional among my case studies.

On the whole, pregnancy was not conceptualized in local systems of knowledge as a period of special care for the mother and the future child.

7.1.4 Problems experienced during pregnancy and their treatment

In a subjective fashion women experienced the effects of poor nutrition through weakness, and dizziness. Several women described the problem of nausea particularly in the first trimester. One of the respondents mentioned

> *"I have four children and I felt nausea in all my pregnancies. It causes great weakness as one does not want to eat any-thing. It makes you feel exhausted and one wants to keep sleeping. Nausea remained persistent throughout my pregnancy."*

Detailed discussion with respondents revealed that the most common problems experienced by them during pregnancy included *kamzori* (weakness); *chakkar* (dizziness); *khoon ki kami* (anemia); *dil kharab hona* (nausea); *ulti/prut julna* (vomiting); *huth pair sujna* (feet and hands swollen); *dil surna/jalan* (heartburn); *khatti dakarain* (acid reflux); *Jisam main dard* (body ache). The other problems related to pregnancy were alsomentioned such as *pani purna* (vaginal discharge); blood pressure, lower abdominal pain, *meday ki tezabiyat* (stomach acidity); *budhazmi* (indigestion); *thakan*

(fatigue); *tidd aapharna* (abdominal bloating); *khoon chutna* (bleeding); *lukk nadard* (backache); *taang main karul parna* (cramp in leg); *qabaz* (constipation).

The treatment women sought to handle these pregnancy related illnesses and problems ranged from traditional home remedies, formal health care to spiritual healing. According to respondents, their health seeking behavior depended on several socio-economic factors such as the nature, extent and type of health problem encountered, the woman's ability to make independent health decisions, availability and access of health facility, and above all, the attitude and health beliefs of the family and towards a women's health care and also her family's willingness and ability to pay for the treatment.

Women said that during pregnancy it is normal to experience weakness, pain and fever and for their remedy it is not considered essential to consult any doctor. Rather any male family member can bring tablets (*goli*) such as paracetamol, panadol and brufen. These are popular and frequently used medication for pain and fever. For the cure of indigestion, abdominal bloating, acidity and vomiting generally women preferred to consume those food items and drinks having a cold effect such as yogurt, curd water,lemonade etc. Women also shared knowledge of using various home remedies to maintain good health and to prevent and cure minor pregnancy related issues. For example, *pudina* (mint leaves) is considered good for indigestion, vomiting, nausea and diarrhea. But in case of more serious complications such as bleeding, spotting, unusual pain, breech baby etca medical professional is also consulted. Women reported that they prefered to visit the LHV's house in the village to receive advice for their various *zanana masail* (gynecological problems). She keeps a stock of medicines at home and provides them with *taqat ki golian* (Iron and Zinc tablets) for pregnant women. In case of severe vomiting and dehydration, she is able to administer adrip. They also have equipment to check blood pressure.

If any pregnancy related health problem is believed to be the result of any supernatural cause like *purchawan* (evil shadow), *buri nazar* (evil eye), or *jadu tuna* (magic) then spiritual healing is the preferred mode of treatment. In the village there is a shrine of the

saint Shah Ghareeb. There are also many famous shrines and *pirs* in nearby villages. Women informed me that they frequently visit a famous shrine in village 'Burhan' and also the Gham Mit Shrine in the village Kharsheen. Women reported that shrines are holy places so they go there to solve their various problems and make *mannat* (pledge), recite the Quran and perform*dua* (pray) to defeat and neutralize the bad effects of evil forces.Pregnant women and those who miscarried reported visiting the shrine of Burhan to get preventive *taweez* (amulets) for a successful and healthy outcome of that pregnancy.

7.1.5 Gender preferences during Pregnancy

Women did not explicitly mentioned gender preference and said that girls are as good as boys. They considered girls more caring and perceived them as "mother's helpers" while boys were valued for their economic contribution and they were perceived as *"father's arms."* Moreover, they are needed to continue the family name. Due to perceived advantages, boys are wanted more in numbers than girls. The majority of the mothers preferred fewer girls then boys. But all women wanted a baby boy as their first new born *(palethi ka bacha).*

One of the respondents highlighted the significance of having both genders as,

> *"Aulad mitha mewa hay. Beti ki apni jaga hoti hay betay ki apni. Betyon se ghar main ronak hoti hay aur wo maa baap ka ziada dard kerti hain laiken hain to praya maal. Betay na ho to banda budhan barey khawar ho jaye. Mertay welay koi pani moon main dalney wala na ho. Allah ji dono meway day. Agar khali betay hon to bahuein lay aye gain wo to fir wi beti ki kami kisi hadd tak poori ker day gi laykin ager khali betyan ho to fir banda akheer akela hi reh jaye ga. Prayi aulad (damaad) se kia umeed rukhni. Sambhalta wohi hay jisko under se chik lagay. Apnay betay or koi nahi."*
>
> Children are like sweet dry fruit. Daughters have their own place and sons have theirs. Daughters dazzle the home and they are more caring towards their parents but they are another's treasure. The absence of sons can demean parents in old age. On one's death bed, there will be no one to pour water in one's mouth. May God give both fruits (referring to children of both genders). If there are only sons then they can bring daughters-in-law who can substitute a daughter to some extent but in case of having only daughters finally a person is left alone. One cannot hope from other's children (son-in-

law). Only the one having real feelings in their heart can look after you, none other than real sons.

According to my respondents, both sons and daughters were equally dear to them and they do not prefersons over daughters, rather they simply expected to give birth to a son. The pressure to produce a son becomes more acute when women need to give birth to a male in fewer overall lattempts. Findings reveal that apart from the demands of husbands and mothers-in-law to produce a son, there are practical reasons behind son preferences.A woman is considered metaphorically *majboor* "helpless", and *otar*, *nikhatar* "alone" in society if she produces no sons. Similarly, when Shehla gave birth to a baby girl, her in-laws said, *"tu jamaya ki hai jo manji tay laitin hain."* (What have you borne, that you need to lie on the cot?)

Women also mentioned various Quranic verses and other *duas* (prayers) for concieving a male child. Many women mentioned that frequently reciting the following *dua* during pregnancy is believed to be effective for having a male offspring.

"O My Lord! Leave me not childless, though You are the Best of the Inheritors." (Qur'aan: 21:89)

Another *wazeefa* (Sacred Spell) which is considered authentic and powerful to have *Aulad-e-Narina*(a male child) is that after confirmation of pregnancy a woman starts reciting Surah Yaseen daily while placing hand on her *naaf* (umbillic). This should be continued for forty days. Women also mentioned reciting Surah Muzammil, Surah Maryam, and Surah Yusuf for having a healthy pregnancy and to fulfill their wish to be blessed by a baby boy. Women also mentioned visiting shrines and getting *taveez* (amulets) for this purpose. One of the respondents said,

> *"Main Mullo wali Ziarat se taveez leti thi peenay waley bhi aur pehan kay rukhnay waley bhi. Main nay pooray nou maheenay taveez pehan kay rakha chamray main daal kay kaali dori kay saath. Meri teen betiyan thi aur betay kay liye jis nay mujhay jo bhi bataya wo main nay kiya."*

> I used to get amulets from the Shrine of Mullo for the purpose of drinking as well as for wearing. I kept wearing amulets for nine months (the gestattion period) folded in a leather pouch to be worn which is used to wear in a leather covering (tied) with black thread. I had three daughters and I did everying which was told me by anyone in the quest to have a son.

Older women or mothers-in-lawparticularly emphasized the importance of sons in terms of bringing a daughter-in-law into the house. Everyone agreed on the fact that daughters are married off to other houses and may not be available at a time of emergency. In older age if there is no son then there will be nobody to give a drop of water at the time of sickness. Sons, remain with the parents and care for them when they are not able to work.

> *"Puttar kis ko acchay nahin lagtay. Burhape main wohi samhbaltay hain. Puttar wohi hay jo apnay tid se nikla ho. Damad to damad hota hay beta nahi ban sakta. Maa baap ki qadar unki aulad (son) he ker sakti hay. Beto say bahar hay. Puttar baho le ke aata hay wo ghar sambhalti or khidmat kerti hay. Bachay paida kerti hay. Puttar ki nasal wadati hay."*
>
> Who does not like sons? Sons, look after one in old age. A real son is the one who is born from your own womb. A son-in-law is a son-in-law and cannot be an alternative to a real son. Only your children (sons) can value their parents. All joys are with sons. A son brings a daughter-in-law who manages the household and serves you. She gives birth to children and continues the son's family line.

The value of sons is further reinforced through television serials. Women mentioned different dramas such as *Janam Jali, Zindagi Gulzar hay* etc which shows the plight of women having only daughters. Women also reported that even doctors in hospital discourage sterilization for women having none or only one son.

7.2 Delivery & Childbirth

The majority of the women still continue to give birth at home as mentioned. Birth was primarily percieved as a natural process. It is widely believed that it does not require the assistance from any medical expert. Hospitals, for the most part, were perceived as being for emergencies.

Women in Choha Sha Ghareeb are socialized to keep quiet about their pain and remain patient (*sabir*) in the time of suffering. One respondent said

> *"Shor sharaba kernay se sirf tame he lamba hota hay. Allah raakha hota hay jab aurat bacha paida ker rehi ho iss liye khamoshi ikhtiyaar kerni chahiye aur Allah ko yaad kerna chahiye. Maa ko bacha paida kertay waqt her dard kay badlay ajer ka wada kia gya hay. Issi waja se maon kay pero kay neechay jannat hoti hay."*
>
> Making noise during child birth only prolongs labor. Allah protects mothers giving birth so one should stay quiet and remember Allah. Mothers are promised to get reward for each contraction (*dardain*) they bear during child-birth. This is the reason mothers have heaven under their feet.

One other woman commented

> *"Aurto main qudarti tor per dard bardashat kernay ka mada hota hay. Bachay ki dardo main shifa hoti hay kai undrooni muslay theek ho jatey hain. Delivery main aurton ka ganda khoon zaya hota hay to baad main phir unka jisam taza khoon bana deta hay."*
>
> Women have a natural capacity to endure pain. Labor contractions do have a cure (*shifa*) for many internal problems. Women waste dirty blood during delivery but later on their body makes fresh blood.

The 'authoritative knowledge' in this environment is not based on the bio-medical understanding of reproductive health; rather, it is based on the practices of women over generations. Women have seen their mothers and grand-mothers doing it in the same way. This becomes more prominent when it comes to choosing a place of delivery. Most of the women mentioned that they agreed to deliver at home on the recommendations of their mother-in-law and mother and other married ladies who were mothers. Shaista narrated it in this way:

> *"Main pehlay bachay ki pedaish per buhat darri hoi thi kionkay main nay suna hoa tha kay bara dardnaak marhala hota hay. Mujhay samajh nahi lag rahi thi kay husptal jaon kay gher pe rahoon. Laiken her koi yehi mushwara de raha tha kay gher pe delivery behtar hay kionkay gher waley mojood hotay hain. Meri saas nay bataya kay uskay saat bachay hoey, sub kay sub dai kay hathon or koi masla nahi hoa. Aadhi raat ko uth kay husptal main jana na siraf sharam wali baat hay bulkay iss main bara khatra hay kionkay dactro nay tu apni asani dekhni hoti hay or paisay batornay kay liye unhain bara operation kernay ki jaldi hoti hay. Main nay unki (saas) ki baat suni aur gher pe hi delivery kurwai. Meri saas nay mujhay dardain taiz kernay kay liye garam doodh or desi ghee ka kaara pilaya. Unho nay kafi gharelo heelay kiye or waqfay waqfay se meray jisam ki maalish keri rahi. Husptal main tu nursain purwa hi nahi kerti. Mujhay lagta hay kay wo (saas) bilkul sahi thi kionkay mujhay gher pe kum masla hoa."*

> I was really afraid on my first delivery as I heard it is a painful process. I was confused whether to choose hospital or stay at home. But everyone was suggesting that home delivery is better because of the presence of family. My mother-in-law said that she gave birth to seven children, all with the assistance of the midwife and nothing wrong happened. Going to hospital at midnight is not only shameful but also a great risk as doctors prefer their own ease and hurried to do cesareans births to charge more money. I followed her (mother-in-law) advice and delivered at home. My mother-in-law gave me a concoction made with hot milk and desi ghee to ease the labor pain. She tried various home remedies and massaged my body from time to time. In hospital nurses do not bother. I feel that she (her mother-in-law) was absolutely right as I had less trouble at home.

Shaista's views illustrate that she preferred home birth as families encourage women to stay at home. Sarwat discusses this as:

> *"Husptalon main paisay barey lagtay hain. Iske ilawa meri maa or uski maan sab hi nay gheron main hi bachay paida kiye. Wo aurtain husptal jati hain jinhain koi na koi masla hota hay. Humarey gao ki meri jaan pehchan ki sab hi aurton nay ghar per hi case kerwaya. Iss main asani hay kionkay dai apnay pind main hi rehti hay or ussay case kernay ka pata hay. Mujhay poora din dardain lagi rehi laiken dai nay sambhala or main husptal main koi nahi gai."*
>
> Going to hospital cost more and beside that my mother and grand-mother all gave birth at home. Those women go to hospital if they have some problems. Most of the women in the village known to me gave birth at home. It is easy because the midwife is from our own village and she knows how to deal with a case. I was in labor for a whole day but the midwife helped me and I didn't need to go tothe hospital.

7.3 Decision regarding the place of delivery

Building on to the notion of practicing reproductive rights is the location of decision. Families are an indispensable part of the decision making processes, and women locate this within their cultural norms. Cultural practices becomethe episteme of knowledge and play a key role in shaping women's understanding of their reproductive rights as their perception is mainly locatedin how they decide to go through various phases of their reproductive years, largely informed by the family and community values. Women's choice of place for giving birth indicates their socio-cultural and economic context: for example, the presence of the mother-in-law, midwife or other female relatives etc.

Traditionally, in the village, the mother-in-law and other female relatives provide comfort and support along with the midwife as the experience of having gone through all these stages by themselves makes them aware what needs to be done. That's how women utilize each others experiences. For them, the environment of home ensures more comfort, emotional support of other women, security, and honor.

Women reported that mostly husbands have the authority to decide the place of delivery and generally they decide if there comes a point where the wife comes in life threatening condition that it warrants being taken to the hospital. The way in which one respondent shared her account of the complications that she experienced during labor and the actions taken as a remedy provide insight to understand the roles various family members played in such dangerous situations. Fahmida said

> *"Hamal kay dino main gaon ki dai mujhay check kerti thi jo bari tajarbay kar hay. Usne uthwain maheenay main bataya kay bacha buhat mota hay aur gher pe iska hona mushkil hay. Meri umer sirf 21 saal thi or ooper se main buhat kamzor thi. Dai kay mashwara dene kay bawjood mera mian or uski maa dono mujhay husptal le ke janey pe razi na hoye. Unko yehi khof tha kay dactrain mera bara upration na ker dain jiskay paisay bhi ziada lagtay hain or opper se khatarnaak hota hay. Meri saas to mujhay yehi sunati rehti kay main uski or khandan ki baqi aurto ki tarah gher pe hi case kraon gi. Main to razi nahi thi laikin phir main nay apni marzi apnay mian or iskay gher walo kay dhamkaney ki waja se chor di."*

> During pregnancy, I had been examined by the 'dai' in the village who is quite well experienced. She suggested during the 8th month that the baby is over-weight and will be difficult to deliver at home. I was just 21 years old and on top of that I was very weak. Despite the recommendation of 'dai' my husband and his mother did not agree to take me to the hospital. They were afraid that doctors may perform C' section which is costly as well as dangerous. My mother-in-law kept scolding, saying that I had to deliver at home just like her and other women of their family do. I was reluctant but I had to give up my choice in the face of the reprimand of my husband and his family.

She gave up her choice and minimized her agency in this scenario to comply with the normative perception of being a submissive wife and daughter-in-law. She refrained from showing stubbornness (*zid*) and expressed herself to be demanding. She had a heavy blood loss and became very pale after giving birth at hoem. She went through severe pain due to the*dai's* several inducements.

Many other such narratives explain that women are often not being able to choose the place of delivery. They cannot demand to be taken to the hospital against the decision of their families. Razia, another respondent, delivered her child at home. Her husband and his brothers thought that it is a matter of shame if a pregnant woman goes to the hospital with hanging tummy and walks in front of other men (*ghair aadmi)*. They did not even allow her to visit any health facility for anti-natal check ups. Around midnight, her contractions or labor pains started but did not disturb anyone at home. She woke up her mother-in-law just one hour before delivery. The *dai* was called and she successfully delivered a baby boy around six in the morning. Razia said,

> *"Abhi dardain bhi ziada sakhat nai lagi aur bacha asani se ho gaya laiken awl bahir nahi ayi. Buhat zida khoon chutnay ki waja se meri halat bari kharab ho gayi. Dai or baqi ki aurto nay baray harbay kiye. Meray baal moon main daley taa kay main ulti keroo. Mere mian say bhi kaha kay teen dafa gher ki chat se watta neechay phenkay jo bara mana hoa totka hay awl kay bahir anay ka laiken koi heela na hoa aur dai ki maalish or doosray harbo kay bawjood do teen ghentay tak awal bahir na ayi. Bachay ki halat kharab ho gayi aur meri bhi. Her banda hi apna apna mashwra de raha tha. Main behosh ho gayi aur dai nay mujhay husptal le ke janey kay liye kaha. Mujhay qareeb kay husptal main le ker gaye jahan pe unho nay ilaj kia. Laiken mera buhat zaida khoon zaya ho gaya aur main tu bus murney hi lagi thi. Ub bhi wo tame yaad ata hay tu main khofzada ho jati hoon."*
>
> Although the labour pains were not much severe and I delivered the baby with ease, but the placenta did not come out. My situation became critical due to excessive bleeding. The *dai* and older females tried different strategies. They put hair in my mouth so that I would vomit. My husband was asked to throw a stone three times from the roof which is a well known practice to make the placenta fall but nothing worked and despite the *dai's* massage and other remedies placenta did not come out for 2-3 hours.. My baby got 'serious' and so did I. Various people giving different opinions. I fell unconscious and then the midwife recommended to take me to the hospital. I was taken to the nearest hospital where I was given treatment. But I lost so much blood and I was nearby died. I still feel afraid whenever I remember that time.

These two examples and other similar ones highlight women's lack of autonomy even in situations of obstetric emergencies. They cannot speak and say that their situation necessitates hospitalization. Preference for home deliveries is further intensified with the birthing experiences of older women who share stories of giving birth alone without any

assistance or on the way home from the fields. Birth has traditionally been the domain and responsibility of women.

The life style and workload of women may also affect the choice of where to give birth. As the story of Resham explains:

> *"Jab mera bacha honey wala hota mujhay roz marra ka kaam kerna parta tha. Kapray dhona or pooray tabar ka khana pakana. Meri jurrat hi nahi thi husptal main ja ker check up kerwaney ki kionkay udhar pohunchaney main he ghanta dehdh lag jata hay. Iss halat main busain wagnain badalna konsa asan hay. Her kisi nay mujhay yehi kaha kay agar main hamal main bhi kaam kaaj kerti rahoon or bhagti dorti rahoon to phir bacha jamnay main koi ziada masla nahi hota. Jis din mera baccha hoa uss din bhimain nay kapray dhoey thay. Muthi muthi dardain bhi lagi thee per main nay koi rola ruppa nahi kia. Main nay suna tha kay inn dardo ko bardashat kernay ka bura hi sawab hay or iss time jobhi mango wo suni jati hay. Main nay khamoshi se bardasht kia. Thora time laga, sham ko dardain shuru hoi or raat ko das bajay mera kaka bhi ho gya. Issi tarah, turtay phirtay, kam sham kertay hoay fato fat bacha bhi ho gya."*
>
> I had to do routine work during pregnancy. I had to wash clothes and prepare food for the entire family. I could not afford a visit to hospitals for check-ups as it takes at least one and half hours to reach hospital. It's not convenient to change buses/vans in this condition. Everybody suggested to me that women who keep doing work during pregnancy and remain active have lesser complications during childbirth. I washed clothes even the day I delivered. I felt light contractions but I did not make a fuss. I was told that bearing labor pain is highly rewarding and the wishes made during labor are fulfilled. I remained silent and remained patient. It took me a few hours, the pain started in the afternoon and my son was born around 10 at night. That's how, while running around and doing work I gave birth to my son and it happened so quickly.

The above mentioned story of Resham demonstrates how her daily household responsibilities in maintaining a family took precedence, when choosing to do something that takes time away from those needs. It reveals that along with the availability of health services and the need to decrease cost, women also rely on each other's experiences that become a guide to making choices about themselves. As Resham mentioned in her conversation, endurance and patience are expected from a woman and that is what solves all troubles. She emphasized how easy it was at home, implying that serving the family and going with their wishes is a noble job.

7.4 Preference for Home Birthing

Although women understand the possible risk, yet they emphasize that they didn't need to go to the hospital. Health interventions are reserved in case of emergency. Women mentioned that they go to hospital mostly when they see an unusual symptom during pregnancy such as spotting, lower placenta, etc.

It is not the case that women plan to give birth at home as they do not care about their health and security.Rather, as older women explained; they had more fears associated with delivery at health facility and prefer the ease and privacy of their own homes.Women mentioned that they resisted medical interventions, until they felt it became inevitable. The above mentioned narratives of the women touched the fact that women tried to avoid hospital delivery unless they felt they had no other options. The meanings of birthing were culturally constructed through the lived experiences of those women who were already mothers.

Moreover, choosing a health facility also depends on the type of health facilities available to women. Rani's choice of hospital for giving birth sheds light into the provision of poor quality medical services available to women.

> *"Jab adhi raat ko mujhay dardain lagi to main husptal chali gayi. Eik poora din or raat dardon main guzar gaye. Unho nay mujhay eik ward main rukha jo pehlay he full thi. Lady doctor bus eik he dafa aye moaina kernay kay liye laiken kuch kaha he nahi. Kuch ghanto kay baad jab nurse nay dekha kay bus ab thora time reh gya hay to phir unho nay mujhay labor room main bhej dia jahan per 5 bed lagay thay or un sab per aurtain laiti hoi thee. Mujhay eik or aurat kay sath eik he bed pe laitna pura. Pehnnay kay liye jo kaprya diye wo khoon kay dagh se bheray hoye thay jiasay kisi nay tazay tazay istmal kiye hon. Mera buhat dil kharab hoa or main nay aya se kaha kay wo mujhay saaf kapray day laiken uss nay mujh per chillana shuru ker dia kay ager main nay itni farmaishay kerni thi to phir nia nakor gher se lay ati. Wo dard se krahti aurton kay saath badtamizi ker rahi thi. Uss nay bari nangi zaban istamal ki or kahan kay hum log pehlay to mian kay saath mazay kerti hain or phir yahan aa kay unkay sur pe chekhain marti hain. Mujhay wahan apni bari beizti mahsus hoi"*

> I went to hospital when my contractions started around midnight. I remained in labour for one whole day and night. They placed me in a ward which was over-crowded. The lady doctor only came once to examine my condition but did not say anything. After few hours when the nurse noticed that little time

> was left then they shifted me into the labor room where there were 5 beds and all were occupied by women. I had to share a bed with another lady. They gave me a gown to wear which was full of blood stains like somebody just used it. I felt sickened and asked the female attendant to give me a clean gown but she started yelling at me that if I am so demanding then I should have brought a brand new (gown) with me. She was rude to all the females who were crying with pain. She used abusive language and said that first we enjoy with our husbands and now start screaming here over their heads. I felt very insulted there.

The above-mentioned story of Rani touches the fact that the behaviour of staff of hospital is not appropriate and women who chose to utilize the health services at hospital are treated merely as numbers, rather than as mothers.This phenomenon further becomes clear through Neelam's experience. She said:

> *"Husptalo ka umla iss tension waley mahol main reh reh kay bereham ho jata hay. Unhain koi purwah hi nahin hoti, kisi ki takleef per tawajoh hi nahin daitay. Awazain he daitay reho na doctor jawab de gi or na aya. Unka to ye roz ka kaam hay. Meri baari to nangi tangain dhampnay kay liye chaddar tak nahi di. Kamzori se mera poora jisam kaamp raha tha laiken merey bar bar mangnay per bhi unhon nay nahi di. Shayed case itnay ziada hotay hain kay unhain faraq hi nahi perhta. Main dard se mur rehi thi or main nay aya ko bulaya kay mujhay pakar kay bithaye laiken uss nay kora jawab dia kay dardon kay baghair to banda maa nahin banta na. Wo khup dalney se mana kerti hain or main nay mehsus kia kay wo khas tor per unn aurton se ziada sakhti kerti hain jin kay agay bhi bachay hoon or unhain sara kuch pata ho."*
>
> Hospital staff is crude as they become used to this stressful environment. They are very insensitive and pay least attention to your pain. You just keep calling and the doctors and their attendants do not respond. For them it's a routine matter. In my case, I was unable to get a piece of cloth to cover my naked legs. Due to weakness, all my body started shivering but they did not give me despite several requests. It was very careless on their part, may-be due to the presence of too many cases. I called the attendant to help me to sit as I was dying with pain and she straight-forwardly replied that pain cannot be avoided if I am becoming a mother. They stop you from panicking and I felt that they are particularly more harsh with women who already have children and know the procedure.

The above mentioned stories in a way validate suspicions of women about health facilities. They raise concerns over being mistreated and dehumanized in the medical spaces. This lack of caring is juxtaposed to the supportive environment of one's home.

This is further echoed by Shabnam's story as she discusses her experience:

> *"Pehlay bachay ki baari main husptal hi gayi thi kionkay main koi khatra mol nahi lena chahti thi. Main kafi kamzor thi. Saara time to mera dil kharab hota raha or main kuch ziada kha pi nahi saki. Main doctor or dai dono se mashwra laiti thi or unho nay mujhay koi bhi aisi waisi baat nahi batai thi. Jab dardain shuru honey kay baad husptal gayi. Dus ghantay dardain lenay kay baad doctor ayi or kehnay lagi kay main baliyan or koka nikal doon kionkay wo mujhay barey operation kay liye lay kay ja rehey thay. Uss may kaha kay mazeed intizaar mumkin nahi laiken koi waja nai batayi. Main to sakhat tension main aa gaye kionkay meray wehmo guman main bhi nahi tha kay aakhir main mere saath ye ho ga. Unho nay merey ghar walo ko kaha kay wo kum se kum teen khoon ki botlon ka bandobast kerain kionkay khoon lagana puray ga. Ek mussebat hi per gayi kionkay mera banda logo kay peechay bhag raha tha khoon dene kay liye. Mujhay to normal delivery ki he umeed thi laiken soorte haal bilkul hi badal gayi. Unho nay operation ki waja se paisay bhi ziada liye or operation kay baad sirf teen din kay liey rukha or uss main bhi khaney peenay kay liye kuch nahi dia . Her cheez gher se ati thi. Itni door husptal main ana jana eik alag museebat thi gher walo kay liye. Mujhay khoon bhi nahi lagaya or khud apnay paas hi rukh liya. Shayed wo humarey jaisay majboor logo se khoon ekatha ker kay phir agay baich dete hain. Main nay to dohri takleef dekhi kionkay mujhay normal bacha paida kernay ki dardain bhi hoi or baray operation ki takleef alag jo lambay arsay tak rehti hay."*

> I went to hospital to give birth to my first child. I didn't want to take any risk. I was quite weak. Through my pregnancy I had nausea and I could not eat much. I used to consult both doctor and midwife and they did not diagnose any risk. I went to hospital once the labor pain started. I remained in labor for more than ten hours and then the doctor said that I need to remove my earrings and nose pin as they were taking me for a caesarean section. She (doctor) said it's not possible to wait any more but did not give me any reason for that. It was stressful as I never thought it will end up like this. They asked my family to arrange minimum three bags of blood for blood transfusion. It was a situation of panic as my husband has to run after people for blood donation. I was expecting a natural/normal birth but suddenly the situation turned different. They charged us a huge money for a caesarean delivery and kept me only for three days in which they gave me nothing to eat or drink. Everything was brought by my family. Visiting a far away hospital was another hassle for the family members. I received no blood transfusion and they kept it themselves. May-be they collect it from miserable people like us and then they sell it. I suffered double as I had to undergo longer labor pains than normal birthing as well as long-lasting suffering of a C-section.

Shabnam's story illustrates her lack of trust in the hospitals as she suspected that possibly the blood bags are collected not for a genuine cause but rather to sell. She also mentioned 'non provision of food' during her stay which indicates less care provided to women who choose that health facility. Furthermore, she was also not given an explaination as to what went wrong and why a caesarean section was chosen? It left her feeling ignorant as she was not given justification for what was being done. Her saying '*I suffered double*" shows her disappointment and apprehensions with the bio-medical option. Such stories add to suspicions of other women and they become apprehensive about visiting the hospital. Women showed great reluctance to have a caesarean section as they were terrified of the post-operative pain associated with a caesarean section. Moreover, they also mentioned concerns such as fear of mistake during surgery and heavy blood loss during the surgery, fear of not having more than three or four births, infertility, and complications such as infection of the uterine incision, and backache due to anesthesia that can follow caesarean section. They also reported that doctors recommend precautions after caesarean birth which are difficult for them to follow. For example getting pregnant soon after caesarean is extremely discouraged and in the lives of most of them pregnancies were not planned especially where husbands did not agree to using birth control. They also reported that women who undergo a caesarean cannot do heavy physical work and they had to fetch water and many such things which require lifting weight. Seher's story explains it as,

> *"Tareda bacha honey ki waja se mera bara operation hoa. Chillay main may nay sirf eik hafta he aram kia or phir mamool kay kaam kaaj shuru ker diye. Chillay kay panchwain haftey main meray pait kay tankey toot gaye. Main nay pani se bhari baalti utha kay janwaro kay barey main rukhi. Eik din to main nay kisi ko nahi bataya liken phir dard meri bardasht se bahir ho gya. Meri saas ne bajaye mujh se hamdardi kernay kay mujhey ye sunaya kay budduai or gunahgar aurto kay bachay operation se hotay hain warna gaon main dher aurtain hain jinho nay khud kamzor honay kay bawjood theek thak motay bachay normal gher pe he paida kiye."*
>
> I had a caesarian birth because of the mal-positing of the baby. I was given rest only for a week in post partum period and then I started doing routine work. In the fifth week of post partum, my abdominal stitches were ruptured as I lifted a bucket full of water to be placed in the animal shed. Foe one day I did not tell any-one but then I gave up as I had unendurable pain. My mother-in-law instead of being sympathetic said women who are cursed and sinful

have to experience surgical births otherwise there are plenty of women in the village who despite being weak gave birth to healthy children through normal birth at home.

The narratives shared by women revealed their lack of information shared by the health professionals and the way they treated women which made them feel ignorant, uncertain and downhearted. Many women showed their dissatisfaction with the services provided at hospitals. Moreover, they were not sure why a particular procedure was adopted and they were just given instructions which they were expected to follow without any objection. This lack of information sharing puts women in a disadvantaged position. This coupled with the cultural perception regarding the procedure adopted influence women's choice of a health facility. As the above mentioned views of Seher highlight, a caesarian section is culturally perceived as a curse and punishment. Women also perceived it as the incompetence of the doctor who could not manage to successfully conduct a vaginal birth. The risk of undergoing a caesarean section helps explain why all those women who received antenatal care in the health facility did not turn up for the delivery and may finally have chosen to deliver at home as it makes them feel more relaxed and comfortable. Moreover, women also mentioned the caesarean birth at hospitals as being against their cultural norms. One of the respondents explained it as,

> *"Sheher kay husptalo main to aksar bara operation kertay hain wo bhi marad dactar or behoshi wala lamba suan bhi kamar ki haddi main zanana dactrain nahin legati wo bhi marad dacter hi lagata hay jo bari besharmi ki baat hay. Ye humara rawaj nahi kay ghair mardo kay agay banda nanga ho jaye."*
>
> A caesarean section is common in the hospitals of the city and that too is performed by male doctors and the big needle (injection used for anesthesia) is not inserted by lady doctors in the spine and that is also performed by a male doctor which is a matter of great shame. To be nude in front of stranger men is not our custom.

Hospitals are chosen in case of emergency or health risk or in the absence of family membersand the ability of home delivery. Moreover, the women stated that family and to a larger extent, community beliefs and norms influence health care decisions made by them. The circumstances in which they are placed can influence their choices. There are

no fixed rules and there were many women choosing both home and hospital delivery depending on their personal and social circumstances.

7.4.1 The Role of the Midwife in Managing Birth at Home

In the village, traditional birth attendants or *dais*have become an extension of the primary health care systemand provide reproductive health-related services for manypregnant women.Previous studies also found that village women have more trust in the skill and care provided by midwives. However,the findings of a study in a rural community in Oaxaca (Sesia 1996) revealed that midwives rarely implement the new skills in to their traditional practice of obstetrical care. The midwives admit that the reason for continuing their traditional techniques is because the pregnant women, their families, and the community all wish for the traditional care of a midwife.

Women mentioned that they inform the *dai* (traditional birth attendants) when their labor begins. Now-a-days *dais* do have mobiles and they can be contacted over the phone but traditionally a male or female relative of the patient visited the*dai's* home personally to fetch her to attend the woman in labor. The *dai*then checks the woman and tells her the expected time of the delivery. If there is little time then she waits there until the child is delivered and if there is much time then she gives woman herbal medicine or home made concoctions to sooth the labor pains.*Dais* are the famous practitioners of indigenous medicine in the village. Despite the availability of a government hospital and other private clinics for deliveries, still home birthing is a popular choice for many women we have seen. Women also said that these days *dais* are very careful and if they see any complications which are beyond their expertise then they refer the woman to the hospital.

First of all, *dai* checks the positioning of child and gives a massage to straighten its position. As mentioned by dai,

> *"Bacha check kernay kay liye pota lagatay hain hath pe dastana charha kay. Pachaas rupay ka paikat milta hay jis main 150 dastana hota hay. Her dafa nya dastana istamal kertay hain. Potay se hi puthay sidhay bachay ka pata chal jata hay. Jab duggi dhai inch kay faslay pe a jaye tu samjh aa jati hay kay kum nayray hay. Bar bar potay se check nahi kertay kionkay aurat ko dard hota hay. Ziada se ziada teen dafa."*
>
> To check the baby, a finger tip is placed inside after wearing (disposable) gloves on the hand. A pack of 150 (disposable) gloves is available for 50

> rupees. A New glove is used each time. The positioning of the baby is also determined by placing a finger tip inside (cervix). When the water bag is felt at the distance of two and half inches then it means the final stage of delivery is near. A finger tip is not used too frequently to examine as it is painful for the woman. Three times maximum.

The *dai* also administers various traditional medicines and applies other methods. She advises women not to make a noise as it will do nothing except prolong their labor. She asks the women to push downward and she also massages their stomach to ease the labor. *Dai's* fry onion in *desi ghee* (butter oil) till they turn brown and then apply it on a cotton swab which is inserted into the vagina. They also apply warm *desi ghee* on the perineum. *Desi ghee* is perceived as a natural lubricant which makes the birth canal more *coola* (greasy), which facilitates an easy fetal descent. *Dai's* also advise pregnant women to start taking *desi ghee* with hot milk in the last month of pregnancy. Women also explained the benefits of using castor oil with milk a few days before the expected time of delivery for an easy child-birth. Women frequently mentioned with pride the quantity of *desi ghee* consumed in their events of childbirth. They also use *desi ghee* with cloves, turmeric etc for the same purpose. Women informed that these traditional strategies applied by the *dai* prove to be very useful to speed up the childbirth. In hospitals they perform *chota operation(*episiotomy: a cut in the perineum) which later on takes time to heal. Women who went through anepisiotomy also mentioned the problem of frequent urination after childbirth.

The *dai* also hot compresses the back of the mother giving birth to provide her comfort and relieve her pain. The *dai* advises the woman to keep walking during the pain and hold the upper corner of any door or window to push downward. Moreover, the *dai* also asks women to vomit by putting their hair in their mouth or by falling on a washing machine for an easy fetal descent. The *dai* was of the view that usually the first delivery takes more time and the labour pains can be as long as 18 hours but subsequent deliveries are relatively easier and the labour time generally does not exceed more than 10 hours.

The *dai* also gives an injection in thigh (*sunj*) to sooth labor pains. The use of injections during delivery is very common among women in the village for the purpose to reduce labor pains. TBA said,

"Teekay lagana sahi hay kionkay wo darad khich laytay hain. Banda sakhalla ho jata hay. Aajkal aurto kay under bardasht koi nahi or wo kamzor bhi hoti hain kay ziada der zor laga sakain. Teekay se tame kum lagta hay or bacha asani se ho jata hay. Teekay do tarah kay hotay hain, eik 10 rupay ka milta hay or eik 50 rupay ka. Teekay pehlay se la ker fridge main rukh detay hain. Eik aurat ko do teekay lagatay hain, eik daen sunj main or doosra baen sunj main. Teeko se dardain taiz ho jati hain."

Using injections is alright as they take away labor pains. A person feels relieved. These days, women have little stamina and they are also too weak to push for a long time. An injection can reduce the labor time and make delivery easier. There are two types of injections, one is available for 10 rupees and the other one is available for 50 rupees. Injections are brought in advance and kept in a refrigerator. Two injections are given to one woman (giving birth), one (injection) in the right thigh and the second (injection) in the left thigh. Injections speed up labour pains.

The woman giving birth is supposed to wear a loose dress. She keeps wearing a shirt but the *shalwaar* (trouser) is taken off in the final stages of giving birth. When the bulging is seen at the perineum, the *dai* asks the woman to take her position for delivering the baby. The delivery is performed in all three positions - standing, squatting and lying but the most preferred one is the squatting position in which a woman sits on two bricks which elevates her from the ground. The females of the family have already arranged old and used clothes, *bori* (sack), plastic sheets etc which are spread underneath on which the baby descends. These used clothes and plastic sheets absorb blood and other leakings underneath the woman. Women wish and prefer night-time for their delivery so that all these activities taking place at home are kept hidden from other family members.

The *dai* and other females present try their best to provide all possible support for the mother giving birth. The two bricks are placed near to a *charpai* (cot)[64] and the woman in labour holds the frame of the *charpai* firmly and then pushes downward. The *dai* advises the woman in labor to push with every contraction. When the water bag breaks and the *dai* sees the bulging of the perineum, she knows that the baby is about to descend. The *dai* holds the baby to save him/her from falling on the cloth and puts pressure on the woman's abdomen for the expulsion of the placenta. The *dai* does not cut the cord until the placenta (*awal*) comes out. In order to speed up the expulsion of the placenta, the *dai* massages a woman's abdomen and often makes the woman cough by putting her hair in

[64] A bed with four legs and a wooden frame strung with interwoven rope

her mouth and also gives her hot traditional herbs to drink. Various kinds of traditional and spiritual methods are tried to take the placenta out. Women are also informed that in case of a delayed placenta the husband is asked to go to the roof and throw three stones and then the placenta comes out quickly. The *dai* and the females present also recite Quranic verses to expedite the expulsion of the placenta.The gender of the new-born isnot disclosed till the placentacomes out.The expulsion of the placental indicates that the whole process of child-birth has been completed.

Once the placenta comes out, the *dai* cuts the cord (*naru*) with anything available on the spot e.g. a kitchen knife, a sharp stone, a blade etc. The cord is then tied with the same thread used for stitching clothes. The *dai*then gives a bath to the new-born with warm water and cleans its mouth from any dirt. Then the baby is dressed and wrapped with a piece of cloth. Usually the mother or grand-mother wets her finger with her saliva and puts it in the baby's mouth which is known as *ghutti*[65] *dalna.* It is assumed that the baby is going to adopt the characteristics of the person who gives the *ghutti* (the baby's first food). The koal (*surma*) is put on the baby's eyes. Any male family members digs up a pit in the courtyard of the home where the *dai* buries the placenta.

The body of the new mother has to be kept warm and must be protected from cold. For this purpose, mostly a disprin tablet and boiled eggs are given immediately after childbirth. The *dai* does not onlyassist during childbirth but also provides apost-natal massage service and dietary advice to the new mother. Beside that, *dais* also provide treatment for common reproductive health problems like vaginal discharge, irregular menstruation, infertility, obesity, abdominal pain etc.

The majority of women preferred delivery at home with the assistance of TBA. One of the respondents said,

> *"Dactrain appko chor char kay chali jati hain nurso kay rehmo karam pe. Laiken dai to appkay sath rehti hay kafi tame tak. Wo gaon main hi rehti hay iss liye usko kabhi bhi bula lo. Wo ziada paisay bhi nahi mangti or bara lihaz kerti hay."*
>
> Doctors leave you unattended at the last hour and you are left at the mercy of nurses. But the TBA stays with you most of the time. She lives in the village

[65]The first food generally consisting of sugar and honey given to the baby after coming to this world.

so she can be called anytime. She does not ask for more money and they are quite considerate.

One of the respondents said,

> *"Husptaal janey ki kia zarooat hay, darad to eik hi jaisa hota hay chahey husptaal ho ya phir gher."*
>
> There is no need to go to hospital. The pain is same whether it is in hospital or at home."

7.4.2 Equipment and Remuneration of the *dai.*

Dais mostly do not have any special equipment except a knife and few herbal medicines and injections that are used for soothing the labor pains and speeding up the placenta expulsion. They tincture iodine to disinfect the baby's cord after it is cut. The bricks used for making a woman sit, the used clothes and plastic sheets to mange the mess and the water to give a bath to the new-born, a bar ofsoap to clean hands, are arranged by the family themselves. The *dai* is responsible for cutting the umbilical cord and the proper disposal of all the polluting items used during childbirth. In some cases, the *dai* also performs the task ofplastering the earthen floor with a mixture of clay and cowdung after the baby is delivered.

There is no fixed payment or remuneration forthe *dai*. Usually they are paid in both cash and kind. Their remuneration depends on the financial capacity of the family as well as the gender of the new born. A *dai* receives 500 to 2000 rupees in cash and sweetmeats and a three piece suit *shalwar qamez* and *dupatta* as remuneration or *mubarki*.

7.5 Protected Postpartum

The post partum period is locally known as *chilla* or *chaliyan* which mainly lasts for forty days followed childbirth and it is marked by many rituals and other social practices.

Interestingly, women themselves mentioned certain "unhealthy" actions such as not taking a shower during this postpartum period (*chilla*) because it has ill effects on their health, particularly in the form of pain. Unlike the periods of pregnancy and birth, the

physical vulnerability of a woman is explicitly recognized during the post partum period. During this culturally defined period of confinement, women usually do not engage in any household work.

Chilla is a period of ritual seclusion for a woman as they are considered impure after giving birth. Due to post partum bleeding, they cannot offer prayers and stay in a separate room and have no sexual contact with their husband. Mother and the baby are considered vulnerable and other family members try to protect them. Many respondents mentioned

"Qabar ka moon challis din tak khula rehta hay"

The mouth of the grave remains open (for mother and baby) for forty days.

The postpartum period is traditionally percieved as a time to recover and rest but there is considerable individual variation in terms of its adherence.

7.5.1 Diet during Confinement

To overcome weakness, some special types of foods are also prepared for women during the *chilla* such as *kaara, panjeeri, yakhni.*Therefore, food taboos and food proscriptions are common during pregnancy and postpartum.Women are supposed to drink warm water boiled with carom seeds during postpartum to remove unnecessary fats from the body and return it to a state of equilibrium.

Post partum bleeding is known as *nafas* or *gandakhun* which can last for the period of forty days maximum. It is considered highly polluting and for different women it has a different duration. The majority of the women said that their post partum bleeding does not last for longer than two weeks. Furthermore, women related the speed with which they returned to their normal routine work after giving birth to various factors such as the health and age of the mother, economic resources to spend on health, familial circumstances, and also the gender of the new-born. Women mentioned this fact that in case of a son, the attitude of family members is more caring as compared to the occasion of a daughter's birth. Mainly women talked about *chilla* as a time when their regular duties were suspended. Most women agreed that care is necessary atleast in the first two weeks after giving birth. If there are other females at home to assist in work then the woman in confinement will not do anything but if there is no one to help then she would do everything herself. Many times, the midwife who assists in the delivery visits the

house for seven days to massage the new mother and also to wash her and her infant's clothing which are considered ritually polluted (*napak kapray*).

Women prefer to spend their post partum period in the care of their natal family where they are well taken care off. Women said that they and the new born were pampered particularly by their own mothers during this time of physical vulnerability. Most women said that they serve their husband and their families but whenever they are sick and they need to be cared for then they have to look back to their natal home (*maika*)

One of the women explained,

"Ookhay time te mawaan hi khalnian hann."
The mother is the only support during tough days.

There are various traditional practices followed in *chilla* to cure pain and weakness. These include ingestion of certain substances with healing properties. For example, hot (*garam*) and nutritious (*taqat wali*) foods are fed to women during *chilla*. Women during *chilla* are supposed to avoid eating food with cold properties such as cold water, *lassi* (curd milk), fruits and they must eat *desi ghee*, eggs, *yakhni*, meat, fish and chicken to increase their hemoglobin and regain the lost blood. Women also avoid chilies. Instead their food (curry) is cooked with turmeric (*haldi*) and black pepper. Women were also traditionally fed *panjeeri* which is made with semolina (*sooji*) cooked with *desi ghee* and mixed with nuts which include almonds, raisins, pistachio, dried coconut and other dried fruit and grinded herbs such as salvia plebeian (*kamarkas*), lotus seed (*phul makhana*) and *charmagaz* which is a combination of four seeds (almonds, pumpkin seeds, cantaloupe seeds and water-melon seeds). The ingredients of '*panjeeri'* have heating properties (*taseer*) and it is mainly consumed to gain energy and also relief from pain caused by weakness. Women also mentioned another nutritious food which is made from floor cooked with milk and then mixed with almonds, pistachio and *charmagaz*. Women during confinement eat this whenever they feel hungry. It is considered good to provide energy and also to increase the quantity of breast milk.

After giving birth women are also given special hot drinks such as *kaara*, made from fresh milk boiled with dried fruit such as pistachio, dried dates (*chohara*), almonds and cardamom. This concoction is reported to help women produce sufficient breast milk. Another hot drink (*pakya pani*) is made with water boiled with carom seeds (*ajwain*), cardamom (*ilaichi*), aniseed (*sonf*) and cinnamon (*dal chini*). Women mentioned that this water is very useful to remove fats (*badi*) from the body and it is particularly useful to lose belly fats and extra weight women gain during pregnancy. It is also consumed as a kind of traditional medicine which helps to avoid constipation and indigestion. *Panjeeri* and *kaara* are costly foods and only consumed by those women who can afford them.

To increase the quantity of breast milk the mother is given high calorie, high fat diet. For example, a special root *sundh* (dried ginger) is cooked in *desighee* and crushed and mixed with sugar. *Bakray ki siri* (a head of a goat) and *bakri ojhri* (tripeman of goat) is also cooked and given to the new mother.

Women emphasized the role of a good diet to recover heavy blood loss (post-partum aemorrhage) after delivery. The blood deficiency is cured by consuming various types of food like fried mutton liver (*choti kaleji*) etc. One of the respondents said

> *"Goliyan garam hoti hain. Iss se behtar hay banda taqat wali khoraak khaye. Kamzori dawayon se nahi khoraak se theek hoti hay. Kachi pakki bakri kaleji khaney se naya khoon banta hay. Humari nanyo dadyo se yehi riwaj chala aa raha hay."*
>
> Tablets are hot. It is better to take rich food. Weakness is recovered from diet not from medicines.Eating shallow fried mutton liver makes new blood.This tradition has been continued from our maternal/paternal grandmothers.

During *chilla*a woman's body is dconsidered hot and it must be protected from cold. Manywomen reported keeping the room warm in which they stayed. They even took these precautions during summers and slept without a fan in hot weather just to avoid complications. One woman said

"Chillay main aurat ka jism kacha or garam hota hay agar chillay main thand se bachna chaye agar thand lag jaye to sari umer dard se jaan nahi chutti iss liye chillay main ihtiyat karne chahye thanday pani se, thandi hawa se or thandi cheezay khanay se"

During post partum a woman's body is weak and hot and it must be protected against cold. If a woman gets cold then she will suffer from body aches for the rest of her life. For that reason women must avoid cold water, cold air and cold food.

Most women wrapped their heads and waists with cloth during *chilla*. They believed that tying a piece of cloth around the head helped prevent headaches and prevented cold air from entering at the top of the head. Nottying the head meansthere are chances to suffer from a long-lasting headache. Women also wrapped their waists to stop air entering and to make their stomach small again. Women also reported that they do not watch TV or speak loudly as it may give them a prolonged headache. Similarly, women are not supposed to comb their hair or brush their teeth atleast for one week or untill the time they stop bleeding.

Full body massage is done for women during *chilla* and that is mostly done by the midwife. She does massage using hot mustard oil. It is a simple massage and any other female relative can do it as well. Massage is also considered helpful to prevent cold and air to enter into the body so that the body will not swell. The *dai* in the villages takes 2000 rupees for doing a full body massage for ten days. According to women, it prevents the body from swelling. Women do not take a bath during the time they have post partum bleeding and this practice was explained in terms of preventing water from entering the body. One respondent said,

"Mujhay yaad hay chillay main meri maa ajwain kapray ki potli main daal ker paani main pakati thi. Main uss pay baith kay uss pani ki dhooni laiti thi ta kay under ka gand bahir nikal aye or phir main wohi potli neechay rukhti thi taa k jab main garam pani se nahaon to pani ya hawa meray under na jaey meri maa kehti thi ye bara mufeed totka hay. Iss se jisam nahi pholta or na he under koi kharabi hoti hay."

I remember during post partum my mother used to boil water with caron seeds wrapped in a piece of cloth. Then I would sit on this pot of water to let smoke or vapor enter inside so that all the dirty fluids come out. Then I used to insert that swab of clothe into the vagina so that air or water do not enter in my body when I take shower with hot water. My mother said it is a useful tip as it prevents the body from swelling and internal infection.

Women should not bathe until they stop bleeding and the final ritual bath is taken on the 40th day after child birth which is known as *'chilla nahana'* which means to come back to the state of purification. Many women said that they distribute sweets or give alms to celebrate this occasion of having a successful birth.

7.5.2 Post-natal Care.

Women thus described the *chilla* as period of physical vulnerability that requires taking extra care to recover their weakness in order to ensure long-term health. They perceived *chilla* as a time of rest and healing.

The *dai* also provides post-natal services that include giving a bath to the mother and child, washing their dirty clothes, massaging the mother and child and advising the mother about use of traditional herbs and diet. Massage is considered very useful for pain relief and relaxation. Massage is done with mustard oil and sometimes with desi ghee as well. This helps to restore the mother's strength, heal any birth wound, and keep the mother's body warm. The *dai* said,

> *"Magar ki maalish achi hoti hay kionkay iss se doodh aata hay, sur ki maalish kero to chakkar nahi aatay aur pait ki maalish kernay se ganda khoon nikal jata hay."*
>
> A Shoulder massage is good for the release of (breast) milk, a head massage prevents dizziness and the abdominal massage is done to drain out dirty blood.

Women said that during childbirth all the joints of their body are open. So it becomes really important that women eat rich and hot food and massage their bodies daily for atleast ten days.

CHAPTER NO 8

FERTILITY REGULATION: INDUCED ABORTION & FAMILY PLANNING

Discourse on fertility regulation is significantly relevant to the lives of all women. Their decisions with regards to the choice of birth control methods and induced abortions are influenced by the social conditions around them. Though seeking abortion is medically putting the women's health at risk, yet the fear of relying on contraceptives or the inability to use any birth control method due to any personal or social reason outweigh the risks of opting for induced abortion. This chapter illuminates the various strategies women employ in order to regulate their fertility which, I discuss under the sub-themes (a) misscarriages and induced abortion (b) family planning practices. These themes elucidate how women make their reproductive choices and enact their agency in the context of their traditions and culture.

8.1 Local Perception of Abortion and Miscarriage

Abortion is perceived as sin especially if it is done after four months. Children are perceived as a 'Gift from God' and the attempt to induce an abortion is perceived as defiance to God. Women who undergo abortion feel guilty about it and try to keep it secret. According to them, such an attempt is made in *majboori* (of necessity) when there is no other option then terminating a pregnancy.

Misscarriage (also known as spontaneous abortion and pregnancy loss) is highly feared. Such women are avoided by other women as they believe that such a woman is possessed and that she can inflict her ill effect on other women and children. Women reported that they refrain from visiting that woman's home for sometime. They even avoid passing by her home to avoid any sickness or misfortune.

Due to mal-nourishment, disdain of precautions, absence of immunization and lack of detailed and regular check-ups by a doctor or trained midwife, the incidence of still-births and miscarriages is very high in the village but it is attributed to*purchanwan* (the evil shadow). *Purchanwan* is believed to be communicable. When a child or a woman suffering from *purchanwan* comes near a healthy woman or child, the other person will also come under that shadow. According to respondents, there are three major sources of

purchawan which include evil spirits and other supernatural being like *jin/pari*, infertile women, and those women who have miscarried.

When a woman experiences still-birth or miscarriages, she visits the shrine of Choha Shah Ghareeb and other shrines known for curing of childlessness. This spiritual healing is thus suplemented by special food such as a mixture of ground rice, sugar and water. These are given to a woman who has either miscarried or experienced a still-birth. *Nashasta* is also given to prevent miscarriages and still births. *Nashasta* is made from ground wheat, dry fruits, coconut, poppy seeds, and cucumber and melon seeds.

8.2 Induced Abortion

The act of induced abortion is locally described as "*safaikrwana*" (Dilation and Curettage) which means to get the uterus cleaned, '*bachaa girana'* (to drop the fetus) *or zaya kerwana,* meaning 'to throw out or to waste the fetus' and *'Qatal Kerna'*.[66] The perception of abortion being a wrong and sinful act was prominent among the respondents. It was perceived as something immoral and unacceptable by the majority of women but with exceptions depending on their situation when it is left as the only option. Women considered abortion to be more offensive when it is done after four months, when the fetus has developed. According to the women

"Chothay maheenay main Rooh aa jati hay'
The spirit enters the fetus in the fourth month (of pregnancy).

8.2.1 Shame and Secretiveness

Women were hesitant to discuss their attempts of induced abortion because of the intense feelings of guilt and shame associated with it. These feelings were often articulated in religious terms, as many women reported that abortion is just like a murder if performed at a later stage, four months onwards. The use of the word 'sin' indicates that it is

[66]In Pakistan abortion is illegal .The 1930 Law of Crime (Section 312) in the constitution of Pakistan forbids any attempt of abortion unless woman's health is in danger. It states that whoever voluntarily causes a pregnant woman to miscarry shall, unless such miscarriage is in good faith for the purpose of saving her life, is to be punished with imprisonment (Shah 1986:191). According to the findings of the study that was conducted in Pakistan in 2002, 14 out of 100 pregnancies end in induced abortions (Sathar *et al* 2007).

considered against the religious teachings and something for which they will be punished at the Day of Judgment.

Lack of spousal communication due to social norms prevents women from explicitly discussing reproductive health related issues including family size and the need forcontraception. Married women who are sexually active, but not using any family planning method are, at constant risk of unwanted pregnancy.

My key informants, including a *dai* (traditional midwife) and LHW, informed me that induced abortion is a common practice among women who wanted to get rid of an unwanted pregnancy. According to them, women try to induce abortion by using various clandestine and dangerous methods and when they experience any problem or complication then they come to them for a solution. Justifiable reasons mentioned for abortion were financial constraint, child spacing, limitation of family size, the sex composition of currently living children, etc. Furthermore, the decision to abort or to continue with an unwanted pregnancy is based on other social factors such as in the case of pregnancy outside wedlock and pregnancy at a later age.

Abortion in case of a pregnancy out of wedlock is perceivedas both 'sinful' and an 'infamy act' that destroys the honor of the entire family.Abortion is viewed as a relief and the only resort from the dishonor that is expected from the disclosure of an illegal pregnancy. As *dai* reported

> *"Kai bachiyon ki mayen jab unko pata chalay kay unki kanwari dhee pait se hay mere se rabta kerti hain. Wo bari pareshaan hoti hain doosro kay hatho zaleel honey kay khof se aur baghair shadi kiye beemar honey ki sharmindgi sey."*
>
> Many mothers of girls contact me after they know their unmarried daughter is pregnant. They are so depressed due to the fear of being ridiculed by others and being ashamed of a pregnancy out of wedlock.

Dai further said,

> *"Ghair shadi shuda larkiya mere pass lay atey hain kionkay unhain (parents) doosro se chupana parta hay. Najaez kaam tughair islami hay iss liye iss se honey wale bachay ko koi qabool nahi kerta."*
>
> Unmarried girls are brought to me as they need to hide it from others. As illegal sexual intercourse is unislamic so pregnancy resulting from it is not acceptable.

According to my key informants, being unmarried and pregnant means to be in the worst possible situation. My respondents did not openly acknowledge happenings of this kind but the *dai* who performed such abortions mentioned that extramarital relations leading to illegal pregnancies are rare happenings but their existence cannot be denied despite strict societal and familial control over young girls.

Due to the tradition of early marriages, many women who are sexually active and still in the reproductive span feel embarrassed when conceiving after their earlier children had married and they had grand-children. Women experienced mockery and they were looked down upon by others for giving birth in older age once they have become grandmothers. In such kind of situations, abortion was performed to avoid humiliation and shame.

Zahida who went through six DNC(s) says

> *"Mera blood pressure tez hota hay or bhi bimarya hain aur main manssoba bandi ki koi cheez istimaal nahi ker sakti. Mera mian bhi ehtiyat nahi kerta. Ubmera jawantra bhi hay or eik dotra bhi. Mujhay sharam ati hay tid nikaltay hoey. Ye koi munasib baat hay k main manji pe laiti hoon or jawantra mera kaka dekhnay aye."*
>
> I have high blood pressure and many other diseases and cannot use any contraceptive for health reasons. My husband does not use any precaution. I have a son-in-law and a grand-child. I cannot continue the pregnancy because of shame. It does not look appropriate that i am lying on a bed and he (the son-in-law) comes to see my new-born.

Regarding the side effects and health implications of induced abortion she further explained,

> *"Bachay zaya kernay wali goliya kha kha kay mera jisam phool gaya hay. Bachay zaya kraney ki waja say jisam main kamzori aur khoon ki kami ho gayi hay. Jab goliyo say hamal zaya na ho to machine say safai kurwani purti hay. Chaar maheenay say ooper time churr jaye to aurat ki jaan ko bhi khatra hota hay."*
>
> My body has swollen after the repeated use of abortion tablets. Induced abortion has caused weakness and anemia in the body. When pills do not abort pregnancy then one has to go for dilation & curettage. Woman's health is in danger if it is done after four months (of pregnancy).

Another woman reported that she had to borrow money from her neighbors as she has five children and her eldest daughter who is nineteen years old strictly warned her to leave home if she (her mother) bears an additional child. Her daughter lamented to her that instead of thinking about her daughter's marriage she herself is busy in child bearing.

8.2.2 Methods Used for Abortion

a) Home based methods

Women apply various home remedies to induce bleeding at the initial stage of pregnancy. Womenwho cannot afford to pay a gynecologist or any health provider or who wanted to keep their abortion secret usually resort to home remedies.

These home remedies include an intake of various food items such as *chohaaray* (dried dates), eggs, *sundh* (dried ginger), *kahva* (herbal tea), papaya, *ajwain* (onion seeds), carrot seeds, fennel seeds etc. Women also mentioned ingestion of various herbs such as *haliyo*, the traditional name for a poisonous herb used to induce bleeding. The root of *itsit* (traditional term used for a poisonous herb) is also kept inside the uterus to abort a pregnancy. Women also mentioned placing sharp edge of *murghi ka pankh* (Chicken's feather) into the opening of uterus to induce bleeding. Another clandestine method mentioned by the respondents was inserting matchsticks into the uterus to cause bleeding. The LHV said that many times women come to her with vaginal bleeding and cramping and then she has to clean the uterus where these matchsticks are retained.

Besides eating these things, women also adopt various other strategies such as jumping from a height, heavy exercise and weightlifting, massage on abdomen or by punching the belly etc. Women also mentioned different clandestine methods of having an abortion by placing sharp or dirty objects into the vagina, for example, insertion of metal sticks to induce bleeding.

c) Drugs/Oral Pills

Women also consulted the midwife and LHW in the village who provided them herbal medicine either for eating or to be placed inside the vagina to induce bleeding. They also provided women pills such as gynaecosid, which is specifically for the purpose of aborting a pregnancy. Women also mentioned taking aspirin, paracetamol and other pain killer tablets to induce an abortion. Women also mentioned that whenever they missed their periods and they hada doubtas to whether they were pregnant, they also take family planning pills (Familla 28) to induce bleeding. The LHV of the village informed me that

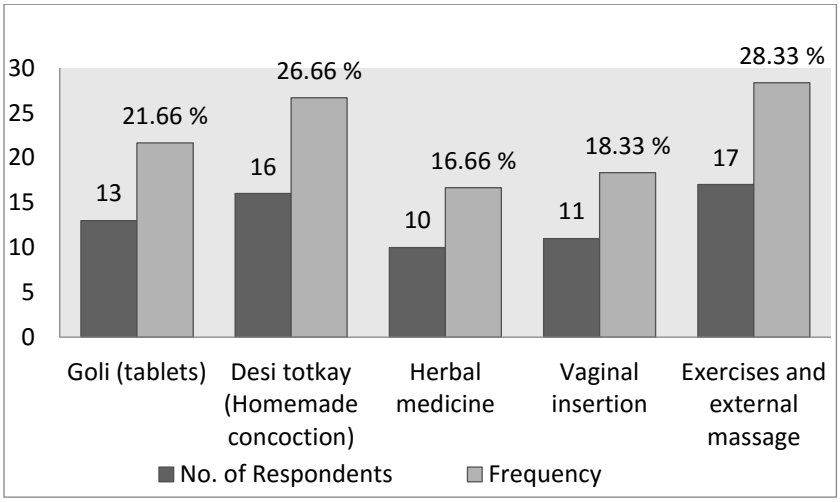
she uses injection named Methergine for causing an abortion and a tablet which is available for 150 rupees can also be used for this purpose. The cost of tablets varied depending on their quality and efficiency, and ranged from rupees 150 to 900. In her opinion, using tablets is the most effective and quickest method for abortion. She also said that women also keep Argat Capsules inside their uterus to induce bleeding. These capsules were available in dark brown color and made with fish oil. These were supposed to be very hot and quite effectively used for the purpose of abortion.

d) Surgical Methods

When the home remedies fail or the pregnancy is at a later stage, then women who wished to terminate pregnancy opted for surgical methods and the most common was dilation & curettage (D&C) which is mostly performed by doctors, nurses, midwives or LHVs. Women informed me that dilation & curettage (D&C) is a very painful process and it is done with a machine and so it has a high risk of wounding the insides of the uterus, infection and later on heavy bleeding. The LHV informed that she has this machine for performing dilation & curettage (D&C) but women also go to private clinics in Hassan Abdal and Wah Cantt particularly when they need to keep their abortion secret.

Women also mentioned some dangerous and clandestine procedures adopted by them to induce abortion. It includes insertion of roots of herbs through the birth canal which is a painful procedure.

Figure No 8.1 Methods Used for Abortion



Besides hospitals and health clinics, abortion is also performed secretly at the residence of providers such as the *dai*or the LHW who charge less and also keep it a secret.Women also said that they resorted to home remedies as the health providers like doctors and nurses in the clinics and even the TBA or LHW in the village take advantage of their situation (*majboori*) and charge more than the stipulated amount. Access to safe abortion services is restricted by law and for that reason trained medical practitioners were also reluctant to provide services in government hospitals due to a fear of prosecution. The cost of services in private clinics is also very high. That is why women prefered to contact the TBA or LHW who also charge them more money for doing a *safai* (Dilation and Curettage) as compared to their fee for assisting a normal delivery. The cost of abortion varied, depending on the situation in which abortion becomes the only resort and also how advanced the pregnancy was. Sayyida, the*dai* told me:

> *"Ghair shadi shuda larkiyan or wo jinka bacha pakka ho jaye unn se main ziada paisi laiti hoon. Mere khyal main ye meri bari reyat hay unke saath. Her koi iss kaam main hath nahi dalta. Ye okha kaam hay. Zindagi mot ka masla hota hay. Maa peo kay liye iss se ziada beizti kia hogi kay unki kunwari larki pet se ho jaye. Agay peechay ka bara pressure hota hay baghair shadi kay taluqat per or phir baghair shadi kay bachay jamnay per, issi liye to maa baap majoboor kertay hain betiyo ko bacha zaya kraney kay liye taa kay unki bachat ho jaye badnami se, be izzati se or koi masla na ho agey banda dhondney main. Baaz dafa log mujhay apnay gher bulatey hain kaam kerwaney k liye. Main burqa pehan k jati hoon taa k agey peechay kay log mujhay shanakht na ker lain phir gher waloo se puch perteet na shuru ker dain kain mera kia maqsad hay aney ka. Meim maghrib k baad hi jati hoon ta k purdah reh jaye. Ager main*

gher ja ker unka kaam keroo to phir wo ziada paisay detay hain 30000 tak bhi. Aurtain mere gher bhi ati hain bacha zaya kerwaney or main kuch ghanto main unka masla hal ker daiti hoon."

> I charge more for unmarried girls and also from those women who are in an advanced stage of pregnancy. I think, I extend them a big favor. Not everyone can do this kind of work. It's a difficult task. It's a matter of life and death. It is highly shameful for parents if their unmarried daughter is pregnant. Due to social pressure against premarital relationships and pregnancy out of wedlock, parents compel their unmarried daughters do an abortion to avoid a bad reputation, dishonor and problems in arranging marriage with a future husband. Sometimes, people call me to their homes to perform the procedure. I go their wearing a *burqa*[67] (veil) so people in the surrounding cannot identify me and probe the concerned family about the purpose of my visit. To preserve secrecy, I visit the house after sunset. They give me extra money sometimes up to thirty thousand rupees when I provide them home service. Women also come to my residence for abortion and I just solve their problem in a few hours.

The *dai* who is also an '*Aya'* (nursemaid) at the private hospital of Wah Cantt learnt to do abortion by observing the practices of Lady Doctors and nurses. She mentioned the use of abortion sticks available with the name of SEA TANGLE TENTS to extract the fetus. According to her,

"Iss lakri ni dundee pichay taga lamakna hay jari bacha dani ander rukhun honi hay. aye ander ja kay phul veni hay tay bachay ki jakar kinni hay. Fir taga kicho tay jara kuj banya hona hay baar nikal julna hay. Hika dundee naal 60 bachay zaya ho julnay hun. Hamal pakka wi ho jullay tay main zaya ker layni haan, paaway chewan maheena lug jullay."

> This wooden stick with a hanging piece of string is inserted inside uterus. It swells after reaching inside and captures the fetus. Then the string is pulled and the fetus comes out. It works effectively. One stick is used for 60 abortions. I can do an abortion in late pregnancy, even in the sixth month.

8.2.3 Reasons behind induced abortion

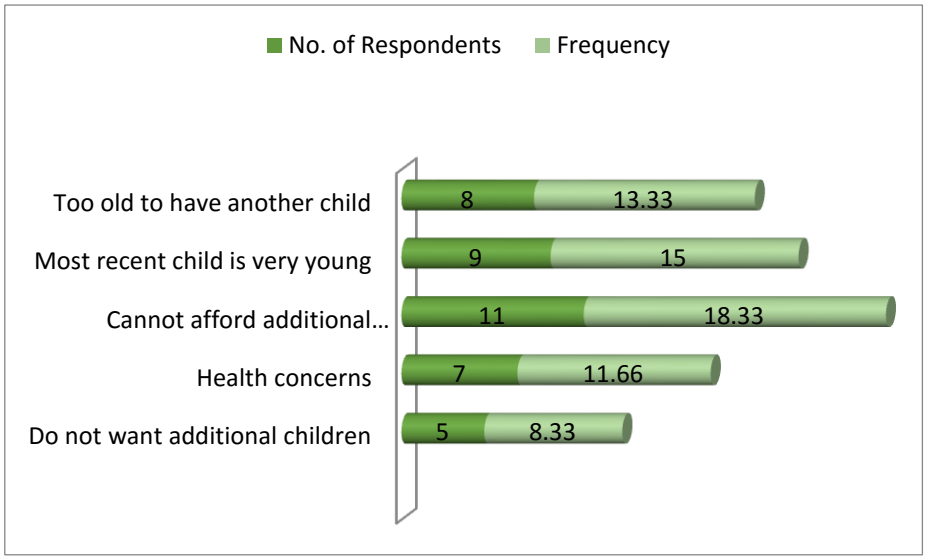
In-depth interviews with respondents revealed that the young married women generally usedthe word *safai karana* (cleaning of the uterus) to indicate abortion and senior women on the other hand, described abortion as 'wasting or murdering' of a fetus. Respondents gave various reasons for choosing abortion. This shift in the use of terms reveals the

[67] A kind of veil covering the body, usually from the head to the feet.

necessity and social acceptance of induced abortion now-a-days. Women gave various reasons for having an induced abortion that showed the notion of induced abortion is moving forward from being a sinful activity to a socially negative but necessary practice. Unintended pregnancy was the primary reason for seeking abortion. Women entered motherhood early but after completing a desired family size, pregnancies became unwanted.[68]

The table below illustrates various reasons for having an abortion and the most common reason cited was financial constraint and untimed pregnancy with the most recent child too young. The other reasons included late age pregnancy, health concerns and completion of desired family size.

Figure No 8.2 Reasons for having an abortion



[68] Protection from unintended pregnancies can help to avoid about one-fourth of all maternal deaths that occur in the developing countries. It also allows women to limit family size and remain healthy during their reproductive span (Sheraz and Zafar, 2010).

8.3 Awareness of Family Planning Methods

The key concept of family planning can simply be defined as “a program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control (Britannica, 1994). The practice of family planning among women in the locale is somewhatcongruent with contraceptive trends observed in the rest of Pakistan. According to the Pakistan Demographic and \Health Survey (2012-13), the majority of Pakistani women have knowledge of at least one method of contraception. injectables and the pill (95 percent each), female sterilization (91 percent), , and IUDs (86 percent) are the most popular and commonly known birth control methods among women, followed by male barrier method that is condoms (82 percent). Modern methods are more widely known than traditional methods; almost all the women know of a modern method, while 73 percent have knowledge of a traditional method. Survey results showed that the knowledge of injectables, IUDs, pills, and female sterilization are known to more than 85 percent of currently married women. As far as the use of family planning methods is concerned, 35 percent of currently married Pakistani women were using some kind of family planning; twenty six percent used modern methods, and nine percent opted for traditional methods. Among traditional methods used, withdrawal is the most popular method that is opted by 9 percent of currently married women. Interestingly, the use of withdrawal has doubled from 4 percent in 2006-07 to 9 percent in 2012-13.

The following table summarized the perception of currently married women with regards to various contraceptives.

1. **Condoms**: Women understood their husbands did not have much pleasure during intercourse through this method.They also reported that condoms cause blisters in their genitalia and weakens their sexual strength as reported by their husbands. At the same time, it was also considered risk free as compared to other methods but it could not be used unless the husband agreed. A few women also said that sometimes the condom breaks during sexual intercourse.

2. **Pills**: Birth control pills wereavailablein most pharmacies with or without a prescription. They were user friendly and it was up to the female to take it everyday at the

same time. But women frequently mentioned the difficulty of remembering its daily intake and so a few got pregnant despite their use of pills. Side effects associated with pills as mentioned by them includedhormonal imbalance and irregular bleeding, excessive bleeding and eveninfertility, nausea, loss of appetite, anemia, stomatch and weight gain.

3. **Intrauterine Device (IUD):** This was locally known as '*chulla'*or *'*Copper-T'and it functions as a foreign device in the uterus that prevents conception. This requires assisitance of the LHW or doctor and it is provider-controlled. The risks associated with IUDs are irregular periods, excessive bleeding, bloating, cysts in the uterus or overaries, and complications in becoming preganant again.

4. Coitus Interruptus or withdrawal: This was locally known as *'bahir farigh hona'*, which refers to the practice of withdrawing the male sex organ to stop sperm from entering into woman'svagina to prevent conception occuring. It required self control and cooperation of the husband. Findings revealed that the most common reason among women for the preference of withdrawal was the absence of side effects as compared to the above-mentioned female-based hormonal and surgical methods.

5. **Injecttons:** They were locally known as *'waqfay kay teekay' which* were avaiable for various durations but this method required female mobility and increased expenses to visit the service provider. In addition, women mentioned that injections are hot and the most common side effects associated with them were spotting and irregular bleeding.

6. **Female sterilization (Laparoscopy):**

The facility of sterilization is provided free of cost in government hospitals and it is considered only viable for those women who have completed their desired family size and do not want additional children. It requires permission from the husband for taking such definitive measures.

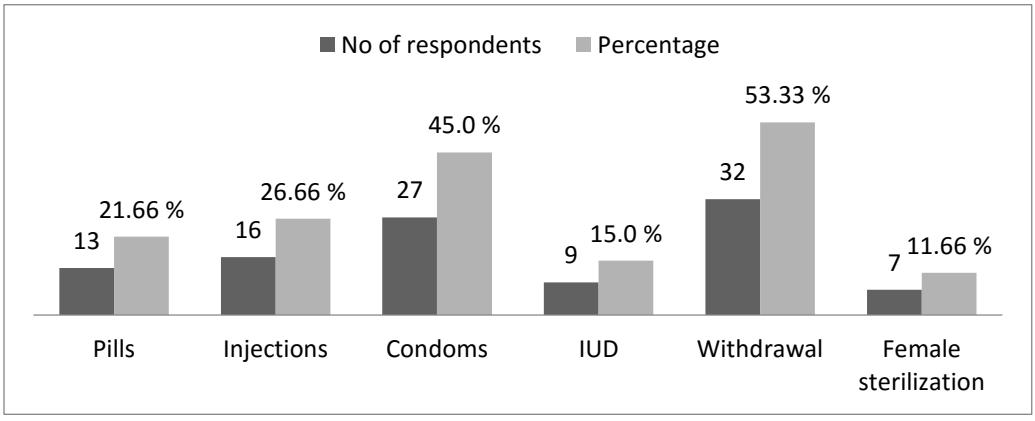
Sterilization is locally referred to as *'bachay bund kernay wala operation'*. It is kind of permanent method, although possible but very difficult to reverse process. Those women who have given birth to a desired combination of children of both genders were likely to resort to this method. Women showed satisfaction with these free government sponsored operations. They felt happy because they could keep the money for their own use. Some of the women confessed that they went against the wishes of their husbands and in-laws

who wanted more children or who considered it a sin. For example Sajida explained, *"I have five surviving children and my husband never agreed to use any birth control method. I desperately wanted to be sterilized but he did not allow. He has no permanent source of income. He works on daily wages and most of the times he comes back home with emty hands. My children had no food and clothes. Then my mother-in-law agreed that there is no need for additional children so I went to the hospital for the operation without telling my huband."*

5. Male Sterilization (Vasectomy): It was a popular and appropriate method for birth control and locally called '*murdana nusbandi*'. The negative response is mainly based on a religious argument that a surgical procedure that renders men infertile is against religion. Women reported that men generally were not willing to have a vasectomy due to the fact that childbirth affected their reproductive health most; it was considered their own responsibility to take precautions to prevent birth. Only one case of vasectomy was reported in the village which was done because a man's wife was sick and not fit for further reproduction or sterilization. Women unanimously agreed that men should not go for vasectomy. Rani stated, "*Vasectomy is not good for men as they have to work hard and lift heavy weights.*"

The following table shows preferred family planning methods among women.

Figure No 8.3 PreferredFamily Planning Methods



The total is not 100% as women knew or preferred multiple methods of contraception

8.3.1 Knowledge and Practice of Family Planning

Women in village Choha Shah Ghareeb were getting increasingly informed about family planning. The results of the in-depth interviews withwomen clearly showed this trend which is summarized in the following table.

Table No 8.1 Contraceptive Trends

Contraceptive Trends	**%**
Basic knowledge of any contraception	**95%**
Knowledge of modern family planning methods	**73.33%**
Knowledge of traditional methods of family planning	**78.33%**
Primary service provider:	Lady Health Worker and Lady Doctor
Primary source of information	The majority of women identified word of mouth or interpersonal communication with friends and relatives as the main source of information. In addition, women mentioned television as popular sources of information.

Information regarding the choice and effects of contraceptives is transferred fromwoman to woman through their lived experiences and sharing of narratives and this is considered more reliable.Women relied more on those around them for information which shaped their perception about using or not using birth control methods. Women were aware of pills, injections, Copper-T, condom and apart from these they also knew and practiced traditional methods such as withdrawal. The calendar method was not known to them.

Women mentioned various sideeffects caused by these family planning methods such as irregular menstruation, or no periods at all, backache, headaches, nausea,depression, dizziness, acne, loss of appetite, weight gain, spotting, blurred eye sight, excessive

growth of facialhair etc. However, the LHWs did not address these concerns, and women handled their apprehensions based on the opinion of those around them. As Saba indicated, she started using Copper-T on the advice of her sister-in-law

> *"Meri jaithani nay challa rakhwaya tha. Jab mera teesra bacha hoa to uss nay mujhay bhi yehi mashwra dia. Usne kaha kay goliyan garam hoti hain aur un se kamzori bhi hoti hay or sub se burh kay unka tu wakhta he rehta hay. Usne mashwra dia kay challa rukhwane se banda lambay arsey tak sakhalla ho jata hay."*
>
> My sister-in-law used copper-T and she suggested I do the same after my third child was born. She told (referring to her own experience) me that pills are hot and they cause weakness and above all, they are not convenient to use. She suggested that using Copper-T makes you feel more stress-free for a longer time.

The above mentioned narration showed that her source of information regarding the choice of contraceptive method was another woman from her family who had a bad experience with oral pills but she was convinced of the effectiveness of Copper-T. Saba relied on her sister-in-law's experience and it showed how the understandings of theseexperiences are co-constructed with other women and become a guideline forindividual decisions. Women said that they shared their experiences within their social network which becomesan entry point of knowledge for other women.

According to my respondent's views, the presence of LHWs is important for her as she maintains regular interactions with her. Being from the same community, women felt comfortable talking to her and the LHWs provided them with family planning awareness and contraceptives according to their needs. The LHW told me herself that she advises women to stop using injections or pills in case they experience any side effects and directed them to convincing their husbands to use condoms, which is the safest method and causes no damage to a women's reproductive system. According to the LHW women are free to choose any method of contraception. But when they fall sick due to any reason while using a contraceptive, they will associate it with the contraceptive. If any birth control method did not bring the desired result, they will assume the method was not effective but actually its use may be incorrect. Sanam told me her use of pills as,

> *"Main mansoob bandi ki goliya istamal keri thi kionkay wo menhgi bhi nahi hoti or asanni se bhi mil jati hain. Laiken maloom nahi kia hoa main*

unke istamal kay bawjood bhi hamla ho gayi. Main nay to baqaidgi se istamal ki thee. Ager kisi din main goli khani bhool bhi jati thi to aglay din eik kay bajaye do kha kay apni ginti sahi poori ker laiti thi."

I used family planning pills as they are not expensive and can be accessed easily. But I don't know what happened and I got pregnant despite their use. I used them regularly. In case I forgot to take the pill any day, then next day I would take two instead of one to make my counting correct.

Sanam's views regarding the use of oral pills shows her ignorance about the actual use of such pills. Pills are supposed to be taken daily at about the same time of day. Pills work effectively if they are taken as directed. They keep the correct level of hormones in a woman's body. Sanam stopped using pills as she thought pills were ineffective. Women's experience with the use of a particular contraceptive shapes their perception. Women develop apprehension about contraceptives when they hear about the experiences of those around them. Memoona talks about the side effects of injections and pills as

"Main teekay istimaal kerti thi or unki waja se mujhay baar baar dagh lagta tha. Main napaak rehti thi iss waja se or namaz bhi nahin purh sakti thi. Iske ilawa, meray periods bhi kharab ho gay thay. Her do haftay baad ho jatay thay. Teekon ki waja se main kafi bemar ho gayi thi or main phurti se ghar ka kaam nahi ker sakti thi pehlay ki tarah. Meri behan nay goliyan istimaal ki or ussay bhi buhat ziada bleeding hoti thi or uska jisam bhi phool gaya tha. Mere khyal main tu ye mansooba bandi kay tareeqay khatray se khali nahi. Inki waja se aurton kay jisam main koi na koi nuqas ho jata hay. Iss se tu behtar hay k banda kuch bhi na istamal keray. Jitney bachay paida kernay ho paida ker lay or phir operation kurwa le bajaye mansooba bandi ker kay beemar honay kay."

I used injections and I used to have spotting quite often. I remained impure because of that and could not offer prayers. In addition, my periods were also disturbed. I would have them every two weeks. Injections made me sick and I was unable to do my work actively like the way I used to do before. My sister used pills and she also bled a lotand her body was swollen as well. In my opinion, family planning methods are not free from risks. Women do get some sort of defect in their bodies because of them. It is better not to use any (contraceptive). One can have the desired number of children and then go for sterilization instead of getting sick due to practicing family planning.

Thus, experiential knowledge in the social network of women plays a significant role in informing women about the available choices and theireffectiveness. Memoona, like many other women became uncertain after hearing these rumors about contraceptives like

pills and injections. Though women become great sources of information for each other, their opinions regarding the side effects may not be entirely correct scientifically. Previous studies on family planning have also found a significant relationship between a woman's chances of practicing family planning and the number of contraceptive users in her network.Social networks may discourage women from using modem methods if the members of the network do not practice this type of family planning (Kohler et al. 2001).Communication about family size norms and the use of family planning play a significant role in changing fertility behavior (Mahmood and Ringheim 1996).

Family planning methods and their perceived viability is at the heart of discourse surrounding women's fertility control behavior. What made women more apprehensive was possible harm due to using these contraceptives. The findings revealed that inaccurate information may lead to negative perceptions with regards tovarious contraceptives. For example, women associated certain long-term side effects with the prolonged use of modern contraceptives. Like Shameem, who said about the adverse effects of Copper-T on her reproductive system:

> *"Meri shadi jaldi ho gayi 17 saal ki umer main or jab mera akhri bacha hoa tub main 30 saal ki thi or main mazeed bachay nahi chahti thi isi liye main nay mansooba bandi ka socha. Kai aurto nay bachay band kranay wale operation ka mashwra dia laiken mujhay operation se darr lagta tha. Mera khawand gubara istamal kernay per razi nahi tha aur uss nay mujhay keh dia tha kay ye mera masla hay kay main jaisay bhi keroon. Main nay kuch saheliyun se slah ki or yehi undaza lagaya kay challay kay kum nuqsaan hain. Main phir center chali gayi aur unho nay saal kay liye rukh dia. Koi khaas dard bhi nahi hoi. Meray jisam ko ye raas aa gaya tha iss liye paanch saal main nay yehi istimaal kia. Laiken phir mujhay buhat ziada menses honey lagay jaisay khoon ka nalka khul jay sirf mahwari main hi nahi balkay agay peechay bhi. Main mahwari main brufin kha laiti thi dard kay liye. Phir main nay challa bhi nikalwa dia laiken meri halat waisi hi rehi. Khoon itna zaya hota tha kay main kamzor or peeli zard ho gayi. Main lady doctor kay paas gayi tu uss nay bataya kay meri bachay dani main rasoli hay aur achi khasi bari hay. Uss nay mujhay durra diya kay ager ye na nikalwai tu aur bari hoti jaye gi aur phir ja kay ye cancer bhi ban sakti hay. Iss barey operation kay ilawa mere paas koi aur rusta hi nahi tha. Iss operation kay baad main buhat moti ho gayi. Sub log yehi kehtay hain lamba challa rukhwaney se ye sub kuch hoa hay iss nay mera saara andruni nizaam khrab ker dia."*
>
> I got married early at the age of 17 and my last child was born when I was 30. I did not want to have more children so I thought about doing family

> planning. Many women suggested to me tubiligation but I was afraid of surgery. My husband was not willing to use a condom and said that it is my concern how I do that. I just discussed the matter with some friiends and guessed that copper-T has fewer side effects. So I went to the center and they inserted it for one year. It was not very painful. I kept using it for five years as it suited my body. But then i had heavier menstrual flows just like blood started flowing from a tap not just during periods but also in beween periods. I used to take brufin so that I have less pain during periods. Then I removed copper-T but my condition did not change. Due to blood loss I became weak and pale. I consulted a gyneologist who said that I had developed a cyst in my uterus and it is quite large in size. I got scared as she said that if it is not removed it will keep growing in size and and ultimately can turn into cancer. I had no option other than this major surgery. I became obese after surgery and everybody says that it is due to the prolonged use of the copper-T which has spoiled my internal (reproductive) system.

Just like Shameem, there were other women who mentioned the fact that the long-term use of contraceptives can negatively affect the reproductive system and can even be a risk to their life. These fears include complications in getting pregnant again, infertility, infections, developing a cyst in the ovaries or uterus, period irregularities, pain during intercourse to more dreaded diseases such as cancer.This indicates that women may not be aware of the appropriate and adequate knowledge regarding harmful side effects and the management of family planning methods. Therefore, to ensure women's right to regulate her fertility, it is necessary that they receive accurate information and comprehensive counseling regarding the proper use of family planning methods to enable them to choose a method most suitable for them with a greater degree of self-confidence.

Many women mentioned that they prefered relatively safer methods such as withdrawal, condoms, abstinence, but these required cooperation from the husband. Apart from the fear of side effects, women also mentioned other personal and cultural reasons for not using contraceptives that included opposition of the husband or his family, religious concerns, difficult access to family planning services etc.

One of the respondents said,

> *"Munsooba banda kay liye condom sub se behtar hay. Teekay, challa aur goli sub koi na koi nuqas daal detay hain. Mitli, ulti, wazan ki ziyadti, kamzori waghera. Condom ka faida hay iss liye kay ye mard nay istamal kerna hota hay. Aurat ko iska koi nuqsaan nahi hota."*

> The condom is best for the purpose of family planning. Injections, Copper T and pills all have some kinds of side effects. Nausea, vomiting, increase in weight, weakness etc. Condoms have benefits as it is used by men and there are no side effects for women.

Naushin Mahmood (1992) in her study on contraceptives use in Pakistan suggested thatthe fear of a husband's opposition and the assumption that family planning would reflect an intention to avoid having children are two major concerns faced by women who wished to avoid pregnancy. However, what women understood is not always the reality because when probed by Mahmood, many husbands denied having a negative opinion about family planning. Her findings suggested that changing men's dominant role in reproductive decision making requires women'sempowerment to have the ability to negotiate choices (1992: 144).

In this study, the average duration of any contraceptive use among married women was up to 2 and half years. Therationale for limited use isthat the contraceptive was drop or switched due to side effects or due to a commonly held belief that prolonged family planning can create complications in becoming pregnant again.

8.3.2 The Right to Choose Family Planning Method

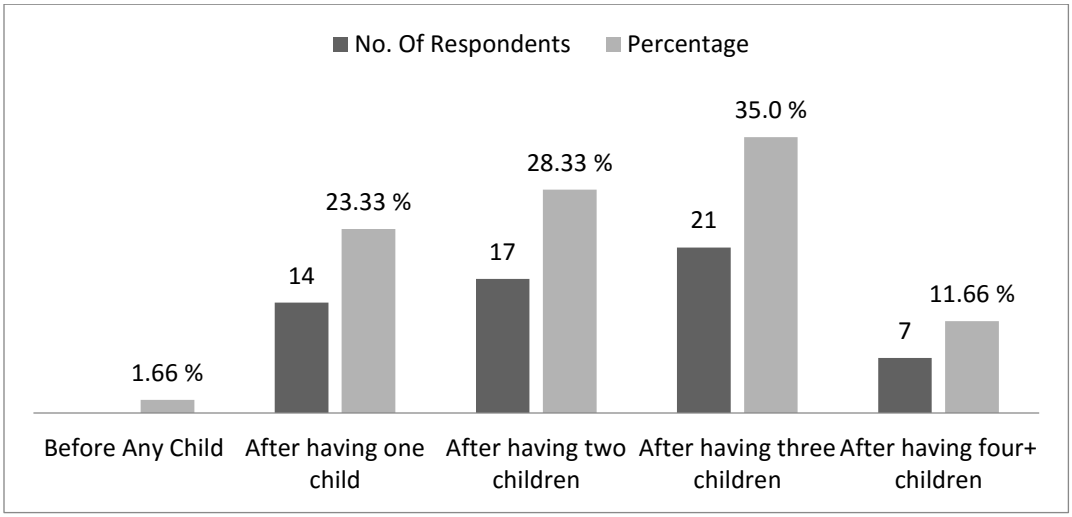
Women said that their tradition does not permit them to make family planning choices alone. They also mentioned that they neverthought about family planning at the time of their marriage because women wanted to become a mother as early as possible to secure their marriage and gain respect by giving birth to a child. Women mentioned reluctance to opt for birth control methods to delay the first birth for fear that it would annoy the husband and his family who wish to see *aulad* (children) and it may create some sort of defect in their bodies which may lead to permanent sterility. According to thePakistan Reproductive Health and Family Planning Survey (2000-1), the majority of the Pakistani married women gave birth to one child by the age of twenty, and that too within the first year of marriage, and the decisions related to pregnancy and family planning are taken by the husband and the mother-in-law (Mumtaz Z, & Salway S:2009).

Reproduction is accorded a central significance in married women‟s lives and the newly-weds are well aware of the fact that they have to adjust to the social expectation of being a submissive wife. They were ready to welcome multiple changes in their lives. They were socialized to keeping the husband and his wishes astop priority and they keep their marital life stable and peaceful, they must fullfill sexual obligations towards their husbands.

> *"Mard he roti kapra deta hay. Sari zimadari wohi poori kerta hay iss liye uski marzi kay baghair kuch bhi nahi kerna chahiyi munsooba bandi bhi nahi. Bachay jamna aurat ka faraz hay or kharchay pooray kerna mard ka kaam hay. Apni marziyan kerna aurat ko zeb nahi deta."*
>
> Men provide food and clothes. They fulfill all the responsibilities, that is why nothing should be done without his consent even family planning. Bearing children is a woman's duty and meeting their expenses is a man's job. It is not appropriate for a woman to exercise her own will.

The above-mentioned views show that social pressure to conform to the husband's wishes remains a powerful determinant in choosing family size. The majority of the women mentioned similar views that the decision regarding family planning and fertility control should be taken with the consent of the husband. In their opinion a man is responsible to earn a living for his family and he knows how many children he can support. Children carry his name and family lineage so his will matters the most from a cultural as well as a religiouspoint ofview. The following figure explains when the respondents started using family planning for the first time.

Figure No 8.4. Use of Contraception for the First Time



Those women who are practicing family planning against the approval of their husbands and families mainly cited "financial constraint" or *paisay ki tangi*as the major reason. One of the respondents who decided for sterilization without permission of her husband justifies her decision as

> *"Mere teen betay or do betiyan hain. Mera banda koi kaam dhanda nahi kerta. Iski laraki tabiat ki waja se isko glass factory sey bhi farigh ker dia. Phir iss nay dehari lagani shuru ki laiken buhat kum isko koi kaam milta hay. Humarey paas khaney ki koi shay nahi thi. Meri dewrani or jaithani jo soortehaal se waqif thi apna bacha khucha khana meray bacho k liye de daiti thi. Mera banda to poora din gher se bahir guzarta hay or bacho kay bhookay moon main dekhti hoon. Inn halat main meray liye mazeed bachay palna mushkil tha. Main nay operation kerwa lia. Jab meray khawund ko pata laga to usney mujhay kutna shru ker dia. Uskay bhayun nay mujhay maar peet se bachaya. Usne mujh se chay maheenay koi kalam nahi kia. Wo kehta hay,"main gunahgar aurat hoon." Laiken main apnay bacho ko bhook se marta nahi dekh sakti. Akhirkar main eik maa hoon."*
>
> I have three sons and two daughters. My husband does not work. Due to his bad temperament he was terminated from the glass factory. Then he started working as a wage laborer but it is seldom he finds work. We had nothing to eat. My sisters-in-law who were aware of this whole situation and used to give me left over food for my children. My husband spends the entire day outside home and it is me who sees the hungry faces of my children. In these circumstances, I could not afford additional children. I went for sterilization. My husband started beating me when he got to know this. Then his brothers saved me from his violence. He did not talk to me for six months. He says, *"I am sinful woman".* But I just cannot see my children dieing from hunger. After all I am a mother.

Another respondent denfended her use of birth control as,

> *"Mera eik beta or do betiyan hain. Meri saas aksar kehti hay kay uske baitay ka beto ka jora ho aur mera khawnd bhi mujh se kehta hay ke eik aadh or bacha ho jaye laiken humara kharcha mushkil se poora hota hay. Aajkal to roti poori kerna mushkil ho gaya hay. Agar to agla bacha larka hoa to phir uski taleem k kharchay kahan se pooray hon gay or agar larki hoi to phir teen betiyon ka jahez kaha se banay ga. Aajkal eik beti ki shadi bhi masla hay logo ki jahez ki lambi chori farmishain hoti hay. Halanken mera apna dil tha ke 2 larkiyan or 2 larkey braber ho jaen laiken hum bacho kay kharchay nahi pooray ker saktay ager khahish ho tab bhi."*
>
> I only had 1 boy and two girls. My mother-in-law often says that atleast his son should have a pair of sons and my husband tells me same to have one more child, but we barely meet all the expenses. These days it has become so diffiult to meet the expenditure of food. If I wil have another boy, then how are we going to pay for his education and if it's a girl then how I will arrange for the dowry of three daughters. These days marrying one daughter is problematic due to the people's demand of huge dowry. Although I also wanted to have equal children from both genders but we can't afford more children even if I want to have them.

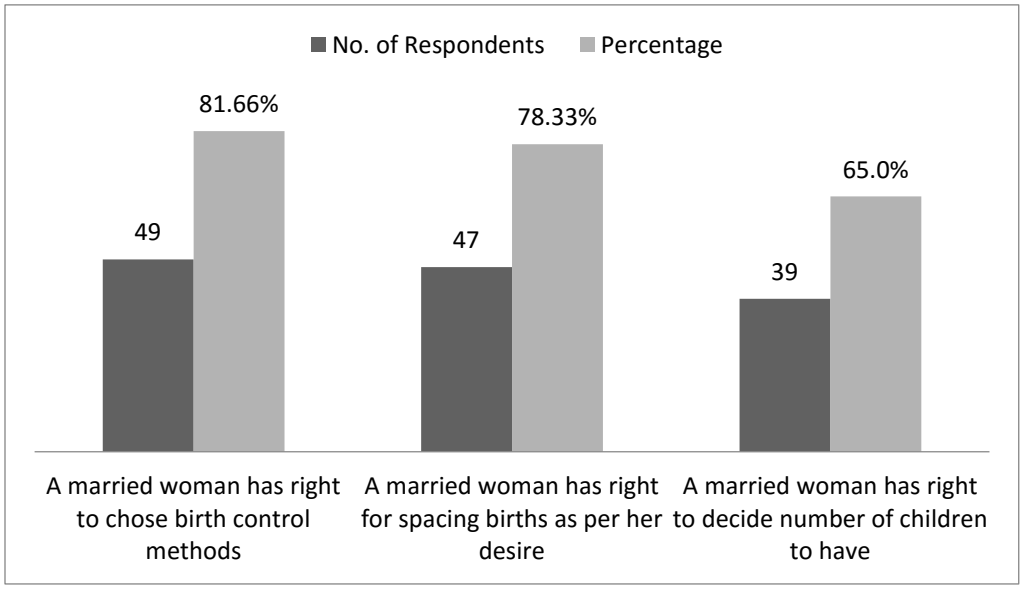
The rationale for family planning is given in the context of economic realities of the time. The above mentioned narratives show that women justified their decision of limiting family size not as their right but being compelled by financial constraints.Women considered *menhgai* (increased cost of living) put economic pressure on the household economy. But women could not overcome the social reality that the husband is their protector and their marital home is shelter for them.Analyzing women's responses reveals socio-cultural traditions that pressurized them to live their lives and also to keep reproducing in socially prescribed ways.

Women had knowledge of various contraceptives and could access them as well. The basic Health Unit is set up in the nearby village of Khuda Gharsheen. Moreover, viilagers with private means of transportation were able to access the nearby health facilities like the district headquarter hospital and all the other private medical facilities in Hassan Abdal and Wah Cantt.In Choha Shah Ghareeb village,the LHV provides door to door family planning counselling services as well as contraceptives to the eligibe couples in the village. Another local female who is also resident of the village left her job after

serving 9 years as LHV to run a private clinic at her home and she also offers basic health and family planning services to local clients. In her opinion,

> *"Ub to her koi munsooba bandi kay baray main janta hay. Jub main nay kai saal pehlay kaam shru kia tha tu ye lafaz kehna bhi be sharmi samjha jata tha. Humain jo government ki taraf se condom miltay thay wo dabbay hum tandoor main jala detay thay kion kay murdo se baat kernay ka tu sawal hi paida nahi hota tha. Ub bhi kafi aurtain aisi hain jo kehthi hain kay 'humara mard nahi manta'. Jab tak murdo main aurton ki sehat se mutalik jaan kari nahi hogi tab tak baqi sub koshishain becar hain."*
>
> Now everyone knows about family planning. When I started working many years back, to utter this word (family planning) was considered shameful. We used to burn condoms in an earthen oven which we received from the government (for distribution) because it was out of question to talk to males. Even now there are many women who say that '*our husband doesn't approve'*.Till the time when men are aware about women health issues, all other efforts are pointless.

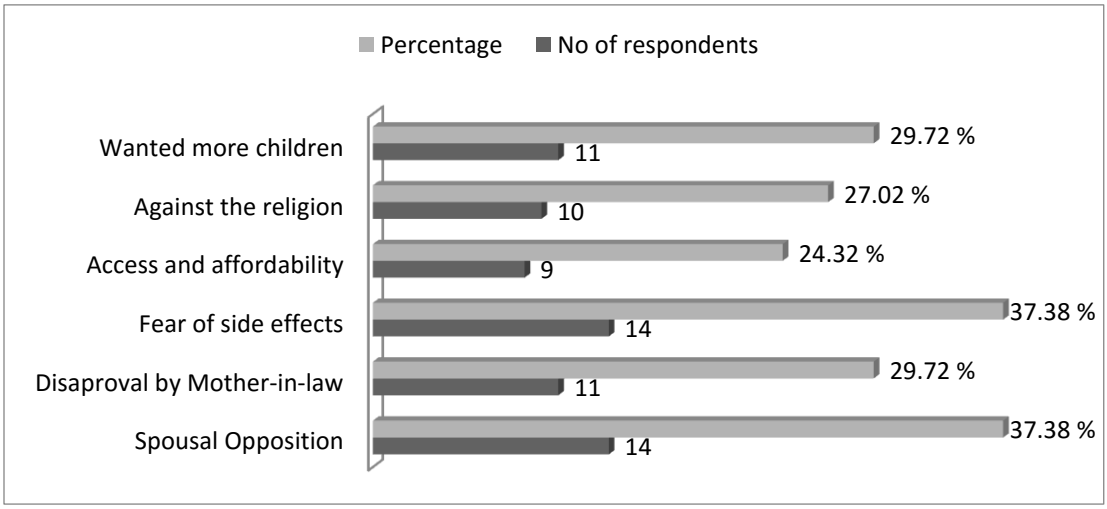
Figure 8.5 Women's Response to the Right to Fertility Regulation



The above mentioned figures show that 81.66% women acknowledged their right to choose birth control methods and 78.33% expressed their right to have a spacing/gap between children according to their own desire. Similary, 65% women acknowledged that it is the right of married women to determine their family size while the rest of respondents (35%) were of the view that men are the breadwinners and they are the ones who earn for their families and it should be their prerogative to decide the number of chidrens they would like to have.

Even as knowledge and practice of contraceptive has been slightly increased in Pakistan, and in this village as well, but the fact remains obvious that still many women were not using contraceptives despite their unmet need for family planning. Previous studies have also discused various factors that include women's restricted mobility, spousal objections, fear of the side effects, as well as poor access and longer distances to health facilities, religious opposition as major barriersin the adoption of family planning (Mahmood 1992;. Adil, et al 1984). Similar reasons were mentioned by the non-users of family planning in this study as well.

Figure No 8.6 Barriers to Use Contraceptives



Total is not 100% as there were multiple responses.

During interviews, it was frequently noticed a tendency to reiterate a real or constructed innocence and deny information related to sexual practices including reproduction and its control. Due to the link of contraceptive use with sexuality, it also became a taboo subject and women, especially younger women were found to be abit shy to discuss this issue due to the cultural sensitivity attached to it. The LHV said that women shared their concerns with her that they wanted to be updated with regards to the recent and available contraceptive choices but requested not to let their family members or other friends and relatives know about their visit. The LHV also mentioned that many wives reported that their husbands have strictly instructed them not to discuss their sexual practices *(miyan biwi ka mail)* with any other person even a female.

The nature of knowledge women shared with me regardingtheir own sexuality and bodywas not always medically correct. Instead, the information transferred through folklore passed on to them from older generations of women was more trusted. For instance, womenhad varying understanding of when they have the highest fertility during a monthlycycle? Many believed that they were most fertile immediately after their periods as the new eggs are formed and some said that their fertility levels remain the same throughout the cycle and one can conceive any time in the month. They had varying opinions with regards to the ideal time of intercourse. Many said that it should be at night as seeing each others sexual organs is a sin and moreover it can make you sick. One woman said that if a woman conceives as an outcome of intercourse that has taken place during the day, she is more likely to have a disobedient child. Similarly, many women believe that skinny women conceive more quickly as they are thought to be more fertile.

One important implication of these findings is the need to supply accurate information and knowledge of reproductive health, sexuality and various methods of family planning, including possible side effects, to all users.

8.3.3 Traditional Methods Used for Family Planning

Women also shared knowledge of certain herbs and oils that served as natural contraceptives, or even helped to increase the probability of conceiving a male child. Respondents mentioned the use of *phitkari* (alm) before having intercourse. According to them, the piece of alm equal to the size of a wheat grain must be kept in the opening of uterus before intercourse and it will not let the semen stay inside uterus and cause conception. Alm is considered antibacterial as well. It is least harmful and it also helps to keep the vaginal hole tight. Similarly keeping small quantity of *afeem* (a drug produced from opium poppies) inside the uterus performs the same function of avoiding conception. Women informed me that eating *arand ke beej* (Seeds of castor beans) after placing them in a capsule covering is useful for child spacing. Moreover, women also mentioned eating *surma*(the traditional name for kohl mostly used as eye cosmetics) which concentrates in the uterus and stops the conception to take place. It is a temporary method of birth control. *Kodi*(the traditional name used for a pearl found in the sea) is ground and given to women who have achieved their desired family size and did not want

more children. Eating the powder of *kodi* makes women *banjh* (sterile) and protects them from unwanted pregnancies.

Women also mentioned that a swab of cotton soaked with dettol or mustard oil and placed inside the vagina before intercourse makes it greasy. Women believed that these lubricants stopped conception. Women who wished to avoid pregnancy also mentioned that they preferred to sit in the squatting position immediately after having intercourse so that the *mard ka pani* (semen fluid) does not stay inside the uterus.

8.4 Spousal communication

Inter-spousal communication with regards to family planning and fertility control is recognized as one of the key factors that facilitates adoption and sustained use of modern birth control methods. In the village, the majority of the women were married at an early age with men who were older than them. Moreover, most of the marriages were arranged by parents. Previous studies have shown that the more say women have in selecting a life partner, the greater is the spousal communication about family planning and modern contraceptive use (Gage AJ: 1995; Haberland N, *et all:* 2003).

There is a lack of spousal communication on basic intimate issues and fertility control measures. Generally these kinds of 'instructions' on family size norms, use of contraceptives, etc. is shared among a network of women with the significant contribution of 'elder women' who have a different perspective on all issues pertaining to reproductive health, which they claim as their experience achieved after spending many years of married life.Women also mentioned their concerns associated with the use of iodized salt and free polio vaccine given to children under five years. According to most of the women, they would like to avoid both considering it as an attempt by the government to make people sterile in order to control the population.

Women considered communication on matters related to Family Planning benefitial for them. For example, Maria did not want more children as she already had three daughters and one boy. She wanted to be sterilized to ensure that she did not become pregnant again but her husband did not allow her, saying. "We have only one son.Who will look after us in our old age?" She said, *"I will keep talking to him and i am sure that i will convince him that if we limit our family size to upto four children then we can be better able to*

educate them and feed them and make them responsible. We will have no worries in our old age."

Many respondents wished to have effective and frequent spousal communication on various reproductive health matters, and they preferred to make reproductive decisions in consultation with their husbands without disturbing their marital harmony. Many women mentioned their limited decision making authority with regards to keeping their family size smaller. But they would give up their wish due to the fact that men are bread earners and so they have the authority to decide how many children they can afford to rear.They preferred to comply with the desires of their husbands and in-laws until they proved their fecundity by giving birth to a few children, particularly sons. After showing their actual reproductive performance, it becomes easy for them to negotiate their fertility preferences such as birth spacing, health concerns, as well as the financial constraints that prevent them from affording a large family. Successful childbearing is a way to attain conjugal agency.

The majority of the respondents agreed that they preferred to avoid discussing those matters with their husband which may annoy them and can become a cuase of conflict. That is why wives are hesitant about initiating a discussion with their husbands over mattters related to sexuality, reproductive health, family planning etc. They had to observe the mood of their husbands before starting discussion on these matters and they were very clear that husbands have the final word which they find difficult to deny or ignore. The majority of them thought child spacing beneficial for their health but again the the decision regarding the number of children to have, the use of contraceptives and the decision to abort rests with the husbands, keeping in mind the number of exisiting sons, as one of the respondents said,

> *"Larko kay shoq main mard purwa nahi kertay kay unki biwi ki sehat theek hay kay nahi"*
>
> In the passion of having sons males do not care about their wives health.

The women in village Choha Shah Ghareeb, however, despite being compromising also confessed that in certain situations it goes beyond their threshold of endurance. In case of closely spaced pregnancies, poor health conditions, and late age pregnancy, or in circumstances of extreme economic misery, sometimes they had to use contraceptives covertly or opt for an induced abortion without the consent of their husbands. Women also appreciated the involvement of men in contraceptive use and mentioned that they felt more confident where their spouses shared the responsibility for family planning and used condoms or withdrawal methods that saved them from the harmful effects of hormonal contraceptives. Overall, they wished for more cooperation from their spouses in this regard and their statements reveal that they understood the significance of discussing reproductive health related issues with their spouses.

CHAPTER NO 9

DISCUSSION AND CONCLUSION

Socio-cultural norms are of particular concern to reproductive rights as they play a significant role in shaping reproductive behaviors of people (Cook, R., 1994). This study of the reproductive rights of women in the Potowar region, was conducted in village Choha Shah Ghareeb, located in Tehsil Hassan Abdal, District Attock. The central argument of the study was to explain how reproductive rights are perceived and practiced by the married women of reproductive age group (15-49 years) living in this community.

Many scholars have argued that socio-cultural norms and traditions are often perceived to restrict women from exercising their reproductive rights by limiting their reproductive choices and reproductive decision-making. An'Naim, for example, argues that it is difficult to escape one's culture and it becomes imperative to acknowledge and understand the role of culture in the realization and practice of reproductive rights (An'Naim, 1995). The study explored women's knowledge about their reproductive rights and reproductive health care as well as their participation in fertility decision making and utilization of reproductive health services such as antenatal care, delivery and postnatal care.

9.1 Local Interpretation of Reproductive Rights

The Urdu equivalent of the term 'Reproductive Rights' is '*Tuleedi-Huqooq'* which literally means 'rights associated with reproduction or giving birth'. The term 'reproductive rights' was brought into widespread use by foreign donors, International declarations or 'Western' organizations. It is generally perceived as a western concept which is not easy to translate into the local language. However, despite the difficulty of translation, it was not an absolutely alien concept for the women.

The word 'right' has different local interpretations. For example, it is perceived as something 'good', 'fair', 'justified', 'acceptable' or 'correct'. The term 'rights' was locally known as '*huqooq'* which implies that it is something really significant for their wellbeing and it must be provided. For example, women explained that it is their right

that all their basic needs are met and their husbands and families must realize and fulfill the responsibility of their economic, social and emotional protection. They also mentioned that it is their *huqq* regarding their husbands that they shouldn't neglect marital responsibilities in terms of giving *muhabbat* (love), doing *purwah* (care) to their wives who leave their family behind and start living with them.

Women in the village did not perceive their reproductive needs exactly in terms of rights and could not express them in the language of an international declaration. When women were asked about their reproductive rights in a straightforward manner, many of them did not have a clue what was being asked but when respondents were probed about specific reproductive rights, such as (1) Right to marry (2) Right to decide the number of children they would like to have. (3) Right to choose contraceptives and abortion care services 4) Right to receive full information concerning their reproductive health, (5) Right to access health services during pregnancy, delivery and confinement, the majority of them recognized that these are their rights. The study explored which of these rights have more recognition and how many of them women actually exercised or wished to exercise?

In-depth interviews with women revealed that their health meanings, beliefs and decisions were situated contextually. In light of the lived experiences of women shared through their narratives the following key themes emerged which are central to comprehend the cultural context within which meanings of reproductive rights were constructed and embedded.

9.1.1 Socialization into submissiveness

This study investigated patterns of women's socialization through questions about their roles and responsibilities, and what was expected of them as daughters, wives, daughters-in-law and mothers. Findings revealed that girls right from the beginning were taught that their primary responsibility is to serve (*khidmat*) their family. To be compromising, flexible, submissive, faithful, docile, modest and selfless were most important features considered in the upbringing of girls. Women possessing these characteristics were valued and respected. Customarily, young girls were socialized to be obedient and taught

they must submit to the decision of their parents and to comply with the wishes of their future in-laws in the same manner.

Girls were not expected to discuss anything related to sexuality until they were married. They hardly received any information about puberty prior to the onset of menstruation. It was considered inappropriate and unnecessary that girls know these things before time. At the onset of menstruation, girls tended to consult their mothers or elder sister or friends who explained to them how to handle the bleeding and wash their dirty clothes away from the eyes of others. Young girls felt severely inhibited about asking questions regarding physical changes that had occurred in their body and they realized that keeping silent on women's health issues is also expected from a grown-up woman. They were just told that menstruation is a normal part of growing up. Women said that giving this kind of information to their young daughters in advance would spoil their innocence. They said that nobody disclosed this information to them when they were young and so they did not feel the need to discuss such issues with their daughters before puberty. The rationale given is that "it is not our tradition" *(ye humara riwaj nahi).*

Unmarried girls understood that talking about sexuality and asking questions about married life is a sign of shamelessness (*be hayai*). Women said that they were informed by sex just one night before marriage. Usually the mother feels shy to explain 'sex' to their daughters so a married sister or cousin is a source of information for the bride becoming somebody's wife. This information is limited to the sexual activity and knowledge about child spacing and contraceptives is not included. The study found that socio-cultural norms expect women to be submissive right from childhood which becomes the foundation for lack of control over their future reproductive health and incapacity to make decisions about themselves.

9.1.2. Preference for Arranged Marriages

The village Choha Shah Ghareeb has a traditional setting, where marriage was considered not exactly as an adult legal right, rather, it was perceived as a parent's prime duty and

religious obligation. The family, particularly the father, holds the primary powers in choosing husbands. Although the majority of the girls were aware that it is their religious and legal right to marry according to their choice but their mothers strictly advised them not to assert their personal choice in this regard as it was considered shameful. Therefore, all girls in their natal homes were socialized to accept their parent's wish as their own wish. The study showed that this belief is still popular among the women who were interviewed as they had the same expectation from their own daughters to submit to their parent's choice wholeheartedly. Interestingly, though findings from the qualitative interviews also indicated that due to the increased awareness created by TV, now young girls have also started conveying their concerns to mothers through an elder sisters or sisters-in-law whenever they felt the proposal was not compatible for them. Yet the notion of having a right to disobey a parent's decision about spouse selection is not well recognized. Similarly, Cherlin (2012) has also noticed a slight change in the ways parental authority is exercised in South Asia and mentioned that now a days parents tend to choose a spouse with their children's agreement. Field findings illustrated a clear preference for endogamous marriages as only 21.66 percent of women were married to non-relatives. The substantial reasons given for their preference included prior familiarity, mutual understanding, and ease in making marital arrangements due to the lower chances of deceit when marrying blood relatives.

Regarding the ideal age at marriage, it was preferred to marry girls as early as possible in order to protect their chastity and honor before marriage. Participants also mentioned the need to marry young so that healthy reproduction could be ensured. At the same time, they also emphasized the need to consider the future well-being of their daughters by marrying them when they are mature enough to meet the challenges of married life and when the maternal risks associated with childbearing would be lower for them.A recent study in Pakistan indicated that getting married after the age of 18 years and later decreased fertility by 29 percent compared to those who married early, before they turned eighteen. Higher age at marriage could reduce marital fertility among women by shortening the exposure length to the chances of pregnancy (Khattak, S. W., & Mustafa, K.: 2016).

Therefore, women's opinion in this study regarding the suitable age for their daughter's marriage may be an important indicator for predicting the future marriage trends in the area.

The cultural norm to accept parent's decision reinforced the tradition that parents are the primary decision-makers, and as a consequence, women were expected to keep their marriage intact even in the most distressing situations. Women said that divorced women experience social disgrace as people around them, without understanding the real factors that lead to divorce, blame the women as stubborn, quarrelsome or of bad character, unable to maintain their marriages.

9.1.3 Sexual Subservience

It was evident from women responses that being a submissive wife and daughter-in-law is the most essential quality expected from them. Non compliance with this expectation annoys the girl's parents as it is considered a matter of shame for her mother who could not socialize her daughter well. Thus, mothers had to fulfill this duty to groom their daughters into sexualized subservient brides. The majority of the respondents were of the view that they have to negotiate their reproductive rights in consultation with their husbands and families. Disagreeing with the husband and in-laws becomes a cause of conflict and may create tensions between families.

When specifically asked about their right to have or not to have sex with their husbands, the majority of the women agreed that they never like to refuse their husbands for religious and cultural reasons. Sex is considered as 'women's duty", "obligation" and a necessary requirement of married life. Women who attempt to challenge a husband'sauthority and to deviate from their traditional gender role as a wife may be put at risk of husband's violence since he perceives this as a threat to his honor and status (Head, S. K. 2012; Counts, et al. 1992; Campbell, et al 1999; Blanc, A. 2001). The results of this study have also shown women's apprehensions of bearing the threatening consequences in case of saying "No" to husband's desire to have sex. These consequences may range from verbal abuse, anger, suspicion to more severe reactions such as beating and forced sex. Women also reported that men cannot control their sexual

desires and refusing them can lead to a negative reaction as they seldom understood the reasons why sex was refused. Generally, many husbands tend to compromise on their sexual needs while their wives were pregnant but a few women reported that their husbands forced them to have sex during the pregnancy and postpartum periods. Women also expressed the views that fulfilling a man's sexual desires keeps husbands and wives closer and dependent on each other, and beside that a husband's unfulfilled sexual desires may lead to misunderstandings, suspicions, verbal abuse, separation and even abandonment. The male domination over females in their sexual relationships has been well documented in studies from other developing countries (Abdel Halim, 2001; Seeley et al., 1994; Connell 2000; Ruxton 2004) which suggest that men in patriarchal cultures are considered the owners of women's bodies,and this justifies for having coercive sex with a wife in case she refuses.

9.1.4 The construction of motherhood through socio-familial expectations

Bearing and rearing children are central to a woman's prestige, power and wellbeing in the rural socio-cultural context and reproduction brings real joys and benefits for women in their relationship with their spouse and his family. The results of the study elaborated that women perceived motherhood as compulsory and a natural outcome of marriage. The newlywed bride is expected to conceive right after marriage to meet the expectations of her husband and other family members. Previous studies conducted in Pakistan (Bhatti and Jeffery, 2012; Moghadam, 2003; Mahmood N. and Ringheim, K. 1994; Maitra and Pal 2008) also indicate women's intention to have a 'quick' child soon after marriage. Having a quick pregnancy meant compliance with social norms and family expectations. It became a prominent finding in this study as well that women themselves did not think of delaying their first pregnancy as becoming mother and having a child, particularly a son, were expected to increase their status in the family, and strengthen their conjugal bond and also reduce the danger of a husband's remarriage. Delaying the first birth and forming specific reproductive plans before giving birth to any child was regarded as unnecessary and unacceptable. Several studies have illuminated the social significance of motherhood emphasizing women's actual goal and achievement in becoming mother (Dutta, 2008; Gaddard, Victoria, 1987; Chodorow 1978; Mead, 1967).

Another important theme that emerged during the course of in-depth discussions surrounding reproductive rights was the question of a woman's role and place if she fails to bear healthy children, including specifically, at least one male child. The majority of participants agreed that infertility and childlessness is cursed and childless women are objects of pity, disdain, criticism, curiosity, exclusion and even condemnation, and are often treated as marginalized figure and seen as someone both personally unfulfilled and socially incomplete. Fear of social stigma, loneliness and marital instability compelled infertile women to seek multiple and novel ways to acquire progeny ranging from biomedical treatment (*dactriilaj*) and home remedies to spiritual healing.

9.1.5 Reproductive Health Care

Many scholars acknowledged that reproduction in many parts of the world is still to a greater extent regulated by socio- cultural and religious norms that hinder the way to achieve universal reproductive health worldwide. The majority of women in many parts of the world experience societal challenges in their attempts to access reproductive health care services (Correa, S. & Petchesky, R. 1994). In Pakistan alone, there is a high maternal mortality rate (MMR) ranging from 300 to 700 deaths for every 100,000 live births, which makes it vital to ensure better reproductive health care services for women (Smith et al., 2003). The present study also discussed how health knowledge, beliefs and health care behavior were shaped by family practices and social networks in the village.

a) Pregnancy &Ante-natal Care

Women constructed the meaning of their reproductive health care in the context of their traditions, local cultural practices, personal experiences as well as the experiences of other women around them. The dominant discourse among women considered conception and the act of giving birth as 'natural' and not requiring medical interventions. They were less likely to receive antenatal care from any clinic or hospital and relied more on their mothers, mothers-in-law, and other experienced female family members who had gone through all these stages. Care during pregnancy and confinement was generally considered the responsibility of other women living in the household. The women emphasized taking good diet instead of relying on medicine. They continued

doing daily work during pregnancy which made it very difficult for them to take 'time out' to visit hospital.

This study found that women also felt the importance of having access to professional medical care in case of a risky or threatened pregnancy to avoid risk and morbidities. They understood that with the help of doctors, they can solve their minor and major health issues ranging from weakness and body aches to miscarriages and infertility. Women tended to seek medical consultation when they were seriously sick and seeking medical treatments becomes inevitable. Similar finding were reported by the Pakistan Demographic and Health Survey (2012-13) that the ratio of receiving antenatal care from a skilled health provider declines with the increase in the number of children. Moreover, there is a large gap in the utilization of antenatal care services among urban and rural women. Sixty seven percent of rural mothers receive antenatal care from a skilled health provider as compared to 88 percent of urban mothers. Although WHO strongly recommends that a woman without pregnancy complications must have at least four antenatal visits to detect any possible health problems (WHO, 2006) still only 26 percent of rural women have four or more antenatal visits as compared to 62 percent urban women. Similar findings were reported by the Pakistan Population Assessment Report (2003) which says that two-thirds of pregnant women receive no prenatal care and the same numbers of pregnant women are anemic.

Many respondents shared their reproductive health-related complications and life-threatening experiences during pregnancy or after giving birth at home, when they needed a doctor but they were not being able to access a hospital or health care facility. The results of this study revealed various obstacles that hinder women's access to antenatal care such as the restrictions imposed by the family, restricted mobility, poor accessibility of services in terms of distance and cost, and hospitals being far making travel difficult during pregnancies. The findings of this study are consistent with many studies conducted in other developing countries which identified the influence of socio-cultural factors such as the number of living children, family size, religion, education, place of residence, occupation, etc. on the utilization of antenatal care among pregnant women (Celik Y. 2000).

b) Delivery and Childbirth

The right to receive health care during the maternal process was ranked first. However, women exercised reproductive rights in some realms, but not in others. The majority of them delivered their children at home depending on the assistance and skill of a traditional birth attendant. Other reasons for the non-preference of hospital birthing include fear of caesarian section, backache due to anesthesia, heavy blood loss, the long distance to reach hospitals, the non-cooperative attitude of service providers, family opposition, difficulty to pay medical bills, etc. Hospitals, for the most part, were perceived as being only for health emergencies. Women reported that mostly husbands have the authority to decide the place of delivery and generally they made decisions such as determining at what point the situation is dangerous enough that it warranted being taken to the hospital. The findings of this study support the National PDHS (2012-13) data that found more than half deliveries (52 percent) taking place at home.

The study revealed that the dominant discourse among women regarding delivery care was not based on the bio-medical understanding of reproductive health; rather it was based on the practices of women over generations. Most of the women mentioned that they agreed to deliver at home on the recommendations of their mother-in-law and mother and other married ladies who were mothers. That is how 'shared knowledge' is created which is transformed into accepted behavioral practices that are culturally reinforced. Young women don't question the authenticity of this traditional knowledge coming from older women out of trust and respect. Moreover, personal satisfaction with home delivery was found to be a significant factor women identified in this study. For them, the environment of home ensured more comfort, emotional support of other women, security, and honor.

c) Post Natal Care

Findings suggest the postpartum period was traditionally perceived as a time to recover and rest but there was considerable individual variation in terms of its adherence. The postpartum care is important for women, because of the increased chances of developing serious complications. Evidence suggests the large number of maternal deaths occur during the first 48 hours after delivery (PDHS 2012-13). As a result, thirty women die

every minute due to birth related problems, aside from the forty eight percent neo-natal mortality rate (Dawn, 2003).

The narratives of women revealed this fact that they did not consider the importance of formal postnatal care for preventive health care. Customarily, they preferred to spend their post partum period, a time of physical vulnerability, with their natal family for purposes receiving care and support. Furthermore, women related the speed with which they returned to their normal routine work after giving birth to various factors such as the health and age of the mother, economic resources available to spend on health, familial circumstances, and also the gender of the new born. The study reported various traditional practices such as special food and ingestion of certain substances to cure pain and weakness. Many other studies have highlighted the significance of understanding the health needs of women in the context of their culture and community thatactually defines how the notion of sickness, disease, and healing are viewed (Airhihenbuwa, 2007; Terry MA 1994; Sathar et al 1988; Grady WR 1993).

9.1.6 Fertility Regulation

Fertility regulation is recommended option for women as successive and unplanned pregnancies cause reproductive illness among women that jeopardizes their health and the children born by them. Many studies have found how culture can influence family planning practices by rejecting certain forms of birth control methods, or by rejecting family planning all together; the accord of a high social status and dignity to people having larger families; the support for those patriarchal values that deny or restrict women's participation in reproductive decision-making; and confine women to their traditional role of motherhood (Packer, C., 1996).The study has explored how women understood fertility regulation through the cultural scripts of their norms and traditions.

a) Knowledge & Practice of Family Planning

The present study also explored women reproductive autonomy and their right to decide number and timing of their children. While assessing their knowledge about modern methods of family planning it became evident that the majority of the respondents (73.33%) had knowledge of modern family planning methods.The notion of family

planning was*aam* (common) and married women freely discussed *mansuba bandi* (family planning) with each other. They identified word of mouth or interpersonal communication with friends and relatives as the main source of information in addition to other sources such as electronic media. The presence of the LHW ensured easy access to family planning methods, which created options that helped women to devise their own reproductive strategies.

The findings of this study highlighted that information regarding the choice and effects of contraceptives is transferred from woman to woman based on their lived experiences. Women were aware of pills, injections, Copper-T, condom and apart from them they also knew and practiced traditional methods such as withdrawal. The calendar method was not known to them. Beside that women also shared knowledge of home remedies that included certain herbs and oils that serve as natural contraceptives.

They mentioned various side effects caused by modern contraceptives such as irregular menstruation, or no periods at all, backaches, headaches, nausea, depression, dizziness, acne, loss of appetite, weight gain, spotting, blurred eye sight, excessive growth of facial hair etc. The results of this study are similar to those conducted previously which found 'health concerns' as a major obstacle to the adoption of contraceptives (Bongaarts and Bruce, 1995; Saleem & Bobak, 2005; Casterline et al., 1997; Yinger 1998). The fear of side effects and health concerns have been reported as a major reason for method switching and discontinuation of female methods- pills, injections and IUDs (Population Council, 1997). Many studies carried out in Pakistan during the past few decades conclude that the major reasons for the failure of birth control methods are the perception that family planning is unacceptable on religious grounds, opposition from husbands, lack of females mobility, discomfort of discussing family planning with the husband and, inadequate family planning services or fear of side effects of modern contraception. These factors make many women reluctant to use contraception thinking it against their best interests (Sathar and Casterline 1998; Sirageldin et al. 1976; Shah and Shah 1984; Mahmood 1992; Mahmood and Ringheim 1996).

It is pertinent to note that the most commonly used contraceptive was the condom, which is a male method of family planning. Among the non-users, the coitus interrupts method

was preferred, which shows the husband's cooperation and willingness to take responsibility to space births and limit family size. Hormonal or chemical methods such as injection and pills had adverse effects on women's health but they were mostly used in case of discordance between the husband and wife over the use of contraception. Some women also admitted that they managed to use contraceptives or got sterilized despite their husband's opposition. The findings provide some basis for suggesting that in Pakistan, the husband's disapproval to use contraceptives may wane in future.

Another aspect which this study illustrated is that the use of contraceptives is positively associated with the duration of marriage and women (35%) started family planning after having three living children. The same finding has been reported from other countries such as in Jordan and Oman (Tawiah, 1997; Al Riyami et al, 2004; Youssef, 2005). Moreover, respondent's views showed that although they were not in favor of having pregnancies without an interval they did not prefer very long *waqfa* (spacing between two births) as well. They considered it appropriate to have another child "on time", not later than two years.

b) Right to Choose Family Planning Method

The study also elaborated women's fertility decision-making and found that the majority of them (78.33%) acknowledged their right for spacing births and (81.66%) expressed their desire to choose birth control methods. But they wished to decide their family size and to control spacing between births in consultation with their husbands. Many of them were found to have little 'say' in reproductive decision making. Almost similar findings have been reported from India and Bangladeshi, that woman had little say in most fertility decisions (Cain, 1982).

Women living in extreme poverty strongly realized the need to keep their family size small out of financial constraints but still they had to forgo their own needs and wishes over the demands of their husbands and also those around them. They perceived their strength and security in terms of their good marital relationships and they felt it wise to maintain a good relationship with their spouse and their in-laws to avoid family conflicts. Women's choices were constituted in the realm of the family and its expectations. This

study also noted that women's desired number of children was not fixed and depended on the sex composition of children. Klitsch (1993) also noted that one in three women wanted to have no more children but the ideal number of children remained more than three children for the majority of the Pakistani women. Culture attaches more value to sons and women having three or more living daughters' desire additional children in the hope of having a male child (Sathar and Casterline 1998). This implies that reproductive rights are difficult to practice in a culture where a large family size is the norm and where sons are preferred over daughters.

The narratives of respondents presented in this dissertation reveal their preference for mutual and coordinated decision-making and believed that the decision regarding family planning and fertility control should be taken with the consent of the husband considering him head of the household who is responsible for earning the livelihood of his family, so he knows how many children he can support. They thought independent decision-making is culturally inappropriate and undesirable. For example, women clearly mentioned that the decisions on reproductive health related issues are not solely theirs; rather these decisions are routinely made by those living around them. They cited various barriers such as spousal opposition, disapproval by mothers-in-law, fear of side effects, access and affordability, religious concerns, against the religion, as the main reasons for not using family planning methods. The findings of this study are consistent with other findings which reported the influential role of husbands and their families in deciding the fertility options and behaviors of women, both directly, by opposing contraceptive use, and indirectly, by not allowing them to visit a health center alone and restricting their mobility, or by reinforcing son preference. Studies indicate that a husband's opposition alone led to a reduction in contraceptive use by 66 percent (Bongaarts and Bruce, 1995). These social restrictions and barriers discourage women from exercising their reproductive rights. What is suggested is that women's reproductive issues must lie within their own domain to freely decide what is best for them (Kazi and Sathar 1997).

It is worth discussing here the issue of 'son preference' that is well documented in this study and that determines family size and influences the fertility intentions of women. The study showed that women having an appropriate number of sons were more willing to practice birth control compared to those with none or only one son. This finding is

endorsed by other studies conducted in Pakistan, Bangladesh and Morocco, which also reported that women with more living sons are more prone to use contraceptives to reduce number of births (Head, S. K. 2012; Fiona and Jan, 1999; Saeed, S 2012; Cater, A.T. 1984; Mahdy and El-Zeiny, 1999). In other words, the greater the number of male children, the more potential advantages they are likely to bring for their parents. But in practical terms, the physical pain and suffering women experience due to frequent childbearing outweightsthe expected benefits that a large family brings to them.

Field data suggests that now fertility decisions of women are influenced by changing socio-economic conditions. The earlier perception that family planning is a sin that would be questioned in the afterlife still exists but now women have developed alternate views and they also mentioned their *majburees* (compulsion) if having to afford the living cost of a large family. Men's occasional *mazdoori* (wage) who earned less made it difficult to afford so many children. They also mentioned future aspirations and a better life style for their children. They expressed their concerns and responsibilities towards the proper upbringing of their children. Although women considered that *menhgai* (increased cost of living) put economic pressure on the household economy, but women could not overcome the social reality that the husband was their protector and their marital homesa shelter for them. Analyzing women's responses reveals that socio-cultural traditions pressurized them to keep reproducing in socially prescribed ways.

c) Choosing Induced Abortion

Women perception of their right to abortion was also assessed. Women perceived abortion as *gunah* (sin) but they also said that it becomes unavoidable and necessary in case of unintended or mistimed pregnancy. The health risks caused by induced abortions were known to them yet they could not comply with the cultural and religious norms when confronted by a situation where abortion was the only remedy. Almost similar evidence has been suggested from rural Bangladesh where women opt to terminate pregnancy autonomously incertain situationsdespite their preference for joint decision-making with their husbands (Ahmed, Islam, & Khanum, 1999; Gipson & Hindin, 2008).Women who attempted induced abortion mentioned various reasons such as

financial constraint, unintended pregnancy, late age pregnancy, child spacing, limitation of family size, the sex composition of currently living children, out of wedlock pregnancy, etc. Abortion was less likely to be considered as a sinful act when their *majboori* (compulsion) was taken into account.

They also mentioned various difficulties in accessing abortion related services. As abortion is considered shameful, it is preferably kept secret. Women resort to various clandestine methods such as homemade concoction/herbal medicine, vaginal insertion, exercises and external massage, oral pills, etc. to induce abortion at home by themselves or with the assistance of older ladies or a traditional birth attendant. In the case of a mature pregnancy, they also opted for surgical methods such as dilation & curettage (D&C) which was mostly performed by doctors, nurses, midwives or LHVs.

d) Spousal communication

Inter-spousal communication with regards to family planning and fertility control is recognized to have a pronounced effect on the sustained use of modern birth control methods. In the village, the majority of the women were married at an early age with men who were older than them. Moreover, most of the marriages were arranged by parents. Previous studies have shown that the more say women have in selecting a life partner, the greater is the spousal communication about family planning and modern contraceptive use (Gage AJ, 1995). Cultures where spousal communication is promoted through media campaigns got an increase in the contraceptive use leading towards reduced fertility (Sharan and Valente, 2002).

This study revealed that women agreed to avoid discussing those matters with their husbands which may annoy them and can become a cause of conflict. They did not want to say or do anything offensive for their husbands and in-laws. Particularly, newlywed couples had no communication with regards to contraceptive use and women knew a child is expected from them. They were happy to comply with these expectations. That is why wives are hesitant to initiate discussion with their husbands on reproductive health issues, fearing a negative reaction from their husbands. This fear factor inhibits many women from practicing their reproductive rights and voicing their reproductive concerns. The same findings have been documented in other studies highlighting women's limited

exercise of their own judgment and their making of decisions based on their personal interests (Zaka, N 2012; Basu 1992; Jejeebhoy and Sathar 2001; Dyson and Moore 1983, Das Gupta1996). However, in this study after giving birth to a few children, particularly sons, women's communication with their husbands and their participation in fertility decision-making improved.

9.2 Application of the Approaches of Medical Anthropology

Theoretically, the present research was grounded in the field of medical anthropology and followed a critical approachand interpretive theory which, according to Green (1998) emphasizes the significance of narrative and lived experiences. In particular, my analysis of reproductive rights perception and practices drew on narrative accounts of women's reproductive health care and it was also influenced by studies that incorporated socio-economic, cultural and religious dimensions regarding women's reproductive roles, son preference and infertility in traditional and Islamic societies (Ali, S.M. 1989, 1999, 2000, 2001,2006; Inhorn 2002, 2006a, 2006b; Unnithan-Kumar, M. 1999, 2002, 2010a, 2010b; Fikree et al, 1993, 2001; Mumtaz Z & Salway S. 2003, 2005, 2007, 2011; Khan, A. 1999; Winkvist, A. & Akhter, Z.A. 1997, 2000; Basu, A. M. 1992; Jeffery & Jeffery 1993, 2002; Kazi et al, 2006; Saleem & Bobak 2005; Rozario, S. (1995); Khawer Mumtaz. 1987, 1996; Petchesky, Rosalind P. 1998a, 1998b; Jejeebhoy, S. J.1995, 2001; Sathar Z & Kazi S. 1990;1997; 2000; Mahmood, N. 1992a, 1992b, 2012).

The use of an interpretive approach proved relevant in exploring connections between various socio cultural factors that facilitate or impede women's fertility objectives and reproductive rights in this research. Thus the use of an interpretive approach was helpful to understand the local worldview of reproductive rights from the perspective of those who experienced them.It emphasized that individual behavior and decisions cannot be separated from the context. For example, pregnancy as a major reproductive event cannot be understood only as a product of woman's fertility intention but that it should be conceptualized as a result of multiple socio-cultural influences.Moreover, pregnancy amplifies women's own social recognition. Women's ability to avoid unwanted pregnancies may be constrained or facilitated by factors such as the husband's behavior,

the absence or presence of supportive family members, societal values regarding the desired family size, availability of appropriate health services, etc. Thus the decision to have children is reflective of the norms and beliefs of the family, the culture, and the community.

The use of critical medical anthropology emphasized the need to take into consideration issues related to power, inequalities, and structural barriers.. It focuses on the pattern of social relationships that shape human behavior and actions.In this study gender role socialization patterns were studied that revealed how gender inequalities were constructed and reinforced through a socialization pattern that treats men as dominant and powerful and by teaching women to be submissive, modest and subjugated.

Critical medical anthropology contextualizes individual health seeking-behaviors within a broader framework to acknowledge the role of culture within the complex issues of power and controlin relation to health. This study provided numerous examples of power inequalities where women had to submit to the authority of their parents while selecting a spouse for them, where they had no control in deciding the number of children because they were economically and socially dependent on their husbands, where they needed written consent of spouses to be sterilized and where they had to experience the opposition of a mother-in-law in seeking reproductive health services.

Agency and resistance are the main features of the critical approach. In the critical analysis, attention was paid to explore those areas where women excercised their agency such as the covert use of family planning and induced abortion where they had to respond to their own health needs to protect themselves from excessive and unwanted child-bearing and when they were not willing to have too many children in poor economic conditions. At the same time women ‘resistance’ to certain cultural norms and practices was observed in case of ‘son preference’, ‘sexual obedience and compromise to keep marriages successful’ and also when they preferred home-based delivery and resisted the formal health care system to adhere to the authoritative knowledge of elder women and in response to family pressure.

9.3 Conclusion

This research indicates that socio-cultural factors carry substantial weight in the recognition and practice of reproductive rights. What is quite obvious is that women in village Choha Shah Ghareeb had knowledge of their various reproductive rights, yet because of their social circumstances, they were not able to access all of them. The study concludes that the neglect and resistance of their reproductive rights to a greater extent originates from their own socio-cultural context. Women feel reluctant to voice their concerns and many times they have no choice except to submit to cultural expectations regarding their traditional role of proving themselves mainly as good wives and good mothers. Despite women's knowledge of all the sufferings related to traditions, they did not think to change these. Breaking customs may have dire consequences for them. Women not complying with cultural norms have much at stake. Traditions and values reinforce women's subordination leading towards early and arranged marriages, non consensual and coercive sexual relationships and unregulated fertility, factors that significantly affect women's reproductive lives. Excessive childbearing, continuous pregnancies, unsafe abortions take a heavy toll on their reproductive health. What is irrefutable is the fact that the only precondition needed to improve the state of women's reproductive rights is their recognition and acceptance of changes in their culture.

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APPENDICES

APPENDIX No 1

Interview Guide for Semi-structured Interview

BasicProfile of the Respondent 1.Name

2.Age

3.Marital Status

4. Total Number of children

a) Male b) Female

5.Number of still births

6. Number of miscarriages

7. Number of abortions

8. What is your education?

9. What is your husband's education?

10. Are you currently working for any paid job? If yes, then your total monthly income from that job? 11. What is your husband's occupation? 12. Monthly income?

13. Do you and your husband own any land on your name? 14. What is the type of family in which you are living?

1. Nuclear

2. Joint

3. Extended

Understanding of 'Reproductive Rights'

1. What do you know about "Reproductive Health Rights"?
2. What are the most important components that must be included in your reproductive rights?
3. In your opinion, do women are entitled for the following reproductive rights?
   a. It is a right of women to decide when and whom to marry
   b. A woman has a right to seek divorce if she is finds herself in unhappy marital union?
   c. It is a right of women to have complete information with regards to her reproductive health care
   d. It is a right of women to access all RH Services without discrimination
   e. It is a right of married women to decide the number and timing of children according to her desire.
   f. It is a right of married women to freely choose any family planning method to control her fertility.
   g. It is a right of married women to make her own decisions concerning her health such as such as choosing contraceptives, place of delivery, sterilization, type of health facility etc.
   h. It is a right of married women to receive better nutrition, and full care during pregnancy, child birth and in post partum period

4. Does recognition of entitlement to any particular reproductive right lead towards its exercise?

Theme 1 Marriage

1. What was your age at the time of marriage? 2. What was your husband's age at the time of marriage? 3. What is the current age of your husband?
4. Did you get married with your cousin or is there any blood relationship between you and your husband?
5. Who took the decision of your marriage? 6. Did your parents ask for your opinion while selecting a spouse for you? 7. If you have a daughter, would you like to have her opinion while choosing her future husband?
8. In your opinion, what is the ideal age for a girl to marry?
9. What kind of wife parents prefer to choose for their son?
10. What kind of husband parents prefer to choose for their daughter?
11. What are the essential qualities of an ideal wife?
12. What makes an ideal husband?
13. What is your opinion about married life?
14. What a woman should do to make her marriage successful?
15. How important children are to secure marriage?
16. Should a woman seek divorce if she is not happy with her husband?

Theme 2 Menstruation

1. At what age you had your first menstrual period?
2. Did you know about menstruation before?
3. Who informed you about menstruation and what?
4. Were you explained to take any precaution during menstruation?
5. Are you satisfied with the type of information received,
7. Do you suggest girls should have prior knowledge before reaching menarche and what should be their source of learning?
8. Are there any restrictions associated with puberty? 9. Did you experience any problem during menstruation
10.Whom did you consult about your problem and how it was treated?
11. Is there any linkage between puberty and reproduction?

Theme 3 Sexuality

1. Do you think that the wife has the right to refuse her husband for having sex in case he has any infection or sexually transmitted disease?
2. Do you think that the wife has the right to refuse her husband for having sex in case she is tired or not in mood?
3. Do you avoid intercourse during pregnancy if yes till when?
4. If your husband wants to have sex during pregnancy or in post partum period but you do not want, then what do you do and In case you say 'no' then what is the reaction of your husband? 5. Have you ever practiced voluntary abstinence to avoid pregnancy?
6. Are you satisfied with your sexual life?
7. How many times it is appropriate to have sex in a week?
8. Who takes initiatives in sexual matters?
9. Can a wife express her sexual desire to her husband?
10. How important it is for a wife to sexually satisfy her husband?
11. Do you think sexual satisfaction play any role in marital harmony?
12. In case you have any problem in sexual relations then whom do you consult?
13. Do you have complete privacy to enjoy sexual intimacy with your husband?

Theme 4 Motherhood and Reproduction

1.Do you think it is the prime responsibility of women to bear and rear children
2. Do children raise status of a married woman among family, community?
3. How do family, neighborhood or community can influence how you feel about having children and the ideal number of children for you to have?
4. How soon should first conception take place after marriage?
5. How do women define their reproductive health and reproductive illness?
6. Can a woman delay her first pregnancy?
7. When did your first child was born?
8. Were you inquired or pressurized to become pregnant soon after marriage?
9. Do you think successful child bearing is a woman's strength?
10. Why children are needed?
11. What is your desired family size and why?
12. What family size your husband prefers and why?

13. How many children families expect you should have?
14. In your opinion gender composition matters in determining total number of children to have?
15. How do you perceive childlessness?
16. Did you experience any problem in conception and whom you consulted to seek cure? 17. Do you think infertility is a disease? 18. What are the causes and consequences of infertility for a married woman? 19. What kind of social or familial beliefs you had to face before becoming mother, while being pregnant and after becoming mother? Can you please respond in the context of your personal experience?

Theme 5 Reproductive Health Care Practices (Pregnancy, Antenatal, Delivery, Post-Patrum)

1.How do women define their reproductive health and reproductive illness?
2. How do you get to know you have conceived and was the conception according to your will or not?
3.What were the complications faced during your last pregnancy and whom did you consult for treatment?
4. What are those complicationsduring pregnancy that needmedical treatment?
5. Do you think is a woman right to receive antenatal care during pregnancy?
6. Do you think anti-natal checkups are important in every pregnancy?
7. Do you go for antenatal checkup and what were the reasons for having/not having the checkups?
8. What are those factors which can prevent a woman from seeking medical advice or treatment during pregnancy? 9. Did you receive any TT injection during pregnancy?
10. Did you take any iron tabletsduring this pregnancy?
11. Do you prefer to take help from the modern reproductive technology during pregnancy? If yes, then what kind of?
12. Is it important to detect genital defects of unborn child during pregnancy?
13. Can a gender of the unborn child be detected before birth and what kind of repercussions it has for the mother?
14. Is this a woman's right to choose where to give birth?
15. In your opinion, what is most important aspect to think before choosing place of delivery? 16. Who selected place of birth when you delivered last time?
17. Who assisted your during delivery and why and what are the traditional practices for conducting delivery at home? 18. How satisfied were you with the treatment you received during last delivery?
19. Did you face any problems during your delivery?
20. Do you consider postpartum care necessary for woman's health? 21. Did you receive post natal care and does family, society, tradition have any role in postpartum care? 22. In

what type of situations you feel that cultural belief played a major role in your reproductive health care?

Theme 6 Miscarriages, Induced Abortion and Family Planning

1. What barriers women face if they try to avoid pregnancy?
2. Should abortion be allowed in case of complicated or an abnormal pregnancy?
3. Do women need permission before aborting a pregnancy and how abortion can be induced at home?
4. Can abortion be allowed as an alternate to contraceptives?
5. What are the appropriate ways to avoid unintended pregnancies?
6. Did you have any miscarriage and what were the causes and from where you sought treatment? What are the family planning methods that you have heard?

1. Pills
2, Injection
3. Condom
4. IUD
5. Rhythm of periodic abstinence
6. Implants
7. Withdrawal
8. Female Sterilization,
9. Male Sterilization,
10. Other (Specify)

7. Have you ever-used any family planning Method? 8. When did you start family planning for the first time and if yes, then what was the reason 9. Who advised you to use that method?
10. What do you think is the appropriate number of children that you wish to have before adopting family planning?
11. From where did you get this method and did you receive all the necessary information regarding the correct use and possible side effects you might have with the method?
12. Can you ask your husband to use any method instead of you?
13. Who takes the final decision for choosing any family planning method?
14. Can you freely choose any family planning method for you?
15. With whom you think you should consult before choosing family planning method?

(For the Non-Users of Family Planning) 16.Who decided not to use any contraceptive? 17. What are the major reasons for not using any family planning method?
18. Do you intend to use any family planning method in future?
19. In your opinion, what are the main hindrances women face to adopt any family planning/method?

20. Do you think wife and husband should have mutual discussion on issues related to fertility control?
21. Do you discuss with your husband on the issue of family size, use of contraception, side effect of contraception, child spacing etc
22. Do you feel comfortable talking to your husband about your health problems?
23. In your opinion what are those cultural beliefs and family practices that shape your fertility preferences?

APPENDIX II

GLOSSARY

aam	Common
akhathe	Jointness
awaara	Wanderer
aapnay tido jammay bachay	One's own biological children
acchar	Pickle
afsos	Console
mahwari ka dard/masla	Dysmenorrhea/menstrual cramps
ajwain	Carom seeds
Allah ki Marzi	God's will
aulad-e-narina	Male child
agarbatti	Scented-wick
afeem	A drug produced from opium poppies
arand ke beej	Seeds of castor beans
bahir farigh hona	Coitus Interrupts or withdrawal
bachaa girana/zaya kerwana	Induced Abortion
bahir farigh hona	Coitus Interruptus or Withdrawal
bahu	Daughter-in-law
bachay band karney wala operation	Sterilization
bara operation	Caesarean Section
biraderi	Kinsfolk
bojh	Burden
be-sharam	Shameless
bachadani ka moon band hona	Blockage of the outlet of uterus
bachadani ka sookhna	Shrinking of the uterus
bachadani pe soj	*S*welling in the uterus
badi	Fats
bakray ki siri	Head of goat
baakri ojhri	Tripeman of goat
banjh or banjer	Barren
banjhpan	Barrenness
be khof	Bold
beauladi	Childlessness
bemar aurat	Pregnant woman
bethak	Sitting Place
bori	Sack
bura saya	Bad shadow
c*harpai*	Traditional rope bed with four wooden legs
dai	Midwife or untrained traditional birthattendant
chaadar	Loose veil which drapes over the body upto knees
chakkar	Extra marital affair
chaliyan or *chaleeswan*	Fortieth day after the death
chappal	Slipper
chai	Tea

charmagaz	Combination of four seeds
chiknai	Lubricating
chilla or *chaliyan*	Post Partum Period
chohara	Dried dates
chota operation	Episiotomy
choti bachadani	Small size of uterus
chotikaleji	Mutton liver
coola	Greasy
dactriilaj	Biomedical treatment
gunah	Sin
dehari daar mazdoor	Wage laborer
doodhpatti	Milky tea
d*esi ghee*	Homemade butter oil
dandaasa	Peel of walnut tree which is used for teeth
whitening*dupatta*	Diaphanous veil
daal	Pulses
dalchini	Cinnamon
desi nuskhas	Traditional herbal medicine
dugga	Mud vessel
eid	Muslim festival
faateha	Praying for the deceased
furz poora kerna	Complete the duty
gosht	Meat
gaachi	Mud
gaddi'	Hereditary decendence of shrine's care taker
galbaat	Gossip
hussal	Shower
ghutti	The first food given to the baby
guzara kerna	To manage or get along
gawah	Legal witnesses
gaachi	Mud
*h*uqooq	Rights
tauleedi huqooq	Reproductive Rights
hakeems	Practitioners of Unani medicine or herbal medicine
haldi	Turmeric
hamal tehrna or *bacha pait payna*	Being pregnant
hamdardi	Sympathy
haq mehr	Antimony
izzat	Respect or Honour
ilaichi	Cardamom
Ilaj kerwana	To seek treatment
imli	Tamarind
jawan larki	A girl who has reached menarche or puberty
jaiphal	Nutmeg
jaldi farigh hona)	Premature *ejaculation*
janj or *baaraat*	Wedding Procession

j*ari bootyan*	*R*oots and herbs
jinsi kamzori	Sexual weakness
Jinsi mislay	*S*exual problems
jisam ki chrbi	Body fat
j*in/pari*	*S*upernatural beings
khujli	Itching
katcha	Muddy
khidmat	To serve
katcha pakka	Bricked as well as mud plastered
kamaittee	Informal Revolving Fund
kanak	Wheat
karyane ki dukaan	Grocery shop
katcha chulla	Mud stove
khal	Hay
kheri	Traditional slipper
khushboo	Fragrance
kotha	House
kaara,	Traditional concoction made with milk & dried fruit
kachay chawal	Uncooked rice
kala amal	Black magic
kamarkas	Salviaplebeian
kamzori	Weakness
kapray ziada ana	Menorrhagia.
kastoori	Curcuma aromatica or fragrant plant
katori	*S*mall bowl
katwa	Traditional dish made from beef.
khoon ki kami	Anemia
khoon	Blood
khusri	Eunuch
koi aas hay	Any hope
koi khuskhabri	Any good news
koila	Coal
kuj hay	Are you expecting?
kodi	Traditional name used for a pearl found in the sea
kahva	Herbal tea
lussi	Curd water
lunger	Sacred food
majburi	Compulsion
mak	Maize
manṣuba bandi	Family planning
menhgai	Inflation
mannat	Sacred wish
mazdoori	Wage
mehndi	Hina
muharram	First month of the Islamic Calendar
maa banna	Becoming a mother

mahwari agey peechay hona	*M*enstrual irregularity
mahwari ka masla	Menstrual Problem
mahwari khul kay na ana	Hypomenorhea
maika	Natal home
majboor	Helpless
majboori	Necessity
miyan biwi ka mail	Sexual practices
mard ka pani	Semen fluid
murghi ka pankh	Chicken's feather
mandi gal	Bad deed
manhoos	Bearer of misfortune
mannat	Wish
marzi	Consent
haan	Yes
haliyo	Traditional name for a poisonous herb
mazaar	Grave of a Muslim holy person or *pir*
mithai, kheer, revriyan	Local sweets
mubarak	Congratulation
muthidard	Dull pain
naaf	Umbilic
nafas or *gandakhun*	Post partum bleeding
naloon main masla	Problem in the fallopian tubes
napak kapray	Ritually polluted clothes
naqas khoraak	Abortive food
naryal	Coconut
*Nazra-e-Qu*ran	Read the Holy Quran verbally,
nikahnaama	Marital agreement
nullain	Fallopian tubes
nuloon ka dard	Pelvic pain
n*amaaz-e-janaaza*	Funeral prayer
namaz	The ritual prayers prescribed by Islam
nasbandī	To get the tubes closed
nashta	Breakfast
nikahnaama	Marriage Agreement.
nazrana	Gift
oter nikhater,	The one without heir to carry their name after them.
paal perhaiz	Precaution
pakya pani	Boiled water
palethi ka bacha	First new born
panjeeri	Traditional dish made with semolina
parchawa	Evil shadow of infertile women
phitakri	A white transparent solid crystal
phulmakhana	Lotusseed
pudina	Mint leaves
puryan	Paper wrapped sachets of powders
parna	Small piece of unstitched cloth

parulla	Large metalled drums used for storage purpose
phubehri	Leucoderma, Skin disease
paratha	Fried flour bread
pulao	Rice cooked in meat broth
pakka	Concrete
purhez	Abstinence
qatal kerna	To murder
rasam	Practice
rishta	Marriage alliance or proposal
riwaj	Custom
rizq	Sustenance
roṭi	Traditionalhomemade bread
rasoli	Fibroids
reham pe zakham	Perineal wounds
rui ka bura	Cotton swab
sabir	Patient
sadqa	Alms
salan	Curry
samjhota	Compromise
shund	Local word for sterile woman
sokan	Husband's second wife
sonf	Aniseed
soowan	Sewing needle
sundh	Dried ginger
sunj	Thigh
surma	Traditional name for koal mostly used as eye cosmetics
susraal	Husband's home
saas	Mother-in-law
sharam	Shame, modesty
Ramazan	Ninth month of the Islamic Calendar, fasting month
saagh	Cooked vegetable
saryun	Mustard
s*halwar kameez*	Loose pants and trouser
sharbat or rooh afza	An eastern drink
siroon paar lana	Remove the burden from the head
sundh	Dried ginger
safai kerwana	Dilation and curettage
taaki or *leerain*	Rag
tandoor	Earthen stove
tanay	Taunts
tandoor	Big earthen oven
taqat	Energy
taqat ki golian	Iron and Zinc tablets
taqat wali	Nutritious
taqdeer ka likha	Destiny
taseer	Heating properties

teelay	Sharp edged sticks
waqfa	Birth spacing
wazeefa	Sacred Spell
zameendars	landlord
zanana masayl	Gynecological problems
zanjeerain'	Chains
zid	Stubbornness